

Framing the Epidemic: the case of UNAIDS

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HIV/AIDS is widely considered to be one of the most challenging issues of the 21st century. The critical nature of the problem, however, has not prompted international consensus around and a strong commitment to preventing its spread and treating those afflicted. Moreover, the extent of the problem varies greatly among states. A growing literature in international relations looks to socialization as a way to better understand how the international community tries to influence the resolution of domestic problems. Ongoing efforts by international organizations to address HIV/AIDS reflect a focus on the disease as a human rights issue, while states often have their own parochial understandings of both the nature of the problem and their obligations to address it.

In this paper, we examine the differences between the international discourse, as represented by UNAIDS, and national level discourses in Russia and South Africa. Through an examination of how the disease is understood by different actors at different levels, we argue that HIV/AIDS as a social issue is not best understood in a general frame of human rights as largely civil and political. Rather, Russia and South Africa have constructed alternative understandings of their roles in fighting the disease through denial, manipulation, and redefinition of the problem itself. Ultimately, these differences demonstrate that different kinds of rights require different kinds of framing and socialization processes, and that social rights differ from civil and political rights in fundamental ways that hamper the ability of UNAIDS to effectively impact change in some states.

Statement of the Problem

The pressuring nature of HIV/AIDS as an international health crisis requires no explication. As a health problem exacerbated by social inequality and lack of education, stemming its spread has proven to be a tremendous task. Its reputation as a disease of deviants – the promiscuous or drug-addicted – has not been entirely eradicated and continues to facilitate its spread. Specifically, HIV/AIDS as a health problem preys upon other social problems to reproduce itself, and this connects it closely to politics. By examining UNAIDS and contrasting its approach to the epidemic with national discourses in Russia and South Africa, we hope to locate disjunctures in how the disease is understood by different actors and assess how such differences affect strategies to prevent and treat it. In this section we will first offer a brief explanation of case selection, followed by a sketch of the epidemic in each country.

We chose Russia and South Africa due to a number of similarities. Both are regional powers that have recently undergone democratic transitions. This speaks to their relative lack of capacity and ongoing issues of institutionalizing social services. Both are federal, presidential systems that experience similar tensions between national leadership and regional priorities. Both have histories of oppression and status as ‘pariah states’ in world politics and thus have some degree of familiarity with international pressure being brought to bear regarding their behavior. While they share many similarities, however, they are at very different points in the spread of HIV/AIDS.

We hope that this key difference will help us identify and analyze different ways in which states respond to international socialization pressures. In this paper, we limit our comparison of Russia and South Africa to the early stages of the health crisis, which concluded in each country by the end of 2001.

The Epidemic in Russia

Since 1998, the number of reported cases of HIV in the Russian Federation has doubled each year. Between 1987 and 1998 there were only 10,993 officially registered cases of HIV-infection.¹ In 1999 the Russian Federation's Ministry of Health raised the total count to 23,502²; in November 2000, the Ministry announced an increase to 72,000³; and as of June 2001, 129,000 cases have been reported.⁴ Over the last three years, the Russian Federation experienced the highest rate of growth of HIV incidence in the world.

Moreover, many observers have noted the prevalence of underreporting in the Russian Federation. In 1998, the Ministry of Health itself estimated the number of unreported cases at 800,000.⁵ In 2000, Dr. Vadim Pokrovsky, head of the Russian AIDS Research and Prevention Center and the country's premier epidemiologist, estimated that 1.3 million people in the country were HIV-positive. At its present rate of growth, Pokrovsky believes that these "real" numbers will reach 3 million by 2003, and 10 million by 2005.⁶ Georgetown University Professor of Demography Murray Feshbach has made similar projections, calculating that HIV will infect 10 percent of the population of the Russian Federation by 2005.⁷ The explosion of the number of HIV-infections in Russia (and throughout Eastern Europe and Central Asia as well) is largely attributed to the prevalence of the disease among intravenous drug users (IDUs) of sharing contaminated needles.

Indicators suggest that intravenous drug use in particular is on the rise in Russia. First, the number of drug-related criminal convictions in the country has risen from 38,650 in 1995 to 216,000 in 1999.⁸ Second, the number of drug users per 100,000 inhabitants that registered at treatment centers has increased from 15.5 in 1995 to 41.8 in 1999. The proportion of heroin users among these drug users has increased from .004% in 1995 to 26.0% in 2000.⁹

¹ UNAIDS, *AIDS Epidemic Update—December 2001*, available at: http://www.unaids.org/epidemic_update/report_dec01/index.html.

² See Yablokova, Oksana, "Russia Says It Is Trying to Head Off AIDS Epidemic," *The Moscow Times*, November 30, 1999; "IN BRIEF: AIDS Cases Grow," *The Moscow Times*, July 24, 2001, p. 4.

³ Kester Klonegah, "Drugs Duty Called Grave Health Risk," *The Moscow Times*, December 21, 2001, p. 10.

⁴ UNAIDS, *AIDS Epidemic Update—December 2001*, available at: http://www.unaids.org/epidemic_update/report_dec01/index.html.

⁵ Veeken, Hans, Russia: Sex, Drugs, and AIDS and MSF, *British Medical Journal*, Vol. 316, No. 7125, (Jan. 10, 1998).

⁶ Kevin O'Flynn, "President Challenged to Boost AIDS Funds," *The Moscow Times*, July 24, 2001, p. 3.

⁷ Murray Feshbach, "An AIDS Catastrophe," *The Moscow Times*, January 14, 2000.

⁸ Dmitriy Pushkar and Mikhail Shevelev, "Criminal Problems," *Moscow News*, July 28, 1999. In this article, Alexander Gagarsky, chief of the Ministry of Justice Department for Statistics and Analysis is quoted, "A whole army of those convicted on drug trafficking and consumption charges is nothing compared with those awaiting trial on the same charges—there are twice as many of them."

⁹ UNDCP, Annual Field Report 2000-Russia, http://www.undcp.org/russia/report_2000-12-31_1_page003.html#C, March 16, 2002.

	1995	2000
Number of Registered Drug Users	155,974	451,603
Number of Registered Heroin Users	624	117,417
Percentage of Registered Heroin Users	.004%	26.0%

These figures not only demonstrate a growing number of drug use, but also a profound increase in the use of heroin—a drug taken intravenously.

The increase in the use of heroin has led to the staggering increase in HIV infection rates through the sharing of needles. Between 1987 and 1995, 28% of the people infected with HIV were IDUs. In 1996, 60% of new HIV infections recorded in Russia were IDUs. Since 1998, 90% of HIV infections in the country are IDUs.¹⁰

	1987-1995	1996	1999
Percentage of IDUs Among Reported HIV Cases	28%	60%	90%

The increase in percentages noted above shows that the primary mode of transmitting HIV is through contaminated needles. UNAIDS reports that an estimated 1% of the 147 million people living in the Russian Federation are intravenous drug users.¹¹ We are now seeing an epidemic of HIV infections among those 1.47 million people.

The spread of the disease from IDUs to other segments of the population is facilitated by the high percentage of IDUs who are well integrated into their local networks of family and friends. Thus, many observers of the epidemic in Russia have noted that the epidemic is by no means isolated among IDUs, who have transmitted HIV into their communities through sexual relationships.¹² As noted in a recent UNAIDS report, in the Russian Federation,

the vast majority of reported HIV infections are related to injecting drug use, which has become unusually widespread among young people, especially young men... Given the high odds of transmission through needle sharing, the fact that young people are also sexually active, and the high levels of sexually transmitted infections in the wider population, a huge epidemic may be imminent.¹³

¹⁰ Irina Krasnopols'kaia, "Delovoi Zavtrak: Glavniy gosudarstvenniy sanitarniy vrach Gennadiy Onishchenko: Ya p'yu vodu iz-pod krana," *Rossiiskaia Gazeta*, August 24, 2001, p. 8. See also UNDCP's annual field report on Russia (2000) and analyses of Open Society Institute's International Harm Reduction Development program, especially "Drug use in Eastern Europe and the former Soviet Union," available at http://www.soros.org/harm-reduction/frame_drug.htm, March 16, 2002.

¹¹ UNAIDS, *AIDS Epidemic Update—December 2001*, available at: http://www.unaids.org/epidemic_update/report_dec01/index.html.

¹² Atlani, Laetitia, Michel Carael, Jean-Baptiste Brunet, Timothy Frasca, and Nikolai Chaika, Social Change and HIV in the former USSR: the making of a new epidemic, *Social Science and Medicine*, Vol. 50, No. 11, (June 2000), pp. 1547-1556.

¹³ UNAIDS, *AIDS Epidemic Update—December 2001*, available at: http://www.unaids.org/epidemic_update/report_dec01/index.html.

While the number of cases of HIV infections in the Russian Federation is currently far fewer than the number in South Africa, the exponential increase of reported (and unreported) HIV infections in the last several years suggests that Russia stands at a critical point in preventing it from becoming an epidemic that is proportional with that of South Africa.

The Epidemic in South Africa

A country of about 40 million people, South Africa's biggest post-apartheid challenge has emerged in the form of massive HIV and AIDS infection rates across the country. While its population is split evenly between cities and rural areas, this has not insulated any geographic section of the country from HIV. South Africa has the largest number of HIV positive and AIDS infected people in a single country in the world. UNAIDS estimates that 19.94% of South Africa's adult population is infected.¹⁴ More than half are women: of 4.1 million adults with HIV, women constitute 2.3 million. Peak prevalence of the disease is found in women ages 20-29. Moreover, new infection rates in women are higher than those in men, especially for young women.

The predominant mode of transmission of HIV in South Africa is heterosexual intercourse. A particular problem for South Africa, however, is the lack of accurate behavioral surveys on patterns over time to identify pressure points at which intervention is most key, such as for certain age groups, frequency of condom use, and so on. What little data that is available on condom use demonstrates that in 1998, no more than 34.5% of men in any give province had ever used a condom (UNAIDS Epidemiological Fact Sheet, 2000). Rates for most provinces were lower. Moreover, these figures represent one-time usage, not that condom use is habitual.

The continuing spread of the disease in South Africa indicates that not only are there growing numbers of people sick and dying, but that the transmission of the disease has not yet reached its peak. What facilitates this in South Africa is a social problem - gender inequality. Four out of five HIV-positive women in the world live in Africa (Lawson, 1999). Sub-Saharan Africa is the only world region in which more women are HIV-positive or AIDS infected than men – 13.3 million women to 10.9 million men) (UNAIDS, Gender and HIV, 2000). Women are being infected at higher rates than men (12-13 new female cases for every 10 male ones), and are younger on average when they contract the virus (UNAIDS, Gender and HIV, 2000). Besides the biological reality that it is easier for a woman to contract HIV from a man during intercourse than vice versa, many problematic roles that are salient for women in developing countries have a major impact on their ability to control their sexual activity, especially in South Africa:

Rape Victims: There is a high coincidence between HIV and other STD's, which are also closely associated with rape and sexual violence, especially due to the likely presence of blood exchange when intercourse is

¹⁴ UNAIDS, Russian Federation, Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections—2000 update (revised), available at: http://www.unaids.org/hivaidinfo/statistics/fact_sheets/pdfs/Russianfederation_en.pdf.

forced.¹⁵ South Africa has the highest incidence of rape in the world. It is estimated that one of three South African women will be raped in their lifetime.¹⁶ There is significant evidence of both legal and medical indifference to this problem.

Research Subjects: As clinical trials are conducted into vaccines for or barriers against HIV and AIDS, the possibility for the exploitation of poor women increases. They may be easily lured into clinical trials with the promise of remuneration without full comprehension of the potential consequences of their participation. These trials are, of course, much easier to conduct in developing countries for these reasons.¹⁷

Sex Workers: As a rule, male clients refuse to use condoms. More generally, economic disadvantages faced by women – lack of land access due to traditional structures of ownership, dependence on absentee husbands who may have one family in a rural area and another in the city – force many women to turn to sex work to support themselves and their children. In South Africa, HIV infection among sex workers in the province of KwaZulu Natal increased from 50% in 1997 to 61% in 1998 (UNAIDS Epidemiological Fact Sheet, 2000).

Wives: Most HIV-positive women in the region are infected by their husbands, as women generally have less control over their own sexual activity than men do. Many women in the region are married to men who are older than they are, increasing the likelihood that a future husband has already contracted HIV (Lawson, 1999). Women who insist on condom use, suggesting infidelity, may also put themselves at greater risk for abuse.

Young Women: In parts of Sub-Saharan Africa, teenage girls have infection rates that are 5-6 times what they are for young men (UNAIDS, Fact Sheet: HIV/AIDS in Africa, 2000). There is also a myth about a cure for HIV in many places in Africa, in which a man who has sex with or rapes a virgin is thereby cleansed of the disease (UNAIDS, Gender and HIV, 2000).

While these roles are insightful in themselves, they are most crucial for their connections to the common problem that underlies them all - gender inequality. It will be difficult if not impossible to address each of these roles in a vacuum that does not consider the deeper attitudes that give rise to these roles and allow them to be perpetuated. Even UNAIDS advocacy of female condoms and the search for a microbicide against HIV (which is at least 3-4 years off), both female-controlled barriers to infection, does not get at the reasons why women are in the position of not being able to ask their male partners for cooperation.

While gender inequality underlies many UN agencies' concerns about HIV/ AIDS, this concern is not explicitly reflected in UNAIDS policy priorities. Worse, it is all but absent from the South African government's rhetoric and policies. The UNAIDS approach is a more technical/legal and cooperative one, and gender inequality is a social problem that would no doubt raise disagreements and problems that might hinder the organization's ability to act on less controversial fronts. Interestingly, this contrasts with the United Nations Development Fund for Women's (UNIFEM) recent statement that "the disease is a health issue, but the epidemic is not."¹⁸ Advocates

¹⁵ AIDS Law Project and Tswaranang Legal Advocacy Centre Conference, 1998, cited in "Women worst hit by AIDS," *Mail and Guardian*, Johannesburg, August 4, 2000.

¹⁶ P. Hawthorne, "An Epidemic of Rapes: Outrage Fuels a Protest Movement in South Africa," *Time*, November 1, 1999, p. 59.

¹⁷ "Women worst hit by AIDS," *Mail and Guardian*, Johannesburg, August 4, 2000.

¹⁸ M. Macan-Markar, "Health Rights: UN Sees Gender Concerns as Key in AIDS Fight," *Inter Press Service*, March 7, 2001.

within the UN are moving towards this understanding, but it will be a uphill battle: “Unless gender inequality, which rests on power relations, is specifically addressed in every strategy, policy, and program that is undertaken, from the global and governmental level to the community and family level, our efforts to reverse the epidemic will be stalled.”¹⁹

Theoretical Background

Both UNAIDS and the Russian and South African states are engaged in processes of framing the epidemic. Consequently, there are multiple discourses taking place, and it is insufficient to examine one or the other. It is this disjuncture, and the significance of it, which we seek to illuminate.

To understand the international context in which UNAIDS operates, we turn to the growing constructivist literature on international organizations (IOs) as performers of socialization processes. Current views of IOs see them alternately as teachers (Finnemore 1996), able to bring pressure to bear on states and influence behavioral conformity (Keck and Sikkink 1998; Finnemore and Sikkink 1998; Risse and Sikkink 1999), and constitutive social environments (Johnston 2000). All of these views highlight that importance of processes of socialization, in which states are encouraged to conform with the norms of the international community through processes of interaction, learning, and behavioral changes. This socialization can occur through shaming or backpatting (Johnston 2000), making connections between domestic groups and international actors to increase leverage and provide information (Keck and Sikkink 1998), organizational teaching and advocacy and the chance to reformulate state interests based on new information (Finnemore 1996), and arguing (Risse 2000).

The most specific and descriptive model of how these socialization processes take place in international relations is found in Risse and Sikkink’s (1999) spiral model. With an eye towards understanding how IOs and international actors have convinced states violating human rights to conform to international human rights standards, Risse and Sikkink elucidate five steps within processes of socialization. First, repression is brought to the attention of transnational networks, who disseminate the information. Second, states deny the validity of the norm or their accountability to it, which is followed by a third stage in which tactical concessions are made by the state to pacify objectors. Fourth, states achieve prescriptive status and accept the international norm, and fifth and finally they exhibit rule-consistent behavior. This process, as enabled and pushed by IOs and other international actors such as transnational advocacy networks, brings an end to the norm-violating behavior of states and molds their behavior to conform with international expectations.

The current approach of UNAIDS is consistent with this model, especially because UNAIDS is increasingly framing HIV/AIDS as a human rights issue. A joint policy statement by UNAIDS and OHCHR (Office of the High

¹⁹ Statement made by Stephanie Urdang, UNIFEM Advisor on Gender and HIV/AIDS, to the committee preparing for the upcoming special General Assembly session on HIV/AIDS to be held this June. See M. Macan-Markar, “Health Rights: UN Sees Gender Concerns as Key in AIDS Fight,” *Inter Press Service*, March 7, 2001.

Commissioner of Human Rights) made in 1998 (and reissued in 1999 and 2001) is structured around the connections between HIV/AIDS and human rights. The statement lists ‘international guidelines’ for state action in addressing the epidemic. These guidelines revolve around institutional capacity, responsibilities and processes; law review, reform, and protection; and the promotion of a supportive and enabling environment for civil society (HIV/AIDS and Human Rights: International Guidelines, 3). The document identifies political, civil, and legal obligations of states to address HIV/AIDS under the rubric of human rights. For example, these guidelines focus on the identification of ‘vulnerable populations’ and the need to ensure anti-discriminatory practices in dealing with people who have AIDS or are HIV-positive.

Yet health itself is not a civil or political right; it is a social right and covered by Article 12 of the International Covenant on Economic, Social, and Cultural Rights. The level of expectations around state safeguarding of economic and social rights reflects a much lower standard than that afforded to civil and political rights. The Covenant’s Article 12 describes the “right to the highest attainable standard of health,” and diffuses responsibility for this right. It advocates taking “into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health.”²⁰

An excerpt of a speech made by Kenneth Roth, Executive Director of Human Rights Watch, at the International AIDS Conference in Durban, South Africa in July 2000 makes this juxtaposition of civil and political with economic and social rights clear. Roth argued that current international efforts to address HIV/AIDS center on anti-discrimination and individual freedom. But these rights are less pertinent than economic and social rights, which require governments to advance basic rights to life necessities such as work, education, food, shelter, and health. But these are rights to which governments pay little attention, especially compared to civil and political rights. Roth continues:

Why do rights-based arguments seem so ineffective in convincing government to provide the resources needed to fight AIDS? The difficulty is best illustrated by contrast with a more classic rights-based appeal – say, a demand to stop torture. Even in countries that practice torture, torture is shameful. By exposing a government’s use of torture, we can shame the government to curtail this inhumane practice. So why can’t similar public shaming be used to force governments to devote the resources needed to fight AIDS? It can, but the process is not nearly as straightforward....The difficulty with invoking economic and social rights in that the duty to respect them is far more qualified than the duty to respect civil and political rights.

²⁰ “Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights,” General Comment No. 14 (2000), The right to the highest attainable standard of health, Article 12 of the International Covenant on Economic, Social and Cultural Rights.

Governments are expected to uphold civil and political rights immediately. Moreover, responsibility for doing so is assigned almost exclusively to the national government in question; there is no opportunity to pass the burden on to others. By contrast, the economic and social rights treaty allows its rights to be fulfilled gradually, over time. Each government is asked only to “take steps” to secure these rights, and to do so only “to the maximum of its available resources, with a view to achieving progressively full realization.” Moreover, the treaty assigns responsibility for compliance more broadly – not only to the immediate national government, but also to the international community as a whole, through the duty to provide “international assistance.” This gradualism and shared responsibility make it much more difficult to shame a particular national government for its poor state of health care...Governments can deflect criticism by blaming others. There is no easy way to move beyond finger-pointing. Or, governments can simply assert that their current contributions, stingy as they might be, are all they owe to meet the AIDS crisis. Again, there are no clear benchmarks by which to rebut these claims.

Consequently, there are three central problems with framing HIV/AIDS as a general human rights issue. First, it makes it difficult to identify what exactly a state is required to do about the epidemic. Second, it diffuses responsibility for the problem by and increases the state’s ability to merely claim that it is “doing everything that it can,” and this is hard to disprove. And third, it is underpinned by the assumption that as long as a state is doing something, no matter how small, it is making progress and more time can be allotted. In the face of the HIV/AIDS epidemic, more time is not a luxury that most people have.

Moreover, Risse and Sikkink’s spiral model is based on the logical starting point that states that are committing acts of norm violation that they should not and are subsequently pressured to cease. The model begins with a violation of human rights, therefore assuming a definition of rights as negative rights rather than positive rights. Negative rights are generally civil and political and require a state *not* to act in a certain fashion, while economic, social and cultural rights are generally positive rights that imply a state duty to take certain steps. Consequently, when states violate human rights the goal of the international community is generally to convince them to *stop* doing something – torturing political prisoners, outlawing free opposition and criticism of the government, assassination of opposition leaders, and so on. These are much more clearly defined tasks than the positive task of fighting HIV/AIDS, especially considering that the epidemic is enabled by different social factors in different contexts as argued in our statement of the problem in section one. The emphasis on human rights focuses the UNAIDS framing of the epidemic on factors such as non-discrimination, worker privacy, the right to have a family, and related issues. Recent fact sheets and press releases by UNAIDS²¹ also emphasize this legalistic notion of protection from HIV/AIDS. The UNAIDS discourse around HIV/AIDS and state behavior, then, focuses on trying to convince states to take civil and political actions – provide legal protections for the sick, ensure that people are treated equally, and have special concern for the rights of women and children. But as Roth makes clear, this strategy represents a disjuncture which does not get at the perpetuation of the epidemic itself. A closer examination

²¹ For example, see “Stigma and Discrimination Fuel AIDS Epidemic, UNAIDS Warns,” Durban, 5 September 2001; “Fact Sheet: An overview of HIV/AIDS-related stigma and discrimination,” available at www.unaids.org.

of the discourse around HIV/AIDS at both the national and international levels will help clarify this disjuncture and show how different conceptualizations of positive and negative rights play out in public discussions.

The aforementioned approaches to socialization, however, are also underpinned by an important assumption which limits their efficacy in understanding not how IOs present issues, but how states respond to them and participate in socialization processes at the national level. Control of the socialization and discursive processes mentioned above is assumed to lie at the international level. States are more subject to these processes than they are participants in them. Moreover, they are unidirectional and assumed to have positive outcomes over time. Risse and Sikkink's (1999) spiral model describes a process through which states are slowly drawn into conformity; Finnemore and Sikkink (1998) describe norm life cycles as emerging, cascading, and becoming internalized; dissent is ultimately eradicated and the results are assumed to be positive.

In practice, however, discourse and therefore socialization are not unidirectional and determined; these processes may just as easily be ineffective and subverted as result in complaint behavior. To see how this may happen, we argue that national discourses around HIV/AIDS must be examined and understood as well as the international efforts to socialize state behavior. A crucial part of efforts to socialize states is discursive; negotiations, policy summits, action plans and strategies, and pressures to conform are communicated through particular linguistic choices that can tell us a great deal when closely examined. Consequently, we argue that processes of socialization described by constructivists as instigated by IOs are fundamentally discursive in nature; much is gained and lost in dialogue among international actors and states under pressure. Processes such as arguing, teaching, and pressuring all require an ongoing dialogue in which actors speak about their goals and perspectives in different ways. How – and which - issues are presented in discourse thus has a crucial impact on the outcome of discursive interactions and, in turn, on national policy strategies toward HIV and AIDS.

To analyze discourse, we rely on Milliken (1999), who elucidates three central claims about the importance of discourse in international relations. First, it reflects systems of signification that tell us about power and the construction of social reality. Second, it is produced to help define subjects authorized to speak and to account for what constitutes knowledgeable practices. Third, discourse is by nature incomplete, fluid, and overlapping. This last point raises the issue of discourse as the “play of practice” (Ashley 1989; Doty 1997) in which discourse is an active, ongoing process that opens space for change, discontinuity, and variation (Doty 1996). If socialization takes place through discourse, then it is a complex, layered process of interaction, which has no guaranteed outcomes.

As the cases of Russia and South Africa show, there exists a disjuncture between the UNAIDS discourse of human rights as primarily civil and political and their particular national understandings of the problem. The Russian case is characterized by initial denial followed by a focus on lack of state capacity, while the South African discourse focuses on whether HIV causes AIDS and limits on what policies the state will establish. This conflation of issues reflects the undetermined nature of discourse and therefore socialization, especially when the application of human rights operates in a bifurcated fashion. Both countries seek excuses for a lack of action under the cover of

social rights while UNAIDS pushes civil and political obligations. While this may be a strategic choice on the part of UNAIDS, Russia and South Africa do not share the same outlook and instead construct competing national discourses. Both countries simultaneously claim compliance with UNAIDS guidelines for state action and divert public attention away from clear information about the epidemic. Clearly, political elites in each country are manipulating discourse and actively reshaping what is perceived as their duties to protect rights. Russia is located in the region currently experiencing the most rapid increase of infection rates and South Africa is home to largest number of HIV-positive citizens in the world. HIV/AIDS is not the same problem in each country, nor is it understood in the same way. But in both cases the differences between national and international discourses will show that different kinds of rights – positive instead of negative – require a reconsideration of socialization processes with different logical starting points.

Case Studies: Russia and South Africa

This section will describe the discourses in each state as distinct from the international discourse reflected by UNAIDS. We rely on policy statements, public pronouncements and debates, statements and press releases by political elites and activists, court cases and the public discussion of them, and newspaper articles and press commentaries as reflective of the discourse in each case. As such, we have used process tracing and discursive analysis as our methods of illustrating the evolution of how HIV/AIDS is understood in our two cases.

Russian Federation: Denial and Questions of State Capacity

UNAIDS has framed the epidemic as a human rights concern. It has charged states with the responsibility to both protect their citizens from the threat of HIV infection and provide treatment for AIDS victims. However, the following overview of official statements and debates within the Russian Federation (and its Soviet predecessor) demonstrates that a very different set of priorities defined discussions on HIV and AIDS. These debates have been (and continue to be) relatively uninfluenced by calls of UNAIDS and other international actors to fight HIV/AIDS in the name of protecting the political and civil rights of their population. Rather, the government of the Russian Federation has approached the growing epidemic within its borders first by denying its importance and then, recognizing the threat it poses, claiming incapacity to address it.

(i) Denial

Between 1993 and 1995, the state started the national program, “Anti-AIDS,” to combat the spread of HIV and coordinate the treatment of AIDS. Working in collaboration with a number of AIDS centers, at the federal, regional

(*oblast'*), and district (*raion*) levels,²² this program seemed to signify that the government was prepared to aggressively stem the spread of HIV infection. The fact that the program was renewed and placed under the auspices of the Ministry of Health in 1996 and mandated to operate through 2000 appeared to demonstrate the government's continued political commitment to address the threat posed by the disease.

However, before and after its 1996 renewal, Anti-AIDS continued to receive no funding from the government. Rather than prove political commitment, Anti-AIDS' lack of funding signaled the central government's dismissal of the disease. Moreover, the center conveniently passed off the financial burdens of prevention and treatment to the regional and district levels.

In the budget plan expenses for the program 'Anti-AIDS' have been contracted, although it's already been officially acknowledged that the AIDS epidemic has begun in Russia. In the CIS republics, above all in Ukraine, the number of HIV-infections has also sharply increased...many of them seek recourse in Russia. Several subjects of the Federation propose providing medical examinations for AIDS, but where will the money come from? Expenditures to the Office of Supervision of Epidemics have been reduced 13 percent in comparison to last year. Every time, when it is necessary to carry out medical examinations of the sick who have contacted it, [the Office] makes an appeal to the leaders of the region in order to be allotted special funds for it. The creation of a center to fight AIDS is greatly wanting. Our government, as if on purpose, 'closes' its eyes to the real threat to our country. Naming a public health service is the growing priority at the same time that it erases this sphere from financial documents by the most barbarous means.²³

As illustrated in this passage, even as late as 1997 the state is perceived as unwilling to devote the necessary resources to combat HIV and AIDS. The national government is accused of "closing" its eyes to the burgeoning epidemic, shedding its responsibilities to lower levels of the state. While the center possessed financial incentives to avoid addressing the disease, we see below that denial was due to a combination of factors.

First, during the late Soviet period officials tended to dismiss the possibility that HIV and AIDS would grow to the same proportions as it had in Western Europe and the United States based on ideological grounds. Many officials stated that, while isolated pockets of the Soviet population might become afflicted, the disease would not spread into Eastern Bloc countries. As James Riordan and Igor Kon (1993, p. ?) have noted, some members of the Soviet political elite treated HIV and AIDS as "a Western problem, with overtones of retribution for bourgeois depravity, and accusations against the CIA for unleashing the virus through an experiment gone wrong." Even if many officials may not have believed these charges, the fact that serious attention to the disease was subordinated to Cold War rhetoric suggests that few deemed it a potential public health threat.

Second, supported by low official counts of HIV infections, many officials flatly denied the degree of the epidemic, declaring that it constituted at best a secondary health concern. In December 1992, the newspaper

²² These include the Russian Federal Scientific and Methodological Center on AIDS Prevention (in Moscow), the Russian Federal Clinical Center on AIDS Prevention (in St.Petersburg), 6 Territorial AIDS Centers, and 86 Regional AIDS Centers. In addition, two academic institutions also work in partnership with the state and UNAIDS—the State Research Institute of Family and Education and the State Research Institute of Narcology in Moscow. See UNAIDS, ????.

²³ "Katastrofa meditsiny. Budget-98 opasen dlia zdorov'ia," *Pravda*, October 22, 1997.

Nezavisimaya Gazeta reported that, “Minister of Public Health, Andrei Vorobyov has publicly stated several times that the threat of AIDS is frequently exaggerated by both the news media and specialists themselves. In Mr. Vorobyov’s opinion, Russian health care, which is currently being forced to economize on everything, should focus its attention on combating more widespread diseases...”²⁴

Even as late as 1997, public statements by leading officials suggest a denial of the threat that HIV infections posed to public health. A commentary entitled “Flu is more dangerous than AIDS” shows how officials’ predisposition to focus on *existing* numbers of those infected by HIV, rather than on the *potential* means by which the disease could spread:

The epidemic in Russia has already begun. We have in the country already more than 5 thousand infected with this terrible illness, and with each month the rate [of infection] doubles... First Secretary of Ministry of Health—the main state sanitary doctor of the Russian Federation—Gennadiy Onishchenko made a statement about this at a press conference at Rostov-on-Don. ‘But AIDS is not the most menacing epidemic to befall Russia,’ noted Gennadiy Onishchenko. According to his comments, tuberculosis and flu hold first place in terms of rate of transmission and loss of population. [But] in Russia this winter an outbreak of the unseen virus [HIV] is expected, which, as usual in its initial cycle, will harm the most defenseless—children and the elderly.²⁵

Based on low numbers of reported cases of HIV infection, officials throughout the early and middle 1990s continued to place other health concerns before prevention of the spread of HIV.

A third factor concerns the nature of the disease itself—that HIV could only infect those members of society who engaged in deviant behavior. When the disease first emerged in the late 1980s in the Soviet Union, it was largely spread through homosexual intercourse. It was widely believed that the HIV infections would therefore remain within that subset of the Soviet population. Soviet Deputy Health Minister, Nikolai Bergasov, for instance, is known to have boasted that HIV/AIDS would not penetrate into the Soviet Union because homosexuality was illegal (Zimmerman 1997).

In addition, statements of recrimination by officials—that contracting the disease was a consequence of engaging in illegal activities such as homosexuality, drug use, or prostitution—had the effect of associating people who were infected with HIV with criminal behavior. Accordingly, victims of HIV/AIDS came to be treated by the state as threats to public order. Moreover, the state engaged in “stigmatizing members of groups thought to be of high risk rather than targeting high-risk behavior” (Berkley 1996), reflecting a predisposition to identify groups within its population rather than particular behaviors as its point of focus. Focusing on groups and not on behaviors that spread the disease misdirected state efforts (to the extent that there were any) to address the problem.

A retrospective glance in a recent article suggests that the association between HIV/AIDS and criminality also supported the illusion of security within the population:

²⁴ Cited in *The Current Digest of the Post-Soviet Press*, Vol. XLIV, No. 49 (1992), p. 31.

²⁵ Fakty i Kommentarii, “Gripp—strashnee SPIDa,” *Rossiiskaia gazeta*, October 17, 1997.

Since the first AIDS case was registered in Russia 13 years ago, the country, trying to protect itself against the disease, has gone from one extreme to the other. At first we were lulled into a false sense of security by the view that AIDS only struck the dregs of society, and we could just look on as drug addicts, homosexuals, and prostitutes died off. A decent, well-behaved individual was safe, we thought. Yet, this drastic and far-from-humane tactic failed dismally...²⁶

At the same time, this association likely reduced the number of voluntary screenings for HIV infection, keeping official counts deceptively low. Similarly, the state's policy of public, compulsory HIV screenings between 1987 and 1995, during which 165,470,049 Russians were subjected to mandatory testing by the state, has probably deterred a significant number of people living with HIV from getting testing.

Thus, a mutually reinforcing set of factors about HIV and AIDS in the Russian Federation before 1998 supported the state's denial of the threat of an impending epidemic. Over-reliance on inaccurate official statistics, a conviction that the Eastern bloc was immune from HIV outbreaks, and an assumption that the disease affected only those who engaged in deviant behavior combined to relegate the disease to a secondary or even tertiary health concern.

(ii) Questions of State Capacity

As the numbers of officially reported cases began to rapidly increase in 1998, the discourse surrounding HIV shifted, however, from a position of denial to one that understands the epidemic as seemingly insurmountable. Statements by public officials, activists, and the media within the Russian Federation have construed HIV prevention as a challenge that demands far more resources than the state possesses.²⁷ Since 1998, the debate has come to center on questions of available funds, coherent institutions, and the extent to which the state's administrative apparatus can reach. In short, the debate has centered on state capacity.

In the wake of a growing rate of reported HIV infections in 1998, a primary change in the state's fight against the disease was an infusion of funds to Anti-AIDS. While Anti-AIDS received 21 million rubles (US\$800) (of the 35 million it was promised),²⁸ some continued to charge that, despite its new funding, the program was

²⁶ Marina Sokolovskaya, "Scourge of the Century Takes its Tragic Toll," *Moscow News*, May 24, 2000.

²⁷ This is not to say that the Russian state is not, in fact, a weak state. The outbreak of HIV/AIDS has occurred concurrently with massive political and economic transformations that rapidly dismantled Russia's socialist healthcare system. Privatization and other "shock therapy" prescriptions have left much of the Soviet state apparatus without financial support. The lack of medical supplies, paid professionals, and resources for research, training, and development in the medical sciences has significantly circumscribed the range and level of medical treatment in Russia. Since 1991, Russia has had a declining birth rate from 13.4 births per 1000 people to 9.4; mortality rates among men are nearly triple that of the European average; and life expectancy generally declined from 64.9 years in 1987 to 57.1 in 1995 (Powell 1998).

²⁸ The Synergy Project, "The Russian Federation and HIV/AIDS," available at: http://www.synergyaids.com/files.fcgi/570_Russia5.pdf, March 17, 2002.

poorly coordinated with other governmental and nongovernmental agencies.²⁹ Pokrovsky declared that the program was operating at five percent of the funding it was due, and that the Ministry of Health needed to “involve broad sections of the population, high school teachers, and university professors.” Moreover, he noted that local coffers were empty, forcing AIDS centers at the regional level to request “cap-in-hand” funding from the Ministry of Health to treat AIDS.³⁰

Even the head of the Bureau for the Fight against Illegal Circulation of Drugs MVD, Aleksandr Sergeev, weighed in decrying the lack of funds available to counter rising drug use that was promoting HIV infection: The federal program for the fight against drug use has been adopted, but not one kopek [red cent] has been spent from 1995-1997...The adoption of a new program for the years of 1999-2001 is also, as of today, not funded by a single ruble.”³¹

As one reporter claimed, “First Deputy of the Ministry of Health of Russia, Gennady Onishchenko set forth in an assembly the unpleasant map of the spread of HIV-infection. But a clear national policy towards this problem of Russia is not visible—AIDS concerns official deputies and leaders where it is less [important] than political struggle and budget passions.”³²

The health ministry’s representative to the Russian Center for AIDS Prevention and Control, Dr. Irina Savchenko, sought to counter growing criticism as early as December 2000 by stating that the government was doing its best within its financial constraints. She also noted that greater focus on HIV prevention would undermine the government’s ability to address other health concerns.

Q: Why, in your opinion, are state authorities and politicians so slow to adopt a more dynamic approach to combat the spread of AIDS?

A: Just consider all the health problems alone that the state must tackle: tuberculosis, birth defects, the rise of sexually transmitted diseases, etc. It is impossible to single out the HIV virus alone and treat it at the expense of other illnesses—that would lead to other disasters. I think, given the situation, the authorities have done their best, but it is still not enough. The cost of AIDS research, diagnosis, and even screening donated blood is already too high...We are optimistic that the political authorities will give priority to the prevention and treatment of AIDS. After all, when the disease threatens to play havoc in our society, it is only appropriate for us to ask for more financial resources to combat the disease.³³

By the middle of 2000, however, Russia was experiencing soaring rates of HIV infections. In less than a year the Kaliningrad oblast’ gained 500 new cases, AIDS centers in Moscow were registering 100 new HIV-positive patients

²⁹ See Svetlana Sukhaia, “SOS. SPID idet lavinoi. Epidemiia VICH-SPIDa v Rossii uje prevratilas’ v real’nyu ugrozu nashei natsional’noi bezopasnosti,” *Trud*, December 21, 2000, p. 1. Sukhaia argues that, apart from Anti-AIDS, the Ministry of Science began its own program to develop a vaccine. She calls for “a capable, central management organ” to better unify efforts in the fight against HIV and AIDS.

³⁰ Marina Sokolovskaya, “Scourge of the Century Takes its Tragic Toll,” *Moscow News*, May 24, 2000.

³¹ Svetlana Sukhaia, “SOS. SPID idet lavinoi. Epidemiia VICH-SPIDa v Rossii uje prevratilas’ v real’nyu ugrozu nashei natsional’noi bezopasnosti,” *Trud*, December 21, 2000, p. 1.

³² Tatiana Bateneva, “Jivi, no pomni. Mirovoe soobshchestvo ozabotilos’ edinoi strategiei bor’by so SPIDom,” *Izvestia*, June 27, 2001, p. 3.

³³ Kester Klomegah, “Battling AIDS,” *The Moscow Times*, April 29, 2000.

a day, and the regions of Buryatia doubled its number of cases in a month. In all of Russia, the total number of cases of HIV increased by 7,080 between October 1 and November 1, 2000.³⁴

The explosion of cases in such a short span of time and the increase in criticisms prompted the Ministry of Health to reveal the staggering total of 74,000 HIV victims at an international conference in November 2000. Within the month, the Duma held hearings on HIV prevention. Responding to charges of ineffectiveness, the State Duma recommended to the government of the Russian Federation that a national program be designed for the fight against AIDS between 2002-07, and the creation of a central commission on the social aspects of infectious diseases (including HIV/AIDS, tuberculosis, and hepatitis) and a centralized federal agency to collect donated blood.³⁵

In 2001, federal funding to fight HIV infections and for AIDS treatment was raised to approximately 120 million rubles (US\$4 million).³⁶ Yet this increase in funding has not shifted the focus of public debate. Pokrovsky among others have begun to question not the amount of money allocated, but how it is spent.

The public is really worried about HIV/AIDS, but for some reason the politicians are busy with other things... There are many dubious expenditures by our government. In many cases money spent on HIV/AIDS could be more effective... I spoke to Prime Minister [Mikhail] Kasyanov about it and he said, 'Yes, yes. We understand. It's a very important problem.' But there was no change in the HIV/AIDS budget. I doubt the president is even aware of it.³⁷

The extent to which the debate over state capacity generally, and the allocation and use of funds more specifically can be seen in the fact that Peter Piot, head of UNAIDS was forced to address the question during his visit to Moscow in 2001. "'We are not asking for the moon. These are things that don't cost a lot,' he said as he outlined an anti-AIDS program for Russia. AIDS should be addressed as a national security issue by the top political leadership, he said. 'Human resource limitations are one of the obstacles to economic growth,' Piot said."³⁸ Piot's statement illustrates the challenge that confronts UNAIDS in Russia: how to direct the focus of concern onto questions of state capacity while maintaining pressure on the country's political leadership.

South Africa: The roots of AIDS and reactions to it

In contrast with the framing of the issue by UNAIDS in terms of human rights, especially civil and political rights, the perspective taken by the South African state can be gleaned from state level discourse around HIV and AIDS as

³⁴ Figures compiled *Itar-Tass Weekly News* reports: "Kaliningrad registers 3,000th HIV infection victim," July 6, 1999; "Kaliningrad region registers 3,493 HIV-infected people," May 19, 2000; "More AIDS victims in Buryatia," October 16, 2000; "Russia has 21,572 infected with AIDS virus: Health Ministry," October 28, 2000.

³⁵ Yekaterina Ignatova, "Rossia peregnala Afriku. Po tempam rasprostraneniia SPIDa RF vyshla na pervoe mesto v mire," *Sevodnia*, November 22, 2000, p. 6.

³⁶ Robin Munro, "HIV Spreading Fastest in Ex-Soviet Bloc," *The Moscow Times*, November 29, 2001, p. 1.

³⁷ Robin Munro, "Politicians Urged to Address AIDS," *The Moscow Times*, November 30, 2001, p. 4.

³⁸ Robin Munro, "Politicians Urged to Address AIDS," *The Moscow Times*, November 30, 2001, p. 4.

well as its stated policy priorities. What will be clear is that there is a major disjuncture between the discourse of human rights proffered by UNAIDS and the ways in which HIV/AIDS is understood in the South African discourse. A close look at the political discourse in South Africa shows the pervasive nature of contradiction and confusion around not only whether HIV causes AIDS, a long-dead issue for the international community, but an ongoing paralysis as to what exactly to do about the epidemic. Moreover, many articulated internal understandings of how to address HIV and AIDS in South Africa do not even line up with state leaders' own priorities about the most important steps to take.

In line with UNAIDS recommendations, South Africa has created a National Strategic Plan for HIV/AIDS. Its four stated policy priorities are as follows:

1. Prevention (promote safe and healthy sexual behavior, improve management/control of STI, reduce MTCT [mother-to-child transmission], blood transfusion, post-exposure services, improve access to voluntary testing and counseling);
2. Treatment care and support (in health facilities, in communities, for children/orphans);
3. Research, monitoring, and surveillance (AIDS vaccine development, investigate treatment and care options, policy research, regular surveillance); and
4. Human rights (create appropriate social, legal, and policy environment). (AIDS in Africa: Country By Country, 2000)

These policy priorities, while general, are designed to serve as guideposts in the creation of more effective means to fight the spread of the epidemic. Apart from a few isolated examples, however, these stated priorities are not being implemented in policies, nor are they reflected in the national discourse among political elites surrounding the action they are taking on the disease and what people should do to protect themselves.

One specific example of the government's attempt to implement these priorities can be found in increased condom distribution. The South African HIV/AIDS and STD Directorate touts its success at increasing condom distribution as follows:³⁹

Distribution of Male Condoms (in millions)	1992	1993	1994	1995	1996	1997
Dept. of Health	20	40	40	60	79	170
Social Marketing	0	1	1	2	4	6
Commercial	8	8	8	8	8	8
Total Condoms	28	49	49	70	91	184

While on the surface this appears to be quite an achievement, there is a lot of information missing from this chart. Later on in the report – and with much less prominence – even the Health Ministry acknowledges the nature of the

³⁹ Source for table: Report on Condom Use in South Africa, South African Ministry of Health website, www.health.gov.za/hiv_aids/redhot.htm.

problem with these figures: “The fact is, however, that condom distribution figures do not necessarily mean an increase in condom use.”⁴⁰ Little behavioral data on condom use is available, and factors such as the high prevalence of rape in South Africa and gender inequality more generally suggest that actual condom use is in serious need of more research. This deficiency highlights a lack of state capacity to do more than make condoms available, and as will become clear in the following description of state discourse, the absence of a unified message about the importance of using them. In this example, policy and public discourse are inconsistent; condoms are available, but there is little emphasis on creating conditions under which they may become widely used (such as the empowerment of women).

South African President Thabo Mbeki’s skepticism about the connection between HIV and AIDS is the stuff of nightmare to many activists internationally and in his own country. In January of last year, Mbeki made a phone call to California biochemist David Rasnick, who argues that AIDS is not caused by a virus and that the antiretroviral drugs employed in treating HIV are toxic. After a late night of surfing the Internet and discovering the theories of AIDS dissidents – those who argue that HIV does not cause AIDS – Mbeki wanted to find out more for himself and, according to Rasnick, is “determined not to blindly follow the conventional scientific wisdom on AIDS and its treatment.”⁴¹

This interaction led to months of confusion over what Mbeki really thinks about the link between HIV and AIDS, and consequently what kinds of policies he will and will not pursue in its prevention and treatment. The most public example of his dissidence was reflected at the International AIDS Conference in Durban in July of 2000. Mbeki stated that poverty is the cause of AIDS, and has consistently questioned the ability of a single virus to cause immune deficiency and AIDS.⁴² This led, in part, to a closing speech by former President Nelson Mandela in which he urged Mbeki to focus on treating the disease itself and not to conflate the scientific issues involved. Emphasizing the need to provide mother-to-child transmission treatments, increased education and awareness, and research into a vaccine, Mandela stated that, “I am...old enough and have gone through sufficient conflicts and disputes in my lifetime to know that in all disputes a point is arrived at where no party...will be totally in the right or totally in the wrong. Such a point has been reached in this debate.”⁴³

This debate did not, however, lead to a clearer government stance on the HIV-AIDS connection. The Congress of South African Trade Unions (COSATU), a major ally of Mbeki’s African National Congress (ANC), criticized Mbeki and the ANC heavily for their failure to clarify the link between the virus and the disease. COSATU President Willie Madisha minced no words in a public statement on the issue: “For COSATU the link between HIV and AIDS is irrefutable, and any other approach is unscientific and, unfortunately, likely to confuse

⁴⁰ Report on Condom Use in South Africa, South African Ministry of Health website, www.health.gov.za/hiv_aids/redhot.htm.

⁴¹ T. Masland and P. King, “Flirting with Strange Ideas,” *Newsweek*, April 17, 2000, p. 36.

⁴² R. Swans, “Focus on AIDS Epidemic, Mandela Says,” *New York Times*, July 15, 2000.

⁴³ “Wise Madiba [Mandela’s Xhosa name] Rebukes Mbeki Critics,” *Global News Wire*, South African Press Association, July 14, 2000.

people.”⁴⁴ An internal ANC document was leaked to the press, in which ANC leaders called for Mbeki and his Health Minister to make the link between HIV and AIDS clear.⁴⁵ In response to criticism, the government took the unprecedented step of placing television ads that stated that the president and his cabinet “have never denied a link between HIV and AIDS.”⁴⁶

Yet inconsistencies continued to flood the South African discourse. In an interview with Time magazine, Mbeki stated that there are “a whole variety of things that can cause the immune system to collapse. Endemic poverty, the impact of nutrition, contaminated water... repetitive infections of malaria, ordinary STD’s...all of these will result in immune deficiency.”⁴⁷ Mbeki’s Health Minister, Manto Tshabalala-Msimang, continued to refuse giving a yes or no answer to the question of whether HIV causes AIDS: “I never said it does not, so I don’t know how this question arises. It baffles me.” She added that, “I’m not a baby. I’m not a child, I’m not a schoolgirl. I know how to phrase my answers...I really don’t want questions of yes or no.”⁴⁸ By October, Mbeki announced that he would reduce his public role in addressing the epidemic and designated a team of three cabinet ministers to deal more directly with relevant policy questions. This did not come, however, with any sort of clarification on his position. “The government’s announcement...that Mr. Mbeki was reducing his role in the debate came too late to lift many South Africans’ deepened confusion about AIDS and its origins.”⁴⁹ In addition, his judgment has been questioned by the US and possible donors, not to mention the potential consequences for his presidency.

But the story does not end there. In January of 2001, Mbeki’s AIDS Advisory Panel issued its report on the status of the epidemic in South Africa. The report, however, was not made public until April.⁵⁰ Because the 33-member panel was split almost evenly between dissident and mainstream scientists, it was unable to reach any clear conclusions as to whether HIV causes AIDS or make unified policy recommendations to the government. While many saw this as a way for Mbeki to save face, it nonetheless represented a squandered opportunity to gather information and make recommendations that best fit South African concerns and realities. The anticipated lack of clarity of the report led some leaders to call for the disbanding of the panel.⁵¹

When the report was finally released in early April of 2001, the results were just as confusing as anticipated. Conventional scientists recommended improved public awareness of safer sex methods and better screening practices for infected blood. Dissidents advocated government employment of alternative treatments such

⁴⁴ N. Bramdaw, “Madisha Opposes Mbeki on AIDS,” *Johannesburg Business Day*, September 19, 2000.

⁴⁵ M. Harvey, “Health Minister Offers No Challenge to Mbeki’s AIDS Stance,” *Africa News*, WOZA Internet, Johannesburg, September 18, 2000.

⁴⁶ D. Shapshak, “South African government takes out AIDS ads,” *United Press International (UPI) report*, Johannesburg, September 15, 2000.

⁴⁷ D. Shapshak, “South African government takes out AIDS ads,” *United Press International (UPI) report*, Johannesburg, September 15, 2000.

⁴⁸ “Government Again Challenged on AIDS,” *Global News Wire*, South African Press Association, September 18, 2000.

⁴⁹ R. Swarns, “Comments on AIDS Weaken Mbeki,” *New York Times*, November 1, 2000.

⁵⁰ There is some speculation that the report was withheld due to sensitivity over the physical condition of Nkosi Johnson, age 12, who as young boy dying of ADIS spoke at the International AIDS Conference in Durban urging the South African government to provide access to treatment. See M. Harvey, “Government keeps AIDS panel report secret,” *Africa News*, WOZA Internet-Johannesburg, January 19, 2001.

⁵¹ M. Harvey, “DA [Democratic Alliance] Calls on Mbeki to Disband AIDS Panel,” *Africa News*, WOZA Internet-Johannesburg, March 19, 2001.

as ginseng, Chinese cucumber, and garlic to boost immunity to AIDS, and methods such as massage therapy, yoga, spiritual care, and music and light therapies to address the detoxification of the body.⁵² Dissident scientists also put forward alternative explanations for the epidemic, including conspiracies between condom producers and medical supply manufacturers and World Bank desires to give loans for AZT and condom purchases to ensure poverty in Africa and the continued hegemony of the West. One dissident scientist went so far as to argue that there are really only 75,000 people in Africa with AIDS.⁵³ Democratic Alliance party leaders expressed the concern that association with such “crackpot” theories reduces South African credibility in the international community and harms its ability to address the epidemic constructively.⁵⁴ Interestingly, however, the government response to the Panel’s report was that the goal was never to achieve consensus on anything, and that the report would have “no effect on current AIDS policy.”⁵⁵

Mbeki’s February 9, 2001 State of the Nation address was another source of disappointment for those seeking clarity on the issue. Focusing in part on service delivery and poverty alleviation, he mentioned AIDS once. This prompted varying responses from political leaders. Opposition Leader Tony Leon stated that it was “bizarre” that Mbeki could make such an important address and barely gloss over the issue of AIDS. On the other hand, Inkatha Freedom Party Leader Mangosuthu Buthelezi described Mbeki’s words as “unifying.”⁵⁶ On the issue of a single mention of AIDS, he queried, “How many times should he mention it?” and asserted that, “There is no issue that supercedes poverty.”⁵⁷

What are the potential consequences of Mbeki’s unclear stances and the government’s refusal to clarify the link between HIV and AIDS? Some potential problems have already been mentioned; Mbeki has lost credibility in the international community and with donors and states with the resources to help if political will is present.⁵⁸ He has generated disagreement within his own party about the nature of his objections to mainstream scientific explanations of HIV and AIDS, not to mention the objections of other political players. On a more practical level, however, others have already raised concerns that the lack of a clear statement on the disease encourages individuals to behave as if the transmission of HIV was not cause for concern. Democratic Alliance spokesman on AIDS Kobus Gous expressed concern that the Health Minister’s refusal to clarify the link gives license to South African to continue with unsafe practices and puts obstacles in the way of NGO prevention initiatives, stating that

⁵² “Government Releases AIDS Panel Report,” *News Wire*, South African Press Association, April 4, 2001.

⁵³ M. Harvey, “DA [Democratic Alliance] Calls on Mbeki to Disband AIDS Panel,” *Africa News*, WOZA Internet-Johannesburg, March 19, 2001.

⁵⁴ M. Harvey, “DA [Democratic Alliance] Calls on Mbeki to Disband AIDS Panel,” *Africa News*, WOZA Internet-Johannesburg, March 19, 2001.

⁵⁵ “Government Releases AIDS Panel Report,” *Global News Wire*, South African Press Association, April 4, 2001.

⁵⁶ “South Africa: Party Leaders ‘mainly disappointed’ with president’s speech,” *BBC Worldwide Monitoring*, February 9, 2001.

⁵⁷ “South Africa: Party Leaders ‘mainly disappointed’ with president’s speech,” *BBC Worldwide Monitoring*, February 9, 2001.

⁵⁸ Even South Africa’s main daily newspaper, the *Mail and Guardian*, gave Mbeki a D in its “2000 Report Card,” down from an A- in 1999 and in no small measure due to his “ill-advised and stubborn involvement in the HIV/AIDS controversy.” See “The Good, the Bad, and the Ugly: The 2000 Report Card,” *Mail and Guardian*, Johannesburg, December 22, 2000.

“We [Democratic Alliance members] find this immoral.”⁵⁹ Even more specifically, “AIDS counselors say they now encounter people who assume they can engage in risky sexual behavior, because the president and scientists he supports have minimized the role of HIV and suggested that poverty, more than a factor contributing to AIDS in Africa, is its direct cause.”⁶⁰

The South African government has been an obstacle not only to clear understanding of the issues surrounding HIV and AIDS, but also regarding access to antiretroviral drugs. While the recent lawsuit brought by 39 drug companies in South Africa to protect patent laws was dropped, this does not mean immediate, easy access to treatment. While other African countries such as Kenya have seized on the dropped lawsuit as an opportunity to procure generic drugs that may violate patent laws, South Africa has not. Mbeki has repeatedly refused to declare AIDS a national emergency; if he were to do so legal issues around access to generic drugs would lessen and make it easier for the government to provide cheaper drugs. “The irony is that there is a logical consistency to this madness. For, if Mbeki were to declare a health emergency, he would have to abandon his views that poverty eradication and not the spread of HIV is the greatest challenge in combating AIDS. You cannot declare a medical emergency against poverty.”⁶¹

Moreover, the South African government still refuses to provide widespread access to drugs for the prevention of mother-to-child transmission, despite the demonstrated efficacy in clinical trials and in their use in other countries. Guidelines issued by Health Minister Tshabalala-Msimang in October of 2000 denied the drugs to pregnant women and to rape victims.⁶² Recently, the national government made the treatment available in a handful of selected areas, but it has repeatedly refused to make it more widely available, peppering its position with pleas for patience. Dr. Nono Simelela, the head of the national government's AIDS program, made public statements arguing that South Africa already has the region's largest MTCT program, and that the government needed more time to assess its program before expanding it.⁶³ Current distribution reaches about 10% of women who give birth each year, and the national government is appealing a High Court ruling of December 2001 that ordered the expansion of the program. Mbeki reportedly objects to the treatments because they are toxic, echoing Rasnick's statements about antiretroviral drugs and diverging from UNAIDS concerns about the possible development of drug resistant strains of the virus in women. Drug companies also claim that South Africa has ignored or refused past offers for reduced price or free drug supplies. For example, Boehringer Ingelheim has offered a free five-year supply of drugs that halt mother-to-child transmission of HIV, which has been refused by the South African government.⁶⁴

⁵⁹ “Government Again Challenged on AIDS,” *Global News Wire*, South African Press Association, September 18, 2000.

⁶⁰ R. Swarns, “Comments on AIDS Weaken Mbeki,” *New York Times*, November 1, 2000.

⁶¹ “Smoke and Mirrors,” *Johannesburg Mail and Guardian*, March 15, 2001.

⁶² “UNAIDS, South Africa Issue Policies on Antiretroviral Use to Prevent Vertical HIV Transmission,” *Reuters Health*, October 25, 2000. Also available at www.hivandhepatitis.com/hiv/v10270007.html.

⁶³ R. Swarns, “A Bold Move on AIDS in South Africa,” *New York Times*, February 5, 2002.

⁶⁴ “SA Showdown on Who Has the Right to be Treated for AIDS,” *Sunday Business Post*, April 15, 2001.

The refusal of the national government to agree to the use of MTCT drugs has led Lionel Mtshali, the head of the provincial government of Kwa-Zulu Natal (the province with the highest percentage of people infected), to declare that the provincial government will provide the MTCT drug nevirapine to any pregnant women who wants it, regardless of whether she has even been tested for HIV. Mtshali said he could wait no longer: "Let's face it: It's a desperate situation. None of us in this province hasn't lost a relation to this pandemic. We can't fold our arms when people are dying around us...I live in this province," Mr. Mtshali said. "I have a responsibility in this province. I travel all over this province and I talk to poor people. They appeal to me in desperation. They say, 'What can the provincial government do to save the lives of people who are ravaged?'"⁶⁵ This confrontation reflects the immediate state of the epidemic for those who are faced with it every day. Hospitals in Kwa-Zulu Natal are understaffed, lacking space, and ill-equipped to deal with patients, whom they generally do not see until they are on the verge of death. Denial is still rampant among the sick. Even Nondumiso Khumalo, a 29-year-old nursing assistant in Hlabisa who has tuberculosis, refuses to acknowledge what is most likely happening to her, even though up to 70% of female TB victims there are HIV-positive. Instead, she argues, "I might be bewitched. I know I don't need an H.I.V. test."⁶⁶ Ellen Dube, one of the few HIV/AIDS counselors at Hlabisa Hospital in Hlabisa, says, "I don't dream. I don't cry. But I get migraines. It's what I feel when I visit the parents who are affected and I think, 'Will I myself be sitting there one day?'" This is my nation. The very generation that is supposed to be is dying."⁶⁷ This denial and frustration are only growing in the face of government refusal to take strong action – or even to make strong statements - against the epidemic.

It is clear, then, that there is a major disjuncture between the civil and political rights discourse of UNAIDS and the South African discussion of what causes the disease and whether to allow it to be treated. State denial of the connection between HIV and AIDS, its refusal to provide access to mother-to-child transmission drugs or declare a state of emergency as many other African states have done, and its unclear motivations in dealing with drug companies are complications that interfere with open dialogue on problem solving and prohibit addressing the underlying issues which facilitate the spread of HIV. The state cannot even clarify what it sees as the root cause of the epidemic, much less engage in the creation of a political environment in which an unambiguous strategy is taken to combat its spread. Under continuing pressure to articulate clearly the link between HIV and AIDS, Health Minister Tshabalala Msimang responded defensively, "What have we not done? We have done everything that has been put forward as a guide by UNAIDS or WHO on how to respond."⁶⁸ It seems that the state is not only confused about the causal mechanisms around HIV, but about its own implementation of a strategy to combat AIDS. Combining this confusion with a lack of capacity to implement those policies it has articulated reflects a serious set of problems for the state in combating HIV/AIDS.

⁶⁵ R. Swarns, "A Bold Move on AIDS in South Africa," *New York Times*, February 5, 2002.

⁶⁶ R. Swarns, "A South African Hospital Fights AIDS and Despair," *New York Times*, November 26, 2001.

⁶⁷ R. Swarns, "A South African Hospital Fights AIDS and Despair," *New York Times*, November 26, 2001.

⁶⁸ "Health Minister Corrects Mbeki's AIDS Claim," *Global News Wire*, New Vision, July 19, 2000.

What is unfortunate is not that Mbeki has spoken out about the importance of other factors in addressing HIV and AIDS, for the connections of poverty, other health problems, and socioeconomic conditions are crucial to understanding how HIV can go unchecked. The problem is twofold. First, rather than promoting a multifaceted, nuanced approach to the epidemic that addresses both immediate biological means of transmission and the larger social context in which they take place, state discourse has focused largely on the “Poverty causes AIDS” argument. Poverty and other contextual factors are obviously crucial to the spread of HIV, but they are not the biological cause of its contraction. This preoccupation causes uncertainty and encourages people to ignore the issue and behave as if HIV does not cause AIDS, with the agreement of the President. Second, in its effort to refocus the debate on social factors, it has largely ignored gender inequality as the most important social factor in the transmission of the disease in South Africa.

Concluding Thoughts

Through the examples of Russia and South Africa, this paper has shown how the international discourse of human rights served to undermine the effectiveness of UNAIDS to generate state compliance in two ways. First, framing the epidemic as a general human rights concern shifted attention away from social aspects of the disease that perpetuate its spread and focused on getting states to provide legal protections for the sick. Yet, it is precisely states’ failure to address these social problems—such as intravenous drug use and gender inequality—that enabled the disease to reach epidemic proportions. The focus on political and civil rights that is emphasized by UNAIDS is simply not the primary issue in most countries with populations afflicted by HIV/AIDS.

Second, the discourse of human rights promulgated by UNAIDS is not automatically replicated by state leaders in countries with high incidences of HIV and AIDS. This counters assumptions of unidirectional processes of socialization sometimes found in the study of international organizations. As we demonstrate in our case studies of Russia and South Africa, however, specific national debates on HIV/AIDS revolved around questions of state capacity and the cause of AIDS (respectively), enabling state leaders to put off compliance with UNAIDS indefinitely despite the burgeoning health crisis in their countries. Once the epidemic was framed in human rights terms, it was defined in international law as a social right, which requires states to *initiate* action to comply with international standards rather than cease actions that violate them. This has provided room for states to engage in a “play of practice” that led to an ineffective socialization process—and no substantial commitment by state leaders in Russia and South Africa to address the spread of HIV and AIDS in its critical early stages. As such, these cases suggest a greater need to recognize that different kinds of rights—positive versus negative rights—demand different understandings of socialization processes and a better appreciation for the influence of diverse discourses upon policy formation at the national level.

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