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World Health Organization and Early Global Response to HIV/AIDS: Emergence and Development of International Norms

Young Soo Kim

There have been remarkable coordinated efforts by major donor countries in the international community to grapple with HIV/AIDS epidemic. I claim, from the constructivist perspective, that the norms of the global response to AIDS motivated the funding by reshaping and redefining donors' identity and preferences. I trace the process of how the WHO played a role in developing the norms at the very early stage of the pandemic. The analytical focus lies in the four stages of norms development: sharing information and enhancing awareness, constructing perception and orchestrating collaboration, establishing norms in the United Nations system, and implementing norms through mobilizing and strategizing. I examine the chronology of the WHO activities with the official documentation pertaining to the unprecedented global health crisis.

Keywords: Constructivism, International organization, Global response to HIV/AIDS, International norms, World Health Organization (WHO)

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, 1994-99).

1. INTRODUCTION

Immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) has turned out to be one of the most severe medical catastrophes in human history. It is estimated that the total number of HIV/AIDS related deaths has reached nearly 39 million with 35 million living with HIV/AIDS as of 2013 (UNAIDS, 2014). Even though HIV/AIDS related deaths peaked in 2005 and new annual infections have stabilized since 1997, the numbers remain substantial and still growing (UNAIDS, 2011) (see Figure 1 and Figure 2). In 2013 alone, estimates show that 1.5 million deaths were caused by the epidemic and that a whopping 2.1 million people were newly infected worldwide.

On a brighter note, it is noteworthy, however, that there have been remarkable internationally-coordinated efforts for grappling with the pandemic. Major donor countries, especially the members of the Development Assistance Committee (DAC) in the Organization for Economic Cooperation and Development (OECD), have played a major role as financiers of the combat efforts by providing funding during the last three decades.

Figure 1. People Living with HIV (Source: UNAIDS, 2011: 6)

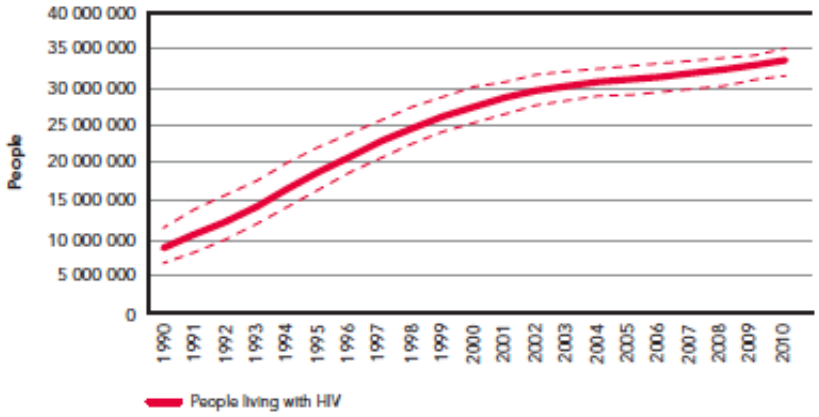
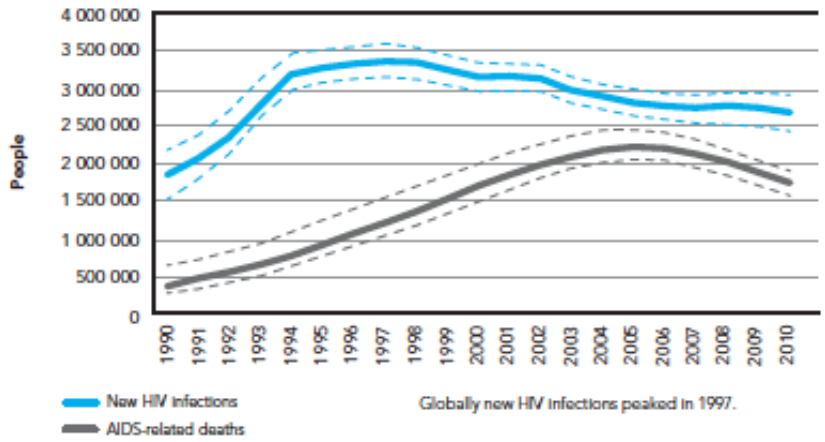


Figure 2. New HIV Infections and AIDS-related Deaths (Source: UNAIDS, 2011: 7)

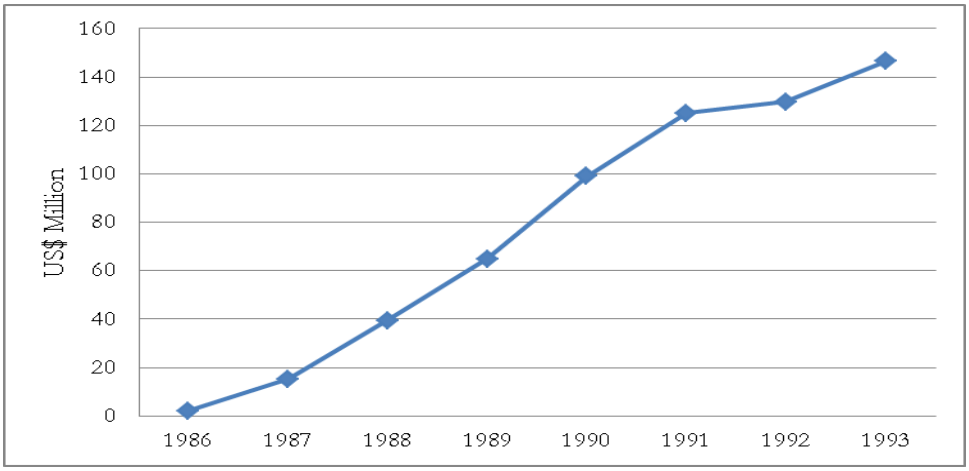


Total global AIDS funding has dramatically increased even in the early stage of the global fight against HIV/AIDS (see Figure 3). Since the US first initiated provision of its foreign aid to fight HIV/AIDS in 1986, most of the DAC members have followed suit by devising foreign aid policy within a relatively short period of time in comparison with other development agenda such as food aid or other health issues.

How can the concerted efforts of the international community against the then newly emerging health crisis be understood? Why and how did most developed countries determine to financially contribute to the global response to HIV/AIDS? Who were, if any, the major actors and what roles did they play in the coordination of financial commitment? This study attempts to answer the puzzles of the motivations and processes of the outstanding international cooperation.

I argue that the norms of the global response to AIDS matters in accounting for the commitment of major donors and that the World Health Organization (WHO) played a

Figure 3. Evolution of Foreign Aid for Response to AIDS (Bilateral Aid)



Source: Mann et al., 1992: 520-521; Mann and Tarantola, 1996 (eds.): 381-383.

significant role in motivating or encouraging global AIDS funding. I explain how the norms emerged and developed to the point where the major donors accepted and shared the sense of urgency and obligation to respond to the health catastrophe. By the norms of the global response to AIDS I refer to the *standard of the behavior of financial contribution for the global fight against HIV/AIDS based on the sense of obligation and urgency*. My main focus lies on the process by which the WHO undertook the global campaign against AIDS by initiating, developing and proliferating the norms of global response to the crisis.

The study consists of three parts: a theoretical discussion, a brief summary of the advent of the AIDS crisis and early inaction, and an analysis of how the norms of a global response to AIDS emerged and developed by the role of the WHO. First, I introduce a major debate between rationalists and constructivists with regard to the motivations of states' behaviors and the theories of norms emergence and diffusion from the constructivist point of view. The theoretical configuration lays a foundation for further discussion about the international norms that shaped the certain behavioral patterns of the foreign policies. Subsequently, I briefly introduce the early history of the outbreak of HIV/AIDS in the 1980s and the early 1990s during which both developed and developing countries were reluctant or unwilling to take any substantive actions pertaining to the health issue. In the final section, which is the nucleus of this study, I explore how the disease gradually gained attention at the global level. I trace the process of how the international society became aware of and responsive to the health agenda with special attention to how the WHO played a role in engendering the contributions of developed countries in the framework of the four stages of the norms development: sharing information and enhancing awareness, constructing perception and cooperation, establishing norms in the UN system, and implementing norms through mobilizing and strategizing. In doing so, I examine the chronology of WHO activities with the official documentation dealing with the unprecedented international health crisis.

2. THEORETICAL DISCUSSIONS

2.1 Norms-Based Theories and Interests-Based Theories

An extant literature on the behavioral motivation of states mainly diverges into two distinctive theoretical perspectives: a strategic self-interest approach and a norms-based approach. The strategic self-interest approach argues that states tend to be motivated by their own strategic and commercial interests. The international relations paradigms compatible with this approach are rationalist international relations theories such as neorealism and neoliberalism. The rationalist theories take the state as exogenously given with fixed interests and preferences. The states tend to rationally behave in pursuit of maximizing power and interests. It is such material interests that shape behavior so that the rationalist theories stick to *material reality* in order to account for states' motivations (Alesina and Dollar, 2000; Berthelemy, 2004; Browne, 2006; Maizels and Nissanke, 1984; McGillivray, 2003; Sogge, 2002).

However, there is another approach distinctive from the rationalist, claiming that countries do not necessarily behave based on their self-interest and absolute egoistic rationale. Lumsdaine (1993) contends that states' behaviors are likely to be shaped by ethical and humanitarian concerns shared among states. Countries are motivated by the normative orientation, which guides what is appropriate behavior with given identity, and within given circumstances of international society. This normative approach is consistent with a constructivist framework in international relations theory (Finnemore, 1996; Finnemore and Sikkink, 2001; Katzenstein, 1996; Wendt, 1992; Wendt, 1999).

As opposed to rationalists that emphasize material reality, constructivists pay attention to the *social reality* in which the interests or preferences of states are mutually constructed through close interaction among state actors. The social reality is likely to shape perceptions, preferences and interests and to change the course of action accordingly. In some cases, the social reality plays a proscribing role in limiting the options in the behavior of states within the constrained range of preferences. In other cases, the social reality prescribes course of action by *constituting, creating or revising* interests of actors through the reconfiguration of preferences. With regards to both regulative and constitutive features of social reality, constructivists aim at explicating how shared ideas and values (social reality) shape and define the interests of states in conjunction with actors' given identity. In this view, interests are "defined in the context of internationally held norms and understanding about what good and appropriate" (Finnemore, 1996: 2).[1] To adopt certain policies, therefore, represents who they are and what they value or what they believe to be appropriate for their constructed perception.

At first glance, the interest-based approach and the norms-based approach seem to provide an irreconcilable and mutually exclusive understanding of actors' behavioral motivations due to their ontological differences. However, it should be noted that the norms-based approach does not disregard material reality. For the norms-based theories, the material reality is understood in the context of social reality. In other words, social reality is what endows material realities with meaning and purpose and provides goals to which the

[1] The norms are defined as "a standard of appropriate behavior for actors with a given identity" (Finnemore and Sinkkink, 1998: 891).

material values are used. Material reality is one of the factors that should be taken into consideration for constructing social reality. In this sense, the norms-based theories are an overarching framework that incorporates the interest-based approach because the social reality usually embraces the material reality.

Along the line, the social reality does not necessarily match with normative or humanitarian values. The preference and interests of states are not necessarily shaped by the values with moral or ethical characteristics but by any values shared in the social relations with other actors. From this perspective, states' behaviors are likely driven by *social reality* regardless of the features of the ideas or norms with either moral and humanitarian values or strategic or economic orientations. In the case of the response to HIV/AIDS, I argue that states (major donor countries) are driven by an idea or perception that HIV/AIDS is an urgent global pandemic that requires immediate international responses. I coin the idea *norms of the global response to HIV/AIDS.*

2.2 Theories of Norms Emergence and Diffusion

This research attempts to explore how the social reality has emerged, developed, and proliferated. In examining the dynamics of global AIDS politics, extant literature on norms development and the role of agents (or norms entrepreneur) is suggestive as theoretical references. Finnemore (1993) sheds light on the role of international organizations that influenced domestic governments' policy adoption and development. She argues that international organizations teach certain ideas and values which countries adopt for their policy choices. The teaching transforms the identities of actors, leading to issues and interests being reframed and redefined. She argues that states are deeply embedded in the social network of an international society and they learn about appropriate behaviors within the international social structure, namely, international organizations. The causal dynamics on the influence of the teaching by international organizations in policy diffusion is illustrated in Figure 4.

Figure 4. Dynamics of the Influence of the UNESCO on Domestic Science Policy (Finnemore, 1993)

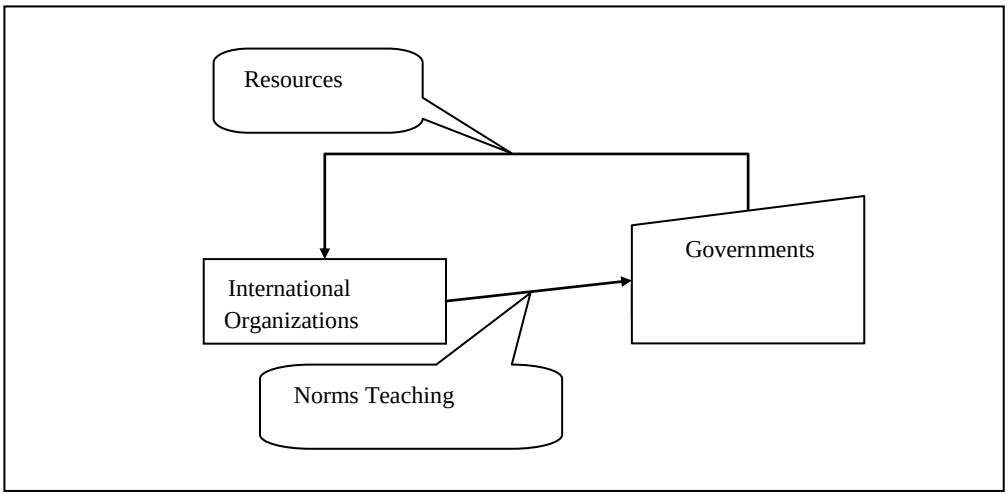


Table 1. Stage of Norms

	Stage 1 Norm Emergence	Stage 2 Norm Acceptance	Stage 3 Internalization
Actors	Norm Entrepreneurs	States, International Organizations, Networks	Law, Profession, Bureaucracy
Motives	Altruism, Empathy, Ideational Commitment	Legitimacy, Reputation, Esteem	Conformity
Dominant mechanism	Persuasion	Socialization, Institutionalization, Demonstration	Habit, Institutionalization

Source: Finnemore and Sikkink, 1998: 898.

Finnemore and Sikkink (1998) construe a three-stage process in norms building: norms emergence, cascade, and internalization. In the process of the norms cycle, they underscore that certain agents (norms entrepreneurs) play a role in calling the attention of other states and persuading them to take hold of a new norm by framing the issues with new languages and interpretations (897). The agents also pressure "targeted actors to adopt new policies and laws and to ratify treaties and by monitoring compliance with international standards" (902). The cycles or stages of norm development are summarized in the Table 1.

Clark (2001) also provides an insightful theoretical claim on the role of norms entrepreneurs and on the four stages of norms development: fact finding, consensus building, principled norm construction, and norms application. In unveiling the process of international human rights norms, she explains how Amnesty International (AI) persuaded nation-states to adopt the principled norms based on the invocation of right and wrong in specific human rights declarations and treaties within the institutional context of the UN (Clark, 2001: 30-35).

The framework of the norm cycle and norms development is also applied to the spread of the prosecutions of individuals accountable for human right violations in the work of Sikkink (2011). She explores how the idea of individual criminal accountability proliferated from Southern Europe and Latin America to the extent that it is accepted as norms (98). She points out the role that a group of individuals, so-called "pro-change alliance," have played in conjunction with like-minded governments, human rights non-governmental organizations (NGOs), and professional associations in provoking the cascade of the norms of justice for individual criminal accountability.

The attention to norms and identities was also given in the field of international political economy. Abdelal, Blyth and Parsons (2010) claim that even in the field of international political economy, which has been self-sufficient with material and rationalist foundations of thoughts, norms and identities gradually become tenable as causal variables that produce neither marginal nor irrelevant findings (4). This line of thinking mostly underscores how agents contributed significantly to making such 'changes' in trade practices, financial policy choices, pattern of integration or disintegration (Abdelal, 2006; Blyth, 2007; Duina, 2006; Herrera, 2005; Jabko, 2006).

Blyth (2007), for instance, delves into how agents' understanding about reality, in other words, 'idea', rather than just material position, determined financial policies in time of crisis.

In accounting for cross-national policy variations in response to the Great Depression, he illuminates the process of 'inter elites persuasion,' which determines "what a crisis means, and how it should be institutionally resolved" (761). The perception or ideas of elites and their attempts at persuasion decide which causal stories on the definition, diagnosis, and solution of the crisis is the most viable for policy options. In addition, Abdelal (2006) uncovers how European actors, especially French policymakers, constituted the rule-based, 'managed' globalization of finance. Different from conventional wisdom on the leading role of the US, it was developed countries in Europe that considered and constituted the practice of capital liberalization as a legitimate policy tool through the mechanism of social learning.

The existing literature is extremely helpful in in unpacking the puzzle of the dramatic increase of global AIDS funding. The literature well traces the process in which agents initiated certain ideas and made them resonated among significant actors (including main policymakers) for establishing domestic policy congruent with the internationally shared perception. This research explores how the main norms entrepreneur like the WHO played a role in enhancing the idea of urgency for immediate international response to HIV/AIDS and mobilizing the resources for the global fight against the pandemic.

3. ADVENT OF HEALTH CRISIS AND EARLY INACTION AND DENIAL OF HIV/AIDS

On June 5, 1981 the Center for Disease Control (CDC) reported five cases of Pneumocystiscarinii pneumonia in homosexual males in Los Angeles in the *Morbidity Mortality Weekly Report (MMWR)* (CDC, 1981: 250-252). The increasing number of 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 et al., 1992). However, it did not take long until they realized that this infection was not confined exclusively to homosexuals.

They determined that various symptoms in a series of patients originated from a compromise of their immune system, and the officials therefore termed the disease, "acquired immune deficiency syndrome" (CDC, 1982: 249-252). In addition to the cause of the disease, scientists determined the routes of transmission, concluding that the disease is transmitted by an agent, which can occur by sexual contact, sharing blood (either by therapeutic blood or by shared needles used for illicit drugs), or during the birthing process (WHO, 1984: 424).[2]

A handful of medical research institutions such as the National Cancer Institute (NCI), the CDC and Pasteur Institute conducted epidemiological research and discovered the origin and transmission of AIDS. Yet, it was beyond their capacity to estimate the size and geographical distribution of AIDS infection due to their loosely organized network. More systemic and collaborating approaches of capable institutions were inevitable for capturing the state of the disease. According to the WHO report, "[B]y October 1983, 27 countries had

[2] The issue of transmission routes of transmission was the most important topic of the first international consultation on AIDS in Atlanta in 1983. 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, from mother to child in pregnancy, giving birth and breastfeeding.

reported a total of 3,290 cases of AIDS, of which only 611 occurred outside the US" (WHO, 1984: 422). Scientists realized that these seemingly small numbers were only the "tips of a gigantic iceberg of future deaths and suffering" but they could not capture the real picture of AIDS. Statistics on AIDS cases show that Africa experienced a sudden jump in AIDS cases in 1986, exceeding the number of American cases when entering the 1990s (see Table 2 and Figure 5). It is reported that the African continent has shown dramatic increase in the number of AIDS cases since then and it accounts for two thirds of the total global AIDS cases as of 2013 (UNAIDS, 2014). It can be said that the relatively low number of cases in Africa in the 1980s was due to the underestimation caused by the lack of reliable sources.[3]

Despite the implicitly recognized assumption of AIDS as an urgent global health catastrophe, the very initial response to AIDS can be characterized as inaction and denial; Inaction was on the part of the developed world at the individual, organizational, and state levels and denial was on the side of the developing world. That is to say, the developed world posed a lack of will and action while the developing world did not admit the problem as readily as they should have.

The inner dynamics of international organizations was partly attributed to the absence of early responses. Officials were reluctant to place AIDS on the agenda because of its apparent connection with homosexuality, prostitution, and drug-use. Moreover, the WHO leadership

Table 2. AIDS Cases Reported to the WHO by Year

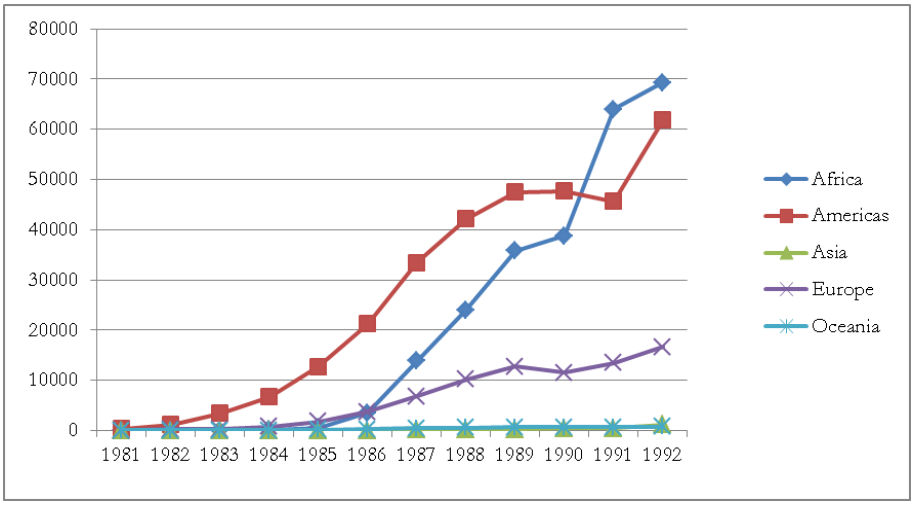
	1981	1982	1983	1984	1985	1986	1987
Africa	0	3	17	187	579	3569	13882
Americas	387	1184	3380	6699	12767	21246	33433
Asia	1	2	8	7	30	71	134
Europe	42	214	291	712	1820	3711	6839
Oceania	0	1	10	50	135	249	409
Total	430	1404	3706	7655	15331	28846	54697

	1988	1989	1990	1991	1992	Total
Africa	23982	35838	38732	63965	69351	250105
Americas	42115	47436	47732	45605	61822	323806
Asia	150	260	407	417	1115	2602
Europe	10169	12701	11468	13453	16589	78009
Oceania	584	664	677	647	714	4140
Total	77000	96899	99016	124087	149591	658662

Source: WHO, "Update: AIDS Cases Reported to SFI Unit," 1 October 1991; Mann and Tarantola, 1996: Appendix A.

[3] According to the GAP Report 2014, the hardest hit region is sub-Saharan Africa. It is reported that 24.7 million people are living with HIV/AIDS including 2.9 million children, which account for two thirds of global total of 35 million people living with HIV/AIDS. Only in 2013, around 1.1 million people died of AIDS (out of 1.5 million globally) and 1.5 million people (out of 2.1 million globally) were newly infected with AIDS in the region.

Figure 5. AIDS Cases Reported on the WHO by year (Source: WHO, 1991; Mann and Tarantola, 1996: Appendix A)



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 found and well taken care of. Even the WHO Director-General, Dr. Halfdan Mahler, confessed in 1987 that he had underestimated the state of the AIDS because he thought AIDS was an American issue so that there was no need to establish exclusive global program for AIDS (Altman, 1986).

The lack of action was also widespread at the state level 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 worried that their sovereignty would be at stake if they joined the international AIDS prevention program, which might result in external intervention into their domestic affairs by multilateral agencies. For example, the US was not interested in internationalizing the issue because their interests were to protect their own citizens under the situation in which the largest portion of AIDS patients were living in the US. Meanwhile, the US government traced the route of transmission of AIDS to the US because they wanted to attribute the substantial incidences to other countries in order to remove attention from themselves. In the end, the US placed official blame upon Haiti by arguing that Africa turned out to have large number of AIDS patients and Haiti had a close connection with Africa (Moore and LeBron, 1986). Dr. Bruce Chabner from the National Cancer Institute announced, "We suspect that this may be an epidemic Haitian virus that was brought back to the homosexual population in the United States" (Farmer, 1992: 265).[4] The targeting resulted in ruthless blood sampling from African patients and an exaggeration of the scale and extent of AIDS in Africa. Will (1991) points out the rationale of the US behavior:

> [a]s the country with by far the largest concentration of AIDS cases, the US faced the

[4] The announcement was cited in *The Miami News* (2 December 1982), 8A.

> prospect of itself being the main target of health sanctions or restrictive measures [...] the US, […], 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 (89).

The problem of developing countries was denial. Developing countries, mainly in Africa and Southeast Asia, were incapable of coping with the internal AIDS problem 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 concerned about their reputations. Western states tended to accuse Africans of having unhygienic customs and religious practices, which they claimed led to the origination and transmission of the virus (Will, 1991: 136). In contrast, Africans regarded AIDS as a Western disease. Specifically, they attributed the disease to widespread homosexuality in the West, which was rare in Africa. They thus believed that the disease was transmitted by Western tourists (Fortin, 1988a: 609).

Another main reason why they failed to recognize the disease was that their recognition would damage the tourism industry and other foreign industrial investment (Fortin, 1988b: 15). The complaints lodged by the African countries were exemplified in the International Conference on African AIDS in Brussels in 1985. Only fifteen Africa delegates attended and boycotted all presentations in the Conference. Moreover, they insisted that there was no decisive evidence of the African origin of AIDS (Norman, 1985: 1140). While the awareness of the AIDS problem grew in developed countries in 1984-85 as a threat to not only themselves but also a large portion of Africa, African leaders themselves turned even more rigid in their denial (Will, 1991: 136). In the face of the denial, it was estimated the number of AIDS cases in Africa to be ten times the reported number (Kingman, 1988: 20).

Africa officially recognized the problem of AIDS and requested assistance from the international community on March 1986 in the First Regional Conference on AIDS in Africa in Brazzaville. Participants officially recognized the gravity of the domestic AIDS problem and adopted a set of recommendations for action in "Recommendations for a Plan of Action for AIDS Control in the African Region of WHO" (WHO, 1986a). The report contained the first blueprints for the structure of National AIDS Control Programs (NACPs) and the National AIDS Committee (NACs) (Will, 1991: 151). In addition, the World Health Assembly in Geneva in 1986 became a real wake-up call to the US and Europe for global action against HIV/AIDS when the Ugandan Minister of Health announced that Uganda was facing serious problems due to HIV/AIDS.

4. THE WHO AND DEVELOPMENT OF THE INTERNATIOAL NORMS OF GLOBAL RESPONSE TO AIDS

The early inaction and denial gave way to the growing global cooperation in coping with the potential global pandemic. Most importantly, international society assigned the WHO a role as an umbrella institution responsible for coordinating the global fight against AIDS. According to the Report of the First Regional Conference on AIDS:

> "[T]here was a strong consensus that the WHO should take a stronger position of leadership and advocacy for national and international programmes for AIDS prevention and control. Governments must be encouraged by the WHO as well as groups within, to establish

active programmes" (WHO, 1986a).

Director-General Mahler made a statement that "[F]or after several years of preliminary activity, it became clear that a global effort would be required to stop AIDS. Just as smallpox eradication only became a reality when the nations banded together under the banner of the WHO, so AIDS will require global mobilisation around a global strategy" in the 42nd Session of the United Nations General Assembly Meeting on 20th October 1987 (WHO, 1987a: 1). The Special Program on AIDS created as the headquarters for the global attack on AIDS on February 1st 1987 was a reflection of his mindset:

> The World Health Organisation recognised its responsibility to mobilise international energies, creativity and resources for global AIDS Prevention and control. The Special Programe on AIDS has been created as the focal point for WHO's global AIDS prevention and control strategy (WHO, 1987b: 1).

This section illuminates the detailed historical process in which the WHO played a role in developing the idea of urgent need for international collaborative action and engendering foreign aid in four stages.

4.1. First Stage: Sharing Information and Enhancing Awareness

The WHO's first strategy was to convene various international forums in which participants could exchange epidemiological and medical knowledge of AIDS. The WHO took advantage of the events as platforms to problematize the issue and invoke awareness. In 1983 the WHO launched consultations with several other agencies for exchanging information. The first meeting was held in Washington on August with co-sponsors like the CDC, Pan American Health Organization (PAHO) and the National Institutes for Health (NIH). The second meeting took place in Aarhus, Denmark in October, which was co-sponsored by the European Regional Office (EURO), the Danish Cancer Society, and the European Organization for Cooperation in Cancer Prevention Studies. In addition to epidemiological and virological information, the social impacts of the disease were discussed in the consultations. The third consultation was held in November in Geneva, Switzerland. As a sole convener, the WHO hosted forty-seven representatives of various organizations from twenty-two countries who gathered for determining the state of AIDS at the global level based upon shared research and information (Will, 1991: 205-206).

One of the most significant events in the first stage was the first International AIDS Conference in Atlanta in April 1985. The WHO co-sponsored the Conference with the CDC and the US Department of Health and Human Service. It was the first official international event that exclusively targeted HIV/AIDS. The Conference was such a breakthrough that the international community was awakened by the shared information and knowledge. Approximately three thousand scientists, public health officials, and journalists from fifty countries gathered for the purpose of sharing knowledge of the virology and epidemiology of AIDS (Chin, 2007: 197; Behrman, 2004: 15). Thousands of participants became aware of the identity and potential impact of AIDS and became overwhelmed by the depressing picture of a present and prospect. As a result of the efforts of the WHO to collect information and data on AIDS, state leaders gradually became cognizant of and even alarmed at the deadliness of the disease, both domestically and globally.

4.2. Second Stage: Constructing Perception and Orchestrating Coordination

The WHO organized an overarching network of global coordination for the global fight against AIDS. Several significant institutional frameworks were created for orchestrating international coordination. This was possible because the reality pertaining to AIDS was constructed on the basis of medical knowledge and the realization of social impact and prospects that challenged international community to mobilize immediate responses. The WHO provoked interpretations or perceptions of AIDS as a 'crisis' that required special cooperative responses internationally. Specific perceptions and interpretations need to be attached to the facts so that a sense of exigent obligations among international community can entail (Clark, 2001: 33-34).

The first step for the collaboration was to establish the Collaboration Centres on AIDS in September 1985. Following the earliest gatherings like the consultation meetings in 1983 and the first International AIDS Conference in April 1985, the WHO undertook the establishment of special collaborating networks including a network of AIDS research organizations. As a result, the WHO Collaborating Centres on AIDS [5] were launched in September 1985, consisting of representative of twenty-eight countries. In the following meetings in Geneva in December 1985, the Centres designed particular AIDS programs including: exchange of information; preparation and distribution of guidelines, manuals, educational materials for the public; assessment of commercially available LAV/HTLV antibody test kits, development of a simple, inexpensive test for field applications, and establishment of WHO reference reagents; cooperation with member states in the development of national programmes/actions for the containment of LAV/THLV infection; advice to member states on provision of safe blood products; coordination of research on therapeutic agents and vaccine; and simian retroviruses. Most of all, the international community reached an agreement on the imperative for collaborative action and assigned the WHO the responsibility for the whole AIDS control and prevention programs (WHO, 1986b: 37-46).

The WHO also set forth plans for the WHO Programme on AIDS from 1986 to 1987. The first Meeting of Potential Donors for the Prevention and Control of AIDS was convened in Geneva in April 1986. Participants pushed the WHO for a role of coordination in global AIDS response and created an administrative unit within the WHO headquarters (WHO, 1986c). Responding quickly to this mandate, Director-General Mahler formally established the AIDS Control Program (CPA) the following day, on April 23, 1986 (Will, 1991: 146). The WHO hosted a subsequent meeting of a group of potential donors where they reviewed the CPA's proposed plan of action and its estimated budget (WHO, 1986d). At the meeting in summer 1986, participating parties approved the establishment of a global program on AIDS based on the principle of the cooperation that donor agencies and recipient parties had agreed upon in the conferences in Bangui and Brazzaville (Will, 1991: 208-212).

The WHO did not stop making progress in developing a more efficient and independent

[5] The Centres were obliged to "provide timely information to WHO for global dissemination, particularly where this is relevant to the prevention and control of disease" (WHO, 1986b: 37). The Centres particularly attempted to standardize the reporting system for AIDS and HIV infection in order to devise an effective mechanism through which to collect and analyze information (WHO, 1986b: 38). This was a very important step for gathering credible and reliable data that could be used to identify regional and international state of AIDS.

program structure that took exclusive care of the health issue. First, the CPA developed dramatically with staff rising to five people and extra-budgetary resources increasing by $5 million in January 1997 (Will, 1991: 147). Second, in the aftermath of the second International Conference on AIDS in June 1986 in Paris, the WHO created an office that designed the WHO's strategic plan and eventually proclaimed the creation of "Special Programme on AIDS (SPA)" in January 1987, which replaced the CPA.[6] With the advent of SPA, international collaborating activities against AIDS emerged rapidly and extensively in terms of donors' contribution and development of strategies for treatment and prevention. The Programme was renamed "Global Programme on AIDS (GPA)" in 1998. Significant roles were assigned to GPA, from research, information gathering and dissemination, to designing a national AIDS program and training people required for implementing the program.

Dr. Mann's contribution as an incipient Director of the GPA cannot be underscored enough. Despite general budgetary curtailment of the whole UN system including the WHO in 1987, the GPA developed remarkably in staffing and budgeting. The number of staff skyrocketed from 2 to 150 at the end of 1987, then to 225 in 1988 and up to 400 in 1989. In terms of the budget, it grew rapidly from $5 million from the outset to $23 million in 1987, to $50 million in 1988, to $90 million in 1989 and up to $100 million in just three years (Behrman, 2004: 48; Will, 1991: 208-209). This was possible because Dr. Mann obtained an independent status of the GPA implicitly from the overall WHO system despite its official status as a sub-system. He persuaded Director-General Mahler to provide full support for the global fight against AIDS. Dr. Mahler recalled that it was Mann that transformed his stance on AIDS from indifference and ignorance toward dedication of "energy, commitment and creativity to the even more urgent, difficult, and complex task of global AIDS prevention" (Behrman, 2004: 44).

Dr. Mann's perception deserves closer scrutiny for building international coordination. He perceived AIDS as "a global problem which requires international solidarity" and advocated this perception in various international gatherings for enhancing recognition of AIDS worldwide urging all members in the international society to cooperate in the global battle (WHO, 1992). For example, he had an opportunity to present at the Fourth International Conference on AIDS in Stockholm, Sweden on June 12, 1988. In the presentation, he encouraged national and international efforts against AIDS, which mobilized people and financial resources through resolute commitment to inter-dependence, communication, and justice (WHO, 1988a: 10).

Dr. Mann's perception was also reflected in the global strategy of the GPA. His 1986 seminar documentation was adopted as SPA's basic strategy in the World Health Assembly in 1987 and the strategic plan was redrafted and renamed as the 'Global Strategy for the Prevention and Control of AIDS' (WHO, 1986d). The Global Strategy served as an official guideline for the WHO's AIDS policies afterward. Based upon the strategic plan and the full support of the WHO Director-General, Dr. Mann attempted to establish new surveillance systems for portraying a more realistic picture of global AIDS. Existing official national AIDS estimates from developing countries were not trusted due to the lack of reliable international network of experts to confirm the estimates. Therefore, he built domestic surveillance capacities by providing developing countries with resources and techniques and

[6] The establishment of the WHO's special AIDS program was formally endorsed by the Fortieth World Health Assembly with a Resolution WHA40.26 in Geneva on 15 May 1987 (Will, 1991: 147).

deploying experts to collect data.

The next step was prevention, mainly by supporting development and promotion of the NACPs in the countries. He visited the countries to meet politicians and public health officials to pressure them to enhance public awareness and to follow GPA leadership to launch prevention programs (Behrman, 2004: 50). The GPA promised to provide governments with technical guidance and expertise as well as resources. Incentives to encourage countries to launch the NACPs were given in the form of short-term programs (six to twelve month long) as well as medium-term programs (a four to six year span) (Mann, 1987; WHO, 1988b).

Dr. Mann's other contribution was to put the disease in the larger context beyond a health agenda. He envisaged various social and cultural implications of the disease associated with promiscuity, extramarital sex, prostitutes, homosexuals, or drug users. He foresaw that such policies as mandatory testing, quarantine or imprisonment would stigmatize the communities and keep them underground, which would end up spreading the disease widely and silently. Mann believed that it was impossible to stop HIV/AIDS unless we approached the issue with a comprehensive strategy encompassing human rights, social equality and development (Behrman, 2004: 47).

The active roles of Dr. Mann mobilized international cooperation. By 1990 GPA was working with over 80 percent of all countries through a variety of activities, including data collection and surveillance, providing financial support to over 130 nation-states, and lobbying for mobilizing resources from developed countries. Slutkin (2000) comments that "[T]he years 1987 to 1990 had been years of great inspiration, idealism, hope and action, and were characterized by the leadership of the international effort by Jonathan Mann" (30).[7] Behnman (2004) also appraises the roles the WHO played in creating a view of AIDS as an urgent global catastrophe and "a public health emergency of international significance" (15). In sum, the role of Dr. Mann was critical as he not only echoed his perception that international solidarity was essential but also designed a general strategy.

4.3. Third Stage: Establishing Norms in the UN System

The WHO's extraordinary roles lie in the establishment of many official resolutions promulgated by the WHO and the UN. The resolutions confirm the shared idea of international collaboration against the pandemic, especially the financial obligations of the developed countries. The first official WHO report on its AIDS activities was 'WHO Activities for the Prevention and Control of AIDS' (WHO, 1985). It was generated by Dr. Mahler in response to the request of member states to prepare the official WHO report on its AIDS activities. The report was presented to the WHO Executive Board, which examined and unanimously endorsed it as a draft resolution on the global AIDS program through Resolution EB77/R12 (WHO, 1986e) in the thirty-ninth World Health Assembly (WHA)[8] in

[7] 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 working with a new Director-General, Hiroshi Nakajima (Hilts, 1990).

[8] The World Health Assembly (WHA) is a "decision-making body of WHO" in which delegations from all WHO members gather annually (in May) in Geneva, Switzerland for discussing various health agenda raised by the Executive Board. The main functions of the WHA are "to determine the policies of the Organization, appoint the Director-General, supervise financial policies, and review and

November 1985. On 16 May 1986 the draft resolution was adopted and promulgated as the first official WHO resolution on AIDS, known as the Resolution WHA39.29 (WHO, 1986f). In the Resolution, the WHA officially recognized AIDS as one of the agendas belonging to the responsibility of the WHO.

The fortieth WHA confirms the intensified role of the WHO and urged the enhanced commitment of member states in Resolution WHA 40.26 in May 1987. The Resolution officially endorsed the SPA as a special institutional apparatus that directed and coordinated the global strategy and programme for the global, urgent and energetic fight against AIDS. The Resolution 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, 1987c). They were also 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 in cash and kind for the implementation of the global strategy.

Resolutions pertaining to AIDS responses were also adopted at the UN level. Following the speech addressed by Dr. Mann as a Director of GPA at UN General Assembly, the UN passed a formal resolution (Resolution 42/8) on AIDS on October 26, 1987. It was an unprecedented moment in that the Resolution was the first official UN resolution exclusively targeting a specific disease for the first time in the history of the organization. The Resolution made the response to HIV/AIDS as high priority and "the central issues of our time in demanding global solidarity" (UN, 1987). Also, the UN General Assembly recognized the "established leadership and the essential global directing and coordinating role" of the WHO in AIDS prevention, control and education" (UN, 1987).

In January 1988, the WHO organized a World Summit of Minister of Health with the government of United Kingdom, the largest meeting where 117 Health Ministries gathered (Berhman, 2004: 48). They announced the London Declaration on AIDS that called 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).[9]

In sum, the WHO attempted to construct international standards of the global response to AIDS by establishing (or helping to establish) resolutions at the level of the WHO and even of the UN. Though the resolutions did not place legal restrictions upon the member states, the countries were within the influence of international norms that encouraged or recommended certain behaviors that would not have otherwise occurred in response to the pandemic.

4.4. Fourth Stage: Implementing Norms through Mobilizing and Strategizing

The WHO made efforts to implement programmes by mobilizing NGOs and devising a particular funding scheme of donor countries. NGOs should be an integral part of a feasible 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,

approve the proposed programme budget" (http://www.who.int/mediacentre/events/governance/wha/en/index.html).

[9] See Mann and Kay, 1991 for more details about the GPA between 1986 through 1989.

training, development, education, women/youth issues, etc" (Will, 1991: 217).[10] Gordenker et al. (1995) comment on the limitation of GPA at the stage of policy implementation; "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" (89). Dr. Mann envisaged that AIDS Service Organizations (ASOs) and AIDS-related NGOs should be included in the AIDS policy implementation process as "a key element in building the GPA program" given their efficient and proficient local access (Gordenker et al., 1995: 54).

The GPA, therefore, attempted to mobilize existing networks of NGOs that enabled more efficient distribution of information and resources. According to the '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). The GPA developed a new coordinating structure and encouraged NGOs to participate in the NACPs and to establish ASOs consortia under the structure (Will, 1991: 217-218; Gordenker et al., 1995: 54).

For creating and managing the network structure, the GPA recruited Robert Grose, an expert of NGO relations from the Overseas Development Administration of the United Kingdom. He was assigned the responsibility of mobilizing NGOs and developing a WHO umbrella structure overarching all organizations by the end of 1987 (Jösson and Söderholm, 1995: 466). Grose worked with other WHO regional officials in Europe for facilitating a new network for strategizing WHO-NGO relations. They contacted officials from the NGO liaison offices at the UN to establish closer relations. Following the preliminary efforts, Grose convened a meeting where GPA staff explained to representatives of ASOs and other AIDS-related NGOs about the transnational umbrella organization in February 1988 in Geneva (Gordenker et al., 1995: 90-91). The GPA, subsequently, circulated a draft of strategy suggesting the establishment of a consortium of ASOs that would have a standing relationship with GPA. In December 1988 and January 1989, the GPA met with a small group of NGO representatives to discuss the network structure.

GPA took advantage of international forums in 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" (Gordenker et al., 1995: 94). In the first International meeting of ASOs in Vienna in late February 1989, representatives of more than fifty organizations held discussions about working relations between ASOs and GPA and spelled out their concerns and recommendations on how to overcome obstacles in drafted statement (Will, 1995: 218; Gordenker et al., 1995: 94-95). The WHO, in response, adopted resolution WHA42.34 that reflected the suggestions and officially recognized the importance of NGOs (WHO, 1989).

The participants of the Vienna meeting also discussed the establishment of the International Council of ASOs (ICASO), which would serve as "means to facilitate information exchanges, coordination and networking, as well as to represent the interests of ASOs" (Will, 1995: 219).[11] In June 1989 the entire ASO movements, with one hundred

[10] The importance of the role of NGOs was formally endorsed both by the UN General Assembly in UN General Assembly Resolution 42/8 and by the London global meeting of Ministers of Health in 1988 (see WHO, 1988c).

[11] The strategy is also found in the research on the activities of human rights NGOs in a human rights subcommittee of NGOs preparing for Tehran conference in 1965. They expanded it into "independent

NGOs working on AIDS, gathered in Montreal for wide-ranging discussions for the establishment of ICASO (Gordenker et al., 1995: 95). In the first International ASO Conference, held as a pre-conference of the Fifth International AIDS Conference, a temporary standing task group was created in charge of developing programs and a structure.

The following conferences also touched upon the issue of the NGOs networking. The Paris International AIDS Conference in 1990 had such basic goals as: facilitating international networking among ASOs, establishing a mechanism for representing the interests of community-based NGOs/ASOs internationally, and enhancing the contribution of NGOs/ASOs to the WHO Global AIDS Strategy (WHO, 1990). The Florence International AIDS Conference in 1991 determined the structure of the ICASO that reflected the demands of the NGOs from developing countries such as decentralized and regionalized structure, replacement of the administration, and relocation of secretariats to Ottawa (Gordenker et al., 1995: 102). The 1992 AIDS Conference in Amsterdam officially acknowledged the role of various actors including NGOs from developing countries and of People with AIDS (Gordenker et al., 1995: 100-101).

It is noteworthy that despite the large number of active ASOs, up to several hundred by the early 1990s, it was the GPA that had policy initiative within the WHO. The GPA played a leading role in orchestrating NGO activities under WHO's strategy for NGOs (Will, 1995: 220-221). That is to say, designing a plan or a strategy fell upon the responsibility of the WHO while NGOs became involved at the implementation stage under the auspices and support of the GPA. Even though NGOs were indispensable, the role of NGOs was constrained to the implementation of the programs in congruent with the WHO strategy.

In addition to the NGOs mobilization, the WHO strategized funding routes for increasing extra-budgetary contributions for implementing programmes. According to the WHO report of the meeting of donors for the prevention and control of AIDS (WHO, 1986c), donor countries were not very responsive to the funding request of the WHO from the outset. Even though there existed several exceptional cases like the US that contributed $1 million, their contributions were just a small part of the $8 million required for implementing the first twenty NACPs. Given the fact that the WHO allocated only $0.5 million from its regular budgetary exclusively for global AIDS response during the 1985-1986 biennium, the GPA had no choice but to depend on extra-budgetary funds (WHO, 1986c). This extra-budgetary strategy was even more imperative because the regular budget of the WHO was already fixed or even cut due to the general recession of world economy and donors' fatigue for foreign assistance in the latter part of the 1980s. Major donor countries were constrained in terms of the capacity and the willingness to increase their regular budget for WHO programmes.

The WHO encouraged donor countries to give extra-budgetary funding for the programmes of the GPA. According to the first WHA resolution on AIDS, WHA39.29 (WHO, 1986f), the WHO Director-General was requested 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). According to the report of the WHO Director-General in 1987 (WHO, 1987d), Dr. Mahler diagnosed that extra-budgetary sources should be guaranteed as an alternative for

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coalition of seventy-six NGOs and fifty independent experts" that worked on NGO recommendation for the conference in 1968. The efforts bore the fruit of establishing NGO forums that enhanced networking for better lobbying capacities since the 1972 Stockholm conference (Clark et al., 1998: 10-11).

tackling the new global agenda of AIDS under the restricted regular budgetary situation of the WHO, which only covered existing programs (Will, 1991: 156). In reality, extra-budgetary funding for AIDS treatment and prevention for 1988-89 was doubled up in comparison with an extra-budgetary funding of 1987 while general development assistance was drastically reduced due to the suspicion about the effect of the humanitarian aid widespread among donor countries.

The drastic financial increase through extra-budgetary funding was feasible because the GPA was flexible in channeling donors' money as a new coordinating mechanism. Historically, the WHO has played a marginal role in directing funding for development assistance for global health while main actors in a development assistance network were bilateral agencies of each government and multilateral banks like the World Bank (Howard, 1989). This was not an appropriate form of funding network that the WHO could depend on for global AIDS funding. Therefore, the WHO was far removed from this main funding network and had to mobilize a new financial network in which it had a central role in raising and coordinating the global AIDS funding. The WHO convened several country-level conferences as a platform for discussing and negotiating new sources and routes of findings. For example, the WHO hosted five donor meetings in Africa by November 1987. The number of participants was four in 1987 but had risen up to twenty-eight by March 1989. It is said that: "GPA's role in coordinating the country level donor meetings cemented its central position in the AIDS funding network. In this position, the WHO was able to lessen its dependence on direct unspecified contributions to the GPA, as well as monies allocated from the regular budget" (Will, 1995: 164).

5. CONCLUSION

It has been over three decades since the first cases of AIDS were reported in San Francisco and New York in 1981. The disease that initially appeared limited in scope and scale turned out to be one of the most devastating global health crises in human history and the dreadful story is still unfolding. The international community, mainly major donor countries, has been grappling with the global health disaster by allocating large sums of money and human resources. The implications of these actions are especially significant, given the initial denial of AIDS and the lack of substantive international responses during the early stage.

I contend that the transformation from inaction to active responses was feasible due to the WHO, whose roles were pivotal in fostering an idea of urgent responses to AIDS with a sense of obligations within the international community. In other words, the WHO, as a norms entrepreneur, developed the norms of global response to AIDS in order to trigger and cultivate financial contributions of major donors to the global fight against the epidemic.

In answering the questions of 'how,' I construe four stages of the process of norms development. Throughout the whole process, the WHO unveiled the real state of AIDS disease and provided a more realistic view on the seemingly destructive health calamity. The WHO problematized the AIDS issue and built the consensus on the urgency of response to the global health crisis. The efforts of WHO and Dr. Mann led to the construction of norms in various resolutions. The WHO also established an overarching coordinating network that mobilized and housed NGOs and ASOs and cultivated extra-budgetary funding for the GPA.

The WHO's efforts paved the way to the remarkable track record of global AIDS funding

in its scale and speed of increase during the new Millennium. Major donor countries increased the foreign aid for AIDS through newly established institutional routes with a proclamation of Millennium Development Goals (MDGs). Among the eight goals and eighteen targets for development, the DAC includes the goal of combating HIV/AIDS, malaria and other disease with specific targets of the fight against HIV/AIDS and the responsibility of developed countries in helping countries in need.[12]

One of the most significant steps taken was the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in 2002. The Global Fund was a novel financing mechanism in which both developed and developing governments, as well as the private sector, civil society and local community, participate under the framework of public-private partnership. As an independent intergovernmental organization, the Global Fund is actively involved in close cooperation with other agencies like the WHO or UNAIDS (Lisk, 2010: 98). From the outset, the Global Fund received voluntary contribution of estimated US$9 billion, which was a dramatic increase in total global commitment toward fight against AIDS (WHO, 2005).

It is also noteworthy that the President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003 as one of the most exceptional bilateral financing for global AIDS by the US. The US authorized a commitment of up to $15 billion dollars over 5 years to support treatment, care, and prevention programs largely focused in fifteen low- and middle-countries devastated by AIDS.[13] The US global HIV/AIDS initiative contributed to consolidating the norms of response to the pandemic.

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[12] The norms of global response to HIV/AIDS are identified in the Millennium Development Goals, which were articulated in the Millennium Declaration of the UN in 2000. In 1996, the DAC paved the way towards setting targets for international development in OECD, "Shaping the 21st century: The contribution of development co-operation. Development Assistance Committee" (http://www.oecd.org/dac/2508761.pdf, accessed 21 April 2012). Subsequently, in 2000, the DAC articulated eight goals and eighteen concrete targets for development, including curbing poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women in the MDGs. Among the goals and targets in the MDGs, the DAC articulates the goal of combating HIV/AIDS with two targets by 2015. Below is the Goal 6 with associated Targets:

Goal 6: Combat HIV/AIDS, malaria and other diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

[13] Visit http://www.pepfar.gov/ for details on the PEPFAR.

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Young Soo Kim, Assistant Professor, Department of Political Science, Loyola University New Orleans, 6363 St. Charles Avenue, Campus Box 112, New Orleans, LA 70118, USA, Tel: +1-504-865-2492, E-mail: yskim@loyno.edu