



HIV and AIDS funding: where does the money go?

Estimated annual spending on the response to AIDS in low- and middle-income countries grew from less than US\$ 300 million in 1996 to US\$ 1.6 billion in 2001 and then to US\$ 10 billion in 2007. UNAIDS estimates that reaching the goal of universal access to HIV prevention, treatment, care and support by 2010 will require steep annual growth until the total reaches US\$ 40 billion in 2010. From 70 to 80 per cent of that will be required in low- and lower-middle-income countries heavily burdened by HIV and AIDS and heavily dependent on financial assistance from donor countries (UNAIDS, 2007a).

Raising so much additional money from donor countries will not be easy. Starting with a UN General Assembly resolution in 1970, their governments have repeatedly promised to increase official development assistance (ODA) until it reaches 0.7 per cent of their gross national product (GNP) but only a few have honoured that promise. The rest have fallen far short, so there has always been a wide gap between what donor countries provide and what low- and lower-middle-income countries need to finance their progress towards an acceptable level of socio-economic development. Other international sources – foundations, non-governmental organizations (NGOs) and private businesses – have never come close to closing that gap, though some have been very generous.

Equally, there was already concern about the disproportionate share of all ODA going to only one disease when, in November 2007, UNAIDS released sharply lower estimates of HIV and AIDS prevalence and showed that the disproportion was even greater than thought. Actual spending falls far short of required spending on the full range of disease and injury in low- and lower-middle-income countries, and not nearly enough is spent on building capacity into their entire healthcare systems (MacKellar, 2005; Kates et al., 2007a).

The best hope may lie in making better use of whatever money may be available. The fact is that much – perhaps most – of the money supposedly spent on the response to HIV in low- and middle-income countries never actually reaches those countries or else, once there, is wasted on inefficient bureaucratic procedures and on programmes and projects that fail to deliver services to the people most in need of those services (UNAIDS, 2006a). Streamlining the flow of money from its source to the front line, and then spending it on interventions that work, could go a long way towards achieving the goal of universal access. Showing donors that their money is being put to good use and achieving results might convince them they should give more.

Photo opposite page:
In Guinea, a health educator at a prenatal clinic encourages pregnant women to have regular HIV tests.

© Giacomo Pirozzi/
PANOS

Total spending on the response to AIDS

Through the UNAIDS Global Resource Tracking Consortium, a number of international and regional organizations are collaborating on gathering the baseline data for making estimates and projections of annual spending on HIV. The data come from a variety of sources but particularly from national governments, and they are often expressed in terms of budgetary intentions rather than actual expenditures and with little detail about government sources and allocations of money. Since 2005, the Consortium has been supplementing this budgetary data with National AIDS Spending Assessments.

The Organisation for Economic Co-operation and Development (OECD) tracks commitments and actual disbursements (which often lag far behind commitments) by donor governments. Their data can be cross-checked using data from recipient country governments, but the use of different categories and reporting periods means that fully accurate cross-checking is often impossible. Details typically lacking in national budgets include domestic household spending and contributions made by international, national and local foundations, civil society organizations and private businesses. Various members of the Consortium attempt to track contributions by some of those but there are major gaps.

Based on the best data available, total spending on the response to AIDS in low- and middle-income countries was US\$ 8.9 billion in 2006. (Since it benefits high-income countries, too, spending on HIV vaccine and other biomedical research and development is not included in this figure.) Of that total, 44 per cent came from donor governments while the rest came in small part from other international sources but in large part from domestic sources (Kates et al., 2007b).

Domestic household overspending

A harsh reality is that the poorest people in the poorest countries are often obliged to cover the highest percentage of all HIV-related health and social costs from their own pockets. There are typically insufficient hospitals, clinics, laboratories and pharmacies in their countries, while those that exist are often understaffed, under-equipped and undersupplied (see Box 7.1). These facilities are often obliged to ask patients and their families to pay fees or to provide their own medicines, meals, clothing and bedding and attend to laundry, bathing and grooming. Equally, individuals and their families must often cover the costs of home-based care, plus support for orphans and other vulnerable children, by out-of-pocket spending.

In high- and upper-middle-income countries, government health and social security programmes often cover 80–95 per cent of the costs of HIV-related health and social care. In low- and lower-middle-income countries, combined government and inter-

Box 7.1 Task shifting: a human resource response to the HIV and AIDS disaster

The world is faced with a chronic shortage of health workers, particularly in sub-Saharan Africa where the World Health Organization (WHO) estimates a shortfall of 820,000 health workers (WHO, 2006a). Not only are sub-Saharan countries not training enough workers, but many highly trained workers are emigrating to meet the demand for health workers in developed countries; this is happening at the same time as the HIV and AIDS epidemic is creating huge increases in demands for health services. About 95 per cent of people with HIV and AIDS live in developing countries and nearly two-thirds of them, some 22.5 million people, are in sub-Saharan Africa (UNAIDS, 2007b).

The 2006 global commitment to scale up HIV services – with the aim of universal access to treatment for all those who need it by 2010 – has created new urgency for intensifying global action to strengthen the health workforce (WHO, 2006a). In May 2006, a WHO-organized international consultation developed a proposal for an AIDS and health workforce plan dubbed “Treat, Train, Retain” (WHO, 2006b). A crucial component of the training strategy is task shifting – that is, the rational delegation of tasks, where appropriate, to less specialized health workers in order to expand the health workforce for increased service delivery. It includes both a redistribution of tasks among existing health workers and, where necessary, the creation of new cadres to extend the workforce capacity by performing clearly delineated tasks. WHO is in the process of producing guidelines and recommendations for countries considering the adoption or expansion of task shifting for the delivery of HIV and AIDS services, and believes it provides a realistic possibility of

expanding the health workforce fast enough to meet the urgent need for HIV services (WHO, 2007).

Task shifting is already being implemented in countries that face acute health workforce shortages at the same time as high HIV burdens. For example, in Malawi, non-physician clinicians and nurses prescribe anti-retroviral treatment (ART) among other services, and the scope of practice of some cadres of community health workers has been extended to allow them to perform HIV counselling and testing. Outcomes have been good in terms of significant increases in the number of people receiving ART and high levels of service-user satisfaction (Ministry of Health, Malawi, 2005). The WHO-commissioned study on task shifting reports good health outcomes, rapid increases in access to HIV services and a high level of patient satisfaction. These findings are consistent with other studies on the effectiveness of task shifting for the delivery of health services, including HIV services (WHO, 2007).

The past few years have seen improved access to anti-retroviral drugs in several African countries, bringing new challenges to community-based HIV interventions such as home-based care. In 2006, the International Federation, in partnership with WHO and the Southern Africa AIDS Information Dissemination Service, developed an HIV prevention, treatment, care and support training kit for community home-based care volunteers. With the involvement of the Zimbabwean Ministry of Health, Hospaz (the Zimbabwe Association of Hospices), Connect (a Zimbabwean training organization in family therapy and systemic counseling) and The Centre (an organization for people living with HIV), training

was launched for Zimbabwe Red Cross Society care facilitators and trainers. The toolkit comprises eight modules and provides a wide spectrum of information covering topics on basic HIV and AIDS, treatment literacy, adherence, palliative care, care for carers, treatment preparedness, counselling, nutrition and positive living. With training, volunteers involved in home-based care programmes can now meet the additional challenges they face in providing treatment-related information and follow-up to people living with HIV, along with the involvement of affected families to ensure successful treatment (International Federation, 2006).

In Malawi, Red Crossers trained using the toolkit explained:

“Our experience of the manual is that it is a very good and effective tool for skills transfer because it is centred on practical work. The manual is full of practical scenes that volunteers encounter in the community as they attend to home-based clients and the chronically ill. The manual uses five to 15 minutes’ mini lectures then participants go to groups for group work that require them to demonstrate the transfer of skills to the client and guardians, then the class critiques the scene and offers constructive support on how to improve.”

While the training described exemplifies adult learning methodology, this may imply a significant shift in methods currently in use to train health workers.

Task shifting is not without other challenges. The *Community Home-based Care in Resource-Limited Settings: A Framework for Action* (WHO, 2002) document proposes a health team mix of professional and para-professionals, and a mix of paid health staff and volunteers to provide care. However, the correct mix of people needed to provide uni-

versal access to HIV prevention, treatment, care and support is not clear or uniform across countries. The WHO draft task-shifting guidelines point to the fact that community health workers tasked with more than a certain number of hours per week should be paid. The question of what represents adequate remuneration remains controversial, and there is a paucity of evidence to indicate what combinations of incentives, including financial and non-financial incentives, are sufficient to motivate and retain community health workers.

The provision of community home-based care provides a special challenge to volunteer organizations like Red Cross Red Crescent Societies; volunteers often discover that the number of hours they work escalates as clients become more ill or leave orphans behind. Their workload becomes unsustainable since it is not providing their livelihood and is often contrary to a Red Cross or Red Crescent Society’s policy on the number of hours a volunteer should work in a week. The International Federation in southern Africa has learned that community home-based care volunteers ‘burn out’ over time or can no longer sustain their workload, so continual recruitment and training of volunteers is necessary. Groups engaged in responding to the crises of human resources in health, including the International Federation, need to define a reasonable role for the volunteer in the provision of care and consider what, in the long run, might be more efficiently provided by paid community health workers. ■

national donor contributions may cover as little as 25 per cent of the costs. Moreover, wide disparities between countries may have more to do with domestic government and donor government policy than with overall national wealth. One analysis found that out-of-pocket spending accounts for 45 per cent of all HIV-related health and social care in Kenya but only 9.4 per cent in Ghana (UNAIDS, 2006a).

In low- and lower-middle-income countries, a large majority of people are too poor to pay any more than they already pay out of their own pockets. In countries heavily burdened by HIV and AIDS, many people are already being driven deeper into poverty by loss of income and increasing expense due to illness and death. Poor people are often criticized for buying fake or quack medicines and for turning to traditional healers, but those may be the only medicines and healers available or the only ones they can afford (though such medicines are sometimes more expensive than conventional medicine). Certainly, the very poor cannot afford to pay for their own anti-retroviral treatment (ART) even when it is available, especially since access to it often involves travel and long stays far from home and work.

Domestic government constraints and waste

National AIDS spending estimates commissioned by UNAIDS have found no obvious correlation between countries' per capita spending on HIV and AIDS, their gross national products and the severity and nature of their epidemics (UNAIDS, 2006a). Some middle-income countries do not qualify for financial assistance from donors and could well afford to be spending more of their own money on HIV. They are not doing so despite the presence of epidemics among certain groups that are now breaking out into the general population. Some low- and lower-middle-income countries cannot afford to spend more of their own money but are not attracting their fair share of financial assistance from donors because they do not happen to be among the 'donor darlings' favoured, for example, by the United States President's Emergency Plan for AIDS Relief (PEPFAR).

While lack of domestic and donor government spending on HIV may be a major problem, domestic governments' misspending of their own and donors' money appears to be an even bigger problem. A number of studies commissioned by the World Bank and other agencies have found that few national AIDS plans are based on sound evidence. As a result, much of the available money is wasted on interventions that do not address the real needs of the people actually living with HIV or at highest risk of infection (Mullen, 2005).

Waste occurs because national AIDS planning, budgeting and implementation fail to:

- **Put people living with HIV and those most at risk of infection at the very centre of the response to HIV.** The whole response should revolve around their needs. Their representatives – chosen by them and accountable to them – should

be at the table first, last and always whenever needs are being assessed, plans and budgets are being formulated and revised, programme and project proposals are being considered, funding decisions are being made, and monitoring and evaluation of results are taking place (see Box 7.2).

- **Build on the strengths of existing service providers.** No matter who owns, operates or funds them, the hospitals, clinics, laboratories, pharmacies and social service agencies that already provide health and social services should also be at the centre of the response to HIV. Determining how to scale up access to HIV prevention, treatment, care and support can be done largely through discussion and negotiation involving them and the people living with HIV and those most at risk of infection.
- **Build on the strengths of the country's own experts and research institutions.** Country- and community-based experience, including life experience from birth, is often a significant part of the expertise relevant to understanding and addressing difficult health and social problems, especially ones involving anything as politically, socially and culturally sensitive as people's sexual behaviour. As a general rule, international experts and research institutions will contribute more if they work in partnership with country- and community-based experts and institutions and engage in two-way transfers of knowledge and skills.
- **Keep building up a body of ever more comprehensive, reliable and up-to-date evidence.** A sound response to HIV is one firmly based on the following types of evidence, much of it country-specific:
 - **Biomedical evidence.** Biomedical scientists are constantly discovering new information about HIV, new mutations of the virus, factors that contribute to transmission, how transmission can be prevented, how opportunistic infections can be prevented and treated, and so on.
 - **Serological and behavioural evidence.** Sentinel surveys at antenatal clinics and other selected sites can track trends in an epidemic. However, periodic population-wide serological and behavioural surveys are necessary in order to identify groups within the population that may be at risk and the factors putting them at risk. In addition, there should be special surveys covering groups that may be hard to identify and question in population-wide surveys, including injecting drug users, men who have sex with men, migrant workers, people displaced by disasters, trafficked people and sex workers.
 - **Evidence about legal, political, cultural, social, economic and other factors.** In many countries, injecting drug use and male-to-male sex are common in prisons. In some countries, doctors are rough and disrespectful of women and girls and especially of those who are poor or come from certain castes or racial and ethnic groups. Systematic study of these and other phenomena – lack of human rights legislation and enforcement – can identify factors that put people at risk of infection and deny them access to appropriate HIV prevention, treatment, care and support.

- **Evidence about service providers and their needs for capacity-building.** When there is money available, more than enough organizations will step forward to claim their share by saying they represent or serve people living with HIV or at high risk of infection. Any such claims should be subject to scrutiny by the legitimate in-country representatives of at-risk groups and by known and established in-country service providers with solid records of achievement. Once the appropriate service providers have been identified, then their needs for capacity-building should be specified. They may, for example, need to build relations with organizations representing marginalized groups and learn how to meet these groups' unique needs for services.
- **Economize wherever possible and insist on evidence-based, results-driven programmes and projects without wavering.** Building on the strengths

Box 7.2 Cameroon's unwed young mothers provide effective, low-cost and sustainable HIV prevention to girls

Under the Federal Ministry for Economic Cooperation and Development, Germany's five development cooperation organizations aim to support effective, low-cost and sustainable responses to HIV. In Cameroon, one such response began in 2000 after a study found that the country's adolescent girls were following worldwide trends, i.e., towards sex before marriage, early sexual initiation and multiple sexual partners. This puts them at high risk of getting pregnant, being removed from schools, having unsafe abortions, being forced into early marriage and acquiring sexually transmitted infections including HIV. Gender inequality adds to their vulnerability.

By comparison to their countrymen, Cameroon's women are considerably poorer, less educated, less informed about sex and less likely to do what is necessary to prevent pregnancy and infection. On average, they are much younger than their male partners and are often subject to coercion and violence by men.

Born and raised in Cameroon, Flavien Ndonko studied anthropology in Germany

and then returned to work with the Germano-Cameroon HIV and AIDS Programme. He understood the cultural background to the study's findings. A girl's 'innocence' is so valued that, when she reaches puberty, her female relatives sometimes 'iron' her breasts to make her unattractive. This extremely painful procedure involves binding a girl's breasts with heated towels then pounding and rolling them flat with stones, wooden pestles or coconut shells. It leaves permanent tissue damage and, sooner or later, may lead to infection, cysts, cancer and the need for breast removal. Whether or not her breasts have been 'ironed', if a girl gets pregnant she is likely to be shunned by her peers and the rest of her community. Her own family may cast her out.

Nadège's story

Nadège was 16 and still at school when her parents sent her to a close family friend and neighbour for tutoring. He made sexual advances and she was, by her own description, "so naïve" and afraid that she could not

resist or tell anyone. When she missed her periods, she told only him. He gave her drugs to induce abortion but they did not work. When her parents noticed she was pregnant, they told her uncle and he beat her so severely that she ran away from home. When she tried to return, her parents took her to a distant crossroads and threw ashes on her to show, in the way of their village, that she was effectively dead and could never come home again. She could not return to school because her uncle would no longer sponsor her.

While cultural traditions may be hard on girls, they can also suggest ways of bridging the gap between the old way of life and the modern one. In Cameroon, a girl's auntie used to be her trusted confidante, teacher and counsellor in sexual matters, which were considered too embarrassing to be discussed with her parents or any other adult. Urbanization, modern transportation and communications, the globalization of youth culture and disparities between rich and poor have undermined that tradition. Now, aunties often live far away but, even if nearby, are no longer equipped with the knowledge or personal experience to help girls cope with the pressures, temptations and risks of modern life.

Ndonko and his colleagues based the Aunties' Programme on that old tradition. It aims to restore self-respect and confidence to unwed young mothers and provide them with the knowledge, skills and mutual support they need to conserve their own sexual and reproductive health and otherwise take care of themselves and their babies. It also aims to turn them into surrogate aunties, with useful roles in their families and communities. Like traditional aunties, these new aunties speak from their own experience as girls who have 'made mistakes' and suffered the consequences. They do not presume to judge or

moralize when engaging other girls in frank discussion about their personal lives.

Launched in 2001, the Aunties' Programme has been established in more than 140 villages and urban neighbourhoods and it continues to grow. Its introduction into each new place starts with requests for permission and support from that place's government, health and education authorities. Programme staff make sure these authorities know the budget is small and that success will depend on their donations of space and staff (e.g., doctors to talk about HIV and how to prevent it) for training courses and meetings.

A team – headed by a social worker or social scientist but consisting largely of aunties trained and experienced in other communities – then begins to identify and interview unwed young mothers. Each one is asked to urge any others they know to come forward for interviews. The interviews are aimed at collecting information on their health and sexual histories, informing them about the Aunties' Programme and inviting them to attend a basic training course to be held in their village or neighbourhood soon afterwards. The three-day course provides the new recruits with knowledge and skills to avoid sexually transmitted infections and unwanted pregnancy and to qualify as aunties.

On the last day, the new aunties are given models of a constitution, electoral code and set of rules for a local Aunties' Association. They are urged to take time to study, discuss and revise these until they are ready to vote on versions for their own association and then nominate and elect their officers. The aim is to empower them but, since they are inexperienced at democratic governance, programme staff remain on call for advice and conflict resolution until they are ready to manage on their own.

Each Aunties' Association serves as a mutual support group but each auntie is also encouraged to engage other girls – for example, in her family, neighbourhood, church or mosque – in conversation about sex and HIV. Those who demonstrate their skill at relating to groups of girls are provided with a set of tools for organizing and delivering a series of presentations in schools, with each presentation focusing on one subject (e.g., puberty); the series adds up to a course on sexual and reproductive health and HIV. As they gain more experience, roughly one in ten aunties attends an additional five-day course in counselling adolescent girls and boys, individually and in couples, and helping them solve problems such as what to do when your partner refuses to use a condom.

There are now more than 140 local Aunties' Associations and 7,000 trained aunties. Five hundred are skilled and experienced at sex education in schools and, working in pairs, they can reach up to 48,000 students a year. Seven hundred are trained counsellors and, collectively, they can counsel around 10,500 adolescents each year.

The programme covers some out-of-pocket expenses (e.g., for baby sitters and travel) and pays the occasional honorarium for special assignments but, in general, the aunties work as volunteers and the programme costs are very low. For example, the cost of basic training varies from €2 to €20 (US\$ 3–30) per new recruit and the cost of counsellor training varies from €170 to €250 (US\$ 258–380) and may be lower in future, as previously trained aunties who have returned to school, achieved their 'A levels' and gone on to university take over from independent consultants.

The programme is constantly improving its monitoring and evaluation procedures. Ques-

tionnaires administered before and after training courses and school presentations, and then repeated months later, indicate a high level of success, considering how difficult it is to change people's behaviour. Recent results show that, before basic training, only 26 per cent of unwed young mothers use condoms on a regular basis but after training, 47 per cent do.

Before basic training, only 39 per cent know their HIV status but after training 48 per cent do and during training as counsellors around 90 per cent do. (Basic training takes place within their own communities but counsellor training takes place elsewhere, where they are more willing to take up offers of testing because they are more confident that no one they know will learn the results.) After becoming aunties, one-fifth return to school and two-thirds take other action (e.g., becoming apprentices or starting a small business) to improve their financial situation.

The results achieved by the aunties' school presentations are sometimes dramatic. In one school, 30 girls dropped out due to pregnancy in the year *before* a series of aunties' presentations and none dropped out the year *after*. Anecdotal evidence suggests that counselling is also effective. It most often focuses on the correct use and benefits of condoms but frequently focuses on morning-after pills, safe and early termination of pregnancy and sexual harassment and rape. Some Aunties' Associations have laid charges against male offenders and have reduced the incidence of sexual violence in their communities by letting potential offenders know there is a good chance they will be named and shamed or prosecuted.

In 2005, Cameroon's local Aunties' Associations established the National Network of Aunties' Associations (RENATA) and it has

mounted campaigns to ban breast 'ironing', gender inequality and sexual exploitation and abuse of girls. RENATA has done much to improve the self-respect and confidence of all

aunties. Auntie Madeleine Songo puts it this way: "After I was on television my family and the neighbours went crazy. Everybody wanted to talk to me, to listen to me." ■

of existing country- and community-based human resources and infrastructure is the best way of making good use of whatever financial resources may be available and also of leaving a legacy of sustainable health and social service provision that addresses not only HIV and AIDS but the full range of disease and injury. When so little money is available, it should be focused on efforts to accelerate access to HIV-related services as quickly as possible. While politicians have critical roles to play in providing leadership, legislation and overall HIV policies and budgets, the administration of policies and budgets should always be done at arm's length from politicians so they cannot divert money to their own pet programmes and projects or to those favoured by their supporters.

- **Include the response to HIV and AIDS in humanitarian situations.** A recent study by UNAIDS and the Office of the UN High Commissioner for Refugees (UNHCR) looked at 28 countries spread through all regions of Africa where conflict and natural disasters have displaced millions of people and brought them into contact with host populations, soldiers and aid workers (UNAIDS and UNHCR, 2005). All but three of the countries had national AIDS plans, but a third of the plans made no mention of refugees and more than half made no mention of activities for addressing their needs. These omissions reflected the failure to look for international financial assistance for such activities. In their joint publication, *Strategies to support the HIV-related needs of refugees and host populations*, UNAIDS and UNHCR recommend that humanitarian organizations join with national AIDS authorities, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank's Multi-Country AIDS Program for Africa (MAP) in taking responsibility for ensuring that the needs of people in emergency situations are taken into account when proposals for funding are developed and approved. They also recommend that humanitarian funding be combined with other funding in those parts of national AIDS budgets that address HIV and AIDS in emergency situations (UNAIDS and UNHCR, 2005).

Civil society's contributions

Most high-income countries deliver significant portions of their health, education, social and other community services through financial agreements with civil society

organizations, including faith-based ones. A recent analysis of data from eight high-income countries found that these organizations contribute added value (not counting government contributions to their budgets) averaging 22 per cent of their health sector economies, 20 per cent of their education sector economies and 19 per cent of their social services sector economies (Salamon et al., 2007).

In 2006, the 22 high-income countries that are members of the OECD's Development Assistant Committee (DAC) channelled US\$ 5.4 billion or 5.2 per cent of all of their ODA through international, national and community-based civil society organizations (OECD, 2007c).

Many of these organizations were able to collect money from other external sources and most added considerable value of their own, including donations of money, time, energy, skills, working spaces, equipment and supplies by their own members and volunteers.

At present, there is insufficient data and analysis on which to base even the most approximate estimates of the sources of money flowing through each of the three levels (international, national and community-based) of civil society organizations engaged in the response to HIV, globally or country-by-country.

Nor is it possible to estimate roughly in financial terms how much value they add through their own contributions. The evidence suggests, however, that the value they add is very considerable (see Box 7.3).

For example, the Christian Health Associations of Africa collaborate with ministries of health on providing 40 per cent of national health care in Kenya and Lesotho, 45 per cent in Zimbabwe, 47 per cent in Liberia and 48 per cent in Tanzania (Dimmock, 2005).

In 2004, the treatment rights group Sidaction surveyed 274 community-based organizations in 45 African countries and found that 68 were prescribing ART, 133 were providing medical follow-up, 156 psychosocial follow-up, 159 education and information on managing the side effects and 141 treatments for opportunistic infections (Sidaction, 2005).

Many civil society organizations are concerned that too often they are not invited to participate in international and national mechanisms where decisions are made about where and how to spend money on HIV. They believe that their financial invisibility may be a reason for this and are collaborating through the International Council of AIDS Service Organizations (ICASO), the International HIV/AIDS Alliance and the UNAIDS Global Resource Tracking Consortium to rectify this situation.

Box 7.3 The importance of community-based organizations: the example of the Treatment Action Campaign's work in Khayelitsha, South Africa

By late 2004, Andile Madondile had been very sick for many months. He suffered from constant diarrhoea, debilitating headaches, shingles and numerous other conditions. He had lost weight and was extremely weak. Yet although he knew something was terribly wrong, the thought that he had HIV – which was confirmed when he finally decided to get tested at a clinic in Khayelitsha, the township in Cape Town, South Africa, where he lives – was terrifying. HIV was not only a death sentence, he believed, but would forever mark him as a person to be shunned and isolated in his community. Was it worth knowing the truth and the subsequent likelihood of experiencing emotionally draining stigmatization? Or better to continue on in ignorance, even if that meant risking almost certain death?

Now 30 years old, Madondile chose the former option, which is why he is still alive more than three years later. It has not been an easy time for him nonetheless. At the time he tested positive, he was living with family members including his mother and some siblings. Confirming his worst fears about HIV-related stigma, several important people in his life reacted quite negatively to the news. He said his partner, with whom he had a daughter (then 3 years old), “ran away”. His brother and sister refused to share utensils with him and recoiled from touching him or even being near him. He eventually moved to live by himself elsewhere in Khayelitsha.

Madondile said two developments helped him survive such trauma: his health improved dramatically after he began taking ART in March 2005, and shortly thereafter he joined the local branch of the Treatment Action Campaign (TAC), a South African NGO that offers

a wide range of HIV prevention and care services in addition to playing a leading advocacy role on behalf of people affected by HIV. Madondile credits the support and encouragement he has received from TAC with helping him regain confidence, stay healthy and eliminate the shame and despair that followed his HIV diagnosis.

TAC is one of the most well known of the civil society organizations (CSOs) that are directly engaged in responding to the HIV epidemic in South Africa. It is the world's largest in terms of absolute numbers of HIV-positive members. Unlike TAC, which has branches around the country, the majority of CSOs are not only much smaller and localized, but also operate on shoestring budgets (if they have any formal budget at all). Accurate estimates of the total number of community-based groups are difficult to obtain because they vary so greatly. Groups of all shapes, sizes and focus areas are formed and become inactive on a regular basis. At one extreme, some are entirely composed of volunteers, raise no money and do not register with authorities.

Regardless of their size and scope, CSOs provide a variety of HIV-related education, prevention and care services that resource-strapped and overwhelmed governments are unable or unwilling to offer. In many settings, especially isolated rural areas, HIV-affected individuals and families must turn to small community-based groups for even the most basic assistance because public sector health and social services are inadequate, inconvenient to access or simply unavailable.

Results from a 2005 survey of community-based groups in South Africa indicated that the HIV-related care and support services most

commonly offered by such groups included "counselling, emotional care, support for [people living with HIV], promoting community care, support groups, and support to families and caregivers". A smaller number of CSOs were able to "provide more specialised care and support functions such as nutrition support, support to orphans and vulnerable children, home-based care, and income-generation projects" (CADRE, 2005).

According to Mandla Majola, the district coordinator of TAC's Khayelitsha branch, the organization's current activities at the grass-roots level include organizing and hosting support groups for HIV-positive individuals and their families, distributing condoms and prevention information, raising awareness about, and seeking care for, victims of gender-based violence and working closely with smaller CSOs in the township that focus specifically on issues such as home-based care and services for AIDS orphans.

TAC's Khayelitsha branch has just five full-time staff members. That it still manages to reach thousands of people points to one of TAC's greatest strengths: nearly all of its activities, from outreach to advocacy to peer education, are undertaken by a small army of volunteers.

Madondile is just one of the more than 1,000 TAC volunteers in Khayelitsha alone. Most, like him, are HIV positive themselves and open about their status. Such openness is not required, but it is encouraged as part of the organization's broad and ongoing campaign to reduce HIV-related stigma. TAC is famous for another high-profile effort: encouraging as many people as possible, HIV-positive or not, to wear t-shirts proclaiming 'HIV-positive' in huge letters. Thousands of 'normal' South Africans at the community level sport them regularly and prominent individu-

als around the world, from former President Nelson Mandela to singer Annie Lennox, have made a point of being photographed wearing one.

Another TAC volunteer, 43-year-old Michael Hamnca, said the climate of openness is crucial to helping connect people in need with the services available to them. He said he and his colleagues often go to clinics, wearing their 'HIV-positive' t-shirts if possible, and hand out information about ART, opportunistic infections and tuberculosis to people waiting to see doctors and nurses. They present themselves as HIV positive and mention where, when and how to find support groups for a wide range of HIV-related issues. Both Hamnca and Madondile said that when talking to members of the community, they often stress how important the 'TAC family' has been at points in their lives when they felt lonely, isolated and oppressed because of their HIV status.

One thousand volunteers may sound like a lot, but the massive need in Khayelitsha for services offered by TAC and other CSOs is likely to continue expanding. In January 2008, some 700,000 people were thought to be living in the township, one of the poorest and most resource-constrained parts of the Cape Town metropolitan area. Every year tens of thousands move there from even poorer areas of Eastern Cape province in search of jobs and social assistance.

Majola, the TAC branch director, said recent surveys indicate that perhaps 17 per cent of Khayelitsha residents are HIV positive, a prevalence rate that mirrors the national one but is twice that of Western Cape province of which Cape Town is the capital. The majority of those already infected are not aware of the fact, he added, and awareness of prevention measures is low even as HIV-related stigma remains high.

It is individuals such as Andile Madondile and Michael Hamnca who are at the forefront of efforts to improve such indicators. Madondile said his first success occurred close to home. A few months after leaving home and joining TAC, he reached out to his brother and sister and spent weeks talking about HIV with them. He said that they now

accept him again and will touch him without fear. The same tactic worked with the mother of his daughter; they were reunited within a year. The family now includes another child, born in 2006. "When people understand how to protect themselves and others, they have no fear," he said. ■

The generosity of foundations and corporations

Funders Concerned About AIDS (FCAA) was founded in 1987 with the aim of mobilizing philanthropy in the United States to respond to AIDS domestically and internationally. By 2000, small and large foundations and corporations were committing more than US\$ 300 million a year. From 2005 to 2006, their commitments jumped sharply from US\$ 354 million to US\$ 979 million while their actual disbursements rose from US\$ 346 million to US\$ 504 million. This sharp increase was largely driven by the Bill & Melinda Gates Foundation, which accounted for 38 per cent of all commitments in 2005 but 75 per cent of all commitments in 2006. The top ten funders accounted for 90 per cent of all commitments in 2006 (Funders Concerned About AIDS, 2007).

From 2005 to 2006, the proportion of all commitments going to the international response increased from US\$ 233 million (66 per cent) to US\$ 882 million (90 per cent). Even more impressive was the fact that, while in 2005 53 per cent of all commitments to the international response went to organizations based in North America, only 15 per cent did so in 2006 (see Figure 7.1 for details). Much of the foundation money went towards strengthening the civil society response and increasing the availability and uptake of HIV testing and treatment.

The European HIV/AIDS Funders Group acknowledges that European foundations and corporations have, collectively, been less generous than those in the United States. One of the problems is lack of transparency, making it hard to get information on foundation and corporate giving in many European countries. The group is working with the UNAIDS Resource Tracking Consortium in order to provide a more comprehensive picture of what sums European philanthropy contributes to the AIDS response in low- and middle-income countries. At the same time, the group believes there is significant capacity for these contributions to increase. Based on the best available data, European foundations and corporations made actual disbursements in 2005 of US\$ 101.2 million to the international AIDS response. Of that, 92 per cent came from the top 15 donors and 25 per cent came from the top donor, Wellcome Trust (European HIV/AIDS Funders Group, 2006).

Donor government spending

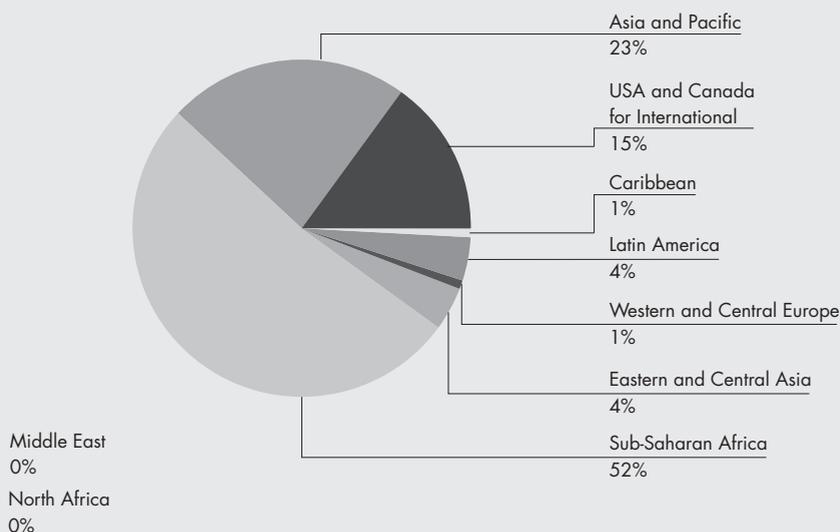
The perpetually broken promise of more development assistance

The world's major donor countries are the 22 member countries of OECD's DAC; they give the name 'official development assistance' to their own and other countries' financial and technical assistance to low- and middle-income countries. The European Commission has its own DAC membership and also contributes to ODA, though its contributions originate with the 27 countries of the European Union of which 15 are DAC member countries.

From 2001 to 2005, gross ODA grew by 120 per cent from US\$ 55 billion to US\$ 122 billion. Debt relief – which costs donor countries little because it involves forgiving loans to low-income countries that are already in arrears or unserviceable – accounted for 35 per cent of the growth; aid to war-torn Iraq and Afghanistan accounted for 34 per cent and emergency assistance due to unusual emergencies accounted for another 18 per cent. If debt relief, aid to Iraq and Afghanistan and unusual emergency aid are excluded, nominal ODA increased by only 33 per cent and

Figure 7.1

Geographical distribution of funding commitments made by foundations and corporations in the United States to the international response to AIDS in 2006



Source: Funders Concerned about AIDS, 2007

most of that increase was offset by currency revaluation and deflation (Kates et al., 2007a).

With less debt relief in 2006, gross ODA fell by 5.1 per cent to US\$ 116 billion. Part of this sum came from non-DAC-member countries (e.g., non-OECD Asian and Middle Eastern countries and non-DAC members of the OECD) but the bulk came from DAC member countries. Net ODA from DAC member countries was US\$ 104.4 billion (Figure 7.2a). Figure 7.2b shows the amount contributed by each and translates it into a percentage of the country's gross national income (GNI) (OECD, 2007b and 2007c).

Figure 7.2a
Net ODA by DAC member countries in 2006

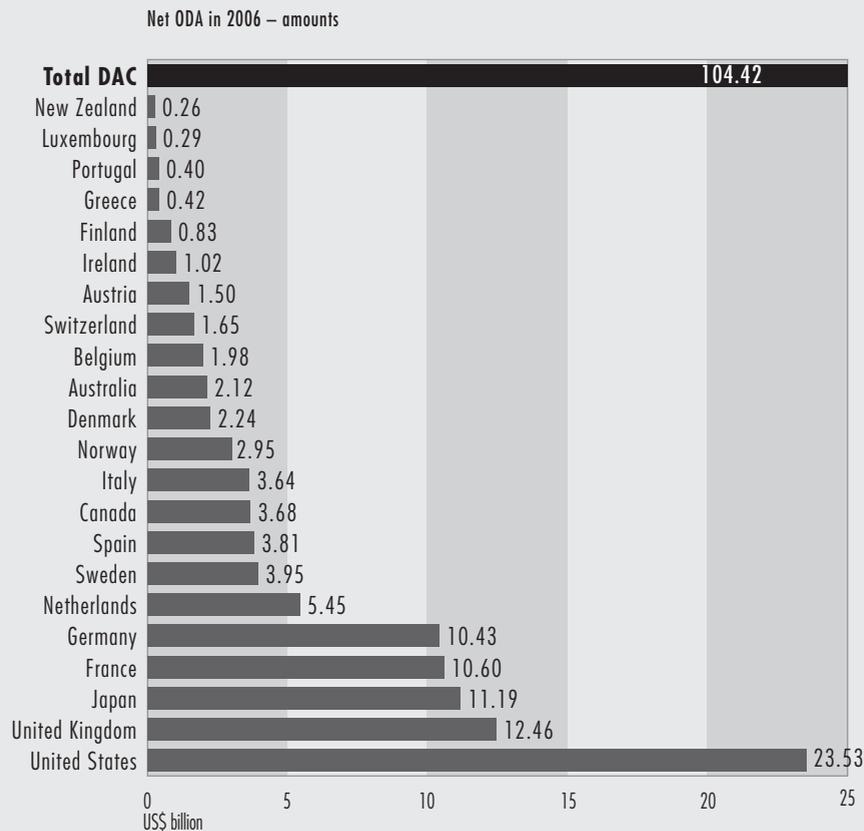
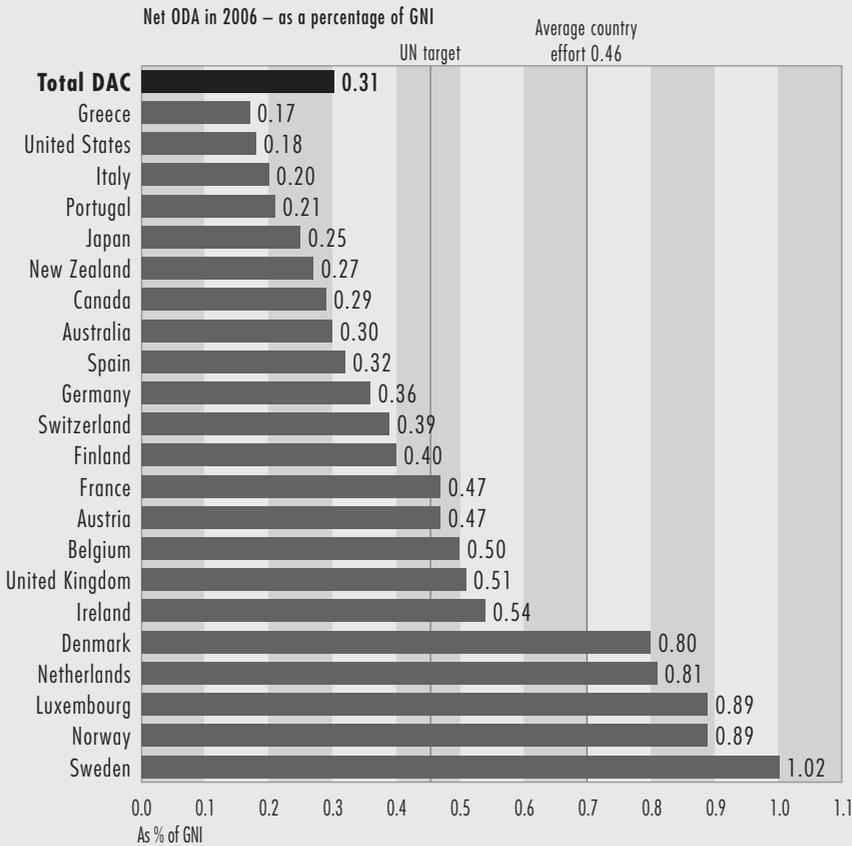


Figure 7.2b

Net ODA in 2006 as a percentage of DAC member countries' GNI



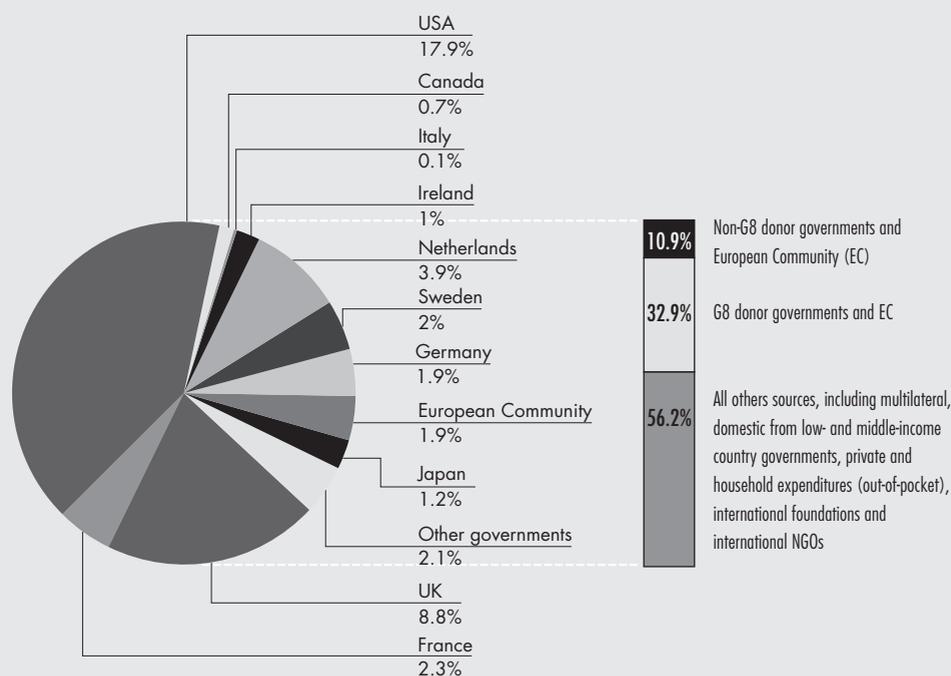
An increasing share going to HIV

Between 2002 and 2006, DAC member countries' commitments and actual disbursements for HIV both increased more than threefold in nominal terms. From 2005 to 2006, their contributions to ODA fell by 5.1 per cent but their commitments to HIV grew by 28 per cent to US\$ 5.6 billion and their actual disbursements to HIV grew by 11 per cent to US\$ 3.9 billion. That represented 44 per cent of the total amount (US\$ 8.9 billion) spent on the response to AIDS in low- and middle-income countries in 2006.

Of the US\$ 3.9 billion, the United States contributed 40.8 per cent, the United Kingdom 20.0 per cent and the Netherlands 8.9 per cent. Calculated as a percentage of

their GNI, the five top donors were, in order, the Netherlands, Sweden, Ireland, the United Kingdom and the United States. Figure 7.3 shows the shares each donor country contributed as a percentage of total spending on the response to HIV (Kates et al., 2007b).

Figure 7.3
DAC member countries' share of total 2006 spending on the response to AIDS in low- and middle-income countries



Source: Kates et al., 2007b.

Allocations to multilateral institutions

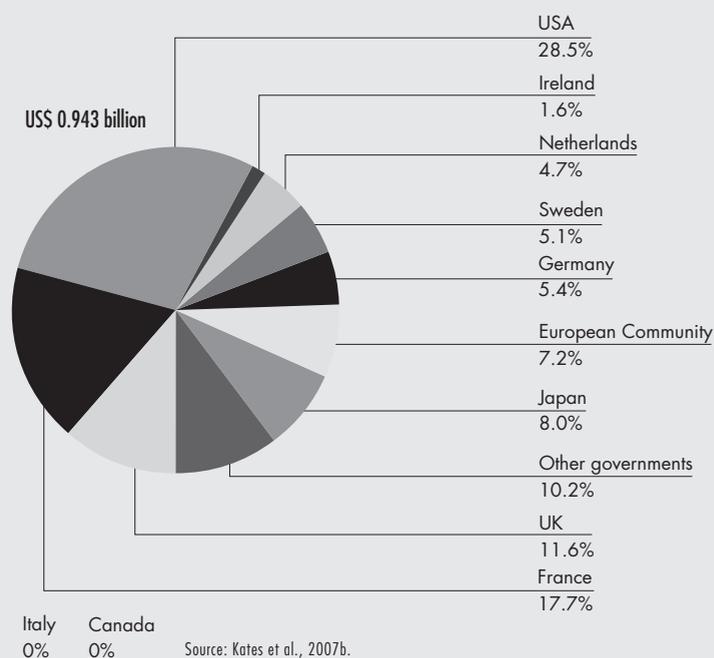
When the Global Fund to Fight AIDS, Tuberculosis and Malaria was launched in January 2002, the hope was that much of its money would come from foundations, businesses and other non-governmental sources. In fact, the Global Fund has been largely dependent on donor country governments. Over the six years from its launch to the end of 2007, it received US\$ 17.9 billion in pledges and US\$ 9.2 billion in actual contributions of which 95.5 per cent came from donor countries. During that time, it approved almost US\$ 10 billion in grants and disbursed US\$ 7.7 billion to grant

recipients. Of its grants, 90 per cent went to low- and lower-middle-income countries and 58 per cent to HIV work (Global Fund, 2007).

Of the US\$ 3.9 billion of ODA from DAC member countries that was disbursed to AIDS in 2006, US\$ 0.943 billion (24 per cent) went to the Global Fund specifically to finance grants for AIDS. See Figure 7.4 for the shares contributed by each country.

Figure 7.4

DAC member countries 2006 contributions to the Global Fund to finance grants for programmes and projects addressing AIDS



Approximately one-third of the US\$ 3.9 billion went to UNAIDS and its ten co-sponsors. Their two-year budget for 2006–2007 was US\$ 2.6 billion and, of the ten co-sponsors, the four given the largest shares were the World Bank (32 per cent), UNICEF (18 per cent), the World Health Organization (13 per cent) and the World Food Programme (8.4 per cent) (UNAIDS, 2006b).

Next to the Global Fund, the World Bank is the world's largest multilateral donor to HIV work in low- and middle-income countries, through its Multi-Country HIV/AIDS Program for Africa, MAP for the Caribbean and other development programmes. Since 2002, it has committed around US\$ 1.9 billion in grants, low-inter-

est loans and credits to HIV work and has disbursed around US\$ 1 billion of that amount (World Bank, 2007).

Bilateral spending on HIV

On average, DAC member countries allocate far more of their ODA to bilateral spending than to multilateral institutions so that bilateral spending has been anywhere from two to four times more important than multilateral spending each year since 2000. The urgent need to respond to HIV and the existence of UNAIDS and the Global Fund have meant that, on average, DAC member countries have allocated comparatively more ODA for HIV to multilateral institutions than to bilateral financial and technical assistance. However, practice varies widely from one DAC member country to another.

The United States, in particular, has a strong preference for bilateral spending of all ODA, including ODA for HIV. In 2006, it committed more than US\$ 3 billion to spending on the response to HIV in low- and middle-income countries and disbursed around US\$ 1.6 billion. While it made a large contribution to the Global Fund, it disbursed around US\$ 1.3 billion through the President's Emergency Plan for AIDS Relief so that its bilateral disbursements far exceeded the Global Fund's disbursements for HIV and also accounted for more than half of all bilateral spending on HIV (Kates et al., 2007b; PEPFAR, 2007).

How effective is donor government spending?

A number of organizations monitor and critically evaluate the spending of ODA in general and of ODA for HIV in particular. The UN Development Programme's *Human Development Report 2005* focused on aid effectiveness and found much room for improvement. The same was true of a 2006 OECD survey to assess how far bilateral agencies and multilateral institutions had to go before they lived up to the principles in the Paris Declaration on Aid Effectiveness (UNDP, 2005; OECD, 2007a). A few of the many other recent assessments have come from ActionAid (ActionAid, 2007), the Center for Global Development HIV/AIDS Monitor (Bernstein et al., 2007; Ootaman, Bernstein and Rosenzweig, 2007), the Centre for AIDS Development and Research Evaluation (Birdsall and Kelly, 2007), the International Gay and Lesbian Rights Association (Johnson, 2007), Oxfam (Oxfam International, 2007) and Save the Children (Foster, 2005).

Opportunities for action

The discussion and the recent assessments mentioned above point to a number of opportunities for action by donor governments and the other international, national and local partners in the response to HIV and AIDS. They include:

- **Stop tying aid.** Tied aid occurs when grants, credits and loans are given on condition that recipient countries use the money to purchase supplies and services from donor countries or their friends, or when the direct offer consists of supplies or services, in lieu of money. It may help donor countries build or maintain historic ties, trade relations and political alliances and, also, provide jobs for their own nationals and subsidies for their own industries, universities, civil society organizations and consulting firms. However, it deprives recipient countries of much of the value of aid when supplies and services from donor countries are not what they really need, are more expensive or less appropriate than those they might find on the open market, or might be provided by their own industries, universities, civil society organizations and consulting firms and leave legacies of improved capacity. Since its inception in 1961, the OECD's DAC has been urging its member countries to untie ODA and, in 2001, it recommended rapid progress toward that goal. Its 2006 progress report found that 16 of the 22 member countries had untied 80 to 100 per cent of ODA to the least developed countries, while Canada, Austria and Germany had untied more than 60 per cent but that Greece, New Zealand and the United States lagged far behind. Around 97 per cent of ODA from the United States to the least developed countries – including ODA channelled through PEPFAR – is tied aid. Largely due to tying by the United States, 58 per cent of all ODA to the least developed countries continues to be tied aid and only 27 per cent of ODA-related contracts for those countries go to in-country suppliers (OECD, 2006).
- **Stop earmarking aid.** Aid is said to be earmarked when grants, credits and loans are given on condition that they are spent for specific purposes that may not be of highest priority to recipient countries. The earmarking of ODA for HIV has become a matter of some controversy, since it has resulted in some countries spending far more on HIV than they do on other health conditions that impact more heavily on their populations. It has also resulted in some comparatively well-off countries getting large amounts of ODA for HIV, while poorer countries go without ODA to meet their urgent needs for healthcare. Between 2001 and 2005, the increase in ODA going to health kept pace with the increase in total ODA but the percentage going to HIV increased while the percentage going to some other critical areas of health decreased. By 2005, the five largest shares of ODA for health were large-system water supply and sanitation (19 per cent), HIV/AIDS and other sexually transmitted disease (16 per cent), health policy and management (11 per cent), infectious disease control (10 per cent), and basic healthcare (9 per cent). Spending on health training and personnel development had declined by 36 per cent to US\$ 0.1 billion, or around 0.6 per cent of all ODA for health in 2005. Not nearly enough was being spent on recruiting, training and retaining health workers, on building, equipping and supplying hospitals, clinics, laboratories and pharmacies, or on establishing national health insurance schemes (MacKellar, 2005; Kates et al., 2007a).

- **Simplify, harmonize and coordinate procedures.** Ashraf Ghani, Afghanistan's former finance minister and now Chancellor of Kabul University and Chairman of the Institute for State Effectiveness, estimates that US\$ 5 billion of ODA is spent on technical assistance to help countries apply for, administer and account for grants, loans and credits (Ghani et al., 2007). The main reason for this is that bilateral, multilateral and other international donors do not harmonize and coordinate their procedures but, instead, have many separate procedures, many of them complicated and requiring frequent donor missions to countries. In 2005, for example, donors sent 791 missions to Viet Nam and only 76 of these were coordinated to serve the purposes of more than one donor (OECD, 2007b). These missions used up millions of the dollars counted as ODA for Viet Nam, and not just in salaries, fees and travel expenses for the donors' representatives and their consultants. Existing and potential Vietnamese recipients were obliged to prepare for these missions and to spend valuable time showing foreign delegations around and explaining their programmes and projects.
- **Provide sustained and predictable aid.** Donors' policies often limit them to providing fixed-term financial and technical support and often mostly to programmes and projects in which their own suppliers are directly involved. What low- and middle-income governments and their health, education and social service providers really need is sustained and predictable financing that increases over time plus, in some cases, technical support from the best available suppliers and preferably from suppliers within their own countries or regions (UNAIDS, 2006a).
- **Insist on responsible financial management.** Most low- and middle-income country governments and their service providers meet public expenditure management standards but some do not. When they do not, it is a disservice to the people of those countries to allow money to be mismanaged. It is also a disservice to the people of those countries to allow foreign governments and corporations to encourage and sustain corrupt practices by offering or tolerating bribes and kick-backs.
- **Apply the principles in the Paris Declaration on Aid Effectiveness.** Made in 2005, the declaration calls for country-led cooperative development processes in which all local, national and international partners collaborate on the mobilization of resources in a coordinated, efficient, effective and sustainable manner. It recognizes low- and middle-income countries' rights to self-government but their need for assistance in building their capacities for effective and responsible self-government (OECD, 2005).
- **Insist on an evidence-based, results-driven response to HIV.** Earlier in this chapter, under the heading 'Domestic government constraints and waste', a list is presented of things national governments and their partners should do but often fail to do when planning, budgeting and implementing responses to HIV. This list indicates the main things that need to be done to ensure that a response to HIV is based on the best possible evidence and achieves the best possible results.

Chapter 7 was written by Stuart Adams, an independent consultant, who has been doing applied social, health and cultural research, planning and writing for three decades. In recent years, his work has focused mainly on the impacts of and response to the AIDS epidemic in low- and middle-income countries. He also wrote Box 7.2. Box 7.1 was written by Pat McLaughlin, Director of Technical Management at the American Red Cross. Box 7.3 was written by Jeff Hoover, who is a freelance researcher, editor and writer based in New York, USA and Cape Town, South Africa.

Sources and further information

- ActionAid. *Making aid accountable and effective: The challenge for the Third High Level Forum on aid effectiveness*, Accra, Ghana 2008. Johannesburg: ActionAid, 2007.
- Bernstein, M. et al. *A Trickle or a Flood: Commitments and Disbursements for HIV/AIDS from the Global Fund, PEPFAR, and the World Bank's Multi-Country AIDS Program (MAP)*. Washington, Center for Global Development, HIV/AIDS Monitor, 2007.
- Birdsall, K. and Kelly, K. *Pioneers, Partners, Providers: The Dynamics of Civil Society and AIDS Funding in Southern Africa*. Johannesburg: Centre for AIDS Development and Research Evaluation (CADRE) and Open Society Initiative for Southern Africa (OSISA), 2007. Available at www.cadre.org.za/pdf/Pioneers_Partners_Providers.pdf.
- Centre for AIDS Development, Research and Evaluation. *Community responses to HIV/AIDS in South Africa: Findings from a multicomunity survey*. Johannesburg: CADRE, 2005. Available at www.synergyaids.org/documents/SAfrica_CommunityResponses_HIV.pdf.
- Dimmock, F. *Christian Health Associations in Africa*. Presented at Christian Connections for International Health Annual Conference, 29 May 2005. Available at www.ccih.org/conferences/presentations/2005/CHAs-dimmock_files/frame.htm.
- European HIV/AIDS Funders Group. *European Philanthropy and HIV/AIDS*. The Hague: European HIV/AIDS Funders Group, 2006. Available at www.efc.be/projects/aids/default.asp.
- Foster, G. *Bottlenecks and Drip-Feeds: Channelling resources to communities responding to orphans and vulnerable children in southern Africa*. London: Save the Children Fund, 2005.
- Funders Concerned About AIDS. *U.S. Philanthropic Commitments for HIV/AIDS: 2005 & 2006*. New York: Funders Concerned About AIDS, 2007.
- Ghani, A. et al. *Will Money Solve Africa's Development Problems?* West Conshohocken, PA: John Templeton Foundation, 2007.
- Global Fund to Fight AIDS, Tuberculosis and Malaria. *Funds Raised and Spent*. Geneva: Global Fund, 2007. Available at www.theglobalfund.org.

- International Federation of Red Cross and Red Crescent Societies. *Zimbabwe Red Cross scores a first on AIDS treatment preparedness*. Press release, 3 May 2006. Available at www.aegis.com/news/ifrc/2006/IF060501.html.
- Johnson, C. *Off the Map: How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa*. New York: International Gay and Lesbian Human Rights Association, 2007.
- Kates, J. et al. *Donor Funding for Health in Low- & Middle-Income Countries, 2001–2005*. Washington DC: The Henry J. Kaiser Family Foundation, 2007a.
- Kates, J. et al. *Financing the response to AIDS in low- and middle-income countries: International assistance from the G8, European Commission and other Donor Governments, 2006*. Washington DC: The Henry J. Kaiser Family Foundation, 2007b.
- MacKellar, L. *Priorities in Global Assistance for Health, AIDS and Population (HAP)*. Working Paper No. 244. Paris: OECD Development Centre, 2005.
- Ministry of Health. *Report of a Country-wide Survey of HIV/AIDS Services in Malawi*. Lilongwe, Malawi: Ministry of Health, 2005.
- Mullen, P. *Review of national HIV/AIDS strategies for countries participating in the World Bank's Africa multi-country AIDS program (MAP)*. Washington, World Bank, 2005.
- Organisation for Economic Co-operation and Development. *2006 Survey on Monitoring the Paris Declaration: Overview of the Results*. Paris: OECD, 2007a.
- OECD. *Development aid from OECD countries fell 5.1% in 2006*. Press release. Paris, OECD, Development Co-operation Directorate, 3 March 2007b. Available at www.oecd.org/document/17/0,2340,en_2649_33721_38341265_1_1_1_1,00.html.
- OECD. *Final ODA Flows in 2006*. Paris: OECD, 2007c.
- OECD. *Implementing the 2001 DAC Recommendations on Untying Official Development Assistance to the Least Developed Countries: 2006 Progress Report to the High Level Meeting. DAC High Level Meeting, 4–5 April 2006*. Paris: OECD, 2006.
- OECD. *Paris Declaration on Aid Effectiveness. High level forum on joint progress toward enhanced aid effectiveness, 28 February to 2 March 2005*. Paris: OECD, 2005.
- Ootaman, N., Bernstein, M. and Rosenzweig, S. *Following the Funding for HIV/AIDS: A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund and World Bank Map in Mozambique, Uganda and Zambia*. Washington DC: Center for Global Development, HIV/AIDS Monitor, 2007.
- Oxfam International. *The World is Still Waiting: Broken G8 promises are costing millions of lives*. Oxfam Briefing Paper 103. Oxford: Oxfam International, 2007.
- President's Emergency Plan for AIDS Relief. *The Power of Partnerships: The President's Emergency Plan for AIDS Relief. Third Annual Report to Congress*. Washington DC: PEPFAR, 2007.

- Salamon, L. et al. *Measuring Civil Society and Volunteering: Initial Findings from Implementation of the UN Handbook on Nonprofit Institutions*. Working Paper No. 23. Baltimore, MD: Johns Hopkins Center for Civil Society Studies, 2007.
- Sidaction, et al. *Expanding access to HIV treatment through community-based organizations*. Best Practice Collection. Geneva, Sidaction, UNAIDS and World Health Organization, 2005.
- UNAIDS. *Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support*. Geneva: UNAIDS, 2007a.
- UNAIDS. *2007 AIDS Epidemic Update*. Geneva: UNAIDS, 2007b.
- UNAIDS. *2006 Report on the Global AIDS Epidemic*. Geneva: UNAIDS, 2006a.
- UNAIDS. *Revised Unified Budget and Workplan 2006–2007*. Geneva: UNAIDS, 2006b.
- UNAIDS and Office of the United Nations High Commissioner for Refugees. *Strategies to support the HIV-related needs of refugees and host populations*. Geneva: UNAIDS and UNHCR, 2005.
- United Nations Development Programme. *Human Development Report 2005. International cooperation at a crossroads: Aid, trade and security in an unequal world*. New York: UNDP, 2005.
- World Bank. *HIV/Projects*. Washington DC: World Bank, 2007. Available at <http://go.worldbank.org/GF367IDHD0>.
- World Health Organization. *Treat, Train, Retain: Task Shifting Global Recommendations and Guidelines*. Draft. Geneva: WHO, 2007.
- WHO. *The World Health Report 2006 – Working together for health*. Geneva: WHO, 2006a.
- WHO. *Treat, Train, Retain: The AIDS and health workforce plan*. Report on the Consultation on AIDS and Human Resources for Health, 11–12 May 2006b.
- WHO. *Community Home-Based Care in Resource-Limited Settings: A Framework for Action*. Geneva: WHO, 2002.