The Ford Foundation's early involvement in global AIDS and grants to Indian AIDS NGOs

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This PhD project is a global, national and local history of the Indian National AIDS Control Programme (NACP) from 1986 to 2005. During my six-week research trip at the Rockefeller Archive Center (RAC) in Tarrytown, New York, I mainly examined the RAC's holdings of the Ford Foundation's files on AIDS in the Human Rights and Governance Program, Ford's grants to Indian AIDS NGOs, as well as some material on the Rockefeller Foundation and other American foundations. These records have contributed an essential perspective on how Ford situated itself within the broader response of global health organisations and other international bureaucracies in regards to how the AIDS epidemic in developing countries should be dealt with. They demonstrate that the Ford Foundation, as an American philanthropy, had been an active voice in early discussions of how the disease should be tackled in developing world contexts. Most significantly, they show how Ford – as one of the first international agencies active before 1992 – had a distinct strategy for its AIDS work in India and its relationship with Indian civil society. This strategy was defined primarily by the Foundation's perception that issues of social development and the social impact of AIDS were under-addressed by other international health agencies as well as the Government of India through its National AIDS Control Organisation (NACO).

I. "The AIDS Challenge: A Ford Foundation Response" and Program Officer Reports: Insiders' Reflections on the History of the Ford Foundation's International AIDS Strategy and Work in India

It is clear from the archival evidence that the Ford Foundation had a clear and dynamic strategy for its national and international AIDS activities vis a vis what it perceived were changing needs in developing countries as the epidemic progressed and the work of other international health bureaucracies, development agencies and bilateral donors. In this first section, I present an

overview of the Foundation's U.S. and developing country AIDS activities drawing from internally produced and circulated documents at various stages. First is a 1987 Information Report prepared for the Board of Trustees titled "The AIDS Challenge: A Ford Foundation Response." Second is a 1998 report by Marjorie Muecke of the Reproductive Health and Sexuality Program Office, which provides a perspective on the thematic connections between Ford's domestic and international AIDS work. Third is a 50th Anniversary Monograph written in 2002 by Radhika Ramasubban and Bhanwar Singh Rishyasringa, which focuses primarily on the AIDS NGO network in India and the shift towards sexuality and reproductive rights. Finally, Jacob A. Gayle reviews Ford's contributions to the global AIDS response in 2006 as the strategy was about to be up-scaled, showing a perspective on how Ford positioned itself in a dynamic landscape of other international AIDS actors.

1987 Why AIDS was A Problem for Developing Countries – What Ford could Contribute

From an information paper prepared for the Board of Trustees titled "The AIDS Challenge: A Ford Foundation Response," we can see an early snapshot of Ford's intended strategy.[1] In June 1987, Ford appointed a group of consultants on both U.S. and foreign aspects of AIDS "from around the country from the fields of medicine, public health, law, and public policy" to help identify areas of "critical, unattended need" that Ford could become involved in.[2] The plan for Ford's domestic work is well defined and articulated, as it clearly lays out the epidemiology of the crisis in various regions, the consequent social problems and the ongoing initiatives of other organisations. In terms of developing countries, the strategy was still somewhat vague, with the report simply stating that it strongly believed that Ford was uniquely positioned to: "[provide] information and logistical support in the developing countries to public health ministries and

non-governmental organizations concerned with developing fair and effective policies and preventive measures to contain the disease, and to share successful strategies."[3]

Chapter III, titled "AIDS in the Developing World: Potential for Foundation Action," shows how at this point, Ford's understanding of AIDS in the developing world and why it was an issue was still uncertain. Regarding the special need for AIDS work in such a context, Ford declares that the disease "threatens a broad cross section of the population in developing nations and compounds their already serious public health, development, and poverty problems."[4] The report notes that, in contrast to the United States, the epidemic in Africa was spread primarily by heterosexual transmission and affected both urban and rural populations equally. In regards to Latin America, particularly Brazil, the report presents more concrete evidence of the number of cases in men and women, also noting that there was significant discrimination against those infected with HIV and perceived risk groups such as homosexuals and sex workers. However, regarding the region of Asia, the report is the least clear, only stating that "[b]ecause of widespread intravenous drug use and prostitution associated with tourism in some countries of the region, … public health officials fear that AIDS is 'knocking at the door' of Asia." Interestingly, there is no mention of the 1980s debt crisis in developing countries, except to note that they are extremely poor.

However, Ford was adamant in this 1987 strategy report on why it needed to get involved: "AIDS has serious consequences for most of the Foundation's work aimed at alleviating poverty and promoting equal justice."[5] Not only that, AIDS was seen as a unique disease due to the "absence of preventive or curative medicines" and the way it would compound issues in developing countries' health infrastructures due to its mode of transmission (sexual, blood transfusion, needles and breastfeeding) and the existing presence of diseases of poverty, such as tuberculosis and malnutrition. The link between AIDS, poverty and macroeconomic development is made in a very interesting way:

Thriving in an environment of poverty, AIDS threatens to push poor nations even deeper into poverty. In Central Africa, it is the productive members of society between ages twenty and fifty – particularly the educated elites – who are falling victim to the disease. Some policy makers are seriously concerned about the future viability of whole nations, not only in terms of net population losses but also in terms of losing essential human capital.[6]

The report continues to denounce restrictive HIV testing policies for international travellers and immigrants in developing countries, declaring that "[h]ow societies choose to deal with the HIV infection, especially since the full dimensions of the problem are still unknown, may be the most important issue facing several Third World governments."

In the next section, the report details the activities of international agencies, focusing in particular on the World Health Organisation's Special Programme on AIDS (SPA) and the United States Agency for International Development (USAID). Here we learn some critical information about the SPA before it became the Global Programme on AIDS (GPA). The goals of the SPA were to improve blood supply, prevent blood/sexual/prenatal transmission and research vaccines. Multilateral agencies like the World Bank and UN system members were happy for the WHO to take the lead. However, the report details that the programme was severely understaffed and underfunded. It notes that some donors were "likely to balk at WHO's proprietary claims to the field" and have asked the SPA to allow UNDP and UNICEF in particular to have more of a say in programme design. While it notes that the US did provide donor funding to the WHO, USAID had begun a five-year contract of $28 million with a consortium of NGOs led by Family Health International to "provide technical assistance to developing countries in their AIDS prevention efforts." USAID also funded $14 million for a communications program run through the Academy for Educational Development (AED) to provide information, education and communication (IEC) materials.

The report then turns to the landscape of international NGO work. It notes that organisations like the International Commission of Red Cross and Red Crescent Societies had focused on clean blood supply, while Save the Children, who worked on education and family planning organisations, had added HIV and STD prevention to their health communication work. It also notes that "somewhat belatedly," development agencies had begun to view AIDS "not only as an international public health problem but also as a threat to the development process itself."[7] Within this, the time was ripe for private U.S. philanthropies to become involved, noting how the Rockefeller Foundation had funded research on sexual behaviour and heterosexual transmission of AIDS in Africa. So how was Ford to carve out a space for itself and make an impact in this landscape considering the problems in the developing world?

Ford notes its advantages and disadvantages and designs its strategy accordingly. First, it could not draw from the financial resources and biomedical technical expertise necessary to become involved in vaccine and treatment research. It notes, "[i]n any event, such work is preeminently a function of governments, and is currently being led by public institutions in the United States and France." Given their past experiences in health, however, where private foundations like Ford could leave their mark was in behaviour change and educational activities. The report notes the strengths of the Foundation being its existing relationships with human rights activists, government policy makers and social scientific programs at select universities in developing countries. Thus, it suggests that it could "help support selected activities in those domains complementing – but not controlled by – governmental mechanisms put in place by the national AIDS committees established by WHO."[8] Education and behavioural change AIDS activities could also build from Ford's previous international work in child survival and reproductive health, its network of community epidemiology and management in Asia, as well as its focus on human rights and connections with women's organisations.

Here we note a few tendencies of the Ford Foundation that we will continue to see throughout the records: it stays away from hard economic as well as scientific and biomedical impact areas, focusing more on social issues like human rights, non-discrimination, sexuality and gender. Thus, it is reasonable to infer that the Foundation understood poverty in terms of social rather than economic development when it made the case for why it needed to be involved with AIDS in developing countries. Ford is also keenly protective of its autonomy and wary of complete control either by multilaterals or national governments. Thus, it aligns its expertise in work that was close to the community and potentially dealt with sensitive issues:

Free of constraints that inhibit government assistance agencies and nongovernment organizations dependent on government funds, the Foundation could work flexibly and sensitively with indigenous groups on such delicate topics as patterns of sexual behaviour and how they might be modified to prevent AIDS.[9]

Ford was aware of how foreign agencies were perceived in developing countries – as "European and American scientists who 'parachute' in to gather data on indigenous populations but are primarily concerned with the effect of AIDS on their own societies" – and hoped to leverage their position as a "long-established, nongovernmental institution" to bypass that.[10] Finally, the report details their discussions with the Nairobi office on potential activities and notes that a grant had already been made through the Rio de Janeiro office to the Brazilian Interdisciplinary Association on AIDS. Thus, we know that before it was active in India, Ford had already had conversations with field offices in Africa and Latin America.

1998 Marjorie Muecke's Overview of Ford's National and International Activities

Despite uncertainties in biomedical understandings surrounding the disease in 1987 when Ford first began to make grants for AIDS activities, the Foundation was one of the most proactive organisations in addressing what it considered neglected social aspects of the disease. A 10 September 1998 draft transition memo report by Marjorie Muecke provides an insider perspective on the early history of Ford's work.[11] From 1987 to 1988, the total amount of funding granted was: $25,869,440 to U.S. activities; $18,696,171 to developing countries; and $2,280,500 worldwide. In terms of the domestic work, Muecke details how her predecessor Cristina Cuevas at the Rights and Social Justice Program focused the Foundation's AIDS portfolio on "developing opportunities for the formulation of national policy."[12] After September 1993, when Muecke came to her position as the New York office's Programme Officer for HIV/AIDS, she "shifted the Foundation's approach from the content of AIDS policy to the participants (not) involved in the process of AIDS policy formation."[13] This was to reflect the fact that the disease had moved from the risk group of white middle class gay men to the general population, which would disproportionately affect the underprivileged. She states that she "proceeded to support activities that would change the infrastructures of exclusion that were accelerating the spread of the virus to women and youth, the poor, people of color, and other groups not benefiting from HIV prevention programs."[14] In terms of actual activities, the focus was on (a) community-based prevention efforts as well as (b) mass media education messages. Muecke focused the Foundation's efforts on representing and including diverse and less-privileged voices, particularly those of women, in prevention and education policies. She also focused on reaching out to Black Church leaders and leaders in the African American Muslim community to help design appropriate health education messages and channels for treatment and counselling. Finally, she led the national strategy to identify and combat sources of stigma and discrimination, particularly concerning faith-based groups'

perceptions of homosexuality. These elements comprised what Muecke named the "AIDS Politics of Inclusion" initiative.

In regards to developing countries, Muecke certainly defends Ford's attention to prevention as a stance against the "current focus of HIV/AIDS at the international level [which] is narrowly directed at medical treatments, pharmaceuticals and vaccine development, as evidenced by the recent International AIDS Conference in Geneva as well as by funding streams."[15] She also saw the need for Ford's presence to balance the dominance of the United States and developed countries in setting the AIDS policy, research and program agendas. Developing countries needed to be "empowered" because domestic policy makers would take medical advances in treatment and reduced mortality rates as signs that the epidemic was abating and reduce international funding. She also initiated a new approach to Ford's worldwide AIDS work, though the strategy here was necessarily less defined in order to be tailored to each location. Like the "Politics of Inclusion" work in the U.S., the Foundation sought to encourage approaches that would "integrate HIV/AIDS with other dimensions of development." Unlike other organisations who resorted to funding highly vertical AIDS work, Muecke saw Ford's experience with reproductive health as an asset in understanding and addressing HIV/AIDS in a more comprehensive way:

Because of its leadership in the field of reproductive health, it has a critical role to play in strengthening the linkages between HIV/AIDS, reproductive health, reproductive rights, and development.[16]

2002 Sexuality and Reproductive Health in India – 50th Anniversary Monograph

In 2002, Ford commissioned Radhika Ramasubban and Bhanwar Singh Rishyasringa to write a monograph titled "Sexuality and Reproductive Health

and Rights: Fifty Years of the Ford Foundation in India" on the occasion of Ford's 50th Anniversary. This document provides an excellent general overview of the work in the country. India was one of first overseas sites that Ford turned its attention to and in turn, the Foundation was one of the most active foreign agencies in initiating responses to AIDS in the country during the early period of 1986 to 1992, which was the year AIDS activities were centralized through a National AIDS Control Organisation (NACO) and up-scaled with a substantial World Bank grant. During this time, Ford felt that the social aspects of AIDS had been under addressed. The disease as approached by the Indian Council of Medical Research (ICMR), which had taken charge, was viewed as "a medical problem of Western origin": that India was "a monogamous society with high moral values and incapable of succumbing to a sexually transmitted disease (STD) like AIDS in a big way." [17] Activities emanating from the Central Government thus focused on controlling sex workers and foreigners.

"With few leads to proceed on, but recognizing the advantage of making an early start in this complex and unfamiliar area of sexual behaviour," Ford identified public education about AIDS and the humane treatment of female sex workers as two areas needing immediate attention.[18] The Foundation's existing Community Epidemiology network served as the basis for NGO involvement. Saroj Pachauri, a Child Survival Program Officer, began looking for organisations Ford could persuade to address AIDS. In this early period before 1992, Ford made grants primarily to medical researchers at the institutions that had discovered the first national case and activist journalists pushing for legal protection of sex workers' civil rights. In particular, the state of Tamil Nadu (where infection was first discovered) was a focus location as Ford built up a small network there consisting of Christian Medical College (CMC), the local Voluntary Health Association of India (VHAI) branch and the South India AIDS Action Programme (SIAAP). Furthermore, Ford organised a consultation in Bombay bringing together the ICMR, CMC, the Tata Institute of Social Sciences, the All-India Institute of Medical Sciences (AIIMS), the National Institute of Virology, media organisations and NGO health activists.

1992 was a seminal year because it was when the first phase of the National AIDS Control Programme began with a grant of $84 million from the International Development Association (IDA) of the World Bank and resulted in "opening the flood gates to external donor funding, most notably the World Bank, and helped legitimize the field somewhat."[19] Ford's grantmaking took on a brisker pace as they focused primarily on Tamil Nadu and Maharashtra, the states with the highest prevalence levels. Despite its achievements, in 1994, Ford commissioned an evaluation of its AIDS grantmaking in India by Ashoke Chatterjee and Dr Kusum Sahgal. Their findings were published in a report titled "HIV/AIDS Awareness & Control: Nineteen NGO Experiences in Delhi, Maharashtra, Tamil Nadu."[20] This report found that there were several unsustainable trends. Ford-funded Indian AIDS NGOs put out fear-based health messages, worked in isolation and lacked mechanisms for evaluation and reflection. Around this time, the AIDS NGO scene in the country rapidly boomed in response to foreign donors' interests and parallel to that came accusations of corruption and lack of regulation.[21]

In light of this, the Anniversary Monograph states that Ford took a step back from its trailblazing strategy and initiated a more "pared down" and efficient approach to grantmaking in 1996. In this new strategy, Ford supported a core group of about fifteen capable NGOs mainly in Tamil Nadu and Maharashtra but also in the cities of Bangalore and New Delhi, which formed part of what it called "NETWORKS." Members of NETWORKS included: CMC, the Naz Foundation India Trust (NAZ), Nalamdana, Y.R. Gaitonde Centre for AIDS Research and Education (YRG Care) and International Nursing Services Association India (INSA). While these organisations did receive funding from other sources, in all their varied activities, each member focused on preventing transmission; care, counselling and support; and establishing guiding principles based on the dignity of HIV patients. The Delhi-based Naz Foundation Trust (which conducted many coordinating and training activities for other more grassroots organisations) is an interesting example of Ford's tendency to designate "intermediary organizations" in its grantmaking as a way to bring grassroots NGOs out of their isolation and in

collaboration with each other. According to the report, many of Ford's NETWORKS alumni became well established and respected in the AIDS civil society community, with some members going on to work in national and international health policy. I will examine this in more detail in the third section.

Perhaps influenced by their NETWORKS members' focus on sexuality as a key social issue in AIDS, Ford began to address issues of sexuality in their health work, changing its Reproductive Health and Population Program to a Sexuality and Reproductive Health Program in 1994. In 1996, Geeta Misra joined the Delhi Sexuality Program with a strong background in NGO activism and Susan Berresford became President of the Sexuality and Reproductive Health field. As a result of this, grantmaking began to emanate from a stance of seeing HIV/AIDS within the framework of sexuality and sexual rights, the dignity and empowerment of women in sex work and protection against sexual violence. Accordingly, Ford funded sex worker's rights projects with the Sonagachi in Calcutta and the SANGRAM in Maharashtra, as well as research on legal protections for sex workers and their rights with a grant to the Centre for Feminist Legal Research in Delhi.

2006 Jacob A. Gayle's Reflections on Ford's Global Response to HIV/AIDS

Finally, Jacob A. Gayle, the Deputy Vice President for HIV/AIDS, reflects on Ford's twenty years of international AIDS work and the changing global epidemiological scenario in 2006 to make a case for the organisation's renewed commitment to the global response.[22] Despite 25 years of prevention and control as well as a decade of advances in highly active antiretroviral therapy (HAART), Gayle cites the UNAIDS statistic that there were over 40 million people living with HIV/AIDS around the world. The epidemic's international epidemiological

profile grew more and more complex as infection spread from core risk groups to the generalized population. Furthermore, he deemed that there was a lack of political commitment and "[i]nsufficient human capacity for leadership and action further hamper[ing] progress, despite an exponential increase in financial resources for action."[23] Gayle clearly still sees Ford as a leader in initiating social change activities. By supporting key activities, issues and individuals early in the epidemic, he argues that Ford created a landscape in which healthy and constructive dialogue about taboo issues could be discussed. Ford's impact could be felt most in countries like Brazil and India, who "owe much to the Foundation for their early successes in activating community/civil society participation in national HIV efforts."[24]

In light of such successes, Gayle discusses the reasoning behind why efforts needed to be up-scaled, not just intensified: "[i]n order to have ultimate success, local initiatives need to be brought to full scale, and they need to be financially secure over longer time frames. Furthermore, gaps still remain at local levels and they need to be addressed before the HIV response can be considered comprehensive."[25] He presents several potential initiatives Ford could pursue during the period of 2006 to 2010, including:

- Senior decision-making and agenda-setting positions for representatives of aid recipient countries in institutions such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and the US President's Emergency Plan for AIDS Relief (PEPFAR) to bring them "up-to-date local knowledge, drawing on our local grantees' experiences."

- Harnessing the application-potential of the knowledge Ford had gathered with diverse local experiences by bringing them together in multi-country mechanisms, allowing them to be implemented through agencies like UNAIDS, WHO and the Global HIV Prevention Task Force. Gayle states: "Ford's global voice could be crucial in ensuring that local innovations are spread and implemented with human rights and equity in mind."[26]

There are many more initiatives proposed, all aimed at taking a more "global," coordinated and comprehensive approach. Thus, one of the most interesting themes that emerges from Gayle's report is that by 2006, Ford was aware that the landscape of global AIDS had changed. It was much less fluid than in the early years and so the Foundation had to define a narrower and more focused role against organisations operating with different areas of expertise, amounts of funding and hierarchies of governance. Not only that, but as their respective epidemiological profiles evolved, developing countries had changing needs as well.

However, the Foundation was well informed as to the activities and impacts of all the global AIDS actors, as well as how some were perceived in various countries. As narrated by Gayle, the Foundation took the stance that all organisations were bringing their talents together towards a common goal: not just preventing and mitigating the impact of the disease itself, but improving social development overall in developing world contexts. Within this, Ford clearly had a distinct understanding of the particular experience and expertise it brought to the table and obviously took pride in its active if relatively smaller role. This allowed Ford to be quite specific about where it could benefit the work of other organisations and vice versa. For example, given their social development orientation, Ford proposed that their grassroots work would progress more smoothly under an umbrella of authority in which the UN system would set the standards and regulations, while prominent international NGOs like Human Rights Watch with offices around the world would monitor violations of rights. And for its own institutional direction, Ford clearly saw the benefits of being "one of the few foundations with an HIV portfolio that includes both US domestic and international grant making": this would allow streamlining of domestic and international efforts into "one global program."[27] As I detail later, this makes Ford a unique case study for my project because it demonstrates how global AIDS was transnational, national and local.

II. Gathering Information and Corresponding with Other Organisations: How to Understand and Mount a Strategic Response to AIDS in Developing Countries and India

The 1987 strategy document, the 50th Anniversary Monograph, as well as Muecke and Gayle's reflective reports, provide an illuminating and comprehensive, if rather polished overview of Ford's national and global work from 1987 to 2006. Thus, it is important to also look into the "rougher" archival details of the information Ford was collecting and its correspondences with various organisations throughout this period. For American grant-makers like Ford who were interested in expanding their activities internationally, understanding how the epidemiology of the disease's transmission differed in contexts outside the U.S. was key to their preparations in the late 1980s. Regardless of Ford's extensive work in India since 1952, these records show how uncertain grantmakers were about what exactly AIDS was and what impact it would have. They paint a more in-depth step-by-step picture of how a philanthropic organisation like Ford confronted the advent of AIDS and framed its response. They tell us what kinds of information and individuals Ford considered accurate and reliable concerning the scenario of AIDS in developing countries, as well as what issues and collaborations they dropped. While some of these were meant more to advise the domestic programme, if aspects of them became part of the international and Indian programme, I have included them because I am also considering the question of whether Ford's understanding of the U.S. epidemic influenced what they viewed as problems in India: i.e.: what did treatment cost mean in the U.S. vs. India?

Beyond Biomedical: Involving the Social Sciences with the SSRC

From the early years, the Foundation did indeed seem to be particularly committed to issues outside the biomedical and scientific, gathering knowledge regarding social issues of anti-discrimination and human rights aspects. In 1987, Ford received a letter from the Social Science Research Council (SSRC), a New York-based non-profit organisation, about "initiat[ing] a conversation" for Ford support of a project on the "social consequences of the AIDS pandemic."[28] The SSRC often turned to private foundations rather than the American government, "whose support seemed more appropriate for the natural sciences," and I think that tendency is well demonstrated here.[29] In the face of uncertainty about a vaccine cure for the disease, the basis for the project was to understand and to project the "social, cultural, economic, and political consequences" of the AIDS epidemic. The SSRC makes a strong case for the need for perspectives from social scientific disciplines: "we are fixed on no idea other than on the necessity for a safeguard against a piecemeal approach in which information rarely crosses disciplinary lines or transcends a focus on a specified problem or issue."[30] After appointing a steering committee from professionals in the natural, medical and social sciences, the SSRC intended to begin three rather ambitious research projects. The first one would forecast the social consequences of the AIDS epidemic, "drawing on demographic and economic projections, epidemiological forecasts, historical analysis, and social theories." The second one would develop social science policy capabilities to advise national governments and other "social institutions" to cope with the epidemic. The third one would "study the consequences of the epidemic outside the advanced industrial societies of the West in Brazil and Africa in particular." To do this, they proposed "foster[ing] indigenous research in the affected societies in partnership with social scientists working on related problems in the U.S. and Western Europe."[31] The letter states that they had already done much work on a national scale but were looking to form a global network of research institutions. It is not clear if Ford did make a

grant to them for this project. However, from Ford's strategy for AIDS prevention in developing countries, it would seem that the philosophy of the SSRC and the work they proposed deeply resonated with them. Almost a year later, the Council had a more clearly defined strategy and had already begun their work. They got back in touch with Shepard Forman, Director of the Human Rights and Governance Program, on 12 August 1988 to invite him to a meeting they would hold on 17 October in New York.[32]

Cost and the Problem of AIDS in the Developing World

It is clear from the copies of articles present in the Office Files of Shepard Forman of the Human Rights and Governance Program that the cost of AIDS in terms of their domestic and potential international programme was indeed a concern. A handwritten note saying "[i]n case you are interested" is sent from Denise Silver to Forman on 11 December 1987 with a copy of Jane E. Sisk's "The Cost of AIDS: A Review of the Estimates" published in *Health Affairs* in summer 1987.[33] There are also copies of John K. Iglehart's "Financing the Struggle Against AIDS," a *Journal of the American Medical Association* piece titled "The Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States," a 1987 Overseas Development Council piece called "AIDS and Poverty in the Developing World" and a piece by Daniel Fox called "The Cost of AIDS from Conjecture to Research." These articles mostly focus on the U.S., examining the hospital and treatment costs HIV patients would have once their disease progressed and the consequent financial burden on the health care and insurance systems.

There is no comment by Ford about these articles in the archival records that I have found, so we do not really know how they factored into the strategy. However, their presence in the archives raises a few questions concerning how

exactly Ford understood the problem of AIDS in a developing world context and how it conceptualized the need for particular types of action. Since the Alma Ata Declaration of 1978, a key discussion among multilateral health and development agencies as well as national governments concerned how developing countries should organise their health infrastructures given a context of limited resources. Alma Ata vs. Selective Primary Care was essentially a debate about how health, particularly infectious diseases, should fit within an economic development framework. This debate is thus also at the crux of critiques public health professionals in India have about their national AIDS programme: if cost given the resource-poor context was such an issue, why was the programme itself so expensive to run and so vertically oriented? The presence of these articles raises critical questions. Given the earlier epidemic in the U.S. and the fact that Ford was an American philanthropy active in domestic AIDS grantmaking quite early on, did information about macroeconomic cost of AIDS in relation to GDP seep into their understanding of what AIDS would cost developing countries? Or (and I hope to investigate this history in the future), was Ford's understanding of why AIDS was devastating in India drawn from their past grantmaking relationships with Indian economists and social scientists who were commissioned to come up with more India-specific measurements of poverty in the early 1970s? In regards to themes and theories in history of international health, this raises the question of scale in historicizing the global AIDS response: how does a grassroots strategy fit into an understanding of top-down public health within a macroeconomic framework? As we will continue to see, Ford rarely engaged with national economic issues as part of the reasoning for their international health work.

Lincoln C. Chen and the Harvard School of Public Health

As early as 1987, Ford was also gathering data from health experts in university research institutions. In a 3 March 1987 letter titled "Implications of AIDS for Ford Foundation Programming" to Ford Officer Oscar Harkavy from Lincoln C. Chen, Takemi Professor of International Health at Harvard University's School of Public Health, Chen describes two studies by Harvard scholars on the implications of the epidemic in developing world contexts: one by Joe Potter and Mike Stoto of the Department of Population Sciences on the demographic impact of AIDS in Central African countries and another by David Hunter of the Department of Epidemiology "examin[ing] AIDS from many perspectives, including policy issues." [34] Chen's assessment was that despite "scientific uncertainty," the AIDS epidemic in Africa and the United States would continue to expand. If Ford was to pursue a program on AIDS nationally and internationally, a sound public health strategy was essential. He encouraged Ford to draw from "historical and comparative experience…[g]enerating scientifically sound information and encouraging sober dialogue on these issues" in designing its approach.

The way Chen positions how the AIDS crisis would be a devastating problem in developing countries is interesting. In addition to what is usually cited by policy literature at this time about the uncertainty of vaccination and drug treatment, he argues that AIDS was likely to become a major cause of death in Africa, "particularly among young adults." This is similar to the macroeconomic argument made about AIDS and population control by the World Bank in the 1993 World Development Report, linking how devastating a disease would be to the GDP of a resource-poor nation due to how many it would debilitate in the economically productive age group of 15 to 40. [35] For Ford's influence in developing countries, Chen had the following advice: "[T[he major issue for an American philanthropy is international health interdependence." [36] By

interdependence, Chen likely referred to the idea that health resources, just like diseases, could traverse national boundaries in an era of increasing transnational movement and connections.[37]

Chen further elaborates on the impact AIDS would have domestically: that "fear-induced" responses that violated ethical and legal codes do not work. He went on to identify the Foundation's child survival and reproductive health programme as the best jumping off point for dealing with AIDS from a "health interdependence" framework:

For any developing country, the issue naturally will be commensurate attention to other health problems (diarrhea, vaccine preventive infections, malnutrition, other sexually-transmitted diseases). Development of a health infrastructure will ensure that control and treatment for AIDS (when technologies are developed as they surely will be) can be made available at affordable costs to people. Investments today, therefore, in oral rehydration and vaccination programs that builds sustained capacity in LDC [least developed countries] are essential both on their own right but also to gain LDC cooperation today and to assist with their AIDS program in the longer-run. No other funding actors are pursuing these lines of potential program development.[38]

Most significantly, Chen's advice strikes a contrast to Ford's later involvement in social and human rights issues at a very grassroots level. His recommendations are far more "top-down" and well versed in debates about macroeconomic costs of disease interventions and their impact on the general health infrastructure, ongoing between WHO, World Bank and other international actors since Alma Ata in 1978. Indeed, the two articles he includes with his letter lean towards more statistically and technically rigorous prevention work than the activities Ford later pursued with the Indian NGOs. In particular, one question that arises here is whether Ford's understanding of how devastating the epidemic would be in India (which could "still be saved" since Asia had a "later" epidemic) came from David Hunter's piece, which makes epidemiological projections about spread and

impact of AIDS in various African countries. In any case, it is not clear whether Chen felt his advice was specifically tailored to the position of a private American philanthropy like Ford among multilateral and bilateral international health and development agencies. Since the concept of a "multi-sectoral" response was new to global health interventions at the time that AIDS became a crisis, it is reasonable to assume no one was quite sure exactly how each actor with influence and resources at different levels could contribute to the global AIDS response.

AIDS in India

In 1987, less than a year after the first cases of HIV/AIDS were discovered in Tamil Nadu and Maharashtra states, Ford was gathering information on India's epidemiological profile in preparation for their grant strategy in the country. A 21 July 1987 inter-office memorandum from Marge Koblinsky to Bill Carmichael, John Gerhart, Shepard Forman and Oscar Harkavy attaches a copy of a 17 January 1987 *Lancet* article by Jacob John of Christian Medical College Vellore titled "Prevalence of HIV Infection in Risk Groups in Tamil Nadu, India."[39] The reason for asking for John and his colleagues at Christian Medical College was because Ford was already funding a Community Epidemiology grant there. From this, Ford understood that AIDS was primarily spread through prostitutes, "a group that obviously sets the stage for possible dissemination through heterosexual spread."

Gathering Experts: The Ford AIDS Consultative Group

A handwritten note from Shepard Forman to Steve Marks on 28 January, probably in 1987 or earlier, reveals that Ford was looking for expertise on the "international legal and human rights dimensions of the AIDS Problem," preferably without "a lot of calling around…w/ one or 2 discreet inquiries."[40] In March 1987, they were still searching for potential consultants, considering people such as Brooke Schoepf, a medical anthropologist and independent consultant who worked on the spread of AIDS in Zaire.[41]

By June 1987, a letter from John D. Gerhart to Richard Horovitz and William Saint indicates that the Ford AIDS Consultative Group had been formed leading up to the December Board meeting (for which "The AIDS Challenge: A Ford Foundation Response" had been prepared) with Robert (Bob) Stein of Environmental Mediation International as lead coordinator.[42] Stein and June Osborn of the University of Michigan School of Public Health would address international issues.[43] Stein would also cover legal and rights aspects, as Osborn would also be in charge of overall health policy. John Marshall formerly with the National Center for Health Services Research would cover the aspects of cost and delivery and care. Jane Delgado of the National Coalition of Hispanic Health and Human Services Organization would cover education and health communication. Mychelle Farmer of the Adolescent Sexually Transmitted Diseases Clinic at University of Maryland Hospital would cover AIDS and teens. Richard Merritt of the Intergovernmental Health Policy Project and Richard Dunne of Gay Men's Health Crisis would address agenda building. Michael Seltzer, an independent consultant of the Foundation Center who authored "Meeting the Challenge: Foundation Responses to Acquired Immune Deficiency Syndrome," would also support by leading his own consultancy on the non-profit sector, mapping funding strategies for the expanding health crisis.[44] In a 5 June 1987 letter to Forman, Seltzer says "The addition of Ford to the small, but rapidly growing, list

of foundations acting against AIDS is very heartening…Given the Foundation's international scope, its longstanding concern for minorities and their civil rights, and its resources, the Foundation is in a position to make a unique contribution." Other individuals served as resource consultants, such as King Holmes of the Harborview Medical Center in Seattle who researched AIDS in Kenya.[45]

The agenda at this stage was still quite open as the Consultative Group had their first meeting on 2 June 1987 in Washington D.C.[46] Stein in his coordinating role encourages the consultants in an update letter to "get in touch with one another and share potential contacts, existing material, and use one another's expertise to the common good."[47] He asks that they "scope out the issues to be addressed, then identify what other work is now ongoing or is proposed and who is doing it, and… devise a program based on the above which will give the Foundation an opportunity to provide useful support to institutions in the areas described."[48] However, what was certain was the overall guiding principle: that "AIDS is a disease which is working significant and long term changes to society."

Gerhart's Comments on Developing Country Strategy

By September 1987, the consultants' recommendations for Ford's AIDS agenda were mostly in place and a few individual grants had already been made. Domestic priorities included: quality of life and care issues, legal issues and shaping public agendas.[49] The goals for the national-level work appear to be well articulated and extremely detailed here as they were in "The AIDS Challenge" Information Report presented to the Board that December. However, the sections on the international and developing country strategies were apparently even sparser than they were in the final Report to the Board. John D. Gerhart's in-depth comments in a 14 September 1987 letter to Forman on the paucity of the recommendations for Ford's international work shows us a crucial moment in which we see the Foundation conceptualising why it needed to be active in developing countries. First, Gerhart starts by saying that "[the consultants' report] would benefit from a little more description of the extent and implications

of the epidemic, such as are contained in the Panos paper."[50] The Panos Institute, a London-based journalism/think tank/non-governmental organisation, had authored an influential report titled "AIDS in the Third World" in 1986 on the implications of AIDS in developing countries. Chapter 5 titled "Africa: AIDS and the Shrinking Development Dollar" in particular talks about how AIDS will impact the national economies of African countries, which is probably what he was referring to.[51] Gerhart goes on to say:

It would be helpful to give some description about why AIDS is going to be much more devastating in the developing countries (poorer general health, poorer health care, many more opportunistic diseases, untested blood supplies, penchant for reuse of needles in inoculations, etc.). It does make the important point that health expenditures are lower per capita than even the costs of a blood test, but it could make this stronger: emphasis must be put on prevention because it is simply impossible to cover the costs of care.[52]

Simply saying that developing countries allocated less of their GDP on public health and that they were poorer was not enough. He asked that they be more specific and detailed about the biomedical and epidemiological particulars of AIDS, noting that King Holmes, their Kenya expert, had commented verbally in conversation with them on the issue of the threat of communicable diseases such as tuberculosis after the immune system was disabled, compounding the health crisis. Gerhart states that the Foundation needed to better understand how AIDS was a problem in developing countries both epidemiologically and macroeconomically to formulate a more appropriate strategy that demonstrated their "comparative advantage." He offers some preliminary thoughts:

I see little benefit in our taking on issues of international testing requirements, visas, etc. since, as the report points out, this has little effect on transmission, and also has the high visibility, is contentious, involves diplomatic feelings, etc. I would think we would have little to offer on that score. Likewise, I think it is expensive and pretentious for us to take a leading role in coordinating either

donors or government agencies since we are a minor actor and not well established in the health field. We have no capacity whatsoever to develop an international health services corps, or an international data base, nor are we an appropriate agency to do these functions.[53]

Gerhart goes on to discuss whether Ford's U.S. work carried any policy relevance for their developing country programme, which he concludes by saying that the contexts were simply too different: developing countries did not have the concepts of job security, health insurance, testing policies, all of which were key strategic areas of Ford's more detailed American AIDS activities. Therefore, Gerhart recommends that they pursue behavioural research, information and education, prevention and targeting of high-risk populations. In his opinion, Ford's comparative strengths in this field were that first, as a non-governmental organisation, they were "less vulnerable to political sensibilities," and second, they could make use of the strong linkages with social science research communities. He concludes by reiterating: "I do not believe we should get heavily involved in the care and cost of care issues, since this is unlikely to have any real impact on the ultimate spread or effects of the disease in the poorest countries."[54] Thus, through Gerhart's comments, we can see the process behind how Ford determined its capacity for impact accordingly for developing countries. Furthermore, this letter shows that at least one Ford official felt that their developing country AIDS programme had to be completely divorced from their U.S. activities.

Discussions with the WHO from 1987 to 1988

Potential Collaboration

On 7 August 1987, there is an inter-office memo from Shepard Forman to various program directors about his meetings with WHO officials: Jonathan Mann, SPA Director, and Axel Mundigo, social science researcher with the Human

Reproduction Program (HRP).[55] The purpose of the meeting was to exchange information about their respective organisations' activities and for Ford to get comments from Mann and Mundigo concerning their upcoming strategy. Mundigo, previously with Ford as a sociologist and demographer, was speaking with Forman about the inclusion of AIDS-related research on sexual behaviour in the WHO's HRP. In terms of Ford's capabilities, Mundigo had said that their advantages were their involvement in rights and policy issues. He gave Forman a few examples of quarantine and the isolation of HIV infected people, advising that "the Foundation should carve out a special and highly visible effort that stresses rights and ethics."[56] Mann was also supportive of Ford focusing on human rights and protections as well as the wellbeing of people living with AIDS. This is not surprising given that Mann was developing a philosophy of the compatibility of human rights and global public health through his leadership of the GPA until 1990 and later in establishing the Francois-Xavier Bagnoud Center for Health and Human Rights at Harvard Public Health in 1993.[57]

However, according to Shepard, Mann also saw a "larger and more comprehensive role for the Foundation." He describes Mann thus: "He is a highly articulate and knowledgeable advocate on the subject and welcomes the Foundation's involvement." Here we see how Ford might have situated itself as support for the core national program directed by the WHO:

Mann urged us to concentrate our efforts in areas not being covered by others or to seek ways to complement activities already underway. For example, he began by noting that WHO is already coordinating the exchange of educational materials between countries and the provision of technical information to national AIDS commissions. The Foundation could, however, play a role in funding evaluators of educational efforts and surveys on societal attitudes and responses to AIDS that would be extremely useful in developing national programs.[58]

More specifically, Mann suggested that Ford could support four main areas: education, technical assistance, rights issues and health care delivery. In education, Mann was concerned that media materials were being prepared but that messages were not reaching people, particularly homosexual males in poor urban settings in developing countries. He suggested that Ford could help fund gay men's organisations in the industrialized world to reach these communities. In terms of health care delivery, he advised that Ford identify organisations that could assist in delivering humane care. He was also keen on the idea of unemployed people living with AIDS receiving training as professional caregivers.

The most interesting section concerned Ford's capabilities in human rights. Mann felt Ford could be most impactful by focusing on rights because "1) no one else is doing it and 2) relative success or failure of our efforts to combat AIDS will depend on prevailing social attitudes and how we deal with the afflicted."[59] Mann was keen to avoid "authoritarian approaches" to the AIDS crisis, which would isolate the HIV-infected and people with AIDS (PWA). Thus, he urged Ford to fund a series of studies on attitudes to AIDS of various sections of society in about twenty countries, including information on legal codes, national policies and how HIV infected and PWA were treated. "Are they rejected by their families? Fired from their jobs? Kept from school?" This would "provide the context for developing a productive atmosphere for working with the disease." [60] Furthermore, the WHO was also concerned with HIV screening and restrictions on international travel and potential human rights abuses, suggesting that Ford keep tabs on legal developments concerning this area.

In another interesting section, Mann said the Ford Foundation could potentially contribute towards technical information but in terms of small donations, not through any activity. Mann told Shepard that the WHO was collaborating with the World Bank to generate information about health care costs and did not believe there was need for Ford involvement, although "some funds from Ford or other private donors might hasten the results."[61] The main thing for developing

countries was to make a context-appropriate model for understanding health cost on a per capita care basis. This would be supplemented by continuous improvements in surveillance and reporting systems, improving the quality of epidemiological data. Mann told Shepard that "[s]imply predicting aggregate costs generates the wrong kind of response and is not useful in any case."[62] He relates that the WHO had begun a project led by James Chin, a social scientist, to undertake a "Surveillance, Forecasting and Impact Assessment." This was meant to develop a set of scenarios that could be used for African and Asian countries, as researchers in Copenhagen had already been working on a model for Europe.[63] Rather than forecasting on a sector-by-sector basis (how HIV impacted the education sector, industry, etc.), there was need for consensus on national rates of mortality, morbidity and transmission. Shepard then told Mann about the work the SSRC was proposing to do and said he "reacted with interest." Mann requested a meeting with those working on this project to coordinate and improve efforts because he felt the WHO was "the proper organization to do this (governments aren't suspicious of them and want the data they can provide)."[64] There is a theme emerging here on the differences between what is appropriate for a multilateral and what is appropriate for a private foundation to do.

Decision to remain autonomous

On 13 October 1987, there is an interoffice memorandum from Forman to "Distribution" on the WHO's coordination of global and national AIDS activities. He describes his meeting with Terry Mooney, an official seconded to the WHO from the Canadian Ministry of Foreign Affairs who was discussing with potential donors leading up to the WHO's fourth Meeting of Participating Parties to take place on 12 to 13 November 1987.[65] Shepard expresses his discomfort with the WHO taking the role of lead international coordinator of all governmental, intergovernmental and civil society work. We can also see the origins of why Ford turned to make links with civil society. He describes the WHO's intention to formally establish its leadership and coordinating role by creating a global commission on AIDS and a Commission of Participating Parties. Furthermore,

the WHO would establish National AIDS Control Programmes with the health departments of national governments, who would set the agenda for research and action on their respective national AIDS crises, "with the expectation that all external funding would be directed through them." We also find a copy of a draft proposal for the WHO SPA Joint Management Structure, as well as the plan for Comprehensive Coordination of Global and National AIDS Activities in this grant file, which states that: "All governmental, intergovernmental and non-governmental efforts, whether scientific, technical or financial, must be consistent with and supportive of WHO's Global Strategy on AIDS as approved by the World Health Assembly."[66] While Mooney was keen for Ford to sit on the Committee of Participating Parties, Shepard apparently told him outright: "a policy that limited grantmaking to agencies and activities approved by an official body such as a National AIDS Control Programme would run counter to the Foundation's general policy of independence in grantmaking."[67] Besides its philosophy on autonomy, it would be interesting to find out precisely what it was that Ford disliked so much about working on core programmes with national governments.

What we do know, on the other hand, is exactly how one Ford official felt about collaboration with the WHO. On 23 October 1987, there is an interoffice memorandum from Oscar Harkavy to Forman about his 13 October letter.[68] Harkavy expresses his strong feelings against the WHO's complete ownership of the global AIDS response: "I became increasingly irritated as I read the WHO document. It claims complete control for WHO over all international AIDS activities, as is WHO's posture on all health matters."[69] He gives some past examples, in which diarrheal disease research centres of developing countries such as Bangladesh "fought valiantly" to avoid being overwhelmed by the WHO "despite the latter's determined effort to take it over." He notes that WHO leadership in the Human Reproduction Program also resulted in bad relations between European and American donors. The only program in disease control that managed to avoid "complete domination" was the Tropical Disease Research (TDR) Programme in which the WHO shared formal sponsorship with the World

Bank and the UNDP. "In sum," he ends, "the WHO document is a heavy-handed bid for absolute control of all AIDS work. Based on experience with other WHO efforts, we should collaborate on the ground, but maintain our own independence of operation."[70]

Contact again for a database

As Ford's approach on rights and social issues solidified about a year later, they were again in contact with the WHO about a comprehensive database on rights work by international organisations in the developing world. On 12 August 1988, there is an interoffice memorandum between Steve Linick and Bill Carmichael, Shepard Forman and John Gerhart about Ford making a possible grant to the WHO's Global Programme on AIDS (GPA).[71] As always keen to "avoid duplicative grantmaking," Ford was looking for information about other international donors working on AIDS in developing countries. Linick had contacted Roy Widdus and Manuel Carballo, programme coordinators of the WHO's GPA, requesting information about the human rights aspects of the disease, who replied that there could be information in their headquarters but that it would be in a "rather unsystematic fashion." Linick answered mentioning the possibility of Ford making a small grant to help generate the data, to which Widdus replied suggesting a joint WHO/Ford effort in "obtaining the necessary information." What came out of this potential collaboration is not clear from the records. Thus, these early correspondences with the WHO show how Ford considered working as support for the core program but found the WHO's desire for proprietary management too stifling. However, it is reasonable to assume that Ford took some inspiration from the WHO officials in their international strategy for AIDS, in particular Mann and his affinity for human rights.

Summary

While the history of global AIDS has often been told as one of institutional responses, these records show that it was also one of individuals and their areas of expertise operating within institutional cultures. Furthermore, they show how when corresponding with the WHO or discussing the central programme emanating from the World Bank's lending, Ford presented an institutional face of a smaller American philanthropy that styled itself as an expert on grassroots human rights and social development issues. While some of these correspondences give us a good understanding of where Ford fit among international health organisations, development agencies and national governments, others remind us of a smaller national-level circle of influence that the Foundation operated in. In the early years of around 1986 to 1988, private American philanthropies were starting to identify the areas of the domestic AIDS crisis they would each address. Within this environment, Ford was unique for pushing both a domestic and an international strategy. Whether it managed this successfully is not a question to investigate here, but tracing the activities of Ford presents a fascinating case study of precisely how the history of global AIDS is international, national and local. Part of global AIDS is the history of one American philanthropy with equally substantial domestic and international programmes that had to present one face to its philanthropic colleagues and another to international health bureaucracies. And as we explore Ford's relationship with Indian civil society in the next section, we will see how they believed social issues relating to AIDS were best solved by the NGO-sector due to their proximity, understanding and influence with local and sometimes marginalized communities.

III. Looking into the Grant Files

In this section, I examine in depth several case studies of the Ford Foundation's grants to Indian AIDS NGOs. Because of the sheer volume of the number of grants and materials within them, I will mainly focus on the early years and significant members of NETWORKS, for which I mainly draw from the recommendations/requests for grant action sections. I also used as background material *AIDS and Civil Society: India's Learning Curve* by Radhika Ramsubban (who was a co-author of Ford's 50th Anniversary Monograph I mentioned earlier) and Bhanwar Rishyasringa. They examine six of the most prominent Ford funded NGOs in their 2005 publication.[72]

1990-1993 Earliest Grants: CMC and IHO

The first grants were made in 1990 to Christian Medical College Vellore (CMC) and the Indian Health Organisation (IHO) in Bombay. As I mentioned earlier, Ford was already supporting the institution through an existing epidemiology program and got their initial understanding of the AIDS epidemic from Jacob John, as evidenced by the presence of his *Lancet* article in Forman's files. These grants were made from the Population Program of the Developing Country Programs Division led by Officer Saroj Pachauri. Ford's early strategy with these two were to support "innovating experimental education, communication and training programs for AIDS."[73] CMC was to build an AIDS Reference and Resource Centre and IHO was to establish an Indian AIDS Foundation in Bombay. In the précis for this initial series of grants, Ford sets a global context:

The AIDS pandemic has created a new agenda of public health concerns worldwide that requires a complex and unprecedented range of institutional innovations. It has brought with it an affirmation of the interdependence between countries and the need for addressing problems through joint action by biomedical and social scientists.[74]

It goes on to state that the brunt of the impact in the developing world was in the regions of Africa and Latin America and that "India and other Asian countries have, therefore, a unique opportunity to face this challenge at an early stage when the magnitude of the problems is still manageable."[75] Furthermore, the advantage was that Asian countries could learn from all other regions that faced an earlier epidemic – the only obstacle was denial that AIDS was an issue. This confirms what we learned from the 1987 strategy, that organisations seeking to work in India, which is designated part of the Asia region and "late to the epidemic,"[76] could still be saved with heavy emphasis on prevention. Furthermore, there is the suggestion that their epidemiological profile would be similar to Africa and Latin America. The précis firmly establishes that AIDS was not just a health issue: "it also impacts on issues of human rights, governance and public policy, education, social services and the quality of life."

It notes the sero-surveillance focused activities emanating from the Government of India (GOI) to reflect the issue of infected blood from donors in the major cities of Madras (now Chennai) and Bombay. In October 1985, the Indian Council of Medical Research (ICMR) established an AIDS Task Force and built up a network of clinical and sero-surveillance to gather epidemiological data, which had since expanded to include the collaboration of state health services. ICMR with support from the WHO also established a Central AIDS Unit to coordinate supplies, quality control and evaluation. The précis states that in addition to these activities, there was a pressing need for the Indian AIDS prevention program to include education and awareness campaigns. This was why the New Delhi office was making its first grants to these organisations for these activities, building on Ford's existing research and service programs on STDs and women's

reproductive health in rural and tribal women in Maharashtra and urban slum women.

Ford chose IHO due to its advocacy, education and counselling work on behalf of prostitutes, drug addicts and hijras (transvestites) in the red-light districts and city slums of Bombay as well as rural and tribal areas in Maharashtra and neighbouring states. It also pioneered AIDS awareness and education through mass media and seminars even before the first national case was discovered. Its director Dr I.S. Gilada was a member of ICMR's AIDS Task Force and worked at J.J. Hospital, an institution in Bombay that provided AIDS and STD treatment and control services. The IHO was to establish an Indian AIDS Foundation, which would disseminate information on AIDS through a variety of print media and television channels; put together education and training programs; and provide community-level education, counselling and care programs through mobile clinics in the red-light districts of Bombay.

CMC, home to a highly-respected Virology Department, was not just a node in the nation's epidemiological surveillance system and one of the four ICMR designated National AIDS Virus Reference Centres. It also a Ford grant recipient for the establishment of an Epidemiology Resource Centre, as mentioned in the first section. I found Ford's reasoning for why they wanted to work with this institution interesting:

It combines technical competence with missionary zeal to serve the poor and the disadvantaged and, through its outreach programs, makes great efforts to provide health care to those who do not have access to hospital facilities. Its Community Health and Development (CHAD), Rural Unit for Health and Social Affairs (RUHSA) and other outreach efforts, provide excellent examples of how research can effectively be translated into relevant program strategies for addressing the health needs of the poor.[77]

Why the focus on poverty as part of health?[78] While this is not the place to fully investigate this question, I would like to mention that one critique of global

health and disease control programs is that they do not work because they fail to address underlying questions of systematic poverty. While this may not be a counterexample per se, it is key to consider how Ford conceptualized their work in health while acknowledging the context of poverty.

It is also interesting that this new AIDS centre that the CMC would build was to focus on psychological assessment and counselling of HIV positive people and people with AIDS. It had three main objectives: first was to construct a database on psycho-social aspects of AIDS and to distribute this information through a newsletter; second was to develop programmes for training health workers and non-health professionals like social workers and teachers to help those with HIV and AIDS cope with psycho-social problems; and finally, it was to organize a forum to discuss policy by bringing together activists, researchers and other professionals to "develop specific recommendations and guidelines for dissemination to Indian audiences."[79] Thus, Ford's first foray into AIDS work in India took the form of grants to two organisations that were already active in national AIDS work. They were both also key nodal centres in national epidemiological information-gathering with experience in treatment and counselling. The content of the work was surprisingly courageous and forward thinking, as activities such as psychological counselling presumes people are already infected with HIV and require not just treatment but also psychological care. This initial group of grants to these two organisations can be viewed as Ford "dipping its toes" and exploring the possibilities of the work it could do.

1991-1995 Group 2

The next generation of grants were made in two main groups. One set comprised of three organisations starting in 1991 for a period of 2 to 3 years, which were International Nursing Services Association of India (INSA), Population Services

International (PSI) and Voluntary Health Association of India (VHAI). Another set of five between 1 and 5 years comprised of grants to five groups, which were the Trust for the Rights of the Underprivileged in Society Today, PREPARE India Rural Reconstruction and Disaster Response Service, All India Institute of Medical Sciences (AIIMS), South India AIDS Action Programme (SIAAP) and Sevadham Trust. Ford conceptualized its role thus:

Additional support for AIDS programs could be critical to stimulating interest among NGOs and state governments in India. Such support would prepare the groundwork urgently needed to develop local expertise and attract donor funds. At this time, when other donors have yet to gear up support for AIDS work and when the state governments, NGOs and researchers have little on-the-ground experience with the multiple dimensions of the problem, the Foundation could make a significant contribution.[80]

During this period, Ford was convinced that behaviour change activities should take precedence as the major element in prevention and Tamil Nadu and Maharashtra would be the regional focus as high prevalence states. The recommendation for grant/FAP action in the précis states that "[a]t the heart of prevention is persuading people to change risky sexual behavior" and cites the reasons why government efforts have been unsuccessful so far in controlling the spread of HIV is because of the "difficulty in bringing about behavioural changes in sexual relationships." [81] Ford's solution to this was to work with nongovernmental organisations because of their proximity to the community and their understanding of local culture. In fact, NGO-led behaviour change activities with high-risk groups should be a key element in prevention: "As AIDS prevention and control measures require the active participation of communities, NGO involvement is being increasingly sought by governments and donors in the fight against the spread of HIV/AIDS."[82]

1994 Mid-point Assessment: Chatterjee and Sahgal on "HIV/AIDS Awareness & Control: Nineteen NGO Experiences in Delhi, Maharashtra, Tamil Nadu"

As mentioned in the overview, in 1994, Ford commissioned Dr Kusum Sahgal (Professor at the Maulana Azad Medical College in New Delhi) and Ashoke Chatterjee (Senior Faculty at the National Institute of Design in Ahmedabad) to conduct a survey of nineteen grantees of the Foundation in the cities of Delhi, Pune, Vellore, Bombay, Nasik and Madras/Chennai. Here I will draw out a few interesting points that were not evident about the report in Ramasubban and Rishyasringa's Anniversary Monograph. The survey reportedly was an assessment of the quality of the IEC (information, education and communication) materials that these organisations had produced, taking into account "how unique are the social, cultural and economic environments within which HIV/AIDS activities are conducted."[83] Despite citing numerous areas in which improvement was needed, in many places it acknowledges that these organisations were working in an uncertain and unstable terrain, faced with opposition from those who resent AIDS work as a "megabuck bandwagon, with lucrative appeal which attracts opportunism and masks other urgent needs." There was no manual for how to do HIV/AIDS intervention, which made these NGOs' work particularly difficult in the "absence of a coherent and sustained support system."[84] It commended these organisations' choice to "enter a service in which complexity, frustration and disappointment is guaranteed." Thus, their first challenge was to "build a stamina for perseverance and suffering capable of being tested at every turn."[85] Sahgal and Chatterjee's survey offers the following:

The consultants have been impressed by the sincerity of purpose which has marked each one of their encounters, and the quality of human fortitude which is the badge of so many persons serving and affected by the HIV/AIDS crisis. In the long term, this is perhaps the most important resource India has toward meeting an uncertain HIV/AIDS future. The significant of the quality of this human

resource goes well beyond one sector. It is a commitment to a holistic, integrated understanding of health, environment and empowerment. It would seem of the utmost importance that this unity of purpose be actively nourished as well as shared. A band of some 20 grantees may appear of little significance as a number, yet each one of them is ideally placed as a catalyst and as a role model. Their demonstration can be significant, and is certainly the most important contribution the Ford Foundation has made, and can continue to make, in what must be the most difficult challenge India's health systems have faced since Independence.[86]

"Intermediary" NGOs in NETWORKS: Case study of The Naz Foundation

As mentioned in the overview, Ford changed its strategy in 1996 to be more efficient, focused and selective in its grantmaking, after a wave of corrupt NGOs due to the immense amount of AIDS funding made available. It also wanted to bring its AIDS work under a reproductive health approach. At this stage, Ford's understanding of India's epidemiological profile was that it would become the "epicentre of the global HIV/AIDS epidemic," citing a UNDP study in which it was predicted that the country would have 4 million recorded cases of HIV/AIDS by the end of the century.[87] Thus, the HIV threat was particularly serious "as India struggles to cope with the heavy burdens of poverty and ill-health."[88] The epidemic had now spread to the general population and without a cure, the most important activities should focus on prevention and within that, the promotion of safe sexual behaviours. However, prevention was difficult in India because (i) the epidemic had not progressed far enough in the country for Indians to witness on a wide-scale the suffering due to progression of HIV infection to AIDS and (ii) discussion about sexuality and sexual behaviours in the country was taboo. While this is not the place to investigate this here, one issue Indian public health

professionals have critiqued over the years is the overestimation by global health agencies of the country's prevalence rates.[89] It is interesting here in 1996 that Ford based its prevention activities based on such statistics, that India was essentially sitting under an "explosive" volcano. The question is, as Ford went further into ground-level grassroots activism, whose statistics informed their understanding of the "need" for their kind of work?

That year, Ford made a set of four grants to what it called "intermediary" or "support" organisations, which meant they would train other more local grassroots organisations in carrying out their AIDS activities. These nodal organisations were meant to "play pivotal roles in the critical areas of training, technical assistance, research and documentation, information sharing and dissemination, and organisational capacity building."[90] They were the Naz Foundation (India) Trust based in New Delhi, the Y.R. Gaitonde Medical, Educational and Research Foundation in Madras, International Nursing Services Association of Bangalore and Counselling and Allied Services for AIDS in Bombay. Of these, I am particularly interested in the Naz Foundation as my fieldwork is based in Delhi. Founded and led by Anjali Gopalan in 1994, the Trust would continue to be a reliable node in Ford's network of AIDS NGOs. The Foundation has become well known in India and internationally for its activism in protecting gay, lesbian and transgender rights in a country where homosexuality is still illegal.[91]

In the proposal for the first grant Ford received from the Naz dated 12 December 1995, we can see exactly how the organisation positioned itself in relation to the central national programme.[92] In the opening section titled "An Urgent Need," we can see that the Naz was also struggling with imprecise figures emanating from various sources about the national prevalence rates:

The Global Program on AIDS (WHO), Harvard AIDS Institute, the Indian Government and various non-governmental agencies give figures that range from several hundred thousand to several million infected persons. What can safely be

said is that unless effective steps are taken quickly, the battle against HIV transmission in India will be lost.[93]

What is interesting in the above text is that I have yet to come across a case where Ford acknowledged the disagreements over epidemiological calculation methods for national prevalence rates. Yet the Naz as its grant recipient was aware of this debate, likely due to its members regularly tracking this information in literature produced by multiple multilateral agencies (WHO, UNDP, etc.) and perhaps also influenced by critiques of Indian public health professionals. This raises the theme in historicizing global AIDS of: whose statistics informed where need and what kind of need is perceived? It also raises a question concerning a grantmaker and recipient's relationship: who was the expert here?

The Naz's proposal goes on to detail six reasons why behaviour-changed focused prevention strategies had not been effective so far, the most significant for my project being that first, most programmes did not address the taboo issue of sexuality and second, that the people carrying out these activities see HIV as "happening to someone 'out there'," misunderstanding the "sexual and drug using reality of our society." The few organisations committed to enacting "multi-level" attitude change were of "a new breed" and had not had enough time to establish the roots that would allow them to be effective.[94]

Given this scenario, the Naz believes the catalyst for scaling up prevention would have to come from voluntary organisations themselves as they "play a significant role in promoting human development." It sets the current scene for NGO activity in the country, stating that it was only after the Seventh Five Year Plan that the government began to acknowledge the crucial role that civil society played. NGOs in all shapes and forms – "from the grassroots level to the highest levels of policy formulation…[w]hatever may be the interaction with the government, whether collaborative or confrontational" – can make a vital contribution:

The role and involvement of NGOs as a catalyst for changes in attitude and behavioural patterns is a vital factor for the success of national programs. Because of their in depth communication with the community, NGOs have greater credibility and encourage a more participatory approach which is conducive to a change in attitudes and behaviour.

In addition to being an instigator of change, the Naz positions itself as one who could be a mentor and coordinator for other more grassroots NGOs in a more deliberately systematic and institutionalized voluntary sector. "Intermediary" or "support" NGOs, in contrast to grassroots NGOs, had two main advantages. Employing staff who were well versed in national and international development issues, they would be able to understand "the full spectrum of service organisations." They also facilitated connections between other voluntary organisations, governments, funding bodies and research institutions. The Naz proposed that it serve as an intermediary NGO. It would take four "nodal agencies" in various districts under its wing, training them in issues such as "The Experiences of Positive People in India" and "Sensitivity to High Risk Groups" and supporting them as they carried out their activities.

IV. The Rockefeller Foundation and the Debt for Development Coalition: American Philanthropies and the Debt Crisis?

Finally, while my main focus at the Rockefeller Archive Center for this research trip was primarily the Ford Foundation due to their vested interest in Indian civil society, the Rockefeller Foundation was also active in global AIDS. It is well known that the Foundation led the way in forming global public-private partnerships for vaccine research such as the International AIDS Vaccine Initiative (IAVI) through the initiative of Seth Berkley, then researcher with the Rockefeller's Health Sciences Division.[95] This is another important piece of the

history of global AIDS, in which a private American foundation initiated a unique model for international public-private collaboration in vaccine research in the 1990s. This is because many other foundations, Ford being a prime example, were more interested in social issues rather than bio-medically focused vaccine research (interestingly, both sides claim that these are under-addressed aspects) and few successfully reached out to collaborate with national governments, multilaterals and for-profit pharmaceutical companies. This raises some questions about the precedents for American philanthropies active later in global AID like the Gates Foundation and the Clinton Foundation.

In addition to this, the Rockefeller Foundation worked with the Ford Foundation, the International Development Research Centre and the John Merck Fund to create the AIDS and Reproductive Health Network in 1988.[96] I also confirmed as was stated in the 1987 "The AIDS Challenge" that the Foundation funded research on behavioural aspects of transmission in African and Latin American countries and was a key actor in funding the research that constructed the "epidemiological profile of AIDS" in developing countries. Though I have not investigated these earlier activities in systematic detail, I do know that the Rockefeller Foundation supported social scientific research on sexual risk behaviour in Costa Rica in 1991. In a series of correspondences between Leonardo Mata, Professor at the Institute for Investigations in Health (INSA) and Dr. Scott Halstead, Director of the Rockefeller Health Sciences Division, Mata makes the case for the prevention-policy relevance of his research which proposed to study knowledge, attitude and practices in regards to human sexuality in Costa Rica at a national level, using an innovative "anonymous ballot" system to interview people who were not comfortable with talking about sensitive topics.[97]

Furthermore, I also came across a very unusual Rockefeller Foundation grant to an NGO called the Debt for Development Coalition, which provides a fascinating insight into the context of American philanthropies' understandings of how AIDS activities should be funded in the context of the balance of payments crisis of the

1980s to 1990s. The Debt for Development Coalition, Inc. was established in 1988 as a tax exempt, 501(c)(3) not-for-profit organisation and received the majority of its funding from the United States Agency for International Development (USAID). To put it in simple terms, its objective was to help NGOs conduct a "debt-for-development swap" in which the debts of developing countries could be turned into economic development opportunities using "innovative exchanges of debt" – what it called "Swaps Against AIDS."[98] The angle was that purchasing such debt would free up critical funds for Third World governments to invest in AIDS prevention. Interestingly, the officer questioning whether this organisation's proposal was in line with the Foundation's strategy does admit it was a rather complex set of financial transactions.

This is interesting because one issue in the critical secondary literature is that AIDS programmes in developing countries (vertical, un-integrated with public health infrastructure, overfunded) are an extension of Selective Primary Care and are thus (a) vehicles for prescribing neoliberal ideologies in health and (b) ineffective in a context ravaged by structural adjustment policies.[99] This is because the central National AIDS Control Programme (NACP) is primarily funded by the World Bank, a multilateral development agency who is also the largest lender in health.[100] The World Bank was closely tracking the data on the balance of payments crisis since the 1980s and corresponding with GOI officials, other regional development agencies like the Asian Development Bank (ADB) and members of the Aid India Consortium. Thus, it is a reasonable conjecture that their intimate involvement in the 1991 Indian debt crisis and formal liberalisation of the economy was at least a factor in determining the shape of the core National AIDS Control Programme, since at least in the case of India, the Bank provided the majority of funding conditional upon certain agreements in regards to the programme design.[101]

So how did these two American philanthropies' understandings of the debt crisis influence their strategy on what kinds of AIDS work needed to be done in the developing world? This is essentially a question of (a) where the Ford and

Rockefeller Foundations each saw their capabilities in developing countries and (b) their general approaches to how problems should be solved: as top-down or ground-up? grassroots or macroeconomic solutions? From this snapshot of the archival records, we see them taking very different tactics. It would seem that the Rockefeller Foundation was at least aware of the idea that AIDS prevention had to be seen in the context of the debt crisis. While it did not have the influence in macroeconomic policy making circles that multilateral agencies like the World Bank had, through an American non-profit with USAID funding like Debt for Development, it indirectly addressed AIDS as an issue of freeing up funding from debt repayments. To them, this was one way to solve the AIDS problem in the specific context of a developing country.

On the other hand, with Ford I have seen little to no mention or engagement with the Indian macroeconomic scenario and how it impacted AIDS, other than to say that India was a developing country with diminishing resources. However, poverty was clearly an issue Ford was intimately familiar with. They funded two Indian economists to research measurements of poverty in the country in the early 1970s. Furthermore, Ford once was privy to high-level policy discussions in India, as the first Ford representative in India, Douglas Ensminger, enjoyed a close relationship with Jawaharlaal Nehru and the Planning Commission. This history needs to be investigated in more detail, but it suggests that by the time AIDS became a crisis, Ford had become an organisation that preferred to keep things small and work ground-up, identifying a need that fit with the work they had already been doing in the country and going from there. Rather than presenting themselves as authorities on matters of health as the Rockefeller Foundation's International Health Division (IHD) and later the WHO did, it was keen to work with non-state actors, civil society and grassroots organisations close to the local community, building up a small system that supplemented the national programme, even avoiding contact with the Central Government. Without making generalizations, it would seem the Ford Foundation on the whole tended to see health as part of social development. Thus, working on social issues – which were conceptualized around a core concept of poverty –

surrounding a particular disease would result in improvements in health. This theme needs to be teased out better, but for me, this case of the Rockefeller Foundation and the Debt for Development Coalition in contrast to Ford's work adds more depth in historicizing global AIDS. It introduces more themes we have to consider: multilateral vs. national government vs. private philanthropy, grantmaking vs. health project lending, social vs. biomedical, top-down vs. ground-up health, health as a result of or as a catalyst for development, and social development vs. macroeconomic development.

V. Conclusions and Implications of Findings for Project

When I initially wrote my proposal detailing why Ford's grants to Indian AIDS NGOs at the Rockefeller Archive Center (RAC) were important for my project, my interests were more India-focused. I stated that I wanted to understand how these NGOs presented their need for Ford funding. Given the national context of the health sector reforms of the 1990s, the privatization and NGO-isation of public health and the vertical orientation of the Indian National AIDS Control Programme (NACP), how did these NGOs make a case for the importance of their work to a foreign grantmaker? After researching the records at the RAC, I have a much more nuanced understanding of how involved Ford was in, not just supporting, but also initiating and directing the Indian NGO sector's AIDS activities through their grantmaking. Given their early involvement before the 1992 scale-up, this has significant implications concerning how the discourse surrounding the epidemic's impact in the country developed. It also goes some way to explain the critique that Indian public health professional have had of both the NACP and civil society "AIDS-*wallas*" work – that it is divorced from the reality of the health sector reforms and un-integrated with the existing health infrastructure. While taking into account the initiative and agency of these NGOs

before Ford got involved, this raises the question of: to what extent did the Foundation's social development orientation establish the discursive framework within which India's AIDS NGOs situated their activities, especially considering they were one of the first international agencies active in India until 1992?

These records also showed that Ford had a distinct strategy and rationale for why social development issues should be strongly promoted in the civil society sector: partly due to practical issues (like resources, existing portfolio, work others were doing and not wanting to work with national governments), but also due to a genuine belief in promoting socially progressive programs and organisations. This is evident from the kinds of organisations and people they were talking to. While this information needs to be balanced with interviews and archival data in India, this was a key finding. It also raises more questions: if Ford was active in African (Kenya) and Latin American (Brazil) countries before India, given their (and everyone else's) lack of experience with AIDS, did they export their findings in these locations to India? Or did they build more from their expertise and understandings of Indian society due to their long relationship since 1952, and if so, how? Furthermore, how exactly did the Ford-supported NGOs exist alongside the NACP and the National AIDS Control Organisation (NACO) after 1992 and at various stages of the programme's phases? This is pertinent as the NACP increasingly decentralized at the behest of the Bank to reflect the fact that health was a state matter in India and there were significant efforts from within NACO to mainstream AIDS with the health infrastructure and other disease/reproductive health programs.

In addition to this, I have found a wealth of archival information about the Ford Foundation's contributions to the global AIDS response. It has shown how uncertain and fluid this terrain was in the early years. The complete ownership of the global response by the WHO with its Special and then Global Programme on AIDS (SPA and GPA) was contested by representatives of developing countries and private philanthropies like Ford. As those in the UN and Bretton Woods systems responded to such critiques and built up collaborative responses (first

WHO and UNDP, then WHO and World Bank and finally UNAIDS in 1996), Ford forged its own path. This has opened up many areas of contextual knowledge that my project could build upon as it is clear to me that this slice of Ford's AIDS activities in India is part of many other narratives that need to be historicized. One area is the history of American philanthropies' involvement in global health, in which much of the critical secondary literature focuses on organisations such as the Bill and Melinda Gates Foundation or the Clinton Foundation who were active later in the global epidemic.[102] Less is known of the activities of this earlier generation of foundations, barring Jennifer Brier's research on Ford's relationship with Brazilian AIDS NGOs. [103] Did the Ford and Rockefeller Foundations set (or re-set) the precedent for how a private US philanthropy could be involved in a global epidemic response in the late 20th century?

Another related area is a balanced understanding rich in archival evidence of how the concepts of multisectorality, a united "global response" and AIDS as more than a biomedical issue came about. The Ford and Rockefeller Foundations are part of a larger group of global and regional actors involving multilateral international organisations such as the WHO and the World Bank, new initiatives like UNAIDS and the Global Fund, bilateral donors like PEPFAR, USAID and the development agencies of other nations, particularly those in northern Europe. In the literature these organisations produce, they present themselves as part of one global "team effort," bringing their various talents to the same table and reinforcing each other's positions. Collaboration and coordination to avoid overlap is a key theme in the history of the global AIDS response particularly in the early years. Within this, Ford's social development orientation as a part of AIDS prevention strikes a significant contrast to the "magic bullet" disease control programmes of the 1950s and 1960s – and yet they did not address macroeconomic issues or engage with the question of health as part of economic development, despite their understanding of poverty and its connections to health in India. So how did this approach to addressing a global epidemic – by everyone at all levels and from all sides – develop and what was it a response to? And exactly how collaborative was it?

My findings from the archival research have been presented chronologically and according to source type rather than organised under themes. This is because I did not want to flatten the "dimensionality" of the sources and their rich potential for historical analysis. As a historian of global health, I often work with officially published policy literature of health organisations and development agencies and these records (on a contemporary topic no less) provided a refreshing and grounded perspective on the unfolding of an unprecedented global epidemic. In some cases, I found full copies of policy documents, research publications and news articles, which signalled when they were consulted and significant in policy circles. In the grant records, I found follow-up reports containing documents such as instructions for games with local teenagers that were used in health education activities, showing a glimpse of the day-to-day workings of an Indian AIDS NGO in the 1990s. By allowing me to trace the narrative of one organisation consistently, these records have provided me with traction and focus in my current research questions but also raised a multitude of new ones. In sum, the rich primary sources of the Ford Foundation held at the Rockefeller Archive Center – from the reflective internal accounts, the handwritten notes, the correspondences, the supporting documents in follow-up reports submitted by grant recipients and the rougher "footprints" of articles and reports gathered – reveal critical insights into the process behind the global AIDS response and how it played out in India from the viewpoint of one American philanthropy.

VI. Endnotes

[1] "The AIDS Challenge: A Ford Foundation Response", 1987, Original – AIDS Report, Box 11: Series II AIDS Background Files, FA717, Human Rights and Governance Program, Office Files of Shepard Forman, Ford Foundation records, Rockefeller Archive Center.
[2] Ibid., p. i.
[3] Ibid., p. iii.
[4] Ibid., p. 4.

[5] I will discuss the Ford AIDS Consultative Group more in the second section. Ibid., p. 35.
[6] Ibid., p. 37.
[7] This perhaps refers to the collaboration between the WHO and the World Bank in AIDS around this time or the Bank's lending to national AIDS programmes and other smaller AIDS activities before India in 1992. Ibid., p. 39.
[8] Ibid., p. 40.
[9] Ibid., p. 40.
[10] Ibid., p. 41.
[11] Marjorie Muecke's transition memo on HIV/AIDS "What we've been doing about HIV/AIDS for the past decade", Reports 015017, Box 752, Catalogued Reports 13949-17726, FA739F, Ford Foundation records, Rockefeller Archive Center.
[12] Ibid., p. 2.
[13] Ibid., p. 3.
[14] Ibid., p. 3.
[15] Ibid., p. 15.
[16] Ibid., p. 18. For more information on exactly how Ford felt about an integrating HIV/AIDS and STDs into existing family planning and reproductive health programmes, an inter-office memorandum on the Fourth International Conference on AIDS in Asia and the Pacific held in Manila, Philippines from 25-29 October 1997 is particularly illuminating. Ford was clearly optimistic about implementing the 1994 Cairo Programme of Action. Memoranda on Fourth International Conference on AIDS in Asia and the Pacific, Manila, October 25-29, 1997, Reports 013852, Box 737, Catalogued Reports 11775-13948, FA739E, Ford Foundation records, Rockefeller Archive Center.
[17] Radhika Ramasubban and Bhanwar Singh Rishyasringa, Report 016626: "Sexuality and Reproductive Health and Rights: Fifty Years of the Ford Foundation in India", Box 853, Catalogued Reports 13949-17726, FA739F, Ford Foundation records, Rockefeller Archive Center, p. 82.
[18] Ibid., p. 82.
[19] Ibid., p. 83.
[20] Ashoke Chatterjee and Dr. Kusum Sahgal, Reports 012767: "HIV/AIDS Awareness & Control: Nineteen NGO Experiences in Delhi, Maharashtra, Tamil Nadu", 1994, Catalogued Reports 11775-13948, FA739E, Ford Foundation records, Rockefeller Archive Center.
[21] Radhika Ramasubban and Bhanwar Singh Rishyasringa, Report 016626: "Sexuality and Reproductive Health and Rights: Fifty Years of the Ford Foundation in India", p. 85. Also, Devaki Nambiar, "HIV-Related Stigma and NGO-isation in India: an historico-empirical analysis", *Sociology of Health & Illness* 34:5 (2012), pp. 714-729. Kavita Misra, "Politico-moral Transactions in Indian AIDS Service: Confidentiality, Rights and New Modalities of Governance", *Anthropological Quarterly* 79:1 (Winter 2006), p. 40.
[22] Jacob A. Gayle, "Early Thoughts about the Ford Foundation and the Global Response to HIV/AIDS", 25-26 January 2006, Reports 016850, Box 867, Catalogued Reports 13949-17726, FA739E, Ford Foundation records, Rockefeller Archive Center.
[23] Ibid., p. 2.
[24] Ibid., p. 3.
[25] Ibid., p. 4.
[26] Ibid., p. 5.
[27] Ibid., p. 10.
[28] Frederic Wakeman to Shepard Forman, 22 September 1987, Box 8 Series II: AIDS Background Files, FA717, Office Files of Shepard Forman Human Rights and Governance Program, Ford Foundation records, Rockefeller Archive Center.

[29] <http://rockarch.org/collections/nonrockorgs/ssrc.php>. (Accessed 27 February 2017).
[30] Ibid.
[31] Ibid.
[32] Frederic E. Wakeman Jr. to Shepard Forman, 12 August 1988, Box 8 Series II: AIDS Background Files, FA717, Office Files of Shepard Forman Human Rights and Governance Program, Ford Foundation records, Rockefeller Archive Center.
[33] Denise Silver to Shepard Forman, "The Cost of AIDS: A Review of the Estimates", in Box 8 Series II: AIDS Background Files, FA717, Office Files of Shepard Forman Human Rights and Governance Program, Ford Foundation records, Rockefeller Archive Center. Original article citation: Jane E. Sisk, "The Costs of AIDS: A Review of the Estimates", *Health Affairs* 6:2 (Summer 1987), pp. 5-21.
[34] Lincoln C. Chen to Oscar Harkavy, 3 March 1987, Reports 012371: Implications of AIDS for Ford Foundation programming, Box 610, Reports 11775-13948, FA739E, Ford Foundation records, Rockefeller Archive Center.
[35] The World Bank made the reverse argument as well, about how much a country could save by investing in prevention. It praises India in particular for adhering to the Bank's advice for a well-designed AIDS programme: "If the transmission rate could be slowed to one every five years, that number could be reduced to only four infected persons in 2000 for every one today. The corresponding reduction in medical costs, after discounting at 3 per cent a year, amounts to $750 by 2000 for each currently HIV-positive person in India, for a total saving of $750 million." World Bank (1993), *World Development Report 1993: Investing in Health*, New York, p. 20.
[36] Ibid.
[37] Ulyssess B. Panisset, *International Health Statecraft: Foreign Policy and Public Health in Peru's Cholera Epidemic* (University Press of America, 2000), pp. 74-75. Julio Frenk and Fernando Chacon, "International Health in Transition", *Asia Pacific Journal of Public Health* 5:2 (1991), pp. 170-175.
[38] Ibid.
[39] Marge Koblinsky to Bill Carmichael, John Gerhart, Shep Forman, Oscar Harkavy, 21 July 1987, Series II: AIDS Background – AIDS in India, Box 8, FA717, Ford Foundation records, Rockefeller Archive Center.
[40] Handwritten Note, Shep to Steve Marks, 28 January, Series II: AIDS Background – AIDS in India, Box 8, FA717, Ford Foundation records, Rockefeller Archive Center.
[41] Shepard Forman to Susan Berresford, "AIDS Consultancy", 16 March 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center.
[42] John D. Gerhart to Richard A. Horovitz and William S. Saint, "AIDS Consultative Group", 6 June 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center.
[43] Shep Forman/Marge Koblinsky to Representatives, 8 June 1987, "AIDS Consultative Group".
[44] Seltzer also founded Funders Concerned about Acquired Immune Deficiency Syndrome. Michael Seltzer to Shepard Forman, 5 June 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center.
[45] Susan V. Berresford to POICs/Deputy POICs, 18 June 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center.

[46] Notes of First Meeting of Ford Foundation Consultants on AIDS Policy, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center, p. 1.
[47] Bob Stein to Ford Foundation AIDS Consultants, "Update", 10 June 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center.
[48] Ibid., p. 2.
[49] Shepard Forman to Susan V. Berresford and William D. Carmichael, "AIDS", 10 September 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center.
[50] John D. Gerhart to Shepard Forman, "AIDS Consultants Report", 14 September 1987, Series II: AIDS Background – AIDS in India, Box 10, FA717, Ford Foundation records, Rockefeller Archive Center, p. 1.
[51] "These young men and women in their twenties and thirties are the breadwinners of today and tomorrow. They support the young and the old – and the nation's economy." It is not clear what projection model this analysis is based on. We know that the Bank was collaborating with the WHO early on to predict loss in GDP due to AIDS for developing countries (Mead Over, "The Macroeconomic Impact of AIDS in Sub-Saharan Africa", 1992), so it will be interesting to investigate whose data the Panos used. Panos Institute, "AIDS in the Third World", (London, 1986), p. 40. In terms of understanding AIDS through cultural theory and discourse analysis of "AIDS in developing countries" representations in newsprint, Paula Treichler's work is interesting. Paul Treichler, "AIDS and HIV Infection in the Third World: A First World Chronicle", in Elizabeth Fee and Daniel M. Fox, *AIDS: The Making of a Chronic Disease* (California, 1992).
[52] Ibid., p. 1.
[53] Ibid., p. 2.
[54] Ibid., p. 2.
[55] Shepard Forman to AIDS Files, 7 August 1987, "Meetings at the World Health Organisation – Geneva", Box 10 Series II: AIDS Background Files, Human Rights and Governance Program, Office Files of Shepard Forman, FA717, Ford Foundation records, Rockefeller Archive Center, p. 1.
[56] Ibid., p. 2.
[57] Elizabeth Fee and Manon Parry, 'Jonathan Mann, HIV/AIDS, and Human Rights', *Journal of Public Health Policy* 29:1 (April 2008), pp. 54 – 71. Jonathan Mann, 'Human Rights and the New Public Health', *Health and Human Rights* 1:3 (1995), pp. 229 – 233.
[58] Shepard Forman to AIDS Files, 7 August 1987, "Meetings at the World Health Organisation – Geneva", p. 2.
[59] Ibid., p. 4.
[60] Ibid., p. 4.
[61] Ibid., p. 3.
[62] Ibid., p. 3.
[63] He mentioned that USAID was also working on a model for developing contexts. Ibid., p. 3.
[64] Ibid., p. 4.
[65] Shepard Forman to Distribution, 13 October 1987, "WHO's Coordination of Global & National AIDS Activities", Box 10 Series II: AIDS Background Files, Human Rights and Governance Program, Office Files of Shepard Forman, FA717, Ford Foundation records, Rockefeller Archive Center, p. 1.
[66] WANG DOC 4951F, WHO Special Programme on AIDS Comprehensive Coordination of Global and National AIDS Activities, Box 10 Series II: AIDS Background Files, Human

Rights and Governance Program, Office Files of Shepard Forman, FA717, Ford Foundation records, Rockefeller Archive Center, p. 1.
[67] Shepard Forman to Distribution, 13 October 1987, "WHO's Coordination of Global & National AIDS Activities", p. 1-2.
[68] Oscar Harkavy to Shepard Forman, 23 October 1987, "WHO's Coordination of Global & National AIDS Activities", Box 10 Series II: AIDS Background Files, Human Rights and Governance Program, Office Files of Shepard Forman, FA717, Ford Foundation records, Rockefeller Archive Center.
[69] Ibid.
[70] Ibid.
[71] Steve Linick to Bill Carmichael, Shep Forman and John Gerhart, 12 August 1988, "Possible Grant to WHO Global Program on AIDS", Box 10 Series II: AIDS Background Files, Human Rights and Governance Program, Office Files of Shepard Forman, FA717, Ford Foundation records, Rockefeller Archive Center.
[72] Radhika Ramasubban and Bhanwar Rishyasringa, *AIDS and Civil Society: India's Learning Curve* (New Delhi, 2005).
[73] Indian Health Organisation Grant No. 08903026, 23 May 1990 to 31 March 1994, Series: Ford Foundation Grants – H to K, Reel 7024, FA732D, Ford Foundation records, Rockefeller Archive Center.
[74] Recommendation for Grant/FAP Action. Indian Health Organisation Grant No. 08903026, 23 May 1990 to 31 March 1994, Series: Ford Foundation Grants – H to K, Reel 7024, FA732D, Ford Foundation records, Rockefeller Archive Center, p. 3.
[75] Ibid., p. 3.
[76] See also Cindy Patton, *Globalizing AIDS* (Minnesota, 2002).
[77] Recommendation for Grant/FAP Action. Indian Health Organisation Grant No. 08903026, 23 May 1990 to 31 March 1994, Series: Ford Foundation Grants – H to K, Reel 7024, FA732D, Ford Foundation records, Rockefeller Archive Center, p. 5.
[78] Ford funded research in India in the early 1970s on a new field called "poverty studies". VM Dandekar and Nilakantha Rath, "Poverty in India – I: Dimensions and Trends" and "II: Policies and Programmes", *Economic and Political Weekly* 6:1 and 2 (January 1971), pp. 25-27+29-48; pp. 106-146.
[79] Recommendation for Grant/FAP Action. Indian Health Organisation Grant No. 08903026, 23 May 1990 to 31 March 1994, Series: Ford Foundation Grants – H to K, Reel 7024, FA732D, Ford Foundation records, Rockefeller Archive Center, p. 6.
[80] Recommendation for Grant/FAP Action. International Nursing Services Association of India No. 09100835, 13 August 1991 to 31 August 1996, Series: Ford Foundation Grants – H to K, Reel 7054, FA732D, Ford Foundation records, Rockefeller Archive Center, p. 4.
[81] Recommendation for Grant/FAP Action. Sevadham Trust No. 09201359, 9 December 1992 to 9 December 1995, Series: Ford Foundation Grants – S to Thel, Reel 7206, FA732G, Ford Foundation records, Rockefeller Archive Center, p. 3.
[82] Ibid., p. 3.
[83] Ashoke Chatterjee and Dr. Kusum Sahgal, Reports 012767: "HIV/AIDS Awareness & Control: Nineteen NGO Experiences in Delhi, Maharashtra, Tamil Nadu", p. 3, 10.
[84] Ibid., p. 12.
[85] Ibid., p. 12.
[86] Ibid., p. 12.
[87] Recommendation for Grant/FAP Action, Naz Foundation No. 09600517, 19 June 1996 to June 1999, Series: Ford Foundation Grants – U to Z, Reel 8354, FA732E, Ford Foundation records, Rockefeller Archive Center, p. 3.
[88] Ibid., p. 3.

[89] The National AIDS Control Organisation (NACO), as well as Indian health statisticians and epidemiologists challenged UNAIDS estimates (what they called "decontextualized numbers") of their national epidemic starting in 2001 and throughout the 2000s. Ritu Priya, "AIDS in Perspective: Between Exaggeration and Denial – Revisiting the Epidemiology of HIV Infection', in Ritu Priya and Shalini Mehta (eds.), *Dialogue on AIDS: Perspectives for the Indian Context* (New Delhi, 2008), p. 29. Lalit Dandona, Vemu Lakshmi, G Anil Kumar, Rakhi Dandona, 'Is the HIV burden in India being overestimated?', *BMC Public Health* 6:308 (December 2006). In fact, in 2007, UNAIDS/WHO state in their 2007 "AIDS Epidemic Update" that they had revised their calculation methods primarily due to Indian health statisticians' challenge. UNAIDS/WHO, 'AIDS Epidemic Update', Geneva (December 2007), p. 3.
[90] Recommendation for Grant/FAP Action, Naz Foundation No. 09600517, 19 June 1996 to June 1999, Series: Ford Foundation Grants – U to Z, Reel 8354, FA732E, Ford Foundation records, Rockefeller Archive Center, p. 4.
[91] However, my project's focus is not on gender and sexuality in global HIV/AIDS, as this is much better handled by medical anthropologists well versed in gender theory, as well as ethnographic research methods. Ford's New Delhi Program Officer Geetanjali Misra has published work on this, as have Suparna Bhaskaran's 2004 *Made in India: Decolonizations, Queer Sexualities, Trans/National Projects*, Stacey Leigh Pigg's 2005 *Sex in Development: Science, Sexuality, and Morality in Global Perspective* and finally, Lawrence Cohen and others in a University of Chicago roundtable discussion titled "Sexual Identity in India". <http://www.ssa.uchicago.edu/sexual-identity-india-session-1-part-1>.
[92] Capacity Building on HIV/AIDS of Intermediary Organisations Project Proposal, the Naz Project 12 December, 1995. Naz Foundation No. 09600517, 19 June 1996 to June 1999, Series: Ford Foundation Grants – U to Z, Reel 8354, FA732E, Ford Foundation records, Rockefeller Archive Center.
[93] Ibid.
[94] Ibid.
[95] "15 Minutes with Seth Berkley President and CEO of International AIDS Vaccine Initiative", *Stanford Social Innovation Review* (Winter 2004). <https://ssir.org/articles/entry/15_minutes_with_seth_berkley>. (Accessed 24 February 2017).
[96] Berkley also published his findings on the epidemiological profile of HIV/AIDS in developing countries in the early 1990s, such as: Seth Berkley, "AIDS in the Developing World: An Epidemiologic Overview", *Clinical Infectious Diseases* 17:2 Controversies in the Management of Infections in Immunocompromised Patients (Nov. 1993), pp. S329 – S336. Seth Berkley, "AIDS in the Global Village: Why US Physicians Should Care about HIV Outside the United States", *Journal of the American Medical Association* 268:23 (December 1992), pp. 3368-3369.
[97] Leonardo Mata to Scott Halstead, June 1991, Box R3030, RG 1.20-1.23, FA471, Subgroup 1.23: Rockefeller Foundation records (A97), Rockefeller Archive Center.
[98] The Debt for Development Coalition, Inc., "Swaps Against AIDS: A New Initiative to Increase Funding for AIDS Prevention and Control", Box R3030, RG 1.20-1.23, FA471, Subgroup 1.23: Rockefeller Foundation records (A97), Rockefeller Archive Center.
[99] Mohan Rao (ed.), *Disinvesting in Health: The World Bank's Prescriptions for Health* (New Delhi, 1999).
[100] In the case of India, the NACP-I in 1992 was an agreement between the World Bank's International Development Agency and the Indian Ministry of Finance.

[101] In the rationale for IDA Involvement in India's AIDS crisis in 1992, it states that the loan is in line with "IDA's strategy for enhancing human capital development in India through high return investments. They also go along with our emerging objective of assisting India in controlling major health problems, while simultaneously improving the quality, effectiveness and efficiency of health systems in a sustainable manner." Memorandum and Recommendation of the President of the International Development Association to the Executive Directors on a Proposed Credit of SDR 59.8 Million to India for a National AIDS Control Project, 9 March 1992, Report No: P-5693-IN, World Bank, p. 2.
[102] Linsey McGoey, *No Such Thing as a Free Gift: The Gates Foundation and the Price of Philanthropy* (London, 2015).
[103] Jennifer Brier, *Infectious Ideas: U.S. Political Responses to the AIDS Crisis* (Chapel Hill, 2009).