Chapter 3

Regimes, norms, and the behavior of the Indian state

I begin by asking why did HIV/AIDS receive undue attention of the Indian state while other endemic diseases, such as diarrhea, childhood diseases, maternal deaths and a collapsing health system receive little or none? Why, and under what circumstances the Indian state behaved/ responded to the HIV/AIDS epidemic in this particular way? Based on the social constructivist theory of international relations (IR), I contend that state behavior is shaped through a process of “norm socialization” in which the state internalizes the principled ideas, values, and norms of a particular regime through a complex process of denial, negotiation, strategic bargaining, and identity formation. Norms are defined as “collective expectation about proper behavior for a given identity” (Jepperson, Wendt, & Katzenstein, 1996: 54); socialization is the “introduction of new members into the ways of behavior that are preferred in a society” (Barnes, Carter, & Skidmore, 1980: 35). The goal of norm socialization is for actors to internalize the norms so that external pressures are no longer needed to ensure compliance.

In this chapter, I examine the conditions under which principled ideas and international norms affect domestic institutional change, and the effect of regimes in norm diffusion and domestic institutional change in India. With respect to HIV/AIDS epidemic, this part examines what were the conditions that led the principled ideas of human rights, voluntary counseling and testing (instead of forcible testing), care and treatment (universal access to anti-retroviral drugs), prevention services (condoms, needle-syringe exchange), drug maintenance and substitution program (instead of criminalizing drugs), confidentiality, non-discrimination, and support services (economic, psychosocial, medical) were institutionalized and internalized in the domestic practices of the Indian state. Assuming that the way India started its AIDS prevention program in 1986, and measures proposed in the draft AIDS Control Bill of 1989 (outlined in chapter 2), a large part of these services would not have been
available to the current infected and affected people unless drastic institutional change and norm internalization had taken place.

Therefore, to put the question from IR theory perspective, this chapter explores why, under what conditions the values, norms, and principles of international HIV/AIDS regimes were internalized and implemented in Indian state’s domestic practices? While this chapter focuses on the reasons and causal linkages of state behavior in a particular way, the processes involved in how behavior-change took place will be explored in the next chapter. In the following few sections, I will first elaborate the definition, nature, formation, and functions of HIV/AIDS regimes, and then proceed to explain why, under what conditions the regimes’ norms and ideas were transmitted to reflect the behavior of the Indian state. A theory of regime as appropriate is therefore in order.

3.1. Regimes: Definition and function

Scholars of IR have noted that HIV/AIDS has acted as a catalyst for international regime formation and the impetus came mostly from transnational actors rather than sovereign states (Boone & Batsel, 2001; Vieira, 2007; Patterson, 2007). Today, a strong global AIDS regime is in place to coordinate the global HIV/AIDS response. The current regime is considered to be one of the most successful and effective cases of transnational cooperation that the world has yet seen (Mameli, 1998). In the following pages I explore how this has happened focusing on both the processes and their effects on the regime.

3.1.1. What is a regime?

The term “regime” was first introduced in IR literature by John Ruggie in 1975. He defined regime as “a set of mutual expectations, rules and regulations, plans, organizational energies, and financial commitments, which have been accepted by a group of states” (Ruggie, 1975: 570). More recently, a collective definition worked out at a conference defined international regimes as a “set of implicit or explicit principles, norms, rules and decision making procedures around which actors’ expectations converge in a given area of international relations” (Krasner, 1983: 2). According to
Krasner (1983: 2), **principles** define the **purpose** the members are expected to pursue (for example, the principle of upholding basic human rights of AIDS infected people and vulnerable groups of sex workers to achieve the purpose of AIDS prevention). **Norms** clarify *legitimate* and *illegitimate* behavior, and *responsibilities* of the states (such as, forcible testing and quarantining HIV-positive people are *illegitimate*; or state can *legitimately* provide drug maintenance and needle-syringe exchange services for injection drug users; or state owe a moral *responsibility* to ensure that HIV-positive people receive care and treatment in a non-discriminatory environment).

**Rules** are still more specific and difficult to distinguish from norms, but they can be altered more easily than norms – rules define the *rights* and *obligations* of members (such as, state has a right not to participate in HIV/AIDS regime, but once they participate they are obliged to report to the regime members about their progress; or the state has a moral obligation to provide anti-retroviral drugs to HIV-positive people. Note these are easier to change than norms). **Decision making procedures** lays out the ways in which members can *implement* their principles (for example, to protect the basic human rights of sex workers, and men having sex with men – MSMs, state can decriminalize prostitution and homosexuality, or bring modifications in legal provisions). Thus, principles, norms, rules and decision making procedures all contain injunctions about state **behavior**: all *prescribe* certain actions, and *prohibit* others (Keohane, 1984: 59).

Keohane (1984: 63) noted that participation in a regime is largely based on state’s self-interest. This means that, as Realists emphasize, they will be largely shaped by their most powerful members, pursuing their own interests (Waltz, 1979). But this is not always the case as the notion of self-interest itself is elastic, and largely constituted by the expectation of likely consequences (Young, 1980, 1983). In fact regimes become necessary under certain conditions to effectively pursue state interest. In a world political economy characterized by growing interdependence, regimes become increasingly useful for governments to solve common problems (such as drugs, terrorism, infectious diseases, environment) and pursue complementary purposes without subordinating themselves to hierarchical systems of control. The major function
of a regime is to facilitate the making of specific cooperative agreements among governments. They facilitate the smooth operation of decentralized international political systems and therefore perform an important function for the state (Keohane, 1984).

If participation in regimes was purely based on cost-benefit calculation, then there would be more noncompliance because of the incentive of individual states form immediate/short-term gain. However, states do worry about their reputation, retaliation, and precedence, which increase their compliance with a regime (Young, 1980). Once a regime is formed, it creates incentives for compliance by making the “environment” more attractive for others to join in. Since regime has a high value and difficult to create, once created, states are more likely to comply (Henkin, 1979).

3.2. AIDS regimes in international politics

During the last two decades of the HIV/AIDS epidemic, several powerful and influential HIV/AIDS regimes had emerged in the international politics playing crucial role in mobilizing state action and affecting the course of the epidemic at global level (Boone and Batsel, 2001). Since their formation, AIDS regimes have repeatedly emphasized greater political commitment of the state to take the disease on the national agenda, allocating greater resources to contain the spread of the epidemic, ensuring basic human rights of the infected and vulnerable groups, and providing treatment and care in a nondiscriminatory environment. Largely, the priority areas identified by the AIDS regimes were instituted in domestic practices in most states. Though some states complied more than others depending on their socio-political structures, available resources, and pressures from above, below, and within, as of 2010, India’s compliance with the AIDS regime could be termed “excellent.” In 2010, India had domestic institutional structures, practices, policies, services, laws, resources, and legal provisions in place to effectively contain the spread of the disease, while continuing to

provide treatment and care for the infected people in a non-discriminatory environment. The important question is, how did all this happen? I will answer this question in the next chapter after briefly reviewing the history of HIV/AIDS regime formation and their role in international politics.

The formation of AIDS regimes can be grouped under three distinct phases based on their pace of formation, capacity of norm diffusion, and strength of influencing the domestic institutional structures of various states. AIDS regimes have passed through three distinct stages – weak, moderately strong, and powerful; each phase broadly corresponding to a decade of AIDS activism and advocacy. The following pages trace the history of AIDS-regime formation through these three distinct phases.

**A weak regime: 1981-1990**

HIV was first discovered in California among a group of gay men in 1981. In the beginning, the lack of scientific knowledge, misrepresentation and mislabeling of the disease fuelled widespread panic, fear, and stigma in the United States (Triechler, 1999). By 1982, there was global recognition of the virus with increasing number of cases being reported from all western countries, and from Australia, New Zealand and Latin American countries – notably Brazil and Mexico (Barnett & Whiteside, 2002). During this period of heightened panic, fear and ignorance, the process of regime formation was slow. In fact, no AIDS-regime existed in the initial six years of the epidemic until WHO launched its Global Program on AIDS (GPA) in 1987.

During the initial period, AIDS activist groups such as the AIDS Coalition to Unleash Power (ACT UP), and the Gay Men’s Health Crisis (GMHC) had developed sophisticated advocacy techniques and lobbying with US policymakers. Their demands included access to drugs as well as cheaper prices, public education about AIDS, and the prohibition of AIDS-related discrimination. In 1985, the first International AIDS Conference was held in Atlanta, Georgia organized by the CDC and cosponsored by WHO and the US Department of Health. By this time, 17,000 cases of AIDS had been
reported and more than 80 percent were from USA.\textsuperscript{90} AIDS quickly became a high-profile disease with US President’s involvement, increased media attention, and activist politics. By May 1987, more than 20,000 Americans had died of AIDS and more than 36,000 had been diagnosed with HIV worldwide.\textsuperscript{91} Yet, the political leadership especially US President Ronald Reagan had yet to make a public statement about the epidemic, which was mainly prevalent in gay communities, injecting drug users, and a few immigrant communities. On May 31, 1987, President Ronald Reagan gave a speech about AIDS at a dinner of the American Foundation for AIDS Research and focused his talk on increasing routine and compulsory HIV testing.\textsuperscript{92} The following day, the Vice President George Bush opened the 3\textsuperscript{rd} International Conference on AIDS in Washington and was booed by the audience when he defended President Reagan’s HIV testing proposals.\textsuperscript{93} By the end of 1987, the WHO was notified of 43,880 cases of AIDS in 91 countries.\textsuperscript{94} With alarming number of HIV cases being reported from several parts of Africa, and almost every region of the world, a group of scientists and health professionals came together under the auspices of WHO to recommend a global strategy for AIDS prevention and control.

In October 1987, AIDS became the first disease ever debated on the floor of the United Nations General Assembly. The UN endorsed the GPA and mobilized the entire UN system in the worldwide struggle against AIDS under the leadership of the WHO.\textsuperscript{95} The GPA advised the governments to create surveillance systems and HIV/AIDS committees within their Health Ministries. GPA’s primary goal was to assist the health


ministries and governments to formulate national plans and programs by providing technical expertise and financial support.

In the initial stage, GPA’s policy focused on the promotion of public awareness, blood screening, condom promotion, and prevention efforts. Jonathan Mann, the head and the most influential figure in the WHO-GPA, propounded a human rights based approach to HIV/AIDS prevention partly being influenced by American gay activism of the early 1980s. However it was clear that even in heterosexual epidemic as in Asia and Africa, protection of human rights of the infected, affected, and vulnerable population was crucial components of HIV prevention and care. Without protecting human rights, effective prevention was almost impossible.96 Thus from 1987 to 1990, under the active leadership of Jonathan Mann, the WHO-GPA helped more than 150 countries to develop short and medium term plan for controlling AIDS (Illife, 2006: 70). India received about $19 million as part of the GPA initiative to implement a medium term HIV/AIDS prevention and control program over three years97 (1989-92).

The International AIDS Society was established in 1988 to coordinate the planning and implementation of the rapidly growing International AIDS Conferences.98 It also became a mouthpiece of the international scientific community and an authentic producer of the epidemiological and biomedical knowledge about the disease. The International AIDS Conferences played a crucial role in the production, control and regulation of AIDS knowledge and discourse, particularly in the developing countries. For example, 18 such conferences have taken place so far, of which only one in a

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96 One may argue how Cuba used a repressive policy and still controlled its epidemic. Cuba is a small island country with excellent prevention services and sex education. This condition does not compare with say, for example, India, a huge democracy, where repressive policy is likely to create a massive backlash. Protection of human rights was the only available way to go. On Cuba, see Parameswaran, G. (2004). The Cuban response to the AIDS crisis: Human rights violation or just plain effective? Dialectical Anthropology, 28: 289-305.

97 There is discrepancy in reporting in the Government documents for the amount of foreign aid that was received by the Government of India between 1989-92. While National AIDS Control Organization’s (NACO) most updated website reports this figure at US$10 million, the Comptroller and Auditor General of India in its audit report of NACO reports this figure at US$19 million. See Comptroller and Auditor General of India (2004), Report of the CAG on the Union Government: Union Government (Civil) Performance Appraisal 3 of 2004, National AIDS Control Program, CAG, Government of India, New Delhi.

developing country (15th Conference in Bangkok, 2004); and since early 1990s till 2010, an average of 65 percent participants were from USA, Canada, and developed countries of Western Europe, whereas the share of Asia and Africa having 82 percent of the disease burden⁹⁹ was only 10-15 percent.¹⁰⁰ These conferences served as the “trade fair” of various industries including pharmaceuticals (such as GlaxoSmithKline, Pfizer Ltd., Roche Pharma, BMS–Virology, Abott Laboratories, etc. for launching their AntiRetroViral Drugs –ARVs), condom manufacturers, and book publishers thereby establishing an international language for understanding, surveillance, and control of the epidemic.

The conferences that began as a professional gathering of thousand people in the 1980s, quickly became a highly politicized platform of NGOs, international organizations, bilateral donors and AIDS activists in the 1990s (Altman, 1998). In recent years, during the last four conferences (2004-2010), any typical conference was of a size of 20,000 participants, with over 1,200 media delegates¹⁰¹ (one media person per 16 participants). NGOs, activists, governments, planners, policy makers, ministers, bureaucrats, academicians, researchers, scientists, mediapersons, international donors, including HIV-positive individuals, sex workers, drug users, and queer communities across the globe came together on a common platform to share knowledge and information about the epidemic. This vast field of knowledge produced “truths” about the epidemic and the conferences became a platform for advocacy, lobbying, and dissemination of “truths” at the global level. As the epidemic has grown, regional level conferences have also become prominent, for example, International Congress on AIDS

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⁹⁹ UNAIDS. (2010). *AIDS epidemic update 2009*. Geneva: UNAIDS. p. 11. Asia and Africa in this calculation only includes Sub-Saharan Africa (22.4 million); Middle East and North Africa (310,000); South and South East Asia (3.8 million); and East Asia (850,000), out of total infected population of 33.4 million in the world. This does not include Pacific islands, Central Asia. http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf.


in Asia and the Pacific, Australian AIDS Conference, or Conference of the AIDS Society of India.

**Gaining strength: 1991-2000**

Despite all these advancements, AIDS regime remained weak until mid-1990s partly due to the lack of clarity and/or tension around the “norms” that the regime was embracing (Patterson, 2007); partly because of the lack of available recourses and commitment of bilateral donors (Vieira, 2007); and also partly because of the resistance of many developing countries to accept these new “norms” as they confronted their cultural values (Ntseane & Preece, 2005; Youde, 2005). For example, WHO officials and some US policymakers wanted a technical and biomedical solution to AIDS (such as drugs and vaccines), but GPA’s (Jonathan Mann’s) political solution of protecting human rights to control the spread of the epidemic was conflicting and disappointed those who advocated for quarantining, forcible testing or immigration control based on one’s HIV-positive status. This tension was also apparent as some developing countries like Uganda and Senegal adopted and emphasized political solution to control AIDS (by giving information to the risk-groups, and openly discussing sex), while India and other African countries were reluctant and hesitant to talk about sex and chose to ignore or deny the epidemic (Dube, 2000; Pisani, 2008). While the epidemic increased between 1991-1995, the global funding also stagnated.

In 1991, under the aegis of the GPA, the International Council of AIDS Service Organization (ICASO) was established to mobilize and support diverse community organizations to build an effective global response to HIV/AIDS.¹⁰² Today, with its headquarter in Toronto (Canada), and regional secretariats located in all five continents, the ICASO’s networks operate globally, regionally and locally reaching over 100 countries.¹⁰³ Needless to say, all NGOs, activist groups, and community service

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¹⁰³ The regional networks of ICASO are: African Council of AIDS Service Organizations (AfriCASO); AIDS Action Europe (AAE); Asia-Pacific Council of AIDS Service Organizations (APCASO); Latin America and the Caribbean Council of AIDS Service Organizations (LACCASO); and North American Council of AIDS Service Organizations (NACASO).
organizations must understand, implement, and follow the same ICASO regime\textsuperscript{104} in order to be eligible for funding. However, the regime was still weak because of the division within WHO officials over political versus biomedical solutions, declining US interest with declining fear of a US heterosexual epidemic, lack of clear norms, and shifting US foreign policy goals after the end of the cold war (Patterson, 2007, p. 6-7; Vieira, 2007 p. 148).

In the early 1990s, the adult prevalence rate of HIV in Western Europe and US was relatively low whereas in Sub-Saharan Africa, and certain parts of Asia (India, Thailand), the virus spread quite rapidly. With growing epidemic, the ineffectiveness of the global response increasingly came under scrutiny and the leadership of the WHO/GPA began to fade. In 1996, the United Nations took an innovative approach to bring together six UN organizations under a common platform to form the Joint United Nations Program on HIV/AIDS (UNAIDS); later four more organizations joined the group in due course. As of 2010, UNAIDS consisted of the efforts and resources of 10 UN organizations: Office of the United Nations High Commissioner for Refugees (UNHCR); United Nations Children’s Fund (UNICEF); World Food Program (WFP); United Nations Development Program (UNDP); United Nations Population Fund (UNFPA); United Nations Office on Drugs and Crime (UNODC); International Labor Organization (ILO); United Nations Educational, Scientific and Cultural Organization (UNESCO); World Health Organization (WHO); and the World Bank. The UNAIDS had a clear mandate and focused on five priority areas: mobilizing leadership and advocacy; providing strategic information and policies to guide AIDS prevention efforts; tracking, monitoring and evaluation of the epidemic; engaging civil

\textsuperscript{104} Some of the guiding principle of ICASO regime are: ensuring protection and fulfillment of human rights of people living with and vulnerable to HIV/AIDS; greater involvement of HIV-positive people in planning, management, and implementation of programs; removing fear, coercion and deception from all HIV/AIDS policies, programs and services; and coordinate relevant international programs by influencing global policy through advocacy at the global level. Organizations that receive ICASO funding usually focus on one or more such priority areas and adhere to the regime principles at the domestic level. Retrieved from ICASO. (2010). \textit{Guiding Principles}. http://www.icaso.org/guiding.html.
society; and mobilizing financial, human and technical resources to support an effective AIDS response at the global level.105

The creation of UNAIDS as a separate multilateral HIV/AIDS agency was an unusual development in the history of the UN. In fact, it was the first time in the history of any single disease that a UN agency was formed. Comparable UN institution, such as UNPolio, UNSmallPox, UNBlackDeath, or UNCholera did not exist at the height of these epidemics. UNAIDS was in-charge of promoting a particular understanding about what HIV/AIDS is and how it should be dealt with by states and non-state actors, thereby underwriting the truths and norms about the epidemic. When UNAIDS opened for business in January 1, 1996 by closing down GPA, it had 91 staffs based at the WHO headquarter in Geneva with a budget of $130 million for 1996-97 (Das & Samarasekara, 2008: 2100). By the end of 2009, UNAIDS Secretariat had grown to over 900 employees and more than 80 country offices106 with a budget of $484 million107 for 2010-11.

Thus with its mandate of advocacy, mobilizing resources, and engaging civil society, UNAIDS was more political in nature than its predecessor, GPA. As UNAIDS admits in one of its publications, “political advocacy was high on UNAIDS’ list of priorities” (UNAIDS, 2008: 48). When it opened in 1996, UNAIDS’ regime was still weak as it lacked funding, and support from US and UK; coordination between co-sponsors proved to be difficult; and its mandate was different from GPA that provided direct financial support to more than 130 states for implementing their HIV/AIDS activities. Now UNAIDS with a different mandate to “coordinate funds” for HIV/AIDS activities rather than directly distribute them left many country in a precarious financial situation (Das and Samarasekara, 2008: p. 2100).

To increase its legitimacy, UNAIDS produced very high-profile scientific studies, flashy, attractive advocacy materials, developed knowledge-base, reports, toolkits and training manuals, based on worldwide HIV-prevalence data and successful HIV/AIDS programs. Pisani (2008) offered an insider story about what UNAIDS did during these initial years – how it played politics in knowledge production by “cooking up the epidemic,” inflating the numbers, or the gravity of the epidemic, instructing the UNAIDS consultants to blow the issue out of proportion, making it a hill out of a mole, or which Pisani simply called, “cooking up an epidemic” (Chapter 1, pp. 13-42).

Similarly, Chin (2008) pointed out that the numbers were intentionally inflated to keep HIV/AIDS high on the political agenda. As Das and Samarasekara (2008) noted, “AIDS is an existential threat in one subregion, Southern Africa. Elsewhere, AIDS exceptionalism can no longer be sustained and damages the credibility of AIDS in the eyes of objective public health specialists” (p. 2101).

The result was obvious – within four years, there was a renewed interest of various stakeholders globally. Funds started to flow in and the available budget for HIV/AIDS prevention jumped from $300 million in 1996 to $800 million in 1999. The US also became interested to contain the epidemic as President Bill Clinton designated HIV/AIDS as a security threat to the United States (Vieira, 2007, p. 150). Clinton’s designation made the National Intelligence Council produce two horrifying reports: one outlined the direct and indirect effects HIV will have on the US and global security over 20 years

108; the other was on the next “wave” of AIDS from five countries, India, Russia Nigeria, Ethiopia and China that will largely be responsible for a future global AIDS epidemic. The total number or infected people as predicted in this report were vastly exaggerated – 50-75 million by 2010. Out of this China will have 10-15 million; India will have 20-25 million; Nigeria will have 10-15 million; Ethiopia 7-10 million, and Russia 5-8 million (NIC, 2002: p. 8). The truth is, that even after a decade of this prediction, as per the latest 2010 data from UNAIDS, India’s total infection stands at

3.2 million (8 times less); Nigeria’s 3 million (5 times less); and so on\textsuperscript{109} (UNAIDS, 2009, *AIDS epidemic update*). Prediction, representation, discursive practices from such powerful institutions as UNAIDS and NIC, had both their meaning and impact. They were successful in raising an alarm and a sense of urgency among bilateral donors, governments, health ministers and other international organizations working on health issues to pay increasing attention and bring HIV/AIDS on the table.

UNAIDS advocacy had a great impact. In January 2000, under the renewed US interest and leadership, the UN Security Council debated the AIDS pandemic – the first time any health issue discussed as a security threat. The US Vice-President, Al Gore, chaired the debate. The Security Council debate brought AIDS to the forefront of the global political agenda. In this debate, the Ukrainian ambassador to the UN advocated for a Special Session on AIDS – a UN General Assembly Special Session (UNGASS), in which the entire UN focuses on one issue of greatest global significance (UNAIDS, 2008: 105). In that same year, the World Bank launched a new program: Multicountry AIDS Program (MAP) for Africa that provided loans to affected countries in the African continent to fight the disease. In July 2000, the communiqué of the meeting of the Group of Eight (G8) nations in Okinawa, Japan, announced an ambitious plan of action on infectious diseases, acknowledging that health is central to economic development. The seeds were sown for what would eventually become the Global Fund for AIDS, Tuberculosis and Malaria in the new millennium. Funds, pledges and commitments for HIV/AIDS activities started to come in from the governments of both developed and developing countries. As UNAIDS admits:

“[it] is clear that together with the work of activists, UNAIDS’ activities during 1998 and 1999, especially in the area of political advocacy, contributed to a change in attitude towards the epidemic. These activities would in turn lead to significant events and actions at the start of the twenty-first century that could never have been predicted in 1999. By the end of 1999, more senior leaders – presidents and prime ministers as well as leaders in civil society – were beginning to speak out about the epidemic and showing commitment to action. In some countries, this was the result of behind-the-scenes diplomacy and hard

negotiations between UNAIDS and political leaders in both the South and North” (UNAIDS, 2008: p. 73, emphasis mine).

While what exactly entailed these “behind-the-scenes diplomacy” and “hard negotiations” are not clear, with these developments, the landscape of UNAIDS regime in general, and the HIV/AIDS regime in particular gained significant strength. New international organizations emerged, such as, International AIDS Vaccine Initiative, Global Alliance for Vaccines and immunizations (GAVI), Global Network of Sex Workers, International Treatment Preparedness Coalition, and other national and international networks of sex workers, queers and vulnerable communities, that significantly influenced the AIDS policy regime. With UNAIDS, the AIDS regime had already gained a momentum that produced a snowball effect toward the turn of the new millennium. The landscape of AIDS activism had completely changed – new organizations formed, new players emerged, more resources flowed in; but voices of decent also started to emerge as excessive focus on a vertical program like AIDS beginning to ruin the health systems in several countries.

A formidable force: 2001-2010

The new millennium brought in a sea change in attitudes to AIDS and, over the next few years, the epidemic and its impact remained a key item on the agenda of global leaders and IOs (UNAIDS, 2008: 169). As a mark of increased commitment and greater international cooperation, the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) was established across the Atlantic in February 2001. PANCAP brought together governments of all countries and territories in the region, IOs, bilateral and multilateral donors, education, health, development, culture, and religious NGOs, networks of people living with HIV/AIDS, and the private sector. Within five years after its establishment, by end-2006, all countries in the Caribbean were members of PANCAP; and the number of actors involved in the AIDS response grew to 60 (UNAIDS 2008: 130). Resources started to flow in with increased advocacy by the PANCAP leaders; and by end-2007, more than 220 projects were operational in the PANCAP constituency, with a total value of more than $880 million (ibid., p. 130).
Thus PANCAP became a highly successful, active, and visible partnership within a very short time.

Two months after PANCAP’s formation, in April 2001, leaders of African states met in Abuja, Nigeria at the summit on HIV/AIDS, TB and Other Related Infectious Diseases. All 53 member states of the Organization of African Unity (OAU) endorsed the Abuja Declaration jointly stating that:

“We, the Heads of State and Government of the Organization of African Unity (OAU)… recognize that the epidemic of HIV/AIDS, Tuberculosis and Other Related Infectious Diseases constitute not only a major health crisis, but also an exceptional threat to Africa’s development, social cohesion, political stability, food security as well as the greatest global threat to the survival and life expectancy of African peoples [para 13, p. 3]. We consider AIDS as a State of Emergency in the continent [para 22: 4]… [we] recall and reaffirm our commitment to all relevant decisions, declarations and resolutions in the area of health and development and on HIV/AIDS [para 21: 4]… We commit ourselves to take all necessary measures to ensure that the needed resources are made available from all sources… We pledge to set a target of allocating at least 15 percent of our annual budget to the improvement of the health sector” [para 26: 5] (OAU, 2001: 1-5, emphasis mine).\(^{110}\)

The alarm raised through this discursive practice such as labeling AIDS as an “exceptional threat,” or “greatest global threat,” motivated other leaders elsewhere to consider AIDS as a “state of emergency.” On the final day of the OAU summit on April 26, 2001, the UN Secretary-General Kofi Annan issued his famous global call for action to contain the HIV/AIDS epidemic. Another two months down the line on June 27, 2001, UNAIDS advocacy finally culminated in the adoption of the famous Declaration of Commitment at the UN General Assembly Special Session (UNGASS) on HIV/AIDS. UNAIDS admits “[The] hard work of UNAIDS and its many partners on advocacy bore fruit at UNGASS in 2001” (UNAIDS, 2008: p. 132).

The Declaration of Commitment was a landmark event in the history of AIDS epidemic. For three days, HIV/AIDS was discussed at the highest level in the world’s

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most high-profile forum, by many heads of state and senior leaders from other sectors. Every night, the AIDS red ribbon glowed on the UN building creating an image of strong commitment widely circulated across the globe through television and newspapers. All 189 member states of the UN signed the Declaration without reservation. As the Declaration reads: “We, heads of State and Government and representatives of States and Governments, assembled at the United Nations… special session of the General Assembly, [are] deeply concerned that the global HIV/AIDS epidemic… constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights” (UNGASS, 2001, para 1-2, p. 6). The Declaration of Commitment also recommended that the multilateral and multisectoral responses be coordinated under the leadership of UNAIDS, “commending the leadership role on HIV/AIDS policy and coordination… of UNAIDS…, [it] could assist, as appropriate, Member States and relevant civil society actors in the development of HIV/AIDS strategies…” (UNGASS, 2001: para 35, p. 14).

The Declaration of Commitment thus represented the willingness, consent, and blueprint for future action of the heads of state producing a powerful national and global response to the AIDS epidemic. Despite major disagreements between states and non-state actors about culturally sensitive and contentious issues such as HIV prevention for sex workers and gay men, UNGASS process demonstrated how the UNAIDS strengthened the AIDS regime. The Declaration became a benchmark for global action; it became a tool for holding the states and leaders accountable. UNAIDS (2008) observed that “extensive media coverage on a scale unprecedented for a UN event contributed to raising awareness globally of the epidemic and its impact. No country and no leader could any longer say they did not know about the exceptional magnitude of the AIDS crisis or about exactly what needed to be done” (p. 132). As Barnet and Whiteside (2002) noted, the process of building consensus on HIV/AIDS policies at UNGASS was probably more important than the end product itself, because the open dialogue between various state and non-state actors challenged the AIDS stigma; discuss contentious issues and come to a compromise, that helped policymakers understand the complexity of prevention.
Though prevention was identified as the most desirable option of global AIDS response at the UNGASS, bypassing the issue of treatment and care of infected people brought serious controversy at the meeting. The Rio Group, a unified negotiating block consisting of 23 Latin American and some Caribbean states (covering entire South America, Central America, and Mexico), along with activist groups such as Health Global Access Project (Health GAP), ACT UP, Médicins sans Frontières (MSF), etc., provided strong opposition advocating treatment and greater access to affordable ARV drugs. The donors, except for France and Luxemburg, opposed this position. For donors, not only the cost and long term sustainability of such a program were of concern (as ARVs must be taken throughout one’s life), but also technical issues, such as capacity to deliver ARVs (qualified doctors, nurses, diagnostic facilities), patient’s adherence to treatment regime, and close monitoring of patients for drug resistance, virus mutation, and side effects were also some of the valid concerns. However the Rio Group was successful in getting their demands heard and elevated the importance of providing accessible AIDS treatment in the final Declaration of Commitment (UNGASS, 2001: Para 55-57, p. 22-23). However, no concrete numerical targets were set for this goal.

The Declaration of Commitment signed by 189 member states finally became the “norms” of the AIDS regime. This does not mean there were no norms before the UNGASS Declaration, but those norms mainly promoted by UNAIDS, IOs, INGOs, and activist groups were open to challenge by individual states – now after being a signatory to the Declaration, these norms were officially received, protected and followed. The norms recognized that HIV/AIDS is inherently linked to human rights, poverty, and gender inequality, and respecting, protecting, and fulfilling the human rights of all individuals is an essential part of any response to HIV/AIDS. The Declaration outlined time-bound targets on HIV prevention, care, support, treatment, and resource mobilization; nations were required to report their progress at every subsequent UNGASS meeting. By 2003, states were asked to develop “multisectoral national strategies and financing plans for combating HIV/AIDS;… confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the

**The Global Fund, PEPFAR and other “big” players**

Following up on UNGASS Declaration of Commitment in July 2001, the leaders of the G8 nations at their summit in Genoa (Italy), finally approved the creation of the Global Fund. A permanent Secretariat was established in January 2002 in Geneva (Switzerland); and within three months in April 2001, the Global Fund Board approved the first round of grants announcing $616 million to be disbursed to 36 countries over two years. Since then through October 2010, the Global Fund Board approved proposals totaling $19.4 billion, and disbursed $12 billion for HIV, tuberculosis (TB) and malaria control efforts;\(^\text{111}\) roughly $1.5 billion a year on average. At the end of September 2010, Global Fund programs were providing ARV therapy to 2.8 million people worldwide; and it had signed a total of 775 grant agreements in 146 countries.\(^\text{112}\)

The Global Fund is a unique case of comprehensive multilateral action for fighting HIV/AIDS, TB and malaria. The Fund’s Governing Board consists of donor and recipient states, multilateral agencies (such as UNAIDS, and the World Bank), NGOs, and private sector representatives. To be eligible for funding, a proposal must be submitted through the Country Coordinating Mechanism (CCM). The CCM is a body in the recipient state consisting of government organizations, NGOs/ activist groups/ PLHIVs, and representatives of bilateral and multilateral donors. The Global Fund hires


international consultants to provide “technical assistance” to the CCM to develop “sound” country proposal to be considered for funding. In fact, to get approved for funding, the country proposal must embody the principles and guidelines taught by the international “experts” to the states under the guise of “technical assistance.” Global fund is thus an important actor in promotion, preservation and furtherance of the “norms” of the AIDS regime in general, and Global Fund regime in particular.¹¹³ Once the grant is approved, the CCM oversees the implementation of projects, whereas a Local Fund Agent, a reputed chartered accounting firm (usually, PriceWaterHouse Coopers, or Ernst & Young type organization) checks the fund performance. The recipient states must also adjust and restructure their existing institutional arrangements to manage the Global Fund’s grant.

The creation of Global Fund (and preceding UNGASS) acted as a catalyst in mobilizing AIDS response across the globe, primarily because huge funding was available. Increasing numbers of National AIDS Control bodies (or similar organizations) were established in the domestic spheres of various low income states. There was also a renewed level of interest and support among bilateral and multilateral donors for tackling HIV/AIDS. Thus in January 2003, the US President George W Bush, in his State of the Union address, announced the launching of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). On May 2, 2003, the US House of Representatives approved the legislation authorizing spending of $15 billion to fight AIDS during the coming five years. This was one of the biggest leap-forward in the AIDS funding. UNAIDS (2008) noted that although Peter Piot, the Executive Director of UNAIDS was disappointed because most money was not go to the Global Fund, “he believed that this was one of the most crucial moments in the history of the epidemic:

¹¹³ As mentioned in the Preface, I was an integral part of writing, conceptualizing and developing Global Fund country proposal for India during Round 4 grant making process (2004). My experience during the Global Fund proposal development finally motivated me to write this dissertation. The Global Fund sent two international experts to work with us (the PFI team). Even at that time, the Global Fund regime was quite strong (and rigid) – at every step, these experts would influence critical decisions that not only suited the Global Fund regime, but also reoriented the India country proposal to Global Fund’s needs. That was a requirement to get the funding.
[when] the most powerful person in the world puts 15 billion dollars on the table, it completely changes the landscape” (p. 169).

Within four months after PEPFAR, the WHO and UNAIDS jointly launched its “3 by 5” initiative in September 2003 that was unanimously endorsed in May 2004 by 192 WHO member states. The goal of “3 by 5” was to put 3 million people living with HIV to ARV treatment by 2005 from a baseline of 400,000 people. The 3 million target by 2005 was still half of all the HIV-positive individuals in need of treatment in developing countries. Though target was not met, and by end of 2005, only 1.3 million people were receiving ARV treatment\(^{114}\) (an increase of 900,000 in two years against a target of 2.6 million, 35%), it was a stepping stone for universal access to ARV drugs advocated by activists. The treatment coverage vastly expanded by 3 times (from 400,000 to 1.3 million), and the state capacity and infrastructure to deliver ARVs were already in place.

In January 2004, the UN Secretary-General Kofi Annan launched the Global Media AIDS Initiative (GMAI) to highlight the importance of the media in responding to the HIV/AIDS. He asked all media companies to commit to using their resources to expand public knowledge, awareness and understanding about the disease. Executives from more than 20 media corporations across 13 countries attended the launch and committed their companies’ resources to raising the level of public awareness and understanding about AIDS (UNAIDS, 2008: 182).

In July 2005, even before the “3 by 5” targets were attained, the leaders and heads of the G8 nations at the UN World Summit decided to upscale the current treatment program to cover “all by 2010” desiring to achieve universal access ARV-treatment, HIV prevention, and care by 2010. The “all by 2010” target is also part of the MDG 6 that includes the goal of halting and starting to reverse the spread of HIV/AIDS by 2015. Though massive progress was made in scaling-up ARV-treatment, it is far shorter than what is needed to achieve anything nearing “universal.” By the end of

2009, 5.2 million people worldwide were receiving ARV therapy that represents only
36% of those in need of treatment based on WHO 2010 guidelines\(^{115}\) (CD4 cell count of
below 350/mm\(^3\)). Though “universal” is defined “as coverage of at least 80% of the
population in need,\(^{116}\) global targets of “all by 2010” for HIV prevention, treatment, and
care are unlikely to be achieved in 2010. Out of 144 low and middle income countries,
only 8 (Botswana, Cambodia, Croatia, Cuba, Guyana, Oman, Romania and Rwanda)
achieved the universal coverage (of at least 80%) by the end of 2009.\(^{117}\) Another 15
countries had achieved the 80 percent target for coverage with antiretroviral prophylaxis
to prevent mother to child transmission of HIV.\(^{118}\) Based on the country-defined targets
for 2010, it was 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
invested in the AIDS response in 2008.\(^{119}\) However, the uncertainty of future funding
given the recent global economic downturn has raised serious concern about treatment
sustainability and potential for scaling up universal access. Global Fund has already
received a commitment of $11.7 billion from it donors for the years 2011-2013, the
largest ever financial pledge for the collective international effort to fight AIDS, TB and
malaria.\(^{120}\)

What is striking about this global AIDS effort is that bulk of it occurred after
2000. The amount of resources available for and directed toward HIV/AIDS prevention
was unimaginable even a decade ago; from $300 million in 1996 to about $14 billion in
2008. A large part of this funding came from PEPFAR, GFATM and World Bank’s
MAP program. However, about one-third (33%) of all AIDS spending in low-and
middle-income countries in 2005 also came from the developing countries themselves

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\(^{116}\) Ibid. Toward universal access, p. 5.

\(^{117}\) Ibid. Toward universal access, p. 6

\(^{118}\) Ibid. Toward universal access, p. 9.


UNAIDS claims that its “advocacy work had contributed to this huge increase in funds” (ibid.).

It is amply clear from the pledges and commitments of 192 member states of the UN that the AIDS regime has gained formidable strength over other issues of social and economic development. Three factors drove the strengthening of the AIDS regime in the new millennium: first, powerful states, particularly the US, have viewed fighting AIDS as in their economic and security interests; second, HIV/AIDS is intricately linked to the issue of human rights, and the activists and networks of human rights remained one of the most successful groups in the international arena in recent times (Keck & Sikkink, 1998; Risse, Ropp & Sikkink, 1999). In addition, almost all states are a signatory to the UN Universal Declaration of Human Rights (1948) regime. Protecting human rights was thus internalized as an important feature of a democratic nation-state. A third factor is due to the intense pressure from the non-state actors, grassroots activists, NGOs, IOs and civil society organizations that constructed the state both “from above” and “from below” to accommodate the demands of these groups (Brysk, 1993; Reich, 2002; Sridhar & Gomez, 2010). AIDS received enormous attention not only because of its intrinsic connection with human rights, but also because of its connection with gender, feminism, poverty, population, health, education, sexuality, development, economic progress, and national security; it drew activist of almost every field under one roof. As AIDS regimes have gained strength over the years, their effects on global health in general, and HIV/AIDS in particular have come to dominate the debated. In the section below I outline some of the effects of AIDS regimes on global health.

3.3. Effects of AIDS regimes on global health

While I have mentioned part of the effects in the previous three sections only in passing, here I pay special attention to explore this issue at length. Of late, especially after 2000s, intense debates have arisen from activists, grassroots AIDS workers, researchers, and national leaders criticizing the adverse effects of powerful AIDS
regimes on global health\textsuperscript{121}; and as counterarguments, the networks of people living with HIV/AIDS, NGOs working on AIDS, and heads of vertical programs have argued the need to maintain and even strengthen these regimes to promote a coordinated global response.\textsuperscript{122} For convenience, I will classify these effects under two broad lines of arguments: 1) those provided in support of the existing AIDS regimes and maintaining the status-quo; and 2) those with a critical stance on how powerful AIDS regimes have been harmful for global health outcomes.

\textit{Yes: AIDS regimes must be maintained and strengthened further}

This line of argument follows the typical AIDS exceptionalism argument advocating that AIDS is truly an “exceptional” disease requiring special attention, special programs, special strategies, more resources and a coordinated global effort to contain the epidemic (UNAIDS, 2004; Piot, 2005). While many activists and researchers, including UNAIDS and GFATM have advocated for integrating AIDS programs in the overall public health systems (UNAIDS, 2006 Chapter 11, pp. 254-80; Global Fund, 2005; WHO, 2008, Chapter 6, pp. 103-08), in reality, AIDS programs were developed as separate vertical programs disjointed from the overall health systems to maintain its special status (Chin, 2007; England 2007, 2008). Specific donors and regimes have preferred separate infrastructure for AIDS programs and services creating the largest vertical program in history (England, 2008; Flock, 2009). Pedro Cahn, the President of the International AIDS Society claimed that “AIDS exceptionalism is not a function of politics, but of facts; HIV is a special virus, with genetic mutability…”. Unlike other diseases, HIV is uniquely linked with sex and drugs, and impacts young and working adults in their prime economic and reproductive lives (Barnet & Whiteside, 2002; Poku & Whiteside 2005), the effects on economies are long-term and intergenerational (Haacker, 2004; Bell, et.al., 2004; Over, 2004). Similar opinion is held

\textsuperscript{121} See for example, Chinai (2003); Chin (2007, 2008); Pisani (2008); England (2007, 2008); Shiffman (2008); Biesma, et.al (2009) among others.
\textsuperscript{122} See for example, World Bank (1997); Ainsworth (1998); UNAIDS (2008, Chapter 9, pp. 243-262); UNAIDS (2009); Poku (2006); Piot (2005); Williams (2005), among others.
by Ngaire Woods, Co-Chair of the UNAIDS Leadership Transition Working Group, who believes that the “scope” of HIV is distinct; it’s not just a health issue and is associated with politically sensitive topics, such as, sex and drugs, and stigmatized groups, e.g., sex workers. This exceptionalism is also clear among a group of researchers and academics (Barnet & Whiteside 2002; Singhal & Rogers, 2003; Ruxrungham, 2004; Barnet 2006). Barnet’s (2006) argument is based on the “distinctiveness” of AIDS as a retrovirus having no cure, and also as a “long wave event,” that remain silent in population without any apparent symptom thus allowing the disease to spread unknowingly until it reaches epidemic proportion. To convince people about its distinctiveness, scholars have always used much controversial statistics (Pisani, 2008): 38.6 million people worldwide were living with HIV in 2005; 4.1 million became newly infected; with 2.8 million lost their lives to AIDS (UNAIDS, 2006. AIDS epidemic update, p. 8); though these figures, were not comparable to a much higher burden of endemic diseases, such as, pneumonia, cancer, diarrhea, infant and maternal mortality, etc., in any known part of the world.

This line or argument thus propagates that since AIDS is exceptional in its “scope,” an umbrella organization like UNAIDS is more desired to tackle the wide-ranging effects of and approaches to HIV/AIDS than a purely health-focused body, such as WHO. UNAIDS’ regime having endorsed by 192 member states of the UN, acts as a powerful agent and as a “legitimate” body that can deliver much needed guidance, tools, expertise, strategies and directions, similar to the role played by the Intergovernmental Panel on Climate Change. Other bilateral or multilateral donors, private foundations, and INGOs also follow UNAIDS regimes thereby having a cascading effect. Thus multiple AIDS regimes and their global initiatives have promoted good governance, transparency, and accountability among recipient countries (Tangcharoensathien, et.al. 2010). Many of these regimes (UNAIDS, GFATM) have been praised for promoting greater participation of NGOs and civil society in decision

125 See, Center for Global Development. (2009). ibid.
making procedures, promoting the principles of GIPA, and for working with civil society groups to make the treatment, affordable, accessible and lower the prices of ARV drugs (Das & Samarasekara, 2009).

AIDS-regimes have also helped in improving the human rights practices in several countries. The introduction of targeted intervention programs among hitherto marginalized groups, such as, sex workers, queers and drug users, has led to their collectivization and lobbying with activists and NGOs to pressure the state to recognize their civil rights by challenging constitutional laws (Patton, 2002; Pisani, 2008; Kole, 2007). With reference to India, I examine these aspects at length in Chapter 5 and Chapter 6 of this dissertation. Also, because of the regime’s influence, many countries have considered AIDS as a national emergency, allocating greater resources on AIDS from domestic budgets and implemented institutional changes and practices to comply with the regime, which is a good sign. UNAIDS has also acted as a global clearinghouse for epidemiological surveillance, providing reliable source of knowledge about the course of the pandemic. Its greatest achievement has been to work as an advocate and promote a strong global response to HIV/AIDS (UNAIDS, 2010).

Implementing AIDS programs also has a spillover effect on other health systems. Many individuals involved with HIV/AIDS control have argued that the impact of greater funding on HIV/AIDS largely has been positive, generating greater attention to and resources not just for HIV/AIDS, but for all health issues (Yu, et.al. 2008; Piot, et.al., 2009). However, by tracking OECD Credit Reporting System funding data over 1998-2007 on four priority areas – HIV/AIDS, health systems strengthening, population and reproductive health, and infectious disease control, Shiffman, Berlan, and Hafner (2009) concluded that available data does not indicate that “donor funding for HIV/AIDS has lifted all boats” (p. s45). Donna Barry and Joia Mukherjee at Partners in Health, a Boston based NGO, argued that treatment of HIV/AIDS is inseparable from the most basic aspects of health care, such as, detection and treatment of TB, STDs, and provision of women’s health. Investing in AIDS therefore is not parallel/vertical, but in addition to the existing structures, something that can be utilized
by patients from other health sectors. This approach allowed the use of vertical funds earmarked for AIDS to provide adequate compensation for medical staff, improve infrastructure, diagnostics, staff and providing general health services. Worldwide only half of the people in need of treatment are currently receiving ARV therapy. Considering the magnitude of the problem, the current level of resources that are directed to AIDS is half of what is needed (UNAIDS, 2009: What countries need, ibid.). It is therefore argued, that current AIDS regimes must be strengthened and maintained for greater advocacy for resource mobilization, coordinate global efforts, and ensuring standards in prevention and care services (WHO, 2008; UNAIDS, 2008).

**No: AIDS regimes and its vertical programs are harmful for global health**

However, critiques have pointed out that one important feature of AIDS exceptionalism has been to distort the global health priorities; HIV/AIDS has been draining resources form other important sectors of health aid (Shiffman, 2008; England, 2009; Sridhar & Batniji, 2008). As early in 2004, in one of its reports UNAIDS observed that:

“It is an unfortunate reality that budgeting procedures too often may mean that new funds for HIV and AIDS can draw resources away from other activities, either at country level, or at donor level. Therefore, all parties need to commit themselves to the principle that additional funding for HIV and AIDS is to be used for additional spending, otherwise displacement is inevitable to the detriment of overall development. (UNAIDS, 2004, p. 145: emphasis mine).

Unfortunately, as Shiffman (2008, 2009) noted, this pledge for “additional” funding for HIV/AIDS did not happen from “additional” donor spending. Instead, the increased funding for AIDS came at the cost of other sectors adversely affected such as reproductive health and population (see Berer, 2004; Yazbeck, 2004 on this); and tobacco control, child immunization and health sector development (see particularly Shiffman, 2006; Garrett 2007), among other sectors. Shiffman (2008) identified a number of dynamics that may contribute to this displacement: 1) donors have hard-budget

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constraints. If a donor chooses to increase funding for one issue, it must decrease funding for other issues unless it can secure additional resources; 2) Bandwagon effects may also occur among donors when influential donors prioritize a particular issue and others simply follow, leading to the neglect of other issues; 3) National health systems have limited human resources. If donors provide extensive funding for one issue, doctors, nurses and other health personnel shift their attention on that issue to the neglect of other problems (Brugha et. al., 2004; Garrett, 2007).

Thus based on empirical evidences from donor funding on four distinct areas – HIV/AIDS, population, health sector development, and infectious disease control from 1992-2005 – Schiffman (2008) demonstrated that AIDS had a displacement effect on other health issues (Table 3.1). In 1992, HIV/AIDS received 7.7 percent of donor health and population aid; by 2003 it received more than a third of all commitments (35.1%). Over the same period the percentage of aid for population declined from nearly a third of all funding (32.1%) to just 8 percent in 2005. Health sector development also experienced a significant decline (Schiffman, 2008: 97, also 2009). Moreover, as Powell-Jackson et.al. (2006) pointed out that GAVI resources contributing to childhood survival (MDG4) is negligible when to compared to the Global Fund and PEPFAR. The current level of aid devoted to childhood survival is inadequate and provides only a fraction of the total resources required to achieve MDG4 for child and maternal health.

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV/AIDS</th>
<th>Infectious diseases</th>
<th>Population</th>
<th>Health system strengthening</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>5.5</td>
<td>5.8</td>
<td>26.4</td>
<td>62.3</td>
<td>100</td>
</tr>
<tr>
<td>1999</td>
<td>14.1</td>
<td>6.6</td>
<td>18.4</td>
<td>60.9</td>
<td>100</td>
</tr>
<tr>
<td>2000</td>
<td>18.9</td>
<td>10.4</td>
<td>18.5</td>
<td>52.2</td>
<td>100</td>
</tr>
<tr>
<td>2001</td>
<td>24.1</td>
<td>11.4</td>
<td>19.4</td>
<td>45.1</td>
<td>100</td>
</tr>
<tr>
<td>2002</td>
<td>21.5</td>
<td>11.9</td>
<td>22.8</td>
<td>43.9</td>
<td>100</td>
</tr>
<tr>
<td>2003</td>
<td>33.8</td>
<td>14.4</td>
<td>15</td>
<td>36.8</td>
<td>100</td>
</tr>
<tr>
<td>2004</td>
<td>30.9</td>
<td>12.1</td>
<td>14.5</td>
<td>42.5</td>
<td>100</td>
</tr>
<tr>
<td>2005</td>
<td>35.1</td>
<td>16.4</td>
<td>8.3</td>
<td>40.1</td>
<td>100</td>
</tr>
<tr>
<td>2006</td>
<td>34.4</td>
<td>15.4</td>
<td>13.5</td>
<td>36.7</td>
<td>100</td>
</tr>
<tr>
<td>2007</td>
<td>47.2</td>
<td>16.7</td>
<td>12.3</td>
<td>23.9</td>
<td>100</td>
</tr>
</tbody>
</table>

Other detrimental effects of a strong global AIDS regime have come to light only very recently. Based on an extensive review of country specific case studies of three global regimes – GFATM, PEPFAR, and the World Bank’s MAP, Biesma, et. al. (2009) cites literature that found these regimes generally distracted governments from coordinated efforts to strengthen health systems to distort their national priorities through imposing implementation conditions (Brugha et al. 2004; World Bank 2004; Stillman and Bennett 2005). They also cited studies that reported skilled staff and personnel from conventional reproductive health and family planning sector migrated to AIDS to “follow the money of the Global Fund” (Schott, et. al. 2005; Wilkinson, et. al. 2006). Similarly in India, BMGF and Global Fund supported activities drew health workers from public sectors to the private sector, INGOs, and bilateral agencies (Flock, 2009). Similar trend was observed in Ethiopia (Banteyerga et al. 2005).

Mead Over, a senior fellow at the Center for Global Development argued that not only is AIDS weakening health systems in the developing world, but also having a pernicious effect on Official Development Assistance. He reported that that AIDS funding from the Government of the United States will consume more than 50 percent of its ODA by 2016, and “squeeze out U.S. spending on other global health needs [creating] a new global entitlement.127″ UNAIDS regime was created to coordinate HIV/AIDS funds. But as Devi Sridhar noted, the global health system is already uncoordinated, chaotic, messy and inefficient with more than 40 bilateral donors, 25 UN agencies, 20 global and regional funds, and 90 global initiatives target health activities and assistance.128 Many are outside the direct purview of UNAIDS, such as GFATM, PEPFAR, UNITAID, BMFG, CHAI, and other large foundations. These regimes have played a prominent role in national policy formulation, guidance and prevention strategies reshaping the landscape of AIDS in recipient countries. As new

donor agencies pop-up, they will fragment the system further and UNAIDS, even as an umbrella agency, can never resolve that problem.

This diverse organizational interests – often competing, and conflicting created huge challenges; inadequate coordination, leadership, competition for power, resources, and influence among National AIDS Commissions, CCMs, UN agencies, etc., threaten the efficacy of today’s global health initiatives.¹²⁹ There are competing interests and conflicting ideologies among AIDS regimes, for example, UNAIDS and PEPFAR. While UNAIDS supports evidence based condom programming, and human rights based prevention programs with sex workers, drug users and queer communities, PEPFAR is clearly opposite focusing on abstinence, faithfulness, and less on condoms. Moreover, PEPFAR’s rigid criteria determined by US Congress stipulated that 33 percent of aid must be spent on treatment; 20 percent on prevention, of which 33 percent must be spent on abstinence-until-marriage programs (US-GAO 2006, p. 1). PEPFAR also required NGOs to sign a pledge that none of its money will be used to provide prevention services to sex workers, and drug users. Moreover, the imposition of the requirement that only ARV drugs that have received US Food and Drug Administration approval can be purchased, threatens the long-term financial sustainability. These drugs manufactured by US pharmaceutical giants are expensive, whereas generic versions produced by India or Brazil may have provided a desired outcome (Pisani, 2008).

UNAIDS has consistently opposed ideologically-driven HIV-responses and highlighted scientific, evidence based programs in their policy documents. However it remained too passive in challenging the PEPFAR programs and policies driven by George W. Bush’s conservative ideology (Das and Samarasekara, 2008). The divergence between UNAIDS and PEPFAR thereby spread conflicting messages in the society that continues to stigmatize sex workers, and provides obstacles in realization of human rights. “UNAIDS has not adequately provided analysis or criticism, at least not in public forums on any of these issues” (ibid, p. 2101). One reason why UNAIDS

remained passive, as Pisani (2008) noted, that UN sponsor organizations compete with one another for funding, attention, and kudos and UNAIDS behaved in a submissive way to please its sponsors, which made UNAIDS lose its independence. Needless to say, US remained one of the largest sponsors of the Global Fund and UNAIDS’ activities.

Even within the domain of AIDS, the regime has shifted its priorities from “prevention” to “treatment and care.” Prevention is the first step, which is crucial and must be strengthened. However as Laurie Garrett in her New York Times article observed:

“The slogan of the first 15 years of the pandemic was, ‘Until there is a cure!’ Today it seems the global health leadership of the world is satisfied with, ‘Until there is lifelong drug therapy for everybody, and no prevention strategy!’ A dangerous sentiment is sweeping over the AIDS establishment, calling for elimination of all funding for HIV vaccine research and prevention programs, shifting those dollars, euros and yen to expanding HIV treatment.”

Another problem raised by scholars and researcher is wasteful expenditures due to large sums of money available AIDS (Hanson, 2003). Much of the money is used inefficiently, because HIV/AIDS programs are not cost effective (England, 2009). For example, Pisani (2008) observed that in East Timor, for only seven known HIV-infected individuals, a sum of $2 million was poured in to design an HIV prevention program. 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 was low due to little prostitution and low drug use. This made the East Timor a country where more organizations were working on AIDS than people infected (p. 288). Similarly BMGF’s largest program in India, Avahan, with a budget of $258 million in five years is also seen as a “waste” with huge corporate-type infrastructure, high staff salaries, expensive travel, workshops, reports, and brochures, with little actual program on the ground, and none of the objectives met, with negligible achievements. Similarly, in May 2009,  

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131 For example, an internal evaluation in 2005 showed a big portion of Avahan’s efforts had gone to waste. As many as 31,000 community members had been contacted by Avahan’s outreach program, but only 11,000 actually visited the clinics. Avahan ran 50 sites for truckers in 6 southern states. By mid-

### 3.4. Compliance with regimes

As of 2010, AIDS regime had well established principles for fighting the disease, and appropriate protocols in place for prevention and care services, treatment, research, vaccine development, drug experiment, counseling and testing, confidentiality, non-discrimination, protection of human rights, etc., including necessary institutions through which to facilitate and implement these principles, and adequate resources to achieve these goals. No other regime in contemporary times has ever been as successful as AIDS to mobilize resources and commitment of 192 states within such a short span. As of 2010, India has \textit{internalized} all these norms and principles of the AIDS regimes – India has a multisectoral strategy of AIDS prevention and control program; HIV/AIDS prevention activities are not just confined within the Ministry of Health, but all Ministries, like Ministry of labor, defense, education, railways, women and child development, power, petroleum, civil aviation, etc., address

2005, only 12 percent of truck drivers were even aware of their services, and only 7 percent took advantage of them. Avahan’s director’s annual salary is $424,894, the second-highest in the foundation globally, and other staff salaries are 4-5 times higher compared to same level staff in other NGOs. Flock, E. (2009). How Bill Gates Blew $258 million in India's HIV Corridor. \textit{Forbes Business Magazine}. Jun 5. Retrieved: http://www.business.in.com/article/cross-border/how-bill-gates-blew-$258-million-in-indias-hiv-corridor/852/0.
the HIV prevention. India’s National AIDS Control Program reflects that prevention, treatment, care and support are all interrelated – each part being an essential component of AIDS struggle. It emphasized that protection of human rights is a prerequisite for combating AIDS and instituted laws to end HIV/AIDS related discrimination; a revised HIV/AIDS Bill is under consideration at the Indian Parliament; India’s AIDS program has been providing universal (and free) access to ARV drugs since 2004; appropriate institutions and structures are in place to upscale HIV prevention and care program. And to comply with the AIDS regime, India prepares Country Progress Reports that are presented at each UNGASS specifying how much of the targets have been accomplished. The logical question that follows, then, why did all these happen? Before I elaborate on “how” all this happened focusing more on the processes involved in the next chapter, the following section provides an explanation of “why” this happened, focusing more on the reasons, and causal linkages.

**Why comply?**

I now come back to answer the second part of my question that I raised in the beginning: under what conditions, the principled ideas and norms of the international HIV/AIDS regime were internalized and implemented in the Indian state’s domestic practices. In an “anarchic” world, as the realist theorists view, where every state seeks to promote and maximize their own interests, why governments ever comply with regime’s principles that are in conflict with what Keohane called as their “myopic self-interest” (Keohane, 1984: 99)? Keohane defined “myopic self-interest” as “governments’ perception of the relative costs and benefits of alternative courses of action with regard to a particular issue, *when that issue is considered in isolation from others*” (1984: 99, original emphasis added). For example, with regard to HIV/AIDS prevention, India’s myopic self-interest will be the Indian government’s perception and calculation of relative cost and benefit of adopting a human rights based approach as opposed to quarantine, forcible testing, and contact tracing approach. India must weigh the relative cost of adopting the later, which may range from government’s loss of immediate access to foreign funds; and loss of reputation in the international arena as a norm violating state; to loss of international support and trade relations with other
countries. The benefits of adopting human rights based approach instead maintain all the three short-term interests as well as in the long run, promote greater international cooperation. However, the long-term cost of adopting a human rights based approach may be to allow the horizontal spread of the epidemic in population that are largely illiterate and impoverished. Was the adoption of rights based approach, then, suitable and effective for India?

As outlined earlier, rights based approach remained a matter of intense debate since its inception both in the US and elsewhere. Though, over the years, such approaches were found to work effectively in developed countries, and to some extent in developing countries (albeit slowly), after two decades of activism in the field of HIV/AIDS, many activists feel that it worsened the epidemic in countries where poverty and illiteracy was widespread. For example, by the time AIDS was discovered in India (1986), there were already 11,932 deaths reported in USA.\(^{134}\) Some of these deaths were of famous people such as, Patrick Cowley, HI–NRG dance and music composer (1982); Michael Foucault, philosopher (1984); Rock Hudson, famous Hollywood star (1985); Richard Amsel, American graphic artist known for his iconic movie posters (1985); Ricky Wilson, American guitarist with the rock band B-52’s (1985); Lee Riachards, American porn star (1985); Mike Davis, social commentator and urban theorist (1986); Gia Carangi, American supermodel of the early 1980s (1986); Perry Ellis, famous American sportswear fashion designer (1986); Roy Cohn, lawyer (1986); Howard Greenfield, American songwriter who was 1991 “Songwriter Hall of Fame” (1986); and other famous porn stars and celebrities. At that time, due to activism and lobbying of Act Up and GMHC coupled with Jonathan Mann’s advocacy of human rights in formulating WHO-GPA, the US government recognized the rights of the infected people and at-risk population.

US adopted a liberal, rights-based policy for HIV prevention that was consistent with personal liberty and rights guaranteed by the American Constitution. The adoption of this approach, therefore, had a structural context in the America: almost all people

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were literate; other factors such as physical quality of life, standard of living, education of parents, health and treatment seeking behavior, etc., that affect information receiving and behavior change were all in favor of a rights based approach. This may be true in most other industrialized countries of Western Europe. In contrast, where 50 percent population was “sheer illiterate,” (this was the literacy figure for India from 1991 Census) and 40 percent population lived below the poverty line (Adams, 2002), what was the “suitability” of adopting such an approach was not clear. It can be argued that the implicit expectation of the Indian policymakers was that the illiterate and impoverished Indians would also behave “safely,” the same way as Americans. Of course due to differences in structural factors (such as education, quality of life, etc. just outlined), where such an approach emerged and where it was later juxtaposed, the assumed “responsible behavior change” did not happen. Thus the initial epidemic was allowed to spread beyond its small, concentrated pockets of origin by adopting the GPA regime.

Indian government was aware that this change in approaches and strategies of HIV prevention by adopting the GPA regime and rights based approach, will damage the course of the epidemic in future. Yet, India compromised its “myopic self interest” of curbing the spread of the epidemic faster. Repressive approach has proven to be effective in limited contexts such as Cuba (Parameswaran, 2004). On a larger scale, smallpox was also effectively eradicated worldwide using such an approach. India, with a good presence of communists (CPI and CPIM) in three of its states with more than 45 communist members in the Parliament in 1989, could have gone the Cuban way, a repressive policy of quarantine, contact tracing, isolation, criminalizing drugs, and prostitution. In fact, when India started its AIDS control Program, it adopted this approach which was formally outlined in the National AIDS Control Bill of 1989. India’s initial strategy in some small pockets such as Chennai and Goa, may have proven to be effective. But concluding so would be highly speculative as such an approach was never field-tested in Indian context. Given the level of resources and

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information India had at that time, the myopic self-interest was likely to be higher than the long term gain. Yet, Indian government withdrew this policy even before it could be effectively and widely implemented. The fact that India complied with the rules and norms of the AIDS regime that conflicted with her “myopic self-interest” poses a potential anomaly for theories, such as realism. Why did India behave in a way that was inconsistent with her self-interest on that issue? Why India not only embraced the liberal AIDS control regime, but also compiled with the regime ever since?

The story is not simple. Realist theorists such as Morgenthau have noted with respect to specialized agencies of the UN system that when there is a conflict between the national interest and the operation of such agencies, “the national interest wins out over the international objective” (1948/1966, p. 509). Even Waltz (1979) noted that since there is no central power in the international system to regulate state behaviors, states as unitary agents exercise their autonomous power to pursue their self-interests. However, neoliberalists like Keohane argued, that the international system is still anarchic, but cooperation is possible through making of norms, rules, regimes and institutions (Keohane 1984; Keohane 1989). Keohane demonstrated that the notion of “national interest” itself is very fluid and constructed in relation to others in which the presence of institutions and regimes play a significant role in state’s definition and construction of their own interest (Keohane 1984: pp. 100-06).

Keohane offered two possible lines of arguments to explain why do states cooperate. First, since regimes are very difficult to construct at the first place, it is only rational for states to obey their rules if the alternative is their breakdown. This is because even an imperfect regime is superior to any politically feasible solution (p. 100). Second, since states belong to a network of regimes on a network of issues at the same time, cooperation becomes an iterated game of prisoners’ dilemma, in which the participants know the expected behavior of members and the potential outcome (p. 100). Violation of one’s commitment in pursuit of its myopic self interest, say, India’s pursuit of repressive approach in the above example, may lead others to do the same on other issues, say, UK’s import restriction on Indian goods. Thus states not only worry about their reputation, but also establishing bad precedents because their violations of
rules may promote rule-violations by others (p. 106). From this perspective, it was therefore wiser for India to give up its myopic self interest and pursue the collective, long term interests of the AIDS regime.

However, social constructivists theorists like Wendt (1992) argued that what is more important is not the anarchy itself but what kind of anarchy it is. According to Wendt, anarchy is “what states make of it,” meaning that anarchy is not genetically fixed by material structure, but socially constructed through processes (Wendt, 1992). Instead of simply taking the state for granted that it seeks to maximize power and interests, constructivists regard the identities and interests of the state as a highly malleable product of specific historical process (Walt, 1998: 40). Finnmore (1996), for example, argued that states do not always know what they want; states are embedded in international social structure, and dense networks of transnational social relations that shape their perceptions of the world, and their role in that world. “States are socialized to want certain things by the international society in which they… live” (Finnmore, 1996: 2).

Thus for constructivists, it is less important to examine the state behavior itself, but to unravel the cognitive and communicative processes through which states construct their identities, and interests, and forms their behavior (Checkel, 2004). They flip the traditional causal arrows from how the main agents of international system – states, influence others, to how states are reconstituted by social norms (Finnemore, 1996; Katzenstein, 1996a). Katzenstein argued that norms are used “to describe collective expectations for the proper behavior of actors with a given identity. In some situations norms operate like rules that define the identity of an actor, thus having constitutive effects that specify what actions will cause relevant others to recognize a particular identity” (Katzenstein, 1996a: 5, original emphasis added). In unraveling the state behavior, constructivists focus more on social ideational factors such as culture, norms, ideas, and identity rather than material interests and the process through which these factors (re)shaped state interests (Adler, 2002; Checkel, 2004). Ideas are cognitive commitments while norms make behavioral claims on individuals (Katzenstein 1996b, p.7). To endorse a norm means it expresses a belief and also created impetus for
behavior change consistent with that belief. While ideas are usually individualistic, norms are collective expectations.

History and identity

In a country where sentiments about colonialism and western intervention remained quite strong; where public service officials did not believe in the human rights of prostitutes, infected people, and injecting drug users; where bureaucracy and legislature believed in quarantining, marking the bodies of prostitutes, or adopting repressive policies for isolation; in such a country the decision to adopt the Western norms of HIV/AIDS prevention must have provided the state with certain direct and indirect, immediate and long term gains, that outweighed the indigenous resistance. In the Indian case, the norms of the HIV/AIDS regime changed India’s behavior by reconstituting its interests/ preferences, in which the state identity played a critical role. The norm that only “bad states use a repressive approach;” or constructing a stigma of pariah state (that do not belong to the civilized world) around using such approaches, reshaped both India’s interests and gave the state an opportunity to reflect on its own identity. As Risse, Ropp and Sikkink (1999) noted that states follow norms to think well about themselves and also want others to think well about them. “Human rights norms have a special status because they both prescribe rules for appropriate behavior and help define identities of the liberal states. Human rights norms have constitutive effects because good human rights performance is one crucial signal to others to identify a member of the community of liberal states” (p. 8, emphasis mine).

This approach to constitutive and behavioral effects of principled norms and ideas draw on social constructivism (Katzenstein, 1996a; Kratochwil, 1989; Wendt, 1992). Actors’ interests and preferences are not given outside of social interaction in the international or domestic environment. Interests are constructed by the identities of actors; what I want to do is largely dependent on who I am. Identities define the range of interests as “possible” and “appropriate.” Thus following Youde (2005), I argue that the twin forces of history and identity reconstituted the interests and preferences of the Indian state to reflect on its own behavior. Youde (2005) argued that if there is a
disjuncture between a regime’s message and the state identity, the state, in all likelihood, will not comply with the regime. Youde (2005) demonstrated that in case of South Africa, the AIDS regime’s message and the South African state identity did not match; South Africa fiercely objected to the Western public health campaigns and emphasized “African solutions” to African problems (Youde, 2005, p. 422). For any regime to operate effectively and transmit its messages in a meaningful way, it is crucial that both the regime constructor and the regime participant share common knowledge, beliefs, and meanings (Youde, 2005: 436). In the Indian case, the regime’s message and the identity of the Indian state closely aligned. India wanted to reaffirm its identity in the international arena as a “liberal democratic state” that respects human rights, dignity and individual liberty guaranteed by its Constitution. The initial repression and the isolationist approach created a disjuncture between the state’s identity and behavior. To reaffirm its identity that India is at par with other similar, “liberal-democratic” states that does not violate individual rights, India adopted a liberal AIDS control regime.

Second, India’s reshaping of state interest was also socially constructed based on its history. Since its birth in 1947, India has chosen to go the secular, democratic way, quite contrary from her breakaway counterpart, Pakistan. Though dirigism laid the foundation of the Indian economy, it upheld the secular beliefs, people’s democracy, and pluralism right since independence. It was only during the 21 months emergency period (1975-77) during Mrs. Indira Gandhi’s regime that India recorded a break in her democratic tradition when some democratic rights, freedom of speech and assembly were temporarily suspended. However, Mrs. Gandhi, and her party, Congress, had to pay a heavy price in the subsequent general election that followed in 1977. Added to this temporary period of dictatorship, Indira’s son, Sanjay Gandhi adopted a coercive policy of population “control” and family planning; sterilization – incentive based or forced, was the method of choice. Srinivasan reported that between April 1976 and March 1977, the number of sterilizations done in India rose to 8.26 million, “more than the total number done in previous five years, and more than the number done in any
other country in the world until that time. Only in the first 6 months from April to September, 1976, under the strong leadership of Sanjay Gandhi, two million Indians were sterilized.

The excess of Sanjay Gandhi’s sterilization campaign and the coercive measures that the government followed, created a tremendous backlash among people. Indira Gandhi generally disregarded such sentiments. She wanted to legitimize her authoritarian rule and called for an election in March 1977. Congress suffered a heavy loss in the general election, and Indira was out of power; the popular mandate of a democratic nation-state clearly articulated that curtailing people’s rights and liberty will not let any government rule. The subsequent political parties have taken a lesson from this history; the issue is so sensitive in a democratic nation-state that no political party, whether ruling, or in opposition, or even without any popular base, want to touch this issue. While there is clearly an “instrumental” reason of vote bank politics (not quite believing that such approach is wrong), over time, this instrumental adoption have come to change the human rights practices in India.

Thus during the initial years of the AIDS epidemic (1986-89), when Congress government (Rajiv Gandhi) in power confronted the same problem of coercion, forcible testing, and quarantine, the memories of emergency had already taught them not to repeat the history, because the cost of doing so would prove to be consequential. Rajiv Gandhi’s government, an heir of Indira Gandhi took the lesson and preferred to adopt a democratic approach, which may be, purely for instrumental reason, or vote bank politics. But history, nonetheless, reconstituted the state interest. Moreover, in the preceding years (1984-88), Rajiv Gandhi’s government implemented a series of economic liberalization programs breaking away from India’s 35 years old dirigiste import substitution strategies of economic growth. Adopting a liberal AIDS control

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regime could be seen as an extension of the state’s willingness to experiment with liberalism. These historical processes reconstituted India’s interests when it adopted the WHO-GPA regime in 1989. However, as Risse, Ropp & Sikkink (1999: 10) noted that even instrumental adaptation of human rights norms sets into motion a process of identity formation, so that norms initially adopted for instrumental purposes are later maintained for reasons of belief and identity. For example, the Congress government though adopted liberal, human rights based AIDS regime, all subsequent governments including BJP with a strong nationalist agenda maintained it, and actively persuaded it to protect India’s liberal democratic identity.

Third, though I take this aspect in detail in the next chapter, mentioning it here briefly is important. India’s NGO movement is quite old dating back to the 1960s (Sen, 1999; Sooryamoorthy & Gangrade, 2001). Though issues were clearly different at that time (poverty, illiteracy, rural development), these movements were possible at the first place because of a strong democratic foundation of the Indian state. This democratic history of rights of assembly, and freedom of speech guaranteed by the Indian constitution played an important role in NGO movement. So when India adopted the repressive policy of AIDS control, activist groups and NGOs in different parts of the country protested to articulate their voices against the state (ABVA, 1991). The present collectivization of sex workers, queers, drug users, etc., can also be seen as a continuum of this democratic struggle. By organizing demonstrations, rallies, and protest marches, these groups were constantly reminding the state of its “liberal,” “democratic” identity and the mismatch that it posed by adopting a repressive approach. As AIDS continued to dominate the landscape, India closely adopted the international AIDS control regimes, which was consistent with her identity of a liberal, democratic, and pluralist society respecting individual rights and freedom.

Strategic calculations

There could be other possible reasons from a geo-strategic perspective. With the disintegration of Soviet Union in 1990, and adopting a structural adjustment program from the World Bank in 1991, India’s strategic interests shifted to closely align itself
with the West. Due to complete reshaping of geopolitical significance of India’s erstwhile economic and trading partner, USSR, the reconfigured Russia lost much of its significance and influence on New Delhi (Kronstadt, 2009). AIDS provided as one of the initial entry points to establish before the world leaders about India’s secular, liberal, democratic image, and establish its identity within the community of the liberal democratic states. AIDS also provided an opportunity of harnessing international cooperation and working with other states and multilateral bodies. By doing so, India wanted to gain support and international legitimacy of the great power structures.

Thus in the post-cold war era, with a reconfiguration of bipolar world order, India’s preferences had changed to more closely align with the US. Not to mention, India-US bilateral relations took a significant turn from this point onwards (Kronstadt, 2009). As US-India bilateral relations improved in the new millennium on “national security” issues such as combating terrorism, India strongly adopted the AIDS regime, because the regime itself is now reconstructed as a “national security” issue for both India and the US. As we have seen that this securitization of HIV/AIDS epidemic reconstituted US interest in the late 1990s (NIC, 2000, 2002; Boone & Betsel, 2001; Vieira, 2007; McCines, 2006), it might have also reshaped India’s preference and behavior as important US-partner in combating terrorism. There may also be other short-term and long-term, direct or indirect benefits associated with the AIDS regime. In the short-term, there was access to huge international funds for AIDS prevention. In the long run, there was improvement of bilateral and trade relationship between India and the West, particularly, with USA and the EU.

3.5. Towards a theoretical model

So far I have only attempted to give an explanation of the possible reasons why India adopted various AIDS control regimes. I did not examine to what extent the principled ideas and norms of the regimes were implemented in the Indian state’s domestic practices, and what were the mechanisms through which this adaptation and norm internalization took place. In the next chapter I aim to provide a theoretical model
explaining first, the extent of norm adaptation/socialization in domestic practices; and second, the processes through which these changes took place.

Following (Brysk, 1993; Reich, 2002; Shiffman, 2007; Sridhar & Gomez, 2010), I argue that the Indian state and its preferences/interests were reshaped/reconstituted from three directions: “from above,” “from below,” and “from within,” each with several important actors and agents. My identification of these actors and agents that reshaped/reconstituted the state interests/priorities from three directions does not exactly match with those of Brysk’s, Reich’s, Shiffman’s, or Sridhar’s.
However, their theoretical framework is nonetheless useful for me as a conceptual and analytical tool to build upon and explain the behavior of the Indian state. In the following figure, I provide an outline of the mechanism and important actors that reshaped the Indian state.

This figure draws on Risse, Ropp & Sikkink’s (1999) five phase spiral model of norm socialization, and Brysk (1993) and Reich’s (2002) reshaping the state. I identify three important stimuli that drive the reshaping of state interests. In the first category, is the reshaping of state “from below:” the important actors in this category include grassroots NGOs/CBOs that work with people living with HIV/AIDS, collectives of sex workers, queers, protests and resistance movements, and other domestic non-state actors, which include civil society institutions. These actors are connected to the actors “from above.” When these actors fail to pursue the state in getting their demands fulfilled, they influence the state by linking with the actors from above, who in turn, exert their pressure from above. Keck and Sikkink (1998) called this boomerang effect. Actors from below can also, directly or indirectly affect the actors “from within” the state. These actors can also directly influence the state by engaging in various kinds of politics. Actors from above have two important linkages: first they can directly affect the state and its institutions from above; and second, they can also affect the actors “from below” thereby exerting their maximum influence. Actors/factors “within” the state again, are influenced, both “from above” and “below” thereby producing a complex linkage and networks of relationships and effects. In the following chapter I argue that India’s norm socialization of HIV/AIDS regimes must be understood and analyzed from this perspective – a holistic and integrated approach.

This is a generalized model that can be applied to various socio-economic, cultural, and political settings to explain norm socialization. However, in other contexts, some or part of the actors and their roles will change, but that does not alter the validity of this overall explanatory framework. Moreover, the spatial differences may only result in timing, effectiveness, and duration of norm socialization process, leaving explanatory framework still valid.
In the following chapter, I elaborate the linkages between international norms and changes in domestic practices, and how these sustained changes take place using this theoretical framework. I develop an explanation of theory and mechanisms through which international norms lead to behavior change.

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