The Pipers Call the Tunes in Global Aid for AIDS: The global financial architecture for HIV funding as seen by local stakeholders in Kenya, Malawi and Zambia

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Much theorising about global health governance has taken a view from above and we aim to complement this with perspectives from grassroots organisations and service providers. Based on a qualitative field study conducted in 2009, we ask "What are the implications of multiple major international financing structures for HIV on local and district-level responses in Kenya, Malawi and Zambia?" 130 interviews were conducted at national level and in six districts, triangulated across public and private sectors. Finding positive as well as negative experiences of engagement with Global Health Initiatives, we suggest that these initiatives should engage with each other, with governments and with local stakeholders to develop a joint Code of Practice for more coherent systems down to community levels.

INTRODUCTION

Much debate on global health governance has centred on control of emerging infectious diseases, seen as a global public good and within a wider framing of global 'health security' narratives, contested in different ways for different diseases.[1] Arguably, AIDS started this trend and President Clinton's declaration of AIDS as an issue of 'national security' to the USA in April 2000, symbolically heralded this new era in Global Health focused on communicable disease, which lead to the launch of both the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the US President's Emergency Program For AIDS Relief (PEPFAR).[2] The past decade has witnessed a change in the funding landscape for health in developing countries with the rise of global health initiatives (GHIs), as well as simultaneous increases in bilateral funding for health sector development; a trend spearheaded by global funding for AIDS in particular.[3]

Debates within the field have been extensive and four areas of debate may be particularly relevant to exploring how global initiatives for health impact on local responses to AIDS and their governance in developing countries. First is a set of inter-linked questions over the basic logics of how to organise decisions and resourcing for health internationally – i.e. whether a specific disease focus in international health assistance is inefficient, divisive and/or undermines rather than strengthens health systems in recipient countries.[4] Second, another set of debates asks questions about 'aid effectiveness' including capacity constraints[5], inefficiencies and blockages[6] or corruption[7] associated with these resource flows and moderated by complex global funding arrangements. Third, significant attention has been given to related controversies over an alleged erosion of national sovereignty and shifts in the roles of different kinds of national and international actors and arrangements, influencing priorities in the context of

such flows of money.[8] Last, whilst a broad consensus on community action as central to effective AIDS responses exists, debates have evolved as to whether these new aid practices, facilitating civil society engagement, actually strengthen the implementation and governance of responses, or not.[9] Much of this theorising has taken a view from the above paradigm, but complementary accounts can emerge if one takes a view from the perspective outlined below that foregrounds the vantage point of grassroots organisations and service providers.[10] In particular, the multiple and joint impacts of global health initiatives and large bilateral donors on the evolution and governance of local responses to HIV need more critical analysis.

Based on results from a field study conducted between March and September 2009[11], we address the question: "What are the implications of multiple major global and bilateral AIDS funding structures for local and district-level responses in Kenya, Malawi and Zambia?" Questions about the governance of the HIV response at national level – including on the effectiveness and harmonisation of funding architectures, the perceived roles and legitimacy of government leadership and the inclusion and participation of relevant non-state stakeholders – were tracked down to explore how local groups respond. Whilst we found that international donors are overwhelmingly seen as ultimately 'calling the tunes', the study explored both negative and positive effects of international funding programs, in terms of responses to HIV and AIDS, and governance. We conclude with some brief reflections on potential implications for improving Global Health Governance in HIV down to local levels.

We use 'governance' in this context to refer to the processes and mechanisms that come to determine who participates in setting agendas, who has the authority and mandate to coordinate the efforts of key actors, and the structures for how resources are distributed, managed and accounted for (what we call the funding architecture). We focus here on these issues because they emerged as important from the perspective of local organisations and significant for their experiences of engaging with the national funding architectures.

METHODOLOGY AND LIMITATIONS

Three countries in sub-Saharan Africa were chosen for having significant global investments in HIV programs – in particular from the 'big three': the World Bank's Multi-country AIDS Program (MAP), the Global Fund (GFATM) and PEPFAR. The countries were also selected for other broad similarities, such as: being low-income countries situated in the same region, having broadly similar systems of government and significant levels of poverty, and experiencing similarly serious HIV epidemics, as well as other health burdens and challenges with health development. The main focus was on recipients of support from international funding programs for HIV, such as non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs) and local public health services; but the study also considered perspectives of other selected stakeholders and groups of community beneficiaries. A qualitative methodology was employed, using interview-based

data collection, with purposeful identification of informants. The design was uniform across countries, with flexibility for some local adaptation.

Based on a review of the literature on health financing for HIV and governance, four sets of debates (described above) emerged around which detailed research questions were formulated. The field work involved: (a) following the flows of resources from the international funders down to communities; as well as (b) triangulation of perspectives across sectors, both locally and nationally. Desk reviews were carried out to map significant funding architectures nationally at the first stage in each country. The study then embarked upon structured in-depth key informant interviews with national level actors from government, donor and civil society sectors. At community level, structured in-depth interviews were carried out with stakeholders from different sectors, in two local sites per country. Stakeholder interviews were carried out with community organisation actors and public sector officials and service providers, in addition to a small number of semi-structured focus group discussions with community beneficiaries. In total, 130 interviews were carried out, as described in table 1.

Table 1: Number of Interviews by Type and by Country

	Kenya	**Malawi**	**Zambia**	**Total**
National key informants (CSO, Donors, Govt)	18 (10, 5, 3)	18 (10, 5, 3)	17 (6, 6, 5)	53
Site level stakeholders (CBO/FBO, Govt)	16 (9, 5)	17 (14, 3)	23 (20, 3)	56
Local focus group interviews/discussions	4	9	8	21
Totals	38	44	48	130

The methodology was not intended to generate quantification of a statistical nature, nor to verify allegations of blockages, inefficiencies etc. Rather, it was chosen because it offers other unique advantages, such as relatively direct reflection of analyses from below and the ability to capture how processes and outcomes are perceived from different vantage-points. The triangulation of perspectives enables the contrasting of subjective positions in order to build up a nuanced account. To the extent that findings build up a consistent picture, they can be seen as illustrative rather than definitive, and in the discussion we link the analysis with findings from other research[12] to anchor our conclusions and suggestions more firmly. Some bias might be expected from certain respondents' potential impressions that researchers might leverage resources from their organisations for specific responses. To reduce such bias, explanations in connection with seeking informed consent clarified the independent nature of the research. Finally, the views of researchers may privilege certain perspectives. To mitigate such bias, interview teams were set up as pairs, in order to cross-check impressions and scripts after interviews. Additionally, one consultation meeting was held with informants in each country to share and validate preliminary findings.

AIDS FUNDING ARCHITECTURES

Despite basic similarities informing the country selection, desk reviews and in-country mapping revealed a number of significant differences in national

architectures for AIDS funding, which are likely to have a bearing upon the governance of country AIDS responses. For example, the role, status and position within government of the main governmental AIDS coordination institutions differed in each country. In Kenya, the National AIDS Control Council (NACC) and the National AIDS/STD Control Programme (NASCOP) sit in two different health ministries, following a split in the wake of a fraught election with a resulting power-sharing government. This is seen by some as posing challenges in providing a united government leadership on AIDS. In Zambia, the National AIDS Council (NAC) reports to the Ministry of Health, but has limited control of resources and is seen as relatively disempowered, as its structural position would not seem to lend itself to having a great influence on cross-sectoral resource allocation decisions. In Malawi, on the other hand, the National AIDS Commission (NAC) is attached to the Office of the President and Cabinet (OPC), outside and above the line-ministries, which gives the Malawi NAC a more elevated position and more authority to lead processes and policy across departments and sectors.

While all three countries have experience of civil society intermediary organisations for disbursing resources, Malawi has discontinued NGO intermediaries and centralised disbursement of funds through NAC for the Global Fund or other pooled funds under the National AIDS Framework, using the public sector administrative infrastructure. Kenya and Zambia also use national and local public sector disbursement systems for some pooled funds, including World Bank funds, but have additional disbursement mechanisms in place for other sectors, for example through the existence of civil society principal recipients (PRs) for the Global Fund.

In the case of the Global Fund, we should distinguish between 'split' principal recipients for 'dual track funding' and 'intermediary sub-recipients'. However, in the popular understanding any civil society organisation (CSO) operating as PR or sub-recipient in order to disburse funds to others CSOs is considered an 'intermediary organisation'. Whilst GFATM PRs are 'split' between government and civil society in Kenya and Zambia, Malawi has one government principal recipient only and has recently centralised its distribution of resources through government structures. Previously international NGOs were used as intermediary sub-recipients.

In all three countries PEPFAR has set up disbursement structures independent of government systems and involving tiers of intermediary partners. In addition, a varying number of other organisations, each with a particular system for disbursement, are funding HIV activities in the respective countries. Thus in each country several independent streams for accessing money exist, some involving government but others not, so that the overall national funding architecture can be described as 'plural'. However, it is important to note that the degree of plurality varies. For instance, the existence of a high degree of central government control of pooled funds in Malawi has reduced the number of separate options for accessing money.

RESULTS

This section reports pertinent findings from the research, starting with perceptions about who sets the national agenda and how effective coordination is. This is followed by the experiences of a range of stakeholders with different funding structures, and comments from community organisations on the constraints they experience in terms of being able to provide the kinds of responses to AIDS that they feel are locally relevant. Finally, we present reflections on the extent to which CSOs are engaged in governance mechanisms.

The starting point is that the vast majority of respondents interviewed felt that major international funders strongly drive agendas nationally, something which will not be news to most readers and which corroborates findings in a range of studies.[13] Even government representatives and donors often spoke freely about the strong influence of donor resources on priorities and what gets funded, and this despite a broad agreement with the core principles of the Paris Declaration of national ownership, harmonisation and accountability.[14] Despite governments officially leading the elaboration of national strategies, these were often described as 'generic' and a respondent from Christian Health Association of Kenya, argued that the Kenya National AIDS Strategic Plan is likely "...identical to others in other countries" and that "the operating processes are driven by donors." Many see donors as simply investing in their own priorities within these frameworks, as described by a civil society respondent in Malawi: "the donors could refuse the funds if they do not agree with an emphasis..."

A central theme emerging from such observations was a sense of lack of coordination, felt down to a community level. One CBO leader in Kayole, Kenya, argued that different donor funded programs "... are not coordinated, because we would have felt the effect... no, you can't be working for seven years and involve with all in the communities and not notice anything!" Speaking of the government's coordination of responses for HIV in Zambia, a local District Health Management Team official argued that "their lack of coordination has led to no or minimal coordination and fragmentation of the whole system of providing HIV/AIDS based interventions." At national level there was a sense amongst most informants that donors generally aim to coordinate between themselves and with governments, if in different ways. The US government was often singled out as least engaged, as caricatured by one government representative in Kenya: "donors do harmonize except for PEPFAR, which does its own things deliberately to cause chaos and confusion." There was a broad recognition of a need for harmonisation by donors and government representatives, although what was understood by such coordination varied significantly. For instance, one bilateral donor in Kenya felt that "government leadership is not there, and... [it] intentionally tries to undermine the coordination alignment we have planned."

Responses to the problem of harmonisation tended to go in either of two directions; some argued for greater coordination through focusing investment in/through the state, such as through 'basket funding' or budget support, whilst another common response was to suggest support through different structures and sectors (including non-governmental sectors). Many government informants predictably tended to argue the former, but several donors expressed deep

concerns over governments' capacities to administer large amounts efficiently or equitably. In the words of one European bilateral donor representative in Kenya, "African baskets have holes; thus we ... can only support if NACC put proper policies in the running of its institution." Perceptions of inefficiency and corruption on the part of government bodies were also common amongst community stakeholders, such as a CBO representative in Kabwe, Zambia, who claimed that "the government is even in the forefront of misusing donor money. When this money comes, government ministers share amongst themselves..."

In terms of experiences with centralising funding through government, Malawi provides a striking example of how this approach is facing challenges, despite fewer suggestions of corruption. As explained by one international FBO representative, "CBOs are unable to access this money. The problem is the system used. The CBO writes a proposal to NAC, NAC responds and conditions have to be fulfilled. Formats, forms used are quite complex." An NGO representative in Zambia felt that "the government has not given to NGO's like in other countries. They give us 0.xx %, basically nothing." In addition, in Nakuru, Kenya, a District AIDS official described the situation "...when they clumped funds together... which was run and controlled by the government; it failed to reach where it was supposed to reach." In some instances new government structures had been created to disburse money, such as for the World Bank's program in Zambia. The World Bank funded Total War on AIDS (TOWA) in Kenya also involved a government run program which was described by some as overly complicated. A member of a leading organisation of people living with HIV (PLHA) in Nairobi explained that "there is also a lot of bureaucracy. NACC has five agencies implementing TOWA. It is hard and cumbersome to bombard communities with all these different agencies..."

As described above, other funding channels existed in each of the countries in addition to those administered through government structures, ensuring a plural funding environment to varying degrees. Experiences with structures for funding that utilised non-governmental bodies were more positive, although still mixed. These involved a broad array of intermediary organisations such as large NGOs, but importantly were perceived to facilitate greater access by community level stakeholders. In Likuni, Malawi, a local CBO leader explained, "CARE stopped in 2006, but handed over our new proposal to the District Assembly, though the DA said they didn't have it, so I resubmitted it to them. I never got any replies... CARE were doing a fine job, because they were trying to find out what we need." In Nakuru, Kenya, a local CBO member described a PEPFAR funded program as "... good, since it has brought together stakeholders to share ideas... [and] KANCO offers meetings sometimes to help know new organizations in town and open up linkages." International NGOs often played significant roles as intermediaries in these systems, but are typically seen as expensive. Reflecting a common sentiment, a CBO leader in Kayole, Kenya, suggested that "they should organise so the money doesn't remain with the NGOs, but so it gets to community groups. I know they use it for nice documentation, their costs and nice big vehicles." Others were more appreciative of the role of intermediary NGOs and a fairly regular suggestion was to invest in national NGOs to play this role instead, as expressed by a representative of

NASCOP in Kenya, "they should find ways of disbursing the funds like using people like KANCO to disburse the funds and report on behalf of the CBOs."

Whilst there is a virtually universal consensus, or belief, that communities are central to the response, community organisations feel constrained not only in accessing resources but also in having a say as to how the money is spent. At the level of setting priorities and agendas, civil society groups often feel their influence over priorities is negligible and that they frequently only end up doing what there is money allocated for, as explained by a respondent of a local CBO in Nakuru, Kenya: "as an organisation we have what we want to do; however, at times, we will do what the donor wants to keep the funds coming." One member of a small FBO in Likuni, Malawi explained: "we wanted to rear chickens but... instead we were told to rear goats ... the donor can just change our priorities... in the end we do not achieve what we want." Some expressed the view that receiving funding from the government can limit CSOs' independence and that they can become reluctant to 'bite the hand that feeds them.' One respondent from a national PLHA group in Malawi said: "I strongly believe that if CSO were getting funds directly from donors, it could have had a voice."

Several donors (especially PEPFAR and Global Fund) feel that civil society is essential in taking community responses beyond a medical approach as well as in holding government to account. In most countries there are formal mechanisms for civil society engagement, most notably the GFATM Country Coordinating Mechanisms (CCM), although these are often claimed to involve tokenistic participation. In Malawi, a national PLHA Network representative explained that "we are not able to speak at meetings and usually communication about meetings comes two to four days before the meeting, which means that we cannot contribute when setting up agendas..." Other opportunities include certain national strategic planning processes, coordination fora or working groups. Some civil society networks do influence government through these, if not always in highly visible ways. However, in many instances these mechanisms were not seen as inclusive or effective. Some respondents are of the opinion that there is specifically a need for fora which are not managed and controlled by government or the donors. According to a representative of the PLHA Network in Nairobi, Kenya, civil society engagement in developing the third Kenya National AIDS Strategic Plan (KNASP III) was seen as positive, but short-lived and that, "...apart from that [referring to this process] we don't have a real national mechanism to involve civil society. Even as NGOs we are not united... For example, the HIV/AIDS act of 2006 – we only read about it in the papers... We can't repeal this law unless as civil society we are united and challenge it."

DISCUSSION

The findings of this study would seem to support the views of several commentators that we need to move beyond a polarised debate about 'vertical' disease specific funding for AIDS vs. 'horizontal' strengthening of health systems, as realities appear to be rather more complex than such polarised positions imply.[15] We would argue that this notion of vertical (versus horizontal) systems is itself not a particularly useful analytical tool in understanding the complex

relationships and dynamics in the governance of internationally funded AIDS responses. Countering the narrow zero-sum view that AIDS funding might have starved resourcing in heath more generally, other research has estimated that funding for HIV has rather been accompanied by increased funding also in other areas of health[16] and thus likely contributed to resourcing health development more broadly. On the one hand, this may need to be treated with caution, as recent research has estimated recipient governments appear to have substituted domestic health funds with international assistance to government health budgets[17], as also reflected in perceptions in this study. This may be a response to a combination of IMF imposed public sector spending ceilings and many donors' desire to strengthen health services through funding public services and budget support. On the other hand, support to civil society from development assistance in particular has had an opposite (and positive) correlation with higher government health spending from domestic resources[18], the level of which appeared to be linked with perceived government commitment and legitimacy for leadership in this study.

Notions of leadership varied amongst our respondents, but were often linked to control over and contribution of resources. Our findings suggest a need for a clearer separation of leadership in regards to the coordination of the direct control of resources. In terms of government leadership coordination, it has been argued elsewhere that global pressures to elevate National AIDS Commissions or Councils (NACs) outside of Ministries of Health have not been particularly successful and that the addition of the Global Fund CCM has created overly complex and unclear coordination challenges.[19] Our findings broadly confirm this complexity, although we found the positioning of the Malawi NAC, outside and above the line-ministries, as clearly having strengthened its position in terms of coordination. Moreover, it is broadly acknowledged that the Malawi NAC centralisation of funding has met with effectiveness challenges for resourcing local groups and our findings overwhelmingly speak against centralising resources for the broader societal response through governments.

Different donors approach coordination in their own respective ways and, indeed, several different fora typically exist for donor coordination. Yet, how the donors actually inter-relate is often a little unclear, even if governments' challenges in leading the donors are clearer. Aside from national political and 'institutional architecture' constraints, the fact that governments are said to hardly contribute financially, partially explains their difficulties in acquiring the authority and perceived legitimacy to lead. Overall, the notion of the sovereign nation state as represented purely by a democratically elected national government seems inadequate in negotiating the relationships between local people responding to HIV in African countries and the global community today. Frameworks and high-level declarations, such as the 2005 Paris Declaration,[20] often take on and reflect state-centric governance frameworks, with little explicit mention of how civil society is to engage nationally or internationally, let alone locally. Yet, many international donors and global health initiatives exalt the virtues of communities and engage directly with civil society at many levels, both strengthening and challenging governments in recipient countries.

A recent emphasis on 'community systems strengthening' by the Global Fund and some civil society networks[21] may provide a new ground for more recognition of some of the capacity and sustainability issues raised by the challenge of improving aid effectiveness to better enable local responses. There may remain a need for more critical analysis of this concept, for example by asking to what extent it may be primarily a reactive response to the push for health systems strengthening. In addition it is not clear to what extent highly diverse community responses are amenable to categorisation as "systems" in any truly useful way. Furthermore, its emphasis on local level public-private complementarities and collaborations could, if taken on its own, contribute to a familiar reduction and 'down-streaming' of the role of civil society to one of service provision as an extension to government. It is also worth bearing in mind that, whilst clearly very significant, the Global Fund is only one of several donor initiatives, so advances in these areas would seem to need broader buy-in from a wider range of programs.

CONCLUSION

On the basis of our analysis, we would argue that several positive effects can be seen from these various global health programs for AIDS. They have strengthened important services, achieved results and saved many lives. The 'big three' have gradually increased stakeholder participation and the involvement of civil society actors, whilst governments have been challenged for greater transparency and accountability. Governments have responded to this pressure in different ways, including proactively and defensively. Importantly, access to multiple channels of support is viewed positively at local levels and enables some community groups to 'stitch together' locally contextualized responses. On the more negative side, access is currently hampered by overly complicated systems. Several constraints are heightened by systems in which control of allocation and disbursement in government bodies is centralized. Responses are further challenged by divergent donor ideologies and approaches (which at times conflate resource control with coordination), as well as by limited perceived government legitimacy and civil society exclusions. While some donors acknowledge a role for civil society as autonomously holding governments to account, the prescribed role for civil society actors is more often reduced to service provision so that in practice advocacy can be limited. The contributions and capacities of civil society formations certainly differ across countries and are shaped by local cultures and histories of social change, as well as increasingly by development interventions and global actors.[22] Yet many critical functions – for example, representing community interests and holding governments or donors to account – are poorly reflected in the divergent practice and approaches of global initiatives. Harmonisation in systems down to community levels is indeed currently highly complex, as well as complicated. Complexity may be necessary and positive, but this does not imply that it also has to be complicated.

In conclusion, we would argue that the key challenge for better governance, in relation to support to local AIDS responses in Africa by global health initiatives for HIV, should centre on how to enable local actors to mount

effective and complementary responses to HIV, through more equitable and efficient resource access, as well as better public-private dialogue, transparency and engagement. We believe that the root problem is a lack of coherence and engagement between the global initiatives, and their sponsoring governments, on these specific issues. One way forward would involve the big global health initiatives engaging with each other, donor and recipient governments as well as local stakeholders to move beyond the Paris Declaration and self-critically develop far more coherent and user-friendly systems for the disbursement of funds, alignment, and coordination 'down to community levels', with the aim to develop a joint donor Code of Practice. The International Health Partnership (plus its related programs) is an example of an initiative that has brought together development partners in the signing of a 'Global Compact' in order to push for progress towards achieving the health-related Millennium Development Goals. A large part of the aim is to improve coordination between actors and to assist in translating the Paris Declaration into practice. One option would be for initiatives such as this to direct effort towards examining ways of also improving coordination at the local level, for example through the mechanism of the reviews or the working groups. We suggest that a Code of Practice should:

- 'Start at home' and improve donor initiatives' interactions and coherence to become more complementary and, above all, less complicated at the community level
- Acknowledge the complementary benefits of plural channels of resourcing beyond the public sector
- Acknowledge the need for investment in building civil society sector capacity, for support to local responses answerable to communities and for holding both governments and donors to account
- Articulate a coherent stance on the potential benefits and role of an autonomous civil society for better overall governance
- Emphasise support to public sector focused on improving governance over resourcing public budgets
- Provide stronger incentives for recipient country governments to allocate domestic public funds to tackling HIV and other health problems, by avoiding substitution of global funds for domestic allocations and preferentially funding complementary civil society activities

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The authors would like to thank, and acknowledge the collaboration of, Netsayi Mudege, George Mgomella, Ireen Namakhoma, Chishimba Mulambia, Joseph Simbaya, Kate Hawkins and all other collaborators in IDS and the three partner institutions: African Population and Health Research Center (APHRC),

Kenya; Institute of Economic and Social Research (INESOR), Zambia, and; Research for Equity and Community Health Trust (REACH), Malawi.

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