LINKING NASA AND NHA: CONCEPTS AND MECHANICS

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Date

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ACRONYMS

HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICHA	International Classification of Health Accounts
MDG	Millennium Development Goals
NASA	National AIDS Spending Assessment
NEC	Not Elsewhere Classified
NGO	Nongovernmental Organization
NHA	National Health Accounts
NSK	Not Specified by Kind
PEPFAR	President's Emergency Plan for AIDS Relief
PG	Producer's Guide
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
SHA	System of Health Accounts
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	Volunteer Counseling and Testing
WHO	World Health Organization

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PREFACE

In recognition of the severity of the HIV/AIDS pandemic, international organizations, policymakers, and donors have made bold declarations and set targets for curbing the spread of HIV/AIDS, mitigating its impact, and extending treatment access. For example, the Millennium Development Goals (MDGs), defined by the international community to serve as a framework for measuring country development progress, aim to halt and reverse the spread of HIV/AIDS by the year 2015. In addition, in 2001, 189 nations adopted *the Declaration of Commitment on HIV*/AIDS at the first-ever United Nations General Assembly Special Session (UNGASS) on HIV/AIDS; this Declaration covers 10 priorities, from prevention to treatment to funding, and was designed as a blueprint to meet the HIV/AIDS MDGs.

The National AIDS Spending Assessment (NASA) is a resource-tracking framework for monitoring the annual flow of funds used to finance the response to HIV/AIDS in a given country. The framework aims to capture HIV/AIDS expenditures that reflect the continuum of services employed in the fight against the epidemic. Drawing from the principles of a number of accounting frameworks as well as the interests of local and international HIV/AIDS stakeholders, NASA aims to serve as an assessment and planning tool helping to inform the gap estimation process and the UNGASS monitoring requirement. The tool is commissioned by the Joint United Nations Programme on HIV/AIDS (UNAIDS) country offices in collaboration with the national AIDS councils.

National Health Accounts (NHA) is a policy tool used to track expenditures on overall health care. It is intended to be conducted on a regular basis as part of a country's health information system. NHA is based on the International Classification of Health Accounts. Use of the framework to focus on a particular priority area is called a "subaccount." HIV/AIDS subaccounts track health expenditures related to HIV/AIDS and are generally conducted by ministries of health in tandem with a general NHA estimation (for overall health). This approach allows HIV expenditures to be placed in the context of overall health care, e.g., to compute the percentage of government health spending on HIV/AIDS. Although focused on health spending, the subaccounts can also report non-health spending as addendum items, and in this way contribute to UNGASS reporting requirements.

While their objectives are not identical, they have overlapping components and so NASA and NHA implementation can occur in a coordinated manner to avoid duplicative and redundant resource-tracking efforts. By doing so, the frameworks can meet the needs of both HIV/AIDS and general health care stakeholders, national and international.

This document, intended for readers with familiarity with the NASA and/or NHA frameworks, describes the frameworks with a focus on how they relate and link through recommended "cross-walks." It also offers suggested approaches for implementing the links – that is to say, how to produce a NASA from a NHA estimation and vice versa.

Given such objectives, it is hoped that these Guidelines will facilitate resource-tracking efforts to allow for the production of locally relevant yet internationally comparable data. This will be instrumental to informing the global and national debates on the status of current efforts and estimated future needs to finance effective HIV/AIDS interventions.

1. INTRODUCTION

1.1 THE NEED FOR ROUTINE HIV/AIDS RESOURCE TRACKING

As a result of successful advocacy efforts that articulated the magnitude of the HIV/AIDS burden and its funding needs, the world has seen a surge in funding for HIV/AIDS programs. While this increase in the level of funding is indeed a welcome development, what is perhaps equally critical is ensuring that the funds are invested in a way that delivers a well-coordinated and improved response to the pandemic. To do this, policymakers require data on the current organization and financing of HIV/AIDS programs as well as on routine expenditure data to determine if funds are being spent as intended and in line with national AIDS strategic plans. By obtaining such data, decision makers can determine the strengths and weaknesses in their countries' response to HIV/AIDS. Specifically, financing data can help monitor use of program funds, identify potential areas for resource mobilization, determine if a financing gap remains, reveal any dependencies on entities to pay for certain HIV programs and so forth. In short, by understanding and monitoring how funds are being spent, policymakers are better equipped to make informed decisions to shape the fight against HIV/AIDS.

> Just as driving requires looking forward with a periodic use of a rearview mirror, economic and social progress requires periodic assessment of current strategies already adopted.

In addition to having an impact at the country level, expenditure data are valuable at the international level to monitor progress achieved towards international declarations and goals, such as the Millennium Development Goals (MDGs), the United Nations General Assembly Special Session (UNGASS) declaration, and other major bilateral program targets including the President's Emergency Plan for AIDS Relief (PEPFAR). The data are critical to informing global discussion and advocacy efforts about the status of current efforts and estimated future needs for HIV/AIDS programs. To facilitate this process, countries are encouraged to pursue regular resource-tracking efforts for HIV/AIDS. Outputs of such efforts can be tabulated using the Joint United Nations Programme on HIV/AIDS (UNAIDS)-sponsored National AIDS Spending Assessment (NASA) framework and the National Health Accounts (NHA) framework. Both frameworks aim to serve the needs of national and international HIV/AIDS and health care stakeholders.

Intended for readers familiar with NASA and/or NHA, this document briefly describes the frameworks, and shows how they are linked and how countries may produce one from the other without replicating data collection efforts – that is to say, how to produce a NASA from a NHA estimation and vice versa.

1.2 OVERVIEW OF NASA

NASA is a resource-tracking framework that seeks to monitor the annual flow of funds used to finance the response to HIV/AIDS in a given country. NASA's classification scheme and framework are presented in two associated UNAIDS documents, namely the *National AIDS Spending Assessment (NASA):*

Classification Taxonomy and Definitions[1] and *Guide to produce National AIDS Spending Assessment (NASA) 2009*.[2]

Given the far-reaching impact of HIV/AIDS on society – affecting not just health but education, economic productivity, social acceptance, and so forth – NASA calls for a multi-sectoral approach to resource tracking. This requires an assessment of expenditures on the full continuum of HIV/AIDS activities that may or may not be health related, including those that occur in education (e.g., school programs on stigma reduction), social development (e.g., empowerment activities), welfare (e.g., income-generating activities), and so forth.

Developed by UNAIDS and drawing from the principles of a number of accounting frameworks as well as the interests of local and international HIV/AIDS stakeholders, NASA aims to serve as an assessment and planning tool. The tool is commissioned by UNAIDS country offices in collaboration with the national AIDS councils.

Current NASA efforts focus principally on the flow of HIV/AIDS funds from government and international sources.[3] NASA organizes HIV/AIDS expenditures into six broad categories:

- *Financing sources*, the originators of HIV/AIDS funds (e.g., Ministry of Finance, rest of the world including donors)
- *Financing agents*, the managers of HIV/AIDS funds (e.g., Ministry of Health, Ministry of Education, nongovernmental organizations [NGOs])
- *Providers*, entities that deliver HIV/AIDS services (e.g., hospitals, health centers, schools, orphanages)
- *Production factors*, or resource costs, inputs used to deliver HIV/AIDS services (e.g., salaries, maintenance, equipment)
- *Spending categories, (*e.g., care, prevention, mitigation, education, human rights)
- *Beneficiaries* or target groups (e.g., men who have sex with men, injecting drug users).

Information on the flow of funds can be organized in a series of two-dimensional NASA tables, including the UNGASS-required funding matrix that shows the flow of funds from *financing sources* to *spending categories.* (See Annex A.)

In short, the NASA framework provides:

- A complete account of all spending, regardless of origin, destination, or object of the expenditure
- A rigorous approach to collecting, cataloguing, and estimating the flows of money related to all HIV and AIDS programmatic areas from prevention and care to social mitigation
- A structure of tracking resources consistently over time to analyze trends, resource mix, and whether or not resources are actually reaching those most in need.

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[1] http://data.unaids.org/pub/BaseDocument/2009/20090227_NASA_Classifications_edition_en.pdf
[2] http://data.unaids.org/pub/BaseDocument/2009/20090406_nasa_notebook_en.pdf
[3] This is due to challenges in obtaining private sector data on a regular basis from all UNAIDS member countries. However, as collection methods are refined and information systems strengthened, it is hoped that such data will be included routinely in NASA estimations.

The underlying principles of the NASA framework are that it be:

- *Exhaustive/ comprehensive,* covering all entities, services, and expenditure categories pertaining to HIV/AIDS
- *Periodic,* the result of a continuous and recurrent recording, integration and analysis, to produce annual estimates
- *Systematic,* the categories and reporting format must be consistent over time and comparable across countries.

Other essential attributes include policy relevance, consistency, comparability, neutrality and standardization. While NASA strives to satisfy the statistical producers' search for "excellence at all costs," emphasis is placed on policy relevance/sensitivity and timeliness. If need be, this should be given priority over the production of precisely accurate estimations. Similarly, more emphasis is given to attributes concerning "comprehensiveness" and "consistency" than to "standardization" and "precise comparability." Finally, NASA aims to link to budgetary processes.

1.3 GOALS FOR NASA

The preference for some attributes over others is perhaps best understood in the context of NASA's policy goals. The framework's principal policy goals are to:

- **Inform the HIV/AIDS resource gap estimation process.** To this end, the NASA algorithm is designed to describe the financial flows and expenditures using the same categories as the globally estimated resource needs.[4] This alignment is recommended to provide local and international stakeholders with needed information on the financial gap between available resources and needed resources.
- **Facilitate country reporting on the financial indicator used to monitor the progress made toward the goals of the *Declaration of Commitment on HIV/AIDS,*[5] adopted at the UNGASS on HIV/AIDS in 2001.** The latest edition of the indicators, financial and otherwise, is entitled *Monitoring the Declaration of Commitment on HIV/AIDS; Guidelines on Construction of Core Indicators–2008 reporting*.[6] Member states are requested to submit their country progress reports on these indicators every two years.
    - The targeted UNAIDS financial indicator is "domestic and international AIDS spending by categories and financing sources." To this end, UNAIDS asks Member States to populate a national funding matrix illustrating the flow of funds from financing sources to AIDS spending categories.

Given the policy importance of these goals and the urgency to achieve them, the NASA framework calls for timely and comprehensive production of estimates, which if need be should be prioritized over other attributes, such as dutiful adherence to accounting standards and precise comparability.

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[4] UNAIDS. August 2005. *Resource needs for an expanded response to AIDS in low- and middle-income countries*. Available at http://data.unaids.org/pub/Report/2005/JC1255_resource_needs_en.pdf

[5] Resolution A/RES/S-26/2

[6] Available at http://www.unaids.org/en/Goals/UNGASS/2008_UNGASS_Reporting_FAQ.asp

In meeting the above-mentioned goals, it is hoped that NASA data will help to address critical policy questions such as:

- Who mobilizes the resources in the current response to the pandemic?
- Which institutions or individuals provide the needed commodities?
- Are the most vulnerable population segments the main beneficiaries?

The goals for NASA were developed against the international backdrop of the HIV/AIDS-related MDGs, which are in large part dependent upon countries' mobilization of adequate resources to fight the pandemic. In addition, NASA goals have been shaped by the context of resource inequities between and within high- and low-income countries – which can be addressed through implementation of better-performing resource allocation mechanisms and increased transparency.

As countries provide more and more detailed information for NASA, the data may be used to:

- Monitor the implementation of a *national strategic plan*
- Monitor advances toward the completion of nationally or internationally adopted goals, such as universal access to treatment or care
- Provide evidence of compliance with the principle of *additionality*, required by a few external donors or international agencies
- Fulfill other information needs as they emerge.

1.4 OVERVIEW OF NHA

Implemented in over 100 middle- and low-income countries, NHA is a policy tool used to track expenditures – their flows and amounts – on overall health care. It is based on the International Classification of Health Accounts (ICHA)[7] and described in the *Guide to producing National Health Accounts, with special application for low-income and middle-income countries,* also called the *Producers' Guide,* or PG.[8] Developed in the early 1990s for developing countries, the NHA tool has been endorsed by numerous multilateral and bilateral organizations including the World Health Organization (WHO), World Bank, U.S. Agency for International Development (USAID), and Swedish International

NHA attempts to offer a comprehensive review of a country's spending on health – including public, private (including out-of-pocket), and donor contributions. NHA is intended to be a routine estimation, institutionalized as part of country health information systems. The NHA framework also has been adapted to track expenditures within several priority area of health, such as HIV/AIDS, malaria, and reproductive health. These estimations are called "subaccounts." They are generally conducted in tandem with a general NHA (that examines overall health) estimation. By doing so, subaccount expenditures can be placed in the context of overall health care, e.g., in the case of HIV/AIDS subaccounts, to compute the percentage of government health spending spent on HIV/AIDS, percentage of total health expenditures spent on HIV/AIDS, and average annual expenditure on health by people living with HIV/AIDS (PLWHA) versus the general population. Also, by maintaining the link to the general NHA estimation process, the HIV/AIDS subaccounts can piggyback on ongoing overall health

[7] Described in *A System of Health Accounts* (OECD 2000), available at http://www.oecd.org/health/sha
[8] World Health Organization, World Bank, and USAID (2003), available at http://www.who.int/nha/create/en

resource-tracking efforts. For example, if a survey is being targeted to donors to ask about their general health expenditures, a module can be added with HIV/AIDS spending questions. Although focused on health spending, the subaccounts can also report non-health spending as addendum items, thus also helping to contribute to UNGASS reporting requirements.

The subaccounts are usually conducted by a country's general NHA team. This team is usually housed in country ministries of health, but can also be found in national bureaus of statistics or independent/academic research institutions. For subaccount purposes, the NHA team would add members with knowledge of HIV/AIDS financing and delivery.

Increasingly, NHA is being institutionalized in many countries and conducted on a routine basis. By "riding" on these data collection efforts, the NHA subaccounts can also be produced regularly to provide meaningful baseline and trend data to assess progress toward national priorities as well as those goals of various global initiatives.

The principal categories of expenditures that are tracked by NHA are the following:

- *Financing sources,* entities that contribute funds to HIV/AIDS health care. This may include the Ministry of Finance, donors, and households.
- *Financing agents,* entities that receive funds from sources and use those funds to directly pay for a HIV/AIDS health service and/ or product. This is an important category as financing agents have the power and control over how funds are used i.e., they have programmatic responsibilities. Examples are the Ministry of Health, national AIDS committees, and insurance schemes.
- *Providers,* entities that deliver the HIV/AIDS health service and/or product to the population/patients. They include hospitals, volunteer community health workers, and clinics.
- *Functions,* HIV/AIDS health services and/or medical goods that are ultimately rendered to the population/patient. They include inpatient curative care, palliative care, and prevention programs.
- *Resource costs,* costs of inputs (resources) used to create health system outputs. They include wages, drugs and pharmaceuticals, and capital expenditures.

Like NASA, NHA presents expenditure information in a series of two-dimensional tables – with one of the above categories listed in the row headings and another in the column headings. Within a NHA table, the funds flow downward, from the "originators" listed in each column to the "recipients" listed in the row headings.

1.5 GOALS FOR NHA HIV/AIDS SUBACCOUNTS

HIV/AIDS subaccounts are first and foremost a policy tool. They provide to both health care and HIV/AIDS stakeholders more specific information on HIV/AIDS spending patterns than do general NHA estimations. Moreover, the subaccounts seek to place HIV/AIDS spending in the context of overall health. Their results can be used in computing the following:

- % of total health expenditures used for HIV/AIDS
- % of government health expenditures used for HIV/AIDS
- % of donor health expenditures used for HIV/AIDS

- % of household health spending used for HIV/AIDS
- Resource use distribution among health providers for overall health expenditures versus HIV/AIDS health expenditures. For example, for overall health service delivery, public providers may use more funds than do the NGO providers that dominate HIV/AIDS service delivery.
- Resource use distribution among health functions for overall health expenditures versus HIV/AIDS health expenditures. For example, the overall health system may spend more on prevention than does the HIV/AIDS sector.

As stated earlier, subaccounts can also track non-health expenditures as addendum items. By doing so, the subaccounts can inform critical policy questions such as:

- What is the total resource envelope (health and non-health) for the fight against HIV/AIDS?
- Where is the money for HIV/AIDS coming from: public, private, and donor sources?
- What is the burden of financing on sero-positive individuals?
- Which entities manage HIV/AIDS resources?
- Which providers receive HIV funds to deliver care?
- How are HIV/AIDS funds being used? For what services? Are they meeting their intended targets?
- Are new donor funds serving as "additional" sources of funds in the fight against HIV/AIDS?[9]

In addressing these questions, the subaccounts can also inform the goals of NASA and help countries monitor their national AIDS strategic plans.

1.6 LINKING OF NASA AND NHA: A COORDINATED APPROACH TO RESOURCE TRACKING

The UNAIDS "Three Ones" principles for the coordination of national HIV/AIDS responses state that, for the most effective and efficient use of country resources, there should be:

- ONE agreed national HIV/AIDS action framework that provides the basis for coordinating the work of all partners
- ONE agreed national AIDS coordinating authority, with a broad-based multisectoral mandate
- ONE agreed country-level monitoring and evaluation system.

Therefore, tracking of HIV/AIDS resources should be linked with ongoing national efforts to track health expenditures.

Thus, it is important to avoid parallel resource-tracking efforts for HIV/AIDS. For example, a country's NHA team members, along with pertinent non-health HIV/AIDS representatives (e.g., from the national AIDS council), should participate in the computation of NASA and NHA. If a NHA estimation is underway, NHA data collection can also capture non-health data so as to inform NASA and required

[9] This question can be addressed when time series data are available.

UNGASS funding matrices. For example, should a donor or NGO survey be conducted for NHA purposes, questions may be added to ask respondents about their non-health HIV/AIDS spending (e.g., income support, legal services for PLWHA, clothing and food contributions to PLWHA). In the final NHA report, this information is included as addendum items following the core analysis on HIV/AIDS health expenditures. Because of the parallel nature of the principal categories of expenditure in both NASA and NHA, the health and non-health data retrieved from a subaccount estimation can be mapped to NASA classifications and tables. These can also be presented in the NHA report as an annex. The same can be said for NASA. If it is able to preserve the health and non-health distinctions, one should be able to produce NHA tables from a NASA estimation. Example of this are presented later on in these guidelines.

The essential message is that countries should embark upon a single coordinated resource-tracking approach for HIV/AIDS with the intent of capturing the expenditures on the continuum of HIV/AIDS services; also, efforts should be made to preserve distinctions wherever possible between the health and non-health expenditures. By doing so, both NASA and NHA estimations can be produced thereby meeting the policy needs of both health care and HIV/AIDS stakeholders (national and international).

2. SCOPE AND BOUNDARIES

This chapter describes the scope and boundaries of HIV/AIDS resource tracking – what is included and what is excluded – and how they relate to NASA and NHA. The discussion is intended to impart an understanding of the links and complementarities of the various approaches and facilitate coordinated and policy-relevant implementation of resource-tracking efforts.

Boundaries demarcate the scope of expenditure estimations – they can help answer questions like "if non-residents incur HIV/AIDS expenses in a country, should their expenditures be included in that country's NASA?" Clearly documented and defined boundaries enable technical teams and other stakeholders to determine what is included in, and excluded from, a country's HIV/AIDS expenditure estimation. This is particularly important for cross-country comparisons. Take the question "are expenditures on condoms an HIV/AIDS expenditure?" In countries where HIV prevalence is low and focus has been on population programs, condom expenditures are likely considered a family planning expenditure. In other countries, where HIV prevalence is high, condoms might be considered primarily a part of HIV prevention. Such a determination has obvious implications when comparing the different types of health expenditure estimates of countries.

2.1 KEY TERMS

Both NASA and NHA frameworks focus on the nature of the expenditure and not the mandate or "job description" of the institution/entity responsible for the transaction. For example, while HIV/AIDS is not the Ministry of Education's principal responsibility, the Ministry may have activities related to HIV/AIDS (e.g., school health prevention programs), and spending on such HIV-related transactions is considered and included.

For determining expenditure boundaries, some key terms related to expenditure are defined as follows:

- **Expenditure** *measures in monetary terms the value of consumption of the goods and services of interest.* Note, while "expenditure" implies a monetary transaction, NASA and NHA include within the term non-monetary transactions, such as donations of commodities[10] or in-kind payments in exchange for provider services (such as at traditional healer providers).
- **HIV/AIDS expenditure** refers to *spending on the continuum of HIV/AIDS-related activities, namely those that are 1) intended primarily to have an impact on the health and social (e.g., economic, legal, and education) wellbeing of PLWHA and 2) intended to prevent the spread of HIV (e.g., condom distribution programs for the general population, with the primary purpose of HIV prevention – not, for example, for family planning).*
    - While both frameworks can produce estimations meeting this definition, NHA distinguishes between health and non-health in its presentation of findings. It focuses on health expenditures

[10] Donations of materials and supplies should be treated to reflect real values, so the amounts should be recorded preferably at historical cost at market prices of the recipient country, net of subsidies minus indirect taxes.

and lists non-health expenditures as addendum items to preserve the integrity of the health accounts framework. This distinction is not mandatory for NASA estimates.

- In theory, both frameworks target public, private, and donor spending on HIV/AIDS. However, due to data collection challenges in many developing countries, NASA to date focuses on spending by government and external sources and is not mandated to include household and employer spending. In contrast, a full NHA HIV/AIDS subaccounts should include such data.

Annex B provides a glossary of additional terms used by NASA.[11]

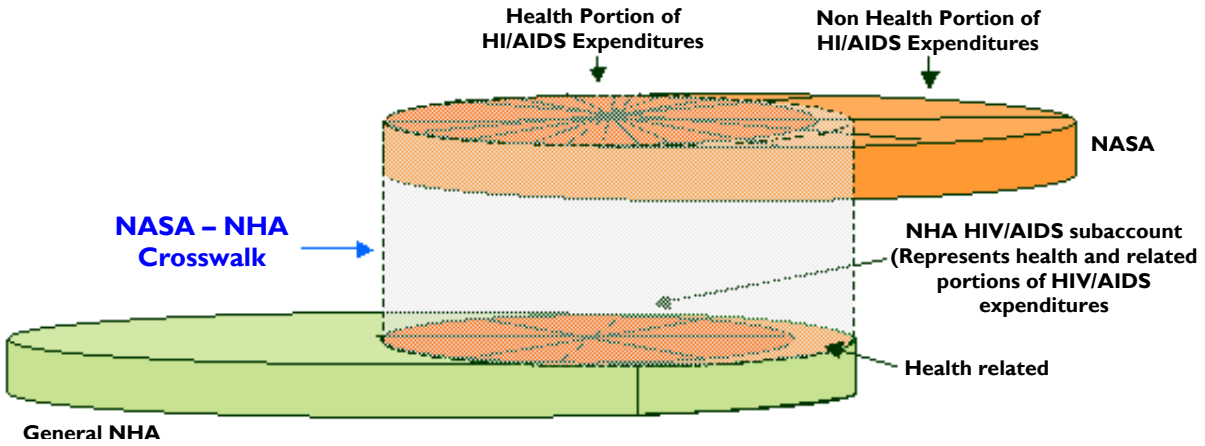
2.2 SCOPE OF HIV/AIDS RESOURCE TRACKING

Figure 1 illustrates the overlaps and distinctions between NASA and NHA. The overlapping areas between the two frameworks include core health and health-related HIV/AIDS expenditures:

- *Core health HIV/AIDS expenditures* are on activities primarily and entirely associated with HIV/AIDS health care.
- *Health-related HIV/AIDS expenditures* are on activities that may overlap with other fields of study such as education, overall "social" expenditure, and research and development. Examples of health-related activities are formal education of health personnel to deliver HIV/AIDS services, and operational research to assess the effectiveness of HIV/AIDS services.

For the overlapping areas, these guidelines present a "crosswalk" (see Section 3) of how to move from one framework to the other. For the non-overlapping HIV/AIDS portion, namely non-health HIV/AIDS expenditures, the NASA categories should be followed and listed as addendum items to the NHA estimation.

FIGURE 1: CROSSWALK BETWEEN NASA AND NHA



Note: Figure 1 is not intended to reflect the size of non-health versus health portions of HIV/AIDS expenditures, as this will be country dependent.

[11] http://data.unaids.org/pub/BaseDocument/2009/20090406_nasa_notebook_en.pdf

In addition to estimating expenditures on services targeted to HIV/AIDS, both frameworks include expenditures that are not necessarily targeted to HIV/AIDS, such as the portion of wages consumed when public hospital staff treat patients who have HIV/AIDS. For these types of expenditures, non-market providers may use their general revenue (contributed by various financing agents for all health services rendered by the provider) to pay for HIV-related services.[12] The same may be said for mainstreaming and systems strengthening activities that affect the delivery of HIV/AIDS services, such as the building on and strengthening of the existing health infrastructure, increasing the number and skills of health care workers, and coordinating and integrating services. However, such activities, if not funded by targeted HIV monies (such as through the World Bank's Multi Country AIDS program), can be challenging to estimate and the costs of doing so should be weighed against local policy needs. Non-targeted spending on HIV/AIDS is essentially outside the purview of programmer resource allocation decisions. However, it is useful to gauge how much of the response for HIV/AIDS is programmable versus non-targeted.

2.3 SOME BOUNDARY DISTINCTIONS

2.3.1 AT THE LEVEL OF SERVICE AND PRODUCT DELIVERY

As shown in Figure 1, the primary distinction between NASA and NHA is the health versus non-health nature of the service or product on which the expenditure is made. Additional distinctions must be made, some of them regarding frequently used services or products:

- *Distribution of condoms*: Under NASA, the cost of all condoms purchased or donated are considered HIV/AIDS expenditures regardless of the primary reason for their use. In NHA, if the principal purpose of the purchase/donation of condoms is to prevent HIV/AIDS (i.e., condoms distribution is part of an HIV/AIDS program), then these expenditures are included in the HIV/AIDS subaccounts. If the principal reason is to meet family planning needs (distribution is part of a family planning program), then the expenditures are excluded from the HIV/AIDS subaccounts (and included in the reproductive health subaccounts).
- *Prevention of mother-to-child transmission (PMTCT) of HIV/AIDS:* NASA treats all PMTCT expenditures as HIV/AIDS expenditures. NHA usually does the same; however, for countries that place PMTCT within a reproductive health program, the country NHA team may for national policy reasons chose to exclude PMTCT expenditures from the HIV/AIDS subaccounts and include them in the reproductive health subaccounts.
- *Management and treatment of sexually transmitted infections (STI):* STI expenditures are treated in a similar manner to PMTCT. A NASA estimation always includes STI expenditures. A NHA estimation, usually includes them – except where the policy context dictates that they are reproductive health expenditures.

To summarize, NASA captures expenditures on a broad and comprehensive range of HIV/AIDS activities, in keeping with the globally recommended multisectoral response to the disease. While NHA estimations may also capture such information, the data are demarcated within boundaries pertaining to HIV/AIDS health and non-health expenditures, and – for the purpose of subaccounts – as HIV/AIDS versus other health priorities, such as reproductive health. The local policy context determines the

[12] It should be noted that the full cost of intermediate inputs (including salaries, equipment, and supplies) at private for-profit providers is embedded in the price charged to patients or insurance schemes. Thus, non-targeted expenditures do not need to be estimated separately in these cases.

inclusion or exclusion of these expenditures.[13] This does not necessarily preclude international comparability. Care should be taken to disaggregate those services that may overlap with other subaccounts so that adjustments may be made to ensure comparability of "apples and apples."

2.3.2 AT THE LEVEL OF SPACE AND TIME

In terms of space and temporal boundaries, NASA and NHA follow similar approaches:

- *Space boundary:* NASA and NHA both track "national" expenditures on HIV/AIDS. However, these national expenditures are not limited to expenditures within the geographic borders of a country; they include expenditures made by a country's citizens abroad. Conversely, both frameworks exclude expenditures of foreigners temporarily within a country's borders.
- *Temporal boundary:* Both frameworks track "annual" expenditure on HIV/AIDS. Attention should be paid to the time boundary during the data collection process, because some governments and organizations report expenditures by calendar year while others report on a fiscal year that differs from the calendar year (e.g., July 1, 2006-June 30, 2007). As per UNGASS reporting needs, NASA asks countries to use the calendar year. The NHA timeframe is generally the calendar year but, depending upon country policymaker preferences, can be the fiscal year used by the country's governments. Another time-related issue is determining when a service or activity takes place or a good procured vis à vis when payment is made for that service or good. Both NASA and NHA use the accrual method of accounting rather than the cash method approach. This means that services and goods are accounted for in the same year they were provided, rather than in the year when payment was made.

[13] Areas of overlap between different subaccounts should be clearly identified. This is more easily accomplished when subaccounts are conducted simultaneously. For example, when an NHA team is simultaneously conducting HIV/AIDS and reproductive health subaccounts, the team must decide to put "STI services" in one or the other of those subaccounts, and should be clearly identified in the subaccount tables.

3. CLASSIFICATION OF EXPENDITURES AND TARGET TABLES

For their overlapping components (see Figure 1 in Section 2), the NASA and NHA frameworks use similar classification schemes to list major expenditure categories (e.g., financing sources, financing agents). This facilitates a crosswalk (or mapping) from one scheme to the other. For non-health HIV/AIDS components (outside the areas of overlap), the resource-tracking team should defer to the NASA breakdown and include these categories as addendum items to the NHA matrices.

3.1 NASA CLASSIFICATION SCHEME

The NASA classification scheme draws from the experience of many accounting frameworks, including the System of Health Accounts (SHA), social protection accounting, government financial monitoring systems, NHA, and National AIDS Accounts. In addition, NASA adheres strictly to the UNAIDS resource needs classifications, which comprise current and capital expenditures. This approach illustrates the current state of expenditures and helps inform the gap estimation process for determining future resource needs. To facilitate coordinated efforts for resource tracking, the NASA classifications have been designed to allow for a crosswalk of the health expenditure categories to the NHA framework.

NASA organizes HIV/AIDS expenditures into six major categories (as mentioned earlier, and defined in Box 1) representing three dimensions in the flow of funds from sources to end uses (Table 1).

Box 1. NASA Categories of HIV/AIDS Expenditures

Financing sources (abbreviated as *FS* for NASA purposes) are entities or pools that fund the purchase of provider services or other forms of mobilization by the financing agents. Examples include Ministry of Finance and donors.

Financing agents *(FA)* are entities that pool financial resources collected from the various financing sources and transfer them to pay for or purchase HIV care, and other services or goods. Financing agents may pool resources that pay directly for resources they consume, such as household out-of-pocket payments, or they may be entities that buy on behalf of specific beneficiaries, such as insurance firms on behalf of employer and household contributions or NGOs on behalf of donors.

Providers (PS) are entities or persons that engage directly in the production, provision, and delivery of services. Providers supply services and/or are responsible for a final product or the subcontracting of a complex process. A provider is usually accountable to the beneficiary for the delivery and the quality of service rendered. HIV and AIDS services are supplied in a wide range of settings outside the health industry and providers, for example, schools and social community centers, in addition to health centers and hospitals.

Production factors (*PF)* for NASA purposes, are inputs or budgetary items (akin to resource cost classifications used in the SHA and NHA) that can be divided into two major categories: 1) current expenditures and 2) capital expenditures. Examples include wages, supplies, and services.

AIDS spending categories (*ASC)* are the HIV/AIDS-related services and products rendered. Examples include mass media, curative care, and research.

Beneficiaries (*BP)* are people who have benefited or have been served by spending on HIV/AIDS goods and services. The beneficiary population is not the intended target of funds, but rather the recipients of HIV/AIDS services and commodities. Beneficiary populations of interest to NASA are those most-at-risk populations such as sex workers, their clients, injecting drug users, and men who have sex with men.

TABLE 1. NASA DIMENSIONS AND CATEGORIES

Dimension	Categories
Financing	1) Financing Sources (FS), and 2) Financing Agents (FA)
Provision	3) Production Factors (PF) and 4) Providers (PS);
Use	5) AIDS Spending Categories (ASC) (care, mitigation, education, human rights, etc.), consumed by 6) Beneficiaries (BF) (e.g., men who have sex with men, injecting drug users)

These classifications are described in their entirety in the National AIDS Spending Assessment (NASA) Classification Taxonomy and Definitions. As with other accounting frameworks, NASA classifications are given alphanumerical codes, followed by a descriptive name. Beginning with a letter prefix referring to the broad category, such as ASC, a NASA classification is followed by a number and lastly a descriptive name, for example, ASC 1.1 Harm-reduction programmes for injecting drug users (IDUs).

3.2 NHA CLASSIFICATION SCHEME

Rooted in the ICHA and adapted for the developing country context as described in the Producers' Guide, NHA also uses alphanumerical codes followed by a descriptive name. As seen in Table 2, the letter prefix refers to broad categories, many of which correspond to those used by NASA. Where a corresponding NASA/NHA category exists, the frameworks generally define the category in an equivalent way, although NHA focuses on health expenditures in that category while NASA also counts non-health expenditures in that category.

TABLE 2. CORRESPONDING NHA AND NASA MAJOR CATEGORIES

Major NHA Categories and Letter Prefixes	Major NASA Categories and Letter Prefixes
Financing Sources (FS)	Financing Sources (FS)
Financing Agents (HF)	Financing Agents (FA)
Providers (HP)	Providers (PS)
Functions (HC)	AIDS Spending Categories (ASC)
Resource Costs (RC)	Production Factors (PF)
	Beneficiary Populations (BP)

Spending on beneficiary populations, while feasible under NHA, does not have a specific coding system in the health accounts framework.

It should be noted that the ICHA approach allows for addition – or elimination – of subcategories to accommodate countries' unique HIV/AIDS entities/services. Specifically, the NHA approach, as stated in its online training course,[14] stipulates the following criteria when designing a country's HIV/AIDS classification structure:

> *Respect, to the extent possible, the existing international standards and conventions while also being flexibility to meet the specific policy needs required for national analysis.* (p. 34)

That is, it is possible to introduce nationally relevant categories but in a way that fits within the broader ICHA categories.

[14] http://www.wpro.who.int/NR/rdonlyres/E04E20C5-3AAE-4B9A-97CD-503108A5E450/0/NationalHealthAccountsOnlineTrainingCoursePOLHN2008.pdf

When introducing new subclassifications, the first two numbers of the code should match ICHA categories. The numbers that follow designate the new, nationally relevant category. Take, for example, a country's decision to compare spending in public and private hospitals: ICHA provides only a broad classification for general hospitals, namely, *H.P.1.1 "General Hospitals."* Should policymakers want to distinguishing hospital types by ownership, NHA teams can add subclassifications:

- HP.1.1.1 = "GOVERNMENT general hospitals"
- HP.1.1.2 = "NON-GOVERNMENT general hospitals"

This NHA approach to classifications allows country teams to cross-walk from nationally relevant classifications to the international standard for classifications. Similarly, the approach facilitates the crosswalk to other frameworks such as NASA.

3.3 NASA-NHA EQUIVALENCY TABLES

The crosswalk between NASA and NHA refers to a one-to-one mapping of health expenditure HIV/AIDS codes. This mapping facilitates the production of NASA tables from NHA estimations and vice versa.

The mapping is illustrated below in the form of NASA-NHA equivalency tables (Tables 3-6), which start from the NASA tables. The left column lists the NASA classification code and the right column lists the NASA descriptive name associated with the code. The middle column lists the NHA code (from the *Producers' Guide*) that corresponds to the NASA term. The letter that follows some NHA codes, for example, "y," is a placeholder for new subcategories, the ultimate number of which depends on the country's needs.

If there are two categories, say, "HC.6.3.y community mobilization," and "HC.6.3.y ABC (abstinence, be faithful, use condoms)," the "y" will be different for each category (as per NHA norms), for example, "community mobilization" will be HC.6.3.1 and "ABC" will be HC.6.3.2. Similarly, if a code is labeled HC.6.3.y.y, the "y" in both places are not necessarily the same unless otherwise specified. To the extent that it is feasible to disaggregate expenditures as listed in the following tables, countries are strongly encouraged to do so.

Non-health HIV/AIDS spending categories are listed as addendum items under NHA and retain the NASA classification codes.

TABLE 3. NASA AND NHA CROSSWALK: CODE EQUIVALENCIES

NASA Code	PG Code	Label and Abridged Content Description
FS.01	**FS.1**	**Public funds**
FS.01.01	FS.1.1	Territorial government funds
FS.01.01.01	FS.1.1.1.1	Central government revenue
FS.01.01.02	FS.1.1.2.1	State / Provincial government revenue
FS.01.01.03	FS.1.1.3.1	Local / Municipal government revenue
FS.01.01.04	FS.1.1.1.2 (central level-loans) FS.1.1.2.2 (state-level loans if applicable) FS.1.1.3.2 (local-level loans if applicable)	Reimbursable loans
FS.01.02	Sum of following three categories	Social Security funds
FS.01.02.01	FS.2.1xHF 1.2	Employer compulsory contributions to Social Security
FS.01.02.02	FS.2.2xHF 1.2	Employee compulsory contributions to Social Security
FS.01.02.03	FS.2.2xHF1.2	Government transfers to Social Security
FS.01.99	FS.1.y	Other public funds not elsewhere classified (n.e.c.)
FS.02	**FS.2**	**Private funds**
FS.02.01	FS.2.1	For-profit institutions and corporations
FS.02.02	FS.2.2	Households' funds
FS.02.03	FS.2.3	Not-for-profit institutions (other than social insurance)
FS.02.99	FS.2.4	Private financing sources n.e.c.
FS.03	**FS.3**	**International funds**
FS.03.01	FS.3	Direct bilateral contributions
FS.03.01.01	FS.3.y	Government of Australia
FS.03.01.02	FS.3.y	Government of Austria
FS.03.01.03	FS.3.y	Government of Belgium
FS.03.01.04	FS.3.y	Government of Canada
FS.03.01.05	FS.3.y	Government of Denmark
FS.03.01.06	FS.3.y	Government of Finland
FS.03.01.07	FS.3.y	Government of France
FS.03.01.08	FS.3.y	Government of Germany
FS.03.01.09	FS.3.y	Government of Greece
FS.03.01.10	FS.3.y	Government of Ireland
FS.03.01.11	FS.3.y	Government of Italy
FS.03.01.12	FS.3.y	Government of Japan
FS.03.01.13	FS.3.y	Government of Luxembourg
FS.03.01.14	FS.3.y	Government of Netherlands
FS.03.01.15	FS.3.y	Government of New Zealand
FS.03.01.16	FS.3.y	Government of Norway
FS.03.01.17	FS.3.y	Government of Portugal
FS.03.01.18	FS.3.y	Government of Spain
FS.03.01.19	FS.3.y	Government of Sweden
FS.03.01.20	FS.3.y	Government of Switzerland
FS.03.01.21	FS.3.y	Government of United Kingdom
FS.03.01.22	FS.3.y	Government of United States
FS.03.01.23	FS.3.y	Government of People's Republic of China
FS.03.01.99	FS.3.y	Government of non-DAC countries/Bilateral agencies n.e.c.

NASA Code	PG Code	Label and Abridged Content Description
FS.03.02	FS.3	Multilateral agencies
FS.03.02.01	FS.3.y	Bureau of the Economic and Social Council (ECOSOC)
FS.03.02.02	FS.3.y	European Commission
FS.03.02.03	FS.3.y	Food and Agriculture Organization of the United Nations (FAO)
FS.03.02.04	FS.3.y	International Labour Organization (ILO)
FS.03.02.05	FS.3.y	International Organization for Migration (IOM)
FS.03.02.06	FS.3.y	Regional development banks (Africa, Asia, Latin America and the Caribbean, Islamic, etc.)
FS.03.02.07	FS.3.y	Global Fund to Fight AIDS, Tuberculosis and Malaria
FS.03.02.08	FS.3.y	UNAIDS Secretariat
FS.03.02.09	FS.3.y	United Nations Children's Fund (UNICEF)
FS.03.02.10	FS.3.y	United National Development Fund for Women (UNIFEM)
FS.03.02.11	FS.3.y	United Nations Development Programme (UNDP)
FS.03.02.12	FS.3.y	United Nations Educational, Scientific and Cultural Organization (UNESCO)
FS.03.02.13	FS.3.y	United Nations High Commissioner for Refugees (UNHCR)
FS.03.02.14	FS.3.y	United National Human Settlements Programme (UN-HABITAT)
FS.03.02.15	S.3.y	United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other humanitarian funding mechanisms
FS.03.02.16	FS.3.y	United Nations Office on Drugs and Crime (UNODC)
FS.03.02.17	FS.3.y	United Nations Population Fund (UNFPA)
FS.03.02.18	FS.3.y	World Bank (WB)
FS.03.02.19	FS.3.y	World Food Programme (WFP)
FS.03.02.20	FS.3.y	World Health Organization (WHO)
FS.03.02.99	FS.3.y	Multilateral funds or development funds n.e.c.
FS.03.03	FS.3	International not-for-profit organizations and foundations
FS.03.03.01	FS.3.y	International HIV/AIDS Alliance
FS.03.03.02	FS.3.y	ActionAID
FS.03.03.03	FS.3.y	Aga Khan Foundation
FS.03.03.04	FS.3.y	Association François-Xavier Bagnoud
FS.03.03.05	FS.3.y	Bernard van Leer Foundation
FS.03.03.06	FS.3.y	Bill and Melinda Gates Foundation
FS.03.03.07	FS.3.y	Bristol-Myers Squibb Foundation
FS.03.03.08	FS.3.y	Care International
FS.03.03.09	FS.3.y	Caritas Internationalis /Catholic Relief Services
FS.03.03.10	FS.3.y	Deutsche Stiftung Weltbevölkerung
FS.03.03.11	FS.3.y	Diana Princess of Wales Memorial Fund
FS.03.03.12	FS.3.y	Elizabeth Glaser Pediatric AIDS Foundation
FS.03.03.13	FS.3.y	European Foundation Centre
FS.03.03.14	FS.3.y	Family Health International
FS.03.03.15	FS.3.y	Foundation Mérieux
FS.03.03.16	FS.3.y	Health Alliance International
FS.03.03.17	FS.3.y	Helen K. and Arthur E. Johnson Foundation
FS.03.03.18	FS.3.y	International Federation of Red Cross and Red Crescent Societies, and National Red Cross Societies
FS.03.03.19	FS.3.y	King Baudouin Foundation
FS.03.03.20	FS.3.y	Médecins sans Frontières
FS.03.03.21	FS.3.y	Merck & Co., Inc
FS.03.03.22	FS.3.y	Plan International
FS.03.03.23	FS.3.y	PSI (Population Services International)
FS.03.03.24	FS.3.y	SIDACTION (mainly Francophone countries)
FS.03.03.25	FS.3.y	The Clinton Foundation

NASA Code	PG Code	Label and Abridged Content Description
FS.03.03.26	FS.3.y	The Ford Foundation
FS.03.03.27	FS.3.y	The Henry J. Kaiser Family Foundation
FS.03.03.28	FS.3.y	The Nuffield Trust
FS.03.03.29	FS.3.y	The Open Society Institute / Soros Foundation
FS.03.03.30	FS.3.y	The Rockefeller Foundation
FS.03.03.31	FS.3.y	United Nations Foundation
FS.03.03.32	FS.3.y	Welcome Trust
FS.03.03.33	FS.3.y	World Vision
FS.03.03.34	FS.3.y	International planned Parenthood Federation
FS.03.03.35	FS.3.y	Order of Malta
FS.03.03.99	FS.3.y	Other international not-for-profit organizations and foundations n.e.c.
FS.03.04	FS.3	International for-profit organizations
FS.03.99	FS.3	International funds n.e.c.

TABLE 4. NASA AND NHA CROSSWALK: PURCHASING AND MOBILIZATION

Financing Agents in the National Response to HIV and AIDS		
NASA Code	**PG Code**	**Label and Abridged Content Description**
FA.01	**HF.A**	**Public sector**
FA.01.01	HF.1.1.	Territorial governments
FA.01.01.01	HF.1.1.1.	Central or federal authorities
FA.01.01.01.01	HF.1.1.1.y	Ministry of Health (or equivalent sector entity)
FA.01.01.01.02	HF.1.1.1.y	Ministry of Education (or equivalent sector entity)
FA.01.01.01.03	HF.1.1.1.y	Ministry of Social Development (or equivalent sector entity)
FA.01.01.01.04	HF.1.1.1.y	Ministry of Defense (or equivalent sector entity)
FA.01.01.01.05	HF.1.1.1.y	Ministry of Finance (or equivalent sector entity)
FA.01.01.01.06	HF.1.1.1.y	Ministry of Labour (or equivalent sector entity)
FA.01.01.01.07	HF.1.1.1.y	Ministry of Justice (or equivalent sector entity)
FA.01.01.01.08	HF.1.1.1.y	Other ministries (or equivalent sector entities)
FA.01.01.01.09	HF.1.1.1.y	Prime Minister's or President's office
FA.01.01.01.10	HF.1.1.1.y	National AIDS Commission
FA.01.01.01.99	HF.1.1.1.y	Central or federal authorities' entities n.e.c.
FA.01.01.02	HF.1.1.2	State / provincial / regional authorities
FA.01.01.02.01	HF.1.1.2.y	Ministry of Health (or equivalent state sector entity)
FA.01.01.02.02	HF.1.1.2.y	Ministry of Education (or equivalent state sector entity)
FA.01.01.02.03	HF.1.1.2.y	Ministry of Social Development (or equivalent state sector entity)
FA.01.01.02.04	HF.1.1.2.y	Other ministries (or equivalent state sector entities)
FA.01.01.02.05	HF.1.1.2.y	Executive office (or office of the head of the State/Province/Department)
FA.01.01.02.06	HF.1.1.2.y	State / Province / Department AIDS commission
FA.01.01.2.99	HF.1.1.1.y	State / provincial / regional entities n.e.c.
FA.01.01.03	HF.1.1.3	Local / municipal authorities
FA.01.01.03.01	HF.1.1.3.y	Department of Health (or equivalent local sector entity)
FA.01.01.03.02	HF.1.1.3.y	Department of Education (or equivalent local sector entity)
FA.01.01.03.03	HF.1.1.3.y	Department of Social Development (or equivalent local sector entity)
FA.01.01.03.04	HF.1.1.3.y	Executive office (or office of the head of the local/municipal government)
FA.01.01.03.05	HF.1.1.3.y	Local/municipal government AIDS commission
FA.01.01.03.99	HF.1.1.3.y	Other local/municipal entities n.e.c.
FA.01.02	HF.1.2	Public Social Security
FA.01.03	HF.2.1.1	Government employee insurance programmes
FA.01.04	HF.2.5.1	Parastatal organizations
FA.01.99	HF.A.x	Other public financing agents not elsewhere classified (n.e.c)
FA.02	**HF.B**	**Private sector**
FA.02.01	H.2.1	Private Social Security
FA.02.02	HF.2.1.2	Private employer insurance programmes
FA.02.03	HF.2.2	Private insurance enterprises (other than social insurance)
FA.02.04	HF.2.3	Private households' (out-of-pocket payments)
FA.02.05	HF.2.4	Not-for-profit institutions (other than social insurance)
FA.02.06	HF.2.5.2	Private non-parastatal organizations and corporations (other than health insurance)
FA.02.99	HF.2.y	Other private financing agents n.e.c.
FA.03	**HF.3**	**International purchasing organizations**
FA.03.01	HF.3	Country offices of bilateral agencies managing external resources and fulfilling financing agent roles
FA.03.01.01	HF.3.y	Government of Australia
FA.03.01.02	HF.3.y	Government of Austria

FA.03.01.03	HF.3.y	Government of Belgium
FA.03.01.04	HF.3.y	Government of Canada
FA.03.01.05	HF.3.y	Government of Denmark
FA.03.01.06	HF.3.y	Government of Finland
FA.03.01.07	HF.3.y	Government of France
FA.03.01.08	HF.3.y	Government of Germany
FA.03.01.09	HF.3.y	Government of Greece
FA.03.01.10	HF.3.y	Government of Ireland
FA.03.01.11	HF.3.y	Government of Italy
FA.03.01.12	HF.3.y	Government of Japan
FA.03.01.13	HF.3.y	Government of Luxembourg
FA.03.01.14	HF.3.y	Government of Netherlands
FA.03.01.15	HF.3.y	Government of New Zealand
FA.03.01.16	HF.3.y	Government of Norway
FA.03.01.17	HF.3.y	Government of Portugal
FA.03.01.18	HF.3.y	Government of Spain
FA.03.01.19	HF.3.y	Government of Sweden
FA.03.01.20	HF.3.y	Government of Switzerland
FA.03.01.21	HF.3.y	Government of United Kingdom
FA.03.01.22	HF.3.y	Government of United States
FA.03.01.23	HF.3.y	Government of People's Republic of China
FA.03.01.99	HF.3.y	Other government(s) / Other bilateral agencies n.e.c.
FA.03.02	HF.3	Multilateral agencies managing external resources
FA.03.02.01	HF.3.y	Bureau of the Economic and Social Council (ECOSOC)
FA.03.02.02	HF.3.y	European Commission
FA.03.02.03	HF.3.y	Food and Agriculture Organization of the United Nations (FAO)
FA.03.02.04	HF.3.y	International Labour Organization (ILO)
FA.03.02.05	HF.3.y	International Organization for Migration (IOM)
FA.03.02.06	HF.3.y	Regional development banks (Africa, Asia, Latin America and the Caribbean, Islamic, etc.)
FA.03.02.07	HF.3.y	UNAIDS Secretariat
FA.03.02.08	HF.3.y	United Nations Children's Fund (UNICEF)
FA.03.02.09	HF.3.y	United Nations Development Fund for Women (UNIFEM)
FA.03.02.10	HF.3.y	United Nations Development Programme (UNDP)
FA.03.02.11	HF.3.y	United Nations Educational, Scientific and Cultural Organization (UNESCO)
FA.03.02.12	HF.3.y	United Nations High Commissioner for Refugees (UNHCR)
FA.03.02.13	HF.3.y	United Nations Human Settlements Programme (UN-HABITAT)
FA.03.02.14	HF.3.y	United Nations Office for Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FA.03.02.15	HF.3.y	United Nations Office on Drugs and Crime (UNODC)
FA.03.02.16	HF.3.y	United Nations Population Fund (UNFPA)
FA.03.02.17	HF.3.y	World Bank (WB)
FA.03.02.18	HF.3.y	World Food Programme (WFP)
FA.03.02.19	HF.3.y	World Health Organization (WHO)
FA.03.02.99	HF.3.y	Other multilateral entities n.e.c.
FA.03.03	HF.3	International not-for-profit organizations and foundations
FA.03.03.01	HF.3.y	International HIV/AIDS Alliance
FA.03.03.02	HF.3.y	ActionAID
FA.03.03.03	HF.3.y	Aga Khan Foundation
FA.03.03.04	HF.3.y	Association François-Zavier Bagnoud
FA.03.03.05	HF.3.y	Bernard van Leer Foundation
FA.03.03.06	HF.3.y	Bill and Melinda Gates Foundation
FA.03.03.07	HF.3.y	Bristol-Myers Squibb Foundation

FA.03.03.08	HF.3.y	Care International
FA.03.03.09	HF.3.y	Caritas Internationalis/Catholic Relief Services
FA.03.03.10	HF.3.y	Deutsche Stiftung Weltbevőlkerung
FA.03.03.11	HF.3.y	Diana Princess of Wales Memorial Fund
FA.03.03.12	HF.3.y	Elizabeth Glaser Pediatric AIDS Foundation
FA.03.03.13	HF.3.y	European Foundation Centre
FA.03.03.14	HF.3.y	Family Health International
FA.03.03.15	HF.3.y.	Foundation Mérieux
FA.03.03.16	HF.3.y	Health Alliance International
FA.03.03.17	HF.3.y	Helen K. and Arthur E. Johnson Foundation
FA.03.03.18	HF.3.y	International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies
FA.03.03.19	HF.3.y	King Baudouin Foundation
FA.03.03.20	HF.3.y	Medecins sans Frontieres
FA.03.03.21	HF.3.y	Merck & Co., Inc.
FA.03.03.22	HF.3.y	Plan International
FA.03.03.23	HF.3.y	Population Services International (PSI)
FA.03.03.24	HF.3.y	SIDACTION (mainly Francophone countries)
FA.03.03.25	HF.3.y	The Clinton Foundation
FA.03.03.26	HF.3.y	The Ford Foundation
FA.03.03.27	HF.3.y	The Henry J. Kaiser Family Foundation
FA.03.03.28	HF.3.y	The Nuffield Trust
FA.03.03.29	HF.3.y	The Open Society Instutite/Soros Foundation
FA.03.03.30	HF.3.y	The Rockefeller Foundation
FA.03.03.31	HF.3.y	United Nations Foundation
FA.03.03.32	HF.3.y	Wellcome Trust
FA.03.03.33	HF.3.y	World Vision
FA.03.03.34	HF.3.y	International Planned Parenthood Federation
FA.03.03.35	HF.3.y	Order of Malta
FA.03.03.99	HF.3.y	Other international not-for-profit organizations n.e.c.
FA.03.04	HF.3	International for-profit organizations
FA.03.99	HF.3.y	Other international financing agents n.e.c.

TABLE 5. NASA AND NHA CROSSWALK: THE PROVIDERS OF THE NATIONAL RESPONSE TO HIV AND AIDS

NASA Codes	PG Codes	Label and Abridged Content Description
PS.01.01	Use of "u" designates public and parastatal	Governmental Organizations
PS.01.01.01	HP.1.u	Hospitals
PS.01.01.02	HP.3.u	Ambulatory care
PS.01.01.03	HP.3.2.u	Dental offices
PS.01.01.04	HP.1.3.u	Mental health and substance abuse facilities
PS.01.01.05	HP.3.5.u	Laboratory and imaging facilities
PS.01.01.06	HP.3.9.2.u	Blood banks
PS.01.01.07	HP.3.9.1.u	Ambulance services
PS.01.01.08	HP.4.1.u	Pharmacies and providers of medical goods
PS.01.01.09	HP.1.4.u	Traditional or non-allopathic care providers
PS.01.01.10	HP.8.2.u	Schools and training facilities
PS.01.01.10.01	HP.8.2.u.u	Primary education
PS.01.01.10.02	HP.8.2.u.u	Secondary education
PS.01.01.10.03	HP.8.2.u.u	Higher education
PS.01.01.10.99	HP.8.2.u.u	Schools and training centres n.e.c.
PS.01.01.11	HP.7.3.u	Foster homes / shelters
PS.01.01.12	HP.7.3.u	Orphanages
PS.01.01.13	HP.8.1.u	Research institutions
PS.01.01.14	HF.A-HP.6.u cell	Government entities
PS.01.01.14.01		National AIDS Commission (NACs)
PS.01.01.14.02		Departments inside the Ministry of Health (including. NAPs / NACPs)
PS.01.01.14.03		Departments inside the Ministry of Education or equivalent
PS.01.01.14.04		Departments inside the Ministry of Social Development or equivalent
PS.01.01.14.05		Departments inside the Ministry of Defense or equivalent
PS.01.01.14.06		Departments inside the Ministry of Finance or equivalent
PS.01.01.14.07		Departments inside the Ministry of Labour or equivalent
PS.01.01.14.08		Departments inside the Ministry of Justice or equivalent
PS.01.01.14.99		Government entities n.e.c.
PS.01.01.99	HP.u.nsk	Government organizations n.e.c.
PS.01.02	HP.1	Parastatal organizations
PS.01.02.01	HP.1.u	Hospitals
PS.01.02.02	HP.3.u	Ambulatory care
PS.01.02.03	HP.3.2.u	Dental offices
PS.01.02.04	HP.1.3.u	Mental health and substance abuse facilities
PS.01.02.05	HP.3.5.u	Laboratory and imaging facilities
PS.01.02.06	HP.3.9.2.u	Blood banks
PS.01.02.07	HP.3.9.1.u	Ambulance services
PS.01.02.08	HP.4.1.u	Pharmacies and providers of medical goods
PS.01.02.09	HP.1.4.u	Traditional or non-allopathic care providers
PS.01.02.10	HP.8.2u*	Schools and training facilities
PS.01.02.10.01	HP.8.2.u.u	Primary education
PS.01.02.10.02	HP.8.2.u.u	Secondary education
PS.01.02.10.03	HP.8.2.u.u	Higher education
PS.01.02.10.99	HP.8.2.u.u	Schools and training centres n.e.c.

NASA Codes	PG Codes	Label and Abridged Content Description
PS.01.02.11	HP.7.3.u	Foster homes / shelters
PS.01.02.12	HP.7.3.u	Orphanages
PS.01.02.13	HP.8.1.u	Research institutions
PS.01.02.14	HF.A-HP.6.u cell	Parastatal organizations n.e.c.
PS.01.99		Public sector providers n.e.c.
PS.02.01		Non-profit providers
PS.02.01.01	Use of "v" designates non-profit, non-faith-based	Non-profit providers, non-faith-based providers
PS.02.01.01.01	HP.1.v	Hospitals
PS.02.01.01.02	HP.3.v	Ambulatory care
PS.02.01.01.03	HP.3.2.v	Dental offices
PS.02.01.01.04	HP.1.3.v	Mental health and substance abuse facilities
PS.02.01.01.05	HP.3.5.v	Laboratory and imaging facilities
PS.02.01.01.06	HP.3.9.2.v	Blood banks
PS.02.01.01.07	HP.3.9.1.v	Ambulance services
PS.02.01.01.08	HP.4.1.v	Pharmacies and providers of medical goods
PS.02.01.01.09	HP.1.4.v	Traditional or non-allopathic care providers
PS.02.01.01.10	HP.8.2v	Schools and training facilities
PS.02.01. 01.10.01	HP.8.2v.v	Primary education
PS.02.01.01.10.02	HP.8.2v.v	Secondary education
PS.02.01. 01.10.03	HP.8.2v.v	Higher education
PS.02.01.01.10.99	HP.8.2v.v	Schools and training centres n.e.c.
PS.02.01.01.11	HP.7.3.v	Foster homes / shelters
PS.02.01.01.12	HP.7.3.v	Orphanages
PS.02.01.01.13	HP.8.1.v	Research institutions
PS.02.01.01.14	HF.2.4.y, HP.6.v cell	Self-help organizations
PS.02.01.01.15	HF.2.4.y, HP.6.v. cell	Civil society organizations
PS.02.01.01.99	HP.6.v.nsk	Other non-profit non-faith-based providers n.e.c.
PS.02.01.02	Use of "w" designates faith-based	Non-profit, faith-based providers
PS.02.01.02.01	HP.1.w	Hospitals
PS.02.01.02.02	HP.3.w	Ambulatory care
PS.02.01.02.03	HP.3.2.w	Dental offices
PS.02.01.02.04	HP.1.3.w	Mental health and substance abuse facilities
PS.02.01.02.05	HP.3.5.w	Laboratory and imaging facilities
PS.02.01.02.06	HP.3.9.2.w	Blood banks
PS.02.01.02.07	HP.3.9.1.w	Ambulance services
PS.02.01.02.08	HP.4.1.w	Pharmacies and providers of medical goods
PS.02.01.02.09	HP.1.4.w	Traditional or non-allopathic care providers
PS.02.01.02.10	HP.8.2.w	Schools and training facilities
PS.02.01.02.10.01	HP.8.2.w.w	Primary education
PS.02.01.02.10.02	HP.8.2.w.w	Secondary education
PS.02.01.02.10.03	HP.8.2.w.w	Higher education
PS.02.01.02.10.99	HP.8.2.w.w	Schools and training centres not else where classified
PS.02.01.02.11	HP.7.3.w	Foster homes / shelters
PS.02.01.02.12	HP.7.3.w	Orphanages
PS.02.01.02.13	HF.2.4.y,	Self-help and informal community-based organizations

NASA Codes	PG Codes	Label and Abridged Content Description
	HP.6.w cell	
PS.02.01.02.14	HF.2.4.y HP.6.w cell	Civil society organizations
PS.02.01.02.99	HP.6.w.nsk	Other non-profit faith-based private sector providers n.e.c.
PS.02.01.99	HP.6.nsk	Other non-profit private sector providers, n.e.c.
PS.02.02	Use of "x" designates private for-profit	Profit-making private sector providers (including profit-making faith-based organizations)
PS.02.02.01	HP.1.x	Hospitals
PS.02.02.02	HP.3.x	Ambulatory care
PS.02.02.03	HP.3.2.x	Dental offices
PS.02.02.04	HP.1.3.x	Mental health and substance abuse facilities
PS.02.02.05	HP.3.5x	Laboratory and imaging facilities
PS.02.02.06	HP.3.9.2x	Blood banks
PS.02.02.07	HP.3.9.1x	Ambulance services
PS.02.02.08	HP.4.1.x	Pharmacies and providers of medical goods
PS.02.02.09	HP.3.3.x	Traditional or non-allopathic care providers
PS.02.02.10	HP.8.2x	Schools and training facilities
PS.02.02.10.01	HP.8.2.x.x	Primary education
PS.02.02.10.02	HP.8.2.x.x	Secondary education
PS.02.02.10.03	HP.8.2.x.x	Higher education
PS.02.02.10.99	HP.8.2.x.x	Schools and training centres not else where classified
PS.02.02.11	HP.7.3.x	Foster homes / shelters
PS.02.02.12	HP.7.3.x	Orphanages
PS.02.02.13	HP.8.1.x	Research institutions
PS.02.02.14	HP.5.x	Consultancy firms
PS.02.02.15	HP.8.3.x	"Workplace"
PS.02.02.99	HP.6.x.nsk	Profit-making private sector providers n.e.c
PS.02.99	HP.x.nsk	Private sector providers n.e.c.
PS.03.01		Bilateral agencies
PS.03.02		Multilateral agencies

TABLE 6. NASA AND NHA CROSSWALK: PREVENTION, CARE-TREATMENT AND SUPPORT, SOCIAL MITIGATION OF PERSONS LIVING WITH HIV AND AIDS AND THEIR DEPENDENTS

NASA Code[15]	PG Code	Label and Abridged Content Description
ASC.01	**Sub-total**	**Prevention**
ASC.01.01	HC.6.3.y +addendum	Communication for social and behavioural change
ASC.01.01.01	HC.6.3.y	Health-related communication for social and behavioural change
ASC.01.01.02	Addendum	Non-health-related communication for social and behavioural change
ASC.01.01.98	Addendum	Communication for social and behavioural change not disaggregated by type
ASC.01.02	HC.6.3.y	Community mobilization
ASC.01.03	HC.6.3.y	Voluntary counseling and testing (VCT)
ASC.01.04	HC.6.3.y	Risk-reduction for vulnerable and special populations[16]
ASC.01.04.01	HC.6.3.y.y	VCT as part of programmes for vulnerable and accessible populations
ASC.01.04.02	HC.6.3.y.y	Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations
ASC.01.04.03	HC.6.3.y.y	Sexually transmitted infection (STI) prevention and treatment as part of programmes for vulnerable and accessible populations
ASC.01.04.04	HC.6.3.y.y	Behaviour change communication (BCC) as part of programs for vulnerable and accessible populations
ASC.01.04.98	HC.6.3.y.y	Programmatic interventions for vulnerable and accessible population not disaggregated by type
ASC.01.04.99	HC.6.3.y.nsk	Other programmatic interventions for vulnerable and accessible populations n.e.c.
ASC.01.05	HC.6.2	Prevention - Youth in school
ASC.01.06	HC.6.3.y	Prevention - Youth out-of-school
ASC.01.07	HC.6.3.y	Prevention of HIV transmission aimed at people living with HIV (PLHIV)
ASC.01.07.01	HC.6.3.y.y	Behaviour change communication as part of prevention of HIV transmission aimed at PLHIV
ASC.01.07.02	HC.6.3.y.y	Condom social marketing and male and female condom provision as part of prevention of HIV transmission aimed at PLHIV
ASC.01.07.03	HC.6.3.y.y	STI prevention and treatment as part of prevention of HIV transmission aimed at PLHIV
ASC.01.07.98	HC.6.3.y.y	Prevention of HIV transmission aimed at PLHIV not disaggregated by type
ASC.01.07.99	HC.6.3.y.nsk	Other prevention of HIV transmission aimed at PLHIV n.e.c.
ASC.01.08	HC.6.3.y	Prevention programmes for sex workers and their clients
ASC.01.08.01	HC.6.3.y.y	VCT as part of programmes for sex workers and their clients
ASC.01.08.2	HC.6.3.y.y	Condom social marketing and male and female condom

[15] ASC1-4, ASC6-8 excludes monetary incentives for staff.

[16] Please refer to the beneficiary population classifications for a listing of those populations that would be included.

NASA Code[15]	PG Code	Label and Abridged Content Description
		provision as part of programmes for sex workers and their clients
ASC.01.08.3	HC.6.3.y.y	STI prevention and treatment as part of programmes for sex workers and their clients
ASC.01.08.4	HC.6.3.y.y	BCC as part of programmes for sex workers and their clients
ASC.01.08.98	HC.6.3.y.y	Programmatic interventions for sex workers and their clients not disaggregated by type
ASC.01.08.99	HC.6.3.y.nsk	Other programmatic interventions for sex workers and their clients n.e.c.
ASC.01.09	HC.6.3.y	Programmes for men who have sex with men (MSM)
ASC.01.09.01	HC.6.3.y.y	VCT as part of programmes for MSM
ASC.01.09.02	HC.6.3.y.y	Condom social marketing and male and female condom provision as part of programmes for MSM
ASC.01.09.03	HC.6.3.y.y	STI prevention and treatment as part of programmes for MSM
ASC.01.09.04	HC.6.3.y.y	BCC as part of programmes for MSM
ASC.01.09.98	HC.6.3.y.y	Programmatic interventions for MSM not disaggregated by type
ASC.01.09.99	HC.6.3.y.nsk	Other programmatic interventions for MSM n.e.c.
ASC.01.10	HC.6.3.y	Harm-reduction programmes for injecting drug users (IDUs)
ASC.01.10.01	HC.6.3.y.y	VCT as part of programmes for IDUs
ASC.01.10.02	HC.6.3.y.y	Condom social marketing and male and female condom provision as part of programs for IDUs
ASC.01.10.03	HC.6.3.y.y	STI prevention and treatment as part of programmes for IDUs
ASC.01.10.04	HC.6.3.y.y	BCC as part of programmes for IDUs
ASC.01.10.05	HC.6.3.y.y	Sterile syringe and needles exchange as part of programmes for IDUs
ASC.01.10.06	HC.6.3.y.y	Drug substitution treatment as part of programmes for IDUs
ASC.01.10.98	HC.6.3.y.y	Programmatic interventions for IDUs not disaggregated by type
ASC.01.10.99	HC.6.3.y.nsk	Other programmatic interventions for IDUs n.e.c.
ASC.01.11	HC.6.3.y	Prevention programmes in the workplace
ASC.01.11.01	HC.6.3.y.y	VCT as part of programmes in the workplace
ASC.01.11.02	HC.6.3.y.y	Condom social marketing and male and female condom provision as part of programmes in the workplace
ASC.01.11.03	HC.6.3.y.y	STI prevention and treatment as part of programmes in the workplace
ASC.01.11.04	HC.6.3.y.y	BCC as part of programmes in the workplace
ASC.01.11.98	HC.6.3.y.y	Programmatic interventions in the workplace not disaggregated by type
ASC.01.11.99	HC.6.3.y.nsk	Other programmatic interventions in the workplace n.e.c.
ASC.01.12	HC.5.1.3.y	Condom social marketing
ASC.01.13	HC.5.1.3.y HC.6.3.y HC.1.3.y	Public and commercial sector male condom provision
ASC.01.14	HC.5.1.3.y HC.6.3y HC.1.3.y	Public and commercial sector female condom provision

NASA Code[15]	PG Code	Label and Abridged Content Description
ASC.01.15	HC.5.1.1.y	Microbicides
ASC.01.16	HC.6.3.y HC.1.3.y	Prevention, diagnosis, and treatment of STIs
ASC.01.17	HC.1.1.y HC.1.3.y HC.6.3.y	Prevention of mother-to-child transmission (PMTCT)
ASC.01.17.01	HC.6.3.y.y HC.1.3.y.y HC.1.1.y.y	Pregnant women counseling and testing in PMTCT programs
ASC.01.17.02	HC.6.3.y.y HC.1.3.y.y HC.1.1.y.y	Antiretroviral prophylaxis for HIV-infected pregnant women and newborns
ASC.01.17.03	HC.6.3.y.y HC.1.3.y.y HC.1.1.y.y	Safe infant feeding practices (including substitution of breast milk)
ASC.01.17.04	HC.6.3.y.y HC.1.1.y.y	Delivery practices as part of PMTCT programmes
ASC.01.17.04	HC.6.3.y.y HC.5.1.3.y	Condom social marketing and male and female condom provision as part of PMTCT programmes
ASC.01.17.98	HC.6.3.y.nsk	PMTCT not disaggregated by intervention
ASC.01.17.99	HC.6.3.y.y HC.1.3.y.y HC.1.1.y.y	PMTCT activities n.e.c.
ASC.01.18	Addendum	Male circumcision
ASC.01.19	HC.6.3.y	Blood safety
ASC.01.20	HC.6.3.y	Safe medical injections
ASC.01.21	HC.6.3.y	Universal precautions
ASC.01.22	HC.6.3.y	Post-exposure prophylaxis (PEP)
ASC.01.22.01	HC.6.3.y.y	PEP in health care setting
ASC.01.22.02	HC.6.3.y.y	PEP after high-risk exposure (violence or rape)
ASC.01.22.03	HC.6.3.y.y	PEP after unprotected sex
ASC.01.22.98	HC.6.3.y.nsk	PEP not-disaggregated by intervention
ASC.01.22.99	HC.6.3.y.nsk	PEP n.e.c.
ASC.01.98	HC.6.3.y	Prevention activities not disaggregated by intervention
ASC.1.99	HC.6.3.y	Prevention activities n.e.c.
ASC.02	**Sub-total**	**Care and Treatment**
ASC.02.01	C.1.3	Outpatient care
ASC.02.01.01	HC.1.3.y HC.1.1.y HC.6.3.y	Provider-initiated testing and counseling (PITC)
ASC.02.01.02	HC.1.3.y	Opportunistic infection (OI) outpatient prophylaxis and treatment
ASC.02.01.02.01	HC.1.3.y.y	OI outpatient prophylaxis
ASC.02.01.02.02	HC.1.3.y.y	OI outpatient treatment
ASC.02.01.02.03	HC.1.3.y.y	OI outpatient prophylaxis and treatment not disaggregated by type
ASC.02.01.03	HC.1.3.y HC.1.1.y HC.5.1.y	Antiretroviral therapy (ART)
ASC.02.01.03.01	HC.1.3.y.y HC.1.1.y.y HC.5.1.y.y	Adult ART
ASC.02.01.03.01.01	HC.1.3.y.y.y	First line ART – Adults

NASA Code[15]	PG Code	Label and Abridged Content Description
	HC.1.1.y.y.y HC.5.1.y.y.y	
ASC.02.01.03.01.02	HC.1.3.y.y.y HC.1.1.y.y.y HC.5.1.1.y.y.y	Second line ART – Adults
ASC.02.01.03.01.03	HC.1.3.y.y.y HC.1.1.y.y.y HC.5.1.1.y.y.y	Adult multi-drug ART after second line treatment failure
ASC.02.01.03.01.98	HC.1.3.y.y.y HC.1.1.y.y.y HC.5.1.1.y.y.y	Adult ART not disaggregated by line of treatment
ASC.02.01.03.02	HC.1.3.y.y HC.1.1.y.y HC.5.1.1.y.y	Pediatric ART
ASC.02.01.03.02.01	HC.1.3.y.y.y HC.1.1.y.y.y HC.5.1.y.y.y	First-line ART – Pediatric
ASC.02.01.03.02.02	HC.1.3.y.y.y, HC.1.1.y.y.y HC.5.1.y.y.y	Second-line ART – Pediatric
ASC.02.01.03.02.03	HC.1.3.y.y.y HC.1.1.y.y.y HC.5.1.y.y.y	Pediatric multidrug ART after second line treatment failure
ASC.02.01.03.02.98	HC.1.3.y.y.y HC.1.1.y.y.y HC.5.1.y.y.y	Pediatric antiretroviral therapy not disaggregated by line of treatment
ASC.02.01.03.98	HC.1.3.y.y HC.1.1.y.y HC.5.1.y.y	ART not disaggregated by age or line of treatment
ASC.02.01.04	HC.6.3.y	Nutritional support associated to ART
ASC.02.01.05	HC.4.1 HC.1.3.y HC.1.1.y	Specific HIV-related laboratory monitoring
ASC.02.01.06	HC.6.3.y[17]	Dental programs for people living with HIV
ASC.02.01.07	HC.1.3.y	Psychological treatment and support services
ASC.02.01.08	HC.6.3.y HC.1.3.y	Outpatient palliative care
ASC.02.01.09	HC.1.4 +Addendum	Home-based care
ASC.02.01.09.01	HC.1.4	Home-based medical care
ASC.02.01.09.02	Addendum	Home-based non-medical /non-health care
ASC.02.01.09.98	Addendum	Home-based care not disaggregated by type
ASC.02.01.10	HP.3.3 x HC.1.3	Traditional medicine and informal care and treatment services
ASC.02.01.98	HC.1.3.y	Outpatient care services not disaggregated by intervention
ASC.02.01.99	HC.1.3.y	Outpatient care services n.e.c.
ASC.02.02	HC.1.1	Inpatient care
ASC.02.02.01	HC.1.1.y	Inpatient treatment of OI treatment
ASC.02.02.02	HC.1.1.y	Inpatient palliative care

[17] NHA would consider this a general health expenditure, not an HIV/AIDS health expenditure. As such it would be included in the general NHA and excluded from the HIV/AIDS subaccount.

NASA Code[15]	PG Code	Label and Abridged Content Description
ASC.02.02.98	HC.1.1.y	Inpatient care services not disaggregated by intervention
ASC.02.02.99	HC.1.1.y	Inpatient services not elsewhere classified (n.e.c.)
ASC.02.03	HC.4.3[18]	Patient transport and emergency rescue
ASC.02.98		Care and treatment services not disaggregated by intervention
ASC.02.99	HC.1 x	Care and treatment services n.e.c.
ASC.03	**Sub-total**	**Orphans and vulnerable children (OVC)**
ASC.03.01	Addendum	OVC education
ASC.03.02	HC.1.1 HC.1.3 HC.6.3	OVC basic health care
ASC.03.03	Addendum	OVC family / Home support
ASC.03.04	Addendum	OVC community support
ASC.03.05	Addendum	OVC social services and administrative costs
ASC.03.06	Addendum	OVC institutional care
ASC.03.98	Addendum	OVC services not disaggregated by intervention
ASC.03.99	Addendum	OVC services n.e.c
ASC.04	**Sub-total**	**Programme management and administration**
ASC.04.01	HC.6.3.y +addendum (for nonhealth)	Planning, coordination, and programme management
ASC.04.02	Addendum	Administration and transaction costs associated with managing and disbursing funds
ASC.04.03	HC.6.3.y	Monitoring and evaluation
ASC.04.04	HC.6.3.y	Operations research
ASC.04.05	HC.6.3.y	Serological-surveillance (Serosurveillance)
ASC.04.06	HC.6.3.y	HIV drug-resistance surveillance
ASC.04.07	HC.6.3.y	Drug supply systems
ASC.04.08	HC.6.3.y	Information technology
ASC.04.09	HC.6.3.y	Patient tracking
ASC.04.10	HCR.1	Upgrading and construction of infrastructure
ASC.04.10.01	HCR.1.y	Upgrading laboratory infrastructure and new equipment
ASC.04.10.02	HCR.1.y	Construction of new health centres
ASC.04.10.98	HCR.1.y	Upgrading and construction of infrastructure not disaggregated by intervention
ASC.04.10.99	HCR.1.y	Upgrading and construction of infrastructure n.e.c.
ASC.04.98	HC.6.3.nsk	Programme management, administration strengthening not disaggregated by intervention
ASC.04.99	HC.6.3.y.	Programme management, administration strengthening n.e.c.
ASC.05	**Sub-total**	**Human resources recruitment and retention incentives, human capital**
ASC.05.01	RC.1.1.y	Monetary incentives for human resources
ASC.05.01.01	RC.1.1.y.y	Monetary incentives for physicians
ASC.05.01.01.01	RC.1.1.y.y.y	Monetary incentives for physicians for prevention
ASC.05.01.01.02	RC.1.1.y.y.y	Monetary incentives for physicians for care and treatment
ASC.05.01.01.03	RC.1.1.y.y.y	Monetary incentives for physicians for program management and administration

[18] For NHA purposes, this refers to designated medical transport or reimbursed private transport. For more details on the definition, please refer to page 119 in the *System of Health Accounts* (OECD 2000).

NASA Code[15]	PG Code	Label and Abridged Content Description
ASC.05.01.01.98	RC.1.1.y.y.y	Monetary incentives for physicians not disaggregated by type
ASC.05.01.01.99	RC.1.1.y.y.y	Monetary incentives for physicians n.e.c.
ASC.05.01.02	RC.1.1.y.y	Monetary incentives for nurses
ASC.05.02.01	RC.1.1.y.y.y	Monetary incentives for nurses for prevention
ASC.05.02.02	RC.1.1.y.y.y	Monetary incentives for nurses for care and treatment
ASC.05.02.03	RC.1.1.y.y.y	Monetary incentives for nurses for program management and administration
ASC.05.02.98	RC.1.1.y.y.y	Monetary incentives for nurses not disaggregated by type
ASC.05.02.99	RC.1.1.y.y.y	Monetary incentives for nurses n.e.c.
ASC.05.01.03	RC.1.1.	Monetary incentives for other staff
ASC.05.01.03.01	RC.1.1.y.y	Monetary incentives for other staff for prevention
ASC.05.01.03.02	RC.1.1.y.y	Monetary incentives for other staff for care and treatment
ASC.05.01.03.03	RC.1.1.y.y	Monetary incentives for other staff for program management and administration
ASC.05.01.03.98	RC.1.1.y.y	Monetary incentives for other staff not disaggregated.
ASC.05.01.03.99	RC.1.1.y.y	Monetary incentives for other staff n.e.c.
ASC.05.02	HCR.2.y	Formative education to build-up an HIV workforce
ASC.05.03	HCR.2.y	Training
ASC.05.98	RC.1.1.y.y	Human resources not disaggregated by type
ASC.05.99	RC.1.1.y.y	Human resources n.e.c.
ASC.06	**Sub-total**	**Social protection and social services (excluding OVC)**
ASC.06.01	Addendum	Social protection through monetary benefits
ASC.06.02	Addendum	Social protection through in-kind benefits
ASC.06.03	Addendum	Social protection through provision of social services
ASC.06.04	Addendum.	HIV-specific income-generation projects
ASC.06.98	Addendum	Social protection services and social services not disaggregated by type
ASC.06.99	Addendum	Social protection services and social services n.e.c.
ASC.07	**Sub-total**	**Enabling environment and community development**
ASC.07.01	Addendum	Advocacy
ASC.07.02	Addendum	Human rights programmes
ASC.07.02.01	Addendum	Human rights programmes empowering individuals to claim their rights
ASC.07.02.02	Addendum	Provision of legal and social services to promote access to prevention, care and treatment
ASC.07.02.03	Addendum	Capacity building in human rights
ASC.07.02.98	Addendum	Human rights programmes not disaggregated by type
ASC.07.02.99	Addendum	Human rights programmes n.e.c.
ASC.07.03	HC.6.3.y	AIDS-specific institutional development
ASC.07.04	HC.6.3.y	AIDS-specific programmes focused on women
ASC.07.05	Addendum	Programmes to reduce gender-based violence
ASC.07.98	Addendum	Enabling environment and community development n.e.c.
ASC.07.99	Addendum	Enabling environment and community development not disaggregated by type
ASC.08	**Sub-total**	**HIV and AIDS-related research (excluding operations research)**
ASC.08.01	HCR.3.y	Biomedical research
ASC.08.02	HCR.3.y	Clinical research
ASC.08.03	HCR.3.y	Epidemiological research
ASC.08.04	Addendum	Social science research

NASA Code[15]	PG Code	Label and Abridged Content Description
ASC.8.04.01	HCR.3.y	Behavioural research
ASC.8.04.02	Addendum	Research in economics
ASC.8.04.03	HCR.3.y	Research on capacity strengthening
ASC.08.04.98	Addendum	Social science research not disaggregated by type
ASC.08.04.99	Addendum	Social science research n.e.c.
ASC.08.05	HCR.3.y	Vaccine-related research
ASC.08.98	HC.R.3.y	HIV and AIDS-related research activities not disaggregated by type
ASC.08.99	HC.R.3.y	HIV and AIDS-related research activities n.e.c.

3.4 RECOMMENDED NASA TABLES

Once HIV/AIDS expenditures are classified, NASA recommends that the data be organized and presented in a series of bivariate tables, each relaying information on the flow of funds from one category to another, for example, financing sources to AIDS spending categories. These tables aim to capture the financing, production, and consumption dimensions of health care spending by revealing the flow of funds between the categories of these dimensions. In addition to these tables, a NASA report should also include summary tables, auxiliary tables (indicating any further analysis), and a listing of policy indicators (e.g., percentage of gross domestic product consumed by the HIV/AIDS national response).

A NASA table is structured such that the table columns show the categories of entities from which a flow starts, i.e., the "originators," and the table rows show the categories of entities, health functions, or commodities into which the fund flows move, i.e., the "recipients." Thus, the table showing the flow from financing sources (*FS*) to financing agents (*FA*) would have financing sources in its column headings and financing agents in the row headings. Similarly, the table showing the flow from financing agents (*FA*) to providers (*PS*) would have the financing agents in its columns headings and providers in the row headings. Recommended NASA tables are as follows:

1. FS x ASC Financing Sources by AIDS Spending Category
2. FS x FA Financing Sources by Financing Agents
3. FA x ASC Financing Agents by AIDS Spending Category
4. PS x ASC Providers by AIDS Spending Category
5. FA x PS Financing Agents by Providers
6. PS x PF Providers by Resources Costs
7. ASC x BP AIDS Spending Category by Beneficiary Populations

Other tables may be constructed if policymakers have information needs not covered by the above tables and if data to populate the tables are available. An example of a filled country NASA table is shown in Annex C.

Minimum UNAIDS international requirements stipulate that countries should report at least the first table (FS x ASC). This UNGASS funding matrix is described in UNAIDS' *Guidelines on Construction of Core Indicators–2008 reporting.* The matrix is also reproduced in Annex A.

The total HIV/AIDS expenditure estimate for each table must be the same to ensure that all funds are accounted for from their sources to their end uses. The NASA three-dimensional system should be reconciled across the three areas. When two dimensions are validated as equal, a mathematical feature stipulates that the third be equal; for example, when (FINANCING x PRODUCTION) ≡ (PRODUCTION x USE) the association (FINANCING x USE) is verified. When the process has been completed, it is important to review the functional breakdown for each agent (and across agents) to make sure that the set of figures makes sense together as well as individually.

3.5 RECOMMENDED NHA AND HIV/AIDS SUBACCOUNT TABLES

Like the NASA tables, NHA tables list the "originators" of the flow in the column headings and the "recipients" in the row headings. In accordance with the tables produced for the general NHA estimation, the HIV/AIDS subaccounts recommend computation of the following two-dimensional tables at a minimum:

1. FS x HF Financing Sources by Financing Agents
2. HF x HP Financing Agents by Providers
3. HF x HC Financing Agents by Functions
4. HP x HC Providers by Functions

In addition, given the many critical issues surrounding human resources and distribution of inputs for HIV/AIDS care (such as drugs, supplies, and lab equipment), there is increasing national and international policy interest in computing a table that illustrates the flow of funds from major financing agents (such as donors, NGOs, and government) across resource costs (HF x RC). Another table of increasing interest is that of financing sources by functions; this table, akin to the UNGASS funding matrix, directly shows how funds from financiers are used.

Depending on the level of inclusion of core, health care-related, and non-health HIV/AIDS expenditures, three possible types of expenditure totals may be estimated within each of the four tables.

- **Total health expenditure (THE) on HIV/AIDS:** This total encompasses expenditures associate with personal, programmatic, and capital-formation activities (HC 1-7, HCR 1). For NHA purposes, this estimate should be tabulated at a minimum and will be used for international comparisons of health HIV/AIDS expenditures.
- **National health expenditure (NHE) on HIV/AIDS:** This total includes THE plus any other health-related expenditures that include research, formal training, and so forth (HC 1-7, HCR1, and any or all of HCR 2-HCR 5). This total best addresses the needs and concerns of health policymakers.
- **Total HIV/AIDS expenditures (THAE):** This is a specific estimate created for the HIV/AIDS context. While not part of the NHA framework, this total refers to the addition of all health, health-related, and non-health HIV/AIDS expenditures. It equates to the total measured by NASA.

These totals must be the same for every NHA table produced – to ensure that every HIV/AIDS "dollar" is tracked from its sources to its end uses. A country example of how a table can present the above totals is in Annex D.

Should both policy motivation and data be available, other flow-of-funds tables can be computed. As recommended in the *Producers' Guide,* these tables may include the following:

- HF x RC Financial Agents by Resource Costs
- HFx A/G Financing Agents by Population Age and Gender Groups

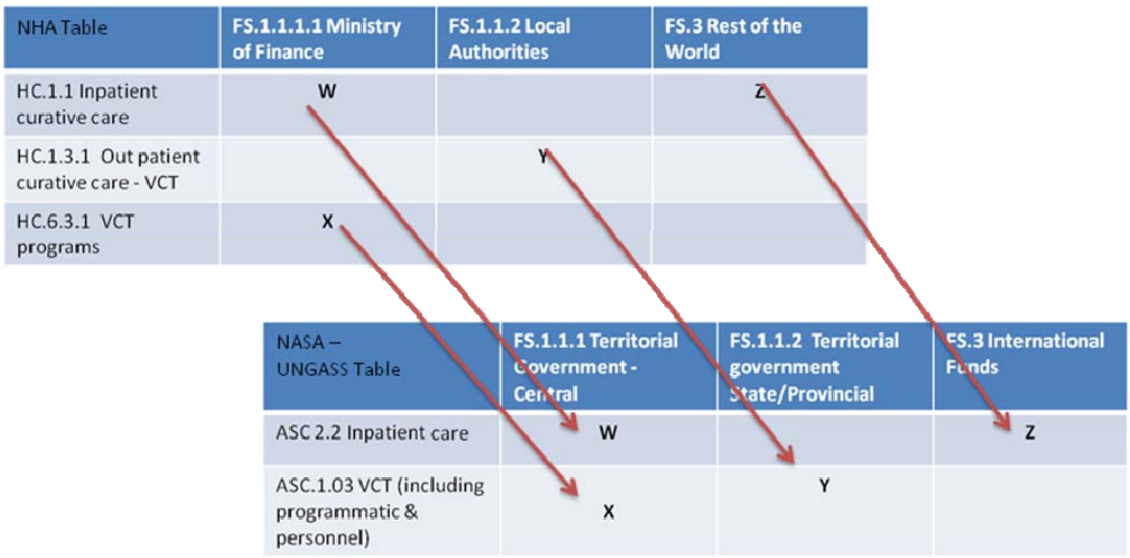
- HF x R Financing Agents by Regions
- HF x SES Financing Agents to the Population classified by Per Capita Household Expenditure Quintile (socioeconomic status)

3.5.1 PRODUCTION OF NASA TABLES FROM NHA HIV/AIDS SUBACCOUNTS

Given the feasibility of a crosswalk between NHA and NASA, particularly for the health portion of expenditures, and given the potential for collecting non-health HIV/AIDS spending using the primary and secondary data collection processes of ongoing NHA resource tracking efforts, countries embarking upon NHA HIV/AIDS subaccounts are encouraged in their reports to also include NASA matrices – at a minimum the UNGASS-mandated table.

A number of countries have started to do both NASA and NHA estimations as part of their resource-tracking reports for their five-year evaluation for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Zimbabwe is one country that has completed a NASA table from an HIV/AIDS subaccount. In this case, the target NASA table was the UNGASS funding matrix, which shows the flow of funds from financing sources to AIDS spending categories (FS x ASC).[19] To compute this table, the NHA team first created a FS x HC table (Annex D). After mapping the NHA classifications to the NASA codes, the team developed a funding matrix (Annex E). This is illustrated in Figure 2.

FIGURE 2: LINKING NHA TO NASA



Note: This figure is purely illustrative. The amount of mapping and linking of NHA to NASA will vary by country and is a function of the level of disaggregation made (which is determined by the country team and the amount of data available). For example, VCT programs may be further disaggregated, and therefore, the "crosswalk" between NHA and NASA would have different levels of disaggregation and mapping. This is another reason why it is very beneficial to work collaboratively from the beginning if both NASA and NHA are being conducted in a country to ensure a correct crosswalk.

[19] It should be noted that since the publication of the UNGASS funding matrix, some of the alphanumerical codes have been revised; thus, the example of Zimbabwe may not correspond exactly to the final NASA classification scheme.

Essentially, the two dimensions of a cell (its originator and recipient) are mapped to the corresponding dimensions in the NASA matrix. So, for example, the cell showing the transfer of funds from FS.1.1.1.1 Ministry of Finance to HC 1.1 Inpatient care would translate to FS.1.1 Territorial government: central x ASC 2.2 Inpatient care.

3.5.2 PRODUCTION OF NHA TABLES FROM NASA TABLES

Table 7 shows how cells in the international sources column of the UNGASS funding matrix can be computed from the Zimbabwe HIV/AIDS subaccount FS x HC table.[20]

[20] Some NASA codes have changed since these data were calculated in 2005. Nevertheless, this illustrates the conversion approach.

TABLE 7. COMPUTING UNGASS CELLS FROM HIV/AIDS SUBACCOUNT CELLS: EXAMPLE FROM ZIMBABWE

NASA CELL (from UNGASS funding matrix FS x ASC)				NHA CELL (from FS xHC table)		
NASA Financing Source (as listed in UNGASS)		**NASA AIDS Spending Category**		**NHA Finacing Source**		**NHA function**
International Sources		**1. Prevention (sub-total)**	=	**FS. 3**	**X**	**Sum of categories below**
International Sources	X	1.1 Mass media	=	FS. 3	X	HC.6.3.5 Mass media
International Sources	X	1.2 Community mobilization	=	FS. 3	X	HC.6.3.3. Behavior change
International Sources	X	1.3 Voluntary counselling and testing	=	FS. 3	X	HC.6.3.2 VCT program
International Sources	X	1.5. Youth in school	=	FS. 3	X	HC.6.3.4 Youth programs (general for all youth programmes)
International Sources	X	1.11 Workplace activities	=	FS. 3	X	HC.6.3.7 Workplace programs
International Sources	X	1.13 Public and commercial sector condom provision	=	FS. 3	X	HC.6.3.6 Condom promotion (donors did not specify if used for social marketing)
International Sources	X	1.17 Prevention of mother-to-child transmission	=	FS. 3	X	HC 6.3.1 PMTCT
International Sources	X	1.99 Others / Not-elsewhere classified	=	FS. 3	X	HC.6.3.nsk Prevention and public helath programs nsk
International Sources	X	**2. Care and Treatment (sub-total)**	=	**FS. 3**	X	**Sum of categories below**
International Sources	X	2.4 Antiretroviral therapy	=	FS. 3	X	HC.1.3.1 ART Treatment
International Sources	X	2.6 Specific HIV laboratory monitoring	=	FS. 3	X	HC 4.1 Clinical lab.
International Sources	X	2.10 Home-based care	=	FS. 3	X	ADDENDUM HBC
International Sources	X	2.13 Opportunistic infection (OI) treatment	=	FS. 3	X	HC.1.3.2 OP treatment for OI
International Sources	X	**3. Orphans and Vulnerable Children * (sub-total)**	=	FS. 3	X	ADDENDUM OVC care and support
International Sources	X	**4. Program Management and Administration Strengthening (sub-total)**	=	FS. 3	X	**Sum of categories below**
International Sources	X	4.5 Sero-surveillance	=	FS. 3	X	HC.6.3.6 Surveillance
International Sources	X	4.10 Upgrading laboratory infrastructure	=	FS. 3	X	HCR.1 Capital formation
International Sources	X	**5. Incentives for Human Resources ** (sub-total)**	=	FS. 3	X	**Sum of categories below**
International Sources	X	5.5 Training	=	FS. 3	X	HCR.2 Education and training
International Sources	X	**6. Social Protection and Social Services excluding Orphans and Vulnerable**	=	FS. 3	X	Addendum PLWHA support
International Sources	X	**7. Enabling Environment and Community Development (sub-total)**	=	FS. 3	X	**data not available**

4. IMPLEMENTING NASA IN COUNTRY

This chapter outlines the recommended implementation process for NASA in a given country. The recommended process aims to adhere to the Three Ones principles of UNAIDS that emphasize coordination and harmonization in the fight against HIV/AIDS.

4.1 STEPS TO IMPLEMENT NASA

STEP 1: PLANNING THE PROCESS

Assess the status of ongoing resource-tracking efforts

A country should compute NASA tables, particularly the UNGASS funding matrix, on a regular basis to monitor the progress achieved in meeting UNGASS and MDG goals as well as local planning needs. In order to do so, it is recommended that links be made to ongoing resource-tracking initiatives and other routine sources of data collection. This avoids the duplication of effort and allows for a more cost-effective and sustainable implementation process.

If the country does NHA estimations, its NHA team should be used as resource-tracking experts for the NASA – and be expanded to include technical representatives from HIV/AIDS stakeholder institutions. Conversely, the team should incorporate NASA data needs into the data collection process for NHA HIV/AIDS subaccounts. This means broadening the process to retrieve non-health HIV/AIDS expenses as well as health expenses.

Even if the country does not estimate NHA, its NASA report should distinguish health and non-health HIV/AIDS spending – and to examine HIV/AIDS health expenditures in the context of overall heath care spending – assuming local policymakers deem this useful.

By incorporating the data needs of both frameworks into the resource-tracking process, the policy needs of general health and HIV/AIDS stakeholders can be met.

Stakeholders as owners of the resource-tracking process

Given the breadth of needed HIV/AIDS information, it is paramount that high-level stakeholders lead and guide the resource-tracking process. Identification and involvement of relevant stakeholders from the onset of the process is important for several reasons:

- Understanding NASA and its relation to ongoing resource-tracking initiatives will win stakeholder support of, rather than resistance to, the new methodology.
- Some stakeholders may need to be convinced that the data they supply to the resource-tracking team will not be used against them (for example, for tax purposes) but rather in an analysis that will provide them useful information.

- In addition to support, stakeholders can provide insight into their subsectors and help identify policy questions of importance to the country and for which NASA needs to provide information.
- Their cooperation will likely facilitate collection of data over which the stakeholders have ownership, adoption of policies based on findings, and implementation of those policy decisions.

All the relevant stakeholders/data owners for both frameworks should be represented (either at the steering committee level or on the NHA technical team). For HIV/AIDS resource tracking, this will involve:

- National AIDS coordinating authority
- Ministry of Health
- Other relevant ministries
- Civil society organizations
- Donor representatives (UNAIDS, Global Fund, etc.)
- Provider umbrella organizations

Selection of the technical team

The resource-tracking technical team designs and implements the data collection and analysis process, and reports on progress made and constraints encountered to the Steering Committee or other core stakeholder groups. The team should comprise financing analysts, accountants, and individuals skilled in primary and secondary data collection and entry processes. Often, team members are from the public sector; however, the team may be strengthened by adding a private consultant who has auditing experience in the private and public health sector. As mentioned earlier, such teams may already exist for other ongoing resource-tracking efforts, such as NHA. It is, of course, of utmost importance to have representatives from the national AIDS coordinating authority as principal participants.

Responsibilities of the technical team are the following:

- Describe the HIV/AIDS response, its structure, and key issues to be addressed by NASA and NHA
- Adapt classification scheme to national context, define scope and boundaries, as well as policy purpose
- Identify each stakeholder/ entity among financing sources, financing agents, and users/providers in the public and private health sectors
- Set up an inventory of secondary data sources and then needed primary sources
- Define and implement for each entity the data collection process
- Validate, enter, and analyze financial data
- Report regularly to the stakeholders, including preliminary findings and constraints encountered during the resource-tracking process
- Write the final report and submit tables (both NASA and NHA) to senior officials of national sponsoring institution (national AIDS council, Ministry of Health) and UNAIDS
- Present the final report to stakeholders.

STEP 2: DATA COLLECTION

The team members are strongly urged to document the steps they took and decisions they made in their first resource-tracking exercises. These records will facilitate the estimations they do in subsequent years and can contribute to the development of shortcuts for the subsequent rounds.

Essentially, data sources can be organized into four broad categories. To minimize financial costs of data collection, to build upon existing resource-tracking efforts, and to avoid unnecessary duplication of efforts, the resource-tracking team should identify sources of information from these four areas in the following order:

1. *Existing information systems*: what types of data are provided on a regular basis through information systems?

2. *Secondary data (existing studies/reports)*: what types of HIV/AIDS studies/reports have already been produced? Perhaps there are useful costing studies or focused expenditure review studies in existence?

3. *Ongoing surveys*: are there any ongoing surveys to which rider questions can be added on HIV/AIDS expenditures? There may be general NHA surveys targeting donors and NGOs. Alternatively, there may be non-NHA surveys underway, such as the Demographic and Health Survey and the Service Provision Assessment. It may be useful to contact organizers of these surveys to discuss the possible addition of HIV/AIDS-specific questions.

4. *NASA-specific surveys*: as a last option, if there is no other way to estimate expenditures, or to piggyback onto ongoing surveys, the team may need to implement a NASA-specific survey.

In listing potential data sources, it is useful to first sketch a funds flowchart based upon the team's knowledge of the organization of the national HIV/AIDS response. Once this is done, it is helpful to identify the data sources (including the addresses and names of contact persons) for retrieving expenditure information. For each source identified, the team should evaluate the level of detail, quality (scope, level of detail, reliability), appropriateness, and sufficiency of the data provided. This will help the resource-tracking team to determine if additional data sources are needed or not.

Once this is done, a data collection plan should be developed. This plan should outline the types of data sources needed, for what purposes, and in what time frame. In addition, each team member should be assigned responsibility for accessing a given data source or, in the case of primary data collection, for coordinating a survey.

STEP 3: DATA PROCESSING

Data collected can be entered into standard software programs such as SPSS, Microsoft Excel, and CSPro. In addition, data may be organized into NASA matrices with the assistance of the NASA-RTS software. Note, prior to analysis, the team should invest the time to properly check and clean datasets. In addition, it is useful to design the output tables such that the NASA and NHA tables are linked (e.g., in Microsoft Excel); thus, when computing one set of tables, the others can be computed automatically.

STEP 4: DATA ANALYSIS

The analysis stage involves a thorough review of numerous data sources and their assembly into a clear picture of HIV/AIDS funding flows. Inevitably during this process, the NHA team will find a number of data conflicts and gaps that necessitate further scrutiny and possible use of alternative estimation techniques. Such techniques will be described in greater detail in a subsequent publication on NASA and HIV/AIDS subaccount methodologies.

The data analysis stage requires access to a lot of direct and indirect HIV/AIDS data, ranging from expenditure to cost, use, population, and prevalence data. Thus, as much data as possible should be collected and organized before analysis begins. Some guiding principles for the analysis itself, particularly for the HIV/AIDS estimation, are to repeatedly check the "primary purpose" of the reported expenditure in question and to revisit the boundaries of NASA. Specific estimation issues include boundary queries (particularly relating to overlaps with other program areas, commodity transfers, and the extraction or addressing of HIV/AIDS expenditures that are part of integrated activities – although to avoid "guesstimates" and losing time, this latter should done only when resultant broken-out costs would be significant). Deriving HIV/AIDS proportions from integrated activities should be done only when the HIV/AIDS expenditure is thought to be sizeable and when the full value of the integrated activity is likely to be a significant overestimate.

Regardless of the approach used, all assumptions and estimation techniques should be thoroughly documented. Countries will find that as their information systems improve and HIV/AIDS data collection becomes routine, they will rely less and less on estimation techniques and more on actual detailed expenditure data.

STEP 5: FINAL REPORT

The NASA exercise is not final until a formal report is completed and submitted to the Ministry of Health, national AIDS coordinating authority, and other key stakeholders, including UNAIDS. An effort should be made to translate the results for decision-making purposes and the political dialogue. It also should be noted that completion of the final report of a country's first NASA and NHA is just a first step toward the longer-term objective of recurrent estimations for the financial information system on the national response to HIV/AIDS.

4.2 TIMEFRAME

The resource-tracking process should be completed while the data and findings are still relevant to the policy process. It is possible to complete a first estimation within one year, depending on data availability and stakeholder collaboration, but it requires setting and meeting deadlines. Unexpected constraints may delay progress. For example, the data collection team may find that some entities do not have data as expected, that available data are not adequately detailed, or that data are otherwise invalid. A second round of data collection may be needed, starting with the task of identifying additional data sources. The Steering Committee may be able to assist the team to circumvent such constraints and identify alternative solutions. Both the NASA and NHA frameworks recommend the production of timely estimations over the development of precisely accurate representations of HIV/AIDS spending patterns, which means that the use of estimation techniques (to be described in a subsequent publication on methodology) may need to be used from time to time.

ANNEX A. UNGASS FUNDING MATRIX

Year_____
Calendar Year: Yes___ No ___
Fiscal Year: _____ (specify beginning/end)
Currency used in Matrix: _____
Average Exchange rate for the year:_____

National Funding Matrix
AIDS Spending Categories by Financing Sources

		Financing Sources											
		Public Sources						International Sources					
										Multilaterals			
AIDS Spending Categories	Total	Public Sub-total	Central/national	Sub-national	Dev. Bank Reimbursable (e.g. loans)	Social Security	All other public	International sub-total	Bilaterals	UN Agencies	Global Fund	Dev. Bank non-reimbursable (e.g. grants)	All other multilateral
TOTAL													
1. Prevention (sub-total)													
1.01 Communication for social and behavioral change													
1.02 Community mobilization													
1.03 Voluntary counseling and testing													
1.04 Risk-reduction for vulnerable and accessible populations													
1.05 Prevention -Youth in school													
1.06 Prevention - Youth out-of-school													
1.07 Prevention of HIV transmission aimed at people living with HIV													
1.08 Prevention programmes for sex workers and their clients													
1.09 Programmes for men who have sex with men													
1.10 Harm -reduction programmes for injecting drug users													
1.11 Prevention programmes in the workplace													
1.12 Condom social marketing													
1.13 Public and commercial sector condom provision													
1.14 Female condom													
1.15 Microbicides													
1.16 Improving management of STIs													
1.17 Prevention of mother-to-child transmission													
1.18 Blood safety													
1.19 Post-exposure prophylaxis													
1.20 Safe medical injections													
1.21 Male circumcision													
1.22 Universal precautions													
1.98 Prevention activities not disaggregated by intervention													
1.99 Prevention activities not elsewhere classified													
2. Care and Treatment (sub-total)													
2.01 Outpatient care													
2.01.01 Provider-initiated testing and counseling													
2.01.02 Opportunistic infection outpatient prophylaxis and treatment													
2.01.03 Antiretroviral therapy													
2.01.04 Nutritional support associated to ARV therapy													
2.01.05 Specific HIV-related laboratory monitoring													
2.01.06 Dental programmes for people living with HIV													
2.01.07 Psychological treatment and support services													
2.01.08 Outpatient palliative care													
2.01.09 Home-based care													
2.01.10 Traditional medicine and informal car and treatment													
2.01.98 Outpatient care services not disaggregated by intervention													
2.01.99 Outpatient care services not elsewhere classified													
2.02 In-patient care													
2.02.01 Inpatient treatment of opportunistic infections													
2.02.02 Inpatient palliative care													
2.02.98 Inpatient care services not disaggregated by intervention													
2.02.99 Inpatient services not elsewhere classified													
2.03 Patient transport and emergency rescue													
2.98 Care and treatment service not disaggregated by intervention													
2.99 Care and treatment services not-elsewhere classified													

3. Orphans and Vulnerable Children (sub-total)													
3.01 OVC Education													
3.02 OVC Basic healthcare													
3.03 Family/home support													
3.04 OVC Community support													
3.05 OVC Social services and administrative costs													
3.06 OVC Institutional care													
3.98 OVC Services not disaggregated by intervention													
3.99 OVC Services not-elsewhere classified													
4. Program Management and Administration Strengthening (Sub-total)													
4.01 Planning, coordination and programme management													
4.02 Administration and transition costs associated with managing and disbursing funds													
4.03 Monitoring and evaluation													
4.04 Operations research													
4.05 Serological-surveillance (serosurveillance)													
4.06 HIV drug-resistance surveillance													
4.07 Drug supply systems													
4.08 Information technology													
4.09 Patient tracking													
4.10 Upgrading and construction of infrastructure													
4.11 Mandatory HIV testing (not voluntary counseling and testing)													
4.98 Program Management and administration strengthening not disaggregated by type													
4.99 Program management and Administration Strengthening not elsewhere classified													
5. Human resources (sub-total)													
5.01 Monetary incentives for human resources													
5.02 Formative education to build-up an HIV workforce													
5.03 Training													
5.98 Incentives for Human Resources not specified by kind													
5.99 Incentives for human resources not elsewhere classified													
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)													
6.01 Social protection through monetary benefits													
6.02 Social protection through in-kind benefits													
6.03 Social protection through provision of social services													
6.04 HIV-specific income generation projects													
6.98 Social protection services and social services not disaggregated by type													
6.99 Social protection services and social services not elsewhere classified													
7. Enabling Environment													
7.01 Advocacy													
7.02 Human rights programmes													
7.03 AIDS-specific institutional development													
7.04 AIDS-specific prgrammes focused on women													
7.05 Programmes to reduce gender-based violence													
7.98 Enabling Environment and Community Development not disaggregated by type													
7.99 Enabling environment and community development not elsewhere classified													
8. Research excluding operations research which is included under (sub-total)													
8.01 Biomedical research													
8.02 Clinical research													
8.03 Epidemiological research													
8.04 Social science research													
8.05 Vaccine-related research													
8.98 Research not disaggregated by type													
8.99 Research not elsewhere classified													

*the term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for social support as orphan

**The item on incentives for Human Resources needs to be disaggregated from the costs for service delivery of the other activities, e.g. in the in- and out-patient service provision. Efforts need to be made to avoid double counting

ANNEX B. GLOSSARY OF NASA TERMS

Reprinted from UNAID's *Guide to produce National AIDS Spending Assessment (NASA)* (Draft, May 2009).[21]

Above the line: transactions which an accounting system includes in the production (or consumption) total considered.

Accounting matrices are defined as the presentation of macro- or meso-accounts in a matrix form, relates to the wide range of possibilities for expanding or condensing this form of display: each transaction to be represented by a single entry and the nature of the transaction to be inferred from its position, in accordance with specific circumstances and analytical needs.

Accounts are a tool which records for a given aspect of economic life: a) the provision and use of resources for the domain under review; b) the changes in assets and in liabilities related to that domain; c) the stock of assets and liabilities at a stated point in time. Accounts measure levels related to a fixed point in time and flows or changes occurring over a period. Accounting is a systematic recording or display of economic transactions expressed in a synthetic or summary format, that conforms to conventionally agreed definitions and rules.

Actual final consumption of general government is measured by the value of the collective (as opposed to individual) consumption services provided to the community, or to large sections of the community, by general government; it is derived from their final consumption expenditure by subtracting the value of social transfers in kind payable. The term underlies in the context of NASA the purchases (including administrative services) made by units of governments for the purposes of preventing the spread of the disease, maintaining a functional status and improving the well-being of dependents affected by the disease of population segments.

Accrual accounting records flows at the time economic value is created, transformed, exchanged, transferred or extinguished; this means that flows which imply a change of ownership are entered when ownership passes, services are recorded when provided and output is entered at the time products are created (see also cash accounting).

Additivity is a property pertaining to a set of interdependent index numbers related by definition or by accounting constraints under which an aggregate is defined as the sum of its components; additivity requires this identity to be preserved when the values of both an aggregate and its components in some reference period are extrapolated over time using a set of volume index numbers. In the NASA context, additionality refers strictly to increases in the volume of financing obtained from external resources to pay for HIV and AIDS goods and services that entail no reduction in the volume of domestic financing. In a broader context, increases of external financing that are not offset by reductions in domestic funding on HIV and AIDS proper (including social mitigation), on opportunistic infections and other HIV and AIDS related promotion of well-being.

[21] http://data.unaids.org/pub/BaseDocument/2009/20090406_nasa_notebook_en.pdf

ARV designates a complex antiretroviral therapy, comprising three or four distinct medications.

Assets: entities over which individual or institutional units enforce ownership rights, and from which owners holding them over a period of time derive economic benefits.

Audit refers to the requirement and practice for economic entities to have their balance sheet, financial reports and accounts examined by a competent accountant in view of an expert statement on the conformity of the financial flows reported in relation to the entity reviewed statutes and the accuracy of the financial status reported.

Basic prices are the preferred method of valuing the AIDS spending or output of the national response to HIV and AIDS. They reflect the amount received by the producer for a unit of goods or services minus any taxes payable plus any subsidies receivable by that unit as a consequence of production or sale (i.e., the cost of production including subsidies). The only taxes included are the taxes on the production process (e.g., business rates and vehicle excise duty paid by business, the transport charges per se to be invoiced separately by producers); the retail prices of commodities are inclusive of total costs (including transportation) referred to as purchaser prices.

A beneficiary is an individual or a population segment entitled or otherwise receiving a commodity paid for a public or a private financing agent (financing pool or out-of-pocket household spending).

Benefits in kind applies to services provided to households free of charge at the point of access or heavily subsidized, such as shelter and board provided to pre-school children during the day or part of the day, financial assistance towards payment of a nurse to look after children during the day, shelter and board provided to children and families on a permanent basis (orphanages, foster families, etc.), goods and services provided at home to children or to those who care for them, miscellaneous services and goods provided to families, young people or children (holiday and leisure centres). The list of these benefits is country-specific as are entitlement and, usually, mode of delivery.

Blood service refers to the timely supply of hospitals with high-quality blood components.

Bottom-up refers to the estimation of the elements of an aggregate and added up to generate the estimated value of the total (a contrasting approach is the top down).

A budget is a detailed prospective payment plan stating the expected source of revenue and the intended purpose of the outlays, usually cast in slices that correspond to the terms or periods that the accounts attempt to measure.

Capital in NASA refers to physical assets (and some intangibles) acquired by providers commodities that are earmarked for the production of final consumption commodities. Several measurement characteristics affect this entry, such as gross (original) value or net (of a notional wear and tear and obsolescence) value, or book value (cost at the time of origin) or replacement value (the present-day value of the expected cost of replacing the asset).

Capital formation refers to the net acquisition of fixed assets or of inventories (net of disposals).

Capital transfers in NASA is the term designating transactions whereby a government authority provides a grant to a private entity to acquire a capital asset.

Capitation designates a payment method by which a fixed amount per person or per patient is paid to the health professionals concerned, regardless of services provided. That amount is determined by average service costs for the range of services expected. In some countries, hospitals are also experience-paid, the basis being, however, the average cost for a list of diagnoses.

Cash accounting refers to records of payments/receipts at the times they occur (see also accrual accounting).

Cash benefits are money transfers to households for a specific social purpose, such as maternity allowances, birth grants, parental leave benefits, family or child allowances, and other periodic or lump-sum payments to support households and help them meet the costs of specific needs (for example, those of the lone parent families or families with handicapped children). The list of these benefits is country-specific as are entitlement and, usually, accessibility mode.

A census is a survey conducted at the level of the entire population or, when economic units, the universe observed when economic units. (see also survey)

The central product classification (CPC) is a classification based on the physical characteristics of goods or on the nature of the services rendered; each type of good or service distinguished in the CPC is defined in such a way that it is normally produced by only one activity as defined in the International Standard Industrial Classification (ISIC).

Changes in inventories is the value of the difference between the production of a branch sector and its sales plus the commodities purchased and not used up in the production process during the accounting period.

The classification of individual consumption by purpose (COICOP) is used to identify the objectives of individual consumption expenditure.

The classification of the functions of government (COFOG) is used to identify the socioeconomic objectives of current transactions, capital outlays and acquisition of financial assets by general government and its subsectors

The classification of the purposes of non-profit institutions (COPNI) is used to identify the socioeconomic objectives of current transactions, capital outlays and acquisition of financial assets by non-profit institutions serving households.

Co-insurance refers to a fixed amount or percentage of the charges levied on commodities delivered.

Collective services are services deliverable simultaneously to a whole community or to particular sections of the community, such as those in a particular region or a locality. Their use is usually passive and does not require the explicit agreement or active participation of all the individuals concerned. Their consumption by an individual does not diminish the amount available to others in the same community or section of the community; there is no rivalry in acquisition. They include the planning, monitoring and evaluation of health programmes, setting and enforcement of public standards, regulation, licensing and supervision of providers (to which public health services contribute in part – see corresponding entry). Because their usage cannot be charged individually, they are frequently financed out of taxation or other governmental revenue.

Community services deal with the systematic monitoring of population health and of interventions designed to enhance the health status of the population. They are closer to collective services in an economic approach (see entry for Collective services). Linkages to the provision dimension which, in turn, mirrors consumption, allow their coverage to be defined. Community programmes are not necessarily publicly delivered services; e.g., programme control activities including vaccination and health promotion and education through NGOs and community volunteers. They can also involve a cure approach with the following characteristics:
• programmes that have a high risk anticipation purpose, disease/disability "prevention";
• a public good, i.e., services accessible to a greater share of the population than would be accessible under prevailing primary income distribution and/or eligibility criteria;
• programmes with a high equity and effectiveness purpose, geared mainly towards vulnerable groups or that are universal so as to ensure very high take-up rates by vulnerable groups;
• programmes whose carry-out entails sizeable economies of scale over the delivery of services at the patient discretion or whose take-up rate might otherwise be uneven;
• programmes that target specific population segments and/or specific risks and/or that use specific technologies to combat diseases spreading across sizeable population segments. Some of them might entail a high subsidy for the procurement of goods, e.g., mass vaccination, the free distribution of condoms, a subsidized supply of prostheses, therapeutic appliances or prevention devices such as treated mosquito nets to vulnerable groups in malaria-prone countries.

Compensation of employees is the total remuneration, in cash or in kind, payable by an enterprise to an employee in return for work done by the latter during the accounting period.

Compliance is the ability of a patient to execute an authoritative therapeutic regimen prescribed by a practitioner. (In a pharmacological context, the respect by a patient of the therapeutic regimen agreed to between the patient and a practitioner is referred to as "adherence" and the shared decision-making and agreement between a patient and a practitioner regarding a therapeutic strategy is referred to as "concordance".)

Confidence interval (CI): the 95% confidence interval or 95% confidence limits refers to a distribution which would include 95% of the results from studies of the same size and design. This is close to but not identical to stating that the true size of the effect (never exactly known) has a 95% chance of falling within these limits. When the interval does not overlap the value against which the outcome should be judged, the result is considered to be statistically significant.

Consolidation is a special kind of cancelling out of flows and stocks; it involves the elimination of those transactions or debtor/creditor relationships which occur between two transactors belonging to the same institutional sector or subsector. In NASA, situations occur in which the central government funds regional or local authorities for specific missions; the consolidated expenditure in not the sum of the two flows but the final outlays of the regional or local deduction made of the intra-governmental transfer from the national to the subnational authorities.

A consumption good or service is one that is used (without further transformation in production) by households, NPISHs or government units for the direct satisfaction of individual needs or wants, or the collective needs of members of the community. In the NASA context, most spending categories fit this definition.

Consolidated refers to net flows of intra-sectoral (intra-governmental or intra-public-sector) transfers.

Consumption of fixed capital represents the reduction in the value of the fixed assets used in production during the accounting period resulting from physical deterioration, normal obsolescence or normal accidental damage. The consumption of capital is a cost of production, excluding thus the value of fixed assets destroyed by acts of war or exceptional events such as major natural disasters which occur very infrequently. Reflecting underlying resource costs and demands at the time a production takes place, this value is not necessarily identified as an exclusive payment but is integrated in a more comprehensive fee-for-service or fee-per-episode, such as the remuneration for dental services; the imputed value of the labour services and of the rental services if capital is estimated from a gross operating surplus (in business accounting usually referred to as profit or gross operating surplus) comprising this mixed income. Consumption of capital is to be distinguished from business accounting depreciation (based on historical costs) as it is a forward-looking measure, determined by future and not past events (the replacement cost of the equipment in use).

Co-payments refer to an arrangement whereby an entitled person pays a part of the cost of services supplied (health care or other HIV and AIDS-related benefit) either as a deductible or flat amount before the third-party payer (usually an insurance-and/or a social protection scheme) pays the remainder or a co-insurance or pro-rated share of the charge or cost of the benefit.

Current expenditure refers to spending on recurring items, notably employee compensation, consumables such as medicines, usage fees including honoraria for professional service suppliers and merchandise other than provider equipment.

Deductibles (see co-payments).

Deflator refers to the implicit or explicit price index used to separate volume and price increases in the observed growth of output.

Depreciation as usually calculated in business accounts is a method of allocating the costs of past expenditures on fixed assets over subsequent accounting periods; note that the depreciation methods favoured in business accounting and those prescribed by tax authorities almost invariably deviate from the concept of consumption of fixed capital employed in the SNA and so the term "consumption of fixed capital" is used in the SNA to distinguish it from "depreciation" as typically measured in business accounts.

Diagnosis refers to the observation and validation of signs, symptoms or tests of a somatic disorder.

Donations of materials and supplies should be treated to reflect real values, so the amounts should be recorded preferably at historical cost at market prices of the recipient country, net of subsidies minus indirect taxes.

Double counting refers to a transaction or other value included twice (or more) in a NASA matrix, such as a co-payment when the part of the reimbursement to a household is not deducted from out-of pocket payments. All transactions should be counted, but only once.

Double deflation is a method whereby gross value added is measured at constant prices by subtracting intermediate consumption at constant prices from output at constant prices; this method is feasible only for constant price estimates which are additive, such as those calculated using a Laspeyres' formula (either fixed-base or for estimates expressed in the previous year's prices) (see also price indices).

Economically significant prices refers to price levels which have a major effect on the supply of goods or services (whereas non-market output refers to commodities provided free of charge or at price levels that generate no substantive obstacles to their consumption.

Employee social contributions are compulsory social contributions and voluntary social contributions.

Employers' social contributions are the value of social contributions paid by employers to provide social benefits for their employees. They are part of compensation of employees. When the payments are not made – i.e., when an employer provides benefits directly to the employees without involving an insurance enterprise, the implicit contributions have to be imputed in the year in which the liability is being created (imputation applies principally but not exclusively for persons funds, including sickness and disability benefits financed by the employer).

For a unit or sector, national accounting is based on the principle of double entry, as in business accounting, whereby each transaction must be recorded twice, once as a resource (or a change in liabilities) and once as a use (or a change in assets).

An entity is an actor or agent in the system (governments, business, organizations, individuals or families).

Etiology refers to the causes of disease and their mode of operation.

Evaluation is a time-bound exercise that attempts to assess systematically and objectively the relevance, performance and success, or the lack thereof, of ongoing and completed programmes. Evaluation is undertaken selectively to answer specific questions to guide decision-makers and/or programme managers, and to provide information on whether underlying theories and assumptions used in programme development were valid, what worked and what did not work and why. Evaluation commonly aims to determine the relevance, validity of design, efficiency, effectiveness, impact and sustainability of a programme.

Evaluative activities comprise situational analyses, baseline surveys, applied research and diagnostic studies. They are distinct from evaluation, although their findings can be used to improve, modify or adapt programme design and implementation.

Evidence-based medicine refers to the conscientious, explicit and judicious use of current best knowledge in making decisions about the care of an individual patient.

Evidence-based (health) system refers to the conscientious, explicit and judicious use of current best knowledge in making decisions about the planning, the conduct and the evaluation of a care and treatment system that serves the objectives of the health system, and specifically the national response to HIV and AIDS.

An expenditure-based GDP consists of total final expenditures at purchasers' prices (including the free on board (f.o.b.) value of exports of goods and services), less the f.o.b. value of imports of goods and services. Except when not calculated, the NASA numerators should be displayed.

Expenditures are the values of the amounts that buyers pay, or agree to pay, to sellers in exchange for goods or services that sellers provide to them or to other institutional units designated by the buyers.

Externalities are changes in the condition or circumstances of institutional units caused by the economic actions of other units without the consent of the former.

Extra-budgetary entities are funds or institutions whose management is generally in the hands of a public authority and that are not regulated by budget appropriations voted on by Parliament.

Factor inputs (resource costs) refer to labour, capital, natural resources, know-how and entrepreneurial resources combined to produce an output of goods and services.

Faith-based organizations, which are part of the non-profit private sector, play an important role in the advocacy, financing and delivery of health care and other services provided as part of the national response to HIV and AIDS. Their role includes the procurement, storage and training in supply management of medicines, maintenance services for medical equipment, medicines production, medicines information services, and the negotiation of arrangements with governments.

Fee-for-service payments refer to medical or other services paid to providers on a service-by-service and/or to or item supplied basis as opposed to flat beneficiary contributions, such as salary payments, prospective case-mix type of payments and capitated forms of payments.

Final consumption of households is the value of the consumption goods and services acquired by households, whether by purchase in general, or by transfer from government units or NPISHs, and used by them for the satisfaction of their needs and wants; it is derived from their final consumption expenditure by adding the value of social transfers in kind receivable. The term underlies in the context of NASA the purchases made by individuals for the purposes of maintaining a functional status and improving the well-being of dependents of patients who have died from AIDS.

Financing agents designate institutions or entities which mobilize funds in the hands of financing sources for the purpose of purchasing NASA-related commodities (those embraced by the NASA spending categories). The purchases or payments constitute an array ranging from outright purchases to subsidies (usually from government to producers, but also crosssubsidization between products) to transfers (to households, intra-government transfers being netted out), from straight to complex forms including advance payments and late payments which NASA invites accountants to adjust (see accrual accounting).

Financial intermediation is the activity by which an institutional unit acquires financial assets and incurs liabilities on its own account by engaging in financial transactions on the market. The assets and liabilities of financial intermediaries have different characteristics so that the funds are transformed or repackaged with respect to maturity, risk, scale in the financial intermediation process.

Financing sources refers in NASA to the various types of transactions whereby resources are transferred from entities holding financial assets to financing pooling agencies which make the discretionary payment and purchasing decisions related to HIV and AIDS interventions.

Fixed assets refers to producer equipment (or structure) continuously or repeatedly used in a production process, such as structures (plant or tracks, for instance) and equipment (e.g., machinery and vehicles).

Flows reflect the creation, transformation, exchange, transfer or extinction of economic value. They involve changes in the volume, composition or value of the assets and liabilities of an institutional unit.

A function refers to a set of determinants which activate a dimension (what dynamizes the pooling and mobilization of funds: the financing function, what activates the provision process: the production function, what makes up final use: the consumption function). In the System of health accounts and in the Guide to producing national health accounts, function designates only end-use.

Functional classifications provide a means of classifying, by purpose or socioeconomic objective (type of service) certain transactions of producers (activities equated with services consumed) and of three institutional sectors – namely households, general government and non-profit institutions serving households (NPISH).

The general government sector consists of the totality of institutional units, which, in addition to fulfilling their political responsibilities and their role of economic regulation, produce principally non-market services (possibly goods) for individual or collective consumption and redistribute income and wealth. It comprises the territorial authorities (central/federal government – regional/provincial/state governments – district/municipal and other local governments), trust funds (principally social security schemes) and extrabudgetary funds but not public corporations; when the latter are included, the precise nomenclature is public sector (the health and other social programmes carried out by public corporations usually conducted with government directives and not as an autonomous corporate decision, the interventions on HIV and AIDS conducted by these corporations are assimilated to quasi extra-budgetary funds and thus reported by most countries as general government). As general government transactions may be tabulated consolidated (net of intra-government transfers) or gross (cash flows out of each level), the estimates should be appropriately qualified.

Grants are voluntary transfers, current or capital in nature (see also subsidies).

The gross domestic product is the total value of output in the economic territory studied, measured at market or purchaser prices or at factor cost.

Gross fixed capital formation is measured by the total value of a producer's acquisitions, less disposals, of fixed assets during the accounting period plus certain additions to the value of non-produced assets (such as subsoil assets or major improvements in the quantity, quality or productivity of land) realized by the productive activity of institutional units. The fixed assets are divided in structures (constructions) and equipment (e.g., for laboratory or surgeries). For operational reasons, transport equipment (vehicles) is often identified separately.

Gross value added is the value of output less the value of intermediate consumption; it is a measure of the contribution to GDP made by an individual producer, industry or sector; gross value added is the source from which the primary incomes of the SNA are generated and is therefore carried forward into the primary distribution of income account.

A health insurance policy is a contract between an individual and an insurer by which in the event of specified diseases (in some contacts also in the event of accidents) the insurer will pay to the insured party a partial (sometimes total) part of the costs incurred, directly to the provider or to the insured party. The main types of contracts are between the general population and a social security scheme; between employers on behalf of their employees; and between individuals and for-profit or not-for-profit entities.

Health promotion is a process to enable individuals or target population groups to increase control over, and to enhance their health status.

Health status is a measure or index to represent a synthetic average or the distribution of these functional characteristics in the population or in targeted population groups.

Health technology assessment is a (rigorous) appraisal of the evidence claims attached to a specific intervention, mainly clinical, and cost-effectiveness. This includes procedures, settings and programmes, the evaluation of medical equipment, pharmaceuticals, therapeutic appliances and therapeutic procedures.

The hedonic method is a regression technique used to estimate the prices of qualities or models that are not available on the market during particular periods, but whose prices during those periods are needed to be able to construct price relatives. It is based on the hypothesis that the prices of different models on sale on the market at the same time are functions of certain measurable characteristics such as size, weight, power, speed, etc. and so regression methods can be used to estimate by how much the price varies in relation to each of the characteristics. The British Office of National Statistics is currently exploring the feasibility and the sensitivity of introducing effectiveness gains in public education and health expenditure, susceptible to influence in years ahead NASA measurement.

Home care relates to medical, paramedical and selected types of social care complementing the medical and paramedical care for patients with functional disabilities provided outside hospitals, dispensaries and health care professionals' offices and delivery facilities, usually in the patient's home.

A household is a small group of persons who share the same living accommodation, who pool some, or all, of their income and wealth and who consume certain types of goods and services collectively, mainly housing and food.

Actual final consumption of households is the value of the consumption goods and services acquired by households, whether by purchase in general, or by transfer from government units or NPISHs, and used by them for the satisfaction of their needs and wants; it is derived from their final consumption expenditure by adding the value of social transfers in kind receivable. Some transactions that it is desirable to include in the accounts do not take place in money terms and so cannot be measured directly; in such cases a conventional value is imputed to the corresponding expenditure (the conventions used vary from case to case and are described in the SNA as necessary).

An imputation is an informed estimation of a missing value, a guess of an expected plausible value when actual data are missing.

Inpatient care refers to services delivered to patients visiting a health care institution (usually a hospital) in which they stay overnight.

The International Classification for Health Accounts (ICHA) consists of three classifications (financing agents, providers, spending categories) adopted as the instrument to construct the System of Health Accounts cross-classification tables.

International Monetary Fund (IMF), comprising around 180 member countries, supervises the exchange rate mechanisms, makes available to its members a pool of foreign exchange to assist them when they have balance of payments difficulties and provides economic intelligence (including statistical services) and analyses to guide macro-economic policies.

Interest (interest payments) is (are) the amount that the debtor becomes liable to pay to the creditor over a given period of time without reducing the amount of principal outstanding, under the terms of the financial instrument agreed between them.

An intervention refers to a wilful exposure to a process (e.g., therapeutic process) designed to alleviate facets of a situation, exposure to an environmental agent, harm from a recent exposure to a risk.

Inventories (also referred to as stocks) consist of finished goods held by a producer prior to sale, further processing or other use) and products (material and fuel) acquired from other producers to be used for intermediate consumption or resold without further processing.

ISIC is the United Nations International Standard Industrial Classification of All Economic Activities; the third revision of ISIC was used in the 1993 SNA. The fourth revision is to be implemented starting in 2008.

Local government units are institutional units whose fiscal, legislative and executive authority extends over the smallest geographical areas distinguished for administrative and political purposes.

Market valuation refers to pricing that is observed or derived for the transactions measured.

Mass media (see communication and behavioural change).

Materials and supplies are goods and services used in the provision process as intermediate inputs, excluding fixed capital or fixed investments whose contribution is measured.

Mitigation relates to programmes targeted to the poor, the vulnerable and other high-risk groups.

Mixed incomes is the income of unincorporated enterprises owned by households to which the owner(s) may contribute with his/her (their) unpaid labour inputs that cannot be separated from the operating surplus, which also covers the income on fixed assets and contains production of households for their own final use.

Morbidity is the rate of illness in a stated population but not death (percentage/per 1000/per 100 000 of total population or population in a defined segment).

Mortality is rate of deaths per 1000 population or other pre-defined population segment.

Non-market refers to output and transactions produced by non-profit institutions supplied free or at a price that is not economically significant (is charged to raise revenue or to reduce excess demand).

Non-profit institutions (NPIs) are legal or social entities created for the purpose of producing goods and services, whose status does not permit them to be a source of income, profit or other financial gain for the units that establish, control or finance them.

Number needed to treat (NNT) is an indicator to measure treatment effectiveness. The number of people that should benefit from a specific treatment or intervention during a given period of time to prevent an additional adverse outcome or achieve an additional beneficial outcome.

Nursing staff designates nurses, medical assistants and midwives (persons who have completed at least a country's basic course in nursing or whose long practical experience and capacitation has earned them formal recognition by the authorities of the hospital concerned of being a practical nurse).

Operating surplus refers to the value arising from the production of goods and services after costs and before allocation of flows to property income.

Opportunity cost is a concept commonly used in economics; it is measured by reference to the opportunities foregone at the time an asset or resource is used, as distinct from the costs incurred at some time in the past to acquire the asset, or the payments which could be realized by an alternative use of a resource (e.g., the use of labour in a voluntary capacity being valued at the wages which could have been earned in a paid job).

Outcome relates to the results of an intervention or process in terms of individual or societal expectations.

Out-of-pocket spending applies to the direct disbursements of households, including in NASA gratuities and payments in-kind, made to health practitioners and to suppliers of social assistance linked to AIDS intervention programmes, including medical goods suppliers (pharmaceuticals and therapeutic appliances), other goods and services whose primary intent is to contribute to the restoration or to the enhancement of the health status and the social status of individuals or population groups as listed in the NASA spending categories and supporting classifications.

Outpatient care refers to medical care and selected forms of social care for patients who are functionally disabled, which is provided to patients visiting a health care institution in which they are kept for only a few hours and accommodation for overnight stay in the facility is not required.

Output consists of those goods or services that are produced within an establishment that become available for use outside that establishment, plus any goods and services produced for own final use.

Own account production is the output for final consumption or for gross capital formation by a producer.

Palliative care (from Latin palliare, to cloak) is any form of medical care or treatment that concentrates on reducing the severity of disease symptoms or slowing the disease's progress, rather than providing a cure. While palliative care may occasionally be used in conjunction with curative therapy, providing that the curative therapy will not cause additional morbidity, the primary aim of palliative care is to improve quality of life by reducing or eliminating pain and other physical symptoms.

Payroll taxes paid by enterprises, assessed as a percentage of the wages and salaries paid on the basis, are identified in the expanded classification of financing sources. PG (see Producers' guide).

PMTCT is the standard abbreviation for Prevention of mother-to-child transmission programmes.

The price of a good or service is the value of one unit of that good or service.

A price index reflects an average of the proportionate changes in the prices of a specified set of goods and services between two periods of time.

A price relative is the ratio of the price of a specific product in one period to the price of the same product in some other period. In PPP comparisons, used notably by two handful of Latin American countries, a price relative refers to the ratios of the same product in two countries.

A Fisher's ideal price index is the geometric mean of the Laspeyres and Paasche price indices. A Fisher's Ideal volume index is the geometric mean of the Laspeyres and Paasche volume indices.

A Laspeyres price index is a weighted arithmetic average of price relatives using the values of the earlier period as weights. A Laspeyres volume index is a weighted arithmetic average of quantity relatives using the values of the earlier period as weights.

A Paasche price index is the harmonic average of price relatives using the values of the later period as weights.

A Paasche volume index is the harmonic average of volume relatives using the values of the later period as weights.

Pre-ART refers to a phase of the treatment of HIV-infected patients that precedes the administration of an antiretroviral or ARV therapy.

Preventive services entail a reduction of exposure to risks and to the effects of increased risks. It focalizes actions linked to specific environments, involving co-responsibility, through behaviour of individuals and communities. Much (unmeasured) prevention is attained in the home, in the workplace and in public spaces, only marginally identified as child protection, breast cancer screening, school health) or in mostly non-care educational community programmes. It involves an individual when the attainment of a public health target is integrated in a personalized care programme. Preventive services are current costs to reduce potential future risks, valued at historical resource use costs, much of which shifted to labour exchanges, to equipment purchases such as automotive equipment.

Prevention comprises services linked to health promotion, primary prevention, secondary prevention, community programmes and services geared to increasing the health stock of a population. There is typically a distinction between:

- health promotion or services designed to reduce risk exposure and their consequences and to enhance the health status of the total population or sizeable population groups;
- Primary prevention relating to overt individual health risks or their effect, the early detection of serious risks for the health of population segments before clinical conditions are perceived or epidemiological warnings emerge; and
- Secondary prevention designed to identify and treat people with an established disease and those at very high risk of developing it, as well as treating and rehabilitating patients who have already had a disease and seek to avoid sequelae and risk factor interventions. Its final aims are to contribute to: extending overall survival, improving quality of life and decreasing need for intervention procedures as well as reducing the incidence of subsequent episodes.

The private sector includes non-financial and financial corporations, non-profit institutions serving mainly households (NPISH) and households.

A PPP (purchasing power parity) is a price relative which measures the number of units of country B's currency that are needed in country B to purchase the same quantity of an individual good or service as 1 unit of country A's currency will purchase in country. For audiences unprepared to use much

economic jargon, PPP are akin to a measure or index attempting to measure in gross terms a level-of-living equivalent.

Private corporations are the resident corporations and quasi-corporations not controlled by government agencies.

PG (Producers' Guide) is the standard abbreviation of the 2003 World Bank/World Health Organization/USAID Guide to producing national health accounts with special applications for low-income and middle-income countries.

Prognosis refers to the probable course of a disease over time.

Providers in NASA are entities which are paid for by financing agents in exchange for, or in anticipation of activities producing commodities entering the basket of NASA goods and services, which can have health care or social care attributes (including administration and advocacy in nature). As activities also yield non-NASA products, NASA is developing a functional classification that is intended to be more rigorous than the ICHA and social care classifications from which the early HIV and AIDS functional classifications are issued.

A production is an activity, carried out under the responsibility, control and management of an institutional unit, which uses inputs of labour, capital and goods and services to produce outputs of goods and services.

Public corporations are resident corporations and quasi-corporations subject to control by government units, with control over a corporation being defined as the ability to determine general corporate policy by choosing appropriate directors, if necessary.

Public administrations as producer of goods and services consider departments, establishments and other entities of a central/federal, regional/provincial or local/municipal which are devoted to the supply of administration, defence, education, health, social, economic promotion and other services, financed through ordinary and supplementary budgets or extra-budgetary funds.

Public health services (in ISIC, Division 07 Health, Group 07.4) relates to the administration, inspection, operation or support of services such as blood-banks (collecting, processing, storing, shipping), disease detection (cancer, tuberculosis, venereal disease), prevention (immunization, inoculation), monitoring (infant nutrition, child health), epidemiological data collection, family planning services and so forth. Their mandate includes the preparation and dissemination of information on community and communal health matters, as well as a contribution to the planning, monitoring and evaluation of health programmes, the setting and enforcement of public standards, and an involvement in the regulation, licensing and supervision of providers. These services are delivered by special teams to groups of clients, most of whom are in good health, at workplaces, schools or other non-medical settings.

Public health services are not normally connected with a hospital, clinic or health practitioner office, although some such institutions may receive a specific public health mandate. Public health services are not routinely delivered by medically qualified doctors, although some may be associated to specific activities, e.g., the screening of blood-bank collection. They comprise specialized testing laboratories but medical analysis laboratories (ISIC class 07.2.4) and laboratories engaged in determining the causes of disease (ISIC class 07.5.0) constitute statistically distinct services.

Public corporations refer to entities owned by a nation which have a substantial degree of financial and managerial independence from the public authority that created them. The public sector comprises all general government entities and public corporations. Purchaser's prices refer to the amount actually paid by the end user (purchaser), excluding any deductible Value added tax (VAT) or similar deductible tax (excluding taxes on intermediate consumption of a health care or social care nature which make up the national response to HIV and AIDS).

Quality refers to characteristics which the evaluator (person or institution) deems to be an important part of the utility a consumer or purchaser derives from a commodity (good or service), such as functional reliability or comprehensiveness of a multi-attribute defined commodity or consistency or durability or attainment of set objectives. A quality is usually a quantity index applied to commodities which offer attributes other commodities of the same class do not have to the same extent.

Quality assurance refers to technical, operational and managerial activities aiming to ensure that all services reaching a patient are safe, effective and acceptable.

Quality of life refers to the ability of a person or population segment to satisfactorily exert his/her functional abilities.

Quantitative data is the term for information which describes the extent of an observed phenomenon in numerical terms.

A quantity index is built up from information on quantities, such as the number or total weight of goods or the number of services. A quantity index has no meaning from an economic point of view if it involves adding quantities that are not commensurate, although it is often used as a proxy for a volume index (see also price index and volume index).

The Quasi corporations are unincorporated enterprises that function as if they were corporations.

R&D health expenditure (ISIC division 07, group 07.5) comprise outlays on the administration and operation of government agencies engaged in applied research and experimental development related to health, grants, loans and subsidies to support applied research and experimental development related to health undertaken by nongovernment bodies such as research institutes and universities. They include outlays on laboratories engaged in determining the causes of disease, but exclude basic research (ISIC class 01.4.0).

A randomized controlled trial is a scientific experiment commonly used in testing health care services.

A register is a written record of events or transactions or names.

Residents comprise general governments, private non-profit making bodies serving households, individuals and enterprises operating within the territory of a given economy.

Resources refers to the side of the current accounts where transactions which add to the amount of economic value of a unit or a sector appear (for example, wages and salaries are a resource for the unit or sector receiving them); by convention, resources are put on the right side of a T-account (see also T-account).

Resource costs are the factor or inputs entering the provision or delivery process. The rest of the world consists of all non-resident institutional units that enter into transactions with resident units, or have other economic links with resident units.

Risk pooling refers to the spreading of potential liabilities of the minority in a large stratified group.

A sample is a segment of a population that is representative of a whole.

Satellite accounts provide a framework linked to the central accounts and which enables attention to be focused on a certain field or aspect of economic and social life in the context of national accounts, with principal focus on value added or time budgets. Common examples are satellite accounts for the environment, or tourism, or unpaid household work.

A sector refers to a group of units sharing a role in an economic system. Conventionally, NASA relates to a public sector, a private sector and a rest-of-the world sector.

A segment is a smaller group.

Services are outputs produced to order and which cannot be traded separately from their production; ownership rights cannot be established over community services and by the time their production is completed they must have been provided to the consumers. A group of service industries, whose outputs have characteristics of goods, concerned with the provision, storage, communication and dissemination of information, advice and entertainment in the broadest sense of those terms, for which ownership rights can be established, may be classified as a quasi goods industry depending on the medium by which these outputs are supplied. A small subset of this subclass enters into the production of a few NASA services.

Sexually transmitted infection (STI) used in the context of NASA as distinct from the more conventional sexually transmitted diseases (STD) – includes a broader population segment, infected but presenting no visible stigma of the disease.

SHA: A System of Health Accounts is the manual diffused by OECD in 2000.

SNA: Standard National Accounts is the Commission of the European Community/International Monetary Fund/Organisation for Economic Co-operation /United Nations/World Bank manual encompassing the conventional and agreed rules to construct and maintain macro-economic accounts. The 1993 edition is not yet uniformly implemented by the majority of nations, which still rely on the 1968 edition. A revised version (SNA08) is expected to be adopted during 2008.

A Social accounting matrix (SAM) is a presentation of the SNA in matrix form that incorporates whatever degree of detail is of special interest. The construction of an SAM exploits the available flexibility to highlight special interests and concerns which the SNA macro-accountants may not sufficiently highlight, displaying the interconnections, disaggregating the household sector into intervention-specific segments, showing the link between income generation and consumption, notably, choosing types of disaggregation appropriate for the subject, incorporating extensive adjustments to serve specific analytical purposes.

Social assistance benefits are transfers made by government units or NPIs to households intended to meet the same kinds of needs as social insurance benefits but provided outside an organized social

insurance scheme and not conditional on previous payments of contributions. Only benefits designated in the NASA functional benefits should be retained in NASA accounting.

Social benefits are current transfers received by households intended to provide for the needs that arise from certain events or circumstances, for example, sickness, unemployment, retirement, housing, education or family circumstances. Only benefits designated in the NASA spending categories classification should be retained in NASA accounting.

Social exclusion (in ISIC, Division 10, Social protection, Group 07) applies to cash benefits and benefits in kind to persons who are socially isolated or at risk of social isolation such as persons who are destitute, low-income earners, immigrants, indigenous people, refugees, alcohol and substance abusers, victims of criminal violence, etc. The activity relates to the administration and operation of schemes relevant to the alleviation of the plight, comprising cash benefits, such as income support and other cash payments to the destitute and vulnerable persons to help reduce the consequences of poverty or assist in difficult situations; comprising benefits in kind, such as short-term and long-term shelter and board provided to destitute and vulnerable persons, rehabilitation of alcohol and substance abusers, services and goods to help vulnerable persons such as counseling, day shelter, help with carrying out daily tasks, food, clothing, fuel, etc.

Social insurance schemes are schemes in which social contributions are paid by employees or others, or by employers on behalf of their employees, to secure entitlement to social insurance benefits, in the current or subsequent periods, for the employees or other contributors, their dependants or survivors.

Social security funds are separately organized from the other activities of government units and hold their assets and liabilities separately from the latter. They are separate institutional units, autonomous funds with their own assets and liabilities and engage in financial transactions on their own account.

Stand by means "in reserve, ready to be used" (e.g., a credit line requested to be usable on call at the borrower's request).

State-owned enterprises (crown-owned enterprises, nationalized enterprises, parastatal entities), treated in the National Accounts as quasi private entities selling their wares on markets, are dealt with by several accountants as quasi-governmental entities for NASA commodities because as secondary producers of NASA-type benefits they do not act according to a commercial logic but, if not wholly according to public policy principles, largely in accordance with social, not economic criteria.

A statistical unit is the unit of observation or measurement for which data are collected.

Structures designate the constructions and immobile fixed investments (capital formation) entering the capital stock.

Subsidies are current unrequited payments that government units, including non-resident government units, make to enterprises on the basis of the levels of their production activities or the quantities or values of the goods or services which they produce, sell or import.

A supply and use table in NASA is a matrix that records how supplies of different kinds of goods and services originate from domestic industries and imports and how those supplies are allocated between various intermediate or final uses, including exports.

Surveillance refers to the close observation of a person or group, especially one under suspicion. The act of observing or the condition of being observed.

A survey is an investigation into the characteristics of a population segment or population samples, usually stratified for representativeness, designed to capture shared characteristics and differences that are grossed up to picture a behavioural relationship.

A T-account is a display which lists in adjacent columns the transactions occurring in the system monitored: the transactions arrayed as uses (expenditure) and resources (revenue), the level of assets and liabilities (changes thereof during the period of observation, usually a year when dealing with NASA categories).

Taxes are compulsory unrequited transfers to general government.

Taxonomy refers to the science or principles of classification.

Therapy refers to a selection of effective treatments which meet the values of a patient or a population segment. (The effectiveness or efficacy of treatments at the individual level is often measured by way of a recuperation of the patient's quality of life, at the level of a population segment, by means of randomized controlled trial).

Top down estimation refers to figures whose aggregate value is known and distributed into plausible elements considered to enter into its composition.

Transactions – at the centre of the NASA tables, created around a cross-classification of two transaction categories each – consist in an exchange between two parties, such as the purchase of NASA commodities against a budget assignment (including an external grant), a direct payment, an entitlement right, or one of a long list of and other.

Transfer payments relate to institutions (usually in NASA governments) transferring assets (money) to households without any payment in return, typically reimbursement of medical and paramedical expenditure.

Transfers are unrequited payment made by one unit to another. The main types are taxes, social contributions and social benefits.

Transparency relates to the openness of a process, to non-secretiveness regarding its value and mode of approach.

Triangulation is a statistical procedure permitting one to impute a missing value by comparing it to estimates found in other datasets comprising it also.

Triaxial means that there are three dimensions.

Unconsolidated refers to intra-sectoral flows (intragovernmental or between private agents) which are added up without netting out.

Unit refers to a fundamental quantity of measurement.

The term use(s) refers to transactions in the current accounts that reduce the amount of economic value of a unit or sector (for example, wages and salaries are a use for the unit or sector that must pay them); by convention, uses are put on the left side of the account

User fees/user charges at government facilities in most countries constitute an essential financing source for the programmes levying them (supporting the operation and the maintenance of the facilities when the user charges for services at publicly funded facilities are retained by it or considered part of its budget). When the fees are returned to the central ministry, they may be included in its recurrent budget. Regardless of the arrangement, where fees have been paid by consumers in return for delivery of services, the household is the appropriate financing agent (for the amount of the fees). Expenditures by the government as a financing agent should be net of those fees. When the ministry of health operates a hospital at a cost of 1000, and the hospital collects 100 in user charges from households the households are the financing agent for 100 (10%) and the ministry of health is the financing agent for 900 (90%). When user fees are returned to the ministry of finance, it is essential that they not be included in the ministry's outlays to avoid doublecounting those expenditures.

Validation is the process of assessing a result by a method (sometimes several methods) other than the method originally used to obtain the cell, row, column, matrix examined.

Value at the level of a single, homogeneous good or service is equal to the price per unit of quantity multiplied by the number of quantity units of that good or service; in contrast to price, value is independent of the choice of quantity unit.

> Gross value added is the value of output less the value of intermediate consumption; it is a measure of the contribution to GDP made by an individual producer, industry or sector; gross value added is the source from which the primary incomes of the SNA are generated and is therefore carried forward into the primary distribution of income account.

Value added tax (VAT) is a tax collected by enterprises in stages (at each sale of a commodity) which is ultimately charged in full to the final purchaser. (The concept is opposed to a sales tax which may be applied in cascade at various stages of transaction, not reimbursed to intermediate purchasers, those before the end stage).

Vector is a set of variables.

A volume index is most commonly presented as a weighted average of the proportionate changes in the quantities of a specified set of goods or services between two periods of time; volume indices may also compare the relative levels of activity in different countries (e.g., those calculated using PPPs).

Vulnerable and special populations, in the context of NASA, are target population segments at high risk of HIV contamination, particularly indigenous groups, migrants, prisoners, recruits in the armed forces, truck drivers, displaced persons in situation of civil war and conflicts. In the context of NASA, orphans – although a vulnerable population segment – are listed under OVC – Orphans and Vulnerable Children and not under the Vulnerable and special populations as this is a specific target group that should not be counted twice.

ANNEX C. EXAMPLE OF COUNTRY NASA TABLE

2006
Swaziland

Data

Total_USD	Public_Sub_Total USD	Central_National USD	Sub_National USD	Dev_Bank_Reimbursable USD	All_Other_Public USD	Social_Security USD	International_ Sub_Total USD	Bilaterals USD	UN_Agencies_Multilaterals USD
8,300,710	1,143,735	1,143,735	-	-	-	-	7,156,976	1,588,988	1,432,567
2,900,173	1,065,683	1,065,683	-	-	-	-	1,834,490	270,385	451,638
580,292	8,045	8,045	-	-	-	-	572,247	-	397,952
2,243,230	10,661	10,661	-	-	-	-	2,232,569	749,962	169,767
6,906	-	-	-	-	-	-	6,906	3,336	-
171,419	-	-	-	-	-	-	171,419	52,555	70,692
354,114	50,672	50,672	-	-	-	-	303,443	-	-
42,331	-	-	-	-	-	-	42,331	-	-
170,591	-	-	-	-	-	-	170,591	54,143	-
713,284	1,228	1,228	-	-	-	-	712,056	458,607	-
63,689	-	-	-	-	-	-	63,689	-	7,371
344,003	4,100	4,100	-	-	-	-	339,903	-	278,576
583,000	-	-	-	-	-	-	583,000	-	12,571
83,677	3,345	3,345	-	-	-	-	80,332	-	-
44,000	-	-	-	-	-	-	44,000	-	44,000
9,383,824	2,619,541	2,619,541	-	-	-	-	6,764,283	30,505	417,221
28,286	-	-	-	-	-	-	28,286	-	-
6,244,129	1,963,042	1,963,042	-	-	-	-	4,281,087	-	-
320,221	-	-	-	-	-	-	320,221	-	320,221
74,285	-	-	-	-	-	-	74,285	-	-
709,236	-	-	-	-	-	-	709,236	-	-
54,564	-	-	-	-	-	-	54,564	18,948	-
294,687	22,990	22,990	-	-	-	-	271,697	11,557	69,357
1,101,420	107,067	107,067	-	-	-	-	994,353	-	5,000
556,997	526,442	526,442	-	-	-	-	30,556	-	22,643
15,027,355	10,287,284	10,287,284	-	-	-	-	4,740,071	23,932	2,175,633
6,866,207	3,536,541	3,536,541	-	-	-	-	3,329,665	184,944	315,379
5,448,470	287,197	287,197	-	-	-	-	5,161,273	1,005,468	346,144
3,050,851	1,349,411	1,349,411	-	-	-	-	1,701,440	30,380	-
907,824	208,868	208,868	-	-	-	-	698,956	-	69,646
128,145	126,848	126,848	-	-	-	-	1,297	-	-
1,297	-	-	-	-	-	-	1,297	-	-
126,848	126,848	126,848	-	-	-	-	-	-	-
49,113,384	19,559,424	19,559,424	-	-	-	-	29,553,960	2,864,217	4,756,590

Total_USD	Global_Fund USD	Dev_Bank_Non_Reimburseable USD	All_Other_Multilateral USD	All_Other_International USD	All_Other_International USD2	Private_Sub_ Total USD	Corporations USD	Consumer_Out_of_pocket USD
8,300,710	3,113,052	-	-	1,022,368	1,022,368	n/a	n/a	n/a
2,900,173	299,378	-	-	813,089	813,089	n/a	n/a	n/a
580,292	158,347	-	-	15,947	15,947	n/a	n/a	n/a
2,243,230	1,299,756	-	-	13,083	13,083	n/a	n/a	n/a
6,906	3,570	-	-	-	-	n/a	n/a	n/a
171,419	-	-	-	48,172	48,172	n/a	n/a	n/a
354,114	303,443	-	-	-	-	n/a	n/a	n/a
42,331	-	-	-	42,331	42,331	n/a	n/a	n/a
170,591	29,489	-	-	86,959	86,959	n/a	n/a	n/a
713,284	253,448	-	-	-	-	n/a	n/a	n/a
63,689	56,318	-	-	-	-	n/a	n/a	n/a
344,003	58,541	-	-	2,786	2,786	n/a	n/a	n/a
583,000	570,429	-	-	-	-	n/a	n/a	n/a
83,677	80,332	-	-	-	-	n/a	n/a	n/a
44,000	-	-	-	-	-	n/a	n/a	n/a
9,383,824	6,238,285	-	-	78,272	78,272	n/a	n/a	n/a
28,286	-	-	-	28,286	28,286	n/a	n/a	n/a
6,244,129	4,281,087	-	-	-	-	n/a	n/a	n/a
320,221	-	-	-	-	-	n/a	n/a	n/a
74,285	74,285	-	-	-	-	n/a	n/a	n/a
709,236	709,236	-	-	-	-	n/a	n/a	n/a
54,564	35,616	-	-	-	-	n/a	n/a	n/a
294,687	145,610	-	-	45,172	45,172	n/a	n/a	n/a
1,101,420	984,539	-	-	4,814	4,814	n/a	n/a	n/a
556,997	7,913	-	-	-	-	n/a	n/a	n/a
15,027,355	1,826,931	-	-	713,576	713,576	n/a	n/a	n/a
6,866,207	2,319,458	-	-	509,884	509,884	n/a	n/a	n/a
5,448,470	380,183	-	-	3,429,477	3,429,477	n/a	n/a	n/a
3,050,851	1,103,759	-	-	567,301	567,301	n/a	n/a	n/a
907,824	261,328	-	-	367,981	367,981	n/a	n/a	n/a
128,145	-	-	-	1,297	1,297	n/a	n/a	n/a
1,297	-	-	-	1,297	1,297	n/a	n/a	n/a
126,848	-	-	-	-	-	n/a	n/a	n/a
49,113,384	15,242,998	-	-	6,690,156	6,690,156	n/a	n/a	n/a

ANNEX D. COUNTRY NHA TABLE

Below is an example of a country NHA table: Zimbabwe HIV/AIDS subaccounts table FS X HC.

Distribution of financing sources by Function (FSxHC), Zimbabwe NHA HIV/AIDS subaccounts 2005

	Financing Sources						*As a % of*
Function	**Ministry of Finance**	**Local Authorities**	**Employers**	**Households**	**Rest of the World**	**Total**	*THAE*
HC.1 Services of curative care	1,137,325,059,329	87,234,426,841	412,444,682,717	8,242,903,243,815	1,348,455,608,938	**11,228,363,021,640**	*54%*
HC.1.1 Inpatient treatment of OI	1,004,470,390,495	49,018,374,138	144,522,677,583	785,790,986,783	-	**1,983,802,428,999**	*9%*
HC.1.3 Outpatient Treatment of OI	132,854,668,834	38,216,052,703	267,922,005,134	7,457,112,257,032	1,348,455,608,938	**9,244,560,592,641**	*44%*
HC.1.3.1 ART Treatment					1,057,137,264,221	**1,057,137,264,221**	*5%*
HC.4 Ancillary services to medical care	11,639,049,637				92,792,962,220	**104,432,011,857**	*0%*
HC.4.1 Clinical Laboratory	11,639,049,637				92,792,962,220	**104,432,011,857**	*0%*
HC.5 Medical goods dispensed to outpatients			83,066,202,651	182,845,092,675		**265,911,295,326**	*1%*
HC.5.1 Pharmaceuticals and other non durable goods			83,066,202,651	182,845,092,675		**265,911,295,326**	*1%*
HC.6 Prevention and public health	285,592,829,454	24,508,673,052	164,213,091,429		5,654,810,542,580	**6,129,125,136,516**	*29%*
HC.6.3 Prevention of communicable diseases	285,592,829,454	24,508,673,052	164,213,091,429		5,654,810,542,580	**6,129,125,136,516**	*29%*
HC.6.3.1 PMTCT					1,178,704,508,287	**1,178,704,508,287**	*6%*
HC.6.3.2 VCT					682,851,098,353	**682,851,098,353**	*3%*
HC.6.3.3 Behaviour Change					,367,860,218,514	**1,367,860,218,514**	*7%*
HC.6.3.4 Youth programmes					12,693,083,380	**312,693,083,380**	*1%*
HC.6.3.5 Mass media					27,120,061,419	**27,120,061,419**	*0%*
HC.6.3.6 Condom Promotion					1,026,772,961,456	**1,026,772,961,456**	*5%*
HC.6.3.7 Workplace programmes					19,744,279,553	**19,744,279,553**	*0%*
HC.6.3.8 Surveillance					196,357,993,078	**196,357,993,078**	*1%*
HC.6.3.nsk Prevention and public health services nsk					842,706,338,540	**842,706,338,540**	*4%*
HC.7 General Health Administration&Insurance	5,706,021,359					**5,706,021,359**	*0%*
HC 7.1 General Government Administration of Health	5,706,021,359						*0%*
HC.R.1 Capital Formation					22,650,913,562	**22,650,913,562**	*0%*
Total HIV&AIDS Health Expenditures	**1,440,262,959,779**	**111,743,099,893**	**659,723,976,797**	**8,425,748,336,490**	**7,118,710,027,300**	**17,756,188,400,260.00**	*85%*
HC.R Health care related functions					282,979,354,842	**282,979,354,842**	*1%*
HC.R.2 Education and training					280,812,504,901	**280,812,504,901**	*1%*
HC.R. 3 Research and Development					2,166,849,941	**2,166,849,941**	*0%*
National HIV&AIDS Expenditures	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	7,401,689,382,142	**18,039,167,755,102**	*86%*
Non health functions					2,905,183,963,745	**2,905,183,963,745**	*14%*
OVC Care and Support					2,150,022,759,242	**2,150,022,759,242**	*10%*
PLWHA Support					246,392,670,366	**246,392,670,366**	*1%*
Home Based Care					508,768,534,137	**508,768,534,137**	*2%*
Total HV&AIDS Expenditures (THAE)	**1,440,262,959,779**	**111,743,099,893**	**659,723,976,797**	**8,425,748,336,490**	**10,306,873,345,887**	**20,944,351,718,847**	*100%*
As a % of THAE	*7%*	*1%*	*3%*	*40%*	*49%*	*100%*	

ANNEX E. EXAMPLE OF NASA FUNDING MATRIX COMPUTED FROM NHA DATA

Below is an example of a NASA funding matrix computed from NHA HIV/AIDS subaccounts data in Zimbabwe.

Appendix B6: Financing sources by UNAIDS AIDS Spending Categories

YEAR ___2005_____

Calendar Year: Yes _X___ No _____

Fiscal Year: _____ (specify beginning/end)

Average Excha 1USD=Z$100,000

AIDS Spending Categories	TOTAL (Local Currency)	Financing Sources								
		Public Sources				International Sources	Private Sources (optional for UNGASS reporting)			
		Public	Sub-Total	Central / National	Sub- National	International Sub-Total	Private	Sub-Total	Corporations	Consumer / Out-of-pocket
TOTAL (Local Currency)	**20,944,351,718,846**		**1,552,006,059,672**	**1,440,262,959,779**	**111,743,099,893**	**10,306,873,345,887**		**9,085,472,313,297**	**659,723,976,797**	**8,425,748,336,490**
1. Prevention (sub-total)	5,932,767,143,437		310,101,502,506	285,592,829,454	24,508,673,052	5,458,452,549,502		164,213,091,429	164,213,091,429	-
1.1 Mass media	27,120,061,419		-			27,120,061,419				
1.2 Community mobilization	367,860,218,514		-			367,860,218,514				
1.3 Voluntary counselling and testing	682,851,098,353		-			682,851,098,353				
1.5. Youth in school	12,693,083,380		-			12,693,083,380				
1.11 Workplace activities	19,744,279,553		-			19,744,279,553				
1.13 Public and commercial sector condom provision	1,026,772,961,456		-			1,026,772,961,456				
1.17 Prevention of mother-to-child transmission	1,178,704,508,287		-			1,178,704,508,287				
1.99 Others / Not-elsewhere classified	2,142,706,338,540		-			2,142,706,338,540				
2. Care and Treatment (sub-total)	12,107,474,862,960		1,236,198,535,807	1,148,964,108,966	87,234,426,841	1,950,017,105,295		8,921,259,221,858	495,510,885,368	8,425,748,336,490
2.4 Antiretroviral therapy	1,057,137,264,221		-	-		1,057,137,264,221				
2.6 Specific HIV laboratory monitoring	104,432,011,857		11,639,049,637	11,639,049,637		92,792,962,220				
2.10 Home-based care	508,768,534,137		-			508,768,534,137				
2.11 Additional/informal providers	-		-							37,861,174,551
2.12 Inpatient care	1,053,488,764,633		1,053,488,764,633	1,004,470,390,495	49,018,374,138	-			144,522,677,583	785,790,986,783
2.13 Opportunistic infection (OI) treatment	**462,389,066,254**		**171,070,721,537**	132,854,668,834	38,216,052,703	291,318,344,717			350,988,207,785	7,602,096,175,156
2.99 Others / Not-elsewhere classified	-		-							
3. Orphans and Vulnerable Children * (sub-total)	2,150,022,759,242		-	-	-	2,150,022,759,242		-	-	-
4. Program Management and Administration Strengthening (sub-total)	224,714,927,999		5,706,021,359	5,706,021,359	-	219,008,906,640		-	-	-
4.1 Programme management	5,706,021,359		5,706,021,359	5,706,021,359						
4.5 Sero-surveillance	196,357,993,078		-			196,357,993,078				
4.10 Upgrading laboratory infrastructure	22,650,913,562		-			22,650,913,562				
5. Incentives for Human Resources ** (sub-total)	280,812,504,901		-	-	-	280,812,504,901		-	-	-
5.5 Training	280,812,504,901		-			280,812,504,901				
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	246,392,670,366		-	-	-	246,392,670,366		-	-	-
7. Enabling Environment and Community Development (sub-total)	-		-	-	-	-		-	-	-
8. Research excluding operations research which is included under (sub-total)	2,166,849,941		-	-	-	2,166,849,941		-	-	-
8.4 Social science research	2,166,849,941		-			2,166,849,941				
	100%		**7%**	**7%**	**1%**	**49%**		**43%**	**3%**	**40%**

* The term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for social support as orphan.

** The item on Incentives for Human Resources needs to be dissagregated from the costs for service delivery of the other activities, e.g. in the in- and out-patient service provision. Efforts need to be made to avoid double counting.