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Dilip K. Das
Department of Cultural Studies
English and Foreign Languages University
Hyderabad, Telangana, India

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*This book is dedicated to the memory of my father, Professor Sadhu Charan Das, whose passion for learning I have always tried to emulate, and my mother, Mrs. Annapurna Das, who always supported me in the effort. I also dedicate this book to my teacher, Professor Prafulla C. Kar, and to Mrs. Mokshada Kar, who have constantly inspired me in my life and academic career.*

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# Contents

# About the Author

**Dilip K. Das** is Professor of Cultural Studies in the School of Interdisciplinary Studies at the English and Foreign Languages University, Hyderabad. He is a recipient of a Fulbright Postdoctoral Fellowship at the University of Illinois, Urbana-Champaign, USA, and a South Asia Regional Fellowship from the Social Science Research Council, New York. His research area is interdisciplinary body studies, and he has published essays on the social dimensions of disease.

# Chapter 1
# AIDS Awareness and Behaviour Change: An Interdisciplinary Perspective

**Abstract** In the absence of vaccine or cure, teaching how to avoid infection seems to be the only strategy for epidemic control. Declining figures of new infection suggest that pedagogic efforts have had a modest success. To enhance its effectiveness, the assumptions underlying pedagogic interventions and their effects must be examined. Given the multiple contexts of the epidemic, it is necessary to examine AIDS pedagogy from an interdisciplinary perspective, and the humanities can be a valuable critical resource in this effort.

**Keywords** AIDS pedagogy · Interdisciplinarity · Critical medical humanities

> Against the urgency of people dying in the streets, what in God's name is the point of cultural studies? (Hall 1992, p. 284)

The HIV/AIDS epidemic, which began in the United States and Western Europe in 1980, is now three-and-a-half decades old. Since then, an estimated 77.3 million people have been infected globally, with 35.4 million succumbing to AIDS-related illnesses. UNAIDS estimates for 2017 indicate 1.8 million new cases and about 1 million deaths in that year alone. However, the number of new infections acquired annually has declined by 47% since 1996, when it had reached a peak of 3.4 million, while AIDS-related deaths have reduced by 51% against the 2004 figure of 1.9 million (UNAIDS 2018a). Based on the achievements of three decades, it appears possible "to end the AIDS epidemic as a public health threat by 2030" (UNAIDS 2018b, p. 8). While these figures are reassuring, suggesting that the epidemic may be on the decline, there is as yet no vaccine, and health education may be the only way to bring down the spread of AIDS. Initially, it was assumed that merely providing information about HIV transmission and prevention would motivate individuals to take precautions. Subsequently, when this did not have the desired effect, more proactive strategies were designed to change sexual and intravenous drug-use behaviours of individuals or groups who were at risk of infection because of their profession, lifestyle and inadequate understanding of the disease. "Gaps in knowledge, attitudes, and behaviours among a target audience can be identified, and

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communication interventions are then targeted to addressing these deficiencies at the individual level" (Singhal and Rogers 2003). Information-based awareness creation and behaviour change communication have been the two main props of educational projects in epidemic control.

*Teaching AIDS* is about pedagogic interventions in India, which it examines in the context of public discourses about AIDS- and HIV-positive people. It attempts to locate these interventions within shifting constructions of the epidemic in media reports, narratives and court decisions about people with disease. It also attempts to understand the wider cultural politics of representing, understanding and responding to disease and persons with disease and the effects these have on the governance of public health. It needs to be stated at the outset that this book is not polemical: it does not seek to discredit AIDS pedagogic interventions in India, which do seem to have played a role in bringing down new infections by 66% since 2000, against a global average of 35% (NACO 2015, p. 5; NACO 2017, p. 340). Rather, it tries to understand how AIDS pedagogy functions as a mode of governing the conduct of people, an exercise of power that seeks to empower and not constrain those it governs, how it constructs the "truth" of AIDS and of the experience of AIDS and what resonances it has with the wider public discourse. In a lecture given to the French Society of Philosophy in May 1978, Michel Foucault explained that the task of critique is to find out not "what is true or false, founded or unfounded, real or illusory, scientific or ideological, legitimate or abusive" but the links between the exercise of power and elements of knowledge (Foucault 1997/2007, p. 59). *Teaching AIDS* is written in the spirit of such inquiry.

The first cases of what later came to be called AIDS were discovered in 1979–1980, among gay men in New York, California, and a number of cities in Western Europe. Since most of the cases were diagnosed with two rare diseases associated with low immunity, *Pneumocystis carinii* pneumonia and Kaposi's sarcoma, it was initially understood as a PCP/KS complex and informally referred to as gay-related immunodeficiency (GRID) because of the population in which it predominantly occurred. In 1982, by when there were a number of heterosexual cases, the Centers for Disease Control and Prevention (CDC) adopted the term acquired immunodeficiency syndrome (AIDS). During the same period, a number of cases of heterosexually transmitted HIV infection were reported from countries in sub-Saharan Africa such as Uganda, Congo, Rwanda and Tanzania (Shilts 1987, pp. 138, 171). In 1985, when the first international conference on AIDS was jointly organized by the CDC and World Health Organization (WHO) in Atlanta, 17,000 cases had been reported worldwide, with more than 80% from the United States. It was officially recognized as an epidemic on a global scale in 1988 when the United Nations, in response to the mounting number of cases reported from various countries, launched the Global Programme on AIDS, the triple objective of which was "to prevent HIV infection, reduce the personal and social impact of HIV infection and mobilize and unify national and international efforts against AIDS" (UNAIDS 2008, p. 15). When UNAIDS was established in 1994, it was estimated that by then there were about 13 million HIV-positive cases worldwide, of whom more than half a million died of AIDS-related opportunistic illnesses. By 1996, when UNAIDS started compiling global data, the epidemic had spread to most parts of the world, with 15.4 million reported cases in sub-Saharan Africa, 1.8 million in Asia, 1.5 million in North America and Western and Central Europe, more than 1 million in Latin America and the Caribbean, 300,000 in North Africa and the Middle East and 80,000 in Eastern Europe and Central Asia. Further, it appeared as a complex of multiple and differentiated regional epidemics, based on transmission modes, rates of spread, geographical foci, HIV subtypes and socio-economic and behavioural characteristics of the populations most affected (UNAIDS 2008). In 2000, at the start of the new millennium, UNAIDS reported a total of 34.3 million people living with HIV/AIDS, with 5.4 million new infections in 1999 and 2.8 million deaths. India alone accounted for 3.7 million people living with HIV, though the average prevalence rate in the population was only 7 per 1000. The epidemic in India was very diverse, with some states reporting almost nil prevalence while others reported 2% or more (UNAIDS 2000).

The first cases of HIV infection in India were detected in 1986, about 5 years after the epidemic emerged in the United States, Europe and sub-Saharan Africa. The initial governmental and public response to this was to deny that it could spread in India, because of strong moral traditions. But the Indian press recycled deeply negative stereotypes of HIV disease and HIV-positive people taken from the Western media, and there was intense moral panic about the disease. In 1992, with the help of a World Bank loan, the government established the National AIDS Control Organization (NACO) as the nodal agency to deal with the epidemic, and a centralized regulatory framework called the National AIDS Control Policy (NACP) was formulated in five phases. At the time, there were only 5879 reported cases of HIV infection and 96 cases diagnosed as AIDS. "Seeking a World Bank loan for HIV/AIDS made no sense. But circumstances were compelling. Media reports of discrimination and social boycott of HIV patients, denial of treatment by hospitals, suicides driven by fear and shame, abandoned dead bodies with no one willing to cremate them, and the handcuffing and jailing of drug addicts in Manipur created panic and disbelief" (Rao 2017, p. 202). Data collection, however, was not done on a large scale, and it was only after the formation of NACO, in the first phase of NACP, that the HIV Sentinel Surveillance (HSS) was instituted, based on seroprevalence figures from antenatal clinics and STD clinics. By 1998, which marked the end of NACP I, there were 3.5 million people living with HIV in India, with 2,85,000 new infections in that year alone (NACO 2004, p.16; NACO 2015, p. 4). In 2005, at the end of NACP II, the number of new infections had dropped to 1,53,000, or almost half the 1998 figure. In 2012, at the end of NACP III, the figure was 96,000, and in 2015 it was 86,000 or a 65.7% decline on the figure for 2000 and 32.3% decline on the figure for 2007 (1,27,000), which was taken as a baseline for NACP IV (NACO 2015, p. 4).

Annual new infection figures are an index of how effectively disease control measures have worked. The significant decrease in the number of new infections during NACP III and NACP IV can be attributed to a number of factors. The first was a multifold increase in the number of sentinel surveillance sites and improved reporting, which made people aware of their HIV status so that they could take precautions against getting infected or, if infected, against transmitting it to others. Second was improved blood safety, which had started from the very first phase of NACP. Third was increased condom distribution through social marketing and needle-exchange facilities for injection drug users; fourth, prevention of parent-to-child transmission; and fifth, free supply of antiretroviral therapy for persons living with HIV that reduced viral loads and consequently transmission of disease. But all these strategies depend upon peoples' knowledge of the facilities available and their willingness to access them, and that is where pedagogy plays a crucial role. Since the decision to test for HIV and sexually transmitted infections, use condoms or uncontaminated needles and syringes, insist on HIV-free blood for transfusion and avail of antiretroviral therapy for therapeutic and prophylactic (in case of parent-to-child transmission) purposes – since the decision in such cases cannot be mandated by law or coerced in any other way – it is only through pedagogic interventions that people can be persuaded to follow the precautions. There may be, therefore, a correlation between the drop in new infections and the shift in pedagogic techniques from a singular focus on informational formats, listing the "facts" and "myths" of AIDS, to a mix of information and behaviour change communication designed specifically for discrete risk groups, in what came to be called "targeted interventions".[1] In this context, it becomes imperative to understand what pedagogy involves as a form of governing peoples' conduct, how it functions and what kind of subjective effects it achieves in those whom it targets. Pedagogy, like all social processes, never exists in isolation but is embedded within larger structures of meaning-making that organize and constitute our knowledge of ourselves and the world; and to understand it effectively, we need to locate it within these structures and the discourses as well as practices they generate. That, in effect, sums up the approach and concerns of *Teaching AIDS*.

Let me now trace the trajectory of arguments developed in the six main chapters of the book. In outline, the chapters are organized on the following themes: conceptual framework and tools of analysis, media accounts and narratives of AIDS as "incipient" pedagogic sources, court decisions that construct the epidemic as a problem for the law, formal pedagogic initiatives formulated by the state and implemented by a range of agencies on behalf of the state and a local popular initiative that combines the knowledge disseminated in official pedagogies with the reinvention of a long-standing ritual tradition.

Chapter 2, titled "Pedagogy, Power and the Subject of Disease Control," explains the key concepts that are used in the book, as tools of analysis. It begins with the concept of pedagogy and its relation to power in the work of Louis Althusser, Paulo Freire and Michel Foucault. Althusser's account of education in his ISA essay brings out its role in sustaining and legitimating social power structures through ideology. Its function is not simply to disseminate knowledge but to do so in ways that make people more amenable to authority. The most telling example of this is the lesson in civic citizenship and moral science, which is a core component in school

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[1] The term was introduced in NACP III, though the strategy had been adopted in the previous phase.

curricula. One may also add lessons on hygiene, which began to be introduced in schools in the late nineteenth century. Freire, too, holds a critical view of education as a tool of political domination, especially in the countries of the global south, but unlike Althusser he also advances a form of liberatory education that is dialogical and problem-oriented rather than providing information. Despite their philosophical differences, Althusser subscribing to an anti-humanist and Freire to a humanist Marxist standpoint, both see education as essentially political, either in the service of power or opposed to it. Foucault's approach to education, however, is radically different, though he too emphasizes its links to power relations. For Foucault, education's chief role is not to promote an ideology but to shape subjectivities. Unlike the Marxists, he views power not as negative, working through ideological false consciousness, but as productive and enabling. As he puts it in *Society Must Be Defended*, the task of political analysis must be to show not how and why people agree to be subjugated (which is the question for ideology critique) but "how actual relations of subjugation manufacture subjects" (Foucault 2003, p. 45).

The role of pedagogy in subject formation is crucial to all three thinkers. For Althusser ideology produces subjects who bear an illusion of autonomy and agency, in the act of self-constitution that he calls "interpellation". For Freire, mainstream pedagogic practices work similarly on the learners, to ensure their continued domination through ideology and the illusion of freedom. An "education for critical consciousness" opposes it and, through such opposition, produces empowered subjects. In Freire, then, the subject is not only one who is subjected but equally one with a capacity for autonomy and agential action. Foucault's view of the subject resembles to some extent this idea but without its liberatory overtones. For Foucault, free subjectivity is not an ideological illusion, but *neither does it exist and function outside the field of power relations*. The exercise of power, in its specifically modern form that he calls "governmentality", enables individuals to choose their course of life, but from options outlined in advance by power. The subject, thus, is produced in a socio-political space that is both enabling and constraining, in a paradoxical relation to power that Foucault terms "subjectivation". While the subject's freedom is the essential condition for this politics, it is not absolute. This should be clear from the way modern systems of law both guarantee freedom and place what are called "exceptions" or "reasonable restrictions" in the name of a higher good that is social. Foucault's emphasis, however, is not on law but disciplinary controls, which are most prominent in the field of pedagogic practice. In its approach to subjectivity in the context of pedagogy, the book's conceptual framework draws on both Althusser's theory of interpellation and Foucault's theory of subjectivation.

Chapter 2 also explains the concepts of norm and normativity, as the regulatory schema within which subjects are produced. It draws on the work of a number of authors, including Mary Douglas, Susan Sontag, Cindy Patton, Sander Gilman, and Thomas Yingling, to understand how normative ideas are discursively produced and legitimated in the context of health and disease, and the social effects of such production. If discourse is one instance of normativity, embodied practice as the performance of norms is the other. The chapter explains the concept of embodiment in Thomas J. Csordas and Judith Butler, the former from a phenomenological and the latter from a post-structuralist perspective, and theories of social practice in Pierre Bourdieu and Victor Turner. Finally, the chapter explains Foucault's concept of "biopolitics", or the politicization of life in modern societies. This concept is crucial in understanding public health governance as one of the main activities of the state, through which it ensures the life and well-being of its subjects. It briefly takes up the negative inflection of biopolitics in Giorgio Agamben and Roberto Exposito, which is explained in greater detail in Chapter 5.

Chapters 3 and 4 deal with what I call "incipient pedagogies", that is, texts that do not take up teaching about AIDS as their objective but which shape opinion about the disease and how it can be comprehended. Some of these texts, especially those discussed in Chapter 4, are in passing overtly pedagogic and are also associated with pedagogic initiatives undertaken by agencies of public health.

Chapter 3, "Incipient Pedagogy I: AIDS in the National Media", is about early media responses to the epidemic. When AIDS first appeared in India in 1986, there was a lot of confusion about its modes of transmission and prevention, the people most vulnerable to it and the kind of problem it posed for society. In the absence of any Indian experience of the disease, the media turned to reports in the Western press which were to a great extent homophobic and stigmatizing. Since transmission of the disease at this time was understood to be predominantly heterosexual, the Indian media did not take up the homophobic perspective but re-articulated the stigma in other ways. First, they stressed that AIDS was of "foreign origin", in a denial of disease that, as Susan Sontag has argued, is xenophobic. Disease always belongs to the outside, the space of the other onto whom it must be projected. Inside the nation, the media produced an othering of spaces like brothels, slums and highways and those who inhabited them, from which it discursively insulated the middle-class home. The reports attributed the spread of disease to prostitutes, migrant workers and truck drivers, who were identified in public health discourse as the "risk groups". In public health parlance, the term meant people at risk of contracting infection: through a slippage in the meaning of risk, the media translated this as groups that posed a danger to others. Subsequently, when a significant number of housewives started testing positive for HIV, media accounts constructed a "victimology" of AIDS founded on the binarism of the "innocent victim" and the "guilty". *India Today* devoted a cover story to the issue, titled "AIDS: Striking Home", with texts and illustrations that established the binary as fact and intensified moral panic. These early media representations played a significant role in shaping both popular and pedagogic understandings of AIDS and influenced social response to the epidemic and the people affected by it.

The chapter discusses how media accounts constructed the epidemic as simultaneously a medical and moral catastrophe, a construction that was to have a significant impact on the National AIDS Control Organization's pedagogic initiatives in its early phase. While the media also documented instances of human rights violations, especially the unlawful custodial detention of sex workers and injection drug users, it tended to justify this as warranted by the severity of the crisis. This was also the view reflected in a number of court cases concerning the rights of HIV-positive people. One of the positive things that the media did, however, was to draw attention to the contamination of blood supply, because of which ensuring blood safety became a priority for the National AIDS Control Policy in its first phase.

By the late 1990s, when AIDS had already "struck home" in a big way, it was no longer possible to believe that it concerned solely the marginal risk groups. It was only then that it became a subject for narratives, of sufficient interest to the literate middle class to warrant their publication. Besides, much of the panic had decreased, making it a topic that one could talk about and not anxiously deny, especially after the availability of antiretroviral therapy made it possible to see AIDS as a fatal but manageable illness. Chapter 4, titled "Incipient Pedagogy II: AIDS Narratives", is about the way the HIV/AIDS epidemic has been recounted in factual and fictional texts, including cinema. The narratives of AIDS that were published at the turn of the century emerge from this conjuncture of events. We note a number of important shifts in the way these narratives construct the epidemic.

First, AIDS comes to be seen as a social rather than biomedical issue, both in terms of the stigma that it generates and the structural factors like gender and economic inequalities that make people vulnerable to infection. Secondly, pedagogy comes to be understood as the only means of controlling the epidemic by inducing disease-preventive and risk-avoidance behaviour, especially since there is no vaccine available. Many of the narratives examined in this chapter are associated with pedagogic projects, either commissioned or subsequently sponsored by them, and all include a pedagogic component. In some narratives, like *Sex, Lies and AIDS*, *Nidaan* and *A Dove in Desert*, the pedagogic function is overt, while in others it is less obvious. Third, there is a shift from a macrosocial perspective, mapping the extent and scale of disease incidence, to a micro-social one that focuses on the individuals affected. In terms of narrative mode, the epidemic comes to be constructed through two forms of writing, the travelogue and the life narrative, with the emphasis gradually shifting to the latter. Fourth, with the emergence of life narratives, AIDS comes to be understood more as illness than disease – that is, a condition that involves the whole person rather than the body as an entity separate from the self, thus emphasizing the subjective experience of illness rather than the objective pathologies described by biomedicine. Accompanying this is a concern with healing, as the process of developing a sense of emotional and spiritual well-being despite the presence of disease. Some of the narratives express the theme of human vulnerability and the need to overcome it through establishing bonds of community and support systems. This theme coincides with a major development in the epidemic when Positive People networks are formed to counter stigma, self-abjection and isolation, through the embodied affiliations that Paul Rabinow calls "biosociality". In the context of the epidemic, biosociality bears an inverse relation to stigma: both involve the body, but while stigma devalues it as diseased and therefore to be isolated, biosociality invests it with a new value as a foundation for community. The shift to biosocial affiliation in turn corresponds with the emergence of two new conceptualizations of embodiment in the epidemic: the use of the term "Person Living with HIV/AIDS" (PLWHA), with its emphasis on *living* with AIDS instead of *dying* of it, and the transformation of "positive" from a sign of disease in the diagnosis of AIDS to a sign of self-affirmation in "Positive People". These discursive articulations constituted a meaning of AIDS opposed to that assigned to it in the first decade of the epidemic. Finally, with *Phir Milenge* and *My Brother … Nikhil*, we note a shift in the understanding of AIDS from a socio-economic problem to a problem that law must address, in protecting the rights of the HIV-positive. The epidemic thus comes to be complexly constructed and represented as simultaneously a medical, economic, social and juridical phenomenon.

An important aspect of these narratives is that they are all produced by and addressed to people who are not themselves infected, and there is a tendency to represent and distance the HIV-positive as objects of compassion. This is more pronounced in the early texts, both factual and fictional, in narrating the life stories of people who have acquired the infection not through "promiscuity" but "innocently", that is, either through blood transfusion or from their spouses. By reproducing the guilt/innocence binary, they unwittingly reinforce the stigma that they seek to counter. In this context, *Phir Milenge* and *My Brother … Nikhil*, which focus more on the subjective experience of illness than on objective conditions of disease, are exceptions.

Chapter 5, "AIDS and the Enigma of Law", examines three court judgments pertaining to HIV disease and one to leprosy, which deal with the constitutional validity of statutes that curtail the fundamental rights of persons with disease on the ground that they pose a risk to the public. *Lucy D'Souza v. State of Goa* (1989) is about a provision of the Goa, Daman and Diu Public Health Act, 1985, which allows the state to isolate persons with HIV/AIDS in the interest of epidemic control. Under this provision, Dominic D'Souza was kept in custody in an abandoned TB sanatorium for 61 days, till a bench of the Bombay High Court ordered his release. In *Lucy D'Souza*, the court ruled that the statute does not contradict the constitutional rights to life, liberty and freedom of movement. *Mr. X. v. Hospital Z* (1998) is about the action of a hospital that had violated the right to privacy and confidentiality of a Nagaland doctor who was HIV-positive, by informing others of his serostatus and causing him severe social ostracism and loss of his job. The court held that the hospital had acted in the interest of the woman he had proposed to marry, thus saving her from disease and death, and was therefore justified in its action. It further ruled that HIV-positive persons should not be allowed to have sex and their right to marry be treated as a "suspended right". *Dhirendra Pandua v. State of Orissa* (2008), which concerned a provision of the Orissa Municipal Act, 1950, that disqualified persons with leprosy from holding public office, similarly ruled that there was no constitutional infirmity in the provision, even as it suggested that the state legislature may consider removing it. The paradox of a law that must protect the right to life and liberty of its subjects by withdrawing the same right from those who are diseased forms the central argument of *M. Vijaya v. Chairman and Managing Director Singareni Collieries* (2001), which is the only judgment that explicitly foregrounds this enigma. But *Vijaya* too, like the other judgments, resolves it in favour of public interest and justifies the exclusion of diseased persons.

The chapter attempts to bring out the contradictions and inconsistencies underlying such exclusion of persons with disease in the name of the public good. The contradictions, it argues, do not become manifest in the structure of the legal system but in the process by which the system is used in the maintenance of law. The dichotomy of structure and process is one that has concerned the study of culture and society since the 1970s. On the one hand, it is necessary to have a sense of the structures by which order is maintained, whether it is the ordering of meaning in language or the ordering of people's conduct in law. But, on the other hand, this abstract structure of ordering does not account for what actually happens. Social reality cannot easily be determined by the rules that law and custom impose on it. When the gap between this reality and the structure of rules becomes insuperable, indeterminacies emerge that compel a rethinking and transformation of the rules. Thus, structure is what both constrains process and is in turn transformed by it, in a dialectical relation that Anthony Giddens calls the "duality of structure". The process central to the legal system is the adjudication of a case, and the judgment is its quintessential inscription. The judgment not only matches acts to statutes, to determine whether they are licit, and prescribe penalties if they are not, but it also explains in the process the rationality of law. Contradictions and inconsistencies, when they appear in specific judgments, undermine that rationality and its attempt to determine the conditions of social existence. Such contradictions and inconsistencies, it is argued, must not be viewed as the errors of an individual judgment but, given the enchainment of judgments through precedents and procedures, the outcome of deeper instabilities in the system of law itself.

The chapter links law to medicine in the form of governance that Foucault calls biopolitics, or the politicization of life. One of the imperatives of the modern state as it emerged in eighteenth-century Europe was to ensure that the subjects are provided with all conditions necessary for health and well-being, which was mainly how it differed from the rule of the sovereign. The rationale behind this was that the strength and prosperity of the state depended on the productive capacity of its subjects, which in turn depended on their health and well-being. In this form of governance, both law and medicine worked to ensure the disciplining of individuals and the regulation of populations in a double exercise of authority that was positive and productive. However, in the case of individuals who were understood to pose a threat to the social order, the medicolegal order functioned negatively, to exclude them from society, and medicine provided the justifications for the sanctions that law imposed. Legal psychiatry came up with the concept of the "dangerous individual", whose rights could be curtailed on the grounds not of what he did but what he was likely to do given his character or condition of disease. This was a major paradigm shift in law, when it turned from actions that must be proscribed to persons who must be socially eliminated. This can explain why persons with disease are treated as a "danger", whose rights may therefore be justifiably suspended to protect the right to life of others. In the case of diseased individuals, thus, the biopolitics that is ordinarily positive and empowers subjects to be productive inverts itself, acquires a negative declension and sacrifices the very life it seeks to nurture and protect.

The chapter argues for a transformation in law's understanding of the diseased person, from one that objectifies them as source of social danger to one that is more responsive to the social vulnerabilities that they themselves suffer under stigma and ostracism. It ends with a discussion of the AIDS Prevention and Control Act, 2017, which was the product of just such a transformation, with one significant shortcoming. While it prohibits any form of discrimination against HIV-positive individuals, it fails to address the discriminations implicit in legal provisions for segregating the diseased and curtailing some of their fundamental rights.

Chapters 6 and 7 are about the main theme of the book: AIDS pedagogy. Chapter 6, “AIDS Awareness Campaigns: Pedagogy as Strategy”, discusses what I term “official” or “national” pedagogies, which draw on large-scale plans and strategies for governing the conduct of people. Using a distinction that I borrow from Michel de Certeau, I call them “strategic” pedagogies. Chapter 7, “AIDS Amma Shrine: Pedagogy as Tactics”, examines a popular initiative undertaken by the governed, which I call, following de Certeau again, “tactical”. In order to understand how the national AIDS pedagogy works, Chapter 6 places it in the larger context of public health strategies, health education and nationalization of epidemic disease. Historically, there have been three major paradigms of public health: quarantine/vaccination, sanitation/personal hygiene and risk surveillance/lifestyle management. In each of these couples, one element targets populations and the places they inhabit, while the other targets individuals, in the double strategy of modern governance that Foucault characterizes as “an *anatomo-politics of the human body*” and “*a biopolitics of the population*” (Foucault 1978, p. 139, italics in original). These paradigms are not mutually exclusive, with one supplanting the other, but draw upon techniques used earlier in re-articulated forms. Thus, the current public health paradigm of risk surveillance/lifestyle management, instituted in the second half of the twentieth century, includes techniques of quarantine and personal hygiene oriented through the notion of risk group and risk practice in dealing with epidemic disease.

Public health pedagogy as a technique of acting upon individuals to follow health-promoting practices emerged with the sanitation/personal hygiene paradigm, in the second half of the nineteenth century, and has continued since then. It was both disseminated among the general public, especially those populations held to be most vulnerable because of illiteracy and poverty, and incorporated into school curricula in the form of primers, so as to raise levels of disease awareness in society. Public health pedagogy as a strategy for governing people has followed a top-down approach, with its experts drawn from medicine, sociology and social work, psychology and communication. At present, it links good health no longer to morality as the old hygienist paradigm did but to lifestyle factors that decrease risk of disease. However, moral norms are often recycled in the form of scientific wisdom especially in the context of infectious sexual disease. This is because public health governance has been since its inception a way of regulating the conduct of its subjects, in a social hygiene that it performs alongside law and discipline. With its emphasis on lifestyle, health education targets the subjectivities of the people it addresses through techniques of interpellation and subjectivation, in producing pedagogic subjects who learn to value health above pleasure and are instilled with a sense of responsible and rational conduct.

The chapter then examines the role of NACO in formulating and instituting AIDS education in India. When the first cases of HIV disease were detected in1986, the Indian government’s response was to deny its presence and to try and seal the boundaries of the country in what Alison Bashford describes as imagining the “geo-body” of the nation (Bashford 2004, p. 115). But when it could no longer be denied as a disease of foreigners, governmental response focused more on the interiors of the nation rather than its borders. NACO was the product of this shift. With the formation of NACO in 1992 and the formulation of the National AIDS Control Policy, the epidemic came to be nationalized primarily in two forms, through a cartographic mapping of spaces of disease and a demographic mapping of populations at risk. In successive phases of the NACP, this strategy came to be scaled up in extending both the reach and the depth of AIDS governance. With regard to pedagogy, nationalization took the dual form of policy centralization by NACO and decentralized implementation by NGOs and community-based organizations, thus opening up multiple sites of governmentality (NACO 2011, p. ix). Pedagogy adopted a technique of double address, aimed at the general population through awareness creation and the risk groups through what came to be called "targeted interventions". Emphasis also shifted from providing information about HIV/AIDS to facilitating behaviour change. The major implication of this shift was the fashioning of the pedagogic subject in policy and practice, deploying techniques of both interpellation and subjectivation.

In conformity with the new public health paradigm, the production of this subject involved the teaching of risk and safety on the one hand and of managing lifestyles on the other. In epidemiological discourse, risk is understood as the degree of one's vulnerability to disease, but in lay language, it is usually construed as danger to the public. Given this semantic uncertainty, AIDS policy formulations and pedagogic texts, though intended to address the epidemic in value-neutral terms and without prejudice to risk groups, are often undermined by the slippage of meaning between risk as vulnerability and risk as danger. The chapter uses a number of texts to demonstrate this. With regard to the pedagogy of lifestyle management, it shows how it is founded on an ideology of free and self-responsible subjectivity, which is the mainstay of liberal or neo-liberal public health governance. There are, however, fundamental contradictions in this ideological conception of subjectivity, the most crucial being the way actual power relations are disguised in the form of an expertise of enablement. The chapter attempts to bring out this contradiction by analyzing two texts that are about teaching individuals to make responsible and health-promoting choices.

The pedagogic construction of HIV/AIDS as a national problem is not insulated from the constructions of the epidemic in the media, narratives and the law. It was the panic about AIDS in the media that led to the creation of NACO and the prioritization of AIDS as public health issue, and not actual morbidity and mortality figures. There are many points on which official AIDS pedagogy either converged with popular understandings of the disease in the media and narratives, especially with regard to moral norms and family values, or opposed them with regard to stigma. As for the juridical construction of AIDS, one of the important issues that pedagogy has addressed is the violation of the human rights of HIV-positive people. For instance, a booklet titled *HIV/AIDS: Stand Up for Human Rights* was produced jointly by the office of the UN High Commissioner for Human Rights, WHO and UNAIDS and circulated as a pedagogic text for the general population. More significantly, in a Delhi High Court case in 2009 regarding the constitutional validity of Section 377 IPC, NACO became impleaded as a respondent. NACO's stand, in support of the petition filed by Naz Foundation, was that the statute, by criminalizing adult same-sex relationships, drove underground gay men, bisexuals and hijras, making it very difficult for pedagogic interventions to reach them. NACO's stand on Section 377 IPC in *Naz Foundation v Government of NCT of Delhi* (2009), together with its support for targeted interventions among men who have sex with men, shows how AIDS pedagogy has responded to the juridical construction of AIDS.

Chapter 7 is about an initiative undertaken not at the official level but by the people acting independently of the official domain. Following de Certeau's distinction between strategy and tactic, the chapter discusses this initiative, the worship of a new "disease goddess" that the people call AIDS Amma, as a tactical response to a local contingency.

The AIDS Amma shrine at Menasikyathanahalli was set up in 1998 by Girish, science teacher in the local government school, to teach people about modes of transmission of HIV/AIDS. Incidence of disease in the rural community led to panic and stigma against HIV-positive people. Girish started the campaign to allay fear, when he learnt that in the previous year an HIV-positive couple had committed suicide due to stigma and their neighbours had cremated their bodies without following ritual traditions. The maintenance of the shrine was subsequently taken up by the community, who conducted weekly worship and organized an annual *jatra* or festival on World AIDS Day. It was entirely a popular initiative, without support from the government or non-governmental organizations. As such, it is an instance of pedagogic efforts that are not part of public health governance and do not use the form and logic of awareness campaigns conducted under the auspices of the state.

The initiative differs from official pedagogies in its use of religion to communicate biomedical information about HIV. Taking his cue from a Mariamma temple on the village outskirts, Girish thought of this method when his attempts in the usual format of official pedagogy had received poor response. In most parts of India, there is a long-standing tradition of the worship of disease goddesses, especially in times of epidemic. Most of these goddesses are associated with smallpox and cholera, epidemics of which were regular occurrences in the past and which took a heavy toll of lives. A few temples had also been set up for a goddess associated with plague after epidemics broke out at the end of the nineteenth century. The most popular of these goddesses are Sitala in the north of India and Mariamma in the south, both associated with smallpox. It is mostly believed that the goddess, who is benign, does not cause the disease but protects her devotees from it, though sometimes she is also imagined as malignant if she is displeased because people neglect her worship. There are certain common features of disease goddess worship. It is ordinarily a local affair, the goddess being a *gramadevata* or village deity, though the belief in disease goddesses is itself more or less pan-Indian. The goddess is often attributed with wide-ranging powers, most of which are associated with the prevention of disease and natural calamities: the tradition of goddess worship, thus, is an imaginative way of resolving crises caused by chance events, when the resources of the community to reduce distress are felt to be inadequate. Weekly *pujas* are held at the shrine of the goddess, normally situated at the entrance to the village, and a day is fixed in the ritual calendar for her annual worship and *jatra*. Worship of the goddess is most often a public affair, with the entire village community participating in it, though domestic worship is not prohibited. Localization, collective participation and attribution to the goddess of the power of ensuring well-being of both individuals and the community are the forms in which disease goddess worship becomes a part of the everyday lives of the people, their ways of being. By linking the AIDS Amma initiative with this long tradition, Girish could ensure acceptance of the information he sought to communicate. But this itself was possible because the tradition was available as a resource, in precisely the same context of epidemic disease crisis that presented itself in Menasikyathanahalli, providing the conditions necessary for Girish's "invention" of AIDS Amma. By looking at the AIDS Amma initiative from this perspective, one understands how its meaning and effects derive not from the logic that Girish intended but the structural intentionality of the tradition.

Acceptance of the pedagogy was ensured by the ritual structure that framed it. Theories of ritual emphasize its performative dimension, meaning not only that rituals need to be performed but equally that their acceptance, meaning and efficacy are an outcome of this performance. The authority that ritual has over the conduct of one's life is the effect of its performative structure, just as its authority ensures its continued performance. By framing the pedagogic content in the ritual of goddess worship, the initiative invested it with the authority of a popular and valued tradition. Further, ritualization linked this authority to the idea of the sacred, thereby separating the pedagogic content from the practico-discursive field of public health communication to which the local community had initially failed to respond. It is the process of ritualization that makes sacred acts that would otherwise be secular or profane, as seen in the way smallpox variolation or *tika* became an integral part of Sitala worship. In this way the acts both gain authority and link the sacred to the everyday life of the practitioners. Thirdly, as embodied activity, ritualization is an important way in which South Asian societies have preserved cultural knowledge and the shared sense of belonging to a collectivity. The perspective of embodiment does not distinguish between mind and body as polarities of existence but assumes their mutual implication in what Scheper-Hughes and Lock call the "mindful body". What this meant in the case of AIDS Amma was that the biomedical ideas could be incorporated into existing ways of knowing and responding to epidemic crisis through the embodied act of offering *puja* and celebrating the annual *jatra*. Memory, consciousness and the body function as a complex in constituting knowledge of disease and integrating it with ideas of personhood in the cosmological order. Acceptance of the pedagogic function of AIDS Amma was ensured by this complex.

The framing of biomedical knowledge in religious ritual, however, leads to certain epistemological effects that appear paradoxical and self-contradictory. It is marked by a series of juxtapositions that bring together otherwise incompatible elements. Thus, AIDS Amma worship assumes divergent explanations of disease, personalistic and naturalistic. It assumes a magico-naturalistic conception in which the body is understood as both open to external supernatural influence and constituted by internal organic processes that follow natural law. It also involves contrary ways of knowing, one performative and embodied and the other discursive and cognitive. These juxtapositions, however, do not affect either the acceptance of the pedagogy or its effectiveness in eliciting popular response. While the epistemology of AIDS Amma may appear paradoxical from a theoretical perspective, the logic of expediency and symbolic assimilation of meaning in practice makes it otherwise in the minds of its practitioners. The objective of the AIDS Amma initiative is pedagogic, to teach the community about HIV/AIDS and the need to destigmatize it, but it seeks to achieve this in a way that differs from conventional AIDS education and behaviour change communication. Insofar as this is concerned, it is a tactical response both to the crisis of epidemic disease and the strategies of public health governance on which it draws. If the activity of governance is located in the position of those who govern, this is an activity that belongs to the governed, without support from though with reference to the former. It thus constitutes an agentiality not dependent on governmental relations of power but on a popular will exercised within the structures of a popular tradition. The significance of the AIDS Amma initiative can only be understood in such a context. To see it merely as AIDS communication or, corollarily, as an artificial ritual is to reduce this significance to its most literal meaning. It then appears to be trivial, an improper innovation beset by contradictions between what it seeks to do and how it does it.

*Teaching AIDS*, as stated above, approaches the HIV/AIDS epidemic in India from an interdisciplinary cultural studies perspective. Here, I wish to make a distinction between *inter*disciplinarity and *multi*disciplinarity. What is crucial to a discipline is the demarcation and defining of its proper object of study. The conceptual and analytic procedures that are specific to disciplines are both defined by and in turn delimit this object. A discipline, in other words, is both an area of study and a form of training that follows the rules appropriate to its object: the questions that may be asked of it, the conclusions drawn and the perspective that bears legitimately on the object. Multidisciplinarity expands the range of questions, answers and perspectives, without putting at risk the boundaries of the disciplines that it brings into convergence. The object is what is crucial, remaining the same even as it passes through the lens of different but compatible disciplines. Interdisciplinarity, in contrast, is concerned not with objects but contexts: what new insights emerge when the object proper to a specific discipline is contextualized in another discipline incompatible with it? For example, what insights can be gained by placing public health strategies, the object proper to medicine, in the context of a political inquiry or by examining court decisions regarding the rights of the HIV-positive as texts that construct and deconstruct the meanings they advance as authoritative? Rustom Bharucha has made a similar distinction between multiculturalism and interculturalism: multiculturalism "is concerned with the cohabitation of different cultural and ethnic groups negotiating an ostensibly common framework of citizenship", while interculturalism offers "a greater flexibility in exploring – and subverting – different modes of citizenship across different national contexts, through subjectivities that are less mediated by the agencies of the state" (Bharucha 2001, pp. 41–42). Disciplines, in other words, rigorously establish sameness, multidisciplinarity negotiates differences to articulate a common objective, and interdisciplinarity proliferates difference by contextually transforming both objects of inquiry and objectives. Like Bharucha's intercultural practice, it is subversive and indisciplined, with no respect for the "proper": "the savage impropriety of object choice that would seem so thoroughly to outrage disciplinarity" (Nelson and Gaonkar 1996, p. 4). This does not mean that interdisciplinarity is nihilistic: on the contrary, it is a critical practice that explores new ways of looking at objects that both disciplinarity and multidisciplinarity ideologically foreclose. Its objective is not restricted to the production of academic knowledge but to inquire into the politics of knowledge itself, the interests that drive it to establish something as the "truth". It is not, to use a distinction from Michel de Certeau that we have already referred to, "strategic" but "tactical" in its deployment of theories, concepts and tools of analysis. In an essay on cultural studies as interdisciplinary practice, Lawrence Grossberg writes:

> To say that its object of study is contextual is to say that the context is the real object of study. Its questions are not defined by theoretical and disciplinary concerns, but are posed, as it were, by the context. The particular theory it deploys will vary with the context and the problem, and it will be judged as a resource and measured by its ability to say something new about the context which can open up new strategic understandings. (Grossberg 1996, p. 143)

*Teaching AIDS* draws upon the methods – and not the methodo*logy*[2] – of interdisciplinary cultural studies, varying the resources it uses according to the context in which its object of study, the HIV/AIDS epidemic in India, appears. As such, therefore, it does not use a singular methodology, but whatever methods are appropriate for the specific context of each chapter. Thus, Chapter 3, which is on early media responses to the epidemic, uses the methods of textual analysis and ideology critique to show how the media constructed HIV/AIDS. It focuses specifically on early media responses because these predated the emergence of pedagogy in the 1990s and influenced its forms and meanings. The chapter on narratives, Chapter 4, uses narratological analysis along with a historicization of disease narratives, to examine a number of texts selected not on the ground that they are representative but because they are symptomatic of the shifting paradigms of how the disease was understood. Chapter 5, which is on AIDS and the law, draws on critiques of jurisprudence in philosophy and legal studies, and it selects for textual analysis a number of Supreme Court and High Court judgments that were important for the medicolegal construction of AIDS. Chapter 6 contextualizes AIDS pedagogy in the history of public health governance and health education and draws on a range of social theories and methods of discursive analysis to examine AIDS intervention efforts undertaken at the official level. Chapter 7, which is on the worship of AIDS Amma in a village community in Karnataka, draws on arguments from the anthropology of religion in India and ritual theory, reworked from the perspective of epistemological critique. Thus, the method followed by the book as a whole is syncretic, drawing on the approach most appropriate for the specific context of analysis. Overall, however, *Teaching AIDS* tries to develop its arguments from resources in the humanities, which it argues can help overcome the strong objectivist bias of the biomedical and social scientific approaches that dominate the field of medical humanities. Humanities, wherever it has figured in the field of medicine, has usually served a

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[2] Interdisciplinarity has no methodology, that is, no overarching framework of procedures and rules of analysis, and no *logos* that grounds it in a singular animating principle.

subordinate role in complementing and enabling a clinical practice that is understood to be more humane in the context of growing professionalism and technoscientific tendencies. While this is certainly valuable, it leaves unquestioned the assumptions underlying technoscientific medicine. *Teaching AIDS*, in contrast, is a project in what may be called *critical* medical humanities, which acquires its critical edge in countering objectivization with the reflective resources of philosophy, literature and cultural studies. It is about the *textuality* of public health governance, the way it represents persons with disease and the consequences of such representation understood as simultaneously linguistic and political. It is, to return to the epigraph from Hall, about how cultural studies can help us understand why people die "in the streets", who are the people who die and the politics of representation that underlies this; it is also about what needs to be done to prevent such avoidable deaths. What is urgently needed in our context, to respond effectively to the urgency of the crisis that AIDS presents, is to politicize it, to bring to the fore the politics that underlies it, and that is the imperative that drives *Teaching AIDS*.

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# Chapter 2

# Pedagogy, Power and the Subject of Disease Control

**Abstract** Pedagogies are structured by underlying ideological and power-knowledge formations that often serve to maintain existing social hierarchies but can also be used to subvert them. Both pedagogies of power and critical pedagogies have subjective effects on those they address. In the context of AIDS, these effects are achieved through awareness creation linked to behaviour change. They generate forms of embodiment that can establish a critical relation to the norms of health and disease and the hierarchies that they sustain. Tactical pedagogies, in responding to the strategies of public health governance, can play a key role in this.

**Keywords** Pedagogy · Power-knowledge · Governmentality · Interpellation · Subjectivation · Embodiment · Tactics and strategies

In this chapter, we will discuss the conceptual framework on which the critique of HIV/AIDS awareness campaigns is based. Given that HIV disease is at present incurable and no vaccine has yet been developed, creating public awareness of the disease is widely held to be the only way of dealing with the epidemic. Awareness creation, of course, needs to be supported by other measures like ensuring safe blood safety, treating sexually transmitted diseases that increase risk of HIV transmission, preventing transmission from mother to child, providing antiretroviral therapy to HIV-positive individuals to reduce viral load, social marketing of condoms and establishing needle-and-syringe exchange centres for intravenous drug users. HIV/AIDS awareness campaigns are designed in two formats: specific campaigns targeting those who are especially vulnerable to HIV infection, termed the "risk groups", and campaigns for what is called the "general population". On the one hand, this is necessary for epidemic control strategies that must take into account differential risks and risk practices. On the other hand, awareness campaigns, in constructing and addressing discrete groups, often unwittingly replicate and reinforce pre-existing moral distinctions and social hierarchies. It is necessary, therefore, to examine how awareness campaigns work and what effects they have on the individuals and groups they target.

Cindy Patton uses the term "national AIDS pedagogy" to refer to institutionally designed procedures for teaching people how to conduct themselves in the epidemic,

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so as to avoid risk of infection (Patton 1996, p. 9). She examines the politics of health education in the United States in the 1980s and 1990s, contrasting the conservativism of government-funded programmes with the initiatives undertaken by the gay community. While the former promoted abstinence and sexual fidelity, the latter attempted to incorporate safe practices into the repertoire of gay sexual behaviour.

> The fatal divide between the citizen's and the deviant's concepts of safe sex increased through the 1980s, especially as gay men educated themselves about the science and sexual politics of the epidemic. While America was busy mounting a national pedagogy that exiled deviance … gay men of all ages pursued safe sex education, which was sometimes underwritten by the desire to be accepted as "responsible citizens," even if infected. (Patton 1996, p. 83)

In borrowing Patton's term "national pedagogy", I try to develop it in two ways. First, I argue that the nation need not be conflated with the state. AIDS pedagogy is not limited to the agencies and initiatives of the state, even though the state is the dominant actor because of its role in the governance of public health. Governmentality, as we will see, is a function of multifarious relations of power that are not necessarily aligned to the agendas of the state,[1] and the national AIDS pedagogy is far less coherent than Patton's account suggests. Secondly, I argue that peoples' relation to this pedagogy cannot be understood as a function simply of compliance or resistance. Patton's approach to the national AIDS pedagogy is polemical, focussing mainly on relations of coercion and resistance. This is understandable, given the extreme polarization in the United States between a heterosexual majority and a gay minority and the dominant perception of AIDS as a "gay disease". It does not, however, take into account the ways in which individuals may operate between the two extremes of conformity and resistance and the heterogeneity of practices in response to pedagogies that seek to homogenize. "If it is true", writes Michel de Certeau, "that the grid of 'discipline' is everywhere becoming clearer and more extensive, it is all the more urgent to discover how an entire society resists being reduced to it, what popular procedures (also 'miniscule' and quotidian) manipulate the mechanisms of discipline and conform to them only in order to evade them" (de Certeau 1984, p. xiv). In the so-called "Pattern III" countries of Asia,[2] where the epidemic

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[1] By "governmentality" Michel Foucault refers to a style of governing based on influencing the conduct of individuals. It emerged in seventeenth-century Europe in response to the demand for strengthening the state after the Treaty of Westphalia (1648) and was distinguished from sovereignty. But it was not exercised by the state alone or its institutions: the state was simply the coordinator and facilitator of networks of power relationships arising at various levels, a function that varied historically in its centripetal strength and effectivity. As Bratich et al. write, the concept of governmentality provided a new way of thinking about power distinct from existing conceptualizations of repression and state coercion. "It made explicit a different relationship between governance and the subject as a way of drawing together the micro and macro analyses of power" (Bratich et al. 2003, p. 4).

[2] The World Health Organization introduced in the late 1980s a global mapping of the AIDS epidemic based on transmission modes and chronology. Pattern One referred to the epidemic in North America and Western Europe, where it first appeared and was predominant in populations of homosexually active men and injecting drug users; Pattern Two referred to the epidemic in Africa,

appeared after the mid-1980s and was transmitted both heterosexually and homosexually, the politics of AIDS control has followed a trajectory quite different from the one that Patton outlines for the United States.

## 2.1 Pedagogy, Ideology, Subjectivity: Freire and Althusser

Pedagogy's link with power is well known. The function of pedagogy, it is argued, is not only to communicate knowledge but equally to either justify or question social hierarchies. This depends on what is held to be valuable knowledge and the way it ought to be communicated. We will discuss in this section two influential theories of pedagogic power, which were developed in the mid-twentieth century by Paulo Freire and Louis Althusser. In the section that follows, we will look at Michel Foucault's theory of pedagogy as function of governance. In *Pedagogy of the Oppressed*, Freire distinguishes between what he calls the "banking concept of education" and "problem-posing education":

> In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing. Projecting an absolute ignorance onto others, a characteristic of the ideology of oppression, negates education and knowledge as processes of inquiry. (Freire 1970, p. 53)

Against this top-down and monologic pedagogy, he proposes a method that is dialogic and encourages critical thinking:

> In problem-posing education, people develop their power to perceive critically *the way they exist* in the world *with which* and *in which* they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation. (Freire 1970, p. 64, italics in original)

He reiterates the distinction in *Pedagogy of Hope*, where he outlines an ethics of teaching:

> Teaching is not a simple transmission, wrought by and large through a pure description of the concept of the object, to be memorized by students mechanically. Teaching … is not reducible merely to teaching students to learn through an operation in which the object of knowledge is the very act of learning. Teaching someone to learn is only valid … when educands *learn to learn* in learning the reason-for, the "why" of the object or the content. (Freire 1994, pp. 67–68, italics in original)

Friere's concept of education, thus, links it to power relations in a double form: the banking model reinforces social hierarchies and the ideology of domination, while the problem-posing model challenges and critiques them. Freire developed his theory of education in the context of a postcolonial Brazil polarized by racial as well as

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predominant among heterosexually active people; and Pattern Three referred to the epidemic primarily in Asia, where it emerged late. It was a conceptual model for identifying different trends of disease transmission, for purposes of evolving preventive strategies, and is still being used by policy-makers globally. However, as a representation of the epidemic, it has had important consequences in stereotyping who gets AIDS, where, and how (Patton 2002).

class hierarchies, contradictions that in his view could be resolved only by a democratization of consciousness. This was the aim of the critical pedagogy that he formulated in his books and practiced in his adult education class, framed within a Marxist humanist perspective and in response partly to Frantz Fanon's call for intellectual decolonization.[3]

Louis Althusser's critique of the educational system in Ideology and Ideological State Apparatuses is broadly similar to that of Paulo Freire, with regard to the role of ideology. The school, functioning as an ideological apparatus of the bourgeois State, "drums" into its pupils "a certain amount of 'know-how' wrapped in the ruling ideology (French, arithmetic, natural history, the sciences, literature) or simply the ruling ideology in its pure state (ethics, civic instruction, philosophy)" (Althusser 1971, pp. 104–105). Pedagogy adopts various means for ensuring the maintenance of domination. By differentiating the "know-how" required for assuming different roles in production – manual workers, technicians, engineers and the higher management – the educational system reproduces the differential skills required for production and thereby reinforces class stratification. By providing a common set of instructions in civic responsibilities and proper conduct, especially in humanities courses, it reproduces the ideology of production relations and inculcates in all of them "respect for the socio-technical division of labour and ultimately the rules of the order established by class domination" (Althusser 1971, pp. 88–89). In this way, the educational system ensures both the perpetuation of the social conditions under which individuals exist and their subjection to the ruling ideology.

Freire and Althusser, thus, view pedagogy as serving an institutionalized oppression, liberation from which is possible only by developing an alternative pedagogy that fosters critical consciousness. For Freire, such consciousness can be achieved by a teacher who "stimulates true reflection and action upon reality", that is, reflection constantly remade into practical action (Freire 1970, p. 65). For Althusser, it is achieved by those teachers who "attempt to turn the few weapons they can find in the history and learning they 'teach' against the ideology, the system and the practices in which they are trapped" (Althusser 1971, p. 106). Both critiques are premised on an oppression/resistance model, according to which pedagogy is understood as generating political effects that are either oppressive or resistant to oppression, thus demystifying its presumed neutrality. In either case, it has crucial consequences for subjectivity, or the capacity to act as subject, in transforming social conditions through praxis. In Freire's account the "banking" model of education dehumanizes the students by suppressing their creativity and their capacity for agential engagement in the world and thus deprives them of subjectivity. Critical pedagogy, in contrast, enables them to "transcend the situation in which their *state*

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[3] "We cannot go resolutely forward unless we first realize our alienation. We have taken everything from the other side. Yet the other side has given us nothing except to sway us in its direction through a thousand twists, except lure us, seduce us, and imprison us by ten thousand devices, by a hundred thousand tricks" (Fanon 2004, p. 163). At the core of Fanon's manifesto for decolonization, *The Wretched of the Earth*, is a critical consciousness that finds strong echoes in Freire's pedagogy for liberation.

*of being* is almost a *state of non-being*, and go on to a *state of being*, in search of *becoming more* fully human" (Freire 1974, p. 129, italics in original). From being passive objects of their conditions of existence, they become subjects who can actively intervene in and transform them. For Althusser, the ideology of the school system induces the students to "misrecognize" their relation to social reality, interpellating and constituting them at one and the same time as "free" subjects as well as "subjected" beings. The school is among the most important of "Ideological State Apparatuses" that ensure compliance to the dominant order, not through coercion as the "Repressive State Apparatus" does, but by complementing the work of the latter through the exercise of hegemony:

> I believe that the ideological State apparatus which has been installed in the *dominant* position in mature capitalist social formations as a result of violent political and ideological class struggle against the old dominant ideological State apparatus [i.e. of the feudal aristocracy and the church], is the *educational ideological apparatus*. (Althusser 1971, p. 103, italics in original)

The chief function of this apparatus is the production of compliant subjects. Althusser's concept of subject formation is based on a psychosocial understanding of identity. Ideologies constitute subject positions that are in accordance with dominant social hierarchies, which in turn derive from multiple parameters of difference like class, race, gender, sexual orientation, ability and disability, health and disease. Identification takes place through unconscious mechanisms by which individuals recognize themselves in these subject positions, as in a mirror-image. The recognition, however, is actually a *mis*recognition of the conditions under which one exists, by which a *real* subjection paradoxically produces the *imaginary* effect of a free subjectivity. Accordingly, ideology is an "imaginary" representation of the relation that individuals bear to their "real conditions of existence", and it is imaginary both because it does not "correspond to reality" and because it consists of images with which we identify.[4] "The reality in question in this mechanism, the reality which is necessarily *ignored* (*méconnue*) in the very forms of recognition (ideology = misrecognition/ignorance) is indeed, in the last resort, the reproduction of the relations of production and of the relations deriving from them" (Althusser 1971, p. 124, italics in original). Althusser terms this process of identification an "interpellation or hailing … which can be imagined along the lines of the most commonplace everyday police (or other) hailing: 'Hey, you there!'" (Althusser 1971, p. 118). In other words, pedagogy constitutes us as subjects in the way it addresses us and the way we respond to that address.

A major difference between the two thinkers, therefore, lies in their understanding of the mechanism of subject formation. Freire's theory is premised on socialist humanism, which assumes that freedom and creativity are innate to the human

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[4] Althusser's account of ideological identification echoes Lacan's dialectic of recognition/misrecognition in the "Mirror Stage" essay, where the image in the mirror symbolizes for the infant "the mental permanence of the *I*, at the same time as it prefigures its alienating destination" (Lacan 2007, p. 3, italics in original). This debt to Lacan is not acknowledged, but is clearly indicated in Althusser's use of terms from the "Mirror Stage" essay.

species but alienated by oppressive relations of production. Critical pedagogy, by making the oppressed conscious of their alienation, enables them to resist subjection in "*becoming more* fully human". As such, subjectivity or the capacity to be a subject is a part of the human essence or "species-being". Individuals exist as subjects, with the ability to act positively on their conditions of existence, prior to the exercise of an oppressive power relation that deprives them of this ability. Like other kinds of humanism, therefore, Freire's theory of critical pedagogy is premised upon the notion of a pre-existing subject. Ideology, which is a form of false consciousness, works by "mythicizing reality", while the critical consciousness that a problem-posing pedagogy induces works by "demythologizing" it (Freire 1970, p. 64). Althusser's theory, in contrast, is premised on the assumption that subjectivity is not an *essence* but the *effect* of the structure of ideology. Ideology is not a "false consciousness" specific to a particular mode of social organization, as it is in Freire, but a "form of specific unconsciousness called 'consciousness'" (Althusser 1969, p. 233) and is present in all societies. That is, it is a "consciousness" in that it informs our understanding of the world but is unconscious to the extent that we are not aware of it. It is a structure of representations, existing as images, ideas and tacit assumptions that determine our practical relation to the world and are therefore both universal and transhistorical.[5] "Human societies secrete ideology as the very element and atmosphere indispensable to their historical respiration and life" (Althusser 1969, p. 232). The "subject" of Freire's socialist humanism is therefore no less an ideological construct than that of the liberal humanist ideology that it seeks to displace. In Freire, the subject exists as an already presupposed category, which Althusser's structuralist approach seeks to deconstruct.[6] Resistance to power lies not in the achievement of subject status, but in *overcoming* the condition of being a subject, where "being a subject" designates both subjection to power and the illusion of free subjectivity. It involves the transformation, not of the individual as unalienated human consciousness, but of the structure of power relations and its representation through "misrecognition" in ideology. Consequently, their notions of history are divergent. For Freire, history is the product of human reflection and action upon reality:

> There is no historical reality which is not human. There is no history *without* humankind, and no history *for* human beings; there is only history *of* humanity, made by *people* and (as Marx pointed out) in turn making them. It is when the majorities are denied their right to participate in history as Subjects that they become dominated and alienated. Thus, to supersede their condition as objects by the status of Subjects – the objective of any true revolution – requires that the people act, as well as reflect, upon the reality to be transformed. (Freire 1970, p. 111, italics in original)

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[5] It is on the basis of its presupposition in everyday practice that Althusser distinguishes ideology from reflective knowledge: "ideology, as a system of representations, is distinguished from science in that in it the practico-social function is more important than the theoretical function (function as knowledge)" (Althusser 1969, p. 231). For the argument that the general structure of ideology is transhistorical, see Althusser 1971, pp. 107–109.

[6] For an account of the differences between humanist and structuralist Marxism, see Stuart Hall (1980).

Althusser, on the other hand, claims that "history is a *process without a subject*, that the dialectic at work in history is not the work of any Subject whatsoever, whether Absolute (God) or merely human" (Althusser 1971, pp. 81–82, italics in original). There is neither a reflecting nor an acting subject, and historical transformation is the outcome of "an accumulation of 'circumstances' and 'currents' … whatever be their origin and sense … [that] '*fuse'* into a *ruptural unity*: when they produce the result of the immense majority of the popular masses *grouped* in an assault on a regime which its ruling classes are *unable to defend*" (Althusser 1969, p. 99, italics in original).

The above arguments are useful in understanding various aspects of the pedagogic strategies at work in public health governance. Conventionally, health education has assumed a "top-down" approach that emphasizes learning and memorizing the "facts" of disease transmission, without inquiring into the structural causes that determine who gets diseased and how – factors like poverty and gender disparity that lead to unequal access to health promoting education. In this model, the educator is assumed to know the "truth" of disease, while the target audience either knows nothing or has only a false knowledge. Thus, many AIDS awareness programmes include lists of AIDS "facts" and "myths", with questionnaires to test the target population's ability to memorize the "facts". In Chap. 6, we will see a number of such pedagogic campaigns targeting the general population, which assume that knowledge of how HIV is transmitted can lead to behaviour change. This assumption is untenable on two counts. First, behaviour – especially sexual behaviour – is driven not by knowledge or reason alone, but equally by impulses that are not subject to rational calculation. Secondly, the power asymmetries underlying relationships between individuals constrain their ability to take disease-preventive decisions: for instance, most Indian women would find it difficult to persuade their husbands to use condoms. By reducing disease vulnerability to simply ignorance or gaps in knowledge, campaigns to create awareness themselves "mythicize" the reality of epidemic. From a Freirean perspective, they perpetuate an ideological privileging of scientific knowledge that obscures the conditions under which individuals engage in sexual acts. A good example of such obfuscation is a card game designed by the ILO Sub-Regional Office for South Asia in 2005. It has 20 question cards on various aspects of the epidemic, from transmission, testing and treatment to stigma and discrimination against the HIV-positive, and a corresponding set of answer cards that provide the answers. The game is designed to follow an instructional session, as a test of the audience's ability to understand and remember the instructions, and its objective is "modifying behaviours that put people at risk of HIV infection" through "correct information" and by "dispelling myths" (ILO A 19). Typically, the game does not include discussion about the constraints imposed by unequal power relationships and therefore leaves unquestioned both dominant social hierarchies and their ideological underpinnings. Notwithstanding the importance of disease-preventive information, such campaigns fail to achieve the behaviour change effects they seek. Further, by ignoring the social conditions that make people vulnerable to disease and focusing solely on individual levels of knowledge, their transformative function is greatly restricted. Freire's critique of the banking model of education and its contrast to the problem-posing model that he proposes can help us see the limitations of such campaigns as public health pedagogy. AIDS education, whether addressing the "general population" or a "risk group", posits the educator as the subject and the addressee as the passive object of the pedagogical relationship. Even where it seeks to promote "interactive" learning, as the ILO card game does, it is only as a token gesture. It does not, in Freire's terms, engage them in "dialogue" and "critical thinking".

A second important aspect of public health education strategy is normativization: by linking disease with deviance, it seeks to reinforce moral norms in motivating behaviour change. Pedagogic strategies are evolved in the context of a society's assumptions about proper and improper conduct, and their effects must be examined in such context. Thus, Cindy Patton's critique of the national AIDS pedagogy in the United States brings out its normative assumptions about sexual conduct, which hold heterosexuality as "normal" and gay/lesbian sex as aberrations from the norm. Thereby, the pedagogy functions not only to communicate (often unclear) messages about safe sex but more importantly to construct subject positions in accordance with moral norms: it is "a procedure for bringing bodies into positions of duty and obligation that are constitutive of identity" (Patton 1996, 9). In India, where disease transmission was initially presumed to be heterosexual, the vilified category was the female sex worker. AIDS education did not include men who have sex with men (MSM), "reflecting the untenable belief of Indian authorities that homosexuality is not widespread in India, that it is a Western import" (Dube 2000). Later, when it did, police frequently raided the offices of non-governmental organizations working with MSM, arrested their workers and confiscated material under Section 377 of the Indian Penal Code, which criminalizes "unnatural" sex. Thus, in 2001 members of Bharosa Trust, a Lucknow-based NGO working with MSM, were arrested and were refused bail because they were, as the trial court put it, "polluting the entire society and encouraging young persons and abetting them for committing the offence of sodomy … in an organized manner" (Human Rights Watch 2002, 19). In a landmark judgment of the Delhi High Court in *Naz Foundation v Government of NCT of Delhi* (2009), persecution of MSM workers and obstruction of awareness efforts were two of the grounds on which the court ruled to exclude consensual adult same-sex acts from the ambit of Section 377 IPC. In fact, the *Naz* decision was essentially about identity and the right of lesbians, gay men, bisexuals and transvestites (LGBT) to dignified existence as citizens and equality before law, showing that what was at stake was not simply an act (as claimed by the Additional Solicitor General of India) but politically defined personhood. Given such a context, AIDS awareness campaigns often unquestioningly reproduce such widely held stereotypes about people vulnerable to disease. The vilification of the prostitute and later of the homosexual was a common feature of the early campaigns. With regard to homosexuality, an AIDS awareness material published by the National AIDS Control Organization stated that sexual diseases are transmitted by "*natural* vaginal or *unnatural* (annal) [sic] sexual intercourse", thus reinforcing the prejudices built into Section 377 IPC though NACO later, as a respondent in *Naz*, argued for its repealment (NACO 1997, p. 4, italics added).

A third aspect of health pedagogy involves the question of activism and social transformation. As we saw above, Freire's account of pedagogy foregrounds human praxis as the motor force of historical change, where praxis refers to reflected action. In the highly polarized context of early AIDS organizing in the United States, when a dominant heterosexual order sought to blame and marginalize homosexuals, struggle against homophobia required the simultaneous development of activism and cultural analysis by gay community groups (Crimp 1988). As Patton notes, Freire's adult literacy programme inspired a number of community-based safe sex initiatives in the critical years of the mid-1980s, such as Stop AIDS (Patton 1996, pp. 107–112). In Patton's view, however, they failed to appreciate the difference between teaching literacy skills and teaching sexual prudence: "while reading and writing skills may be acquired, possessed, and carried around, 'sexual literacy' does not easily translate from space to space" (Patton 1996, p. 108). More importantly, they failed to see how "safe sex" was, like the homophobic construction of gay sex as inherently pathological, not a reality but itself an ideological construct "forged in the desperate tension between the longing to be a citizen and the struggle to survive" (Patton 1996, p. 111). If the "safe sex" model was eventually adopted as pedagogic strategy universally, the combined effects of activism and analysis certainly did contribute, but it was also due to circumstances that forced open dissonances between moral ideologies and the realities of sexual practice and disease transmission: in Althusser's terms, the accumulation of contradictions into a *ruptural unity*. This becomes clearer in the Indian context, where activism has focussed largely on questions of social inclusion and access to information and healthcare. Naz Foundation's pioneering effort to empower LGBTs in their struggle against AIDS could find support from the NACO only on strategic grounds, to remove obstacles in its work of disease control, rather than to counter Section 377 IPC's construction of homosexuality as "unnatural".[7] If in this instance a state agency and an NGO came together on a common platform to challenge an existing law, it was due to a historical conjuncture that opened up gaps between that law and the practice of public health.

An instance of the Freirean pedagogy in the Indian context is the work of the Durbar Mahila Samanwaya Committee (DMSC), which we will examine in more detail in Chap. 6. Started as a campaign to promote safe sex through condom distribution, the DMSC subsequently addressed larger issues such as power differentials between sex workers and clients, financial and social insecurity, criminalization of sex work and harassment by the police. Thus, from a campaign with a limited focus on disease prevention through individual behaviour change, it eventually encouraged the sex workers to think critically about their conditions of existence and ways of transforming them through collective action (Rao 2017, p. 252).

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[7] As we saw above, a NACO publication itself represented homosexuality as unnatural.

## 2.2 Pedagogy and the Disciplining of Embodied Subjects: Foucault

In *Discipline and Punish*, which provides his most thorough account of the modern mass education system, Foucault discusses the meticulous techniques of discipline that "defined a certain mode of detailed political investment of the body, a 'new micro-physics' of power" that emerged in seventeenth century Europe and spread across a range of institutional sites: schools, prisons, army barracks, workshops and hospitals" (Foucault 1977, p. 139). The objective of these disciplinary techniques was the production of "docile bodies", where "docility" meant increased aptitude and increased obedience. The word "docility" is derived from the Latin *docilis* meaning "teachable", and the ideal context for it is pedagogy. Thus, Foucault is able to connect pedagogy with other forms of power, in a "*swarming of disciplinary mechanisms*" that became a key element of modern political rationality (Foucault 1977, p. 211, italics in original). Reconceptualizing power as "disciplinary" also enables Foucault to acknowledge its "productive" effect – for which the pre-eminent context is again pedagogy, for teaching is a mode of exercise of power that increases the productivity of students even as it subjects them to increased control:

> We must cease once and for all to describe the effects of power in negative terms: it "excludes", it "represses", it "censors", it "abstracts", it masks', it "conceals". In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. (Foucault 1977, p. 194)

This is especially relevant to our understanding of AIDS pedagogy, the objective of which is not to suppress those it targets but to empower them through disease-preventive knowledge or knowledge about managing their illness if infected.

There are a number of significant differences between Foucault's account of pedagogy and those of Freire and Althusser. First, unlike them, Foucault does not emphasize the role of ideology. Not that he discounts it altogether but considers it as only one of the mechanisms – and by no means the central one – in the exercise of dominance: "Society's control over individuals was accomplished not only through consciousness or ideology but also in the body and with the body" (Foucault 2000, p. 137). His account of the school system in the eighteenth-century Europe brings out the meticulous ways in which disciplinary controls acted to coordinate the movements and gestures of the body with pedagogic tasks. "Good handwriting, for example, presupposes a gymnastics – a whole routine whose rigorous code invests the body in its entirety, from the points of the feet to the tip of the index finger" (Foucault 1977, p. 152). School discipline also sought to regulate the activities of the body through a detailed structuring of time tables, "throughout which the body is constantly applied to its exercise" (Foucault 1977, p. 151). By emphasizing the role of the body in learning, Foucault is able to move beyond the mind/body dichotomy, to suggest how the objective of pedagogy is not merely to induce learners to think in certain ways but equally to induce in them appropriate modes of embodiment. In the way Foucault uses it, "discipline" refers to both a branch of knowledge and a training of the body. By knowledge, again, Foucault refers to that which is communicated to the learners as well as that which needs to be produced in order to develop more effective strategies of teaching – a meticulous knowledge of the students' abilities and aptitudes, their progress in the educational system and their behaviour patterns, as well as theories of education. Thus, the eighteenth century witnessed a transition from the "historico-ritual mechanisms" for self-formation in the premodern period – rituals of rank and status and the history of ancestries – to "scientifico-disciplinary mechanisms" that made pedagogy a specialized and theorized practice (Foucault 1977, p. 193). Unlike Freire and Althusser, Foucault does not privilege the mind or consciousness in his account of pedagogic power, but explains how it involves both cognitive and bodily techniques, as well as the production of knowledge to make these techniques more effective.[8]

Instead of power-ideology-consciousness, therefore, we have power-knowledge-body. The exercise of power over the body has necessitated the production of multiple kinds knowledge, of which medicine may not be central but is certainly the most prolific: "starting in the eighteenth century human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape" (Foucault 2000, 135). In modern societies, medical authority takes over the functions traditionally ascribed to morality and the law in determining normalcy and deviance (Albert 1986). If power makes knowledge production necessary, the knowledge thus produced enables further extensions of power: "'Truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it" (Foucault 1980, 133). Thus, AIDS pedagogy as a strategy of power requires extensive, population-based documentation and studies of morbidity and mortality rates; of behaviour patterns that increase vulnerability to infection; of economic impact of the epidemic, knowledge-attitude-perception (KAP) surveys of "risk groups"; etc. – which are then used to design appropriate pedagogic content. In 2006, for example, the NACO in collaboration with the UNICEF conducted a countrywide Behaviour Surveillance Survey (BSS) of the knowledge, attitude and behaviour of young adults (15–24 years). "In order to design evidence-based interventions among the young people, it is essential to understand the levels of knowledge about HIV/AIDS, attitude and sexual behaviour of young people" (NACO 2006, p. 2). In other words, knowledge and not ideology is central to pedagogic strategy: it seeks to transmit knowledge to the learners by acquiring knowledge about them. Both kinds of knowledge are certainly driven by ideological imperatives, but are not reducible to them.

Foucault's account of discipline and power-knowledge relationships emphasizes the social *structures* that regulate bodily conduct. Thus, discipline is a "political *anatomy*" that segments space, time, activities and capacities; the panopticon is an "*architectural* apparatus" that exercises power automatically and without need of

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[8] Despite Althusser's emphasis on consciousness, however, there is in his essay an implicit recognition of the corporeality of power when he refers to Pascal's "formula": "'Kneel down, move your lips in prayer, and you will believe'" (Althusser 1971, p. 114). We may say that Foucault's analysis of power relations makes explicit an insight that remains tacit and unrealized in Althusser.

human intervention; dressage or training involves a complex of structured codes: "the physical code of signaling, the medical code of symptoms, the educational or military code of conduct or performance" (Foucault 1977, pp. 139, 201, 190, italics added). Power is exercised as a "multiplicity of force relations" that support one another as a "chain or a system" (Foucault 1978, p. 92). In this system of power relations, the individual as *docile* body is "an effect of power" and an "element of its articulation" (Foucault1980, p. 98). What is missing in this emphasis on structures is the notion of *process*, without which one may understand how the body is socially constructed but not embodiment. It is when Foucault develops the concept of "governmentality" that his account of the relation between the individual and the power structure becomes more dynamic. Thus, in "The Subject and Power", power relations constitute a "field of possibilities in which the behavior of *active* subjects is able to inscribe itself … a way of acting upon one or more *acting* subjects by virtue of their *acting* or *being capable of action*" (Foucault 2000, pp. 341–42, italics added). Governmentality, which is a way of directing the conduct of individuals ("conduct of conducts"), does not prohibit them from acting, but enables them to act freely: "Power is exercised only over free subjects, and only insofar as they are 'free'" (Foucault 2000, pp. 342). Though limited by the "field of possibilities", this is not the illusory freedom of the Althusserian subject in ideology. In Chap. 6, we will see how such an understanding of government enables us to analyse the power relations of AIDS pedagogy.

Foucault arrives at his theory of governmentality through two important moves. First, he links the "microphysics" of everyday power relationships, which had been the theme of *Discipline and Punish* and the first volume of *The History of Sexuality*, to the centralizing authority of state government, but without the monopoly that Althusser accords it in his "Ideology and Ideological State Apparatuses" essay (Foucault 2000, p. 345). In *Security, Territory, Population*, he considers such privileging of the state an "overvaluation" of its role in society: "What is important for our modernity, that is to say, for our present, is not then the state's takeover (*étatisation*) of society, so much as what I would call the 'governmentalization' of the state" (Foucault 2007, p. 109). Secondly, he separates "government" in its technical sense of state administration from the wider sense that the sixteenth- and seventeenth-century treatises on the "art" of government gave to it: "'Government' did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or of groups might be directed – the government of children, of souls, of communities, of families, of the sick" (Foucault 2000, p. 341). There is both a "downward" and "upward" link between the state and the micropolitics of everyday life (Foucault 2007, pp. 94–95), which, we may add, constitutes the sphere of the *national*. Thus, governmentality is a way of acting upon peoples' conduct that is not restricted to the state, though it may refer in the final instance to state action – not because the state is supreme but that in formulating its policies, it takes account of and coordinates between the other instances. As Tony Bennett writes: "for Foucault, the concept of government is not to be confused with that of the state but refers to a much broader sphere of practices in which claims to particular forms of knowledge and authority are invoked in the context of attempts to direct 'the conduct of conduct'" (Bennett 2003, p. 61).[9]

In *Security, Territory, Population*, Foucault distinguishes between a mode of governing that is meticulous in its surveillance and control over the people and one that involves "governing at a distance", the difference, to be more specific, between a police state and a liberal state (Foucault 2007, pp. 347–57). One mode of governing acts directly upon peoples' conduct, prescribing some forms of behaviour and prohibiting others, while the other induces people to act upon themselves and is more properly a "conduct of conducts". While the first acts to restrict freedom, the second ensures that some freedoms are respected, especially the freedom of individuals to act according to their desires and interests insofar as these do not conflict with the interests of others and of the state. What began as an economic theory of *laissez faire* became generalized as a principle of government in the wider sense. In this new form of government, premised on the freedom of the individual, it is the individual's capacity to become self-responsible that is instrumental. James Hay summarizes Foucault's account of liberal (or neo-liberal) governmentality thus:

> Governing at a distance and acting freely both require an implicit contract or arrangement – procedures, techniques, and rules of conduct across different spheres of life. In this sense, freedom (living and governing at a distance) pertains to a new political and governmental rationality, to rules of conduct that are not purely juridical but that decidedly make freedom political and ethical, an ongoing process of governing oneself, properly applying oneself, and acting responsibly across every sphere of life. (Hay 2003, p. 166)

As we will see, public health responses to the HIV/AIDS epidemic in India first took the form of coercion, which were in some cases backed by the law (for instance, mandatory hospitalization of HIV-positive individuals and restrictions on their mobility under the amended Goa, Daman and Diu Public Health Act, 1985). Subsequently, the NACO introduced what was called the "ABC" model of health educational campaigns promoting abstinence, sexual fidelity or the use of condoms as choices of risk-avoidance behaviour. That is, if you are single, abstain from sex; if you are married, be faithful to your partner; if you cannot do either, use a condom. The first two are clearly prohibitions based on moral norms; but the third is neither a prohibition nor does it refer to morality. Considered as a whole, the ABC strategy in AIDS pedagogy takes not a norm but a putatively "natural" tendency (sexual desire) as its starting point, acknowledging its naturalness and its recalcitrance, and utilizes it to induce the individual to act with caution. Given that condom is not an absolute guarantee against infection, it does not seek to eliminate disease – a reality that cannot be eliminated entirely – but to *reduce* the risk of its transmission. It does not curtail the freedom of individuals, but induces them to be responsible to themselves and their sexual partners, in fashioning themselves as prudential subjects in a sexual disease epidemic. What the ABC strategy does, therefore, is to constitute a

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[9] "From this perspective, the question of the state so central to earlier investigations of political power is relocated. The state now appears simply as one element – whose function is historically specific and contextually variable – in multiple circuits of power, connecting a diversity of authorities and forces, within a whole variety of complex assemblages" (Rose 1999, p. 5).

field of possible actions, where the prudential decision is not imposed by an authority but is left to individuals in their self-formation as subjects. Governmentality functions in such instances "in terms of a logic of choice, through transforming the ways in which individuals come to think of themselves, through inculcating desires for self-development that expertise itself can guide and through claiming to be able to allay the anxieties generated when the actuality of life fails to live up to its image" (Rose 1999, p. 88).

Alongside the concept of governmentality, Foucault develops another paradigm of power relations that he links to it: the concept of "biopolitics". What connects the two is that governmentality is a mode of exercising power, while biopolitics is the field in which it is exercised. Though the concept of biopolitics was not his, and long predated his use of it, Foucault gave it a new orientation (Esposito 2008, pp. 13–44). By biopolitics, Foucault refers to the way government poses the life of the population as a political concern, such as the problems of public health, family welfare, food security, disaster mitigation, life insurance and urban housing. In brief, it involves the politicization of life, which had earlier been understood as biological and therefore outside the domain of the social order. Foucault's thesis is that biopolitical governance marks the entry of a society into the "threshold of modernity". As he puts it in an oft-quoted passage in the first volume of *The History of Sexuality*: "For millennia, man remained what he was for Aristotle: a living animal with the additional capacity for a political existence; modern man is an animal whose politics places his existence as a living being in question" (Foucault 1978, p. 143). Though his claim that biopolitics is a product of modernity has been questioned by Giorgio Agamben (1998), who traces its origins to the political philosophy of the Greeks and to Roman law doctrines, Foucault's account of it nevertheless holds good insofar as the politics of modern societies are concerned. It should be obvious from the many ways in which modern states seek to ensure proper living conditions for their people and the fundamental importance given to the "right to life" in modern constitutions. As the Supreme Court of India held in *Vincent Panikurlangara v Union of India* (1987), the state's duty to ensure proper living conditions follows from the right to life: "Article 21 of the [Indian] Constitution guarantees right to life and this Court has interpreted the guarantee to cover a life with normal amenities ensuring good living which include medical attention, life free from diseases and longevity upto normal expectations" (1987 SCR (2) 468). The politicization of life is also obvious in the monopoly that the state enjoys over the lives of its citizens, in deciding whose life must be protected and whose forfeited for the good of others. In *M. Vijaya v Chairman and Managing Director Singareni Collieries* (2001), the Andhra High Court ruled that, according to the Roman law doctrine *salus populi est suprema* ("the good of the people is supreme"), the individual's "life and liberty under certain circumstances be placed in jeopardy or even sacrificed for the public good" (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 514). In *Mr. X v. Hospital Z* (1998), the Supreme Court ruled that the right to marry of HIV-positive individuals be treated as a "suspended right". Such individuals, who are placed in what Agamben calls an "exception",[10] include the HIV-positive, as explicitly stated in the *Vijaya* and *Mr. X* decisions. In Chap. 5, we will see how the governance of public health is underwritten by this ambiguity, when a law that claims to protect all withholds its protection from those who are perceived as a source of public danger. Biopolitics, as Foucault states, is the "power to *foster* life or *disallow* it to the point of death" (Foucault 1978, p. 138, italics in original). If the national pedagogy, used in its widest sense, is not restricted to the state's health education interventions and can be taken to include court judgments (to the extent that they are public documents widely reported in the media), decisions like *Vijaya* or *Mr. X* serve as an underside to the ABC campaign, excluding the HIV-positive from what Rose calls liberal governmentality's "regime of civility" (Rose 1999, p. 88).

## 2.3 Representing Disease: The Social Construction of Reality

This book is about the way health education texts represent AIDS, in framing our understanding of the epidemic. Why should a book on AIDS concern itself with representation, when the epidemic's adverse consequences are chiefly material and organic? At the individual level, AIDS causes physical debility, leading to impoverishment through loss of work and the high cost of treatment and ending eventually in a painful death. At the macrosocial level, it impacts adversely the country's economy, demographic structure and health services. These effects, as policies to control the epidemic all acknowledge, are aggravated by the stigma and discrimination associated with the disease, and that is where the question of representation becomes crucial. The stigma of AIDS is a direct outcome of how we understand and represent it. HIV disease is not contagious, and is not easily transmissible except through a limited number of routes that are well-known. Yet it continues to provoke fear, leading to the social exclusion of those affected by it. Negative media representations, as we will see in the next chapter, play an important role in the perpetuation of fear and stigma. Representation, both in its linguistic and political sense, also determines when and how it is acknowledged as a public health concern, the allocation of funds and protection of the rights of the diseased. AIDS is simultaneously a medical, economic, social and, insofar as it calls for a governmental response, political problem. The issue of representation is crucial to its sociopolitical and

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[10] An exception, in Agamben's account, bears an ambiguous relation to the rule. It is outside the rule, as an exception to it but is also inside the rule, as it can exist only with reference to it. "We shall give the name *relation of exception* to the extreme form of relation by which something is included solely through its exclusion" (Agamben 1998, p. 18, italics in original). In declaring diseased individuals as those whose rights can be "sacrificed" for the good of the people, *Vijaya* places them in this paradoxical position: to the extent that they have rights, they are part of the "people"; yet, to the extent that these rights can be sacrificed, they are set apart. The "suspended right" to marry, similarly, expresses an exception: it exists as a right, but cannot be enforced. Agamben uses the paradox of the exception to explain the precarious position of those who are included in the social order but not protected by it.

psychological consequences. Representations of AIDS and HIV-positive people, as Tamsin Wilton contends, “both reflect and *construct* social and psychological ‘reality’ … [with] profound consequences for the impact of the epidemic” (Wilton 1997, p. 6). “AIDS knowledge”, writes Eric Savoy, “accrues at the interstices of the somatic and the ideological, the body and the body politic” (Savoy 1993, p. 65), and representations are the site of both the consolidation and the contestation of ideologies. Representations, as social constructionists argue, do not simply “reflect” reality, but equally shape our understanding of it:

> Language is capable not only of constructing symbols that are highly abstracted from everyday experience, but also of ‘bringing back’ these symbols and appresenting them as objectively real elements in everyday life. In this manner, symbolism and symbolic language become essential constituents of the reality of everyday life and of the commonsense apprehension of this reality. I live in a world of signs and symbols every day. (Berger and Luckmann 1966, p. 55)

Representations of health and disease work through a binary logic, wherein disease forms the negative ground on which discourse constructs and imparts value to the imaginary ideal of health. Health is an *ideal* in the sense of being a desirable but never actually achieved condition. It is *imaginary* in the sense of being constructed through images with which we seek to identify, in print, on billboards, in television and in cinema, a repertoire of representations that constitutes the cultural imaginary of healthy bodies. Like purity, with which it is often linked, it is a norm that is cultural rather than physical or biological, and their linkage is well-established. In *Sex and Germs*, thus, Cindy Patton states that the fear of infectious disease is a displaced form of the fear of pollution, in a symbolic association of germs with dirt: “Dirt and germs serve an important symbolic role in the social organization of difference” (Patton 1985, p. 11). In *Purity and Danger*, Mary Douglas argues that the traditional idea of dirt as pollution and the modern idea of dirt as pathogenic are connected, as ordering concepts that involve “rejecting inappropriate elements” (Douglas 1966, p. 44). In *Powers of Horror*, Julia Kristeva argues that in Leviticus, “the abomination of leprosy becomes inscribed within the logical conception of impurity” (Kristeva 1982, p. 101). The association of disease with defilement is part of a symbolic classificatory system by which societies legitimize cultural preferences and rule out whatever they find undesirable and devoid of value.

Representations of disease are symbolic, even when they seem literal and realistic. They draw upon metaphors of “otherness” and difference that have, as Susan Sontag (1978, 1988) has argued, multiple social effects ranging from xenophobia and the closing of national borders to stigmatization and social exclusion of the infected, even where (as in the case of AIDS) such quarantine is not warranted. The commonest tropes for imagining disease are “scourge” and “plague”, both deriving from biblical accounts of divine punishment or “visitation” and from the historical experience of epidemics. Disease as “invasion” became a commonplace metaphor with the advent of germ theory in the late nineteenth century, in imagining germs as “invading” the bounded integrity of the healthy body (Sontag 1978 *passim*). Disease is not only imagined through metaphors but is itself a metaphor of choice for disorder, which shows how the concept of disease is a crucial element of symbolic classificatory systems. Phrases like the “cancer” of corruption, moral “lepers”, social “ills”, and avoiding someone “like the plague” are common everyday examples. My personal favourite is political analyst E.P. Unny’s comment on pre-poll alliances between parties with divergent ideologies, which he considers to be unethical: “Bad politics can never remain just bad for ever. At some point it turns apolitical and self destructs. *Political promiscuity ultimately leads to political AIDS*” (Unny 1999, italics added). Disease as metaphor and metaphors of disease imagine disease in ways that construct in advance social responses to it, leading to stigma and discrimination. Representing AIDS as an “invasion” of the body’s immune system is a call to action, to seal borders, identify the risk groups, test them mandatorily, restrict their movement and take them into custodial detention. Representing “promiscuous” political alliances as AIDS stigmatizes the HIV-positive as immoral, their disease caused by promiscuity rather than a virus:

> With this illness, one that elicits so much guilt and shame, the effort to detach it from these meanings, these metaphors, seems particularly liberating, even consoling. But the metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticized, belaboured, used up. (Sontag 1988, p. 94)

As its metaphoric potential shows, disease is understood as *always already* negative, before it is comprehended scientifically. It is in this prior construction, what Thomas Yingling calls its “asymptotic space”, that tropes are formed, circulated and made credible, so that they can spread rapidly, like the virus, from fact to fiction to fact again, from corporeal bodies to the “social body” and from representations to deep convictions in the expanding semiosis of disease discourse:

> The gap between the apprehension and comprehension of the disease [AIDS] is thus an asymptotic space where allegory persistently finds itself at play and where the ongoing histories in which AIDS unfolds (variously comprised of the viral, the personal, the communal, the national, and the global) are referred to larger and more masterful or authoritative histories that guarantee interpretation of its meanings. (Yingling 1997, p. 38)

If, however, the AIDS epidemic is framed by powerful social meanings, these meanings are neither homogeneous nor always in the service of power. Some of its “masterful histories” may attest to the pathologized “unnaturalness” of homosexuality, the “primitiveness” of Africa or Asia, the “immorality” of the prostitute and the drug addict or the “innocent victimhood” of haemophiliacs, thalassemics, women and children. But there is at the same time another history that unfolds and gains momentum even as AIDS-related discriminations continue unabated – that of AIDS activism and the PLWHA (Person Living with HIV/AIDS) movements, which seek to reverse both the epidemic and its repressive social meanings. These draw upon what Eve Kosofsky Sedgwick calls the “transformational grammar” of shame (Sedgwick 1993, p. 63), turning the shame of being diseased into the pride of self-assertion and the solidarity of a people *living with*, not *dying of*, AIDS. Moreover, the critique of AIDS constructions itself constructs AIDS in specific ways, as a politicized disease, a rallying ground in the struggle against the objectifications of technoscientific medicine that recognize pathologies but not persons. In both the range and multiplicity of its social meanings and the ways in which they have been contested, the AIDS epidemic is unique in history (Treichler 1999, pp. 11–41).

## 2.4 Language and the Body in Pain

The analysis of representation or discourse is, therefore, an important tool in countering the adverse meanings of disease and their social effects. The struggle against AIDS requires not only the saving of lives but equally struggles over representation, who gets represented and how, who represents and to what end. Understood in this sense, representation is not simply a linguistic resource but political as well, for it enables people to secure better terms of reference from the culture that denies their existence as subjects. But a common charge against the equation of AIDS with its representations is that it disregards the body. Thus, James Morrison insists that the AIDS epidemic should be understood "*from the standpoint of its sufferers* as, at least in part, organic" (Morrison 1992, p. 174, italics in original).

> The poststructuralist denial of the body in pain – or its denial of bodily pain as a legitimation of anything but the authority that social, signifying systems claim over the body, 'inscribing' it with textual reference – is especially disturbing in the context of a disease that is, quite literally, so inflammatorily subject to the intervention of social formations. (Morrison 1992, p. 171)

However, Morrison's point about experience is complicated by one of the key claims of poststructuralist theory, that experience is never by itself a reliable source of knowledge. It is, first, unstable, inchoate and contingent upon the specific social location of individuals. Secondly, since experience can only be articulated in language, it cannot escape the epistemological uncertainty that underlies all sign systems. Experience, Jonathan Culler states, "always has [a] divided, duplicitous character: it has always already occurred and yet is still to be produced – an indispensable point of reference, yet never simply there" (Culler 1982, p. 63). Bodily experiences, argues Diana Fuss, "may seem self-evident and immediately perceptible but they are always socially mediated" (Fuss 1989, p. 25). Morrison's appeal to an "organic" experience of disease seeks to bypass this uncertainty by claiming for experience an undisputed authority on which the "true" knowledge of AIDS can be founded. This is the logic underlying the identity politics of various forms of activist struggle around disease. By espousing a view of bodily experience as foundational, Morrison overlooks the fact that persons differently implicated in the epidemic often experience their disease differently, that an economically privileged white gay man in the United States does not experience AIDS equally as a poor migrant labourer or sex worker in India does – that there is, in other words, no *standpoint of the sufferer* because people do not all suffer AIDS the same way.

This is not to argue, however, that one's experience of disease is of little value as knowledge: we must not underestimate, for instance, the political value of PLWHA (Person Living with HIV/AIDS) movements. We should neither prioritize the "truth" of bodily suffering nor be overly sceptical of it. The "palpable signs of illness", writes Sander Gilman, "the pain and suffering of the patient, cannot simply be dismissed as a social construction, even though this pain may be understood by patient and health care practitioner alike in a socially determined manner" (Gilman 1988, p. 10). More to the point is Satya Mohanty's approach to the question of experience and its social construction. In outlining what he terms a "postpositivist realist" approach, he provides a middle ground between poststructuralist indeterminacy and a foundationalist view of experience that is especially relevant here. Personal experience is neither entirely personal nor *im*mediate, but mediated through already existing "theories" or evaluative paradigms that are socially constructed; yet it can yield a more or less accurate knowledge of our location as social subjects:

> All experience … is socially constructed, but the constructedness does not make it arbitrary or unstable in advance. Experiences are crucial indexes of our relationships with the world (including our relationships with ourselves), and to stress their cognitive nature is to argue that they can be susceptible to varying degrees of socially constructed truth or error and can serve as sources of objective knowledge or socially produced mystification. (Mohanty 2000, p. 38)

Such an approach to the "truth" of experience avoids both the realist view of, for example, Susan Sontag, who sees all metaphors as distortions of objective facts and therefore in need of being retired, and the contrary view that we can never escape the ideological and the fantasmatic in our attempt to understand reality. It can serve to bring into a more dialectical relationship the experience of the diseased, understood as socially constructed and mediated, and the theoretical critique of disease discourse, in formulating what Cherrie Moraga calls "theory in the flesh" (Moraga and Anzaldua 1981, p. 23). Moraga's point is that we know and act from within our social location through both the experience of suffering that we undergo and the interpretations we bring to this experience. Interpretation and experience, however, are not separate acts but are coextensive: bodily suffering is already interpreted *as* suffering to be experienced as such. Her "theory in the flesh" is founded on a dialectical understanding of bodily experience ("flesh") and the theory-mediated interpretation of the structures of power that constitute one's location *as* a location.[11]

Thomas Yingling's work on AIDS is an example of this effort within poststructuralist criticism. Yingling, who died of complications due to AIDS in 1992, was interested in the way AIDS brought to the surface the gap between our imaginary self-conceptions and the material body. In an essay written perhaps shortly before his death, he reflects: "Why am I so uninterested in intellectual stuff? I still have ideas, I still perform interpretations; but my attention is all riveted on myself" (Yingling 1997, p. 57). The answer lies in "bring[ing] personal discourse and the politics of experience back into AIDS discourse", with experience understood as "a complex semiotic and dialectical process, not simply an unmediated knowledge of

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[11] Moraga defines "theory in the flesh" as one that accounts for how "the physical realities of our lives – our skin color, the land or concrete we grew up on, our sexual longings – all fuse to create a politic born out of necessity" (Moraga and Anzaldua 1981, p. 23). For a more detailed summary of Moraga's argument, see Moya 2000, pp. 91–99.

self and other" (Yingling 1997, pp. 58, 22). One of the central effects of contemporary, mass-mediated knowledge, argues Yingling, is its reification as "information", which is always offered as discrete, autonomous and unlinked to our personal experience of events. Statistics of seropositivity and AIDS deaths and the enumeration of risk groups, however necessary from an epidemiologist's point of view, are an apt instance of this depersonalization of "public" knowledge, its delinking from those "private" spheres where knowledge is apprehended, evaluated and put to use. The task of critique, therefore, is to analyse not just the public structures of ideology, apparatus and representation but also their internalization in the everyday practice of individuals. Personal experience thus becomes "a signifier to mark not private and interior knowledges but the intersection between such knowledges and the collective public structures that frame them" (Yingling 1997: p. 50). On this view, experience is not understood as bodily in opposition to the discursive, or personal as opposed to the social, but is the ground on which the individual body and social discourse are mutually implicated.

Instead of either treating the body as a discursive construct or making it an "organic" ground for the experience and understanding of disease, critique of the ideological and somatic effects of AIDS should focus on the modes of embodiment by which people respond to the norms of sexuality, health and disease. In this approach, embodiment is understood as both natural (organic) and cultural. Under "normal" conditions, the distinction between the two is blurred, and the body is experienced as "nature", while "abnormal" states – disease and disability – bring to the fore the role of culture. As Karen Barad states in the context of the disabled body:

> The luxury of taking for granted the nature of the body as it negotiates a world constructed specifically with an image of 'normal' embodiment in mind is enabled by the privileges of ableism. It is when the body doesn't work – when the body "breaks down" – that such presuppositions generally surface. … It then becomes clear that "able-bodiedness" is not a natural state of being but a specific form of embodiment that is co-constituted through the boundary-making practices that distinguish "able-bodied" from "disabled". (Barad 2007, p. 158)

Mary Douglas explains this simultaneity of the organic and the cultural through the metaphor of "two bodies": "the social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society" (Douglas 1970, p. 72). Embodiment is understood as simultaneously a state in which one exists at a given moment and a process that is lifelong. Thus, Judith Butler, in an account of gendered embodiment, explains it as "a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being" (Butler 1990, p. 45). Butler's argument suggests that there are two dimensions to embodiment: a structure of power relations (the regulatory system of norms) and bodily acts or practices through which people relate to the norms. These embodied practices bear a complex relation to the norms, ranging from compliance to contingent negotiations and resistance. Understanding the pedagogic rationality of HIV/AIDS interventions and their effectivity calls for such a double perspective.

Thus far, we have considered the structures and mechanisms that govern the conduct of individuals. How individuals actually conduct themselves follows the logic not of the rule but of practice, however restricted its scope may be. The relation between rule and practice, as Pierre Bourdieu states, is ambiguous: rule could refer to "a social *norm* expressly stated and explicitly recognized" and distinct from practice or to "the sense of a *scheme* (or principle) immanent in practice" (Bourdieu 1977, p. 27, italics in original). This ambiguity means that practice does not coincide with the rule, but it is not absolutely without relation to it. The question of practice becomes paramount when we turn from the social construction of the body to embodiment as a way of being in the world (Csordas 1994). Though Foucault does not offer a theory of practice, he does distinguish between "moral code" and "morality of behaviours": "one must determine how and with what margins of variation or transgression individuals or groups conduct themselves in reference to a prescriptive system that is explicitly or implicitly operative in their culture, and of which they are more or less aware" (Foucault 1985, pp. 25–26). Thus, one may practice the code of sexual fidelity by refraining from acts of infidelity or by exercising vigilant control not only over one's acts but also over desires or again through the intensity of reciprocal love between partners. Embodied subjectivity in this example is the outcome equally of a code of conduct, which is universally enforced, and the practice of the code, which is specific to individuals. In Foucault, it is one's social context and the moral character that one aspires for which determine what he calls the "practices of self" (Foucault 1985, *passim*). For Bourdieu, the way one responds to the code is determined by the "habitus" or the system of dispositions, inclinations and tendencies which are ingrained in social experience (Bourdieu 1977, pp. 78–87). In other words, both Foucault and Bourdieu emphasize the social over the subjective. While drawing on them, Michel de Certeau offers a theory of practice that gives greater scope to individual choice, without minimizing the role of the social order. In *The Practice of Everyday Life*, he explains the logic of practice through the example of "walking in the city":

> First, if it is true that a spatial order organizes an ensemble of possibilities (e.g., by a place in which one can move) and interdictions (e.g., by a wall that prevents one from going further), then the walker actualizes some of these possibilities. In that way, he makes them exist as well as emerge. But he also moves them about and he invents others, since the crossing, drifting away, or improvisation of walking privilege, transform or abandon spatial elements … And if on the one hand he actualizes only a few of the possibilities fixed by the constructed order (he goes only here and not there), on the other he increases the number of possibilities (for example, by creating shortcuts and detours) and prohibitions (for example, he forbids himself to take paths generally considered accessible or even obligatory). (1984, 98)

Michel de Certeau sees practices as tactical interventions in strategies of power, where "strategies" are institutional mechanisms of control by hegemonic authorities, while "tactics" are the manoeuvers by which the "weak" turns the situation to their advantage, the "art of the weak" (de Certeau 1984, pp. 34–39). The road network of the city, thus, is the strategy by which urban planning controls the movement of people, while shortcuts and detours are tactical means of evading complete control. In this distinction, strategy refers to overall and long-term plans to control outcomes, as in military strategy, while tactics are local and contingent.

An objectivist emphasis on rule structures fails to understand this logic by presupposing practice as mere application of the rule. “The limits of Saussurean objectivism”, argues Bourdieu in the context of structuralist linguistics, “are never more clearly visible than in its inability to conceive of speech and more generally of practice other than as *execution*, within a logic which, though it does not use the word, is that of the rule to be applied” (Bourdieu 1977, p. 24). Victor Turner, similarly, urges a shift from an anthropology of “symbolic systems” into an “ethnography of speaking” (Turner 1987, p. 21), by which he means the practices or performances by which individuals not only manifest the prevailing social order but often critique, modify or resist it. In the anthropology of jurisprudence, Sally Moore proposes a model of cultural analysis that includes “processes of regularization”, which “produce rules and organizations and customs and symbols and rituals and categories and seek to make them durable”, and “processes of situational adjustment”, which refer to practice (Moore 1978, p. 50). In other words, there has been in the study of culture an increasing attention to the way people conduct themselves within a given social order, in a move that does not cancel out the gains of structuralist theory but improves on its ability to explain social actions. Instead of positing code and practice as binaries, it sees them as dialectically linked and mutually transformative.

The concept of “embodiment” draws on both the logic of the social order and the logic of practice. It refers to the way bodily practices, which are governed by the social order but not reducible to it, constitute our being in the world. These practices, moreover, are not individualized but collective, since embodiment takes place in a social world and through social interactions. As “performative acts” in Austin’s (1962) sense,[12] they are constitutive of the lived body as well as embodied subjectivity. Embodiment, thus, combines three “bodies” in one: “having a body in which the body has the characteristics of a thing, being a body in which we are subjectively engaged with our body as a project, and doing a body in the sense of producing a body through time” (Turner 2008, p. 245). Embodied practices are strategic, that is, they are provoked by crises and are deployed to resolve them. Finally, embodied practice is situation-specific: “much of what is important to it cannot be grasped outside of the specific context in which it occurs” (Bell 1992, p. 81).

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[12] In his theory of speech acts, Austin (1962) distinguishes between “constative” utterances that describe or refer to objects and acts outside the utterance itself and “performative” utterances such as promises, orders and declarations that perform the very acts they seem to refer to. We will explain this in more detail in Chap. 7.

## 2.5 Conclusion

This chapter has outlined the theoretical framework of the study, which examines HIV/AIDS awareness campaigns as a form of public health pedagogy. It briefly explains some of the key concepts used in the framework, which will be taken up in more detail in the relevant sections of the chapters that follow. It begins with an account of pedagogy and its links with the exercise of power and subject formation. Since the pedagogic materials studied are primarily texts, the chapter also examines the relation between representation and reality. It then examines the status of personal experience in the understanding of disease as a part of social reality. Finally, it looks at practices of embodiment as responses to the norms of health and disease.

Pedagogy is commonly understood as the communication of knowledge in a neutral and apolitical manner. Such a view suppresses the links that it has with the exercise of dominance, which happens through techniques of persuasion rather than force and is therefore more difficult to recognize. The chapter attempts to bring out these links by drawing on critiques of pedagogy in Paulo Freire, Louis Althusser and Michel Foucault. For Freire and Althusser, pedagogy articulates the dominant ideology and thereby serves to maintain existing social hierarchies. In the guise of communicating a knowledge that is information-based and presumably objective, it introduces ideas of normative conduct that make the learner amenable to the exercise of power. To counter such pedagogies, Freire proposes a critical pedagogy that functions by posing problems instead of providing information and seeks to make learners more aware of the contradictions underlying their social existence. For Foucault, however, ideology is only one of the means by which pedagogy serves the interests of power, which requires additionally the production of knowledge about those on whom it is exercised and meticulous techniques of disciplinary control that are directed to the mind as well as the body. The contrasts between Foucault's account and those of Freire and Althusser, thus, relate to the mode as well as the target of pedagogy. Both are equally important in the context of AIDS awareness campaigns, which seek to induce behaviour change through a combination of ideological persuasion, use of strategies developed from knowledge of sexual behaviour and inducing individuals to practice safe sex. The three accounts also subscribe to divergent theories of power: while Freire and Althusser view power as essentially repressive, Foucault emphasizes its productive role. Freire's theory of critical pedagogy is relevant in the context of collective mobilizations which seek to transform the social conditions that perpetuate hierarchies of dominance and to empower individuals to make prudential decisions. But it fails to explain public health pedagogies that focus on individual freedom in effecting behaviour change, and cannot be considered repressive even as they exercise dominance. For this, it is more relevant to draw on Foucault's account of modern liberal governmentality, which is premised on the freedom of the individual and seeks to inculcate self-responsibility by utilizing free choice.

A major difference between the three thinkers lies in their understanding of the subject. Freire, arguing from the standpoint of socialist humanism, holds that the subject pre-exists relations of power, a claim that is contradicted by both Althusser and Foucault. In Althusser the subject is an effect of the functioning of ideological structures, through an identificatory mechanism that he terms "interpellation". Subject formation is founded on a paradoxical unity of subjection to power and the illusion of free subjectivity, that is, the capacity to think and act as an autonomous individual. Foucault's account of the subject, too, is founded on a paradox, in which subjection to power produces a subject whose freedom is not an ideological illusion, but a reality. Defining governmentality as a form of rule that enables individuals to act, though in ways constrained from the outset by power, Foucault explains subject formation as the outcome of the dual process of subjection and subjectivation. As he puts it in *Society Must Be Defended*, "We should not, therefore, be asking subjects how, why, and by what rights they can agree to being subjugated" – which is the question that Freire asks – "but showing how actual relations of subjugation manufacture subjects" (Foucault 2003, p. 45). The concepts of interpellation and subjection/subjectivation are useful in understanding how pedagogic texts and behaviour change practices function. Texts, especially those accompanied by visuals, position their readers as subjects in the way they address and interpellate them, while behaviour change strategies that induce people to adopt safe sex practices act as modes of self-constitution.

In discussing governmentality, Foucault emphasizes that it is not restricted to the state, but involves a range of institutions with diverse agendas and objectives that work in tandem with the state. This provides us with a perspective from which we may understand how a "national AIDS pedagogy" need not be state-centric, as Cindy Patton assumes it to be, but is much more heterogeneous. As we will see in Chap. 6, though AIDS awareness campaigns were initially undertaken by the state through its agency the National AIDS Control Organization (NACO), they were subsequently transferred to non-state actors like international, national and local NGOs and community-based organizations that could function in ways that the NACO, for various reasons, could not. It is necessary to see how a *national* pedagogy can continue to function through such diverse interventions and sites, without restricting its scope, as Patton does, to the state.

The chapter also explains why it is necessary to focus on representations in understanding the politics of disease control. Texts about the HIV/AIDS epidemic, such as media representations, narratives and pedagogic materials, do not simply represent the disease, but construct our understanding and responses to it. They work by setting up a binary opposition between health and disease, where disease is associated with impurity, contamination and the invasion of the body's integrity. It forms, in other words, the excluded ground on which health is constructed as a positive and valuable ideal. It is necessary to understand this process of symbolization in order to see how the "otherness" of disease becomes attributed to the people affected by it, leading to their stigmatization and social exclusion. Stigma and discrimination, which are critical issues in the HIV/AIDS epidemic worldwide, cannot be adequately understood and countered without understanding the rhetorical effects of representation. This is especially important in the case of pedagogic materials, which must educate people about ways of preventing disease in a manner that does not stigmatize the HIV-positive. Representations, as Althusser's account of ideology shows, are also crucial to subject formation, and how HIV-positive persons and groups perceive themselves as social subjects depends to a great extent on how they represent themselves. Positive self-representations prevent self-stigmatization and can have a transformative impact on how others perceive them. As Douglas Crimp sums up the need to analyse discursive constructions of AIDS:

> AIDS does not exist apart from the practices that conceptualize it, represent it, and respond to it. We know AIDS only in and through those practices. This assertion does not contest the existence of viruses, antibodies, infections, or transmission routes. Least of all does it contest the reality of illness, suffering and death. What it *does* contest is the notion that there is an underlying reality of AIDS, upon which are constructed the representations, or the culture, or the politics of AIDS. If we recognize that AIDS exists only in and through these constructions, then hopefully we can also recognize the imperative to know them, analyze them, and wrest control of them. (Crimp 1988, p. 3)

Alongside representations, personal experience also plays an important role in understanding the social reality of disease. In this context, it is necessary to see how personal experience is never entirely personal, but is mediated by social norms of what counts as meaningful. Since AIDS is known, as Eric Savoy puts it, "at the interstices of the somatic and the ideological" (Savoy 1993, p. 65), one's experience of its effects both bodily and social is as important as representations in public discourse. As we will see in Chap. 4, narratives of illness can provide access to the subjective reality of suffering that objective biomedical accounts of disease tend to suppress. The chapter has referred to the arguments of Thomas Yingling, Cherrie Moraga and Satya Mohanty to emphasize the importance of personal experience, which is not opposed to socially constructed meanings in simple binary fashion, but is the point at which the personal and the social and the organic and the ideological intersect. It is in the intersection of the "private and interior knowledges" and "collective, public structures" (Yingling 1997, p. 50) that subjectivities are formed or denied. The stigma of bodily disease or deformity has an immense capacity to create what Irving Goffman calls "spoiled identity": "Given that the stigmatized individual in our society acquires identity standards which he applies to himself in spite of failing to conform to them, it is inevitable that he will feel some ambivalence about his own self" (Goffman 1963, p. 130). Reflection on personal experience can, in such a context, enable one to see the contradictions in socially acquired identity norms. To overcome the shame of losing a breast to cancer, for instance, Audre Lorde narrates her personal experience as a way of reclaiming self-esteem: "in order to keep myself available to myself, and be able to concentrate my energies upon the challenges of those worlds through which I move, I must consider what my body means to me" (Lorde 1980, p. 22).

One way of juxtaposing the personal experience of AIDS with the normative structures that frame it is by turning to embodiment, as the bodily practices through which people both individually and collectively respond to the norms. As Bryan Turner (2008) explains, the concept of embodiment refers to a corporeal self-fashioning in which body and self, the organic and the cultural and personal and collective experience are inseparably fused. Codes of bodily conduct may delimit the field of possible action, but do not determine conduct exhaustively. Thus, Foucault distinguishes between the “moral code” and the “morality of behaviours” (Foucault 1985, pp. 25–26). Embodiment in this sense is simultaneously a state of being and a process of becoming that is lifelong. To understand how people *live* with AIDS, either as managing one’s illness or managing the risks one is exposed to, and the terms that pedagogy offers for such management, it is imperative to shift from the *structures* of subjectivity to *processes* and *practices* of subjectivation. The chapter outlines such a conceptual shift by drawing on theories of practice in Pierre Bourdieu and Michel de Certeau.

In *The Practice of Everyday Life*, Michel de Certeau makes an important distinction between strategy and tactic. In the context of AIDS awareness campaigns, we may take strategy to refer to the broad framework of action and policy formulated by the state and implemented by non-state agencies – what we have called the national AIDS pedagogy. These are formulated and implemented in terms of long-term objectives and are meticulously planned to avoid contingencies. Their chief tools are cartographic mapping of areas of differential disease incidence, from high-prevalence regions to moderate- and low-prevalence ones, and population-based or demographic mapping of levels of risk. They also attempt to devise standardized pedagogic interventions, replicating models that have proved successful and modifying those that have had less success, with different strategies for the general population and specific risk groups. They are, finally, public health governance projects designed from the perspective of the governors, though they may include others as stakeholders. In contrast to such pedagogies, there may be projects “invented” by the people, the governed, independently of the governors and making tactical use of cultural resources that may not meet the approval of the latter. Such pedagogic initiatives are always local efforts to deal with contingent crises of epidemic disease. Chap. 7 discusses one such initiative, the worship of AIDS Amma in an obscure village in south Karnataka. Following de Certeau, therefore, this book distinguishes between “strategic” pedagogies that are national in scope and are well-planned and “tactical” pedagogies like the AIDS Amma initiative that are local and contingent and re-articulate the lessons of the strategic pedagogies within cultural practices that may appear incompatible. The AIDS Amma temple is a telling instance of what de Certeau calls “making do” (de Certeau 1984, p. 29) – it grafts biomedical knowledge of AIDS onto an age-old tradition of disease goddesses, thereby juxtaposing divergent aetiologies of disease and divergent epistemologies of the body in a manner that may appear perplexing to us but not to its practitioners and which has its own index of efficacy that the strategic approach fails to comprehend.

AIDS awareness campaigns, finally, do not exist in isolation from the public discourse on the epidemic. They are a part of the larger context within which the epidemic comes to be constructed and understood. In the chapters that follow, we will see how ideas about AIDS and HIV-positive people have been disseminated in media reports, narratives and court judgments. Some of these, especially media reports and narratives, communicate information about HIV, its modes of transmission and prevention and serve therefore a pedagogic function without forming part of what we have called the national pedagogy. A number of the AIDS narratives discussed in Chap. 4 were sponsored by non-governmental organizations promoting AIDS education, such as *A Dove in Desert* (2001), *Ek Alag Mausam* (2005) and *AIDS Sutra* (2008). Even those that were not formally associated with pedagogic initiatives weave lessons on disease prevention into the storyline. The media reports and narratives constitute what we may call *incipient* pedagogies, which do not adopt the format of AIDS education campaigns but nevertheless teach people how to conduct themselves in the epidemic. As we will see in Chap. 6, there is a significant exchange of ideas and assumptions between the formal pedagogies and these incipient pedagogies. Chapter 5 examines court decisions regarding the rights of HIV-positive individuals, where we note significant correspondence between these decisions, the media reports and narratives, with regard to assumptions about the disease. In other words, the understanding of AIDS as a social, medical and juridical issue has been dispersed across distinct domains of knowledge, including the pedagogic, in historically shifting constructions of the epidemic. Any attempt to understand how AIDS pedagogies function and what meanings they communicate will be incomplete without locating them in the larger discursive contexts in which the epidemic was socially understood.

HIV/AIDS has been constituted as an object of knowledge in diverse ways, from different perspectives, and across heterogeneous fields of discourse, comprising what Michel Foucault calls a “discursive formation”:

> Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity … we will say, for the sake of convenience, that we are dealing with a *discursive formation*. (Foucault 1972, p. 41, italics in original)

By considering the diverse accounts of AIDS as constituting a discursive formation, we gain an insight into their underlying unities as well as the way the epidemic has been understood as a problem to be addressed from various overlapping perspectives. AIDS is no doubt a reality, but it is in these divergent discourses and the practices they give rise to that its reality comes to unfold to us. AIDS pedagogy, both as a way of knowing the epidemic and evolving practical means of dealing with it, must be examined as an element of this formation.

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# Chapter 3
# Incipient Pedagogy I: AIDS in the National Media

**Abstract** AIDS pedagogies are not insulated from the larger discursive and practical contexts in which the social reality of HIV/AIDS is embedded. As such, therefore, it is necessary to uncover its links with other domains of AIDS knowledge. This chapter examines early media representations of HIV disease in India, with regard to their shifting constructions of the epidemic. These early accounts had a long-term impact on how the reality of AIDS came to be understood.

**Keywords** Discursive construction of HIV/AIDS · Media representations of HIV · Moral panic · Stigma

The HIV/AIDS epidemic is unique in the history of disease in the amount of texts it has generated, including not only scientific literature but administrative and policy documents, population surveys, health education materials, laws and court judgments, socio-economic studies, cultural critique, media reports, poetry, drama, fiction, life narratives, travel narratives, visuals, films and a quilt that memorializes those who have lost their lives to AIDS.[1] It is, in other words, the most textualized of diseases, with a proliferation of meanings that reinforce, contradict, modify or supersede each other in an endless and unstable semiosis. "The AIDS epidemic", Paula Treichler writes, "is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings or signification" (Treichler 1999, p. 11). For some, it is the quintessential "postmodern" disease, in the way HIV infiltrates and subverts the immune system, allegorizing the subversion of erstwhile stable structures of meaning and value, in its perpetual instability and the spectacularity of its effects (Weeks 1990; Haraway 1989; Watney 1988; Edelman 1993). By the time the epidemic surfaced in India in 1986, 5 years after it was identified in the United States, it had already acquired a sizeable volume of non-medical writing on it, reflecting radically different perspectives, understandings and political standpoints. In her extensive bibliography, Treichler cites some 50 articles on AIDS published in this period in popular newsmagazines like *New York Times*, *People Weekly*,

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[1] The AIDS memorial quilt, which is maintained by the NAMES Project Foundation, was started by gay activist Steve Jones in 1987 and now includes more than 48,000 panels from all over the world (Names Project).

D. K. Das, *Teaching AIDS*, https://doi.org/10.1007/978-981-13-6120-3_3

*Newsweek*, *Life*, *Frontline*, *Harper's*, *Time* and *National Geographic*. 1986 also saw the publication of Douglas Feldman's and Thomas Johnson's anthology *The Social Dimension of AIDS*, Dennis Altman's *AIDS in the Mind of America*, David Black's *The Plague Years* and Panos Institute's *AIDS and the Third World*. Michael Callen's *How to Have Sex in an Epidemic* came out in 1983 and Cindy Patton's critique of the cultural politics of AIDS, *Sex and Germs* in 1985. Larry Kramer's vitriolic play on the epidemic, *The Normal Heart*, was staged in April 1985, and *An Early Frost*, the first major film on AIDS – Yingling calls it a bourgeois melodrama on "Oedipal forgiveness" (Yingling 1997, p. 28) – was telecast by NBC in November 1985. This discursive proliferation had an impact on the way AIDS, HIV and HIV-positive people came to be understood in both medical and non-medical literature in India. "[K]nowledge of the virus and other natural phenomena", writes Treichler, "is inevitably mediated through our symbolic constructions of them" (Treichler 1999, p. 152). This includes also biomedical knowledge, which, as we will see in media reports of expert opinion on the epidemic, is frequently influenced by cultural interpretations of disease.

This chapter examines media reports of the epidemic in the early years of the epidemic, though a few are from later periods. AIDS reporting in the first few years of the epidemic set the themes that determined the social understanding of HIV/AIDS as well as responses to it. Initially, the media framed the epidemic in moral terms, leading to stigmatization of the HIV-positive. Subsequently, however, the reports included issues of discrimination and the violation of human rights and the need for compassion for the affected, especially those who were held to have acquired the infection "innocently". The reports are selected, not as a representative sample but to bring out the major themes. To avoid problems of translation, which might not be able to capture the nuances of meaning effectively, only English-language newsmagazines and dailies were sourced.

The identity of a disease, whether biomedical or popular, is the outcome of how it is experienced, understood and presented as a medical, social and political problem. In an essay on the conception of malaria as a "tropical disease", Michael Worboys has shown how factors like "the micro- and macro-politics of British colonial imperialism" shaped what was assumed to be objective knowledge of a biological entity (Worboys 1996, p. 199). Similarly, Mark Harrison has shown how the understanding of cholera in India was tied to Eurocentric presuppositions of the lack of hygiene in tropical lands: "Most medical practitioners were already agreed that 'filth' had a major role in the causation of disease" (Harrison 1999, p. 191). Epidemics of cholera and plague in the nineteenth century provided an opportunity for the colonial government to justify its ideology of cultural difference, to impose sanitary regulations on native populations in safeguarding the health of Europeans and to extend political and economic control (Arnold 1987, 1993; Pati and Harrison 2001; Kamat 2001). The "truth" of disease is, therefore, not its objective existence in the body, though this objective existence is not thereby denied, but the outcome of a range of discourses and practices that identify, define and proclaim it as a medical problem. On this view, the question is not what the truth is, but how it comes to be established as the "truth". As Charles Rosenberg writes:

> The reality is obviously a good deal more complex. Disease is at once a biological event, a generation-specific repertoire of verbal constructs reflecting medicine's intellectual and institutional history, an aspect of and potential legitimation for public policy, a potentially defining element of social role, a sanction for cultural norms, and a structuring element in doctor/patient interactions. *In some ways disease does not exist until we have agreed that it does – by perceiving, naming, and responding to it.* (Rosenberg 1989, pp. 1–2, italics added)

Discursive constructions, as well as the public health policies and practices that derive from them, are a source of prior knowledge about disease that determines individual and social attitudes to it and the responses they call forth. While Rosenberg's claim is that this is how diseases come to be understood in medicine, it is more valid in the case of social understanding of disease, in which the media play a key role in translating biomedical ideas for circulation in lay language. In the sections that follow, we will see how the Indian media constructed the "truth" of AIDS from sources in the international media, expert opinion and what is presumed to be objective information.

## 3.1 Discursive Construction of AIDS in the Indian Media

HIV was first detected in India in 1986, when six sex workers in Chennai tested positive during a random screening for sexually transmitted diseases conducted by Dr. Suniti Solomon, a microbiology professor at Madras Medical College, and her student Dr. Nirmala. Union Health Minister Mohsina Kidwai made a formal announcement in Parliament on April 29, and, as one news article put it, "shocked the nation": "What had been a disease confined to the promiscuous West had suddenly reached India" (Pratap 1986, p. 49). It was widely reported in the media, creating a moral panic that would justify the coercive action of the state when, in the years that followed, police raided brothels, mandatorily tested the women and kept them in custodial detention if found positive. Pyari Bai, a Kolkata sex worker, was illegally detained in a city jail till the High Court directed the authorities to release her (Shetty 1990a, b; Singh 1995; Puri 1986, p. 24). African students in Jabalpur and Quilon were tested, and those found positive were deported (Singh and Pillai 1987). HIV-positive drug users in Manipur were arrested and detained in jails or remand homes (Ali 1991). The government introduced restrictions on the entry of foreigners and non-resident Indians, especially from African countries, who had to produce AIDS-free certificates to be allowed entry (Dube 2000, p. 26). In 1989 Dominic D'Souza, an HIV-positive gay man working with World Wildlife Fund, was arrested and detained in an abandoned TB sanatorium for more than a month[2] (Dube 2000, p. 27). In the same year, the Union government proposed an AIDS

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[2] In 2005, Sanjay Suri made a commercially released film on Dominic's story, titled *My Brother … Nikhil*, directed by Onir. It focuses on the issue of discrimination and the rights of the HIV-positive, especially in the context of law. Chap. 4 discusses the film in detail.

Prevention Bill that would give the state extraordinary powers to "prevent the spread of HIV infection as it may deem necessary" but withdrew it 3 years later as a condition for receiving a World Bank loan for undertaking HIV/AIDS prevention work[3] (Dube 2000, pp. 26, 86).

Infectious disease epidemics, especially if the disease in question is lethal, call for measures that are otherwise unjustifiable in a modern democracy, because of the panic that they create. Moral panic, Stuart Hall et al. argue, is "one of the principal forms of ideological consciousness by means of which a 'silent majority' is won over to the support of increasingly coercive measures on the part of the state and lends its legitimacy to a 'more than usual' exercise of control" (Hall et al. 1978, p. 221). It is undeniable that moral panics are fuelled by ideology, at least to the extent that they are "moral"; but where they concern epidemics, it is necessary to see how they produce effects on the body, and on which bodies, and why. The more pertinent question here is not how a "silent majority" is won over but how such panics function as expedient mechanisms to restore an order putatively disrupted by the disorder of disease. The use of coercive measures, such as drastic public health regulations backed by law, needs to be understood not as a conspiracy by an oppressive state but as a response to crisis. The pertinent question in this context is why disease is *perceived* as disorder, not how states respond to it. As we have seen in the preceding chapter, disease signifies in the social imaginary an invasion of the body's integrity, contamination of an otherwise pure state of health and a threat to the continuance of species being. This is why disease, while signifying disorder, also functions as a metaphor for non-medical phenomena that threaten social order. As diseases are bodily phenomena, it is the body that becomes the target of an ordering that follows a precise pattern: identification of infected and potentially infecting bodies, their segregation and exclusion. Epidemic diseases call forth the negative force of a biopolitical apparatus that protects the health of the majority by withdrawing its protection from the minority that either is, or is liable to be, infected. In Chap. 5, we will see how a medicolegal regime functioning as social hygiene justifies the exclusion of diseased individuals under the juridical principle of *salus populi est suprema*, in the name of a greater public good. The coercive measures of the state and media constructions of "AIDS in India" in the early years of the epidemic were the linked instruments of this ordering, in turn determining how AIDS in India was understood; and dominant notions of the epidemic already in circulation played a key role in giving this process its specific orientation.

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[3] It was under this scheme that the National AIDS Control Policy was formulated and the National AIDS Control Organization was established in 1992 as the nodal agency for initiating and coordinating epidemic-control programmes. See Chap. 6 for more details.

## 3.2 Theory of Foreign Origin

Early national responses to the epidemic, in state measures to control it as well as press reports, assumed that HIV was of foreign origin, attributing it both to the stereotyped "promiscuous West" and "primitive Africa". "If from one perspective AIDS is believed to be the prototypical disease of a modern lifestyle, from another it is seen as a disease of a premodern society that lacks the benefits of basic scientific knowledge" (Das 2005, p. 181). Shortly after the appearance of AIDS in gay populations in the United States, an African origin theory was widely disseminated in the Western media as a disguised attempt to assign blame in conflating origin with cause. Apart from innumerable reports of "African AIDS" in newspapers like *The Times*, *The Guardian* and *The New York Times*, there were articles in internationally circulated magazines, of which I list only a few. *Newsweek* published in 1986 a story titled "Africa in the Plague Years". In 1987, *Life* published an essay on AIDS in Haiti by Richard Selzer. The following year, *National Geographic* published a story by Robert Caputo on AIDS in Uganda. Ed Hooper's *Slim: A Reporter's Own Story of AIDS in East Africa* was published in 1990. In November 1987, CBS telecast "AIDS in Africa" on its "60 Minutes" programme (Fumento 1990, pp. 106–128; Patton 1990, pp. 77–97; Watney 1994, pp. 103–120; Treichler 1999, pp. 99–126). Robert Gallo, the American scientist who isolated a strain of the virus causing AIDS, hypothesized that it originated in Africa, and this was widely reported in the American press (Treichler 1999, pp. 29, 121). Though this was contested by other scientists, including the French virologist Luc Montagnier who had isolated HIV at the same time as Gallo (Fumento 1990, p. 110), the stereotype of "African AIDS" became a recurrent element in narratives of the epidemic's origin.[4] It was also invoked by the media to warn the public of possible future crisis and to draw consolation from the fact that the situation was not yet as bad, thereby serving the double function of arousing anxiety and allaying it. Thus, two of the narratives that we discuss in the next chapter, *Sex, Lies and AIDS* and *Positive Lives*, both written by journalists, extensively use "African AIDS" as a measure of what can happen in India if the epidemic is not halted. We may discern here a much older paradigm of disease that linked it to climate, environment and race, formed in colonialist constructions of "tropical" pathology and reactivated in first world constructions of AIDS topography in the Third World (Treichler 1999, pp. 99–126). "The metaphor of tropical", writes Ann Marie Moulin, "indicated a general dependence on a harsh natural determinism among a population trapped by climatic and geographic conditions. In other words, tropical stood for poverty and for physiological misery" (Moulin 1996, p. 161). The Africanization of HIV may have been for the Western

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[4] "The subliminal connection made to notions about a primitive past and many hypotheses that have been fielded about possible transmission from animals (a disease of green monkeys? African swine fever?) cannot help but activate a familiar set of stereotypes about animality, sexual license and blacks" (Sontag 1988, p. 52).

media a way of resolving the perceived contradiction of the virus emerging in some of the most scientifically advanced nations of the world and to lay the blame elsewhere.

> 'African AIDS' thus legitimates and 'proves' the fantasy of intrinsic correspondences between environment, character, and physical health – constructing 'Africa' as an undifferentiated domain of rot, slime, filth, decay, disease, and naked 'animal' blackness. This infernal and unhygienic territory is the perfect imaginary swamp in which a new virus might 'percolate' … a virus which eventually kills by transforming all its 'victims' into 'Africans', and which threatens to 'Africanise' the entire world. (Watney 1994, 112)

The "foreign origin" theory of the epidemic found wide acceptance in the Indian media, following stories from the West. "There is a school of thought", reported Nisha Puri in *Sunday*, "which unambiguously subscribes to the theory that AIDS in this country has been brought in by foreigners or Indians who have travelled abroad" (Puri 1986, p. 26). The "eminent group of researcher-scientists and specialists in communicable diseases" who advocated this theory and whose credentials Puri stresses included the director-general, deputy director-general and senior deputy director-general of the Indian Council for Medical Research (ICMR), head of the division of epidemiology and communicable diseases, School of Tropical Medicine, Kolkata, head of virology at the All-India Institute of Medical Sciences, New Delhi and a professor of the National Institute of Choleric and Enteric Diseases, Kolkata. Speculations on the Chennai women who had tested positive for HIV centred on whether their infections were "indigenous" or acquired from "foreigners", and when they denied having "entertained 'white skins'", suspicion turned to "dark-skinned foreigners". At the top of the list were "Negroes, Mauritians and Sri Lankans" and Indian labourers who had "contracted the disease in Sri Lanka, Dubai or Malaysia and [became] carriers on their return to Tamil Nadu" (Pratap 1986, p. 50). The media supported the foreign origin theory with strenuously "factual" accounts of infections acquired abroad. Two instances of "innocently" acquired infection were frequently cited. The first was B.R. Makhija, a Mumbai businessman, who had undergone coronary bypass surgery in the United States and had been transfused with infected blood. The other was an unnamed haemophiliac microbiologist from Hyderabad, who had gone to the United States to attend a conference and had received a transfusion of infected anti-haemophilic factor there (Puri 1986, p. 30; Rahman and Chengappa 1986, p. 132; Venugopal and Raghunathan 1986, p. 22). Also cited was the case of a Srinagar bisexual who had "admitted having indulged in homosexual encounters" in Germany (Puri 1986, p. 27). In contrast to Makhija and the microbiologist, the latter was held to be culpable for his disease, in replication of the "innocent victim"/"guilty victim" binarism that was a recurrent stereotype of AIDS reporting in the United States.[5] Nisha Puri's story in *Sunday*

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[5] The "innocent/guilty" binary was a discursive paradigm through which moral distinctions were inscribed into classification of transmission modes, in the translation of medical ideas into lay perceptions. Referring to a congressional debate held on October 14, 1987, Douglas Crimp writes: "The ritual hand-wringing sentiments about innocent children with AIDS pervade the debate, as they pervade the discussion of AIDS everywhere. This unquestioned sentiment must be seen for

quoted the director-general of the ICMR, Dr. A.S. Paintal in support of the foreign origin theory:

> I am so certain that our findings in this matter are 100 per cent accurate that I no longer advance this theory as a hypothesis, but as a fact of life. If in the heading for your article, you use the title, ‘There is no indigenous AIDS virus in India’, you would be right on the mark. (Puri 1986, pp. 26–27)

In 1986, the Union Health Ministry recommended “insistence on AIDS-free certificates for foreigners coming into the country”, while the ICMR proposed a law banning sex “especially [with] foreigners” (Raghunathan 1986, p. 99; Puri 1986, p. 29). If the usual “source” of HIV was held to be America and Western Europe, Africa was invoked through analogy. Citing a study of HIV prevalence in different ethnic groups of Trinidad, Malini Sheshadri in *Frontline* posed the question: “Are Indians less susceptible to AIDS than people of African origin?” (Sheshadri 1986, p. 23) In 1991, when there were 500,000 HIV-positive people in India, Union Health secretary R.L. Mishra reportedly told journalist Siddharth Dube: “considering our social and cultural value and traditions, I feel quite confident that AIDS will not spread as far and as fast as in Africa” (Dube 2000, p. 41). Newsmagazines uncritically recycled colonialist stereotypes of the “diseased tropics”, now buttressed by appeals to “research”: “Research in Western countries has shown that filth, insects, presence of faeces in drinking water, squalid conditions, poverty, a tropical environment, rituals and sacrifices using blood and a high rate of tuberculosis help in the spread of AIDS” (Pratap 1986, p. 49). In citing the views of medical experts or alluding to scientific research, media reports established as the “truth” of AIDS what could otherwise be challenged as opinion. In 1987, government agencies began testing foreign students, especially those of African origin. In Quilon, Kerala, three Tanzanians were found to be positive and were deported, and the District Collector “personally saw to it that everything used by the three afflicted students was destroyed”. In Jabalpur, Madhya Pradesh, six Kenyans were found to be HIV-positive and were also deported. All foreign students were asked by the authorities of Jabalpur University to get themselves tested, failing which they would not be allowed to write the examinations (Singh and Pillai 1987, p. 129). Media reports of these events, by not questioning their rationale, implicitly confirmed the foreign origin theory.

The foreign origin theory was not factually incorrect, for diseases do spread from region to region through travel and migration. This is especially so with increased global communication networks today. But more important than its veracity was its ideological or symbolic function. “Foreign origin” theories are a geopolitical equivalent of self-definitions in which deviance is imagined and projected onto an “other”,

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what it is: a vicious apportioning of degrees of guilt and innocence to people with AIDS” (Crimp 2002, p. 73). In the story about the Hyderabad microbiologist Puri’s report emphasized his “good, middle-class family” background, and that he “was so strait-laced about sex that he used to blush when the word was mentioned” (Puri 1986, p. 30). Later in the epidemic, there was a report about a schoolteacher from Delhi who had acquired infection through “sexually promiscuous behaviour in Zambia” (Baweja and Katiyar 1992, p. 92).

thereby absolving the self of blame. Metaphors of disease as "invasion", which abound in the discourse of AIDS, are founded on the belief that disease originates elsewhere, outside the individual and the national body.

> [HIV] is not the primary killer, but lets down the drawbridge and rolls out the red carpet to a host of opportunistic infections…. It does not enter the human system dramatically, with war cries and brandishing weapons, calling the guards to the turrets at once. It works insidiously, lulls the body's defence mechanisms, subverts the guards, and thus opens the gates to the enemy outside. (Sheshadri 1986, p. 20)

More to the point is Nisha Puri's assessment of AIDS as a national threat: "AIDS in India is not in the nature of an invasion but merely a mild incursion and can be stopped from extending its deadly grip if appropriate action is taken swiftly" (Puri 1986, p. 29). The two statements reveal how disease, the body and the nation converge in the social imagination of disease as disorder.

National responses to infectious disease epidemics compulsively assume that it has come from outside – "disease invariably comes from somewhere else" (Sontag 1988, p. 47) – and the question of origin becomes paramount. The topography of the "outside" may be another country, or it may symbolize spaces in the nation's fringe inhabited by its "other" members, the brothels and the slums. This serves a number of functions, all crucially involved in the self-definition of nations. By assuming an extraneous origin, as we have already stated, it draws upon and reinforces a logic that understands the "self" as healthy and the "other" as diseased, thereby absolving the national self of the moral and organic deviance that disease represents. The "refusal of disease", writes Yingling, "is essential to nationhood" (Yingling 1997, p. 24). In the metaphoric construction of the nation as "body", disease signifies a contradiction: "it is in the self-definition of the national to reject not only disease but the very notion of embodiment it recalls" (Yingling 1997, p. 29). Secondly, it serves as a pretext for shoring up national boundaries and exercising increased vigilance on foreigners and on fringe groups, who are viewed as threats to the nation's health. By attributing disease to a foreign country (or to an "outside" within the nation's boundaries), origin and cause come to be equated in the fixing of blame, so that "the context in which a virus emerges and those first affected are held to be directly responsible for its emergence" (Watney 1994, p. 25). Sontag's point about disease coming from elsewhere is precisely that imagining disease as foreign is a way of attributing wrong-doing to "the non-us, the alien" (Sontag 1988, p. 48). In the "social epidemiology of accusations" (Douglas 1992, p. 85), blame is directed not only at the discredited within the nation but equally at other nations perceived to be culturally different. Most importantly, however, the rejection of otherness signified by disease is a symbolic reassertion of order, because of which foreign origin theories are necessarily complemented by elaborate classifications of the healthy and the diseased within the national space, the "general population" and the "risk groups". In epidemiology, these terms are used to objectively assess levels of vulnerability, for the purpose of preventive intervention; but translated into popular language, they signify differently. The "general population" comes to stand for those who are presumed to be free of disease, the culturally dominant groups understood as the national self, with the "risk groups" being those who pose a risk or danger to their health. It is this conflation of "risk" with "danger" that underlies the terminological translation and makes possible the attribution of blame (Douglas 1992, p. 40). The listing of risk groups in the media induces a sense of ideological control over the otherwise incomprehensible event of epidemic outbreak, whose "sources" can then be identified and isolated. Puri's comment cited above, that AIDS in India is only a "mild incursion" that has not extended its "grip" beyond the fringe spaces of brothels and slums, is an apt instance of the media's role in reassuring the public, even as it keeps alive a sense of anxiety. Paradoxical as it may seem, moral panic and reassurances of order reciprocate each other in a circular relation, as there can be no call for reordering unless society is first perceived as ordered.

Identifying the origin of AIDS required also the creation of maximum symbolic distance from that origin, and media constructions of the epidemic followed a characteristic logic by which the foreign origin theory was coupled with cultural nativism and the assertion of distance between "Indian" values and those of the West or of Africa. *Sunday* quoted the view of a professor of virology at the School of Tropical Medicine, Kolkata, in a description of Indian character that is also a prescription of conduct: "Ours is a sexually conservative society, and men and women still believe in marital fidelity and one sexual partner. Premarital sex is viewed with extreme approbation" (Puri 1986, p. 25). *India Today* reported ICMR chief Dr. A.S. Paintal's advice to "return to traditional Indian sexual conservatism, even abstinence" (Bhargava and Devadas 1988, p. 119). By quoting medical experts rather than laypersons, these opinions were assumed to be scientifically credible, in establishing the "truth" of AIDS as well as of Indian "culture". The epidemic was thus framed within a national legitimation narrative contrasting a "promiscuous West" with a "conservative" and therefore AIDS-free India – a land where, as Nisha Puri claimed, "the deadly disease was unlikely to take its toll" (Puri 1986, p. 30). Such constructions of national character and its distance from the foreign origin of AIDS acted as an ideological sealing of borders, a discursive equivalent of governmental actions restricting the entry of foreigners and deporting those found to be HIV-positive. It is beside the point whether the descriptions are empirically correct or the actions of the government make epidemiological sense: what is being argued is their symbolic import in mobilizing discourse and practice in containing the disorder of epidemic irruption.

## 3.3 Ordering Disorder: Profiling the Nation's "Other"

In setting up an antithesis between a "promiscuity"assumed to be disease-prone and a "sexual conservativism" held to be disease-free, the media attempted to reduce the arbitrariness of disorder by targeting those perceived to transmit disease. The foremost category was the female sex worker, given that they were the first to test positive. Then, as the epidemic spread, people "like labourers, porters, truck drivers, etc." also came to be included, because they are assumed to be "illiterate and ignorant" and "will not take basic precautions" (Pratap 1986, p. 50). In 1989–1990, HIV was reported among intravenous drug users in Manipur (Chatterjee et al. 2002, 135; Deb 2008), and these became the next category in the construction of a "north-east" epidemic driven by drug addiction, political insurgency and sexual promiscuity. By 1992, gay men and hijras began to test positive, too, disconfirming the hypothesis that AIDS in India was heterosexually driven (Dube 2000, p. 17). Puri stated in *Sunday*:

> … the profile of a typical AIDS victim appeared to be limited to those who had abandoned themselves to sexual 'debauchery', or had diverse sexual inclinations – in other words, dope fiends, junkies, homosexuals and whores. The six prostitutes in Madras who were officially declared as the country's first AIDS victims fell firmly into this category. (Puri 1986, p. 25)[6]

Media images depicted sex workers in brothels, HIV-positive drug users in Manipur jails or rehabilitation centres and truck drivers in "seedy highway *dhabas*" (Baria 1997, p. 102), in a visual attempt to contain the infected and the spaces of disease. The sanitary space against which these were defined, visible in its invisibility, was the middle-class household; and "married couples", Puri claimed in *Sunday*, "are generally accepted as belonging to groups that are in almost no danger of contracting AIDS" (Puri 1986, p. 30). Citing the authority of the virology head at the School of Tropical Medicine, Kolkata, she assured readers that "the prospect of a crossover from high-risk groups to the rest of the community is dim" (Puri 1986, p. 25). In addition to the above categories of high-risk people, who were held to be culpable for their disease, the media also constructed a category of "innocent victims". *Sunday* reported in 1990 the story of two haemophiliac brothers who tested HIV-positive: "Most AIDS cases, which have received publicity so far, have been patients who have, according to one view, wrought the affliction upon themselves…. Vinit and Rohit, however, have not been infected because of personal negligence". They were, nonetheless, understood as a potential danger, along with prostitutes and homosexuals: "So far, practitioners of the world's oldest profession have been subject to the severest surveillance – the government has virtually ignored the threat from homosexuals and haemophiliacs" (Sarin 1990, pp. 24–25).

Categorization of risk groups and their discursive segregation, as we have stated above, was the way in which the media tried to build an assurance of order. Crucial to this ordering process was the concept of the border, which signified both the line that demarcates the inside from the outside and the liminal space of possible "crossovers". "Borders", writes Gloria Anzaldua in a passage that is pertinent here, "are set up to define the places that are safe and unsafe, to distinguish *us* from *them*. A border is a dividing line, a narrow strip along a steep edge. A borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary…. The prohibited and the forbidden are its inhabitants" (Anzaldua 1987, p. 3). In other words, the borderland is that which, from within the ordered space, threatens disorder. In media accounts of the epidemic, the inhabitant of the AIDS

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[6] Puri's categorization of the "typical AIDS victim" is drawn from reports in the Western media. In India, HIV infection among intravenous drug users and men who have sex with men was reported much later.

borderland was the "carrier", which in medical science means "a person who harbours the microorganisms causing a particular disease without experiencing signs or symptoms of infection and who can transmit the disease to others" (*Oxford Concise Medical Dictionary* 2010, p. 118). In the context of AIDS, where the term is no longer in scientific use, it was taken to mean someone who was HIV-positive but asymptomatic.[7] *Carrier* and *spread*, argues Jan Zita Grover, are terms that are "central to popular descriptions of HIV transmission":

> AIDS is popularly seen as a disease that was initially *contained*, confined to identifiable "risk groups" that were not part of the "general population." *Spread* (or *leakage*, as it is sometimes called) suggests the insidious movement of the disease or the infection outside its "natural" limits. *Spread* and *leakage* share common sexual and polluting connotations…. (Grover 1988, p. 28)

Thus, Kavita Shetty's story in *India Today* was titled "AIDS Carriers: In Custody" (Shetty 1990a, p. 158). *The Times of India* reported in 2004 that "potential carriers of the virus" included sex workers, truck drivers and migrant workers (Shetty 2004, p. 4). Prostitutes, wrote Baria in *India Today*, "are a major reservoir for the AIDS virus, and, as Dr. Hira points out, 'the border between this original reservoir and the general population is quickly getting porous'" (Baria 1997, pp. 103–104). In 1986, Kolkata sex worker Pyari Bai was found to be HIV-positive and was taken into custody; the doctor who diagnosed her was quoted in *Sunday* as saying: "In the light of her profession, there is a real and urgent danger of her transmitting the virus in areas where AIDS antibodies have not yet been found and probably do not exist" (Puri 1986, p. 24). In Anita Pratap's report in *Sunday*, clients of prostitutes – "labourers, porters and truck drivers," that is, the underclass of society, most of whom were professional blood donors – constitute a "bridge" population that will "transmit the AIDS virus to other sections through their blood donations" (Pratap 1986, p. 50). In addition to the identified risk groups who could be isolated, therefore, media discourse created another category of "carriers" and "bridge populations" who, as inhabitants of the AIDS borderlands, posed the threat of "crossover".

By the mid-1990s the "crossover" had taken place, as many middle-class housewives started testing positive. In March 1997, *India Today* featured what was possibly one of the first cover stories on AIDS in the Indian media, titled "AIDS: Striking Home" (Baria 1997). The issue's cover sets the word "AIDS" against a conspicuously black background, emphasizing its shock impact (Fig. 3.1). An inset of a woman's eyes in chiaroscuro metonymically equates woman with home, signifying the shame and suffering that AIDS brings to both. The text accompanying this visual narrates the pathos of Sunita Rao, a "conservative middle-class housewife" struggling against both the virus and the stigma attached to it. Baria's report includes a number of elegiac pictures in black and white of "victims" and their grieving parents.

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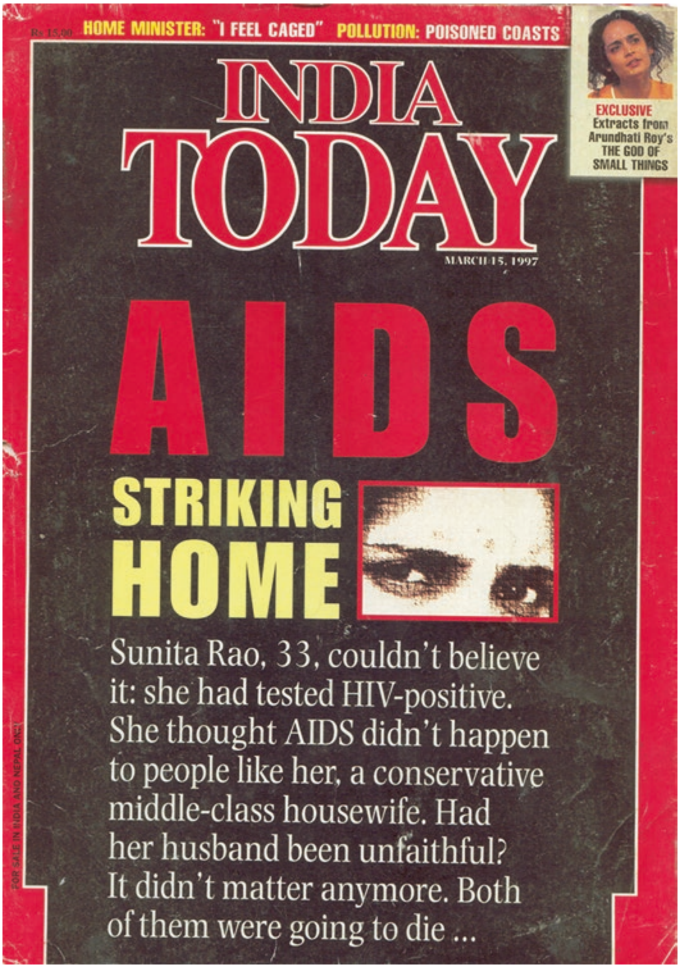
[7] In a report in *India Today*, Singh and Pillai quote the definition of "carrier" by a joint director of health services in Jabalpur: people "who have the capacity to transmit [HIV] to another person but can remain unaffected themselves" (Singh and Pillai 1987, p. 129). Since a person infected with HIV will eventually go on to develop symptoms of disease, this is factually incorrect; but it serves a symbolic function as the carrier is imagined as a threat to the ordering of spaces.



Rs 15.00 HOME MINISTER: "I FEEL CAGED" POLLUTION: POISONED COASTS

INDIA TODAY

MARCH 15, 1997

EXCLUSIVE Extracts from Arundhati Roy's THE GOD OF SMALL THINGS

AIDS

STRIKING HOME

Sunita Rao, 33, couldn't believe it: she had tested HIV-positive. She thought AIDS didn't happen to people like her, a conservative middle-class housewife. Had her husband been unfaithful? It didn't matter anymore. Both of them were going to die ...

FOR SALE IN INDIA AND NEPAL ONLY

**Fig. 3.1** Cover page of *India Today* issue featuring AIDS in middle-class households (Living Media)

The article feeds into popular anxieties of "crossover" through porous borders: "the killer that prowled red-light areas and seedy highway *dhabas* is now stalking bourgeois neighbourhoods and beginning to attack conservative households". No longer confined to the deviant margins – "prostitutes, homosexuals, drug addicts, truck drivers and migrants" – the new transmission chains are "striking at the very core of Indian society" (Baria 1997, p. 102). This core, moreover, is identical with the nation as its valued citizenry: "Specialists are grappling with the national implications of Sunita's private hell" (Baria 1997, p. 102). The virus is imagined as a predator, prowling and stalking, a "silent killer [that] emerges from the shadows" and sneaks "into our backyard"(Baria 1997, pp. 108, 105). Epidemic disorder is imagined as the confounding of distinctions between spaces proper to disease and the clean spaces of urban middle-class households. It reinscribes within the national space the myth of foreign origin and surreptitious border-crossings, in an allegory where the middle-class family, Indian society's "very core", synecdochically represents the nation and *dhabas* and brothels the "outside." The cause of disorder is twofold: the pathogenicity of a virus that does not respect boundaries and the collapse of moral order: "the old concepts of middle-class morality are breaking down" (1997, 103). In other words, disorder is allegorized as the outcome of both spatial and moral transgressions. The dramatis personae of this national allegory of disease comprise the men who bring home disease through sex with prostitutes or promiscuous colleagues and their wives who fall victim to it. On the one side are Rajesh, Thomas Daniel, Raghuram and Sunjay Batwal:

> People consumed by guilt and haunted by fear. It is a private purgatory: confiding in your family can make you a pariah, confiding in colleagues may cost you your job, there are virtually no professional counsellors. And the end, when it comes, is ignoble. (Baria 1997, p. 108)

On the other side are the wives they infect but who patiently bear their suffering. They are the "heroines" of this tragedy of familial loss: "Betrayed by their husbands, often condemned by their in-laws for a crime they did not commit, they still find the strength to forgive, nurture and fight for their doomed families" (Baria 1997, p. 108). The way the epidemic is narrated, drawing on tropes of disorder, collapse of boundaries, suffering and loss, constitutes its "reality" in the social imaginary of disease.

An infectious disease epidemic signifies disorder at various levels, medical, moral and political. It throws into disarray the healthcare system by making unprecedented and inordinate claims on its resources. Where health is predominantly understood as personal responsibility, vulnerability to infection signifies a failure of bodily, mental and moral self-discipline. It is also a challenge to the state's ability to govern effectively in times of crisis, in ensuring the well-being of its subjects. Early responses to the AIDS epidemic, therefore, range characteristically from denial to hasty assessments of risk, calls for increased self-discipline and the reordering of personal and collective lifestyles, coercive measures on the part of the state and identification of individuals and groups perceived to pose a threat. The media disseminate these strategies of social reordering, in their attempt simultaneously to assure the public and create moral panic. Representations of HIV/AIDS and HIV-positive people in the Indian media in the first decade of the epidemic reflected these characteristics. While this did not check the spread of epidemic – on the contrary, it increased it by driving underground those already infected – it resulted in unprecedented discrimination, abuse of civil liberties and stigmatization through moral policing (Lawyers Collective 2003, pp. 1–19). Epidemiological classification of risk groups, a necessary strategy, had the unintended effect of increasing stigma, as those identified as being at higher risk were themselves understood to be a risk to the health and morals of others. The most stigmatized categories were sex workers, both male and female, truck drivers and migrant labourers.

Stigma, which literally means a mark made by branding, functions as a mechanism of social control by identifying and discrediting those guilty of transgression. It is a means by which societies lay down norms of conduct and may be directed against individuals, their families or even the social groups to which they belong. The sources of stigma may be moral, juridical or medical, and in some cases, as in leprosy and AIDS, a combination of all three. Thus, in nineteenth-century India, the leper was understood as immoral, the stigmata of leprosy being the outward sign of his "uncleanness"; the Lepers Act of 1898 criminalized the pauper leper, who could be arrested if found on the streets and sent to a leper asylum; and medical assumptions of contagion, which were by no means scientifically established, reciprocated and rationalized both moral and legal stigmatization. Likewise, in *Mr. X* versus *Hospital Z* (1998), the Supreme Court of India ruled that persons with AIDS have no right to marry, marriage being a bodily as well as moral relationship, and if they do marry and transmit their infection to their wives, they would be guilty of criminal offence under Sections 269 and 270 of the Indian Penal Code. In such cases, the decision on who is to be stigmatized and socially excluded vests primarily in the medical authority, medicine being, as Foucault puts it, "*an instance of social control*": "The doctor becomes the great adviser and expert, if not in the art of governing at least in that of observing, correcting, and improving the social 'body' and maintaining it in a permanent state of health" (Foucault 2000, pp. 98, 100). But for it to be effective, it must be a juridical decision as well, as it involves the question of fundamental rights. In the social exclusion of those stigmatized on account of disease, we see a convergence of morality, medicine and the law.

Stigma, therefore, is a symbolic structure of social ordering that ensures conformity to norms of conduct, with implications for both how others view the stigmatized and how the stigmatized view themselves. According to Erving Goffman, stigma marks the gap between expectations about persons, their "virtual social identity" and their "actual social identity". Operating in this gap, it creates "spoiled identity" (Goffman 1963, p. 12).

> By definition,… we believe the person with stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class. (Goffman 1963, p. 15)

Corollarily, in the person stigmatized, it produces a sense of social inferiority, what Sander Gilman calls "self-stereotyping," or the internalization of "otherness". "The reality behind the image … is not at the heart of the matter. Rather it is the acceptance, for any number of reasons, of the projection of the Other as at least an aspect of self-definition" (Gilman 1988, p. 6).

## 3.4 Imag(in)ing the "AIDS Victim"

The visuals accompanying media articles on AIDS constitute an important source of the meaning of disease. In his 1964 essay, "Rhetoric of the Image," Roland Barthes explained the process of visual signification as involving two levels of denotation and connotation: "the literal image is *denoted* and the symbolic image *connoted*" (Barthes 1977, p. 37). The denoted image presents the object as real, especially when the image is a photograph. While hand-drawn images make obvious the conventions that they follow (perspective, pencil lines or brush strokes, style, etc), photographs are assumed to depict reality directly through the mechanical apparatus of camera:

> In the photograph – at least at the level of the literal message – the relationship of signifieds to signifiers is not one of 'transformation' but of 'recording', and the absence of a code clearly reinforces the myth of photographic 'naturalness': the scene *is there*, captured mechanically, not humanly (the mechanical is here a guarantee of objectivity). (Barthes 1977, p. 44)

The power of photography as evidence, thus, lies in the unquestioned belief that it is a "true" record of reality, what Sturken and Cartwright call "the myth of *photographic truth*". Photography as a veridical technique, or a technique of truth-telling, was a product of nineteenth-century Western positivism and its emphasis on visual objectivity: "In the context of positivism, the photographic camera was taken to be a scientific tool for registering reality and was regarded by its early advocates as a means of representing the world more accurately than hand-rendered images" (Sturken and Cartwright 2001, p. 17). The photographic image thus came to be an important component in at least two kinds of texts that presumed to tell the truth: scientific, especially biomedical, writing and journalism.

Barthes' point is that the realism of the photographic image is the result of a visual coding system that opposes painting to photograph, thereby obscuring the role of camera techniques – angle, focus, composition, etc. – and techniques of printing. In other words, the denotative sign itself connotes a meaning and value that equates photography with truth. In addition to the denotative sign, the image connotes meanings that are coded not individually but with reference to the repertoire of images specific to a culture and which relate to its dominant ideology: "The common domain of the signifieds of connotation is that of *ideology*, which cannot but be single for any given society, no matter what signifiers of connotation it may use". The "rhetoric" of the image, by which he means the set of connotators, thus expresses the "signifying aspect of ideology" (Barthes 1977, p. 49). In images of disease, visual rhetoric is structured on norms of health that devalue disease as deviance and stigmatize diseased persons.

The visuals accompanying articles on AIDS in the Indian media in the early years of the epidemic connoted a range of interlinked meanings attributed to HIV-positive people: fear, isolation, shame, loss of dignity, etc. An *India Today* story about a migrant worker from Chucher in Uttar Pradesh, Govind Singh, carries a

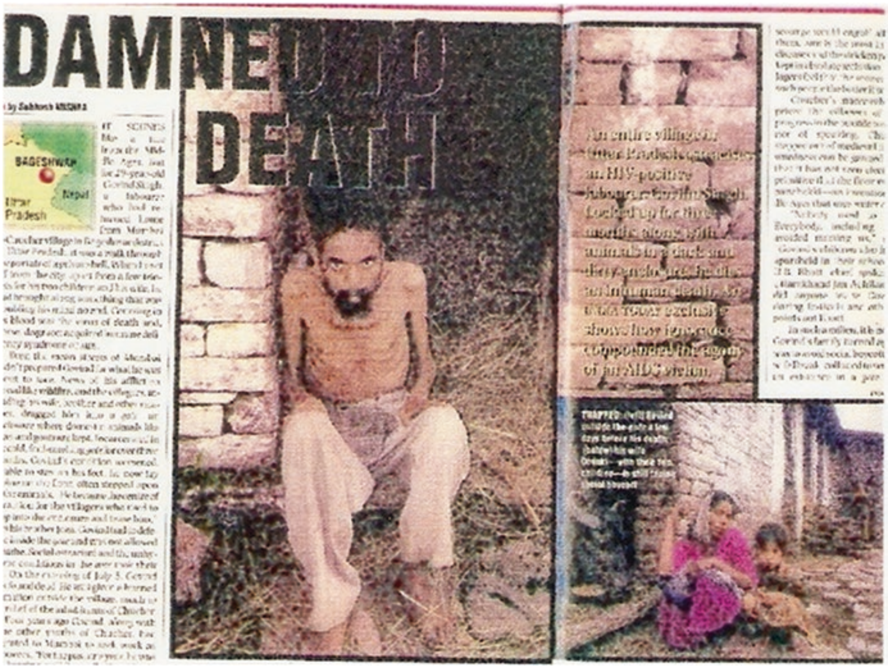


**Fig. 3.2** *India Today* picture showing Govind sitting outside the cowshed (Living Media)

picture (Fig. 3.2) of him sitting huddled in a “cold, foul-smelling *gote*” or enclosure for domestic animals where he was confined till his death (Mishra 2000).

The article, which is about misconceptions that lead to stigmatization of HIV-positive people, visually reproduces the stigma that it is supposed to allay. The text presents Govind’s world in stark contrast to that of *India Today*’s middle-class readership: “Chucher’s inaccessibility have [sic] deprived the villagers of the light of progress in the outside world. In a manner of speaking, Chucher hasn’t stepped out of mediaeval times. Its backwardness can be gauged from the fact that it has not seen electricity. It is so primitive that the flour mill is run by a panchakki – an invention of the Middle Ages that uses water current” (Mishra 2000). The visual highlights this contrast, by connoting disease in terms of ideologically constructed differences of economic status, cleanliness and dirt, dignity and abjection, felicity and pathos. The differences serve to underline the distance between the reader and Govind even as the visual and text try to elicit sympathy. A *Sunday* report (Ali 1991) on the epidemic in Northeast India shows a young man in jail, hiding his face against a wall scribbled with messages about AIDS (Fig. 3.3). Like the earlier picture, this also connotes the sense of shame and isolation that HIV-positive individuals are assumed to experience, underlining their status as “victims”. The denotative meanings serve to naturalize the connotations as the “reality” of being seropositive, in a fatalism attributed to stigmatized terminal diseases. A picture of an HIV-positive

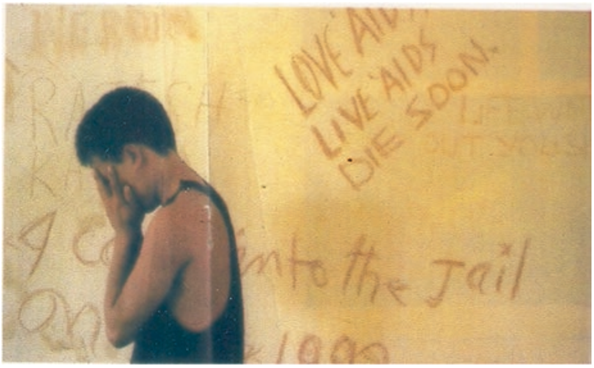


**Fig. 3.3** *Sunday* picture showing intravenous drug user confined in a rehabilitation home (ABP Group)

**Fig. 3.4** *India Today* picture of Lata Batwal with her children (Living Media)

widow, Lata Batwal, and her children accompanying the *India Today* cover story discussed above uses lighting and silhouette to connote the loneliness and suffering of the “AIDS victim” (Fig. 3.4).

Unlike the other two images, however, that of Lata Batwal emphasizes not difference but the sameness of a middle-class domesticity “invaded” by the virus. Taken together, these images of AIDS narrate the spread of epidemic from the “otherness” of high-risk groups and their habitats (slums, jails and de-addiction centres, brothels) to the general population, thus supplementing the moral panic that the stories both incite and seek to allay.

Given the fear that it arouses, images of disease serve the function of discursively isolating and containing pathogenic spaces. They visually connote the boundaries between the presumably healthy viewers and diseased individuals, through techniques of composition and framing. According to Sander Gilman, this is one of the chief objectives of disease iconography:

> Disease, with its seeming randomness, is one aspect of the indeterminable universe that we wish to distance from ourselves. To do so we must construct boundaries between ourselves and those categories of individuals whom we believe (or hope) to be more at risk than ourselves. (Gilman 1988, p. 4)

Thus, pictures accompanying the early media stories of AIDS in India emphasized the otherness of diseased spaces – brothels, slums, remand homes, AIDS wards, etc. – constituting a repository of images that shaped social understanding of who gets AIDS and how. The pictures of Lata Batwal and other middle-class "AIDS victims" accompanying the *India Today* cover story dissolve the connotations of distance, with two main effects: compassion for those we perceive as same but less fortunate than ourselves and fear that we too may be at risk. They also seek to redefine the "AIDS victim", from one who has deserved victimhood to that of undeserved suffering – corresponding to the shift in media stereotypes from the "guilty" to the "innocent" as AIDS came to increasingly affect middle-class housewives and their children.

The visuals were the most widely used techniques for imagining and constructing a "victimology" of AIDS, with virtually every article supplementing text with pictures. Apart from standard journalistic practice – "a picture is worth a thousand words" – the image has a greater ability than text to connote pathos in a manner that appears direct and unmediated. Media images of HIV-positive people juxtapose compassion and stigmatization in a linked antithesis through the figure of the "AIDS victim," which is how persons with HIV/AIDS are popularly designated. The term "victim", first, constitutes them as passive objects of compassion; second, it entails a distinction between the "guilty", who are held to be responsible for their condition because of sexual promiscuity or drug abuse, and the "innocent", who are not responsible for their infection but have acquired it through transfusion of blood or blood products, such as haemophiliacs and thalassemics, or from their spouses. While the latter become legitimate objects of compassion, the former are stigmatized. The term "AIDS victim", in other words, expresses a "patronage that simultaneously grants "victims" powerlessness and then assigns them blame for that powerlessness" (Grover 1988, p. 30). The slippage between compassion and stigmatization is evident in an AIDS awareness poster that we will discuss in a later chapter, about a fictitious child prostitute called Mehr-un-Nisa: what begins as compassion for this "AIDS victim" subsequently transforms her into a victimizer who infects others. On June 13, 2004, *The Times of India* carried a report titled "AIDS Victim Knocks HC Door for Justice", about one Annapurna Maharana who was duped by her lover and sold to a brothel, subsequently rescued and returned to her village where she was repeatedly raped by several men.

> A distant relative allegedly raped her several times. She then went to her uncle's house in Chakraghunathpur village of Kendrapara district. But her troubles did not end there. Annapurna's uncle Pravat Kumar Das allegedly sold her off to one Penga Das of Rukuit village. After raping and torturing her for three months, Penga Das reportedly tried to kill her by dousing her with kerosene. However, she managed to escape and has since been running from pillar to post to get help.
>
> According to officials of the district AIDS cell, the woman is an AIDS patient and has infected several people who had physical relations with her. The district AIDS cell will collect blood samples of the infected villagers of Chakraghunathpur and Rukuit to test whether they are afflicted with AIDS or not (*TOI* 2004).

The report gives two sharply contrasted views of Annapurna, as victim of both a fatal disease and predatory men and as a victimizer who infects "several people who had physical relations with her”. The fact that she is HIV-positive is given far more emphasis than the crimes committed against her – abduction, rape, torture and attempt to murder (Das 2011, pp. 23–24). As stereotypical “AIDS victims”, Mehr-un-Nisa and Annapurna serve as figures for a rhetoric of compassion that simultaneously constitutes them as human and alienates them from their presumed humanity.

## 3.5 Conclusion

Media representations of HIV/AIDS in the early years of the epidemic emphasized the foreign origin of the disease, both as a way of denying its impact in India and constructing a paradigmatic national self as moral and therefore immune to infection. Two origins were attributed to HIV/AIDS, drawing on already existing stereotypes in the Western media. One was that the epidemic originated among homosexual communities in America and Europe. As the early cases of HIV infections were detected in gay men, a homophobic public discourse attributed the disease’s origin to them. Subsequently, when HIV disease was found among heterosexuals in several African nations, speculations emerged about a possible zoonotic origin in a species of monkeys, transmitted to humans by consumption of their meat and spread through sexual promiscuity and scarification practices held to be common to such cultures. Out of these speculations, the Western media created the myth of African AIDS, reactivating colonialist stereotypes of the diseased tropics. Following these “leads”, the Indian media in the first years of the epidemic attributed its origin either to a homosexually promiscuous West or to a primitive Africa, to confirm the government’s claim that the disease was not indigenous and, given the conservative nature of our society, would not spread. But when this was no longer tenable with increasing numbers of people testing positive, the media responded by stigmatizing certain behaviours and the “risk groups” to which they were attributed, such as sex workers, hijras, homosexuals, migrant labourers, truck drivers and intravenous drug users, irrespective of whether they were infected or not. Stigma and the moral panic that it occasioned had a reciprocal relation to the coercive measures implemented by the state: the public health and legal measures reinforced stigma by socially excluding the HIV-positive, while the stigma of being infected and potentially infecting provided ideological justification for the measures taken. Since most people acquired their first impressions of the epidemic from reports in the media, these became the founding sources of their knowledge about AIDS. This was true not only of laypersons but also of medical practitioners, who, with the exception of a few more familiar with the disease, perpetuated the stigma against the HIV-positive by refusing to treat them or admit them to their wards (Chaudhuri 2008; Jain 2002, pp. 200–203). The early media accounts of the epidemic reveal a number of important characteristics.

(i) The first was a denial of the epidemic as indigenously transmitted, attributing it to others, either foreign nationals or marginalized groups within the country, who were then blamed for spreading the infection. This followed a pattern of constructing cultural difference that Hayden White calls "ostensive self-definition by negation": "In times of sociocultural stress, when the need for positive self-definition asserts itself but no compelling criterion of self-identification appears, it is always possible to say something like: "I may not know the precise content of my own felt humanity, but I am most certainly not like that" and simply point to something in the landscape that is manifestly different from oneself" (White 1978, pp. 151–152). This negative self-definition, directed against both those who inhabited fringe socio-economic groups and those who emulated "Western" ways, resulted in the setting up of discursive boundaries between the diseased and the presumably healthy middle-class households.

(ii) They were based on moral distinctions that held disease to be a sign of deviance, the outcome of pleasure-seeking behaviours that transgressed social norms. Risk-group classification, a necessary epidemiological strategy to control transmission, coincided with already existing patterns of stigmatization, especially concerning sex workers, homosexuals and transgenders, drug users, truck drivers and slum dwellers. Thus, state measures through regulation and law, public health discourse and popular notions of morality and deviance came together in intensifying stigma. As Rao contends, this had an impact on the early pedagogic initiatives undertaken by the National AIDS Control Organization, which focused on teaching people to be morally conservative, avoid sex with prostitutes and strengthen family values instead of effective promotion of condom use (Rao 2017, p. 203).

(iii) In popularizing risk-group terminology, media reports conflated risk as vulnerability to disease with risk as danger, thereby justifying the exclusion of the HIV-positive and the violation of their fundamental rights to freedom and equality. As we will see in Chap. 5, this conflation was reflected in a number of court judgments which ruled that statutes to isolate infected individuals and restrict their freedom of movement were constitutionally valid in the name of a greater public good. It is not that the media reports fed directly into the court decisions, but they constructed ways of "knowing" AIDS that influenced judges' understanding of risk and danger.

(iv) A major concern in the media reports, though rarely stated as such, was the preservation of social order, in which disease was held to be disruptive. As Mary Douglas has argued, ideas of social order are founded on classification systems that symbolically organize our cultural world: "Culture, in the sense of the standardized values of a community, mediates the experience of individuals. It provides in advance some basic categories, a positive pattern in which ideas and values are tidily ordered" (Douglas 1966, p. 48). Thus, things are perceived to be dirty, unclean or polluting if they are not in the place assigned to them as proper: shoes on the dinner table, food on the floor or mud on clothes instead of the ground. This symbolic system organizes our ideas of physical and moral cleanliness as well as the cleanliness promoted by hygienic theory. Media accounts, therefore, recurrently distinguished between middle-class households, understood as spaces of health and hygiene and the slums and brothels held to be spaces where disease is rampant and where it must be confined. Hence the intense anxiety when middle-class housewives start testing positive for HIV, thus exposing, as Farah Baria put it in her 1997 cover story in *India Today*, the "very core of Indian society" to the virus and creating a "private hell" which, because it affects the core, has "national implications". Media reports represented the "disorder" of disease through a double technique, on the one hand allaying fears of the virus's spread and on the other intensifying anxieties of its "crossover" from the slums and brothels to middle-class households.

(v) A major way in which the epidemic has been problematized in both public discourse and pedagogy concerns the "truth" of AIDS. Pedagogic texts, as we will see in Chap. 6, characteristically differentiate between the "facts" and "myths" of the disease, and knowledge is promoted as crucial to its prevention. AIDS is a problem because it is difficult to know its truth, even with advances in biomedical research. If to fully know a disease is to find a cure or a vaccine for it, AIDS is still unknown territory. The promotion of knowledge about HIV in pedagogic campaigns, therefore, may be seen as an attempt to contain and delimit its epistemological uncertainty. The early media reports tried to do this discursively through a veridical technique that became a characteristic of AIDS reporting: the citing of expert medical opinion to buttress what could otherwise be dismissed as mere opinion. Instances, as we have seen, include moral ideas of "crossover" presented as medical facts or the notion that poverty and filth predispose one to AIDS. Pictures of doctors and researchers in white coats, examining patients, drawing blood for tests and doing lab work, served as visual equivalents of the citations. Finally, statistical figures are used to confirm apprehensions of spread, even as these projections and estimates are held to be questionable.[8] Thus, a range of discursive veridical techniques was used by the media to establish the "truth" of AIDS and thereby to construct the epidemic as a serious medical, social and moral problem.

Simultaneously as the Indian media reported the epidemic in stereotypical ways derived largely from the Western media and carefully selected quotes from Indian medical authorities, in accordance with dominant moral assumptions of disease and diseased people, it also reported aspects of the epidemic that were to have a positive impact on pedagogy. It brought to public attention instances of discrimination and human rights abuse, though most such reports appeared later when AIDS was no longer understood to be a contagious disease and a threat to the public (Mander 2002; Ray 2004; Karkaria 2005). It was around this time that pedagogic initiatives started focusing on countering discrimination and stigma. In 2003, a joint publica-

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[8] See, for instance, Sarkar and Ganguly 2004; Pandey 2005; *TOI* 2005; TNN 2005.

tion of UNAIDS, World Health Organization and the Office of the United Nations High Commissioner for Human Rights distributed in India a booklet produced for African countries titled *HIV/AIDS: Stand Up for Human Rights* that addressed the issue of stigma. In 2007, UNAIDS co-produced with the Border Security Force a film titled *Saavdhaan*, which included among its several themes the problem of discrimination against the HIV-positive. In 2012, the fourth phase of the National AIDS Control Policy formalized the inclusion of this issue as a core thrust area for pedagogic interventions called "Reducing stigma and discrimination through Greater involvement of PLHA[9] (GIPA)" (NACO 2017, p. 11). In the first decade of the epidemic, the media widely reported infections acquired through contaminated blood: though most were about "innocent" versus "guilty victims", some emphasized the need to ensure safe blood supply. Thus, Thapa and Rattanani's article in *India Today* was a detailed account of the state of blood banks in the country, the reasons for neglect in ensuring blood safety and the steps that need to be taken (Thapa and Rattanani 1995). When the first National AIDS Control Policy was implemented in the mid-1990s, blood safety was a major component, and pedagogic initiatives advised people to insist on AIDS-free blood.

Media accounts of AIDS, therefore, did not merely describe the event of epidemic: they constituted a discursive field that determined how HIV and HIV-positive people came to be understood and what social responses were deemed appropriate. By terming these an "incipient pedagogy", I wish to emphasize their importance for the emergence of formal methods of public health education. It was in response to these early notions of disease, either in continuity with their underlying assumptions or more often in seeking to refute them, that AIDS awareness campaigns were subsequently evolved. They do not thereby constitute a pedagogy, as their intended objective is not to teach people but to provide news. But by considering them as *incipient* pedagogic sources, we take a broader view of how people are taught about disease in ways not restricted to institutionalized pedagogies and their formal contexts of implementation.

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[9] Acronym for "Person Living with HIV/AIDS".

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# Chapter 4
# Incipient Pedagogy (II): AIDS Narratives

**Abstract** This chapter examines written and cinematic narratives of AIDS in India, many of which were linked to pedagogic projects. It brings out the diverse ways in which HIV/AIDS was understood as a medical, social, ethical and juridical problem in popular discourse. Many of these narratives focus on the subjective experience of disease as illness, thus engaging the disease/illness polarity to show how it can either perpetuate the idea of disease as personal devastation or resist it through collective biosocial formations like the PLWHA movement.

**Keywords** Disease/illness · Disease cartographies · Illness narratives · Biosociality · PLWHA · Vulnerability

By 2000, it had become evident that AIDS had reached epidemic proportions in India and could no longer be dismissed as a foreign disease.[1] Neither was it possible, with large numbers of presumably conservative middle-class men and women testing positive, to dismiss it as a disease of deviants and the poor. Its social consequences in terms of stigma, discrimination and human rights abuse also came to be more widely recognized as factors in its spread. Not that the stereotypes and their negative effects disappeared entirely, but they came to be increasingly questioned. It became imperative to see AIDS as a problem concerning society in general and therefore deserving a wider concern than had so far been accorded. This was perhaps why AIDS, which had been of marginal interest and confined to reports in the media, could become a topic of narrative representation. The present chapter discusses selected written and cinematic narratives of AIDS as symptomatic of shifts in the continuing construction of the epidemic as a social rather than medical issue.

We can identify in these narratives a number of common characteristics, which relate to changes in the way they represented the epidemic. Firstly, they are produced by people who are themselves uninfected and are addressed to people who are presumably also uninfected, all of them belonging to a middle class that has the cultural resources to produce and access narratives. This is an important factor, as it influences the way the epidemic and those affected by it come to be viewed.

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[1] The estimated number of HIV-positive cases in 1990 was 0.2 million, which by 2000 had increased to 3.86 million, that is, by about 20 times (NACO 2004, p. 16).

D. K. Das, *Teaching AIDS*, https://doi.org/10.1007/978-981-13-6120-3_4

Secondly, while they continue to address epidemiological issues like incidence and spread of epidemic disease, the focus shifts to social issues such as the economic and gender disparities that increase chances of infection, stigma and discrimination against HIV-positive individuals and legal implications. These two characteristics – the privilege of a largely unaffected middle class to represent the epidemic and social concern about those affected – lead to a third key characteristic, the interpellation of the addressee as compassionate subject, inspired by ideals of social justice. Since AIDS was still not seen as a serious threat for those outside the designated risk groups – sex workers, migrant labourers, intravenous drug users, truck drivers and gay men – the only way in which the reader could be addressed and recruited into the narrative was through compassion. Fourthly, the narrativization of the epidemic marks a shift from ideas of disease as objective condition to the subjective experience of illness, a distinction that we will examine shortly. One effect of this is that the focus turns away from the scale and spread of the epidemic to life stories of HIV-positive individuals, their families and caregivers. The epidemic came thus to be constructed in ways quite different from those of the media representations of the first decade. The shifts in representation coincided with a change in epidemic control strategies from coercive intervention to pedagogy, as campaigns on AIDS prevention through awareness and behaviour change, non-discrimination against HIV-positive people and recognition of their rights assumed priority. Some of these narratives, as we will see, were either commissioned by pedagogic projects or subsequently sponsored by them, and the creation of awareness was an integral component in all. No doubt these changes were more humane and progressive in terms of social justice, but they also enabled an extension of power over larger populations, targeting both those perceived to be at risk and those who were not themselves at risk but needed to develop tolerance and compassion. They reveal what Foucault called the medicalization of modern societies, the way in which health and disease have become issues of paramount sociopolitical, legal and cultural concern both nationally and globally.

## 4.1 Disease Versus Illness

Disease and illness refer to the same phenomenon of bodily dysfunction and are often understood to be synonymous. Medical anthropology, however, makes a distinction between the two terms, as both explanatory paradigm and approach to patient care. Disease is understood as the biological process that results in organic dysfunction, while illness is the subjective perception of this process. Disease, in other words, is what the doctor diagnoses based on signs and symptoms, while illness is what the patient experiences:

> In the scientific paradigm of modern medicine, disease refers to abnormalities of the structure and function of body organs and systems. Diseases are the named pathological entities that make up the medical model of ill-health … and which can be specifically identified and described by reference to certain biological, chemical or other evidence…. Illness refers to

> the subjective response of the patient to being unwell; how he, and those around him, perceive the origin and significance of this event; how it affects his behaviour or relationships with other people; and the steps he takes to remedy this situation…. It includes not only his experience of ill-health, but the meaning he gives to that experience. (Helman 1981, p. 548)

Further, the concept of disease refers to the affected body part or system, while illness refers to one's perception of the whole person as embodied entity. This is what it means to say that illness perceptions are personal or subjective. Helman emphasizes the fact that disease and illness are not distinct phenomena, but overlapping "ways of constructing reality, of imposing meaning on the chaos of the phenomenological world" (Helman 1981, p. 548).

The disease/illness binary is an explanatory paradigm that has emerged and gained significance in the context of institutionalized biomedical practice and is perhaps not so relevant to medical practices in other systems and traditions. Its epistemological foundation is the notion of objectivity that underlies empirical science – the privileging of "evidence" and devaluation of subjective perception in a "disease" perspective and, corollarily, the view that such objectification is dehumanizing in an "illness" perspective. For those who subscribe to ideas of illness, the gap between the two perspectives is understood as leading to gaps in communication that adversely affect the doctor-patient relationship. As a practising physician, therefore, Helman believes that general practitioners should "be aware of how the perspectives of the lay and medical models of ill-health differ and should recognize the clinical implications of these differences" (Helman 1981, p. 551). Similarly, Arthur Kleinman argues that this divergent construction of health disorder is built into the institutional ideology of modern biomedicine, which does not accord legitimacy to the patient's suffering:

> … biomedicine presses the practitioner to construct *disease*, disordered biological processes, as the object of study and treatment. There is hardly any place in this narrowly focused therapeutic vision for the patient's experience of suffering. The patient's and family's complaints are regarded as *subjective* self-reports, biased accounts of a too-personal somewhere. The physician's task, wherever possible, is to replace these biased observations with *objective* data: the only valid sign of pathological processes, because they are based on verified and verifiable measurements…. This is a view from a depersonalized nowhere. Thus, the doctor is expected to decode the untrustworthy story of *illness as experience* for the evidence of that which is considered authentic, *disease as biological pathology*. (Kleinman 1995, p. 32, italics in original)[2]

The doctor's inattention to the patient's suffering is a theme often expressed in the narratives that we will discuss, which emphasize the illness dimension of AIDS rather than disease. If the narratives construct an ideal reader who is compassionate, the shift from disease to illness is crucial to that construction.

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[2] The critique of biomedical practice in Kleinman and Helman is influenced by insights that they draw from ethnography, which privileges subjective accounts over impersonal facts. Cecil Helman was a practitioner of family medicine as well as trained anthropologist and held academic positions in both disciplines. Arthur Kleinman is both a psychiatrist and professor of medical anthropology.

## 4.2 Representing Disease and Illness

Disease refers to a condition or state of the body, while illness refers to an experience. As such, the generic forms by which they are represented differ, more so in the context of epidemic. The ideal form for representing epidemic as disease is the map and survey, while that for representing epidemic as illness is the life narrative. In the nineteenth century, cartographic techniques were used in mapping areas of disease, linking pathogenicity with population, climate, vegetation and topography. The first disease maps made were perhaps of the plague epidemic in Bari, Naples, in 1690–1692, included in a report by the provincial administrator Filippo Arrieta (Koch 2005, pp. 19–24). But the most well-known instance was the mapping of cholera that John Snow undertook during the outbreak in Soho, London, in 1854, by which he was able to link incidence and spread of cholera to the water supply system (Koch 2005, pp. 75–103). It was only after the advent of germ theory in the mid-nineteenth century that medical mapping became a major genre of representing disease and a tool of public health governance. Mapping was understood to be a scientific method of linking discrete disease incidents to a topographical context, thereby reducing the aleatory nature of epidemic phenomena – in short, a way of ordering the disorder of disease. A form of writing about disease that coincided with mapping in both time and perspective was the medical topographical survey. A number of such surveys of disease distribution were published in the nineteenth century by European doctors stationed in India, such as James Johnson's *The Influence of Tropical Climates, more especially the Climate of India, on European Constitutions* (1813) and James Ranald Martin's *Notes on the Medical Topography of Calcutta* (1837) (Arnold 1993, pp. 23–27; Arnold 2005, pp. 47–49). The topographical survey served the same function as the maps of disease: by identifying disease locations and densities of occurrence, it provided a discursive means to both assess the situation and gain control over it. Illness, in contrast, is best represented in the form of narrative, as Richard Gwyn writes: "We fabricate and endorse beliefs about health and illness continually through discourse, out of the stories that we tell one another and the stories that we hear from those around us" (Gwyn 2002, pp. 17–18). If the map and the survey reduce the aleatory nature of epidemic outbreak, stories try to make sense of the random suffering that illness causes.

What is the difference between the map and the narrative as representational forms? The map privileges spatiality, the state of disease at any given point of time, and the history of shifts in epidemic patterns are accessible only by comparing maps drawn at different times – as was done, for instance, in mapping the patterns of cholera outbreak in colonial India (Koch 2005, pp. 300–301; Gilbert 2003, pp. 113). Narrative, in contrast, privileges temporality, for it transcribes *changes* of state through linkages that are both causal and chronological. As with map and history, so too with narrative and spatiality: space and time are the fundamental correlates of both representations, but the emphasis differs. Maps are oriented towards the construction of space, while narratives are oriented towards the construction of time. A further distinction can be made between map and narrative. Like the biomedical concept of disease, the map is a construct based on objective data – numbers, densities and coordinates. Like the lay concept of illness, what narrative recounts is experience and subjective response to the world – if events are what constitute the movement of the story, its plot, the subjective responses of the characters are what imbue the events with meaning. The concept of illness, as Cassell writes, involves the whole person: "Disease … is something an organ has; illness is something a man has" (as cited in Helman 1981, p. 548). As such, therefore, narrative with its emphasis on the character's experience in time is the most appropriate form for representing illness.

Phenomenology holds that personal experience is always understood as temporal. As Maurice Merleau-Ponty puts it, "all our experiences, inasmuch as they are ours, arrange themselves in terms of before and after, because temporality … is the form taken by our inner sense" (Merleau-Ponty 1962, p. 476). In the *Phenomenology of Perception*, Merleau-Ponty conceives of life as the field of presence of the body, where the subject exists as an embodied consciousness. It is the present moment of perception in relation to which one understands past and future, memory and anticipation, in the subjective experience of time. If on the one side temporality is linked to experience, on the other it is linked to the subject, this double linkage being what makes life appear coherent both as individual existence and collective or social being:

> As my living presence opens up a past which I nevertheless am no longer living through, and on a future which I do not yet live, and perhaps never shall, it can also open on to temporalities outside my living experience and acquire a social horizon, with the result that my world is expanded to the dimensions of that collective history which my private existence takes up and carries forward. (Merleau-Ponty 1962, p. 503)

Arguing from St. Augustine's concept of a threefold present – the coexistence in our consciousness of a present of the past that we remember, a present of the present that we attend to and a present of the future that we anticipate – Paul Ricoeur holds that narrative is the archetypal form in which the experience of life can be imagined: "The entire province of narrative is laid out here in its potentiality, from the simple poem, to the story of an entire life, to universal history" (Ricoeur 1984, p. 22). It is not coincidental, therefore, that stories of illness, whether they are the accounts rendered every day in the clinic or the memoir of one's suffering, are the only ways in which the experience of illness can be represented – and the only way in which one's illness can be made real to others and vice versa.

## 4.3 The Disease Travelogue: *Sex, Lies and AIDS* and *Positive Lives*

Cartographies of disease and narratives of illness: the biosocial phenomenon that we understand as disease/illness is predominantly represented and constituted in these two generic forms. A genre of narrative that combines both the cartographic imagination of space and the narratological imagination of temporal experience is the disease travelogue, to which belong the first two narratives that we will examine, Siddharth Dube's *Sex, Lies and AIDS* (2000) and Kalpana Jain's *Positive Lives* (2002). Both construct their accounts of the epidemic around the trope of travel, combining the exploration of disease landscapes with life stories of HIV-positive individuals. Jain's narrative is about a journey that she undertook in 2001, covering 15,000 km in 4 months, to report on the epidemic. Dube's book may not actually describe a journey, but the idea of journey functions as a recurrent metaphor. *Sex, Lies and AIDS* opens with the metaphor, which is repeated over the next few pages: "this book is a romp through sex in today's India, a serious journey towards understanding AIDS" (Dube 2000, p. 1). "The best journeys are taken with a trustworthy guide. I promise to be this for you" (Dube 2000, p. 3). "All journeys have a purpose, or more than one purpose. This journey has three…. to understand how we can protect ourselves…. to understand why India is today suffering from a severe and worsening epidemic of HIV/AIDS…. to see what the government and we can do to prevent India from slipping into a catastrophic epidemic of HIV/AIDS" (Dube 2000, p. 1–2). The journey also has multiple meanings. "The journey we're going to share is a sexual journey…. Our journey is also necessarily a technical, scientific and medical one…. Our journey is also an exploration of the aspects of Indian society that make the majority of adult Indians, whether poor or middle class or rich, very vulnerable to contracting HIV…. And finally, our journey is an investigation" (Dube 2000, p. 3–6). Jain's journey, which as I stated is literal, is also a "journey of understanding AIDS"; "a journey through life, through our social and economic realities and through our systems of governance and welfare"; an HIV-positive person's "journey, from learning about the infection, to accepting the situation, and learning to live with it"; and the "journey of HIV and its different faces" (Jain 2002, pp. xviii–xix).

In the disease narrative, the trope of travel serves a number of important functions. First, it maps the transmission of disease both spatially and temporally. *Sex, Lies and AIDS* documents the spread of epidemic in the high-prevalence states of Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur, Mizoram and Nagaland and medium-prevalence states like Gujarat, Delhi, West Bengal and Kerala and its emergence in low-prevalence states like Punjab, Himachal Pradesh, Rajasthan, Uttar Pradesh, Bihar and Orissa. It divides the epidemic into three time frames – its origins in 1986–1991, growth in 1992–2000 and future from 2000 onwards. In other words, it presents a chronotopic[3] account of the epidemic, where time and space are merged to suggest its overwhelming scale of disaster. *Positive Lives* records Jain's visits to cities like Chennai, Mumbai, Imphal, Pune and

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[3] The term "chronotope" was introduced by Mikhail Bakhtin in "Forms of Time and of the Chronotope in the Novel", to refer to the way narratives represent the intersection of time and space: "spatial and temporal indicators are fused into one carefully thought-out, concrete whole. Time, as it were, thickens, takes on flesh, becomes artistically visible; likewise, space becomes charged and responsive to the movements of time, plot and history. This intersection of axes and fusion of indicators characterizes the artistic chronotope" (Bakhtin 1981, pp. 84–85).

Visakhapatnam, flashpoints of epidemic like Peddapuram in Andhra Pradesh and Namakkal in Tamil Nadu, remote villages and truck stops along major highways.

The trope of travel also authenticates the narration through personal experience and first-hand observation. “As a health policy specialist and journalist who has worked on HIV/AIDS prevention in India and abroad for over a decade”, writes Dube, “I am probably technically well qualified” (Dube 2000, p. 3). He records the number of trips he has made to different parts of India, Kenya and Uganda, to witness the scale and impact of the epidemic. Jain undertakes her journey across India, “walking through areas that were inaccessible by road” (2002, p. xvi), to personally discover the “reality” of AIDS:

> I wanted to see for myself whether HIV was really spreading as fast as international agencies would have us believe. Initially, I did not believe that the moral fabric of our society would allow for such a spread. But when I travelled to the high-prevalence states of Maharashtra, Karnataka, Andhra Pradesh, Tamil Nadu and Manipur, as also to a state stated to be low in prevalence – Bihar – I was duly shocked at what I found. (Dube 2002, p. xvii)

In travel discourse, journeys function as epistemological and veridical techniques, reliable ways of knowing the truth of the world. While this is true of travel writing at any time, it gained a special significance in European modernity when it coincided with the central paradigm of science, the method of empirical observation. In emphasizing the visual over other ways of knowing, travel writing confirmed the privilege of the ocular in the Western episteme and its realistic aesthetic.[4] In other words, it served as a discursive mode of authentication and truth-telling. Thus, Dube emphasizes the value of unbiased observation in knowing the truth of AIDS in India: “Journeys of discovery require travellers to go forth with open eyes and mind” (Dube 2000, p. 3). “Travel across India with your eyes and mind wide open to its realities”, he urges, “and you will see that there is sex happening everywhere, across its length and breadth, from Kutch to Kohima, from Kashmir to Kanyakumari” (Dube 2000, p. 42). Rhetorically, his narrative emphasizes the visual: the stories of HIV-positive people that he includes are “portraits”; the epidemic grows from “first

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[4] The importance of the visual in European epistemology can be traced to the seventeenth century, with developments in empirical science, theories of perspective in art and the emergence of visual technologies. In *Discourse on Method, Optics, Geometry and Meteorology*, Rene Descartes claimed: “All the management of our lives depends upon the senses, and since that of sight is the most comprehensive and noblest of these, there is no doubt that the inventions which serve to augment its power are among the most useful that there can be” (Descartes 1965, p. 65). Similarly, in his treatise on the circulation of blood, William Harvey claimed in the preface to Dr. Argent, President of the London College of Physicians, that his account was based not on “the tenets of Philosophers” but on scientific facts “for more than nine years confirmed … in your presence by numerous *ocular demonstrations*” (Harvey 1963, pp. 4–7, italics added). Vision, write Marita Sturken and Lisa Cartwright, “is understood as a primary avenue to knowledge and sight takes precedence over other senses as a primary tool in the analysis and ordering of living things” (Sturken and Cartwright 2001, p. 299). According to Foucault, modern clinical practice was premised on the superiority of observation as a source of knowledge: “the privileges of a pure gaze, prior to all intervention and faithful to the immediate, which it took up without modifying it, and those of a gaze equipped with a whole logical armature, which exorcised from the outset the naïvety of an unprepared empiricism” (Foucault 1973, pp. 107).

flames" to a "fire in the tinderbox forest"; Africa's present and India's future are "charred lands" (Dube 2000, pp. 57, 9, 34, 108).

Finally, by juxtaposing landscape and "deathscape",[5] the trope of travel in disease narratives stages the spectacle of disease as unprecedented devastation, in an effect that confirms to its oculocentrism. For illustration, we may turn to a travelogue published in 1901 on leprosy in India, John Jackson's *In Leper-Land*. Jackson was the founder-treasurer of Missionary Pence Association, a charitable organization based in London that financed the work of leprosy missions. *In Leper-Land* is an account of a tour of leper asylums across India that he undertook in 1900, covering 7000 miles across the length and breadth of the country. Jackson's narrative was intended both as a report on the work of the asylums and an appeal to readers for financial support, and appended to it are advertisements seeking contributions. A recurrent feature of the narrative is its juxtaposition of images of exotic Indian landscapes with horrifying images of "tainted" lepers, in an ambivalence that was characteristic of the discourse of colonialism. Thus, he describes the beauty of the Himalayan range seen from the mission at Chandag Heights: "We behold a mighty range of magnificent peaks, clad with eternal snow and projected in bold relief against a sky of indescribable beauty" (Jackson 1901, p. 138). Christaram, the asylum at Purulia, has "a really pretty, pleasing appearance", but Jackson is shocked by the horrible condition of some of its inmates: "I took a number of photos, including one of a man who was decidedly the most painful case to look at that I had so far seen. Both eyes were entirely gone, leaving only empty sockets, and the nose had so sunk in, that the face was flat. The mouth was misshapen, and altogether this was the most terrible face I had yet seen. An old woman also struck me as a sad case. Her teeth were gone and her gums swollen and perfectly black, giving her face a most ghastly look" (Jackson 1901, p. 88). Similarly, the natural beauty of Almora is belied by the horrifying presence of leprosy: "The disease is evidently of a very malignant type in this district, notwithstanding the mountain air. As I studied the congregation we found gathered in the Church of the Asylum on the Sunday afternoon, I realized afresh what a scourge of humanity this dreadful disease is" (Jackson 1901, p. 127). In *Positive Lives*, Jain describes in like manner the scene at the Bel Air hospital for AIDS:

> Panchgani is a picturesque hill resort, 250 km from Mumbai, and a seven-hour-long drive away. In this serene township, nature and man seem to coexist harmoniously. Deeply inhaling its pure clean air, I headed towards my destination, the Bel Air hospital. With its buildings dotting several acres of sprawling green, the place seemed unlike any hospital I had visited…. the initial, overall effect was appealing. Only later did I realize how much sickness and death lay hidden amidst this beauty. (Jain 2002, pp. 19–20)

In the sanatorium at Tambaram, Chennai, she witnesses patients in different stages of suffering: "many have been reduced to bones, a result of the typical wasting

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[5] I take this term from David Arnold's *The Tropics and the Travelling Gaze*, where he uses it to show how it was used by medical travelogues to pathogenically inflect a land already marked by its existence in the tropics. Deathscapes "reinforced this spatial sense of a mortality inscribed on the landscape" (Arnold 2005, p. 42).

syndrome of HIV, a few stare vacantly at the ceiling and some seem asleep, death-like, mouth half-open, and clothes dishevelled" (Jain 2002, p. 190). At the Bel Air sanatorium, "it seemed as though men, women and children were simply waiting for life to end". Throughout her journey, the "death and sickness that I saw sometimes overwhelmed me" (Jain 2002, p. xv). The juxtaposition of landscape and deathscape serves to heighten the spectacularity of disease, making it an object of both horror and fascination. In Dube's *Sex, Lies and AIDS*, too, there is a recurrent fascination with images of disease and death:

> Crores of young and middle aged Indians infected, sick and dying. Thousands from the wealthy and lakhs from the middle class pushed into poverty. Even larger numbers of the low-income and poor driven into destitution. Countless children orphaned. Villages, communities and even entire generations decimated. (Dube 2000, p. 115)

Of the impact of the epidemic in Africa, he writes:

> Neither words nor numbers can describe the horror that HIV/AIDS has created in Africa. The sickness and death inflicted on crores of people. The grief inflicted on their surviving children, relatives and friends…. Take the total of the bombs, deaths and agony of the two world wars, locate them in a single continent, and even that carnage would be dwarfed by that being wrought in Africa by HIV/AIDS. Destruction on this scale defies description, defies comprehension. (Dube 2000, pp. 108–9)

The comparison of AIDS in India with "the hellish levels seen in the worst-hit African nations" (Dube 2000, p. 119) is repeated several times in Dube's narrative. "Africa's present HIV/AIDS-caused hell", he claims, "is very probably India's future" (Dube 2000, p. 115). One reason for this comparison could be Dube's familiarity with the epidemic in Africa, through research trips, workshops and World Bank projects with which he was associated (Dube 2000, p. 109–110). But the more important reason seems to be his unquestioning acceptance of a stereotype of "African AIDS" that was widely circulated in both the international and Indian media. As we saw in the previous chapter, one of the sources of infection was thought to be students from African countries, which led to mandatory testing and their deportation if found positive. More to the point was Nisha Puri's comment, cited in Sect. 3.3, that AIDS was spread by contaminated water, lack of hygiene, poverty, rituals and sacrifices using blood and the prevalence of tuberculosis – all of them conditions existing in "a tropical environment". Dube assumes that the African nations were more susceptible to the epidemic because of illiteracy, poverty and inadequate health services, which may be factually correct. But underlying the assumption is a tropicalization of disease that bears closer analysis.

While geographically the tropics were defined and differentiated physical locations, in cultural discourse, they were homogenized as a symbolic landscape that, along with its humanity, served to distinguish them from an equally homogenized "temperate" world. David Arnold coins the term "tropicality" to refer to "the ideas, associations and practices that congealed around the central idea of tropical difference" (Arnold 2005: 231). If the figure of the "tropics" signified in travel literature the exoticism of Asia and Africa and the plenitude of nature, it signified in medical literature a land of dirt, disease and death, both figurations serving to establish its "otherness" from Europe. The responsibility for such unwholesome qualities was attributed not only to the land itself but to its inhabitants as well, who succumbed to their physical environment instead of subduing and improving it. In *Notes on the Medical Topography of Calcutta,* James Ranald Martin wrote of the insalubrious condition of the city in a passage that is worth quoting at length:

> The soil and the inhabitants … always react on each other. A sober, industrious race of inhabitants, for example, will have a greater desire to improve their country than men of a contrary character, and will also possess greater physical power to carry their desire into execution. Place such a body of men in a district overrun with noxious weeds and timber, and fast degenerating into a morass; and can there exist any rational doubt that they will clear it sooner, and longer preserve it in that improved state, than men of a different disposition? Place in a similar situation, or even in the district thus improved, a body of men who are idle and intemperate, and the immediate result will be, that the soil will deteriorate for want of proper care, the weeds will re-appear, the drains will become obstructed, the edible products of the earth will lessen in quantity, and diminish in their nutritive quality: the inhabitants will become unhealthy from the bad state of their grounds; and the diminution of their physical powers thus produced, will disable them progressively more and more from remedying the causes of evil. Many of these effects will doubtless first be felt in their own persons, but it is undeniable that they must ultimately operate on their visitors. On this obvious principle is founded the axiom of medical cartography "that a slothful and squalid looking population invariably characterizes an unhealthy country". (Martin 1837, p. 45)

For Martin, this served as both indictment of the native population and its habitat and a plea for sanitary improvements to be undertaken by the colonial authorities. Though much of India is not in the tropical zone, its discursive incorporation into the "tropics" was achieved by medical cartographic writing such as Martin's *Notes*. The emergence of tropical medicine as a clinical specialization in the late nineteenth century institutionalized and gave legitimacy to this pathologization of the tropics (Arnold 1993; Curtin 1996; Harrison 1999; Pati and Harrison 2001). Tropical medicine, as Michael Worboys comments, was "shaped by the micro- and macro-politics of British colonial imperialism and its medical politics" (Worboys 1996, p. 199). In the nineteenth century, a whole body of writing, from travel literature to maps and topographical surveys to textbooks, reports and papers on tropical medicine, popularized, circulated and gave credence to the assumption of what we may term a patho-geography of otherness:

> Through their voluminous studies of medicine and illness, doctors and surgeons helped to form and give a seemingly scientific precision to abiding impressions of India as a land of dirt and disease, of lethargy and superstition, of backwardness and barbarity – images which have remained so powerful even in the contemporary understanding of India – and to contrast this Orientalized India with the cool-headed rationality and science, the purposeful dynamism, and the paternalistic humanitarianism of the West. (Arnold 1993, pp. 292)

The reiterated contrasts with Africa in *Sex, Lies and AIDS* are a rhetorical technique to magnify the scale of the epidemic and its urgency, but they also reinforce the negative stereotype of the diseased tropics that was characteristic of colonial discourse and is now characteristic of much First World reporting on AIDS in the Third World (Treichler 1999, pp. 99–126; Watney 1994, pp. 103–20).

We have made a distinction between cartographies of disease and narratives of illness. In this context, *Sex, Lies and AIDS* and *Positive Lives* draw on three distinct representational modes, two of which – travelogue and demography – serve the function of mapping disease, while the third, life story, narrates the subjective experience of illness. *Sex, Lies and AIDS* includes in its survey of the epidemic 12 "portraits" of HIV-positive individuals who are intended to represent a cross section of society: a pavement dweller, 2 sex workers and a hijra representing the underclass, a truck driver and a housemaid representing the working class, 2 men and a woman representing the middle class and a gay man (Dube 2000, p. 57–84). In *Positive Lives*, the account of Jain's travels to the places of disease is interspersed with stories of the people she meets from all classes and in varied locations, to emphasize not only the epidemic's spread but also the suffering and stigma it entails and the courage of those who struggle to live with dignity: "If in these years the virus has gone about devastating young lives, it has also shown how the human spirit can find ways of making life meaningful" (Jain 2002, p. 247). The inclusion of such life stories of patients is a common feature of disease narratives, where it serves an important function. It expresses a sense of the human tragedy, which cannot be expressed in statistical information, and thereby elicits compassion. In *Positive Lives*, accounts of personal suffering that show the "face of the epidemic" contrast with the impersonality of what Jain calls the "cold lexicon of statistics" with its "language of numbers" (Jain 2002, pp. 15–16). Jackson's *In Leper-Land* devotes a tenth of its 270-page narrative to stories of lepers in the mission asylums, to elicit the sympathy of readers.[6] The communication of information, as Walter Benjamin argued, presents events in a manner that reifies them, abstracting them from their affective value for the reader: "Man's inner concerns do not have their issueless private character by nature. They do so only when he is increasingly unable to assimilate the data of the world around him by way of experience. Newspapers constitute one of many evidences of such an inability" (Benjamin 1969, p. 158). Stories of individual suffering are intended to counter this reification and to restore to events their affective import. As rhetorical strategy, giving a "face" to disease is a way of eliciting the reader's subjective feelings to what would otherwise appear impersonal and distant.

The inclusion of life stories also serves another function, that of constituting subjectivities. Both *Sex, Lies and AIDS* and *Positive Lives* constitute in their address an implied reader who is presumed to be free of disease. One of the objectives of Dube's narrative is to instil in his readers compassion for those affected by overcoming their "preconceptions and prejudices":

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[6] Jackson's intention, however, was to elicit sympathy not so much for the patients as for the missionaries who risked infection to dedicate themselves to this very "Christian" work. He mentions specially Mary Reed, a missionary at the Chandag Heights asylum who herself contracted leprosy: "Many Missionaries (as this volume bears witness) are doing devoted work among these diseased outcasts, but to Mary Reed alone among English-speaking missionaries has been accorded the distinction of ministering as a leper to the lepers" (Jackson 1901, p. 142).

> As mortals, as people who are ourselves at risk of contracting HIV/AIDS (or suffering other tragedies), we must remember that every single person infected got it innocently, unwillingly, through no fault of theirs. Nobody, absolutely nobody, deserves to get HIV/AIDS. Nobody deserves to die prematurely and with such suffering. On this journey and later, we must respond with humanity and compassion, without bigotry or prejudice, to the huge numbers of Indians who have or will contract HIV/AIDS. (Dube 2000, p. 3)

Similarly, *Positive Lives* opens with an appeal to readers to overcome their middle-class norms, expressed in terms of her own moral transformation:

> When I started this work, like almost everyone else, I considered HIV as being something distant. I must confess I too believed that it was largely a disease of the promiscuous. I, with my middle-class attitudes and years of conditioning of what was right and wrong, felt secure that I, my family and my children were safe. It's only after coming to closely know people with HIV that I began to see how HIV could afflict any one of us…. (Jain 2002, p. xv)

While compassion may be an appropriate way of countering stigma and discrimination, we need to understand its logic, especially the way it positions the compassionate subject and the object of compassion. On the one hand, compassion as empathy for the other's suffering is a way of dissolving the perceived differences between self and other that give rise to discrimination. But on the other, compassion as pity presupposes and reinforces difference. As Adorno and Horkheimer put it in the *Dialectic of Enlightenment*, the "narcissistic distortions of pity, such as the exaltations of the philanthropist and the moral self-awareness of the social worker, are still intensified confirmations of the difference between rich and poor" (Adorno and Horkheimer 1972, p. 103) – or, in the present context, the healthy and the diseased. In the play of this ambiguity, the discourse of compassion may either serve to mitigate discrimination or continue it in the guise of an altruism that objectifies the other. Further, compassion, pity and fear as allied emotions form the motive force of tragic catharsis: they "are aroused", writes Jan Zita Grover, "ultimately to be cathartically disposed of, to enable the passive spectator of the AIDS 'spectacle' to remain passive, and eventually to distance him- or herself from the scapegoated object of pity and fear" (Grover 1988, p. 29).

In eliciting the compassion of the reader, it is significant that both Dube and Jain *select* specific life stories to narrate, predominantly of people who have acquired infection through heterosexual or homosexual acts. Jain also includes the stories of intravenous drug users from the northeast. These are people who, from an orthodox moral perspective, are "guilty" of the transgressive acts that led to their infection, so that they seem to be least deserving of compassion. By enlisting them in their narratives, Dube and Jain try to counter the stigma attached to lifestyles perceived as deviant; but in doing so, they unwittingly reinforce the norms that make them appear deviant in the first place. This ambivalence is explicit in Jain's account, when she tries to explain the reasons for the spread of infection to what is called the "general population" – that is, groups understood to be at low risk. First, she considers sex to be "the most lethal and dangerous mode of transmission" (Jain 2002, p. 17), though why this is so is never made clear. In fact, it is intravenous transmission that carries the highest risk, and in the case of an incurable fatal disease, any transmission is "lethal and dangerous". Sex is a form of bodily conduct subject to the most intense moral control, because it is the source simultaneously of the preservation of life through procreation and what puts life at risk through undisciplined pleasure.[7] An implicit moralism underlies Jain's narrative of a sexually driven epidemic, as she attributes it partly to decline in traditional sexual mores: "Today, with better communication, increased mobility, increased socializing between young men and women, besides the incursion of mass media, primarily Western, into the cultural and sexual lives of all societies, sexual scripts are being rewritten" (Jain 2002, p. 47). A Gujarat housewife who contracted infection through extramarital sex is "a classic example of how sexual attitudes are changing even in the most traditional communities" (Jain 2002, pp. 48–49). While Jain also blames tradition in communities that customarily engage in sex work like the Kalavanthulus of Peddapuram and the Banchharas of Mandsaur (Jain 2002, pp. 51–59), it is "promiscuity", which she defines as "reckless sexual acts", which is commonly the cause of infection (Jain 2002, p. 48). The concept of promiscuity, like that of immorality, is based on a norm rather than a fact and is used to express social disapproval of conduct that is held to be transgressive. In her account of the epidemic, Jain tries consciously to avoid stigmatization, to overcome what she confesses are her "middle-class attitudes", but, as we see above, the moral norms persist at a covert level.

The rhetorical techniques of Dube's narrative are crucial to understanding the way it constructs the epidemic. By emphasizing its scale and rapidity, Dube points to the urgency of the crisis and the need for prompt and proactive measures. It calls for strategic interventions as well as large-scale social transformations such as legalizing sex work, eradicating poverty and illiteracy, ensuring social justice through laws and public policy and establishing a society of tolerance. By presenting the epidemic as an unprecedented crisis, Dube's narrative intensifies anxieties, which it then seeks to allay through recommendations for disease-preventive action on the part of the public and the state, especially safer sexual options and AIDS education. *Sex, Lies and AIDS* is not in itself a pedagogic text, but it prescribes pedagogy along with the practice of safe sex as the only way to control the epidemic (Dube 2000, pp. 131–138). Without undermining the appropriateness of what it recommends, the way the narrative portrays the epidemic makes education the legitimate form of public health management, in an exercise of authority more extensive than segregation of the diseased. Since the major part of pedagogic intervention is carried out by non-governmental organizations, this also marks a move to the delegation of the state's positive biopolitical functions in a neo-liberal regime to non-state agencies, in a multiplication of the sites of national governance. Thus, Dube's construction of the epidemic corresponds to a stage when disease control strategy shifted from coercive measures on the part of the state to pedagogic campaigns conducted largely by the voluntary sector. As we will see in Chap. 6, this has had

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[7] Thus, in *Society Must Be Defended*, Foucault writes: "Sexuality exists at the point where body and population meet. And so it is a matter for discipline, but also a matter for regularization" (Foucault 2003, pp. 251–52).

major implications for issues of disease control within the larger context of social order and the governance of individuals and populations.

The life stories of HIV-positive individuals in *Sex, Lies and AIDS* emphasize the suffering, both physical and emotional, caused by disease. This is in continuity with his representation of AIDS as a crisis that can be resolved through pedagogic interventions. The life stories in *Positive Lives*, in contrast, include those of HIV-positive people who have been able to overcome stigma and self-abjection and take an active role in implementing policies and building support networks. Such networks began to be established in India in the late 1990s, with the Indian Network of Positive People (INP+) being formed by Ashok Pillai, K.K. Abraham, Dr. Tokugha and others at Chennai in 1996. In 1997, the Network of Maharashtra People with HIV (NMP+) was formed, followed by the Tamilnad Network of Positive People (TNP+) founded by Rama Pandian in 1999. *Positive Lives* reconstructs this history, taking its title from the self-designation that the support groups adopted to resist stigmatization, re-signifying the term "positive" in their diagnosis:

> This is the new mood around AIDS: collective action and strength. Positive people's groups that have emerged over the past five years or so, have provided those infected with the virus an admirable example of endurance, and how to cope with social attitudes. Simultaneously, they have helped bring people together, to find strength in their collective being, and to unite and find a common voice that is forceful enough to be heard. (Jain 2002, p. 224)

Though stories of suffering are present, emphasis is on the biographies – with which Jain opens and ends her narrative – of positive people network organizers like Ashok Pillai, Abraham, Rama Pandian, Kousalya, R. Elango and Deepak.

*Positive Lives* ends, therefore, with a much more affirmative account of the epidemic than Dube's book or the media reports that we saw in the preceding chapter, representing HIV-positive individuals no longer as *victims* of a catastrophe but as persons *living* with the virus. With the introduction of antiretroviral therapy (ART) in 1996, especially after it was made available free of cost in 2004, it was possible to live with the virus for much longer periods, from 15 to 20 years after diagnosis. As a result, some of the moral panic surrounding the disease abated, though stigma continued: public health efforts now focused on prevention of new infection, management of existing illness and reduction of stigma. More importantly, HIV-positive individuals began to take an active part in epidemic control as stakeholders in government agencies and non-governmental organizations and by setting up support groups.

Positive people networks bring into being a new form of community founded on the shared experience of illness that cuts across other differentia of identity. AIDS is not the only disease that has enabled such affiliation: patient and caregiver groups have formed around such life-threatening chronic illnesses as cancer and haemophilia. The Haemophilia Federation of India (HFI), for instance, was established in 1983 to provide information about disease management and access to low-cost treatment. These contemporary forms of embodied community exemplify what Paul Rabinow terms "biosociality" – "new group and individual identities and practices" coalescing around disease, like the neurofibromatosis groups that he mentions

(Rabinow 2005, p. 188). Rabinow's claim is that such identity formations, which are the outcome of technoscientific manipulation of the body, signify a radical move beyond the nature/culture or natural/social dichotomy: "Nature will be known and remade through technique and will finally become artificial, just as culture becomes natural" (Rabinow 2005, p. 186). In the context of illness, these new forms of biosocial community like HFI and positive people groups serve to resist the naturalization of the normative differences that constitute the social understanding of diseased bodies, especially their stereotyping as "victims". Stigmatization and biosociality can be understood as being in inverse relation to each other. Both stigma and biosociality refer to the diseased body; but if stigma devalues the body, producing it as the "other" or the antithesis of identity – "we encounter in living with AIDS the production of non-subjects, people for whom the mirroring illusions of discourse are broken" (Yingling 1997, p. 16) – biosociality revalues it as the foundation of community. If stigma leads to ostracism and isolation, biosociality leads to bonding and togetherness. Finally, if stigma is the structure that is imposed on the diseased by the healthy majority, biosociality is their countervailing response to the imposition.

Positive people networks also point to the complex relation between normative structures and practice. While norms regulate practices, they do not exhaustively determine them. In the affiliation that HIV-positive people voluntarily seek, they acknowledge the difference between health and disease that unites them as a group and collectively distinguishes them from others: to identify on the basis of the condition of disease is to accept its reality. On the other hand, by attempting to gain control over their circumstances, they resist the passivity that, as *patients*, the norms of health and disease subject them to. The term "positive people" is both an acknowledgement of the signifier of disease and its re-signification in a different, and more enabling, context. Such affiliative networks do not challenge the norms, but neither do they comply with them fully – which may account for the fact that they are able to form relatively autonomous channels for sharing information and experience while seeking support from and participation in government-run programmes. If official pedagogies are part of the governance of public health, positive people networks represent the response of the governed.

## 4.4 *AIDS Sutra*: Living with the Virus

Negar Akhavi's anthology *AIDS Sutra* (2008), which was published in the third decade of the epidemic, is representative of another shift in the narration of the HIV/AIDS epidemic: it recounts the bodily experience of disease no longer as exceptional devastation but as everyday social existence of the people affected. Being an anthology of essays written by diverse authors, it is difficult to categorize it under a single theme or perspective, but most of the pieces are about people living with the virus and dealing with its effects from day to day, overcoming stigma and self-abjection, marrying and bringing up families and forming communities and identities based on their bodily condition.

*AIDS Sutra* brings together 16 short articles about various aspects of the epidemic, the individuals and groups affected and the ways in which they deal with their illness and its social consequences. Nikita Lalwani's "Mr X versus Hospital Z", Siddharth D. Shanghvi's "Hello Darling" and Shobhaa De's "When AIDS Came Home" are life narratives, the first about an HIV-positive doctor who became an AIDS activist and the other two about persons who died of AIDS. Travelogues include Kiran Desai's "Night Claims the Godavari" about sex workers in Andhra Pradesh, Siddhartha Deb's "The Lost Generation of Manipur" about intravenous drug users in the northeast, Sunil Gangopadhyay's "Return to Sonagachhi" about the red-light district of Kolkata and Aman Sethi's "The Last of the Ustaads" about long-distance truck drivers. Then there are the chapters that deal with the everyday lives of HIV-positive people. Sonia Faleiro's "Maarne Ka, Bhagaane Ka" and C.S. Lakshmi's "At Stake, the Body" are about sex workers, while Salman Rushdie's "The Half-Woman God" and Mukul Kesavan's "Nowhere to Call Home" are about hijras and men who have sex with men (MSM). William Dalrymple's "The Daughters of Yellamma" is about the devadasis or temple courtesans of South India. Jaspreet Singh's "Bhoot ki Kahanian" is about AIDS orphans, and Nalini Jones' "Life in the Time of Positives" is about couples living with AIDS. Vikram Seth's "A Poem about AIDS" is on an elegy that he had written on a person with AIDS. Amit Chaudhuri's "Healing" is about his visit to hospitals in Mumbai offering services to HIV-positive people and the doctors who practised there, followed by a trip to Mumbai's red-light district Kamathipura. Collectively, therefore, the articles include multiple aspects of the epidemic and cover all the known risk groups in the epidemic, especially those that are conventionally stigmatized as being "responsible" for their disease, which the book as a whole seeks to counter.[8]

The articles in *AIDS Sutra* are framed by a number of different contexts that are linked to the social history of the epidemic. The first is the pedagogic context: the anthology was commissioned by Avahan, an HIV/AIDS organization established by the Bill and Melinda Gates Foundation in 2003, as part of its effort to disseminate information about the disease and to reduce stigma. A recurrent theme in the articles is the role of non-governmental organizations in promoting AIDS awareness, facilitating support networks for HIV-positive people and providing care and counselling services. Nearly half (7 out of 16) are either about voluntary organizations or mention the work done by them alongside other issues. Public agencies, prominently the

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[8] A notable exception is the haemophiliac or thalassemic, who, as we have seen in Chap. 2, was incorporated into the media discourse as "innocent victim". This is because transmission of HIV through blood or blood products is currently rare. According to National AIDS Control Organization estimate, the percentage of HIV-infected blood decreased significantly from 1.2% in 2007 to less than 0.2% in 2014–2015 in NACO-supported blood banks. In 1996 the Supreme Court mandated banning of professional donation and the creation of a National Blood Transfusion Council (NBTC), the apex body for policymaking and monitoring of transfusion services. The Government of India adopted the National Blood Policy in April 2002 to ensure adequate supply of safe blood and blood products in the country. Though there are no studies of HIV transmission in haemophiliacs and thalassemics, there has possibly been a decline in transmission rates due to better services (NACO 2016).

police and government-run hospitals, appear to play a largely negative role. Thus, Sonia Faleiro's article is about police harassment of sex workers, which is also mentioned in passing by a few other articles. "Hospitals in India", writes Siddharth Shanghvi, "are infamous for their despicable treatment of the infected":

> One 2006 study noted institutionalised discrimination towards positive patients. Denial of healthcare, mandatory HIV testing, lack of counselling, and the public disclosure of HIV positive status were some of its troubling conclusions. Nurses often wore double gloves, and doctors donned masks unnecessarily when treating positive patients. The linen of positive patients was burned. Such prejudice is probably due to ignorance surrounding HIV transmission. Over half of the healthcare workers believed HIV was transmitted by touching someone positive. Nearly half were under the impression that the breath of a person with HIV could spread the disease. (Shanghvi 2008, p. 69)

Only one article, Amit Chaudhuri's "Healing", records the dedicated service of a few individual doctors in public hospitals in Mumbai. The visibility of the NGO sector is thus paralleled by the invisibility of government agencies, except as negative instances. Since the NGOs have often involved representatives from the risk groups as stakeholders, the articles also emphasize how their work as peer educators has empowered individuals who no longer see themselves as "victims". Thus, Sonia Faleiro writes of Radhika, a sex worker volunteering for an NGO: "Outreach work … has given her a self respect whose value, for her, is above price" (Faleiro 2008, p. 92). Sunil Gangopadhyay commends the work done by the Durbar Mahila Samanwaya Committee (DMSC), which started as a government initiative in 1992 but was established as a sex workers' collective 3 years later. Visiting Sonagachhi after a gap of several decades, he observes: "I could detect a distinct change in the psyche of the women. They don't perceive themselves as sinners and fallen women anymore. They don't claim to be victims of a cruel destiny either. They speak of their profession, quite naturally and spontaneously, as though it was one of many" (Gangopadhyay 2008, p. 169). Similarly, Nalini Jones describes the transformation in Ashwini, an HIV-positive housewife, after she joins an NGO: "more independence, love and encouragement from her family, support from counsellors, and eventually a job with a network. Ashwini is now a counsellor herself, a role that gives her enormous fulfilment" (Jones 2008, p. 325). Jones also notes the change in the attitude of others when Jayanthi, another HIV-positive housewife, joins a support network: "all they saw when Jayanthi came into view was a deadly disease. Now they see a married woman with a good job, leading a normal life" (Jones 2008, p. 331). The entry of the voluntary sector in AIDS work has significantly altered the perception of the epidemic, from a purely medical to a medico-social issue where decision-making often shifts from public health authorities to HIV-positive individuals and their support networks and where distinctions between private and public, individual and social and personal and political are dissolved.

A second context is the use of art in AIDS activism. What stands out in *AIDS Sutra* is its literary excellence: the pieces are written, as Amartya Sen puts it in his foreword, by "some of the finest and most innovative authors of the subcontinent". The "understanding of a complex reality", writes Sen, "not only demands facts, figures and empirical details, but also the use of our responsive imagination to interpret what is going on, so that crude facts can be transformed into informed comprehension" (Sen 2008, p. 2). The use of art as an initiative to counter stigma and promote awareness points to an aspect that has been singular to this epidemic, the role that representations play in the social understanding and response to disease. Sander Gilman explains thus:

> What does art show us? Certainly not the "real" world. The images of Bosch or Van Gogh, of Warhol or Escher may reflect the mental representations of some inner world but not the mundane one in which we live. And yet these private constructions are real. They are expressions of myths about the world, the ideas that we project onto it and that shape our understanding of the realities that we experience. The central reality for the healthcare practitioner is illness. One rarely questions that physical illness is real, that it is part of the world. We see the signs and symptoms of illness, and they tell us something about the state of the patient. Not so evident is that this process of "seeing" is highly charged by the qualities that we ascribe to illness. Indeed, we can create "diseases" that have a life quite independent of any biological, emotional, or psychopathological source. (Gilman 1988, p. 18)

If AIDS has had a discursive existence quite apart from its biomedical aspects, this is because the stakes are high. On the one side are the stigmatizing representations of AIDS, which it shares with other diseases like leprosy; on the other – and this is perhaps unique to AIDS – is an activist aesthetic that deploys, as Simon Watney puts it, "a cultural politics that is sensitive to the complex processes that produce subjectivities", revealing how representations are never simply reflections of a given reality (Watney 1990, p. 190). This is unique to the AIDS epidemic because of the way it unfolded globally: its first impact was on the gay community in the United States, a community with immense cultural capital. Those affected by the disease and its accompanying stigma included writers, artists, intellectuals, filmmakers, actors and musicians, and they mobilized their cultural resources in what came to be dubbed "Art Against AIDS". The last two decades of the twentieth century produced a massive corpus of novels, plays, poems, life stories and memoirs, paintings, photographs and films on AIDS and HIV-positive people, apart from an equally large volume of activist and critical writing. Gay community aesthetic responses subsequently set the pattern for similar responses elsewhere and with regard to other groups of high-risk individuals. *AIDS Sutra* is a product of this context.

A third context for the narratives in *AIDS Sutra* is the change in the understanding of who gets AIDS and how, a shift from moralistic perceptions that hold individuals responsible for their choice of lifestyle to the acknowledgement of social factors. "The exercise of personal responsibility", notes Amartya Sen, "varies radically from one community to another depending on the social circumstances, and it would be rather simple-minded to see these variations as endogenous diversities in personal decision making, divorced from the way society influences the choices and actions of individuals" (Sen 2008, p. 13). In accounting for why some individuals opt for a hijra lifestyle, Mukul Kesavan writes:

> It seemed to me that poor non-straight men in Bangalore grew into a kothi identity because their material and social circumstances were so oppressive and so intolerant of sexual difference that effeminacy (which in a more hospitable environment might have grown into a spectrum of sexual behaviours), found itself channelled into the one pariah form that traditional society tolerated: the kothi/hijra. So instead of growing into a range of identities –

> transgender, transvestite, some attracted to women and others to men, and gay – they all became kothis, absorbed into a kind of default identity that had traditionally received boys or young men who felt sexually out of step with their peers. (Kesavan 2008, p. 186)[9]

Likewise, the accounts of sex workers emphasize the role of poverty, lack of social support, traditional practices like those of the devadasi community that drive women into prostitution and the unequal power relationships that make it impossible for them to negotiate safe sex. In *AIDS Sutra*, people are shown to live and act by individual choice, but a choice often significantly constrained by their social circumstances. This approach to the AIDS epidemic was the outcome of a shift from biomedical to social explanations of disease transmission, and it enabled the destigmatization of HIV-positive people. As Tamsin Wilton argues, emphasis on individual responsibility leads to a "moralistic and victim-blaming model of disease" (Wilton 1997, p. 1).

While emphasizing the importance of social factors, however, *AIDS Sutra* also emphasizes the struggle of individuals to overcome self-abjection and to lead normal lives. Thus, Nikita Lalwani writes of Dr. Tokugha: "this is the first thing that strikes you about Toku: his spotless skin and demeanour, the infallible quality of seeming to be in very good health…. any sense of physical weakness is hidden – something you have to be told about, rather than glean for yourself" (Lalwani 2008, pp. 32–33). C.S. Lakshmi's story is about a group of sex workers who "are no more individuals struggling alone with their bodies, but a community of women who share their lives, and work for one another" (Lakshmi 2008, pp. 105). Salman Rushdie writes about a hijra peer educator who "is vocal, confident, self-assured. She wants to be a voice in the HIV/AIDS campaign, and to help save what she, too, calls 'the third gender of India'" (Rushdie 2008, pp. 116). There is also Nalini Jones' account of Ashwini and Jayanthi, HIV-positive housewives who work as peer counsellors. These examples point to yet another context for the representation of the epidemic in *AIDS Sutra*: the normalization of HIV-positive lives with the availability of antiretroviral therapy in the mid-1990s, enabling individuals to make choices that had not been possible earlier. The articles in *AIDS Sutra* give an affirmative inflexion to the notion of individual responsibility, from "being responsible" as culpability for one's circumstances to "taking responsibility" as a way of actively transforming them. With ART, AIDS has become a manageable chronic disease, requiring lifestyle changes through personal effort as with other chronic ailments like cardiovascular disease or diabetes mellitus. This is perhaps why many of the life stories narrated in *AIDS Sutra* emphasize everyday activities, in representing HIV-positive individuals *living with* rather than *dying from* the virus.

The contexts discussed above constitute a conjuncture or combination of events that has transformed the social history of AIDS. It is characterized by (a) shift from a biomedical to a social model of disease; (b) shift from a notion of personal

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[9] In hijra terminology, the term kothi refers to those who prefer to be penetrated and panthi to those who penetrate; and double deckers are those who do both. Some kothis, as Kesavan notes, imagine themselves as women and may undergo castration or nirvana, but this is not mandatory to hijra identity (Kesavan 2008, p. 185).

responsibility to an understanding of the social factors constraining personal choice; (c) the convergence of different kinds of knowledge, from the biomedical model of disease to the social model of disease transmission to the subjective model of illness experience; (d) the entry of non-medical or lay experts (activists, social workers, counsellors and specialists in behaviour change communication) into a field once monopolized by public health authorities; and (e) the establishment of community support networks by those affected in the epidemic. If this combination of events is taken to constitute the new social reality of AIDS, its narrativization *constructs* that reality in providing its forms of explanation. *AIDS Sutra*, as a text of the epidemic, is an exceptionally apt instance of that construction.

The contributors to *AIDS Sutra* are not themselves HIV-positive, with little personal experience of the disease, and for whom the writing of the article was perhaps the first opportunity to meet HIV-positive people. Shobhaa De is probably the only contributor to have personally encountered the epidemic. This is true of all AIDS narratives in India that I have been able to access: they are produced by individuals who see themselves as disease-free and who represent or speak on behalf of the diseased. The silence of those affected may be because the majority of them do not have access to the cultural capital and the resources to publish their stories, while those who do are reluctant to come out in public because of stigma. The last two decades have seen the publication in India of autobiographies and memoirs by some of the most stigmatized social groups – gay men, lesbians, sex workers, hijras – but not the HIV-positive. In this situation, representations of HIV-positive people often take one of two forms: they are either moralistic, negatively stereotyping the HIV-positive as the abjected "other", or are lessons in compassion for their supposedly healthy readers. Happily, the articles in *AIDS Sutra* escape this compulsive binarism, except Shobhaa De's "When AIDS Came Home". De's story is purportedly about her family chauffeur, Shankar, who is diagnosed with AIDS and succumbs to it; but it is actually about her own middle-class moral values, which she attempts to overcome through compassion:

> One part of me wanted to say to him, 'Get out, you filthy swine. Just get the hell out.' The other part of me questioned my baser instincts. Where was my liberal self when I needed it most? My stated stand on the HIV affected? Was I too a hypocrite, saying politically correct things in public and then turning my back on the very people I claimed to support? (De 2008, p. 250)

"I didn't want to sound accusing", she explains, "neither did I want to make any judgments. Yet I felt repulsed" (De 2008, p. 249). Most of the account deals with Shankar's close personal ties with her family, his sense of duty and loyalty to them and his affection for her children: in other words, it is about her world rather than his, objectifying him by norms of conduct that are hers. She tells her children that he contracted the infection in a blood transfusion: "Call it my last lie for Shankar, but I wanted him to be remembered differently" (De 2008, p. 254). In this judgment and acquittal, De, unlike the other authors in the anthology, reveals a conventional viewpoint that understands infection as moral culpability. Compassion functions, as it usually does in AIDS narratives, to compensate for a stigmatization that underwrites it, in what Watney describes as a "familiar humanist pathos to stir reluctant sympathies" (Watney 1990, p. 179).

To return to Amartya Sen's point about the understanding of disease that a "responsive imagination" can bring, it is pertinent that there has been in the last few decades a significant transformation in the biomedical paradigm. Symptomatic of this shift is the development of what is called "narrative medicine", which uses the resources of literature to make biomedical practice more sensitive to nuances of meaning in doctor-patient relationship. Narrative medicine was institutionalized in 2009 as a master's programme at Columbia University Medical Center, by Rita Charon and her colleagues. It trains healthcare practitioners to be attentive to clinical interactions, especially the interpersonal nature of communication. As Maura Speigel and Danielle Spencer contend:

> For where more than in the medical context, so rife with power iniquities and rigid hierarchies, does one need to call out our social embeddedness and contingent identities; and where more than in the patient's unasked questions, unspoken anxieties, and unanswered telephone calls does one recognize the fragility of communication in the medical encounter? Where more than in our technocratic era does one need to explore the limits of rationality and positivism? (Speigel and Spencer 2017, p. 29)

Narrative medicine may be seen as a response to Cecil Helman's call more than 30 years back, for physicians to recognize the clinical implications of patients' stories of *illness* instead of objectifying them in verifiable signs and symptoms of *disease*. Narrative medicine can also be understood in terms of another binary that we will examine in greater detail in Chap. 7: curing versus healing. Briefly, curing refers to a specific regime of treatment that targets an organ or a system of organs to restore it to normalcy, while healing refers to inducing a sense of well-being that involves the whole person and is at once bodily, cognitive, emotional and social. Curing is an objective medical technique, while healing is a subjective art. Seen from this perspective, narrative medicine and other similar approaches that draw on the resources of the humanities seek to complement biomedical therapeutic practice with the art of healing. The turn to art as a way of dealing with the disorder of disease may be seen as concurrent with a larger move to make medical knowledge and practice more sensitive to the subjective dimension of clinical interactions, by drawing on the imaginative resources of literature.

## 4.5 Narrative and the System of Norms

In the foregoing sections, we have discussed factual accounts of the epidemic, from the journalistic in *Positive Lives* and *Sex, Lies and AIDS* to the belles-lettristic in *AIDS Sutra*. In the section that follows, we will examine a novel and four fiction films as representations of the HIV/AIDS epidemic in India. In considering them separately, however, I do not imply that factual and fictional narratives are distinct in their strategies of representation or in what they represent. All narratives represent actions and events, as well as the world in which these occur and become meaningful, and the way they do this is not significantly different. On the relation between historical and literary narratives, Hayden White observes:

> Historians are concerned with events which can be assigned specific time-space locations, events which are (or were) in principle observable or perceivable, whereas imaginative writers – poets, novelists, playwrights – are concerned with both those kinds of events and imagined, hypothetical, or invented ones. The nature of the kinds of events with which historians and imaginative writers are concerned is not the issue. What should interest us in the discussion of "the literature of fact" or, as I have chosen to call it, "the fictions of factual representation" is the extent to which the discourse of the historian and that of the imaginative writer overlap, resemble, or correspond with each other. (White 1978, p. 121)

What is common to factual and fictional accounts is the "mode of explanation" and the "mode of emplotment" by which narratives construct and attribute significance to the events they represent (White 1978, p. 66). Thus, an explanatory model that understands disease as calamitous employs a plot structure that is closer to pathos than one that understands it as display of human endurance, courage and solidarity. That is the difference, as we have seen, in how *Sex, Lies and AIDS*, *Positive Lives* and *AIDS Sutra* represent the "facts" of the epidemic. The choice of a specific explanation-emplotment schema is linked to one's ideological understanding of the normative world of actions and events – which is first, never personal but shared; second, connected both to real events and the meaning we make of them; and third, rarely coherent and monolithic. Narrative opens up gaps or indeterminacies in the ideological-normative system, which may then be questioned or at least lose some of its persuasive force. On the other hand, it may reinforce the system by glossing over its inconsistencies, which can then be brought out only in reading against the grain. While this is true of both kinds of narrative, my claim is that it is more explicit in imaginative literature because of the way it foregrounds and problematizes ideology. To cite Hayden White again, "By drawing historiography nearer to its origin in literary sensibility, we should be able to identify the ideological, because it is the fictive, element in our own discourse" (White 1978, p. 99).[10]

How do narratives represent social norms? Paul Ricoeur explains this through a tripartite schema of representation that he calls mimesis$_1$, mimesis$_2$ and mimesis$_3$. Drawing on Aristotle's theory of mimesis, Ricoeur argues that narratives represent actions that are invested with meaning by what we have termed the ideological-normative system, which the reader interprets with reference to his or her experience

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[10] White's argument about "literary sensibility" is directed at a positivist historiography that treats historical "facts" as objective records of the past, with a meaning that is assumed to inhere in them instead of being an effect of the way they are represented. In his view, a literary approach reveals how these "facts" are discursively constituted – "fictions" in that sense – in accordance with ideological positions that underwrite the historical representations. Literature's attentiveness to discourse and meaning makes possible an ideological critique that positivist historiography cannot undertake. For a related view, see Dominic La Capra's distinction between the "documentary" and "work-like" approaches to historical representation: "The documentary situates the text in terms of factual or literal dimensions involving reference to empirical reality and conveying information about it. The 'worklike' supplements empirical reality by adding to it and subtracting from it. It thereby involves dimensions of the text not reducible to the documentary, prominently including the roles of commitment, interpretation, and imagination" (La Capra 1983, p. 30).

of the world. The mimetic process of narrativization, in other words, mediates between the social norms that govern human activity and the reader's experience of these norms. Mimesis$_1$ refers to the "pre-understanding of the world of action, its meaningful structures, its symbolic resources, and its temporal character" (Ricoeur 1984, p. 54). Mimesis$_3$ refers to the reader's understanding of action and meaning derived from experience of "the world wherein real action occurs and unfolds its specific temporality" (Ricoeur 1984, p. 71). Mimesis$_2$, which refers to the creative process, has the function of mediating between the two, by articulating the "sense" of the symbolic system that narrative re-presents with "reference" to the world of experiential reality: "What the reader receives is not just the sense of the work, but, through its sense, its reference, that is, the experience it brings to language and, in the last analysis, the world and the temporality it unfolds in the face of this experience" (Ricoeur 1984, pp. 78–79). Ricoeur's schema is especially useful in examining how narratives of disease impact on the way we understand disease and diseased people, in connecting emplotment with the explanatory paradigms derived from our culturally mediated experience. Given that these explanatory paradigms, however systematized, are never entirely coherent – they constitute, as Geertz puts it, "a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into another, which are at once strange, irregular, and inexplicit" (Geertz 1973, p. 10)[11] – reading involves an active interaction with the world represented in narrative, ranging from "ideological confirmation of the established order" to "social criticism" (Ricoeur 1984, p. 79).

In attempting to counter stigmatization, the narratives we have examined point to the norms that govern social understanding of health and disease. To do so, they emplot their accounts of the epidemic through stories of people who have acquired infection by sex and drug use and activities associated with transgressive pleasure-seeking conduct and therefore most stigmatized. The reason is obvious: in showing how such people are not moral "deviants" who deserve their fate, they make us more sensitive to human vulnerability. But in choosing to tell such stories, they implicitly confirm the structures of discrimination, even as they question them. The ambivalence of such representation is evident, for instance, in Kalpana Jain's view that the epidemic was intensified by promiscuity and change in moral values, which belies her conscious determination to be non-judgmental. Shobhaa De's account of her chauffeur's illness and death is another instance of this ambivalence. Narratives that seek to destigmatize the HIV-positive do so by opposing a dominant moral norm, which holds them culpable for their disease, with a norm that resists it and values empathy and concern for the other. Where the opposition is clear and unambiguous, the narrative exposes inconsistencies in the dominant order and calls it to question. Where it is not, as in our examples above, the process of reading opens up the inconsistencies that underlie and destabilize the narrative's mode of explanation.

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[11] In explaining mimesis$_1$, Ricoeur refers to Geertz's theory of culture as the symbolic universe within which human activity acquires a significance that is shared by those who belong to that universe. Explanatory paradigms belong to the symbolic field where acts and meanings intersect: their persuasive force derives from the collective acceptance of the symbolism.

Narratives of disease may reiterate and confirm the structures of stigmatization, or they may represent them more critically; in either case they act upon the way we understand and respond to disease as a social phenomenon. Corollarily, our social understanding of disease, which is never individual but neither is it uniform and universal, determines how we respond to and receive narratives of disease.

## 4.6 "Innocent Victims": *A Dove in Desert*, *Nidaan*, *Ek Alag Mausam*

In Chap. 2, we saw how media representations of the HIV/AIDS epidemic reinforced norms of conduct by contraposing those who acquired infection through transgressive pleasure-seeking acts with those who acquired it "innocently". Thus, Farah Baria's cover story in *India Today*, "AIDS: Striking Home", contrasts the "guilt" and "fear" of the men who bring home the virus with the heroism of the wives they infect, their "strength to forgive, nurture and fight for their doomed families" (Baria 1997, 108). The binarism of guilt versus innocence serves two functions. First, it configures the distinction between permissible and impermissible conduct within a moral order, valuing acts that are socially approved and devaluing those that are not. Second, it signifies the suffering of disease as deserved punishment for those who are guilty of transgression and as pathos for the innocent. If the former implies a view that moral justice will prevail, the latter seems to be unjust – but an injustice that results from the sins of others. The guilty are thus doubly responsible for the moral disorder of disease, for calling it on themselves by their transgressive acts and causing others to suffer it. The guilty/innocent binary, thus, functions as a powerful instrument of stigmatization in accordance with the moral order of society.

In the three narratives that we will consider in this section, the protagonists acquire their infection innocently. Kalaiveni in Samuthiram's novel *A Dove in Desert* (1998/2001) and Aparna in the film *Ek Alag Mausam* (2005) are infected by their husbands, while Soumya in *Nidaan* (2000) is infected through a transfusion of infected blood. While all three narratives deploy the guilt/innocence binary, thus reinforcing the normative system, they do so in different ways in resolving the crisis of illness and impending death. What is common to all, however, is a concern with human vulnerability, which is a crucial step in the destigmatization of AIDS and HIV-positive people. To that extent the narratives render problematic the normative distinctions on which the social exclusion of the diseased is founded.

*Nidaan* was perhaps the first Indian film on HIV/AIDS. Directed by Mahesh Manjrekar and produced by R. V. Pandit, it was dubbed in Tamil as *Uyirin Uyirae*. The film's title, which means "diagnosis" in Hindi, was reportedly given by the then Prime Minister Atal Behari Vajpayee, and the film was exhibited with tax exemption in several states of the country (Rangarajan 2000). Government sponsorship thus framed the film in a pedagogic context, both to educate audiences about HIV/AIDS and to sensitize them against stigma. Its melodramatic plot deals with the sudden emergence of the disease in a "normal" middle-class family, where it is least expected to surface. The protagonist Soumya is the stereotypical "innocent victim" of AIDS narrative, who acquires the infection not through sex or drugs but blood transfusion, and the fact that she is a teenager with no sexual experience makes her doubly innocent.

Soumya is the only daughter of a middle-class couple, Suhasini and Anirudh Nadkarni. A student in a local college, she is in love with her classmate Ninad Kamat, son of another middle-class couple. While writing her Class XII examinations, she falls ill and is subsequently diagnosed with HIV disease. She had undergone appendectomy in her childhood, and it is assumed that she acquired the infection through blood transfusion. Undaunted by her condition, Soumya insists on completing her examinations and secures a high rank. She marries Ninad with the consent and support of both families, and, though they do not consummate the marriage, they are a happy couple. But by then the disease has progressed, and she has to be admitted to a hospital. Only one dream remains for Soumya, to meet her idol film actor Sanjay Dutt. The story ends with Dutt's arrival in the hospital as Soumya lies dying, fulfilling her childhood dream and providing a satisfying closure to the drama of thwarted hope. Soumya's death is not shown on the screen, but is narrated by Ninad in a voice-over.

Disease has frequently figured in mainstream Hindi cinema – examples include Hrishikesh Mukherjee's hugely successful *Anand* (1971) and *Mili* (1975) – but there are some obvious problems in making a film about AIDS. First, it is an intensely stigmatized disease involving lifestyles not considered to be "properly" middle class, making it difficult to predict the film's appeal to a predominantly middle-class viewing public and therefore its commercial viability. Secondly, because of the stigma, it is difficult to romanticize AIDS and fit it into the already existing formats of film melodrama, as Mukherjee could do with the relatively less stigmatized cancer. By locating the story of AIDS in a representative middle-class family, *Nidaan* is a bold attempt to introduce the topic in a social setting that strictly avoids any discussion of sex. Though Soumya's infection is through blood, sexual transmission is explicitly discussed by the doctor who diagnoses her condition. The film's chief focus is the stigma of AIDS, as Soumya is subjected to humiliation by her friends as well as some of the hospital staff. It thus seeks to counter the norms that engender stigma, by opposing moral taboos and promoting empathy and compassion for the diseased. At the same time, however, it reinforces the norms in a number of ways. By portraying a teenager who contracts HIV through blood transfusion, *Nidaan* reproduces the media stereotype of haemophiliac and thalassemic children who, as we have seen in the previous chapter, were recruited into AIDS discourse as conventional figures of "innocence". Her condition is understood against the culpable infection of those who are "guilty" – sex workers, homosexuals, drug addicts and "bridge populations" like bisexuals, truck drivers, migrant labourers and the poor. By attempting to suppress sexual transmission, the film actually prefigures it constantly as the context that makes Soumya's disease coherent. There is thus a tension between the film's attempt to speak openly about sex and the suppression of sexuality in its plot, especially in the relation between Soumya and Ninad. The denial of the body, understood as the source and site of moral corruption and disease, is a recurrent theme in narratives constructed on the guilt/innocence polarity.

*A Dove in Desert* (*Palai Pura* in Tamil, published in 1998) first appeared in serial form in the weekend edition of the Tamil daily *The Dinamani*. The English translation, which was published in 2001, was sponsored by the AIDS Prevention and Control (APAC) project of Voluntary Health Services, a non-profit multi-speciality hospital and research institute at Chennai, Tamil Nadu, as part of its AIDS awareness campaign. As a field publicity officer and subsequently joint director of field publicity in the Government of Tamil Nadu, Samuthiram, had organized programmes on HIV/AIDS, and the novel was an outcome of his experiences in meeting with HIV-positive people: "The more I saw things for myself, the more I felt for the innocent victims of HIV" (Samuthiram 2001, p. 9). The idea came to him from an actual incident, when Samuthiram learnt that Kausalya, an HIV-positive housewife and AIDS activist, had prevented a marriage "between a [sic] HIV infected groom and an innocent bride" (Samuthiram 2001, p. 11).

*A Dove in Desert* narrates the story of Kalaivani, a college educated woman who returns to her village to undertake social reform. She is the leader of the local Nehru Yuva Kendra or youth centre and is actively involved in an adult literacy campaign for women and in setting up a maternity hospital in the village. She is engaged to marry Manohar, a computer engineer from the same village and also dedicated to social service. Manohar is found to be HIV-positive, and Dr. Chandra, who informs him of his serostatus, tries to persuade him to postpone the marriage till the diagnosis is confirmed. Instead, Manohar visits a quack who assures him that there is nothing wrong with his blood, and he marries Kalaivani. His brother-in-law Velu threatens to abduct Dr. Chandra if she intervenes and tries to stop the marriage. His company sends Manohar to the United States on an important project, but he is denied entry at New York as he is HIV-positive. The local dailies report the story, and it spreads widely. Kalaivani, who feels betrayed by him, leaves him to return to the village. Manohar lives on in Chennai a broken man, having lost his job, wife, social status and self-respect and faced with the fear of a horrible death. He befriends a group of HIV-positive persons, among whom is a woman called Esther. They abandon themselves to the disease and death, turning to intravenous drugs as escape and engaging in sex work to fund their addiction. Manohar becomes a male sex worker providing services to rich homosexual tourists.

Meanwhile, Kalaivani suffers intense anguish in being infected and betrayed by her husband and being ostracized by the villagers and even some of her family. However, she recovers with the help and support of her parents, Dr. Chandra and the local AIDS specialist Dr. Asokan. She aborts the child she is carrying, works at a clinic for HIV-positive people run by an unscrupulous Dr. Sumathi, prevents the marriage of one of the clinic's patients to a woman who is unaware of his disease and exposes Dr. Sumathi. The incident is widely publicized in the media, and Kalaivani becomes a celebrity in the campaign against AIDS. She visits various places to talk about her disease and the risk that women run in getting married without knowing the serostatus of their husbands. This marks a symbolic return to her life before HIV, when she was active in social work, and it helps her to overcome suffering. With the help of Dr. Asokan and Dr. Chandra, she sets up a voluntary organization called Movement for Prevention of Unfair Marriages. Thus, the story of Kalaivani’s endurance and moral growth is paralleled by Manohar’s abandonment to disease and despair. Esther brings a dying Manohar back to his village to be reunited with wife and family and to atone for the wrong that he did to Kalaiveni, who finally forgives and accepts him. The novel ends with Kalaivani asking Esther to join her organization, in a gesture that is symbolic both of her own moral transformation and her power to transform others: “Kalaivani, standing on high ground, extended her hand towards Esther. Esther seized it. She, who seized the hand, came to the high ground without dragging down the helper” (Samuthiram 2001, p. 335).

*Ek Alag Mausam* (A Different Season), produced and directed by K.P. Sasi for ActionAid India as an AIDS awareness initiative, follows a broadly similar plot except for the contrast between the wife’s story and that of the errant husband. Aparna Verma is infected by her husband Suresh, a travelling salesman, and she discovers it in a routine check-up during pregnancy. She leaves Suresh to stay with her mother and seeks work as a volunteer in Jeevan Jyoti, a clinic for HIV-positive persons run by Dr. Machado. The rest of the film is about her attempt to cope with her illness and the emotional trauma of betrayal. Initially distressed by the suffering and death she sees at Jeevan Jyoti, she gradually adjusts and is happy to work there. She adopts the daughter of a sex worker, Rita, who dies of AIDS, to compensate for the child she had had to abort. She falls in love with George, an HIV-positive volunteer who works at the clinic as truck driver and assistant to Dr. Machado, but refuses to marry him because she doubts his morals. Subsequently, after she has left George and Jeevan Jyoti, she learns from Dr. Machado that he was infected through a transfusion of infected blood donated by the doctor’s own son. The film ends with their reunion, and the anticipation of a new beginning in “a different season”.

In all three narratives, the pedagogic function is foremost: *Ek Alag Mausam* was sponsored by a non-governmental organization as an AIDS awareness initiative, the English translation of *A Dove in Desert* was sponsored by an AIDS project, and *Nidaan* was subsidized by the government for health educational purpose. Though they are not pedagogic in format, information about AIDS is included in different ways. In *Nidaan* Dr. Potnis, the family physician who diagnoses Soumya’s illness, explains about HIV and its routes of transmission to her father as well as directly addressing the viewer in some shots. In *A Dove in Desert*, Dr. Chandra explains the disease to her fiancé Sankaran in a long passage that covers HIV’s mode of action, symptoms and the politics of “African AIDS” (Samuthiram 2001, pp. 117–121); and there are pedagogic inserts wherever the action shifts to the doctors in the novel and their clinics. *Ek Alag Mausam* does not directly address pedagogic concerns, as Aparna and the other characters are aware of how HIV is transmitted, but references to transmission and prevention occur in conversations; and there is a sequence in which Jeevan Jyoti volunteers conduct an awareness campaign at the brothel from where they rescue Rita. Besides, *Ek Alag Mausam* is about the stigma of AIDS rather than disease-preventive information, as the CEO of ActionAid India is reported to have told *The Hindu*: the film is a “message of dignity for the victims and is a means for reaching out to people, sensitising them and calling their attention towards clinics which work towards their cause. It is to create a value judgment for the sufferers who want to lead a normal life with goals and ambitions" (Siddiqui 2003). The presence of the doctor in the narratives serves an essential rhetorical function. As the voice of authority on matters of health and disease, the doctor lends credibility to opinions actually expressed by an author who is not a specialist. Further, the doctor's words translate the experience of illness into disease, just as the clinical settings in these narratives do, in what Gwyn calls a "reification" of experience: "One of the consequences of these processes of reification is that the medical establishment has authorized itself … to be the sole provider of their treatment, and has derogated rival systems and alternative healers as charlatans and quacks" (Gwyn 2002, p. 45). In *A Dove in Desert*, the quack is Pechimuthu, the local vaid who misleads Manohar into believing that he is disease-free (Samuthiram 2001, pp. 70–73).

Countering medicalization and its reifying effect is the narratives' focus on the subjective experience of the protagonists. By shifting from their medically diagnosed condition to an experience of illness that combines the bodily, emotional and social consequences of AIDS, the narratives present a complex understanding of the epidemic not reducible to any one dimension. Insofar as this is concerned, the views of the doctor are simply one perspective among other equally pertinent ones and certainly not the definitive understanding that medicalization promotes. This is what makes narratives of AIDS different from AIDS awareness projects that privilege biomedical information. It is also, as we will see in Chap. 6, one of the reasons for pedagogic interventions using narrative as a means of communicating information. It may be argued that whenever pedagogy needs to address AIDS as an ethical and social issue, it is narrative that must provide the framework because narrative emplotment connects the ethico-social domain of lived existence with its symbolic organization in discourse, in what Ricoeur terms "the 'metaphorical' transposition of the practical field by the muthos" (Ricoeur 1984, p. 46).

The shift from disease to illness in these narratives leads to two important effects. One is a focus on a process of healing that seeks to restore, not health because that is not possible with AIDS, but a sense of relative well-being best expressed in the phrase "living with AIDS". It is about overcoming fear, self-abjection and despair, accepting death as an eventuality but also willing oneself to live with dignity and developing a sense of positivity to counter the negation of self that an HIV-positive diagnosis brings. Since disease isolates, especially in the case of AIDS, it means seeking relationships and support systems both within the family and outside. If Soumya in *Nidaan* is able to accept death, it is because of her will to live and the support of her parents, husband and in-laws. Similarly, Kalaivani overcomes the emotional trauma of disease and betrayal by forming an organization to protect other women from suffering her fate, with support from Chandra and Kesavan. But the narrative that focuses exclusively on the need to heal is *Ek Alag Mausam*. Jeevan Jyoti is more like a commune than a clinic, where they are not "patients" but residents who help with gardening, cooking, comforting the dying and cremating them after death and running the home day to day. Dr. Machado gives them drugs smuggled from America, Ayurvedic preparations and herbal remedies – whatever is at hand and works. But more than medication, he gives them moral support: "Of course you will die", he tells them in a counselling session. "We will all die one day. Who will say when? Then why this fear of dying? What is important is that we are alive today" (Dattani 2005). *Ek Alag Mausam* constructs the epidemic not as catastrophe but human vulnerability, which is the second effect of the shift from disease to illness.

The concept of vulnerability, which literally means open to wounding,[12] has assumed importance in the context of theories of embodiment: to exist as embodied is to be open to the precariousness of life in the world. In *The Body and Society*, Bryan Turner argues that the sense of vulnerability is fundamental to the formation of community: "The afflictions and uncertainties of our social being generate inter-societal patterns of dependency and connectedness that in their more psychological manifestations result in sympathy and empathy, without which society would not be possible" (Turner 2008, p. 244). For Levinas, the experience of suffering calls for a response that is the basis of the "inter-human", the ethical responsibility that one bears to the other, which is both prior to and the foundation of community: "the suffering of suffering, the suffering for the useless suffering of the other person, the just suffering in me for the unjustifiable suffering of the Other, opens upon suffering the ethical perspective of the inter-human" (Levinas 1988, p. 159). The "inter-human" must be distinguished from the compassionate subject of media representations, which is like the banal form of responsibility that Levinas dismisses as "a simple exchange of courtesies" and "an 'inter-personal commerce' of customs" (Levinas 1988, p. 165). Unlike most AIDS narratives of the "innocent victim", *Ek Alag Mausam* does not interpellate its viewers as compassionate subjects; instead, it shows subjects bonding with one another in relationships of dependence and mutual assistance, bound together in their vulnerability.

Despite the focus on illness and healing and the concern with human vulnerability, however, the narratives are normative in their understanding of the moral import of disease. This is underlined by their choice of the "innocent victim" as protagonist. In *Nidaan*, Soumya's condition is understood against the transgressive conduct of those who seek pleasures of sex and drugs. *A Dove in Desert* allegorizes the difference between the guilty and the innocent in the inverse parallelism of Manohar's story and Kalaivani's. Linked to this are other dichotomies that construct the moral vision of the novel – the bad doctor and the good, the bad father and the good, the corrupt and the honest, those driven by self-interest and those who work selflessly. In *Ek Alag Mausam*, the travelling salesman, truck driver and prostitute are the "other" against whom Aparna's infection is understood. The most revealing instance of this conformity to norms is when the film attributes George's infection to blood transfusion and not sex, thus absolving him of guilt in the eyes of Aparna as well as the viewer and making possible the happy ending. There is a conflict between the ethical implications of healing and vulnerability on the one side and conformity to

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[12] "The concept of vulnerability is derived from the Latin for 'wound'. Although *vulnus* refers to real wounds in the human body, it is in many respects a metaphor for frailty. Wounds are open and they open us to life; the wound is a metaphor of the human condition" (Turner 2008, p. 244).

hegemonic social norms on the other, and this is because of the traditionally sentimental or melodramatic form. As Judith Laurence Pastore writes in the context of *At Risk*: "it is difficult to write a traditional novel about AIDS that remains true to the realities of the disease" (Pastore 1992, p. 41).[13] Pastore is right, but for the fact that AIDS, or for that matter any disease, has no reality except as it is represented – whether in medical discourse, journalism or literature. Insofar as the narratives represent human vulnerability as real, they counter the moralism that underlies the social reality of disease; but insofar as they reproduce the conventional plot of melodrama, they reinforce it. To return to our discussion of White and Ricoeur above, there is a tension in these narratives between their mode of emplotment and the explanatory paradigms within which they seek to recast the idea of disease. *A Dove in Desert*, which is perhaps the most overtly moralistic, has a passage where Kalaivani objects to a proposal for condom distribution on moral grounds, till Asokan convinces her otherwise:

> Kalaivani! None is born as a prostitute. It is all due to circumstances. You too had once involuntarily extended your hand to a lorry driver. If only Chandra had not intervened, what would have been your position? Your argument of chastity does not arise here, although, a commercial sex worker knows the importance of chastity more as a loser than as a housewife. (Samuthiram 2001, pp. 317–318)

The last sentence reveals an ambivalence that questions the norm of chastity even as it accepts and approves of it and is an apt instance of the complex relation that such narratives bear to the ideological-normative system.

Samuthiram wrote another novel where HIV/AIDS figures as a minor theme. *The Third Gender*, or *Vaadaa Mali* (1997) in Tamil, narrates the story of Suyambu, a rural youth studying in an engineering college in Chidambaram who suddenly discovers a strange desire to identify as a woman. Expelled from college and beaten severely by his father and brother, he runs away to live with hijras in a Chennai slum and then to Delhi where he is accepted into a gharana as the adopted daughter of its guru, Ganga Devi. After Ganga Devi's death, Suyambu, now castrated and renamed Mekalai, becomes the new guru and works for the upliftment of hijras. The theme of AIDS occurs briefly at the end of the novel, when Mekalai visits her old friend Fatima in the AIDS ward of a hospital in Chennai. Dr. Kantharaj gives them a lesson on HIV, how it is transmitted and how it can be prevented. The guilt/innocence binarism emerges in the distinction that Mekalai makes between homosexuals and hijras: "Homosexuals have themselves to blame for their condition", she declares, implying that hijras are not to be blamed (Samuthiram 2002, p. 285). *Vaadaa Mali* was first published in serial form in the Tamil magazine *Ananda Vikatan* in 1994 and subsequently published as a novel in 1997. The English translation was published in 2002 and was sponsored by UNAIDS as part of its AIDS awareness initiative. Insofar as the social history of

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[13] There are close similarities between *Nidaan* and Alice Hoffman's *At Risk* (1988), which makes Pastore's point relevant to the film. In both the protagonist is a teenage girl in a middle-class family who acquires infection through blood transfusion, and both stories are presented as family melodrama.

the epidemic is concerned, *The Third Gender* is indicative of the inclusion of hijras and transgendered persons in the risk groups for AIDS and as target of pedagogic strategies for behaviour change.

## 4.7 Disease as Culpability: *Phir Milenge* and *My Brother… Nikhil*

In the previous section, we looked at narratives that deal with the moral culpability of being diseased. The present section will examine two Hindi films that are about the question of legal culpability. A number of divergent discourses come together in constituting the AIDS epidemic as a problem: these are primarily the biomedical, moral, governmental and juridical. Whatever their degree of divergence, however, they are all ways of knowing disease that are linked to the exercise of power – that is, they generate techniques of social ordering and control, from epidemiological testing and risk reduction, stigmatization and social exclusion of the diseased, framing and implementation of policies for disease control and pedagogies of behaviour change to legal restrictions on the freedom and mobility of HIV-positive individuals. Linked to the practices they generate and authorize, they constitute what Foucault calls a "power/knowledge" formation. Further, these discourses are not insulated from each other, existing in discrete domains, but mutually inform and inflect one another. Thus, biomedical ideas about disease and contagion, as Sontag (1978, 1988) and Douglas (1966) have shown, are often modulated by moral metaphors; and disease control policies and pedagogies are informed by both medical and moral constructs, as too are laws and court judgments. Together, they form a practico-discursive ensemble that seeks to frame dominant explanations of epidemic, which are neither coherent nor unchanging. Transformations in the way the AIDS epidemic is understood take place when inconsistencies in the explanatory paradigm come to the fore and render it no longer tenable. My argument has been that these are not inconsistencies with regard to some external and objective reality of the disease but arise either internally when one set of ideas and practices conflicts with another or when they conflict with the subjective experience of illness. The two narratives that we will now discuss are imaginative instances of such transformation.

Like the narratives that we discussed in the foregoing section, *Phir Milenge* (2004) and *My Brother … Nikhil* (2005) are life stories of HIV-positive individuals. In the former film, Tamanna Sahni is sacked from the advertising firm where she works because of her infection. In the latter, Nikhil Kapoor is taken into custody when found to be infected, under a public health act of the state of Goa. In both instances, therefore, an HIV-positive individual is sought to be socially excluded contrary to their constitutional rights for no reason other than the presence of disease. As both films emphasize, these are unprecedented cases when there are no laws dealing specifically with HIV/AIDS, and it is legally difficult to redress the violation of their right to freedom and equality. Such violation is common in the event of diseases that are highly stigmatized, and the films are about the need for law to respond to it. In taking up this theme, thus, they add a new dimension to how the HIV/AIDS epidemic came to be understood and represented.

Tamanna Sahni is a young and competent advertising executive, creative head of TJ Associates. She is found to be HIV-positive when she donates blood for a surgery that her sister undergoes. Her boss Subramaniam sacks her because he is afraid that the stigma may adversely affect his agency's public image, though the reason he officially gives is professional incompetence. Tamanna decides to challenge this and, after losing the case in the lower court, eventually succeeds in the High Court on appeal. Tamanna acquires the infection from her lover Rohit – who, significantly, lives in the United States. Thus, while the film challenges stereotypes in not portraying her as "innocent victim", it confirms them by implying the "foreign origin" of AIDS. Rohit returns home when he is in the terminal stage of disease, and the second half of the film crosscuts Tamanna's victory in court with her emotional loss when Rohit eventually dies. Tamanna is finally reconciled to his death, sets up her own advertising agency and proves herself when she features on the cover page of *Business Today*.[14]

Nikhil Kapoor, too, is a successful person and has just been declared state champion in swimming when a routine blood test turns up positive. The state swimming association debars him, and he is not allowed into the pool. He is also turned away from home by his father and seeks refuge with his gay partner, Nigel, who is a scientist in the oceanography institute. When rumours reach the police, they take him into custody under a provision of the Goa Public Health Act and detain him in an abandoned sanatorium. Shocked by the stigma and panic in town, his parents leave for Mumbai, but his sister Anamika stays back to look after him. With the help of a sympathetic lawyer, Anamika, her lover Sam and Nigel fight Nikhil's case in court and simultaneously conduct a mass campaign to win public opinion in favour of Nikhil. He is released after 3 months in custody but finds that he has been sacked by the firm where he worked. He finds a job as music teacher in his former school and is gradually accepted back into society. Thus, Nikhil is able to lead a normal life with the help of others, especially Anamika, Sam and Nigel, who set up a support group for the HIV-positive. He is also reconciled to his parents, who eventually bring him back home. When Nikhil dies they accept Nigel as a son, indicating that they are reconciled also to Nikhil's gay sexuality.

The stories of Nikhil and Tamanna express two related themes, the stigmatization of the HIV-positive and the need for law to protect them from stigma. Both are accounts of how society discriminates against people with disease, until law eventu-

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[14] The plot of *Phir Milenge* closely resembles that of *Philadelphia* (1993), a Hollywood film that recounts the story of a young gay lawyer sacked by his boss when he is diagnosed with HIV disease. In both films, the protagonist's counsel is young and inexperienced but presents his case passionately, the only difference being that Andrew Beckett's lawyer in *Philadelphia* is black and therefore subject to discrimination himself. In both, again, victory in court is juxtaposed with death and loss – in *Philadelphia* the death of Andrew himself. If *Phir Milenge* is a remake of *Philadelphia*, however, it is nowhere acknowledged in the film's credits or publicity.

ally comes to their rescue. While the court is the central institution in resolving the crisis of disease, the two films approach it in divergent ways. In *Phir Milenge* the main action is courtroom lawyering, while in *My Brother … Nikhil*, it is mobilizing public sympathy. In fact, the court is never shown on-screen, even though it plays a crucial role in turning around Nikhil's life. The difference is important in the way the films understand the relation between law and stigma in the context of disease.

Stigma, disease and law refer to three distinct domains of knowledge: stigma exists in the field of morality, disease in that of medicine and law in that of jurisprudence. Though distinct, these domains are linked through the common function they serve in regulating the conduct of individuals and preserving social order. Albert (1986) argues that the system of morality is the oldest and is premodern, while those of law and medicine appear later in modernity. Albert's historical schema may not be quite accurate, for medical and legal systems have existed alongside institutions of morality in most, if not all, societies. But it is true that these are the three principal sources of social control, which work by distinguishing the "normal" from the "abnormal" in terms of ideas of deviance, illness and illegality. The difference, however, is that in modern societies medicine and the law are understood as "objective" modes of knowledge, rational systems based on the privilege of evidence, while morality is not. Hence the assumption, in the context of discrimination against HIV-positive people and violation of their rights, that law can remedy the wrongs that are committed in the name of public morality.

*Phir Milenge* reflects this assumption without question and confirms it narratively when Tamanna and her lawyer Tarun eventually succeed in securing the protection of the law. If their petition fails in the lower court, it is because Tarun is a young lawyer and is not able to argue and present his case as effectively as the much more experienced counsel for TJ Associates. In other words, if the court is not able to render justice, it is lawyering that is at fault, not law. This is the implication of most representations of courtroom drama: they are tests of the ability of the lawyer, or sometimes of the validity of a statute, but rarely of the *rationality* itself of law. Courtroom dramas, in other words, are conservative: they conserve what is assumed to be the normative function of law. The plot of *Phir Milenge* presents an opportunity to question law's rationality, in the judgment of the lower court, but fails to take it up. The court rules that both defences claimed by Subramaniam that Tamanna acted incompetently and that he was not aware of her HIV status when he sacked her are false but also hold that in sacking her Subramaniam did not act outside the law. In other words, the court believes that Subramaniam sacked Tamanna because she was HIV-positive, which is in principle contrary to the constitutional right to equality. How can his act then be within the law, unless law does not recognize Tamanna's right to equality or suspends it because of her condition of disease? Infectious disease becomes a crisis for the law when the right of the diseased persons appears to be in conflict with the right of those who may presumably be infected by them. In such case, law often resorts to what is implicitly a withdrawal of its protection from the diseased, in ensuring the protection of the larger public. Had *Phir Milenge* taken up this issue in the hearings before the High Court, it could have opened up the inconsistencies in law's rationality, to show how decisions are made not always on objective grounds but often because of the very stigma that law is expected to counter. The film shows the lower court hearings in great detail on-screen, but of the High Court it shows only what appears to be Tarun's summation. I argue that this was because it could not imagine law to be otherwise than what it assumes it to be: a rational system based on objectivity rather than one influenced by the ideological presuppositions of stigma.

The absence of lawyering in *My Brother … Nikhil* points to a different understanding of law. Nikhil's lawyer advices them not on points of law, as Tarun does in *Phir Milenge*, but on the need to gain public sympathy. The effort to restore justice begins outside, in the space of public opinion where stigmatization operates, and its restoration in the law court follows. This may be read in two ways. While it may not be a conscious intention on the part of the filmmaker to question the rationality of law and to show how legal decisions are influenced by popular perceptions, it clearly does not reflect the understanding of law as a normative institution that is fundamental to legal positivism. It cannot be that the film is more concerned about public stigma than the question of law, for it is the injustice of the Goa Public Health Act that provides the primary motivation for the plot. *My Brother … Nikhil* does not assume law to be insulated from morality but continuous with it even as it distances itself from it and upholds reason rather than morality as its norm. This is an important perception, for it leads us to ask why there is no law to protect the rights of the HIV-positive. Both the films point to this question explicitly, but do not pursue it. The answer is not that AIDS was unprecedented when it emerged as a legal issue. There are laws against people transmitting their infection to others, for law is obliged to protect the lives of its subjects. There is also at present a law against those who discriminate against the diseased and violate their right to equality. The HIV/AIDS Prevention and Control Act, 2017, is the first legislation in the country to protect the rights of the diseased. But, significantly enough, it is silent about the discriminations built into the system of law itself, when statutes provide for the social exclusion of the HIV-positive. The question before the law, therefore, is whether the presence of disease can be a reasonable ground for excepting people from the "equal protection" that it guarantees to them under the constitution.

*Phir Milenge* and *My Brother … Nikhil* are not pedagogic insofar as information about AIDS is concerned, presumably because their middle-class audience was well-informed about HIV by the time the films were made. Though reference to transmission routes appears in conversations, the pedagogic function is not overt, and there is no doctor to act as its credentialed spokesperson. This is where they differ most significantly from *A Dove in Desert*, *Nidaan* and *Ek Alag Mausam*. Pedagogy here functions with regard to stigma, and especially stigma that leads to the violation of legal rights of the HIV-positive. *Phir Milenge* and *My Brother … Nikhil*, in other words, are symptomatic of a construction of the HIV/AIDS epidemic that shifts from biomedical to social frames of explanation and from a discourse of compassion to one of rights and their restitution. It is this construction that figures prominently in the social understanding of the epidemic today.

## 4.8 Conclusion

The HIV/AIDS epidemic first appeared in India in 1986, triggering at once moral panic and stigmatization of infected individuals as well as risk groups, through negative stereotypes that the media circulated and reinforced. By the end of the first decade, however, much of the panic had decreased, especially after the availability of antiretroviral therapy made it possible to see AIDS as a fatal but manageable illness. At the same time, the epidemic spread outside the identified risk groups and became a matter of general concern. The narratives of AIDS that were published at the turn of the century emerge from this conjuncture of events. We note a number of important shifts in the way these narratives construct the epidemic.

1. AIDS comes to be seen as a social rather than biomedical issue, both in terms of the stigma that it generates and the structural factors like gender and economic inequalities that make people vulnerable to infection.
2. Pedagogy comes to be understood as the only means of controlling the epidemic by inducing disease-preventive and risk-avoidance behaviour, especially since there is no vaccine available. Most of the narratives examined in this chapter are associated with pedagogic projects, either commissioned or subsequently sponsored by them, and all include a pedagogic component. In some narratives, like *Sex, Lies and AIDS*, *Nidaan* and *A Dove in Desert*, the pedagogic function is overt, while in others it is less obvious.
3. There is also a shift from a macrosocial perspective, mapping the extent and scale of disease incidence, to a micro-social one that focuses on the individuals affected. In terms of narrative mode, the epidemic comes to be constructed through two forms of writing, the travelogue and the life narrative, with the emphasis gradually shifting to the latter.
4. An important aspect of these narratives is that they are all produced by and addressed to people who are not themselves infected, and there is a tendency to represent and distance the HIV-positive as objects of compassion. This is more pronounced in the early texts, both factual and fictional, in narrating the life stories of people who have acquired the infection not through "promiscuity" but "innocently", either through blood transfusion or from their spouses. By reproducing the guilt/innocence binary, they unwittingly reinforce the stigma that they seek to counter. In this context, *Phir Milenge* and *My Brother … Nikhil* are exceptions.
5. With the emergence of life narratives, AIDS comes to be understood more as illness than disease – that is, a condition that involves the whole person rather than the body as an entity separate from the self and emphasizes the subjective experience of illness rather than the objective pathologies of biomedicine. Accompanying this is a concern with healing, as the process of developing a sense of emotional and spiritual well-being despite the presence of disease.

6. Some of the narratives express the theme of human vulnerability and the need to overcome it through establishing bonds of community and support systems. This theme coincides with a major development in the epidemic when positive people networks are formed to counter stigma, self-abjection and isolation, through the embodied affiliations that Paul Rabinow calls "biosociality". In the context of the epidemic, biosociality bears an inverse relation to stigma: Both involve the body, but while stigma devalues it as diseased, biosociality invests it with a new value as foundation of community. The shift to biosocial affiliation in turn corresponds with the emergence of two new conceptualizations of embodiment in the epidemic: the use of the term "person living with HIV/AIDS" (PLWHA), with its emphasis on *living* with AIDS instead of *dying* of it, and the transformation of "positive" from a sign of disease in the diagnosis of AIDS to a sign of self-affirmation in "positive people". These discursive articulations constituted a meaning of AIDS opposed to that assigned to it in the first decade of the epidemic.
7. Finally, with *Phir Milenge* and *My Brother … Nikhil*, we note a shift in the understanding of AIDS from a socio-economic problem to a problem that law must address, in protecting the rights of the HIV-positive. The epidemic thus comes to be complexly constructed and represented as simultaneously a medical, economic, social and juridical phenomenon.

*My Brother … Nikhil* was based on an actual incident, when Dominic D'Souza, an HIV-positive gay man, was arrested under a provision of the Goa, Daman and Diu Public Health Act, 1985, and kept in custodial detention in an abandoned sanatorium for more than a month. His mother Lucy D'Souza approached the government with no effect and finally petitioned the Goa bench of the Bombay High Court and secured his release. She filed another petition challenging the concerned provisions of the act, but the court dismissed it as without merit. The gap between the two judgments, one restoring Dominic's right to freedom and the other upholding the statute that set it aside, reveals a fundamental ambivalence in the way law understands the diseased body. The next chapter will examine the implications of this ambivalence.

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# Chapter 5

# AIDS and the Enigma of Law

**Abstract** A distinctive feature of the AIDS epidemic is the way it has been problematized in law. On the one hand, law seeks to counter social stigma and discrimination and to restore to diseased individuals their rights as subjects. On the other, it has tended to exclude them as sources of risk and a danger to public health. This chapter explores the enigma that the diseased body presents before law, by analysing a number of court judgments regarding the rights of persons with disease.

**Keywords** Structure/process · Biopolitics · Legal normativity · Judicial interpretation and indeterminacy · Anomaly · Medico-legal regime

Chapter 3 concluded with two films that are about the legal issues entailed in the epidemic, with regard to discrimination against the HIV-positive. *Phir Milenge* is about discrimination at the workplace, which takes the form of stigmatization by co-workers and employers, denial of benefits and termination of service. If termination of service is less common than other forms of exclusion, it is most often because employees do not disclose their serostatus. In a UNAIDS-sponsored study, Shalini Bharat, Peter Aggleton and Paul Tyrer report: "Many had a strong fear of social isolation and stigmatization, and they worried about losing their job if they were to reveal their status" (Bharat et al. 2001, p. 34). *My Brother … Nikhil* is about discriminatory laws that curtail the rights of people with disease. In India, a number of statutes provide for restrictions on individuals with infectious disease, with the intention of safeguarding the right to life of those who are presumed to be healthy. To cite a few instances: Section 53 of the Goa, Daman and Diu Public Health Act, 1985, empowers the government to test individuals suspected of being infected with HIV and isolate them if found positive; Section 16(1)(iv) of Chapter III of the Orissa Municipal Act, 1950, disqualifies from public office persons with leprosy, tuberculosis or mental illness; Special Marriage Act, 1954, Indian Divorce Act, 1869, Parsi Marriage Act, 1936, and Dissolution of Muslim Marriage Act, 1939, all provide for the dissolution of a marriage on grounds of infectious sexual disease. Implementation of such statutes by the authorities has involved the curtailment or suspension of fundamental rights of diseased individuals, especially the right to life under Article 21, right to freedom under Article 19 and right to equality before law

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under Article 14. *My Brother … Nikhil* and *Phir Milenge*, in highlighting the legal dimensions of the epidemic, call attention to the way law understands and responds to the diseased body.

There is an enigmatic moment in *Phir Milenge*, when the lower court acknowledges that Tamanna was terminated from service because of HIV-related discrimination but holds the termination – and, therefore, the discrimination that underlies it – to be within the law. The film, however, fails to explore this enigma, and the matter is settled when the High Court rules in her favour. *My Brother … Nikhil*, in seeking to counter a discriminatory statute, turns to public opinion and thus suggests that law and moral norms are not as discontinuous as they are assumed to be. By keeping the legal process entirely off-screen, however, it fails to show how law attempts to resolve this crucial issue. This will become apparent when we discuss below the judgment of the case on which the film was based, the detention of Dominic D'Souza under the Goa, Daman and Diu Public Health Act, 1985. The two films, therefore, point to a problem that lies within the law but stop short of bringing to light its deeper implications. This is perhaps because they assume law to be based on a rationality that might occasionally be infiltrated by the irrationality of stigma but is eventually able to free itself. The narrativization of the epidemic as a medico-legal issue is not able to develop into a critique of law because of what Pheng Cheah and Elizabeth Grosz, in their characterization of rationalist legal theory, describe as "the premise that law embodies universal reason and truth" (Cheah and Grosz 1996, p. 3).

## 5.1 Structure and Process in Law

The legal system is often understood to be a coherent structure of rules, procedures and remedies that serve as a framework for maintaining social order, a view that ultimately derives from Thomas Hobbes' hypothesis in *The Leviathan* that law emerged as a mechanism for the preservation of the community against the baser instincts of individuals.[1] This is despite the fact that the legal system has actually developed in piecemeal fashion, in ways that are often contingent on needs that have emerged historically. Thus, H.L.A. Hart in *The Concept of Law* argues that law is a hierarchically coordinated structure of "primary rules of obligation" and "secondary rules of recognition, change and adjudication" that is the "heart of the legal system" (Hart 1961, p. 98). "Making the bits and pieces 'systematic'", writes Sally

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[1] Thus, Hobbes writes in the opening of the Second Part of *The Leviathan*: "The final cause, end, or design of men (who naturally love liberty, and dominion over others) in the introduction of that restraint upon themselves, in which we see them live in Commonwealths, is the foresight of their own preservation, and of a more contented life thereby; that is to say, of getting themselves out from that miserable condition of war which is necessarily consequent, as hath been shown, to the natural passions of men when there is no visible power to keep them in awe, and tie them by fear of punishment to the performance of their covenants, and observation of [the] laws of nature" (p. 103).

Moore, "is the after-the-fact work of professional specialists, or the before-the-fact work of political ideologues" (Moore 1978, p. 9).

The systematization of law as a pedagogic technique is undertaken to constitute it as a "science" of jurisprudence. To conceive of a field of knowledge as a science is to emphasize its objective dimensions and to excise from it whatever is held to be subjective:

> For the bulk of modern jurisprudence, the law is public and objective; its posited rules are structurally homologous to ascertainable 'facts' that can be found and verified in an 'objective' manner, free from the vagaries of individual preference, prejudice and ideology. Its procedures are technical and its personnel neutral. Any contamination of law by value will compromise its ability to turn social and political conflict into manageable technical disputes about the meaning and applicability of pre-existing public rules. (Goodrich et al. 1994, p. 17)

Chief among the subjective ways of knowing that this scientific view of the legal system must expunge is morality, understood as an amorphous set of norms and preferences that lack both consensus and universal reason. If *Phir Milenge* opposes law to stigma, and presents law as that mode of knowledge and practice that can remedy the biases of stigma, it is because of this assumption of law's foundation in objectivity and reason. The systematization of law as a political ideal, in contrast, is based on an ideological notion of wholeness or integrity as a value, which is not to say that the scientific ideal is any less ideological. As Foucault rhetorically asks: "Which speaking, discoursing subjects – which subjects of experience and knowledge – do you then want to 'diminish' when you say: 'I who conduct this discourse am conducting a scientific discourse, and I am a scientist'?" (Foucault 1980, p. 85). As the privileged episteme of modernity, science – whether it is biomedical or jurisprudential – is linked to networks of power and knowledge that are ideologically structured. One of the points that we will attempt to bring out in the sections that follow will be the influence that moral norms and preferences exercise on judicial decisions presumed to be based on scientific facts and the ambiguity in these judgments about what constitutes the scientific truth of disease.

Apart from the ideological persuasions of a scientific or political model, the systematization of law as coherent structure leads to the suppression of contingencies that can come to light only in the process and practice of law. In fact, that is one of the main arguments against an overdue emphasis on structure in the human sciences. To understand the practice of morality, argues Foucault, it is not enough to identify the "'moral code'": it is equally necessary to "determine how and with what margins of variation or transgression individuals or groups conduct themselves in reference to a prescriptive system that is implicitly or explicitly operative in their culture," what he calls "'the morality of behaviors'" (Foucault 1985, pp. 25–26). In outlining a theory of cultural performance, Victor Turner posits what he calls "the 'ethnography of speaking'", against the "abstract and hence static patterns and structures" by which structuralist anthropology sought to analyse socio-cultural existence (Turner 1987/1988, p. 21). Similarly, Michel de Certeau opposes practices or "ways of operating" to the structure or "grid" of disciplinary systems, to bring to light the complex link between the "socio-economic order" and the contingent tactics through which individuals negotiate their relation to it (de Certeau 1984, p. xiv). Theories of process or practice do not disregard the notion of structure but focus on its transformation over time in addition to its synchronous regularities. This is what Anthony Giddens calls the "duality of structure", the idea that structures both govern practice and are in turn constituted and reconstituted in it, in "the *fundamentally recursive character of social life*" (Giddens 1979, p. 69, italics in original). Thus, Giddens prefers the term "structuration" to indicate this dialectical relation between structure and process and, implicitly, between synchrony and diachrony. Similarly, in a discussion of the structure of ritual activity, Catherine Bell uses the term "ritualization" to indicate the process by which certain acts come to be distinguished from other acts and from their everyday contexts in being structured and coded as ritual (Bell 1992, p. 74). Both are process-oriented terms and indicate how structures are formed and transformed in the process of activities that they simultaneously govern. The transformations happen when contradictions between the abstract structure and the contingent reality become insuperable, a point that we will discuss in detail when we examine the court judgments. As Sally Moore writes in the context of law but which is equally true of other contexts of social existence: "A model that is artificially timeless and focuses exclusively on regularities and systematic consistencies is useful because it is selective; but being so selective it has severe limitations. The question repeatedly raised in the last two or three decades is, whether a focus on regularity and consistency should not be replaced by a focus on change, on process over time, and on paradox, conflict, inconsistency, contradiction, multiplicity, and manipulability in social life?" (Moore 1978, p. 37).

In the instance of law, the process that is central to it is adjudication and the decision, textually inscribed in the judgment. In the process of adjudication, the court judgment performs a number of functions. Firstly, it correlates statute and act, that is, determining which portion of the law applies to the act under scrutiny. If law is understood as a taxonomy of legal and illegal acts,[2] the judgment tries to fit particular acts to the general categories that the system of law defines. Secondly, it determines the outcome: in the case of criminal acts, for instance, the fixing of responsibility and the determination of penalty in a calibrated ratio of guilt and punishment. In determining the applicability of law to act and its juridical outcome, the judgment necessarily interprets both law and fact in what Robert Cover calls "the hermeneutic of the texts of jurisdiction" (1986, p. 1613). Ronald Dworkin (1982) and Stanley Fish (1989) have likened this to literary interpretation, an analogy to which we will return in our discussion of interpretation and indeterminacy in law. Finally, and this is especially when it is the question of the validity of a statute, the judgment explains the rationality of law, its intention or reason. To understand

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[2] Cf. Hart: "law must predominantly, but by no means exclusively, refer to *classes* of person, and to *classes* of acts, things, and circumstances; and its successful operation over vast areas of social life depends on a widely diffused capacity to recognize particular acts, things, and circumstances as instances of the general classifications which the law makes" (Hart 1961, p. 124, italics in original).

how law regulates the social order, it is not enough to examine its system or structure: we must also look at the process in which this structure is realized, and the court judgment is the quintessential instance and textual inscription of this process.

## 5.2 Law and the Enigma of Biopolitics

Before we proceed to the discussion of the court cases, it is necessary to examine briefly the link between law, medicine and the body, to understand how disease poses a problem for the law. In explaining this link, I draw on Michel Foucault's account of modern governance as a "biopolitics". Foucault was certainly not the first to use this term: it was introduced by Rudolf Kjellén in 1920 in *Outline for a Political System* to refer to the homology between the organism and the state as a *body* politic. This was then developed in different directions by a range of authors to stress the parallels between the laws of nature and of governance, disease and political crisis, the body's immunity and the state's defence (Esposito 2008, pp. 17–24). Foucault's originality lay in situating biopolitics in the context of modern networks of power, not just as an analogy for politics but functioning as the key principle in the political rationality of the state. Briefly, biopolitical governance emerges when, starting in the eighteenth century in Europe, the life of subjects becomes an element in the calculations of statecraft. The politicization of life, which marks "a society's 'threshold of modernity'", (Foucault 1978, p. 143) first manifests in Europe in the institution of the police, an administrative wing of the state that deals with matters like health, food supply, housing, education, family welfare, support of the infirm and the aged, work and recreation and religion and morals – in short, the physical, moral and spiritual well-being of the people as a whole. If this becomes a central element of the state's reason, the *raison d'Etat*, it is because the state can thrive only if its subjects are happy, healthy and productive and can contribute to the wealth of the state: "the objective of the police is everything from being to well-being, everything that may produce this well-being beyond being, and in such a way that the well-being of individuals is the state's strength" (Foucault 2007, p. 328). Subsequently, when from the nineteenth century onwards the role of the police is restricted to the maintenance of law and order, other departments of the state bureaucracy take over its biopolitical functions. Foucault distinguishes biopolitical governance from sovereignty and posits them in a neat antithesis: "The right of sovereignty was the right to take life or let live. And then this new right is established: the right to make live and let die" (Foucault 2003, p. 241). In the modern state's pursuit of this right, medicine as the science of human life becomes the privileged form of knowledge, in "the general medicalisation of behaviours, conducts, discourses, desires, etc." (Foucault 1980, p. 107). Foucault's critique of the governmental exercise of power in modernity brought to the fore the role of medicine in the regulation of society. On the one side is a clinical practice centred on "individual examination, diagnosis and therapy" while on the other is public health, "the concurrent organisation of a politics of health, the consideration of disease as a political and economic problem" (Foucault 2000a, pp. 90–91). If one functions as a disciplinary mechanism to normalize individuals, the other functions as a regulatory apparatus to normalize populations. Medicine comes to be constituted thus as the instrument of a biopolitical governance that continuously extends its authority on the microsocial as well as macrosocial level. In the first volume of *The History of Sexuality*, Foucault characterizes the institutionalization of this mode of power relations as the convergence of two linked procedures: a disciplinary "*anatomo-politics of the human body*" and a regulatory "*biopolitics of the population*" (Foucault 1978, p. 139, italics in original).

In the context of the body, medical authority functions alongside the authority of law in the exercise of social control. Foucault makes an initial distinction between law and discipline as techniques of control. Both techniques depend on the separation of the abnormal from the normal, structured on an acceptable level of risk that is taken to be the norm. But while law separates to exclude and penalize the abnormal, discipline separates to transform and normalize them. He then links law and discipline in the modern form of the exercise of power, when law begins to function as a normalizing force in prisons that are now appropriately called "penitentiary", "reformatory" or "correctional facility". In our times, writes Foucault, "the procedures of normalisation come to be ever more constantly engaged in the colonisation of those of law" in "the global functioning of what I would call a *society of normalisation*" (Foucault 1980, p. 107, italics in original). However, when law and medicine converge in what we may call a medico-legal regime of power, it is not law that is modified and "humanized" by discipline but the disciplinary apparatus of medicine that acquires the power to impose sanctions and exclude those who are diseased. Or, more accurately, medicine serves to explain and justify law's exclusion of the abnormal. In an essay on nineteenth-century legal psychiatry, Foucault notes how law began to concede to the medical expert the authority to decide when it was faced with a number of crimes committed with full knowledge and intention but without reason. He traces the evolution, through a number of shifts in the relation of law and medicine, of "a perpetual mechanism of summoning and of interacting between medical or psychological knowledge and the judicial institution" that resulted in the medicolegal concept of the "dangerous individual" or the person who poses a danger or risk to society (Foucault 2000, p. 199). The concept empowers law to socially exclude such persons on the basis not of what they do, acts that *actually* harm others, but what they are, in being constitutionally or by character *predisposed* to harm others. "A form of justice that tends to be applied to what one is", writes Foucault, "is what is so outrageous when one thinks of the penal law of which the eighteenth-century reformers had dreamed, which was intended to sanction, in a completely egalitarian way, offenses explicitly defined beforehand by law" (Foucault 2000, p. 199). This shift in the medico-legal paradigm from act to person, and from actual guilt to the presumption of guilt, explains why persons with infectious disease can be segregated and incarcerated even when they have not infected anyone. In being incarcerated as "dangerous individuals", they may not be made more amenable to discipline and reform, but the risk they pose to society can be neutralized.

In the main, however, Foucault did not bring together, as he did in the "Dangerous Individual" essay, his ideas on medicine and law as mechanisms of control. In *Discipline and Punish*, thus, he considers law separately, as the coercive instrument of sovereign power that is modified by governmentality, losing some of its punitive function in taking up the task of rehabilitating the offender. He discusses techniques that emerge in the prison, such as panoptic surveillance, which then come to be utilized in hospital architecture, but does not examine the coordination of law and medicine in the control of subjects of government. The theme of medicine's political role recurs throughout Foucault's account of the modern state, with essays like "The Politics of Health in the Eighteenth Century" and "The Birth of Social Medicine" focusing exclusively on medicine as "social hygiene". But the emphasis is on its positive function in a biopolitics that is productive and includes the healthy as well as the infirm, in its bid to optimize the productivity of its subjects.

The decisive link between medicine and the law must be sought not in a productive exercise of biopolitics but in its negative declension, which Foucault mentions but does not elaborate. In *Society Must Be Defended,* he examines a paradox that appears at the limits of biopolitics, when the right to "make live" turns into its antithesis, the power to "take life": "How can a power such as this kill, if it is true that its basic function is to improve life, to prolong its duration, to improve its chances, to avoid accidents, and to compensate for its failings?" (2003, p. 254). Foucault resolves the paradox by seeing it as the juxtaposition of sovereign right and biopolitical obligation, with Nazism being its "paroxysmal" instance: "The two mechanisms – the classic, archaic mechanism that gave the State the right to life and death over its citizens, and the new mechanism organized around discipline and regulation, or in other words, the new mechanism of biopower – coincide exactly" (Foucault 2003, p. 260). However, by taking instances from Nazism and atomic power, he neglects to see how the paradox operates in familiar contexts, such as the denial of rights to the diseased on the ground that they pose a threat to the public. There is a clear link here to the argument he develops in the "Dangerous Individual" essay, which is worth emphasizing because it can problematize decisions regarding persons with disease that are apparently unproblematic. Of course, modern democratic states, unlike the Nazi state, do not normally exterminate their ailing populations,[3] but literal killing is not what Foucault has in mind. Rather, what he means is "indirect murder", which includes "political death, expulsion, rejection" (Foucault 2003, p. 256). The denial of rights to persons with disease and the withdrawal of the protection of law is a "killing" of the same order. The court judgments that we examine in the following sections oppose the exercise of their constitutionally

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[3] In October 1939, Adolf Hitler initiated the Tiergartenstrasse 4 programme to terminate the lives of people with incurable diseases, mental or physical disability, and the elderly. As Giorgio Agamben notes, this was based on the juristic concept of *lebensunwerten Leben* or "life unworthy of life", propagated by Karl Binding and Alfred Hoche in an essay titled *Authorization for the Annihilation of Life Unworthy of Being Lived*, in which they justified the extermination of the ill in order to nurture the lives of those considered to be valuable to the state (Agamben 1998, pp. 136–139). The concept of *lebensunwerten Leben*, therefore, is an apt instance of the limits of biopolitical rule that Foucault examines.

guaranteed rights to the threat they are assumed to pose for the public, even as it is admitted that HIV (or, in one case, leprosy) is not easily transmissible. We need to approach the logic of this exclusion not in terms of the opinions and beliefs of a particular judge but as a function of the way the medico-legal order understands the diseased body. Law, writes Ronald Dworkin, "is not a matter of personal or partisan politics" (Dworkin 1982, p. 527), and the interpretation that a particular judge places on a statute, its validity or applicability, is constrained to a large extent, if not entirely, by an understanding implicit in law as a system, which precedents are supposed to bring out.

While discussing judgments that rule to exclude persons with HIV, we must bear in mind that an equally good number of judgments have upheld their rights as well. For instance, in *MX v. ZY* (1997), the Bombay High Court ruled that HIV infection cannot be a ground for removal of an employee from service, nor can a public sector undertaking deny employment to a person on the same ground. MX was working as a casual labourer in a public sector corporation ZY and was due for confirmation as a regular employee. Initially, medical tests certified his fitness for the job and he was selected. Subsequently, however, he was found to be HIV-positive, and his name was deleted from the selection list and his contract as casual labourer terminated. After consulting international guidelines regarding HIV-related discrimination at the workplace and precedents, and taking into account the petitioner's medical reports, the Court was convinced that he posed no risk to the health of other employees and was fit to work in the capacity to which he had been appointed. His removal from service was in violation of Article 14 (right to equal protection of law) and Article 21 (right to life) of the Constitution and was therefore illegal. The Court ordered the corporation to reinstate him as casual labourer, allow him to reapply for full-time employment and pay back wages since the date of his dismissal. *MX v ZY* was a landmark judgment and "for the next two years the rulings from the Indian judiciary began to advance the rights of individuals afflicted with HIV" (Krishnan 2003, pp. 806–807). In a number of cases pertaining to HIV-related discrimination at the workplace, courts ruled in favour of the petitioners.[4] What this shows is that the social exclusion of the diseased body in law was not a consistent phenomenon, which may be due to different approaches that courts have taken to the problem of infectious disease. But, taken together, the judgments show how underlying contradictions and inconsistencies emerge in the process of law, which may not be apparent in the legal system. They reveal a fundamental indeterminacy in law's understanding of the diseased person, perceived in a characteristic polarization either as a threat to the social body or as a legal subject vested with inalienable rights.

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[4] The list of discrimination cases successfully litigated by Lawyers Collective, a non-governmental organization working for human rights, includes *MX v. ZY* (1997), Bombay High Court; *CSS v. State of Gujarat* (2001), Gujarat High Court; *Badan Singh v. Union of India* (2002), Delhi High Court; *X v. State Bank of India* (2002), Bombay High Court; *G v. New India Assurance Co. Ltd.* (2004), Bombay High Court; *S. Indian Inhabitant of Mumbai v. Director-General of Police, CISF* (2004), Bombay High Court; *RR v. Superintendent of Police &* (2005); and *X v. Chairman, State Level Recruitment Board* (2006) (Lawyers Collective, *Judgment & Orders*).

## 5.3 Segregating the Diseased: *Lucy D'Souza V. State of Goa*

On the morning of 14 February 1989, Dominic D'Souza, a 29-year-old employee of the World Wildlife Fund living in the parish of Varra in South Goa, was arrested and placed under custodial detention in an abandoned sanatorium for TB patients. Dominic had donated blood at the local hospital, and it was found to be HIV-positive. This was Goa's first known case of HIV infection, and the stigma against AIDS – and possibly his gay lifestyle – cost him both his freedom and his job. Dominic was detained under Section 53(1)(vii) of the Goa Daman and Diu Public Health Act, 1985, as amended by the Goa Public Health (Amendment) Act, 1987, which empowers the Health Officer to order the removal of a person with infectious disease to a hospital or other appropriate place, if it appears to the Health Officer that "his presence is a danger to the people in the neighbourhood". Goa is a place frequented by foreign tourists, and in the late 1980s, AIDS was still perceived as a disease of foreigners. Dominic's case triggered apprehensions about a possible outbreak of epidemic, and the reaction of the government was swift. His mother Lucy D'Souza and a friend, Isabel de Santa Rita Vaz, approached health department officials, legislators and even the chief minister of Goa to get him freed, but to no avail. Eventually in late March, Lucy filed a petition for his release in the Goa Bench of the Bombay High Court, and Dominic was set free on an interim order dated 18 April 1989, after more than 2 months of confinement (Dube 2015, pp. 141–145). The court, significantly, did not find any illegality in the statute under which he was detained but ordered his release on the ground that "the blood test given to D'Souza was deemed unreliable" (Krishnan 2003, p. 798). After his release, Dominic became active in creating awareness about HIV/AIDS and founded a voluntary organization called Positive People, with Isabel Vaz, Cynthia Andreda, Loreto Pinto and a few other friends. Positive People was formally registered on 8 May 1992, and Dominic died of complications due to AIDS about a fortnight later, on May 27. In a documentary film on the 25th anniversary of Positive People and a tribute to Dominic, Isabel Vaz states: "When Dominic was found to be HIV-positive, the personal trauma that he went through gave him, I think, the motivation to try and make it easier for people who were caught in the same kind of situation" (Muller 2017).

*Lucy D'Souza v. State of Goa* (1989), which was heard in the Goa Bench of the Bombay High Court, sought to challenge the validity of Section 53(1)(vii) of the Goa, Daman and Diu Public Health Act on four grounds: (a) the mandatory isolation provision lacks scientific basis; (b) it is counter-productive; (c) the discretion of the Health Officer to isolate is unguided and uncontrolled; and (d) it is procedurally unjust in the absence of right of hearing. The petitioners also claimed that the provision violates the right to equal protection of the law under Article 14, right to freedom of movement throughout the territory of India under Article 19(1)(d) and right to life and personal liberty under Article 21 of the Constitution. The Court dismissed the petitioners' contentions point-by-point and held that the isolation provision was reasonable, procedurally correct and not violative of the constitutionally guaranteed rights. Subsequently, as the judgment notes, the Goa Public Health (Amendment)

Act, 1989, made isolation a discretionary requirement to be decided by the State and not the Health Officer, but Dominic's detention was prior to this amendment. As Anand Grover of Lawyers Collective, the counsel for the petitioners, stated in *Dominic's Dream*, "the case was actually dismissed but Government was persuaded not to bring in a drastic law which had mandatory testing, breach of confidentiality, and then isolation" (Muller 2017).

With regard to the petitioners' claim that the isolation provision was unscientific, the Court responds in two ways. It first presents the science of AIDS as uncertain, with many of its findings being inconclusive and contradictory, in order to weaken the claim of the petitioners. "Science, with all its progress, yet does not know the origin of HIV… Research into the causes and cure of the disease is going on and is still incomplete. From time to time varying and sometimes even conflicting expert reports are published by various organisations including World Health Organization (WHO). It appears that AIDS still continues to be a subject upon which much has remained to be said" (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 358). In other words, it dismisses scientific knowledge of HIV/AIDS and the reports of international organizations as inaccurate and unreliable. Then, it relies on a Brown University publication on "Managing AIDS Patients" and a publication of the National Institute of Communicable Diseases (NICD), Government of India, to establish a scientific basis for isolation. Further, from the Court's citation of these documents, neither of them appears to recommend isolation in asymptomatic cases of HIV infection like Dominic's: the cited passage of the Brown University document recommends it for "AIDS associated conditions such as infectious diarrea or tuberculosis", while the NICD citation is not about isolation at all but surveillance of risk groups (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 358). With regard to the charge of being counter-productive, the Court admits that this may be true at times because it may drive people underground and that the ideal way of dealing with the epidemic ought to be "science and not discrimination". Yet it holds that "'ideal' is not always 'practical' in life," and when "such a high risk to public health exists, erring on the safer side may be permissible" (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 358). As for the charge that there are no guidelines for the provision to be followed, the Court cites a document of the State Government's policy on the issue. The guidelines, however, stipulate isolation and deportation only for foreign nationals found to be HIV-positive; Indian nationals from other states are to be sent back, while the Goan resident "may not be interned, instead he should be allowed to go to his place of work or residence on the condition that he visits the nearest Primary Health Centre for follow-up at least once a month" (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 360). He is liable to be isolated only if he defaults on this condition. With regard to the discretionary power of the Health Officer being uncontrolled, the Court admits that there is a possibility of misuse of authority, but that cannot be a ground for invalidating the statute. Finally, with regard to the absence of the right of hearing, on the natural justice principle of *audi alteram partem* ("listen to the other side"), the Court holds that giving prior notice about isolation is not an essential condition as it may be impracticable under certain conditions, as stated in Smith's *Judicial Review of Administrative Action*, 4th edn., p. 184 ff.

Absence of pre-decisional hearing, therefore, does not render the statute invalid, and more so because the statute does not preclude post-decisional hearing, or the right to be heard after being taken into isolation (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 360–361).

The Court's main argument about isolation concerns its justifiability. It concedes that isolation may have deeply negative consequences for the individuals isolated: "It is an invasion upon the liberty of a person. It can affect a person very adversely in many matters including economic. It can also lead to social ostracization". But public interest warrants it because of the danger of spread. Curiously, the Court justifies isolation also for the good of the person isolated: "it may also be in the interest of an AIDS patient, because he may become desperate and lose all hopes of survival and, therefore, has to be saved against himself". But if this is granted, and we agree that isolation can prevent the patient from taking his life, for how long should he be isolated? For it to be actually effective, he must be isolated till he dies a natural death, which means life-long quarantine, as he can take his life at any time after he is released. The only persuasive argument of the Court is when it balances the individual's right to liberty against public interest, supplemented by the state's duty to ensure the improvement of public health under Article 47 of Directive Principles of State Policy of the Constitution. Where "there is a conflict between the right of an individual and public interest, the former must yield to the latter" (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 358). But this argument can hold only if AIDS is communicable in everyday social intercourse, otherwise what is offered as "public interest" would be indistinguishable from stigma and prejudice. The Court lists four routes of transmission as unquestionable: sexual, through contaminated injecting apparatus, through contaminated blood or blood products, and from infected mother to child. A fifth route, through exchange of fluids like tears, saliva, urine, etc., is treated as inconclusive (AIR 1990 Bom 357–358). It should be obvious that none of the routes held to be certain indicate the possibility of transmission through ordinary everyday contact with an HIV-positive person.

There are clear gaps and inconsistencies in the judgment in its reference to scientific knowledge of the epidemic and the opinion of experts and in the variance between the documents it cites and the meaning it construes of them. These discrepancies belie the tone of reasoned argument that the judgment, as a text of legal rationality, adopts. More revealing is its use of the metaphor of AIDS as "invasion", a trope that the media made popular in its representation of the epidemic. "AIDS has invaded human race in a big and rapid way" (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 358). In the context of Goa, "AIDS is many times considered as a foreign invasion" (*Lucy D'Souza v. State of Goa* AIR 1990 Bom 359). The trope of invasion, as we discussed above (Sect. 2.2), serves two important functions in the "othering" of disease: it attributes disease to an external source or "foreign origin" and, by seeing it as war, identifies as "enemy" both the virus and the bodies in which it harbours. Analysis of the *Lucy D'Souza* judgment as a text shows that more is at stake than the rationality of an impugned law. Underlying its defence of isolation is an ideological notion of the integrity of the social "body", which the body of the diseased threatens to "invade" and disrupt. The ideology that underlies this notion becomes apparent when we realize that the disease in question is not contagious and cannot be easily transmitted in everyday social interaction. We will see how this notion informs as well the next two judgments under discussion.

*My Brother … Nikhil* is a sensitive portrayal of Dominic's custodial detention and his efforts after release to help other HIV-positive people. It rightly focuses on the question of stigma, which was what motivated the government of Goa to act as it did. But by keeping off-screen the legal process and the judgment, it obscures the fact that law, which constitutionally guarantees equal protection to all its subjects, withdraws its protection from some in the name a "public interest" not easily distinguishable from stigma. The stigmatization of HIV/AIDS and HIV-positive people is worrisome, but it is more worrisome when it motivates decisions of the law that are supposed to expunge stigma.

## 5.4 Suspended Rights: *Mr. X V. Hospital Z*

In May 1995 Dr. Tokugha Yepthomi, who worked as an eye specialist in the Nagaland State Health Services, and his brother-in-law, a government minister, accompanied Itokhu Epthomi to Chennai. Epthomi, who was the minister's uncle, had to undergo a surgery for abdominal aortic aneurysm. Tokugha voluntarily donated blood for the surgery, which was routinely screened and found to be HIV-positive. The hospital discarded the blood and, without informing Tokugha, informed his brother-in-law instead, who chose not to disclose it to him till 6 months later, after he was engaged to be married: "After encouraging me to get engaged and helping me decide on marriage, he waited till the day I returned with the wedding dress and gathered everyone I knew, to make the announcement" (Lalwani 2008, p. 23). The marriage was called off, Tokugha lost his job and was socially ostracized. "They all know my status in Nagaland. And there is such a stigma, so much shame. People are criticizing me. Then I start thinking I want to disappear" (Lalwani 2008, p. 24). He relocated to Chennai and joined YR Gaitonde Centre for AIDS Research and Education, which was run by Dr. Suniti Solomon, the doctor who detected the first cases of HIV infection in 1986. In 1996 he met Anand Grover and told him his story. With Grover's help, he filed a petition with the National Consumer Disputes Redressal Commission for damages against the hospital on grounds of breach of confidentiality. But the Commission dismissed his petition in an order dated 3 July 1998, directing him instead to seek remedy in a civil court. With Grover as his counsel, he then filed a special leave petition in the Supreme Court, in appeal against the order of the Commission.

In *Mr. X v. Hospital Z* (1998), the petitioner claims that the hospital violated its "duty of care" in not respecting his right to confidentiality and is thus liable for damages. Further, the hospital is also liable in infringing upon his right of privacy, which is part of the constitutionally guaranteed right to life and personal liberty under Article 21. In response to this, the Court observes that the doctor's duty to maintain confidentiality, which is part of "duty of care", is inscribed in the Hippocratic Oath and is included in both the International Code of Medical Ethics and the Code of Medical Ethics prescribed by the Indian Medical Council. As such, it enjoins healthcare practitioners not to reveal personal information of the patient, except in a court of law under orders to do so by the judge. In revealing the petitioner's serostatus to a person other than himself, the hospital had apparently violated its duty to maintain confidentiality and his co-relative right to confidentiality. While every right implies a co-relative duty not to violate that right, this is not an absolute rule as there are exceptions. The Court's interpretation was that in this case the petitioner's right to confidentiality does not impose on the hospital a corresponding duty to maintain it, as non-disclosure would have caused a risk to the life of the person he was engaged to marry. There are provisions for this in codes of medical ethics, both in India and internationally, and the Court cites some of them in support. Exceptions include instances where "the public interest would override the duty of confidentiality", such as "the investigation and prosecution of serious crime or where there is an immediate or future (but not a past and remote) health risk to others" (*Mr. X v. Hospital Z* (1998) 8 SCC 304). Moreover, the Hippocratic Oath lacks statutory value and cannot be enforced by law. On these grounds the Court dismisses the petitioner's claim of breach of confidentiality. With regard to privacy, it holds that though it is part of a fundamental right under Article 21, it is not absolute and is "subject to such action as may be lawfully taken for the prevention of crime or disorder or protection of health or morals or protection of rights and freedoms of others" (*Mr. X v. Hospital Z* (1998) 8 SCC 306). The Court cites precedents from *Gobind v. State of M.P.* (1975), *Roe v. Wade* (1973) of the US Supreme Court and the European Convention on Human Rights regarding restrictions on the right of privacy. By disclosing the petitioner's serostatus, the hospital had saved the life of the person he was to marry, who "too would have been infected with the dreadful disease if the marriage had taken place and consummated" (*Mr. X v. Hospital Z* (1998) 8 SCC 307). As such, therefore, the disclosure comes under an exception and is not violative of the petitioner's right either to confidentiality or privacy.

Having settled the issue thus, the Court then goes on to make certain observations that reveal a response more ideological than the objective rationality of the decision. It first looks at the institution of marriage, which is "a sacred union, legally permissible, of two healthy bodies of opposite sexes", the object of which "is the procreation of equally healthy children" (*Mr. X v. Hospital Z* (1998) 8 SCC 307). It cites various Marriage Acts in force in India, which include provisions for the dissolution of a marriage on grounds of venereal disease. By citing the instance of venereal disease, the Court is able to shift the consideration from health to morality, in claiming that the "emphasis … in practically all systems of marriage is on a healthy body with moral ethics" (*Mr. X v. Hospital Z* (1998) 8 SCC 308). It then undertakes a second shift, from considerations of health and morality to those of criminality. Citing Sections 269 and 270 of the Indian Penal Code, which criminalize negligent and malignant transmission of fatal infectious disease, the Court contends that "if a person suffering from the dreadful disease 'AIDS', knowingly marries a woman and thereby transmits infection to that woman, he would be guilty of offences" under those sections of the law (*Mr. X v. Hospital Z* (1998) 8 SCC 309).

Thus, there is a triple indictment of the diseased individual on grounds not only of pathogenicity but equally of immorality and criminality. Further, since Section 270 IPC criminalizes transmission only when one knows and transmits his or her disease with malignant intent, the diseased individual is understood to be one whose objective is to harm others. This allows the Court to attribute such objective to the petitioner and to conclude that it "cannot assist that person in that object" (*Mr. X v. Hospital Z* (1998) 8 SCC 310). The final paragraph of the judgment is an "othering" of the HIV-positive, by implicitly labelling "them" as "undisciplined" and afflicted by "human failing" and thus distinct from a "we" who are presumably not:

> "AIDS" is the product of undisciplined sexual impulse. This impulse, being a notorious human failing if not disciplined, can afflict and overtake anyone howsoever high or, for that matter, how low he may be in the social strata. The patients suffering from the dreadful disease "AIDS" deserve full sympathy. They are entitled to all respect as human beings. Their society cannot, and should not be avoided, which otherwise, would have a bad psychological impact upon them… But "sex" with them or the possibility thereof has to be avoided as otherwise they would infect and communicate the dreadful disease to others. (*Mr. X v. Hospital Z* (1998) 8 SCC 310)

This is an instance of the kind of moral judgment that leads to the stigmatization of the HIV-positive, even as it seeks to counter that stigma by urging that they be respected as human beings and not ostracized because of disease. It thereby juxtaposes a moral norm that sees disease as sign of deviance with another that seems opposed to it in import, the norm of empathy, in a manner that brings to light the ambivalence of compassion, whether in narrative or in law.

The judgment clearly indicates an understanding of the diseased individual as a source of danger to society, whose rights are therefore not enforceable. The hospital's disclosure of his serostatus appears justifiable as it prevents him from infecting another person – presuming, of course, that had he been informed instead he would have kept it a secret and gone ahead to consummate the marriage. Such a presumption is consonant with the view that the Court seems to hold about the malignant intentions of HIV-positive people. By recasting the petitioner as a "dangerous individual" rather than one whose rights to confidentiality and privacy are breached, the breach of the rights appears justifiable. But, as we have said, it requires us to ascribe intentions to him in the same way that legal psychiatry in Foucault's account ascribed to the "dangerous individual". This is made explicit in the Court's ruling that the right to marry of such individuals "shall be treated to be a 'suspended right'" (*Mr. X v. Hospital Z* (1998) 8 SCC 308). While rights in law may be suspended, either temporarily or permanently, what seems curious here is that the petition was *not* about the right to marry. As Jayanth Krishnan comments: "Why the Court decided to expand its ruling so extensively is unclear. The question before the Court was very narrow, namely whether the Commission below had properly dismissed Mr. X's complaint against the hospital for revealing his HIV status to a third party. The petition never raised issues such as the right to divorce or the right to marry" (Krishnan 2003, p. 809). As the Court's ruling on the right to marry had implications as well for marriage between HIV-positive persons with knowledge of each other's serostatus, a clarification was sought from the Supreme Court through an interlocutory appeal, and the case was reopened.

In *Mr. X v. Hospital Z* (2002), the Court ruled that the observations made in the earlier judgment about rights of HIV-positive persons were unwarranted, after the Court had settled the matter of the hospital's disclosure: "all those observations made by this Court in the aforesaid matter were unnecessary, particularly when there was no consideration of the matter after notice to all the parties concerned" (*Mr. X v. Hospital Z* (2003) 1 SCC 503). Given this rectification by the Court, it is possible to see the earlier judgment as an erroneous interpretation of the law by a particular bench. But it also reveals two crucial aspects of law's understanding of the diseased person. Firstly, it belies rationalist assumptions that law excludes moral considerations as subjective and based on presumption, a contradiction that appears not in the system of law but in the adjudication process. Hart's privileging of norms of legality over moral norms in defence of what he calls the wider view of law follows from his focus on system, not process. The commonly held assumption that law conforms to the moral order, he asserts in *The Concept of Law*, does not ipso facto mean "that the criteria of legal validity of particular laws used in a legal system must include, tacitly if not explicitly, a reference to morality or justice" (Hart 1961, p. 185). It is in the interpretation of law, as the judgment in *Mr. X. v. Hospital Z* (1998) explicitly states, that references to morality are necessary: "moral considerations cannot be kept at bay and the Judges are not expected to sit as mute structures of clay in the hall known as the courtroom" (*Mr. X v. Hospital Z* (1998) 8 SCC 310). Secondly, it shows how in the medico-legal form of biopolitical governance the preservation of life is necessarily predicated on the exclusion of those perceived to be a threat. It is in protecting the life guaranteed under Article 21 that law must set aside the rights of privacy and marriage of the diseased individual, which, significantly, are components of the same right to life. Thus, life in the biopolitical order can only be preserved by placing under suspension life itself, in a curious aporia that Roberto Esposito calls the logic of "immunity": "This is where the structurally aporetic character of the immunitary process is to be located: unable to directly achieve its objective, it is forced to pursue it from the inside out. In so doing, it retains its objective in the horizon of meaning of its opposite: it can prolong life, but only by continuously giving it a taste of death" (Esposito 2011, pp. 8–9).

## 5.5 Disease as Contagion: *Dhirendra Pandua V. State of Orissa*

*Dhirendra Pandua v. State of Orissa* (2008) is not about HIV/AIDS but leprosy, a disease that is socially understood in ways very similar to AIDS. Firstly, leprosy is a highly stigmatized disease, attributed to deviant conduct in a moralistic framework specific to Christianity but generalized in societies that had been colonized by Europeans. As Mary Douglas writes in *Risk and Blame*, in late medieval Europe where it was widespread "the disease was thought to be transmitted by sexual penetration. Endowed with an inordinate sexual appetite, lepers were incestuous, lepers were rapists, lepers sought to spread their condition by forced sexual intercourse with healthy persons" (Douglas 1992, p. 96). One can see resemblances between this vilification of lepers and the characterization of the HIV-positive in the concluding paragraph of *Mr. X. v. Hospital Z* (1998). In colonial India, both public health administrators and missionaries saw leprosy as the sign of moral degeneration, one outcome of which was the segregation of lepers under the Indian Lepers Act, 1898. The "perceived need to lock up leprosy-affected men at night to prevent their procreation", notes James Staples, "implies some link between the disease and sexual promiscuity; an association heightened by the not uncommon connections made between leprosy and syphilis" (Staples 2007, p. 66). Mention has already been made in the preceding chapter of John Jackson's *In Leper-Land*: on visiting the leper asylum at Purulia and witnessing the work of the missionary in charge, Rev. H. Uffmann, Jackson has a vision of "this faithful pastor leading forwards hundreds of once loathsome lepers, now spiritually cleansed and eternally healed" (Jackson 1901, p. 76). As Staples explains, colonial understanding of leprosy in India derived ultimately from accounts of lepers in the Bible, especially Chapter 13 of Leviticus, and was widely circulated in missionary literature (Staples 2007, pp. 72–76).

Secondly leprosy, like AIDS, has commonly been misunderstood as a contagious rather than infectious disease. We will see the implications of this in our discussion of the judgment in *Pandua*. In fact, there was a prolonged controversy about the presumed contagiousness of leprosy before the Lepers Act of 1898 was passed, with medical opinion being sharply divided. For instance, a report prepared by Timothy Lewis and David Cunningham, medical assistants to the Sanitary Commissioner of India, held that leprosy is not contagious but hereditary and recommended strongly against segregation (Lewis and Cunningham 1877, pp. 70–73). The Leprosy Commission of 1890–1891 appointed by the Government of India held that leprosy is contagious but also opposed segregation (Leprosy Commission 1892, pp. 456–57). On the other hand, Dr. Henry Vandyke Carter of the Indian Medical Service argued that the disease is highly contagious and "the segregation of lepers seems most desirable" (Carter 1872, p. 5). There were also non-medical authors like Henry Press Wright who held that segregation was the only means of containing spread of the disease. In *Leprosy and Segregation*, Wright fears that colonialism might cause the re-entry of the disease in England, from where it had been more or less eradicated for two centuries, unless lepers in the colonies were segregated: "we in England surely have more reason to dread a re-introduction of the malady than to boast of its complete departure from us. Ere we are aware of it the fearful scourge may again be actively in our midst; and England, who thought herself so safe, be with her closely packed population again in the field of its cruel ravages" (Wright 1885, p. 101). The same fear is reiterated in stronger terms in Wright's *Leprosy: An Imperial Danger* (1889). A reading of *Dhirendra Pandua v. State of Orissa* reveals that neither the controversy nor the fear has abated even after more than a century and even when a diagnosis of leprosy, or Hansen's Disease, is no more a sentence of terrible death.

On 20 September 2003, Dhirendra Pandua and Surendra Chandra Mohanty were elected councillors to the Basudevpur Notified Area Council (NAC) in Bhadrak district of Orissa. Ten days later, Pandua was elected chairman of the NAC, while Mohanty, who had also contested, lost. On 10 October, Mohanty filed a petition in the Election Tribunal challenging Pandua's election on the ground that he was a leprosy patient. Section 16(1)(iv) of the Orissa Municipal Act, 1950, disqualifies from election as councillor persons with leprosy, tuberculosis or mental disease, while Section 17(1)(b) debars them from continuing in office if they subsequently contract any of the diseases specified. Accordingly, after confirming the facts the Election Tribunal directed Pandua to resign both as chairman and councillor of the NAC. Pandua filed a writ in the Orissa High Court challenging the order of the Election Tribunal; but the Court, after examining the documents and finding no error in the Tribunal's order, dismissed his writ application as being without merit (*Dhirendra Pandua v. Election Tribunal* 101 (2006) CLT 264). Pandua then filed an appeal in the Supreme Court against the order of the High Court.

In *Dhirendra Pandua v. State of Orissa* (2008), the questions before the court were (a) whether the High Court order in dismissing Pandua's writ was correct in law and on the facts of the case and (b) whether the disqualifications under Sections 16(1)(iv) and 17(1)(b) of the Orissa Municipal Act, 1985, were discriminatory and violative of Article 14 of the Constitution. After examining the orders of the Election Tribunal and the High Court along with documents submitted before them and the relevant provisions of the Orissa Municipal Act, 1985, the Court found no error and therefore dismissed the petitioner's claim that the High Court order was legally erroneous. With regard to the second question, which the petitioner's counsel "faintly referred to" during the course of hearing, Court ruled that "this contention is also untenable" as the class legislation prohibited under Article 14, the right to equality before law, does not include "reasonable classification for the purpose of legislation" (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 320). The term "class legislation" means a law that applies only to a certain class of persons and is held to be unreasonable and violative of Article 14, whereas "reasonable classification" is a law that (a) groups together as a class persons distinguished from others on intelligible and well-defined criteria of difference and (b) has a rational relation to the object that the law seeks to achieve. The disqualifying provisions of the Orissa Municipal Act, 1985, class together persons of unsound mind or with leprosy or tuberculosis, conditions that are objectively verifiable and reasonably differentiate them from persons who do not have these conditions. It is then necessary to see whether the classification satisfies the second criterion. The object sought by the disqualification provisions is to prevent the spread of leprosy, which, as the judgment states in Para 20, is "a major health problem" that "not only leaves behind a terrifying image of disfigurement, the patient and his family is ostracized from the society" ((2008) 17 SCC 317). The disqualification of persons with leprosy from holding office as municipal councillor can only be valid if it has a reasonable connection with this object.

The Court first cites a medical source, Sloane-Dorland Annotated Medical-Legal Dictionary, which states: "Leprosy, which is also known as Hansen's Disease, is *a mildly infectious degenerative tissue disease* caused by the micro-organism

Mycobacterium leprae" (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 317). Then, in the operative part of the judgment the Court states:

> The obvious object and the purpose sought to be achieved by the said restriction appears to be that *being a contagious disease*, it … can be transmitted via droplets from the nose or mouth during close and frequent contacts with untreated infected persons, therefore, the other elected Councillors or the members of the public with whom they are required to have day-to-day close contact as Municipal Councillors, may also get affected by the disease. (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 320, italics added)

It concedes that a patient can be fully cured by aggressive medication, but does not consider this relevant since "the Legislature in its wisdom has thought it fit to retain such provision in the statute in order to eliminate the danger of its being transmitted to other people from the person affected by the disease" (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 320). Further, it also points out that the current scientific knowledge of leprosy does not warrant segregation and that many States and Union Territories, on the recommendations of the Government of India's Working Group on Eradication of Leprosy, "have repealed the antiquated Lepers Act, 1898 and subsequent similar State Acts". With these facts in mind, the Court suggests that "the Legislature may consider whether it is still necessary to retain such provisions in the statutes" (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 321).

From the above, it is clear that there is a fundamental contradiction in the Court's argument. If segregation is unwarranted and has in fact been discontinued, it must be because leprosy no longer poses the "danger" it was once thought to pose. That the Court is convinced of this is evident, when it states that the legislature may consider repealing the disqualifying provisions. Yet, it holds that the classification in these provisions bears "a just and reasonable relation with the object sought" and that Sections 16(1)(iv) and 17(1)(b) of the Orissa Municipal Act "are not violative of Article 14 of the Constitution" (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 321). It concurs with the "wisdom" of a legislature that socially excludes or segregates persons with leprosy while at the same time advising it to do otherwise. The outcome of these confusing standpoints is that it is unclear whether the Court considers leprosy to be a "danger" or not. The contradiction undermines the rationality of the Court's argument in dismissing Pandua's appeal as "being devoid of any merit" (*Dhirendra Pandua v. State of Orissa* (2008) 17 SCC 321).

What underlies the Court's insistence that leprosy poses a "danger", despite the scientific knowledge that contradicts it and which the Court holds to be true? I think it is the crucial terminological shift from leprosy being a "mildly infectious disease" in the citation from Sloane-Dorland, to its being a "contagious" disease in the operative part of the judgment. "Infection" and "contagion" may refer to the same disease process but have different implications. Firstly, at the literal level, infection refers to the presence of disease-causing pathogenic organism in the individual body, while contagion refers to the transmission of the pathogen from body to body. This difference constructs contagion and infection differently, the first being primarily a problem for society and the second being a problem mainly for the individual affected. It is evident that this distinction underlies the need to socially exclude or segregate people whose disease is – *or is understood to be* – “contagious” rather than “mildly infectious”. It serves as a rhetorical strategy to construct Pandua’s identity as what Foucault calls a “dangerous individual,” who can then be eliminated (Foucault 2000b, p. 193). The terminological shift is, therefore, not without consequence for the argument that the Court makes out against persons with leprosy holding public office, notwithstanding the knowledge it gleans from current scientific knowledge, public health policy and the legislative acts of many states and union territories. Secondly, contagion as a concept in the discourse of health and disease is more moral than medical in its symbolic significance. As Mary Douglas writes: “we find that certain moral values are upheld and certain social rules defined by beliefs in dangerous contagion” (Douglas 1966, p. 4). Contagion as a moral concept derives from the symbolic meanings attributed to pollution in social life, which function as “analogies for expressing a general view of the social order” (Douglas 1966, p. 4). They signify a society’s disapproval of people who transgress boundaries, either in terms of who they are (“untouchables”) or what they do (engaging, e.g., in illicit sexual acts). When attributed to objects, pollution signifies that which is not in its right place, like shoes on the dining table or food spattered on clothes: polluting objects are, like dirt, “matter out of place” (Douglas 1966, p. 44). “In short”, writes Douglas, “our pollution behaviour is the reaction to any object or idea likely to confuse or contradict cherished classifications” (Douglas 1966, p. 45). Martha Nussbaum connects Douglas’s idea of contagion with moral disgust, which at its core is a reaction to our vulnerability and mortality, but becomes extended to other objects or beings symbolically associated with this core meaning. Thus, clothing worn by a person with infectious disease continues to be seen as contagious or contaminated even after it has been washed thoroughly and disinfected. “The extension of contamination is mediated by social boundary-drawing, with the result that the disgusting is only what transgresses these boundaries” (Nussbaum 2004, p. 94).

Deploying the symbolic meaning of contagion and its association with moral disgust, therefore, is a means to justify the existing social order and to restore order when it has been transgressed. In this strategy, as Douglas argues in *Risk and Blame*, accusations of being diseased serve as a powerful instrument, especially if the disease concerned is already stigmatized as sign of moral degeneracy. Leprosy and AIDS are, in this context, the most opportune, as diseases understood to be “contagious” in both medical and moral terms and therefore capable of causing what Douglas calls “insidious harm” (Douglas 1992, p. 90). The point is not to minimize the actual health risks of such diseases but to see how such risks may be used to justify the social exclusion of individuals or groups held to be transgressive. The rhetoric of “danger” associated with leprosy and AIDS, thus, serves to shore up social boundaries and, in Douglas’s words, provide a “resource for maintaining particular cultural regimes” (Douglas 1992, p. 85). The terminological shift in *Dhirendra Pandua* may be understood in this context as a strategy justifying the exclusion of someone perceived to be a source of danger to society.

## 5.6 Interpretation and Indeterminacy in Law

In the analysis of the three judgments above, we have tried to bring out inconsistencies that emerge in the adjudication process when courts interpret the case before them. In *Lucy D'Souza*, scientific knowledge is first dismissed as uncertain, to counter the petitioner's claim that isolation of the HIV-positive is unscientific and then relied upon to justify it as scientific. A policy document of the state government is presented as proof that the procedure for isolation follows guidelines, but the document does not recommend isolation except as a last resort. In *Mr. X. v. Hospital Z*, the Court exceeds its terms of adjudication by ruling that HIV-positive individuals' right to marry be treated as a "suspended right", when the appeal was not about marriage but confidentiality and privacy. In *Dhirendra Pandua*, it is unclear in the mind of the Court whether leprosy should be considered dangerous enough to disqualify a person from public office and subject him to stigma and discrimination. It concurs with the legislature's wisdom in including such provision in the statute yet advises the same legislature to consider repealing it. Are these inconsistencies simply instances of poor adjudication, or do they point to an ambivalence about disease and diseased people that is deeply entrenched in law as a mechanism of social defence? Do they, in other words, point to some deficiency in law as system that is brought to the fore in the process of law? In this section we will consider some arguments about interpretation and indeterminacy that seek to problematize the presumed rationality and settled logic of law.

One of the main assumptions about law is that it is based on a rational consensus that is universal, deriving its authority from self-evident moral principles inscribed in rules that one feels obliged to follow. In this view, a proposition in law can be either true or false and not ambivalent: it "is true if some event of a designated law-making kind has taken place, and otherwise not" (Dworkin 1982: 528). That is, it is true if posited as law and legal practice requires simply to apply it in specific instances – law is to be implemented, not interpreted, where interpretation is understood to be a subjective activity open to arbitrariness. It is on this basis that Hart argues in favour of a view that privileges legal over moral norms and holds that "morally iniquitous rules may still be law", without subtracting from their validity *as* law (Hart 1961, p. 212). Since law is based on universal reason – the standards of natural justice – it is most often just; and justice in law "consists in no more than taking seriously the notion that what is to be applied to a multiplicity of different persons is the same general rule, undeflected by prejudice, interest, or caprice" – undeflected, in other words, by subjective motivations (Hart 1961, p. 206). Hart describes law as a structure of primary rules, which correspond to universally accepted norms, such as "restrictions on the free use of violence, theft, and deception to which human beings are tempted but which they must, in general, repress, if they are to coexist in close proximity to each other" (Hart 1961, p. 91). But these primary rules are subject to a number of "defects" such as lack of systematization or uncertainty, historical changes that necessitate their modification and "the *inefficiency* of the diffuse social pressure by which the rules are maintained" (Hart 1961, pp. 92–94). To reduce the indeterminacy resulting from these defects, law supplements them with a number of secondary rules, namely, the "rule of recognition" that identifies a rule as primary, "rules of change" that empower an agency to introduce new primary rules or repeal old ones and "rules of adjudication" that empower designated individuals to authoritatively determine whether a primary rule has been violated and to enforce it (Hart 1961, pp. 91–99). While the core of the legal system is determinate, indeterminacies may emerge in its "fringe of open texture" (Hart 1961, p. 133), when courts are required to strike a balance between conflicting interests, as in the cases we have discussed. Indeterminacies are reduced by established procedures such as precedents, which guide interpretation and restrict its arbitrariness.

> None the less, the life of the law consists to a very large extent in the guidance of both officials and private individuals by determinate rules which, unlike the applications of variable standards, do not require from them a fresh judgment from case to case. This salient fact of social life remains true, even though uncertainties may break out as to the applicability of any rule … to a concrete case. (Hart 1961, p. 135)

Interpretation in this context is both unnecessary and may lead to an arbitrariness that the system of law is designed to expunge.

"The great merit of Hart's analysis", writes Stanley Fish, "is that it makes clear the close relationship … between the threat posed to law by force and the threat posed to law by interpretation" (Fish 1989, p. 505). It is in the rationality of determinate rules that Hart finds the resistance of law to the force of both violence and rhetoric. Fish's critique of Hart's positivism shows how the latter, in keeping at bay the contingency of interpretative violence, actually undermines his own argument through concessions that he makes to interpretation in the practice of law. Thus, Hart distinguishes between a "core of certainty" and a "penumbra of doubt", a "duality" that "imparts to all rules a fringe of vagueness or 'open structure'" where interpretation may find play (Hart 1961, p. 123). But the core itself, argues Fish, was what was once argued, interpreted and established as core and is therefore subject to reinterpretation:

> … whatever is invoked as a constraint on interpretation will turn out upon further examination to have been the product of interpretation, or, to put it in Hart's terms, although it is always possible to distinguish a settled core from the area of open texture that surrounds it, that core has itself been formed by the very forces it supposedly repels. While the distinction between core and penumbra can always be made at a particular moment, at another the *interpretative* conditions within which the distinction is perspicuous can be challenged and dislodged; if that happens, the distinction will not so much disappear as it will take on a new *historical* form, one that is no less precariously in place than its predecessor. (Fish 1989, p. 512, italics in original)

Thus, Fish takes interpretation from the fringe to which Hart had confined it and relocates it, to use Hart's phrase, at "the heart of the legal system". However, Fish does not make out a case for indeterminacy: he is concerned, instead, with the centrality of "force" as rhetorical coercion in law, which is not in itself indeterminate. "Force, in short, is already a repository of everything it supposedly threatens – norms, standards, reasons, and, yes, rules" (Fish 1989, p. 522).

For Ronald Dworkin, too, interpretation is at the heart of law: "legal practice is an exercise in interpretation not only when lawyers interpret particular documents or statutes, but generally" (Dworkin 1982, p. 527). Dworkin's argument hinges on the relation between description and evaluation. Are propositions that report on which law is applicable, merely referential or also evaluative – that is, do they refer to some settled principle, a "core" in Hart's term, or do they express a preference for a particular state of affairs? Judicial propositions, he contends, are "not simply descriptive of legal history in some straightforward way, nor are they simply evaluative in some way divorced from legal history. They are interpretative of legal history, which combines elements of both description and evaluation but is different from both" (Dworkin 1982, p. 528). For this reason, literary interpretation can serve as "a model for the central method of legal analysis" (Dworkin 1982, p. 541). In both, the ideal is neither a subjective evaluation that is unconstrained nor an objective description constrained by its reference but a combination of both. In literature, questions of genre, modes of employment and characterization and the conventions of history or tradition restrict the free play of meaning. In legal analysis, likewise, the judge's freedom to interpret is restricted by established procedures and precedents where "no statute figures centrally in the legal issue" (Dworkin 1982, p. 542). Precedents and the conventions of legal history serve to minimize personal opinion and arbitrariness, in what Dworkin calls the "complex chain exercise" of the legal process (Dworkin 1982, p. 543). Fish, while concurring broadly with Dworkin's characterization of interpretation in law, is critical of the way he argues it, especially his understanding of legal history as purely objective and intentionality in interpretation as purely subjective, thereby falling into "a version of the fallacies … he so forcefully challenges" (Fish 1989, p. 88). Precedents, which constitute the matter of legal history, are not given at the outset *as* precedents: they become so through a process of interpretation. To select a case that may appropriately serve as a precedent, one actually appropriates and *constructs* a similarity that one assumes to be given:

> To see a present-day case as similar to a chain of earlier ones is to reconceive that chain by finding in it an applicability that has not always been apparent. Paradoxically, one can be faithful to legal history only by revising it, by redescribing it in such a way as to accommodate and render manageable the issues raised by the present. (Fish 1989, p. 94)

If the precedent is the product of the interpretative process, it cannot exist outside it as an index of law's objective history. Conversely, interpretation in neither law nor literature is a matter of subjective personal intention but that of an interpretative community which is transpersonal. Precedents establish an intentionality that is specific to the chain and "to read something identified as part of a chain enterprise is ipso facto to be in the act of specifying that same intention" (Fish 1989, p. 99).

In opposing interpretation to what is presumed to be the determinative regularities of law as a coherent system of rules, however, neither Fish nor Dworkin address the question of indeterminacy as built into the structure of law. In *Law as Process*, Sally Moore approaches law as a technique of social regulation, alongside other techniques like the mores and customs of a society as well as the rules of non-state corporate bodies. Social regulation, she argues, happens through two opposing mechanisms, “processes of regularization” that “fix social reality” and give it “form and order and predictability” and “countervailing processes” that seek to adjust to concrete and variable situations (Moore 1978, p. 50). If the processes of regularization work to produce determinate and durable rules, processes of “situational adjustment” work by “exploiting indeterminacies in the situation, or by generating such indeterminacies, or by reinterpreting or redefining the rules or relationships” (Moore 1978, p. 50). The merit of her argument lies in her characterization of legal history as a piecemeal arrangement having multiple sources, instead of being a coherent and homogeneous system: “where the actual history of legal systems is known, it is evident that the institutions and the rule complexes and principles of which they are composed were not generated at one moment of time, nor in response to one set of values, nor one set of political, social, or economic conditions” (Moore 1978, pp. 11–12). Homogenization and systematization are the effects of “the after-the-fact work of professional specialists” (Moore 1978, p. 9). As such, therefore, there are structural indeterminacies built into the very system of law, which the legal process brings to the fore. “The basic postulate proposed is that the underlying quality of social life should be considered to be one of theoretically absolute indeterminacy. To put it simply, in this model social life is presumed to be indeterminate except in so far as culture and organized or patterned social relationships make it determinate” (Moore 1978, pp. 48–49). Indeterminacy is not the outcome of individual intentions but arises from “internal contradictions, inconsistencies, and ambiguities within a universe of relatively determinate elements” (Moore 1978, p. 49). Individuals may only exploit these existing factors, in furthering their interests in the process of situational adjustment.

In advancing a theory of interpretation and indeterminacy in law, I try to combine insights from Fish and Dworkin with those of Sally Moore. Indeterminacy in the form of internal contradictions and gaps in law’s understanding of the diseased body are an outcome of the process of interpretation in its adjudicative function. To return to the analogy between literary and legal interpretation, we must note a difference that Dworkin fails to mention: literary interpretations are concerned with meanings and do not have major implications for the material lives of those concerned, while legal interpretations, which end in punishments, do. In this sense, literary interpretations are relatively innocuous, even if they may damage careers of authors. “Legal interpretation”, writes Robert Cover, “takes place in the field of pain and death”:

> Legal interpretative acts signal and occasion the imposition of violence upon others: A judge articulates her understanding of a text, and as a result, somebody loses his freedom, his property, his children, even his life. Interpretations in law also constitute justifications for violence which has already occurred or which is about to occur. When interpreters have finished their work, they frequently leave behind victims whose lives have been torn apart by these organized, social practices of violence. Neither legal interpretation nor the violence it occasions may be properly understood apart from one another. (Cover 1986, p. 1601)

The violence of law need not be confined to acts of criminal sentencing: a judgment that rules out marriage of people with disease, or holds their segregation as constitutionally valid, is also a form of violence. Cover ties interpretation to violence in three steps. Firstly, the linguistic acts by which judges understand and explain the law are linked to physical acts of others in carrying through the outcome of the sentence, which Cover calls "the hermeneutic of the texts of jurisdiction" (Cover 1986, p. 1613). Secondly, the decision of the judge triggers the violent acts of others in such a way that the normal psychosocial inhibitions against inflicting pain and death are suspended or suppressed. It is the hierarchical structure of the judicial institution that ensures that the executioner does not refuse to do his job because his conscience bothers him. Finally, the acts of violence and their judicial authorization are constituted within an institutional context that is made to appear just, iconically represented in the Sword of Justice. Cover calls this context "*conditions of effective domination*" (Cover 1986, p. 1616, italics in original).[5] Cover's view of law as violence is a restatement of the theory of constraint, with two major differences: it does not justify the violence of law but critiques it, and it critiques it not from the principles on which it is founded but on the effects it secures. The linkage of interpretation, indeterminacy and violence will constitute the framework of analysis in the section that follows.

## 5.7 The Enigma of Corporeal Justice: *M. Vijaya V. Chairman and Managing Director, Singareni Collieries*

On 30 January 1998, Masaraboina Vijaya, wife of a pump operator at Singareni Collieries Company Limited, underwent surgery for removal of uterus in the company's Maternity and Family Welfare Hospital at Godavarikhani. She had been diagnosed with chronic inflammation of the cervix and advised hysterectomy. During the surgery she was transfused one unit of blood donated by her brother, Pettam Lakshmirajam. Two months later, Vijaya was diagnosed with HIV disease. Her husband, Ailaiah tested negative, but the brother who had donated blood tested positive. She presumed that the hospital had not screened the blood for HIV before transfusing it, leading to her infection; and a writ petition was filed in the Andhra High Court based on a letter she sent to the Chief Justice of the Court. After hearing the response of the company and examining the facts of the case, the Court held that Singareni Collieries were guilty of "malfeasance and misfeasance" – deliberate conduct by public officials that is unlawful and amounts to wrongdoing – and directed them to forthwith pay her an amount of Rupees 1,00,000 to meet costs incurred by her, in addition to any damages granted under civil procedure.

In *M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* (2001), the Andhra High Court had not only to consider the legal issues

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[5] There are, of course, limits internal to the system of law that restrict the possibility of arbitrary violence. The system of appeals and the constitution of a bench of judges ensure that no single individual can authorize violence. Further, absolute consensus in interpretation being uncommon if not impossible, especially in cases involving death sentence, it often happens that if one judgment sentences the other may acquit (Cover 1986, pp. 1628–1629).

arising out of the unlawful action of the company but also to issue directions to the government and non-governmental organizations on implementation of epidemic control programmes. Apart from the counsels for the two parties, thus, the Court heard the Advocate-General of Andhra Pradesh and a number of interveners allowed to join the litigation, to bring in different perspectives on the epidemic and its management. The judgment, therefore, is wide-ranging and includes subjects like the history of HIV/AIDS, routes of transmission, the burden of disease globally and in India, national and international efforts to curb the epidemic, social effects of stigma and ostracism and disease control legislation. It is, in other words, a text that examines the problem posed for law not only by the diseased body but the epidemic as a whole, in terms of the social, medical, economic, governmental and legal issues it raises.

One of the key issues that the Court examines concerns the rights of the HIV-positive. It discusses the AIDS Prevention Bill, which was introduced in the Parliament in 1989 but was not passed: "The central theme of the Bill was to segregate AIDS patients" and to "condemn the patients rather than helping and protecting them" (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 513). In continuation of this theme, the Court examines the legal position in case of conflict between the fundamental rights of the infected individual and the obligation of the state to protect the health of others. This obligation stems from the fundamental duty of the state to improve public health under Article 47 and from the right to life under Article 21 of the Constitution. It cites *Vincent Panikurlangara v. Union of India* (1987), which held that the state is obliged to "enforce creation and sustenance of good conditions of health" (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 514). Given that two equally compelling principles of rule are in conflict, how should the state act?

> Can the State segregate HIV-positive patients in hospitals from others? Can the State compel high-risk groups like migrant workers, truck drivers, prison inmates and sex workers to undergo HIV-AIDS test and deny those persons normal life? Can the state deny the privileges and facilities to those persons who are tested HIV+ve (HIV-AIDS)? (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 514)

"These are", it observes, "some of the paradoxical questions, which have come before Courts all over the world" (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 514). It then tries to resolve the paradox by citing the Roman law doctrine of Salus Populi est Suprema Lex (the good of the people is the supreme law). This doctrine, it explains:

> is based on the implied agreement of a member of the society that his own individual interest and welfare shall in all cases of necessity yield to that of the community and *that his life and liberty under certain circumstances be placed in jeopardy or even sacrificed* for the public good. (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 514, italics added)

It follows this up by citing a chain of precedents where the principle has been applied in deciding such hard cases where no explicit rules exist, including *Lucy D'Souza v. State of Goa* (1989) and *Mr. X. v. Hospital Z* (1998).

The full implication of the principle of public good can be brought out by comparing it with another principle in Roman law that is discussed extensively by Giorgio Agamben in *Homo Sacer*. Agamben cites a passage from Pompeius Festus' treatise *On the Significance of Words* to explain this principle: "The sacred man [*homo sacer*] is the one whom the people have judged on account of a crime. It is not permitted to sacrifice this man, yet he who kills him will not be condemned for homicide" (Agamben 1998, p. 71). To the extent that he is *sacer*, he is inside divine law – but the ban on sacrifice places him outside it; to the extent that he is *homo*, he is inside human law – but the permissibility of killing him without it being *homi*cide places him outside it. "What, then, is the life of this *homo sacer*, if it is situated at the intersection of a capacity to be killed and yet not sacrificed, outside both human and divine law?" (Agamben 1998, p. 73). Put simply, the *homo sacer* is someone held to be a public enemy who can be killed without the necessary ritual of a trial by court. Agamben considers the principle to be "an originary *political* structure" (Agamben 1998, p. 74, italics in original), that is, the *homo sacer* is the figure in whom the structure of politics as sovereign rule originates. To understand how this is so, we need to first understand the enigmatic character of this figure of double exception, excepted from both the law of humanity and that of the gods. Exception is not the same as exclusion but the setting outside of something that continues paradoxically to be inside: to be excepted, an entity must first belong to the set from which it is excluded, and it can continue to be an exception only so long as it is held to be otherwise included. Using an oxymoron, for the oxymoron is the only structure in language that can capture this contradiction, Agamben terms it an *inclusive exclusion* (Agamben 1998, p. 21, italics in original). Placed in such an exception, the diseased person does not cease to be a citizen on being diseased; but while continuing to be citizen, he cannot exercise the rights that otherwise accrue to citizens. This is the ultimate meaning of the suspension of right in *Mr. X. v. Hospital Z*: the right is not revoked, but it cannot be enforced; and as long as his right exists, Mr. X is a citizen, but to the extent that it cannot be enforced, he is placed outside the privilege of citizenship.

The *homo sacer* is linked to the sovereign through a corresponding exception, which it is the primordial right to the sovereign to create. "Sovereign", writes Karl Schmitt in *Political Theology*, "is he who decides on the exception" (Schmitt 1985, p. 5). It is the head of the state, for instance, who decides when a political emergency – an exceptional situation when ordinary laws may be suspended – is to be declared, such as under Article 48 of the Weimar Constitution or Article 352 of the Indian Constitution. Schmitt's reference is not to the sovereign as an individual but as a *function* of politics, the function of deciding on how and when an exception is to be made. It is the sovereign function that makes one a sovereign, whether king, head of state, or judge. Drawing on this argument from Schmitt, Agamben connects the exception under which the *homo sacer* is placed with the exception that the sovereign creates: "At the two extreme limits of the order, the sovereign and *homo* *sacer* present two symmetrical figures that have the same structure and are correlative: the sovereign is the one with respect to whom all men are potentially *homines sacri*, and the *homo sacer* is the one with respect to whom all men act as sovereigns" (Agamben 1998, p. 84). It is this relation that constitutes the originary structure in which human life becomes subject to the calculations of political rule, a form of exercise of power that Agamben, following Foucault, calls biopolitics. Agamben, however, goes beyond Foucault in extensively drawing out and exposing what Foucault had briefly hinted at, the negative declension of biopolitics and its link to biopolitics' positive function – in the way politics and the law pose as problem the diseased body, the body of the condemned criminal, of the prisoner of war, of the *lebensunwerten Leben* or "the life that does not deserve to live" such as the patient on life support today[6] or the Jew, the homosexual and the handicapped in Nazi Germany.

The figure of the *homo sacer* enables us to understand the paradox that *Vijaya* highlights: as I have written elsewhere, "it is *not* an anomaly of medico-legal reasoning, the lapse of an otherwise normative *nomos*, but the very condition on which law acquires its force" (Das 2012, p. 110) – and, I may add, its power to justify what must be sacrificed in order to protect that which is held to be a good. The right to life that Article 21 protects, as *Vijaya* explains, "is not mere animal existence" but the "right to enjoy all faculties of life," including "healthy life" (*M. Vijaya v. Chairman and Managing Director, Singareni Collieries Company Limited* AIR 2001 AP 514). Disease, in being the sign of a life that lacks all faculties of life, places the body in which it harbours outside this right, and "law must withdraw from this paradoxical life before it can decide on the question of living" (Das 2012, p. 110). The sacrifice of the life and liberty of the diseased person must follow the norm of law even if it may depart from the norm of justice, in the asymptotic relation that law often bears to justice.

In "The Force of Law", Derrida discusses the aporia that requires law to render justice and simultaneously makes it impossible to do so within the terms set by the law. In Derrida's account, this aporia takes two distinct forms of indeterminacy or undecidability. One is "the oscillation between two significations or two contradictory and very determinate rules, each equally imperative" (Derrida 2002, p. 252), which is what we find in the *Vijaya* decision. The decision cannot uphold both values, the rights of the individual and the good of society, for if it conforms to the one, it must set aside the other. In other words, justice on one account entails injustice on the other, in a polarity that is irreducible. The second form of the *aporia* is the

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[6] An apt instance of the state's exercise of this negative biopolitical function in euthanasia is the judgment of the Supreme Court in *Aruna Ramachandra Shanbaug v. Union of India* (2011), where the Court ruled that the decision to terminate life is the right not of the patient's family nor of the doctor, but of the state through its judiciary, in its function as parens patriae (father of the country): "in the case of an incompetent person who is unable to take a decision whether to withdraw life support or not, it is the Court alone, as parens patriae, which must ultimately take this decision, though, no doubt, the views of the near relatives, next friend and doctors must be given due weight" (*Aruna Ramachandra Shanbaug v. Union of India* (2011) 4 SCC 521).

impossible reconciliation between the generality of a norm and the particularity of the "case" referred to it:

> How to reconcile the act of justice that must always concern singularity, individuals, groups, irreplaceable existences, the other or myself *as* other, in a unique situation, with rule, norm, value, or the imperative of justice that necessarily have a general form, even if this generality prescribes a singular application in each case? (Derrida 2002, p. 245)

Legal normativity presupposes a perfect adequation between questions of law and questions of fact but what happens when the singularity of a case resists efforts to subsume it under the generality of a norm that it invokes?

The most extreme form of this aporia is the anomaly. The logic of judicial classification is undermined when it confronts the anomalous, which, as Mary Douglas argues in *Purity and Danger*, exists as a possibility in every taxonomic system.

> Culture, in the sense of the public, standardized values of a community, mediates the experience of individuals. It provides in advance some basic categories, a positive pattern in which ideas and values are tidily ordered. And above all, it has authority, since each is induced to assent because of the assent of others. … Yet they cannot neglect the challenge of aberrant forms. Any given system of classification must give rise to anomalies, and any given culture must confront events which seem to defy its assumptions. (Douglas 1966, p. 48)

Anomaly, in other words, is the outcome of a structural relation between the singular and the system that orders singularities, categorizes and classifies them. In the judicial context, anomaly is an effect of the functioning of the schema or classificatory grid of law, when it encounters a situation that is unprecedented and cannot easily be assimilated into the precedents that it summons. An anomaly is both *an-homalos*, not the same, and *a-nomos*, outside the law of sameness and difference. It is outside the law but not without reference to it, for it is in terms of the law that it appears anomalous.[7] Thus, the anomaly shares the same structure of exception as the *homo sacer* in Agamben's exposition. The challenge that anomaly poses for law is evident in a wide range of instances, where bodily existence provokes the law because it threatens the social order in unprecedented ways. AIDS is an apt example, as there exists no clear position on how law is to respond to the HIV-positive: as *Vijaya* states, there is neither settled legislation nor determinate case law in India

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[7] Thus, in the Indian Penal Code's classification of sexual offences, lesbianism is an anomaly that law can neither capture nor exclude but must hold in an equivocation in which it exists only in its non-existence. An illuminating instance of this concerned two girls from Halol in Gujarat, Sonu Avtar Singh and Rekha Marwari, who were in a lesbian relationship and eloped from their homes on 1 January 2006. They were subsequently caught in Sonu's village near Amritsar and brought back in police custody to Halol. But they could not be prosecuted under Section 377 of the Indian Penal Code, which criminalizes "unnatural" sex. As the district superintendent of police told the press, "To invoke section 377, one has to prove penetration" (*TOI* 2006, p. 3). They were released after they "made a categorical public assertion before district authorities that they were not lesbians but just friends who wanted to live together" (Khan 2006, p. 12). The lesbian's body, unlike that of the homosexual, is an anomaly that law cannot prosecute and also cannot even name (See Das 2006).

regarding prevention of HIV/AIDS and protection of the constitutional rights of those infected.

*M. Vijaya v. Chairman and Managing Director Singareni Collieries* differs from the other judgments in that it foregrounds the enigma of the diseased body in law. To recognize it as an enigma, a paradoxical question that admits no easy resolution, is the first step in an adjudication that is responsible not just to the norms of law but equally to those of justice: as Derrida writes, “for a decision to be just and responsible, it must … be both regulated and without regulation, it must preserve the law [*loi*] and also destroy and suspend it enough to have [*pour devoir*] to reinvent it in each case, rejustify it, reinvent it at least in the reaffirmation and the new and free confirmation of its principle. Each case is other, each decision is different and requires an absolutely new interpretation, which no existing coded rule can or ought to guarantee absolutely” (Derrida 2002, p. 251). In other words, law must be attentive to the singularity of difference and the perpetual possibility of injustice when the universality of rule is applied to the specificity of a case. It is only then that the enigma of the anomalous body can provoke a transformation that is limitless in that it is always ongoing, “the locus”, as Cheah and Grosz put it, “of a justice that is always yet to come” (Cheah and Grosz 1996, p. 24).

In this context, it is significant that the government recently passed the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017, to lay down and protect the rights of HIV-positive people. This is perhaps the first statute that addresses the rights of the diseased and is therefore a major legislative achievement. It makes any form of discrimination against HIV-positive individuals, in education, employment, access to healthcare, access to insurance, use of public facilities and common resources, etc., a cognizable offence. It ensures the accountability of the government in providing welfare measures, pedagogy and other needs of the HIV-positive. But what is significant about the Act is its silence about the provisions in law that exclude diseased persons from the exercise of some of their fundamental rights, when these rights come into conflict with the fundamental duty of the state to protect the health of the public. It is in this silence that the enigma of the diseased body continues to exist, as a problem that law must think beyond itself to resolve.

## 5.8 Conclusion

The present chapter has examined three court judgments pertaining to HIV disease and one to leprosy, to bring out contradictions and inconsistencies underlying the exclusion of persons with disease in the name of the public good. Such contradictions, it is argued, do not become manifest in the structure of the legal system but in the process by which the system is used in the maintenance of law. Accounts of law’s structure often emphasize its coherence, as H.L.A. Hart does *in The Concept of Law*. But any consideration of law’s history, as Sally Moore argues, will show how it is put together in a piecemeal fashion, in response to changing historical contingencies. As such, therefore, there would be gaps, which retrospective professional accounts of law gloss over in constructing the coherence of the legal system. It is in the processes of law, therefore, that these gaps emerge, leading to inconsistencies.

The dichotomy of structure and process is one that has concerned the study of culture and society since the 1970s. On the one hand, it is necessary to have a sense of the structures by which order is maintained, whether it is the ordering of meaning in language or the ordering of people's conduct in social relationships. But, on the other, this abstract structure of ordering does not exhaust all the possible and contingent ways in which people make meaning or act in society. Social reality cannot easily be determined by the rules that law and custom impose on it. When the gap between this reality and the structure of rules becomes insuperable, indeterminacies emerge that compel a rethinking and transformation of the rules. Thus, structure is what both constrains process and is in turn transformed by it, in a dialectical relation that Giddens calls the "duality of structure". The process central to the legal system is the adjudication of a case, and the judgment is its quintessential inscription. The judgment not only matches acts to statutes, to determine whether they are licit, and prescribes penalties if they are not, but it also provides in the process an exposition of the rationality of law. Contradictions and inconsistencies, when they appear in specific judgments, undermine that rationality and its attempt to determine the conditions of social existence. Such contradictions and inconsistencies, it is argued, must not be viewed as the errors of an individual judgment, but given the enchainment of judgments through precedents and procedures, the outcome of deeper instabilities in the system of law itself.

The chapter links law to medicine in the form of governance that Foucault calls biopolitics or the politicization of life. One of the imperatives of the modern state as it emerged in eighteenth-century Europe was to ensure that the subjects are provided with all conditions necessary for health and well-being, which was mainly how it differed from the rule of the sovereign. The rationale behind this was that the strength and prosperity of the state depended on the productive capacity of its subjects, which in turn depended on their health and well-being. In this form of governance, both law and medicine worked to ensure the disciplining of individuals and the regulation of populations in a double exercise of authority that was positive and productive. However, in the case of individuals who were understood to pose a threat to the social order, the medico-legal order functioned negatively, to exclude them from society, and medicine provided the justifications for the sanctions that law imposed. It introduced the concept of the "dangerous individual," whose rights could be curtailed on the grounds not of what he did but what he was likely to do given his character or condition of disease (Foucault 2000b). This was a major paradigm shift in law, when it turned from actions that must be proscribed to persons who must be socially eliminated. This can explain why persons with disease are treated as a "danger", whose rights may therefore be justifiably suspended to protect the right to life of others. In the case of diseased individuals, thus, the biopolitics that is ordinarily positive and empowers subjects to be productive, inverts itself, acquires a negative declension and sacrifices the very life it seeks to nurture and protect.

The chapter first examines three court judgments, *Lucy D'Souza v. State of Goa* (1989), *Mr. X. v. Hospital Z* (1998) and *Dhirendra Pandua v. State of Orissa* (2008), to bring out the discursive strategies by which they justify the exclusion of persons with disease. In doing so, the analyses expose contradictions and inconsistencies that undermine the reasoning that the judgments follow. *Lucy D'Souza* first questions the reliability of science in understanding the truth of HIV disease and then uses the same science to argue that the isolation of the HIV-positive is scientific. It cites various documents in support of its claims, but the passages it cites vary from the construal it places on them. *Mr. X. v. Hospital Z* not only justifies restrictions on the rights to confidentiality and privacy of persons with HIV/AIDS but also declares that their right to marry be treated as a suspended right – when the petition was not about marriage but breach of confidentiality and privacy. It presumes that persons with HIV wilfully seek to transmit their disease to others, so that the curtailment or suspension of their rights may appear just. Finally, it links disease with immorality and criminality in a triple indictment that presents the diseased individual as a danger to the social order in all possible ways. *Pandua*, which deals with a case of leprosy and not AIDS, employs a terminological shift from "infection" to "contagion", to present the petitioner's disease as a "danger" even as it cites current medical knowledge, public policy and legislation that indicate otherwise.

Such inconsistencies, it is argued, are the outcome of interpretative processes in adjudication. While some jurists like Hart hold that law is a determinate system wherein there is little scope for interpretation, others like Stanley Fish, Ronald Dworkin and Robert Cover argue differently. Fish's critique of Hart shows how interpretation is not only what judges most often do, but that it is interpretation that establishes what is to be considered as determinate. Dworkin's view is that law is necessarily interpretative, not only in the process of courtroom lawyering but in adjudication as well. But the play of interpretation is restricted by legal history in the form of established procedures and precedents, which are objective and nonarbitrary. Personal intentions and biases of judges have very little scope in the process of law. To this, Fish replies that (a) the presumed objectivity of legal history is the product of interpretation by individual judges and therefore cannot be a constraint on it and (b) judicial intention is never subjective and personal but the product of an interpretive community. But both Fish and Dworkin, while emphasizing on the centrality of interpretation, do not attend to the question of indeterminacy. For this, we turn to Sally Moore's account of the process of law from an anthropological perspective: Moore argues that, given the piecemeal nature of the evolution of legal systems, gaps exist that become manifest in the practice of adjudication. Law, like other systems of social regulation, involves two complementary processes, processes of regularization and of situational adjustments. Because of gaps in the system, the convergence of these processes generates contradictions and inconsistencies that complicate law's capacity to determine social existence.

Cover's argument about judicial interpretation links law with a violence that is not a sign of its malfunctioning but is integral to its logic. Judicial interpretation, he writes, "takes place in the field of pain and death". Law institutionalizes violence in linking the words of the judge with the violent acts of the warder and the executioner in a setting that suspends their innate resistance to harming others and ensures the condition of effective domination. It creates a shared reality in which all – judge, prisoner, warder and executioner – submit to the morality of violence but where the burden of this violence falls on only one and not the others. It is in the context of this shared reality that domination becomes effective, intrinsic to law as practice and naturalized as morally just.

The chapter then examines the judgment in *M. Vijaya v. Chairman and Managing Director Singareni Collieries* (2001), which is singular in the way it acknowledges the enigma at the heart of corporeal justice. Can the state segregate persons with HIV/AIDS, compel those at risk to test and deny their rights and privileges as citizens if they test positive? It tries to resolve this through the Roman law principle that the good of the people is the highest law, under which someone whose rights conflict with that good must sacrifice those rights in the interest of social order. The principle of public good can be understood critically if we compare it with the Roman law doctrine of the *homo sacer*, someone who is considered to be a public enemy and can be killed without the ritual of a trial. Law places the *homo sacer* in a space of exception, in which he is included in law to the extent that it is law that declares him as such, but is also excluded in that law withdraws its protection from him. This is analogous to the diseased citizen who is perceived as a threat to the public: he does not cease to be a citizen because of his disease, but his rights are suspended and he cannot enforce his privileges of citizenship. The figure of the diseased citizen as *homo sacer* explains the enigma that *Vijaya* highlights. In this figure, we see the asymptotic relation that law bears to justice, when law is required to render justice but cannot do so as law. Derrida illuminates the source of this paradox in two ways: (a) where law has to decide between two opposed imperatives, both of which are equally valid, and (b) where law confronts the singularity of a case that exceeds the adequacy of a universal rule because it is unprecedented. We have called the latter instance an anomaly, drawing on Mary Douglas's theory of social classification. The *homo sacer* and the anomalous body, both placed under an exception by law, are figures that inhabit the enigma of corporeal justice and subject it to an indeterminacy without limit or resolution. But the recognition of this limitless enigma is the beginning of a transformation that can make law more responsive – and responsible – to justice.

This, however, is a response that cannot be made *in* law, in a juristic discourse and practice that privileges the legal norm over the norm of justice. The HIV/AIDS Prevention and Control Act, 2017, for instance, prohibits all forms of discrimination against HIV-positive people, but does not address the problem within law itself that sets aside their rights in ensuring the health of others. This requires an imaginative resolution that can come from either philosophy or literature, to which law must respond. Derrida's "Force of Law" is an instance of the philosophical. For the literary, let me briefly turn to *Billy Budd, Foretopman*, a short novel that Herman Melville wrote just before his death in 1891. Billy is conscripted as a sailor on board the *H.M.S. Indomitable*, where by his good nature he befriends all his shipmates except the master-at-arms, John Claggart. Claggart detests Billy's goodness and popularity, because he lacks those qualities in himself. He falsely implicates Billy in a plot of mutiny, and Captain Vere calls both to his cabin. Billy, deeply hurt and angered by the false charge, punches Claggart, who dies. Though Vere is sympathetic, the rules require that Billy must be tried, and he calls a court to judge him. The court holds Billy guilty of murder but is unwilling to sentence him to death because they know how he was provoked. Vere urges them to follow not their sympathies nor their conscience but the law, which he admits is unjust:

> … in natural justice is nothing but the prisoner's overt act to be considered? How can we adjudge to summary and shameful death a fellow-creature innocent before God, and whom we feel to be so? … But do these buttons that we wear attest that our allegiance is to Nature? No, to the King… Our vowed responsibility is in this: That however pitilessly that law may operate, we nonetheless adhere to it and administer it. (Melville 1952, pp. 879–880)

Vere's dilemma is that he knows Billy is innocent, but under the strict maritime law of the Mutiny Act, he must hang. *Billy Budd* is an ethical exploration of the enigma of law, which is called upon to render justice but cannot do so as long as it remains law. To be just, Vere must respond to the singularity of Billy's innocence, which the law that he is committed to will not allow. In the enigma of Billy's conviction and death, thus, Melville compels us to rethink the relation between law and justice in ways consonant with Derrida's philosophy.

In conclusion, it must be emphasized that court judgments have an important bearing on how disease is perceived socially. They may not directly impact health pedagogy, as media accounts and narratives can. But, as we have argued in the conclusion to Chap. 1, AIDS pedagogy is constituted from sources that are diverse: if biomedical ideas of disease are one, ideas that circulate in the media, literature, cinema and the law are the others. "Bodies are positioned", write Cheah and Grosz, "by various (religious, familial, secular, educational, etc.) narratives and discourses to become emblems, tableaux of social laws and rights, illustrations and exemplifications of law, forming and rendering pliable flesh into determinate bodies" (Cheah and Grosz 1996, p. 17). But corollary, we may add, law returns to these narratives and discourses the bodies that it determines and invests with meaning, so that they are never discretely positioned as legal, familial, secular, religious or medical but the product of all of these at once. In the next chapter, we will examine how AIDS pedagogies incorporate, refute or respond in other ways to the multiple significances of the body in social existence.

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# Chapter 6
# AIDS Awareness Campaigns: Pedagogy as Strategy

**Abstract** This chapter examines HIV/AIDS awareness campaigns in two contexts: the history of public health governance and health education and the history of the institutionalization of AIDS pedagogy through NACO and successive AIDS control policies. Drawing on these contexts, it discusses a number of pedagogic interventions in terms of their rationality, modes of governance, semiotic effects and effects on subjectivity.

**Keywords** Public health paradigms · Heath education · Strategic pedagogies · IEC · Critical pedagogy · Nationalization · NACO · NACP

When bubonic plague broke out in Bombay Presidency in 1896 and spread subsequently to other parts of British India, the government appointed a Plague Commission headed by Surgeon-General Sir Arthur M. Branfoot of the India Office Medical Board, to suggest measures to deal with the epidemic. In its report, the Commission noted:

> In the early days of plague in India most strenuous efforts were made to stamp it out by the means adopted in European countries in dealing with epidemic disease, but these efforts failed and they too often led directly to the misfortunes which they were designed to avert. When it was recognized that it was impossible to deal effectively with the epidemic without the help of the people themselves, a policy of persuasion and assistance was substituted for the more rigorous measures, but this also failed to prevent the extension of the disease, although in many places some degree of success was achieved. (Lamb 1908, p. i)

The "means adopted in European countries" concerned chiefly mandatory isolation of the infected and sealing their houses so as to contain the spread of disease, in a strategy that functioned through "multiple separations, individualizing distributions, an organization in depth of surveillance and control, an intensification and a ramification of power" (Foucault 1977, p. 198). But, as the Commission notes, this did not work in India: there were massive riots and popular resistance to the coercive measures of the government, leading in one instance to the assassination of Pune's Plague Commissioner W.C. Rand in 1897 (Arnold 1987, p. 64; 1993, p. 215). The government was forced to abandon compulsory segregation and vaccination and instead attempted to educate the people, with the help of local opinion leaders, about the benefits of such measures. Thus, in a letter to the Secretary, Government

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of India, dated 18 August 1873, Sanitary Commissioner J.M. Cuningham wrote: "There can be no question that the municipalities must form centres from which education in sanitary matters should spread among the people, and there is no more important duty for the Sanitary Commissioners to discharge than that of encouraging … and creating the desire for sanitary improvements" (cited in Harrison 1994, p. 108). The report of the Plague Commission provided "scientific approval for this shift from a coercive to a more conciliatory policy" (Arnold 1993, pp. 234–236).

I begin with this account of the plague and its medico-political consequences for two reasons: first, because it marks what could very well be the first emergence of public health education in India and, second, because it shows how coercion gives way to pedagogic strategies when it proves ineffective. As Lamb's summary report notes, pedagogy does not guarantee the eradication of disease but can achieve "a degree of success" relative to coercion. When the HIV/AIDS epidemic first appeared in India in 1986, it precipitated a crisis that seemed to justify measures like mandatory testing, isolation of suspect individuals and populations and even a proposal from the director of the Indian Council of Medical Research (ICMR) to legally ban sex with foreigners and non-resident Indians (Bhargava and Devadas 1988, p. 117). But by 1992, when the National AIDS Control Organization was established as the nodal agency for dealing with the epidemic, it was decided to focus instead on creating awareness about HIV disease, its modes of transmission and prevention.[1] Over the years, declining rates of new infection suggest that pedagogy has achieved at least a modest success.

## 6.1 Paradigms of Public Health

The emergence of public health governance has been traced to eighteenth-century Europe, when it was considered a part of the state's obligation to ensure the well-being of its subjects. As Michel Foucault states in "The Politics of Health in the Eighteenth Century", private and public medicine emerged simultaneously to deal with the biopolitical problem of disease (Foucault 2000c, p. 90). Public health governance focused on disease prevention or prophylaxis, while private medicine focused on therapeutic treatment of individuals, in the general "medicalization" of society: "starting in the eighteenth century human existence, human behaviour, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape" (Foucault 2000b, p. 135). Of especial concern was the outbreak of epidemic disease, which not only took a heavy toll of lives but was equally a burden on medical resources. The major technique used at first to contain disease was segregation of the infected and setting

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[1] The first phase of the National AIDS Control Programme (1992–1999) included among its specific objectives the creation of "a satisfactory level of public awareness on HIV transmission and prevention" and developing "health promotion interventions among risk behaviour groups" (NACO 2000, p. 18).

up of *cordon sanitaires* around locations of disease. In *Discipline and Punish*, Foucault discusses how measures to control the spread of plague at the end of the seventeenth century functioned through a meticulous system of quarantine and surveillance (Foucault 1977, pp. 195–200). Quarantine depended upon a classification of spaces and bodies as pathogenic or healthy and restrictions on the passage between the two. “Under a system of quarantine, illness somehow resided in places, as it was places that had to be kept separate. To be sure, the movement of people was controlled, but only in that they brought one place into contact with another” (Armstrong 1993, p. 395).

A related technique to control spread of disease, which was developed and adopted along with quarantine, was inoculation. Outbreaks of smallpox were frequent in Europe throughout the century, peaking in 1760, with an average mortality rate of approximately 1 in 8. Inoculation or variolation, which involved the transference of smallpox variola into the body, was introduced as a preventive measure in 1720. Initially, the variola was taken from the pox or sores of people infected with the disease, but in 1796 Edward Jenner perfected a technique using bovine instead of human variola. From the beginning of the nineteenth century onwards, Jennerian vaccination replaced inoculation as prophylaxis against smallpox (Foucault 2007, pp. 57–58). At the time, however, there was no way of knowing how inoculation or vaccination worked,[2] but its results were evident: as Berthollet stated with regard to bodily changes caused by vaccine, “What is the nature of this difference and change? No-one knows; experience alone proves its reality” (cited in Foucault 2007, p. 80, n. 5). The practice of variolation had long been in existence in parts of Asia, especially China and India, and even in Europe, but it was only in the eighteenth century that it become modernised and established as standard epidemiological technique.

In the second half of the nineteenth century, the technique of quarantine was substituted by sanitary procedures. “The last great attempt at massive quarantine in England occurred in 1831 with the outbreak of Asiatic cholera” (Armstrong 1993, p. 394). Sanitation signified both continuity with and difference from quarantine as a public health strategy. Like quarantine, it was concerned with spaces: the state of the soil, water, air and human habitations. But while quarantine isolated both spaces and bodies marked as pathogenic, the logic of sanitation was to separate the body from its physical environment:

> The great innovation of sanitary science, however, was to interpolate a new space of hygiene into [the] more traditional geographical diagram of public health, namely that of the volume of the human body. Doubtless this corporal space was at first treated as quasi-topographical with an emphasis on ‘topographical anatomy’, but, at the same time, it was also clearly delineated by a new boundary which marked the separation of the space of the body from the space of geography. Contemporary strategies of hygiene thus began to shift their attention from monitoring movement between one place and another place to between the human body and its geographical context. (Armstrong 1993, p. 396)

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[2] Research on the immune system began in the early years of the twentieth century, but immunology as a field of medical knowledge emerged only in the 1960s with the discovery of cellular mechanisms (Cruse and Lewis 1999, p. 1).

Toxicity was understood as existing not just in the external environment but also in the human body. It was the outcome of metabolic processes essential to life, the by-products of which were sweat, faeces and urine. Sanitary science thus focused also on the proper elimination of such poisonous wastes, returning them to their proper place in the water, air or soil, where they would be diluted and their toxicity dissipated. Even dead bodies, which were potential sources of toxicity, had to be properly absorbed into the environment, and the disposal of corpses became the subject of a series of Burial Acts from 1852 onwards in England (Armstrong 1993, p. 399). Sanitary policy was implemented by the centralized agency of the eighteenth-century police, one board of which was concerned with keeping urban environments safe for human habitation:

> The air, aeration, ventilation, especially in towns, will all be linked … with the theory of miasmas, and a whole new politics of amenities, of new urban space, will be organized by reference to and subordinated to concerns and principles of health: the width of roads, the dispersion of elements that may produce miasmas and poison the atmosphere. (Foucault 2007, 325)

Alongside sanitation and in complement to it, personal hygiene came to be emphasized as a practice of health-seeking behaviour. But it was not possible for the state to ensure personal hygiene as easily as it could ensure proper sanitation, as the conduct of individuals was understood to belong to a domain of the private free from the reach of public authority. The one place where this could, however, be attempted was the school, where the children were still in a formative stage and could be taught healthy habits; moreover, the school was the place where infections could easily spread from one child to another, from thence to the family, to the neighbourhood and eventually to the rest of society. The turn of the century witnessed the emergence of a new strategy of public health, pedagogy, which has since come to dominate the practice of preventive social medicine. Not only were schoolchildren subjected to frequent examination by health inspectors but were also made to read primers on hygiene as a compulsory component of curricula. Public health strategies developed in the metropolis came to be adopted in the colonies,[3] and, following this, hygiene was introduced in Indian schools in the early twentieth century. J.M. Cuningham, the sanitary commissioner of British India, wrote *A Sanitary Primer for Indian Schools*, which was translated into several Indian languages and prescribed in schools in the 1880s. The book was considered to be too general and unspecific to be useful but continued to remain on the curriculum till after his retirement, when it was replaced by *The Way to Health* published by the Madras Christian

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[3] The rationale for introducing these strategies in the colonies, however, differed. It was to ensure the health of the European population, especially the army, which could not be done without also ensuring conditions of health in the native population (Jeffery 1988, pp. 92–99; Levine 1994; Harrison 1994, pp. 60–98; Curtin 1996; Pati and Harrison 2001). Mark Harrison cites from the report of the Sanitary Commissioner of the Government of India in 1892 that the troops "will never be safe as long as the native population and its towns and villages are left uncleaned to act as reservoirs of dirt and disease" (Harrison 1994, p. 77). I have underplayed the differences between metropolitan and colonial public health rationalities for the sake of coherence, but differences were certainly there.

Vernacular Education Society (Harrison 1994, p. 90). In the introduction to *Sanitary Primer*, after emphasizing the value of good health for well-being and prosperity, Cuningham states the book's objective:

> In a little book like this it is impossible to discuss everything that bears on health, or even to discuss any one of these things very fully; but a few simple words about the most important of such things may easily be understood even by children. They may easily learn what are the principal laws of good health; how these laws are either neglected or violated in every Indian town and village; and what can be done to remedy this state of things, and make these towns and villages more healthy than they are. (Cuningham 1882, p. 4)

If sanitation was the strategy of disease prevention adopted by public health governance for populations and places, personal hygiene was its complement in the private sphere of individuals, the purpose of which was to inculcate in them habits of healthy living.

Since the 1970s, claims Armstrong, a new regime of public health has emerged that focuses neither on the quarantine logic of classifying and delineating disease locations nor on the sanitary logic of separating the body from a toxic environment but on the maintenance of a balance between nature, human activities, individual conduct and collective practices that increase vulnerability to disease.

> The new public health therefore demands a wider hygienic strategy than a simple personal hygiene. It necessitates political activity to promote 'environmentally-friendly' policies; it calls for an ecological approach to health; and, for the individual, it requires an extension from concerns with body boundaries or individual psychology to examination of 'lifestyle'. In its new guise of health promotion, public health is now concerned with generating and monitoring 'political awareness' in its widest sense. (Armstrong 1993, p. 405)

With advances in therapeutic and preventive medicine, diseases that had once been fatal were now easily curable and controlled. In December 1979, the World Health Organization announced the eradication of smallpox globally (WHO 1979). Diseases like tuberculosis, malaria, cholera, plague and leprosy were brought under control and effective treatments made available. Attention came to be focused, therefore, on a number of chronic diseases that were on the rise due to environmental and lifestyle factors, like hypertension, obesity, diabetes, cancer and coronary disease. Till the arrival of HIV/AIDS in 1981, it was widely believed that infectious disease epidemics were a thing of the past, and health discourse shifted quite significantly from the notion of "germ" to that of "risk," that is, genetic, environmental, metabolic and behavioural factors that predispose one to vulnerability of chronic disease. Though AIDS is not technically a lifestyle disease, it has been predominantly associated with particular lifestyles, and therefore it has been possible to assimilate it into the terminology of risk. It is not that the notion of hygiene has receded: as AIDS pedagogy shows, it continues to inform approaches to disease prevention. But it is reoriented towards a risk-based perspective through terms such as "risk practices", "risk groups" and "risk avoidance".

"The notion of risk", argues Bryan Turner, "is crucial to any debate about modernity because the process of modernization involves an intensification and multiplication of social risk, both at the level of the individual and at the level of social collectivities" (Turner 1995, p. 219). Turner summarizes Ulrich Beck's argument in

*Risk Society* (1992) that while risks have always existed in any society because of the aleatory nature of social and natural phenomena, in contemporary societies they have become multiplied, intensified and globalized. The sources of risk may be economic due to the fragmentation of the labour market; environmental due to aggressive exploitation of resources; medical due to the iatrogenic effects of new diagnostic, therapeutic and pharmacological trial procedures and due to the spread of epidemics through transnational migration; social due to overdependence on public institutions like the state that are themselves undergoing transformation; and security-related due to the globalization of terror. While agreeing in general with Beck's thesis about the contemporary significance of risk, Turner proposes that it is more important to see how an increased perception of risk has led to a proportionate increase in social regulation: "as the macro social and economic environment becomes more unstable and uncertain, then new systems of surveillance and government would be put in place to provide some control and regulation over the environment both social and natural" (Turner 1995, p. 226).

In the governance of public health, the regulation of individuals is achieved by the new orientation that it gives to traditional notions of personal hygiene. It calls for self-regulation through the management of lifestyle, that is, patterns of social and personal relationships, consumption, work and leisure, and, most importantly, the pursuit of pleasures. While the hygienist model is founded on the moralization of conduct, the emphasis here is on morality as well as the avoidance of risk. The human body is increasingly drawn into a prudential calculus that calibrates pleasures related to sex, addictive substances and food, with the risks that they pose to health, in what Chris Shilling calls "body projects":

> At a time when our health is threatened increasingly by *global* dangers, we are exhorted ever more to take *individual* responsibility for our bodies by engaging in strict self-care regimes. Heart disease, cancer and a host of other diseases are increasingly portrayed as avoidable by individuals who eat the right foods, stop smoking and take sufficient quantities of exercise. Self-care regimes require individuals to take on board the notion that the body is a project whose interiors and exteriors can be monitored, nurtured and maintained as fully functioning. (Shilling 2003, p. 5)

We can characterize the developments in public health governance outlined above by a schema of three major paradigms, each centring on a coupling of population and spaces on the one side and the individual on the other. The first paradigm, which characterizes public health interventions till the mid-nineteenth century, is quarantine/vaccination. It involves the segregation of spaces and populations held to be pathogenic, complemented with the vaccination of healthy individuals. The second paradigm, from the mid-nineteenth to the mid-twentieth century, is sanitation/personal hygiene, involving sanitary projects at the governmental level and practices of hygiene at the individual level. The third paradigm, which characterizes contemporary public health, is risk surveillance/management of lifestyle, the former identifying practices and populations at high risk and the latter inculcating prudence in personal conduct. This differs from the schema proposed by Armstrong, which identifies four regimes of public health: quarantine, sanitary science, interpersonal hygiene and hygienic surveillance (Armstrong 1993, p. 405). First, Armstrong's schema fails to bring out the link between macro-level and micro-level procedures that together constitute the political rationality of modern governance, by correlating the individualization of subjects with their totalization as populations.[4] Second, sanitary science was complemented, not succeeded, by hygiene, both personal and interpersonal: if the school, as Armstrong points out, could be the salutary site of hygienist pedagogy at the turn of the twentieth century, it was because it was a zone of unsanitary encounters. Personal hygiene, given the nature of social existence, necessarily includes the setting up of sanitary boundaries against contact and contagion.

The schema I have proposed is, of course, a convenient way of mapping the shifts in the paradigms of public health. Actual practice is more complex with continuities and overlaps between earlier paradigms and emergent ones. Thus, techniques of quarantine continued to structure and classify spaces and populations in projects of sanitation, while vaccination continues even now to be a major mainstay against infectious diseases. In the context of HIV/AIDS, segregation, hygiene and risk surveillance function simultaneously in both social and public health responses to the epidemic. The advantage of such a schema, however, is that it enables us to understand both the shifting priorities and the provenance of techniques deployed in public health today, in terms of how they simultaneously articulate, reorient and differ from their earlier forms. In this schema, it should be apparent that quarantine/vaccination corresponds to what Foucault characterizes as law, sanitation/hygiene to discipline and the surveillance of risk/management of lifestyles to security. Quarantine, like law, depends on the binary division of the population into healthy and diseased. Vaccination does not follow this logic,[5] but it has required, like quarantine, enforcement through law. Thus, the Compulsory Vaccination Act was passed by the government of British India in 1880, to enforce the vaccination of children for smallpox and ban the indigenous practice of inoculation or variolation, as it was held to be unsafe.[6] In England, similarly, there were a series of Vaccination Acts passed between 1853 and 1873, some of which made vaccination mandatory and banned variolation. The sanitation/hygiene paradigm isolates spaces of disease and targets people vulnerable to disease, not to confine them but with the objective of reform and improvement; the preferred strategy of the hygienist model is not punishment for transgressions but the inculcation of self-discipline through pedagogy.

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[4] Cf. Foucault: "The main characteristic of our modern rationality … is neither the constitution of the state, the coldest of all cold monsters, nor the rise of bourgeois individualism. I won't even say that it is a constant effort to integrate individuals into the political totality. I think that the main characteristic of our political rationality is the fact that this integration of the individuals in a community or in a totality results from a constant correlation between an increasing individualization and the reinforcement of this totality" (Foucault 1988b, pp. 161–162).

[5] Foucault considers vaccination a mechanism of security rather than of law, in that it tries to reduce the risk of disease and not to eliminate it altogether (Foucault 2007, pp. 57–58).

[6] For an account of the difficulties encountered in enforcing vaccination law, see Bhattacharya (2001, pp. 245–258). These difficulties ranged from conflicts between the officers of the Indian Medical Service and the civilian administrators, the half-heartedness of municipal officials in carrying out vaccination programmes, to resistance by local populations.

It was assumed that individuals would learn for their own good, since health was considered a value. Both the quarantine/vaccination and sanitation/hygiene paradigms, despite their differences, are based on the assumption that the risk of disease can be eliminated through appropriate public health measures. The third paradigm, risk surveillance/lifestyle management, assumes in contrast that risk is a reality that cannot be entirely eliminated but must be accepted and minimized through regulatory controls and behaviour change. In the case of HIV/AIDS, it accepts that people may not discipline themselves to practice celibacy or marital fidelity nor can they be forced to do so by law, and should therefore be advised to use condoms to reduce risk of infection. Therefore, the objective of public health intervention here is not the ideal of total disease eradication – which at present seems impossible given the absence of cure or vaccine for HIV disease – but the containment of risk and of levels of new infection within acceptable limits. While lifestyle management targets individuals to inculcate disease-preventive behaviour, risk surveillance quantifies the vulnerability of specific populations, the burden of disease in the nation and the costs involved to keep it low. The functioning of risk surveillance strategies can be explained by Foucault's account of how security mechanisms work. They assume that "risks are not the same for all individuals, all ages, or in every condition, place or milieu [and, we may add, lifestyle]. There are therefore differential risks that reveal, as it were, zones of higher risk and, on the other hand, zones of less or lower risk" (Foucault 2007, p. 61). Populations with higher risk, who pose a danger to the rest of society, can be rendered "safe" either by restricting their freedom under law, as we saw in Chap. 5, or by teaching them proper conduct, disciplining their desires and helping them manage their lifestyles, which is the subject of this chapter.

## 6.2 Health Education, Expert Knowledge and the Shaping of Subjectivity

In Europe, health education began with the hygienist model in the late nineteenth century, especially when industrialization, urbanization and overcrowding in cities increased the vulnerability of people to disease. A major site, as mentioned above, was the school, where healthy habits could easily be inculcated among children. It was also targeted at the poor, because of a stereotype that linked disease to poverty. "Epidemic disease was rife in the overcrowded and poverty-stricken cities, and this led to a particular association in the middle-class mind between poverty, immorality and disease" (Wilton 1997, p. 39). In England, interventions were the responsibility of statutory local authorities, especially the medical officers which each town was required to appoint under the Public Health Act, 1848. But they were also carried out by philanthropic groups, which tried to promote middle-class virtues and ways of life in the name of teaching the poor. Wilton mentions a book of recipes written by Charles E. Francatelli, chief cook to Queen Victoria. Francatelli's *A Plain Cookery Book for the Working Classes* (1861) teaches its target readers how to prepare healthy, cheap and nutritious food and also to accept “donations” of the more expensive dishes from “noblemen and gentlemen’s mansions” in the neighbourhood (cited in Wilton, p. 40). In the colonies, health education was taken up very actively by missionary organizations, such as the Madras Christian Vernacular Education Society that published the school primer *The Way to Health*. Hygiene, observes Harrison, “was an important element of their ‘civilizing mission’, in which moral and medical teaching went hand in hand” (Harrison 1994, p. 90). The linking of medicine and morality, however, was not restricted to missionary or philanthropic interventions but has been generally the approach at least insofar as sexual disease is concerned. Thus during the Second World War, when the spread of sexually transmitted infections among American soldiers became a serious problem, the US government issued a number of health education posters and pamphlets. *Sex Hygiene and Venereal Disease*, a pamphlet for new recruits issued by the War Department, stated: “Sex relations should be kept for marriage. Between people who aren’t married they lead to shame, sorrow and disease… Good morals limit these sex relations to marriage” (US War Department 1942, pp. 5–6). “The Army”, it urged, “can protect you from many diseases, but you’ll have to protect yourself from syphilis and gonorrhoea” (US War Department 1942, p. 12). As we will see, this convergence of medicine and morality continues to structure the pedagogic understanding of AIDS, often quite overtly.

Given that health education since its inception has communicated biomedical rather than popular ideas about health and disease – popular knowledge is often dismissed as mythical and misleading[7] – doctors and not moral leaders are invested with the authority to decide what lessons are to be imparted. This, we may say, is the major difference between the missionary and philanthropic interventions of the past and health education in its current form, notwithstanding the fact that moral ideas continue to be disseminated in the guise of medical wisdom. The first hygiene primer used in Indian schools, thus, was written by Dr. J.M. Cuningham, the sanitary commissioner. Doctors, writes Foucault, “have the task of teaching individuals the basic rules of hygiene, which they must respect for the sake of their own health and that of others: hygiene of food and habitat, exhortations to seek treatment in case of illness” (Foucault 2000a, b, c, p. 99). Health education, therefore, has adopted a “top-down” approach that authorizes expert knowledge and draws on a range of expertise from biomedical ideas to theories of sociology, psychology and mass communication (Wilton 1997, p. 40). The latter do not compete with biomedical knowledge but supplement, contextualize and translate it for the “masses”. Health education thus constructs a new “regime of truth” that not only decides what can be said about health and disease but equally how it may be said and by whom.[8]

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[7] Thus, many awareness campaigns during the first phase of the National AIDS Control Programme in India used the format of “facts” versus “myths” in communicating knowledge about transmission and prevention of HIV. We will examine some of these in more detail later.

[8] The phrase “regime of truth” is Foucault’s. The exercise of power, he argues, necessitates the production of knowledge, which then enables strategies to be formed to enhance power’s reach. “‘Truth’ is linked in a circular relation with systems of power which produce and sustain it and to

It is new in the sense that social decision-making on the conduct of individuals has passed from morality and the law to science.[9] As Nikolas Rose states, this has had diverse consequences for understanding how the truth of health pedagogy works:

> The location of ethical statements within the field of science is double-edged. On the one hand, in freeing many questions concerning the proper conduct of life from the authoritative prescriptions and proscriptions of political, religious, and social authorities, it pluralizes the answers that can be provided, opening up a field of diversity within which each subject is obliged to locate themselves. On the other hand, in relocating these questions of the conduct of life within the field of expertise, in tying it to norms of truth and health, it binds subjects to a subjection that is the more profound because it appears to emanate from our autonomous quest for ourselves – it appears as a matter of our freedom. (Rose 1999a, p. 260)

In other words, by recasting the question of ethical conduct within a scientific or biomedical discourse health education is simultaneously liberating and constricting. It liberates one from the constraints of morality by offering a choice: sexual infection can be avoided either by choosing to abstain, or remaining faithful to one's partner, or simply by using a condom. The fact that the choice is constrained to only three options is irrelevant. At the same time, it subjects one to a new disciplinary authority more profound because it no longer appears as discipline but freedom. Its novelty is that it is a form of discipline that is premised on the individual's freedom and not coercion. It is a subjection that, paradoxically, liberates and (to use the language of much contemporary health education) "empowers", and this paradox is crucial to understanding how the new medicalized approach to sexual conduct functions.

In the next section, we will examine how both the epidemic and the pedagogic responses it necessitated were framed within a national context, with the state at its centre but the agencies of control and regulation dispersed across a wide range of sites. It was the nationalization of AIDS pedagogy that contributed to the coherence of what would otherwise appear to be diverse interventions each with its own rationality and significance. The coherence, as we will see, has been, first, in terms of the centralization of disease control policy and second in the resonances between pedagogic projects carried by different agencies.

## 6.3 NACO and the Nationalization of AIDS

In 1992, the Indian government was given an International Development Association (IDA) loan of 84 million US dollars from the World Bank, to start a programme in consultation with the World Health Organization (WHO) for controlling the AIDS

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the effects of power which it induces and which extend it. A 'regime' of truth" (Foucault 1980, p. 133).

[9] Edward Albert (1986) has argued that this is typical of modern societies, where in matters of social conduct, the authority of medicine supersedes that of morality and law. Albert's view coincides with Foucault's argument about the general "medicalization" of society starting from the eighteenth century.

epidemic. Though the epidemic broke out in 1986, in these 6 years, it did not appear to have spread much: there were only 5879 reported HIV-positive cases with 96 developing AIDS, 13 of whom were foreigners. There appeared, as Rao has pointed out,[10] no urgent reason to prioritize HIV/AIDS as public health issue, and the government seems to have accepted the loan primarily because of the widespread panic and stigma (Rao 2017, p. 202). On the insistence of WHO, a National AIDS Control Organization (NACO) was established as the new nodal agency for dealing with the epidemic, a role that had been assigned in 1986 to a task force of the Indian Council of Medical Research (ICMR). NACO was headed by a project director of additional secretary rank drawn from the Ministry of Health and Family Welfare, Government of India. Simultaneously, the National AIDS Control Programme for prospective strategy planning and implementation was launched in four phases, the first covering the period 1992–1998, the second 1999–2006, the third 2007–2011 and the fourth 2012–2017, followed by the National Strategic Plan for HIV/AIDS and STI from 2017 to 2024. Over the years, NACO's approach to disease control and the nature and scope of the strategies adopted have changed in keeping with changes in the scale and pattern of the epidemic. In the sections that follow, we will try to map these shifts and draw out their implications in terms of underlying philosophies of governance, with a focus on pedagogic interventions. Given the complexity of HIV/AIDS, which requires responses ranging from the biomedical to the psychosocial, political, economic and communicational, pedagogy has been only one among a number of different strategies of disease control. But given also the predominant understanding that risk of infection correlates with gaps in knowledge and faulty behaviour patterns, which can be rectified through teaching, pedagogy has been and will continue to be the chief strategy for preventing new infections, till at least a vaccine for HIV is developed. Further, the epidemic is also understood as fuelled by stigma and discrimination, which drive it underground, and pedagogy is again the chief strategy to counter them and promote tolerance. Finally, pedagogy has been used to address the legal and human rights issues arising out of AIDS-related discrimination.

"Nation-forming," writes Alison Bashford, "has found one of its primary languages in biomedical discourse, partly because of its investment in the abstract idea of boundary, identity and difference, but also because of the political philosophy that thinks of the population as one body, the social body or the body of the polity" (Bashford 2004, p. 3). Bashford's concern is with how the nation defines itself against an outside world understood as source of pathogenic risk, in which maritime quarantine and restrictions on immigration "enabled a particular geographic imagining of Australia" (Bashford 2004, p. 116). As we have seen in Chap. 2, an analogous situation had prevailed in India in the early years of the epidemic, so long as AIDS could be construed as being of "foreign origin". But by 1992, it was not so

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[10] K. Sujatha Rao served as Director General of the National AIDS Control Organization from 2006 to 2009 and has written perhaps the most comprehensive history of its functioning since its inception in 1992 (Rao 2017, pp. 201–297).

much the border as what lay inside it that became the concern of nosopolitics.[11] How was the AIDS epidemic in India posed as a problem for the nation, and not just the individuals affected by it? While it may not have significantly affected national economic growth, it was presumed to have had a major impact on the microeconomic level of households and by extension the nation. NACO's Status Report on the epidemic in 1997 states: "Increasing rates in HIV infection and death through AIDS will have an impact not only on individuals, households and communities, but also on some of the benchmarks of human development: life expectancy, per capita income, school enrolments and health" (NACO 1997, p. 1). Similarly, the NACP III document states: "The epidemic can entail adverse consequences to our achievement of health and development goals, namely child mortality and poverty. AIDS related productivity losses can be substantial. At the micro level household surveys show a 9.24% decline in incomes and an increase of 10% in health spending. If unchecked the epidemic scenario, over a 14 year period, can lower labour productivity and increase public health expenditure by 10–15%" (NACO, NACP III: To halt and reverse the epidemic, p. 1). In one of the vision statements of NACO, the nationalizing rhetoric converges individuals, families and the nation into a single entity, what Bashford calls "one body": "the irony is, that this fragile virus can take an individual, a family, *indeed the country*, on a trajectory of loss, if the infection goes unimpeded" (NACO 2003, p. 9, italics added). It imagines on the one side a fragile and miniscule virus and on the other the vast collective body of the nation, in the unfolding of a disaster that it is the state's duty to avert. In other words, it was posed as a problem for both the individuals and families affected as well as the nation, which the state would need to address in the absence of any adequate response from society: "When there is a new public health threat inadequately recognized by the civil society and participatory approaches are limited, it is necessary that the central government play a major leading role at the start-up phase to initiate a national response" (NACO 2000, p. 22). The setting up of the *National* AIDS Control Organization was the first step in that direction.

Under NACP I, where the emphasis was on centralization of epidemic control, two of the chief objectives were (a) creating public awareness about HIV to stimulate civil society response and (b) monitoring the epidemic nationally.[12] With regard to monitoring, though there were surveillance centres established by the National Institute of Communicable and Enteric Diseases at Imphal and by Christian Medical College at Vellore, there was no mechanism for nationwide surveillance. During NACP I, NACO established a sentinel surveillance system in antenatal clinics (ANCs) and sexually transmitted disease (STD) clinics for high-risk groups (HRGs), fixing 1% HIV prevalence among the attendees of the former and 5% among the latter as indicators of epidemic scale. The choice of ANCs was on the assumption that HIV incidence in pregnant women, who could reasonably be expected to have been infected by their husbands, would indicate the extent of the epidemic in the

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[11] Literally, politics of disease, from the Greek *nosos* meaning disease. I borrow the term from Foucault (Foucault 2000b, p. 91)

[12] Other objectives were blood safety, STD control, support services for people living with HIV/AIDS and involvement of all states and union territories in epidemic prevention.

general population. The data collected from sentinel surveillance, thus, would give a rough estimate of disease incidence among both high-risk groups and the general population. Based on this, the states of the country were mapped into three categories: (a) high prevalence (exceeding 1% prevalence among ANC attendees and 5% among HRGs), (b) moderate prevalence (below 1% among ANC attendees but 5% or more among HRGs) and (c) low prevalence (below 1% among ANC attendees and below 5% among HRGs) (NACO 2000, p. 5).[13]

The primary objectives of NACP I were scaled up in subsequent phases to cover as much of the national population as possible. NACP II decentralized the national response by setting up State AIDS Control Societies (SACS), and NACP III furthered this decentralization by setting up District AIDS Prevention and Control Units (DAPCUs). Mapping of HIV levels now included the categorization of not only states but within them districts, which were divided into four groups. Under the 2007 classification, 156 districts were listed in Category A (more than 1% HIV prevalence among ANC attendees), 39 in Category B (less than 1% HIV prevalence among ANC attendees with more than 5% among HRGs), 278 in Category C (less than 1% HIV prevalence among ANC attendees with less than 5% among HRGs, with "known hotspots") and 111 in Category D (less than 1% HIV prevalence among ANC attendees with less than 5% among HRGs, with no "known hotspots" or with inadequate data) (Rao 2017, p. 213). In other words, the scope of public health governance was intensified in terms of both area of coverage and depth of penetration. The sites of governance, too, were multiplied in an extension of reach: from a central organization to state agencies to district units concerned with the health of the general population, to non-governmental, voluntary and community-based organizations focused on the high-risk groups. As the NACO report of 1999–2000 put it: "Since most of these groups are extremely marginalized both socially and economically, it is not possible to access them through conventional government services. NGOs, Community Based Organizations and other appropriate agencies are able to reach out to these populations more effectively" (NACO 2000, p. 58).

The nationalization of the epidemic in India, therefore, has taken a form quite different from that described by Bashford for Australia, at least from the early 1990s onwards when the "foreign origin" theory lost purchase. Epidemic flows come to be understood in terms of internal patterns, spreading first from high-risk groups to the general population and from cities to rural areas. Borders continue to be a concern but are understood as requiring strategies different from those for mainland spaces: "The porous boundaries of the country and the major cross-border flows of various population groups by land [and] sea require an enhanced regional approach" (NACO 2000, p. 23). Controlling the epidemic, therefore, has taken two forms. One involves strategies of geographical mapping, with ever-increasing penetration from the country as a whole to states and then to districts and from metropolitan centres to other

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[13] In 1999, the high prevalence states were Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur and Nagaland; moderate prevalence states were Gujarat, Goa and Pondicherry; and the rest were low prevalence (NACO 2000, pp. 2–3).

urban spaces to the rural hinterland. Such mapping yields data on differential HIV incidence levels, represented in colour-coded maps of India showing disease densities, on the basis of which region-specific strategies of epidemic control can be designed (Rao 2017, pp. 211–214). If one form has been cartographic, the other has been demographic, involving large-scale population studies and more individualized Behavioural Surveillance Surveys[14] following the same logic of intensified penetration, but this time into bodies rather than spaces. The nationalization of the AIDS epidemic, thus, has come to be imagined through this dual perspective on the country's land and people, rather than its risk-prone boundaries with other nations. Pedagogic strategies, which have been the mainstay of disease prevention (supported by other measures like blood safety, testing and counselling, STD services and, since 2004, free supply of antiretroviral therapy), are inserted in the demographic mapping of the national population.

Two important points need to be kept in mind. The first is that NACO was by no means the sole agency in the nationalization of AIDS: it was simply the *nodal* agency. There were, as we have stated, multiple sites of governance, including the SACS and DAPCUs, the India offices of intergovernmental health organizations like WHO and UNAIDS, non-governmental organizations and community organizations, corresponding to which there were multiple sites of nationalization. The prevention and control of the epidemic, in other words, has been based on a structure of centralization with regard to policy formulation and decentralization with regard to implementation. This results in a form of nationalization of strategy and pedagogy in which the nation coincides with but is not reducible to the state. Secondly, nationalization of the epidemic was the outcome of a political decision, as an approach to developing coherent and sustained strategies to limit an epidemic dispersed across diverse spaces and populations. What needs to be stressed, therefore, is its *political* nature, to see how AIDS is not simply biological but equally a politico-pedagogic construct, parallel with its construction in factual and fictional narratives, media discourse and the discourse and practice of law.

## 6.4 NACO and the Nationalization of Pedagogy

Corresponding to the nationalization of the epidemic, measures to control it were also developed on a national scale, at first through centralization of pedagogic strategies and subsequently through their decentralization with central control over policy. During the first phase of the National AIDS Control Programme, pedagogic initiatives were largely undertaken by NACO, with the expertise being provided by international health agencies like WHO and UNAIDS. Subsequently, with the setting up of state units and the greater involvement of non-governmental and

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[14] The Behavioural Surveillance Survey (BSS), which began in 2001 with a sample population 15–24 years of age, seeks to measure "trends in cognitive information on HIV/AIDS and to assess changes in sexual behaviour and risk practices" (NACO 2006, p. xiv).

community-based organizations, the initiatives were decentralized but were designed in accordance with operational guidelines issued by NACO. According to Sujatha Rao, about 40 such guidelines concerning different components of the epidemic control policy were developed by 2009 (Rao 2017, p. 220). For pedagogic campaigns, NACO issued the *Information, Education and Communication Operational Guidelines* in 2007.

The focus in the initial years of NACP was on creating awareness about HIV/AIDS in the general population, through interventions designed to communicate basic biomedical information. Since most of the pedagogic material was in the form of printed posters, handouts or booklets, in both English and regional languages, it was assumed that they could read and understand the messages: in other words, the general population was tacitly held to be the literate middle class. The information was arranged into "facts" and "myths", in a presumably objective format that has continued to structure AIDS knowledge till date. Thus, a booklet currently available on the NACO website, titled *Tell Me the Truth about HIV/AIDS*, has a section on "How does HIV spread? How can I avoid getting HIV?" based on facts, followed by another on "Will I get HIV if…" dismissing the myths (NACO, Tell me the truth about HIV/AIDS). Similarly, a card game developed by the International Labour Office in 2005 aims to modify the behaviour of factory workers by teaching "correct information" and "dispelling myths" (ILO n.d., A 19). A booklet titled *From Know More to No More: AIDS* published by UNAIDS in 2004 has a section on "Myths and Misconceptions", the rest of the booklet being devoted to facts (Cupatha and Zutshi 2004, p. 15). The most explicit form of such information-based pedagogy was the "Know AIDS for No AIDS" campaign adopted by a number of different agencies, which used posters, hoardings, milestones on highways, flashcards and booklets to popularize the message (Fig. 6.1).[15] Underlying such awareness creation strategy is the assumption that providing factual information about the modes of disease transmission and prevention would suffice: readers would be able to rationally incorporate such information into their sexual lifestyles because they all aspire to be healthy. This assumption, however, is problematic. "Information about health", writes Tamsin Wilton, "is not passively consumed but actively *processed* in the context of pre-existing health beliefs. Any information which appears to diverge greatly from already held health beliefs is likely to be rejected or profoundly modified by the individual" (Wilton 1997, p. 45). In other words, informational statements do not exist in isolation from the larger discursive and sociocultural contexts within which they come to mean and acquire significance. Culture plays an important part in this processing of information, for ideas about illness and health are as much cultural as they are biomedical. Further, as Rafael Diaz argues, practices considered to be risky must be understood "not in terms of 'deficits' in individuals' knowledge, motivation, or skills, but rather as behaviour that may have meaning and be quite rational within a given socio-cultural context" (Diaz 2000, p, 196). The context that defines peoples' behaviours and practices may be understood as what Pierre Bourdieu calls the "habitus", which is "a socially constituted system of cognitive and motivating structures" that induces us to act in certain ways (Bourdieu 1977,

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[15] For a critique of this campaign, see Das (2005).

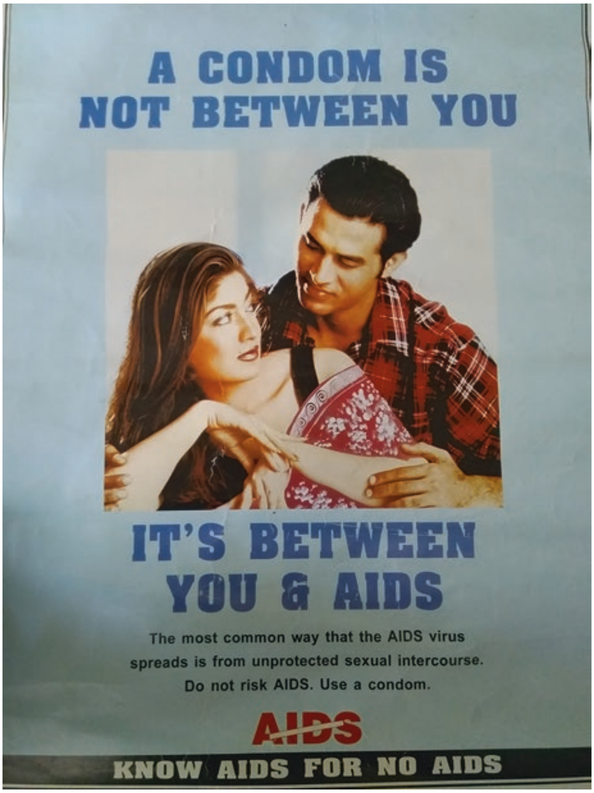

**Fig. 6.1** "Know AIDS for No AIDS" campaign poster (NACO)

p. 76). The sociocultural context that Diaz emphasizes and Wilton's "pre-existing" beliefs are organized by the habitus as the structure of cultural knowledge within which we make sense of our actions and their appropriateness or inappropriateness in given contexts. Interventions that limit themselves to biomedical information, and see culture as either irrelevant or antagonistic to scientific reason, fail to produce the intended effect because they do not take into account the role of the habitus in predisposing individuals and communities to process knowledge and act in certain ways. In the next chapter, we will see an approach that works with and not against the habitus, in motivating people to access health-promoting information by re-articulating a long-standing tradition of dealing with epidemic crisis.

When it became evident that information alone would not work, NACP II turned to behaviour change communication. Chief among its objectives was "to shift focus from raising awareness to changing behaviour through intervention, particularly for groups at high risk of contracting and spreading HIV" (NACO 2000, p. 25). This was a major change in paradigm, as it no longer assumed that individuals are motivated to act if they have correct scientific knowledge but saw how behaviour was dependent on a complex of personal, social and psychological factors that need to be addressed as much as gaps in information. But behaviour change strategies have another drawback: they focus solely on individuals, without adequately taking into account social-structural factors on which they have little control such as disparities of gender and economic status, and consequently disparity in degrees of autonomy while making decisions (Singhal and Rogers 2003, pp. 211–212; Wilton 1997, pp. 42–43). Thus, Diaz comments: "even though many of the models give some weight to the impact of social norms on individuals' behavior, each assumes that the behavior in question is under individual volitional control" (Diaz 2000, p. 194). Besides, behaviour change communication has its rationale in a form of governance that is distinctly neo-liberal, and it reinforces the neo-liberalist idea of health as "primarily the responsibility of the individual" (Wilton 1997, p. 42). We will see more of this in Sect. 5.6, where we analyse two behaviour change interventions.

Based on theories of behaviour change, NACP II initiated what later came to be called "targeted interventions" among groups practising high-risk behaviour.[16] These included female sex workers, migrant workers, truck drivers, men who have sex with men and intravenous drug users. At the same time, it continued awareness-raising efforts with regard to the general population, including family health awareness campaigns and campaigns for youth in schools and colleges (NACO 2000, p. 29). A major campaign with high visibility was the Red Ribbon Express, a specially equipped seven-coach train that travelled throughout India with the objective of creating awareness about HIV/AIDS and AIDS-related stigma and discrimination. NACP II continued an ambitious programme begun under NACP I in partnership with the National Service Scheme and the Ministry of Human Resource Development, called "Universities Talk AIDS", which had proved unsuccessful because it was perceived as going against cultural norms (Joshi 1994). The Adolescence Education Programme in schools, too, faced opposition for the same reason and had to be suspended in some states (Rao 2017, pp. 230–231).

The targeted interventions, in contrast, have had relatively greater success, and if there was a 66% decline in new infections in 2015 compared to those in 2000 (NACO 2017, p. 2), it was partly due to the targeted interventions, together with other strategies like ensuring blood safety, condom promotion and needle exchange, treatment of sexually transmitted infections and the free distribution of antiretroviral therapy. A total of 1948 targeted interventions among high-risk groups were conducted under NACP III, reducing HIV prevalence in female sex workers and men who have sex with men by almost half in the period 2007 to 2011 (NACO 2017, p. 9).

In Chap. 1, we discussed the relation of pedagogy to subject formation in terms of two major mechanisms, interpellation and subjectivation. This distinction can help us understand the different ways in which awareness creation and targeted intervention work as twin mechanisms of pedagogy. Interpellation refers to the way in which, in addressing the individual, representations constitute them as subjects of ideological control. As Althusser puts it, "*all ideology hails or interpellates con-*

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[16] The term was introduced in the third phase of NACP, which scaled up the interventions in terms of numbers and groups. Where priority had earlier been accorded to interventions for sex workers and long-distance truck drivers, NACP III included new groups like men who have sex with men, intravenous drug users and migrant populations. See also Rao (2017, pp. 264–274).

*crete individuals as concrete subjects*" (Althusser 2001, p. 117, italics in original). Even where pedagogic texts restrict themselves to providing correct information, the function of interpellation is never absent but is disguised by what seems to be objective discourse. To "know" AIDS is to be "knowledgeable" in an epidemic in which such knowledge is promoted as life-saving. As we will see in the *Let's Talk about AIDS* booklet in Sect. 6.6 below, such campaigns are founded on a distinction between knowledge and ignorance re-signified as health versus disease. Though it is not necessary for the text to address the reader or the viewer directly as "you", in health education this is quite often how it is presented. Thus, the US War Department pamphlet cited above opens with: "Sex is one of the most important things in *your* life, for it makes *you* a man. It's something to be proud of. But like everything else *you* prize, it must be well cared for" (US War Department 1942, p. 3, italics added). The hetero-masculinist ideology that is promoted by the army – sex "makes you a man" – constitutes the recruits it addresses or recruits them into positions of subjectivity that include among other things the value of health over pleasure.

Subjectivation, in contrast, works not through textual address but through incorporating a set of practices. Foucault holds that the link between pedagogy and subject formation is forged not in ideology but in the new disciplinary strategies introduced in the eighteenth century in the context of mass education. These included techniques of training, examination and correction; regulation of learning through timetables and a system of graded promotions; and the establishment of continuous surveillance over the learners' bodily, scholastic and social activities. "The individual", he argues, "is no doubt the fictitious atom of an 'ideological' representation of society; but he is also a reality fabricated by this specific technology of power that I have called 'discipline'" (Foucault 1977, p. 194). It is in being subjected to the power relations of discipline that one becomes a subject, that is, enabled to think and act as an individual. The status of being a subject is thus a reality that one aspires for, and not as in Althusser the imaginary effect of ideological interpellation. In the kind of health education that Rose discusses in the passage cited above, this involves interventions that seek not to address and inform but to change behaviour through persuasion. It consists in a form of subjection that is also a mode of "subjectivation" (Foucault 1985, p. 29), in that it makes one a subject with the autonomy to choose his or her lifestyle. As Saba Mahmood explains in Politics of Piety, the "paradox of subjectivation" is that "the very processes and conditions that secure a subject's subordination are also the means by which she becomes a self-conscious identity and agent" (Mahmood 2005, p. 17). The difference between Althusser's concept of interpellation and Foucault's subjectivation is twofold. First, interpellation is about how power comes to act on the subject, while subjectivation is about both exercise of power and, corresponding to it, the subjects' action on themselves. Second, in Althusser's account, the freedom of the subject is illusory, as he is "stripped of all freedom except that of freely accepting his submission" (Althusser 2001, p. 123). Whereas in Foucault's dialectic of subjection/subjectivation, we have a very different understanding of freedom: "Given a code of actions, and with regard to a specific type of actions (which can be defined by their degree of conformity with or divergence from the code), there are different ways to 'conduct oneself' morally, different ways for the acting individual to operate, not just as an agent, but as an ethical subject of this action" (Foucault 1985, p. 26). However, both are equally important in understanding the subjective effects of health education, which uses texts as well as a range of techniques to induce individuals to act in specific ways.

How does one resist ideological interpellation and subjectivation by power? The answer, I think, lies in what Freire (1974) calls "education for critical consciousness". As we have seen in Chap. 2, Freire distinguishes between a mode of teaching that perpetuates domination over individuals by "indoctrinating them to adapt to the world of oppression" (Freire 1970, p. 59) and one that makes them aware of their contexts and the contradictions underlying them. Educational methods that enable such awareness subvert interpellative mechanisms by revealing how subjugation comes to be disguised as freedom. If ideological representations work by "mythicizing reality", a critical pedagogy works towards "demythologizing" it (Freire 1970, p. 64). With regard to processes of subjectivation, critical pedagogy enables individuals to transform their relation to their contexts, now demythologized and understood as linkages between instances of power that had seemed unconnected. Thus, a critical pedagogic programme in literacy is not just about making individuals literate in the sense of being able to read and write but connects it to the larger sociopolitical conditions that perpetuate illiteracy and powerlessness. Practices of learning thereby become integrated with collective political mobilization and are not merely individual effects to acquire skills. Subjectivation takes place in resistance to relations of power and not in compliance with them. We will see below two such examples of subjectivation, in HIV/AIDS intervention projects in Sonagachhi and Sangli.

The shaping of subjectivity is crucial to the success of behaviour change pedagogy, since changes in behaviour are dependent on one's larger sense of selfhood. Awareness creation through Information, Education and Communication (IEC) seeks to interpellate its addressees, by using texts and images that induce identification with the healthy subject positions that they explicitly or implicitly construct and with the practices of seeking health that they promote. Interpellation here must be understood as a continuous process, not restricted to a single text but effected and reinforced through continuous multimedia messaging. This seems to be the rationale behind West Bengal State AIDS Control Society's "Buladi" series, which was launched on 1 December 2004 as a "360 Degree Surround Campaign". To enable identificatory processes in its target group, especially women and youth, the campaign adopts the familiar figure of the neighbourhood agony aunt who advises people on matters of HIV prevention, with "the traditional look of a rag doll with chubby features and outspoken in her safe sex messages" (*About the 360 Degree Surround Buladi Campaign*).

Targeted interventions follow a different logic. To understand this, we will take up two examples of targeted interventions among commercial sex workers that have proved effective: the Sonagachhi and the Sangli projects.[17] Sonagachhi in Kolkata, located in the northern part of the city, is one of the largest brothels in the country.

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[17] Other interventions among sex workers include the Ashodaya project in Mysore and Project Thozhi in Chennai (Rao 2017, pp. 257–259; Singhal and Rogers 2003, pp. 183–186).

Its history goes back to colonial times, when it was established by the East India Company for its soldiers, employing local widows for sex work. In 1992, the All India Institute of Hygiene and Public Health and the World Health Organization established STD clinics for the sex workers, under the charge of epidemiologist Smarajit Jana. The initiative, named Sexual Health Intervention Project (SHIP), included creating awareness about condom use and prevention of sexually transmitted infections and HIV/AIDS. The sex workers, however, were not very keen about using condoms against the demands of their clients. Even when they were, it was difficult for them to enforce it due to the power asymmetries of gender and class between them and their clients. Besides, the sex workers were more concerned about issues like stigma, discrimination and harassment by local gangsters and the police. It was, therefore, decided to widen the scope of the intervention to integrate behaviour change pedagogy with the socio-economic improvement in a participatory manner, by recruiting from among them peer educators and helping them organize into a collective (Rao 2017, pp. 251–54). The Durbar Mahila Samanwaya Committee (DMSC), established in 1995, became “one of the most powerful social work groups in West Bengal” (Gangopadhyay 2008, p. 166). Lobbying with the state government, it could tactically get the Cooperative Act amended[18] and was able to establish a credit society, a school, its own health clinics and social marketing networks for condoms.

> By 1999, Durbar had evolved into an ideologically driven self-governing entity. Its ambition was to heighten political activism to scale by a strategy of social activism and by working across with other sex workers as well as other exploited groups on a common platform of action. They needed to gain strength to face the political and social power system that exploited them. (Rao 2017, pp. 253–254)

Sangli, a district in southern Maharashtra, has the highest incidence of HIV in the state after Mumbai. In 1992 Meena Seshu, a graduate in social work from Tata Institute of Social Sciences, Mumbai, set up a non-governmental organization called SANGRAM (acronym for Sampada Grameen Mahila Sanstha), working exclusively with women in sex work in the Maharashtra-Karnataka border. “Sex work in this region”, writes Seshu, “is an offshoot of the traditional *devadasi* system that has historically been a cultural feature of these inter-state border districts. The institution continues to endure there, with a visible presence of women who are routinely dedicated to the profession by their natal families” (Seshu 2005, 139). SANGRAM initially focused on awareness creation and condom promotion, recruiting peer educators from among the sex workers for this purpose. Subsequently, when common issues of harassment and discrimination came on board, a collective named VAMP (Veshya AIDS Mukabla Parishad) was constituted in 1996, which tactically negotiated these issues with the authorities and other dominant groups alongside awareness creation and condom distribution, with support from ActionAid India and

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[18] Since sex work has no legal recognition in India, it is difficult to get a sex workers association registered as a collective. Further, the West Bengal Co-operative Societies Act, 1983, had a clause debarring from the board of directors any person convicted of an offence involving moral turpitude, under Section 27(10)(b) of the Act.

subsequently the Maharashtra government. "For VAMP, its acceptance within the framework of a governmental programme of national importance conferred legitimacy on the organisation vis-a-vis the outside world" (Seshu 2005, p. 151).

In both the Sonagachhi and Sangli projects, the success of the intervention depended on integrating pedagogic strategies into contingent and tactical negotiations with power relationships in the larger social context. In other words, the initiatives enabled the sex workers to act and take care of themselves in ways that were constitutive of a new sense of identity. Seshu reports: "Almost all of them say that they are proud to be card-holding members of their own collective organisation. This pride in being open about who they are acts as a role model for their sisters in prostitution" (Seshu 2005, p. 154). Visiting Sonagachhi after decades, Gangopadhyay observes: "Though Sonagachhi looked the same, I could detect a distinct change in the psyche of the women. They don't perceive themselves as sinners and fallen women anymore. They don't claim to be the victims of a cruel destiny either. They speak of their profession, quite naturally and spontaneously, as though it was one of many" (Gangopadhyay 2008, pp. 169). There are two important differences between interpellation and subjectivation as health pedagogic strategies, in the relation they assume with those they target. First, interpellative strategies assume that people are passive recipients of messages which they incorporate into their lifestyles, while subjectivation positions them as active and aspiring for a change in their bodily, psychological and social conditions that becomes the ground for a new self-definition. It involves not only cognitive and ideological dimensions of selfhood but is essentially a mode of embodiment. Second, interpellation as Althusser explains it, especially in his example of Christian religious ideology (Althusser 2001, p. 120), works by individualizing the subject, while subjectivation, as in our examples, seeks to integrate individuals into a collectivity. This, as Bryan Turner remarks, is how embodied subjectivity is linked to one's social world: "embodiment is a collective project because it takes place in a life-world that is already social. Embodiment is not an isolated project of the individual; it is located within a social world of interconnected social actors" (Turner 2008, p. 245). The incorporation of the condom into sexual behaviour is, therefore, not solely an individual or bodily act; it is simultaneously individual and collective of the body as well as the mind in a conceptual paradigm that Scheper-Hughes and Lock call "the mindful body": "The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle" (Scheper-Hughes and Lock 1987, p. 31). Targeted interventions like the Sonagachhi and Sangli projects enable individuals to self-organize as collectivities and make possible tactical ways of bodily and social action on which behaviour change depends. Sujatha Rao attributes the success of these projects to collectivization and notes that where this has not happened, the effectivity of behaviour change strategy is limited. "While the NGOs used the language of empowerment such as 'the right to make choices, participatory decision-making' that are now the hallmarks of a collective, they held on to their power as well as their control over the sex workers, who operated as project beneficiaries and not as self-actualized individuals" (Rao 2017, p. 260). Yet, Rao adds, "in some places like Ahmedabad, Bangalore, Hyderabad, Mumbai, Bagalkot in Karnataka, Kannur in Kerala, Kolkata, Chennai, and a few other small cities like Tirupati and Bhiwandi, NGOs did try to capacitate the community regarding their health and other issues within a framework of collectivization" (Rao 2017, pp. 260–261).

Insofar as the national AIDS pedagogy is concerned, the two major ways in which it has developed are through (a) assessments of risk, in terms of which disease-preventive messages are constructed and targeting priorities decided, and (b) inducing changes in behaviour and lifestyle. Sentinel surveillance data, correlated with data from the Behavioural Surveillance Surveys (BSS) and the Integrated Behavioural and Biological Assessment (IBBA),[19] indicate levels of condom use, safe injecting practices and awareness of disease prevention methods, which become the basis for designing interventions. These are concerned with populations, as part of what we have called demographic mapping. Behaviour change strategies, in contrast, are concerned with individuals in their personal capacity to incorporate safe practices, behaviour itself being understood as personal though it is also shaped by social norms. The next two sections, therefore, will focus on *surveillance of risk* and *management of lifestyle* which, as we have seen in Sect. 6.1 above, are the two poles of public health governance in its current paradigm.

## 6.5 The Pedagogy of Risk: Mehr-un-Nisa and *Let's Talk About AIDS*

In the contemporary public health paradigm, the notion of "risk" supersedes the hygienist notion of "germ" in aetiologies of disease, so much so that vulnerability to even infectious diseases like HIV/AIDS and hepatitis B is understood in terms of risk factors. One reason for this shift may have been the decline in epidemics from the mid-1950s onwards. Charles Rosenberg attributes the shift to the new visibility of chronic conditions like cancer, diabetes, heart disease and depression, which have required both the prediction of future disease through screening and the management of lifestyle based on such prediction. "The burden of our health anxieties has over the course of the twentieth-century shifted to the chronic and to the individual – to the risk of cancer, diabetes, cardiovascular disease as well as behavioral ills, most conspicuously depression in its protean varieties" (Rosenberg 2008, p. 10). Screening for signs of future disease, such as elevated cholesterol and blood sugar levels, hypertension and BRCA mutations for cancer, have created what

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[19] "The IBBA consisted of household surveys to assess behavioural responses towards safe sex practices, namely, the use of condoms and an understanding of how HIV spreads among HRGs" (Rao 2017, p. 211). Carlos Cáceras, however, argues that such surveys – what are called knowledge, attitude and practice (KAP) studies – often oversimplify "the heterogeneity of specific sexual acts, the variety of ways persons refer to them, and the variability of their contexts, [making] it difficult to fully understand sexual behavior and risk-taking on the basis of responses to a few seemingly simple questions" (Cáceras 2000, p. 250).

Rosenberg calls "proto-disease" – deviations from normalcy that are not yet symptomatic but existing in "the borderland between risk factor and manifest illness" (Rosenberg 2008, pp. 11–12). The tests certainly indicate real risks, and Rosenberg's point is not to set aside this fact but to show how the tests also serve powerful financial and professional interests: "I refer not only to the pharmaceutical companies alert to shareholder profits, but to healthcare administrators, public health workers, and disease advocates who have bought into the doctrine of screening, risk management and therapeutic preemption" (Rosenberg 2008, p. 13).

"We live", states Rosenberg, "in a world of ambient risk" (Rosenberg 2008, p. 7). Curiously, the word "risk" does not necessarily signify a negative outcome, though that is how it is most often understood nowadays. It originally meant a neutral calculation of loss and gain, in which sense it entered the lexicon of gambling in seventeenth-century Europe. "*Risk* then meant the probability of an event occurring, combined with the magnitude of the losses or gains that would be entailed" (Douglas 1992, p. 23). Subsequently, argues Douglas, it underwent a politicization that correlated risk with danger and projected the probability of negative outcome on to marginalized groups: "dangers to the body, dangers to children, dangers to nature are available as so many weapons to use in the struggle for ideological dominance" (Douglas 1992, p. 13). Most prominently, it was nineteenth-century forensic psychiatry that institutionalized this negative inflection of risk, by establishing the idea of the "dangerous individual" who was "by his very existence … a creator of risk" (Foucault 2000a, p. 198). In both law and medicine, and in the medico-juridical order as we saw in Chap. 5, this conjugation of risk and danger has served as a mechanism of social hygiene, to preserve the "health" of the social body. Accusations of transmitting disease, especially those associated with immorality, are a potent instrument of this social hygiene, AIDS being the latest and most explicit instance. In an essay on the violation of human rights in the AIDS epidemic in the United States, David Richards (1988) cites public health proposals to quarantine people with HIV disease and court decisions that justify their removal from jobs.[20] "As soon as immorality is associated with infectious disease the syndrome of social exclusion is buttressed with accusations of causing insidious harm" (Douglas 1992, p. 84). But the politicization of risk can be worked both ways and not simply in the service of dominance as Douglas claims, and the AIDS epidemic is an instance of this as well. It can work to resist marginalization and exclusion of the infected, in the realization of a larger social good. Much of the work of NACO lies in this direction. *However, it is in this ambivalent border between a public health of exclusion and one that seeks to be more inclusive that slippages of meaning and effect occur, belying the intended effects of both pedagogic policy and practice.*

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[20] The general argument of Richards' essay is that contemporary medico-juridical regimes couch moral objections to diseased people in the languages of law and public health, by deploying the age-old notion of "moral plague" – that indiscriminate deaths in epidemics "are not pointless and inexplicable and without remedy, but can be understood and brought within our control as condign punishments for some wrong or failure" (Richards 1988, p. 519).

The most explicit form of this slippage is the double understanding of risk in risk group terminology as indicating both vulnerability to disease and liability of transmitting it to others. The former is what public health discourse means by the term, while the latter is what it most often means in its translation in lay discourse. Thus, as we saw in Chap. 3, the media in the early years of the epidemic often tended to use the term "risk group" in this latter sense. But such a clear-cut distinction between a public health discourse that understands risk accurately and a lay discourse that distorts its meaning is not entirely true, as the following instances from NACO's policy documents show:

> Trends indicate that HIV infection is spreading in two ways: from urban areas to rural areas, and from individuals practising risk behaviours to the general population. (NACO 1997, p. 2)

> All over the world, it has been commonly found that particular groups of people are more vulnerable than others to the HIV/AIDS epidemic. These groups, because of their behavioural attributes, are prone to contract the infection more quickly and spread the disease in a very short period. (NACO 2000, p. 58)

> Certain categories of people, who are at a higher risk of acquiring and transmitting HIV infection, also described as "Core transmitters," assume importance in prioritizing cost effective interventions to prevent HIV infection. (NACO 2001, p. 21)

The claims made in such statements are not factually wrong – that some individuals are more prone to infection than others or that some of them may be grouped together on the basis of common profession or common lifestyle and sexual or injecting drug use patterns. But it must be emphasized that their *grouping* is not a fact – sex workers or truck drivers or injecting drug users or migrant workers do not all actually exist socially as discrete groups – but an epidemiological construct adopted for the purpose of developing standard patterns of intervention in terms of design and cost. The consequence of obscuring this point and thus "naturalizing" the risk groups is a new form of stigmatization that stems not from public health policies that seek to exclude them but ironically from those that seek to include and support them: "public attention on efforts at service provision run the risk of accelerating the isolation and stigma that NGOs work to resolve. The case of truck drivers is an interesting case in point …. Today, in some parts of the country, a young trucker must hide his profession if he is to find a bride" (Chatterjee and Sahgal 2002, p. 73).[21] Further, if the "individuals practising risk behaviours" "spread the disease" to others, it is because those others practice the same risk behaviours that are attributed only to the risk groups. Thus, transmission of HIV in commercial sex acts happens because the client does not wish to use a condom and not because of any behavioural aversion to condom use on the part of the sex worker: yet, AIDS control policies find it difficult to imagine clients of sex workers as a risk group.[22] Stigmatization of risk groups resulting from what are

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[21] To avoid such unintended effects of meaning, policy documents sometimes use the term "key populations", which is both more neutral in implication and serves the purpose of constituting them into groups for epidemic prevention and control.

[22] There is, of course, the practical difficulty of constituting them as a group for public health purposes, given that people will not identify themselves as "client of sex worker". However, the point

otherwise good policies founded on social justice is like the iatrogenic diseases of healthcare: they contradict the gains that are sought to be achieved because of the indeterminacies that underlie all human attempts to control phenomena. Terminologies like "core transmitters", which are presumed to be objective and merely denotative descriptions, fail to appreciate how language works and how description tends always to slide into prescription and denotation into connotation. One of the lessons that the theory of discourse has taught us is that we can no more predict and control our meanings than we can, to pursue the parallel with iatrogenesis, the side effects of medication. We can, however, expose the contradictions underlying their apparent coherence, making it possible to transform their significance.

To bring out this slide of meaning in risk group classification in pedagogic practice, we will use two AIDS awareness texts addressing the general population, both produced by a communication agency in Orissa in the mid-1990s and circulated locally. The first is a poster dealing with the risks of commercial sex (Fig. 6.2). The text reads: "MEHR-UN-NISA, DAUGHTER OF A PROSTITUTE, WAS ONE OF THE EARLIER AIDS VICTIMS. She hardly went astray for 10 months, said Paru – her mother. Failing to cope with her fatherless history sheet, Mehr-un-Nisa, at a tender age of 15, forced her way into the profession of her mother. Within less than 10 months, she picked up the disease most dreaded by all of her friends out there. How many people could she have infected, in turn? YOU COULD BE THE NEXT VICTIM". To the left of this text is a head-and-shoulders shot of Mehr-un-Nisa and to its right a faded picture in blue tint of sex workers in a brothel. The poster vilifies the prostitute as source of disease and is characteristic of some of the early campaigns. As Sujatha Rao, who was once chief of NACO, states: "We had little understanding of how to 'communicate' a sensitive subject like the use of condom to a conservative society. Simplistic deductions guided strategy. Since sex workers were

She hardly went astray for 10 months, said Paru - her mother. Failing to cope with her fatherless history sheet Mehr-un-nisa, at a tender age of 15, forced her way into the profession of her mother. Within less than 10 months, she picked up the disease most dreaded by all of her friends out there. How many people could she have infected, in turn ?

**Fig. 6.2** Mehr-un-Nisa poster (DIPS Communication)

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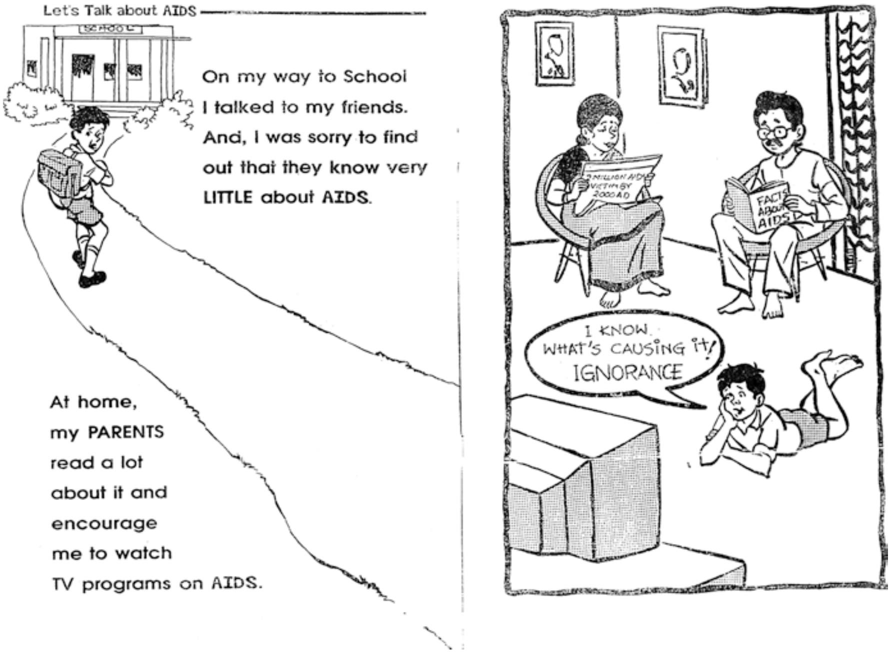
here is not whether it is feasible to construct such a group but why public health policy cannot even imagine the idea.

perceived as the ‘reservoirs’ of HIV infection, people needed to be forewarned and motivated to stay monogamous or desist from visiting sex workers” (Rao 2017, 203). Mehr-un-Nisa is first indicted on three counts – she is immoral (“went astray”), of illegitimate birth (“fatherless”) and criminal (she has a “history sheet” or police record) – and the logical outcome of all three is AIDS. The text, therefore, holds her responsible for her infection, the “guilty victim” of the media stereotype that we saw in Chap. 3. The attribution of responsibility is further stressed by the use of active verb forms throughout: she *went* astray, *forced* her way into prostitution and *picked up* the virus as if by choice. Thus, the text rhetorically transforms her from the passive “victim” of the opening to the active victimizer of the concluding message: “YOU COULD BE THE NEXT VICTIM”. The poster reveals the way in which media stereotypes of the sex worker as infected and infecting were recycled in pedagogic texts, in an attempt to *discursively* contain the epidemic to risk groups. In the process they come to be understood not just as vulnerable but equally a source of pathogenic risk and danger. The fact that the poster is a bad campaign, insensitive to those who are infected, is *not* beside the point: it brings out explicitly the slippage of meaning that is otherwise only implied in policy statements that describe the risk groups as “core *transmitters*” who are “prone” to infection because of their “behavioural attributes”. It brings out, in other words, implications that are disguised in the presumed objectivity of a scientific or social-scientific register of language. If such implications were not intended either in the policy documents or in the poster campaign – which in all likelihood they were not – it makes it all the more necessary to examine the assumptions that underlie the slippage of meaning.

These assumptions are made explicit in a booklet that was produced for distribution, again designed by the same agency and again also a bad example. *Let’s Talk about AIDS*, which like the Mehr-un-Nisa poster is in English, targets schoolchildren belonging to the middle class. The narrator, who is himself a child on his way to school, finds out that his friends know very little about AIDS and hence the lesson. He talks about “[b]ad people” who “have too many sex partners” and get AIDS, which they transmit to “healthy” persons by donating their contaminated blood: lesson – “test the blood properly before use” (Mishra and Rath 1995, pp. 3–4). Then he talks about a “drug addict” who gets AIDS by sharing needles: lesson – “use disposable needles always”. These are the “facts”, and then come the “myths” in what has become the characteristic format for IEC materials targeting the general population. AIDS is not spread “if we PLAY together” or “EAT together” or even by “kissing … but not too hard!” (Mishra and Rath 1995, pp. 9–11). It ends with a picture showing the narrator dragging away a boy who was intending to have premarital sex, with the message “AVOID TEENAGE SEX!” (Mishra and Rath 1995, p. 12). The ideological core of the booklet is an illustration (Fig. 6.3) showing the narrator and his parents at home, all of them busy acquiring information about AIDS: the father from a book titled *Facts about AIDS*, the mother from a newspaper and the son from the TV (Mishra and Rath 1995, p. 2). Contrasted to this is another illustration (Fig. 6.4) showing an unkempt figure surrounded by bubbles of HIV, groggily stepping out of a brothel where two scantily clad prostitutes stand watching him (Mishra and Rath 1995, p. 4). The first illustrates the space of the middle-class

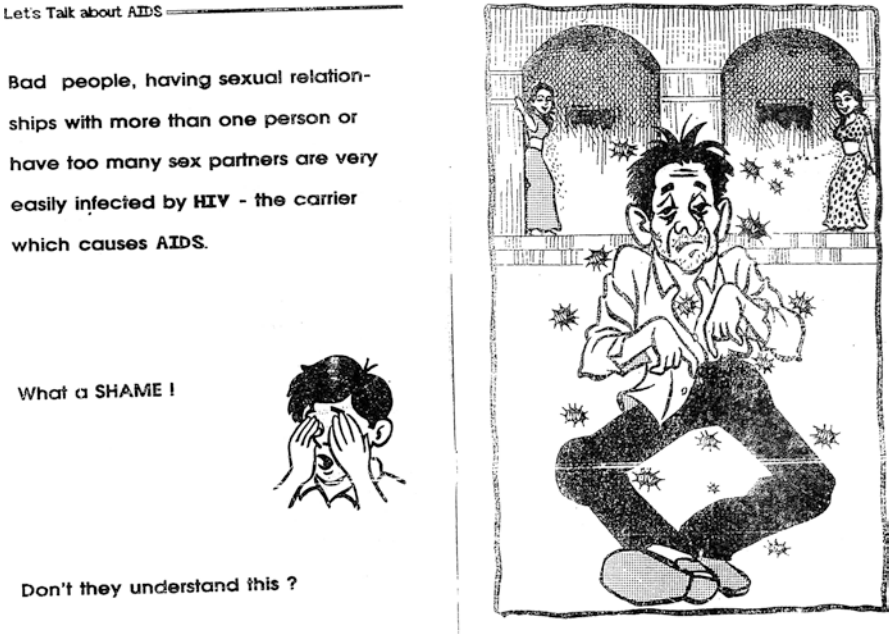


Let's Talk about AIDS

On my way to School I talked to my friends. And, I was sorry to find out that they know very LITTLE about AIDS.

At home, my PARENTS read a lot about it and encourage me to watch TV programs on AIDS.

**Fig. 6.3** *Let's Talk About AIDS* booklet, p. 2 (DIPS Communication)



Let's Talk about AIDS

Bad people, having sexual relationships with more than one person or have too many sex partners are very easily infected by HIV - the carrier which causes AIDS.

What a SHAME !

Don't they understand this ?

**Fig. 6.4** *Let's Talk About AIDS* booklet, p. 4 (DIPS Communication) family and the second that of the contaminated and contaminating outside, thereby deploying a typically middle-class Indian binary of what Partha Chatterjee calls "*ghar* and *bāhir*, the home and the world":

> The world is the external, the domain of the material; the home represents one's inner spiritual self, one's true identity. The world is a treacherous terrain of the pursuit of material interests, where practical considerations reign supreme. It is also typically the domain of the male. The home in its essence must remain unaffected by the profane activities of the material world – and woman is its representation. (Chatterjee 1993, p. 120)

Recast in terms of the text's hygienist concerns, the *bāhir* is the domain of illicit sex, treacherous both morally and pathogenically, and pursued for pleasure rather than rightful procreation – in other words, the mirror inversion of all that the *ghar* as the space of the middle-class conjugal family ideally represents. Taken together, the two illustrations construct an imagined sanitary space by working a set of oppositions deriving from the *ghar/bāhir* pair – licit/illicit, erotic/reproductive, wife/whore, clean/dirty, hygienic/unhygienic, healthy/diseased and informed/ignorant – resolved as the distinction between the AIDS-free home and the AIDS-ridden brothel. The purpose of this contrast, like the *ghar/bāhir* distinction, is to maintain the separation of the two spaces – it tells us, in other words, not to bring the virus from the brothel into the sanctified and sanitary space of home. It is the same ideological imagination that underlay the observation of a virology professor that AIDS cannot spread much in India because of strong family values: "Ours is a sexually conservative society and men and women still believe in marital fidelity and one sexual partner" (Puri 1986, 25).[23] It is also the same imagination that underlay NACO's School AIDS Education Programme that, according to its report on intervention efforts in 1999–2000, "reinforces family values" (NACO 2000, p. 45). While the family has long been the essential hinge between the micro-politics of personal conduct and the macro-politics of the state,[24] it is in public health strategy in the nineteenth century that this was most evident, especially in the pedagogic inculcation of hygienic norms. "The home", writes Nikolas Rose, "was to be transformed into a purified, cleansed, moralized, domestic space" (Rose 1999b, p. 74). By instrumentalizing the family, public health governance could link the political objective of ensuring the well-being of the population with the individual's aspiration for good health. "A 'private' ethic of good health and morality can thus be articulated on to a 'public' ethic of social order and public hygiene, yet without destroying the autonomy of the family – indeed by promising to enhance it" (Rose 1999b, p. 74). In the context of the HIV/AIDS epidemic, however, the imagination of the middle-class family as sanitary and disease-free is troublesome, not because of its ideology but for the way it disguises risks to women who acquire infection

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[23] This observation, reported in an article that appeared in *The Sunday* newsmagazine, was widely held by the media as well as public health authorities in the early years of the epidemic. See Sect. 3.2 above.

[24] The family, argues Foucault, becomes from the mid-eighteenth century a key instrument in governing the population in matters concerning "sexual behavior, demography, the birth rate, or consumption" (Foucault 2007, p. 105).

within the family space itself. The valorization of the middle-class family expresses both the assurance that it is safe and the anxiety that it may no longer be so. It is not "family values" that need to be reinforced, whatever be their power to ward off disease, but practices that entail risk of infection and those that do not. In the way it legitimates a stereotypical and misleading image of the familial space as contrasted to the space of the brothel, *Let's Talk about AIDS* is the index of a pedagogy that has defeated its own objective by recycling moralistic notions of who gets diseased and how. Admittedly, it was produced at a time when there were no clear ideas about designing such material in a value-free manner, but we see how the assumptions persist even in texts that consciously try to be non-discriminatory and value-neutral. Thus, one of the instructional stories in the World Health Organization's *Handbook on AIDS Home Care* is about HIV entering into the space of the conjugal family and its consequences. In the first part of this story, Ravi is led astray by his dissolute friend Srinivasan, who introduces him to one of his girlfriends called Remani; and on one occasion, when his wife and child are away, Ravi gets drunk and has sex with her. This single act of indiscretion results unfortunately in his getting infected with HIV, which he then passes on unknowingly to his wife Radha. Their second child, a son, becomes also infected and dies within a year (WHO 1996, pp. 24–32). As in *Let's Talk about AIDS*, this tale of Ravi and Radha represents risk as an external danger that invades the otherwise safe space of the family, thereby upholding the ideological privilege of the *ghar* over the *bāhir*. While this may be how HIV often spreads in the general population, descriptions however realistic have also the implicit effect of justifying and naturalizing the ideologies in which they are embedded. By reading NACO's policy statements and the WHO's *Handbook on AIDS Home Care* alongside the poster and the booklet, assumptions that underlie public health discourse and lead to slippages in the meaning of risk are brought to the fore.

These pedagogic texts try to induce behaviour change in people who are uninfected but at risk of infection because they practice unsafe sex. In the Mehr-un-Nisa poster and booklet for schoolchildren, the object of pedagogy is to get people to adhere to moral norms. In *Handbook on AIDS Home Care*, however, we notice a shift to what has been called the ABC campaign: *abstain* from sex, *be* faithful to your partner and use *condoms* (WHO 1996, pp. 44–45). Following Foucault, this can be understood as a shift in pedagogic strategy from the disciplinary to the governmental model. Discipline seeks to inculcate in its subjects control over themselves and their desires, and moralism is its most appropriate form, and that is what we see in the poster and the booklet. Governmentality, on the other hand, does not seek to impose a rule of conduct on its subjects but to manage their possibilities for action so as to direct them towards the most favourable outcomes.[25] It begins not with an ideal of moral conduct that suppresses desire but on the premise that desire is a reality that cannot be suppressed or eliminated and needs to be managed. This is how, as Foucault explains, the incitement to sex and the regulation of sexual con-

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[25] In "The Subject and Power", Foucault calls governmentality "a 'conduct of conducts' and a management of possibilities" (Foucault 2000a, b, c, p. 341), in which the freedom of the subject is both the precondition for the exercise of power and the condition for its continued possibility.

duct converge: “the techniques of power exercised over sex have not obeyed a principle of rigorous selection, but rather one of dissemination and implantation of polymorphous sexualities” (Foucault 1978, p. 12).Thus, the ABC campaign outlines three alternatives for action, two of which are disciplinary and moralistic while the third is pragmatic: if you cannot discipline yourself by either abstaining from sex or observing sexual fidelity, protect yourself against infection by using a condom.

> Certainly, if Ravi had been faithful to his wife, this story might have been very different. Ravi could not have known if Remani was infected with HIV, and for that reason he should have used a condom. Use of condoms would have protected Ravi from getting the infection and passing it on to Radha. (WHO 1996, p. 45)

The difference between the poster and the booklet on the one hand and the *handbook* on the other is that while the former impose responsibility on their pedagogic subjects, the latter tries to make them *self*-responsible by choosing whichever course they think fit. As we will see in what follows, this is a form of governance associated with a liberal political philosophy, which holds that the best way of governing is to govern least. Its central paradigm is free market or laissez-faire economics, where governmental intervention is restricted to the regulation of broad conditions like ensuring fair trade practices and the freedom to import and export. It is premised on the freedom of individuals to choose their course of action, rather than compelling them to act in prescribed ways as discipline does. Translated into the practice of public health, this means voluntarily managing their lifestyles by subjects who are deemed to be autonomous.

## 6.6 Teaching Lifestyle Management: *Saavdhaan* and *Handbook on AIDS Home Care*

To explain the pedagogy of lifestyle management, we will take two texts, the film *Saavdhaan* and the second part of the story of Ravi and Radha in the WHO *Handbook*, which is not about risk but living with AIDS. Both use the format of narrative to communicate their message: as the *Handbook* states, “A story can be a very useful and effective way of explaining the key issues surrounding HIV and AIDS” (WHO 1996, p. 21). This is because it is more engaging than a set of instructions, and by presenting what appears to be a real life situation encourages the audience to identify common experiences and reflect on them. But there is a more important reason for the relevance of narrative, especially in the context of living with HIV/AIDS. Narratives, as we saw in Sect. 4.2 above, are ideally suited for representing illness rather than disease – that is, the subjective experience of suffering and struggle rather than the objective conditions of pathology. To live with HIV disease is to live with one’s subjective experience of it, which is at once emotional and cognitive, deeply personal and yet social, involving disease facts as well as perceptions of what it means to be diseased. The avoidance of disease does not necessarily involve such a subjective relation to it, which is why behaviour change communication about safe sex prefers the informational format rather than story. Thus, though *Let's Talk about AIDS* is in the form of a story, it is essentially about information on how to avoid infection.

*Saavdhaan – It's a battle against HIV/AIDS*, which was released on World AIDS Day 1 December 2007, was produced jointly by UNAIDS and the Border Security Force and targeted the soldiers of the paramilitary agency. It therefore draws on the language of combat and troop activities, and the title, which literally means caution, is also the order to stand at attention. The film is set in a commando unit and opens with an anti-insurgency exercise. The title and the film's opening sequence, thus, establish the context in order to engage the target audience. After the exercise the soldiers are ordered to report at the medical inspection room early next day, for an HIV test. To convince them of the importance of testing, Constable Suresh tells them the story of a brave BSF soldier named Rajesh Kumar who contracts infection from sex workers in the nearby town. He learns of his infection when he donates blood for another soldier injured in an ambush by insurgents. Meanwhile, his pregnant wife and their 3-year-old son test positive, and the son subsequently dies. Rajesh is at first devastated, both by his own guilt and the stigma he faces. He also fears that their second child would be infected. But the unit's doctor Ashraf Khan counsels him and tells him how to prevent it and how to lead a better life. Suresh concludes: "This is the story of that daring soldier. The one who didn't lose heart with the mistake he had committed but began to give his life a new shape and meaning". It is then that he reveals himself as Rajesh Kumar's son, who was saved because of timely antiretroviral therapy. The plot of Rajesh is intercut with the parallel plot of Chaudhury, the owner of a local eatery, who contracts HIV from an injection with contaminated needle and syringe. The film joins two stories, the framing story of the commandos and the framed story of Rajesh and Chaudhury.

*Saavdhaan* uses this device of framed narrative to communicate information about HIV. In the framed story, Ashraf Khan talks about its transmission through sex and blood and from infected mother to child and how it can be prevented. He also talks to the soldiers about unfounded fear and stigma and the need to be more tolerant and supportive of people with HIV. Curiously, however, the film does not mention condoms, though condom promotion as epidemic control strategy had become a priority from NACP II onwards – perhaps because it may be viewed as encouraging promiscuity. The film is overtly moralistic in its recurrent reference to Rajesh Kumar's "mistake" for which he was "punished" through the death of his first child. The parallel plot structure, in which Rajesh's story of guilt is intercut with Chaudhury's story of "innocent" suffering, reinforces its moral tone. But its main theme, which provides the point of departure into narrative, is neither moral conduct nor any other kind of disease-preventive behaviour. It is about testing and how it can effect positive changes in one's life even if one is infected. In the framing story, Constable Suresh concludes his account with the advice that they all must take the test, because the "first step towards getting cautious about the disease is to get the HIV test done". He is alive today, he tells his unit mates, and has been able to realize his father's dream of joining the BSF because Rajesh was "informed about AIDS at the right time". The theme of the framing narrative is voluntary testing, while that of the framed narrative is living with AIDS. The frame device links the two themes, to convey how testing is crucial to knowing one's disease, accepting its reality and making positive lifestyle changes.

*Saavdhaan* uses an interesting technique to persuade its viewers to test. While the story itself is fictional, it ends with shots of actual Border Security Force officials voluntarily testing along with the soldiers. A.K. Mitra was the director-general and R.K. Panchnanda the inspector-general of BSF at the time when the film was made, and Mitra was present at the film's release (*Times of India* 2007). In this case, the presence of the outfit's highest authority does not signify an official command to test but an encouragement to voluntarily do so when they themselves set the example. Thus, by juxtaposing fiction and reality, the film dissolves the gap between audience and screen, the real world and its image, in an interpellation of the soldier as pedagogic subject that is effective because of the juxtaposition. The presence of the officials only highlights the fact of choice, which is a crucial element in the film's mode of subjectivation. At the same time, it reveals how this choice needs necessarily be guided by an authority whose presence for this purpose is unquestionable. It makes visible a working of power that is ordinarily concealed in the ideology of free choice.

If *Saavdhaan* is about testing as a way of managing one's life, the second part of the WHO *Handbook* story is about living with HIV/AIDS. After the death of her husband and son, Radha, who now knows that they died of AIDS and that she too is infected, decides to set her life in order. She opens a shop to support herself and her daughter, takes training as peer educator and sets up a support group with other HIV-positive women. With the help of the local health centre staff, they learn how to provide home care for those who develop AIDS. The community assists HIV-positive women abandoned by their husbands to work and support themselves. Gradually, the women acquire courage and learn "to play a more active role in negotiating safer sexual relationships" (WHO 1996, p. 75). The story, however, emphasizes Radha's role in the setting up of the community support group and its activities, as an index of her self-transformation from passive victim to an active agent of change: "Radha played a major role in helping the community to provide care for those who are infected with HIV or have AIDS" (WHO 1996, p. 66). She becomes an example to others in her struggle against the disease, and when she dies, it is a dignified end: "She went", says Prema, her mother, "as one should, proud and in peace. She taught us in her death much about our lives" (WHO 1996, p. 85). In other words, unlike the Sonagachhi and Sangli interventions, the *Handbook* privileges the individual over the work of the collectivity.

*Handbook on AIDS Home Care* is not itself a pedagogic text but a guide on how to counsel HIV-positive people and their caregivers; and the story of Ravi and Radha and the pictures appended to the book are intended to be used by public health educators as resource material. It is about methods of teaching, emphasizing participatory processes that seek to encourage the learners to reflect on their circumstances and induce them to choose health-promoting options: "People will learn to do things which will help them to stay healthy" (WHO 1996, p. 13). It is, in other words, about the formulation of strategies and their logic, revealing thereby the underlying conception of the subject that the governance of public health targets and hopes to shape. As in *Saavdhaan*, the element of choice is understood as most crucial to behaviour change intervention for lifestyle management. Since it is the individual who exercises choice, pedagogic texts like these reinforce the ideology of the free and self-responsible individual that embeds liberal forms of public health governance. In *Powers of Freedom*, Nikolas Rose explains this as a strategy of "responsibilization":

> Disciplinary techniques and moralizing injunctions as to health, hygiene and civility are no longer required; the project of responsible citizenship has been fused with the individuals' projects for themselves. What began as a social norm here ends as a personal desire. Individuals act upon themselves and their families in terms of the languages, values and techniques made available to them through professions, disseminated through the apparatuses of the mass media or sought out by the troubled through the market. Thus, in a very significant sense, it has become possible to govern without governing society – to govern through the 'responsibilized' and 'educated' anxieties and aspirations of individuals and their families. (Rose 1999b, p. 88)

In other words, the texts position their addressees as subjects who aspire voluntarily to live in accordance with norms of health, which are incorporated as projects of selfhood. Foucault calls such projects "technologies of the self", which correlate with the techniques of power by inducing "individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves" in accordance with preferred life goals (Foucault 1988a, 18). The pedagogy of lifestyle management, as we have seen in the stories of Rajesh Kumar and Radha, centres on the subjectivity of those it addresses, which is why narrative is its appropriate form. Rose describes this as a new form of governance in neo-liberal societies that he calls "governing the soul", which requires both a centralized political authority and a dispersed network of professionals trained in "the management of subjectivity" (Rose 1999a, p. 2). One reason for its adoption in neo-liberal societies is that it shifts the responsibility of ensuring public health from the state to individuals, thereby reducing its priority in terms of public spending. Thus, when NACO was downgraded from an independent department to a part of the Department of Health in the Ministry of Health and Family Welfare in September 2014, it was anxiously perceived by civil society members as proof "of the falling priority of HIV/AIDS" (Rao 2017, p. 289). Another reason for shifting the responsibility to the individual is that it is politically convenient in matters involving their private lives, where direct intervention by the neo-liberal state may be deemed inappropriate. Ironically, in the pedagogy of lifestyle management, intervention is not withheld or withdrawn but extended and intensified, though disguised in the form of teaching individuals an expertise developed in their own interests. For the pedagogy to be actually effective instead of merely circulating comforting assurances, it should question the ideology of personal responsibility and not uphold it; but it is doubtful whether it can do that and still remain true to governmental strategy. If NACO could not facilitate collectivization of sex workers as the DMSC in Sonagachhi and SANGRAM in Sangli did, argues Sujatha Rao, it was because of its "bureaucratic set up that was by its very nature conservative and 'status quoist'" (Rao 2017, p. 256). Its interventions, therefore, have been restricted to the promotion of condom use, which is understood predominantly as individual choice and therefore individual responsibility.

## 6.7 Conclusion

In order to understand how the national AIDS pedagogy works, this chapter places it in the larger context of public health strategies, health education and nationalization of epidemic disease. Historically, there have been three major paradigms of public health: quarantine/vaccination, sanitation/personal hygiene and risk surveillance/lifestyle management. In each of these couples, one element targets populations and the places they inhabit, while the other targets individuals, in the double strategy by which Foucault characterizes modern governmentality. These paradigms are not mutually exclusive, with one supplanting the other, but draw upon techniques used earlier in re-articulated forms. Thus, the current public health paradigm of risk surveillance/lifestyle management, instituted in the second half of the twentieth century, includes techniques of quarantine and personal hygiene oriented through the notion of risk group and risk practice in dealing with epidemic disease.

Public health pedagogy as a technique of acting upon individuals to follow health-promoting practices emerged in the sanitation/personal hygiene paradigm of the second half of the nineteenth century and has continued since then. It was both disseminated among the general public, especially those populations held to be most vulnerable because of illiteracy and poverty, and incorporated into school curricula in the form of primers, so as to raise levels of disease awareness in society. Public health pedagogy as a strategy for governing people has followed a top-down approach, with its experts drawn from medicine, sociology and social work, psychology and communication. At present, it links good health no longer to morality as the old hygienist paradigm did but to lifestyle factors that decrease the risk of disease; however, moral norms are often recycled in the form of scientific wisdom especially in the context of infectious sexual disease. This is because public health governance has been since its inception a way of regulating the conduct of its subjects, in a social hygiene that it performs alongside law and discipline. With its emphasis on lifestyle, health education targets the subjectivities of the people it addresses through techniques of interpellation and subjectivation, in producing pedagogic subjects who learn to value health above pleasure and are instilled with a sense of responsible and rational conduct.

The chapter then examines the role of NACO in formulating and instituting AIDS education in India. When the first cases of HIV disease were detected in 1986, the Indian government's response was to deny its presence and to try and seal the boundaries of the country in what Alison Bashford describes as imagining the "geo-body" of the nation (Bashford 2004, p. 115). But when it could no longer be denied as a disease of foreigners, governmental response focused more on the interiors of the nation rather than its borders. NACO was the product of this change. With the formation of NACO in 1992 and the formulation of the National AIDS Control Policy, the epidemic came to be nationalized primarily in two forms, through a cartographic mapping of spaces of disease and a demographic mapping of populations at risk. In successive phases of the NACP, this strategy came to be scaled up in extending both the reach and the depth of AIDS governance. With regard to pedagogy, nationalization took the dual form of the centralization of policy formulation by NACO and its decentralized implementation by NGOs and community-based organizations, thus opening up multiple sites of governmentality. Pedagogy adopted a technique of double address, aimed at the general population through awareness creation and the risk groups through what came to be called "targeted interventions". Emphasis also shifted from providing information about HIV/AIDS to facilitating behaviour change. The major implication of this shift was the fashioning of the pedagogic subject through policy and practice and deploying techniques of interpellation and subjectivation.

In conformity with the new public health paradigm, the production of this new subject involved the teaching of risk and safety on the one hand and of managing lifestyles on the other.[26] In epidemiological discourse, risk is understood as the degree of one's vulnerability to disease, but in lay language, it is usually construed as danger to the public. Given this semantic uncertainty, AIDS policy formulations and pedagogic texts, though intended to address the epidemic in value-neutral terms and without prejudice to risk groups, are often undermined by the slippage of meaning between risk as vulnerability to risk as danger. The chapter uses a number of texts to demonstrate this. With regard to the pedagogy of lifestyle management, it shows how this is founded on an ideology of free and self-responsible subjectivity, which is the mainstay of a liberal or neo-liberal public health governance. There are, however, fundamental contradictions in this ideological conception of subjectivity, the most crucial being the way actual power relations are disguised in the form of an expertise of enablement. The chapter attempts to bring out this contradiction by analysing two texts that are about teaching individuals to make responsible and health-promoting choices.

The pedagogic construction of HIV/AIDS as a national problem is not insulated from the constructions of the epidemic that we have seen in the preceding chapters, in the media, narratives and the law. It was the panic about AIDS in the media that led to the creation of NACO and the prioritization of AIDS as public health issue, and not actual morbidity and mortality figures. We have also seen the many points on which official AIDS pedagogy either converged with popular understandings of the disease in the media and narratives, especially with regard to moral norms and family values, or responded to them with regard to stigma. As for the juridical construction of AIDS, one of the important issues that pedagogy has addressed is the violation of the human rights of HIV-positive people. For instance, a booklet titled

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[26] Castel, however, argues that the current paradigm of intervention, which focuses on factors of risk rather than the conduct of individuals, does not concern subjectivity "because there is no longer a subject" (Castel 1991, p. 288, italics in original). This is because it does not involve personal intervention, as did the hygienist paradigm, but a bureaucratic approach to risk that depends on statistical correlations of vulnerability and not individual conduct. While Castel's argument may be true of the surveillance of risk in some contexts, like screening for genetic predispositions to disease, it certainly does not explain pedagogic interventions involving *both* risk *and* lifestyle management in epidemic control – which, we may say, take the subjectivity of those targeted as their starting point.

*HIV/AIDS: Stand Up for Human Rights* (Grubb et al. 2003) was produced jointly by the office of the UN High Commissioner for Human Rights, WHO and UNAIDS and circulated as a pedagogic text for the general population. More significantly, in a Delhi High Court case in 2009 regarding the constitutional validity of Section 377 IPC, NACO became impleaded as a respondent. NACO's stand, in support of the petition filed by Naz Foundation, was that the statute, by criminalizing adult same-sex relationships, drove underground gay men, bisexuals and hijras, making it very difficult for pedagogic interventions to reach them (*Naz Foundation v. Govt. of NCT of Delhi*, 2009). NACO's stand on Section 377 IPC, together with its support for targeted interventions among men who have sex with men, shows how AIDS pedagogy has responded to the juridical construction of AIDS.

This chapter has dealt with the strategies of public health governance in the context of the HIV/AIDS epidemic in India. The word "strategy" is etymologically linked to a position of authority: it is derived from the Greek *strategos*, meaning a general or commander of an army. In a non-martial context, it refers to the planning and directing of large-scale operations, such as the policy formulations of NACO and other public health agencies. It is in this sense that Michel de Certeau uses the term, associating it with governance and opposing to it the "tactics" of the governed. The next chapter will examine a popular pedagogic initiative undertaken by a village in Karnataka in tactical response to a contingency that was purely local, in contrast to the strategic and governmental response to national crisis. The AIDS Amma campaign, unlike the official campaigns, was neither intended for the whole of the country nor had any links with the agencies of disease control belonging to the state and to the voluntary sector. We will see how the logic of this unusual intervention and the source of its inspiration were radically different from the pedagogic efforts discussed in this chapter.

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# Chapter 7
# AIDS Amma Shrine: Pedagogy as Tactics

**Abstract** This chapter examines a popular pedagogic initiative, the shrine of AIDS Amma in a village in south Karnataka, which combines biomedical ideas of HIV/AIDS with an age-old tradition of disease goddess worship. It discusses AIDS Amma on three aspects: its genealogical descent, ritual structure and epistemological implications. It considers the AIDS Amma initiative as a tactical pedagogy that responds to a local contingency through creative re-articulation of cultural resources and biomedical ideas of disease transmission and prevention.

**Keywords** Ritualization · Performativity · Embodiment · Curing and healing · Tactics and strategies

In the previous chapter, we examined AIDS awareness campaigns undertaken by government agencies and non-governmental organizations. Teaching about disease in such official contexts accounts for almost the entire body of AIDS awareness campaigns in India, and it is tied to the state's mandate of public health. Here, pedagogy clearly functions as a governmental technique, the objective of which is to induce people to be disciplined, prudential and productive. In other words, its objective is to produce what Michel Foucault calls "docile bodies" – that is, individuals who are amenable to the persuasive force of the campaigns in altering their lifestyles and modes of sexual behaviour. "A body is docile that may be subjected, used, transformed and improved" (Foucault 1977, 136). In this context "docile" does not simply mean passive. As Saba Mahmood explains, it also means someone who is amenable to teaching, responsive to the inducements of pedagogy.[1] The emphasis is on direction rather than control, in a mode of exercise of power that Foucault calls "governmentality":

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[1] "Although we have come to associate docility with the abandonment of agency, the term literally implies the malleability required of someone in order for her to be instructed in a particular skill or knowledge – a meaning that carries less a sense of passivity than one of struggle, effort, exertion, and achievement". Mahmood adds in a footnote: "One of the meanings listed for docility in the *Oxford English Dictionary* is: "the quality of teachableness, readiness and willingness to receive instruction, aptness to be taught, amenability to training" (Mahmood 2005, p. 29).

D. K. Das, *Teaching AIDS*, https://doi.org/10.1007/978-981-13-6120-3_7

> "Government" did not refer only to political structures or to the management of states; rather, it designated the way in which the conduct of individuals or of groups might be directed - the government of children, of souls, of communities, of families, of the sick. It covered not only the legitimately constituted forms of political or economic subjection but also modes of action, more or less considered and calculated, that were destined to act upon the possibilities of action of other people. To govern, in this sense, is to structure the possible field of action of others. (Foucault 2000b, p. 241)

Coercive methods of control, such as mandatory testing of suspected individuals, confinement if found to be infected, closure of brothels and suspension of HIV-positive persons' right to marry, as we have seen, are not entirely absent; but the main strategy is persuasion through pedagogic means. AIDS pedagogy, in the main, is "governmental" in two senses: it seeks to guide the behaviour of individuals towards risk avoidance, and it is carried out in the final instance under the auspices of the state. Such governmental pedagogies deploy a range of techniques that have a double orientation, one targeting individuals and the other populations (either the "general population" or discrete "risk groups"). Further, the techniques involved may seek to induce self-discipline (e.g. the practice of celibacy or of sexual fidelity) or risk avoidance (e.g. the use of condoms).

Against the political armature of governance, which is from the perspective of those who govern, Partha Chatterjee posits a "politics of the governed", by which he means the activities of the people as distinct from those of the state, in the network of power relations that constitutes governmentality. While the statist ideal holds that the relation between the two forms of activity – the government's exercise of power and the people's response to it – ought to be seamless, what actually appears is a heterogeneity that often, in postcolonial societies, contextually juxtaposes the modernity of the state with the practices of long-existing vernacular traditions. "Much recent ethnographic work has established that these 'other' times are not mere survivors from a pre-modern past: they are new products of the encounter with modernity itself" (Chatterjee 2004, p. 7). He provides two examples of such heterogeneity, the first from everyday experience when business professionals wait for the approval of their astrologers before closing a deal or factory workers refuse to operate a new machine unless it is ritually consecrated. The second is a novel on the nationalist struggle for Indian independence, Satinath Bhaduri's *Dhorai charitmanas* (1949–1951), that adopts both its title and form from Tulsidas's religious epic *Ramcharitmanas*.[2]

A clear instance of what Chatterjee means by the "heterogeneous time" of postcolonial modernity is the AIDS Amma shrine at Menasikyathanahalli village in

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[2] Chatterjee presents this argument in the context of postcolonial modernity and subaltern politics. But it is equally valid in the context of the modernisation of health services under colonialism, where a condition of medical pluralism or the existence of multiple therapeutic practices, both traditional and modern, prevails. In both contexts, structures of governance do not limit possibilities of choice and agency on the part of the governed, who may draw upon the structures themselves in tactically manipulating them. In identifying a mode of activity distinct to the governed, Chatterjee's thesis, like that of Michel de Certeau, distinguishes between the apparatuses of power and the tactics employed by those subjected to it.

**Fig. 7.1** AIDS Amma shrine (Author)

south Karnataka. Set up by a local high school science teacher, N. Girish in 1998, it consists of a granite stone slab shaped like a milestone set on a cement platform under a huge *neem* or Margosa tree. The slab, painted in white with a yellow border, has a motif in black of a male-female silhouette with the virus between and an inscription in Kannada meaning "Scientific Temple" (Fig. 7.1). In a personal interview, Girish explained that the figure of the man and woman signifies religion, the colour black signifies ignorance and white signifies knowledge or intelligence. It is set outside the village, next to a water tank the walls of which bear information about HIV/AIDS in Kannada (Fig. 7.2). Adjacent to it are a Shiva temple and a temple of Mariamma, the local village deity. People who come to worship at these temples are directed to the AIDS Amma shrine, where they perform *puja* and read the messages on the walls. AIDS Amma, as Girish explains, does not cure but blesses those who worship her with knowledge about the disease. It is a pedagogic initiative, but one undertaken not by the government or NGOs but the local community, in order to resolve the crisis created by the emergence of HIV disease in the locality. This fact, as we will see, bears importance for the unusual method it employs.

Menasikyathanahalli is a small village off the Mandya-Mysore state highway in south Karnataka, about 40 km from Mysore city. It is located in Tirumakudalu-Narasipura Taluka of Mysore district. The nearest town is Bannur with a population of about 25,000. At the time of the 2011 census, the village included 579 households with a total population of 2659, 1352 men and 1307 women, with a sex ratio of 967 which was lower than the state average of 973. Its literacy rate (57.99%) was also

**Fig. 7.2** Entrance to Menasikyathanahalli village (Author)

lower than the average literacy rate for the state (75.36%). Literacy rate among men was estimated to be 64.55% and that among women 51.30%. The population of Scheduled Caste residents was 289 (139 men and 150 women), and of Scheduled Tribes 9 (6 men and 3 women). The village has a government school, where Girish taught during the time he set up the AIDS Amma shrine. In 2011 nearly half of the population (46.86%) comprised of agricultural workers, of whom 528 were cultivators owning or co-owning land and 312 landless labourers. The main cash crop is sugarcane, and the region is popularly known as the sugar bowl of Karnataka. When I visited the village in September 2017, I saw truckloads of sugarcane for dispatch to factories in Mandya and Mysore.

In 1997, an HIV-positive couple from a nearby village committed suicide because of ostracism. The couple used to run a roadside eatery, and when news of their serostatus spread, people started avoiding their hotel. They were forced to take this extreme step due to stigma and loss of livelihood. The neighbours burnt their corpses with kerosene, without performing any rituals. There was some unease about the way they had been treated, but panic about the disease spreading was high, especially as there were rumours of other HIV-positive people living in the locality. Raids and closure of brothels in Mandya had compelled sex workers to move to Bannur and other small towns in search of custom, and knowledge about safe sex was lacking, creating conditions for the spread of infection. When Girish was transferred to the local school the following year, he heard of the case from his students.

To address fears of contagion and reduce stigmatization of the HIV-positive, Girish started an awareness campaign in Menasikyathanahalli and the nearby villages. Initially, he and his students organized several camps to disseminate knowledge about the disease using posters, digital presentations and questionnaires in the customary format for AIDS education. When this failed to elicit much response, he decided to use religion as a tactic of persuasion. The idea of the AIDS Amma shrine was, as he put it, "a strange mixture of science and religion", and he dubbed it a "scientific temple". Every Friday, people used to worship at the nearby Mariamma temple, to protect them against adversities and especially chickenpox and measles. "Taking the advantage, I started *puja* early in the morning … in order to attract the new devotees". *Puja* consisted of lighting incense sticks and offering flowers, bananas and coconut to the deity, after which they would read the information written on the walls of the water tank. Either Girish or one of his students would conduct the worship. Initially, there was some resistance as people felt that installing the shrine there would lead to stigma against the entire village, affecting the marriage prospects of their daughters, but they were eventually persuaded. When persons from a neighbouring village demolished the shrine that Girish had built, the Menasikyathanahalli residents mobilized funds to have it rebuilt with a much stronger foundation: "The present temple", said Girish, "is built entirely by the villagers. I have not even spent a single paise". The people were told that AIDS Amma did not cure, but would protect them from disease if they heeded her instructions. Later, when the shrine was widely publicized in local Tamil and Kannada newspapers, people from far off places also visited it. Girish recalls a group of HIV-positive persons from Namakkal in Tamil Nadu visiting the shrine, where they offered puja, revealed their serostatus to the goddess, seeking her protection, and experienced relief from fear.[3] It is not quite clear whether the pedagogic initiative has had much impact, though Girish claims to have conducted a few studies that showed favourable outcomes. But for more than 2 years after its installation, the shrine drew large crowds of devotees every Friday. Weekly worship has now declined, but an AIDS Amma *jatra* is held every year on World AIDS Day, December 1. The goddess is taken out in a procession, in the manner usual for such annual ceremonies for local deities, followed by poster competitions, talks and other activities promoting awareness (Personal interview, 8 September 2017).

The main point about the AIDS Amma initiative is the way it combines two radically different forms of medical explanation. While it is true that Western biomedical knowledge has largely supplanted indigenous ways of healing, this is neither uniform nor does it make the two modes of knowledge and practice radically incompatible in a binary either/or fashion. In a discussion of health-seeking behaviour among villagers in Papua New Guinea, Andrew Strathern and Pamela Stewart observe: "people's attitudes tend to be pragmatic and processually oriented. They may seek biomedical therapy at the same time as consulting a diviner or witchfinder. The one does not rule out the other, because they are perceived as dealing with different aspects of a complex reality" (Strathern and Stewart 2010, pp. 172–73). In fact, this seems to be a common practice where different medical paradigms and therapeutic methods prevail in a context of what is called "medical pluralism". What is different about AIDS Amma worship, however, is that it is not about seeking

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[3] They had read about the shrine in *The Dinathanthi*, a popular Tamil daily. There were a few reports in English also: see David (1999), Portnoy (2000) and Kumar (2007).

recourse to therapy, but the communication of scientific knowledge. At the same time, the availability of pluralistic medical practices is what enables it to communicate this knowledge in ritual form. It needs to be situated in both contexts, that of AIDS pedagogy and that of the worship of disease deities, to understand its logic and effectivity. In our discussion of this singular pedagogic initiative, therefore, we will focus on three aspects: its genealogical descent, ritual structure and epistemological implications.

## 7.1 Genealogical Descent

Genealogically speaking, the tradition of goddess worship, which has existed in India for centuries, serves as a prelude to the worship of AIDS Amma. In using the term "genealogy", I am drawing on an argument that Foucault took from Nietzsche and developed into a methodology for interpreting successions and affinities. The concept of genealogy is based on not continuities, like the concept of history, but contingent linkages that do not follow a predetermined structure. As Foucault states in "Nietzsche, Genealogy, History", "The search for descent is not the erecting of foundations; on the contrary, it disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what is imagined as consistent with itself" (Foucault 2000a, pp. 374–5). In other words, the tracing of descent is not a search for the origin but the uncovering of affinities between practices that appear to be diverse and dispersed, of identifying their points of emergence in "substitutions, displacements … and systematic reversals" (Foucault 2000a, p. 378). Foucault's account of the deployment of pastoral techniques in modern governmentality can serve as a methodological example. The priest's authority over parishioners was a form of power that guided peoples' conduct through persuasion rather than coercion, directed at individuals as well as populations, based on meticulous knowledge of their moral state and aspirations, for their spiritual well-being and not to extract from them services or wealth, and conceived as service rather than rule. When government came to be defined and practised in eighteenth-century Europe, it drew its inspiration from this traditional and by-then declining form of power, modifying its objectives and techniques to suit the needs of secular authority. That was when the discourse of statecraft incorporated into its vocabulary terms previously associated with the pastorate: "minister", "ministry", "public service" and "administration" (Foucault 2000b, pp. 332–35; Foucault 2007, pp. 183–85). Government could draw its inspiration from the pastorate not because of an evolutionary logic, but due to affinities that were symbolic rather than causal. Governmentality, in other words, was a contingent re-articulation of the principles of pastoral authority, as an imaginative rather than technical resolution to the problem of ruling. Its main features were the use of persuasion, the production of knowledge for an exercise of power that targeted both individuals and collectivities and the objective of ensuring the well-being of its subjects. This form of imagining authority existed as a cultural resource in Europe, and the art of government redeployed it according to a practical rather than programmatic strategy. By using the term “genealogy” in my account of the AIDS Amma initiative, I emphasize the fact that the AIDS Amma initiative did not *evolve* in any (teleo)logical manner from Sitala, Mariamma or the plague and cholera goddesses, but that it was a chance connection between a form of imagination that was available and a context of use that seemed suitable and pragmatic. Their linkage is not literal but symbolic, based on perceived affinities rather than logical connections. AIDS Amma must neither be confused with Sitala, nor understood as serving the same functions.

The worship of goddesses is a long-established tradition in India. N.N. Bhattacharya provides an exhaustive account of their origins, powers, nomenclature, geographical distribution, and forms of worship. They are generally imagined as maternal deities, made explicit in the south Indian nomenclature with the suffix *amma* or mother added to the name: Mari*amma*, Bhagavathi*amma*, Mais*amma*, Sithal*amma*, etc. Bhattacharya speculates that the practice originated among settled tribes, when people turned to agriculture for subsistence rather than hunting, a trend that he finds distributed throughout the ancient world: “the Earth Mothers came into being when people began to settle down in agricultural communities” (Bhattacharya 1999, p. 34). In India, they were originally local deities who were subsequently synthesized into pan-Indian traditions. Origin stories of some of the goddesses suggest such a process of synthesis. Whitehead reports three versions of Mariamma’s origin: in one she is the wife of Rishi Piruhu, in another she is the wife of the poet Thiruvallur and in the third the wife of Rishi Jamadagni and mother of Parasurama (Whitehead 1921, pp. 115–116). Hanumanthan reports another version in which Mariamma was “originally a Buddhist nun of Nagapattinam, who used to sit under a neem tree and do penance” (Hanumanthan 1980, p. 97). Commenting on the many versions of Sitala in different parts of India, Ferrari writes that she is a composite deity “shaped by the encounter with diverse communities, traditions, public policies and ethical discourses” (Ferrari 2015, p. 88). Indologists have interpreted the existence of multiple versions as the outcome of a synthesis of Dravidian and Aryan cultures and/or of a process of Sanskritization (Whitehead 1921, p. 117; Bhattacharya 1999, p. 56; Wadley 1980, p. 34); but what seems more likely is that these local traditions proliferated and were assimilated across diverse religious and caste communities, without any uniformity or design. Some of the deities associated with disease, for instance, were worshipped by Hindus, Buddhists, Sikhs and Muslims alike, sometimes under the same name and sometimes under different names, and their worship among Hindus was neither confined to any particular caste community nor had specific caste officiants (Bhattacharya 1999, pp. 53–54; Jash 1982, p. 192; Ferrari 2015). However, a distinction needs to be made between these local traditions of worship and the pan-Indian religions to which they have been assimilated, to better understand their forms and functions.

These deities are all associated with local adversities, such as floods, droughts and epidemic diseases, most notably smallpox and cholera. Goddess worship is performed in response to a crisis brought on by ecological and cosmological[4]

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[4] By “cosmological” I mean ideas referring to the natural, social and spiritual environment that we inhabit and which we imagine as being ordered and harmonious. Tambiah explains it as “the body

imbalance, which it is believed to resolve. What enabled the proliferation and assimilation of these deities was the common way in which these crises were understood and imaginatively resolved across different communities. Three aspects predominate in the worship of the mother goddesses. One pertains to its extremely localized nature: the goddess presides over the village as its ruling deity or *gramadevata*, and her shrine is usually situated at the entrance to the village. As Nicholas writes of Sitala: "The conception that it is a particular village and not any other unit that receives the benefit of her worship is in some instances enacted by processions circumambulating the village, planting flags where paths cross the village borders, or otherwise bounding the village before her *puja* is begun" (Nicholas 1981, p. 37). Alongside the *gramadevatas* there were in the past city goddesses or *nagara-devatas* who "were not only protective deities but also maintainers of luck and prosperity (*nagara lakshmi*), and popular stories about their departure from a city were meant to convey the idea of imminent danger or reversal of fortune" (Bhattacharya 1999, p. 43). However widely distributed it may be, the worship of such deities follows local customs, forms of worship and festal calendars. The second aspect pertains to the multiple powers ascribed to the goddess. Thus, in the east Sitala is associated with smallpox but is worshipped in the north as a protector of children and in Gujarat as "the giver of good fortune, husbands and sons" (Wadley 1980, p. 35). She is invoked in Bhojpuri *sohar* songs as *sarvadukhantakarini*, or "one who ends all sorrows" (Ferrari 2015, p. 31). In the *Skanda Purana*, she is invoked as a goddess who protects against planetary afflictions (*grahapida*) (Ferrari 2015, p. 9). Mariamma is worshipped in the south as the goddess of rain as well as of smallpox. The third aspect of mother goddess worship relates to its collective nature, with the entire village participating in the event. As Nicholas states of Sitala, domestic worship may be performed but "the most usual ritual [is] carried out by the village as a collectivity for the benefit of all its residents" (Nicholas 1981, p. 40). These three aspects of the cult of mother goddesses – localization, collective rituals and multiplicity of powers attributed to the deity – suggest a symbiotic linkage between the worship of the goddess, the everyday life of the village and the cosmological ideas that constitute its imagined ordering. The location of shrines at the entrance to the village, preventing adversities and disorder from encroaching into it, signifies this connection between the deity and the preservation of cosmological order.

Of the powers attributed to the goddesses, the most recurrent one is protection from epidemic disease. Epidemics of smallpox and cholera were common throughout most of India, causing very high mortality. Smallpox epidemics generally erupted in the dry season from February to May, gradually subsiding with the coming of rains and recurring roughly once every 5 years. Epidemics of cholera coincided with cycles of drought and famine, when people were forced to drink contaminated water from tanks and pools (Nicholas 1981, pp. 34–39; Arnold 1993, pp. 117, 168). Though there were indigenous treatments available, excessive

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of conceptions that enumerate and classify the phenomena that compose the universe as an ordered whole and the norms and processes that govern it" (Tambiah 1980, p. 21).

mortality was due to the rapid progress of both diseases after onset of infection and their highly contagious nature. Epidemics put inordinate strain on the therapeutic resources of the community, leading to collective panic and a sense of crisis. With developments in modern medicine, however, smallpox no longer exists and mortality due to cholera has been greatly reduced; but it is significant that the worship of deities associated with the diseases continues. As Ferrari notes, the worship of Sitala continues even decades after smallpox was officially declared to be eradicated in 1977 (Ferrari 2010, p. 145). What this may indicate is that the efficacy of the deities is not restricted to their curative powers alone, but encompasses the collective sense of well-being of the village. I think this is what the popular attribution of diverse powers to them signifies.

Of the deities associated with the two diseases, the most widely worshipped is the goddess of smallpox. This may have been due to the extreme virulence of the smallpox epidemics, in contrast to cholera which was more endemic. The two most well-known smallpox goddesses are Sitala in the north and Mariamma in the south. Sitala often appears as one of seven sisters who are associated with different diseases. The names of the sisters and even their number vary from place to place. In one temple in Kolkata, they are represented as Jhanta Bibi ("Lady of the Broom", Sitala), Ola Bibi (associated with cholera), Jhola Bibi (associated with diarrhoea), Utha Bibi (associated with vomiting), Masan Bibi (associated with whooping cough), Bahari Bibi ("The Beautiful Lady") and "a variant of Durga", Candi Bibi (Ferrari 2015, p. 43). In terms of iconography, the sisters are usually found together in the same temple complex, with devotees offering *puja* at each of the shrines in turn. In Bihar, the various names of Sitala include Kankar Mata, Phulmata, Pansahimata, Badimata and Gulsaila-Mata. Muslims of Madhya Pradesh worship her as Mata, or Mata Masani, while in Assam she is worshipped as Ai and in Orissa as Thakurani (Bhattacharya 1999, p. 53). Smallpox being understood as a disease caused by excessive heating of the body, Sitala and Mariamma are both "cooling" goddesses, and their worship includes the offering of cold foods. Mariamma, as already stated, is also worshipped as a goddess of rain: "Popular etymology defines *Mari* as rain that cools down the heat of the land, and cures smallpox and chickenpox, which are considered to be heat generated epidemics" (Granziera 2010, p. 613 *fn*.13). Other names of the goddess associated with smallpox in the south include Sukhajamma, Kannagiamma and Bagavathiamma (Bhattacharya 1999, p. 55; Hanumanthan 1980, p. 99). Among indigenous communities in Orissa, the Kondhs attribute smallpox to Joogah Penoo, a god who is believed to sow the seeds of disease, and the goddess Dharma Pinnu, while the Kotas attribute it to Nisaniguda and the Mahalis to Bada-Candi and Ranga-Candi (Pati 2001, p. 6; Bhattacharya 1999, p. 76). The goddess associated with cholera in Bengal is known by various names, such as Olai-Candi, Ola-Bibi and Didi Thakrun. In Uttar Pradesh and Punjab, she is worshipped as Mari or Mari Bhawani and as Moti Mata in central India. In the south she is worshipped as Maridiamma and Kalumaiamma. The cholera goddess is generally worshipped in aniconic form, usually as a pot under a neem tree (Bhattacharya 1999, pp. 56–57). Epidemics of plague appeared rather late in India, the first major one occurring in 1896, and instances of plague-goddesses are few. Bhattacharya mentions plague deities worshipped as Bombai Mai in Gaya (the 1896 epidemic occurred in Bombay Presidency) and as Plague-amma and Uramma in the south (Bhattacharya 1999, p. 56). Significantly, though the disease caused massive deaths – more than 8.5 million in the years between 1896 and 1914 – it was perceived differently from smallpox and cholera. Plague was a new disease, and before it could be assimilated into the existing disease cults, the harsh sanitary measures instituted by the colonial health authorities caused more panic than the disease itself. "It was the state's motives which provoked a crisis of comprehension, not the activities of an irate or capricious goddess" (Arnold 1993, pp. 201–202).

The attribution of supernatural agency to disease as a symbolic resolution of crisis prevails in many parts of the world. Strathern and Stewart term such beliefs "personalistic", as distinct from "naturalistic" explanations that view disease as the outcome of bodily processes. "In the personalistic system, illness is predominantly traced to actions of malevolent agents such as sorcerers or punitive ones such as ancestors. In the naturalistic system, recourse is had to theories about the properties of the body itself and non-intentional aspects of causation in the cosmos" (Strathern and Stewart 2010, p. 11). The crucial distinction here is between intention or agency on the one side and causal processes on the other: therapy in personalistic systems depends on the identification of the agents and their appeasement or expulsion through magical means (chants and rites), while in naturalistic systems it involves reversing the effects of organic processes through medical intervention. The worship of disease goddess, though similar to the personalistic, is different in that the deity is often invoked to *protect* against disease and not because she *causes* it.[5] The goddess, of course, is understood as ambiguous, with malevolence and benevolence often coexisting as two sides of her personality. Thus, Sitala, who is represented in her iconography as holding a broom and winnowing basket, is variously described as using them to scatter the pustules of smallpox or to sweep them away (Ferrari 2015, pp. 50–51). But, as Ferrari shows, it is the latter that is predominant, the malignant Sitala being almost confined to a local tradition in Bengal, and she is most often regarded with devotion rather than fear. Devotion or *bhakti* figures as the central element of her worship because she protects her devotees, and this may be the reason for disease deities in general being imagined pervasively as mother. The location of the shrine at the entrance to the village, at a vantage point where she may protect it from the incursion of adversities, also points to her role as protector rather than agent. The distinction is not trivial, for it bears on the question of efficacy which, in the case of Sitala, appears to be more psychological than organic. It is stated in the *Naradapurana*: "If a man worships Sitala Devi in the Dark Forest, he should not fear *visphotaka* [pustules]", as well as in *Bhava-prakasa*: "I bow to the goddess Sitala who destroys the fear of all diseases. Upon approaching [her], one is no longer scared by smallpox" (cited in Ferrari 2015, pp. 9–10). As Misra points

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[5] In a personal communication, Venkat Rao points out that prakriti or 'nature' in the Indian context, which is often associated with the figure of the goddess, may generate the body but has no sovereign authority over it in the form of, for instance, causing disease.

out, Sitala worship has “proved to be a boon to the rural folk in the release of psychological tension, at the time of the epidemic” (Misra 1969, p. 141).

The AIDS Amma shrine at Menasikyathanahalli draws on this long-established tradition of disease goddesses, in order to gain acceptance for the pedagogic messages that Girish put together from official AIDS awareness campaigns. Like many representations of these deities and the *gramadevatas*, it is aniconic, a simple stone slab with symbolic motifs set in a space marked out by a concrete platform. It is set outside the village under a *neem* tree, following the traditional practice that associates *neem* with curative properties and hence with disease deities. Worship, too, follows tradition in the performance of *puja* with offerings of flowers, fruits and incense, but instead of chants and songs invoking the goddess, one reads the messages on the adjacent walls. This is because AIDS Amma does not directly protect her devotees from disease but blesses them with knowledge that may prevent it. The calendar of worship, too, follows the pattern established by convention, with weekly *pujas* (Fig. 7.3), now discontinued, and an annual festival or *jatra* where the goddess is taken out on a procession circumambulating the village (Figs. 7.4 and 7.5). Two points emerge from this contextualization of AIDS Amma. One is that the disease goddess tradition, which represents an imaginative resolution of collective crisis, is amenable to adaptations, transpositions and re-articulations in a manner typical of popular practice. Practice theory, especially in Bourdieu and de Certeau, emphasizes such adaptability and inventive use of already existing resources or resources “at hand” as pragmatic solutions for the problems of everyday existence. What is emphasized is less a rule to be followed than an effect to be achieved or an

**Fig. 7.3** AIDS Amma puja (H.N. Girish)

**Fig. 7.4** AIDS Amma taken out on procession through village (H.N. Girish)

**Fig. 7.5** AIDS Amma jatra, with Girish standing second from left (H.N. Girish)

outcome realized. The other point that emerges from the genealogical contextualization is that the idea of AIDS Amma as a tactic for teaching about AIDS was possible because of this tradition: while the tradition did not attribute a goddess to AIDS, it provided the conditions and the symbolic universe within which the idea could be given shape. As Paul Ricoeur explains, "To understand a ritual act is to situate it within a ritual, set within a cultic system, and by degrees within the whole set of conventions, beliefs, and institutions that make up the symbolic framework of a culture" (Ricoeur 1984, p. 58). The idea may have come from an individual, Girish; but its popular acceptance and adoption by the village community is a collective act founded on the pre-existing cultural knowledge of epidemic crisis resolution. This is not to undermine the contribution of Girish to this unique project of de-stigmatisation and disease prevention; but to attribute it entirely to the efforts of a single individual, as journalistic accounts have done,[6] is to underestimate the force of that cultural knowledge. Girish's adaptation may be understood as a mode of cultural learning common in South Asian societies, in which the invention of a new goddess to address an unprecedented disease epidemic acquires significance through analogy.[7] Culture provides people with the symbolic resources that signify their actions as meaningful to them: as Geertz states, it is "the imaginative universe within which their acts are signs" (Geertz 1973, p. 13). In this view, the meaning of the AIDS Amma initiative is *at once* the promotion of biomedical knowledge *and* more than that, where the knowledge promoted and the significance that exceeds it are not distinct but inseparably linked in the efficacy of the initiative.

## 7.2 Ritual Structure

The worship of AIDS Amma, composed of a ritual *puja* and a pedagogy, began as a response to a specific crisis. When HIV disease spread rapidly in Karnataka in the mid-1990s,[8] brothels in urban centres like Mandya were forced to close down, and the sex workers moved to smaller towns adjoining villages. Spread of the epidemic into rural areas led to fear of infection and stigmatization of the HIV-positive. The AIDS Amma worship was an effort directed at both teaching the local community about disease transmission modes and countering stigma, and their willing participation in the ritual was an index of how they perceived the threat of AIDS.

In the AIDS Amma initiative, ritual connects the symbolism of the liturgical order with the practical need to resolve a crisis at hand. How does it do this?

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[6] See, for instance, Kumar (2007).

[7] I owe this insight to Venkat Rao.

[8] Till 1994, there were only seven reported HIV-positive cases. Between 1993 and 1998, the year the AIDS Amma shrine was established, the number of new cases increased annually from 9 in 1993 to about 50 in 1997 and 1998. Karnataka was identified as a high-prevalence state in 2003; and by 2004 there were 33, 108 persons with HIV/AIDS in the state, of which 2065 were in Mysuru and Mandya districts (Pradhan et al. 2006, pp. 4–5).

According to Rappaport, ritual structure is composed of "canonical" elements that are taken unchanged from tradition and "indexical" elements that refer to the current context of performance: "Whereas the indexical is concerned with the immediate the canonical is concerned with the enduring" (Rappaport 1979, p. 179). In a similar schema, Tambiah proposes that ritual is able to link an enduring cosmological order to an immediate social reality through "*indexical symbol* and *indexical icon*" (Tambiah 1980, p. 153), terms that he takes from C. S. Peirce's semiotic theory. In Peirce's threefold taxonomy, the classifying principle is the structural relation between the sign and what it signifies: icon is based on resemblance, index is based on causal connection, and symbol is based on linkage that is conventional (Culler 1975, pp. 18–19).[9] Tambiah combines all three in proposing how ritual as signifying and communicative act connects conventional ideas that symbolize the cosmological order with iconic and indexical references to the present context of its performance. "The duality thus points in two directions at once – in the semantic direction of cultural presuppositions and conventional understandings and in the pragmatic direction of the social and interpersonal context of ritual action" (Tambiah 1980, p. 154). Thus, ritual communicates by linking meaning and practice, convention and context, in a signifying strategy that simultaneously deploys all three sign categories. On the view proposed by these two schemas, we see how the worship of AIDS Amma links the canonical or cosmological meaning with reference to the crisis resulting from a new epidemic disease and the need to resolve it. But both formulations, as Bell points out with regard to Rappaport, neglect the way in which the canonical and the contextual interact with and mutually transform each other, through which "ritual 'invents' tradition in order to afford a sense of legitimized continuity with the past and to experience tradition as fixed" (Bell 1992, p. 120). The AIDS Amma initiative is in this sense an "invented tradition", where the performative context re-articulates and creatively transforms the canonical sign instead of simply supplementing it.[10] We will examine this in more detail later when we consider the epistemological implications of AIDS Amma worship as tactical pedagogy.

Popular participation in the AIDS Amma initiative indicates acceptance by those who participate, but does it also indicate their belief that it works? We must first make a distinction between acceptance of a ritual and belief in its efficacy: while belief is an internal condition experienced by the individual, acceptance is a public act through which individuals collectively agree to follow a liturgical procedure that they consider authoritative. Two features of ritual are important in inducing acceptance: its public nature and collective participation. Efficacy of a ritual is conse-

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[9] Rappaport, too, refers to Peirce's taxonomy of signs, but he assigns different values to the three categories: "The invariance of liturgy may be an icon of the seeming changelessness of the canonical information that it incorporates, or even an index of its actual changelessness, but canonical information itself rests ultimately upon symbols" (Rappaport 1979, p. 182).

[10] Cf. Hobsbawm and Ranger: "'Invented tradition' is taken to mean a set of practices, normally governed by overtly or tacitly accepted rules and of a ritual or symbolic nature, which seek to inculcate certain values and norms of behaviour by repetition, which automatically implies continuity with the past" (Hobsbawm and Ranger 1983, p. 1).

quent upon such acceptance and not on belief. Secondly, in a religious context, belief and acceptance are linked, as Geertz contends: “religious belief involves not a Baconian induction from everyday experience – for then we should all be agnostics – but rather a prior acceptance of authority which transforms that experience” (Geertz 1973, p. 109). Or, as Althusser eloquently states it, in a rephrasing of Pascalian doctrine: “Kneel down, move your lips in prayer, and you will believe” (Althusser 2001, p. 114). Althusser’s statement is about the material existence of ideology, how it operates not only in the consciousness but equally in embodied ritual acts, which in their performance induce both acceptance and belief. Rappaport, too, expresses the same idea, though he stresses the public nature of such acts in contrast to Althusser’s emphasis on individual psychology, and the importance of acceptance rather than belief in contrast to Geertz: “In kneeling … he is not merely sending a message to the effect that he submits in ephemeral words that flutter away from his mouth. He identifies his inseparable, indispensable, and enduring body with his subordination” (Rappaport 1979, p. 200). If the village community responded positively to Girish’s intervention, it was because they accepted that it could address their crisis; and this acceptance was based not on Girish’s individual efforts but on the force of the ritual tradition. The AIDS Amma worship may have been initiated by an individual, but its observance in ritual form was a collective act of adherence to a long-standing tradition of ordering the disorder of disease. As Rappaport emphasizes, what is important in ritual is that it is not the invention of any individual: “I take ritual to be a form or structure, defining it as the performance of more or less invariant sequences of formal acts and utterances not encoded by the performers” (Rappaport 1979, p. 175). By participating in a ritual, “the performer accepts, and indicates to himself and to others that he accepts, whatever is encoded in the canons of the liturgical order in which he is participating” (Rappaport 1979, p. 193, italics in original).

To understand the question of belief and acceptance, we must examine ritual as a form of communication. Rituals, whether they are about deities or more mundane concerns, are essentially communicative acts that signify through words as well as bodily gestures. Their efficacy depends on how meaningful they appear to those who perform them. But ritual is not just a medium for the transmission of meanings, which could equally well be transmitted through other media. The meaningfulness of a ritual has more to do with how they are performed, as the proper way of following enduring traditions. As Rappaport states, “ritual is not simply an alternative way to express certain things, but that certain things can be expressed only in ritual”, such as “social contract, morality, the concept of the sacred, the notion of the divine, and even a paradigm of creation” (Rappaport 1979, p. 174) – that is, meanings that refer both to the cosmological universe and social world. Speech act theory provides a conceptual framework for understanding what is distinctive about ritual communication.

In *How to Do Things with Words*, J. L. Austin lists three types of communicative acts. The most common form is the “locutionary”, which either describes an object, action or event or presents a fact: it is “a certain sentence with a certain sense and reference”. The second form, less common than the locutionary, is the “illocutionary", which is a conventional utterance that is intended to do something such as promising, requesting or ordering. To say "I promise to …" or "I request you to …" is not to *describe* a thought that one has, for promises and requests are not made in the mind, but to *do* the promising or requesting in *saying* it. In the locutionary speech act, the referent is extrinsic to the utterance, while in the illocutionary it is intrinsic. Austin includes the "performative utterance"[11] – promises, orders, requests – as a species of illocutionary speech act. The third genre of speech acts is the "perlocutionary", which is "what we bring about or achieve *by* saying something", such as promising, requesting and ordering. It is the *effect* of the utterance, not the utterance itself, and is complementary to it (Austin 1962, p. 108). Crucial to the performative is that it must follow a formal convention for it to have its intended effect, without which it becomes subject to what Austin calls "infelicities" (Austin 1962, p. 14). Thus, there is a specific linguistic form that convention prescribes for performatives like the promise, "with verbs in the first person singular present indicative active" (Austin 1962, p. 56). Though Austin was by no means a proto-structuralist, his account of the performative anticipates the idea that discourse produces what it seems to express or represent, which is fundamental to all varieties of linguistic constructionism.

Ritual acts and performative utterances have a number of key aspects in common, which would allow us to consider them as analogous. They both follow convention, reiterating a formal code prescribed more or less inflexibly by tradition, both involve a context of social interaction, and need to be performed in order to come into force. It is on this analogy that Tambiah and Rappaport extend speech act theory to ritual. "Ritual action", writes Tambiah, "in its constitutive features is performative in these three senses: in the Austinian sense of performative wherein saying something is also doing something as a conventional act; in the quite different sense of a staged performance that uses multiple media by which the participants experience the event intensely; and in the third sense of indexical values – I derive this concept from Peirce – being attached to and inferred by actors during the performance" (Tambiah 1980, p. 119). Like the illocutionary utterance, ritual is a special form of communication that involves more than merely the transmission of meaning. This is what Rappaport means when he states that "certain things can be expressed only in ritual" – just as certain things like promises, requests or orders can only be made in performatives. Ritual communication constitutes the cosmological meanings it expresses and transmits. Corollarily, cosmological meanings, which Rappaport calls "cognized models" or "a people's knowledge of their environment and of their beliefs concerning it" (Rappaport 1979, p. 98), can only be transmitted in ritual form. Bernhard Giesen calls ritual acts "constitutive performances" that do not reflect an existing order but bring it into being: "the ritual performance is the poesis of order and this order exists only because it is performed" (Geisen 2006, p. 340). Thus, the ritual of Sitala or Mariamma worship does not simply inform

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[11] As Austin explains, "The name is derived, of course, from 'perform', the usual verb with the noun 'action': it indicates that the issuing of the utterance is the performing of an action" (Austin 1962, p. 6).

participants of the fact of the goddess's magical powers, it *invests* her with these powers in their acceptance of the ritual's illocutionary force. To the participants it matters little whether it has objective validity: the question before them is not *why* it is performed but *how* it must be performed in order to be felicitous and effective. Without the "constitutive poesis" of ritual, as Giesen contends, the cosmological order cannot be founded, and this requires that "we simply give up the doubts as to whether the action is staged or spontaneous, artificial or authentic, true or false … and take the performance for real" (Geisen 2006, p. 340).

A distinction, however, needs to be made between ritual acts and the concept of performativity in speech act theory. First, speech act theory emphasizes the priority of structure: it is in the functioning of its conventional structure that the illocutionary utterance produces its perlocutionary effects. It is conservative, in that performance is understood to conserve the bond between structure and effect. It therefore underplays the performative activity itself, the *process* of performance and the possible indeterminacies that may result. In Austin, for example, this conservative orientation is evident in the way he sets aside indeterminacies as "infelicitous", signalling the failure of the performative act. In ritual, if not in speech, cosmological meanings are not only consolidated but also opened up for transformation, which happens in the process of performance. As Victor Turner states, the relationship between the cosmological order and the ritual performance

> … is not unidirectional and "positive" – in the sense that the performative genre merely "reflects" or "expresses" the social system or the cultural configuration, or at any rate their key relationships – but that it is reciprocal and reflexive – in the sense that the performance is often a critique, direct or veiled, of the social life it grows out of, an evaluation (with lively possibilities of rejection) of the way society handles history. (Turner 1988, pp. 21–22)

Ritual traditions are not static corpora of knowledge, but dynamic and responsive to changes of context and meaning. As suggested above, the relation between the canonical elements and the performative context that the indexical signs point to is dialectical, so that new contexts may result in reconfiguration of meaning. In invoking the disease goddess tradition, the AIDS Amma initiative reactivates a function not associated with the goddess's power to heal but one that is pedagogic – which in the worship of Sitala, for instance, communicates norms of hygiene. By situating the goddess within a biomedical context, it reconstitutes her powers for an effect different from the traditional and is in this sense an "invention". The reconfiguration takes place in what Turner describes as the liminality of the performance process. We will return to this in the section on epistemology.

The second important difference between the concepts of performative utterance and ritual act lies in the fact that the latter is embodied while the former is not. To the extent that a performative utterance is uttered, it certainly involves the body; but speech act theory does not emphasize this. What Searle and Austin examine are cognitive structures, not bodily acts. The essential medium of ritual communication, in contrast, is gesture, intonation and motions of the body, which would constitute a "language" only in an analogical sense, where they function as signs in a systemic repertoire that Clifford Geertz calls "webs of significance": "man is an animal suspended in webs of significance. I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of a law but an interpretative one in search of meaning" (Geertz 1973, p. 5). To illustrate this thesis, Geertz gives the example of winking as sign in "a stratified hierarchy of meaningful structures in terms of which twitches, winks, fake-winks, parodies, rehearsals of parodies are produced, perceived, and interpreted" (Geertz 1973, p. 7). Similarly, Erving Goffman emphasizes the "sign" value of "clothing; sex, age, and racial characteristics; size and looks; posture; speech patterns; facial expressions; bodily gestures" in everyday social interactions (Goffman 1959, p. 24). Such approaches treat the body as a text, to be interpreted in terms of a shared body semiotics that is culturally determined. While this is a valuable insight into the body as a biocultural, rather than merely biological, formation, it does not include the viewpoint of embodiment as modes of being constituted through practices of the body. Personhood is the outcome of how we conduct ourselves as embodied beings, and this is nowhere more evident than in rituals: to perform a rite is not only to signify and reiterate a cosmology but also to situate oneself within it. In Rappaport's example of kneeling cited above, the gesture, especially when it is part of a sacred rite, does not merely acknowledge an authority, but it places one in submission to it: "He identifies his inseparable, indispensable, and enduring body with his subordination" (Rappaport 1979, p. 200). In an account of two crises among the Navajo, the first due to an epidemic outbreak of hanta virus and the second owing to unforeseen draught, Thomas Csordas argues how recourse to local healing traditions became a way of asserting identity, contributing "to the ongoing constitution of … the 'body' politic' of Navajo society in its vulnerable yet resistant confrontation with the dominant society" (Csordas 2002, p, 163). Similarly, David Hardiman (1984) argues how the outbreak of epidemic smallpox in a fishing community in south Gujarat in 1922 led people to seek the protection of a goddess, Devi, which eventually became a collective act of Adivasi self-assertion. In both instances, embodiment played a key role, in the form of ritual healing among the Navajos and as dietary austerities and goddess possession among the Adivasis of Gujarat. The linking of ritual acts with identity was possible because of long-standing traditions that established shared practices of embodiment as belongingness to one's cultural community.

In many societies rituals constitute a major resource for preserving and transmitting knowledge considered essential for maintaining social order. These may be marriage rituals, rituals relating to birth and death, rites associated with agricultural cycles of sowing and harvesting or, as we have been discussing, rituals of disease goddess worship. They may refer to the domain of the sacred, or to that of the profane, or may connect the two in regulating the everyday conduct of people. It is in acquiring such knowledge that one participates in the shared sense of belonging to a community; and the acquisition, as Bourdieu argues, takes place through embodied acts that are subjective. The body is neither an instrument to be manipulated nor a sign to be interpreted, but the subject of a cultural knowing that he calls "the *socially informed body*" (Bourdieu1977, p. 24):

> Every group entrusts to bodily automatisms those principles most basic to it and most indispensable to its conservation. In societies which lack any other recording and objectifying instrument, inherited knowledge can only survive in its embodied state …. The body is thus continuously mingled with all the knowledge it reproduces, which can never have the objectivity and distance stemming from objectification in writing. (Bourdieu 1977, p. 218, *fn*.44)

In *Cultures of Memory in South Asia*, D. Venkat Rao distinguishes between "lithic" societies that privilege writing and archival methods based on documentation and "a-lithic" societies that preserve cultural inheritances in embodied practices of singing, dancing and ritual performance (Rao 2014, p. 34). In this context, it is not unusual that the worship of the disease goddess includes not only *puja* and her invocation in chants but equally songs and dances expressing devotion. Ferrari discusses the emergence of a specific song culture around the worship of Sitala, the *Sitalamangalakavya*, in fifteenth-century Bengal, adapted into on-stage recitations and theatrical performances in the *jatras* or festivals to the goddess (Ferrari 2015, pp. 23–27). In the *sohar* tradition of the Bhojpuris, Sitala is invoked and praised as a protector of women, linking the experience of the sacred with everyday existence: "While singing their love for Sitala, women of different ages, background and social status learn to cope with daily hardships, and to strengthen their position in the society as members of the *strijati*" (Ferrari 2015, p. 28). In such performances, the body, as Rao puts it, "plays the substrate of what comes forth from it, whether it is recitation, speech, narrative, performative or song" (Rao 2014, p. 80). It is both substrate for the articulation of cultural memory and the subjective core of one's identification with it. In this articulation, the act of remembering is not separated from the body, as cognitive rather than physical, but in and through it. It is in embodied form that these practices of memory, or "mnemocultural" practices, come to be *disseminated*, *diversified* and *commingled* across different communities. In one instance of Sitala worship that Ferrari observed, it included elements of Mariamma worship performed by devotees from the south: "Indigenous communities seem to enjoy the festive mood of Tamil celebrations and their spectacular displays of bravery and endurance. Though ethnicity and culture inform different, and somehow divergent, dispositions in matters of ritual practice, Sitala is not subsided by the presence of Mariyamman" (Ferrari 2015, p. 101). *Puja* and the singing of devotional songs, which are traditional ways of invoking Sitala, thus come to mingle with performances associated with the worship of Mariamma, such as "possession, oracular speaking, … marching with firepots on the head, fire-walking, … and austerities like *alaku*, a loose label indicating a series of devotional performances such as the piercing of the cheeks, tongue, bottom lip or back with spears, arrows and hooks" (Ferrari 2015, p. 101). These bodily acts do not function as a sign for some other meaning but are subjective acts in fulfilment of a vow made to the goddess, in preserving one's lived relation to her.

Healing traditions often involve the intense experience of possession, when the deity enters the body of the ritual practitioners. In Sitala worship, possession is not a sign of disease but a visitation by the goddess in response to the call of the devotee. Like the votive performances of fire-walking and *alaku*, it is an embodiment of the devotee's relation to the goddess. Ferrari explains possession as a "filling" or "pressure" experienced by the devotee as "a sign of the living presence of Sitala" (Ferrari 2015, p. 95). For women who are possessed, it is a way of publicly relieving distress caused by oppressive domestic relationships, often including violent movements, abusive language and accusations against those responsible for the oppression. In Ferrari's account, thus, possession is a religious experience that may address issues other than religious, and visitation by the goddess is often a conscious opportunity for the possessed to remedy their social circumstances. This is an important observation from the perspective of ritual's social efficacy, and he rightly emphasizes it. But he pays little attention to another fact that he observes, that the context of possession "permits forms of behaviour otherwise unacceptable" (Ferrari 2015, p. 96). If it does so, it is because it takes place in a zone where the norms of acceptable everyday conduct are suspended. Possession, which is called *bhar* or "pressure" in Bengali, is *khelna* or "play" in Hindi; and play, as Victor Turner reminds us, is "a liminal or liminoid mode, essentially interstitial, betwixt-and-between all standard taxonomic nodes" (Turner 1988, p. 168). Possession dissolves the boundaries that ordinarily divide consciousness and the body, sacred and profane, which makes it a deeply ambiguous phenomenon that appears real to the one who undergoes it but fake to others who observe (Ferrari 2015, p. 98). As a mode of embodiment, it indicates the simultaneity of the magical and the naturalistic, human and divine, in an indeterminacy that, according to Csordas, characterizes practices of religious healing (Csordas 2002, pp. 86–87). One aspect of this indeterminacy is that the body, which is objectified in being possessed as passive recipient of the visitation, becomes also the subject that actively wills the goddess to possess it: the heightened emotional and physical states of possession are induced by intentional acts that are structured and ritualistic. Thus, the experience of possession, as it traverses the boundaries of the sacred and the profane, also exhausts attempts to reduce it to either the body as object or consciousness as self/subject.

What is it that distinguishes the activity of possession from other types of bodily acts that it may resemble? It seems to me that it is the ritual form, which takes it out of the everyday to invest it with the meaning and value of a sacred act. "It is his familiar and everyday life", writes Mircea Eliade, "that is transfigured in the experience of the religious man: he finds a cipher everywhere" (Eliade 1957, p. 183). The sacred and the profane are not, in other words, distinct domains: it is the structuring activity of ritualization that constructs and establishes the boundaries, just as it can possibly also dissolve them. Ritual possession by Sitala is a structured performative activity that signifies the presence of deity, but it also establishes a link between embodied practice and the shared sense of belonging to a cultural community. Phenomena of possession by deities are always public events, where one individual's possession induces possession in others (Sax and Weinhold 2010, pp. 244–45). In functioning as a sign, it also constitutes a way of being in the cosmological order.

To understand how rituals both transfigure mundane activities into sacred acts and constitute embodied subjectivity, we may look at another element of Sitala worship, the practice of variolation. Variolation, also known as *tika* or "mark", involved the transference of smallpox virus or variola from an infected to uninfected person. Widely practised in India since long before Jennerian vaccination was introduced in the nineteenth century, the operation was conducted by ritual practitioners or *tikadars* drawn from different *jatis*. In Bengal, they were mostly *napits* (barbers), *malis* (gardeners), *tantis* (weavers) or *kumars* (blacksmiths); in Balasore in Orissa, they were Mastan Brahmins, a subcaste lower in the hierarchy (Arnold 1993, p. 131, Pati 2001, pp. 12–13). Variolation, however, was distinct from other medical procedures that required specialists, like midwifery or bone setting. What marked it as distinct was its religious significance, for it was traditionally understood as part of the worship of Sitala. Before performing the operation, the variolator, who followed a strict ritual procedure, would invoke the blessings of Sitala to ensure its success. Thus Ferrari describes:

> Variolation was indeed a *Sitala-puja* in which the goddess was awakened, invited and worshipped as an immanent presence in the village. The 'patient' was literally equated to Sitala and the room where s/he was lying was her abode. Invocations in the form of *vandhanas* (bonding prayers), *namdaks* (loud calls), and *mantras* in corrupted Sanskrit (extrapolated from Sitala-mangal-kavyas) were conducive to the process of *akarsana* (lit. attraction, also awakening of the goddess). Once the presence was ensured, the variolator proceeded with the next phase, inoculation, a ritual explained as *sthapana*, the stabilisation and installation of the goddess into the hosting body. (Ferrari 2010, p. 156)

An officer of the Bengal Medical Service, Col. Robert Pringle wrote in 1885: "Religion seems to have been so mixed up with the whole practice of inoculation, that it partook more of a religious ceremony than exhibition of medical skill; while the goddess of smallpox 'Seetla' by name, was propitiated by gifts to her priests and her shrines, and special hymns were sung in her honour" (cited in Ferrari 2015, p. 135). In its association with the sacred, variolation differed not only from other traditional medical practices but also from Jennerian vaccination, which was made mandatory by the colonial government in many parts of the country (Bhattacharya 2001). The chief objection to the Jennerian vaccine, as Arnold explains, "was its raw secularity. There was no ritual or dietary prescription; no Sitala prayers or Ganges water; no appeal to the goddess of smallpox to guide the child safely through such a dangerous defile" (Arnold 1993, p. 143).

Catherine Bell argues that ritual acts are not in themselves different from other acts performed in a non-ritual context: it is the process of ritualization that sets them off as distinct, gives them a distinct meaning as liturgical event and attributes to them specific powers and effects. The "significance of ritual behaviour lies not in being an entirely separate way of acting, but in how such activities constitute themselves as different and in contrast to other activities" (Bell 1992, p. 9). The shift from ritual as structure to ritualization as process is an important one, for it brings to light the way in which activities are separated from their everyday or mundane contexts and constituted as sacred. When combined with the idea of embodiment, it indicates how rituals involve not only structures of signification but also generate ways of being through bodily practice.

> The strategies of ritualization are particularly rooted in the body, specifically the interaction of the social body within a symbolically constituted spatial and temporal environment. Essential to ritualization is the circular production of a ritualized body which in turn produces ritualized practices. Ritualization is embedded within the dynamics of the body defined within a symbolically structured environment. (Bell 1992, p. 93)

As techniques of immunization, variolation and vaccination were not widely different in method or effect. In fact, before vaccination was made mandatory by the colonial government and variolation outlawed, several British physicians found nothing objectionable in the customary practice. Arnold cites J. Z. Holwell, surgeon in the East India Company and temporary Governor of Bengal, who reported in 1767 to the College of Physicians in London that variolation "adds no malignity to the disease taken in the natural way, nor spreads the infection, as is commonly imagined in Europe" (Arnold 1993, p. 129). What made variolation questionable and inferior to vaccination in the mind of the British was the religion with which "it was so mixed up", as Pringle put it. Corollarily, what made it more authentic in the minds of those who resisted the government's attempt to ban it was its ritualization as part of Sitala worship.

We will now turn to some major implications of the ritual of disease goddess worship, which as I argue have a bearing on the AIDS Amma initiative. The worship of disease goddesses has involved two components, one liturgical and the other therapeutic. Sometimes, as in the case of smallpox variolation, a prophylactic component may also be included. These do not exist as distinct and autonomous practices, but are integrated through ritualization of therapy. In Sitala worship, therapy includes the prescription of cooling foods, often uncooked, the goddess herself being understood as cool. The patient is anointed with *neem* and sandal paste and fanned with *neem* leaves dipped in water, as *neem* is held to be cooling. The use of *neem* may reduce secondary infections as it has antibacterial properties. Therapy is accompanied by chants that invoke the goddess and seek her blessings in restoring the patient to health. To use the terminology of Strathern and Stewart, we find two distinct explanations of disease juxtaposed in the worship of Sitala: liturgy assumes the "personalistic", which holds that disease is caused or alleviated by supernatural agency, and therapy assumes the "naturalistic", which emphasizes an organic view of pathology and cure. What concept of the body do these explanations *taken together* imply? On the one hand, the body is understood to be a natural entity, obeying the causal laws of nature. On the other, it is open to magical influence, where by "magic" I mean the sense defined by Marcel Mauss in *The General Theory of Magic*:

> … in medical practice, words, incantations, ritual and astrological observances are magical; this is the realm of the occult and of spirits, a world of ideas which imbues ritual movements and gestures with a special kind of effectiveness, quite different from their mechanical effectiveness. It is not believed that the gestures themselves bring about the result. The effect derives from something else, and usually this is not of the same order. (Mauss 1972, p. 25)

That is, the magical and the mechanical (which I take to mean causal) have different effectivities in restoring the patient to health, a point that I will turn to shortly. A medical practice that combines both kinds of effectivity, as the worship of disease goddesses does, implies that the body is a *magico-naturalistic* complex open both to its internal mechanisms and the forces of the cosmological order. The internal mechanisms work in synergy with the cosmological forces, not independently of them, as the ritualization of *tika* suggests. It is thus distinguished from medical practices that privilege the naturalistic, like modern biomedicine as well as ayurveda, siddha and unani. That the magico-natural conception of the body did not exist in the literate medical traditions points to both its vernacular origin and its resistance to incorporation into formal systems. If certain kinds of cultural knowledge, as Rao holds, were disseminated primarily through embodied practices, formalization was not the way in which they came to be preserved.

Mauss's distinction between the magical and the mechanical suggests another distinction that we may make for heuristic purposes. We can broadly distinguish approaches to health on two poles, curing and healing. As Strathern and Stewart explain, "curing refers to an act of treating successfully a specific condition, for example a wound or a case of diarrhea or infestation by worms. Healing, by contrast, refers to the whole person or the whole body seen as an integrated system with both physical and spiritual components" (Strathern and Stewart 2010, p. 7). Curing, in other words, seeks to restore the body to health, while healing seeks to produce a state of well-being that includes but is more than good health. Curing is technical, corresponding to Mauss's mechanical effectivity; healing corresponds to the magical and is an art. That is why healing rituals form part of the imagined ideas of order that we call cosmological and are often understood by those who do not practise them as mystical. The divide between curing and healing is not an absolute one, for they often occur together: what can be distinguished are medical practices that are oriented towards the curing pole, such as biomedical intervention, and those that are oriented towards the healing pole, such as disease goddess worship. As we have seen, the worship of Sitala includes curative techniques alongside rituals of healing but emphasizes the latter. While the sense of well-being cannot be reduced to good physical health, the two are mutually constitutive, and one cannot experience the one without also experiencing the other. Consequently, we must understand medical practices as ranging on a continuum between the two poles.

The curing/healing polarity can provide an insight into how the embodied practices of disease goddess worship become effective. Embodiment problematizes the division between the magical and the mechanical, by dissolving the distinction between the body and the mind/soul and therefore the distinction between curing and healing: "Immediately implicated is the conventional distinction between mind and body, along with a series of derivative distinctions between culture and biology, the mental and the material, culture and practical reason, gender and sex" (Csordas 1994, p. 7). Nancy Scheper-Hughes and Margaret Lock coin the term "mindful body" to refer to a concept of personhood that integrates consciousness, emotion and the body with the social and intersubjective, which they consider essential to a holistic concept of medicine but which biomedical knowledge and practice forcefully exclude for ideological reasons:

> We would like to think of medical anthropology as providing the key toward the development of a new epistemology and metaphysics of the mindful body and of the emotional, social, and political sources of illness and healing. Clearly, biomedicine is still caught in the clutches of the Cartesian dichotomy and its related oppositions of nature and culture, natural and supernatural, real and unreal. If and when we tend to think reductionistically about the mind-body, it is because it is "good for us to think" in this way. To do otherwise, using a radically different metaphysics, would imply the "unmaking" of our own assumptive world and its culture-bound definitions of reality. (Scheper-Hughes and Lock 1987, p. 30)

Seen from this perspective, the worship of the disease goddess as embodied practice is a healing that cures and is effective both as restoration of well-being for the individual concerned and, for the community, as the collective restoration of a metaphysical order threatened by epidemic crisis. I am arguing that we can understand the full import of the AIDS Amma initiative, why it needs to ritualize the knowledge it communicates and what kind of effectivity it seeks, only by considering it as the inheritance of a tradition of care that included the human in all its aspects and relationships.

In the foregoing discussion, we have noted a number of salient features of the vernacular tradition of disease goddess worship:

1. It is a popular practice that has developed independent of, though not unrelated to, the literate medical traditions of India.
2. It is highly localized, limited to a single village or a cluster, even if it is widespread as a form of practice.
3. It is founded on a conception of the body as a magico-naturalistic complex, requiring simultaneously therapy and invocation of deity as twin strategies of health-seeking.
4. Its efficacy depends on embodied and ritual acts that address both disease and its psychological effects, in order to restore the whole person to health and well-being.
5. Ritualization enables the performative linking of the practical concerns of cure and prophylaxis to a long-standing tradition of ordering disorder and restoring cosmological balance.
6. It is a collective response to a crisis, involving the entire community in acts that simultaneously carry forward cultural knowledge and are constitutive of belongingness and personhood.

The AIDS Amma initiative correlates with this tradition quite closely. It is an initiative of the people, not supported by any official institutions. It is localized, its objective being to address the panic created by the appearance of HIV disease in the area. Though the shrine acquired some publicity later and was visited by people from places as far away as Tamil Nadu, it was patronized primarily by local communities. It involves both a naturalistic and a magical conception of the body and draws on liturgical practices such as weekly *puja* and annual *jatra* as well as medical knowledge. Through its liturgical form, it links this knowledge to an existing cosmological imagination, and the people were able to relate to it because of this.

The single most important difference between the AIDS Amma initiative and Sitala or Mariamma worship is that, unlike them, it is pedagogic, its aim being not to heal but to instruct. It adopts the ritual form of goddess worship in order to facilitate this aim, when the usual format of communication failed because people were not able to relate to its scientific discourse. Ritualization, as we have already stated, proved effective because the people of Menasikyathanahalli were able in some way to identify with it. An important factor, as Girish informed me, was the existence of a Mariamma temple at the entrance to the village, where people used to worship every Friday. Ritualization of the biomedical information helped in two interrelated ways, involving cultural knowledge and practical predispositions. First, it was a way of thinking about disease and resolving epidemic crisis that was part of the cultural knowledge of the community, which the adoption of ritual reiterated and reactivated in the context of a new disease. Practices, in this way, are flexible ways of living in the world and can help formulate successful responses to new situations as well as familiar ones. We have seen how it was possible for people to reduce the unfamiliarity of plague by creating a Bombai Mai, Plague-amma or Uramma. By success here, we do not mean cure but alleviating the panic of epidemic outbreak and finding an explanation for what would otherwise seem inexplicable: insofar as this kind of efficacy is concerned, it is pertinent to remember that there was no cure at the time for such diseases in any system of medicine, Western or South Asian. In explaining the difference between theoretical and practical knowledge, Bourdieu uses the analogy of the map: it is the "gulf between this potential, abstract space, devoid of landmarks or any privileged centre … and the practical space of journeys actually made, or rather of journeys being actually made" (2). Biomedical information about HIV, like the map, was abstract, and Girish's initial attempts to communicate it failed. Ritualization enabled it to be assimilated into familiar patterns of experience and understanding, a form of practical knowledge like that gained from journeys actually made. Secondly, ritualization activated what Bourdieu calls the "habitus", or the set of dispositions that structure practices and which derive from a community's existing knowledge and experience of situations:

> The structures constitutive of a particular type of environment … produce *habitus*, systems of durable, transposable *dispositions*, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can be objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor. (Bourdieu 1977, p. 72)

Dispositions, Bourdieu explains, are not rules but inclinations or tendencies, especially bodily, to act in predetermined ways without becoming rigidified or formalized and are open to transformation depending on the context and the relation to it of the acting individual. They constitute "a *way of being*" (Bourdieu 1977, p. 214, *fn*.1, italics in original) and are therefore subjective responses to objective conditions, such as (in the case of AIDS Amma) the irruption of epidemic disease. Dispositions never originate in individuals but are collective structures that the members of a community share without being entirely conscious of them – that is, they act in predisposed ways without reflecting on why they do so. Thus, Bourdieu distinguishes "practical mastery of the classificatory schemes" from "symbolic mastery" or "conscious recognition and verbal expression" of the schemes themselves (Bourdieu 1977, p. 88). Embodiment involves "symbolic manipulations of body experience" in accordance with these predisposed ways of being that assimilate personhood to one's location in a cosmological order: they "tend to impose the *integration* of the body space with cosmic space by grasping in terms of the same concepts … the relationship between man and the natural world" (Bourdieu 1977,

p. 91). Ritualization of the biomedical information in the form of goddess worship activated the dispositions that enabled participants to assimilate it into existing patterns of experiencing and understanding disease, with the effect that they were better able to relate to it than to conventional pedagogic formats. The major difference between the AIDS Amma initiative and institutional forms of behaviour change communication is that it uses culture as a *means* to communicate rather than treating it merely as context or even impediment.

## 7.3 Epistemological Implications

The AIDS Amma initiative differs from other pedagogic projects in being what Girish described as “a strange mixture of science and religion”. It is “strange” in the sense that it does not conform to the usual understanding of the scientific and the religious as ways of knowing phenomena; and this strangeness may lead to either dismissing it as hocus-pocus if one holds a scientific view of disease or confusing its pedagogic function with the ritual’s function of healing if one holds a religious view. The supplicants from Namakkal, for instance, hoped that AIDS Amma would help them overcome their affliction, till Girish advised them otherwise. Both ways of understanding the AIDS Amma initiative read it restrictively and are in Geertz’s sense thin descriptions. A “thick description”, in contrast, attempts to understand such events in multilayered contexts – “a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and inexplicit”, which thick description “must contrive somehow first to grasp and then to render” (10). In the preceding sections, we have tried to unravel these conceptual structures and their effectivity in addressing epidemic crisis, as context for interpreting AIDS Amma. In the present section, we will examine the contrary ways of understanding body and disease that are implicit in and structure the AIDS Amma initiative. The convergence of science and religion produces the following key juxtapositions:

1. It assumes divergent aetiologies of disease: If one holds that disease is caused by a pathogenic agent, the other holds that it is caused or cured by divine agency.
2. Correspondingly, it assumes divergent conceptualizations of the body – one magical, assuming that the body is open to supernatural influence whose force is to be acknowledged in ritual, and the other naturalistic, believing that it follows natural laws that can be observed and known and their effects resisted or prevented.
3. It conjoins radically different practices of knowing, one performative and requiring structured and coded bodily acts and the other cognitive and directed at acquiring discursive knowledge.
4. Corresponding to this, it implies contrary ways of relating to knowledge – One subjectively, through embodied practice, and the other objectively, through reflection and reason. In actual practice, though, the binarism of the corporeal

and the cognitive is dissolved in the experience of embodiment, which, as we have seen in the discussion of the Sangli and Sonagachhi projects in the preceding chapter, is centred in the "mindful body".

5. If ritual is a way of encoding and remembering a knowledge held to be valuable, the AIDS Amma initiative ritualizes a kind of knowledge – science – that is presumed to be resistant to ritual.

Underlying this series of juxtapositions is a convergence of tradition and modernity that constitutes what Partha Chatterjee calls "heterogeneous time" (Chatterjee 2004, p. 7). Modernity, as stated earlier, does not necessarily supplant existing modes of knowledge, but often provides a new context for their re-articulation and revaluation. In this context, Hobsbawm and Ranger remark that modernity does not make traditional ways of being "unadaptable" to the new circumstances and therefore "unviable": "Adaptation took place for old uses in new conditions and by using old models for new purposes" (Hobsbawm and Ranger 1983, p. 5). They refer to such adaptations as "invented tradition", by which they mean the reiteration of practices, usually ritualized, from a significant past, such that it establishes continuity with that past while emphasizing change (Hobsbawm and Ranger 1983, p. 1–2). The reiteration, as I have argued above in the context of the canonical and the indexical in ritual, does not simply append the present context to the past tradition, it also alters that tradition significantly. There is a double re-articulation of context and meaning, which is evident in the way the AIDS Amma initiative transforms the goddess from one who restores well-being to one who blesses with knowledge. In this, as we have seen, it brings to the fore what had been tacit in Sitala worship: the teaching of hygienic and dietary norms. One of the *vrat kathas* (exegeses of the *vrat* or fast) that Wadley mentions enjoins devotees "to keep houses very clean, to spread cowdung every day (on the floor), to do the *puja* of Bhagavati, to not eat salt, to not season foods, to not fry things, to not put anything on the pot, to not yourself eat hot things nor feed them to a pox victim, to serve only very cold things, etc." (Wadley 1980, p. 38). Such *kathas* are devotional narratives that include both instructions on the rituals and precepts on norms of conduct, thereby linking the performance of sacred rites to everyday life. The AIDS Amma initiative re-articulates the healing tradition to emphasize this function in juxtaposing ritual with biomedical information.

I have stated above that ritualization creates a liminal zone where boundaries between sacred and profane, consciousness and the body and subject and object are blurred. Liminality, as used by Arnold Van Gennep, refers to the act of crossing a symbolic threshold, and it provides a structure exclusively for certain types of ritual such as rites of passage (Van Gennep, 1960, p. 21). Victor Turner, however, extends the structure to rites in general:

> … the whole *ritual process* constitutes a threshold between secular living and sacred living. The dominant genres of performance in societies at all levels of scale and complexity tend to be *liminal phenomena* …. liminality and the phenomena of liminality dissolve all factual and commonsense systems into their components and "play" with them in ways never found in nature or in custom, at least at the level of direct perception. (Turner 1988, p. 25, italics in original)

To supplement Turner's point with an analogy from speech act, the recitation of a performative in a context different from its conventional usage generates indeterminacies, incongruent juxtapositions and effects that exceed the intention of the utterance. "[G]iven that structure of iteration, the intention animating the utterance will never be through and through present to itself and to its content. The iteration structuring it a priori introduces into it a dehiscence and a cleft [*brisure*] which are essential" (Derrida 1988, p. 18). Such a performative act may be understood as dissolving the boundaries between felicity and infelicity that Austin sets up as a rule. The AIDS Amma initiative, understood in this sense as a performative ritual act, re-cites disease goddess worship in the context of a new disease, grafting existing significations into a radically incongruent context of discourse (biomedical) and practice (official AIDS pedagogy) and drawing their conceptual and practical distinctions into a zone of liminality and indistinction.

Whether we approach it as invented tradition or performative reiteration, therefore, we see that indeterminacy and the juxtaposition of divergent elements is not an accidental effect, or the effect of a deconstructive reading, but of essence to its epistemology in transforming both traditional and modern ways of knowing and responding to epidemic crisis. It is subject, of course, to the risk of misunderstanding: as Girish says of the Namakkal petitioners or Ferrari states of persons with AIDS worshipping Sitala in Bengal, the devotees "believe in the possibility of recovery from HIV positiveness through worship" (Ferrari 2010, p. 162). But this does not minimize its effectiveness as pedagogy, in the sacral authority it imparts to the instruction it provides. When Ferrari dismisses the value of the initiative as "artificial … adaptation" (Ferrari 2010, p. 144) and writes:

> AIDS Amma was born in anomalous context. On the one hand there is no supporting myth. On the other, she just borrowed elements from the local plague-goddess (Mariyamman). She has no *sakti* to give, as her power is turned by non-ritual specialists into lay knowledge, i.e., information. (Ferrari 2010, p. 164)

he ignores the fact, first, that it is not healing but knowledge that is its intended outcome and, second, that the goddess's *sakti* is not a quality that is intrinsic but the performative effect of her ritual. It is subject, of course, to the unintended effects that Ferrari points out, just as any performative utterance is not reducible, as Derrida writes, to the intention animating it.

## 7.4 Tactical Pedagogy

In terming the AIDS Amma pedagogy a "tactical pedagogy", I distinguish it from the conventional behaviour change communication strategies used in the governance of public health. Unlike these strategies, it does not originate in agencies of governance, both "governmental" and "non-governmental", but is a popular initiative. It may have been started by an individual in authoritative relation to the people as science teacher in the local school, but as we have seen, it was eventually taken over and continued by the people of Menasikyathanahalli. Unlike behaviour change campaigns, the initiative – that is, the combination of ritual and instruction – is not top-down, but is motivated by the long-standing practices of its subjects. In this sense, it is (to use Chatterjee's term) the "politics of the governed" in response to the politics of government. That it responds to official AIDS pedagogy is clear in the way it draws upon it. Secondly, it differs from most behaviour change campaigns in the way it uses culture as a resource, a point that we have already made.

By calling it "tactical", I am also including in my understanding of its dynamics a sense of practice as Michel de Certeau defines it: "ways of operating". Rules governing behaviour may exist, but people actually operate on the basis of tactical conformity and departure with regard to these rules. Such tactics "trace 'indeterminate trajectories' that are apparently meaningless, since they do not cohere with the constructed, written, and prefabricated space through which they move". They are meaningless, that is, from the perspective of those who fabricate and prescribe the spaces of use: for their practitioners they are meaningful ways of negotiating power relations. De Certeau further writes of tactics:

> They are sentences that remain unpredictable within the space ordered by the organizing techniques of system. Although they use as their *material* the *vocabularies* of established languages …, although they remain within the framework of prescribed *syntaxes* …, these "traverses" remain heterogeneous to the systems that they infiltrate and in which they sketch out the guileful ruses of *different* interests and desires. (de Certeau, 1984, p. 34)

Understood in terms of its dynamics and not the intention of its originator, the AIDS Amma initiative is a tactical utilization of the material of official pedagogy and the practical resources of popular culture, to connect the knowledge it communicates to their embodied lives as devotees of the mother goddess – and thereby to re-articulate its "interests and desires".

The body lies at the centre of the field of practice, both the body as an object of care and concern and the body as subject of practical action. The AIDS Amma initiative is in this sense all about the body learning to take care of itself in performing the pedagogy of care. Embodiment, as Csordas emphasizes, unfolds neither in theoretical, reflective knowledge of the body, the "objectified body" of biomedicine and biological science, nor in the "preobjective" body of an imagined natural existence, but in "the play of the preobjective and objectified body in experience" (Csordas 1994, p. 7). Ritual embodiment in healing practices, like the goddess worship to which AIDS Amma bears kinship, is not subject to the classificatory schemes of theory like the distinctions between magical and natural causation or between religion and science. The juxtaposition of divergent elements, which may seem paradoxical and self-contradictory from a theoretical perspective, are not so in embodied practice. In combining ritual with public health pedagogy, the epistemology of AIDS Amma is at cross-purposes with the theoretical schema of the latter, even as it draws upon its practico-discursive regimes. The logic of this epistemology, like the logic of ritual practice, is not that of reason but of expediency: "Rites, more than any other type of practice, serve to underline the mistake of enclosing in concepts a logic made to dispense with concepts; of treating movements of the body and practical manipulations as purely logical operations …" (Bourdieu 1977, p. 116).

## 7.5 Conclusion

The AIDS Amma shrine at Menasikyathanahalli was set up in 1998 by Girish, science teacher at the local government school, to teach people about modes of transmission of HIV/AIDS. Incidence of disease in the rural community led to panic and stigma against HIV-positive people, and Girish started the campaign to allay fear. The maintenance of the shrine was subsequently taken up by the community, who conducted weekly worship and organized an annual *jatra* on World AIDS Day. It was entirely a popular initiative, without support from the government or non-governmental organizations. As such, it provides an instance of pedagogic efforts that are not part of public health governance and do not use the form and logic of awareness campaigns conducted under the auspices of the state.

The initiative differs from official pedagogies in its use of religion to communicate biomedical information about HIV. Taking his cue from a Mariamma temple on the village outskirts, Girish thought of this method when his attempts in the usual format of official pedagogy had received poor response. In most parts of India, there is a long-standing tradition of the worship of disease goddesses, especially in times of epidemic. Most of these goddesses are associated with smallpox and cholera, epidemics of which were regular occurrences in the past and which took a heavy toll of lives. A few temples had also been set up for a goddess associated with plague after epidemics broke out at the end of the nineteenth century. The most popular of these goddesses are Sitala in the north of India and Mariamma in the south, both associated with smallpox. It is mostly believed that the goddess, who is benign, does not cause the disease but protects her devotees from it, though sometimes she is also imagined as malignant if she is displeased because people neglect her worship. There are certain common features of disease goddess worship. It is ordinarily a local affair, the goddess being a *gramadevata* or village deity, though the practice has been widespread throughout India. The goddess is often attributed with wide-ranging powers, most of which are associated with the prevention of disease and natural calamities: the tradition of goddess worship, thus, was an imaginative way of resolving crises caused by chance events, when the resources of the community to reduce distress were felt to be inadequate. Weekly *pujas* are held at the shrine of the goddess, normally situated at the entrance to the village, and a day is fixed in the ritual calendar for her annual worship and *jatra*. Worship of the goddess is most often a public affair, with the entire village community participating in it, though domestic worship is not prohibited. Localization, collective participation and attribution to the goddess of the power of ensuring well-being of both individuals and the community, are the forms in which disease goddess worship becomes a part of the everyday lives of the people, their ways of being. By linking the AIDS Amma initiative with this long tradition, Girish could ensure acceptance of the information he sought to communicate. But this itself was possible because the tradition was available as a resource, in precisely the same context of epidemic disease crisis that presented itself in Menasikyathanahalli, providing the conditions necessary for Girish's "invention" of AIDS Amma. By looking at the AIDS Amma initiative from this perspective, one understands how its meaning and effects derive not from the logic that Girish intended but the structural intentionality of the tradition.

Acceptance of the pedagogy was ensured by the ritual structure that framed it. Theories of ritual emphasize its performative dimension, meaning not only that rituals need to be performed but equally that their acceptance, meaning and efficacy are an outcome of this performance. The authority that ritual has over the conduct of one's life is the effect of its performative structure, just as its authority ensures its continued performance. By framing the pedagogic content in the ritual of goddess worship, the initiative invested it with the authority of a popular and valued tradition. Further, ritualization linked this authority to the idea of the sacred, thereby separating the pedagogic content from the practico-discursive field of public health communication to which the local community had initially failed to respond. It is the process of ritualization that makes sacred acts which would otherwise be secular or profane, as seen in the way smallpox variolation or *tika* became an integral part of Sitala worship. In this way the ritual acts both gain authority and link the sacred to the everyday life of the practitioners. Thirdly, as embodied activity ritualization is an important way in which South Asian societies have preserved cultural knowledge and the shared sense of belonging to a collectivity. The perspective of embodiment does not distinguish between mind and body as polarities of existence, but assumes their mutual implication in what Scheper-Hughes and Lock call the "mindful body". What this meant in the case of AIDS Amma was that the biomedical ideas could be incorporated into existing ways of knowing and responding to epidemic crisis through the embodied act of offering *puja* and celebrating the annual *jatra*. Memory, consciousness and the body function as a complex in constituting knowledge of disease and integrating it with ideas of personhood in the cosmological order. Acceptance of the pedagogic function of AIDS Amma was ensured by this complex.

The framing of biomedical knowledge in religious ritual, however, leads to certain epistemological effects that appear paradoxical and self-contradictory. It is marked by a series of juxtapositions that bring together otherwise incompatible elements. Thus, AIDS Amma worship assumes divergent explanations of disease, personalistic and naturalistic. Correspondingly, it assumes a magico-naturalistic conception in which the body is understood as both open to external supernatural influence and constituted by internal organic processes that follow natural law. It also involves contrary ways of knowing, one performative and embodied and the other discursive and cognitive. These juxtapositions, however, do not affect either the acceptance of the pedagogy or its effectiveness in eliciting popular response. While the epistemology of AIDS Amma may appear paradoxical from a theoretical perspective, the logic of expediency and symbolic assimilation of meaning in practice makes it otherwise in the minds of its practitioners. The objective of the AIDS Amma initiative is pedagogic, to teach the community about HIV/AIDS and the need to de-stigmatize it, but it seeks to achieve this in a way that differs from conventional AIDS education and behaviour change communication. Insofar as this is concerned, it is a tactical response both to the crisis of epidemic disease and the strategies of public health governance on which it draws. If the activity of governance is located in the position of those who govern, this is an activity that belongs to the governed, without support from though with reference to the former. It thus constitutes an agentiality not dependent on relations of power but on a popular will exercised within the structures of popular tradition. The significance of the AIDS Amma initiative can only be understood in such a context. To see it merely as AIDS communication or, corollarily, as an artificial ritual is to reduce this significance to its most literal meaning. It then appears to be trivial, an improper innovation beset by contradictions between what it seeks to do and how it does it. But these contradictions are what actually make it meaningful in the context of both a pragmatic re-articulation of tradition and of evolving an AIDS pedagogy that counters the objectification of the body in biomedical discourse and practice. By drawing on the tradition of the disease goddess, AIDS Amma worship inserts into the knowledge it communicates a subjective experience of the "reality" of disease that its practitioners can effectively relate to. In the concluding chapter that follows, we will see how this can contribute to a redefined medical humanities that does not seek to simply complement the work of medicine but at the same time to productively critique it.

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# Chapter 8
# Conclusion: Towards a Critical Medical Humanities

**Abstract** The social reality of disease is the outcome of a complex of diverse understandings, such as the perceptions of doctors and patients, public health policies and practices, media accounts, narratives, and legal statutes and court decisions. The study of AIDS pedagogy warrants, therefore, an approach that brings out the multiple sociocultural, political, biomedical and juridical contexts within which the epidemic is framed. To be effective, pedagogies must critically engage with these contexts, which require an interdisciplinary approach that a critical medical humanities can provide.

**Keywords** Interdisciplinarity · Epistemological critique · Critical medical humanities

This book examines the ways in which the social reality of the HIV/AIDS epidemic in India has been understood in various interlinked contexts: media reports, narratives, law and pedagogy. By the term "social reality", we mean not the material conditions of our existence but the way we know them as a totality, a knowledge that is the outcome of both discursive structures and the practical experience of reality. Disease no doubt is a material entity, caused by pathogens or organic dysfunctions that produce material effects on the body. But the way we understand it in lived experience and represent this understanding to ourselves, its affective impact and the stigma attached to it, are not reducible to objective pathological conditions. Thus, Charles Rosenberg argues that knowledge of disease is lodged so deeply in sociocultural perceptions that no explanation of it, including the clinical, is value-free. While this is true of all diseases, it is especially true of epidemic disease that poses a problem for public health, the reality of which is constructed in the "nexus between biological event, its perception by patient and practitioner, and the collective effort to make cognitive and policy sense out of those perceptions" (Rosenberg 1989, p. 4). In the preceding chapters, we have seen how the HIV/AIDS epidemic has been understood through shifting constructions of it as a medical, social and juridical problem, requiring simultaneously clinical, epidemiological, cultural and political responses. Epidemic disease is too complex and sensitive an issue for it to be reduced to a singularly technoscientific explanation, as public health policy and

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pedagogy have long recognized. *Teaching AIDS* argues that this recognition must engage more critically with the significances we attribute to specific disease epidemics, for it to be effective. Accordingly, the book has emphasized a number of themes that enable such critical engagement.

*(a) The Contexts of Pedagogic Practice* AIDS educational projects, like all social practices, are embedded in larger contexts that give them their meaning and effectivity. We need to examine the discursive and sociocultural contexts in which AIDS is understood: ideas about health and disease not just in public health but in other domains as well and the linkages that exist between them. These contexts, as we have seen, produce meaning effects that may have been unintended but which have a profound impact on how pedagogic interventions are received. Thus, campaigns like the Mehr-un-Nisa poster discussed in Chap. 6 that reproduce stereotypes of the prostitute as source of disease, while cautioning people against unsafe sex, reinforce moral norms that serve to intensify stigma. Chapter 7 examines a popular initiative that grafts biomedical messages onto a context of ritual practice, which gives them an authoritative force that the messaging initially lacked for those it targeted. If the first example shows how cultural context can distort the meaning intended, the latter shows how it can equally enhance the effectivity of the intervention. Meanings and their effects in terms of the practices they generate do not work in isolation from their contexts of use, though they cannot at the same time be reduced to these contexts. Contexts, in other words, are never determinate, and the AIDS Amma initiative shows how messages can be creatively recontextualized to make them more effective.

We also need to examine the historical context of health education as a mode of public health governance. Historically, health education has assumed a top-down approach, with messages issuing from positions of authority, both medical and political. What are the implications of this approach for the way it constitutes the subject-position of the addressee? Corollarily, what subjective effects do pedagogic interventions like peer-education programmes have on those whom they address? How do different paradigms of public health, such as quarantine/vaccination, sanitation/personal hygiene and risk assessment/lifestyle management, determine the modes of address and the kinds of knowledge that pedagogies communicate? In what institutional contexts do pedagogies emerge, and how do these contexts enhance or constrain their effectivity? The genealogy of public health education can enable us to better understand the mechanisms by which AIDS awareness interventions function, by locating these mechanisms in their historical contexts of emergence. Studying the institutional contexts of AIDS pedagogy provides insights into the power-knowledge relations that drive it and the way pedagogies emerging from outside such institutional contexts work.

In understanding the relation between meanings, practices and their contexts of production and dissemination, interdisciplinary approaches can provide important critical insights. As we have stated in the introduction, interdisciplinarity shifts objects from the familiar contexts in which they are known into new contexts that are incompatible from a disciplinary or multidisciplinary perspective. Thus, examining public health as an object of study in the context of cultural politics enables us to link it with normative structures and the power relationships in which they are embedded and ask questions that would not be possible otherwise. Particularly questions about the role of public health policies and strategies in enabling and justifying social control:

> Were individuals responsible for the behavior that placed them at risk – or were they passive victims of inimical social circumstances? Few physicians could ignore either kind of causation – and, in fact, were well aware that both factors could interact, creating "vicious cycles" of poverty, environmental deprivation, immorality, and ultimate and inevitable disease. In this sense disease became an occasion and agenda for a generation-long debate about the relation among state policy, medical responsibility, and individual culpability. (Rosenberg 1989, p. 13)

As Lawrence Grossberg claims with regard to cultural studies, interdisciplinarity involves not "re-mastering the disciplines into a new mega-formation" – the formation, we may add, that multidisciplinarity seeks – but "a rigorous and pragmatic approach to gaining whatever knowledge is necessary to map a particular context and answer a strategic question" (Grossberg 1996, p. 145).

*(b) Pedagogy as Critique* For AIDS pedagogy to be effective in transforming both the behaviours of individuals and the contexts of their everyday existence, it must engage critically with these contexts. This is the essence of Paulo Freire's idea of what he calls "education for critical consciousness": "an active educational method helps a person to become consciously aware of his context and his condition as a human being as Subject" (Freire 1974, p. 48). A mode of teaching that does not encourage reflection on the context works only to reinforce that context and the interests of ideological domination that it serves. Our discussion of the Sonagachhi intervention in Chap. 6 has brought out the role of Freireian methodology in transforming what began as a condom promotion programme among sex workers into a multidimensional and collective activity to change their condition of existence. It encouraged them to think critically about such broader issues as their financial insecurities, the power differentials between them and their clients and criminalization of sex work leading to police harassment, which negatively impacted their ability to negotiate condom use (Rao 2017, p. 252). In contrast, a pedagogic method that does not engage critically with the context, like the ILO card game also discussed in Chap. 6, skirts issues of power that constrain individual behaviour and the subjective capacity to take disease-preventive decisions.

To develop a critical pedagogy, it is not enough to reflect on the social contexts of everyday life: it is equally necessary to reflect critically on the relation of the pedagogic initiative *itself* to the norms that underlie these contexts. This is a major limitation of conventional behaviour change communication approaches. By simply identifying the structural constraints on behaviour without addressing the need to transform them, such approaches place the burden of change on individual responsibility in a manner that is unrealistic. Further, most behaviour change pedagogies are based on social scientific theories that are positivistic, in that they posit models of social existence that are then taken for granted. By not reflecting on the relation of these models to the system of norms that constrain social action, they implicitly normalize the models they posit.

*(c) Incorporating Critical Consciousness into Ways of Being* The Sonagachhi intervention also illustrates how the consciousness generated by a critical pedagogy needs to be realized in the everyday lives of people and incorporated into their embodied practices. This is especially important in AIDS pedagogy, which is not simply about knowledge of the virus but equally about techniques by which one prevents bodily disease. On this view, the body is understood as the principal site of power relations, both those that seek to subject people to an authority and those that seek to empower them. Embodiment and empowerment are in this context both individual and collective, as well as being both cognitive and performative, that is, simultaneously ways of knowing and of doing. As Bryan Turner remarks of embodiment, they are collective projects because they take place in lifeworlds that are already social, and need therefore be integrated into these lifeworlds or ways of being. Behaviour change communication strategies that focus on individuals alone, depending on what we may call "self-responsibilization", fail to appreciate how the change must be incorporated (literally, as *corporeal* techniques) into the collective life of subjects in order to transform both behaviour and the context in which it happens. There is a reciprocal relation between reflection on the contexts of one's existence and ways of being, in which each animates and is capable of transforming the other.

The social understanding of disease is no doubt structured by norms that determine how it is experienced individually and collectively as reality. Individual experience, as we have seen in Chap. 2, acquires significance through shared meanings of what counts as significant. But the norms regulating the meaning of disease also undergo transformation, as the shifting constructions of AIDS show. The understanding of AIDS as devastation, thus, is now replaced, even if not entirely, by one that views it as a chronic but manageable illness. The availability of antiretroviral therapy certainly plays an important role in this transformation, but equally important is the collective self-identification of the HIV-positive as persons *living* with HIV and AIDS. What this suggests is that personal experience of disease, collectivized as a shared way of being, is capable of changing social perceptions. The meaning of disease, as Rosenberg argues, is the outcome of patients' experience as much as it is of the expertise of medical professionals and public health policymakers, and the experience of patients can transform it.

*(d) Objectifying Epistemologies and Subjective Experience* Behaviour change pedagogies in the HIV/AIDS epidemic are usually based on large-scale studies of the knowledge, attitude and perception of subjects regarding sexuality, like the Behaviour Surveillance Surveys and Integrated Behavioural and Biological Assessments conducted by the National AIDS Control Organisation. Such surveys, it is held, can provide quantifiable data to be used as empirical tools for designing interventions, based on the assessment of specific risk-practice frequencies. However, as Carlos Cáceras notes, there are certain limitations to the use of such

quantitative data. The responses may be subject to biases due to inaccurate recall ("recall bias") or the influence of social norms that favour certain types of responses and suppress others ("social desirability bias"). More importantly, they tend to oversimplify the actual complexity of human sexual behaviour and how it is understood: "the heterogeneity of specific sexual acts, the variety of ways persons refer to them, and the variability of their contexts, make it difficult to fully understand sexual behaviour and risk-taking on the basis of responses to a few seemingly simple questions" (Cáceras 2000, p. 250). Corresponding to these techniques of quantification in behaviour research is what Cecil Helman points out as an assumption underlying medical assessments of normalcy:

> … it is assumed that normality can be defined by reference to certain physical and biochemical parameters such as weight, height, haemoglobin level, blood counts, levels of electrolytes or hormones, blood pressure, heart rate and so on. For each measurement, there is a numerical range within which the individual is healthy and normal. Disease is often seen as a deviation from these normal values, and accompanied by abnormalities in the structure or function of body organs or systems. (Helman 1981, p. 548)

The observations of Cáceras and Helman suggest that there are subjective dimensions of human experience, of sexuality or of disease, that objective methods of assessment fail to capture and that these dimensions are crucially significant in understanding experience. As modes of knowledge, both social science and biomedicine in such instances are founded on objectifying epistemologies that preclude subjectivity, because it is difficult to quantify and to interpret. Law too, as we have seen in Chap. 5, is objectivist, in its dependence on fact and its inability to resolve enigmas that challenge the privilege of factuality. When public health governance is driven by such positivist approaches in law, medicine and the social sciences, the social reality of disease that it constructs tends to be oversimplified and reduced to the empirical. *Teaching AIDS* emphasizes the importance of an approach to AIDS pedagogy that tries to overcome the limitations of objectivism, through resources in literature, philosophy, culture and the humanities. It thereby calls for a deeper critical engagement with the ideological assumptions underlying knowledge of the human – that is, what constitutes valid knowledge and the procedures that establish it as valid.

The distinction between "disease" and "illness" that Helman makes, and the significance he attributes to it for clinical practitioners, is intended to overcome the objectivist limitation we have discussed above and to make medicine more sensitive to the experience of the patient. A number of approaches to the practice of medicine have emphasized this need. More recently, Rita Charon has referred to the "deep-seated tensions within a contemporary bioscientific ethos that challenges the particular with the universal, the personal with the corporate, and the intimate with the mechanized" (Charon 2017, pp. 157–158). The objective of the "narrative medicine" approach that she and her colleagues have developed at Columbia University is to overcome these "tensions" through the resources of literature: "narrative medicine teaches the skills of close and attentive reading in order to better understand narrative competence and relationality and to explore their implications for healthcare" (Spiegel and Spencer 2017, p. 15). One of the goals of critical medical anthropology, write Hans A. Baer, Merrill Singer and Ida Susser in *Medical Anthropology and World System: A Critical Perspective*, is to "create a more humane health care system and more humane lives for all the people", by developing sensitivity to the personal dimensions of the experience of disease (cited in Strathern and Stewart 2010, p. 218).

The humanizing of medical practice, which is now a key emphasis in medical humanities curricula, has in my opinion two inadequacies, notwithstanding the immense benefits it has to offer. The first is its concern largely with the clinical context, which may be due to the increasingly professional and technoscientific nature of medical care in the West. One may reasonably say that the patient as a *person* is irrelevant to the contemporary practice of healthcare, which reduces the patient to specific organs that are scanned by machines and documented in diagnostic reports. The inclusion of the patient's subjective experience in clinical decisions is a way of reclaiming the "self" that such technoscientific medicine has erased. But this concern, however necessary, overlooks the problem of objectification in public health governance, where the subjective experiences that constitute the reality of disease are equally important in decision-making.

Secondly, given its location in the clinical context, the call for humanizing takes for granted the privilege of biomedicine to know the "truth" of disease, supplemented by perspectives from the humanities. The humanities, in other words, are limited to providing the medical equivalent of "soft skills", which clinicians need to establish, as Spiegel and Spencer put it, "a deeper rapport" with their patients and to open themselves "to the experience of another despite – or perhaps because of – the limitations of language" (Spiegel and Spencer 2017, p. 34). What they fail to see is that the limitations are not solely linguistic, but epistemological. Without underestimating the value of such use of humanities, we need to direct its resources in a more critical manner, to engage with the epistemological presuppositions of technoscientific medicine and the social hierarchies they tacitly serve. "Where scientific reason is the dominant cognitive authority", observes Andrew Ross, "its cultural and economic role in maintaining a social system of inequalities must be open to analysis and to reform in ways that go far beyond internalist adjustments and purifications" (Ross 1996, p. 174). This is not intended as an adversarial stance: medicine, law and the social sciences are all about what the humanities are centrally concerned with: understanding the human. The new insights that may be produced through a deeper engagement between these disciplines will be as useful for the humanities as it will be for the other disciplines. If interdisciplinarity, as we stated in Chap. 1, is "indisciplined", this indiscipline need not necessarily be seen as the destruction of order, but can make possible a reordering of new disciplinary concerns and insights that will enrich our ways of knowing ourselves and the world. What we need is a *critical* medical humanities that draws on the strengths of interdisciplinary knowledge, and *Teaching AIDS* is an effort in that direction.

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