



Republic of Botswana



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

**BOTSWANA**  
**NATIONAL AIDS SPENDING ASSESSMENT**  
**2006 TO 2008**

DRAFT 1



**BOTSWANA NATIONAL AIDS SPENDING ASSESSMENT, 2006 – 2008:  
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)  
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## 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 Organizations
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
CHBC	Community Home Based Care
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control and Prevention
CEGAA	Centres for Economic and Governance of AIDS in Africa
CSW	Commercial Sex Workers
DAC	District AIDS Coordinator
DDF	Domestic Development Fund
DHT	District Health Team
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
IDCC	Infectious Disease Control Centre
HSS	Health Systems Strengthening
IDU	Intravenous Drug User

IPMS	Integrated Patient Management System
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
NACA	National AIDS Coordinating Agency
NASA	National AIDS Spending Assessment
NGO's	Non-Governmental Organizations
NSF	National Strategic Framework
OI	Opportunistic Infections
OOPE	Out-Of-Pocket Expenditure
P	Pula (Botswana currency)
PEP	Post-Exposure Prophylaxis
PEPFAR	President's 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
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

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## EXECUTIVE SUMMARY

This Botswana National AIDS Spending Assessment covers the years 2006, 2007 and 2008. It follows upon the first spending assessment which was undertaken in 2006 covering the years 2003 – 2005.

Per the findings, spending on HIV/AIDS in Botswana for the years 2006, 2007 and 2008 from all sources of funding was P1,676 billion, P2,047 billion and P2,359 billion respectively. The main source of funding is the Government of Botswana (public) accounting for P1,18 billion (70%), P1.32 billion (64%) and P1,50 billion (66%) of the spending for 2006, 2007 and 2008 respectively. The combined spending for the three years is P6.082 billion. Spending over the period is dominated by Care and Treatment at P3,07 billion (50%). This is followed by spending on OVC at P1,338 billion, Program management at P902 million and Prevention P566 billion.

Public funds were spent mainly on care and treatment (P2,335 billion) followed up by spending on OVCs (P1,314 billion) and then prevention (P203 million), over the three year period. Funds from the international sources were spent mainly on program management (P745 million), followed up by treatment and care (P646 million) and then prevention (P346 million). A total of P120 million was spent by the private business corporations included in the study.

In comparison to the National Strategic Framework (NSF) 2003 – 2009, total spending on HIV/AIDS including the results of the first NASA stands at P8,955 billion compared to an estimated P12,615 billion per the NSF. Looking at proportional spending; Actual Care and Treatment proportional spending is 52% compared to 54% per NSF, actual prevention proportion is 10,6% compared to 10% per NSF, program management is 14.3% compared to 7% and psychosocial support is 22.3% compared to 17% per NSF.

The population group that benefited the most from the spending on HIV/AIDS is the people living with AIDS, consuming approximately 48% of the spending over the three year period 2003 -2009. The next population group to benefit the most is the 'Other key populations', which includes orphans and the vulnerable children, the youth, and children to be born or born of mothers living with HIV. This group consumed 23% of the financial resources over the three year period.

Looking at the budgetary items, the cost category that consumed the most resources is labour costs at 26%, followed by spending on food and nutrition at 20% and antiretroviral drugs at 13%. When spending is classified using the broad split between recurrent and capital, the results show that 91% was spent on recurrent compared to 9% on capital expenditure.

Challenges being faced by the service providers include the different reporting formats and cycles that different donors have. This calls for skilled financial personnel which most of the service providers cannot afford due to poor funding for salaries.

In conclusion, it should be noted that NASA, as a monitoring and evaluation tool, can only be effective if it provides accurate information timely. This calls for the process of gathering this NASA information to



be

institutionalised

within

NACA.

## CHAPTER 1: INTRODUCTION

### 1.1 Global Background

Per the UNAIDS 2008 Report on the Global AIDS Epidemic, an estimated 33million people are infected with HIV/AIDS worldwide. Over two thirds of these people living with HIV are from Sub-Saharan Africa (22million). This is a region with approximately only 12,5% of the world's population. Southern Africa has a disproportionate share of the global burden, with 35% of the people living with AIDS and 38% of all AIDS death occurring within the sub region. The UNAIDS reports notes that the prevalence appear to have stabilized in Sub-Saharan Africa, but at very high levels, especially in Southern Africa were most of the countries reported prevalence rates of over 15%.

In a poor region like Southern Africa, the economic impact of HIV has been very adverse. Health systems are severely stressed by the needs of AIDS patients. 'Socially the impact is devastating, given the human cost of so much illness and so many deaths, while the rise in the number of orphans and the breakdown of family structures poses challenges for both state and social support systems'.<sup>1</sup>

Per the 2008 UNAIDS Report, in 2008, global funding for HIV reached its highest ever; US\$13,8billion. Domestic expenditure accounted for 52% of the funding, followed by direct bilateral cooperation (31%), multilateral institutions (12%) and the philanthropic sector (5%). According to report, most countries have set universal access targets for 2010 that are ambitious and that reach real people. For countries to reach the specific targets they have set, an investment of US\$ 25 billion will be required in 2010: US\$ 11.3 billion more than is available today. The bulk, 48%, is required by Southern African countries. This is against the backdrop of a global financial crisis that could adversely affect funding in the short to medium term.

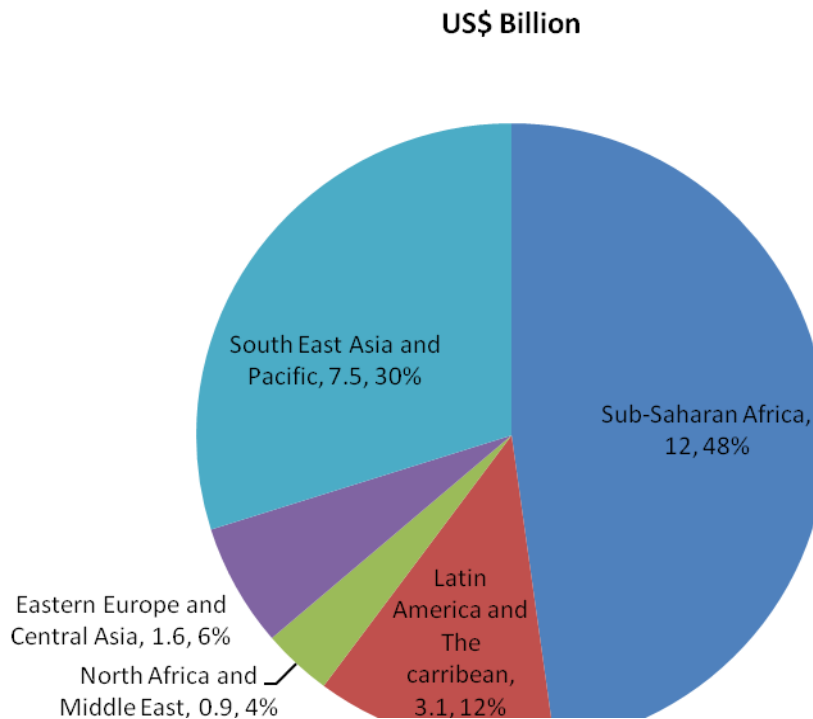
With many of the most affect countries reported to be increasingly using their own resources in the fight against the HIV, the burden of the disease could compromise delivery on the other millennium development goals. Most of the Southern Africa countries require massive financial resources to fight the epidemic and with the governments already burdened with high levels of un-employment and the consequent need to provide free basic necessities like general health care, shelter, education and clean water among others, mobilization of resources to fight the epidemic is a difficult balancing act. The major sources of external funding in the region remain; the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the World Bank and the US Presidential Emergency Plan for AIDS Relief (PEPFAR).

Figure 1 below illustrates the regional breakdown of the estimates needed in the fight against HIV in 2010 per UNAIDS.

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<sup>1</sup> The Economic Impact of HIV/AIDS – Econsult Botswana (Pty) Ltd - 2006

**Figure 1.1: Regional Breakdown of Investments Needed**



Source: 2008 UNAIDS Annual Report

## **1.2 Botswana Background Information**

Botswana is a Southern African country with a population of about 1,8 million people and one of the highest HIV prevalence rates in the world. Like in all the other Southern African countries, the epidemic is generalized. Per the BAIS III<sup>2</sup>, 2008, the estimated prevalence rate is 17.6% compared to 17.1% in BAIS II of 2004. Estimated new infections in 2008 were 10,587 or 2.89%.

Botswana's huge economic gains that have been made since the discovery of diamonds, coupled with the pursuit of prudent and consistent macro-economic policies are gravely threatened by the scourge of HIV and AIDS. The government, with the support of development partners and other international funding agencies is intensifying the fight against HIV. In the process significant resources have been

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<sup>2</sup> Botswana AIDS Impact Survey III, 2008

committed to interventions targeted at prevention, provision of treatment and care and social mitigation programs. As this report will highlight later, most of the spending on HIV and AIDS in Botswana is on treating and caring for people living with HIV and on provision of material support and financial support to the orphans and vulnerable children.

Botswana is one of the first countries in Africa to set up an ant-retroviral program to benefit people infected with HIV. While the government is the major financier of the program, support is being received to fund the program from PEPFAR since 2005 and significant donations of antiretroviral drugs is received from the African Comprehensive HIV/AIDS Partnership (ACHAP)<sup>3</sup> and the Bill Clinton Foundation.

### **1.3 NASA Objectives and Scope**

The National AIDS Spending Assessment (NASA) is principally an accounting exercise, whose purpose is to track and report on the flow of resources intended to combat HIV and AIDS. It is not an audit. It describes the allocation of resources from their origin, down to the end point of service delivery, among the various institutions engaged in the HIV and AIDS fight. Given the significant amount of resources being invested in the fight against the disease, NASA does help countries reflect on actual spending against the set national priorities. NASA information should thus assist to inform programme and policy level decision makers, among others.

The use of NASA as a monitoring tool is noted in the following paragraphs lifted from the foreword to the 'National AIDS Assessment (NASA) Classification Tables & Definition (UNAIDS)':

*'The budgetary process at work in all nations of the world, in compliance with requirements instilled by the International Monetary (IMF), by the World Bank (WB), by the Regional Development Banks (AfDB, ADB, CDB, EBRD, IADB, IsDB, etc), by the United Nations Development Program (UNDP), by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), by other intergovernmental institutions, by several bilateral aid programs and through global schemes such as the High Indebted Poor Countries (HIPC) initiative, global objectives such as the Millennium Development Goals (MDG), require an integrated measurement of the cost of programs and of the financial response to societal challenges. NASA is designed as a core tracking tool for these monitoring and evaluation mandates without displacing or attempting to substitute the utilisation of any other method or tool already in use.*

*NASA can also be of use in documenting information about the supplementary nature or additionality of international financial assistance, whose strategic importance as a catalyst and as a promoter of action exceeds often its quantitative share in the mobilisation of resources by societies. A primary tool to be used by each National AIDS Coordinating Authority, NASA, is expected to provide recurrent information on a country's financial absorptive capacity, and basic information to start the analyses on structural bottlenecks, as well as on issues about the equity, the efficiency and effectiveness of the resource allocation process. These are all essential pieces in a strategic information system aimed at supporting an expanded and effective response to HIV, as well as empowerment of the communities interested in an effective and prompt response'.*

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<sup>3</sup> ACHAP is a partnership between Bill and Melinda Gates Foundation and the Merck Pharmaceutical Foundation

The objectives of the Botswana NASA were:

- To prepare country estimates of total flows of financing and expenditures for HIV/AIDS, from all international and public (domestic public, private and NGOs) sources.
- To develop a database of key financial transactions supporting HIV/AIDS health and non-health expenditures.
- To identify the flow of expenditures by source, function, provider of services, target population and object of expenditure – from national level down to district level.
- To prepare a written report of the international, private and public expenditures for HIV/AIDS in Botswana to inform the NSP and also for evidence based decision-making.

This is the second assessment of AIDS spending in Botswana. The first spending assessment, undertaken in 2006, covered the three years 2003 to 2005. This second NASA covered three years; 2006, 2007 and 2008, tracking actual expenditure among public, external (international) and private (insurances and businesses) sources. It was not intended to cover out of pocket expenditure. Like in the first assessment, the current NASA was also expected to assess and possibilities for the NASA to be institutionalized.

## **1.4 Structure of the report**

This report has been organised into four (4) chapters. The first chapter presents background information on HIV and AIDS status globally and in Botswana. It also discusses Botswana response to the epidemic through the National Strategic Framework 2006 – 2008. Chapter 2 looks at the methodology followed in gathering the data for the report and the key assumptions made in preparing the report. Chapter 3 presents the findings of the NASA in detail. Chapter 4 discusses some of the challenges faced by the stakeholders and makes recommendations based on the findings.

### **The Three Dimensions that Integrate NASA<sup>4</sup>**

In NASA, the financial flows and expenditures related to the National Response to HIV are organised according to three dimensions; finance, provision and consumption. These three dimensions incorporate six categories:

#### **Financing**

- i. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and also make programmatic decisions
- ii. Financing sources (FS) are the entities that provide money to financing agents

#### **Provision of HIV Services**

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

#### **Use**

- v. AIDS spending categories (ASC) are HIV-related interventions and activities
- vi. Beneficiary populations (BP) are the targeted segments of the population intended to benefit from the service, e.g. sex workers, men who have sex with men, people living with HIV, etc.

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<sup>4</sup> National AIDS Spending Assessment (NASA): Classification Taxonomy and Definitions - UNAIDS

### 1.5 The National Strategic Framework 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”<sup>5</sup>.

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	Target Year	
	Year 2001/2002	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 mothers who are infected at 18 months	21-40%	50%	100%
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

<sup>5</sup> The National Strategic Framework for HIV/AIDS 2003-2009 (NACA)

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

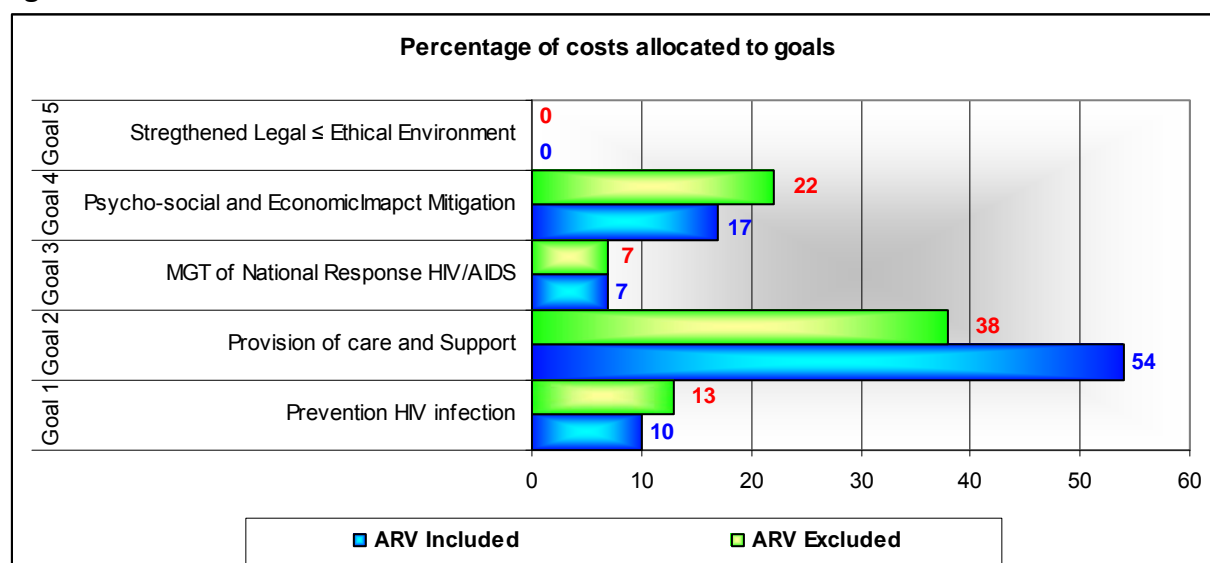
Importantly, a comprehensive costing of the above goals has been undertaken in support of the development of the National Strategic Framework<sup>6</sup>. Key stakeholders from Government, Civil

<sup>6</sup> National AIDS Coordinating Agency (NACA), National HIV/AIDS Strategic Framework 2003-2009. Botswana.

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 1.2: 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
<b>Total</b>	910.9	1,043.1	1,250.0	1,595.0	2,106.0	3,165.0	<b>10,070.0</b>
<b>ARV Drugs</b>	38.4	139.2	251.0	374.0	504.0	642.0	<b>1,948.6</b>
<b>Grand Total</b>	<b>949.3</b>	<b>1,182.3</b>	<b>1,501.0</b>	<b>1,969.0</b>	<b>2,610.0</b>	<b>3,807.0</b>	<b>12,018.6</b>

**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
<b>Objective 1</b>	<i>Increase the number of persons within the sexually active population (especially 15-24 years) who</i>						
<b>1</b>							



	<i>adopt HIV prevention behaviours in Botswana by 2009</i>						
<b>Total</b>	106.6	181.6	205.6	174.4	144.8	148	<b>961</b>
<b>Objective 1 2</b>	<i>Decrease HIV transmission from HIV+ mothers to their newborns by 2009</i>						
<b>Total</b>	75.5	55.2	53.8	53.8	12.2	0	<b>250.5</b>
<b>Objective 1 3</b>	<i>Decrease the HIV prevalence among transfuse blood in the country</i>						
<b>Total</b>	3.7	4.2	5.1	6.1	7.3	8.7	<b>35.1</b>
<b>Goal 2 Provision of Care and Support</b>							
<b>Objective/Y ear</b>	<b>2002-3</b>	<b>2003-4</b>	<b>2004-5</b>	<b>2005-6</b>	<b>2006-7</b>	<b>2007-8</b>	<b>Total</b>
<b>Objective 2,1</b>	<i>Increase the level of productivity of PLWHIV/AIDS. specially those on ARV who adopt HIV prevention behaviours in Botswana by 2009</i>						
<b>Total</b>	38.6	266.0	428.5	596.1	793.4	1,005.4	<b>3,128.0</b>
<b>Objective 2,2</b>	<i>Decrease the incidence of TB among HIV+ patients in the country</i>						
<b>Total</b>	70.2	19.7	9.0	0.0	0.0	0.0	<b>98.9</b>
<b>Objective 2,3</b>	<i>Increase the number of skills of health workers providing accurate diagnosis and Tx of OI</i>						
<b>Total</b>	300.1	355.9	343.5	521.0	784.0	1,224.5	<b>3,529.0</b>
<b>Goal 3 MGT of National Response to HIV/AIDS</b>							
<b>Objective/Y ear</b>	<b>2002-3</b>	<b>2003-4</b>	<b>2004-5</b>	<b>2005-6</b>	<b>2006-7</b>	<b>2007-8</b>	<b>Total</b>
<b>Objective 3,1</b>	<i>Ensure the implementation of NSF Minimum HIV/AIDS Response Packages by all sectors. Ministries. districts and parastatals</i>						
<b>Total</b>	4.3	2.6	6.6	6.6	14.3	14.3	<b>48.7</b>
<b>Objective 3,2</b>	<i>Ensure the full implementation of all planned HIV/AIDS activities at all levels</i>						
<b>Total</b>	204.3	114.1	119.6	73.7	45.2	80.1	<b>637.0</b>
<b>Goal 4 Psychosocial and Economic Impact Mitigation</b>							
<b>Objective/Y ear</b>	<b>2002-3</b>	<b>2003-4</b>	<b>2004-5</b>	<b>2005-6</b>	<b>2006-7</b>	<b>2007-8</b>	<b>Total</b>
<b>Objective 3,1</b>	<i>Minimize the impact of the epidemic on those infected and/or affected, public service and economy</i>						
<b>Total</b>	128.9	169.4	221.8	309.1	447.4	822.9	<b>2,099.5</b>

Goal 5 Provision of a Strengthened Legal and Ethical Environment							
Objective/Y ear	2002- 3	2003- 4	2004- 5	2005- 6	2006- 7	2007- 8	Total
<b>Objective 3,1</b>	<i>Create a supportive. Ethical. legal and human rights-based environment conforming to international standards for the implementation of the National Response</i>						
<b>Total</b>	0.8	1.9	1.9	1.9	1.9	0.0	<b>8.4</b>

NACA reported that the development partners had committed approximately 253.6 million<sup>7</sup> (as at 2004), but some Development Partners had yet to 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 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).

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<sup>7</sup> This includes the Global Fund money

## CHAPTER 2: THE METHODOLOGY

Per the UNAIDS, the National AIDS Spending Assessment (NASA) resource tracking methodology is designed to describe the financial flows and expenditures using the same categories as the globally estimated resource needs. This alignment was conducted in order to provide necessary information on the financial gap between resources available and resources needed, and in order to promote the harmonization of different policy tools frequently used in the AIDS field<sup>8</sup>.

The tracking of spending on HIV and AIDS in Botswana followed the NASA resource tracking methodology. The processes followed are explained in the following paragraphs.

### 2.1 Preparatory Work

The process began in May 2009 with NACA calling a stakeholders inception workshop. In June 2009 CEGAA<sup>9</sup> provided training to the Research assistants on the NASA methodology and software.

### 2.2 Permission Letters

Formal letters requesting permission to access data were sent to the permanent secretaries of ministries of health and local government and to the principals of the other stakeholder organisations.

### 2.3 Data Collection

#### a) Database of all Stakeholders

Using information from NACA, a primary database of all stakeholders involved in the HIV and AIDS was developed. Information from some of the international funding agencies confirmed and yielded other stakeholders missing from the NACA information. The database for private sector profit making organisations was developed using information from Botswana Business Coalition on AIDS (BBCA). It is important to note that the BBCA information was based on companies who are members of BBCA and might thus not necessarily be representative of all companies involved in the HIV and AIDS fight.

#### b) Development of Questionnaires

The UNAIDS NASA format for the questionnaires was adjusted to suit the Botswana situation. These were used by the research assistants during the data collection. Refer to Appendix VI

#### c) The Approach to Data Collection

Data collection process used two approaches namely “top down” and “bottom up”. Top down approach involved collecting data from the primary sources and agents. Bottom up approach involved collecting detailed data from the providers and linking this back to the agent and the

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<sup>8</sup> [www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp)

<sup>9</sup> Centre for Economic Governance and AIDS in Africa.

source. Triangulation was used to create each complete transaction, so as to avoid double counting.

Triangulation implies balancing; Source of Funds = Agents= Service Providers

**d) Sources of Data**

Primary financial data was collected from NACA, other relevant government departments, international donor agencies and major NGOs. The data also assisted with the identification of all the stakeholders involved in the provision of AIDS services.

The primary sources of data, in most cases provided detailed expenditure incurred by them and disbursements to other organisations. The intention being to trace the funds to the level of the service provider and use the service providers' detailed data to prepare the NASA. However, in cases where it was not possible to get information from service providers and detailed expenditure records of the service providers could be obtained from the primary sources of data, these were used for inclusion in the NASA (e.g. expenditure of small NGO's funded by ACHAP were captured using the ACHAP records).

**e) Sites Visits**

Site visits were intended to provide more detailed expenditure information from the service providers at the district level as well as provide insight into the funding mechanism and implementation challenges.

Visits to districts were divided into two trips. The first trip took two weeks (from 6<sup>th</sup> July 2009 to 17<sup>th</sup> July 2009) and was aimed at familiarising research assistants with data collection tools. After the completion of the first trip, research assistants had time with supervisors to evaluate the former's work and strengthen their approach in accessing information. On the second trip, research assistants returned to places they visited on the first trip to correct mistakes pointed out and to complete work left. Teams then moved on to collect data from other districts. This second trip took about 9 weeks (from 27<sup>th</sup> July 2009 to 29<sup>th</sup> September 2009).

11 Districts were selected based on population size and HIV prevalence statistics. These were:

- Gaborone
- Central district
- Selibe Phikwe
- Francistown
- Chobe – visited Kasane
- Maun
- Ghantsi
- Kgalagadi – visited Tsabong
- Jwaneng
- Kweneng
- Sowa

Every effort was made to access information from the following offices:

- District AIDS coordinator's office

- District Health Teams (DHT)
- Social and Community Development (S&CD) units:
- Economic Planning and Treasury departments
- Matrons and Chief Medical Officers
- Program coordinators for PMTCT, CHBC and ARV programmes

## 2.4 Data Processing

The data collected was first captured in Excel sheets for cleaning, performing calculations and estimates. In the excel sheets, the data was verified, checked and balanced before being transferred to the NASA Resource Tracking Software (RTS). NASA RTS has been developed to facilitate the data processing into matrices of different classification axes. The NASA RTS outputs were exported to Excel software to produce summary tables, and graphs for analysis.

## 2.5 Assumptions and Estimations

### Differing financial years

Different financial years are used by the various stakeholders. While every effort was made to capture the financial expenditure within each calendar year, it proved difficult in many instances to harmonise all the data accordingly. Therefore, where the financial year of any organization was not corresponding to the calendar year, the organisation's financial year was adopted and used consistently over the three years and with the assumption that the financial year differences are balanced out over the three year period.

### HIV and AIDS Expenditure Estimations

In terms of transaction numbers, only 6% of 2006 and 2007 and 7% of 2008 transactions were subjected to estimations. However in terms of value these transactions represent 42% of 2006 and 2007 total expenditure and 44% of the 2008 total expenditure.

The following were subjected to estimates:

#### a) ARV Drugs/Medicine Consumption

The objective was to arrive at the cost of drugs/medicine actually consumed. The approach was to obtain the number of patients on ARVs each year and multiply this by the average cost of drugs per year.

Using BHRIMS information we calculated the average number of patients on ARVs each year. This was multiplied by the average cost of the ARV drugs per patient per year.

The average cost of ARVs per patient was calculated using a combination of IPMS and PIMS statistics together unit cost of drugs/medicine from CMS.

The drugs are either procured by the government of Botswana using government resources and PEPFAR funds, or are donated by the Clinton Foundation and ACHAP. Donated drugs were

included in the above calculations. CMS guided us in splitting the drugs/medicines between the different sources.

**b) PMTCT Drugs**

The number of women who are HIV positive on delivery, and receiving ARVs as part of the PMTCT programme were obtained from BHRIMS. Using information on average number of weeks women are on PMTCT and the dosage obtained from the DHAPAC, we estimated amount of drugs consumed each year and multiplied by the unit cost of AZT obtained from CMS.

**c) Patient Care**

This proved to be one of the most difficult estimates to come up with. The approach was to obtain the percentage of patients attending health facilities who are reported as seeking treatment for HIV and AIDS related illnesses. Then apply this percentage to the expenditure from the Ministry of Health, Department of Clinical Services and the Ministry of Local Government health clinics expenditure.

The latest Health Statistic Report (2006) only has about 3% of patient discharges reported as HIV and AIDS related treatments. Health professionals spoken to all agree that the figure is a gross understatement of HIV and AIDS. This is a result of the statistics not reporting HIV co-infection with other diseases that are classified separately in the statistics. The system of classifying diseases does not report the number of patients suffering from other diseases like tuberculosis and pneumonia that are co-infected with the HIV.

We then obtained estimates of the percentage of HIV and AIDS positive inpatients at Princess Marina Hospital which came at 41%. Health professional spoken to also indicated that approximately 75% of patients in hospitals medical wards are HIV positive. In an attempt to corroborate the estimate, a medical person helped us identify, from the Health Statics Report, those diseases that would normally be confined to the medical ward. We calculated 75% of these and expressed this as a percentage of the total inpatient discharges. The 75% of the medical ward came to approximately 42% of the total inpatient discharges. We then settled for 40%.

The previous NASA, covering the years from 2003 to 2005, used an estimate of 32%

**d) STI Drugs**

HIV related STI patient numbers were obtained from the Health Statistics Report and the Min of Health Department of AIDS Prevention and Care STI unit. The drug cost of treating each patient was also provided by the STI unit from consultation with CMS.

**e) IPT Drugs**

Ideally, number of patients should have been multiplied by the cost per each treatment course to arrive at the cost of the drugs consumed. However with a course completion rate of less than 40% over the three years, it became difficult to come up with estimates for the average period that patients are on treatment. Hence we used the drugs issued/dispensed to the health facilities as supplied by CMS and multiplied by the isoniazid unit cost.

**f) Laboratory Reagents**

Viral loads and CD4 counts - Obtained the number of tests per year and cost per unit from Botswana Harvard Reference Laboratory.

Rapid test kits – Obtained the number of tests per year from the BHRIMS and the unit costs from the National Health laboratories.

#### **Pooled Funds**

Where the information provided did not enable the splitting of expenditure between various donor organisations funding an entity, we assumed distribution to the identified HIV activities based on each source's proportional contribution to the total funds.

## **2.6 Limitations of the Collected Data**

- a) Despite the efforts made to collect data from all organisations, some organisations and district councils did not respond. These were left out of the NASA, except to the extent that the information could be obtained from the secondary data source
- b) In the instances where consumption was estimated using number of beneficiaries, there was no estimation of the wastages and losses that naturally occur throughout the distribution channel, thus potentially underestimating the overall cost
- c) Patient care expenditure constitutes the single largest value contribution to the overall expenditure. The determination of the figure is based on a ratio/percentage that is difficult to determine and has some subjectivity.
- d) Completeness of the private sector data, especially as related to private profit making organisations cannot be vouched for completeness.

## **2.7 Challenges Faced**

### **Data Collection and Analysis Related Challenges**

- 1. Slow/ no access to key players' data - Some stakeholders were slow in providing the information required for NASA. In the extreme cases, some stakeholders did not give access to the information required. All these called for prolonged negotiations in order to access the information.
- 2. Some organisations, especially CBOs, had problems unveiling their expenditures on accounts that their sponsors must give them permission. This delayed the process of data collection.
- 3. Diverse financial reporting formats that are different from the NASA classifications. It thus took time to customise the data for the NASA.
- 4. Organisations carrying out activities that are difficult to classify per the NASA spending categories, especially programmes cutting across different spending categories. In some instances organisations did not provide enough information to enable classification of their activities.

### **NASA Classification Related Challenges**

1. It is sometimes not easy to make the decision on which of the organisations is the agent. Agents are defined as entities that pool resources to finance service provision programmes and also make programmatic decisions. A difficult example is the PEPFAR funds earmarked for the government of Botswana and programmatically managed by the local CDC program office (BOTUSA) and NACA. Is the program decision made by NACA or BOTUSA?

## **2.8 Validation of Results**

The preliminary results of the NASA were presented to the stakeholders on the 9<sup>th</sup> of March 2010. Valuable feedback was received, and where relevant has been incorporated in this report.

## **2.9 Comparison of the First and second Botswana NASA**

The first NASA was restricted to covering AIDS spending within the public sector and international donor organisations and NGOs because of time constraints. The time could also not allow the spending activities to be broken down into production factors (expenditure categories).

The second NASA was intended to be broader and provide more detailed information on the production factors. It covered the public sector, international organisations and the private sector. Data collection in 11 districts began in June 2009, ending at the end of September 2009. Analysis and adaptation of the data was completed in the main at the end of February 2010.



## CHAPTER 3: PRESENTATION AND DISCUSSION OF KEY FINDINGS

### 3.1 Total Spending

The total annual expenditure on HIV/AIDS in Botswana from all sources of funding have increased gradually during the three years under study from P1,676 billion in 2006 to P2,359 billion in 2008. No assessment has been done as to whether or not this represents an increase in real terms after factoring in inflation. Over the six year period (including the first NASA), which also coincides with the period of Botswana's National Strategic Framework for HIV/AIDS 2003-2009, a total of P8,955 billion has been spent on HIV/AIDS in Botswana.

Table 3.1 below is a summary of expenditure for the three years under study together with the years covered in the first NASA and also showing the sources of funding:

**Table 3.1: HIV Spending Summary 2003 - 2008**

Year	Public Funds Pula	Private Funds Pula	International Funds Pula	Total Pula
2003	669,896,574	4,262,832	74,461,453	748,620,859
2004	788,594,044	10,305,885	186,947,219	985,847,148
2005	899,152,324	10,852,044	228,251,150	1,138,255,518
2006	1,181,145,332	29,448,342	465,437,167	1,676,030,841
2007	1,320,878,702	37,889,937	688,584,839	2,047,353,478
2008	1,549,573,817	52,674,443	756,472,593	2,358,720,853
	<b>6,409,240,793</b>	<b>145,433,483</b>	<b>2,400,154,421</b>	<b>8,954,828,697</b>

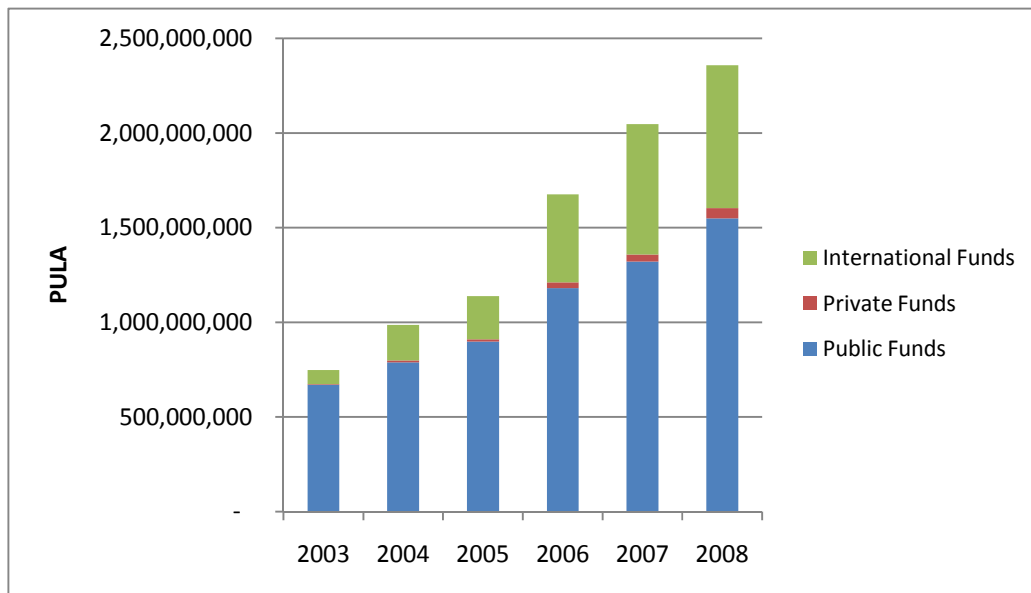
### 3.2 Funding Sources

The government remains the major source of HIV and AIDS funding in the country, accounting for 70%, 64% and 66% of spending in 2006, 2007 and 2008, respectively (Fig 3.1 and Fig 3.2). This has come down from the over 80% spent on each of the first three years of the NASA; 2003-2005. The increased proportion of spending on HIV in Botswana by the international sources can be attributed in part to the PEPFAR increase in funding during 2006-2008, mainly to the government of Botswana through the mega cooperative agreement. There has also been included in the current NASA an estimate of the value of the ARV drugs donated through ACHAP and the Bill Clinton Foundation. This was not done in the first NASA covering 2003-2005.

The reported increase in spending within the private sector from 2005 to 2006 is a result of a deliberate effort in the current NASA to cover more private sector organisations involved in the HIV and AIDS fight.

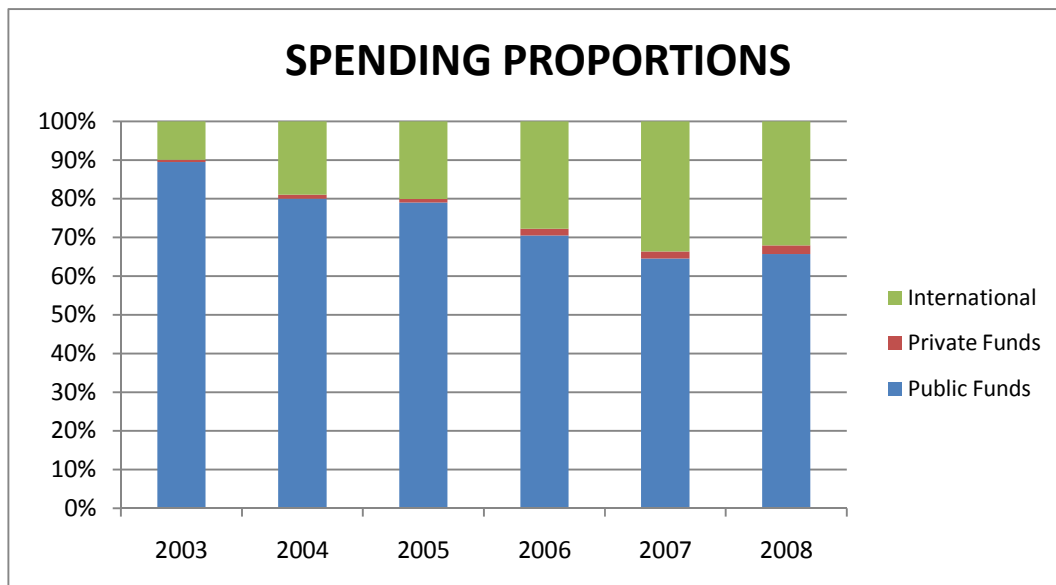
Overall spending on HIV is driven by provision of treatment and care which constitutes 50% of spending over the six year period 2006 – 2009 (Figure 3.3). With increased number of people seeking treatment over the years, spending has increased in tandem.

**Figure 3.1: Source of Funding Over a Six Year Period**



The figure below demonstrates the increasing proportion of funding from international donor organisations.

**Fig 3.2: Source of Funds Spending Proportions**



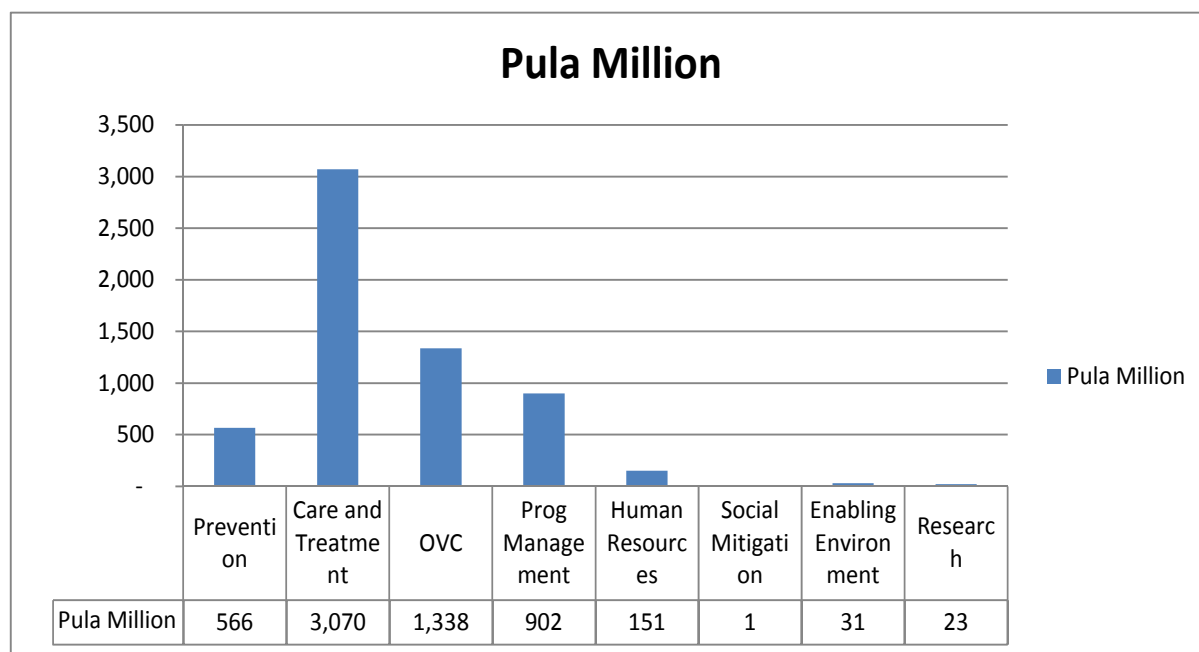
### 3.3 The National Funding Matrices

Appendices I (a) to I(c) provide the detailed split of funded activities against the funding sources for each of the years 2006, 2007 and 2008.

### 3.4 Spending Priorities

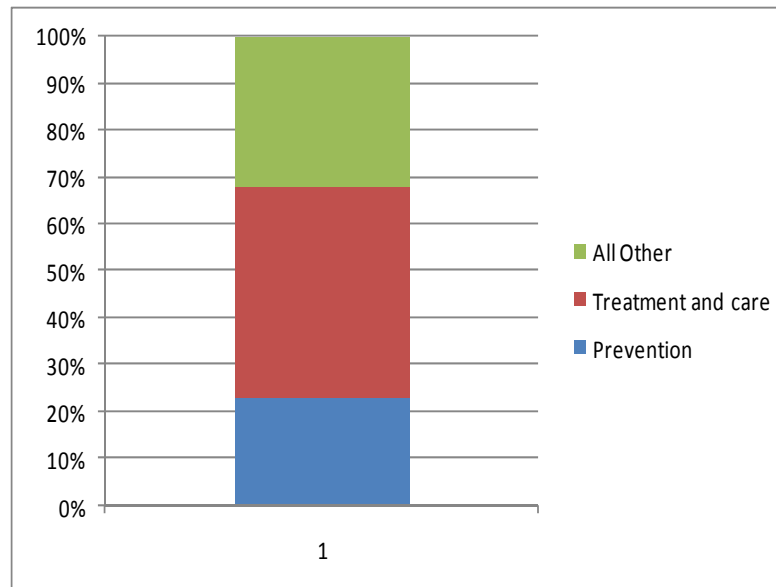
Figure 3.3 illustrates the overall (all sources) proportional spending in Botswana by 8 key NASA categories from 2003 -2008. Treatment and care at P3,07 billion accounts for 50% of spending, followed by caring for orphans and vulnerable children at P1,338 billion ( 22%), program management at P902 million (15%) and prevention at P566million (9%).

**Fig 3.3 Combined Spending Proportions 2003-2006**



A comparison with 14 other countries with a generalised epidemic like Botswana, confirms the high proportional spending on treatment, followed by prevention. In Botswana however there is also large spending on orphan care using government funds.

**Fig 3.4 Spending Proportions for 14 Countries with a generalised epidemic**



**Source: 2008 Report on the Global AIDS Epidemic (UNAIDS)**

#### **Spending Priorities by Source of Funding**

Public funds are spent mainly on treatment and care of people living with AIDS and also looking after orphans and vulnerable children. With the population of people living with HIV continuing to increase, there is bound to be an increase in related morbidity over the years, although this should be at a reducing rate due to the large scale provision of ARV drugs and opportunistic infections prophylaxis. Hospital estimates are that 40% of patient care is related to HIV and AIDS. In the first NASA covering 2003 to 2005, the estimate was put at 32%. With these percentages used to apportion the overall hospital and clinics expenditure to HIV and AIDs spending, this has led to a higher figure being reported in the current NASA for HIV related in-and outpatient care.

Increased spending on ARV drugs provide another reason for the overall increased government spending on treatment. Per the BHRIMS report as of March 2005, there were 31,223 HIV positive people on HAART. This increased to 59,228 by December 2006 and to 95,051 by December 2008.

The orphan care program has also seen large resources being spent (especially on food.) Per BAIS III the percentage of children aged below the age of 18 who are orphans moved from 12.7% in 2001 to 16.2% in 2008. Although a proportionate high amount is being spent on OVC support, the percentage of OVCs whose households receive basic external support only stood at 31,2% as of 2008. In Botswana an orphan is a child below 18 years who has lost one (single) or both parents.

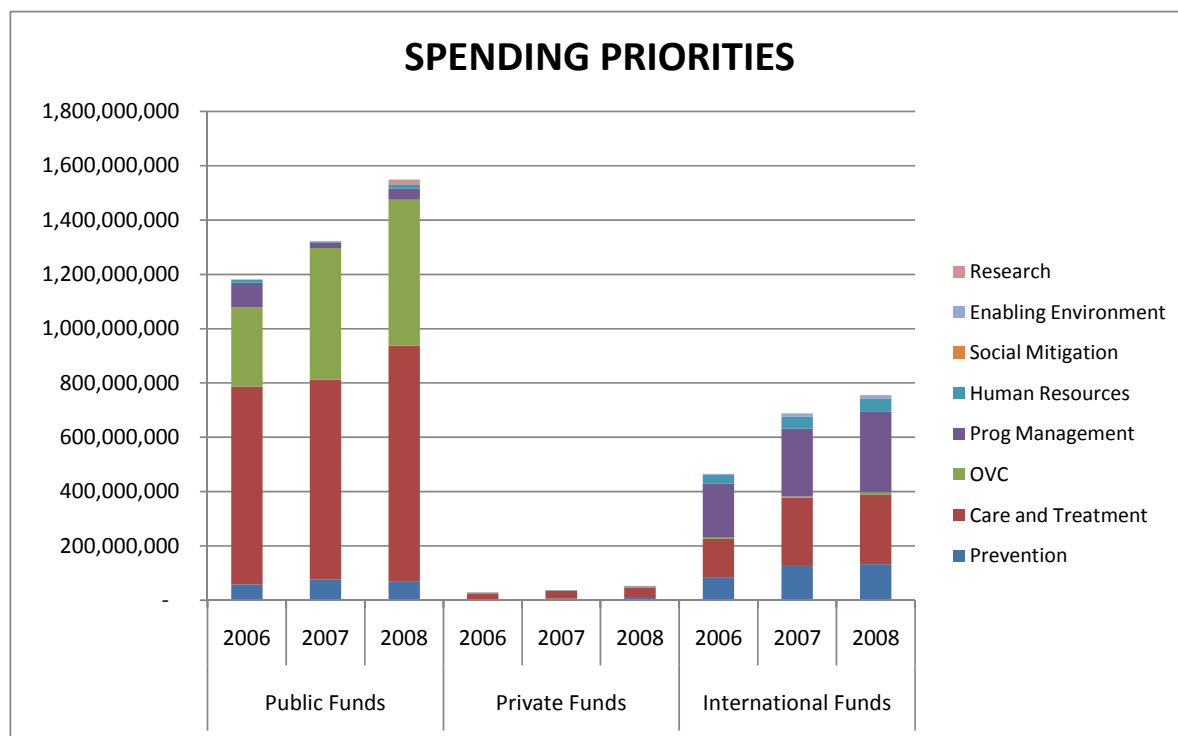
A vulnerable child is a child below 18 years who meets any of the following criteria

- Lives in an abusive environment
- Lives in a poverty stricken family and cannot afford basic services
- Heads a household
- Lives with a sick parent
- Is infected with HIV
- Lives outside family care

As reported in the National Situational Analysis on OVC in Botswana, 96,4% of support to OVC is from the Government and mainly in the form of food<sup>10</sup>. Refer to 3.7 below.

External donor organisations also spent significant funds on care and treatment (purchase and donation of ARV drugs) but spent a relatively high proportion on program management related to capacity building of NGOs and community programs and health systems strengthening. Private funding sources spent most of their funds on treatment.

**Figure 3.5 Spending Priorities by Sources of Funding**



<sup>10</sup> National Situational Analysis on Orphans and Vulnerable Children in Botswana – Ministry of Local Government Department of Social Services (June 2008)

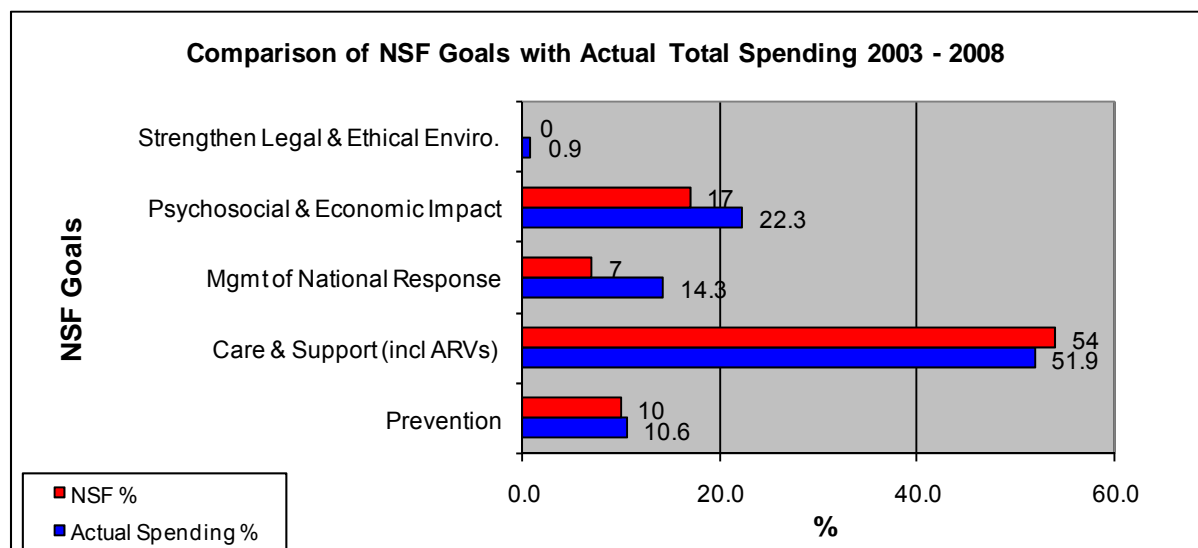
### 3.5 Comparison of Spending to the NSF (2003-2008)

At P8,955 billion, actual spending on HIV is approximately P3,7 billion below the NSF estimate of P12,615 billion. Its either the NSF was overestimated, or less funds than estimated were raised.

Interesting is the comparison of the proportional spending as per fig 3.6 below. Actual spending proportions on Treatment and care and prevention are within the NSF estimates. Proportional spending on psychosocial support which is made up mainly of OVC spending and program management is much higher than per NSF. Again a qualification needs to be made of the NSF estimates as the proportional spending percentages shown only added up to 89%. This raises doubt on the accuracy of the NSF figures.

While spending can be compared and assessed against the NSF, one thing that must be highlighted is that NASA cannot measure the effectiveness of the interventions that consumed the reported financial resources. Spending within the NSF budget does not necessarily reflect the achievement of set goals and objectives.

**Figure 3.6 Comparison of HIV Spending to the NSF (2003 – 2008)**



### 3.6 Treatment and Care Spending (All Sources)

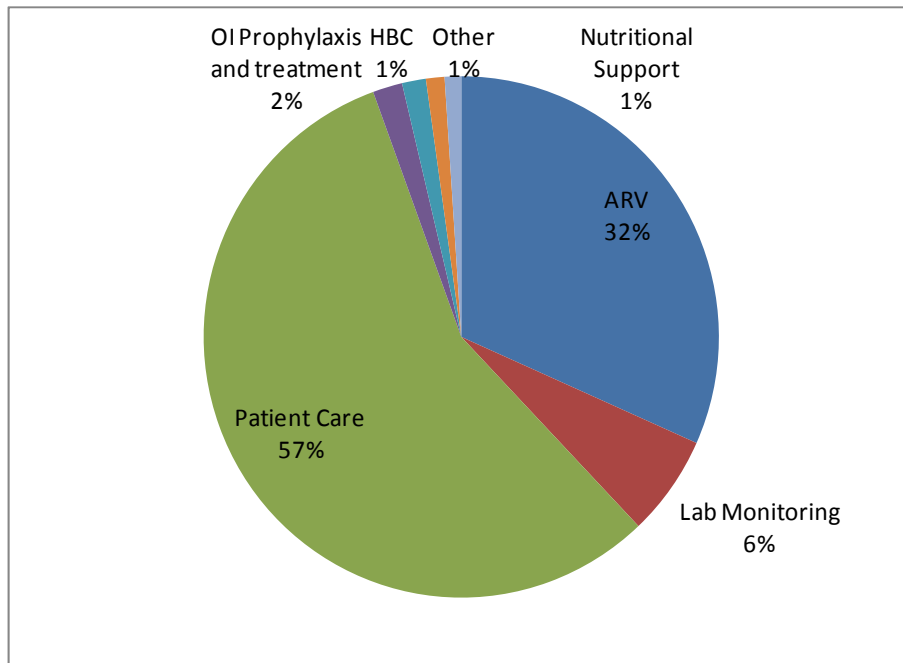
Appendices II (a) to II(c) provide the detailed analysis of the treatment and care spending by all sources of funding. Spending on treatment constitutes 53% of 2006, 50% of 2007 and 49% of 2008 overall HIV spending in Botswana. A closer look at the makeup of 2008 spending is provided below by making a detailed analysis of the 2008 NASA figure.

#### Treatment and Care Spending 2008 (All sources)

At P1, 163 billion, treatment and care comprises the largest of the key AIDS Spending Categories for 2008. This represents 49% of the total spending for the year. As figure 3.7 below demonstrates, the

major part of spending on treatment and care is patient care (in- and out-patient). Patient care is made up mainly of 40% of Department of Clinical Services and Local Government health clinics expenditure. This is followed up by spending on Anti retroviral therapy. The bulk of the anti-retroviral figure comprises drugs funded through public funds and international sources (Appendix II (a)).

**Figure 3.7: Treatment Spending (All Sources) 2008**



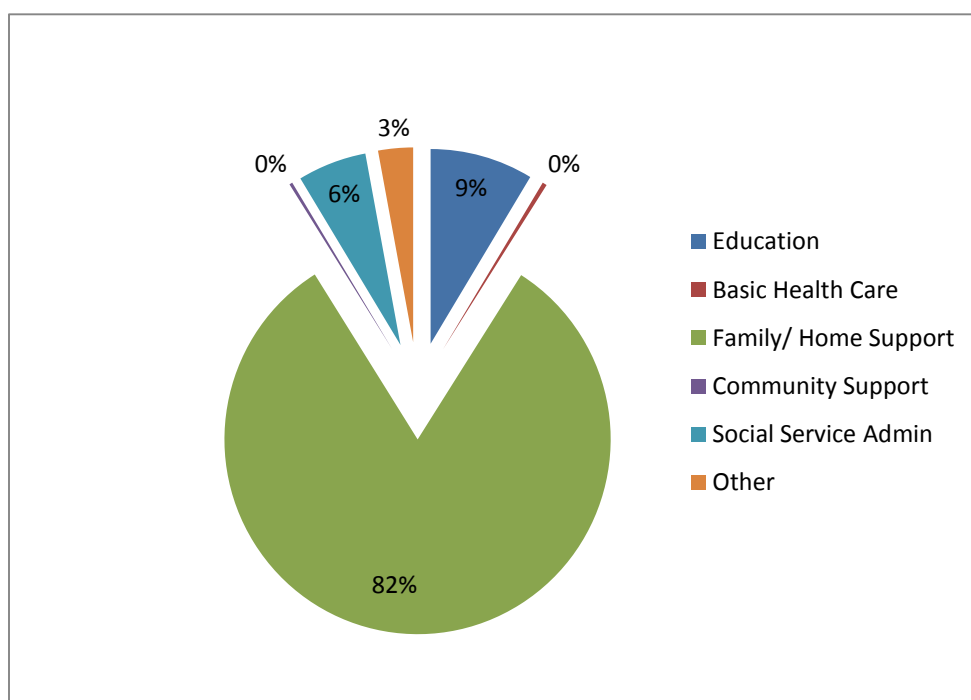
### 3.7 OVC Spending

Spending on orphans and the vulnerable children make up 18%, 22% and 23% of spending for 2006, 2007 and 2008 respectively (Refer appendices I (a) to I(c)). It is mainly financed through public funds. Family/home support comprises the food baskets for orphans. It is by far the largest component of the orphan care program. Per the National Situational Analysis on OVC in Botswana (June 2008), of households receiving assistance under the OVC program, 91.6% received assistance in the form of food while 55,5% received educational assistance<sup>11</sup>. With education free in public primary schools, and until

<sup>11</sup> National Situational Analysis on Orphans and Vulnerable Children in Botswana – Ministry of Local Government Department of Social Services (June 2008)

recently, in secondary schools as well, education support includes materials, uniforms and other school needs. Figure 3.8 below shows the distribution of OVC spending in 2008.

**Figure 3.8: OVC Spending (All Sources) 2008**



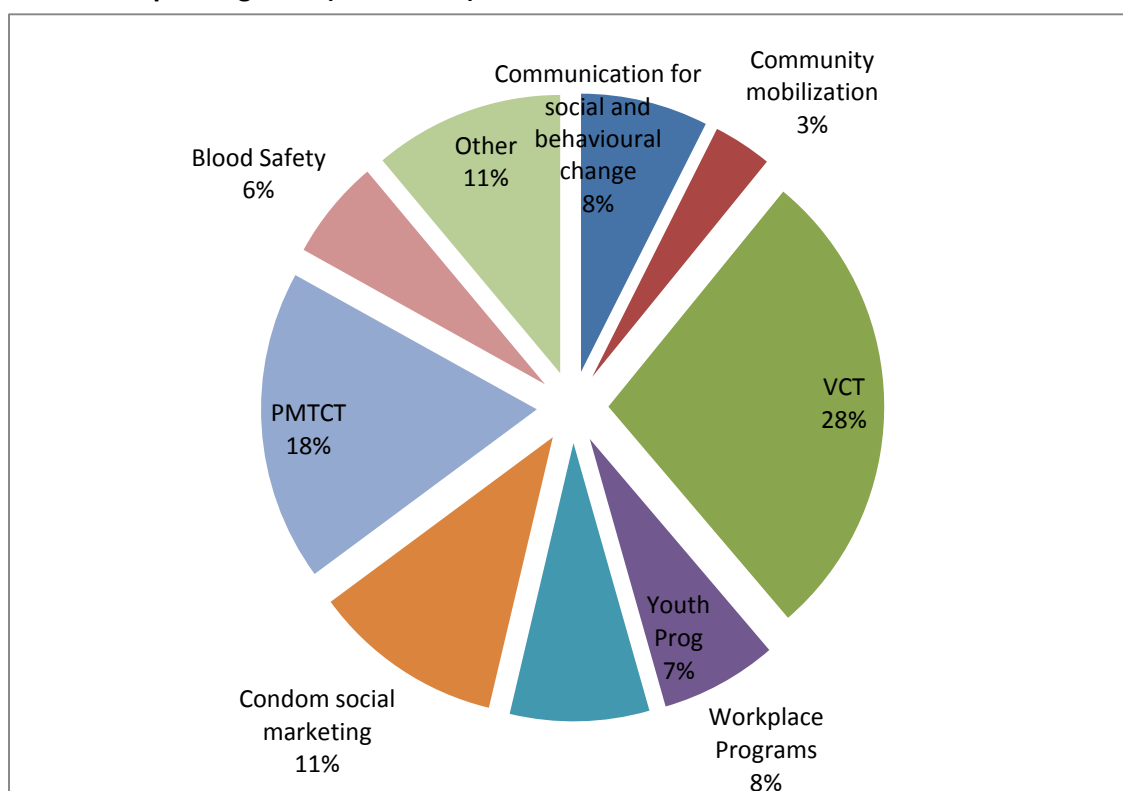
### 3.8 Prevention Spending

The main funding source for the preventive spending is the international funding agencies/development partners (refer appendices I (a) to I(c)). The proportional funding by the international sources has increased from 57% in 2006 to 61% in 2007 and to 63% in 2008.

The pie chart below shows the split in total spending on prevention by all the stakeholders in 2008. There is a wide spread of activities financed through international and public funds. The largest portion; VCT is mainly attributable to Tebelopele, a local Ngo which is delivering VCT throughout the country. VCT comprises the program running costs plus test kits; PMTCT comprises drugs, milk formula, salaries of program coordinators, workshops/trainings, etc. Condom social marketing is made up mainly of the activities associated with the distribution and promotion of condom use. The commodity costs have been left out because of the challenge in getting a percentage that can be attributable to HIV spending.



**Prevention Spending 2008 (All Sources)**



### 3.9 Program management and administration

With a high proportion of funds from the international sources spent on program management and administration, it is important to make an analysis of this spending category. The portion of the overall program management and administration spending financed by international sources is 69% in 2006, 91% in 2007 and 87% in 2008. The table below is a breakdown of 2008 spending on program management and administration funded by international sources

**Table 3.2: Breakdown of International Spending on Program Management and Administration 2008**

	<b>Amount Pula</b>	<b>%</b>
ASC.04.01 Planning, coordination and programme management	247,303,201	83.30%
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	344,369	0.12%
ASC.04.03 Monitoring and evaluation	17,714,893	5.97%
ASC.04.04 Operations research	14,983,712	5.05%
ASC.04.05 Serological-surveillance (serosurveillance)	2,507,523	0.84%
ASC.04.06 HIV drug-resistance surveillance	232,896	0.08%
ASC.04.07 Drug supply systems	2,992,585	1.01%
ASC.04.08 Information technology	55,859	0.02%
ASC.04.09 Patient tracking	78,870	0.03%
ASC.04.10 Upgrading and construction of infrastructure	10,682,358	3.60%
	<b>296,896,266</b>	

Planning, coordination and programme management refers to expenditure incurred at the administrative level outside the point of health care delivery, including the dissemination of strategic information, planning/evaluation of programs and interventions and capacity building. It is important to note that the table above represents spending of funds from the international sources only. It does not reflect the service providers consuming these funds. These international sourced funds are spent by the government, local offices of international agencies, NGOs and community based organisations. Appendix III (a) to III(c) provides a breakdown of spending categories by service providers for 2008.

### **3.10 Beneficiary populations**

The NASA approach attempts to track all expenditure from source, through the agent, to the service provider by activity and finally to the actual beneficiaries of spending. Figure 3.8 is a representation of the percentage benefit in value, of the six broad NASA population categories. These broad categories can each be further divided into various sub-categories. Refer also to appendices IV (a) to IV(c) which is a matrix of the spending per spending categories and beneficiary populations.

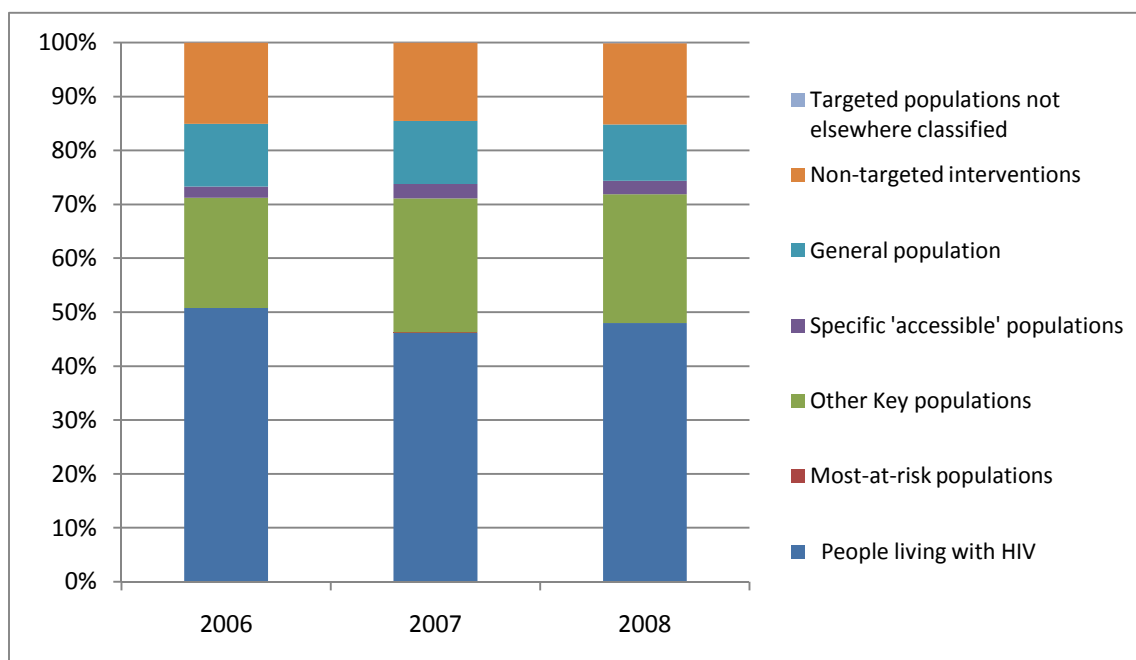
The main category benefiting from NASA are the people living with HIV and AIDS, consuming approximately 48% of the finances over the three years 2006, 2007 and 2009. This is expected, given the corresponding high spending of care and treatment.

The 'Other Key populations' is the beneficiary group spending the second largest portion of resources (23%). Included in this group for the Botswana NASA are; orphans and vulnerable population, children born or to be born of mother living with HIV, children and youth out of school and recipients of blood products.

The general populations can be sub-divided by age and gender. The general population refers to the interventions targeting the general population as a whole and not any particular accessible or key

population<sup>12</sup>. Non-targeted refers to spending on activities not belonging to explicitly selected or targeted populations or interventions benefiting the population in an indirect manner, like program management and administration expenses. Specific accessible populations can be sub-divided into people attending STI clinics, elementary school children, junior/high school students, health care workers, military, and police and factory employees.

**Figure 3.8 How the Key Populations Benefited 2006 – 2008**



### 3.11 Budgetary Items/Production Factors

The current NASA went one step more than the first by breaking down the spending by each service provider into production factors/budgetary items. Table 3.3 shows the split of the budgetary items across all the service providers for the three year 2006 -2008. Labour cost is the largest consumer of the resources at 26% for the combined three years, followed by food and nutrients (mainly orphan care food basket) at 20% and antiretroviral at 13%. P5,5m (91%) was incurred on recurrent expenditure items.

<sup>12</sup> National AIDS Spending Assessment(NASA): Classification taxonomy and Definitions (UNAIDS)

**Table 3.4 Budgetary Items for 2006 - 2008**

PF Categories	2006	2007	2008	Total	%
PF.01 Current expenditures	Pula	Pula	Pula	Pula	
PF.01.01 Labour income (compensation of employees and remuneration of owners)					
PF.01.01.01 Wages	427,715,164	494,379,301	671,150,029	1,593,244,494	26.20%
PF.01.01.02 Social contributions	1,451,343	1,974,269	3,171,662	6,597,274	0.11%
PF.01.01.03 Non-wage labour income	3,404,228	1,497,560	1,405,714	6,307,502	0.10%
PF.01.01.98 Labour income not disaggregated by type	5,987,235	5,999,659	7,208,874	19,195,768	0.32%
PF.01.02 Supplies and services					
PF.01.02.01 Material supplies					
PF.01.02.01.01 Antiretrovirals	211,757,509	271,651,814	307,977,381	791,386,704	13.01%
PF.01.02.01.02 Other drugs and pharmaceuticals (excluding antiretrovirals)	7,883,196	1,620,627	1,608,489	11,112,312	0.18%
PF.01.02.01.03 Medical and surgical supplies	83,433	113,651	238,885	435,969	0.01%
PF.01.02.01.04 Condoms	23,860	841,251	12,157,691	13,022,802	0.21%
PF.01.02.01.05 Reagents and materials	81,518,024	97,394,883	87,990,676	266,903,583	4.39%
PF.01.02.01.06 Food and nutrients	350,936,023	478,044,346	450,192,433	1,279,172,802	21.03%
PF.01.02.01.07 Uniforms and school materials	1,912,581	15,115,426	43,115,024	60,143,031	0.99%
PF.01.02.01.98 Material supplies not disaggregated by type	24,709,171	44,308,155	44,707,879	113,725,205	1.87%
PF.01.02.01.99 Other material supplies n.e.c.	32,213,881	14,161,556	38,860,194	85,235,631	1.40%
PF.01.02.02 Services					
PF.01.02.02.01 Administrative services	122,943,890	166,764,379	177,076,245	466,784,514	7.67%
PF.01.02.02.02 Maintenance and repair services	1,442,630	2,378,782	9,332,094	13,153,506	0.22%
PF.01.02.02.03 Publisher-, motion picture-, broadcasting and programming services	6,650,413	27,118,920	13,890,996	47,660,329	0.78%
PF.01.02.02.04 Consulting services	8,646,773	21,334,983	15,121,759	45,103,515	0.74%
PF.01.02.02.05 Transportation and travel services	45,630,280	39,948,163	46,295,190	131,873,633	2.17%
PF.01.02.02.06 Housing services	3,353,953	5,357,159	6,982,272	15,693,384	0.26%

PF Categories	2006	2007	2008	Total	%
PF.01.02.02.07 Logistics of events, including catering services	13,721,253	23,798,329	32,571,532	70,091,114	1.15%
PF.01.02.02.08 Financial intermediation services	1,929,472	787,596	1,504,508	4,221,576	0.07%
PF.01.02.02.98 Services not disaggregated by type	96,425,255	116,372,460	141,470,726	354,268,441	5.82%
PF.01.02.02.99 Services n.e.c.	6,009,016	28,963,363	26,394,524	61,366,903	1.01%
PF.01.98 Current expenditures not disaggregated by type	20,190,388	25,146,393	19,901,046	65,237,827	1.07%
PF.01.99 Current expenditures n.e.c.	1,093,019	2,004,189	9,136,832	12,234,040	0.20%
<b>PF.02 Capital expenditures</b>					
PF.02.01 Buildings					
PF.02.01.01 Laboratory and other infrastructure upgrading	5,373,040	3,707,982	3,159,790	12,240,812	0.20%
PF.02.01.02 Construction of new health centres	44,692,566	1,817,958	9,226,261	55,736,785	0.92%
PF.02.01.98 Buildings not disaggregated by type	239,730		6,767,442	7,007,172	0.12%
PF.02.01.99 Buildings n.e.c.	3,257,230	15,555,308	4,851,849	23,664,387	0.39%
PF.02.02 Equipment					
PF.02.02.01 Vehicles	4,701,638	1,187,679	4,586,216	10,475,533	0.17%
PF.02.02.02 Information technology (hardware and software)	4,889,406	10,187,933	3,159,128	18,236,467	0.30%
PF.02.02.03 Laboratory and other medical equipments	11,136,747	5,299,144	4,357,017	20,792,908	0.34%
PF.02.02.98 Equipment not disaggregated by type	717,664	8,095,612	4,168,174	12,981,450	0.21%
PF.02.02.99 Equipment n.e.c.	2,006,832	5,363,327	1,794,156	9,164,315	0.15%
PF.02.98 Capital expenditure not disaggregated by type	15,722,751	17,582,495	38,283,046	71,588,292	1.18%
PF.02.99 Capital expenditure n.e.c.	2,609,953	760,502	3,215,780	6,586,235	0.11%
PF.98 Production factors not disaggregated by type	103,051,294	90,718,324	105,689,339	299,458,957	4.92%
	<b>1,676,030,841</b>	<b>2,047,353,478</b>	<b>2,358,720,853</b>	<b>6,082,105,172</b>	<b>100.00%</b>

### 3.12 Funding Processes, Reporting Requirements and Financial Systems

#### a) Public Sector Funding Channels

NACA coordinates all HIV activities funded using public funds. At the beginning of each financial year Government ministries through their Planning Units submit project memorandum (proposals) to NACA requesting funding. NACA reviews the proposals and then submits them to the Ministerial planning Unit (MPU) for approval. Once approved they are forwarded to the Ministry of Finance Development planning (MFDP). MFDP either approves, adjust or reject the memorandum. NACA then accesses the approved funds from the MFDP, through the MPU and transfers these to the implementing ministries in line with approved project memorandum. NACA reports to the MFDP through the MPU on funds disbursed and project implementation.

NACA also coordinates all funding from international sources or development partners that are channelled through the government. The principal recipient is almost always the Ministry of Finance and Development Planning (MFDP).

### **District level Funding**

Irrespective of the source of funding, programs undertaken at the district level are routed through the Ministry of Local Government from NACA. At the districts level the funds are held by the district treasury offices on behalf of the programs. Program managers can then access the funds for their programs. These funds are for programs like PMTCT, orphan care, IPT, DMSAC activities and CHBC.

### **Public Entities Accounting Systems**

All entities receiving funds for HIV and AIDS have to maintain a separate vote's ledger for each program. In this way spending on each program/activity can be monitored. With all public ministries implementing workplace wellness programs funded through NACA, all ministries therefore receive some HIV/AIDS funding that have to be accounted for in the NASA.

At ministerial level, vote's ledgers are maintained by the administration and accounting officers. Spending is controlled by the program coordinators who also have the program activities reporting responsibilities.

At the district level, treasury officers have to maintain separate ledgers for each program. However in some districts program funds are mixed up in one vote, making it difficult for program managers to access the funds and monitor spending on the program that they are in charge of. Quite often they complain of unavailability of funds for their programs because they are not aware that their funding has been received and added up with other programs and there is poor communication from the treasury offices in advising the programs of their funding availability. In the process some of these funds are sometimes used for activities that they were not meant for.

### **Public Health Care Activities Funding Processes**

In Botswana healthcare is delivered through decentralised system with primary health care being the pillar of the delivery system. Botswana has an extensive network of health facilities (hospitals, clinics, health posts, mobile stops) clustered in twenty four (24) health districts<sup>13</sup>. The health services are under

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<sup>13</sup> Botswana Health Statistics Report 2005 – Central Statistics Office.

the management of the Ministry of Health (MOH) which oversees all the hospitals (referral, districts and primary) and the Ministry of Local Government (MLG), which is in charge of clinics, health posts and mobile stops.

- **Public Hospital Funding Activities and Processes**

The funding for the core activities of hospitals is by the government, through the Ministry of Health. All drugs are purchased centrally, through the Central Medical Stores (CMS), which is part of Ministry of Health. Laboratory reagents are procured through the National Health Laboratory (NHL), which is also part of the Ministry of Health. Donors such as ACHAP also provide some financial support, in particular, funding IDCCs and Resources centres.

Hospitals services can broadly be classified into inpatient and outpatient care and treatment. Chapter 2 explains in detail how treatment relating to HIV and AIDS has been arrived at for inclusion in the NASA.

Hospitals produce monthly reports of patient numbers and drugs and annually produce a report of activities for submission to the MOH. They do not produce financial report, as the financials are consolidate and produces at the Ministry level. They do maintain vote ledgers for their running expenses.

- **Public Clinics Activities and Funding Processes**

The funding for the core activities of the clinics is by the government through MLG. Clinics provide outpatient treatment. Nationally, clinics and health posts are the most frequently used health facilities for outpatient care and treatment, accounting for approximately 87% of all outpatient activity in the country as of 2005<sup>14</sup>. As for Hospitals above, the estimate for inclusion in NASA has been arrived as explained in Chapter 2.

Clinics report on their activities to the District Health Teams (DHT) who then report to the Ministry of Local Government. Financial reports are produces at the DHT level for MLG.

**b) NGO Funding Processes**

The NGOs operating in Botswana are not for profit institutions receiving funding from a wide spectrum of donors like USAID, PEPFAR (through CDC), ACHAP, EU, Form Syd, Global Fund and the Government of Botswana.

NGOs normally go through the process of tendering for international donor funds once program announcements are made by the donor organisations. They thus receive direct funding from donors for their programs. Donors have various ways of transferring funds to the NGOs. Disbursements can be either monthly or quarterly based on the cash flow projections. The NGOs working with sub-grantees (other NGOs or community organisations) have to work with these sub-grantees in ensuring they produce information in the format that can be easily consolidated for donor reporting.

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<sup>14</sup> Botswana Health Statistics Report 2005 – Central Statistics Office

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**

It was noted that many NGOs have poor management capacity, especially financial. Although clear reporting guidelines are provided, many NGOs cannot report accurately and timely 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. With each donor having its own financial report format and cycle, this calls for versatile financial management skills which are usually lacking in most of the organisations. A heavy burden is then placed on the limited financial management resources available, leading to late reporting and poor quality reports.

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.

### **c) External Sources of Funding – Development Partners in Botswana**

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 Forum Syd, 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, work plans 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.

### ***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 efficient spending or that spending may not be according to the project proposal.

### ***Challenges of the DP Data***

Though recipients of DP funds have to report regularly, 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.

### ***d) 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.

### ***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. Based on an agreed programs and work plans, relevant government departments make requisitions to UN agencies who then disburse 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, government departments also request 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 MFDP, 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 the relevant Ministry and finally to the unit implementing the program.

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 busiest in terms of expenditure and implementation. This often reflects as under-spending 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).

## **CHAPTER 4: RECOMMENDATION AND CONCLUSIONS**

This chapter presents recommendations, which flows from the finding made during the NASA process.

### **4.1 Funding for Program Management**

Donors are reluctant to fund the administrative functions of organizations, including salaries. Organisations involved in the HIV/AIDS fight are thus forced to hire people with limited management skills, especially finance and accounting personnel. As a result of limited employment incentives, there is also high staff turnover. This compromises the quality of financial reporting and has adverse implications on absorptive capacity.

The donor community is encouraged to change its mindset and allow organizations to attract skilled personnel by offering competitive salaries.

### **4.2 Improved financial information systems**

There is the need to improve the financial information system in terms of the quality and accuracy of HIV/AIDS expenditure data. In some institutions, retrieval of the required information was difficult. Non-retrieval of some information led to some of the institutions providing incomplete information, while slow retrieval of information delayed the data collection phase.

NACA maintains a monitoring tool called BHRIMS. This only captures and reports statistical information without financial data. This could be improved to allow for the reporting of associated financial information.

### **4.3 Differing Reporting Formats and Cycles**

Each donor has its own reporting format and cycle. This calls for versatile financial management skills which usually is lacking in most of the organizations. Heavy burden is also placed on the limited financial management resources available, leading to late reporting and poor quality reports.

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 reporting requirements to the government of Botswana. CDC for instance has continued to show its willingness to align its reporting cycle to that of the government of Botswana.

Within the government system, there is also need to harmonise reports flowing to the different ministries from the implementers. The CHBC programs complain of duplication of work as there are two reporting formats for MOH and MLG . An effort should be made to harmonise these reports.

#### **4.4 Spending on most at risk population**

Spending on the most at risk population such as for commercial sex workers (CSWs) and men who have sex with men (MSM) was almost zero for the three years. Less priority was given in intervention targeting most at risk population. There is a need to measure their needs and design interventions to reduce the risks they are exposed to.

#### **4.5 Improved Coordination of Activities**

Some of the DACS noted that some NGOs and community projects are getting funding from NACA and other donors without them knowing. This makes it difficult for the DAC to monitor HIV and AIDS activities in their districts. This could easily lead to duplication of activities within a district.

There is also the potential for overcrowding if HIV/AIDS activities are not properly coordinated (i.e. all donors/organisations funding the same interventions)

Therefore it is recommended that the coordination of implementers' activities be improved to avoid duplication of activities.

#### **4.6 Institutionalisation of NASA**

The current NASA has been done for a period of three years. The usefulness of any information for decision making purposes is based on its timely production. Thus for policy and decision makers to make appropriate use of the NASA findings, it ideally should be undertaken regularly (annually). This is possible if NASA is institutionalised within the Monitoring and Evaluation (M&E) framework. Reporting of NASA information can be integrated with the existing mechanism within the M&E framework. However, these processes require standardization of the expenditure information reporting from all the various organizations.

It is possible for NACA to design simple forms that implementers can use to make returns on a quarterly basis. This can be done through the adaptation of UNAIDS designed forms used for the current NASA. As this will obviously place an additional reporting burden on implementers, the forms can be customised to be as simple as is possible.

#### **4.7 Statistics for HIV patients**

One of the biggest challenge that was associated with this NASA and which will also be a challenge in the next NASA is the estimation of spending at the hospitals and clinics that can be allocated to HIV/AIDS. The basis used to allocate the patient care costs to HIV/AIDS is the ratio of HIV/AIDS patients to the overall number of patients seeking treatment. With the health statistics reports only reporting the diagnosis and leaving out HIV co – infections, there is need for a regular study of patients using hospitals and clinics services because of complications relating to HIV/AIDS. This will provide a better basis for the allocation of patient care spending.

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## APPENDICES

### APPENDIX I (a) – Spending Matrix 2008

Botswana National Spending Matrix	Sources of Fund						
Jan to December 2008	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula Thousands			Bilateral	Multilaterals			
	Public Funds	Total Private Funds	Direct bilateral contributions	Multilateral Agencies	All Other international		
Grand Total	1,549,574	52,674	491,126	9,788	255,558	756,473	2,358,721
ASC.01 Prevention	68,083	8,656	95,783	3,610	34,039	133,432	210,171
ASC.01.01 Communication for social and behavioural change	4,766	1,087	9,642	175	44	9,860	15,713
ASC.01.02 Community mobilization Total	578	-	1,629	63	4,980	6,671	7,249
ASC.01.03 Voluntary counselling and testing (VCT)	7,067	404	39,988	-	10,934	50,922	58,393
ASC.01.04 Risk-reduction for vulnerable and accessible populations	-	-	3,315	-	-	3,315	3,315
ASC.01.05 Prevention – youth in school Total	6,695	1	2,855	45	863	3,764	10,460
ASC.01.06 Prevention – youth out-of-school Total	-	-	3,069	-	863	3,933	3,933
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)	1,083	-	778	-	19	798	1,880
ASC.01.11 Prevention programmes in the workplace Total	12,842	3,953	366	-	-	366	17,161
ASC.01.12 Condom social marketing	86	2,364	8,846	101	12,137	21,084	23,534
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	-	-	-	-	1,738	1,738	1,738
ASC.01.17 Prevention of mother-to-child transmission (PMTCT) Total	32,040	-	6,011	-	-	6,011	38,051
ASC.01.18 Male circumcision Total	-	-	711	378	-	1,089	1,089
ASC.01.19 Blood safety Total	-	-	11,682	-	572	12,254	12,254
ASC.01.20 Safe medical injections Total	-	-	4,300	-	-	4,300	4,300
ASC.01.98 Prevention activities not disaggregated by intervention	2,795	847	2,583	-	1,888	4,471	8,113

Botswana National Spending Matrix	Sources of Fund						
	Public Funds	Private Funds	International Funds			Total International	Grand Total
Jan to December 2008			Bilateral	Multilaterals			
Currency: Pula Thousands							
ASC.01.99 Prevention activities n.e.c.	132	-	9	2,848	-	2,857	2,989
					-		
ASC.02 Care and treatment	869,688	38,255	101,004	27	153,706	254,737	1,162,680
ASC.02.01 Outpatient care	329,578	37,967	89,717	-	153,706	243,423	610,967
ASC.02.02 Inpatient care Total	540,108	289	2,930	-	-	2,930	543,327
ASC.02.98 Care and treatment services not disaggregated by intervention	-	-	8,357	-	-	8,357	8,357
ASC.02.99 Care and treatment services n.e.c.	1	-	-	27	-	27	28
					-		
ASC.03 Orphans and vulnerable children (OVC)	537,222	3,351	8,324	-	161	8,485	549,058
ASC.03.01 OVC Education Total	47,256	167	-	-	13	13	47,436
ASC.03.02 OVC Basic health care	33	2	2,034	-	-	2,034	2,069
ASC.03.03 OVC Family/home support Total	450,220	-	287	-	6	293	450,512
ASC.03.04 OVC Community support Total	95	804	376	-	143	519	1,418
ASC.03.05 OVC Social Services and Administrative costs	31,476	31	98	-	-	98	31,605
ASC.03.06 OVC Institutional care Total	-	105	-	-	-	-	105
ASC.03.98 OVC Services not disaggregated by intervention	-	2,243	5,506	-	-	5,506	7,749
ASC.03.99 OVC services n.e.c.	8,142	-	23	-	-	23	8,165
					-		
ASC.04 Programme management and administration	41,279	1,832	236,741	4,017	56,139	296,896	340,008
ASC.04.01 Planning, coordination and programme management	29,678	1,684	205,537	2,333	39,433	247,303	278,666
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds Total	357	-	344	-	1	344	701
ASC.04.03 Monitoring and evaluation Total	-	-	13,466	1,451	2,798	17,715	17,715
ASC.04.04 Operations research Total	122	-	3,557	-	11,427	14,984	15,106
ASC.04.05 Serological-surveillance (serosurveillance) Total	-	-	2,508	-	-	2,508	2,508
ASC.04.06 HIV drug-resistance surveillance Total	-	-	-	233	-	233	233
ASC.04.07 Drug supply systems Total	-	-	2,993	-	-	2,993	2,993
ASC.04.08 Information technology Total	71	-	56	-	-	56	127
ASC.04.09 Patient tracking	-	-	79	-	-	79	79
ASC.04.10 Upgrading and construction of infrastructure Total	11,051	130	8,203	-	2,480	10,682	21,863



Botswana National Spending Matrix	Sources of Fund						
	Public Funds	Private Funds	International Funds			Total International	Grand Total
Jan to December 2008			Bilateral	Multilaterals			
Currency: Pula Thousands							
ASC.04.99 Programme management and administration n.e.c	-	18	-	-	-	-	18
					-		
ASC.05 Human resources	15,162	56	43,996	341	3,519	47,856	63,074
ASC.05.01 Monetary incentives for human resources Total	13,000	-	1,163	-	-	1,163	14,163
ASC.05.02 Formative education to build-up an HIV workforce	-	-	928	-	2,326	3,254	3,254
ASC.05.03 Training Total	2,162	56	41,782	341	1,043	43,165	45,383
ASC.05.98 Human resources not disaggregated by type Total	-	-	124	-	-	124	124
ASC.05.99 Human resources n.e.c. Total	-	-	-	-	151	151	151
					-		
ASC.06 Social protection and social services (excluding OVC)	-	-	383	-	-	383	383
ASC.06.01 Social protection through monetary benefits Total	-	-	383	-	-	383	383
					-		
ASC.07 Enabling environment	592	524	1,851	1,794	7,994	11,638	12,755
ASC.07.01 Advocacy Total	-	-	-	-	79	79	79
ASC.07.02 Human rights programmes Total	-	4	41	845	11	897	901
ASC.07.03 AIDS-specific institutional development Total	446	32	1,608	947	4,519	7,074	7,552
ASC.07.04 AIDS-specific programmes focused on women Total	-	-	-	-	361	361	361
ASC.07.98 Enabling environment not disaggregated by type Total	-	421	93	-	2,196	2,289	2,710
ASC.07.99 Enabling environment n.e.c. Total	146	67	108	1	829	938	1,152
					-		
ASC.08 HIV and AIDS-related research (excluding operations research )	17,547	-	3,045	-	-	3,045	20,592
ASC.08.03 Epidemiological research Total	17,547	-	-	-	-	-	17,547
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type Total	-	-	1,353	-	-	1,353	1,353
ASC.08.99 HIV and AIDS-related research activities n.e.c. Total	-	-	1,692	-	-	1,692	1,692

## APPENDIX I (b) – Spending Matrix 2007

Botswana National Spending Matrix

Sources of Funds

Jan to December 2007	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula Thousands			Bilateral contributions	Multilateral Agencies	International Organisations		
	Public Funds Sub total	Total Private Funds	Direct bilateral contributions	Multilateral Agencies	Other international Total		
<b>Grand Total</b>	<b>1,320,879</b>	<b>37,890</b>	<b>488,231</b>	<b>9,810</b>	<b>190,544</b>	<b>688,585</b>	<b>2,047,353</b>
<b>ASC.01 Prevention</b>	<b>76,138</b>	<b>5,914</b>	<b>102,346</b>	<b>1,698</b>	<b>25,805</b>	<b>129,849</b>	<b>211,901</b>
ASC.01.01 Communication for social and behavioural change	2,503	1,019	11,301	420	1,369	13,090	16,612
ASC.01.02 Community mobilization							
Total	159	9	1,484	159	4,974	6,616	6,783
ASC.01.03 Voluntary counselling and testing (VCT)	9,711	557	39,435	-	12,847	52,282	62,550
ASC.01.04 Risk-reduction for vulnerable and accessible populations	2	-	5,727	-	-	5,727	5,729
ASC.01.05 Prevention – youth in school Total	-	-	3,737	-	466	4,204	4,204
ASC.01.06 Prevention – youth out-of-school Total	46	-	3,948	-	466	4,414	4,460
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)	760	-	1,787	23	20	1,831	2,591
ASC.01.08 Prevention programmes for sex workers and their clients	-	-	222	-	-	222	222
ASC.01.11 Prevention programmes in the workplace Total	6,993	3,393	-	-	-	-	10,387
ASC.01.12 Condom social marketing	103	-	6,008	92	1,841	7,941	8,044
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	-	-	-	-	1,193	1,193	1,193
ASC.01.17 Prevention of mother-to-child transmission (PMTCT) Total	55,859	-	4,379	-	-	4,379	60,238
ASC.01.19 Blood safety Total	-	-	17,998	-	672	18,670	18,670
ASC.01.20 Safe medical injections Total	-	-	5,300	-	-	5,300	5,300
ASC.01.98 Prevention activities not disaggregated by intervention	-	618	124	-	1,957	2,081	2,699
ASC.01.99 Prevention activities n.e.c.	2	318	896	1,003	-	1,899	2,219
<b>ASC.02 Care and treatment</b>	<b>736,826</b>	<b>28,248</b>	<b>132,630</b>	<b>767</b>	<b>114,072</b>	<b>247,468</b>	<b>1,012,542</b>
ASC.02.01 Outpatient care	303,418	27,403	130,394	595	114,072	245,060	575,881
ASC.02.02 Inpatient care Total	433,408	845	1,434	111	-	1,545	435,797
ASC.02.98 Care and treatment services not disaggregated by intervention	-	-	802	61	-	863	863

Botswana National Spending Matrix		Sources of Funds					
Jan to December 2007	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula Thousands			Bilateral contributions	Multilateral Agencies	International Organisations		
<b>ASC.03 Orphans and vulnerable children (OVC)</b>	<b>484,505</b>	<b>1,576</b>	<b>4,305</b>	<b>-</b>	<b>1,116</b>	<b>5,421</b>	<b>491,502</b>
ASC.03.01 OVC Education Total	18,483	102	-	-	15	15	18,601
ASC.03.02 OVC Basic health care	28	14	427	-	-	427	469
ASC.03.03 OVC Family/home support Total	439,064	-	309	-	33	341	439,406
ASC.03.04 OVC Community support Total	8,437	10	249	-	-	249	8,696
ASC.03.05 OVC Social Services and Administrative costs	12,727	-	130	-	67	198	12,925
ASC.03.98 OVC Services not disaggregated by intervention	5,575	1,449	984	-	958	1,942	8,966
ASC.03.99 OVC services n.e.c.	191	-	2,206	-	43	2,248	2,439
<b>ASC.04 Programme management and administration</b>	<b>20,392</b>	<b>1,442</b>	<b>208,303</b>	<b>4,091</b>	<b>37,062</b>	<b>249,456</b>	<b>271,291</b>
ASC.04.01 Planning, coordination and programme management	15,803	1,242	178,807	1,581	26,980	207,368	224,414
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds Total	28	-	5,593	4	8	5,606	5,634
ASC.04.03 Monitoring and evaluation Total	-	9	4,676	2,505	1,842	9,022	9,031
ASC.04.04 Operations research Total	122	-	169	-	6,169	6,338	6,460
ASC.04.05 Serological-surveillance (serosurveillance) Total	717	-	1,128	-	-	1,128	1,845
ASC.04.07 Drug supply systems Total	-	-	4,768	-	-	4,768	4,768
ASC.04.08 Information technology Total	1,044	-	10	-	2	12	1,055
ASC.04.09 Patient tracking	-	-	3,322	-	-	3,322	3,322
ASC.04.10 Upgrading and construction of infrastructure Total	2,097	191	9,830	-	2,062	11,892	14,180
ASC.04.99 Programme management and administration n.e.c	581	-	-	-	-	-	581
<b>ASC.05 Human resources</b>	<b>2,938</b>	<b>82</b>	<b>33,882</b>	<b>577</b>	<b>8,815</b>	<b>43,274</b>	<b>46,294</b>
ASC.05.01 Monetary incentives for human resources	350	-	375	569	326	1,269	1,620
ASC.05.02 Formative education to build-up an HIV workforce	-	-	82	-	6,247	6,330	6,330
ASC.05.03 Training	2,588	82	33,425	8	2,082	35,515	38,185
ASC.05.99 Human resources n.e.c.	-	-	-	-	159	159	159
<b>ASC.06 Social protection and social services (excluding OVC)</b>	<b>-</b>	<b>-</b>	<b>364</b>	<b>-</b>	<b>-</b>	<b>364</b>	<b>364</b>
ASC.06.04 HIV-specific income generation projects	-	-	364	-	-	364	364

Botswana National Spending Matrix		Sources of Funds						
Jan to December 2007	Public Funds	Private Funds	International Funds			Total International	Grand Total	
Currency: Pula Thousands			Bilateral contributions	Multilateral Agencies	International Organisations			
ASC.07 Enabling environment	80	628	4,682	2,678	3,674	11,034	11,741	
ASC.07.01 Advocacy	-	-	12	-	29	41	41	
ASC.07.02 Human rights programmes	-	74	2,294	211	640	3,145	3,219	
ASC.07.03 AIDS-specific institutional development Total	80	47	1,886	2,415	787	5,088	5,215	
ASC.07.04 AIDS-specific programmes focused on women Total	-	-	-	-	84	84	84	
ASC.07.98 Enabling environment not disaggregated by type	-	16	387	10	1,504	1,900	1,916	
ASC.07.99 Enabling environment n.e.c.	-	491	104	42	631	776	1,267	
ASC.08 HIV and AIDS-related research (excluding operations research )	-	-	1,719	-	-	1,719	1,719	
ASC.08.02 Clinical research Total	-	-	320	-	-	320	320	
ASC.08.99 HIV and AIDS-related research activities n.e.c.	-	-	1,399	-	-	1,399	1,399	

## APPENDIX I(c) – Spending Matrix 2006

Botswana National Spending Matrix							
Jan to December 2006	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula thousands			Bilateral contributions	Multilateral	International Organisations		
	Public Funds	Private Funds	Direct bilateral contributions	Multilateral Agencies	Other international Total		
Grand Total	1,181,145	29,448	306,761	16,900	141,776	465,437	1,676,031
ASC.01 Prevention	58,647	2,562	65,759	1,960	15,056	82,775	143,984

Botswana National Spending Matrix							
Jan to December 2006	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula thousands			Bilateral contributions	Multilateral	International Organisations		
ASC.01.01 Communication for social and behavioural change	888	796	6,153	540	-	6,693	8,377
ASC.01.02 Community mobilization	74	20	196	787	3,592	4,575	4,669
ASC.01.03 Voluntary counselling and testing (VCT)	6,111	-	27,046	-	5,171	32,217	38,328
ASC.01.05 Prevention – youth in school	-	-	1,164	-	866	2,030	2,030
ASC.01.06 Prevention – youth out-of-school	47	-	42	-	109	151	198
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)	336	-	672	110	-	783	1,119
ASC.01.11 Prevention programmes in the workplace	2,910	1,154	-	180	-	180	4,245
ASC.01.12 Condom social marketing	1	-	8,465	-	1,239	9,703	9,705
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	3	-	175	-	210	385	388
ASC.01.17 Prevention of mother-to-child transmission (PMTCT)	48,169	-	5,785	-	-	5,785	53,954
ASC.01.19 Blood safety	-	-	7,669	-	2,516	10,186	10,186
ASC.01.20 Safe medical injections	-	-	8,000	-	-	8,000	8,000
ASC.01.98 Prevention activities not disaggregated by intervention	106	592	392	-	1,353	1,745	2,443
ASC.01.99 Prevention activities n.e.c.	-	-	-	342	-	342	342
<b>ASC.02 Care and treatment</b>	<b>728,606</b>	<b>22,833</b>	<b>58,468</b>	<b>4,741</b>	<b>80,525</b>	<b>143,734</b>	<b>895,174</b>
ASC.02.01 Outpatient care	363,165	22,540	49,982	2,505	80,525	133,012	518,717
ASC.02.02 Inpatient care Total	365,441	294	5,458	2,213	-	7,671	373,405
ASC.02.98 Care and treatment services not disaggregated by intervention	-	-	3,029	-	-	3,029	3,029
ASC.02.99 Care and treatment services n.e.c.	-	-	-	23	-	23	23
<b>ASC.03 Orphans and vulnerable children (OVC)</b>	<b>292,104</b>	<b>1,523</b>	<b>1,792</b>	<b>-</b>	<b>2,049</b>	<b>3,842</b>	<b>297,469</b>
ASC.03.01 OVC Education Total	2,078	56	-	-	-	-	2,135
ASC.03.02 OVC Basic health care	4	1	179	-	-	179	184

Botswana National Spending Matrix							
Jan to December 2006	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula thousands			Bilateral contributions	Multilateral	International Organisations		
ASC.03.03 OVC Family/home support Total	284,964	-	-	-	-	-	284,964
ASC.03.04 OVC Community support Total	99	-	-	-	-	-	99
ASC.03.05 OVC Social Services and Administrative costs	2,009	-	-	-	-	-	2,009
ASC.03.98 OVC Services not disaggregated by intervention	1,900	1,466	1,613	-	2,049	3,662	7,028
ASC.03.99 OVC services n.e.c.	1,049	-	-	-	-	-	1,049
<b>ASC.04 Programme management and administration</b>	<b>89,752</b>	<b>1,258</b>	<b>157,916</b>	<b>7,694</b>	<b>33,894</b>	<b>199,504</b>	<b>290,514</b>
ASC.04.01 Planning, coordination and programme management	40,210	1,125	153,677	4,006	28,166	185,849	227,184
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds Total	1	-	6	121	1	128	129
ASC.04.03 Monitoring and evaluation Total	7	-	251	1,755	746	2,752	2,759
ASC.04.04 Operations research Total	251	-	-	-	2,700	2,700	2,951
ASC.04.05 Serological-surveillance (serosurveillance) Total	676	-	478	-	-	478	1,154
ASC.04.07 Drug supply systems Total	-	-	2,528	-	-	2,528	2,528
ASC.04.08 Information technology Total	2,254	6	175	-	-	175	2,435
ASC.04.10 Upgrading and construction of infrastructure Total	43,818	128	802	1,811	2,281	4,894	48,839
ASC.04.98 Programme management and administration not disaggregated by type	251	-	-	-	-	-	251
ASC.04.99 Programme management and administration n.e.c	2,283	-	-	-	-	-	2,283
<b>ASC.05 Human resources</b>	<b>11,091</b>	<b>144</b>	<b>22,356</b>	<b>357</b>	<b>7,987</b>	<b>30,700</b>	<b>41,935</b>
ASC.05.01 Monetary incentives for human resources	4,773	-	173	241	206	621	5,394
ASC.05.02 Formative education to build-up an HIV workforce	-	-	-	-	4,855	4,855	4,855
ASC.05.03 Training	2,145	144	22,183	116	2,402	24,700	26,989
ASC.05.99 Human resources n.e.c.	4,173	-	-	-	523	523	4,696

Botswana National Spending Matrix							
Jan to December 2006	Public Funds	Private Funds	International Funds			Total International	Grand Total
Currency: Pula thousands			Bilateral contributions	Multilateral	International Organisations		
<b>ASC.06 Social protection and social services (excluding OVC)</b>	-	10	40	-	-	40	51
ASC.06.01 Social protection through monetary benefits Total	-	10	-	-	-	-	10
ASC.06.04 HIV-specific income generation projects Total	-	-	40	-	-	40	40
<b>ASC.07 Enabling environment</b>	514	1,117	429	2,148	2,266	4,843	6,474
ASC.07.01 Advocacy Total	-	-	-	-	22	22	22
ASC.07.02 Human rights programmes Total	37	690	114	-	253	367	1,094
ASC.07.03 AIDS-specific institutional development Total	97	57	314	1,643	816	2,774	2,927
ASC.07.98 Enabling environment not disaggregated by type Total	90	-	-	174	538	713	802
ASC.07.99 Enabling environment n.e.c. Total	291	371	-	331	636	968	1,630
<b>ASC.08 HIV and AIDS-related research (excluding operations research )</b>	431	-	-	-	-	-	431
ASC.08 HIV and AIDS-related research (excluding operations research ) Total	431	-	-	-	-	-	431

## APPENDIX II (a) – Treatment and Care 2008

### BOTSWANA NATIONAL SPENDING ASSESSMENT

#### Treatment and Care

Fiscal Year Ending 31 December 2008

	Total	Public Funds	Private Funds	Bilateral Agents	Multilateral Agencies	International not-for-profit organizations and foundations
	Pula	Pula	Pula	Pula	Pula	Pula
<b>2.01 Outpatient care</b>						
2.01.01 Provider- initiated testing and counselling	623,700	623,700	-	-	-	-
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	21,470,316	962,324	-	15,425,361	-	5,082,631
2.01.03 Antiretroviral therapy	368,525,923	110,260,309	37,966,526	71,732,497	-	148,566,591
2.01.04 Nutritional support associated to ARV therapy	13,491,944	13,485,628	-	6,316	-	-
2.01.05 Specific HIV related laboratory monitoring	72,789,646	72,375,113	-	414,533	-	-
2.01.07 Psychological treatment and support services	4,796	4,796	-	0	-	-
2.01.09 Home based care	17,426,417	15,244,035	-	2,134,852	-	47,530
2.01.99 Outpatient care services not elsewhere classified	116,634,474	116,622,088	-	3,110	-	9,276
<b>2.02 In-patient care</b>						
2.02.02 Inpatient palliative care	2,929,965	-	-	2,929,965	-	-



2.02.98 Inpatient care services not disaggregated by intervention	540,397,237	540,108,459	288,778	-	-	-
2.98 Care and treatment services not disaggregated by intervention	8,357,164	-	-	8,357,164	-	-
2.99 Care and treatment service not elsewhere classified	28,484	1,420	-	-	27,064	-
<b>Total</b>	<b>1,162,680,066</b>	<b>869,687,872</b>	<b>38,255,304</b>	<b>101,003,798</b>	<b>27,064</b>	<b>153,706,028</b>

## APPENDIX II (b) – Treatment and Care 2007

### BOTSWANA NATIONAL SPENDING ASSESSMENT

#### Treatment and Care

Fiscal Year Ending 31 December 2007

	Total	Public Funds	Private Funds	Bilateral Agents	Multilateral Agencies	International not-for-profit organizations and foundations
	Pula	Pula	Pula	Pula	Pula	Pula
<b>2.01 Outpatient care</b>						
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	13,009,705	1,605,949	-	4,617,885	-	6,785,871
2.01.03 Antiretroviral therapy	338,505,293	92,343,412	27,402,895	111,746,405	-	107,012,581
2.01.04 Nutritional support associated to ARV therapy	18,560,343	18,555,023	-	-	-	5,320
2.01.05 Specific HIV related laboratory monitoring	64,318,507	52,049,912	-	12,268,595	-	-

2.01.07 Psychological treatment and support services	28,377	-	-	-	20,510	7,867
2.01.09 Home based care	44,899,769	42,304,338	-	1,761,174	574,102	260,155
2.01.99 Outpatient care services not elsewhere classified	96,559,384	96,559,384	-	-	-	-
<b>2.02 In-patient care</b>						
2.02.01 Inpatient treatment of opportunistic infections	1,433,816	-	-	1,433,816	-	-
2.02.02 Inpatient palliative care	110,810	-	-	-	110,810	-
2.02.98 Inpatient care services not disaggregated by intervention	434,252,229	433,407,538	844,691	-	-	-
2.98 Care and treatment services not disaggregated by intervention	863,325	-	-	801,975	61,350	-
<b>Total</b>	<b>1,012,541,558</b>	<b>736,825,556</b>	<b>28,247,586</b>	<b>132,629,850</b>	<b>766,772</b>	<b>114,071,794</b>

## APPENDIX II (c) – Treatment and care 2006

### BOTSWANA NATIONAL SPENDING ASSESSMENT

#### Treatment and Care

Fiscal Year Ending 31 December 2006

	Total	Public Funds	Private Funds	Bilateral Agents	Multilateral Agencies	International not-for-profit organizations and foundations
	Pula	Pula	Pula	Pula	Pula	Pula
<b>2.01 Outpatient care</b>						
2.01.02 Opportunistic infection outpatient prophylaxis and treatment	4,134,337	1,559,216	-	2,575,121	-	-
2.01.03 Antiretroviral therapy	270,140,440	132,696,951	22,539,746	34,487,097	-	80,416,646
2.01.04 Nutritional support associated to ARV therapy	23,717,007	23,687,776	-	29,231	-	-
2.01.05 Specific HIV related laboratory monitoring	65,641,740	54,169,451	-	11,472,289	-	-
2.01.07 Psychological treatment and support services	100,301	100,301	-	-	-	-
2.01.08 Outpatient palliative care	108,074	-	-	-	-	108,074
2.01.09 Home based care	68,231,558	64,308,450	-	1,418,226	2,504,882	-
2.01.99 Outpatient care services not elsewhere classified	86,643,267	86,643,267	-	-	-	-
<b>2.02 In-patient care</b>						
2.02.02 Inpatient palliative care	2,212,922	-	-	-	2,212,922	-
2.02.98 Inpatient care services not disaggregated by intervention	371,192,023	365,440,711	293,545	5,457,767	-	-
2.98 Care and treatment services not disaggregated by intervention	3,028,559	-	-	3,028,559	-	-

2.99 Care and treatment service not elsewhere classified	23,378	-	-	-	23,378	-
<b>Total</b>	<b>895,173,606</b>	<b>728,606,123</b>	<b>22,833,291</b>	<b>58,468,290</b>	<b>4,741,182</b>	<b>80,524,720</b>

### Appendix III (a) – Spending Categories by Service Providers 2008

Botswana NASA

Jan to December 2008

Spending Categories by Service Providers

ASC categories	Public Sector Providers	Non-profit non-faith-based providers	Non-profit faith-based	For profit private sector providers	Bilateral agencies	Multilateral agencies	Other Providers	Total
	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula
ASC.01 Prevention	104,275,223	84,989,705	10,658,290	7,501,571	-	378,141	2,368,332	210,171,262
ASC.02 Care and treatment	1,089,470,571	33,880,924	58,266	38,255,304	-	-	1,014,999	1,162,680,064
ASC.03 Orphans and vulnerable children (OVC)	544,054,405	4,596,082	407,853	-	-	-	-	549,058,340
ASC.04 Programme management and administration	70,499,967	58,863,777	7,822,943	4,042,544	195,786,191	2,992,490	-	340,007,912
ASC.05 Human resources	23,419,540	39,162,531	440,892	51,400	-	-	-	63,074,363
ASC.06 Social protection and social services (excluding OVC)	-	382,581	-	-	-	-	-	382,581
ASC.07 Enabling environment	146,355	11,332,119	382,075	894,087	-	-	-	12,754,636
ASC.08 HIV and AIDS-related research (excluding operations research )	17,546,697	3,044,998	-	-	-	-	-	20,591,695
<b>Total</b>						<b>3,370,631</b>		

	1,849,412,758	236,252,717	19,770,319	50,744,906	195,786,191		6,766,662	2,358,720,853
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## Appendix III (b) – Spending Categories by Service Providers 2007

Botswana NASA

Jan to December 2007

### Spending Categories by Service Providers

ASC categories	Public Sector Providers	Non-profit non-faith-based providers	Non-profit faith-based	For profit private sector providers	Bilateral agencies	Multilateral agencies	Other Providers	Total
	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula
ASC.01 Prevention	113,310,394	75,781,150	18,684,380	4,125,250	-	-	-	211,901,174
ASC.02 Care and treatment	965,762,864	16,248,782	-	28,566,621	-	-	1,963,291	1,012,541,558
ASC.03 Orphans and vulnerable children (OVC)	487,138,232	3,776,455	576,878	10,000	-	-	-	491,501,565
ASC.04 Programme management and administration	50,183,943	38,298,636	7,271,775	4,485,567	168,468,282	2,582,822	-	271,291,025
ASC.05 Human resources	17,489,135	28,785,352	19,424	-	-	-	-	46,293,911
ASC.06 Social protection and social services (excluding OVC)	348,153	15,900	-	-	-	-	-	364,053
ASC.07 Enabling environment	943,558	10,398,243	257,875	-	-	-	141,665	11,741,341
ASC.08 HIV and AIDS-related research (excluding operations research )	320,006	1,398,845	-	-	-	-	-	1,718,851
<b>Grand Total</b>	<b>1,635,496,285</b>	<b>174,703,363</b>	<b>26,810,332</b>	<b>37,187,438</b>	<b>168,468,282</b>	<b>2,582,822</b>	<b>2,104,956</b>	<b>2,047,353,478</b>

### Appendix III (c) – Spending Categories by Service Providers 2006

Botswana NASA

Jan to December 2006

#### Spending Categories by Service Providers

ASC categories	Public Sector Providers	Non-profit non-faith-based providers	Non-profit faith-based	For profit private sector providers	Bilateral agencies	Multilateral agencies	Other Providers	Total
	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula
ASC.01 Prevention	78,525,217	50,047,053	13,128,350	1,932,312	-	350,774	-	143,983,706
ASC.02 Care and treatment	850,217,240	24,199,827	2,770	20,724,537	-	29,231	-	895,173,605
ASC.03 Orphans and vulnerable children (OVC)	291,447,636	6,021,312	-	-	-	-	-	297,468,948
ASC.04 Programme management and administration	104,980,536	29,306,201	2,674,344	683,020	148,415,348	3,752,516	701,549	290,513,514
ASC.05 Human resources	16,256,678	23,464,420	1,658,401	-	-	555,393	-	41,934,892
ASC.06 Social protection and social services (excluding OVC)	-	50,544	-	-	-	-	-	50,544
ASC.07 Enabling environment	-	6,435,686	16,800	-	-	22,000	-	6,474,486
ASC.08 HIV and AIDS-related research (excluding operations research )	-	431,146	-	-	-	-	-	431,146
	<b>1,341,427,307</b>	<b>139,956,189</b>	<b>17,480,665</b>	<b>23,339,869</b>	<b>148,415,348</b>	<b>4,709,914</b>	<b>701,549</b>	<b>1,676,030,841</b>

## Appendix IV (a) – Spending Categories by Beneficiary Population 2008

Botswana NASA

Jan to December 2008

Spending Categories by Beneficiary Populations

	People living with HIV	Other Key populations	Specific 'accessible' populations	General population	Non- targeted interventions	Targeted populations not elsewhere classified	Grand Total
ASC Categories	Pula	Pula	Pula	Pula	Pula	Pula	Pula
ASC.01 Prevention	1,273,488	20,758,397	24,236,325	138,858,842	22,958,594	2,085,614	210,171,260
ASC.02 Care and treatment	1,099,537,435	-	10,325,149	43,872,016	8,937,165	8,294	1,162,680,059
ASC.03 Orphans and vulnerable children (OVC)	-	542,300,300	2,783,671	340,051	3,634,318	-	549,058,340
ASC.04 Programme management and administration	18,156,939	59,916	8,473,368	16,897,460	296,318,990	101,238	340,007,911
ASC.05 Human resources	12,661,462	-	11,926,343	32,710,775	5,764,995	10,788	63,074,363
ASC.06 Social protection and social services (excluding OVC)	-	-	-	382,581	-	-	382,581
ASC.07 Enabling environment	202,950	-	825,738	8,927,825	2,798,122	-	12,754,635
ASC.08 HIV and AIDS-related research (excluding operations research )	-	-	1,353,333	3,218,555	16,019,807	-	20,591,695
<b>Total</b>	<b>1,131,832,274</b>	<b>563,118,613</b>	<b>59,923,927</b>	<b>245,208,105</b>	<b>356,431,991</b>	<b>2,205,934</b>	<b>2,358,720,844</b>



## Appendix IV (b) – Spending Categories by Beneficiary Populations 2007

Botswana NASA

Jan to December 2007

### Spending Categories by Beneficiary Populations

	People living with HIV	Most-at- risk populations	Other Key populations	Specific 'accessible' populations	General population	Non-targeted interventions	Targeted populations not elsewhere classified	Grand Total
ASC Categories	Pula	Pula	Pula	Pula	Pula	Pula	Pula	Pula
ASC.01 Prevention	2,232,179	222,337	19,051,303	21,863,575	127,193,853	40,769,951	567,975	211,901,173
ASC.02 Care and treatment	929,492,074	-	-	13,956,308	58,299,750	10,789,498	3,930	1,012,541,560
ASC.03 Orphans and vulnerable children (OVC)	-	-	489,200,749	188,785	1,167,301	944,730	-	491,501,565
ASC.04 Programme management and administration	13,516,539	-	-	3,680,582	19,351,270	234,742,633	-	271,291,024
ASC.05 Human resources	572,151	-	-	12,596,876	25,606,456	7,518,428	-	46,293,911
ASC.06 Social protection and social services (excluding OVC)	364,053	-	-	-	-	-	-	364,053
ASC.07 Enabling environment	958,398	-	-	1,114,954	7,631,755	2,036,234	-	11,741,341
ASC.08 HIV and AIDS-related research (excluding operations research )	320,006	-	-	1,398,845	-	-	-	1,718,851
<b>Total</b>	<b>947,455,400</b>	<b>222,337</b>	<b>508,252,052</b>	<b>54,799,925</b>	<b>239,250,385</b>	<b>296,801,474</b>	<b>571,905</b>	<b>2,047,353,478</b>

## Appendix IV (c) – Spending Categories by Beneficiary Populations 2006

Botswana NASA

Jan to December 2006

### Spending Categories by Beneficiary Populations

	People living with HIV	Other Key populations	Specific 'accessible' populations	General population	Non-targeted interventions	Targeted populations not elsewhere classified	Grand Total
ASC Categories	Pula	Pula	Pula	Pula	Pula	Pula	Pula
ASC.01 Prevention	1,173,442	46,868,516	13,663,111	71,959,022	10,003,430	316,186	143,983,707
ASC.02 Care and treatment	772,171,867	-	7,117,350	94,388,732	21,495,657	-	895,173,606
ASC.03 Orphans and vulnerable children (OVC)	-	296,404,856	-	1,064,092	-	-	297,468,948
ASC.04 Programme management and administration	71,970,124	24,908	1,689,610	8,538,174	208,287,788	2,910	290,513,514
ASC.05 Human resources	5,386,171	2,195	11,710,021	15,034,990	9,801,515	-	41,934,892
ASC.06 Social protection and social services (excluding OVC)	40,294	-	10,000	250	-	-	50,544
ASC.07 Enabling environment	2,500	-	757,377	3,585,851	2,126,115	2,643	6,474,486
ASC.08 HIV and AIDS-related research (excluding operations research )	-	-	-	9,355	421,791	-	431,146
	<b>850,744,398</b>	<b>343,300,475</b>	<b>34,947,469</b>	<b>194,580,466</b>	<b>252,136,296</b>	<b>321,739</b>	<b>1,676,030,843</b>

## Appendix V – Sources of Data

			Years Covered		
	Source of Data	Nature of Spending Data	2006	2007	2008
<b>PUBLIC</b>					
ARV Programme	NACA	Actual	Yes	Yes	Yes
	MLG - Councils	Actual	Yes	Yes	Yes
	MOH - ARV Drugs	Estimate	Yes	Yes	Yes
PMTCT	MOH Expenditure	Actual	Yes	Yes	Yes
	MLG - Councils	Actual	Yes	Yes	Yes
	MOH - Drugs	Estimate	Yes	Yes	Yes
Laboratory Monitoring	MOH/BHP	Estimate	Yes	Yes	Yes
DMSAC Activities	NACA	Actual	Yes	Yes	Yes
Orphan Care	MLG - Councils	Actual	Yes	Yes	Yes
Patient Care	MOH	Estimate	Yes	Yes	Yes
AIDS at the Workplace	NACA	Actual	Yes	Yes	Yes
IEC	NACA	Actual	Yes	Yes	Yes
IDCC	NACA	Actual	Yes	Yes	Yes
STI	MOH	Actual	Yes	Yes	Yes
CHBC	MLG - Councils	Actual	Yes	Yes	Yes
IPT	MOH	Estimate	Yes	Yes	Yes
Epidemiology Research	NACA	Actual	Yes	Yes	Yes
Ministry of Health - Department of HIV and AIDS	MOH	Actual	Yes	Yes	Yes
NACA Admin Expenditure	NACA	Actual	Yes	Yes	Yes
<b>International Organizations</b>					
Global Fund	Recipients	Actual	Yes	Yes	Yes
Forum Syd	Forum Syd	Actual	Yes	Yes	Yes
PEPFAR	BOTUSA/NACA	Actual	Yes	Yes	Yes
UNICEF	UNICEF	Actual	Yes	Yes	Yes
UNAIDS	UNAIDS	Actual	Yes	Yes	Yes
UNDP	UNDP	Actual	Yes	Yes	Yes

			Years Covered		
	Source of Data	Nature of Spending Data	2006	2007	2008
UNFPA	UNFPA	Actual	Yes	Yes	Yes
WHO	WHO	Actual	Yes	Yes	Yes
ACHAP	ACHAP	Actual	Yes	Yes	Yes
BHP Research	BOTUSA	Transfers	Yes	Yes	Yes
PSI	PSI	Actual	Yes	Yes	Yes
Pathfinder	Sub-recipients	Actual	Yes	Yes	Yes
NASTAD	NASTAD	Transfers	Yes	Yes	Yes
KNVC Foundation	BOTUSA	Transfers	Yes	Yes	Yes
John Hopkins University (JPIEGU)	BOTUSA	Transfers	Yes	Yes	Yes
Family Health International	Sub-recipients	Actual	Yes	Yes	Yes
Academy for Educational Development (AED)	AED	Actual	Yes	Yes	Yes
SCMS - Crown Agents	SCMS	Actual	Yes	Yes	Yes
John Hopkins University	BOTUSA	Transfers	Yes	Yes	Yes
PCI	Sub-recipients	Actual	Yes	Yes	Yes
American Society of Microbiology	BOTUSA	Transfers	Yes	Yes	Yes
Baylor College of Medicine	BOTUSA	Transfers	Yes	Yes	Yes
IDM*	BOTUSA	Transfers	Yes	Yes	Yes
Safe Blood 4 Africa	BOTUSA	Transfers	Yes	Yes	Yes
University of California San Francisco	BOTUSA	Transfers	Yes	Yes	Yes
University Research Corporation	BOTUSA	Transfers	Yes	Yes	Yes
University of Pennsylvania	BOTUSA	Transfers	Yes	Yes	Yes
John Snow International (JSI)	Actual	JSI	Yes	Yes	Yes
University of Pennsylvania	BOTUSA	Transfers	Yes	Yes	Yes
University of Washington (I - TECH)	Actual	I-TECH	Yes	Yes	Yes
<b>Local NGOs and CBOs</b>					
BONELA	BONELA	Actual	Yes	Yes	Yes
BONEPWA	BONEPWA	Actual	Yes	Yes	Yes
BOCAIP	BOCAIP	Actual	Yes	Yes	Yes
BBCA	BBCA	Actual	Yes	Yes	Yes
BONASO	BONASO	Actual	Yes	Yes	Yes
Tepelopele	Tepelopele	Actual	Yes	Yes	Yes

			Years Covered		
	Source of Data	Nature of Spending Data	2006	2007	2008
BOCONGO	BOCONGO	Actual	Yes	Yes	Yes
Humana People to People	Humana People to People	Actual	Yes	Yes	Yes
BOFWA	BOFWA	Actual	Yes	Yes	Yes
BNYC	BNYC	Actual	Yes	Yes	Yes
YOHO	YOHO	Actual	Yes	Yes	Yes
Otse Home Based Care (OHBC)	OHBC	Actual	Yes	Yes	Yes
BORNUS	BORNUS	Actual	Yes	Yes	Yes
Hope Worldwide	Hope Worldwide	Actual	Yes	Yes	Yes
Makgabaneng	Makgabaneng	Actual	Yes	Yes	Yes
PACT	PACT	Actual	Yes	Yes	Yes
Kothatso	Kothatso	Actual	Yes	Yes	Yes
Tarisanyo	Tarisanyo	Actual	Yes	Yes	Yes
YWCA	YWCA	Actual	Yes	Yes	Yes
CEYOHO	CEYOHO	Actual	Yes	Yes	Yes
HRDC	HRDC	Actual	Yes	Yes	Yes
COCEPWA	COCEPWA	Actual	Yes	Yes	Yes
Masiela Trust	Masiela Trust	Actual	Yes	Yes	Yes
Bana Ba Letsatsi	Bana Ba Letsatsi	Actual	Yes	Yes	Yes
Paka le masa Support Group	Paka le masa Support Group	Actual	Yes	Yes	Yes
Love Pasture	Love Pasture	Actual	Yes	Yes	Yes
Women's Against Men	Women's Against Men	Actual	Yes	Yes	Yes
<b>Profit Making Institutions</b>					
BPOMAS	BPOMAS		Yes	Yes	Yes
Debswana	Debswana		Yes	Yes	Yes
BOMAID	BOMAID		Yes	Yes	Yes
BNPC	BNPC		Yes	Yes	Yes
BPC	BPC		Yes	Yes	Yes
KBL	KBL		Yes	Yes	Yes
FNB	FNB		Yes	Yes	Yes
BBCA	BBCA		Yes	Yes	Yes

			Years Covered		
	Source of Data	Nature of Spending Data	2006	2007	2008
Associated Fund Administration (AFA)	AFA		Yes	Yes	Yes

## APPENDIX VI

### Form 1 – Source of Funds

Year of the expenditure estimate: _____ (NB. Please use one form per year)		
<b>Objectives of the form:</b> <ol style="list-style-type: none"> <li>I. To identify the origin of the funds used or managed by the institution during the year under study.</li> <li>II. To identify the recipients of those funds.</li> </ol>		
Name of the Institution:		
1. Financial Year: (if not calendar year, please ask for quarterly expenditure reports)		
2. Person to Contact (Name and Title):		
3. Address:		4. E-mail:
5. Phone:		6. Fax:
<b>Type of institution:</b> Select category of institution with an "X".	6.1 Central government	
	6.2 Provincial government office	
	6.3 District government office	
	6.4 Private-for-profit national / business	
	6.5 Private-for-profit international	
	6.6 National / local NGO/CBO	
	6.7 International NGO (eg ActionAid, Save the Children)	
	6.8 Bilateral Agency	
	6.9 Multilateral Agency	

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

**7. Destination of the funds (recipients of your 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 (currency)	Funds <u>spent</u>
8.1 Institution: Contact:		
8.2 Institution: Contact:		
8.3 Institution: Contact:		
8.4 Institution: Contact:		
8.5 Institution: Contact:		
8.6 Institution: Contact:		
8.7 Institution: Contact:		
8.8 Institution: Contact:		
8.9 Institution: Contact:		
8.10 Institution: Contact:		
8.11 Institution: Contact:		



<b>TOTAL:</b>		
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**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 of One Unit in Year of Assmnt (& Currency)	TOTAL Monetary Value in Year Assmnt (& Currency)
8.6 Institution:  Contact:			
8.7 Institution:  Contact:			
8.8 Institution:  Contact:			
8.9 Institution:  Contact:			
8.10 Institution:  Contact:			
8.11 Institution:  Contact:			
<b>TOTAL:</b>			

**8. If you know how the funds were spent by your recipients, please complete a Providers form (Form # 2) for each institution to whom you sent funds, in order to gain information on Functions, Beneficiary Populations.**

**9. 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.

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

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

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

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

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

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g. Any other comments, suggestions etc?

**10. Who completed this form?**

**Name:** \_\_\_\_\_ **Position:**

\_\_\_\_\_

**11. Surveyor:**

**12. Date:**        /        / 20\_\_

**Form 2 - Financing Agents**

<b>Year of the expenditure estimate:</b> _____ <b>(NB. Please use one form per year)</b>		
<b>Objectives of the form:</b> To identify the origin of the funds used or managed by the institution during the year under study.		
<b>III.</b> To identify the recipients of those funds.		
<b>Name of the Institution:</b>		
<b>13. Financial Year:</b> <b>(if not calendar year, please ask for quarterly expenditure reports)</b>		
<b>14. Person to Contact (Name and Title):</b>		
<b>15. Address:</b>		<b>16. E-mail:</b>
<b>17. Phone:</b>		<b>18. Fax:</b>
<b>Type of institution:</b> Select category of institution with an "X".	6.10 Central government	
	6.11 Provincial government office	
	6.12 District government office	
	6.13 Private-for-profit national / business	
	6.14 Private-for-profit international	
	6.15 National / local NGO/CBO	
	6.16 International NGO (eg ActionAid, Save the Children)	
	6.17 Bilateral Agency	
	6.18 Multilateral Agency	

**For all AGENTS ask about their operational/ running costs/ overheads and capture these in form 3 under the identified activities.**

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

**Origin and Destination of the funds transferred to other orgs:** List the institutions from which your agency received funds during the year under study, and the organization to whom you transferred those funds.

ORIGIN OF FUNDS		DESTINATION OF FUNDS			
Origins of the funds (Name of the Institution and Person to Contact)	Funds received (Indicate currency, Pula or US\$ or Euros)	Organizations to Whom these Funds were Sent	Amount transferred (Indicate Currency)	Organizations to Whom these Funds were Sent	Amount transferred (Indicate Currency)
7.1 Institution: Contact:		7.1.1		7.1.2	
7.2 Institution: Contact:		7.2.1		7.2.2	
7.3 Institution: Contact:		7.3.1		7.3.2	
7.4 Institution: Contact:		7.4.1		7.4.2	
7.5 Institution: Contact:		7.5.1		7.5.2	

7.6 Institution: Contact:		7.6.1		7.6.2	
7.7 Institution: Contact:		7.7.1		7.7.2	
<b>TOTAL:</b>					

**8. Origins and Destinations of non financial resources (donated goods):** 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 Resource provided & Quantity	Total Monetary Value of Items Provided (& Currency)	Destination of the Non-Financial Goods (Name of the Institution and Person to Contact)	
7.8 Institution: Contact:			7.8.1	7.8.2
7.9 Institution: Contact:			7.9.1	7.9.2
7.10 Institution:				

Contact:			7.10.1	7.10.2
7.11 Institution: Contact:			7.11.1	7.11.2
7.12 Institution: Contact:			7.12.1	7.12.2
<b>TOTAL:</b>				

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

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

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

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

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

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

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

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

n. Any other comments, suggestions etc?

**11. Who completed this form?**

**Name:** \_\_\_\_\_ **Position:**

\_\_\_\_\_

**12. Surveyor:**

**13. Date:**        /        / 20\_\_

### Form 3 – Service Providers

<b>Origin of the information:</b> 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:

<b>Year of the expenditure estimate:</b> _____ (Use separate forms for each year)			
<b>Objectives of data collection from the Provider:</b>			
I. To identify the origin of the funds spent by the provider in the year understudy. II. To identify in which NASA Functions/ activities the funds were spent. III. To identify the NASA Beneficiary Populations for each NASA Function/ activity. <b>IV. To identify the NASA Production Factors for each Function/ activity.</b>			
<b>Will you present the financial data in Botswana Pula (P)?</b>	<b>Yes</b>	<b>No</b>	
<b>If no, will you present the figures in US Dollars? (US\$)</b>	<b>Yes (US\$)</b>	<b>No</b>	<b>Other:</b>
<b>Name of the Provider:</b>			
<b>1. Person to Contact (Name and Title):</b>			
<b>2. Address:</b>		<b>3. E-mail:</b>	
<b>4. Phone:</b>		<b>5. Fax:</b>	
<b>6. Type of institution:</b> 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/CBO/CSO/ FBO/ Churches	
7. National non-profit research agency	
8. International NGO/CSO (eg. ActionAid, Save the Children)	
9. Bilateral Agency	
10. Multilateral Agency	
11. Other (specify):	

**7. Origin of the funds received:** List the institutions that gave your organisation funds which you 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 (Indicate currency for each amount)
7.1 Institution: Contact:	
7.2 Institution: Contact:	
7.3 Institution: Contact:	
7.4 Institution: Contact:	
7.5 Institution: Contact:	
<b>TOTAL:</b>	

**7a. Origin of non financial resources (donated goods):** 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 &	Monetary Value of ONE Item (in Year of Assessment)	Total Monetary Value of Items Received (&
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	Quantity		Currency)
7.6 Institution: Contact:			
7.7 Institution: Contact:			
7.8 Institution: Contact:			
7.9 Institution: Contact:			
7.10 Institution: Contact:			
<b>TOTAL:</b>			

Please indicate the use of these non-financial items (**donated goods**) in the table 8.5 below.

<b>8. Use of the funds your organization received:</b>		
I. Identify and quantify the NASA Functions in which the funds were spent. II. Identify and quantify the NASA Beneficiary Population(s) of each Function. III. Use NASA notebook to classify Functions and Beneficiaries and Populations, using the name and code as they appear in the notebook for their identification.		
<b>8.1 Expenditure of the funds received from "7.1"</b>		
Function (Activity) 1:	District of implementation:	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
Function (Activity) 2:	District of implementation:	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		

<b>Function (Activity) 3:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 4:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
Total Expenditure from the amount from '7.1'		
Total un/overspent from the amount from '7.1'		

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

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<b>8.2 Expenditure of the funds received from "7.2"</b>		
<b>Function (Activity) 1:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 2:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		

<b>Function (Activity) 3:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 4:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
Total Expenditure from the amount from '7.2'		
Total un/overspent from the amount from '7.2'		

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

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<b>8.3 Expenditure of the funds received from "7.3"</b>		
<b>Function (Activity) 1:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 2</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 3:</b>	<b>District of implementation:</b>	Amount spent

		(US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 4:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
Total Expenditure from the amount from '7.3'		
Total un/overspent from the amount from '7.3'		

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

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<b>8.4 Expenditure of the funds received from "7.4"</b>		
<b>Function (Activity) 1:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 2:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 3:</b>	<b>District of implementation:</b>	Amount spent

		(US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 4:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
Total Expenditure from the amount from '7.4'		
Total un/overspent from the amount from '7.4'		

**8.2.a If funds were unspent from '7.4' what are the reasons for under-spending?**

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**NON-FINANCIAL (DONATED) GOODS – INDICATE HOW THESE WERE USED**

<b>8.5 Utilization of the <b>donated goods</b> received from "7.6"</b>		
<b>Function (Activity) 1:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 2:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>8.6 Utilization of the <b>donated goods</b> received from "7.7"</b>		



<b>Function (Activity) 1:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 2:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>8.7 Utilization of the <b>donated goods</b> received from "7.8"</b>		
<b>Function (Activity) 1:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		
<b>Function (Activity) 2:</b>	<b>District of implementation:</b>	Amount spent (US\$ or P)
Total spent on this Activity/ Function:		
Beneficiary Population:		
Beneficiary Population:		

## 9. Additional Qualitative Information Required:

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

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

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c. What are the key bottlenecks to spending?

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

Explain your answer.

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

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

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

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

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h. How could these be addressed or reduced?

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**10. Interviewer:**

**11. Date:**        /        / 20\_\_

