ZAMBIA'S NATIONAL AIDS SPENDING ASSESSMENT

2010-2012

DRAFT 3

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Foreword

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AFDB	Africa Development Bank
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
ARVs	Antiretroviral Drugs
ASC	AIDS Spending Category
BCC	Behaviour Change Communication
BP	Beneficiary Population
CBO	Community-Based Organisation
CCT	Currency Conversion Tax
CDC	(US) Center for Disease Control
CHAZ	Churches health association Zambia
CHBC	Community and Home-Based Care
CSI	Corporate Social Investment
CSO	Civil Society Organisation
CSW	Commercial Sex Workers
DfID	Department for International Development (UK)
DOTS	Directly Observed Treatment, Short-course
EU	European Union
FA	Financing Agent
FBO	Faith-Based Organisation
FFT	Financial Transaction Tax
FS	Financing Source
GARPR	Global AIDS Response Progress Report (formerly UNGASS report)
GDP	Gross Domestic product
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GRZ	Government of the Republic of Zambia
JFA	Joint Financing Arrangement
HCT	HIV Counselling and Testing
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HTA	High Transmission Area
IDU	Intravenous Drug User
IEC	Information, Education, and Communication
IF	Investment Framework
IGA	Income Generation Activities
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population
MDG	Millennium Development Goals
MDR- TB	Multidrug-resistant Tuberculosis
MOE	Ministry of Education
MOH	Ministry of Health
MOF	Ministry of Finance
MOT	Modes of Transmission

MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
MTEF	Medium-Term Expenditure Framework
NAC	National AIDS Council
NASA	National AIDS Spending Assessment
NASF	National AIDS Strategic Framework
NHA	National Health Accounts
NHSP	National Health Strategic Plan
n.e.c.	not elsewhere classified
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OIs	Opportunistic Infections
OOPE	Out-of-Pocket Expenditure
OOP	Out-of-Pocket
OPEP	Occupational Post-Exposure Prophylaxis
OTC	Over-The-Counter (medications purchased without a prescription)
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PETS	Public Expenditure Tracking Survey (now known as Expenditure Tracking Survey, ETS)
PF	Production Factor
PITC	Provider-Initiated Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnerships
PWID	People who inject drugs
RTS	Resource Tracking Software
SADC	Southern African Development Community
SES	Socio-Economic Status
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDP	The United Nations Development Programme
UNGASS	United Nations General Assembly on HIV/AIDS
USA	United States of America
USAID	United States Agency for International Development
US$	United States Dollars
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization
ZMW	Zambian Kwacha (rebased)
ZNAN	Zambian National AIDS Network

EXECUTIVE SUMMARY

The National AIDS Spending Assessment (NASA) (2010-2012) is the third effort to track all the HIV/AIDS spending in Zambia from all sources (excluding out-of-pocket) and across all sectors. The first NASA was undertaken for the years 2005 and 2006. For the years 2007 to 2009, the Public Expenditure Tracking (PETS) approach was applied[1]. The NASA provides an in depth examination of the HIV/AIDS by detailed categories of activities, providers of services and the beneficiaries. NASA applies a standardised and comprehensive methodology for collecting, coding and analysing of HIV expenditure. It allows countries to understand if they are allocating funds according to their priorities and for the greatest investment in terms of impact.

The total spending for Zambia was approximately ZMW 1.24 billion (rebased) in 2010 (US$257 million) on HIV, increasing by 6% to ZMW1.31 billion (US$269 million) in 2011. In 2012 the amount increased again by 12% to reach ZMW 1.46 billion (US$283 million). The public sector contributed ZMW 43.7 million in 2010 which increased by 90% to ZMW 83 million in 2011 but decreased slightly in 2012 to R82 million (6% of total HIV spending). However, these figures do not include MOH indirect spending on HIV still pending (from the National Health Accounts, NHA), making it more likely that the amount would have been much higher.

The biggest contributor to HIV/AIDS funds in Zambia was the external sources, which contributed 92% of the total HIV funding in 2012. In nominal terms external sources contributed approximately ZMW 1.2 billion in 2010 which increased by 2% (to ZMW 1.207) and further increased by 13% in 2012 to ZMW 1.36 billion. Bilateral organisations were responsible for the largest portion of the externally sourced HIV funding, totalling 77.8%, 85.3%, 91.1% of total external funds in 2010, 2011 and 2012 respectively.

In all 3 years, private funding accounted for 1% of the total spending of HIV/AIDS in Zambia. However, it should be noted that private sources included in the survey were not representative since they were not systematically sampled, but the larger organisations were purposively sampled. However, their response rate was very poor. From the data that was acquired from private companies, the total spending on HIV in 2012 was ZMW 12million which increased by 44% to ZMW 17.7 million in 2011 and decreased by 10% to ZMW 15.9 in 2012.

In terms of the agents of the HIV/AIDS spending, that is, who controls how the money is spent, the bulk of the funds were controlled by external funders. In 2012, financing agents were split as follows: public agents = 7%, private agents = 7% and external agents = 86%.

[1] World Bank. 2013. Expenditure Tracking for HIV/AIDS in Zambia (2007-2009).

Considering the breakdown of the HIV/AIDS spending by thematic area, Zambia's spending on prevention activities in Zambia decreased by 24% from ZMW 288 million in 2010, to ZMW 219 million in 2011, but then increased again by 11% to ZMW 244 million in 2012. Similarly treatment and care (not only ART) spending decreased by 7% from ZMW 534.6 million to ZMW 499 million[2] and increased by 7% to ZMW 531.9 in 2012. OVC support decreased by 12% in 2011 and by a further 10% in 2012 to reach ZMW 44 million.

Comment [T3]: NAC: is the footnote correct that USG funds were down??

Looking into the thematic areas, the prevention activities in Zambia decreased by 24% from ZMW 288 million in 2010, to ZMW 219 million in 2011, but then increased by 11% to ZMW 244 million in 2012. The highest expenditure was prevention not disaggregated[3] which accounted for 36.1% (ZMW 104 million) proportional prevention spending in 2010, 30.9% (ZMW 67.9 million) in 2011 and increased once more to 33.6% (ZMW 82 million) in 2012. However, had the financial information been fully disaggregated we would have been able to distribute the amounts to their respective activities. It was followed by HIV Counselling and Testing (HCT) which accounted for 29% (ZMW 83.7 million) proportional prevention spending in 2010, increasing to 33.6% (ZMW 73.9 million) in 2011 and falling to 23.2% (ZMW 56.7 million) in 2012. It was then followed by PMTCT which accounted for 20.9% proportional prevention spending in 2010, increasing to 19.6% in 2011 and falling to 22.5% in 2012. All other prevention activities were very small proportions with VMMC being 7.7% of total spending on prevention in 2012 and the rest at less than 1%

Within the treatment and care category, The total spending on treatment was ZMW 534.6 million in 2010 and decreased by 7% to ZMW 499 million in 2011 and increased by another 7% to ZMW 531.9 in 2012. ART was the largest component at 50.6% (ZMW 270 million) of treatment and care spending in 2010, 70.2% (ZMW 350.6 million) in 2011 and 67% (ZMW 356 million) in 2012. The next largest proportional treatment spending in 2012 was HIV-related laboratory monitoring (12.4%, ZMW 65.9 million) followed by 'out-patient care services not disaggregated' (8.7%, ZMW 46.5 million), while the other treatment activities received 4% or less.

The total spending on national systems strengthening and programme management in 2010 was ZMW 321 million, and it increased by 35% in 2011 to ZMW 433 million and a further 19% increase in ZMW 515.5 million. The spending on orphans and vulnerable children in 2010 totalled ZMW 56.6 million but decreased by 12% to ZMW 49.7 million in 2011 and a further decrease of 10% in 2012. The decrease could be attributed to the reduction in the Global Fund contributions in 2012. Much of the OVC funds went

[2] This reduction in treatment and care spending in 2011 may have been due to a reduction in PEPFAR funding in this year.

[3] 'Not disaggregated' means that the expenditure data was not broken down in specific categories.

through the Zambian National AIDS Network (ZNAN) and Churches Health Association Zambia (CHAZ). The total spending on Social protection, enabling environment and research activities was ZMW 14.5 million in 2010, and it increased to ZMW 77.8 million and a further increase to ZMW 92.6 million in 2012. The spending on research was apparently very low in both years, but may have been due to USG funding not disaggregated sufficiently to show specific research spending.

When examining the service providers of the HIV services in Zambia, the bulk of HIV services in Zambia were provided by Non-profit organisations including all PEPFAR implementing partners (IPs) spending 92.3% of total spending (ZMW 1.1 billion) in 2010, 89.7% (ZMW 1.17 billion) in 2011 and 91.3% (ZMW 1.3 billion) in 2012. These were followed by public entities that spend 6.3%, 8.4%, and 7.2% of the total spending in 2010, 2011, and 2012 respectively.

Regarding the beneficiaries of HIV/AIDS spending, 38% was spent on Non-targeted interventions followed by PLHIV (33%), general populations (21%), OVC and vulnerable populations (6%) and accessible populations (2%) in 2012. The bulk of spending on PLHIV benefitted from treatment and care services, while the bulk of the spending on the general population was through prevention interventions. The bulk of the national systems strengthening and programme management spending was non-targeted.

The key recommendations generated from the findings and the feedback from the NASA stakeholder validation meeting were as follows:

- There is need to consider the best investment of available funds – basic programmes, critical enablers, development synergies.
- Zambia needs to consider alternative domestic sources of funding for, and to improve the sustainability of, its HIV response.
- Need to improve financial information systems with annual routine reporting on expenditure to be submitted to NAC, and build capacity for financial management.
- Need for improved development partners' harmonisation, alignment and transparency in their operations.
- To ensure aid effectiveness, there is need to improve financial data collection so as to link the financial inputs with the outputs, so as to ascertain areas of potential efficiency gains.

1. Introduction and Background

This report presents the findings of the National AIDS Spending Assessment (NASA) undertaken in Zambia for the period 2010-2011.

This NASA has captured all the public spending, all foreign (external) spending, and some of the business sector's contributions. The individuals' contributions through out-of-pocket expenditures (OOPE) have not been captured and may, or may not, represent a significant share to the total spending on HIV/AIDS in Zambia.

1.1 Zambia's Socio-economic Indicators

Zambia had a population of approximately 13 million people in 2011(Zimba, 2011). This has become a major challenge in the provision of social and economic opportunities for a decent livelihood. Zambia is a highly urbanized country with over one-third of the total population lives in urban areas along the major transportation corridors, while rural areas are under populated (USG, 2012). With the HIV/AIDS epidemic ravaging the country, the population is estimated to reach 15.2 million by 2015, 45% of which will be a young population (6.9 million) below the age of 15 years. This indicates a high dependency ratio (Zimba, 2011).

The United Nations Development Programme (UNDP) Human Development Report (HDR) for Zambia pegs the health index at 0.458. This places Zambia below the regional average of 0.463 (UNDP, 2010). Table **1:**1 below summarizes the indicators noted in the HDR.

Table 1: Zambia Country Profile: Human Development Indicators from 1980 to 2011

Human Development Index Rank	164
Health Life expectancy at birth (years)	49
Education index (expected and mean years of schooling)	0.48
Income GNI per capita in Purchasing Power Parity terms (constant 2005 international $)	1,254
Inequality Inequality-adjusted HDI	0.303
Poverty Multidimensional Poverty Index (%)	0.328
Gender Inequality Index	0.627
Sustainability Adjusted net savings (% of Gross National Income)	1.4
Demography Population, total both sexes (thousands)	13,475.0

Source: UNDP Website (2014).

Zambia's economy is made up of services industry, manufacturing, agriculture, and mining. Though services make up 60% of the gross domestic product, agriculture represents 17% of Gross Domestic Product (GDP) and employs more than 70% of the working population (GOZ and EU 2008). Manufacturing's GDP weight is 18% and employs 11% of the working population and the bulk of the non-agriculture workers are employed in the service industry (GOZ and EU 2008). Zambia's economy experienced stagnation from 1989 into the 1990s and only started accelerating from the year 2000, averaging 4.6% a year between 2000 and 2005 and reaching 6%-7% in 2007. According to the Africa Development Bank (AFDB) (2014)[4], the growth of the Zambian economy has been positive, averaging over 6.1% between 2006 and 2010. They note that inflation was 16.6% in 2008, falling to 9.9% in 2009 and further to 7.8% by March 2010. Glassey (2011) notes that even with the economic growth in the recent years, poverty was still high, and that economic growth had failed to stop poverty increasing.

[4] AFDB, 2014. Zambia Profile. Accessed on 5 May 2014 Available on http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/zambia.pdf

1.2 Health, HIV and TB in Zambia

The Abuja agreements been used as a basis for governments in Africa to measure their progress towards acquiring universal quality health care. The Abuja Agreement of 2001 notes the allocation of 15% of government's total budget towards health financing as the most acceptable. The 15% does not include external funds being spent on health financing in the respectable country, only the government finances. An Equinet Study in 2008 revealed that in the East and Southern African countries Zambia was the only one who surpassed the 15% target allocating approximately 17.5% in 2006 (Equinet,2009). See

Figure **1**. In addition, applying a resource allocation formula that integrates poverty and health needs in each district or location has led to an equitable resource allocation across the districts (Equinet/PPD ARO, 2008). In 2011, total, public, and private health expenditure (% of GDP) in Zambia was 6.12%, 3.66%, and 2.46% respectively (Index Mundi 2014). Public health expenditure, as a % of total health expenditure was 59.79% whilst as % of government expenditure it was 15.98% as of 2011[5].

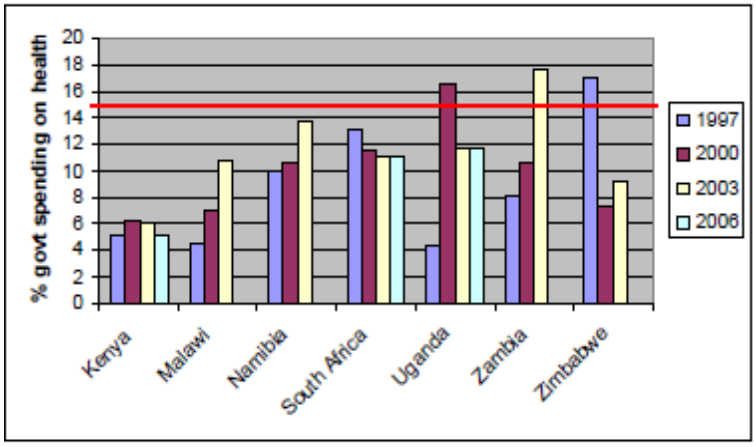
In 2012 Zambian National Budget, the allocation to health was increased by 45% to ZMW 2,580 billion[6]. In Zambia's 2013 budget, the health sector received an allocation of ZMW 3.6 trillion or 11.3% of the budget out of which ZMW 594.1 billion would be spent on drugs and medical supplies and ZMW 110.8 billion was provided for procurement of varied medical equipment[7].

Figure 1: Percentage of total government expenditure allocated to health 1997-2006

5 IndexMundi. 2014. Zambia's Health Expenditure. Accessed on 5 May 2014. Available on http://www.indexmundi.com/facts/zambia/health-expenditure

6 2012 Full Budget address speech by Finance Minster Alexander Chikwanda. Accessed on 6 May 2014. Available on http://www.lusakatimes.com/2011/11/11/2012-full-budget-address-speech-finance-minster-alexander-chikwanda/

7 Zambian's 2013 National Budget Analysis By MAIMBOLWA MULIKELELA. Accessed on 5 May 2014. Available on http://ukzambians.co.uk/home/2012/10/17/zambians-2013-national-budget-analysis/#sthash.6YlQWBKz.dpuf



Source: Equinet (2009).

Zambia's health indicators offer a basis for analysis into possibilities of improving the health sector. Table 2 provides Zambia's mortality and Burden of Disease indicators.

Table 2: Zambia's health indicators for 2009

	Indicators 2009				
			Country	**Regional Average**	**Global Average**
Zambia's Mortality and Burden of Disease	Life expectancy	Male	46	52	66
		Female	50	56	71
		Both	48	54	68
	Adult mortality rate per 1000 adults 15-59 years	Both sexes	527	383	176
	Under 5 mortality rate (per 1000 live births)	Both sexes	141	127	60
	Maternal mortality ratio(per 100 000 live births)		470	620	260
	Prevalence of HIV(per1000 adults 15-49 years)		135	47	8
	Prevalence of Tuberculosis (per 100 000 population)		309	475	201

Source: World Health Organization (2009).

Mortality rate, infant (per thousand live births) was recorded to be 68.9 in 2010 (World Bank 2010) and declined to 66.6 in 2011(Index mundi, 2014). The life expectance has slowly improved recording 52.36 years for both male and females, 51.13 years for males and 53.63 years for females. This could be attributed to improved health sector service provision as compared to the earlier years. Furthermore, increased HIV/AIDS

interventions may also take credit increased life expectance. However, the indicators could fare better with improved service delivery in the health sector.

HIV and AIDS in Zambia

Comment [T4]: Can NAC please update these stats?

HIV and AIDS continue to place a heavy burden on Zambia's health care system. Zambia's National HIV prevalence stood at 14.3% as of the year 2007 (NASF 2011-2016). Lusaka's (Zambia's capital city) HIV prevalence stands at 22% (CIDRZ, 2012). This prompted Zambia to be ranked the 7th among the most affected countries in the world by UNAIDS in 2008. In 2012, 56,000 adults and children were newly infected by HIV.[8] In 2012, the number of adults and children living with HIV were 950,000 (of which 490,000 were women) and 160,000 respectively.[9] The female to male prevalence ratio for the age group 15-24 dropped from 3.7 in 2004 to 1.6 in 2007. As of March 2011, more than 350,000 Zambians were on Anti-Retroviral Treatment (ART) receiving ARVs and this number increased to 480 925 in 2012. The number is projected to increase steadily over the coming years (UNDP, 2011). Over 25,000 children living with HIV were on antiretroviral treatment by the end of 2010 - that is 62% coverage (UNDP, 2011).

The Know Your Epidemic Know Your Response study (2009) revealed HIV prevalence levels in Antenatal Clinic (ANC) clients are on the decline (Zambia NAC, WB and UNAIDS, 2009). The largest decrease in HIV prevalence were observed among pregnant women aged 15-19 and 20-24 years. The number of new infections in children aged 0-14 years declined dramatically since reaching the peak at 21,189 in 1996 to 9,196 in 2009. GRZ's National guidelines for HIV Counseling and Testing of Children (2011) noted that the 0-14 age group constitutes about 10 per cent of all HIV infections in Zambia and most of them are due to mother to child transmission and over 21000 children living with HIV/AIDS were actively on treatment by end 2009. In Zambia, an estimated 16,654 new infections of HIV occurred in 2009 in children (NAC, 2009). By end of 2010, 25,000 children were on ART, equaling 62% coverage (UNDP, 2011). HIV prevalence in antenatal clients aged 15- 19 declined from 13.9% in 1994 to 8.5% in 2006/7 (NASF, 2006).

Tuberculosis (TB)

As in most SADC countries, TB is a major health threat and is one of the top ten causes of death and morbidity in Zambia (USG County Profile-Zambia, 2012). Zambia's TB incidence was 433/100,000 in 2011, the 10th highest worldwide (USG County Profile-Zambia and CIDRZ 2012). TB-HIV co-infection accounts for the highest numbers of TB

[8]World Health Organisation, 2014. Incidence Rates. Accessed on 6 May 2014. Available on http://apps.who.int/gho/data/node.main.HIVINCIDENCE?lang=en
[9]World Health Organisation, 2014. Incidence Rates. Accessed on 6 May 2014. Available on http://apps.who.int/gho/data/node.main.HIVINCIDENCE?lang=en

cases. The World Health Organisation (WHO) estimates 70% of TB patients in Zambia are HIV positive and TB is the leading cause of death in HIV infected patients (CIDRZ 2012). Pregnant women, children and prisoners are also high-risk groups of TB. Unlike South Africa, Multidrug-resistant (MDR) TB is a minor problem in Zambia with only estimated 577 new MDR-TB by the end of 2011 among sputum smear positive (SS+) cases, although only 26 cases were confirmed in 2007(USG County Profile-Zambia, 2012). No reports of extensively drug resistant (XDR) TB have been confirmed as of March 2009 but this is likely to have changed due to increased default rates of TB patient, noted to be 3% in the Sub-Saharan African Region (USG County Profile-Zambia, 2012).

1.3 The Zambian National AIDS Strategic Framework

The National Health Strategic Plan (NHSP) 2006-2010 national priority number 4(a) addresses HIV/AIDS, Sexually Transmitted Infections (STIs) and Blood Safety (NHSP, 2006:3). It commits to reducing the spread of HIV/AIDS and STIs by increasing access to quality HIV/AIDS, STI and blood safety interventions (NHSP, 2006:3). The National AIDS Strategic Framework (NASF) 2011-2015 was been developed as a follow up from the NASF 2006-2010 that highlighted its commitment to offer universal access in treatment and care, prevention and social support. The NASF 2011-2015 strives to accomplish two major results namely:

- Reduction in the rate of new infections from 82,000 in 2009 to 40,000 by 2015;
- Extending the lives of people living with HIV/AIDS (PLWHIV), and measures the increased percentage of PLHIV alive more than thirty six months after initiation of ART. (NASF, 2011:XI).

To ensure the success of NASF 2011-2015 the "Three-One" principles of having one coordinating authority, one national strategic framework and one national Monitoring and Evaluation (M&E) framework has been developed. To achieve wider socio-economic development and successfully attain the MDGs, the alignment of the NASF 2011-2015 to other national strategic frameworks such as Sixth National Development Plan (SNDP), Vision 2030, The Poverty Reduction Strategy, and the Gender Plan of Action is required. Zambia's long-term Vision 2030 aims to have a "nation free from the threat of HIV and AIDS by 2030"and "to halt and begin to reverse the spread of HIV' by 2015 as agreed in the MDGs" (NASF, 2011:1).

Priority number 4(b) addresses the TB issue by noting that the Ministry of Health (MOH) seeks to halt and begin to reduce the spread of TB through effective interventions (NHSP, 2006:3). A National TB Strategic Plan was developed for the period 2006–2010 outlining priority areas in the fight. It highlighted the need to reduce the socioeconomic impact of HIV/AIDS through the eradication of TB. This is because the co-infection rate between the two diseases is very high. In so doing, the government

has partnered with different organisations to help fight TB notably the President's Emergency Plan for AIDS Relief (PEPFAR) and CIDRZ. There has been some success in the implementing the anti-TB campaigns i.e. 100% Directly Observed Treatment, Short-course (DOTS), coverage. GRZ also achieved a success rate of 74% case detection for all forms of TB and an 85% treatment success rate as per WHO target of 85% (USG Country Profile, 2012). However, the DOTS case detection of SS+ TB was only 58% in 2007 (USG Country Profile, 2012).

1.4 Public Allocations for HIV in Zambia

In terms of HIV/AIDS, the National Aids Spending Assessment (NASA) in 2006 noted that HIV financing had increased in Zambia. There was a 48% (or $47 million) increase in actual expenditure to ZMW 207,909,244 in 2006 from 2005 (GRZ-NASA, 2008). A larger proportion of household expenditure was out of pocket payment (OOPP) on health care, with private households' OOPP (as a percentage of Private Health Expenditure) increasing between 2004 and 2006 (Save the Children, 2008). Consequently, on per capita basis actual health, spending from both donors and GRZ increased between 2004 and 2007.

Donor funding has been filled with corruption scandals with Ministry of Health being accused of misusing funds. Relations with Western donors notably Sweden and the Netherlands and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) soured with reports of corruption within the MOH. The GFATM froze $118m in health grants since August 2009, and the EU put $28m for road building on hold on conditions that certain reforms were in place before continuance of funding (Africa Report Online News, 2010). Eighty three percent of the 2011 budget was to be financed domestically with the aim of reducing donor dependence following the above-mentioned debacle (Africa Report Online News, 2010).

In October 2012 the Global Fund and the Zambian government signed an agreement of US$ 102 million (about ZMW 500 billion) for HIV programmes to be implemented by the Churches Health Association of Zambia.[10] From the grant, over 404,275 people would be counselled and tested, 80,479 placed on treatments, 84,000 males circumcised and 70,050 OVCs would receive care and support.[11]

[10] K500 billion Aids agreement historic – NAC. Accessed on 6 May 2014. Available on http://www.lusakatimes.com/2012/10/11/k500-billion-aids-agreement-historic-nac/

[11] Zambia: Nation Gets $102 Million Grant for HIV/Aids
By CHILA NAMAIKO, 11 October 2012. Accessed on 6 May 2014. Available on http://allafrica.com/stories/201210110820.html

2. The Rationale for an HIV/AIDS Spending Assessment

The budgetary allocations indicate the government's commitment to HIV. However, there are limited data on how previous allocations have been spent in various programmes and on activities and their outcomes. Hence, resource tracking of expenditure on HIV is a critical activity that enables a country to monitor its spending according to its National Strategic Plan (NSP), to measure the degree of harmonisation and alignment of all the actors involved in HIV, and to measure their financing gap, so as to improve their allocative decision-making and resource mobilisation processes.

The National AIDS Spending Assessment (NASA) is a methodology developed and promoted by UNAIDS as an approach that comprehensively identifies and measures all the spending on HIV within a country, and which has been particularly useful for countries undertaking a review of their National Strategic plans (NSPs) and in their reporting on the financial indicator for the GARPR[12] reports.

3. Aim and Objectives of the NASA in Zambia

The overall goal of the NASA was to contribute to strengthening comprehensive tracking of actual spending from all sources that comprises the national response to HIV in Zambia, for the years 2010 to 2012, so as to leverage both technical and financial support for the development, implementation, management, monitoring, and evaluation of the national HIV response.

The objectives of the NASA in Zambia were:

1. To adapt NASA methodology, classification and tools to the Zambian context;
2. To build requisite capacity for AIDS resource tracking using the NASA methodology in NAC, Ministry of Health, Ministry of Community Development and Mother and Child Health, Ministry of Finance and other key line ministries;
3. To conduct an AIDS spending assessment focusing on public, private and external resources for the response from 2010 to 2012 (3 financial years) and budgeted expenditure for 2013;
4. To catalyse and facilitate institutionalisation of tracking of AIDS expenditures in national institutions;
5. To identify the flow of expenditures on HIV and AIDS by sources of funding, functions, service providers and target beneficiary population;
6. To prepare a report of the AIDS expenditure patterns that will contribute towards the mid-term review of the NASF and inform prioritisation of resources for the remaining years of the NASF.

[12] Global AIDS Response Progress Report (formerly UNGASS reports).

The National AIDS Council managed the entire NASA process, and contracted a team of local researchers to collect the data. The Centre for Economic Governance and AIDS in Africa (CEGAA) provided technical support to the local team through training, quality control and undertook the analysis of the data.

The NASA was able to achieve most of the objectives of identifying the flows of HIV funding from public, private and external sources. Unfortunately, there were no specific efforts to institutionalise resource tracking through this process, since the skills were gained by the contracted researchers, and not by NAC and the other ministries.

4. Methodology and Scope

This project utilised the NASA methodology developed by UNAIDS and which builds on the National Health Accounts (NHA) approach. The research involved the collection of comprehensive quantitative expenditure data, as well as some qualitative data regarding funding flows, conditionalities, reporting requirements, financial information systems, and causes of bottlenecks and inefficiency in spending. These data were collected through face-to-face interviews with key respondents who represent the sources of funds, the agents/managers of funds, and providers of services, in all nine provincial departments and at national level. In addition, the expenditure records of all actors were obtained, reviewed, and analysed.

The study coverd the financial years 2010 to 2012. According to the NASA methodology, every ZMW spent on HIV is counted and the following information is recorded: the funding source, the funding agent, the funded activity, the service provider and the beneficiary. This database is then analysed in different ways to obtain a picture of total funds spent, what the funds were spent on, by whom and on whom they were spent, who provided the funds, and who controlled them.

4.1. NASA Concepts

In NASA, financial flows and expenditures related to the national response to HIV are organised according to three dimensions: finance, provision, and consumption/utilisation. Each of these dimensions is broken down into two categories, for a total of six categories. The classification of the three dimensions and six categories constitutes the framework of the NASA system as follows:

Financing

1. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and make programmatic decisions (purchaser-agent).
2. Financing sources (FS) are entities that provide money to financing agents.

Provision of HIV services

3. Providers (PS**)** are entities that engage in the production, provision and delivery of HIV services.
4. Production factors/resource costs (PF) are inputs (labour, capital, natural resources, "know-how," and entrepreneurial resources).

Utilisation

5. AIDS spending categories (ASC) are HIV-related interventions and activities.
6. Beneficiary segments of the population (BP) are key population groups such as men who have sex with men, injecting drug users, etc.

In addition to being a standardised tool, these classifications provide a means to check the comprehensiveness, consistency, neutrality (with regard to financing and mode of delivery) and the plausibility of single dimensions. The cross-classifications provide information on the coherence of the system and its axes.

The AIDS spending classification (ASC) is a functional classification that includes the categories of prevention, care, and treatment, and other health and non-health services related to HIV. After review and evaluation of past response strategies to HIV, the programmes, and budget lines have been structured into eight classes of spending categories:

1. Prevention;
2. Care and treatment;
3. Orphans and vulnerable children;
4. Programme management and administration;
5. Human resources;
6. Social protection and social services;
7. Enabling environment; and
8. Research.

Each of these thematic areas are further sub-divided into several sub-categories of activities, providing greater detail of the national response. (See Appendix C for the NASA ASC definitions.)

4.2. Study Design

The study design was a quantitative survey of all sources, agents, and service providers of HIV, using interviews with key respondents and the collection of their expenditure data, and applying the NASA methods of analysis. Mainly quantitative data were collected, along with some additional qualitative data regarding processes and bottlenecks.

During the planning phase, extensive efforts were made to map all the actors engaged in the HIV response in Zambia, so as to develop the sampling frames for development partners, public departments and facilities, businesses with HIV programmes, health insurance companies (medical aid schemes), and all the NGOs, CBOs and FBOs

providing HIV services. The following sections describe the sources of information that have been used to create the sampling frames to be applied for each of the different study populations. However, it is important to note that this NASA attempted to apply a survey design and so sampling was not applied, and every actor (sources, agents and service providers) was targeted for inclusion.

4.3. Study Population

The study was intended to include all sources of funding for HIV, including:

- Public (all), external (all), private (only larger businesses were included, excluding all private medical services since medical insurances did not provide data, and excluding out of pocket expenditure (OOPE);
- National and provincial levels (provincial breakdown pending) - four provinces were included in sample, but all the spending of all provinces were captured through the central levels and head quarters;
- All agents of funding for HIV;
- Providers of HIV services in Zambia – including public facilities; NGOs and international NGOs.

For each of these organisations/departments, the Directors, Programme Managers, Finance Directors, and Finance Officers were interviewed.

Note that this study did not interview HIV-infected patients, since individual or household spending on HIV was not included in the scope of the study. The collection of out-of-pocket expenditure (OOPE) normally requires a large household survey, with cost and time implications beyond the scope of this project.

4.4. Sampling Frames and Techniques

During the planning phase, extensive efforts were made to map all the actors engaged in the HIV response in South Africa, so as to develop the sampling frames for development partners, public departments and facilities, businesses with HIV programmes, health insurance companies (medical aid schemes), and all the NGOs, CBOs and FBOs providing HIV services. The following sections describe the sources of information that have been used to create the database of respondents. However, it is important to note that this NASA attempted to apply a survey design and so sampling was not applied, and every actor (sources, agents and service providers) was targeted for inclusion.

4.5 Missing or not collected data and assumptions applied

There were data that were not collected, either deliberately or because the data was not provided, despite many effortsto obtain the data, as follows:

- The MoH indirect spending from public revenue for opportunistic infections outpatient costs (the data from NHA 2012 were not obtained);
- Private health care spending (insurances) were not obtained;

- Out-of-pocket expenditure was omitted; and
- Many of the development partners' head-quarter (in-country) operational and salary costs were not provided.

According to the NASA principles, only actual expenditure was captured as far as possible, and was obtained in the majority of case. However, in some cases, this was not possible, and certain assumptions had to be applied as follows:

- The PEPFAR expenditure data could not be broken down by their implementing partners, and therefore all the USG funds had to be lumped under one service provider category which meant that they could not be identified as public, NGO, university, mines etc. The PEPFAR expenditure actiities were matched as closely as possible to the NASA categories.
- Pooled funds, such as the JFA, were coded as pooled and therefore the individual contributors are not labelled individually as the Financing Sources.
- Some sources gave lumped sums for three year periods, and where service providers could not validate their actual spending, these figures were divided equally between the years and assumed to have been spent.

4.5. Data Collection and Tools

The data have been collected through face-to-face interviews with the relevant persons within the selected organisations, using interview schedules that were administered by data collectors. Appointments with the respondents were made beforehand. Interviewees were also requested to provide their expenditure statements and financial reports for detailed and validated data.

The interview schedules were based upon those developed by UNAIDS, and improved by CEGAA through their application in several SADC countries. The schedules are attached in Annexure B. The tools have mostly used quantitative closed-ended questions regarding sources of financing and expenditure, with some open-ended qualitative questions regarding the funding mechanisms, bottlenecks and absorption.
Four interview schedules were developed, as follows:

- Interview schedule 1 – for all sources of financing for HIV
- Interview schedule 2 – for all agents (managers/conduits) of funds for HIV
- Interview schedule 3 – for providers of HIV services

The data collectors and capturers who were contracted by NAC were trained in the NASA methodology, in the use of the interview schedules, and in general interviewing and research skills.

4.6. Data Analysis

The data were captured firstly in the hard copies of the interview schedules. They were then entered into Microsoft Excel spread sheets where they were cleaned and verified, and any missing, incomplete, or contradictory data were identified and addressed. Finally they were entered into the NASA Resource Tracking Software (RTS) which is a Microsoft Access-based programme created by UNAIDS. The aggregation and analysis was undertaken in this programme, and further analysis and graphical displays were processed in Excel. The NASA principle of capturing only completed transactions and the processing of the data first in Excel sheets also assisted the team in undertaking triangulation, and reduced the chances of double counting.

5. Key Findings

In this section, all the spending on HIV in Zambia is presented, covering all sources: public, external (multilateral, bilateral and international foundations), and private (including some businesses, whilst excluding all private medical services since medical insurances did not provide data, & excluding OOPE). The first section provides a high-level perspective on the total HIV spending envelope in Zambia, followed by breakdowns of the spending by agent, activities, provider of services, beneficiaries, and production factors.

5.1. Total HIV/AIDS Spending in Zambia

As shown in Figure 2 below, in 2010 Zambia spent approximately ZMW 1.24 billion (US$ 257 million) on HIV, increasing by 6% to ZMW 1.31 billion (US$ 269 million) in 2011. In 2012 the amount increased again by 12% to reach ZMW 1.46 billion (US$ 283 million). Given that the response from the private (For-Profit) sector was underestimated due to poor response, and that the 'hidden' contributions of the Ministry of Health through the out-patient treatment of opportunistic infections, the total spending on HIV is somewhat estimated here.

Note that NASA only captures those funds that were actually spent by the recipient service providers in the reporting period. Hence budget allocations and donor commitments are not captured – only those amounts that were independently verified to have been spent in service delivery have been included.

In 2010, the largest contributor to HIV/AIDS funds was the external sources, with 95% of the 2010's total funding followed by the public sector which contributed only 4% and private sources with 1%. In nominal terms external sources contributed approximately ZMW 1.2 billion in 2010 which increased slightly by 2% (to ZMW 1.207) and further increased by 13% in 2012 to ZMW 1.36 billion. The public funds proportional spending increased by 2% in 2011 whilst the nominal amount increased by 90% to ZMW 83 million. However, in 2012 the public spending slightly fell to R 82 million though proportionally it remained at 6% of the total spending. The private spending maintained a 1% proportion of total spending throughout the 3 years. However, the nominal amount increased from ZMW 12 million in 2010 by 44% to ZMW 17.7 million and a 10% decrease in 2012 to approximately ZMW 16 million. The Zambian total per capita spending on HIV/AIDS in 2010 was ZMW 19.4 which increased to ZMW 19.7 in 2011 and to ZMW 20.1 in 2012.

Figure 2: Total and Per Capita Spending on HIV in Zambia by Source (ZMW, 2010-12)

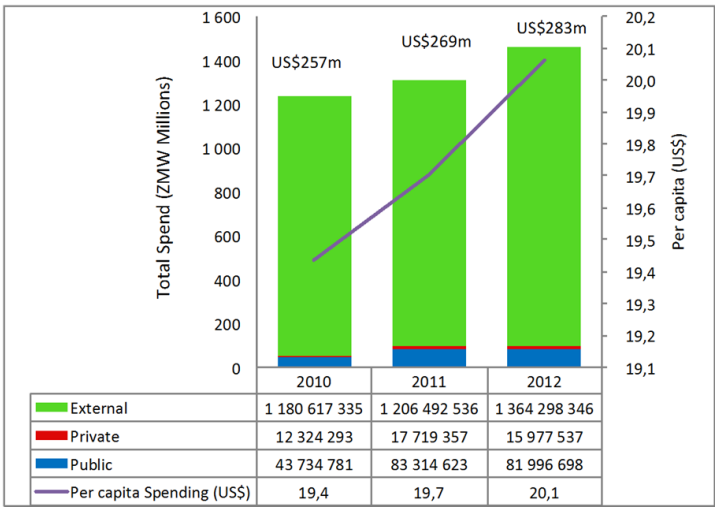


Table 3: Total Spending on HIV in Zambia by Source (ZMW, 2010-12)

	2010 (ZMW)	2010 % Share	2011 (ZMW)	2011 % Share	2012 (ZMW)	2012 % Share
Public Source	43 734 781	4%	83 314 623	6%	82 001 698	6%
Private Source	12 324 293	1%	17 719 357	1%	15 977 537	1%
External	1 180 603 170	95%	1 207 802 686	92%	1 364 567 258	93%
Totals (ZMW)	1 236 662 244	100%	1 308 836 666	100%	1 462 546 493	100%

5.2. Sources of HIV/AIDS Spending in Zambia

This section provides a more detailed analysis of the sources of HIV/AIDS financial resources in Zambia.

5.2.1. Public Sector Spending

As noted above, the public sector contributed ZMW 43.7 in 2010 which increased by 90% to ZMW 83 million in 2011 but decreased in 2012 to R 82 million. However, these figures do not include the MOH indirect still pending (from NHA), making it more likely that the amount would have been higher. Of the public resources, 99.4% came from central government in 2012.

Figure 3 and Table 4 show that provincial government contributed 1% of the total public funds or ZMW 431 thousand in 2010 which decreased by 44% in 2011 and increased by 93% in 2012. The local government funds decreased by 46% from ZMW

66.8 thousand to ZMW 36.3 thousand in 2011 and further decreased by 55% in 2012 to a mere ZMW 16.5 thousand.

Figure 3: Sources of all public funds for HIV/AIDS in Zambia 2012
(Total = ZMW 82m, US$16m)

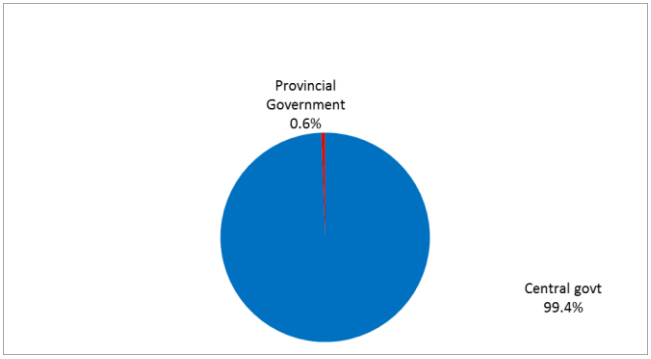


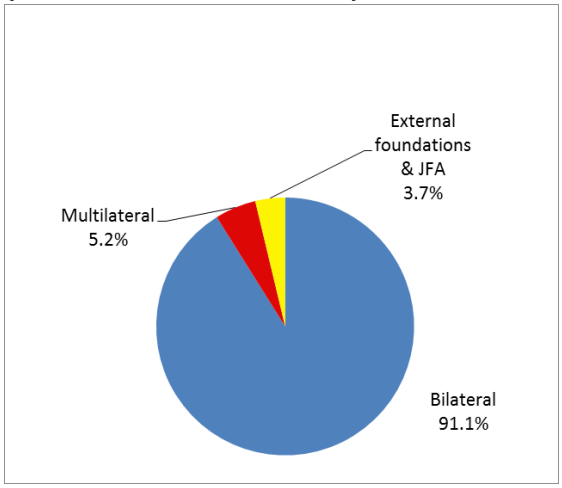
Table 4: Public Spending on HIV in Zambia (ZMW, 2010-12)

Public Sources	2010	2010 % share	2011	2011 % share	2012	2012 % share
Central Government	43 236 901	98.9%	83 038 702	99.7%	81 517 327	99.4%
Provincial Government	431 065	1.0%	239 576	0.3%	462 921	0.6%
Local and other public funds	66 815	0.2%	36 345	0.0%	16 450	0.0%
Total Public	43 734 781	100.0%	83 314 623	100.0%	81 996 698	100.0%

5.2.2. External Sources

The biggest contributor to HIV/AIDS funds in Zambia was the external sources. They contributed 95% of the 2010's total funding (ZMW 1.2 billion), which increased by 2% (to ZMW 1.207 billion) and further increased by 13% in 2012 to ZMW 1.36 billion.

Figure 3: Sources of all External funds in Zambia 2012
(Total = ZMW 1.4bill, US$ 264mill)



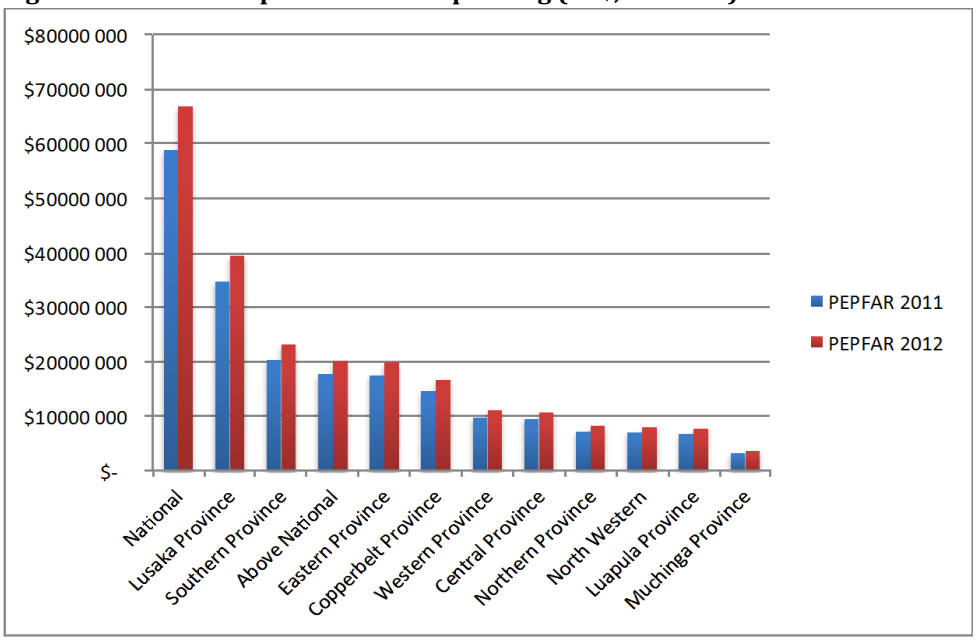
5.2.2.1. Bilateral External Sources

Bilateral organisations were responsible for the largest portion of the externally sourced HIV funding, totalling 77.8%, 85.3%, 91.1% of total external funds in 2010, 2011 and 2012 respectively. In total, the bilateral funding increased by 21% in 2011 to ZMW R1.02 billion from R918 million and a further 21% in 2012 (ZMW 1.24 billion). Over this three-year period, the Government of the United States of America (USG) was the largest contributor, with ZMW 903 million in 2010 (or 76.6% of total external funds), ZMW 1 billion in 2011 (84.1% of total external spending) and ZMW 1.2 billion in 2012 (89.8% of total external spending). The rest of the contributors accounted for less than 1% (of total external spending) each in all 3 years. These included the Governments of German, Japan, Ireland Norway and Sweden and other external Government agencies. Table 5 shows the bilateral breakdown whilst Figure 4 and Figure 5 show a detailed provincial split of PEPFAR spending.

Table 5: Sources of all Bilateral funds in Zambia (ZMW, 2010-12)

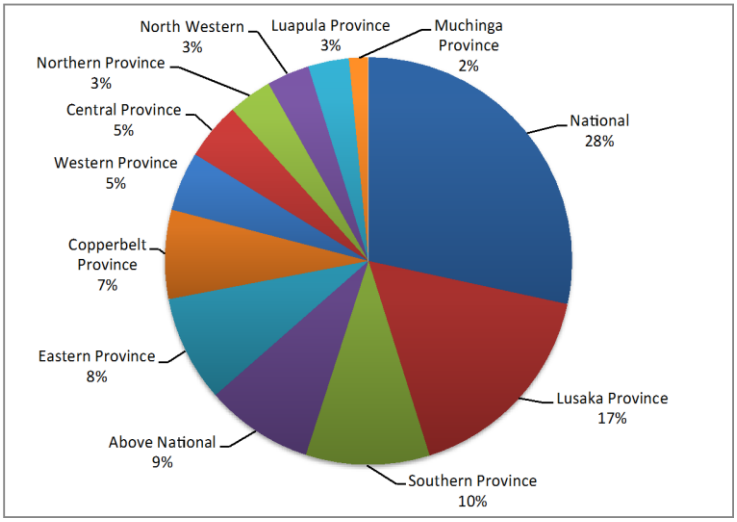
Bilateral	ZMW (2010)	US$ (2010)	Share of Total External Aid (%)	ZMW (2011)	US$ (2011)	Share of Total External Aid (%)	ZMW (2012)	US$ (2012)	Share of Total External Aid (%)
Govt of Germany	221 688	46 060	0.0%	138 528	28 451	0.0%	3 749 996	724 497	0.3%
Govt of Ireland	6 641 796	1 379 970	0.6%	4 178 424	858 169	0.3%	4 747 017	917 121	0.3%
Govt of Japan	3 945 250	819 707	0.3%	6 048 050	1 242 154	0.5%	4 292 700	829 347	0.3%
Govt of Norway	1 529 089	317 700	0.1%	3 050 359	626 486	0.3%	3 100 604	599 035	0.2%
Govt of Sweden	1 969 360	409 175	0.2%	801 452	164 603	0.1%	1 589 019	306 997	0.1%
Govt of United Kingdom	243 491	50 590	0.0%	0	0	0.0%	0	0	0.0%
Govt of USA	903 804 597	187 784 043	76.6%	1 014 772 838	208 415 042	84.1%	1 224 941 087	236 657 861	89.8%
Other Govmt agencies	0	0	0.0%	109 000	22 387	0.0%	430 000	83 076	0.0%
Total Bilateral Aid	**918 355 271**	**190 807 245**	77.8%	**1 029 098 651**	**211 357 291**	85.3%	**1 242 850 423**	**240 117 933**	91.1%

Figure 4: Provincial Split of PEPFAR Spending (US$, 2011-12)



Source: PEPFAR Expenditure Analysis, 2013.

Figure 5: PEPFAR Provincial Spending (%, 2012)



Source: PEPFAR Expenditure Analysis, 2013.

5.2.2.2. Multilateral External Sources

Multilateral organisations contributed 17%, 6.1%, and 5.2% of the total external funding in 2010, 2011, and 2012 respectively. Amongst the multilateral sources, The

Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) made the largest contributions of the multinationals in all three years of ZMW 135 million (11.5% of total external aid in 2010), ZMW 70.6 million (5.9% of total external aid in 2011) and ZMW 67.4 million (4.9% of total external aid in 2012). This was followed by other multilaterals which accounted for 5% of total external aid in 2010. The European Union (EU) followed with 0.2% of total external aid whilst the rest were below less that 0.2%. The same trend followed over the next two years, however with the EU becoming second largest contributor. Other multinationals included the UN agencies such as the International Labour Organisation (ILO), World Bank, and the World Health Organization (WHO). Of the UN agencies, UNAIDS contributed more than its counterparts in each of the three years i.e. ZMW 173 thousand in 2010, ZMW 881 thousand in 2011 and ZMW 959 thousand in 2012. **Table 6** shows the breakdown of multilateral sources and Table 7 gives a breakdown of the UN agencies in 2010 and 2012.

Table 6: Sources of all Multilateral funds in Zambia (ZMW and %, 2010-12)

Multilaterals	ZMW (2010)	US$ (2010)	Share of Total External Aid (%)	ZMW (2011)	US$ (2011)	Share of Total External Aid (%)	ZMW (2012)	US$ (2012)	Share of Total External Aid (%)
European Union	1 915 599	398 005	0.2%	1 253 117	257 366	0.1%	850 137	164 246	0.1%
ILO	745 874	154 971	0.1%	584 310	120 006	0.0%	181 157	34 999	0.0%
Global Fund	135 638 277	28 181 649	11.5%	70 640 557	14 508 227	5.9%	67 488 118	13 038 663	4.9%
UNAIDS	835 168	173 523	0.1%	881 645	181 073	0.1%	959 972	185 466	0.1%
UNICEF	835 963	173 689	0.1%	151 316	31 077	0.0%	687 035	132 735	0.1%
UNHCR	716 896	148 950	0.1%	133 133	27 343	0.0%	61 763	11 933	0.0%
UNODOC	139 290	28 940	0.0%	285 106	58 555	0.0%	243 647	47 072	0.0%
World Bank	3 395	705	0.0%	0	0	0.0%	0	0	0.0%
WHO	817 383	169 828	0.1%	218 137	44 801	0.0%	0	0	0.0%
Other Multilaterals	59 383 500	12 338 147	5.0%	0	0	0.0%	0	0	0.0%
Multilateral Total	**201 031 345**	**41 768 407**	17.0%	**74 147 321**	**15 228 450**	6.1%	**70 525 049**	**13 625 396**	5.2%

Table 7: Sources of Funding for UN Agencies (ZMW, 2010 & 2012)

2010	UN AGENCIES							
SOURCES	ILO	IOM	UNAIDS	UNICEF	UNHCR	UNODC	WHO	Totals
SIDA	0	1 005 725	0	0	0	0	0	1 005 725
EU	0	11 727	0	0	0	0	0	11 727
ILO	745 874	0	0	0	0	0	0	745 874
UNAIDS	0	0	818 008	0	0	0	0	818 008
UNICEF	0	0	0	835 963	0	0	0	835 963
UNHCR	0	0	0	0	716 896	0	0	716 896
UNODC	0	0	0	0	0	139 290	0	139 290
WHO	0	0	0	0	0	0	794 258	794 258
Total (ZMW)	**745 874**	**1 017 452**	**818 008**	**835 963**	**716 896**	**139 290**	**794 258**	**5 067 741**

2012	UN AGENCIES						
SOURCES	ILO	IOM	UNAIDS	UNICEF	UNHCR	UNODC	**Totals**
SIDA	0,00	279 501,00	0,00	0,00	0,00	0,00	279 501
ILO	181 157,00	0,00	0,00	0,00	0,00	0,00	181 157
UNAIDS	0,00	0,00	959 972,00	0,00	0,00	0,00	959 972
UNICEF	0,00	0,00	0,00	316 472,00	0,00	0,00	316 472
UNHCR	0,00	0,00	0,00	0,00	61 763,00	0,00	61 763
UNODC	0,00	0,00	0,00	0,00	0,00	243 647,00	243 647
Total (ZMW)	**181 157,00**	**279 501,00**	**959 972,00**	**316 472,00**	**61 763,00**	**243 647,00**	**2 042 512**

5.2.2.3. International Foundations

There were a number of international foundations funding various HIV activities in Zambia. These were relatively small contributions, but together contributed 5.2%, 8.6%, and 3.7% of total external aid in 2010, 2011 and 2012 respectively. The organisations included, International HIV/AIDS Alliance; Bill and Melinda Gates Foundation; Plan International; World Vision, International Planned Parenthood Federation, and other international foundations (non-profit) organizations. The Joint Funding Arrangement (JFA) is a pooled funding mechanism of various external sources was also included here, and the JFA was the biggest contributor of the International Foundations with 3.8% of total external aid (or ZMW 45 million) in 2010, 2.7% (ZMW 32 million) in 2011 and ZMW 34 million in 2012.

Table 8: Sources of all International funds including JFA pooled sources in Zambia (ZMW, 2010-12)

International Foundations	ZMW (2010)	US$ (2010)	Share of Total External Aid (%)	ZMW (2011)	US$ (2011)	Share of Total External Aid (%)	ZMW (2012)	US$ (2012)	Share of Total External Aid (%)
International HIV/AIDS Alliance	3 871.00	804	0.0%	0.00	0	0.0%	0.00	0	0.0%
Bill and Melinda Gates Foundation	8 360 393	1 737 044	0.7%	1 750 568	359 533	0.1%	1 768 828	341 736	0.1%
Plan International	119 731	24 877	0.0%	236 923	48 659	0.0%	172 257	33 280	0.0%
World Vision	0	0	0.0%	66 485	13 655	0.0%	3 900	753	0.0%
International Planned Parenthood Federation	0	0	0.0%	4 392	902	0.0%	0	0	0.0%
International foundations (non-profit) n.e.c.	7 338 861	1 524 800	0.6%	69 115 623	14 195 035	5.7%	14 896 539	2 878 002	1.1%
International for profit organizations	11 202	2 327	0.0%	6 800	1 397	0.0%	11 050	2 135	0.0%
JFA (pooled sources)	45 396 661	9 432 092	3.8%	32 065 773	6 585 700	2.7%	34 070 300	6 582 361	2.5%
Internat. Foundations & Corporations Total	**61 230 719**	**12 721 945**	5.2%	**103 246 564**	**21 204 881**	8.6%	**50 922 874**	**9 838 268**	3.7%
Total External Aid	**1 180 617 335**	**245 297 597**	100.0%	**1 206 492 536**	**247 790 621**	100.0%	**1 364 298 346**	**263 581 597**	100.0%

NB. The JFA is made up of several Development Partners, but were lumped together for purposes of tracking the spending in this NASA.

5.2.3. Private sector sources

In all 3 years, private (for profit business) funding accounted for only 1% of the total spending of HIV/AIDS in Zambia. However, it should be noted that the businesses were not representative since they were not systematically sampled, and their response rate was poor. For the information that was acquired, in 2010 the total of private sources was ZMW 12 million which increased by 44% to ZMW 17.7 million in 2011 and decreased by 10% to ZMW 15.9 in 2012. It is important to note that the study did not seek to capture out-of-pocket expenditure (OOPE) comprehensively. The amount represented here does not include private health care spending (insurances) or any shortfalls they might have paid by individuals with health insurance.

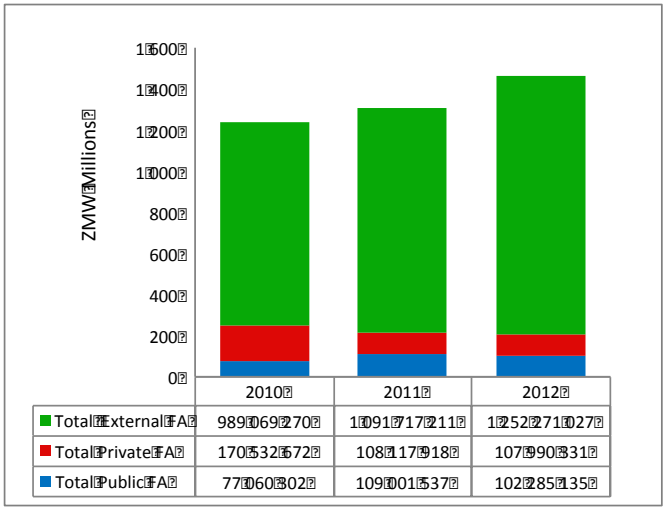
Table 9: Private Sources in Zambia (ZMW, 2010-12)

SOURCES	2010	2011	2012	2012 US$
For Profit funds	10 558 833	17 171 598	15 322 216	-
Household funds	-	-	5 920	-
Not For Profit funds (NGOs)	1 765 460	547 759	649 401	-
Private financing sources n.e.c.	-	-	-	-
Private	12 324 293	17 719 357	15 977 537	3 086 850

5.3. Agents of Funding for HIV/AIDS in Zambia

Figure 6 and Figure 7 provides a breakdown of provides a more detailed analysis of spending by funding agent. Given that the externals funders provided the highest proportion of funding to the total expenditure for all three years, it is not surprising that the bulk of the funds were controlled by external agents as depicted in Figure 6, 93% in 2012, while public agents managed only 6%.

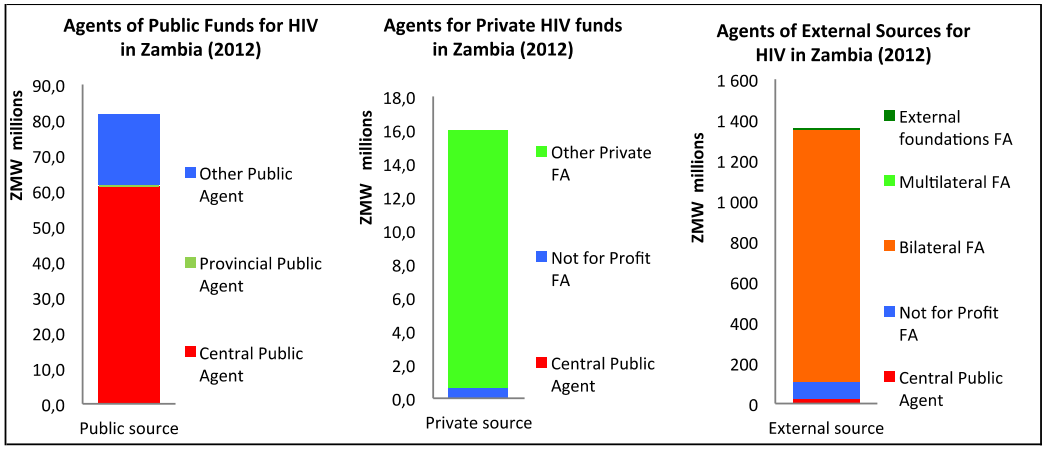
Figure 6: Agents (managers) of HIV/AIDS Funds in Zambia (ZMW, 2010-12)



	2010	2011	2012
Total External FA	989 069 270	1 091 717 211	1 252 271 027
Total Private FA	170 532 672	108 117 918	107 990 331
Total Public FA	77 060 302	109 001 537	102 285 135

Figure 7 shows the agents for the specific souces in 2012, where the public sources were mostly managed at the central level (75%), the private funds were mostly managed by the other private agents (96%), and the external sources were managed mostly (91%) by bilateral agents, mostly the USG funds through PEPFAR. For the Global Fund (GF) contributions, usually it is the Country Coordinating Mechanism (CCM) who determines the priorities and develops the GF application in line with those. It is also the CCM who determines the service providers and key interventions, and therefore the agent for the GF was coded as a private agent, as shown in the figure below.

Figure 7: Funding Agents for the Different Sources of Funds in Zambia (ZMW, 2012)



5.4. HIV/AIDS Spending Activities in Zambia

The total spending on HIV/AIDS in Zambia can firstly be broken down into eight broad thematic areas, as follows:

A. **Prevention** – such as behavioural change communications (BCC), youth programmes, voluntary medical male circumcision (VMMC), elimination (prevention) of mother-to-child transmission (eMTCT), post-exposure prophylaxis (PEP), HIV counseling and testing (HCT), most-at-risk and other vulnerable group interventions (MARP), condoms etc.
B. **Treatment** – such as anti-retroviral treatment (ART), home-based care (HBC), palliative care, out- & in-patient costs for opportunistic infections (OI), etc.
C. **Orphans and vulnerable children** (OVC) – health, family (e.g. food support, IGAs), educational and social support interventions.
D. **National systems strengthening & programme coordination** - co-ordination, planning, M&E, surveillance, operational research, drug supply systems, facility upgrading etc.
E. **Human resource** capacity building – this section includes only training and capacity building for staff, but the actual salaries were captured under the activities the staff performed – where this data was provided.
F. **Social protection** – cash transfers, HIV-related IGAs, material (in-kind) support, etc. This category excludes any interventions for OVCs.
G. **Enabling environment** – advocacy, human rights protection, gender-based violence (GBV) prevention, institutional development etc.
H. **Research** – clinical, social (behavioural/economic) etc. Note that surveillance and M&E expenditure is not captured here but under programme management.

Each of these thematic areas are then further disaggregated into several sub-categories, allowing for great flexibility to represent the country's response.

As shown in Figure 8, Figure 9 and Table 10, most of the HIV funds in Zambia were spent on treatment activities in all three years. In 2010, 43.2% of total funds were spent on treatment, which included ART, home-based care (HBC), palliative care and TB treatment. This was followed by National systems strengthening and programme coordination (26%), prevention interventions (23.3%), and OVC support (4.8%). The remaining categories were human resource development (training etc.), receiving only 1.7% of the total, research receiving 0.6%, social protection receiving 0.2%, and enabling environment (human rights protection, advocacy etc.) receiving 0.3%.

In nominal terms, spending on prevention activities in Zambia decreased by 24% from ZMW 288 million in 2010, to ZMW 219 million in 2011, but then increased by 11% to ZMW 244 million in 2012. Similarly treatment nominal spending decreased by 7% from ZMW 534.6 million to ZMW 499 million, which could have been due to the reduction in the Global Fund, and then increased by 7% to ZMW 531.9 in 2012. OVC support decreased by 12% in 2011 and by a further 10% in 2012 to reach ZMW 44 million, a worrisome situation considering the spending was relatively low.

Figure 8: Spending on HIV Activities in Zambia (ZMW mill, 2010-12)

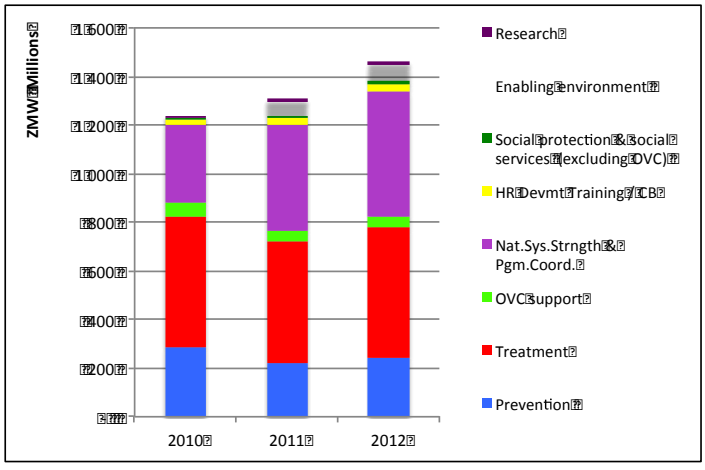


Figure 9: Proportional Spending on HIV Activities in Zambia (%, 2010-12)

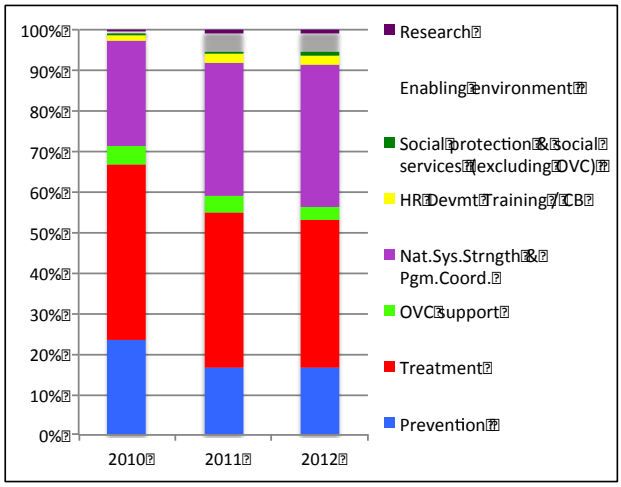


Table 10: HIV Activities in Zambia – thematic areas (ZMW mill and %, 2010-12)

Activities (ZMW)	2010	% share in 2010	2011	% share in 2011	2012	% Share in 2012
Prevention	288 474 868	23.3%	219 890 151	16.8%	244 187 072	16.7%
Treatment	534 699 055	43.2%	499 106 486	38.2%	531 984 891	36.4%
OVC support	56 607 465	4.6%	49 739 836	3.8%	44 756 431	3.1%
Nat.Sys.Strngth & Pgm.Coord	321 860 489	26.0%	433 305 992	33.1%	515 554 078	35.3%
HR Devmt Training / CB	20 462 339	1.7%	27 686 561	2.1%	33 157 959	2.3%
Social protection & social services (excluding OVC)	2 586 931	0.2%	7 740 589	0.6%	13 204 488	0.9%
Enabling environment	4 298 434	0.3%	56 821 305	4.3%	63 695 882	4.4%
Research	7 686 834	0.6%	13 235 600	1.0%	15 731 785	1.1%
Totals	1 236 676 415	100.0%	1 307 526 520	100.0%	1 462 272 586	100.0%

5.4.1. HIV/AIDS Activities by Source of Funds

Public HIV and Spending Activities

Figure 10 shows the HIV/AIDS spending activities of the public funding in Zambia. However, due to the unavailability of the MOH indirect spending from public revenue for OI outpatient costs the proportion might change for public funds. Public prevention nominal spending increased drastically from ZMW 4.2 million to ZMW 34.7 million in 2011 but decreased again by 49% to ZMW 17.7 million in 2012. Proportional prevention spending increased from 9.7% of total public spending in 2010 to 41.7% in 2011 and by a further 21.6% in 2012. Nominal public treatment expenditure increased from ZMW 38.5 million in 2010 by 25% to ZMW 48 million and by a further 32% to

ZMW 63.6 million in 2012. OVC public support decreased by 85% from ZMW 96,000 in 2010 to ZMW 14,000 in 2011 and increased 7 fold in 2012 to ZMW 96,000 – but still is normally very small. Human resources development public expenditure increased by 64% in 2011 and by a further 310% in 2012. For further details refer to Figure 10 and **Table 11**.

Figure 10: HIV/AIDS Spending Activity of Public Funds in Zambia (ZMW mill, 2010-12)

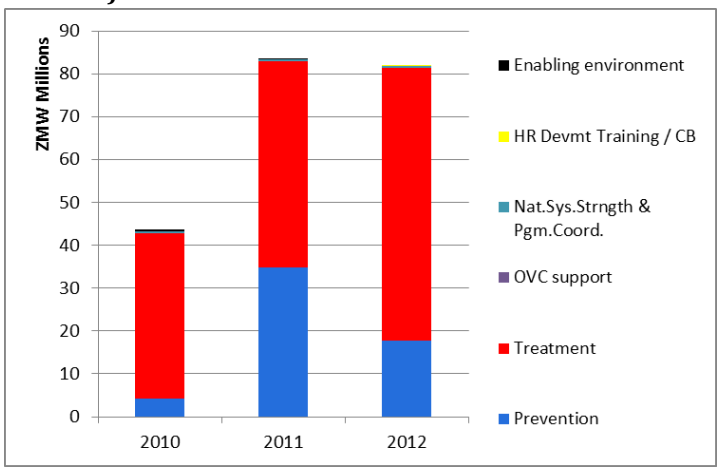


Table 11: HIV/AIDS Spending Activity of Public Funds in Zambia (ZMW mill and %, 2010-12)

Public Activities	2 010	% share in 2010	2 011	% share in 2011	2 012	% share in 2012
Prevention	4 236 733	9.7%	34 758 371	41.7%	17 742 013	21.6%
Treatment	38 508 932	88.1%	48 100 462	57.7%	63 589 958	77.6%
OVC support	96 000	0.2%	14 000	0.0%	96 000	0.1%
Nat.Sys.Strngth & Pgm.Coord.	448 925	1.0%	411 200	0.5%	480 182	0.6%
HR Devmt Training / CB	13 128	0.0%	21 591	0.0%	88 545	0.1%
Social protection & social services	-	0.0%	-	0.0%	-	0.0%
Enabling environment	431 065	1.0%	9 000	0.0%	-	0.0%
Research	-	0.0%	-	0.0%	-	0.0%
Totals	43 734 783	100.0%	83 314 624	100.0%	81 996 698	100.0%

External HIV Spending Activities

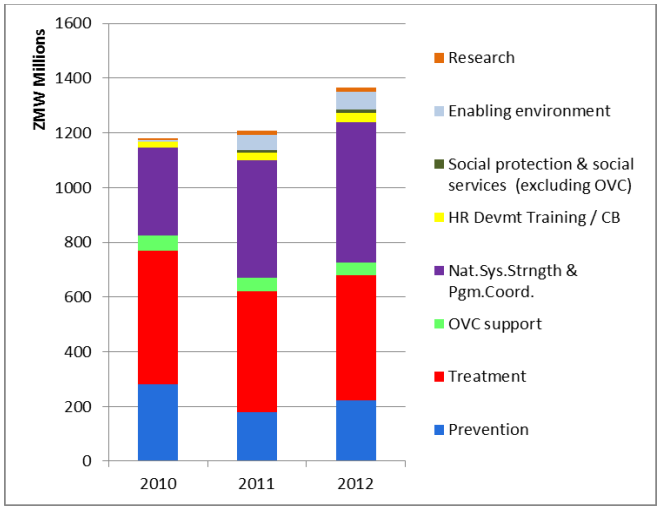
Similar to public expenditure, treatment was the largest expenditure activity with the use of external funds. This was followed by the national systems strengthening and programme coordination in 2010 and 2011. However in 2012, the external spending on national systems strengthening and programme coordination surpassed treatment

spending by ZMW 54 million nominally. **Table 12** and Figure 11 show the HIV/AIDS spending activities of external funds in Zambia. The external funds on prevention activities decreased by 36% from ZMW 280 million to ZMW 179.9 million in 2011 and increased by 23% to ZMW 221 million in 2012. The external proportional prevention spending decreased from 23.7% of total external expenditure in 2010 to 14.9% in 2011 and by increased to 16.2% in 2012. Nominal external funds spending on treatment decreased from ZMW 490 million in 2010 by 10% to ZMW 439 million and increased by 5% to ZMW 459 million in 2012. Notably, external sources for enabling environment increased from ZMW 3.8 million to ZMW 56.8 million in 2011 and again to ZMW 63.6 million. For further details on other activities, refer to **Table 12** and Figure 11.

Table 12: External HIV/AIDS Spending Activities in the Zambia (ZMW and %, 2010-2012)

External Activities	2 010	% share in 2010	2 011	% share in 2011	2 012	% share in 2012
Prevention	280 212 229	23.7%	179 946 249	14.9%	221 016 279	16.2%
Treatment	490 243 634	41.5%	439 629 396	36.4%	459 551 871	33.7%
OVC support	55 612 061	4.7%	49 540 540	4.1%	44 470 446	3.3%
Nat.Sys.Strngth & Pgm.Coord.	320 051 472	27.1%	431 924 117	35.8%	513 847 410	37.7%
HR Devmt Training / CB	20 449 211	1.7%	27 663 743	2.3%	33 068 187	2.4%
Social protection & social services (excluding OVC)	2 494 530	0.2%	7 740 589	0.6%	13 204 488	1.0%
Enabling environment	3 867 369	0.3%	56 812 305	4.7%	63 695 882	4.7%
Research	7 686 834	0.7%	13 235 600	1.1%	15 443 785	1.1%
Totals	1 180 617 340	100.0%	1 206 492 539	100.0%	1 364 298 348	100.0%

Figure 11: External HIV/AIDS Spending Activities in the Zambia (ZMW mill, 2010-2012)



Private HIV Spending Activities

Table 13 and Figure 12 give a breakdown of activities on which the private funds were spend on. Treatment was dominant in all three years though it increased as a proportion of private spending from 48% in 2010 to 64% in 2011 and reduced to 55% in 2012. It was followed by prevention activities and national systems strengthening and programme coordination and OVC support. The rest of the private activities recorded less than 1% proportional spending of private funds.

Figure 12: Private HIV/AIDS Spending Activities in the Zambia (ZMW mill, 2010-2012)

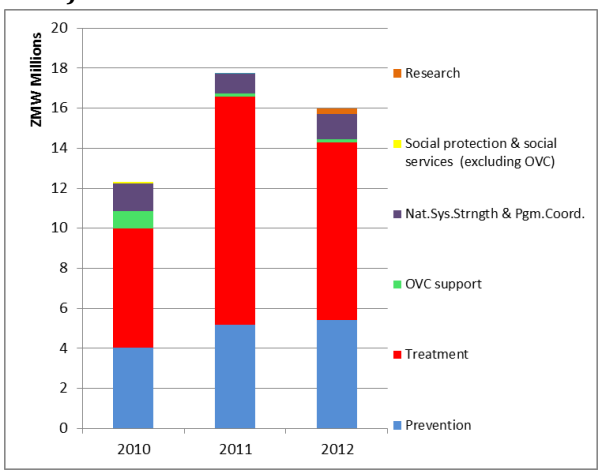


Table 13: Private HIV/AIDS Spending Activities in the Zambia (ZMW and %, 2010-2012)

Private Activities	2 010	% share in 2010	2 011	% share in 2011	2 012	% share in 2012
Prevention	4 025 906	33%	5 185 531	29%	5 428 780	34%
Treatment	5 946 489	48%	11 376 628	64%	8 843 062	55%
OVC support	899 404	7%	185 296	1%	189 985	1%
Nat.Sys.Strngth & Pgm.Coord.	1 360 092	11%	970 675	5%	1 226 486	8%
HR Devmt Training / CB	-	0%	1 227	0%	1 227	0%
Social protection & social services (excluding OVC)	92 401	1%	-	0%	-	0%
Enabling environment	-	0%	-	0%	-	0%
Research	-	0%	-	0%	288 000	2%
Totals	12 324 292	100%	17 719 357	100%	15 977 540	100%

The following sections provide greater breakdown of the thematic areas by the specific activities.

5.4.2. Breakdown of Spending on Prevention Activities

Figure 13 and Table 13 shows a breakdown of prevention activities in Zambia, which in total decreased by 24% from ZMW 288 million in 2010, to ZMW219 million in 2011, but then increased by 11% to ZMW 244 million in 2012. The highest expenditure was prevention not disaggregated which accounted for 36.1% (ZMW 104 million) proportional prevention spending in 2010, 30.9% (ZMW 67.9 million) in 2011 and increased once more to 33.6% (ZMW 82 million) in 2012. However, had the financial information been fully disaggregated we would have been able to distribute the amounts to their respective activities. It was followed by HIV Counselling and Testing (HCT) which accounted for 29% (ZMW 83.7 million) proportional prevention spending in 2010, increasing to 33.6% (ZMW 73.9 million) in 2011 and falling to 23.2% (ZMW 56.7 million) in 2012. It was then followed by PMTCT which accounted for 20.9% proportional prevention spending in 2010, increasing to 19.6% in 2011 and falling to 22.5% in 2012. All other prevention activities were very small proportions with VMMC being 7.7% of total spending on prevention in 2012 and the rest at less than 1%. Refer to **Table 13** for more information on the other activities. It's however important to note that condom spending is low in all 3 years because they are often included in the MOH primary health centre kits which include other items as well.

Figure 13: HIV/AIDS Prevention Activities in Zambia (ZMW mill, 2010-2012)

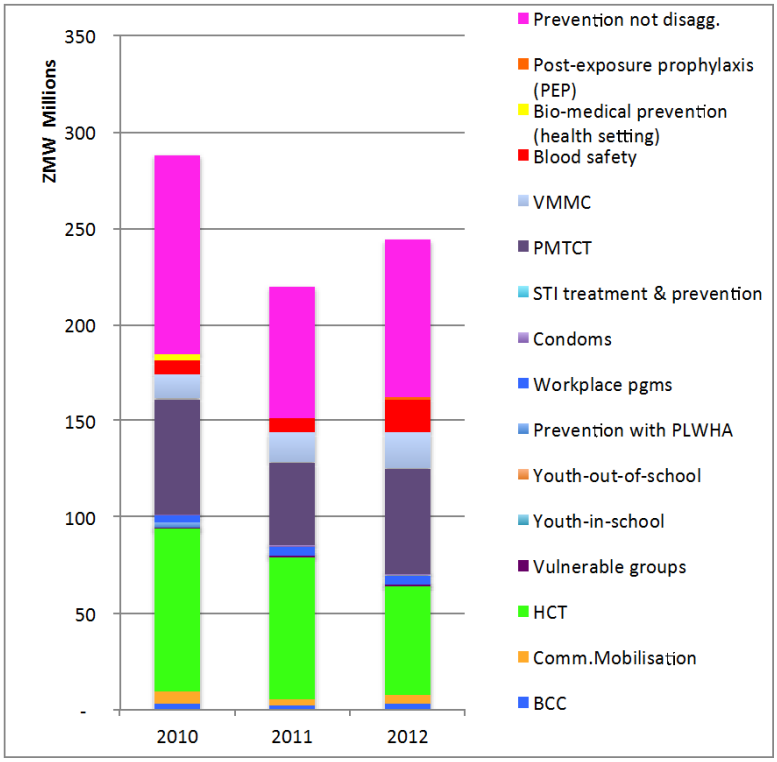
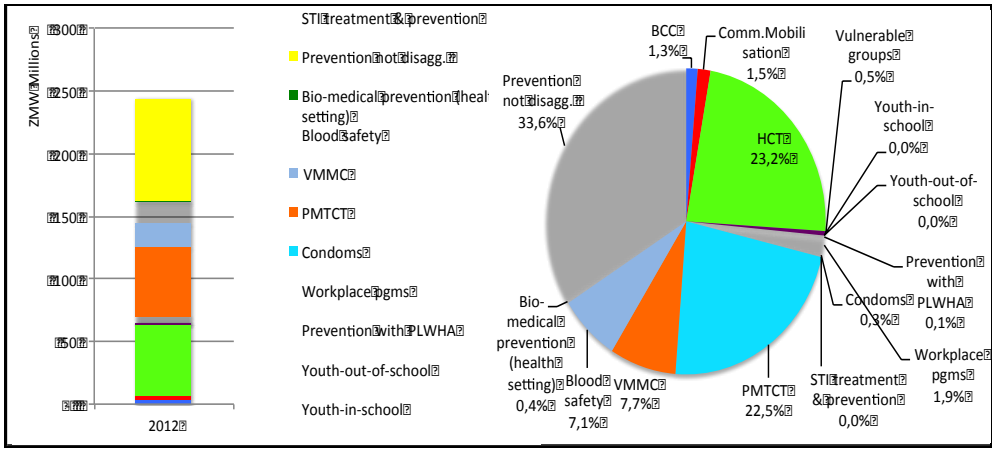


Table 14: HIV/AIDS Prevention Spending in Zambia (ZMW mill, 2010-2012)

Prevention Activities (ZMW)	2 010	% share in 2010	2 011	% share in 2011	2 012	% share in 2012
BCC	3 449 199	1.2%	1 852 197	0.8%	3 223 999	1.3%
Comm.Mobilisation	6 519 222	2.3%	3 402 072	1.5%	3 626 000	1.5%
HCT	83 714 594	29.0%	73 947 456	33.6%	56 697 463	23.2%
Vulnerable groups	410 240	0.1%	935 186	0.4%	1 140 438	0.5%
Youth-in-school	62 592	0.0%	114 052	0.1%	55 497	0.0%
Youth-out-of-school	41 137	0.0%	866	0.0%	866	0.0%
Prevention with PLWHA	3 347 854	1.2%	125 289	0.1%	223 340	0.1%
Workplace pgms	3 207 003	1.1%	3 966 995	1.8%	4 598 267	1.9%
Condoms	594 283	0.2%	783 256	0.4%	673 202	0.3%
STI treatment & prevention	88 083	0.0%	8 420	0.0%	8 684	0.0%
PMTCT	60 151 976	20.9%	42 999 569	19.6%	54 885 561	22.5%
VMMC	12 425 699	4.3%	15 755 360	7.2%	18 791 334	7.7%
Blood safety	7 507 500	2.6%	7 233 256	3.3%	17 344 223	7.1%
Bio-medical prevention (health setting)	2 556 000	0.9%	-	0.0%	-	0.4%
Post-exposure prophylaxis (PEP)	137 022	0.0%	812 260	0.4%	886 610	0.0%
Prevention not disagg.	104 262 464	36.1%	67 953 917	30.9%	82 031 588	33.6%
Total Prevention Spending	288 474 868	100.0%	219 890 151	100.0%	244 187 072	100.0%

Figure 14: Breakdown of HIV/AIDS Prevention Spending in Zambia (ZMW mill and %, 2012)



5.4.3. Breakdown of Spending on HIV Treatment Activities

The total spending on treatment was ZMW 534.6 million in 2010 and decreased by 7% to ZMW 499 million in 2011 and increased again by 7% to ZMW 531.9 million in 2012. ART was the largest component at 50.6% (ZMW 270 million) of total treatment spending in 2010, 70.2% (ZMW 350.6 million) in 2011, and 67% (ZMW 356 million) in 2012. Nominally ART increased by 29% in 2011 and by 2% in 2012. Note that this includes all the production factors required to deliver the ART service: salaries, ARVs,

laboratory costs etc.). The next largest proportional spending in 2012 was HIV-related laboratory monitoring (12.4%, ZMW 65.9 million) followed by 'out-patient care services not disaggregated' (8.7%, ZMW 46.5 million), while the other treatment activities received 4% or less. Refer to Table 15 and Figure 16 for more details.

Figure 15: HIV/AIDS Treatment and Care Spending in Zambia (ZMW mill, 2012)

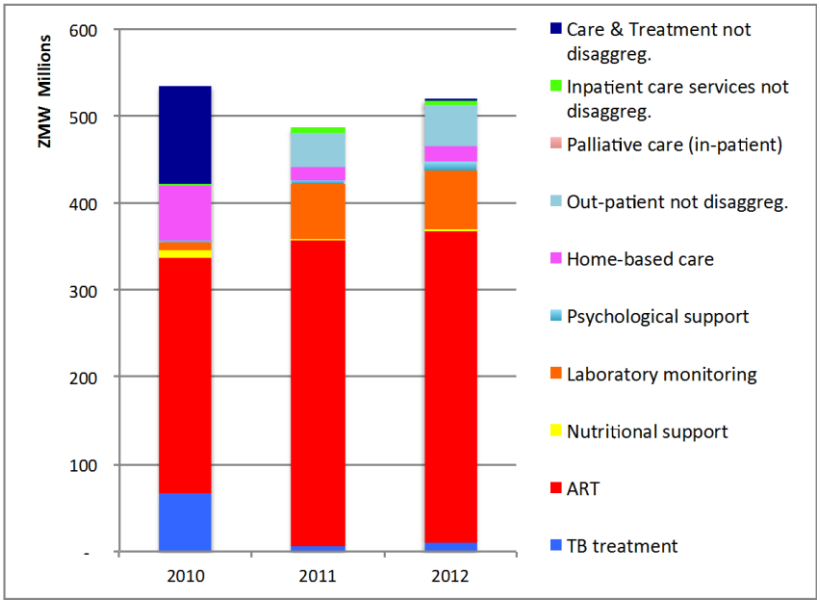
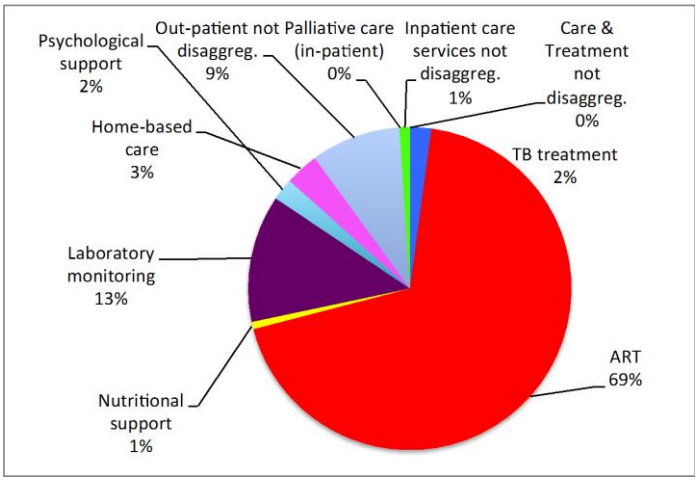


Table 15: HIV/AIDS Treatment and Care Spending in Zambia (ZMW mill and %, 2012)

HIV Treatment and Care Activity (ZMW)	2010	% share in 2010	2011	% share in 2011	2012	% share in 2012
PITC		0.0%	11 911 722	2.4%	14 379 412	2.7%
TB treatment	66 019 008	12.3%	6 374 331	1.3%	10 989 724	2.1%
ART	270 816 486	50.6%	350 609 730	70.2%	356 237 025	67.0%
Nutritional support	9 837 165	1.8%	3 252 641	0.7%	3 792 219	0.7%
Laboratory monitoring	8 456 393	1.6%	61 948 404	12.4%	65 947 939	12.4%
Psychological support	1 831 265	0.3%	4 839 789	1.0%	11 383 686	2.1%
Home-based care	63 014 062	11.8%	14 767 274	3.0%	17 402 195	3.3%
Out-patient not disaggreg.		0.0%	38 537 093	7.7%	46 508 513	8.7%
Palliative care (in-patient)		0.0%	200 843	0.0%	15 234	0.0%
Inpatient care services not disaggreg.	2 157 009	0.4%	6 664 659	1.3%	5 326 784	1.0%
Care & Treatment not disaggreg.	11256766700.0%	0	0.0%	-	216000.0%	0.0%
Total Treatment Spending	534 699 055	100.0%	499 106 486	100.0%	531 984 891	100.0%

Figure 16: HIV/AIDS Treatment and Care Proportional Spending in Zambia (%, 2012)



5.4.4. Breakdown of Spending on Activities for Orphans and Vulnerable Children

The spending on orphans and vulnerable children in in 2010 totalled ZMW 56.6 million but decreased by 12% to ZMW 49.7 million in 2011 and a further decrease of 10% in 2012. The decrease could be attributed to the reduction in the Global Fund. Much of the OVC funds went through the Zambian National AIDS Network (ZNAN) and Churches health association Zambia (CHAZ). As the figure below shows, the bulk of OVC expenditure was OVC services not disaggregated (ZMW 49.9 million) in 2010 and (ZMW 20.3 million) 2011. In 2012 OVC education was the largest intervention (53.7% of total OVC spending, ZMW 24 million) followed by OVC family/home support (24.9% of total OVC spending, ZMW 11.2 million) and OVC services not disaggregated (20% of total OVC spending, ZMW 8.9 million).

Figure 17: HIV/AIDS OVC Support Spending in Zambia (ZMW mill, 2010-2012)

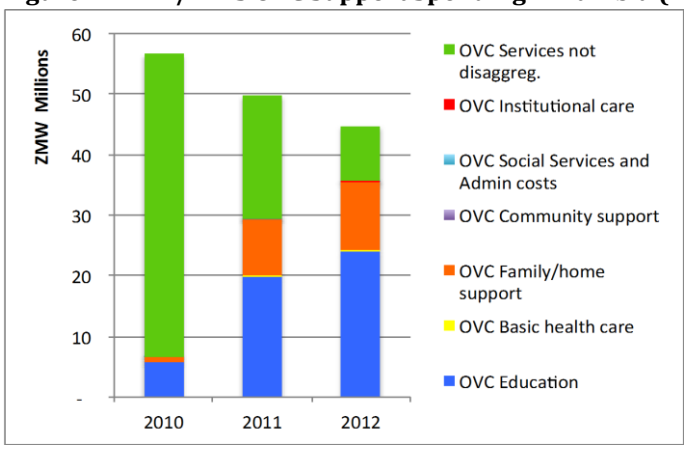


Table 16: HIV/AIDS OVC Support Spending in Zambia (ZMW mill and %, 2012)

OVC Support Activity (ZMW)	2010	2011	2012	% Share ('12)
OVC Education	5 645 720	19 884 546	24 047 706	53.7%
OVC Basic health care	5 000	237 296	286 455	0.6%
OVC Family/home support	963 425	9 172 359	11 165 337	24.9%
OVC Community support	35 000	46 971	22 699	0.1%
OVC Social Services and Admin costs	15 795	-	8 663	0.0%
OVC Institutional care		23 740	257 000	0.6%
OVC Services not disaggreg.	49 942 525	20 374 924	8 968 571	20.0%
Total OVC Care and Support	**56 607 465**	**49 739 836**	**44 756 431**	**100.0%**

5.4.5. Breakdown of Spending on HIV/AIDS National Systems Strengthening & Programme Management

The total spending on national systems strengthening and programme management in 2010 was ZMW 321 million, and it increased by 35% in 2011 to ZMW 433million and a further 19% increase in ZMW 515.5 million. In 2012 the largest proportion was spend on planning, coordination and programme management (48%, ZMW 246.9 million) followed by administration and transaction costs in managing and disbursing funds (28.9%, ZMW 148.7 million), drug supply systems (10.2%, ZMW 52.8 million) and M&E (5%, ZMW 25.7 million). The rest were below 5%. Refer to Table 17 for other activities in this category.

Figure 18: HIV/AIDS National Systems Strengthening & Programme Coordination Spending in Zambia (ZMW mill, 2010-2012)

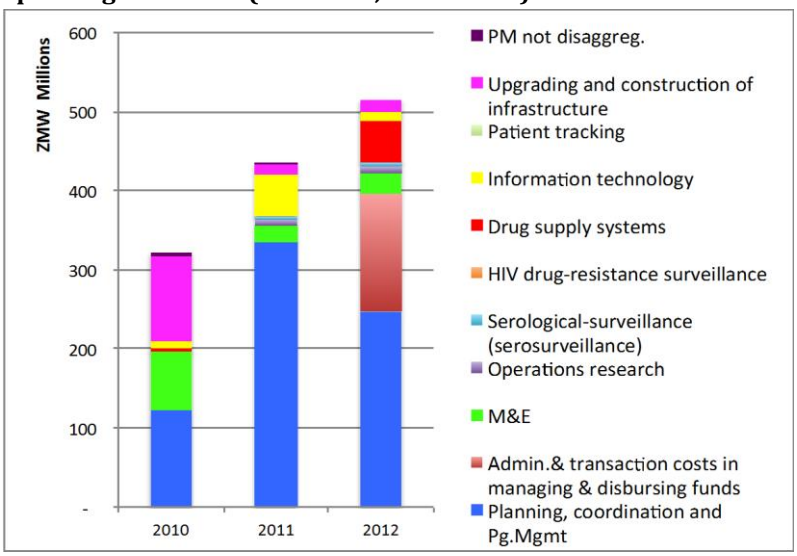


Table 17: HIV/AIDS National Systems Strengthening & Programme Coordination Spending in Zambia (ZMW mill and %, 2010-2012)

Nat.Syst.Strengthening Activities (ZMW)	2010	2011	2012	% Share ('12)
Planning, coordination and Pg.Mgmt	122 973 472	335 714 096	246 895 336	47.9%
Admin.& transaction costs in managing & disbursing funds		-	148 739 822	28.9%
M&E	73 418 016	19 847 834	25 767 640	5.0%
Operations research		7 037 416	8 495 321	1.6%
Serological-surveillance (serosurveillance)		4 569 992	5 516 734	1.1%
HIV drug-resistance surveillance	1 225	507 777	612 970	0.1%
Drug supply systems	5 003 500	240 000	52 825 180	10.2%
Information technology	7 643 523	52 755 196	10 146 582	2.0%
Patient tracking		50 407	19 880	0.0%
Upgrading and construction of infrastructure	107 797 536	12 323 274	16 534 613	3.2%
PM not disaggreg.	5 023 217	260 000	-	0.0%
Total Prog.Management Spending (US$)	**321 860 489**	**433 305 992**	**515 554 078**	**100%**

5.4.6. Breakdown of Spending on HIV/AIDS Human Resources Capacity Building

The total spending on human resources capacity building was ZMW 20.4 million in 2010, and it increased by 35% to ZMW 27.6 million and a further 20% increase to ZMW 33.2 million in 2012. However, training may have been underestimated in this category since much of it was captured under the national systems strengthening and programme management, as per the PEPFAR expenditure analysis classifications. Refer to Table 18 and Figure 19 for more details on human resources capacity building.

Figure 19: HIV/AIDS Human Resources Capacity Building Spending in Zambia (ZMW mill, 2010-2012)

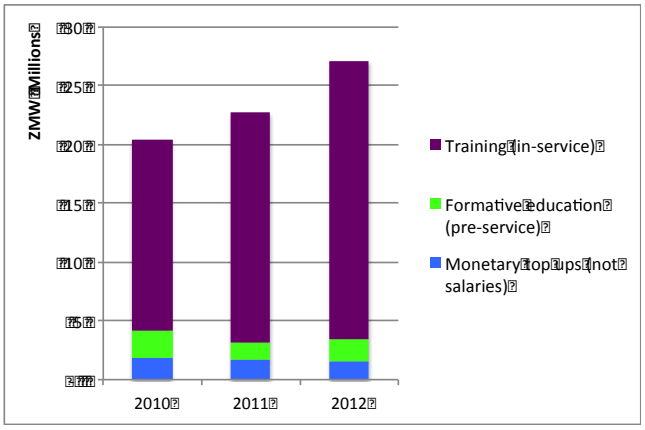


Table 18: HIV/AIDS Human Resources Capacity Building Spending in Zambia (ZMW mill and %, 2010-2012)

HR Capacity Building Activities (ZMW)	2010	2011	2012	% Share ('12)
Monetary top ups (not salaries)	1 842 161	1 666 660	1 507 879	4,5%
Formative education (pre-service)	2 258 245	1 478 221	1 925 497	5,8%
Training (in-service)	16 361 933	19 557 933	23 709 899	71,5%
Total HR Capacity Building Spendng	**20 462 339**	**27 686 561**	**33 157 959**	**82%**

5.4.7. Breakdown of Spending on HIV/AIDS Social Protection, Enabling Environment, Research Spending

The total spending on Social protection, enabling environment and research activities was ZMW 14.5 million in 2010, and it increased dramatically to ZMW 77.8 million and a further 19 % increase to ZMW 92.6 million in 2012. Spending on institutional development was highest in 2011 and 2012 (ZMW 40.5 million and ZMW 48.8 million respectively) followed by research (ZMW 13.2 million and ZMW 15.7 million respectively), other Enabling Environment not disaggregated (ZMW9.6 million and ZMW 11.5 respectively) and income generating activities. However, the spending on research may be under-represented since the PEPFAR expenditure analysis classification would have captured research spending under their programmatic focus. Refer to Figure 20 and Table 19 for more details.

Figure 20: HIV/AIDS Social Protection, Enabling Environment, Research Spending in Zambia (ZMW mill, 2010-2012)

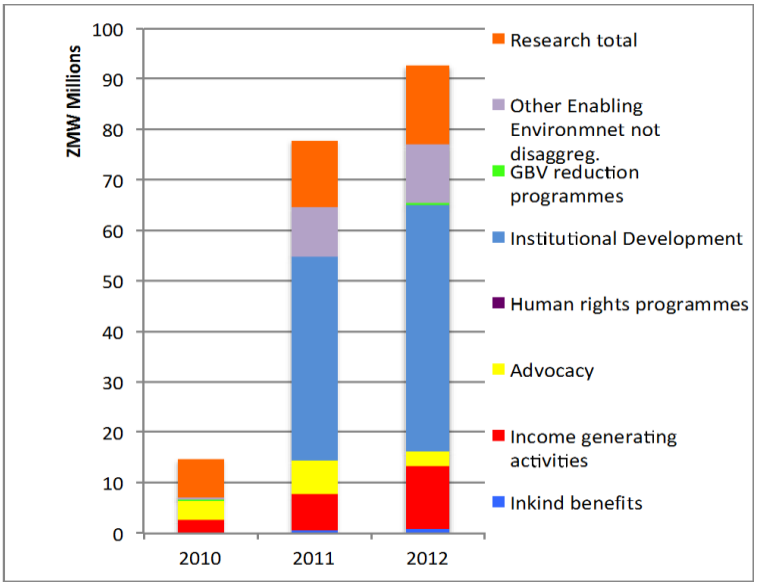


Table 19: HIV/AIDS Social Protection, Enabling Environment, and Research Spending in Zambia (ZMW mill and %, 2010-2012)

Social Protection, Enabling Environment and Research Activities	2010	2011	2012	% Share ('12)
Inkind benefits		567 621	685 213	0.7%
Income generating activities	2 586 931	7 172 968	12 519 275	13.5%
Advocacy	3 700 560	6 512 216	2 785 556	3.0%
Human rights programmes	168 987	-	229 909	0.2%
Institutional Development		40 472 082	48 856 479	52.7%
GBV reduction programmes	376 507	204 275	268 082	0.3%
Other Enabling Environmnet not disaggreg.	52 380	9 632 732	11 555 856	12.5%
Research total	7 686 834	13 235 600	15 731 785	17.0%
Total	**14 572 199**	**77 797 494**	**92 632 155**	100.0%

5.5 Spending within the Investment Framework

The Investment Framework (IF), developed by UNAIDS (Swartlander, 2011) and Partners, assists countries to **maximize the impact of the HIV programmes and interventions on their HIV incidence and deaths[13].**

The objectives of developing an Investment Case are to:

1. Correct the mismatches between the epidemic and response
   - address emerging trends as well as prevalent risks, burdens and gaps
   - prioritise allocating resources to evidence-based interventions with the greatest impact
2. Identify how to go to, and maintain, required scale/coverage
   - more rapid scale up may save more lives and money in the medium-long term
3. Cut unnecessary costs or diversion of capacity
   - focus on: big issues e.g. procurement; redirect capacity from less effective interventions
4. Generate efficiencies in the HOW of implementation to ensure ability to achieve scale and limit financial burden
   - e.g. systems duplications, technology,
   - scale constraints: service models, HRH etc.
5. Ensure sustainability:
   - manage fiscal space; mobilise domestic & international finance flows; stakeholder support.

[13] Investing for Results. Results for People. Guidance 2012. UNAIDS/PCB(30)12.CRP.4

The NASA findings can provide valuable insight into the current and past funding of programmes, so that within the Investment Framework, it can be ascertained if reprogramming is necessary. The NASA findings are therefore presented here according to the main categories of the IF:

- ✓ Basic programmes
- ✓ Critical enablers
- ✓ Synergies with the development sector.

The **basic programmes** are those which have a direct effect on HIV transmission, risk, mortality, and morbidity, and include the following sub-categories:
1a. Key populations at higher risk with the focus mostly on men having sex with men, commercial sex workers and their clients and injecting drug users. The basic activities for the mentioned groups include condom, education, and communication.
1b. Elimination of new infections in children through biomedical means i.e. PMTCT
1c. Behaviour change programmes
1d. Male and female condom promotion, procurement and distribution
1e. Treatment, care and support for people living with HIV
1f. Voluntary medical male circumcision

The **critical enablers** are less structured and include activities that are necessary to support the effectiveness and efficiency of the basic programme activities. There are two sub-components:

- ✓ Social enablers; which include community mobilization, voluntary counselling and testing, human rights and advocacy and stigma reduction
- ✓ Programme enablers; which include, "capacity building for community based organisations, programme management, and strategic planning".[14]

The **development synergies** include those investments in other sectors that can have a positive effect on HIV outcomes, such as:

- ✓ Social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems and community systems.

Therefore:
"The point of the Investment Approach is not to supply firm prescriptions for cost allocations but rather to provide conceptual frameworks that may help in shaping country-level discussions... The interventions that are more HIV-specific or have a specific HIV outcome would warrant a greater share of resources for HIV; those that primarily contribute to other health or development outcomes while being HIV-sensitive might cost more overall but would warrant a much smaller share of HIV-specific funding"(UNAIDS & UNDP, 2012) [15].

[14] A New Investment Framework for the Global HIV Response. UNAIDS ISSUES BRIEF . 2011
[15] UNAIDS & UNDP (2012). Understanding and acting on critical enablers and development synergies for strategic investments.

After cross-walking the NASA categories to the Investment Framework categories (see Appendix C for more details); the spending on HIV/AIDS in Zambia in 2010-2012 within the IF is presented in the following figures and table.

The total spending on the basic programmes was ZMW 599.3 million in 2010, decreasing to ZMW 533.3 million in 2011 and increasing by 5% in 2012 to ZMW 580 million. In 2012 critical enablers made up another 36% (ZMW 500 million), while the development synergies only had 1%. However, it is important to note that there was additional spending captured through the NASA process which could not easily be placed into one of the three core categories. These are labelled above as 'other NASA spending' (non-IF categories). These included training, upgrading, and construction of infrastructure, and prevention programmes in the workplace. These interventions are equally important in the Zambian HIV/AIDS response.

Figure 21: NASA Findings within the Investment Case Categories (ZMW mill and, 2010-2012)

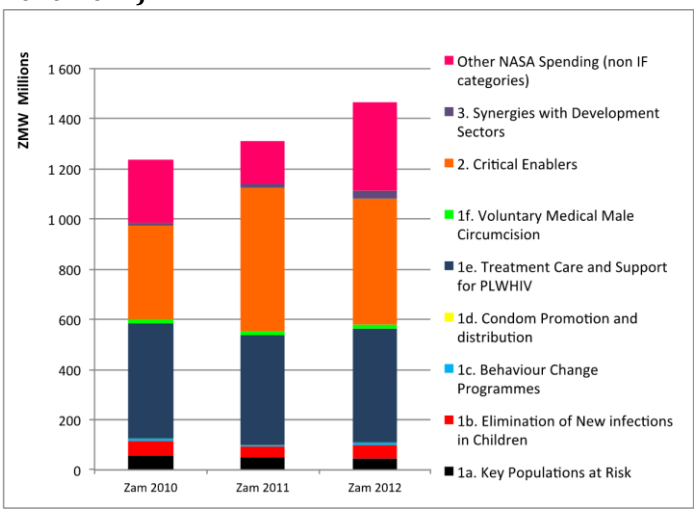
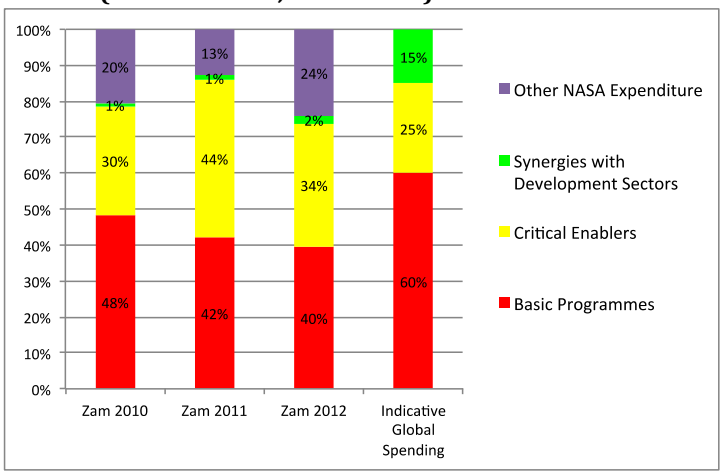


Table 20: NASA Findings within the Investment Case Categories (ZMW mill and %, 2010-2012)

Investment Framework Categories	Zam 2010	Zam 2011	Zam 2012	Share of Total (2010-12)
1a. Key Populations at Risk	566 607 465	497 752 836	447 756 431	4%
1b. Elimination of New Infections in Children	607 151 976	423 999 569	548 885 561	4%
1c. Behaviour Change Programmes	95 514 480	62 278 356	83 383 855	1%
1d. Condom Promotion and distribution	594 283	783 256	683 378	0%
1e. Treatment Care and Support for PLWHIV	4 600 145 388	4 377 095 689	4 528 982 278	34%
1f. Voluntary Medical Male Circumcision	124 256 699	157 555 360	187 913 334	1%
2. Critical Enablers	3 738 790 066	5 718 165 530	5 004 187 334	36%
3. Synergies with Development Sectors	105 590 021	152 186 540	308 325 477	1%
Other NASA Spending (non-FF categories)	2 529 300 37	1 672 443 84	3 505 609 38	19%
Total HIV Spending in Zambia (ZMW)	**12 366 576 415**	**13 075 265 520**	**14 622 725 86**	**100%**

There is no global golden standard to indicate what might be the best proportional mix of spending on these categories, as every country epidemic and response is different. However, based on average global spending patterns, Swartlander (2011) proposed the Investment Approach be split as follows; 60%, 25% and 15% for basic programmes, enablers, and synergies respectively at a global level. It does not translate to country level allocations. This is the split we however apply as a rough comparative guide as shown in the figure below.

Figure 22: Proportional NASA Findings within the Investment Case Categories in Zambia (ZMW mill and, 2010-2012)



It can be seen above that the proportional spending on treatment in all three years is lower than the possible global average (60%). Importantly, the critical enabler spending is slightly higher ranging from 30% to 44% as opposed to 25%. The spending

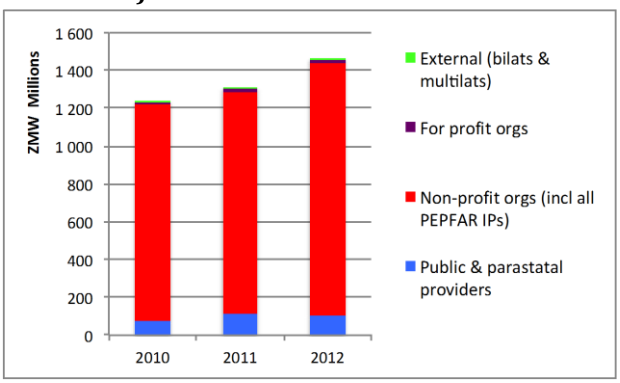
on synergies was very low i.e. 2% in 2012 and 1% in both 2010 and 2011 as opposed to the suggested 15%. The 'other NASA spending' made up 20%, 13%, and 24% of the total spending on HIV/AIDS in Zambia in 2010, 2011 and 2012 respectively.

The following section looks at the detail of the types of HIV service providers in Zambia.

5.6. Providers of HIV/AIDS Services in Zambia

According to the NASA classification, the broad categories of service providers are public, private (NGOs and businesses), and external (where the development partners spend money themselves on programmes or operational costs). As shown in Figure 23, Table 21 and Table 22, the bulk of HIV and TB services in Zambia were provided by Non-profit organisations including all PEPFAR implementing partners spending 92.3% of total spending (ZMW 1.1 billion) in 2010, 89.7% (ZMW 1.17 billion) in 2011 and 91.3% (ZMW 1.3 billion) in 2012. These were followed by public entities that spend 6.3%, 8.4%, and 7.2% of the total spending in 2010, 2011, and 2012 respectively. Limited external providers spend an average of 7% in the 3 years whilst For profit organisations spend less that 2% in all 3 years whilst. However, since the MOH indirect expenditure was not captured, public entities proportion of total spending is likely to be higher.

Figure 23: Spending by Providers of HIV/AIDS Services in Zambia (ZMW mill, 2010-2012)



NB. All PEPFAR Implementing Partners could not be disaggregated and so were lumped together under non-profit organisations.

Table 21: Providers of HIV Services by the broad categories (ZMW and %, 2010-2012)

Providers by Type (ZMW)	2 010	% share in 2010	2011	% share in 2011	2012	% share in 2012
Public & parastatal providers	78 223 227	6.3%	109 453 904	8.4%	105 778 675	7.2%
Non-profit orgs (incl all PEPFAR IPs)	1 141 124 648	92.3%	1 172 634 180	89.7%	1 334 692 779	91.3%
For profit orgs	10 411 402	0.8%	17 393 005	1.3%	15 813 043	1.1%
External (bilats & multilats)	6 917 138	0.6%	8 045 431	0.6%	5 988 089	0.4%
Total	1 236 676 415	100.0%	1 307 526 520	100.0%	1 462 272 586	100.0%

When looking in more detail at the types of service providers, Table 22 below shows that the PEPFAR partners consumed 83% of the funds, and then the GF principle recipients (CHAZ etc.) with 5%, followed by the public primary health facilities with 4.4%. The others consumed small amounts, but it should be noted that because the hidden spending of the MOH on out-patient opportunistic infections was not included, the spending by the MOH (public clinics) is underestimated here. Although the MoCDCH moved out of the MOH, their funding continued to be managed by MOH. The spending by the hospital for profit is the Mopani Mines (private for profit) hospital. The for profit higher education was for the Livingston Institute of Business, but for which no spending was recorded in 2011 for HIV/AIDS. It is of concern that the other NGOs, CBOs, FBOs (who were not PEPFAR partners) had their funding halved in 2012.

Table 22: Providers of HIV Services in Zambia (ZMW, 2010-12)

Service Providers (ZMW)	2010	2011	2012	% Share ('12)
Public Hospitals	5 363 652	6 121 586	0	0.0%
Public Primary Health Facilities	33 999 243	69 325 233	63 821 433	4.4%
Higher education (public)	0	11 200	2 500	0.0%
NAC	33 280 356	25 567 258	20 360 027	1.4%
MOE	119 276	122 567	113 644	0.0%
MoCDCH	253 695	0	0	0.0%
Ministry of Defence	156 810	216 260	243 588	0.0%
Govt organizations included above	2 283 959	2 278 217	5 823 439	0.4%
Blood banks (Parastatal)	2 047 500	4 996 400	14 643 968	1.0%
Higher education (Parastatal)	498 901	528 776	556 091	0.0%
Parastatal organizations n.e.c.	219 835	286 407	213 985	0.0%
CHAZ)	142 631 762	72 774 833	74 250 731	5.1%
NGOs, CSOs, FBOs & CBOs	94 688 289	85 051 011	35 501 047	2.4%
PEPFAR IPs (lumped)	903 804 597	1 014 808 091	1 224 941 001	83.8%
Hospitals (For profit)	649 220	263 284	1 162 296	0.1%
Laboratories (For profit)	5 100	124 000	0	0.0%
Higher education (For profit)	8 395	245	760	0.0%
Workplace (For profit)	9 748 687	17 005 447	14 649 987	1.0%
Bilateral offices (in-country)	3 872 603	6 065 082	4 505 696	0.3%
Multilateral offices (in-country)	3 044 535	1 980 349	1 482 393	0.1%
Total	**1 236 676 415**	**1 307 526 520**	**1 462 272 586**	100.0%

5.7. Beneficiaries of HIV/AIDS Spending in Zambia

The NASA categories firstly categorises the beneficiaries of HIV/AIDS spending into six broad categories, each of which are then broken down further. However, the depth of the analysis is often hindered by the limited breakdown of the expenditure data by the type of beneficiary.

The six broad categories of beneficiaries are as follows:

- PLWHA – can be broken down by age and gender, if the expenditure data allows
- Most at Risk Populations – traditionally men who have sex with men (MSM), commercial sex workers (CSW), and intravenous drug users (IDUs). However, in Zambia, only spending on CSW was found.
- OVCs and other vulnerable groups (prisoners, migrants, etc.).
- Other key populations – school/ university students, police/ army.
- General population – efforts that target the entire population e.g. BCC, mass media, HCT
- Non-targeted – interventions that are not targeted at any group/person/population e.g. national systems strengthening, programme management, M&E, infrastructural development, and research.

The spending according to these broad categories in 2012 are shown in the figure below, with the largest proportion (38%) being non-targetted interventions, followed by interventions directly benefitting PLHIV (33%). The general population benefitted from 21%. OVCs and other vulnerable groups received 6% of services, and accessible populations only 2%. These are broken down in more detail below.

Figure 24: Beneficiaries of HIV Spending in Zambia (%, 2012)

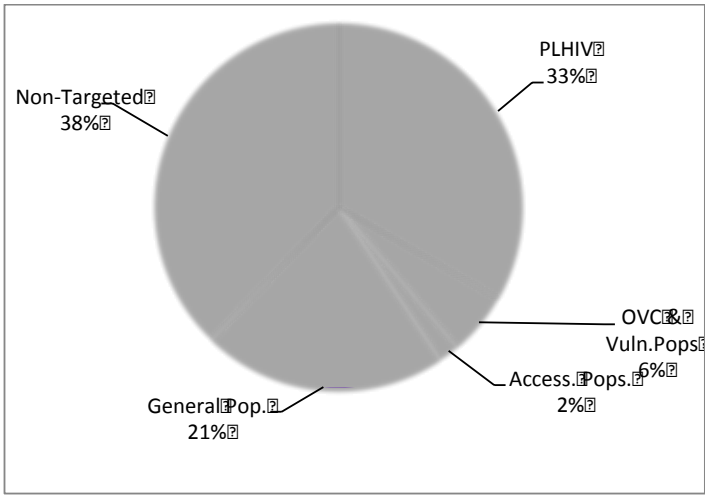
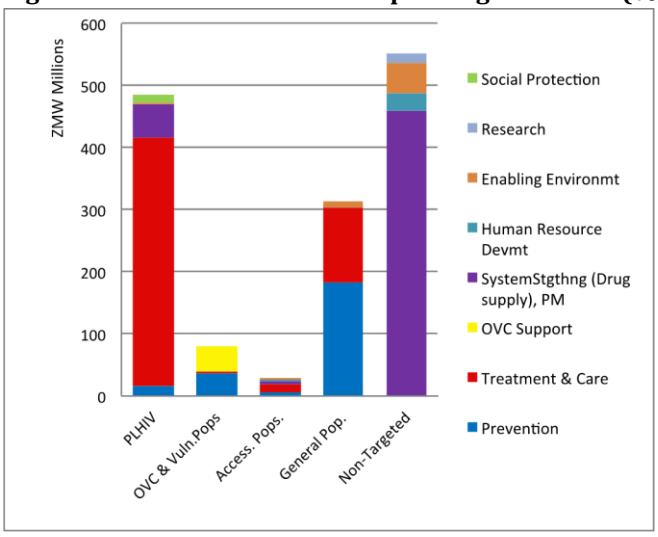


Figure 25 shows which the interventions from which these categories benefitted.

Figure 25: Beneficiaries of HIV Spending in Zambia (%, 2012)

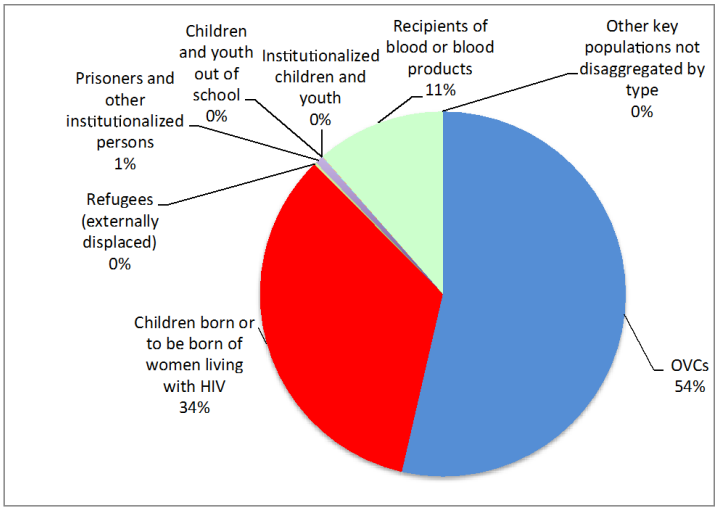


Considering the types of services that the different groups of beneficiaries are benefitting from, the figure 25 shows that the bulk of PLHIV were reached by treatment and care services, while the bulk of the general population were reached by prevention interventions. This is to be expected. Also as expected, it can be seen that the bulk of the national systems strengthening and programme management spending was non-targeted. Further breakdown of the key population spending is shown in Table 23 below.

Table 23: Spending on Key Populations in Zambia (ZMW and %, 2010-12)

Key populations	OVCs	Children born or to be born of women living with HIV	Refugees (externally displaced)	Prisoners and other institutionalized persons	Children and youth out of school	Institutionalized children and youth	Recipients of blood or blood products	populations not disaggregated by type	Total
2010	57 824 335	59 200 496	427 060	752 439	50 962	-	7 507 500	6 000	**125 768 792**
	46%	47%	0%	1%	0%	0%	6%	0%	100%
2011	48 915 252	16 685 208	70 050	629 481	18 081	90 630	7 233 256	-	**73 641 958**
	66%	23%	0%	1%	0%	0%	10%	0%	100%
2012	43 956 389	19 632 968	33 963	687 594	866	-	17 344 223	-	**81 656 003**
	53.8%	24.0%	0.0%	0.8%	0.0%	0.0%	21.2%	0.0%	100.0%
Total	**150 695 977**	**95 518 673**	**531 073**	**2 069 514**	**69 909**	**90 630**	**32 084 979**	**6 000**	**281 066 755**

Figure 26: Proportional spending on Vulnerable Populations (total spending over three years)



When examining the beneficiaries of the spending by the financing agents, it can be seen that in 2011 and 2012, the public agent spending benefitted primarily PLHIV, the private agent and external agent spending had a large portion non-targeted.

5.8. Production Factors

The NASA attempted to collect the production factors (PFs), or cost components, of all the HIV/AIDS spending in Zambia. However, not all the respondents could provide this additional level of breakdown. Therefore some of the current expenditure was labelled as 'current not disaggregated' while any infrastructural development or upgrading, was labelled as 'capital not disaggregated'. As the figure and table below indicate, the large proportion of not disaggregated (21% in recurrent expenditure) undermines the usefulness of the remaining spending that could be disaggregated since no assumptions can be drawn in terms of efficiencies for specific interventions.

Table 24 and Figure 27 below give the breakdown of the production factors for Zambia from 2010-2012. The 2012 recurrent expenditure was 94.3% of the total spending on HIV/AIDS, and capital was only 5.7%. This seems a bit low and may have missed some capital investments or infrastructural upgrading. Or it indicates that the investment in capital improvements was low in 2012. The ARV component of ART was 21% of total spending in 2012 whilst wages and salaries formed 26% of total spending. However, salaries are probably incorporated in the 'recurrent not disaggregated' portion. It increased by 127% from ZMW 132 million in 2010 to ZMW 299.7 million in 2011 and by a further 1% to ZMW 301million in 2012.

Figure 27: Production Factors for HIV Spending in Zambia (ZMW mill, 2010-2012)

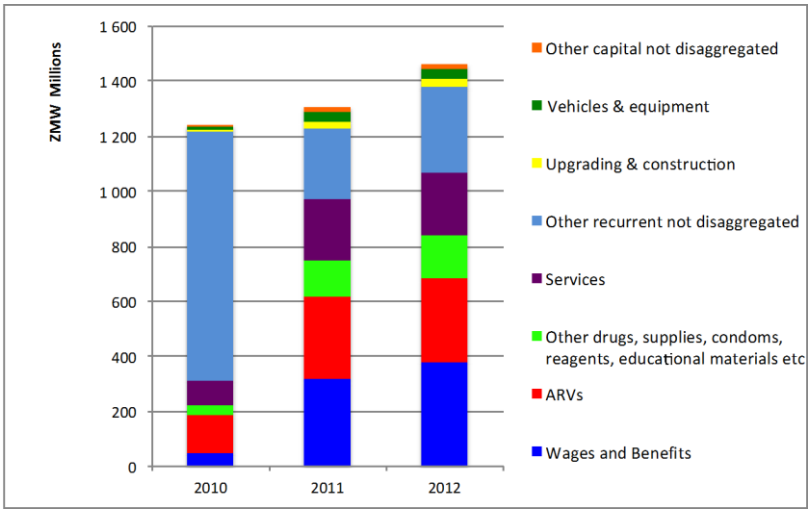


Table 24: Zambian HIV Production Factors – Recurrent Expenditure (ZMW, 2010-12)

CURRENT EXPENDITURES	2010	2011	2012	% Share ('12)
Wages & benefits	51 247 039	315 251 334	379 598 370	26%
Antiretrovirals	132 062 998	299 799 666	301 816 395	21%
Other drugs and pharmaceuticals (excluding antiretrovirals)	*5 942 749*	*60 347 865*	*75 493 593*	
Medical and surgical supplies	*2 511 412*	*16 248 875*	*23 711 325*	
Condoms	*581 783*	*858 501*	*721 764*	
Reagents and materials	*1 731 059*	*2 572 031*	*3 006 168*	
Food and nutrients	*17 404 691*	*6 324 351*	*7 921 683*	
Uniforms and school materials	*5 645 720*	*5 214 931*	*6 336 777*	
Material supplies not disaggregated by type	*6 596 762*	*39 725 658*	*37 960 467*	
Sub-total Other drugs (excl ARVs), supplies, reagents, educational materials	40 414 176	131 292 212	155 151 777	11%
Administrative services	*36 437 929*	*42 453 859*	*38 046 445*	
Maintenance and repair services	*672 893*	*848 221*	*851 036*	
Publisher-, motion picture-, broadcasting services	*2 814 580*	*1 195 765*	*1 034 440*	
Consulting services	*10 191 374*	*25 923 757*	*29 007 319*	
Transportation and travel services	*15 044 822*	*75 182 801*	*96 551 746*	
Housing services	*240 937*	*0*	*225 791*	
Logistics of events, including catering services	*20 755 816*	*37 505 670*	*15 111 118*	
Services not disaggregated by type	*1 817 043*	*43 893 203*	*52 186 416*	
Sub-total Services	87 975 394	227 003 276	233 014 311	16%
Other recurrent not disaggregatated or n.e.c	904 205 385	256 954 280	310 022 156	21%
Sub-Total RECURRENT	1 215 904 992	1 230 300 768	1 379 603 009	94.3%

Table 25: Zambian HIV Production Factors – Capital Expenditure (ZMW, 2010-12)

Capital expenditures	2010	2011	2012	% Share ('12)
Laboratory and other infrastructure upgrading	*8 360 393*	*0*	*0*	
Construction of new health centres	*0*	*0*	*0*	
Buildings not disaggregated by type	*0*	*23 381 403*	*28 238 298*	
Sub-total Upgrading & construction	8 360 393	23 381 403	28 238 298	1.9%
Vehicles	1 605 313	4 866 920	5 333 464	
Information technology (hardware and software)	7 776 933	3 483 169	3 817 035	
Laboratory and other medical equipments	351 320	8 327 394	468 122	
Equipment not disagg. Or n.e.c	50 765	20 800 911	25 132 132	
Sub-total Vehicles and equipment	9 784 331	37 478 394	34 750 753	2.4%
Capital expenditure not disagg. Or n.e.c	2 411 487	16 115 632	19 442 408	
Other Capital not disaggregated or n.e.c	2 626 700	16 365 958	19 680 527	1.3%
Sub-total CAPITAL	20 771 424	77 225 755	82 669 578	5.7%
TOTAL Production Factors	**1 236 676 416**	**1 307 526 523**	**1 462 272 587**	100%

6. Summary and Recommendations

Comment [T5]: This section still to be beefed up – NAC/UNAIDS input please

The key findings of the Zambian NASA (2010-2012) can be summarised as follows:

- The HIV/AIDS response in Zambia is heavily dependent upon external aid (92% of total HIV spending).
- Public sector contribution is under-estimated due to missing MOH hidden costs (salaries etc.).
- Business sector is only contributing to their workplace programmes and may be putting employees onto public services (apart from the mining health services).
- The bulk of funding is managed by the external sources and their implementing partners as service providers (primarily PEPFAR partners).
- Treatment spending appears to have decreased slightly, which may have been due to reduced GF, or weaker patient tracking.
- Prevention activities were taking 18% of total spending in 2012.
- Spending on research and training may be under-represented since the PEPFAR spending for these two were captured under the activity/programme for which it was undertaken (PEPFAR data).
- Spending on OVCs has decreased, and other social protection, impact mitigation, enabling environment spending are very low.
- Funding for local NGOs (non-PEPFAR IPs) has reduced (halved over the period).
- Production factor analysis was challenging where the respondents could not provide the breakdown – important to ascertain possible areas of efficiencies.

Based on the NASA findings presented above and the stakeholder feedback at the validation meeting, the following broad recommendations are made:

- The Zambian stakeholders should consider the best possible investment package of interventions – basic programmes, critical enablers, development

synergies. Spending on the basic programmes could be low, given the both the treatment demand and the need for effective prevention interventions. For example, was the spending on prevention adequate and on the most impactful programmes?

- Zambia needs to consider alternative domestic sources of funding for, and to improve the sustainability of, its HIV response.
- Improved financial information systems generally and specifically within the public system, with mandatory annual reporting on HIV expenditure of all stakeholders (including private medical insurances) would greatly enhance the understanding of the Zambian response. This would enable NAC to better coordinate and mobilise funds effectively.
- Routine financial data collection would require the necessary capacity development within the various agencies.
- There may be need for greater development partner harmonisation, alignment and transparency.
- In order to measure and improve the effectiveness of HIV funding, there is need to the linking of financial input data with outputs so as to ascertain areas of inefficiencies.

The National AIDS Council of Zambia and UNAIDS wish to thank all the respondents for sharing their data, the local researchers for collecting the data, and the Centre for Economic Governance and AIDS in Africa for ensuring quality of the data collection, analysis and presentation.

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APPENDICES:

Appendix A: Detailed Tables of the Zambian HIV/AIDS Spending

Zambian HIV Sources and Agents (2010-2012, ZMK, US$)

2010 (ZMK)	Public FA	Private FA	External FA	Totals (ZMW)	% Share
Public Source	43 297 216	437 565	0	43 734 781	4%
Private Source	1 000	12 320 793	2 500	12 324 293	1%
External	33 762 086	157 774 314	989 066 770	1 180 603 170	95%
Totals (ZMW)	77 060 302	170 532 672	989 069 270	1 236 662 244	100%
2010 (US$ mill)	Public FA	Private FA	External FA	Total (US$)	% Share
Public Source	8 995 889	90 913	0	9 086 803	4%
Private Source	208	2 559 899	519	2 560 626	1%
External	7 014 770	32 780 867	205 499 017	245 294 654	95%
Totals (US$)	16 010 867	35 431 679	205 499 537	256 942 083	100%
2011 (ZMW)	Public FA	Private FA	External FA	Totals (ZMW)	% Share
Public Source	83 063 302	251 321	0	83 314 623	6%
Private Source	0	17 719 357	0	17 719 357	1%
External	25 938 235	90 147 240	1 091 717 211	1 207 802 686	92%
Totals (ZMW)	109 001 537	108 117 918	1 091 717 211	1 308 836 666	100%
2011 (US$)	Public FA	Private FA	External FA	Total (US$)	% Share
Public Source	17 059 623	51 617	0	17 111 239	6%
Private Source	0	3 639 219	0	3 639 219	1%
External	5 327 220	18 514 529	224 217 953	248 059 701	92%
Totals (US$)	22 386 843	22 205 364	224 217 953	268 810 159	100%
2012 (ZMW)	Public FA	Private FA	External FA	Totals (ZMW)	% Share
Public Source	81 528 777	472 921	0	82 001 698	6%
Private Source	22 020	15 955 517	0	15 977 537	1%
External	20 734 338	91 561 893	1 252 271 027	1 364 567 258	93%
Totals (ZMW)	102 285 135	107 990 331	1 252 271 027	1 462 546 493	100%
2012 (US)	Public FA	Private FA	External FA	Total (US$)	% Share
Public Source	15 751 309	91 368	0	15 842 677	6%
Private Source	4 254	3 082 596	0	3 086 850	1%
External	4 005 861	17 689 701	241 937 988	263 633 551	93%
Totals (US$)	19 761 425	20 863 665	241 937 988	282 563 078	100%
NB. Private sources are not representative since they were not systematically sampled.					

Zambian HIV Sources by Activities (2010-2012, ZMK)

Activities (ZMW, 2010)	Public funds	Private Funds	External funds	Totals (ZKw'000s	% Share
Prevention	4 236 733	4 025 906	280 212 229	288 474 868	23.3%
Treatment	38 508 932	5 946 489	490 243 634	534 699 055	43.2%
OVC support	96 000	899 404	55 612 061	56 607 465	4.6%
Nat.Sys.Strngth & Pgm.Coord	448 925	1 360 092	320 051 472	321 860 489	26.0%
HR Devmt Training / CB	13 128	-	20 449 211	20 462 339	1.7%
Social protection & social services (excluding OVC)	-	92 401	2 494 530	2 586 931	0.2%
Enabling environment	431 065	-	3 867 369	4 298 434	0.3%
Research	-	-	7 686 834	7 686 834	0.62%
Totals	**43 734 783**	**12 324 292**	**1 180 617 340**	**1 236 676 415**	**100.0%**

Activities (ZMW, 2011)	Public funds	Private Funds	External funds	Totals (ZKw'000s	% Share
Prevention	34 758 371	5 185 531	179 946 249	219 890 151	16.8%
Treatment	48 100 462	11 376 628	439 629 396	499 106 486	38.2%
OVC support	14 000	185 296	49 540 540	49 739 836	3.8%
Nat.Sys.Strngth & Pgm.Coord	411 200	970 675	431 924 117	433 305 992	33.1%
HR Devmt Training / CB	21 591	1 227	27 663 743	27 686 561	2.1%
Social protection & social services (excluding OVC)	-	-	7 740 589	7 740 589	0.6%
Enabling environment	9 000	-	56 812 305	56 821 305	4.3%
Research	-	-	13 235 600	13 235 600	1.01%
Totals	**83 314 624**	**17 719 357**	**1 206 492 539**	**1 307 526 520**	**100.0%**

Activities (ZMW, 2012)	Public funds	Private Funds	External funds	Totals (ZMW)	% Share
Prevention	17 742 013	5 428 780	221 016 279	244 187 072	16.7%
Treatment	63 589 958	8 843 062	459 551 871	531 984 891	36.4%
OVC support	96 000	189 985	44 470 446	44 756 431	3.1%
Nat.Sys.Strngth & Pgm.Coord	480 182	1 226 486	513 847 410	515 554 078	35.3%
HR Devmt Training / CB	88 545	1 227	33 068 187	33 157 959	2.3%
Social protection & social services (excluding OVC)	-	-	13 204 488	13 204 488	0.9%
Enabling environment	-	-	63 695 882	63 695 882	4.4%
Research	-	288 000	15 443 785	15 731 785	1.08%
Totals	**81 996 698**	**15 977 540**	**1 364 298 348**	**1 462 272 586**	**100.0%**

Zambian Providers of HIV Services by their Agent (ZMW, 2012)

ZMW, 2010	Public Providers	NGOs, CBOs, NP Providers (incl.PEPFAR IPs)	External Providers
Central public agent	68 232 301	15 000	0
Regional public agent	728 520	0	0
Other public agent	8 042 533	41 948	0
Households contributions (OOPE)	0	2 198 670	0
Not For Profit agent	9 500	157 320 124	0
Total other private agents	0	11 018 543	0
Bilateral agents	23 125	906 590 875	3 872 603
Multilateral agents	1 187 244	835 963	3 044 534
International Foundation agents	0	73 514 926	0
Total (US$)	**78 223 223,00**	**1 151 536 049,00**	**6 917 137,00**

ZMW, 2011	Public Providers	NGOs, CBOs, NP Providers (incl.PEPFAR IPs)	External Providers
Central public agent	96 404 638	25 245	0
Regional public agent	669 403	0	0
Other public agent	11 880 441	21 810	0
Households contributions (OOPE)	0	1 351 592	0
Not For Profit agent	67 843	88 012 797	0
Total other private agents	8 200	17 367 336	0
Bilateral agents	572	1 018 194 873	6 065 080
Multilateral agents	422 806	231 753	1 980 350
International Foundation agents	0	64 821 777	0
Total (US$)	**109 453 903,00**	**1 190 027 183,00**	**8 045 430,00**

ZMW, 2012	Public Providers	NGOs, CBOs, NP Providers (incl.PEPFAR IPs)	External Providers
Central public agent	81 551 584	18 500	0
Regional public agent	608 735	8 500	0
Other public agent	19 768 558	329 258	0
Households contributions (OOPE)	14 650	3 344 119	0
Not For Profit agent	131 000	88 451 615	0
Total other private agents	0	15 775 035	0
Bilateral agents	3 460 500	1 228 638 565	4 505 696
Multilateral agents	243 647	316 472	1 482 393
International Foundation agents	0	13 623 754	0
Total (US$)	**105 778 674,00**	**1 350 505 818,00**	**5 988 089,00**

Zambian HIV Activities by Beneficiary groups (2010-2012, ZMK)

	Beneficiary group					
Activities (ZMW, 2010)	**PLHIV**	**OVC & Vuln.Pops**	**Access. Pops.**	**General Pop.**	**Non-Targeted**	**Total**
Prevention	4 257 444	67 772 469	9 201 655	207 243 300	-	288 474 868
Treatment & Care	527 879 060	628 352	5 214 654	976 989	-	534 699 055
OVC Support	-	55 977 004	630 461	-	-	56 607 465
Programme Mgmt	240 000	-	12 172 195	-	309 448 294	321 860 489
Human Resource Development	2 257 373	175 432	18 011 739	17 795	-	20 462 339
Social protection	1 371 396	1 215 535	-	-	-	2 586 931
Enabling Environmt	853 927	-	7 999	3 384 128	52 380	4 298 434
Research	379 314	-	-	96 242	7 211 278	7 686 834
Total (ZMW)	**537 238 514**	**125 768 792**	**45 238 703**	**211 718 454**	**316 711 952**	**1 236 676 415**
% of Total	43.4%	10.2%	3.7%	17.1%	25.6%	

Activities (ZMW, 2011)	**PLHIV**	**OVC & Vuln.Pops**	**Access. Pops.**	**General Pop.**	**Non-Targeted**	**Total**
Prevention	10 720 947	24 615 730	6 528 246	178 025 228	-	219 890 151
Treatment & Care	388 800 939	269 494	10 432 642	99 603 411	-	499 106 486
OVC Support	-	48 588 314	1 151 522	-	-	49 739 836
Programme Mgmt	284 307	-	3 212 798	-	429 808 887	433 305 992
Human Resource Development	25 669	-	22 665 108	13 297	4 982 487	27 686 561
Social protection	7 740 589	-	-	-	-	7 740 589
Enabling Environmt	12 293 463	-	8 509	4 047 251	40 472 082	56 821 305
Research	-	168 420	3 619	-	13 063 561	13 235 600
Totals (ZMW)	**419 865 914**	**73 641 958**	**44 002 444**	**281 689 187**	**488 327 017**	**1 307 526 520**
% of Total	32.1%	5.6%	3.4%	21.5%	37.3%	

Activities (ZMW, 2012)	**PLHIV**	**OVC & Vuln.Pops**	**Access. Pops.**	**General Pop.**	**Non-Targeted**	**Total**
Prevention	16 509 108	37 878 677	7 037 441	182 761 846	-	244 187 072
Treatment & Care	400 693 985	1 109 985	10 724 912	119 456 009	-	531 984 891
OVC Support	-	42 667 341	2 089 090	-	-	44 756 431
Programme Mgmt	52 841 080	-	3 160 577	599 412	458 953 009	515 554 078
Human Resource Development	-	-	3 504 376	53 627	29 599 956	33 157 959
Social protection	13 204 488	-	-	-	-	13 204 488
Enabling Environmt	3 006 895	-	27 396	11 800 912	48 856 479	63 695 882
Research	-	-	-	-	15 731 785	15 731 785
Total (ZMW)	**486 255 556**	**81 656 003**	**26 543 792**	**314 671 806**	**553 141 229**	**1 462 272 586**
% of Total	33.3%	5.6%	1.8%	21.5%	37.8%	

Zambian HV Beneficiaries by Type of Provider (2010-2012, ZMK)

Zambian Providers by Beneficiary groups 2010							
Providers	**PLHIV**	**Key Pops.**	**OVCs & Vuln.Pops**	**Accessible pops.**	**General Pop.**	**Non-Targeted**	**Totals (US$)**
Public	39 160 816	0	3 481 102	1 524 250	4 895 656	29 161 403	78 223 227
Private	496 344 490	0	122 114 325	42 773 117	206 014 368	284 289 750	1 151 536 050
External	1 733 208	0	173 365	941 336	808 430	3 260 799	3 044 535
Totals	**537 238 514**	**0**	**125 768 792**	**45 238 703**	**211 718 454**	**316 711 952**	**1 236 676 415**
% Share	43,4%	0,0%	10,2%	3,7%	17,1%	25,6%	100,0%
Zambian Providers by Beneficiary groups 2011							
Providers	**PLWHA**	**Key Pops.**	**OVCs & Vuln.Pops**	**Accessible pops.**	**General Pop.**	**Non-Targeted**	**Totals (US$)**
Public	48 676 675	0	5 823 429	1 646 617	32 538 286	20 768 897	109 453 904
Private	369 821 077	0	67 748 479	42 335 865	249 150 901	460 970 863	1 190 027 185
External	1 368 162	0	70 050	19 962	0	6 587 257	1 980 349
Totals	**419 865 914**	**0**	**73 641 958**	**44 002 444**	**281 689 187**	**488 327 017**	**1 307 526 520**
% Share	32,1%	0,0%	5,6%	3,4%	21,5%	37,3%	100,0%
Zambian Providers by Beneficiary groups 2012							
Providers	**PLWHA**	**Key Pops.**	**OVCs & Vuln.Pops**	**Accessible pops.**	**General Pop.**	**Non-Targeted**	**Totals (US$)**
Public	64 010 686	0	15 336 012	2 117 990	1 316 024	22 997 963	105 778 675
Private	421 327 588	0	66 286 028	24 212 806	313 278 143	525 397 057	1 350 501 622
External	917 282	0	33 963	212 996	77 639	4 746 209	1 482 393
Totals	**486 255 556**	**0**	**81 656 003**	**26 543 792**	**314 671 806**	**553 141 229**	**1 462 272 586**
% Share	33,3%	0,0%	5,6%	1,8%	21,5%	37,8%	100,0%

Appendix B: Cross-walking the NASA Spending categories to the Investment Approach

2. Critical Enablers	Other NASA expenditure not included in the Investment Framework
ASC.01.02 Community mobilization	ASC.01.07.98/99 Prevention of HIV transmission aimed at PLHIV not disaggregated by type and n.e.c.
ASC.01.03 Voluntary counselling and testing (VCT)	ASC.01.11 Prevention programmes in the workplace
ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations	ASC.01.15 Microbicides
ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible populations	ASC.01.20 Safe medical injections
ASC.01.07.03 STI prevention and treatment as part of prevention of HIV transmission aimed at PLHIV	ASC.01.21 Universal precautions
ASC.01.11.01 VCT as part of programmes in the workplace	ASC.01.22 Post-exposure prophylaxis (PEP)
ASC.01.11.03 STI prevention and treatment as part of programmes in the workplace	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds
ASC.02.01.04 Nutritional support associated to ARV therapy	ASC.04.05 Serological-surveillance (serosurveillance)
ASC.02.01.07 Psychological treatment and support services	ASC.04.06 HIV drug-resistance surveillance
ASC.02.01.08 Outpatient palliative care	ASC.04.07 Drug supply systems
ASC.02.01.09 Home-based care (medical and non medical)	ASC.04.08 Information technology
ASC.02.01.10 Traditional medicine and informal care and treatment services	ASC.04.10 Upgrading and construction of infrastructure
ASC.02.01.98/99 Outpatient care services not disaggregated by intervention	ASC.04.09 Patient tracking
ASC.04.01 Planning, coordination and programme management	ASC.05.02 Formative education to build-up an HIV workforce
ASC.04.03 Monitoring and evaluation	ASC.05.03 Training
ASC.04.04 Operations research	
ASC.07.01 Advocacy	
ASC.07.99 Enabling environment n.e.c.	
ASC.08 HIV and AIDS-related research (excluding operations research)	
3. Synergies with development sectors	
ASC.06.02 Social protection through in-kind benefits	
ASC.06.03 Social protection through provision of social services	
ASC.06.04 HIV-specific income generation projects	
ASC.06.98 Social protection services and social services not disaggregated by type	
ASC.06.99 Social protection services and social services n.e.c.	
ASC.07.04 AIDS-specific programmes focused on women	
ASC.07.05 Programmes to reduce Gender Based Violence	

Appendix C: NASA Data Collection Tools

AREAS OF OPERATION: REGION/S	

HIV/AIDS SPENDING ASSESSMENT IN EHTIOPIA (NASA)
FORM 1 FOR ALL SOURCES OF FUNDING FOR HIV/AIDS
(External Partners/ Donors / Businesses / Insurance Companies /MOFED))

Year of the expenditure estimate: 2010-2012 **(NB. Please report years separately)**			
Objectives of the form: I. To identify the origin of the funds used or managed by your institution during the year under study. II. To identify the recipients of those funds.			
Name of your Institution (Source of HIV/AIDS funds):			
1. Your organization's Financial Year: (if not calendar year, please provide 6mthly, or quarterly expenditure reports)			
2. Person to Contact (Name and Title):			
3. Address:		**4. E-mail:**	
5. Phone:		**6. Fax:**	
	Type of Institution	**X**	**NASA Code**
Type of institution: Select category of institution with an "X" and put correct NASA code	6.1 Central (national) government		**FS 01.01.01**
	6.2 Provincial government office		**FS 01.01.02**
	6.3 District government office (local government or district)		**FS 01.01.03**
	6.4 Private-for-profit national (SA) / business / insurance scheme		**FS 02.01**
	6.5 Private-for-profit international		**FS 03.04**
	6.6 National / local CSO or CBO and FBO or non-FBO		**FS 02.03**
	6.7 International Foundation or NGO (e.g. Action Aid, Save the Children)		**FS 03.03.____**
	6.8 Bilateral Agency		**FS 03.01.____**
	6.9 Multilateral Agency		**FS 03.02.____**

IF YOU/ THE SOURCE ALSO KNOWS THE DETAILED EXPENDITURES OF YOUR/ THEIR RECIPIENTS THEN ALSO Complete a Providers form (Form # 3) for each institution about what the funds were used for, in order to gain information on Functions, Beneficiary Populations and Production Factors. (NB. One Form 3 per provider/ recipient of funds).

Who completed this form? _____

Date: _____

Time of starting interview: _____ Time of ending interview: _____

GENERAL QUESTIONS RELATING TO 2010-2012

a. Please briefly describe the key types of HIV/AIDS activities that you fund, support or deliver. (**Interviewer required to ask specific activities according to the NASA code book and then code accordingly)**

2010-2012 Recipients

7. A. To whom did your Organization give / send funds for HIV/AIDS services in SA (recipients of your funds) in 2010-2012:

I. List the institutions to which funds were transferred during the year under study.
II. Quantify the transferred funds.
III. Quantify the transferred funds *reported as spent* during the period under study. If no information is available regarding the amount spent, state "No Data" in the cell.

Destination of the funds (Name of the Institution and Person to Contact) **2010-2012**	Funds transferred (indicate currency & amount)	Funds spent
i. Institution: Provinces of Operation: Contact Person:		
ii. Institution: Provinces of Operation: Contact:		
iii. Institution: Provinces of Operation: Contact:		
iv. Institution: Provinces of Operation: Contact:		
v. Institution: Provinces of Operation: Contact:		
TOTAL:		

2010-2012 Recipients cont.

7B. Recipients of non financial resources (donated goods): List the institutions to which your agency donated non-financial resources, during **2010-2012.**

Recipients of the non financial resources (Name of the Institution and Person to Contact) **2010-2012**	Type of Goods donated & Quantity Received	Monetary Value of One Unit in Year of Assmnt (& Currency)	TOTAL Monetary Value in Year Assmnt (& Currency)
vi. Institution: Provinces of Operation: Contact Person:			
vii. Institution: Provinces of Operation: Contact:			
viii. Institution: Provinces of Operation: Contact:			
ix. Institution: Provinces of Operation: Contact:			
x. Institution: Provinces of Operation: Contact:			
TOTAL VALUE:			

If you know how the funds were spent by your recipients in 2010-2012, please complete a Providers form (Form # 3) for each institution to whom you sent funds, in order to gain information on Functions & Beneficiary Populations.

AREAS OF OPERATION: REGIONS	

HIV/AIDS SPENDING ASSESSMENT IN ZAMBIA (NASA)
FORM 2 FOR ALL AGENTS OF FUNDING FOR HIV/AIDS
(Entities which receive funds and transfer them to other service providers.
E.g. CCM, MOH, CDC)

Year of the expenditure estimate: 2010-2012 (NB. Please report years separately)			
Objectives of the form: I. To identify the origin of the funds used or managed by your institution during the year under study. II. To identify the recipients of those funds.			
Name of your Institution (Agent for HIV/AIDS funds):			
1. Your organisation's Financial Year:			
2. Person to Contact (Name and Title):			
3. Address:		**4. E-mail:**	
5. Phone:		**6. Fax:**	
	Type of Institution	**X**	**NASA Code**
Type of institution: Select category of institution with an "X" & give correct NASA code	Central (national) government		
	Provincial government office		
	District government office (local government or district)		
	Private-for-profit national / business / insurance scheme		**FA 02.06**
	Private-for-profit international		**FA 03.04**
	National / local CSO or CBO and FBO or non-FBO		
	International NGO (e.g. Action Aid, Save the Children)		
	Bilateral Agency		
	Multilateral Agency		

If the Agent also provides services itself, then these services and expenditures are captured in Form 3.
Also all the overhead (operational, running) costs of the AGENTS must be captured in form 3 under the identified activities/ services provided by the Agent.

IF THE AGENT KNOWS THE DETAILED EXPENDITURES OF THEIR RECIPIENTS THEN ALSO Complete a Providers form (Form # 3) for each institution about which the Source / Agent has information regarding what the funds were used for (NB. One Form 3 per provider/ recipient of funds).

Who completed this form? _____
Date: _____
Time of starting: _____ Time of ending interview: _____
HIV/AIDS Activities Supported/ Provided

Please briefly describe to me the kinds of HIV/AIDS activities in Zambia that you fund, support or deliver.

NB. The activities that you deliver yourself must be captured separately in Form 3.

(Interviewer required to ask specific activities according to the NASA code book and then code accordingly)

PAGES 3 AND 4 RELATE TO 2010-2012

7. Origin and Destination of the funds transferred to other orgs in 2010-2012: List the institutions from which your agency received funds during the year under study, and the organization to which you transferred those funds.

ORIGIN OF FUNDS (2010-2012 (If more sources than rows provided please use another form, labelled clearly)		**DESTINATION OF FUNDS (2010-2012) (If there were more than 2 Recipients for a Particular Source, please move to next row)**			
Origins of the funds (Name of the Institution and Person to Contact)	Funds received (Indicate currency, ZMW or US$ or Euros)	Organizations to Whom these Funds were Sent	Amount transferred (Indicate Currency)	Organizations to Whom these Funds were Sent	Amount transferred (Indicate Currency)
i. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
ii. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
iii. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
iv. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
v. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
TOTAL:					

2010-2012 Non-Financial Goods

7b. Origins and Destinations of non-financial resources (donated goods) in 2010-2012: List the institutions from which your agency received non-financial resources, during .

Origins of the non-financial resources (Name of the Institution and Person to Contact)	Type of Resource provided & Quantity	Total Monetary Value of Items Provided (& Currency)	**Destination of the Non-Financial Goods** (Name of the Institution and Person to Contact)	
vi. Institution: Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
vii. Institution: Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
viii. Institution: Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
ix. Institution: Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
x. Institution: Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
TOTAL:				

If you know how the funds were spent by your recipients, please complete a Providers form (Form # 3) for each institution to which you sent funds, in order to gain information on Functions, Beneficiary Populations.

AREAS OF OPERATION: REGION/S	

HIV/AIDS SPENDING ASSESSMENT IN ZAMBIA (NASA)
FORM 3 FOR ALL PROVIDERS OF HIV/AIDS SERVICES
(Public, NPO, Private for Profit Agents which also deliver services)

Year of the expenditure estimate: 2010-2012 **(NB. Please report years separately)**			
Objectives of data collection from the Provider: III. To identify the origin of the funds spent by the provider in the year understudy. IV. To identify in which NASA Functions/ activities the funds were spent. V. To identify the NASA Beneficiary Populations for each NASA Function/ activity. VI. To identify the NASA Production Factors for each Function/ activity.			
Name of the Organization Providing HIV/AIDS Services:			
8. Person to Contact (Name and Title):			
Address:	**E-mail:**		
Phone:	**Fax:** **NASA code**		
9. Type of institution: Select category of institution with an "X" & put NASA code	1. Public central (national) government		
	2. Public provincial government		
	3. Public local government (or district)		
	4. NAC		**PS 01.01.14.01 or PS 01.99**
	5. Private-for-profit national (business)		**FS 02.01**
	6. Private-for-profit international businesses		**FS 03.04**
	7. Local (Zambian) CSO or CBO and FBO or non-FBO		
	8. Non-profit research inst (Zambian)		
	9. For-Profit Research inst.		
	10. International NGO/CSO (e.g. ActionAid, Save the Children)		
	11. Bilateral Agency		
	12. Multilateral Agency		
	13. Other (specify):		
In which Currency will you present your Expenditure data?			

Please could all Service Providers ALSO provide electronic or hard copies of their monthly expenditure records for 2010-2012, – presented by source/ funder and by programme / activity.

Who completed this form? _____

Date: _____
Time of starting: _____ Time of ending interview: _____

a. Please briefly identify the key HIV/AIDS activities / services that your organization undertakes / provides.
(Interviewer required to ask specific activities according to the NASA code book and then code accordingly)

2010-2012 Income

10. A. Origin/ Source of the funds your organization received in 2010-2012: List the institutions that gave your organisation funds which you spent during 2010-2012. For each source indicate who was the agent – who decided on what the funds are to be spent.	
Source and Agent of the funds (Name of the Institution and Person to Contact)	Funds received during the year under study (Indicate currency for each amount)
xi. Source: Agent: (Ask who makes decisions on the use of funds for this source & code accordingly)	
ii. Source: Agent:	
ii. Source: Agent:	
v. Source: Agent:	
TOTAL:	

3B. Origin of non-financial resources (donated goods) in 2010-2012: List the institutions that granted *non-financial* resources during 2010-2012.			
Origin of the non-financial resources (Name of the Institution and Person to Contact)	Type of Resource received & Quantity	Monetary Value of ONE Item (in Year of Assessment)	Total Monetary Value of Items Received (& Currency)
xv. Institution:			
xvi. Institution:			
xvii. Institution:			
xviii. Institution:			
TOTAL:			

2010-2012 Expenditure

11. Use of the funds your organization received for services delivered in 2010-2012: IV. Identify and quantify the NASA Functions in which the funds were spent. V. Identify and quantify the NASA Beneficiary Population(s) of each Function. VI. Disaggregate the beneficiaries by Gender and Adult/Child, if possible VII. Please include your overheads & management/support costs (shared or total)		
Expenditure of the funds received from "i" = Source & Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	No's Of Beefs:	
Beneficiary Population:	No's Of Beefs:	
Function (Activity) 2 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 3 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 4 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Overheads/ admin /support costs (if not already included in the above)		
Total Expenditure from the amount from 'i'		

Total un/overspent from the amount from 'i'	

If funds were under- or over-spent from 'i' what are the reasons for this?

2010-2012 Expenditure cont.

Expenditure of the funds received from "ii" = Source & Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 2 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 3 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 4 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Overheads/ admin /support costs (if not already included in the above)		
Total Expenditure from the amount from 'ii'		

Total un/overspent from the amount from 'ii'	

If funds were under- or over-spent from 'ii' what are the reasons for this?

For the other sources (iii etc.), please complete additional expenditure sheets and staple to this form.

(2010-2012) Use of Non-Financial Goods
NON-FINANCIAL (DONATED) GOODS – INDICATE HOW THESE WERE USED in 2010-2012

Utilization of the donated goods received from "vi" = Source/ Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Function (Activity) 2 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Utilization of the donated goods received from "vii" = Source/ Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Function (Activity) 2 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Utilization of the donated goods received from "viii" = Source/ Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	
Function (Activity) 2 (describe & code later):		Amount spent (ZMW)
District of implementation:	Total spent on this Activity/ Function:	

Appendix D: NASA AIDS Spending Categories—Codes and Definitions

ASC.01 PREVENTION

Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Results include a decrease in HIV infections among the population and improvements in quality and safety in health facilities with regard to therapies administered exclusively or in large part to HIV patients. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals.

ASC.01.01 Communication for social and behaviour change: Programmes that focus on social change and social determinants of individual change. A campaign for social and behaviour change provides general information addressing regions, states or countries. This entry includes, but is not limited to, brochures, pamphlets, handbooks, posters, newspaper or magazine articles, comic books, TV or radio shows or spots, songs, dramas or interactive theatre. This category excludes condom social marketing as a result of an activity coded under *ASC.01.12 Condom social marketing* and any other information services which are part of any of the spending categories described as prevention programmes (mother-to-child transmission prevention programme, to reduce stigmatization or to promote access to voluntary counselling and testing), and any other communication for social and behaviour change recorded in prevention programmes: *ASC.01.04 Risk-reduction for vulnerable and accessible populations, ASC.01.05 Prevention – youth in school, ASC.01.06 Prevention – youth out-of-school, ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV), ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs), ASC.01.11 Prevention programmes in the workplace, ASC.01.12 Condom social marketing, ASC.01.16 Prevention, diagnosis, and treatment of sexually transmitted infections (STI) and ASC.01.21 Male circumcision*.

ASC.07.01 Advocacy constitutes the locus for reporting non-health communication for social behaviour change programmes. When joint programmes comprise *health risks avoidance* messages and *non-health risks avoidance* messages which can be separated, additional digits may be introduced (with indication of the pro-rating methodology adopted):

> **ASC.01.01.01 Health-related communication for social and behaviour change:** Programmes targeting the health risks of HIV prevention campaigns (e.g. ABC addressing general population[16]); campaigns with an explicit prevention purpose.

[16] ***ABC*** is a set of prevention strategies and activities (including training) to promote abstinence, to delay sexual debut, and to promote fidelity and partner-reduction messages and related social and community norms. "ABC" activities include: (A) abstain from penetrative sexual intercourse (also used to indicate delay of sexual debut); (B) be faithful (reduce the number of partners or have sexual relations with only one partner); and (C) use condoms consistently and correctly. The (A) and (B) Components targeting the general population should be coded under *ASC.01.01 Communication for social and behaviour change*. The (C) component targeting general population should be coded under *ASC.01.12 Condom social marketing*. "ABC" activities targeting specific accessible or most-at-risk populations should be coded under the corresponding ASC's (e.g. *ASC.01.04 Risk-reduction for vulnerable and accessible populations, ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV), ASC.01.08*

ASC.01.01.02 Non-health-related communication for social and behaviour change: Programmes targeting the non-health risks**;** addressed in HIV prevention campaigns and any other mass media-related activities whose contents are not within the boundaries of health (as described in NHA), and whose content is not recorded under ASC.07.

ASC.01.01.98 Communication for social and behaviour change not broken down by type: Campaigns for which it is not possible to break down its contents as health or non-health.

ASC.01.02 Community mobilization: Activities that create community commitment and involvement in achieving programme goals. This includes, but is not limited to: involvement of community groups (e.g. neighbours of PLHIV or OVC) in programme planning and mobilization of community resources, peer education, including training of peer educators on prevention, support groups, and self-representation. These activities are aimed at behaviour change and risk reduction but are focused mainly on small communities` members rather than on the broader population. These activities are usually performed by the community members to target their own community.

ASC.01.03 Voluntary counselling and testing (VCT) (excluding VCT services targeted in: *ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations, 01.08.01 VCT as part of programmes for sex workers and their clients, ASC.01.09 VCT as part of programmes for MSM, ASC.01.10.01 VCT as part of programmes for IDUs and ASC.01.11.01 VCT as part of programmes in the workplace* and *ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes.*). This is the process by which an individual undergoes counselling, enabling them to make an informed choice about being tested for HIV.[17] Client-initiated confidential voluntary counselling and testing includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). All HIV testing must be carried out under the conditions of the three Cs: counselling, confidentiality, and informed consent. The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

Testing to identify people requiring treatment is included in the Treatment and Care section and should be coded as provider-initiated testing.

Counselling and testing in the context of preventing mother-to-child transmission is coded under prevention of mother-to-child transmission (PMTCT).

Tests performed on a mandatory basis as part of the employment policy or visa requirements are not recommended by UNAIDS and should be classified under *ASC. 04.13. Mandatory HIV testing (not VCT)*.

Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs), ASC.ASC.01.11 Prevention programmes in the workplace and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes).*

[17] Voluntary Counselling and Testing (VCT), UNAIDS Technical Update, May 2000.

ASC.01.04 Risk-reduction programmes for vulnerable and accessible populations[18]**:** These populations include specific vulnerable groups such as indigenous groups, recruits, truck drivers, prisoners, and migrants. Special attention should be given to those people in situations of conflict, i.e. refugee situation and internal displacement. It excludes most at risk populations (MARPs) activities covered by categories *ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*.

ASC.01.04.01 VCT as part of programmes for the vulnerable and accessible population includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible population includes all the programme costs related to condom promotion and provision for vulnerable and accessible populations, not only the cost of the fungibles.

ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible population

ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible population: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not broken down by type

ASC.01.04.99 Other programmatic interventions for vulnerable and accessible population not elsewhere classified (n.e.c.).

ASC.01.05 Prevention – youth in school: Programmes that focus on young people enrolled in primary and secondary schools. Prevention programmes in school include a full complement of tools to prevent HIV transmission. These comprise a comprehensive, appropriate, evidence-based and skills-based sex education; youth-friendly health services offering core interventions for the prevention of transmission through unsafe drug injecting practices; and consistent access to male and female condoms. A critical element is the integration into school-based settings of life-skills-education programmes. Skills-based health education and interactive teaching methods have been shown to promote healthy lifestyles and to reduce risky behaviour. The life-skills-based HIV education in schools is a didactic and specific learning process that teaches young people to understand and assess the individual, social, and environmental factors that raise and lower the risk of HIV transmission. (Teacher training—when measurement is required—should be measured in accordance with the latest UNICEF

[18] In the previous drafts of NASA Notebook this category was labelled as "Programmes for vulnerable and special populations".

guidelines.)[7] To track benefits, the accountant may wish to report expenditure on life-skills activities in both primary and secondary schools as a part of the education system spending (either independent or jointly with the health system). This programme should be coded and cross-classified with the specific beneficiary populations receiving the services, principally young people enrolled in primary and secondary schools (aged 6–11 and 12–15).

ASC.01.06 Prevention – youth out of school: Programmes that focus on young people aged between 6 and 15 out of school. The tools of these programmes are comprehensive, appropriate, evidence-based and skills-based sexual education; youth-friendly health services (through drop-in centres or outreach work) offering core interventions for the prevention of the transmission; and consistent access to male and female condoms. The cost of training peer educators for peer outreach working with youth out of school should be included under this category.

ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV): Programmes to reduce risky behaviours by infected people are aimed to decrease the rate of infection in the population. The goal is to empower people living with HIV to avoid acquiring new STIs and prevent the transmission of HIV to others. The programmatic interventions should be coded according to their characteristics as follows:

ASC.01.07.01 Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.01.07.02 Condom social marketing and male and female condom provision as part of prevention of HIV transmission aimed at PLHIV

ASC.01.07.03 STI prevention and treatment as part of prevention of HIV transmission aimed at PLHIV

ASC.01.07.98 Prevention of HIV transmission aimed at PLHIV not broken down by type

ASC.01.07.99 Other prevention of HIV transmission aimed at PLHIV not elsewhere classified (n.e.c.)

ASC.01.08 Prevention programmes for sex workers and their clients: Programmes to promote risk-reduction measures including outreach (including by peers), voluntary and confidential HIV counselling and testing, prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs) and consistent access to male and female condoms. Interpersonal communication (face-to-face) to reach sex workers at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection. This programmatic activity should be coded and cross-classified with the specific population segment receiving the services: *BP.02.02 Sex workers (SW) and their clients*. The programmatic interventions should be coded according to their characteristics as follows:

ASC.01.08.01 VCT as part of programmes for sex workers and their clients includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients

ASC.01.08.03 STI prevention and treatment as part of programmes for sex workers and their clients

ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.01.08.98 Programmatic interventions for sex workers and their clients not broken down by type

ASC.01.08.99 Other programmatic interventions for sex workers and their clients not elsewhere classified (n.e.c.)

ASC.01.09 Programmes for men who have sex with men (MSM). Programmes that focus on men who regularly or occasionally have sex with other men. These programmes include risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs). Interpersonal communication (face-to-face) to reach MSM at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection. This programmatic activity should be coded and cross-classified with the specific beneficiary populations receiving the services: *BP.02.03 Men who have sex with men (MSM)*. The programmatic interventions should be coded according to their characteristics as follows:

ASC.01.09.01 VCT as part of programmes for men who have sex with men (MSM) includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

ASC.01.09.02 Condom social marketing and male and female condom provision as part of programmes for men who have sex with men (MSM)

ASC.01.09.03 STI prevention and treatment as part of programmes for men who have sex with men (MSM)

ASC.01.09.04 Behaviour change communication (BCC) as part of programmes for men who have sex with men (MSM): interventions aimed to promote risk reduction measures, including peer outreach.

ASC.01.09.98 Programmatic interventions for men who have sex with men (MSM) not broken down by type

ASC.01.09.99 Other programmatic interventions for men who have sex with men (MSM) not elsewhere classified (n.e.c.)

ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs): Programmes that focus on reducing harm because of drug use and reducing risk of spread. They include a set of treatment options such as substitution treatment and the implementation of harm-reduction measures (peer outreach, and sterile needle and syringe programmes), voluntary and confidential HIV counselling and testing and prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs). This programmatic activity should be coded and cross-classified with the specific beneficiary populations receiving the services: *BP.02.01 Injecting drug users (IDU) and their sexual partners.* The programmatic interventions should be coded according to their characteristics as follows:

ASC.01.10.01 VCT as part of programmes for injecting drug users (IDUs) includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.

ASC.01.10.02 Condom social marketing and male and female condom provision as part of programmes for injecting drug users (IDUs)

ASC.01.10.03 STI prevention and treatment as part of programmes for injecting drug users (IDUs)

ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for injecting drug users (IDUs): interventions aimed to promote risk reduction measures, including peer outreach.

ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for injecting drug users (IDUs)

ASC.01.10.06 Drug substitution treatment as part of programmes for injecting drug users (IDUs)

ASC.01.10.98 Programmatic interventions for injecting drug users (IDUs) not broken down by type

ASC.01.10.99 Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.)

ASC.01.11 Prevention programmes in the workplace: Programmes that focus on reducing risk factors in the workplace. These provide HIV prevention services for employees and the families of employees including: male and female condom distribution, up-to-date information, education and communication on HIV prevention, peer education, and any other communication for behaviour change activities. The programmatic interventions should be coded according to their characteristics as follows:

ASC.01.11.01 VCT as part of programmes in the workplace includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT). The cost of VCT includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.

ASC.01.11.02 Condom social marketing and male and female condom provision as part of programmes in the workplace

ASC.01.11.03 STI prevention and treatment as part of programmes in the workplace

ASC.01.11.04 Behaviour change communication (BCC) as part of programmes in the workplace: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.01.11.98 Programmatic interventions in the workplace not broken down by type

ASC.01.11.99 Other programmatic interventions in the workplace not elsewhere classified (n.e.c.)

ASC.01.12 Condom social marketing refers to programmes that make condoms more accessible and acceptable. They include public campaigns to promote the purchase and use of condoms and exclude commercials made by corporations and procurement programmes as a public service. Programmatic interventions to promote the use of condoms as part of programmes for vulnerable, accessible, and most-at-risk populations should be coded in their corresponding ASC (i.e.: *ASC.01.04 Risk-reduction for vulnerable and accessible populations, ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV), ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs), ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes)*.

ASC.01.13 Public and commercial sector male condom provision refers to procurement of male condoms regardless of mode of distribution (cost-free, subsidized or commercially priced; accessibility to the general population or to specific groups). This includes the fungibles (condoms) and any other cost incurred in the distribution and provision. Nonetheless, not all the condoms distributed have a HIV prevention component (some people use condoms exclusively for birth control purposes). There are different approaches to estimate the expenditures on HIV-related condom use. One recommended approach is to use nationally available demographic surveys or sexual behaviour surveys to ascertain the fraction of

condoms attributable exclusively to birth control. This fraction or percentage should then be subtracted from the total numbers of condoms estimated for ASC.01.13. Male condoms as part of specific programmes for key populations and populations at higher risk should not be coded in ASC.1.13, but on their corresponding ASC (i.e.: *ASC.01.04 Risk-reduction for vulnerable and accessible populations, ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV), ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs), ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes)*.

ASC.01.14 Public and commercial sector female condom provision refers to procurement of female condoms regardless of the mode of distribution (cost-free, subsidized or commercially priced; accessibility to women). The fraction of female condoms attributable exclusively to birth control should be subtracted from the total numbers of condoms estimated for ASC.01.14 (as described in ASC.01.13). Female condom distribution as part of programmes for vulnerable, accessible, and most-at-risk populations should be coded in their corresponding ASC (i.e.: *ASC.01.04 Risk-reduction for vulnerable and accessible populations, ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV), ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs.) ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes)*.

ASC.01.15 Microbicides refers to procurement of compounds applied inside the vagina or rectum to confer protection against STI. Once these become available, the resource tracking team should identify investment in programmes, making microbicides available proven to be safe and an effective complement to prevent, or at least, reduce new HIV infections.

ASC.01.16 Prevention, diagnosis, and treatment of sexually transmitted infections (STI): Prevention and care services, including diagnosis and treatment, related to STIs. From a HIV perspective, the treatment of STIs is coded as preventive (from a health system's perspective, this treatment is curative). The expenses for improved clinical management of STIs include medical consultations, tests, and treatment for syphilis, gonorrhoea, herpes, candidiasis, and trichomoniasis. This entry should be coded and cross-classified with the specific beneficiary populations receiving these services (e.g. *BP.04.01 People attending STI clinics*). The services comprised under this heading are programmes targeting the general population; services targeting specific population segments should be coded under: *ASC.01.04 Risk-reduction for vulnerable and accessible populations, ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV), ASC.01.08 Prevention programmes for sex workers and their clients, ASC.01.09 Programmes for men who have sex with men (MSM), ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)* or under *ASC.01.11 Prevention programmes in the workplace.*

ASC.01.17 Prevention of mother-to-child transmission (PMTCT) refers to services aimed at avoiding mother-to-child HIV transmission. These include counselling and testing for pregnant women, antiretroviral prophylaxis for HIV-positive pregnant women and neonates, counselling and support for safe infant feeding practices. PMTCT-plus ARV-treatments should be coded

under antiretroviral therapy (treatment after delivery) ASC.02.01.03. When a HIV-positive woman receives antiretroviral therapy before she knows she is pregnant and no change in the antiretroviral prescription occurs, the antiretroviral treatment should be included under *ASC.02.01.03 ARV therapy*. Cultural sensitivity leads some countries to label the service "parent-to-child transmission" to avoid stigmatizing pregnant women and to encourage male involvement in HIV prevention. Prevention of parent-to-child transmission then becomes PTCT. When adequate information is accessible, the position may be split, using another digit, between:

ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes. This category includes activities in which both HIV counselling and testing are accessed by pregnant women who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of this activity includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.

ASC.01.17.02 Antiretroviral prophylaxis for HIV-positive pregnant women and neonates

ASC.01.17.03 Safe infant feeding practices (including substitution of breast milk)

ASC.01.17.04 Delivery practices as part of PMTCT programmes. This includes delivery (both vaginal delivery and elective Caesarean section) and postpartum care as a part of PMTCT programmes.

ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes performed on PMTCT sites and/or antenatal clinics aimed to prevent mother-to-child HIV or STI transmission during pregnancy or breastfeeding. This includes condoms and any other cost incurred in the distribution and provision.

ASC.01.17.98 PMTCT activities not broken down by intervention

ASC.01.17.99 PMTCT activities not elsewhere classified (n.e.c.).

ASC.01.18 Male circumcision refers to the removal of the prepuce or foreskin covering the tip of the penis. It is important to identify an intention to prevent HIV when performing the male circumcision. Male circumcisions are performed in many countries as a usual practice and not related to a particular HIV programmatic intervention. When male circumcisions are part of country-specific programmatic HIV prevention activities, the cost of these interventions should be recorded here. Expenditures related to the promotion of male circumcision as part of an HIV preventive programme, should also be accounted for here.

ASC.01.19 Blood safety: Blood safety (including blood products and donated organs) expenditures and investment in activities supporting a nationally coordinated blood programme to prevent HIV transmission. This category included policies, infrastructure, equipment, and supplies for testing activities and management to ensure a safe supply of blood and blood products.

ASC.01.20 Safe medical injections: Medical transmission/injection safety targets the development of policies, in-service training, advocacy, and other activities to promote (medical) injection safety. They include distribution/supply chain, cost, and appropriate disposal of injection equipment and other related equipment and supplies. Only expenditure targeting the prevention of HIV transmission should be included.

ASC.01.21 Universal precautions (when the main or exclusive purpose to implement them is to limit HIV transmission) refer to the use of gloves, masks, and gowns by health care personnel to avoid HIV infection through contaminated blood. These are standard infection control practices to be used universally in health care settings to minimize the risk of exposure to pathogens, e.g. the use of gloves, barrier clothing, masks, and goggles to prevent exposure to tissue, blood and body fluids, waste-management systems (except disposal of injection equipment, tracked under *ASC.01.20 Safe medical injections*). This activity aims to target health care workers (*BP.04.05 Health care workers*). Universal precautions are shared across the health system and are not AIDS-specific. Expenditures within universal precautions are limited to those specifically aimed to prevent the transmission of HIV in health care facilities. Expenditure on safety procedures in blood banks may not be separable from the other costs incurred by that activity and are reported under *ASC.01.19 Blood safety*.

ASC.01.22 Post-exposure prophylaxis (PEP). This includes interventions and antiretroviral drugs after exposure to risk, which may be developed adding one digit as:

ASC.01.22.01 PEP in health care setting

ASC.01.22.02 PEP after high-risk exposure (violence or rape)

ASC.01.22.03 PEP after unprotected sex

ASC.01.22.98 Post-exposure prophylaxis not broken down by type

ASC.01.22.99 Post-exposure prophylaxis n.e.c.

ASC.01.98 Prevention activities not broken down by intervention includes all preventive programmes, interventions, and activities for which the resource tracking team does not have available information to classify them into a specific two-digit ASC.

ASC.01.99 Prevention activities not elsewhere classified (n.e.c.) includes all other preventive programmes, interventions, and activities which the country considers relevant and are not listed above.

ASC.02 CARE and TREATMENT

Care and treatment refers to all expenditures, purchases, transfers, and investment incurred to provide access to clinic-based, home-based or community-based activities for the treatment and care of HIV-positive adults and children. The treatment and care component includes the following interventions and activities.

ASC.02.01 Outpatient care is any medical care delivered without requiring admission to a hospital. It refers to expenses aimed at optimizing quality of life for HIV-positive people and their families. They refer to the continuum of care by means of antiretroviral therapy, symptom diagnosis and relief; nutritional support; psychological and spiritual support; clinical monitoring, related laboratory services, and management of opportunistic infections (excluding TB treatment, which should be included on TB sub-accounts) and other HIV-related complications; and culturally-appropriate end-of-life care. Outpatient care comprises the following interventions and activities:

ASC.02.01.01 Provider-initiated testing and counselling (PITC) refers to the expenditures related to the delivery of HIV testing for diagnostic purposes. Under certain circumstances, when an individual is seeking medical care, HIV testing may be offered. This may be part of the diagnosis—the patient presents symptoms that may be attributable to HIV or has an illness associated with HIV, such as tuberculosis—or this may be a routine offer to an asymptomatic person. For example, HIV testing may be offered as part of the clinical evaluation of patients with STIs.

The cost of testing includes an initial test, followed by a confirmatory test if reactive. The cost of PITC includes the entire provision process: physician, laboratory, and post-test counselling. PITC excludes the testing under PMTCT coded as *ASC.01.17.01 Pregnant women counselling and testing*. Voluntary counselling and testing is a preventive intervention, and must be coded under *ASC.01.03 Voluntary counselling and testing (VCT)*. Tests performed on a mandatory basis as part of the employment policy or visa requirements are not recommended by UNAIDS and should be classified under *ASC. 04.13. Mandatory HIV testing (not VCT)*.

ASC.02.01.02 Opportunistic infections (OI) outpatient prophylaxis and treatment.

ASC.02.01.02.01 Opportunistic infections (OI) outpatient prophylaxis: includes but is not limited to the cost of isoniazid to prevent TB and cotrimoxazole to protect against pathogens responsible for pneumonia, diarrhoea, and their complications. Children born to women living with HIV receive 18 months of treatment with cotrimoxazole on a prophylactic basis.

ASC.02.01.02.02 Opportunistic infections (OI) outpatient treatment: refers to a package of medications, diagnoses, and care used for treatment of HIV-related diseases provided on an outpatient basis. OI are illnesses caused by various organisms, some of which do not cause usually disease in people with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic illnesses common in people diagnosed with AIDS include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral, and fungal infections. The total cost of outpatient treatment of opportunistic infections is to be reported, not the AIDS treatment cost.

ASC.02.01.02.98 Opportunistic infections (OI) outpatient prophylaxis and treatment not broken down by type

ASC.02.01.03 Antiretroviral therapy. The specific therapy includes a comprehensive group of recommended antiretroviral drugs, including the cost of supply logistics and the entire ART service delivery (including the cost of human resources involved) for either adults or children.[19,20] The number of people being treated is based on country-specific evidence of current coverage. ART includes all modalities of ARV therapy. When an aggressive therapeutic course is received, which is intended to suppress viral replication and to slow the progress of HIV, the therapy is labelled highly active antiretroviral therapy (HAART); the usual combination of three or more different drugs such as two nucleoside reverse transcriptase inhibitors (NRTIs) and a protease inhibitor, two NRTIs and a non-nucleoside reverse transcriptase inhibitor or other combinations characterize this subclass, which has been shown to reduce the presence of the virus to a point where it becomes undetectable in a patient's blood. Where detailed information is collated, it may be broken down into:

ASC.02.01.03.01 Adult antiretroviral therapy

ASC.02.01.03.01.01 First-line ART – adults

ASC.02.01.03.01.02 Second-line ART - adults

ASC.02.01.03.01.03 Adult multidrug ART after second-line treatment failure

ASC.02.01.03.01.98 Adult antiretroviral therapy not broken down by line of treatment

ASC.02.01.03.02 Paediatric antiretroviral therapy

ASC.02.01.03.02.01 First-line ART – paediatric

ASC.02.01.03.02.02 Second-line ART – paediatric

ASC.02.01.03.02.03 Paediatric multidrug ART after second-line treatment failure

ASC.02.01.03.02.98 Paediatric antiretroviral therapy not broken down by line of treatment

ASC.02.01.03.98 Antiretroviral therapy not broken down either by age or by line of treatment.

The term ART (antiretroviral therapy) clearly refers to an antiretroviral combination of at least three drugs. The population of patients with HIV infection may be classified as follows: (a) pre-ART, receiving care and prophylaxis; (b) first-line ART; (c) second-line ART, (d) second-line failure, but still under antiretroviral treatment with a multi-drug regimen called

[19] http://www.who.int/hiv/pub/guidelines/WHO%20Adult%20ART%20Guidelines.pdf
[20] http://www.aids info.nih.gov/

salvage or rescue therapy. Category (a) is coded as *ASC.02.01.08 outpatient palliative care*; (b), (c), and (d) should be coded under *ASC.02.01.03 Antiretroviral category*.

ART should be administered as part of a package of care interventions, including the provision of cotrimoxazole prophylaxis, the management of opportunistic infections and co-morbidities, nutritional support, and palliative care. The cost of human resources involved in the provision of these services should be explicitly recorded under different treatment categories. PMTCT plus ARV-treatment activities should be assigned this code. Among children, other activities should be coded within programmes for orphans and vulnerable children (OVC) affected by HIV. The expenditures associated with this activity should be accounted according to the specific beneficiary populations receiving the services, such as women or children.

ASC.02.01.04 Nutritional support associated with ARV therapy. Nutrition plays an important role in maintaining the health of people living with HIV. Adequate nutrition is essential to maintain a person's immune system, to sustain healthy levels of physical activity, and for quality of life. Adequate nutrition is also necessary for optimal benefits from antiretroviral therapy. Nutrition should become an integral part of countries' response to HIV. The consumption of nutrients and all the logistics involved in the delivery process of nutritional support should be accounted under this category.

ASC.02.01.05 Specific HIV-related laboratory monitoring includes laboratory expenditures for the delivery of CD4 cell count, viral load determination, and testing for drug resistance aimed to monitor the biological response to antiretroviral therapy and to determine the disease progression for a person with HIV-related disease. The CD4 cell count is a measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV. A CD4 cell count is used by health care providers to determine when to begin, interrupt, or halt anti-HIV therapy; when to administer preventive treatment for opportunistic infections; and to measure response to treatment. A normal CD4 cell count is between 500 cells/mm^3 and 1400 cells/mm3 of blood, but an individual's CD4 count can vary. In HIV-positive individuals, a CD4 count at or below 200 cells/mm3 is considered an AIDS-defining condition. The viral load (VL) determines the amount of HIV RNA copies in a blood sample, reported as the number of HIV RNA copies per ml of blood plasma. The VL provides information about the number of cells infected with HIV and is an important indicator of HIV progression and the efficacy of a treatment. The VL can be measured by different techniques, including branched-chain DNA (bDNA) and reverse transcriptase-polymerase chain reaction (RT-PCR) assays. VL tests are usually performed when an individual is diagnosed as HIV-positive and repeated at regular intervals after diagnosis. Resistance testing consists of a laboratory test to determine whether an individual's HIV strain is resistant to any anti-HIV drugs and to guide their clinical treatment. Other tests to monitor patients, e.g. biochemical and haematological tests should also be included as ASC.02.01.05 Specific HIV-related laboratory monitoring.

HIV drug resistance surveillance is aimed at the epidemiological monitoring of the prevalence and circulation of resistant viral strains among HIV-positive specific populations. The authorities are therefore provided with the number or proportion of HIV-

positive people in a given population whose HIV is resistant to particular anti-HIV drugs. The former activity for epidemiological purposes should therefore be coded under *ASC.04.06 HIV drug-resistance surveillance*.

ASC.02.01.06 Dental programmes for people living with HIV refers to odontological and related services performed on people living with HIV.

ASC.02.01.07 Psychological treatment and support service refers to psychological ambulatory services for people living with HIV including the consultation and antidepressant drugs prescribed in the treatment; e.g. if the National AIDS Programme hires the psychologist to be available for provision of psychological support and treatment to any person with HIV it should be recorded under this AIDS spending category. This category excludes all other psychological support services recorded under VCT activities (i.e.: in *ASC.01.03 Voluntary counselling and testing (VCT), ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations, ASC.01.08.01 VCT as part of programmes for sex workers and their clients, ASC.01.09.01 VCT as part of programmes for MSM, ASC.01.10.01 VCT as part of programmes for IDUs*) or *ASC.02.01.08 Palliative care* and *ASC.02.01.03 Antiretroviral therapy*.

ASC.02.01.08 Outpatient palliative care refers to treatment that addresses pain and discomfort associated with HIV. This includes all basic health care and support activities, whether clinic-based, home-based or community-based activities for HIV-positive adults and children and their families aimed at optimizing quality of life for HIV-positive people and their families throughout the continuum of care by means of symptom diagnosis and relief, and culturally-appropriate end-of-life care. Clinic-based, home-based or community-based care and support activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV should be coded under Orphans and Vulnerable Children and the antiretroviral treatment coded under antiretroviral therapy.

ASC.02.01.09 Home-based care is external support for individuals chronically ill with AIDS. This may include but is not limited to the home visits of medical or non-medical staff to assess living conditions, address psychological needs, accompany ill people with HIV to the hospital. These visits might include provision of in-family home-based psychological support to the family members, teaching family members basic information on HIV, first aid, nutrition etc.

> **ASC.02.01.09.01 Home-based medical care:** minor medical care, supplies for medical care mainly including human resources (nurse, social worker or relevant). This category excludes ARV (ASC.02.01.03), nutritional support for ART (ASC.02.01.04), psychological support and treatment (ASC.02.01.07), and Palliative care (ASC.02.01.08).
>
> **ASC.02.01.09.02 Home-based non medical non-health care.**
>
> **ASC.02.01.09.98 Home-based care not broken down by type.**

ASC.02.01.10 Traditional medicine and informal care and treatment services. Traditional medicine refers to health practices, approaches, knowledge, and beliefs

incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose, and prevent HIV or maintain well-being, e.g. traditional Chinese medicine, homeopathy, naturopathy, herbal medicine, and chiropractic methods. Complementary therapies are additional forms of treatment used as an adjunct to standard therapy, while alternative therapies are used instead of standard therapy. These services are usually delivered by alternative and informal providers and specifically include AIDS-related activities.

ASC.02.01.98 Outpatient care services not broken down by intervention includes all outpatient interventions and services for which the resource tracking team does not have available information to classify it into a specific three-digit ASC.

ASC.02.01.99 Other outpatient care services not elsewhere classified (n.e.c.). Includes all other outpatient interventions and activities not recorded above, and considered by the country as a relevant expense.

ASC.02.02 Inpatient care: All in-hospital care activities for HIV-positive adults and children aimed at the treatment of HIV-related disease by means of diagnosis procedures, surgery, intensive care, and overall hospital care. Hospital treatment for opportunistic infections should be coded as ASC.02.02.01. Although antiretroviral treatment is usually provided on an ambulatory basis, it should be coded under ASC.02.01.03, regardless of the setting in which is provided; ambulatory clinic or hospital.

ASC.02.02.01 Inpatient treatment of opportunistic infections (OI): The treatment of opportunistic infections (OI) refers to a package of medications, diagnoses, and care used for treatment of HIV-related diseases. OI are illnesses caused by various organisms, some of which do not usually cause disease in people with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic illnesses common in people diagnosed with AIDS include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral, and fungal infections.

ASC.02.02.02 Inpatient palliative care refers to treatment that addresses pain and discomfort associated with HIV. This includes all inpatient basic health care and support activities aimed at optimizing quality of life for HIV-positive people throughout the continuum of care by means of symptom diagnosis and relief, and culturally-appropriate end-of-life care. Clinic-based inpatient activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV should be coded under Orphans and Vulnerable Children and the antiretroviral treatment coded under antiretroviral therapy.

ASC.02.02.98 Inpatient care services not broken down by intervention includes all inpatient interventions and services for which the resource tracking team does not have available information to classify it into a specific three-digit ASC.

ASC.02.02.99 Inpatient care services not elsewhere classified (n.e.c.). Includes all other inpatient care interventions, and activities not recorded above and considered by the country as a relevant expense.

ASC.02.03 Patient transport and emergency rescue: includes transport by ambulance and all other means of transport used for HIV patients undergoing treatment, and costs incurred by relatives travelling for the purpose of providing company and assistance to these patients.

ASC.02.98 Care and treatment services not broken down by intervention includes all care and treatment programmes, interventions, and services for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.02.99 Care and treatment services not elsewhere classified (n.e.c.). Includes all other care and treatment programmes, interventions, and activities not recorded above and considered by the country as a relevant expense. The resource tracking team will create subheadings to provide a comprehensive picture of all expenditures allocated to the care and treatment of people living with HIV and patients with advanced HIV-related disease and not listed above (e.g. some types of cancers). These services are aimed at people living with HIV and patients with advanced HIV-related disease and should be coded under ASC.02.99.

ASC.03 ORPHANS and VULNERABLE CHILDREN (OVC)

An orphan is defined as a child aged under 18 who has lost one or both parents regardless of financial support (whether national AIDS programme-related or not). In the NASA context, all expenditures to substitute for the parents taking care of their children because they have died from HIV; expenditures incurred in providing social mitigation to all double orphans and half or single orphans need to be included. In this context, vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them.

The resource tracking team should take into consideration that in sub-Saharan Africa the services to all orphans living below the nationally defined poverty line are considered as AIDS-related. Outside sub-Saharan Africa the resource tracking represents the AIDS contribution to general orphan programmes. This category refers to children living below the poverty line who are dual orphans (children who have lost both parents), near orphans (children who will be orphaned in the following year) and half or single orphans (children who have lost one parent).

All services aimed at improving the lives of orphans and other vulnerable children and families affected by HIV should be accounted. The "preventive health services for orphans and vulnerable children", duly identified under *ASC.01 Prevention*, should not be counted twice. Palliative care, including basic health care and support and TB/HIV prevention, management, and treatment, in addition to the related laboratory services and pharmaceuticals, when delivered within programmes for orphans and other vulnerable children affected by HIV, should be coded in this class. Other health care associated with the continuum of HIV illness, including HIV/TB services, when delivered outside a programme for orphans and other vulnerable children affected by HIV, should be coded under the specific care programme. ART

for children should be coded under *ASC.02.01.03.02 Paediatric antiretroviral therapy*. The OVC component includes the following interventions and activities.

ASC.03.01 OVC Education. Primary school and secondary school (school fees, uniforms, books and supplies, special fees/assessments).

ASC.03.02 OVC Basic health-care refers to basic child care services such as immunizations, routine health care, nutritional supplements (e.g. vitamins, proteins etc), sexual and reproductive health services for older children). The expenditures to be included under this code refer to those for any children who in principle should be provided for by the parents; in their absence, social protection programmes pay for their access to basic services. The health services here are not HIV-specific. ART for children should be coded under ASC.02.01.03.02.

ASC.03.03 OVC Family/home support refers to in-kind support such as bednets, clothes and shoes, blankets and bedding, food (not an ART-related nutritional support), and other support. This category excludes all services as part of institutional care, coded under *ASC.03.06 OVC Institutional care*.

ASC.03.04 OVC Community support refers to identification of OVC in the community, outreach for OVC, training and supporting full-time community workers, child care.

ASC.03.05 OVC Social services and administrative costs e.g. birth certificates and other administrative and institutional arrangements necessary for implementing OVC care. Child welfare, a term used to refer to a broad range of social programmes that contribute to the well-being of children should be coded under this category.

ASC.03.06 OVC Institutional care refers to integrated care provided in an institutional setting, including food (not an ART-related nutritional support), health care, education, clothes, shoes, bedding, psychosocial support and economic self-sufficiency, and all other services addressing the needs of orphaned children. These can be categorized as support services, supplementary programmes, or substitute care. Communal foster care is an integrated service provided by children's homes, orphanages, mission and boarding schools, workhouses, borstals, monasteries, and convents. This category excludes all services as part of support to families with OVC, coded under *ASC.03.03 OVC Family/home support*.

ASC.03.98 Services for OVC not broken down by intervention Services addressing the needs of and specifically targeting orphans and vulnerable children, for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.03.99 Services for OVC not elsewhere classified (n.e.c). All other services addressing the needs of and specifically targeting orphans and vulnerable children, not listed above.

ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION

Programme expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and

facility upgrading through purchases of laboratory equipment and telecommunications. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole. It is important to note that when linking programme expenditure to people's access to treatment and prevention, only the share of investment that contributes to a HIV response and required to finance the services provided as part of the response to the HIV scourge be included. The programme management component includes the following interventions and activities:

ASC.04.01 Planning, coordination, and programme management refers to expenditure incurred at the administrative level outside the point of health care delivery, including the dissemination of strategic information, on best practice—programme efficiency and effectiveness, planning/evaluation of prevention, care, and treatment efforts; analysis and quality assurance of demographic and health data related to HIV, and the testing of implementation models even though these may be conducted in a delivery institution. Also included are coordination activities, for instance in support of the "Three Ones" principles: Coordination of a single approved AIDS action framework and support to build/strengthen one National AIDS Coordinating Authority. Also included are expenditures related to the conduct of national AIDS strategic planning and of human resource planning (e.g. district level). The resource tracking for human resources under programme costs is different to the disbursements of human resources as reported for personnel providing prevention and treatment—ASC.01 and ASC.02—because they are offered as part of health care delivery services (e.g. salary of a doctor dedicated to PMTCT, which would be a component of PMTCT and should be accounted as a production factor of the ASC related to PMTCT).

ASC.04.02 Administration and transaction costs associated with managing and disbursing funds. Costs incurred in managing programmes within the national response to HIV, providing routine and ad-hoc administrative supervision and technical assistance to the programme staff, excluding those under *ASC.04.09 Supervision of personnel and patient tracking*. Expenditures aimed at searching for and contracting a financing agent authorized to assume the purchasing function for a given AIDS spending category, are also included under ASC.04.02. This may be a multiple layer process, identified and monitored or external to the financing process proper. This item attempts to trace the costs of this procedure. This category records a sometimes multi-layered process by which the designer or primary designer of a HIV programme decides to entrust the running of a programme to an agent. Overheads related to the management of funds should be recorded here.

ASC.04.03 Monitoring and evaluation: The purpose of M&E is to provide the data required to: 1) guide the planning, coordination, and implementation of the HIV response; 2) assesses the effectiveness of the HIV response; and 3) identify areas for programme improvement. In addition, M&E data are required to ensure accountability to those affected by HIV, in addition to those providing financial resources for the HIV response.[21] M&E therefore includes expenses related to ascertaining the direction and ultimate achievement of measurement of programme progress, the provision of feedback for accountability and quality, and implementation of targeted programmatic evaluation, the implementation and upgrading of information

[21] Organizing Framework for a Functional National HIV Monitoring and Evaluation System, UNAIDS/MERG, April 2008.

management systems (e.g. other monitoring and health management information systems), the evaluation of prevention, care, and treatment efforts. Expenditures on M&E should include the salaries of the staff who implement M&E programmes. Expenditures to conduct National AIDS Spending Assessments (NASA) should be included under this code.

ASC.04.04 Operations research. This refers to investments and expenses incurred in performing applied operations research aimed at improving the management, delivery, and quality of health services. An operations researcher faced with a new problem is expected to determine which techniques are most appropriate given the nature of the system, the goals for improvement, and constraints on time and computing power.

ASC.04.05 Serological surveillance (serosurveillance). This category includes expenditure on registry, processing of information to be used to document the incidence, and specific prevalence of the epidemic in the general population as well as in specific populations. Also included are sentinel studies, mandatory reporting of cases, and epidemiological analysis. Surveillance implies ongoing and systematic collection, analysis, and interpretation of data on a disease or health condition. Collecting blood samples for the purpose of surveillance is called serosurveillance. Built upon a country's existing data collection system, second-generation HIV surveillance systems are designed to be adapted and modified to meet the specific needs of differing epidemics. For example, HIV surveillance in a country with a predominantly heterosexual epidemic will differ radically from surveillance in a country where HIV infection is mostly found among MSM or IDUs. Surveillance for drug resistance is to be recorded under *ASC.04.06 HIV drug-resistance surveillance*. The surveillance programmes aim to improve the quality and diversity of information sources by developing and implementing standard and rigorous study protocols, using appropriate methods and tools.

ASC.04.06 HIV drug-resistance surveillance includes the setting up of sentinel sites, laboratory operations, materials and goods, and the integration and support for the activities of a National HIV-Drug Resistance Committee. HIV drug resistance surveillance is aimed at the epidemiological monitoring of the prevalence and to determine the circulation of resistant viral strains among specific HIV-positive populations. This provides the number or proportion of HIV positive people in a given population whose HIV is resistant to particular anti-HIV drugs. The genotypic antiretroviral resistance test (GART) determines whether a particular strain of HIV has specific genetic mutations associated with drug resistance. The test analyses a sample of the virus from an individual's blood to identify any genetic mutations associated with resistance to specific drugs. The phenotypic assay is different from a genotypic assay; it uses an indirect method, and determines by a direct experiment whether a particular strain of HIV is resistant to anti-HIV drugs.

ASC.04.07 Drug supply systems include the procurement processes, logistics, transportation, and supply of antiretroviral and other essential drugs for the care of people living with HIV. These expenditures aim to increase the capacity of logistics and drug supply systems, including staffing, development of administrative systems, and upgrading of transportation infrastructure. These activities involve support systems for pharmaceuticals, diagnostics, medical equipment, medical commodities, and supplies to provide care and treatment of people living with HIV and related infections. This includes the design, development, and implementation of improved systems for forecasting, procurement, storage, distribution, and

performance monitoring of HIV pharmaceuticals, and of relevant commodities and supplies. This includes actual spending to improve ordering, procurement, shipment, and delivery of the full range of HIV-related pharmaceuticals, diagnostics, and other medical commodities. Antiretroviral drugs purchased and delivered, must be coded under *ASC.02.01.03 Antiretroviral therapy*.

ASC.04.08 Information technology. Implementation and upgrades of information systems, software, and hardware integrated in information networks to manage HIV-related information.

ASC.04.09 Patient tracking. The activities and resources to provide adherence support or treatment preparedness require to be accounted explicitly. Including resources and personnel working in the field on supervision activities or direct tracking of patients ensuring compliance with and preparation of treatment. These activities need to be accounted explicitly for HIV patients and special populations (e.g. IDUs). Salaries for the personnel required to provide treatment and care services are covered to some extent in *ASC.02 Care and Treatment* (e.g. community health workers) and the human resource component in *ASC.05.01 Monetary incentives*.

ASC.04.10 Upgrading and construction of infrastructure deals with investments, purchases, and expenses on the construction, renovation, leasing, procurement (equipment, supplies, furniture, and vehicles), overheads and/or installation for the implementation of HIV programmes. They include capital investments for building infrastructure that provide HIV services. The programme investments include high fixed start-up costs (e.g. buying computers and e-mail connectivity), specifically activities for clinical monitoring and for the purchase of new equipment. Also included are development and strengthening of laboratory facilities to support HIV-related activities including purchase of equipment and commodities, provision of quality assurance, staff training, and other technical assistance.

ASC.04.10.01 Upgrading laboratory infrastructure and new laboratory equipment

ASC.04.10.02 Construction of new health centres includes investment in new facilities to handle the prevention, treatment, and care of people living with HIV.

ASC.04.10.98 Upgrading and construction of infrastructure not broken down by intervention

ASC.04.10.99 Upgrading and construction of infrastructure not elsewhere classified (n.e.c.)

ASC.04.11 Mandatory HIV testing (not VCT). In some countries HIV testing is being performed on a mandatory basis as a part of the employment policy or visa requirements. Although UNAIDS does not recommend mandatory testing as part of prevention or care and treatment strategies, some countries spent significant funds on this intervention.

ASC.04.98 Programme management and administration not broken down by type includes all programme expenditures for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.04.99 Programme management and administration not elsewhere classified (n.e.c) includes all other programme expenditures not listed above.

ASC.05 HUMAN RESOURCE CAPACITY DEVELOPMENT

This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. The HIV workforce is not limited to the health system. Included in this category is the direct payment of wage benefits for health care workers. These expenditures are aimed at ensuring the availability of human resources from what is currently available in the health sector. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories.

For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions—*ASC.01 Prevention* and *ASC.02 Care and treatment*—and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well—ASC.04 (Programme Management).

The incentives for human resources currently covers mainly nurses and doctors; in a broader public health approach, the concept should also apply to monetary incentives to counsellors, clinical officers, compliance supporters, and laboratory staff.

ASC.05.01 Monetary incentives for human resources.

ASC.05.01.01 Monetary incentives for physicians. Wage benefits for doctors incorporated into the total remuneration package as a way of attracting and retaining human resources for health.

ASC.05.01.02 Monetary incentives for nurses. Wage benefits for nurses incorporated into the total remuneration package as a way of attracting and retaining human resources for health

ASC.05.01.03 Monetary incentives for other staff. Wage benefits for laboratory personnel, and other staff associated with delivering HIV-related services. Strengthening the cadres of community health workers is also covered. This should include the costs for health workers, social workers, especially nurse practitioners, clinical officers, and laboratory technicians.

ASC.05.01.98 Monetary incentives for human resources not broken down by staff includes all incentive programmes for human resources expenditures for which the resource tracking team does not have available information to classify it into a specific three-digit ASC.

ASC.05.02 Formative education to build up an AIDS workforce includes the provision of education for additional nurses and physicians who will be required in the future. Activities to strengthen or expand pre-service education, such as curriculum development or faculty training, are also coded under this category.

ASC.05.03 Training. Pre-service training sessions for all the appropriate professionals and para-professionals, both health and non-health. This includes continuing education delivered through various means, organized specifically for this purpose, such as workshops. Support for building specific skill areas should also be included here, for example, strengthening interpersonal communication, improving laboratory skills, and nutritional education for people living with HIV and their families. This category excludes in-service "learning-by-doing" training and mentoring, which is considered a part of the related service e.g. in-service (when a social worker or a nurse shows family members which particular actions should be performed in terms of care inside the family) training for relatives to carry out home-based care for their family members should be counted as part of *ASC.02.01.09 Home-based care*. This category also excludes training for teachers to build their capacity to provide HIV-related information as a part of school programme (tracked under *ASC.01.05 Youth in school*), and training for peer educators on HIV prevention (tracked under *ASC.01.02 Community mobilization*)—to be consistent with the Resource Needs Model.

ASC.05.98 Human resources not broken down by type includes all human resources expenditures for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.05.99 Human resources not elsewhere classified (n.e.c) includes all other human resources expenditures not listed above.

ASC.06 SOCIAL PROTECTION and SOCIAL SERVICES

Social protection usually refers to functions of government or nongovernmental organizations relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by requirements such as sickness, old age, disability, unemployment, social exclusion, etc.. Social protection comprises personal social services and social security. It includes expenditures on services and transfers provided not only to individual people but also to households, in addition to expenditures on services provided on a collective basis.

ASC.06.01 Social protection through monetary benefits refers to conditional or unconditional financial support, such as grants and cash transfers (including child social assistance grants, foster care grants, disability grants, "medical pensions", early retirement and disability benefits for people living with HIV, or family members). Cash transfers and grants aim to reduce poverty by making welfare programs conditional or unconditional upon the receivers' actions. Cash transfers and grants provide money directly to poor families via a "social contract" with the beneficiaries—for example, sending children to school regularly or bringing them to health centres. For extremely poor families, cash provides emergency assistance, while the conditionalities promote longer-term investments in human capital.

ASC.06.02 Social protection through in-kind benefits refers to food security, food parcels (not associated with ART nutritional support), clothing, school fee rebates, books, transport and food vouchers, and other in-kind support for HIV-positive people.

ASC.06.03 Social protection through provision of social services refers to the development of activities aimed at social mitigation for people living with HIV and their families including funeral expenses, burial society fees, day care services, and transportation for patients.

ASC.06.04 HIV-specific income generation relates to projects and efforts to develop public work programmes, skills development, sheltered employment, livelihood, micro-credit, and financing. Small grants for business activities for people living with HIV are also included.

ASC.06.98 Social protection services and social services not broken down by type includes all social protection services and social services expenditures for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.06.99 Social protection services and social services not elsewhere classified (n.e.c.) includes all other direct financial support and social assistance to families affected by HIV that comprises a social protection aspect not included above.

ASC.07 ENABLING ENVIRONMENT

ASC.07.01. Advocacy.[22] Advocacy in the field of HIV includes a full set of services that generate an increased and wider range of support of the key principles and essential actions to promote HIV prevention and reduce stigma and discrimination. It also includes the promotion of the scaling-up of national, regional HIV programmes by national governments with key partners, such as bilateral and multilateral donors, civil society, and the private sector.

Also included are promotion and support of the development of a strong HIV constituency at the regional and country level, among civil society, including: community groups, policy-makers, opinion leaders, leaders of faith-based organizations, women's groups, youth leaders, and people living with HIV to strengthen their capacity to advocate for effective HIV prevention, care, and social support. Spending on all advocacy efforts to enhance the national response to HIV. Expenditures related to strategic communication (e.g. distribution of strategic information) and policy development should be recorded under *ASC.04.01. Planning, management and programme coordination*.

ASC.07.02. Human rights programmes cover all the activities and resources invested for the protection of human rights, legislative aspects of a broad number of areas of social life, such as employment and discrimination, education, liberty, association, movement, expression, privacy, legal counselling and services, efforts to overcome discrimination and improve accessibility to social and health services. Advocacy for human rights should be coded as *ASC.07.01 Advocacy*. Programmes focused on the human rights of women and girls should be coded as *ASC.07.04 AIDS-specific programmes focused on women.*

[22] Previously labelled as ASC.07.01 Advocacy and strategic communication

ASC.07.02.01 Human rights programmes empowering individuals to claim their rights by providing knowledge and understanding of their rights and responsibilities under human rights and/or domestic legal systems, including dissemination of information and materials relating to human rights. This includes general human rights programmes aimed at the general population in generalized and concentrated epidemics. This category includes specific stand-alone programmes that aim to empower and enable members of vulnerable groups to participate meaningfully in decision-making processes. When human rights consultation is a part of Behaviour Change Communication (BCC) for specific most-at-risk or other key and vulnerable populations these expenditures should be included in the respective categories in Prevention.

ASC.07.02.02 Provision of legal services and advice to promote access to prevention, care, and treatment: includes cost of legal consultancy, legal representation of the individuals in court and related expenditures.

ASC.07.02.03 Capacity building in human rights includes but is not limited to the specific activities targeting national human rights institutions, ombudsmen or other independent bodies aimed at strengthening the protection against human rights violations that are HIV-related or increase vulnerability to HIV.

ASC.07.02.98 Human rights programmes not broken down by type.

ASC.07.02.99 Human rights programmes not elsewhere classified (n.e.c.).

ASC.07.03 AIDS-specific institutional development. This refers to investment in capacity building of nongovernmental organizations (including faith-based organizations). It includes strengthening the ability of key local institutions to implement HIV programmes efficiently with diminishing reliance, over time, on external technical assistance. This includes services that improve the financial management, human resource management, quality assurance, strategic planning, and leadership and coordination of partner organizations. Expenditures on the institutional development of nation-wide organizations, e.g. National AIDS Coordinating Authority, are recorded under ASC.04.01. Planning, coordination and programme management.

ASC.07.04 AIDS-specific programmes focused on women. Programmes targeting women and girls, in addition to those explicitly included in the spending categories described above, for instance improved reproductive health activities, assistance, and counselling addressing abused women and programmes to protect the property and inheritance rights of women and girls.

ASC.07.05 Programmes to reduce gender-based violence. Programmes to reduce violence against women. Also known as violence against women (VAW), this is a major public health and human rights problem throughout the world. VAW has implications for HIV transmission and is often ignored. Expenditures for the response to sexual violence include the design of social and health policies, all the services that provide comprehensive, sensitive, and quality care to victims of sexual violence. The expenditures cover several areas: assistance and counselling addressing abused women, promotion, and policy measures that will support the provision of comprehensive and ethical services to people who have experienced sexual violence; activities

of police departments, health services, prosecutors, social welfare agencies, and nongovernmental service providers, such as rape crisis centres. Post-exposure prophylaxis after exposure to risk because of violence or rape should be coded under *ASC.01.22.02 Post-exposure prophylaxis after high-risk exposure.*

ASC.07.98 Enabling environment activities not broken down by type includes environmental and community enablement programmes for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.07.99 Enabling environment activities not elsewhere classified (n.e.c.) includes all other environmental and community enablement programmes not included in the above classes.

ASC.08 HIV-RELATED RESEARCH (excluding operations research)

HIV-related research is defined as the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well-being. It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS. Managers and administrators should be included when they spend at least 10% of their time supporting research activities. Researchers include postgraduate students but do not include technicians. Technicians and equivalent staff are people whose main tasks require technical knowledge and experience. They participate in R&D by performing scientific and technical tasks involving the application of concepts and operational methods, normally under the supervision of researchers. This category excludes operations research on health systems aimed to improve health outcomes, including project or programme evaluation, which should be coded under ASC.04.04.

Research—with the exception of operations research—is not directly linked to the provision of services, and therefore, might be considered to be a satellite component of the expanded response to HIV. Care should be taken to correctly classify research activities properly and not to include other activities frequently confused with research, such as population studies for epidemiological surveillance, or monitoring and evaluation of the programmes. The following activities are included when directly related to HIV and the resource tracking activities within the NASA are considered optional.

ASC.08.01 Biomedical research, which comprises the study of detection, cause, treatment, and rehabilitation of persons with specific diseases or conditions, the design of methods, drugs, and devices to address these health problems, and scientific investigations in areas such as the cellular and molecular bases of disease, genetics, and immunology.

ASC.08.02 Clinical research, which is based on the observation and treatment of patients or volunteers.

ASC.08.03 Epidemiological research, which is concerned with the study and control of diseases and exposures and other situations suspected of being harmful to health: care should be taken to exclude epidemiological surveillance.

ASC.08.04 Social science research, which investigates the broad social aspects of HIV.

ASC.08.04.01 Behavioural research, which is associated with risk factors for ill health and disease with a view to promoting health and preventing disease. Care should be taken to exclude epidemiological surveillance as well as evaluation of preventive interventions.

ASC.08.04.02 Research in economics, which investigates a wide range of economic aspects of HIV and the AIDS epidemic.

ASC.08.04.98 Social science research not broken down by type

ASC.08.04.99 Social science research not elsewhere classified (n.e.c.)

ASC.08.05 Vaccine-related research. Specific activities aimed to support basic, laboratory, clinical, and field-related research for developing and testing a HIV vaccine.

ASC.08.98 HIV-related research activities not broken down by intervention includes HIV-related research programmes for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

ASC.08.99 HIV-related research activities not elsewhere classified (n.e.c.) includes all other HIV-related research programmes not included in the above classes.

Appendix E: Production Factor descriptions (cost components)

Cost Category	Definition
Communication / Messaging / Printing	• All avenues of communication, including printed materials and media campaigns, for all parties (e.g., ART patients, general population, ANCs, etc.)
Condoms	• Funds spend on condoms, excluding delivery or supply chain costs
Conferences / Workshops	• All expenses related to non-training conferences or workshops (e.g., per diems, hotel, refreshments, travel reimbursements, etc.)
Direct Budget Support	• Money given directly to the Ethiopian government to use at its discretion, though within certain parameters is also acceptable (such as specifically for HIV programmes)
Domestic travel expenses	• Funds spent on domestic travel, including vehicles, maintenance, fuel, driver salaries, taxis, airline tickets, domestic hotels, lodging, and per diems
Drugs	• Payments for drugs, including ARV's, cotrim or PEP drugs, pills, and drug-eluting implants
Food Supplies	• Funds spend on acquiring food supplies, nutritional supplements, or water
General Operating Expenses	• General running costs not captured in other categories, such as rent / utilities for a building, but also for administration staff and functions (including salaries)
International travel expenses	• Funds spend on international travel, including flights, hotels, visas, per diems, and vehicles (if applicable)
Lab Equipment and Supplies	• Lab equipment and consumable (pipettes, gloves, re-agents, etc.) purchases

Cost Category	Definition
Medical Equipment - Consumables	• Medical equipment that is one-time use and neither drugs nor lab equipment • E.g., test kits, needles, band-aids, catheters, etc.
Medical Equipment - Reusable or diagnostic equipment	• Medical equipment that is not lab equipment and is reusable for multiple patients, for example monitoring, therapeutic or life support equipment
Non-Office Capital Expenditure / Infrastructure	• Equipment or software that is non-medical, like a computer, printer, or information system, that will likely last longer than 12 months • Infrastructure expenses from buildings or projects • Excludes lab equipment
Procurement and Supply Management	• Transportation costs for all purchases (equipment, commodities, products, medicines) including packaging, shipping, insurance and handling. Warehouse, PSM office facilities, and other logistics requirements. Procurement agent fees. • Do not include staff, TA, PSM Information Technology systems, health products or health equipment costs, as these costs should be included in the categories above.
Program Salaries / Incentives	• Refers to costs for program staff excluding administrative staff (which is counted in General Operating Expenses) and technical assistance

Cost Category	Definition
Research / M&E	• Funds spent on program-related research and M&E expenses, including clinical and survey-based research and all M&E expenses, including salaries
Technical Assistance	• Salaries and other related costs for technical assistance projects for the Government of Ethiopia
Training	• Training programs, including program allowances, fees, food, etc.; also includes pre-employment training • Also includes training workshops and any expenses included
Other	• Any costs not included in the above