



Republic of Botswana



**Botswana National AIDS Coordinating Agency (NACA)
Joint United Nations Program on AIDS (UNAIDS)**

**BOTSWANA
NATIONAL AIDS SPENDING ASSESSMENT
2003/04 TO 2005/06**

FINAL DRAFT

26 September 2007

Approved by the UNAIDS Secretariat Unit of Resource Tracking

Awaiting FINAL Approval from the National AIDS Coordinating Agency (NACA)



**BOTSWANA NATIONAL AIDS SPENDING ASSESSMENT, 2003/04 – 2005/06:
LEVEL AND FLOW OF RESOURCES AND EXPENDITURES
FOR THE RESPONSE TO HIV/AIDS**

BOTSWANA NATIONAL AIDS COORDINATING AGENCY (NACA)

JOINT UNITED NATIONS PROGRAMME ON AIDS (UNAIDS)

Gaborone, Botswana

First draft, November 2006

Final draft, September 2007

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TABLE OF CONTENTS

	Page
Abbreviations	4
Acknowledgements	5
Chapter 1: Introduction	6
Chapter 2: Methodology	15
Chapter 3: Key Findings of the NASA	23
Chapter 4: Recommendations and Conclusions	39
References	45
Appendix I ~ Sources of Data	47
Appendix II ~ Interviews Held and Organisations Contacted for Information	49
Appendix III ~ Botswana NASA Matrices	53
Appendix IV ~ Public & International Spending Categories	56
Appendix V ~ Botswana Total Spending by Expanded Categories	58
Appendix VI ~ Beneficiary Matrices	59
Appendix VII ~ NASA Data Collection Forms	60
Tables	
Table 1.1 NSF Targets by Goals	8
Table 1.2 Estimated Costs of the NSF	10
Table 1.3 Estimated Costs of the NSF Goals	11
Table 2.1 Site Selection	17
Table 3.1 Spending by NGOs in 2005	28
Figures	
Figure 1.1 Estimated Costs of the NSF Goals	10
Figure 3.1 Sources of Funds for HIV/AIDS in Botswana (2003/04 to 2005/06)	23
Figure 3.2 Total Spending by Category (2005/06)	24
Figure 3.3 Public and Donor Spending Priorities in 2005/06	24
Figure 3.4 Proportional Spending Priorities in 2005/06	25
Figure 3.5 Comparison of NSF Goals with Actual Total Spending in 2005/06	25
Figure 3.6 Preventative Spending Activities in 2005/06	27
Figure 3.7 Public Spending on Treatment Activities in 2005/06	28
Figure 3.8 Beneficiaries of Total HIV/AIDS Spending	30
Figure 3.9 Agent Proportional Spending on Beneficiaries (2005/06)	30

Abbreviations

ART	Antiretroviral Therapy
ACHAP	African Comprehensive HIV/AIDS Partnerships
BHRIMS	Botswana HIV/AIDS Response Information Management System
BOCAIP	Botswana Christian AIDS Intervention Programmes
BONASO	Botswana Network of AIDS Service Organisations
BONEPWA	Botswana Network of People Living with HIV/AIDS
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
BPOMAS	Botswana Public Officers Medical Aid Scheme
CCM	Country Coordinating Mechanism
CSW	Commercial Sex Workers
DAC	District AIDS Coordinator
DDF	Domestic Development Fund
GDP	Gross Domestic Product
GFATM	Global Fund to Fight TB, HIV/AIDS and Malaria
GoB	Government of Botswana
HDI	Human Development Index
HIPC	Heavily Indebted Poor Countries Initiative
HSS	Health Systems Strengthening
IDU	Intravenous Drug User
MAP	Multi-country HIV/AIDS Programs
MARPs	Most at Risk Populations
MFPD	Ministry of Finance and Development Planning
MLG	Ministry of Local Government
MOH	Ministry of Health
MPU	Ministerial Planning Unit
MSM	Men who have sex with men
MTR	Mid-Term Review
NACA	National AIDS Coordinating Agency
NASA	National AIDS Spending Assessment
NGO's	Non-Governmental Organizations
NSF	National Strategic Framework
OI	Opportunistic Infections
OOPE	Our-Of-Pocket Expenditure
P	Pula (Botswana currency)
PEP	Post-Exposure Prophylaxis

PEPFAR	Presidential Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Purchasing Parity Power
STD	Sexually Transmitted Diseases
t	thebe (Botswana currency)
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Acknowledgements

This project was made possible through the support of Mr Chris Molomo, Coordinator of the Botswana National AIDS Coordinating Agency (NACA), Ms Monica Tselayakgosi, the Program Planning Manager of NACA, and Mr Peter Stegman, Strategic Planning Consultant to NACA. None of the data collection would have been possible without Edward Madigela, the NACA driver, who safely and patiently drove us to all the appointments and site visits. In addition, UNAIDS have offered invaluable support through Mr Evaristo Marowa, UNAIDS Country Coordinator, Wayne Gill, Mona Drage, Irene Maina and Annie Jensen. In terms of undertaking the NASA work, we are indebted to the NACA representatives: Basipo Madandume and Jane Moshosho-Alfred, who contributed their skills, expertise, time and enthusiasm to the process. The project would have been impossible without their invaluable contribution, and through the process they have become NASA experts, and thus have been capacitated to undertake the NASA methods on an on-going basis in their country. This has been an important outcome of this Mission.

Permission to access the relevant data were kindly provided by the Permanent Secretary of Health and of Local Government.

Our grateful thanks to all the respective respondents who took time to be interviewed and to provide us with their expenditure records. Special thanks to the district level staff (in the district administration, AIDS Co-ordinators, hospitals, clinics, NGOs, etc) who welcomed us and shared their time and information freely.

The UNAIDS NASA team was represented by CEGAA¹ consultants: Teresa Guthrie, Patricia Allen and Qinani Dube – who contributed their particular skills and expertise to ensure a methodologically sound process and a comprehensive and accurate final report.

¹ Centre for Economic Governance and AIDS in Africa.

Chapter 1 ~ Introduction

According to the recent UNAIDS Global Report on HIV/AIDS (2006²), an estimated 38.6 million [33.4 million–46.0 million] people worldwide were living with HIV at the end of 2005. An estimated 4.1 million [3.4 million–6.2 million] became newly infected with HIV and an estimated 2.8 million [2.4 million–3.3 million] lost their lives to AIDS. Overall, the HIV incidence rate (the proportion of people who have become infected with HIV) is believed to have peaked in the late 1990s and to have stabilized subsequently, notwithstanding increasing incidence in several countries.

In sub-Saharan Africa, the region with the largest burden of the AIDS epidemic, data also indicate that the HIV incidence rate has peaked in most countries. However, the epidemics in this region are highly diverse and especially severe in southern Africa, where some of the epidemics are still expanding. There are no clear signs of declining HIV prevalence in Southern Africa—including in Botswana, South Africa, Namibia and Swaziland, where exceptionally high infection levels continue (UNAIDS, 2006).

The enormous burden of the epidemic over developing countries has been highlighted, especially with regards to development, and was been described as the “single greatest reversal in human development” (Human Development Report, 2005). The epidemic has shortened average life expectancy by more than two decades in several countries, claiming an estimated 2.9 million lives in 2006 (UNAIDS, *AIDS Epidemic Update*, 2006). The particular burden on the health care systems has been highlighted.

In response, the commitment of resources to HIV/AIDS has accelerated since the 2001 United Nations Special Assembly on HIV/AIDS (UNGASS), with an annual average increase of US\$ 1.7 billion between 2001–2004, compared with an average annual increase of US\$ 266 million between 1996 and 2001. Available funding in 2005 reached US\$ 8.3 billion (UNAIDS, 2006).

In many of the Sub-Saharan countries, the funding for prevention, treatment and care has depended largely on external sources of funding. However, the situation is different in Botswana where the response to HIV/AIDS has been funded primarily by public revenue. Botswana therefore offers a hopeful example to Southern Africa of national and political commitment to the issue.

Importantly, domestic public expenditure from governments has also significantly increased in low-income sub-Saharan African countries, and more moderately in middle-income countries. In 2005, domestic resources reached US\$ 2.5 billion (UNAIDS, 2006).

The African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, held in Abuja, Nigeria on April 2001, with attendance of the Head of States of the Organization of African Unity, gave occasion to the United Nations Secretary-General, Kofi Annan, to launch the initiative for a Global Fund on HIV/AIDS and other infectious diseases³.

² UNAIDS, 2006. 2006 Report on the Global AIDS Epidemic.

http://data.unaids.org/pub/GlobalReport/2006/2006_GR-ExecutiveSummary_en.pdf

³ UN. Secretary-General Proposes Global Fund For Fight Against HIV/AIDS And Other Infectious Diseases At African Leaders Summit. Press release SG/SM/7779/Rev.1 26-04-01.

The major sources of funding for HIV/AIDS in region remain: the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the World Bank AIDS through the Multi-country HIV/AIDS Programs (MAP), the Presidential Emergency Plan for AIDS Relief (PEFAR), as well as many other cooperation agencies are allocating resources in the region, most of it as bilateral assistance to development. In relatively few years, the availability of resources has dramatically increased for some of these countries, at a pace unlikely to encompass the absorptive capacity of the institutional arrangements and health care systems⁴.

However, according to the recently released UNAIDS estimates of the financial resources required for Universal Access to prevention, treatment, care and support, there is a global funding gap of US\$8.1billion in 2007 (UNAIDS, 2007).

The analysis of the sources and uses of funds is always very useful, but specially in situations of scarcity of resources, due to the high importance of an effective allocation. By identifying the financial gaps and the functional overlapping, as well as the total amount of resources devoted to AIDS, the financial sources and providers of services, several opportunities to improve the results of the investments might emerge. On the other hand, when the financial flow increases abruptly, it is also important to keep track of the resources, to ensure the strengthening of local capacities and the best possible use of the additional funding.

National AIDS Spending Assessment

The National HIV/AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV/AIDS. It describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease. This is tracked by financing source whether it is public, private or foreign and among the different providers and beneficiaries (target groups).

To date more than twenty countries have estimated National AIDS Accounts (NAAs), most of which have developed institutionalized arrangements for continuous tracking. A database of around 100 country/years of estimates has been generated.⁵

UNAIDS attempts to promote the transfer of knowledge and the development/strengthening of national capacities that may be applied to the design of proposals oriented to increase the level and improve the use of resources allocated to tackle the disease.

Country Background Data and HIV/AIDS Situation

Botswana is a landlocked country in Southern Africa. It has a population of about 1.7 million people. In the last two decades it has enjoyed a steady economic growth largely due to good governance and the judicious use of its natural resources (MoH, 2005),

⁴ UNAIDS, 2004. Ghana National HIV/AIDS Accounts, 2002-2003.

⁵ SIDALAC, The financing of the national response against AIDS in Latin America and the Caribbean and the flow of international financing. México, 2003.

mainly diamonds. It generally has better socio-economic indicators than other countries in the region.

UNAIDS estimated Botswana's HIV prevalence in 2005 at 24.1% [23.0%–32.0%] (UNAIDS, 2006). The Botswana AIDS Impact Survey (BAIS II) Popular report found a prevalence rate of 17.1% (19.8% for females and 13.9% for males) (NACA, 2004:14⁶). The Botswana Sentinel Site Survey of pregnant women estimated the adjusted national prevalence rate in 2005 to be 33.4% (MoH, 2005⁷). The high prevalence rates have resulted in serious developmental and social problems impacting negatively on all sectors. The President, H.E. Festus Mogae has described the HIV/AIDS epidemic as a national emergency, and a war which the government and people of Botswana are determined to win.

Botswana National Strategic Framework for HIV/AIDS 2003-2009

The purpose of the National Strategic Framework (NSF) is firstly to articulate, disseminate, and educate the public at large on agreed national priorities and strategies within a scope of vision 2016. Secondly, to provide a clear guidance for Ministries, districts, NGOs and the private sector to enable them to work in a collaborative manner in achieving the intended goal of the National Response to HIV/AIDS, which is to "ELIMINATE THE INCIDENCE OF HIV AND REDUCE THE IMPACT OF AIDS IN BOTSWANA".

The goals of the NSF are:

1. Prevention of HIV infection
2. Provision of Care and support
3. Strengthened management of the National Response to HIV/AIDS
4. Psychosocial and economic Impact Mitigation
5. Provision of a Strengthened and ethical environment

The targets for each are presented below.

Table 1.1 NSF Targets by Goals

Goal 1: Prevention of HIV Infection

Impact Indicator Source: UNAIDS Report 2001	Baseline Year 2001/2002	Target Year	
		2006	2009
Percentage increase of HIV prevention knowledge of people aged 15-49	34%	80%	100%
Percentage of adoption of HIV preventions behaviours of people aged 15-49 in Bots by 2009	NA	50%	80%
Percentage reduction in infant born to HIV infected	21-40%	50%	100%

⁶ NACA. 2004. Botswana AIDS Impact Survey II. Popular Report 2004. NACA in Collaboration with CSO and other development Partners.

⁷ Botswana Ministry of Health, Department of HIV/AIDS Prevention and Care. 2005. Botswana Second Generation HIV/AIDS Surveillance: Technical Report.

mothers who are infected at 18 months			
Percent decreased of the HIV prevalence in pre-transfused blood and blood products	9%	100%	100%
Percent decreased in the HIV incidence among sexually active population	6%	50%	80%
Percent decreased in the STI prevalence among sexually active population (syphilis)	2.4%	50%	100%

Goal 2: Provision of treatment, care and support

Impact Indicator Source: UNAIDS Report 2001	Baseline	Target	
	Year 2002	2006	2009
Percent of PWLA on HAART returning to productive live	NA	100%	100%
Percent reduction in the national HIV bed occupancy rates	50-70%	25-50%	10-30%
Percent reduction in infant born to HIV infected mothers who are infected at 18 months	21-40%	50%	100%
Percent reduction in the National crude mortality rate	12.42/1000	12/1000	10/1000
Percent reduction in the AIDS proportional mortality ratio	19.6%	50%	50%

Goal 3: Strengthened Management of the National Response to HIV/AIDS

Impact Indicator Source: UNAIDS Report 2001	Baseline	Target	
	Year 2002	2006	2009
Percent increase in the number of Sectors, Ministries, Districts, and Parastatals implementing the NSF Minimum HIV/AIDS Response Package	NA	100%	100%
Percent increase in the number of Sectors, Ministries, Districts, and Parastatals implementing annual planned HIV/AIDS activities at all levels	NA	100%	100%

Goal 4: Psycho-social and Economic Impact Mitigation

Impact Indicator Source: UNAIDS Report 2001	Baseline	Target	
	Year 2002	2006	2009
Percent of households with registered orphans receiving care and support to orphans	57%	100%	100%
Percent absenteeism and sickness in Government, Ministries, Parastatals and the private sector	NA	10%	5%
Percent reduction of the impact in the economy due to HIV/AIDS	NA	50%	50%

Goal 5: Provide a Strengthened Legal and Ethical Environment

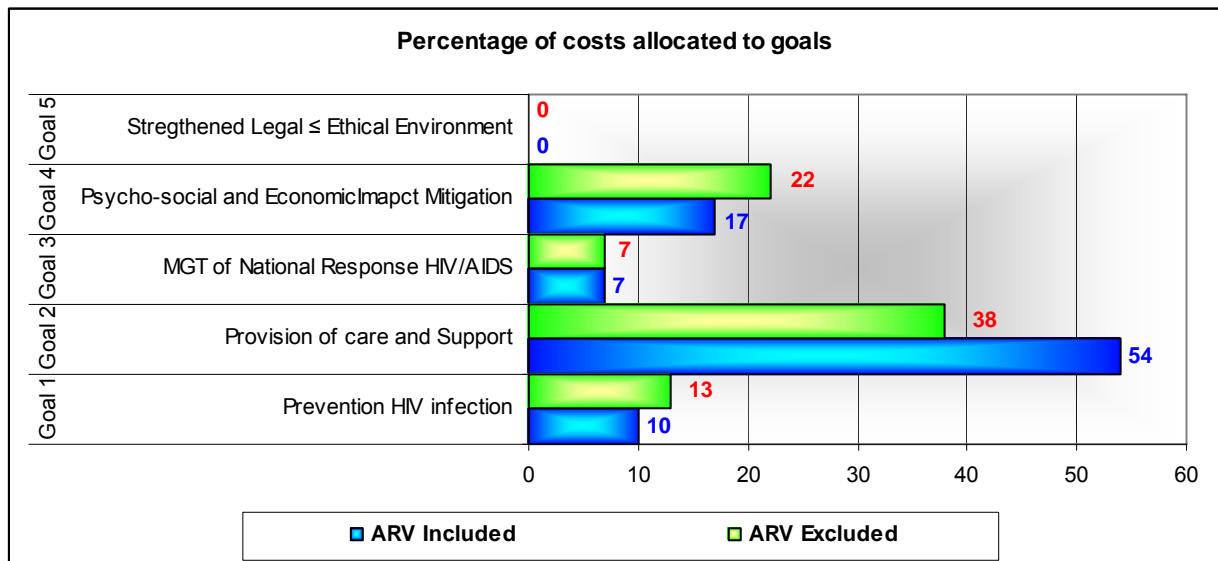
Impact Indicator Source: UNAIDS Report 2001	Baseline	Target	
	Year 2002	2006	2009
Composite policy index on number of policies on ethical, legal, and human rights issues relating to HIV/AIDS in circulation to support implementation of the National Strategic Framework	1.0	1.0	1.0
National Composite Index	1.0	1.0	1.0

The Botswana National Strategic Framework (NSF) Resource Requirements

Importantly, a comprehensive costing of the above goals has been undertaken in support of the development of the National Strategic Framework⁸. Key stakeholders from Government, Civil Society and Development Partners were consulted and information regarding programmatic inputs over the period of the National Strategic Framework were collated to provide NACA with an overview of both the human and financial resources needs.

The chart and the table below show the percentage of the total costs that were intended to be allocated to the goals of NSF.

Figure 1.1: Estimated Costs of the NSF Goals



The total costs of the National Response were estimated to be 12.615 million Pula (for the period 2002/03 to 2007/08). This estimate was made using data which was available at the time and it was noted that the total costs would change, as more data become available. The tables below show the total cost per year, and the overall total with and without ARV drugs in millions of Pula, and by each Goal (Table 1.2).

Table 1.2: Estimated Costs of the NSF

Financial Year	2002-3	2003-4	2004-5	2005-6	2006-7	2007-8	Total
Total	910.9	1,043.1	1,250.0	1,595.0	2,106.0	3,165.0	10,070.0
ARV Drugs	38.4	139.2	251.0	374.0	504.0	642.0	1,948.6
Grand Total	949.3	1,182.3	1,501.0	1,969.0	2,610.0	3,807.0	12,018.6

(NACA, 2004: 94).

⁸ National AIDS Co-ordinating Agency (NACA), National HIV/AIDS Strategic Framework 2003-2009. Botswana.

Table 1.3: Estimated Costs of the NSF Goals (in Pula billions)

Goal 1 Prevention of HIV infection							
Objective/Year	2002-3	2003-4	2004-5	2005-6	2006-7	2007-8	Total
Objective 1 1	<i>Increase the number of persons within the sexually active population (especially 15-24 years) who adopt HIV prevention behaviors in Botswana by 2009</i>						
Total	106.6	181.6	205.6	174.4	144.8	148	961
Objective 1 2	<i>Decrease HIV transmission from HIV+ mothers to their newborns by 2009</i>						
Total	75.5	55.2	53.8	53.8	12.2	0	250.5
Objective 1 3	<i>Decrease the HIV prevalence among transfuse blood in the country</i>						
Total	3.7	4.2	5.1	6.1	7.3	8.7	35.1
Goal 2 Provision of Care and Support							
Objective/Year	2002-3	2003-4	2004-5	2005-6	2006-7	2007-8	Total
Objective 2,1	<i>Increase the level of productivity of PLWHIV/AIDS. specially those on ARV who adopt HIV prevention behaviors in Botswana by 2009</i>						
Total	38.6	266.0	428.5	596.1	793.4	1,005.4	3,128.0
Objective 2,2	<i>Decrease the incidence of TB among HIV+ patients in the country</i>						
Total	70.2	19.7	9.0	0.0	0.0	0.0	98.9
Objective 2,3	<i>Increase the number of skills of health workers providing accurate diagnosis and Tx of OI</i>						
Total	300.1	355.9	343.5	521.0	784.0	1,224.5	3,529.0
Goal 3 MGT of National Response to HIV/AIDS							
Objective/Year	2002-3	2003-4	2004-5	2005-6	2006-7	2007-8	Total
Objective 3,1	<i>Ensure the implementation of NSF Minimum HIV/AIDS Response Packages by all sectors. Ministries. districts and parastatals</i>						
Total	4.3	2.6	6.6	6.6	14.3	14.3	48.7
Objective 3,2	<i>Ensure the full implementation of all planned HIV/AIDS activities at all levels</i>						
Total	204.3	114.1	119.6	73.7	45.2	80.1	637.0
Goal 4 Psychosocial and Economic Impact Mitigation							
Objective/Year	2002-3	2003-4	2004-5	2005-6	2006-7	2007-8	Total
Objective 3,1	<i>Minimize the impact of the epidemic on those infected and/or affected. public services. and economy</i>						
Total	128.9	169.4	221.8	309.1	447.4	822.9	2,099.5
Goal 5 Provision of a Strengthened Legal and Ethical Environment							
Objective/Year	2002-3	2003-4	2004-5	2005-6	2006-7	2007-8	Total
Objective 3,1	<i>Create a supportive. ethical. legal and human rights-based environment conforming to international standards for the implementation of the National Response</i>						
Total	0.8	1.9	1.9	1.9	1.9	0.0	8.4

NACA reported that the development partners have committed approximately 253.6 millions⁹ (as at 2004), but some Development Partners had yet to

⁹ This includes the Global Fund money

finalise budgets or agree to amounts for their particular budgeting cycles. In addition, most, if not all the development partners, were not able to commit beyond the next four years of the NSF time frame.

“The tracking of funds or economic governance of HIV/AIDS resources is assuming important dimensions as global source of funding multiply. NACA, with its partners, must ensure accountable systems are in place through which funds may be channelled and tracked”, states the NSF (NACA, 2004).

The Mid-Term Review of the National AIDS Strategic Framework in Botswana

Currently, the Government of Botswana, through its National AIDS Coordinating Agency, is facilitating a Mid-Term Review (MTR) of the NSF (2003-2009). The goal of this MTR is to identify and assess the strengths, weaknesses, facilitators and constraints of the management and implementation of the national response to HIV/AIDS under the National Strategic Framework 2003-2009, document key themes and emerging issues, and recommend appropriate action aimed at greater achievement of the national response over the remainder of the plan period. Thus, rather than being a relatively narrowly focused programmatic review, the MTR seeks to establish what impact the NSF has had on the national response overall.

The convergence of, among others, the recent reaffirmation of commitment to the UNGASS Declaration, the drive toward Universal Access to prevention, care, treatment and support, and the Mid-Term Review of the NSF, have pointed to the need for the alignment and integration of processes and the rationalisation of efforts. It is within this context that the National AIDS Spending Assessment (NASA) exercise must be viewed, and was undertaken as a contributory effort within Botswana's Mid-Term Review process.

Issues of funding and financial management play a critical role in the effective implementation of the national response. Thus, in order to gain a clear picture of how and where money moves in Botswana's national response, this important area forms Component 3 of the Mid-Term Review of the National Strategic Framework (2003-2009).

The timely undertaking of this NASA exercise, aside from enabling Botswana to meet its obligations under the UNGASS, contributes information regarding the actual expenditure of funds, which will provide reporting some of the data required to meet some of the MTR objectives.

However, it has been stressed that this NASA aimed to make an important contribution to the overall understanding of funding and financial management for HIV/AIDS, but that this short project would not be able to answer all the questions/issues regarding funding and financial management that the MTR seeks to address. Nevertheless this report makes useful recommendations for the future 'shape' of the NSP, and will hopefully lead to the institutionalisation of a system of tracking funds which is extremely valuable to governments, donors and service providers.

NASA Project Objectives and Scope

Within the mid-term review framework, the main objectives of this NASA project were:

- 1) To develop country estimates of total flows of financing and expenditures for HIV/AIDS, from all international and public (domestic) sources of financing¹⁰.
- 2) To identify and train core professionals within NACA and relevant partners in order for the NASA to be done on a regular basis to comply with the production of financial estimates for the NSF MTR, UNGASS, Millennium Development Goals, and other policy objectives.
- 3) To develop a database of each financial transaction supporting HIV/AIDS health and non-health expenditures.
- 4) Identification of the flow of expenditures by sources, functions, providers of services, target populations and object of the expenditures (budget item¹¹).
- 5) To prepare a written report of the international and public expenditures for HIV/AIDS in Botswana to inform the NSF MTR.

Note that the project was undertaken in a very short timeframe (6 weeks) in order to provide timely information for the MTR. This time was shortened further by the delay in obtaining permission.

A key aim of the project has also been to transfer skills to the NACA staff and to build the capacity and systems to improve NACA's financial monitoring mechanisms. Importantly, the two NACA staff who have been critically involved throughout this process are now experts in the NASA process and can easily continue the collection and analysis of the data, and update the database on an annual basis. *However*, this depends upon the acknowledgement of the value and contribution of this effort, and on the staff given support in terms of commitment of time and resources for the process.

The project has achieved all of its intended objectives, with the exception of capturing the production factors for *all* the expenditures, since this level of data was either not available, or required extensive additional data collection and estimations which were beyond the available time of this project. Nevertheless, where this data was available, it was incorporated in the software.

The project did not aim to capture the private spending on HIV/AIDS, such as that contributed by the business sector, private insurances, the churches and faith-based organisations, and those made by individuals and households (out-of-pocket expenditure, OOPE).

In addition, although providing baseline data, the NASA project could not explore in detail the effectiveness of spending, bottlenecks, the financial management systems, and absorptive capacity issues. The study did not examine the quality of services provided nor the outputs and impact of spending. However, it provides the first data requirement of an accurate assessment of what was actually spent, in order to

¹⁰ Since Out-of-Pocket expenditure (OOPE) assessment requires substantially longer time and given that NACA is considering conducting a household survey, the private OOPE expenditure was not captured in this NASA project.

¹¹ The successful identification of beneficiaries and objects of expenditure will be dependent upon the degree of detail available from the service providers.

undertake the out-put/impact analysis at a later stage. The perspectives of the service-users were not obtained, and their expenditure on HIV/AIDS was not captured.

The NASA methodology does not aim to provide audited accounts of expenditure, and does not highlight cases of mis-spending or corruption. It seeks to accurately reflect what has been spent on HIV/AIDS in the country, and on which functions, identifying the beneficiary groups of this spending. This information is critical to assess the progress towards the national priorities, and to identify the key gaps in spending, requiring attention.

Report Structure

The report has been organized in four chapters. The report does not provide an overview of the background information on the HIV/AIDS epidemiology in Botswana, nor on the country's response, since these aspects will be provided by NACA in their Mid-Term Review Report. The first chapter describes the methods and techniques applied, as well as the work process and limitations faced. The second chapter contains the results of the NASA estimation. The third chapter focuses on the findings of the site visits, to ascertain spending at the district level. A discussion on the results is included in the third chapter, and recommendations made in the final chapter.

Chapter 2 ~ Methodology

This chapter contains a brief description of the approach, the procedures and limitations of the National AIDS Spending Assessment (NASA) project conducted in Botswana.

Overall Approach

The NASA methodology allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures that, in public, international and private sectors, are addressed to confront the HIV/AIDS epidemic. This accounting must be exhaustive, covering entities, services and expenditures; periodic, as result of a continuing recording, integration and analyses, to produce, ideally, annual estimates; systematic, as their structure of the categories and records/reports must be consistent over time and comparable across countries¹².

Importantly, NASA captures all HIV/AIDS spending according to the priorities/ categories found in national strategic framework, and thus allows countries to monitor their own progress towards their goals. In addition, it is not limited to health-related spending, but identifies and captures all the other spending related to HIV/AIDS, such as social mitigation, legal services, educational and life-skills activities, psychological support, care for orphans and vulnerable children (OVCs), and those efforts aimed at creating a conducive and enabling environment.

The financial flows refer to the flow of resources by different financial sources to service providers, through diverse mechanisms of transaction. A transaction compiles all of the elements of the financial flow, the transfer of resources from a financial source to a service provider, which spends the money in different budgetary items to produce functions (or interventions) in response to HIV/AIDS addressing specific target groups or to address unspecific populations (or the general population). NASA uses both top-down and bottom-up techniques for obtaining and consolidating information.

This methodology employs double entry tables –matrices- to represent the origin and destiny of resources, avoiding double-accounting the expenditures by reconstructing the resources flows at every transaction point, rather than just adding up the expenditures of every agent that commits resources to HIV/AIDS activities.

In addition to establishing a continuous information system of the financing of HIV/AIDS, NASA facilitates a standardized reporting of indicators monitoring progress towards the achievement of the target of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV/AIDS (UNGASS I & II). (UNAIDS, 2006c:7).

¹² UNAIDS. 2006c. National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level. (draft- work in progress).

Data Collection

Preparatory Mission

A short preparatory mission was undertaken in September 2006 in order to ascertain NACA's requirements, to discuss the nature and extent of the NASA estimation, and to determine the terms of reference of the assessment and the roles and responsibilities of each involved party.

There were delays in the following aspects: the requesting of permissions from various Ministries, development partners, facilities etc., and the collection of the preparatory data *prior* to the commencement of the Mission. The delay in these greatly hindered the data collection process and reduced the time available for data collection and analysis. This delayed the delivery of the final report.

Obtaining Permissions

Permission from the Permanent Secretary of Health and MLG was required in order to access the Ministry of Health (MoH) and Ministry of Local Government (MLG) data. Some permissions took four weeks to be received and thus seriously hampered the data collection. Some critical data was only obtained in the very last week of the Mission, shortening the time for the data analysis.

Database of all Stakeholders

A database of all the stakeholders involved in HIV/AIDS, sources, agents and providers, was developed using NACA's information and the NGOs database from BONASO. Obtaining updated contact details of key respondents took some time.

Literature Review

In preparation for the NASA analysis, the NACA staff collected some background information and literature regarding the HIV/AIDS epidemiological profile of the country, the surveillance findings, and the national response. Botswana has well-developed statistical and surveillance systems, and the Botswana HIV/AIDS Response Information Management System (BHRIMS) system prepares detailed quarterly reports on the status of HIV/AIDS in the country. In addition, the public service providers report quarterly to MoH and NACA on the numbers of clients, and thus each service has records of their beneficiary populations (many of these reports are hand written).

Development and issuing of Questionnaires

The UNAIDS NASA format for the questionnaires was adjusted to suit the Botswana situation, particularly the addition of qualitative questions regarding funding processes and challenges. The adjusted questionnaires were sent to the key respondents and appointments then made during which the data was requested and the forms completed. Generally the questionnaires were too complicated to be self-administered.

Sources of Data

Primary data was collected from the majority of large donors, NGO's and all the relevant government departments. Since the data was direct from primary sources, and since we were able to include the majority of players, it is believed that the findings presented here are a good representation of the major spending on HIV/AIDS in Botswana.

Detailed expenditure records were obtained from the majority of primary sources of data, for all three years. Only a few were not available and were either obtained from secondary sources (e.g. expenditure of small NGOs was captured from PEPFAR's and other donor reports), or were estimated using the best available data and most suitable assumptions. These are discussed in the below.

Since the DP records were not actual expenditure, the expenditure reports from the key recipient department and NGOs were the first selected data. Where it was not possible to get primary data from the smaller recipients, then the DPs records were used. Great care was made not to double count transactions. Where the primary data was not obtained from the smaller donors, these smaller allocations made to NACA were captured from NACA's records. Small donations made to small NGOs who were not interviewed will not have been captured, but these would form a very small proportion of the total funds.

Some of the contact numbers for the district level NGOs were outdated and non-contactable. Some were not primarily focusing on HIV/AIDS activities. Time was very short and thus the numbers of district NGOs visited was limited. Nevertheless, most of the main NGOs are situated in Gaborone, and the majority were visited. In addition, those national NGOs with district level branches were able to provide the expenditure for all their branches, which was captured.

Please refer to Appendices I and II for a list of all the sources of data included and excluded.

It must be noted that on the whole, all players; government, NGOs, and donors were very keen to share their records with the research team and to share their problems and suggestions for improvements. Delays were only experienced where it was difficult to extract the HIV/AIDS specific expenses from others, such as laboratory testing costs for HIV/AIDS from the overall expenses of the health laboratory.

Site Visits

It was decided that site visits would provide the more detailed expenditure information from the service providers at district level, as well as providing their insights into the funding mechanisms and implementation challenges.

Given the short-timeframe we could not include a representative sample, and therefore decided to ensure that we had representation from different facilities within cities, towns, townships, urban villages and villages – in order to capture the different unit costs at these different levels of operation.

So the team selected the following sites, based on a number of factors, including their status as mentioned above, the facility types covered, the population, the HIV prevalence and the physical location/ accessibility of the sites.

Table 2.1 : Site Selection

District	Status	HIV Prev (%)	Sources of Data	Health Facilities Visited
Gaborone	City	34.2	Ministries & Departments. DPs, UN agencies, NGOs	None

S/Phikwe	Town District	> 47	DAC, DC, matrons, CMOs, programme coordinators, treasurers, pharm & lab technicians. NGOs where possible.	1 hosp. 1 clinic
Kasane	Township	47		1 hosp.
Serowe	District: Urban village	37.5		1 hosp. 1 clinic
Palaype	Sub-district urban village			1 hosp. 1 clinic
Kweneng-East	Urban village	31.5		1 hosp. 1 clinic
Goodhope	Village	20.8		1 hosp. 1 clinic

Within each, the District Councils, the District Administration, and selected hospitals, clinics and health posts, and some NGOs where possible, were visited.

Every effort was made to interview the following positions in each site (where available):

- Council Secretary
- District AIDS Coordinator at the District Administration (unfortunately most were attending an ACHAP meeting)
- Matron and Chief Medical Officer of the District (or sub-district) Council
- Treasurer at District (or sub-district) Council
- Matron and CMO at the hospital or clinic
- Coordinators of the following programmes:
 - ARV programme
 - PMTCT
 - CHBC – both the Community and Social Development (CSD) and Health components
 - Orphan care
- Pharmacist and laboratory technicians

These site visits and interviews provided valuable information, from the perspective of district programme implementers and treasurers, regarding the financial flow mechanisms, reporting mechanism, actual expenditure and outputs, implementation and operationalisation of the budgets, and the challenges and bottlenecks in spending being experienced. In addition, it provided an important opportunity for the implementers to speak to NACA representatives, and they expressed their gratitude for this opportunity.

Unfortunately most of the sites had only received the letter from NACA explaining our purpose the day before, and (some had never received it), so we were completely unexpected (despite efforts to phone ahead and introduce ourselves. Many people were not available, or were new to the posts, so could not provide useful data. They all complained about the short notice, and requested that next time the facility staff should be copied on such correspondence to the Council Matrons, so that they could prepare timeously.

Validation of Estimates

The preliminary results were firstly presented to the Technical Working Group on the financial components of the MTR, and subsequently to representatives of all key stakeholders and sectors. The meeting was well attended and participants provided valuable confirmation of the key findings as well as making useful recommendations.

The main assumptions for all estimations were also presented, and generally these were accepted as valid. All the suggestions and recommendations have informed the development of this report, and were most appreciated.

Data Processing

The data collected was first captured in Excel® sheets, and checked and balanced. All of the information obtained was verified as far as possible, to ensure the validity of data from the records of the source, the agents and the providers. The data was then transferred to the NASA Resource Tracking Software (RTS), which has been developed to facilitate the NASA data processing, and provides step-by-step guidance along the estimation process and makes it easier to monitor the crosschecking among the different classification axes. The RTS outputs (double-entry matrices) were exported to Excel® to produce summary tables, graphics and analysis.

Assumptions and Estimations

Since the majority of the data used was from primary sources, and given that Botswana has relatively well functioning health and financial information systems, it meant that this NASA only needed to use estimation for a few specific spending categories, as described below. Also the Central Health Statistics for 2003 and 2004 were extremely valuable in providing numerous indicators, such as number of beds, admissions and average number of bed days in different facilities, causes of mortality, in-patient treatment related to HIV/AIDS etc, which improved the estimations where they were used.

Differing Financial Years

It was found that differing financial year periods were used by the government, by development partners and by providers. While every effort was made to capture the actual expenditure within each fiscal year, according to the government's fiscal year, it nevertheless proved very difficult to harmonise all the data accordingly. Given the shortage of time, it was decided to utilise a general 12 month period and to assume that the expenditures fell into the government's fiscal year, and that the slight inaccuracies would be corrected for in the following year. In this way, the data accurately shows the trends over the 3-year period.

Estimations ~ Public Sector ~ MoH

The Central Medical Stores provided us with the consumption of drugs for ARVs, PMTCT, STIs, OIs and IPT. They informed us that they supplied these to the facilities based on their rate of consumption, so as to avoid surplus stocks on shelves. Therefore their figures were almost equal to actual consumption for these drugs.

Primary hospital costs – primary HIV hospital expenditure was not easily available. However, the total expenditure for general hospitals was available, as was patient days, average length of stay, and discharges. In order to estimate the expenditure of primary hospitals, we used a proportion of beds to check the difference between a general and

primary hospital and it was found to be 27%. We also used number of staff and it gave us the same percentage. Therefore we assumed 30% of the general hospital expenditure was equal to primary hospital expenditure. Therefore we used 30% to estimate the average cost of a day in the primary hospital. In primary hospitals we also used 32% of the discharges plus the TB discharges.

In estimating the expenditure of in-patient care for HIV-related illnesses, we used 32% of hospital costs (plus TB discharges). The Botswana Health Statistics of 2003 indicated that 32% of the beds at the hospitals are occupied by people living with HIV /AIDS or are suffering from HIV/AIDS related diseases. In the validation meeting with the Technical Working Group, they suggested we must include also the TB discharges. Unfortunately the health statistics reports for 2004 and 2005 were not available and hence we used the 32% for all the years. This may therefore be an over- or under-estimation.

With the advent of ARVs, it was noted that hospitalisations were still increasing but at a slower rate to earlier years.

In estimating the Clinic out-patient HIV/AIDS costs, a share of the total clinic costs was calculated using the share of consultations that were HIV-related.

The Botswana Public Officers Medical Aid Scheme (BPOMAS) covers ARVs for its members. It was decided to include the BPOMAS spending on drugs for ARVs in 2004 and 2005, for the public servants. Since members contribute half the premium and the remainder is paid by the employer (government), the total amount reportedly spent was split between MoFPD and the individual, as out-of-pocket expenditure (OOPE).

Estimations ~ Public Sector ~ MLG

The reported Orphan care spending was not disaggregated according to the NASA classifications for OVC functions, namely; education, health, family support, community support, and organisational costs. The detailed OVC daily expenditure records from two districts were obtained, and each cost was attributed to the appropriate function. Based on the results of these districts, the same proportional breakdown between the specific OVC functions were applied to the national level Orphan Programme spending. This application will have ignored differences between the differing needs of orphans as being experienced in the different districts.

To estimate the Community Home Based Care (CHBC) unit costs (per patient), the total CHBC expenditure (within MLHG and MOH) was divided by the reported number of beneficiaries for each year.

In order to obtain the production factors for the CHBC programme spending, detailed data was obtained from two district programmes, broken down by the NASA production factor categories, and these proportions were then applied to national CHBC expenditure.

Estimations ~ Private Sector

Salaries within NGOs are not usually captured under specific functions, so based on the proportional share of the functions of the total budget, the salaries are apportioned accordingly.

For those national NGOs which sent transfers to district branches, and did not have detailed expenditure for these amounts, a similar breakdown of funds between functions was assumed to exist at district level as at national level.

For NGOs which pool funds from various sources, and thus specific sources could not be linked with specific functions, the recipient NGO was taken as the 'virtual agent' and the total amount received was divided between the functions according to NGOs' expenditure records.

The contribution of the businesses was not collected in this NASA project and therefore no attempt was made to estimate them. Therefore this report completely excludes the business sector contribution.

Limitations of the Assessment

The limitations of this study are highlighted below:

Limitations of the Available Data

Between 2004 and 2005, the information systems have shown a marked improvement, and much of the financial data has been computerized. However, generally we found a incomplete data for 2003, with poor records and a lack of systems which meant that record keeping was not maintained after staff turn-over. Many respondents informed us that they were newly appointed to the position and did not have access to any records before their employment commencement. In addition, much re-structuring of units/agencies took place in the period of study, resulting in the moved location of accounting records and we found many of the 2003 records were inaccessible. This has resulted in weak and incomplete figures for the year 2003/04, which thus have a high degree of uncertainty and incompleteness for this year.

The production factors could not be captured for the expenditure of NACA. This was due to the fact that in order to ascertain the production factors for each expenditure required capturing approximately 20 box files (per year) of hand-written entries, and locating the corresponding vouchers (which were not stored systematically), to ascertain the detail required. Efforts were made to hire two data capturers to do this additional analysis, however, they could not be secured in time to undertake the work. This was regrettable, but did not affect the capturing of the expenditure made by NACA and the identification of its functions and beneficiary groups. While the production factors for some expenditures were captured, it was not possible to obtain them for all transactions.

Much of the data collected was not in suitable formats for the NASA assessment, and therefore required preparation, restructuring and some addition processing, in order to be standardised to the NASA format.

Limitations due to the Data Unavailability

The Department of Social Services within the MLG informed us that they did not have reliable expenditure records from the district Orphan care and HBC programmes, yet the

districts that were visited informed us that they do send quarterly expenditure reports to MLG. These reports could not be accessed.

The personnel and overhead costs of the Department of HIV/AIDS within MoH were not obtained and thus were not included in the assessment.

Due to the late notification of the relevant programmes at district level of our intended site visits, many key informants were unavailable or could not provide the data at short notice. In particular, very few District AIDS Coordinators were interviewed due to their unavailability at the time of the site visits.

Limitations due to the Short Timeframe for the Assessment

As mentioned, the project could not include private expenditure; private insurances, businesses, traditional healers, and OOPE, in the short project timeframe. It is intended that NACA will continue with these analyses.

The data collected on HIV/AIDS related research was limited to the Botswana Harvard Project, and the university was not interviewed in this regard. Therefore the research expenditure presented here is an underestimation.

The timeframe was further shortened by the delayed receipt of permission from the relevant government bodies and some development partners.

The lack of an updated database of all the stakeholders and their contact details also delayed the data collection process.

Given these aspects, the data collection and analysis phases were compromised, and the drafting of the report was delayed.

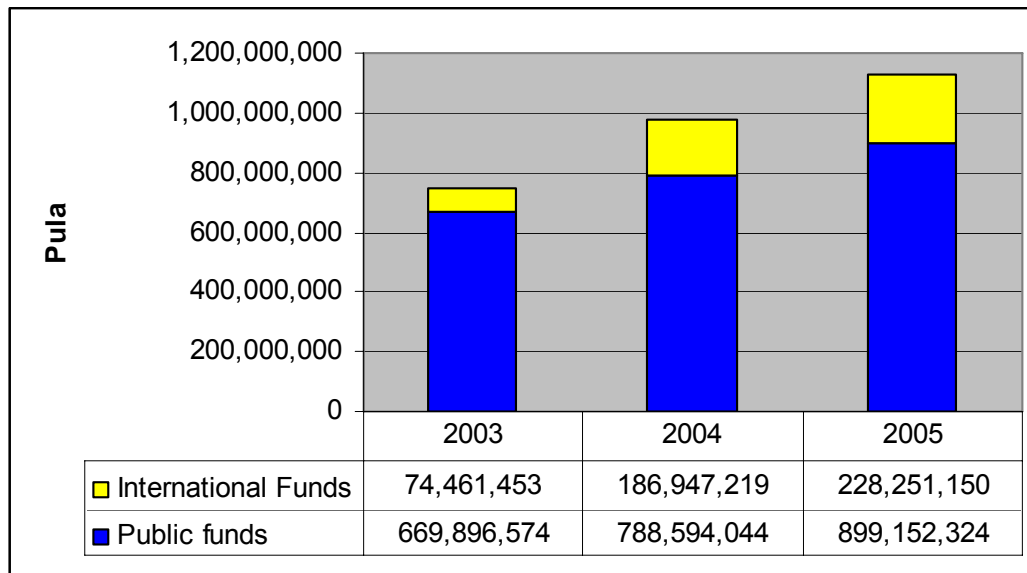
Nevertheless, the project collected the majority of the required data, mostly from primary sources, and therefore this report is felt to be an accurate representation of the majority of HIV/AIDS public and donor spending in Botswana. It excludes private sector spending on HIV/AIDS, which will hopefully will be included in the next NASA.

Chapter Three ~ Key Findings of the NASA

Total Expenditure on HIV/AIDS and Sources of Funding in Botswana

The total expenditure on HIV/AIDS (public and external, excluding of private) in Botswana has steadily increased over the three year period of assessment, to Pula 1,138 million in 2005/06. The graph below shows the large proportion that public sources contribute to the total funds spent; 89%, 80% and 79% in 2003, 2004 and 2005 respectively. The share contributed by external sources has gradually increased over the period; 10%, 19% and 20%.

Figure 3.1: Sources of Funds for HIV/AIDS in Botswana (2003/04 to 2005/06)



Note that this assessment captured NGO spending but did not include other private sources, namely those contributed by the business sector, private insurances and individuals and households. It is envisaged that NACA will continue with annual NASAs and therefore can include the private sector contributions in future.

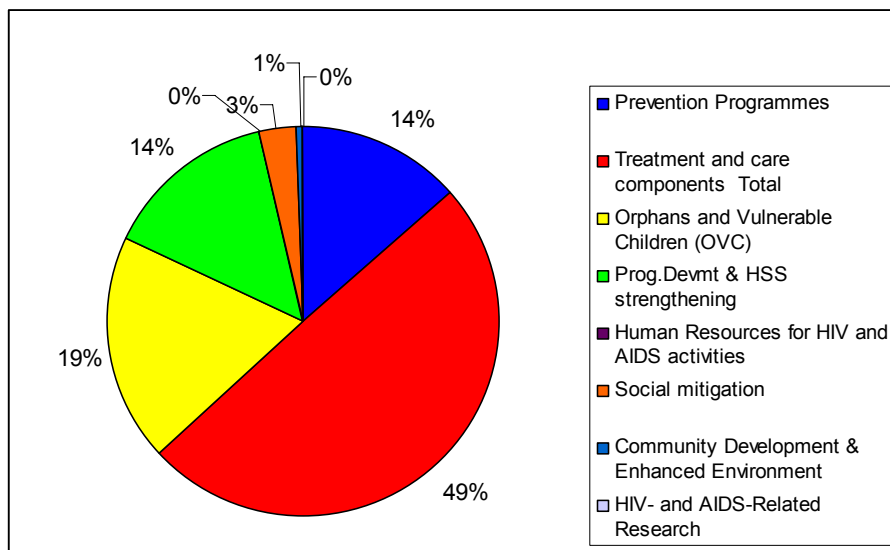
In addition, the sources of data for 2003/2004 were weak and incomplete due to poor data systems at that time. Many agencies could not provide us with their 2003 expenditure records, and thus these could not be captured and were not estimated. Therefore the spending for this year is an under-estimation.

In terms of actual allocations (amounts of Pula) spent, it would appear that the total expenditure found to be at Pula 1,138 million in 2005/06, falls short of the estimated required resources of Pula 1,969.00, representing only 58% of the estimated need.

Funding Priorities – Spending Categories

Considering the broad categories of programmes in response to HIV/AIDS, the differing priorities between the public and external agents are illustrated in the graph below.

Figure 3.2: Total Spending by Category (2005/06)



The figure above shows the proportional spending by the key 8 categories in 2005/06, showing the dominance of the treatment component, being primarily the public ARV programme. Figure 3.3 below shows the breakdown by source of funds.

Figure 3.3: Public and Donor Spending by Category in 2005/06

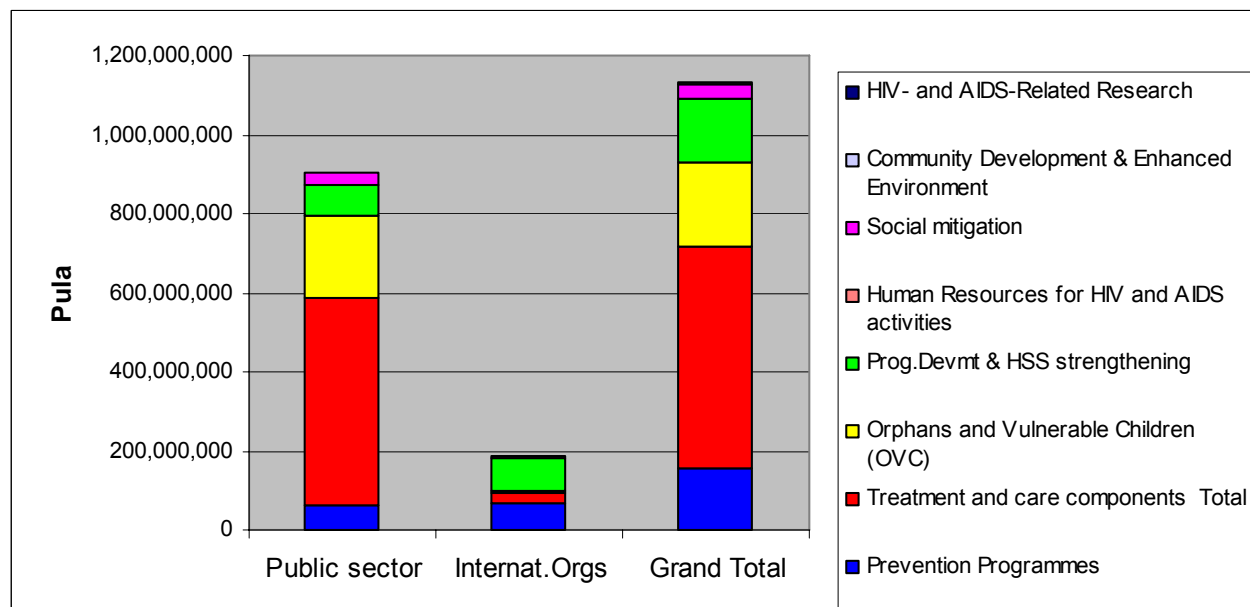
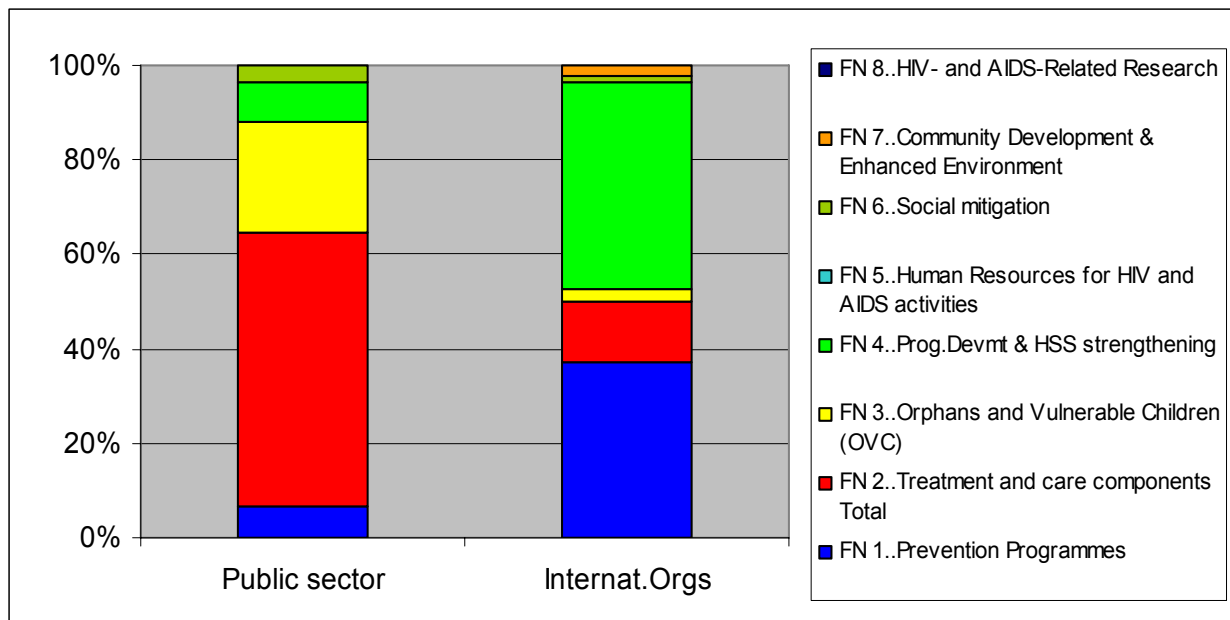


Figure 3.3 shows the spending priorities of public and donors in actual Pula. The total column indicates some success at ensuring even spread of the funds over the key categories, excepting for the dominance of spending on treatment (the public ARV programme). The respondents argued that this reflects the consultation that occurs between government and the key donors in determining the funding priorities and contributions of each, showing positive attempts to harmonise and to avoid duplication and gaps. The figure 3.3 below shows the spending of sources as proportions (in percentages of the total).

Figure 3.4: Proportional Spending Priorities in 2005/06



HSS = health systems strengthening.

Figure 3.4 indicates the Government of Botswana's commitment to providing free treatment to HIV-positive persons, and to the care of orphans, while showing that the external agents focused on prevention programmes and efforts at programme public and health systems strengthening. Of concern are the relatively small proportions being channeled to prevention activities, social mitigation efforts, community development, with almost no spending for human resources enhancement¹³ and HIV-related research.¹⁴ For changes in spending priorities over the three year period, refer to Appendix IV.

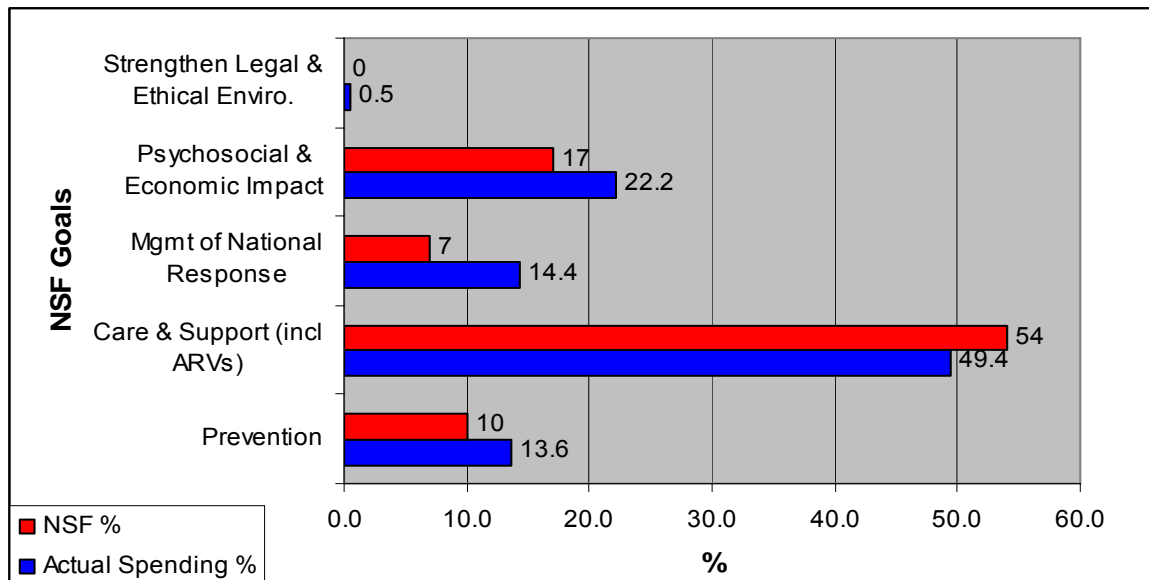
When the total spending is compared with the intended NSF intended *proportional* allocations to each programme (presented earlier on pages 10-11), it appears that approximately 50% is going to treatment and support, slightly under the intended 54%, and that 22% is going to economic impact mitigation (primarily through the allocations made to the Orphan programme), slightly over the intended 17%. The allocations to the management of the national response (14%) are greater than the intended 7%, but

¹³ This does not refer to personnel costs, which are captured under their respective functions, but rather those additional resources required to entice professionals into the HIV/AIDS field.

¹⁴ This assessment did not seek out all the HIV-related research in the country, and thus is probably a large under-estimation.

included here were the NASA categories of programme development and research. Note that the reported proportions intended for the NSF goals did not add up to 100% so it appears that the actual spending is over-estimated. Overall, it appears that the GoB and the DPs are integrating their efforts and are comprehensively moving towards the proportional balance of spending priorities set in the NSF.

Figure 3.5 Comparison of NSF Goals with Actual Total Spending in 2005/06



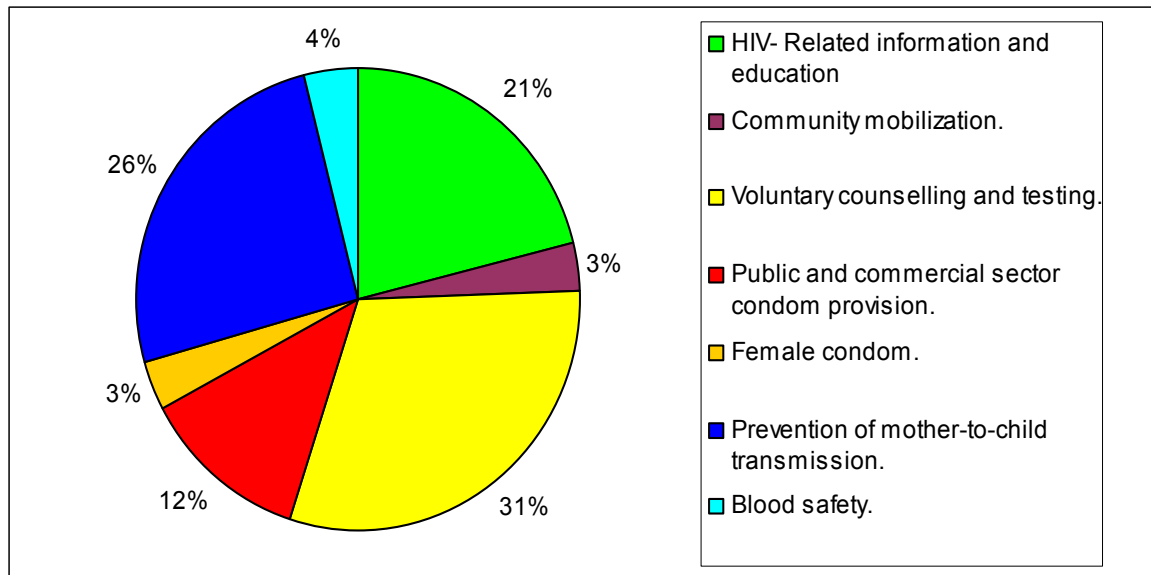
Source: GoB 2006 National Strategic Framework for HIV/AIDS. NASA Estimates 2005/06. (Note that the NSF % did not add up to 100%).

In terms of actual allocations (amounts of Pula) spent, it would appear that the total expenditure found to be at Pula 1,138 million in 2005/06, falls short of the intended amount of Pula 1,969.00, representing only 58% of target.

Spending on Preventative Activities

Within the total preventative component, in 2005 the largest proportions went to VCT (31%), PMTCT (26%) and IEC (21%), as shown in Figure 3.5 below. There was no reported spending on: programmes focused on commercial sex workers (CSW), men who have sex with men (MSM), harm-reduction programmes for injecting drug users (IDU), microbicides, post-exposure prophylaxis (PEP), and safe medical injections. While the existence of these groups is not denied, it was explained that since the epidemic in Botswana is generalised and non-specific, and the virus is transferred primarily through heterosexual intercourse, it was important to focus resources on those programmes directed at the general population. In addition, since all the services are provided free to all Botswana citizens, and every effort it made to make them accessible, then it is assumed that persons belonging to any of the high risk groups can access any service they require, without specifically targeting them.

Figure 3.6: Total Spending (Public and Donor) on Preventative Activities (2005/06)

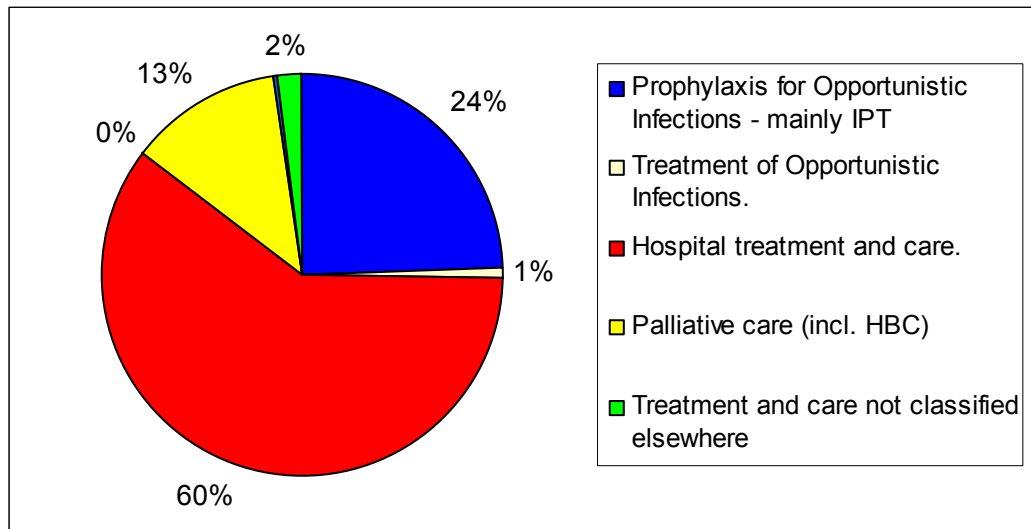


Note the above graph shows the TOTAL public and external expenditure

Figure 3.6 below shows the components of public spending on treatment and care, the largest portion going to hospital care (40%), then ARVs (37%) and followed by OI prophylaxis (which is primarily IPT) at 16% and then palliative care at 6%. A very small portion goes to OI treatment (less than 1%). This may be due to the effort put into preventing TB infections through the IPT programme. However, the assessment may have underestimated the total costs for OI as the overheads were not estimated, and this only includes the drug costs, as provided by the CMS.

Spending on Treatment Activities

The external sources contributed relatively little on treatment activities (approximately P 23.5million in 2005/06), compared to the public contribution (P 530million). Figure 3.6 below shows the breakdown of the total (public and donor) spending on treatment activities, the ARVs taking the largest share at 60%, followed by prophylaxis for opportunistic infections (24%). This was made up mainly of the spending on IPT which is given to all HIV-positive persons as a TB preventative measure. This may have caused the small spending on actual treatment of OIs, although this assessment probably underestimated the HIV-related spending on TB treatment. Botswana gives a positive example to other African countries to invest in IPT.

Figure 3.7 Total Spending on Treatment Activities in 2005/06**Spending by NGOs in the Delivery of Services**

An examination of the NGOs sector spending, shows a focus on preventative activities (60%), with VCT comprising almost 50%. This is mostly attributable to Tebelopele, a large NGO delivering VCT services throughout the country. Interestingly they also contributed to the delivery of ARV (24%) of their total spending.

Table 3.1 NGO Spending by Category in 2005/06

Spending by NGOs (2005/06)		
Prevention Programmes:	Pula	%
HIV- Related information and education	5,273,984	
Community mobilization.	29,755	
Voluntary counselling and testing.	19,724,740	
Prevention Programmes Total	25,028,479	60
Treatment and care components:		
Antiretroviral therapy.	10,043,034	
Nutritional support associated to antiretroviral (ARV) therapy.	52,300	
Palliative care.	114,182	
Psychological support, groups etc.	383,177	
Treatment and care components Total	10,592,693	25
OVC	28,570	0
Programme development	3,550,640	8
Social mitigation	657,556	2
Community Development and Enhanced Environment to Reduce Vulnerability	1,438,869	3
HIV/AIDS-Related Research	581,476	1
Total NGOs Spending (Pula)	41,878,283	100

BENEFICIARIES OF HIV/AIDS SPENDING IN BOTSWANA

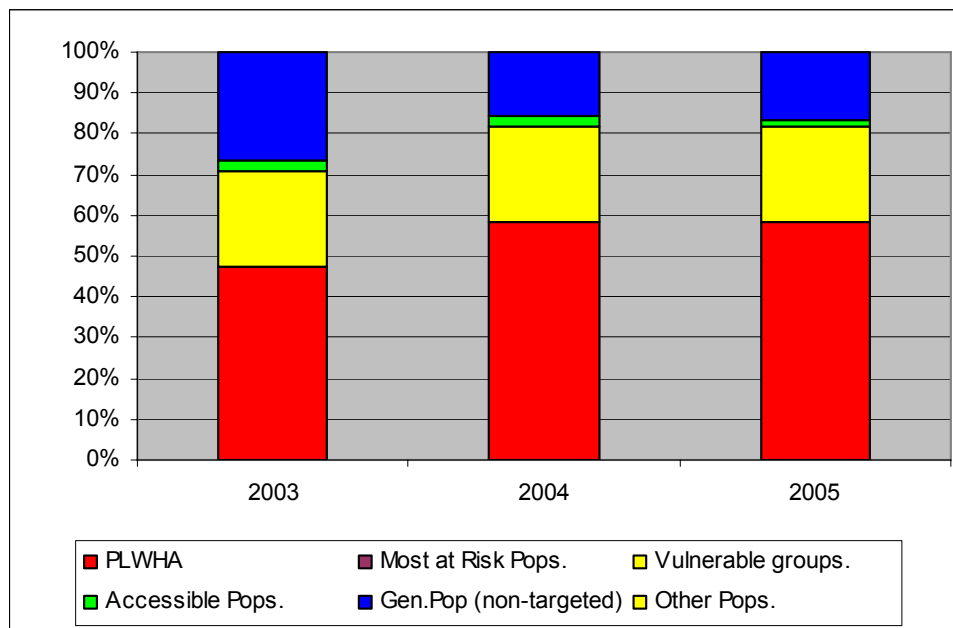
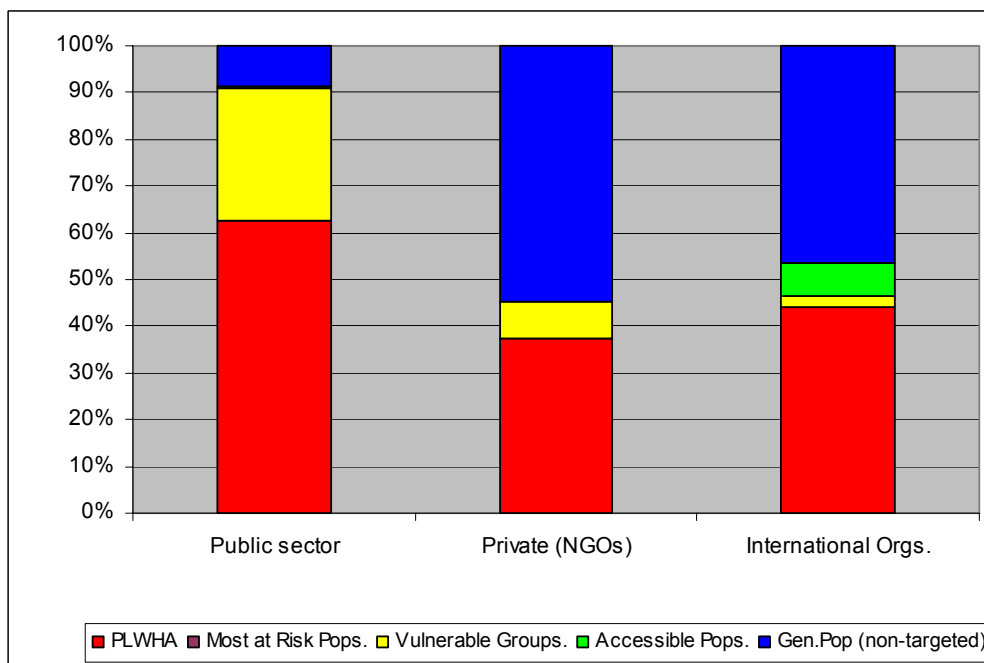
The NASA approach attempts to track all expenditure from source, through agent, to service provider by activity and finally to the actual beneficiaries of the spending. This analysis may be limited by the poor availability of data, but usually the service providers can provide their target groups, and their spending can be attributed proportionally.

The broad NASA categories of beneficiaries are PLWHA, accessible groups, vulnerable groups, most at risk populations (MARPs), and general (i.e non-targeted spending).

The category of PLWHA can be broken down into sub-categories by age and gender. The category of accessible groups includes: People attending STI clinics, Children in school, Youth at school, University students, Women attending reproductive health clinics, Health care workers, Sailors and Military. MARPs include: Injecting (IDU) and other drug users and their sexual partners, Sellers of sexual services (SW) and their clients and Men who have sex with men (MSM). Vulnerable groups includes: Orphans and vulnerable children (OVC), Children born or to be born to HIV mothers, Refugees (externally displaced), Internally displaced populations (because of an emergency), Migrants / Mobile Populations, Refugees, displaced persons and people separated from their families, Prisoners and other institutionalized persons, Truck drivers / Transport workers & commercial drivers, People affected by trafficking and violence, Youth at social risk, Children and youth living in the street, Children and youth gang members, and youth out of the school, Institutionalized children and youth, and Partners of persons living with HIV.

The analysis by beneficiary group in Botswana shows that people living with HIV/AIDS form the largest beneficiary group over the three years (almost 60%), which reflects the generalized epidemic in the country. However, there was no reported spending on vulnerable populations in all three years, such as for commercial sex workers (CSWs), men who have sex with men (MSM), intravenous drug users (IUDs) and so on. Accessible population spending was primarily through school educational programmes and some targeting of the police and defense forces. Programmes targeting women specifically were also limited.

Considering beneficiary group spending by agent, Figure 3.9 below shows that the public sector agents primarily target PLWHA and some funds to vulnerable groups, while NGOs have a large portion non-targeted spending (primarily through VCT offered by Tebelopele). Again, most at risk groups were not specifically targeted by any of the agent types. But, as discussed earlier, since the HIV epidemic in Botswana is generalized and all services are available and accessible to all, then such targeting was not considered necessary. Perhaps a study of service utilization by the MARPs would be useful to ascertain whether they do need additional specific targeted services.

Figure 3.8 Beneficiaries of Total HIV/AIDS Spending (2003/04-2005/06)**Figure 3.9 Agent Proportional Spending on Beneficiaries (2005/06)**

Funding Processes, Reporting Requirements and Financial Systems within the Key Sectors

PUBLIC SECTOR FUNDING CHANNELS

CAPITAL (or DEVELOPMENT) BUDGET

In Botswana the HIV/AIDS programme is regarded as one of the projects under the Capital/Development budget. All government ministries through their Planning Units submit Project Memoranda (proposals) to NACA requesting funding for HIV/AIDS programmes. NACA reviews proposals and then forwards the consolidated requests to the Ministerial Planning Unit (MPU) which also reviews them. Once approved they are forwarded to the Ministry of Finance and Development Planning (MFDP). MFDP may approve, adjust or reject the Project Memoranda. Through the MPU, the MFDP then gives NACA feedback on which how much has been approved citing the tranche numbers. NACA then accesses the approved funds from MFDP through the MPU and transfers these to the implementing ministries in line with the approved project memoranda. NACA is expected to report to MFDP through the MPU on funds disbursed and project implementation.

District Level Funding Processes

During our limited site visits, the Council Matrons, programme coordinators and facility personnel were extremely helpful and willing to give us as much information as they could regarding the district level spending. They were pleased to have the opportunity to speak to NACA representatives, and to show us their activities, achievements and tell us their challenges. They requested that NACA staff try to meet with them more regularly to monitor the usage of their funds. Most respondents suggested that NACA should give them clear guidelines and formats for the expenditure reporting required. However, many also complained that they are too busy in service delivery to prepare detailed reports. Added to which most of them do not have computers and so their statistical reporting is all done manually. We found that generally very good statistical records of beneficiaries and services are kept by facilities and programmes, some more disaggregated than others.

The programme coordinators at sub-district level informed us that they send quarterly expenditure reports to the district Treasurers. These confirmed that they compile quarterly district expenditure reports which they send to MLG. We were able to get the clinic expenditure from MLG and the Financial Technical Services (previously LAFU), but we were unable to get the expenditure of the Orphan programmes from the Department of Social Services within MLG.

The Treasurers were extremely helpful and were able to print out summary expenditure ledgers for all the programmes for all the years. Apart from PMTCT, CHBC and orphan care, all the other HIV/AIDS money, when transferred to the district, is lumped together under one vote when it is transferred to districts, and often there is no clarity on what the transferred funds were intended for. This makes the effective management of these funds very difficult. Programme Managers also complained that the budgets they submit to NACA are usually cut substantially, with no explanation as to which activities should

be reduced, so the coordinators are left with the difficult task of having to prioritise services with the limited resources and no guidance on how to do so.

Clinics were not making any expenditure themselves since all their expenses are covered centrally by MLG, so they could only provide statistics on their patients.

Hospital staff tended to be busy and so sent some information after the site visits has ended. We could not obtain their salary expenditure which is paid by MoH and MLG. These will have to be collected from MOH or MLG, and captured by function.

MoH provided the annual reports received from hospitals, which provided very comprehensive data on their services and beneficiaries. Thus we were able to get the data required to estimate the inpatient expenditure.

Most districts could not tell us their expenditure on testing and drugs for HIV/AIDS, since they order those from Central Medical Stores (CMS). CMS provided drug costs for ARVs, PMTCT, STI and OI treatments.

On the whole, the District AIDS Coordinators were not available for a number of reasons, but those interviewed indicated that they tend to be overwhelmed trying to perform a co-ordinating role, while also managing the DMSAC funds – which proves challenging due to the financial systems of the District Administration systems (some funds are still under the District Councils, which leads to further delays and difficulties). The DACs receive NACA funds as well as other funds directly from donors. These others might form a substantial amount and specific attention would be needed to capture these adequately. We were also informed that the DACs report quarterly on their NACA expenditure for BHRIMS. These reports were not made available to the research team.

Public Hospital Activities and Funding Processes

Hospitals services can be broadly categorised into inpatient and outpatient treatment and care. Hospitals are administered by the MOH. The services they provide as relate to HIV/AIDS are:

- PMTCT
- IPT
- STI management
- ARV testing and issue ARV drugs
- Routine testing

Sources of funding for Hospitals

The core activities of hospitals are funded by the government through MOH and NACA.

Donors, such as ACHAP, also provide some financial support, in particular, funding the IDCCs and the Resource centres. Drugs are sourced centrally by the government through CMS.

Hospital Expenditure Reporting Mechanisms

Hospitals produce monthly reports of patient numbers and drugs. Annually they produce a report of activities undertaken for submission to the MOH. No financial reports are

produced to accompany the narratives. However Hospitals maintain vote ledgers for their running expenses except for the salaries which are paid directly from the Ministry of Health.

Public Clinics

Clinics report on the HIV/AIDS services delivered to the District Health Teams which then report to the MOH. This is mainly patient statistics. Otherwise clinics do not have anything to do with financial reports as all their finances are dealt with by the District Health Teams. Clinics monthly statistical reports are mostly manually written.

Challenges faced by Hospitals and Clinics

- Shortage of medical personnel and pharmaceutical technicians
- Some hospitals have overloading of patients after working hours and during weekends as a result of closure of some satellite clinics
- The Chief Medical Officers (CMO) has to split their time between administration of the hospitals and patient consultation.

Public Workplace Activities

According to the NSF, all public ministries were to implement workplace HIV/AIDS activities, and funds for these were directed from the Domestic Development Fund through NACA to each Ministry. This was an effort to mainstream HIV/AIDS activities into all sectors.

Importantly, the Botswana Police Services reported also allocating additional funds from their recurrent budget for their HIV/AIDS activities, showing a strong commitment to mainstreaming.

Due to the short timeframe for this analysis, the private sector expenditure on workplace activities was not captured. It is assumed that this would form a significant proportion of the total spending on HIV/AIDS and thus should be captured in the next phase of the NASA.

NGOs Funding Processes

The NGOs operating in Botswana are not for profit organisations receiving funding from a wide spectrum of donors like USAID, PEPFAR, ACHAP, EU, DFID, Global Fund and the Government of Botswana, among other donors. International NGOs operating in Botswana act as both programme implementers/service providers and as agents for the donor organisations.

Funding Channels for NGOS

NGOs go through the process of tendering for international donor funds once program announcements are made by donor organisations. They thus receive direct funding from the donors for their programs. Donors have various ways of transferring funds to the NGOs. Disbursements can be either quarterly or monthly based on the cash flow

projections. The NGOs that work with sub-grantees then have to work with the sub-grantees in ensuring that they produce information in the format that can be easily consolidated when requesting transfer of funding from the donors.

Donor Reporting Requirements

Donor organisations request progress reports at various intervals. These reports can be monthly or quarterly and consist of both narrative and financial reports.

Reporting requirements vary between donor organisations. In some cases when organisations are sub-grantees of another organisation, the main grantee organisations request them to submit all supporting documents for the payments/expenses included in their financial reports.

Challenges faced by NGOs in securing funding

Organisations face various challenges as regards securing funding. Among them are:

- Botswana's classification as an upper middle income country affects (reduces) the amount of donor funds that are channelled by the international donor organisations
- Government and parastatals assuming implementers' role and thus competing for donor funding
- Some NGOs feel there is a slow response of the Country Coordinating Mechanism (CCM) for the Global Fund proposal endorsement

Bottlenecks and Challenges in the Financing Systems for NGOs

It was noted that many NGOs have poor management capacity, especially financial. Although clear reporting guidelines are provided, many NGOs cannot report accurately on their expenditure. Since many donors are reluctant to pay salaries, NGOs are forced to employ persons of limited skills. Efforts to build capacity in financial systems are undermined by the high rate of staff turn-over. The problem of high staff-turnover was not limited to the NGO sector, but was also prevalent in the public sector.

Many NGOs struggle to fund their administrative functions as donors are only interested in funding those functions that directly impact their programs. This also affects the quality of administration staff that organizations can afford.

Funding from the government in particular takes time to be made available to the NGOs, as the process of approving funding is slow. This frustrates the efforts of the organizations in delivering service.

Spending rules vary between donor organizations. For example United States Government (USG) funds can only be spent following the "ABC" approach where AB projects can't spend money on C whereas non AB projects have to cover AB messages. Similarly the Dutch money comes with the understanding that regional issues and approaches appropriate to the southern Africa need to be followed rather than a country specific approach. Japanese money comes with clear guidelines for spending on asset oriented expenditures. Funds also come in with restrictions on the extent to which expenses can be realigned.

Challenges of the NGO Data

As part of the funding conditions, many donors require that grantee organizations are audited annually. Thus the quality of the data obtained from the NGOs can be relied

upon. However because the classification of expenses are based on organizations and donor reporting requirements, matching the expenditure to NASA categorization was the biggest challenge.

Some of the audited accounts are not split per donor organization but expenses are summed up based on the nature of expenditure. Splitting the expenses between the projects being undertaken was then based on the assumption that projects incurred expenses in direct proportion to their funding, which is not always the case.

External Sources of Funding – Development Partners in Botswana

Because Botswana is classified a middle income country, the The external sources of funding for HIV/AIDS in Botswana form a relatively small proportion of the total spending, increasing from 10% in 2003 (approximately P74 million) to 19% in 2004 (P187 million). In 2005 the amount increased to P228 million which formed 20% of the total. This decreasing proportion was due to the large and increasing allocations made by the Government of Botswana to HIV/AIDS.

The key development partners (DPs) in Botswana are PEPFAR, ACHAP and Global Fund. The UN Agencies also make differing contributions, some primarily in technical support resources. Other smaller donors include Bristol Myers Squibb, SIDA, DFID, SADC and others.

DP Funding Channels

The Ministry of Finance and Development Planning (MFDP) is the principal recipient for all donor funds granted for the implementation of HIV/AIDS programmes in the public sector. These grants may be transferred to the Government of Botswana (GoB) as an advance before programme implementation or as a reimbursement to the Botswana Government after programme implementation. NACA accesses all these funds and disburses the money to implementers (mainly MOH and MLG) according to their budgets, workplans and other agreed procedures. In return, NACA on behalf of the government of Botswana is expected to report back to donors in the form of periodic financial and narrative progress reports on funds disbursed and programme implementation. The reporting format may differ from one donor to another. All the donor funded projects are implemented in accordance with the signed Memoranda of Agreements between the donor and the MFDP (on behalf of the GoB), the project document and the annual work plans.

District level departments develop their budgets and submit these to NACA, which compiles and submits these to the donor. The donors then approve, adjust or reject the applications. Transfers are usually made upon request from NACA or the departments. There may be a few months delay in the transfers. The process for NGOs to receive funding directly from DPs is described under the NGO paragraph.

DP Reporting requirements

Each DP requires different reporting formats and styles, and regular expenditure reports which must be submitted before further transfers will be made. These differing requirements place great burden on the recipients, in some cases, requiring specific

financial officers just to attend to that DP's funds. Overall, the reporting data regarding donor fund expenditure are better than those for public expenditure.

Bottlenecks and Challenges in the DP Financing Systems

It was noted that the reporting requirements can delay requests for funding, which may hinder project implementation. Delays in transfers can cause projects receiving the funds late in the implementation cycle, which either leads to under-spending or 'dumping' where the recipients try to spend funds quickly, resulting in inefficient spending or that spending may not be according to the project proposal.

There are many factors which contribute to poor absorptive capacity, inherent in the entire transaction process, from source, through agent to provider. All these aspects need close examination and attention, but which were beyond the scope of this project.

It was noted that many NGOs have poor management capacity, especially financial. Although clear reporting guidelines are provided, many NGOs cannot report accurately on their expenditure. Since many donors do not wish to pay salaries, NGOs are forced to employ persons of limited skills. Efforts to build capacity in financial systems are undermined by the high rate of staff turn-over.

Challenges of the DP Data

The records from the DPs tend to show only commitments and transfers. These usually do not equate to actual expenditure by either the recipient public services providers or the NGOs. This results in an *overestimation* of the actual spending in the country, *from the perspective of the DP*, who may argue that they have contributed more than the NASA reports.

The analysis of the NASA data was greatly impeded by the problem of all the differing financial years, used by the government, DPs and NGOs. This made comparison problematic. In the short time-period it was not possible to adjust the differing years to the government's cycle, and thus it was decided to make use of a 12 year period without stipulating the month of commencement and closure. This still allowed for accurate comparison over the three year period, and double counting was avoided.

UN Agencies Funding Processes

The UN agencies and the World Health Organisation (WHO) are in the main not implementing agencies but operate in Botswana through their implementing partners. Their partners are primarily government ministries and departments, and a few NGOs. UNICEF increased its number of NGO operational partners from 4 to 30 between 2003 and 2006.

UN Funding Channels

UNAIDS, UNICEF, UNDP, UNFPA and WHO explained that they work closely with the government in determining their strategic plans and areas of prioritisation, so as to fit with the countries priorities. For example, UNICEF and government together develop a multi-sectoral 5 year plan, which both parties sign, and then develop appropriate annual operational plans. This is viewed as a strong and positive partnership in planning. Based on these, the relevant government departments make requisitions to UNICEF who then disburses the funds, usually on a quarterly basis.

UNICEF does not transfer funds to NACA but provides technical support and training to the NACA staff.

In addition, it was reported that the government departments are requesting more direct payments for specific services or goods, such as workshops, meetings, etc., where the UN agency or WHO will pay directly to the service providers. This avoids the bureaucracy of the government systems.

UN Recipient Reporting Requirements

The recipient department is required to submit quarterly expenditure reports directly to the UN agency, and copied to MLG or MoH and MoF, before additional tranches will be processed. In addition, annual reports are required indicating the achievements and difficulties, as well as ensuring that progress is aligned to the strategic plan. This appeared to be the standard processes for all the UN agencies.

Quarterly review meetings are also held to monitor progress, as well as a final annual review meeting. Efforts are made to ensure sustainability of projects, and integration between government departments.

Bottlenecks and Challenges in the UN Financing Systems

The process of disbursement from UN agencies can take some time, since the cheque must be issued to the Government of Botswana, it goes first to the Ministry of Finance, then to Ministry of Local Government and finally to the Department of Social Services, who implements the programmes. In addition, many departments request disbursements rather late, leading to periods without funding.

Another key challenge is the different financial years of government (March to February) and the UN agencies (January to December). This means that as the UN is closing accounts and slowing down, the government is going into their third quarter and usually the most busy in terms of expenditure and implementation. This often reflects as underspending of the UN commitments in their end-of-year reports, because the bulk of expenditure will happen in the final quarter of government's year (i.e the first quarter of the next calendar year).

In terms of efforts to harmonise financial years, the difficulty is that the UN agencies operate on the financial year of their international headquarters, which are globally applicable, and cannot be changed easily. Importantly, UNAIDS is making efforts to change theirs to match the government's cycle.

Another possible option would be for the UN agency to block funds which would be made available for the beginning of the year, as cash advances. However, the government departments indicated that this would lead to complex and long-winded processes to get the funds to service providers at the district level, and would challenge their reporting mechanisms.

Challenges of the UN Data

The UN agencies could provide their annual global figures for expenditure, or transfers, made for specific programmes. However, data was not obtained on the factors of production. The other complication is that much of the UN financial systems are centralized at their headquarters, and thus the country offices do not have updated summarized expenditure reports on their HIV/AIDS programmes. The clear exception

here were UNICEF's records which were extremely well organized and detailed. The WHO could only give us round figures for their HIV/AIDS programme without details of activities and production factors. A number of financial persons explained that they were unaware of the records before their own employment in the system. This implies loss of institutional memory with staff turnover, and a clear lack of institutionalized reporting systems.

It appears that a large proportion of funds are spent, on technical experts for Botswana. These amounts, including their consultancy fees, travel and per diem, could not be ascertained, as these records are usually maintained at UN headquarters.

Estimating Proportions of Expenditure for HIV/AIDS

The expenditure for UNAIDS was obviously all for HIV/AIDS activities. For UNICEF, HIV/AIDS is now their flagship programme, which means they have a large HIV/AIDS Prevention and Mitigation Programme, which incorporated Care of OVCs and PMTCT projects, and that all the other technical programmes have a component related to HIV/AIDS. The Adolescent and Youth Lifeskills Project focuses primarily on HIV/AIDS issues. For the other programmes, it was felt that 20% of their expenditure could be attributed to HIV/AIDS.

CHAPTER FOUR ~ RECOMMENDATIONS and CONCLUSIONS

A number of recommendations may be made, which flow directly from the expenditure findings, and which were also found during the site visits, primarily suggested by district level service providers. These are all presented below.

General Recommendations Relating to Funding Mechanisms

The alignment and harmonisation of financial years and reporting requirements would greatly enhance the efficient use of funds and simplify the reporting process for recipients. Donors should continue to improve the alignment of their agendas with the national need and the priorities identified in the NSF. Increased pooled funding for management by NACA would assist this process, which would allow for one report to be submitted to all contributors to the basket fund.

It would simplify reporting of the development budget expenditure if the same codes were used as are used in the recurrent budget for HIV/AIDS programmes.

The system of request and disbursement of funds has strict inbuilt procedures and controls, which are important to reduce inappropriate access to funds. However, these can become bureaucratic and time-consuming, causing bottlenecks in transfers and delays in spending and implementation of services. Options for simplifying and streamlining some of these processes should be considered. For example, the current system of *quarterly* requests for funds can undermine the programmes effective planning and implementation and thus *bi-annual* requisitions, reports and transfers, instead of quarterly, might reduce some bottlenecks.

In addition, in order to ensure the correct usage of funds, greater emphasis should be placed on the scrutiny of the expenditure records being submitted by districts, with appropriate response and feedback be given to districts. This would enhance their effective implementation of their budgets and their reporting quality. Aggregation of the quarterly reports into annual reports should be undertaken by the MLG and MoH, and these presented to NACA timeously.

Those HIV/AIDS funds which are transferred to districts should be split according to the programs (not lumped into one vote) with specific codes for specific functions, and with details of where funds are from and their intended purpose. Since NACA provides requisition numbers with every transfer to ML and MoH, these same numbers should accompany the transfers to district level.

Recommendations Relating to Reporting and Information Systems

NACA and Local Government need to be clearer on the reporting requirements for the expenditure of HIV/AIDS funds at district and sub-district levels. Reporting formats should be provided, and quarterly (or preferably bi-annual) reports to the required quality be insisted upon, from both sub-district and district level back to central government. Once the MLG or MoH receive the expenditure reports from districts,

prompt feedback should be made to NACA. Alternatively, all the district level reports should be copied to NACA when sent to MLG or MoH. The same could apply to those expenditure reports sent directly to development partners.

A weak link in the reporting cycle appears to be between the MoH or MLG and NACA for those funds received from NACA. There should be greater emphasis on this reporting requirement with NACA stipulating the reporting required format. NACA could insist on regular accounting for received funds before granting further transfers.

Sub-districts lack the capacity to effectively manage and report on their expenditure of HIV/AIDS funds. It was suggested by a number of persons at district level that NACA should employ a specific person who oversees the expenditure and reporting of HIV/AIDS funds at district level, and who assists the sub-districts to improve their financial management and information systems.

All sub-districts should have adequate access to computers to allow for electronic monitoring of expenditure and for the easier generation of reports.

It is suggested that district expenditure reports attempt to link their expenditure with the outputs (or services delivered), as were indicated in the budget proposals, and provide a measure of the degree of achievement of the targets.

Generally, the financial reporting system within NACA could be improved. Incorporation of the financial reporting to the BHRIMS information systems would greatly enhance its usefulness.

Recommendations to Relating to Spending Priorities and the Achievement of the NSF Goals

When comparing the proportional actual spending in 2005/06 against the intended proportions for the NSF Goals, it appears that NACA has been successful in managing the allocations to obtain the required proportional balance. However, the actual amounts spent still fall short of the estimated required resources.

The findings presented here show the dominance of the expenditure on ARVs, highlighting Botswana's commitment to providing free ARVs to all in need, and to improving access through the roll-out to clinics. The next largest allocation was made to the care of orphans.

However, due to the risk of over-medicalising the response to HIV/AIDS, there may be need to increase the spending on preventative activities, social mitigation efforts, community development, with almost no spending for human resources enhancement¹⁵.

The Botswana National Strategic Framework states that:

"The vision for Botswana's National HIV/AIDS Strategic Framework is no new infections in the country by 2009. While seemingly over ambitious, this vision can be achieved if the allocation of resources is directed towards a greater emphasis on prevention than the current focus on treatment and care."

¹⁵ This does not refer to personnel costs, which are captured under their respective functions, but rather those additional resources required to entice professionals into the HIV/AIDS field.

Therefore in line with this aim, NACA might want to increase its funding of preventive activities, but without reducing the allocations to ARVs. This would entail making the total expenditure on HIV/AIDS larger, which will be necessary to attain the NSF targets.

The analysis of the beneficiaries of spending show a strong focus on PLWHA, which reflects the large spending on ARVs. The next category are the OVCs who benefit from the emphasis on the OVC programme. The limited targeting of Most at Risk Populations (MARPs) might need consideration. Although Botswana does have a generalized epidemic, and the GoB has focused on making all services available and accessible to all the population, these MARPs may require particular attention.

Recommendations to NACA

NACA should make routine follow-up on expenditure of funds transferred, and undertake annual, or routine, visits to the implementers of programmes. These would be appreciated by the service providers, and would provide a mechanism for two-way flow of information between NACA and the service providers.

NACA could also assist to develop the skills of district level providers in financial management, reporting quality, and general budget planning and execution.

It is suggested that NACA develop and maintain the database of all HIV/AIDS stakeholders in Botswana. The database developed by the NASA research team for this assessment could act as a useful starting point. The private sector actors would have to be added.

Recommendations to MoH and MLG

As suggested earlier, MoH and MLG could improve its reporting to NACA of funds spent on HIV activities.

MLG should use the quarterly expenditure reports sent by districts to report to NACA. These should be aggregated into annual spending, by function/ activity. It is suggested that the NASA categories be used as a standardized method of capturing spending.

Suggestions for Hospital and Clinic Systems

- Rehire retired medical personnel on a temporary basis to help ease staff shortages.
- There is need for the provision of computers and training in their use to aid the production of quality reports.

Recommendations to Development Partners and UN Agencies

Development partners (DPs) should summarise the expenditure reports from their recipients, and compare the annual actual expenditure with the transfers/ commitments. This would quantify the absorptive capacity and the scope of the problem of under-spending.

The alignment and harmonisation of the DPs financial years and reporting requirements would greatly enhance the efficient use of funds and simplify the reporting processes. Alignment of agendas is also necessary, and increased funding through a pooled mechanism (or 'basket funding') would strengthen the GoB's response.

In harmonising and aligning funding mechanisms between DPs, attention should be paid to every aspect of the funding chain that might contribute to poor absorptive capacity.

DPs should avoid 'dumping' of funds towards the end of financial years, and decrease the delays in transfers, so that these occur timeously and allow for adequate implementation time.

There is need for emphasis on the building of capacity of recipient organisations in financial planning, management and reporting.

Donor organisations need to devote resources to build capacity of programmes that they fund, especially human resources and be willing to fund salaries.

The UN agencies need to improve their financial reporting systems, and disaggregate their expenditure according to the NASA spending categories classifications.

Attention is required to the UN funding channels as these are bureaucratic and slow.

In-country UN offices should have greater control over their HIV/AIDS related expenditure and record keeping, so as to enable improved planning and monitoring. The ATLAS system should assist in this regard.

The costs of technical assistance to countries should be costed and included in NASAs. However, this is particularly challenging since the data required resides at the UN Headquarters and is inaccessible to country UN offices. Access should be granted to this information.

Recommendations Relating to Service Delivery

There is need to improve the absorptive capacity of all service providers, in order to spend efficiently and effectively. This will entail a thorough examination of the many factors that contribute to limited absorptive capacity, from source, through agent, to provider, and a concerted effort by all players to improve upon these.

Limited human resource capital was mentioned in almost every interview with the district programmes as seriously impeding their ability to spend and to implement efficiently. This issue must be addressed with some urgency with attention to strengthening health systems more generally, including equipment, space and other aspects.

It is suggested that requests made by service providers to NACA/ MLG/ MoH, should be supported by an assessment of need for the service, and reporting against its expenditure should mention the degree of meeting the identified need.

Service providers should attempt to link their expenditure records with the outputs (or services delivered) and to compare these with intended targets, as indicated in budget proposals.

In addition, NACA, MLG or MoH should not cut requested budgets without attention to the need and without justification and explanation to the recipient. The providers interviewed specifically requested assistance in reducing their implementation plans to 'fit' their cut budgets.

Donor organisations need to devote resources to build capacity of recipient programmes, especially in terms of human resources and be willing to fund salaries.

Recommendation relating to the next NASA in Botswana

This NASA has provided an important base-line study of the main public and donor funds going to HIV/AIDS in Botswana. It will be a relatively simple process to maintain the NASA database if the expenditures are captured on a routine basis. Data collection will become easier if expenditure reporting is done according to the NASA classifications. The private and OOPE expenditure should be added in future NASAs.

In addition, future NASA estimations of national costs for ARV and PMTCT drugs and testing costs should consider the degree to which the national treatment protocol guidelines are adhered to by the service deliverers. This would require detailed information from studies considering these aspects and will provide a more accurate estimate of actual utilisation.

Inclusion of the Central Medical Stores (CMS) running costs, personnel, overheads and transport costs attributable to HIV/AIDS must be calculated and incorporated in the assessment. This will require detailed information from CMS, in terms of space utilisation and quantities of HIV/AIDS drugs as a proportion of their total stocks.

The data collections forms were reported to be too complicated for self-administration by the informants. They should be either modified and simplified, or only be used in face-to-face interviews. Generally the latter provides better response rate and more accurate data capturing.

The next steps after this NASA, to prepare for the MTR report would include:

- Ensuring that the two NACA staff members trained in the NASA techniques through this process be allocated to the ongoing task of data collection, to ensure the maintenance of the database, so as to make annual assessments progressively easier each year.
- Securing the services of additional data capturers to capture the production factors for all the NACA expenditure for the period.
- Planning for the assessment of the private sector expenditure on HIV/AIDS. This will require a database of all businesses that have HIV/AIDS programmes or make contributions to HIV/AIDS activities if out-of-pocket expenditure is also to be included, then some attention is required to the methodology to be used. A household level survey or indepth case studies could be used, both having their inherent strengths and weaknesses, and having differing time and financial implications.

The Research team wishes to thank NACA and UNAIDS for this opportunity, and to thank all the respondents who so willingly provided information and insight into the funding mechanism issues and challenges.

The important commitment to addressing HIV/AIDS in Botswana made by the President of Botswana and the GoB has been highlighted by the expenditure evident in this report and is to be commended.

Attention to the recommendations made herein would greatly enhance the HIV/AIDS response and the achievement of the NSF goals.

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APPENDIX I ~ SOURCES OF DATA

STATUS OF DATA	2003	2004	2005	Primary	Second.	Source	Estimation
<u>PUBLIC</u>							
MoH - hospitals	✓	✓	✓	✓		Vote ledger expenditure	Bottom-up
MoH - PMTCT	✓	✓	✓	✓		Vote ledger expenditure	Both
MoH - ARVs	✓	✓	✓	✓		Vote ledger expenditure	Both.
MoH - HBC	✓	✓	✓	✓		Adapted Central CMS, STI Unit - Epi.	Both
MoH - STIs	x	✓	✓	✓			Est.03
MoH - IPT	x	✓	✓	✓		NACA, IPT	Est.03
MoH - CMS	x	✓	✓	✓		CMS, drugs, staff, O/H	
MoH - Nat. Health Lab	Impossible to disaggregate HIV costs from general lab costs						Est.03
MLG - clinics	✓	✓	✓	✓		Central MLG & MOH, Health Statistics Unit.	Top-down
MLG - HBC	✓	✓	✓	✓		Districts, No central	Both
MLG - OVCs	✓	✓	✓	✓		Districts, No central	Bottom-up
MoE	✓	✓	✓		✓	From NACA ledgers	
BDF	✓	✓	x	✓			Est.05
BPS	✓	✓	✓	✓			
Prisons	✓	✓	✓		✓	NACA ledgers	
BPOMAS	x	✓	✓			Salaries missing	
Other Ministries (Workplace)	✓	✓	✓		✓	NACA	

STATUS OF DATA	2003	2004	2005	Primary	Second.	Source	Estimation
<u>EXTERNAL</u>							
PEPFAR	✓	✓	✓	✓		PEPFAR	Verification
ACHAP	✓	✓	✓	✓		ACHAP	from some
GLOBAL FUND	x	✓	✓	✓		GLOBAL FUND	recipients
UNICEF	✓	✓	✓	✓		UNICEF	
UNFPA	x	✓	✓	✓		UNFPA	
UNAIDS	x	✓	✓	✓		UNAIDS	
WHO	x	x	x	Data not disaggregated sufficiently			
BHP - research	forthcoming					BHP	
BHP - testing costs	captured under public prgms					BHP	

Pathfinder	✓	✓	✓		✓	Recipients (excl.YOHO)
PSI	✓	✓	✓	✓		PSI
Other donors to NACA	✓	✓	✓		✓	NACA records

STATUS OF DATA	2003	2004	2005	Primary	Second.	Source	Estimation
NGOs							
BONASO	✓	✓	✓	✓		BONASO	Adjustments
BONEPWA	✓	✓		✓		BONEPWA	Adjustments
BOCAIP	✓	✓	✓	✓		BOCAIP	Adjustments
Tebelopele		✓	✓	✓		Tebelopele	Adjustments
BONELA	✓	✓	✓	✓		BONELA	Adjustments
HUMANA	✓	✓	✓	✓		HUMANA	Adjustments
HRDC (for research)	x	x	x				
CEYOHO		✓	✓		✓	ACHAP	
Missing	-	Action taken					
BPOMAS							
salaries related to HIV/AIDS		Not estimated					
DACs & MACs		Estimated using Ministry salary grades					
salaries missing		Used donor records of transfers (not actual expenditure)					
A few small NGOs (eg. YOHO, COCEPWA, FBOs)							

APPENDIX II - Interviews Held and Organisations Contacted for Information

Our thanks to all for their time and assistance.

Public Institutions – National Level

Ministry of Health:

Department of HIV/AIDS Prevention and Care – Ms Barbara Mudanga & Dr Florindo de la Gomez

- PMTCT - Koona Keapoletswe
- STI Management - Dr Mwambona
- IPT programme
- STD programme
- CHBC Programme
- Routine Counselling and Testing
- Financial department – Anna Nokane

National Health Laboratory – Dr Mtoni & Mr Joseph Senosi

Central Medical Stores - Ms Molefi & Reddy

Health Statistics Unit - Statistician - Judith Letebele

Ministry of Education – Mrs S. Nkoane

Ministry of Local Government:

- HIV/AIDS Unit (now under the Primary Health Department) - Mrs Dundu Matcha, Ivan Makati, Donald
- Department of Social Services – Mr D. Semausu
- CHBC (Orphan Care) - Mr B. Semommung & K. Ralekgobo, Penny S. Makuruetsa, Lumba Nchunga

Ministry of Finance and Development Planning:

Budget Control Office – Ms Peters

Botswana Police Services - Ms D. Motladiile

Botswana Defence Force - Lt Col. R. Phetogo

BPOMAS – Mr Ebineng

Development Partners

BOTUSA (for PEPFAR funds) - Reuben Haylette

ACHAP - Collin Blumton

GFATM – Mabel Ramekwa

UNICEF - Dorothy Ochola-Odongo, David Kanje, Waheeda Lottering, Cynthia Mawema

UNAIDS – Irene Maina

UNDP - Lydia Matebesi

UNFPA – Moses Keetile

WHO – Dr Owen Kaluwa and Jacob

Botswana Harvard Laboratory - Dr Madisa Mine, Mosetsana Modukanele, Dr Rosemary M. Musonda

NGOs

PSI- Joan Ngare & Mr. Gosh

Humana People to People- Galengkope Kebonang
BONELA- Nana Gleeson & Christen Steglen
BONASO - David Mbulawa
BONEPWA – Ben Aliwa, Annah Obuseng & Prachanda Man Shrestha
BOCAIP - Osandi Kebasitile & Irene Kwape
PACT- Ms Allison
Tebelopele - Mr Moatshe & Otilia
Fair Lady Day Care Center (Kasane) – Jane Mabuto & Jill

District Level

Serowe:

Serowe Treasury Headquarters - Mr Phiri
Matron - Lechedzani Motlhabane
Deputy Council Secretary – Mr Molepolole
Chief Community Development Officer – Ms Moilwa

Sekgoma Hospital

Matron - Tshepo Mphoeng
Chief Registered Nurse - L. Kgaboesele

Palapye – District Health Team (DHT)

Senior Medical Officer - Dr Kabamba
Matron - Wendy Mokotedi
PMTCT Coordinator - Masego Kgosietsile
CHBC Coordinator - Sekani Chikunyana
CSDS Coordinator – Ms Maimula

Kediretswe Clinic

Nurse in Charge - Naomi Phang

Lotsane Clinic

Nurse in Charge - Baboloki Mogotsi

Selibe – Phikwe Town Council

Matron Selena Mahube
Senior Nursing Officer - Mrs Madochuwa
Public Health Specialist - Dr Trudi Nanison
Pharmacy Technician - Brian Kivumbi
HBC coordinator - Ms Nselo
PMTCT - Ms Sing
TB coordinator - Patricia
Treasury - Dorothy Bashe
Community Nurses
Botho Obusitse

T. Arvesen
G. Ntshelo

Selebi-Pikwe District AIDS Coordinator - Mrs Molemogi

Social and Community Development:

SnCD Coordinator - Mr Mokgethi
CHBC - Ms Mosetlha
Orphan Programme - Bakani Bakane & Ms Mosetlha

Selibe – Phikwe Govt Hospital

Pharmacist - Ms Maphisa
L. Abotseng
Administration Officer - Matlhodi Sarona
Laboratory - K. Ndlovu

Kasane – DHT

Public Health Specialist - Dr Handa
ARV programme Coordinator - Dr Musa

Kasane Primary Hospital

Chief Medical Officer - Dr Kenneth Chibwe
Matron - Ms Berlin Maposa
Laboratory Technician - Ndiko Nthaba
IPT Regional Coordinator - N. Makubate

Kweneng East District

Orphans Programme - Ms. B Simane
DAC-Ms B. Mahatelo
Matron DHT

Goodhope Sub District - District Council

Orphan Programme -Ms Segobaetso
Matron - Ms A Babitse
PMTCT Coordinator - Ms Rasetshwane

Discussions were also held with the **Researchers from ORC Macro International Inc.** who were undertaking a costing of the ARV programme at the same time as the NASA: Frank Dadzie, Iddrisu Sulemana & Melahi Corcuera Pons

APPENDIX III ~ BOTSWANA NASA MATRICES
2,005 Botswana Sources to Agents

Amount in pula		SOURCES					
AGENTS		FS 1..Public funds		Public funds Total	Private funds	International Funds	Grand Total Pula
Agents:	Sub Agents	MoFDP	NACA				
FA 1..Public sector	FA 1.2.Central government	793,694,682		793,694,682		33,364,814	827,059,496
	FA 1.3.State/provincial government	90,480,659		90,480,659		253,000	90,733,659
	FA 1.4.Local/municipal government	308,725		308,725			308,725
	FA 1.6.Government employee insurance programmes.	10,043,034		10,043,034			10,043,034
	FA 1.7.Parastatal organizations.					495,880	495,880
FA 1..Public sector Total		894,527,100		894,527,100		34,113,694	928,640,794
	FA 2.3.Private households' virtual fund for out-of-pocket payments				10,043,034		10,043,034
	FA 2.4.Not-for-profit institutions serving households (other than social insurance)	20,373	556,421	576,794	746,359	30,241,594	31,564,747
	FA 2.5.Private non-parastatal organizations and corporations (other than health insurance)					2,808,300	2,808,300
FA 2..Private sector Total		20,373	556,421	576,794	10,789,393	33,049,894	44,416,081
FA 3..International Organizations						64,226,664	64,226,664
	FA 3.1.Country offices of Bilateral Agencies Total					64,226,664	64,226,664
	FA 3.2.Multilateral - UNAIDS					3,401,019	3,401,019
	UNICEF				37,808	6,731,525	6,769,333
	UNDP	4,048,430		4,048,430		2,310,762	6,359,192
	UNFPA					4,120,894	4,120,894
	GFATM					28,359,542	28,359,542
	FA 3.2.Multilateral Agencies Total	4,048,430		4,048,430	37,808	44,923,742	49,009,980
	FA 3.3.International not-for profit organizations				24,843	46,122,963	46,147,806
	FA 3.4.International for-profit bodies					5,814,193	5,814,193
	FA 3.4.International for-profit bodies Total					5,814,193	5,814,193
FA 3..International Organizations Total		4,048,430		4,048,430	62,651	161,087,562	165,198,643
Grand Total Pula		898,595,903	556,421	899,152,324	10,852,044	228,251,150	1,138,255,518

2,004 Botswana Sources to Agents									
Amounts in Pula		SOURCES							
AGENTS						Public funds Total	Private funds	International Funds	Grand Total Pula
		FS 1..Public funds			Central government Total				
Agents:	Sub Agents	MoH	MoF	NACA					
FA 1..Public sector									
	FA 1.2.Central government	8,371	503,445,104		510,237,739	510,237,739		14,192,401	524,430,140
	FA 1.3.State/provincial government	365,069	2,339,232		2,704,301	2,704,301			2,704,301
	FA 1.4.Local/municipal government		258,519,966		258,519,966	258,519,966			258,519,966
	FA 1.6.Government employee insurance programmes.		8,162,742		8,162,742	8,162,742			8,162,742
FA 1..Public sector Total		373,440	772,467,044		779,624,748	779,624,748		15,091,005	794,715,753
	FA 2.3.Private households' virtual fund for out-of-pocket payments						8,162,742		8,162,742
	FA 2.4.Not-for-profit institutions serving households (other than social insurance)		164,768	1,134,104	1,298,872	1,298,872	1,799,459	23,015,590	26,113,921
	FA 2.5.Private non-parastatal organizations and corporations (other than health insurance)							1,382,607	1,382,607
FA 2..Private sector Total			164,768	1,134,104	1,298,872	1,298,872	9,962,201	24,398,197	35,659,270
FA 3..International Organizations								39,059,751	39,059,751
	FA 3.1.Country offices of Bilateral Agencies Total							39,059,751	39,059,751
	UNAIDS							3,352,073	3,352,073
	WHO							1,996,875	1,996,875
	UNICEF						109,081	5,344,986	5,454,067
	UNDP		7,670,424		7,670,424	7,670,424	234,603	1,624,514	9,529,541
	FA 3.2.Multilateral Agencies Total		7,670,424		7,670,424	7,670,424	343,684	13,333,372	21,347,480
	FA 3.3.International not-for profit organizations							95,064,894	95,064,894
FA 3..International Organizations Total			7,670,424		7,670,424	7,670,424	343,684	147,458,017	155,472,125
Grand Total Pula		373,440	780,302,236	1,134,104	788,594,044	788,594,044	10,305,885	186,947,219	985,847,148

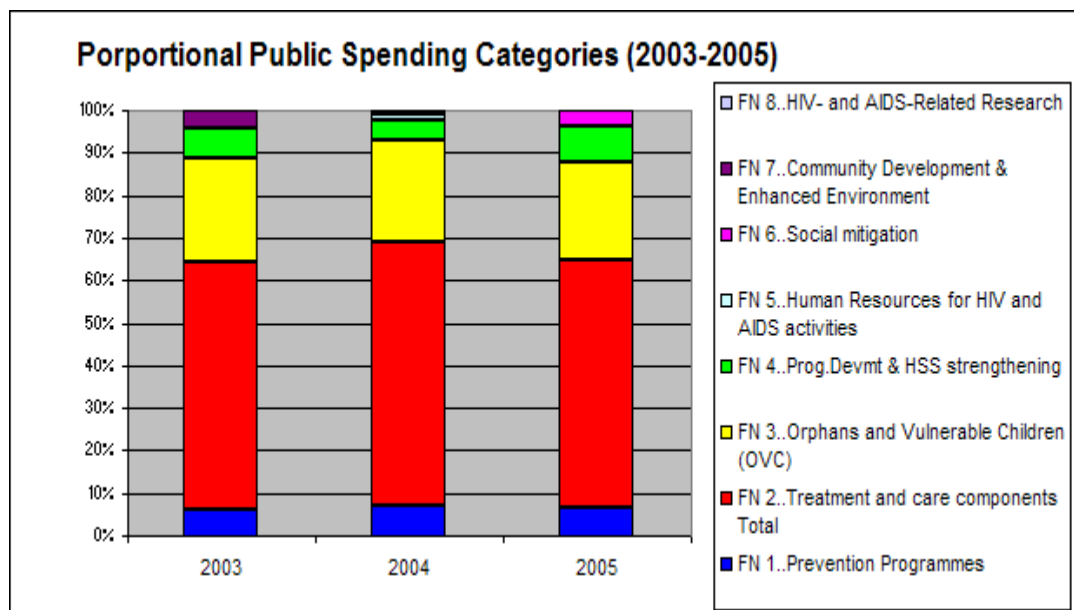
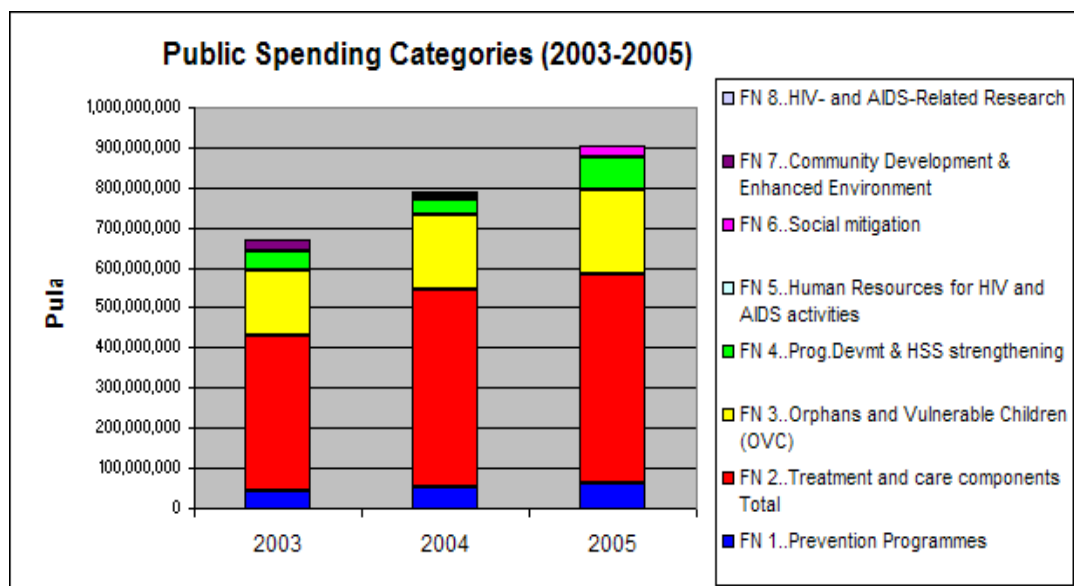
2,003 Botswana Sources to Agents									
Amounts in Pula		SOURCES							
AGENTS		FS 1..Public funds				Public funds Total	Private funds	International Funds	Grand Total Pula
		Central Govt.							
Agents:	Sub Agents	MoD	MoFDP	NACA	MoF				
FA 1..Public sector	FA 1.1.Territorial government								
	FA 1.2.Central government	311,752	611,403,328		45,289,130	657,004,210		5,693,080	662,697,290
	FA 1.4.Local/municipal government		8,020,744			8,020,744			8,020,744
FA 1..Public sector Total		311,752	619,424,072		45,289,130	665,024,954		5,693,080	670,718,034
	FA 2.4.Not-for-profit institutions serving households		204,343	4,667,277		4,871,620	4,114,717	2,558,630	11,544,967
FA 2..Private sector Total			204,343	4,667,277		4,871,620	4,114,717	2,558,630	11,544,967
FA 3..International Organizations	FA 3.1.Country offices of Bilateral Agencies							4,268,783	4,268,783
	FA 3.1.Country offices of Bilateral Agencies Total							4,268,783	4,268,783
	UNICEF						148,115	7,257,632	7,405,747
	UNDP							2,518,191	2,518,191
	FA 3.2.Multilateral Agencies Total						148,115	12,015,234	12,163,349
	FA 3.3.International not-for profit organizations							49,925,726	49,925,726
FA 3..International Organizations Total							148,115	66,209,743	66,357,858
Grand Total Pula		311,752	619,628,415	4,667,277	45,289,130	669,896,574	4,262,832	74,461,453	748,620,859

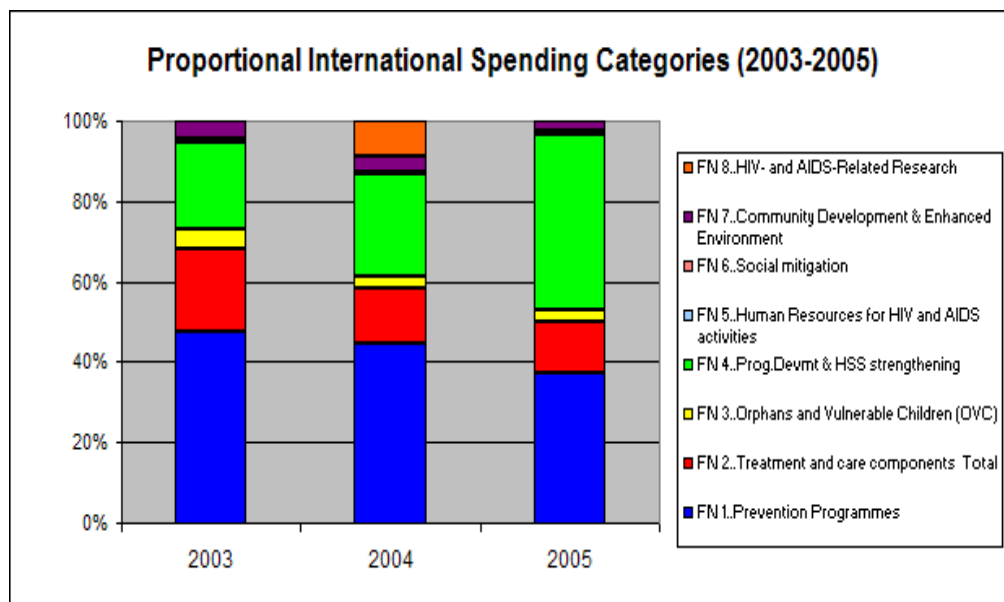
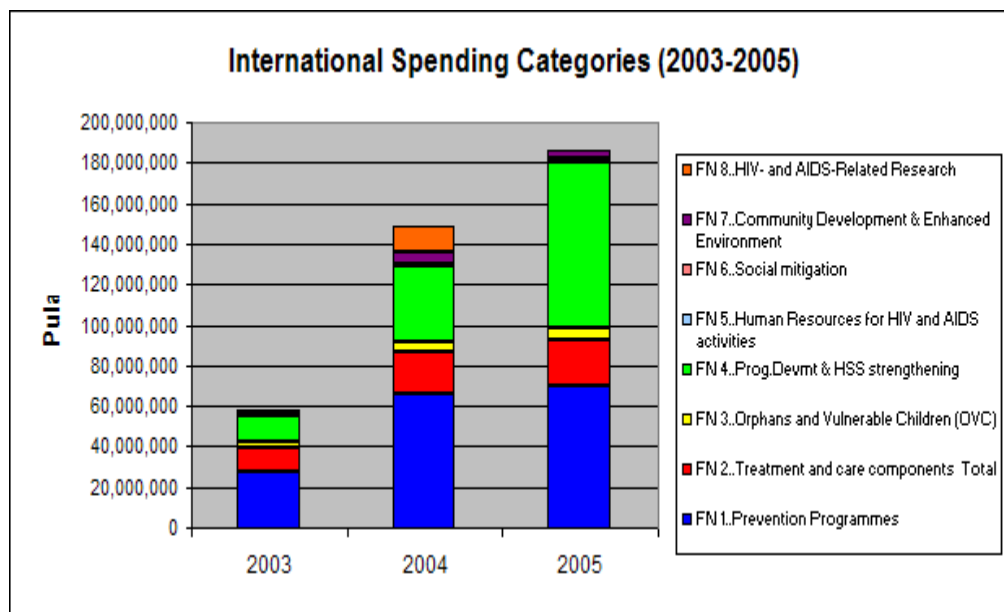
2,005	Botswana	Agent-Function											
Amounts in Pula	Public sector	Private sector	Bilateral Agencies	Multilat. Agencies					Multilat. Agencies Total	Internat. NPOs	Internat. for-profit bodies	Int. Orgs Total	Grand Total Pula
SPENDING CATEGORIES				UNAIDS	UNICEF	UNDP	UNFPA	GFATM					
FN 1..Prevention Programmes	59,885,850	25,028,479	25,475,813	2,368,815	3,871,003	924,087	4,120,894	2,722,247	14,007,046	28,767,950	1,265,000	69,515,809	154,430,138
FN 2..Treatment and care components Total	526,003,751	10,592,693	1,077,957					9,772,869	9,772,869	9,376,124	3,208,293	23,435,243	560,031,687
FN 3..Orphans and Vulnerable Children (OVC)	210,676,609	28,570			931,100			512,616	1,443,716	4,128,198		5,571,914	216,277,093
FN 4..Prog.Devmt & HSS strengthening	77,515,831	3,550,640	37,672,894	818,108	1,882,858	1,280,567		15,351,810	19,333,343	24,286,296		81,292,533	162,359,004
FN 5..Human Resources for HIV and AIDS activities													
FN 6..Social mitigation	32,137,081	657,556			84,371				84,371	2,139,009		2,223,380	35,018,017
FN 7..Community Development & Enhanced Environment				214,096		4,154,538			4,368,634			4,368,634	5,807,503
FN 8..HIV- and AIDS-Related Research		581,476											581,476
Grand Total Pula	906,219,122	41,878,283	64,226,664	3,401,019	6,769,332	6,359,192	4,120,894	28,359,542	49,009,979	68,697,577	4,473,293	186,407,513	1,134,504,918

2004 Botswana Agent-Function													
Amounts in Pula	Public sector	Private sector	Bilateral Agencies	Multilat. Agencies					Multilat. Agencies Total	Internat. NPOs	Internat. for-profit bodies	Int. Orgs Total	Grand Total Pula
SPENDING CATEGORIES				UNAIDS	UNICEF	UNDP	UNFPA	GFATM					
FN 1..Prevention Programmes	54,019,107	15,179,760	23,111,535	2,907,584	1,577,393	3,257,352	1,014,924		10,071,733	33,022,329		66,205,597	135,404,464
FN 2..Treatment and care components Total	489,133,267	9,887,953	2,326,944						490,105	17,727,014		20,544,063	519,565,283
FN 3..Orphans and Vulnerable Children (OVC)	189,133,308	896,017			2,035,201	42,269			2,077,470	2,730,773		4,808,243	194,837,568
FN 4..Prog.Devmt & HSS strengthening	39,725,753	7,882,994	11,535,407	286,704	1,467,572	518,876			2,465,442	23,817,033		37,817,882	85,426,629
FN 5..Human Resources for HIV and AIDS activities													8,920,682
FN 6..Social mitigation	8,670,509	147,567			373,900				373,900			373,900	9,191,976
FN 7..Community Development & Enhanced Environment				157,784		5,711,044			5,868,828			5,868,828	7,616,089
FN 8..HIV- and AIDS-Related Research		86,402	351,750							13,132,000		13,483,750	13,570,152
Grand Total Pula	789,602,626	35,827,954	37,325,636	3,352,072	5,454,066	9,529,541	1,014,924		21,347,478	90,429,149		149,102,263	974,532,843

2003 Botswana Agent-Function													
Amounts in Pula	Public sector	Private sector	Bilateral Agencies	Multilat. Agencies					Multilat. Agencies Total	Internat. NPOs	Internat. for-profit bodies	Int. Orgs Total	Grand Total Pula
SPENDING CATEGORIES				UNAIDS	UNICEF	UNDP	UNFPA	GFATM					
FN 1..Prevention Programmes	42,429,151	2,876,050	4,268,783	1,971,582	3,835,661				5,807,243	17,661,149		27,737,175	73,042,376
FN 2..Treatment and care components Total	388,798,292	1,374,444								12,001,941		12,001,941	402,174,677
FN 3..Orphans and Vulnerable Children (OVC)	162,299,648				941,371				941,371	2,030,291		2,971,662	165,271,310
FN 4..Prog.Devmt & HSS strengthening	48,899,150	6,839,223		178,554	2,019,309				2,197,863	10,374,132		12,571,995	68,310,368
FN 5..Human Resources for HIV and AIDS activities													
FN 6..Social mitigation		13,215			609,406				609,406			609,406	622,621
FN 7..Community Development & Enhanced Environment				89,277		2,518,190			2,607,467			2,607,467	30,224,204
FN 8..HIV- and AIDS-Related Research	1,247,756	71,189											1,318,945
Grand Total Pula	670,615,819	11,849,036	4,268,783	2,239,413	7,405,747	2,518,190			12,163,350	42,067,513		58,499,646	740,964,501

APPENDIX IV ~ PUBLIC AND INTERNATIONAL SPENDING CATEGORIES





APPENDIX V ~ Botswana Spending by Expanded Categories

2005. Botswana. Total Expenditure by Function Expanded	
PREVENTION PROGRAMMES	Total Spending (Pula)
HIV- Related information and education	30,378,081
Community mobilization.	4,606,040
Voluntary counselling and testing.	43,922,298
Programmes focused on female sex workers and their clients.	
Programmes focused on male sex workers and their clients	
Programmes focused on men who have sex with men (MSM).	
Programmes focused on transgender individuals.	
Harm-reduction programmes for injecting drug users (IDU).	
Prevention programmes for people living with HIV.	
Condom social marketing.	2,253,876
Public and commercial sector condom provision.	17,759,973
Female condom.	4,709,051
Microbicides.	
Improving management of STIs.	4,017,719
Prevention of mother-to-child transmission.	36,744,769
Blood safety.	5,408,431
Post-exposure prophylaxis.	
Safe medical injections.	
Prevention not classified elsewhere	4,629,900
Prevention Programmes Total	154,430,138
TREATMENT AND CARE PROGRAMMES	
Provider initiated testing (routine testing should be here)	
Antiretroviral therapy.	211,060,244
Nutritional support associated to antiretroviral (ARV) therapy.	52,300
Prophylaxis for Opportunistic Infections - mainly IPT	85,348,658
Treatment of Opportunistic Infections.	2,699,228
Hospital treatment and care.	209,048,551
Laboratory monitoring.	641,785
Palliative care (incl. HBC)	43,721,886
Psychological support, groups, coping strategies.	720,954
Treatment and care not classified elsewhere	6,738,081
Treatment and care components Total	560,031,687
Orphans and Vulnerable Children (OVC)	216,277,093
Programme development and strengthen health care systems for HIV and AIDS activities	162,359,004
Social mitigation	35,018,017
HIV- and AIDS-Related Research	581,476
Grand Total (Pula)	1,134,504,918

APPENDIX VI Beneficiary Matrices									
2,005 Botswana Agent-Beneficiaries									
Amounts in Pula					NB. The beneficiaries were not identified for all spending				
Agents	PLWHA	Most at risk populations	Vulnerable groups.	Accessible populations	General population		Gen.Pop Total	Other Pops.	Grand Total
					Adult females	People not disaggregated by age/gender			
Public sector	560,194,676		253,298,906	4,754,671	4,709,051	8,392,074	14,797,754	61,777,422	894,823,429
Private sector	15,403,398	28,463	3,252,329			19,684,129	19,684,129	3,001,022	41,369,341
International Orgs.	83,460,200		4,554,493	13,007,556		10,752,500	10,752,500	77,149,575	188,924,324
Grand Total P	659,058,274	28,463	261,105,728	17,762,227	4,709,051	38,828,703	45,234,383	141,928,019	1,125,117,094
Percentages	58.58	0.00	23.21	1.58	0.42	3.45	4.02	12.61	100.00

2,004 Botswana Agent-Beneficiaries									
Amounts in Pula					NB. The beneficiaries were not identified for all spending				
Agents	PLWHA	Most at risk populations	Vulnerable groups.	Accessible populations	General population		Gen.Pop Total	Other Pops.	Grand Total
					Adult females	People not disaggregated by age/gender			
Public sector	499,915,983		224,309,399	11,856,249	19,038	33,621,285	33,640,323	19,880,672	789,602,626
Private sector	18,039,582		185,592			8,510,355	10,191,429	7,411,351	35,827,954
International Orgs.	49,624,679		5,959,203	12,410,415		21,175,829	21,268,879	62,598,837	151,862,013
Grand Total P	567,580,244		230,454,194	24,266,664	19,038	63,307,469	65,100,631	89,890,860	977,292,593
Percentages	58.08	0.00	23.58	2.48	0.00	6.48	6.66	9.20	100.00

2,003 Botswana Agent-Beneficiaries									
Amounts in Pula					NB. The beneficiaries were not identified for all spending				
Agents	PLWHA	Most at risk populations	Vulnerable groups.	Accessible populations	General population		Gen.Pop Total	Other Pops.	Grand Total
					Adult females	People not disaggregated by age/gender			
Public sector	326,380,977		171,481,165	8,882,180	2,392,083	77,026,511	79,418,594	84,270,532	670,433,448
Private sector	6,845,710					295,364	295,364	4,707,962	11,849,036
International Orgs.	20,654,424		2,971,662	12,487,559			342,572	29,766,858	66,223,075
Grand Total P	353,881,111		174,452,827	21,369,739	2,392,083	77,321,875	80,056,530	118,745,352	748,505,559
Percentages	47.28	0.00	23.31	2.85	0.32	10.33	10.70	15.86	100.00

APPENDIX VII ~ NASA DATA COLLECTION FORMS

Botswana National AIDS Spending Assessment



Form # 1 – Financing Sources / Agents

BOTSWANA NASA **DATA COLLECTION – FORM # 1 (SOURCES / AGENTS)**

Year of the expenditure estimate: _____			
Objectives of the form: I. To identify the origin of the funds used or managed by the institution during the year under study. II. To identify the recipients of those funds.			
Indicate what currency will be used throughout the form with an "X":	Local currency	US\$ Exchange rate in Year of Assessment	Other (specify):
Name of the Institution:			
1. Person to Contact (Name and Title):			
2. Address:		3. E-mail:	
4. Phone:		5. Fax:	
6. Type of institution: Select category of institution with an "X".	6.1 Public central government		
	6.2 Public regional government		
	6.3 Public local government		
	6.4 Private-for-profit national		
	6.5 Private-for-profit international		
	6.6 National NGO		
	6.7 International NGO		
	6.8 Bilateral Agency		
	6.9 Multilateral Agency		

If your institution is a SOURCE please jump to table 8, and following sections. If your institution is an AGENT please complete table 7 and 7a, and following sections.

7. Origin of the funds transferred: List the institutions from which your agency received funds during the year under study.

Origins of the funds (Name of the Institution and Person to Contact)	Funds received
7.1 Institution: Contact:	
7.2 Institution: Contact:	
7.3 Institution: Contact:	
7.4 Institution: Contact:	
7.5 Institution: Contact:	
TOTAL:	

7a. Origins of non financial resources: List the institutions from which your agency received non financial resources, during the year under study.

Origins of the non financial resources (Name of the Institution and Person to Contact)	Type of Goods donated	Quantity Received	Monetary Value in Year Assessment
7.6 Institution: Contact:			
7.7 Institution: Contact:			
7.8 Institution: Contact:			
7.9 Institution: Contact:			
TOTAL			

8. Destination of the funds:

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

Destination of the funds (Name of the Institution and Person to Contact)	Funds transferred	Funds <u>spent</u>
8.1 Institution: Contact:		
8.2 Institution: Contact:		
8.3 Institution: Contact:		
8.4 Institution: Contact:		
8.5 Institution: Contact:		
TOTAL:		

8a. Recipients of non financial resources: List the institutions to which your agency donated non financial resources, during the year under study.

Recipients of the non financial resources (Name of the Institution and Person to Contact)	Type of Goods donated	Quantity Received	Monetary Value in Year Assessment
8.6 Institution: Contact:			
8.7 Institution: Contact:			
8.8 Institution: Contact:			
8.9 Institution: Contact:			
8.10 Institution: Contact:			

TOTAL:			
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9. Additional information on transferred funds reported as spent: Complete a Providers form (Form # 2) for each institution about which the Source / Agent has information regarding what the funds were used for, in order to gain information on Functions, Beneficiary Populations and Production Factors.

10. Consumption of the funds: If the institution consumed resources in producing services or goods, (i.e. administrative costs in managing the funds), complete a Providers form (Form # 2) regarding those funds.

Additional Qualitative Information (feel free to add as many rows as you need)

- a. Please describe how institutions apply and access funds from your institution. Please describe the funding flow mechanisms.

- b. What are the conditionalities that your institution insists upon in transferring funds to organizations?

- c. What are the reporting requirements for organizations receiving funds from your institution?

- d. What are the key difficulties faced by recipient organizations in efficiently spending the funds transferred to them by your institution?

- e. What are the key causes of bottlenecks in the funding mechanisms?

- f. What are the other issues/ challenges related to funding for HIV/AIDS services?

g. Any other comments, suggestions etc?

11.Surveyor:	12.Date: / / 20__
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BOTSWANA NASA
DATA COLLECTION – FORM # 2 (PROVIDERS)

Origin of the information: Select with an "X" the source of the information on the Provider	
A) Information given by the Provider itself.	
B) Information given by other institution than the Provider (i.e.: Agent or Financing Source)	
In case of B), complete:	
Institution:	Person to Contact (Name and Title):
Phone:	E-mail:

Year of the expenditure estimate:_____

Objectives of data collection from the Provider:			
III. To identify the origin of the funds spent by the provider in the year understudy. IV. To identify in which NASA Functions/ activities the funds were spent. V. To identify the NASA Beneficiary Populations for each NASA Function/ activity. VI. To identify the NASA Production Factors for each Function/ activity.			
Indicate what currency will be used throughout the form with an "X":	Local currency	US\$ Exchange rate in Year of Assessment	Other (specify): _____
Name of the Provider:			
13. Person to Contact (Name and Title):			
14. Address:		15. E-mail:	
16. Phone:		17. Fax:	
18. Type of institution: Select category of institution with an "X".	1. Public central government		
	2. Public regional government		
	3. Public local government		
	4. Private-for-profit national		
	5. Private-for-profit international		
	6. National NGO		
7. International NGO			
8. Bilateral Agency			
9. Multilateral Agency			

19. Origin of the funds received: List the institutions that granted the funds spent during the year under study.

Origin of the funds (Name of the Institution and Person to Contact)	Funds received during the year under study
7.10 Institution: Contact:	
7.11 Institution: Contact:	
7.12 Institution: Contact:	
7.13 Institution: Contact:	
7.14 Institution: Contact:	
TOTAL:	

7a. Origin of non financial resources: List the institutions that granted *non financial* resources during the year under study.

Origin of the non financial resources (Name of the Institution and Person to Contact)	Type of Resource received	Quantity Received	Monetary Value in Year of Assessment
7.15 Institution: Contact:			
7.16 Institution: Contact:			
7.17 Institution: Contact:			
7.18 Institution: Contact:			
7.19 Institution: Contact:			
TOTAL:			

20. Destination of the funds:

- IV. Identify and quantify the NASA Functions in which the funds were spent.
 V. Identify and quantify the NASA Beneficiary Population(s) of each Function.
 VI. Use NASA notebook to classify Functions and Beneficiary Populations, using the name and code as the figure in the notebook for their identification.

8.1 Expenditure of the funds received from "7.1"

8.1.1 Function (Code and Name)				Amount spent
Code:	Name:			
8.1.1.1 Beneficiary Population (Code and Name):				
Code:	Name:			
8.1.1.2 Beneficiary Population (Code and Name):				
Code:	Name:			
Total spent on the Function:				
8.1.2 Function (Code and Name)				Amount spent
Code:		Name:		
8.1.2.1 Beneficiary Population (Code and Name):				
Code:	Name:			
8.1.2.2 Beneficiary Population (Code and Name):				
Code:	Name:			
Total spent on the Function:				
8.1.3 Function (Code and Name)				Amount spent
Code:		Name:		
8.1.3.1 Beneficiary Population (Code and Name):				
Code:	Name:			
8.1.3.2 Beneficiary Population (Code and Name):				
Code:	Name:			
Total spent on the Function:				
Total Expenditure from the amount from '7.1'				
Total unspent from the amount from '7.1'				

8.1.a If funds were unspent from '7.1' what were the key reasons for under-spending?

8.2 Destination of the funds received from "7.2"

8.2.1 Function (Code and Name)				Amount spent
Code:		Name:		
8.2.1.1 Beneficiary Population (Code and Name):				
Code:	Name:			

Code:		8.2.1.2		Beneficiary Population (Code and Name):		
Name:						
Total spent on the Function:						

Code:		8.2.2		Function (Code and Name)		Amount spent
Name:						
Code:		8.2.2.1		Beneficiary Population (Code and Name):		
Name:						
Code:		8.2.2.2		Beneficiary Population (Code and Name):		
Name:						
Total spent on the Function:						

Code:		8.2.3		Function (Code and Name)		Amount spent
Name:						
Code:		8.2.3.1		Ben		
Name:						
Code:		8.2.3.2		Beneficiary Population (Code and Name):		
Name:						
Code:		8.2.3.3		Beneficiary Population (Code and Name):		
Name:						
Total spent on the Function:						
Total Expenditure from the amount from '7.2'						
Total unspent from the amount from '7.2'						

8.2.a If funds were unspent from '7.2' what are the reasons for under-spending?

8.3 Destination of the funds received from "7.3"						
Code:		8.3.1		Function (Code and Name)		Amount spent
Name:						
Code:		8.3.1.1		Beneficiary Population (Code and Name):		
Name:						
Code:		8.3.1.2		Beneficiary Population (Code and Name):		
Name:						
Total spent on the Function:						

Code:		8.3.2		Function (Code and Name)		Amount spent
Name:						
Code:		8.3.2.1		Beneficiary Population (Code and Name):		
Name:						
Code:		8.3.2.2		Beneficiary Population (Code and Name):		
Name:						
Total spent on the Function:						

8.3.3 Function (Code and Name)			Amount spent
Code:		Name:	
8.3.3.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.3.3.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
Total Expenditure from the amount from '7.3'			
Total unspent from the amount from '7.3'			

8.3.a If funds were unspent from '7.3' what were the key reasons for under-spending?

8.4 Destination of the funds received from "7.4"			
8.4.1 Function (Code and Name)			Amount spent
Code:		Name:	
8.4.1.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.4.1.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
8.4.2 Function (Code and Name)			Amount spent
Code:		Name:	
8.4.2.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.4.2.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
8.4.3 Function (Code and Name)			Amount spent
Code:		Name:	
8.4.3.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.4.3.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
Total Expenditure from the amount from '7.4'			
Total unspent from the amount from '7.4'			

8.4.a If funds were unspent from '7.4' what were the key reasons for under-spending?

8.5 Destination of the funds received from "7.5"			
8.5.1 Function (Code and Name)			Amount spent
Code:		Name:	
8.5.1.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.5.1.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
8.5.2 Function (Code and Name)			Amount spent
Code:		Name:	
8.5.2.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.5.2.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
8.5.3 Function (Code and Name)			Amount spent
Code:		Name:	
8.5.3.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.5.3.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
Total Expenditure from the amount from '7.5'			
Total unspent from the amount from '7.5'			

8.5.a If funds were unspent from '7.5' what were the key reasons for under-spending?

21. Production Factors: In order to finish the form, complete ANNEX 1.

Additional Qualitative Information Required:

1. What are the major difficulties you face with regard to securing funding?

2. What are the major difficulties you face with regard to spending and reporting on funds?

3. What are the key bottlenecks to spending?

4. Are the funds you receive adequate to run your HIV/AIDS programmes?

Explain your answer.

5. With regard to donor funds that you receive, what conditions (directions) are given for you to spend the donor money?

6. What are your thoughts regarding the reporting requirements for donor funds?

7. If you also receive government funding, are these funds more accessible than donor funds and if so, why?

8. What are your key challenges in implementing HIV/AIDS services?

9. How could these be addressed or reduced?

22. Interviewer:	23. Date: / / 20__
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DATA COLLECTION GUIDE ~ TREATMENT AND CARE

The present tool presents basic situations for Treatment and Care on data availability and possible solutions for each circumstance in order to capture actual expenditure on the services delivered.

1. Example on Antiretroviral therapy.

FN 2.2. ***Antiretroviral therapy.*** The specific therapy includes a comprehensive set of recommended antiretroviral drugs, including the cost of supply logistics for either adults or children. The number of people being treated is based on country-specific evidence of current coverage.

FN 2.2.1. ***Antiretroviral therapy for adults***

FN 2.2.2. ***Antiretroviral therapy for children.***

2.1 Data available: Actual Expenditure.

- 1) With the information of actual expenditure complete a simple table where the Code and Name of the NASA Function is stated, and add the amounts on actual expenditure. It is also very important to complete the information identifying the source or informat:

Code	Function	Expenditure
FN 2.2.1.	Antiretroviral therapy by gender and age	
Source of information.		
Institution:	Person to Contact (Name and Title):	
Phone:	E-mail:	

- 2) Second step: complete data on NASA Production Factors; specify what comprehends the expenditure in the different Production Factors.

FN 2.2.1 Antiretroviral therapy by gender and age		
Code	Profuction Factor	Expenditure
TOTAL		

- 3) Set up a table where the Beneficiary Population is identified:

FN 2.2.1 Antiretroviral therapy by gender and age		
Code	Beneficiary Population	Expenditure
TOTAL		

2.2 No data on expenditure. Data available: ARV consumption.

1. List the ARV consumed during the year under study.
2. Define the unit (presentation, quantity, doze).
3. Complete data on the number of units consumed.
4. Complete data on the price of each ARV. (Consult the NASA notebook for a detailed explanation on prices and costs).

5. Calculate total expenditure using the PxQ approach (Prices by Quantities).
 6. Identify the Source of the information.

ARV	Unit definition	Number of Units Consumed	Unit Price	Expenditure (PxQ)
TOTAL				

Source of information.	
Institution:	Person to Contact (Name and Title):
Phone:	E-mail:

Since ARV treatment also includes the cost of supply logistics, the supply logistic activities should be captured in a table like next one, where the activities are related to one or more NASA production Factors.

Activitie	NASA Profuction Factor (Code and Name)	Expenditure
TOTAL		

Source of information.	
Institution:	Person to Contact (Name and Title):
Phone:	E-mail:

The Beneficiary Population could be captured in a table as the one shown in 1.1. 3).

2.3 No data on expenditure, nor on ARV consumption. The only data available is the number of people being treated based on country-specific evidence of current coverage.

In this case, one possible way of estimating actual expenditure is to multiply the number of people under ARV treatment by the cost of the country specific ARV average treatment.

Capture the number of adults and children under ARV therapy.

Beneficiary Population	Quantity
Adults under Antiretroviral therapy	
Children under Antiretroviral therapy	

Source of information.

Institution:	Person to Contact (Name and Title):
Phone:	E-mail:

In a table similar to this one, the average ARV therapy should be detailed and its cost estimated using the PxQ approach. Note: One table should be done for adults and other one for children.

ARV Therapy - Antiretroviral drugs and the cost of supply logistics.				
Activitie	Unit definition	Number of Units Consumed	Unit Price	Expenditure (PxQ)
TOTAL				
Source of information.				
Institution:	Person to Contact (Name and Title):			
Phone:	E-mail:			

The activities of the ARV average therapy should be related to its corresponding NASA production Factors.

Activitie	NASA Profuction Factor (Code and Name)	Expenditure
TOTAL		
Source of information.		
Institution:	Person to Contact (Name and Title):	
Phone:	E-mail:	

2. Example on Monitoring Tests.

FN 2.7 **Laboratory monitoring.** This includes expenses for the access and delivery of CD4 cell testing and viral load to monitor the response to antiretroviral therapy and disease progression among people living with HIV.

2.1 Data available: number of tests delivered.

Capture the number of tests done during the year under study, and the source of information.

Number of CD4 Tests done in the year under study:	
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Number of Viral Load Tests done in the year under study:		
Source of information.		
Institution:		Person to Contact (Name and Title):
Phone:		E-mail:

Capture all the expenses for the access and delivery of each test, identifying the corresponding NASA Production Factors, and add the cost of each component.

CD4 Test components	NASA Production Factor (Code and Name)	Cost
TOTAL		

Once the total cost of each test is estimated, multiply the cost of each test by the number of tests done. Sum both figures, and that is one way to estimate the expenditure in Laboratory Monitoring.

STAKEHOLDER DATA COLLECTION TOOL ~ Institutional Role

Year/s of the expenditure estimate:_____	
Objective of the Questionnaire:	
VII. To identify the role or roles of the institution to determine the most suitable form to use for data collection.	
Name of the Institution:	
1. Person to Contact (Name and Title):	
2. Address:	3. E-mail:

4. Phone:

5. Fax:

6. Questions to identify role of the institution in order to determine its role in the fight against HIV/AIDS during the year of the estimate.

6.1 Does the institution provide funds for HIV/AIDS (Source)	YES	NO
6.2 Does the institution transfer funds to other institutions for activities connected with the fight against HIV/AIDS? (Agent)	YES	NO
6.3 Does the institution produce goods and/or services for the fight against HIV/AIDS? (Provider)	YES	NO

7. Institutional Status – select category of the institution with an 'X'

10. Public central government	
11. Public regional government	
12. Public local government	
13. Private-for-profit national	
14. Private-for-profit international	
15. National NGO	
16. International NGO	
17. Bilateral Agency	
18. Multilateral Agency	

8. Forms for the institution. According to the answers in item 6, choose the form to be completed for data collection:

- 7.1 If Institution is Source and/or Agent – complete form number 1
 7.2 If Institution is a Provider – complete form number 2
 7.3 If Institution is an Agent and Provider – complete forms 1 and 2

Forms:

1. Source / Agent
2. Provider

DATA COLLECTION FORM ~ ANNEX 1
PRODUCTION FACTORS

1. Use NASA notebook to complete data on Production Factors.

Origin of the Funds	7.1			7.2		
Production Factors	8.1.4	8.1.5	8.1.6	8.2.1	8.2.2	8.2.3
PF 1.1.1 Wages						
PF 1.1.2 Social contributions.						
PF 1.1.3 Non-wage labour income						
PF 1.2.1 Material supplies.						
Antiretrovirals						
Other drugs and pharmaceuticals						
Medical and surgical supplies						
Condoms						
Reagents and materials						
Food						
Other supplies.						
Administrative services						
Maintenance and repairs						
Staff training,						
Market research,						
Consulting services						
Transportation and travel expenses						
Housing,						
Other services						
PF 1.3 Consumption of fixed capital.						
PF 1.4 Interest.						
PF 1.5 Subsidies to providers.						
PF 1.6 Transfers to households.						
PF 1.7 Other current expenditure.						
PF 2.1 Buildings						
PF 2.2.1 Equipment						
Other						
Capital transfers to providers.						
Total spent on the Function (Each function expenditure must be equal to the amount reported in item 8):						

Origin of the Funds	7.3			7.4		
Production Factors	8.3.1	8.3.2	8.3.3	8.4.1	8.4.2	8.4.3
PF 1.1.1 Wages						
PF 1.1.2 Social contributions.						
PF 1.1.3 Non-wage labour income						
PF 1.2.1 Material supplies.						
Antiretrovirals						
Other drugs and pharmaceuticals						
Medical and surgical supplies						
Condoms						
Reagents and materials						
Food						
Other supplies.						
Administrative services						
Maintenance and repairs						
Staff training,						
Market research,						
Consulting services						
Transportation and travel expenses						
Housing,						
Other services						
PF 1.3 Consumption of fixed capital.						
PF 1.4 Interest.						
PF 1.5 Subsidies to providers.						
PF 1.6 Transfers to households.						
PF 1.7 Other current expenditure.						
PF 2.1 Buildings						
PF 2.2.1 Equipment						
Other						
Capital transfers to providers.						
Total spent on the Function (Each function expenditure must be equal to the amount reported in item 8):						

Origin of the Funds	7.5		
Production Factors	8.5.1	8.5.2	8.5.3
PF 1.1.1 Wages			
PF 1.1.2 Social contributions.			
PF 1.1.3 Non-wage labour income			
PF 1.2.1 Material supplies.			
Antiretrovirals			
Other drugs and pharmaceuticals			
Medical and surgical supplies			
Condoms			
Reagents and materials			
Food			
Other supplies.			
Administrative services			
Maintenance and repairs			
Staff training,			
Market research,			
Consulting services			
Transportation and travel expenses			
Housing,			
Other services			
PF 1.3 Consumption of fixed capital.			
PF 1.4 Interest.			
PF 1.5 Subsidies to providers.			
PF 1.6 Transfers to households.			
PF 1.7 Other current expenditure.			
PF 2.1 Buildings			
PF 2.2.1 Equipment			
Other			
Capital transfers to providers.			
Total spent on the Function (Each function expenditure must be equal to the amount reported in item 8):			