

The Power of Norms in Global AIDS Politics: The Role of the World Health Organization

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The developed countries in the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD) have converged in their behavior of foreign aid for HIV/AIDS. In accounting for the convergence of the global AIDS funding among the countries, constructivists in international relations theory would claim that the norms of global response to AIDS motivates foreign aid for AIDS by reshaping and redefining donors' identity and preferences. By the norms of global response to AIDS I mean "a high degree of consensus shared among developed countries that they are implicitly or explicitly obliged to financially contribute to the global fight against HIV/AIDS based on the sense of urgency of the global health catastrophe." I assume that the World Health Organization (WHO) played a significant role as a norms entrepreneur in developing the norms. With regard to a theoretical framework of international norms development, Ann M. Clark (2001) introduces the four stages of international human rights norms development (fact finding, consensus building, construction of norms and implementation of norms) and the role that Amnesty International played as a norms entrepreneur. I argue that her theoretical framework also works in explaining the development of the norms of global response to AIDS. In terms of methodology, I conduct process-tracing that explores how the norms emerged and developed by the efforts of WHO in the period of 1987 to 1993.

"GPA (Global Programme on AIDS)'s mission is to mobilize an effective, equitable and ethical response to the pandemic. It strives to raise awareness, stimulate solidarity, and unify world-wide action. Dedicated to strengthening the capacity of countries and communities to prevent HIV transmission and reduce the suffering of people already affected, it provides technical and policy guidance to governments, other agencies and NGOs. At the same time, it promotes and supports research to develop new technologies, interventions and approaches to AIDS prevention and care."

GPA Strategic Plan, 1994 – 1999

How can global AIDS politics be understood? Why do developed countries financially contribute to this global health issue? Who are the major actors that have influenced the resource-mobilizing and coordination-encouraging processes in the global response to AIDS? I argue that norms of global response to AIDS played a significant role in motivating or encouraging global AIDS funding and that the World Health Organization (WHO) was the organization that took a part in the emergence and development of the norms. By *norms of global response to AIDS*, I mean a certain level of consensus shared among developed countries that they

are implicitly or explicitly obliged to financially contribute to the global fight against HIV/AIDS based on the sense of urgency of response to the global health catastrophe. In this article, I explain how the norms of global response to AIDS emerged and developed strongly enough for developed countries to accept the ideas of seriousness and urgency on the global health issue and to feel obliged to respond to it. Most of all, I focus on the process that WHO initiated the global campaign against AIDS, specifically their efforts to develop and proliferate norms of global response to AIDS.

This article consists of four parts: a theoretical discussion, a brief summary of the advent of AIDS crisis, a description of the inaction period, and an analysis of how the norm of a global response to AIDS emerged. In the theoretical discussion, I introduce the framework used by Ann Marie Clark (2001) to describe the international norms dynamics of human rights with special focus on the role of Amnesty International. I contend that Clark provides a useful theoretical framework in grappling with the international norms of global response to AIDS, as well as international human right norms in general. Subsequently, I briefly introduce the history of the outbreak of HIV/AIDS in the early 1980s and show how the disease gradually gained attention on the global level. I trace the process

through which international society became aware of and responsive to the issue of HIV/AIDS. The next section deals with the stage of inaction – or even denial – of states on the issue of AIDS, both in the North and the South. In the final section, I explore stages of norms development and how the WHO has played a role in engendering attention of states with regard to global AIDS agenda. In doing so, I examine the history of WHO activities and official documentation dealing with this unprecedented international health crisis.

THEORETICAL ORIENTATION

In understanding the dynamics of international norms emergence, Clark (2001) provides an insightful theoretical framework which explains how nongovernmental organizations (NGOs) contribute to the development and implementation of international norms. For example, she argues that Amnesty International attempted to persuade nation-states to adopt the principled norms of human rights based on the invocation of right and wrong (Clark, 2001: 30). In doing so, Amnesty International was deeply involved in the process in which UN declarations and treaties have been built within the institutional context of the United Nations. The process was stratified into four stages: fact finding, consensus building, principled norm construction, and norms application.

The first stage of fact finding is the period during which information about specific cases of human rights violations is collected and publicized. During this stage, the information is interpreted with reference to the facts and normative principles of right and wrong. Clark articulates that “information about human rights abuses become a node around which clarification of existing normative standards can take place” (Clark, 2001: 33). At the second stage, consensus about the need for human rights’ norms is reached. For this, generalized patterns of human rights abuse are verified among member states by Amnesty International playing a part in enhancing awareness and engendering certain responses. It is problematizing facts with reference to human rights principles and consensus building on the need for norms that take place in this stage (Clark, 2001: 34).

At the third stage, legal standards are developed that “formally elaborate on principles of right and wrong” (Clark, 2001: 35). The role of Amnesty International is to be deeply involved in the negotiating process, determining the level of obligations of member states in specific human rights declarations and treaties from the drafting stage at the UN. Amnesty International “has regularly participated in debates and lobbying over what should be included, or excluded, over nuances of wording, and over the projected and actual implications of how new formal norms may be framed” (Clark, 2001: 35). At the last stage of norm application, the

norms are adopted and applied in nation-states, which consequently alter their human rights practices.

This theoretical framework is likely to provide some guidelines for understanding norms emergence in the global response to AIDS in that it highlights *who* are main actors, *what* the actors did, and *how* they acted at separate stages with specific focus on causal mechanism of human rights norms development. However, there are some caveats to keep in mind when applying this theoretical framework to the AIDS case study. First, it should be remembered that WHO is an intergovernmental organization (IGO), not an NGO. Unlike NGOs, the WHO is comprised of nation states and the causal mechanisms differ from those of NGOs as a result. Second, the attributes of the norms should be taken into consideration. Human rights norms are prohibitive: that is, these norms prevent states from undertaking certain actions or behaviors. In response to the AIDS epidemic, however, the norms tend to engender – or even enforce – certain types of actions (i.e., being committed to global AIDS prevention and treatment programs). In other words, they are prescriptive norms that encourage actors to behave in a certain way.

THE ADVENT OF THE HIV/AIDS CRISIS

On June 5, 1981 the Centers for Disease Control (CDC) reported five cases of *Pneumocystiscarini* pneumonia in homosexual males in Los Angeles in its publication *Morbidity Mortality Weekly Report* (MMWR) (CDC, 1981: 250 – 252; see also Slutkin, 2000; Chin, 2007; Merson, 2006). The increasing cases of Pneumocystis Pneumonia and Kaposi’s Sarcoma in gay communities in California and New York alerted the medical community that an unknown disease was proliferating among homosexuals (Mann, Tarantola & Netter, 1992). It did not take long until the CDC realized that this infection was not confined exclusively to homosexuals. The organization also noted that the various symptoms seen in patients actually originated from a compromised immune system; the disease was given the name *Acquired Immune Deficiency Syndrome*, or AIDS (CDC, 1982: 249 – 252).

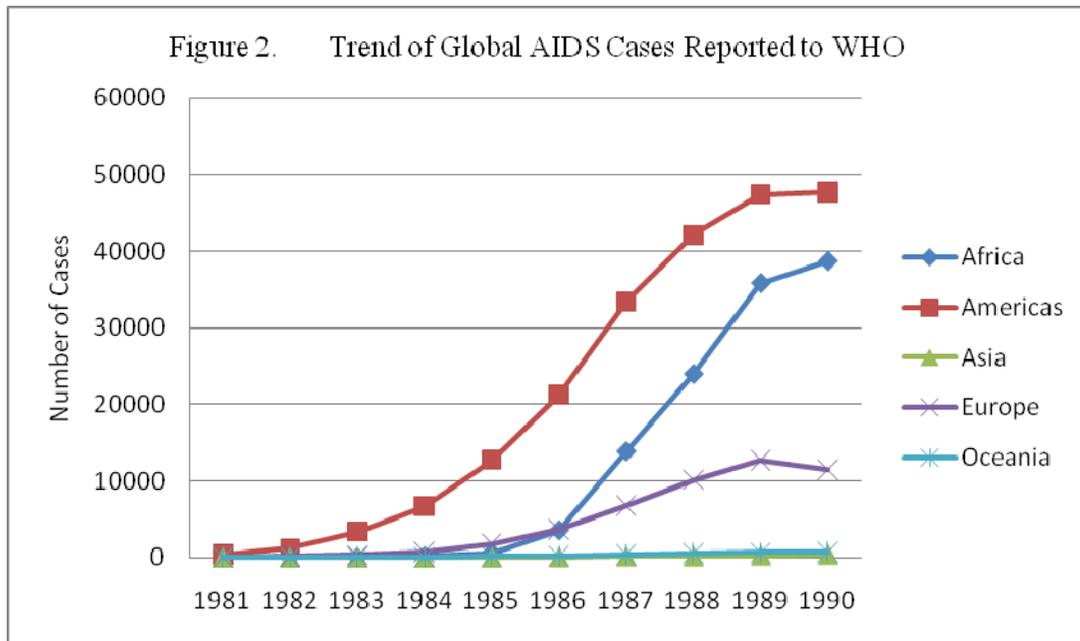
Having uncovered the cause of the disease, the next vital issue was to determine how the disease was transmitted. Scientists concluded that AIDS could be transmitted through sexual contact, blood sharing (either by therapeutic blood or by shared needles used for illicit drugs), or during the birth process (WHO, 1984: 424).¹ A handful of medical research institutions such as the National Cancer Institute (NCI), CDC and the Pasteur Institute played a critical role in conducting epidemiological research which helped the medical community reach consensus on the origin and transmission of AIDS (Lerner & Hombs, 1998: 3-5).

However, it was beyond their capacity to estimate the size and geographical distribution of AIDS infection

FIGURE 1. AIDS Cases Reported to the World Health Organization, by Year

Year	Africa	Americas	Asia	Europe	Oceania	Totals
1981	0	387	1	42	0	430
1982	3	1184	2	214	1	1404
1983	17	3380	8	291	10	3706
1984	187	6699	7	712	50	755
1985	579	12767	30	1820	135	15331
1986	3569	21249	71	3711	249	28846
1987	13882	33433	134	6839	409	54697
1988	23982	42115	150	10169	584	77000
1989	35838	47436	260	12701	664	96899
1990	38732	47732	407	11468	677	99016
1991	37580	21057	126	8211	267	67241
Totals	154369	237439	1196	56178	3046	445325

SOURCE: World Health Organization, “Update: AIDS Cases Reported to SFI Unit,” 1 October 1991.



due to their loosely organized network. For an accurate estimation, more systemic and collaborative approaches were necessary. According to the World Health Organization (1984: 422), “[B]y October 1983, 27 countries had reported a total of 3290 cases of AIDS, of which only 611 occurred outside the U.S.” Scientists realized that these seemingly small numbers were only the “tips of a gigantic iceberg of future deaths and suffering” but they could not figure out the real picture of AIDS.

As seen in Figure 1, the real picture of the AIDS problem failed to be captured in the 1980s and the early 1990s (WHO, 1991). First, the number of AIDS cases in Africa – which turned out to be the hardest hit region of the world – had been severely underestimated. In comparison with the Americas, Africa was depicted as having a less serious problem with AIDS. Second, as seen in Figure 1, the underestimation in Africa was particularly remarkable prior to 1986. As the chart demonstrates, the number of cases drastically increased

in 1986, which was accompanied by official acknowledgment of the problem of AIDS by African leaders. In short, the international community failed to figure out the state of AIDS prevalence at the early stage due to both a lack of networking capability and the willingness to report by national governments.²

Experts assumed that that AIDS would become a pandemic; thus, the disease was considered a socio-political issue that required the use of multidimensional approaches within a global context. Despite the implicitly recognized assumption of AIDS as an urgent global health catastrophe, inaction and denial were more predominant in regard to the global AIDS response. Each state, especially those in the developing world, was reluctant to reveal its own state of the problem or to respond explicitly and promptly to it even when having acknowledged the epidemic. Even worse, international organizations were not pleased to touch upon the issue, especially given certain social implications which made the issue an uncomfortable topic of discussion.

INACTION AND DENIAL

The initial response to AIDS can be characterized as inaction of the developed world in individual, organizational and state level as well as denial by the developing world. That is to say, the developed world possessed a lack of will to take the actions necessary to cope with the disease while the developing world did not even admit to having a problem with AIDS.

Despite the fact that the initial response to AIDS was made by the scientific community, feuds and competition existed among researchers and institutes over credit for being the first to discover the AIDS virus; therefore, their efforts did not lead to an international response to AIDS (Will, 1991: 199). Montagnier from France was the first individual to publish on the isolation of LAV in 1983, but the United States government gave an American, Gallo, credit for the first identification of HTLV-III later that year. The polemics also resulted in organizational level competition among NCI, CDC, and the Institut Pasteur for the AIDS research initiatives and additional resources based on the official recognition for first discovery of the AIDS virus.

The internal dynamics of international organizations also contributed to the lack of an early global response to AIDS. Officials were reluctant to place AIDS on the agenda because of its apparent connection with homosexuality, prostitution, and drug use. In addition, the WHO leadership did not have an appropriate perception of the global AIDS problem. The WHO Director of Communicable Diseases Division regarded AIDS as a disease of rich countries where most patients were identified and taken care of. Even the WHO Director General, Mahler, confessed that he had underestimated the state of the AIDS pandemic because

he thought AIDS was an American issue, thus there was no need to establish a global program designed exclusively for AIDS (Altman, 1986). Will (1991: 204) summarizes the dynamics of inaction to AIDS prevalence in this stage:

[t]he response to AIDS by the most important governmental agencies was dictated more by parochial organizational and personal interests than by a desire to serve the national interest... global institution building was constrained by IO officials who did not wish to take on tasks that could threaten the organization's record of success.

At the state level, the lack of action was also widespread in both developed and developing countries. Developed countries were reluctant to act on this issue because it did not help protect their own citizens. States were also worried that by joining the international AIDS prevention program, their sovereignty would be placed in jeopardy. In other words, developed countries were not pleased that their policy making process related to this issue would be open to the external intervention by cooperating with multilateral agencies. For example, the U.S. was not interested in internationalizing the issue of AIDS because its interests are to protect its own citizens in a situation where the largest portion of AIDS patients were thought to live in its territory. Meanwhile, American government did trace the route of transmission of AIDS to the United States because they wanted to attribute their own substantial incidence of AIDS cases to other continents in order to remove attention from themselves. In the end, the U.S. government placed official blame upon Haiti by arguing that Africa was discovered to have a high number of AIDS patients and Haiti had a close connection with Africa (Moore & LeBron, 1986). This resulted in ruthless blood sampling from African patients and exaggerated the scale and extent of AIDS in Africa. Will (1991: 89) points out the rationale of the U.S. behavior:

[a]s the country with by far the largest concentration of AIDS cases, the US faced the prospect of itself being the main target of health sanctions or restrictive measures... the US, if not sanctioned, then encouraged research and press reports that over-dramatized and exaggerated the incidence of AIDS in Africa. Moreover, if it could be shown at the same time that US was not "responsible" for causing AIDS, then so much the better.

From the virological and epidemiological point of view, research contributed to the domestic goal of the U.S. government to protect their citizens from the disease. The knowledge collected by researchers was used to develop domestic prevention programs for the health security of their own citizens. However, the U.S. was not thinking about investing their budget in

stemming the spread of the disease at the global level (Will, 1991: 88-89). Other developed countries like Germany and France, with national traditions of generous development assistance programs for global health, did not participate in the initial global AIDS response despite relatively high cases of AIDS in their own population. It can be said that their fear of losing national sovereignty outweighed their tradition of providing development aid.

The problem in the southern hemisphere was one of denial. Basically, states in the South, located mainly in Africa and Southeast Asia, are incapable of coping with the internal AIDS problem by themselves due to the lack of resources. The main reason why such states, especially African countries, hardly admitted the outbreak of the disease was that they were ashamed that AIDS apparently originated in Africa. Western states tended to accuse Africans of having unclean customs and practices, which they claim led to the origination and transmission of the virus (Will, 1991: 136). In contrast, Africans treated AIDS as a Western disease, one that was spread by homosexuals (a practice that was considered rare in Africa). Thus, they believed that the disease was transmitted by western tourists (Fortin, 1988b: 609). They were reluctant to speak on this issue for fear that their tourism industry and other foreign investments would be damaged. The Africans' complaints were exemplified in the international conference on African AIDS in Brussels in 1985. Only 50 African delegates attended this conference, but they boycotted all of the presentations. In addition, they declared that there was no decisive evidence on the African origin of AIDS (Norman, 1985: 1140). Given this denial, Kingman (1988: 20) estimated the number of AIDS cases in Africa was actually ten times the reported number.

During 1984-1985, AIDS awareness grew in the northern hemisphere, as leaders saw the disease as a threat not only to their countries but also to Africa. During this same time period, however, African leaders grew more rigid in their denial of the existence of AIDS (Will, 1991: 136). It wasn't until 1986-1987 that African leaders officially recognized the problem of AIDS and requested assistance from the international community. Following the 1985 Bangui meeting where nine African leaders gathered to assess the threat of AIDS, the first regional conference on AIDS was held in Brazzaville in March 1986. Leaders from every African nation were present. At this conference, participants officially recognized the seriousness of domestic AIDS problem and adopted a set of recommendations for action: *Recommendations for a Plan of Action for AIDS Control in the African Region of WHO* (WHO, 1986a). The report contained the first blueprint for the structure of the National AIDS Control Programs (NACPs) and the National AIDS Committee (NACs) (Will, 1991: 151). In addition, the 1986 World Health Assembly became a real wake up call to the U.S.

and Europe to participate in global action against HIV/AIDS when the Minister of Health in Uganda announced that his country was in serious trouble due to the spread of the disease.

WHO AND THE DEVELOPMENT OF A GLOBAL RESPONSE NORM

As mentioned above, it was the scientific community that initiated medical and epidemiological investigations on AIDS. However, the scientists and researchers failed to mobilize international attention on this issue because they were interested not in stemming the disease; instead, they were racing to build a reputation as the discoverer of a seemingly scientifically significant virus. Furthermore, leading institutes – NCI, CDC and the Pasteur Institute – also did not play a role in bringing the issue to the forefront of the international agenda. Instead, these institutes worked to serve the interests of their individual countries rather than cooperating to build a global program. In the end, it was the World Health Organization that became obligated to coordinate the global fight against AIDS. While WHO did not voluntarily launch a global AIDS program, it was assigned the responsibility to coordinate efforts because of its mission to direct a generalized global health agenda.

First Stage: Fact Finding. WHO's first response was to convene three international consultations on AIDS in 1983. These three meetings served three purposes: to exchange information from an epidemiological and virological perspective, to analyze the current state of the disease, and to examine the social impact of AIDS. The first meeting was held in Washington and was co-sponsored by the CDC, Pan American Health Organization (PAHO) and National Institutes for Health (NIH). The second meeting, held in Aarhus, Denmark, was cosponsored by the European Regional Office (EURO), the Danish Cancer Society, and the European Organization for Cooperation in Cancer Prevention Studies. In these first two consultative meetings, participants exchanged information about AIDS from both medical and social perspectives and attempted to establish a foundation for further global meetings. As a result, a third international meeting was held in November 1983 in Geneva, Switzerland, under the auspices of WHO. During this meeting, 38 public officials from 19 countries gathered sharing information and ideas to figure out the situation of AIDS at the global level (Will, 1991: 205 – 206).

WHO continued its information sharing activities after the meeting, including a special international forum where participants could exchange epidemiological and medical knowledge of AIDS. Its most significant accomplishment was the first International AIDS Conference which took place in Atlanta in April 1985. WHO co-sponsored the

conference with the CDC and the U.S. Department of Health and Human Services. It was the first official international event that exclusively targeted HIV/AIDS. Approximately 3,000 scientists, public health officials, and journalists from 50 countries gathered for the purpose of sharing knowledge of virology and epidemiology of AIDS (Mann, Tarantola & Metter, 1992; Chin, 2007: 197; Will, 1991: 144 – 145; Behrman, 2004: 15). In addition, WHO set forth plans for a Programme on AIDS from 1986 to 1987.

As a result of WHO's use of international meetings to collect information and data about AIDS, state leaders gradually became aware of – and alarmed by – the deadliness of the disease not only at the domestic level, but globally. One year after the First International AIDS conference, the First Meeting of Potential Donors for the Prevention and Control of AIDS was convened in Geneva in April 1986. Participants pushed WHO to coordinate the response to the global AIDS epidemic and to create an administrative unit within WHO headquarters (WHO 1986c). Responding quickly to this mandate, Mahler formally established the AIDS Control Program the following day: April 23, 1986 (Will, 1991: 146).

WHO hosted a subsequent meeting for a group of potential donors to review the CPA's proposed plan of action and its estimated budget (WHO, 1986b). The CPA³ was replaced by the official Special Program on AIDS (SPA) in February 1987. The SPA was established as a separate program under the direct subdivision of the Director General of WHO. The establishment of the WHO's special AIDS program was formally endorsed by the 40th World Health Assembly under *Resolution WHA40.26* (Will, 1991: 147). In short, WHO made an effort to collect the data and information about AIDS through international forums, which led to enhancing awareness of the disease and developing a sense of urgency for response within the international community. SPA was assigned several significant tasks, ranging from research, information gathering and dissemination to designing national AIDS program and training people that are required for implementing the program.

Second Stage: Consensus Building. WHO played a vital role in building consensus within the international community in order to coordinate the response to the global health crisis. WHO problematized the AIDS issue by hosting international forums. For example, the First International AIDS Conference was a breakthrough because the international community was awakened by the information shared during the conference. Participants became aware of the general picture of AIDS and overwhelmed by a very depressing picture in terms of treatment and prevention:

[h]opes for a quick vaccine were put to rest; mortality rates for HIV-positive individuals were

raised from the incredulously optimistic 5-20 percent; incubation periods, from the time of infection to actual AIDS, were not predicted at an average of 5.5 years and in some cases reaching 14 years; the spread of AIDS in Africa was occurring so rapidly it could not be linked to any risk group or behavior; and finally, the cost of AIDS to society, alone in the US, would begin to approach \$50 billion in a few years time (Will, 1991: 145).

The Conference was a breakthrough in that the end result was a growing awareness of the urgency of the problem. Above all, the Conference was extremely significant because it started the discussion over the issue of establishing special collaborating networks for global response. This was possible because the WHO provided a chance for concerned participants to gather and share information about medical knowledge, social impacts, and prospects. Furthermore, WHO played a role in framing AIDS as a crisis that required a special cooperative response at the international level.

The establishment and subsequent activities of GPA were a significant leap forward in the consensus building response to AIDS. Following the first International AIDS Conference, a WHO Consultation was convened to discuss the creation of a collaborating network of AIDS research organizations. The consultation suggested a proposal for a concrete action plan that included the creation of a *collaborating center*. This center convened a series of meetings in Geneva during September and December 1985 to design programs to deal with the AIDS issue. These programs included: the exchange of information; the preparation and distribution guidelines, manuals, educational materials for the public; an assessment of commercially available LAV/HTLV antibody test kits; the development of a simple, inexpensive test for field applications; the establishment of WHO reference reagents; cooperation with Member states to develop national programmes/actions for the containment of LAV/THLV infection; advice to member states on provision of safe blood products; and the coordination of research on therapeutic agents and vaccines and simian retroviruses. Most of all, WHO was assigned the responsibility in the whole AIDS control and prevention programs (WHO, 1986d: 37 – 46).

During the summer of 1986, the establishment of a global program on AIDS was approved during meetings by participating parties and WHO staff launched their activities for a global AIDS campaign (Will, 1991: 208 – 212). Subsequently, WHO recruited Dr. Jonathan Mann to create a special WHO program to deal exclusively with the global issue of HIV/AIDS. In the aftermath of the second International Conference on AIDS held in Paris in June 1986, WHO created an office to design WHO's strategic plan for responding to AIDS. With the formal establishment of the Special AIDS Program (SPA)⁴ in January 1987, international

collaborating activities emerged rapidly and extensively in terms of donors' contribution and development of strategies for treatment and prevention.

Despite general budgetary curtailment of whole UN system – and more specifically WHO – in 1987, the Global Programme on AIDS showed remarkable development in regard to the number of staff and the size of budget. The number of staff skyrocketed from two to 150 by the end of 1987, and to 225 in 1988. In terms of the budget, it also grew rapidly from \$5 million at the outset to \$23 million in 1987 with subsequent growth to \$50 million in 1988, \$90 million in 1989, and up to \$100 million in following three years (Behrman, 2004: 48; Will, 1991: 208 – 209). WHO gained a significant reputation in a global fight against HIV/AIDS.

This was possible because GPA obtained an implicitly independent status from the overall WHO system despite its explicit status as a sub-system of WHO. This independence can be attributed to the remarkable commitment and leadership of Dr. Mann. Dr. Mann persuaded Halfdan Mahler, then Director General of WHO, to provide full support the global fight against AIDS. Mahler credited Mann for his change in attitude from indifference and ignorance to having “energy, commitment and creativity to the even more urgent, difficult, and complex task of global AIDS prevention” (Behrman, 2004: 44).

The role of Dr. Mann should not be disregarded in global response to AIDS. Mann's perception of the AIDS issue was that it was “a global problem which requires international solidarity” (WHO 1992). First, Mann attempted to bring his view of AIDS to the forefront in various international gatherings. He took advantage of the meetings as a platform for enhancing recognition of AIDS worldwide, urging all members in international society to cooperate and share strategies in the global battle. For example, he had an opportunity give an address at the Fourth International Conference on AIDS in Stockholm, Sweden, in June 1988. In the presentation, he established the norms of global response to AIDS by encouraging national and international efforts against AIDS and mobilizing people and financial resources through resolute commitment to interdependence, communication, and justice (WHO, 1988a: 10).

Second, Mann's influence can be found in GPA's global strategy. With the full support of WHO's director general, Mann attempted to implement a global strategy. Mann's work from 1986 was adopted as SPA's basic strategy by the World Health Assembly in 1987. Based on the *Global Strategy for the Prevention and Control of AIDS* (WHO, 1986b), Mann initiated the first step, *surveillance*. He did not trust the official national estimates of AIDS infection from developing countries due to the absence of a reliable international network of experts to confirm the data. Therefore, he

attempted to build domestic surveillance capacity by providing resources and techniques and deploying experts to collect data.

The next step was *prevention* – which was to support development and promotion of national AIDS programs at the country level. Mann visited various countries to meet politicians and public health officials; he wanted to ensure that they understood the urgency of enhancing public recognition of the risks associated with HVI/AIDS and to launch prevention programs. In other words, “GPA was making countries acknowledge the disease, but much more than that, it was making them devise and pursue strategies to combat it” by developing an international collaborative network (Behrman, 2004: 50). Mann also provided resources to the countries that decided to launch national AIDS programs, both in the form of short-term programs (6-12 months long) as well as medium-term programs that lasted four to six years (Behrman, 2004: 46; Mann, 1987; WHO, 1988b).

The third step was to frame the impact of the disease within a larger social context – one that extended beyond health. Mann realized that the disease had a negative impact on communities that were already marginalized: prostitutes, homosexuals, and drug users. Public policies that focused on mandatory testing, quarantining, and/or imprisoning these marginalized individuals kept them underground and made it harder to control the spread of the disease. Mann attempted to establish a comprehensive strategy that encompassed human rights, social equality and development. For Mann, HIV/AIDS could not be stopped without approaching it with a broader social context (Behrman, 2004: 47).

By 1990 – mainly due to Mann's efforts – GPA was working with over 80 percent of the world's countries through a variety of activities including data collection and surveillance. It was also providing financial support to over 130 nation-states and was lobbying the developed countries to mobilize additional resources. Slutkin (2000: 30) noted that “[T]he years 1987 to 1990⁵ had been years of great inspiration, idealism, hope and action, and were characterized by the leadership of the international effort by Jonathan Mann.” Behnman (2004: 15) also appraises the roles the WHO had played through which HIV/AIDS gained recognition as “a public health emergency of international significance.”

Third Stage: Construction of Norms of Global Response to AIDS. Many of the WHO and UN resolutions spelled out the theme of obligations to the global society, especially the financial obligations of the developed countries in response to AIDS. WHO's first resolution was created to increase awareness about AIDS among WHO member states. The member states requested that Dr. Halfdan Mahler, Director-General of

WHO, prepare the official WHO report on its AIDS activities. It was the first official WHO report on AIDS activities and was presented to the executive board in November 1985 (WHO, 1985). The Executive Board examined the report and decided unanimously to endorse it. At the same time, the board adopted a draft resolution, *Resolution EB77/ R12*, on the global AIDS program (WHO, 1986e). At the subsequent 39th World Health Assembly, member states endorsed the draft of the executive board's AIDS resolution, *Resolution WHA39.29*, as the first official WHO resolution on AIDS in May 1986 (WHO, 1986f).

The 40th World Health Assembly adopted the Global AIDS strategy in May 1987. In the resolution *WHA40.26*, GPA was officially endorsed as the global strategy and programme structure to combat AIDS (WHO, 1987a). In the resolution, WHO confirmed that it would continue to fulfill its role of directing and coordinating the global, urgent and energetic fight against AIDS. WHO identified its role as a global actor which would encourage other members in international society to cooperate with the agenda. It endorsed the establishment of a SPA as a special institutional apparatus that designed global strategy and programme structure.

The report also highlighted the roles of member states. First, the states were required to “cooperate fully with one another in facing this worldwide emergency within the context of the policy of technical cooperation among countries through the adoption of compatible programmes and transfer of appropriate technology” (WHO, 1987a). They were encouraged to accept the program and share information on AIDS and related infections in full openness. Most of all, the member states were urged to make voluntary contributions – both cash and in-kind – for the implementation of the global strategy. In sum, the report called for states to respond to the global crisis through collaboration such as sharing information or abiding by the programme suggested by WHO. Member states were also obliged to make a certain financial contributions (WHO 1987a).

A resolution pertaining to the global AIDS response was also adopted at the UN level. Following a speech by Dr. Mann at the U.N. General Assembly, the United Nations passed a formal resolution on AIDS on October 26, 1987. The resolution made AIDS a high priority and called it one of “the central issues of our time in demanding global solidarity” (UN, 1987). Also, the General Assembly recognized the “established leadership and the essential global directing and coordinating role of WHO in AIDS prevention, control and education” (UN, 1987).

In January 1988, WHO – in coordination with the government of the United Kingdom – organized a World Summit of Ministers of Health, the largest meeting yet with 117 health ministries in attendance (Behrman, 2004: 48). During this meeting, the London

Declaration on AIDS was announced; this declaration calls for “the full opening of channels of communication in each society; the forging of a spirit of social tolerance through information, education and social leadership; and the protection of human rights and dignity in AIDS prevention programme” (WHO, 1988c: 7; Mann & Kay, 1991).

In sum, WHO attempted to construct international norms for a global response to AIDS by establishing resolutions at the level of WHO and the United Nations. Although the resolutions do not place legal restrictions upon the member states, the countries are bound by international norms that encourage or recommend certain behaviors that would not otherwise occur in the global response to AIDS.

Fourth Stage: Implementation of the Norms of Global Response to AIDS. WHO has made efforts to implement the designed strategies. Implementation consists of mobilizing NGOs and devising a particular funding scheme for donor countries. In fact, one of the most remarkable roles that WHO has played in the implementation of a global AIDS strategy was to mobilize NGOs. GPA made every effort to engage them by organizing relationships with the NGOs. GPA realized the NGOs were the inevitable elements that should be included for successful a global AIDS program given that “the organizational environment was complex; a great variety of organizations could potentially be involved, including NGOs active in health care, training, development, education, women/youth issues, etc” (Will, 1991: 217). The coordination with NGOs was also indispensable in that NGOs had more efficient and proficient local access for successful program implementation. Gordenker, Coate, Jönsson, and Söderholm (1995: 89) commented that “GPA could provide technical and financial support to governments but in spite of virtually worldwide legitimacy would be hindered in reaching out, or perhaps down, to local communities.” Mann also claimed that AIDS Service Organizations (ASOs) and AIDS-related NGOs should be included in the AIDS policy process as “a key element in building the GPA program” (Gordenker, Coate, Jönsson, & Söderholm, 1995: 54). The importance of the role of NGOs was formally endorsed both by the UN General Assembly in *Resolution 42/8* and by the London Global Meeting of Ministers of Health in 1988 (WHO, 1988c).

Even though NGOs are indispensable, the role of NGOs was constrained to the implementation of the programs within the WHO strategy. Designing a plan or a strategy was the responsibility of GPA yet NGOs were supposed to be involved at the implementation stage under the auspice and support of GPA. It can be said that NGOs were mobilized by GPA for the purpose of implementing the WHO AIDS programs (Gordenker, Coate, Jönsson, & Söderholm, 1995: 54).

In order for GPA to develop coordinating relationships with NGOs, GPA should have first determined the configuration of the existing network of NGOs. According to its *Draft Strategy for GPA-NGO Cooperation*, “GPA must gain a greater understating of existing network, of what NGOs need to support their work, and of what they can contribute to national, local or global programs” (WHO, 1988d). Second, GPA needed to develop a coordinating structure that enabled more efficient distribution of AIDS information. Third, GPA had to encourage NGOs to participate in National AIDS Control Programs (NACPs). Finally, GPA supported NGOs to establish ASOs consortia (Will, 1991: 217 – 218).

In order to coordinate relations with NGOs, GPA recruited Robert Grose; he was responsible for mobilizing NGOs and developing the WHO umbrella structure to coordinate AIDS organizations the end of 1987 (Jönsson & Söderholm 1996, 128). Grose worked with other WHO regional officials in Europe such as Mooney and Birgitte Gredler to facilitate a new network that strategized WHO-NGO relations. They also contacted officials from the NGO liaison offices at the United Nations to establish closer relations with NGOs. In February 1988, Grose convened a meeting in Geneva meeting where the GPA staff explained to representatives of ASOs and other AIDS-related NGOs about the type of umbrella organization that were encompassing transnational scope (Gordenker, Coate, Jönsson, & Söderholm, 1995: 90-91). Subsequently, GPA circulated a draft strategy document which suggested the establishment of a consortium of ASOs that would have a standing relationship with GPA.

In December 1988 and January 1989, GPA met with a small group of NGO representatives to discuss the issue; the First International Meeting of ASOs followed in February 1989 with representatives of more than 50 organizations gathering in Vienna. During this meeting, participants talked about the development of working relations between ASOs and GPA (Gordenker, Coate, Jönsson, & Söderholm, 1995: 94-95). The participants reached a consensus on the drafted statement which spelled out their concerns and the obstacles to their work as well as recommendations to WHO on how to overcome the difficulties in working with ASOs (Will, 1991: 218). Considering what has been discussed in Vienna, WHO adopted *Resolution WHA42.34*, officially recognizing the importance of NGOs (WHO, 1989). In the Vienna meeting, participants also discussed the establishment of an International Council of ASOs (ICASO) but no concrete measures were determined.

GPA took advantage of three international forums that encouraged NGO involvement in the global response to AIDS: the Paris NGO conference and the International AIDS Conferences in 1991 in Florence and in Amsterdam in 1992. Gordenker, Coate, Jönsson

& Söderholm (1995: 94) point out that “[A]n international forum through which major transnational NGOs could maintain contact with GPA fitted nicely with hopes of reducing some aspects of the uncertainty and turbulence around their growing international attention to AIDS.”

Following the Vienna international meeting, participating NGOs prepared for the next gathering which became the first official international ASO conference. The conference was held in Montreal in June 1989 as a pre-conference of the Fifth International AIDS Conference which took place two days after the ASO conference (Gordenker, Coate, Jönsson, & Söderholm, 1995: 95). Approximately 100 NGOs working on AIDS gathered at the conference to participate in wide-ranging discussions, which included the issue of establishing ICASO. ICASO would serve as a “means to facilitate information exchanges, coordination and networking, as well as to represent the interests of ASOs on an international level” (Will, 1991: 219). During the conference, a temporary standing task force was established to develop the structure for ICASO. Basically, the NGOs wanted the consortia to be directly involved in the policymaking process of the GPA’s Global Management Committee (GMC), the highest policy-making body (Will, 1991: 219). GMC consists of representatives from the governments that contributed to the GPA budget plus six IGOs which were cooperating intensely with GPA. Although the NGOs had attended the January 1988 GMC meetings as observers, they wanted to be full members of GMC. This issue was discussed and accepted by GMC because GPA sought to create an umbrella organization which included all of the all actors involved in the WHO global AIDS program. However, the NGOs failed to officially obtain full member status in the GMC meeting because they failed to reach an agreement about which organizations would represent the ASOs at the Paris NGO conference (Will, 1991: 220).

The basic goals of the 1990 Paris NGO conference were to: facilitate international networking and technical exchange among ASOs, national networks and regional consortia; establish a mechanism for addressing the shared needs and representing the interests of community-based NGOs/ASOs internationally, including the establishment of ICASO; develop recommendations and guidelines for future NGO action and collaboration; maximize the availability of AIDS-related information; heighten awareness of the NGO/ASO perspective on and contribution to the AIDS effort; and enhance the contribution of NGOs/ASOs to the WHO Global AIDS Strategy (WHO, 1990a).

However, the general mood of the conference was one of discontent and conflict. First, two co-sponsors of the conference, the Comité France SIDA and the

Washington-based National Minority AIDS Council (NMAC), disagreed about the format of the conference. The Comité France SIDA wanted a formal organization with an agenda restricted to issues such as science and treatment with a formal set of presentation. In contrast, NMAC preferred a focus on skills and training in a casual setting that cover a variety of topics through the use of discussions. Second, the southern delegates had different needs from the northern delegates in terms of drugs and treatment protocols. The northern delegates focused on the latest treatment protocols while the southern delegates focused on local health care and social and environmental improvements. In addition, the North and the South failed to reach a consensus on the ICASO proposal. The South claimed that their opinion was not reflected in the proposal because they were not allowed to be involved in the drafting process (Gordenker, Coate, Jönsson & Söderholm, 1995: 95). In the midst of the prevailing discontent, it was impossible for NGOs to agree upon representative NGOs to attend the GMC meeting:

With the controversial nature of ICASO, it has become difficult to represent the varied perspectives and interests of NGOs, and the presence of a full NGO member has been postponed while a growing number of NGOs participate as observers (Jönsson & Söderholm, 1996: 130).

The same atmosphere was widespread in the Florence International AIDS conference in 1991. In response to the discontent from NGOs that the topic of Paris conference predominantly focused on scientific issues while disregarding the social aspects of AIDS, the Florence conference was organized into two subsets: a scientific conference titled *Science Challenging AIDS* and a NGO conference named *Communities Challenging AIDS*. However, the humanistic dimension was not clearly defined so that the roles of People with AIDS (PWA) groups, ASOs, and other NGOs were ambiguous (Gordenker, Coate, Jönsson & Söderholm, 1995: 101). In fact, medical scientists looked down upon AIDS activists for not having an understanding about the complicated scientific research pertaining to the disease. What was worse is that the scientists did not even recognize the existence of the NGO meetings at the conference.

Disagreement among NGOs about the structure of ICASO continued in the Florence conference. NGOs from the South demanded decentralization and regionalization of ICASO structure. In the end, their requests were reflected in a formal mission statement, containing ICASO reorganization by replacement of the administration and relocation of the secretariat to Ottawa (Gordenker, Coate, Jönsson & Söderholm, 1995: 102).

It was at the 1992 AIDS conference in Amsterdam where balance and compromise were achieved in terms

of the conference theme and the role of various actors. The widespread conflicts between medical scientists and AIDS activists and within the NGO community were settled down thanks to the efforts of conference organizers. On the agenda, the organizers attempted to balance the social aspects of the disease with the issue of biomedical science. They also made a special effort to involve PWAs and NGOs from the southern hemisphere.

Even though the number of active ASOs in the world had grown to several hundred by the early 1990s, WHO put AIDS policy initiatives within the domain of the GPA. Essentially, WHO's strategy for dealing with NGOs was to give GPA the lead in organizing NGO activities (Will, 1991: 220-221).

When it comes to the global AIDS funding, WHO played a role in organizing a new coordinating network exclusively for global AIDS funding. Moreover, WHO attempted to encourage developed countries to give global AIDS funding by devising a particular strategy such as 'multi-bi' funding. From the outset, donor countries were not very responsive to WHO's requests for global AIDS funding. According to WHO's report on the meeting of donors for the prevention and control of AIDS (WHO, 1986c), most of the representatives from donor countries were hesitant to make a specific commitment for global AIDS funding. Even though several exceptional cases existed, such as the United States which contributed \$1 million, the amount was just a small part of what was required – \$8 million – for implementing 20 NACPs. Given the fact that WHO allocated just \$500,000 from its regular budget for global AIDS response during the 1985-1986 biennium, it seemed indispensable for GPA to depend on extra-budgetary funds for global fight against AIDS (WHO, 1986c).

WHO encouraged donor countries to give global AIDS funding as an extra-budgetary contribution. This was reflected in the statements that have been promulgated by WHO. According to the first WHA resolution on AIDS, *WHA39.29* (WHO, 1986f), the WHO Director General was required to "explore ways and means of increasing the extent and types of WHO's cooperation with Member-States in combating this infection; to seek for that purpose the necessary extra-budgetary resources" (Will, 1991: 155-156). In a report from 1987 (WHO, 1987b), WHO Director General Mahler stated that extra-budgetary sources should be guaranteed as an alternative for tackling the new global agenda of AIDS given the restricted regular budgetary situation of WHO which covered existing programs (Will, 1991: 156). In reality, extra-budgetary funding for AIDS treatment and prevention for 1988-89 was twice the amount received in 1987.

The drastic increase in extra-budgetary funding was feasible because GPA was flexible in channeling donors' money as a new coordinating mechanism (see

FIGURE 3. Major Funding States in the Health Issue Area

Country	Via WHO		Assessed Contribution Aid	Bilateral Health
	Extra-budgetary Contribution To 1987	1988-89		
Canada	44.5	20.1	17.4	?
Denmark	79.3	31.2	4.1	?
France	15.9	7.5	37.5	224.0
Germany	37.1	13.6	46.8	81.0
Japan	27.0	22.0	61.5	208.0
Italy	23.5	24.3	21.5	180.0
Netherlands	68.6	31.7	9.9	83.0
Norway	64.3	33.9	3.0	110.0
Sweden	175.3	65.6	7.1	62.0
UK	54.3	47.2	27.5	75.0
US	143.8	100.3	145.9	529.0

Source: WHO, Financial Report and Audited Financial Statements for the Financial Period 1 January 1988 – 31 December 1989 (43rd World Health Assembly, 27 March 1990), pp. 21-22, 64-66; and Lee Howard, “The Evolution of Bilateral and Multilateral Cooperation for Health in Developing Countries,” in Michael Reich and Eiji Mauri (eds), *International Cooperation for Health: Problems, Prospects, and Priorities* (Dover, MA: Auburn House, 1989), P. 347.

Figure 3). Historically, WHO has played a marginal role in directly funding general development assistance for global health. The main actors in the development funding network were bilateral agencies within each government and multilateral banks such as the World Bank. WHO was dislocated from this main funding network. In short, development assistance for general health depended on a bilateral channel (Howard, 1989).

WHO mobilized a new financial network in which it played a central role in raising and coordinating the funding for global AIDS. First, WHO attempted to convene country level conferences. WHO had hosted five donor meetings in Africa by November 1987. In 1987, only four organizations participated; by March 1989, this number had grown to 28. It can be said that “GPA’s role in coordinating the country level donor meetings cemented its central position in the AIDS funding network. In this position, WHO was able to lessen its dependence on direct unspecified contributions to the GPA, as well as monies allocated from the regular budget” (Will, 1991: 164).

Second, WHO developed a new strategy for mobilizing global AIDS funding. In the aftermath of the drastic increase in global AIDS funding over three years, WHO confronted the obstacle of general financial restriction for development assistance. In

order to overcome the general financial impediment, WHO needed to establish a new approach, which is a ‘multi-bi’ funding strategy. In this strategy, donor countries were allowed to specify how their contribution was to be used. At GMC meeting in November 1990, this financial issue was discussed and the new strategy was introduced and recommended (WHO, 1990b).

It was made clear that the GPA preferred its funding as undesignated contributions, but if it generated substantial additional funds, the GPA was willing to accept them as designated funds (Will, 1991: 160).

As a result of the new tactics, the total amount of funding, as well as the ratio of multi-bi funding, increased even though the budget for general development assistance was decreased (Will, 1991: 159).

CONCLUSION

It has been about twenty five years since the first case of AIDS was reported in Los Angeles. A disease that initially appeared limited in scope has turned out to be one of the most devastating global health crises in human history, resulting in approximately 25 million deaths and 38.6 million people living with HIV. In

response to the global health disaster, the international community has started to take an active role by allocating large sums of money and human resources to the issue. The implications of these actions are especially large, given the initial denial of the AIDS virus and the lack of country response at the global level.

I contend that this transformation was possible due to the active role of WHO in the global response to AIDS. WHO played a decisive role in enhancing awareness of AIDS and fostering a sense of urgency within the international community to respond to the disease. The norms of global response to AIDS emerged and developed, and these norms have encouraged the international community, especially developed countries, to be responsive to AIDS in developing countries that are in need of assistance. It can be argued that WHO contributed to creating and proliferating the norms that enhance awareness on the urgency of response to AIDS and triggered global AIDS funding.

With regard to the process of norms development, Clark provides a plausible theoretical framework which stratifies it into four stages: fact finding, consensus building, norms construction, and implementation of norms. It can be argued that WHO played a decisive role in every stage. At the first stage, WHO attempted to collect the epidemiological data and virological information about AIDS. Not only the medical information but also social aspects of the disease were discovered and analyzed in various kinds of international meetings convened by WHO. WHO's fact finding process helped to uncover the real state of the AIDS crisis and provided a more realistic perception on the scale and impact of the seemingly destructive health calamity. At the second stage, WHO built consensus around the need for and urgent response to the global health crisis. WHO problematized the AIDS issue in particular international forums such as the first International AIDS Conference in Atlanta and in WHO consultation meetings. The role of Dr. Mann as the first Director of GPA cannot be disregarded. He designed a general strategy on AIDS such as surveillance, prevention, and comprehensive approaches, which became grand themes in the global fight against AIDS. He also attempted frame the issue in terms of international solidarity by taking advantage of international gatherings such as the Fourth International Conference on AIDS.

The efforts of WHO and Dr. Mann led to the construction of norms in various resolutions such as WHO's first resolution on AIDS in May 1986 (WHA39.29), WHA resolution in 1987 (WHA 40.26), United Nations resolution in 1987 (Resolution 42/8) and the *London Declaration on AIDS* (WHO, 1988c). These resolutions shed light on the role of WHO and GPA in tackling the global AIDS issue as well as the

commitment of international community, especially the financial dedication of developed countries.

In order to implement its strategies on the ground, WHO used two strategies: the mobilization of NGOs and the adoption of 'multi-bi' funding tactics. NGOs are indispensable in because they have local access – which is needed for the successful program implementation. In terms of the funding tactics, donor countries were more willing to specify how their money would be spent so that WHO channeled the funding as requested by the donors even though WHO preferred undesignated funding.

NOTES

¹ The issue of transmission routes was the most important topic of the first international consultation on AIDS in Atlanta in 1983 and the consultation proclaimed the statement validating three means of transmission: first, through blood and blood products (transfusions, sharing of needles); second, through sexual relations in which body fluids were passed; and third, mother to child (WHO, 1987).

² AIDS turned out to be the most severe medical catastrophe in human history in resultant of approximately 25 million deaths and 38.6 million people living with HIV (UNAIDS, 2006).

³ According to Will, the staffing of the CPA had risen to five, and extra-budgetary resources had been increased by another \$5 million in January 1997 when it was replaced as Special Programme on AIDS (SPA) (Will, 1991: 147).

⁴ It was initially named 'Special Programme on AIDS (SPA)' when it was created in 1987 and renamed 'Global Programme on AIDS (GPA)' in 1988.

⁵ Dr. Mann led the effort of developing the international norms of global response to AIDS in the period from 1987 to 1990. Dr. Mann resigned in 1990 over difficulties associated with working with a new Director General.

REFERENCES

- Altman, L. (1986, November 21). Global program aims to combat AIDS 'disaster'. *New York Times*.
- Behrman, G. (2004). *The invisible people: How the U.S. has slept through the global AIDS pandemic, the greatest humanitarian catastrophe of our time*. New York: Free Press.
- Centers for Disease Control. (1981). Pneumocystis Pneumonia – Los Angeles. *MMWR* 30: 250 – 252.
- . (1982). Persistent, generalized Lymphadenopathy among homosexual males. *MMWR* 31: 249-252.

- Chin, J. (2007). The international response to the AIDS pandemic. pp. 197-211 in *The AIDS Pandemic: The Collision of Epidemiology with Political Correctness*. Oxford, UK: Radcliffe Publishing.
- Clark, A. M. (2001). *Diplomacy of conscience: Amnesty International and changing human rights norms*. Princeton, NJ: Princeton University Press.
- Fortin, A. J. (1988a). *AIDS and the Third World*. Paper presented to the 14th World Conference of the IPSA, Washington, D.C.
- . (1988b). The politics of AIDS in Kenya. *Third World Quarterly*, 9 (3): 609 – 919.
- Gordenker, L., R.A. Coate, C. Jönsson & P. Söderholm. (1995). *International cooperation in response to AIDS*. New York: Pinter Publishers.
- Howard, L. (1989). The evolution of bilateral and multilateral cooperation for health. In M. Reich & E. Mauiri, (Ed.). *International Cooperation for Health: Problems, Prospects, and Priorities*. Dover: Auburn House.
- Jösön, C., & P. Söderholm. (1996). IGO-NGO Relations and HIV/AIDS. In T. Weiss, & L. Gordenker, (Ed.). *NGOs, the UN and Global Governance*. Boulder: Lynne Rienner Publishers.
- Kingman, S. (1988, September). Ten times more' AIDS cases in Africa, *New Scientist*.
- Lerner, E. K., & E.H. Mary. (1998). *AIDS crisis in America: A reference handbook*. (2nd Ed.). Santa Barbara: ABC-CLIO CA.
- Mann, J. (1987). The World Health Organization's global strategy for the prevention and control of AIDS. *The Western Journal of Medicine*, 147 (6): 732 - 734.
- Mann, J., D. Tarantola, & T. Netter. (eds.). (1992). *A Global Report of AIDS in the World I*. Cambridge: Harvard University.
- Mann, J., & D. Tarantola. (Ed.). (1996). *A Global Report of AIDS in the World II*. Oxford: Oxford University.
- Mann, J., & K. Kay. (1991). Confronting the pandemic: The World Health Organization's Global Programme on AIDS, 1986 – 1989. *AIDS* 5 (suppl. 2): 221 – 229.
- Merson, M. (2006). The HIV-AIDS pandemic at 25 – The global response. *New England Journal of Medicine*, 354: 2414-2417.
- Moore, A., & R. LeBron. (1986). The Case for a Haitian Origin of the AIDS Epidemic. pp. 79-94 in Feldman, D., & T. Johnson. (Ed.). *The Social Dimension of AIDS*. New York: Praeger.
- Norman, C. (1985). Politics of science clash on African AIDS. *Science*, 230.
- Slutkin, G. (2000). Global AIDS 1981-1999: The Response. *International Journal of Tuberculosis and Lung Disease*, 4 (2): 24 – 33.
- United Nations. (1987, October 26). *Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)*. (Resolution 42/8).
- UNAIDS. (2006). *2006 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.
- World Health Organization. (1984). Acquired Immunodeficiency Syndrome – An assessment of the present situation in the world: Memorandum from a WHO meeting. *Bulletin of the WHO* 62 (3): 424.
- . (1985). *WHO Activities for the Prevention and Control of AIDS*. Geneva, 25 November 1985 (EB77/42).
- . (1986a). Recommendations for a Plan of Action for AIDS Control in the African Region of WHO. *Report of the First Regional Conference on AIDS in Africa* in Brazzaville, 11-13 November 1986 (WHO/GPA/AFR/88.1).
- . (1986b). *Global WHO Strategy for the Prevention and Control of AIDS – Projected Needs for 1986 – 1987*, Geneva 1986 (WHO/CPA/86.2).
- . (1986c). *Report of the Meeting of Donors for the Prevention and Control of AIDS*, 21 April 1986 (WHO/AIDS/CPA/86.1)
- . (1986d). Second Meeting of the WHO Collaborating Centers on AIDS: Memorandum from a WHO Meeting, *Bulletin of the WHO* 64 (1) 1986.
- . (1986e). *Summary Records: 77th Executive Board*. Geneva, WHO, 1986 (EB77/SR/12-13).
- . (1986f). *Acquired Immunodeficiency Syndrome (WHA39.29)*.
- . (1987a). *Fortieth World Health Assembly: Global Strategy for the Prevention and Control of AIDS* (WHA 40.26).
- . (1987b). *WHO Activities for the Prevention and Control of AIDS*. Report by the DG. Geneva.
- . (1988a). *The Global Picture of AIDS* presented at the IV International Conference on AIDS. Stockholm, Sweden.
- . (1988b). *Guidelines for the Development of a National AIDS Prevention and Control Programme*. Geneva.
- . (1988c). *AIDS Prevention and Control: Invited Presentations and Papers of the World Summit*

of Ministers of Health on Programme for AIDS Prevention. Geneva.

- (1988d). *Draft Strategy for GPA-NGO Cooperation*, November 1988.
- (1989). *Nongovernmental Organizations and the Global Strategy for the Prevention and Control of AIDS*. The 42nd World Health Organization (WHA42.34).
- (1990a). *Final Reports*, Second International Conference of AIDS-related Non-governmental and Community Organizations, Paris, France, 1-4 November 1990.
- (1990b). *Consideration of Designated Contributions to GPA*, Geneva, 3 October 1990.
- (1991). *Update: AIDS Cases Reported to SFI Unit*, October 1991.
- (1992). *SIDA/AIDS. Report of the External Review of the World Health Organization Global Programme on AIDS*, Jan 1992. Geneva (WHO/GPA/GMC (8)/92.4).
- Will, K. D. (1991). *The Global Politics of AIDS: The World Health Organization and the International Regime for AIDS*. Ph.D. Dissertation.

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