Chapter 7
Conclusion

This dissertation started off with a question: What determines which issue gets priority in the national development agenda over the others? In other words, why did the Indian state prioritize HIV epidemic over other endemic diseases at all levels of its policy, program and institutional structures? A simple shortcut answer that can be derived from this dissertation is that, states do not always know what they want. They are taught to want certain things by the domestic and international society in which they live. NGOs, activist networks, other state, and non-state actors act as their “teachers,” while “norms” are the ultimate teaching that they receive through a process of socialization. In one sentence, the Indian state prioritized HIV-epidemic over other endemic diseases causing more mortality, because it was taught to do so as both appropriate and desirable for being in the category of liberal democratic states.

This version of interpretation draws on social constructivism. Actors’ interests and preferences are not given outside of a social matrix. They simply do not drop from above or emerge out of thin air so as a state will just go and grab them. State’s interests and preferences develop in constant interaction with other actors in the domestic and international system and always in relation to others, in which the ideational and communicative processes and collective meaning-making play an important role. International norms serve as the ideational and communicative factors and provide an opportunity to states for collective meaning-making through which they develop, re/define, and assert their identity. Interests and preferences are therefore not static.

But this story still does not tell us which issue will make up to the national priority and which issue will not. Why diarrhea, for example, is not treated with the same urgency, commitment and resources? Simple answer – there’s no UNDiarrhoea (like UNAIDS), no Global Fund for Diarrhea, or no President’s Emergency Plan for safe drinking water (like PEPFAR). While one may call this oversimplistic, my answer begs a question: Why there’s no transnational body or intergovernmental organization
(regime) for safe drinking water? Though emergence of regimes and transnational cooperation depends on several factors, I will briefly mention four important ones here:

First, how successfully the issue itself is “framed” as “important” by activist networks and norm promoters. From my preceding account in Chapter 2 and 3, I have demonstrated that the AIDS activists and lobbyists were highly successfully in promoting the disease by “framing” it as “exceptional”. This gave rise to the regime formation and donor bandwagoning effect, in which donors allocated their resources by simply following what other, “more legitimate” donors were doing. This reduced the risk of allocation for donors, as well as gain international legitimacy.

Second, prominence of the norm and their adoption by “advanced” Western states are more likely to diffuse the norm internationally. AIDS norms were first adopted and promoted by the liberal democracies of the West. Later, by adopting the norms, other states sought to identify themselves in the same group of “liberal,” “advanced,” “progressive” states. I have demonstrated in Chapter 3, how by adopting norms, the Indian state developed, embraced, re/de(fined), and asserted its liberal-democratic identity in the international arena. Advanced states do not have a problem of diarrhea, so they would be least interested to promote the norm for safe drinking water. Moreover, states would be more interested to solve the problem of clean water if it threatens the legitimacy of the elites. Where elites do not use public urinal, they would be least interested to solve the problem of clean water for women to maintain a safe genital hygiene that make them vulnerable to HIV infection at the first place.

Third, the intrinsic nature of the issue/norm itself determines its diffusion. Diarrhea or diabetes or malnutrition for that matter did not succeed primarily because there was no norm promoter for diarrhea or malnutrition at the first place -- no activist networks for “framing” malnutrition as “lethal” and can cause HIV infection if one is malnourished. In contrast, the intrinsic nature of AIDS having no cure was “framed” as lethal creating a culture of fear and panic that drew widespread public attention.

\[281\] This is a statement made by Luc Montagnier, 2008 Nobel Prize winner in Physiology of Medicine for co-discovering HIV in 1982. Interview in *House of Numbers*, 2009 directed by Brent Leung. See the verbatim transcript of the interview in Chapter 1.
Diarrhea, diabetes or asthma also do not interfere with human rights in the same way as HIV does. Norms that interfere with human rights and bodily harm or injury are more likely to succeed. And human rights norms are special because adoption of these norms helps define the identity of states and find a member of their own community, usually “liberal” states (Risse and Sikkink, 1999: p. 8).

And finally, as I have mentioned in Chapter 2, world-time context is another important factor for norm diffusion. Historical events such as major depressions, scientific breakthrough, or “issue-fatigue” provided a favorable ground for AIDS norm diffusion compared to other endemic diseases. Endemic diseases remained a part of human civilization for over 10,000 years. AIDS emerged in a historical juncture when there was an “issue depression” and “issue fatigue” among NGOs and development establishments, as poverty, basic needs, population, environment, gender were already much talked about for over three decades. HIV was new, and provided an opportunity for NGOs to capitalize on the disease. As Finnmore and Sikkink (1998) noted, if we compare women’s suffrage, where norm emergence took 80 years and norm cascade took another 40 years, the issue of violence against women took less than 20 years from emergence to cascade. The speed of normative change is therefore accelerating. For HIV/AIDS, norm emergence to norm cascade took less than 10 years in most parts of the globe, and in the case of India, it was just five years (1987 to 1992).

So far I have only responded to the first part of my question that I started this dissertation with. Now let’s come to my second question: What’s the net result of “teaching” the states to learn what’s important for them? I suggest a lot. Few important ones I have already outlined in Chapter 3, 5 and 6. Avoiding repetitions, I would nonetheless like to mention a few here. First, the “teaching” created complete misplaced priorities for development and resource allocation fuelled by vested interest groups. I don’t say that this “teaching” was unimportant or unnecessary, but in case of AIDS, I say it was necessarily a “bad” teaching. Bad not because the “teachers” lacked knowledge or were misinformed, but because they were too ideologically guided and had a political agenda to achieve. Whereas India or African countries should focus more
on structural conditions that make people vulnerable to HIV infection at the first place, they are spending too much on ideologically driven programs.

Global HIV-industry is now “too big and out of control” resulting in the creation of the largest vertical program in history. Growing from a merely $300 million enterprise in 1996 to over 14 billion in 2008, HIV has become a supersize monster “with too many vested interests and reputations at stake” (England, 2008: ibid.). It has drawn away funds from other diseases (Shiffman, et.al., 2009; Shiffman, 2008; Biesma, et. al., 2009; Sridhar & Batniji, 2008); separated HIV from overall sexual and reproductive health services; created huge parallel infrastructure that constrained the development of health services (England, 2007); and drawn away qualified health workers from other underfunded sectors creating chronic shortages in these areas. In 2009, the total number of AIDS related deaths worldwide was nearly the same as that among children under five years in India alone.

Globally, the amount of money spent on AIDS every year is over 100 times more than what is spent in safe drinking water projects in developing countries. The “sugar bowl” of AIDS funding has increased so big in its size that diverse species of ants have crawled into the sugar bowl to get their share (Pisani, 2008: p. 271). So there is culture and AIDS, energy and AIDS, forestry and AIDS, fisheries and AIDS, transport and AIDS, children and AIDS, media and AIDS, waste management and AIDS, but in most countries the problem is either “sex and AIDS,” or “drugs and AIDS” or both. But the rhetoric of “HIV is a development problem” or “HIV is everyone’s problem” has scattered so much sugar around that the government and

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NGOs do not want to crawl toward the “sex” or the “drugs” bowl (ibid., p. 271). Places where they crawled into sex and drugs bowl have had a boomerang effect.

In India, the first throw of the boomerang was changing human rights practices with sex workers, drug users, and MSMs through “targeted interventions.” Instead, this boomeranged in their collectivization, social movements and political struggle for civil and political rights. These new social movements have been empowering for the marginalized communities creating new meanings around bodies, rights, and citizenship. On the other hand, the new social movement of hitherto marginalized groups and state’s changing human rights practices have created varieties of fundamentalism and societal resistance based on the discourses of national culture and family. They are exemplified in homophobic reactions and anti-gay lawsuits; abolition of prostitution supported by hardliners; forcing to close down HIV prevention projects with sex workers in Kerala; ban on the dance bars in Maharashtra; or torching and burning down hundreds of sex workers houses in Bihar.

7.1. So what?

Other than fulfilling the requirements for a PhD degree in geography, what is the value of the above conclusions? What lessons can one learn from this 300-page dissertation? In the following part I will argue that the “value” of the above conclusions must be understood from two different perspectives — first the value that it offers to the activists and policy making community; and second its value for the academic community, scholars, and theorists.

A. Policy and programmatic implications

1. One of the first lessons that can be learned from these conclusions is that attempts to impose regimes’ norms without cultural consideration may backfire. For development projects to be sustainable, participatory and empowering for local communities it must not ignore the local culture, which is both a means and ends of development. My claim is consistent with Vijayendra Rao and Michael Walton’s (2004) work, *Culture and public action* that brilliantly explicates how culture affects
development and public policy making. They cited two examples of famine-aid work in Sudan that miserably failed because of the lack of understanding of local culture; and HIV/AIDS prevention work among sex workers in Sonagachi (Kolkata) that succeeded as an international model of prevention work due to cultural sensitivity. Ignorance of this contextualized notion of common sense, which James Scott (1998) called *metis*, has been endemic among policy makers in government and in development institutions.

One example of this ignorance is how Bill Gates blew away his $258 million in India’s *Avahan* project286 by paying over $424,000 annual salary to Avahan’s Director, and 4-6 times more salary to other project staffs than comparable NACO officers or other NGO-employees, besides huge travel expenses for airfare. A culturally informed approach is not a prescription, but a way of seeing, in which it is understood that individuals are driven by a set of culturally influenced motives, incentives, beliefs that interact with economic incentives to produce outcomes (Rao and Walton, 2004: p. 9).

With respect to HIV/AIDS prevention in India, programs that were not culturally sensitive, have created a backlash and more nationalistic, “anti-HIV-prevention” rhetoric.

2. Another important value that this dissertation adds is by raising some fundamental questions about India’s HIV/AIDS program that are bound to intrigue both activists and policymakers. Questions, such as, *should AIDS be given equal priority (if not less) as other diseases* is bound to be met with stiff resistance, because it threatens the livelihood of millions who survive on the AIDS-program.

Can HIV/AIDS be integrated within the existing overall health infrastructure that India currently has? This is another line of thinking that India has seen very recently after voices of dissent were articulated criticizing a vertical program structure. Now India is slowly moving towards “mainstreaming”. But then, this begs another question: *how to make use of the huge vertical AIDS infrastructure created over 25 years to deliver services for other endemic diseases, such as maternal health and child*

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care? For example, can the State AIDS Control Societies be converted to evolve into a State Communicable Disease Control Society that takes care of diarrhea, malaria, dengue, and other communicable diseases, including AIDS? Similarly, can the ART centers be made more “inclusive” to provide “basic” health services, and medicines for diarrhea, cold, fever, childhood illnesses and maternal conditions, including ART? This proposal, again, will possibly face fierce resistance from PLHA networks, and the counterarguments will likely be that this will reduce the overall quality of services delivered. While there’s no denying that “quantity” is a major limiting factor in ensuring “quality,” where people do not even have the access to “basic” health care, everyone receiving some would ensure better distributive justice, rather than some receiving all situation.

3. And finally, the general lesson that can be learned is that regimes, some of which are highly effective, though promote good causes, can also distort national priorities. Thus assuming that regimes promote a common interest and a political goal, can both be beneficial and counterproductive. My findings also indicate that compliance to the regimes’ norms was not only the result of the regime itself, but rather, norm socialization came about due to the attitudinal changes among policymakers — i.e., the factors from within — in which regime influence was only the driving force/catalyst. It’s the internal constitution of state – the global connection and networking of policy making community, international reward system, and regime’s norms catalyzed the state to change from within. This observation is consistent with Jill Keesbury’s (2003) observation about the effectiveness of post-Cairo population regimes in South Asia.287

B. Contributions in academic and theoretical debates

In the process of answering my central questions, this dissertation also contributes greatly to some of the following academic fields.

Contribution to IR theory literature.

One important way this dissertation contributes to the study of IR is by developing an understanding about how regimes and their norms affect domestic change of a middle-income country with regard to health. I offer a model for “reshaping the state” and argue that a state’s interests and preferences can be reconstituted transcending their identity boundaries. This model explains that even if a state is not a liberal democracy, it can be socialized into reconstituting its interest to want liberal democracy by the actors and processes mentioned in the model. Depending on the existence and role of actors, the timing and pace of norm socialization will differ in various socio-economic political and cultural contexts. But this will not alter the overall validity of this explanatory framework.

Contribution to the AIDS literature

Though voices of dissent from and within the AIDS-establishment are newly emerging and they are not many, by empirically demonstrating the misplaced health priorities, this dissertation adds on to an off-the-track AIDS literature. Activist-literature supporting AIDS exceptionalism and the need to maintain an exceptional global response by further increasing resource allocation on AIDS exist in abundance. As Smith and Whiteside (2010) observed, however, the voices of dissent have started coming from 2007. Considering this, my dissertation is quite contemporary in highlighting that AIDS is among “many other” diseases that will continue to wreck India, and to contain the epidemic we need to strengthen the response, but differently. As long as AIDS is not treated with other diseases, and like other diseases, it will continue to fuel stigma and discrimination.

Thus what India needs is an effective response and not exceptional response. And that effective response, I call is “primary prevention” — arresting the factors for transmission that make people vulnerable to HIV infection at the first place. They would include arresting rural-urban migration by generating employment in the rural
areas; solving urban-slum and housing problems to enable migrant workers to bring their families to cut down the need to visit sex workers; solving the problem of public urinals for women to make sure that clean water is available that does not lead to genital tract or urinary tract infection; strengthening the treatment of sexually transmitted infections and reproductive tract infections that offers an entry point for HIV at the first place; and promoting basic school education so that people can read the AIDS awareness messages. Where 35 percent people can not even read and write, who the huge billboards with AIDS messages are directed to? People who read and write have already cut down their chances of infection by half simply by being able to read and write!

**Contribution to the political economy of development**

By adopting a political economy approach to the analysis of HIV/AIDS, this dissertation contributes greatly to the field of political economy of health and illness. The actors identified in this dissertation, and their interconnections provide a good starting point and a theoretical framework to experiment in other contexts. It provides a framework for political economy of resource allocation on public health.

**Contribution to queer studies, gender studies**

Finally, by exploring two of the most vulnerable groups for HIV infection, and their struggle for civil and political rights, this dissertation contributes greatly to the ongoing theoretical debates on feminist studies, queer studies, gender studies etc. By analyzing prostitution from a feminist perspective and situating the collectivization of Indian prostitutes within the broader framework of feminist literature, this study is able to delineate the ideological orientation of the Indian feminist movements and that of the prostitutes’ collectives. My analysis challenges the Indian radical feminist assumptions that argue for prohibition of prostitution. Similarly in queer studies, I challenge some of the assumptions about liberating the queer sexualities and politically organizing them to perform in Western style queerness. I also delineate the politics of naming of alternate sexualities as “gay” or “MSM” for HIV prevention purposes.
7.2. Epilogue

The UNGASS Declaration of Commitment, 2001 in a 46-page document had identified 11 priority areas containing 103 articles. The Declaration was one among several other normative regimes that India adopted, for example, Millennium Declarations, 2000; Global Strategy Framework, 2001; Political Declaration on HIV/AIDS, 2006, etc. It was not possible for me to examine India’s compliance with every single article of each of these regimes. I have only identified certain critical areas of policy, program, and institutional structures where compliance is worth mentioning. Each of these areas has been examined in separate tables in Chapter 4. Despite the geographic, political, socio-cultural and economic diversity that India presents from the rest of the world (say, for example, Iran, or Nigeria), the UNGASS Declaration provided a standard frame on which every state to act. It would have been an interesting exercise to compare the degree of norm socialization between India, a liberal, secular democracy with an autocratic, Islamic state in the Middle East, or a relatively new democracy with widespread concurrent sexual partnership in West Africa. But given the constraints at the individual level for completing the requirement for a PhD, that idea is set aside for a future project. Nonetheless, the current exercise was worth investigating after a decade of ratifying the Declaration by the Indian government.

Critiques have pointed out that reversing the tide of AIDS funding may not only be difficult, but might also face fierce resistance from the gigantic HIV-industry. Tom Coates, a professor of global AIDS research at the University of California, Los Angeles said, “Let’s not drag AIDS care and prevention down to the level of every other disease, but let’s bring everything else up to the level of AIDS. This may be a very wishful thinking. But as Daniel Halperin, an AIDS expert at the Harvard School of Public Health said, “At the end of the day, there are limits to how big the public health

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“We have a system in public health where the loudest voice gets the most money. AIDS has grossly distorted our limited budget.”

By the time I completed writing this dissertation, I had developed a severe “HIV fatigue.” I do not want to hear this word, “HIV,” anymore. Without being too cynical, every time I hear the words “HIV” and “AIDS” from NGOs, I smell a dead rat. All they talk about is AIDS — more treatment, more facilities, more medicines, more benefits, more rights, more perks, more money, more of everything; and if you are not HIV-positive, you are better off dead — such a sick attitude to address a public health problem. Globally, some HIV activists are also showing signs of HIV fatigue and burn-out. Until a new “epidemic” is freshly constructed, AIDS will likely to receive the same level of attention, if not less. And by the time another issue emerges to take the center-stage of development, several million lives of would have been perished simply by not having enough to eat, or clean water to drink, or a place safe to sleep. Sadly enough, sad stories rarely get written!

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