(DRAFT)

NATIONAL AIDS COMMISSION (NAC), MALAWI

JOINT UNITED NATIONS PROGRAMME ON AIDS (UNAIDS)

MALAWI

NATIONAL AIDS SPENDING ASSESSMENT 2007/2008 AND 2008/2009

LEVEL AND FLOW OF RESOURCES AND EXPENDITURES TO CONFRONT HIV/AIDS

Prepared by

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KEY PROJECT PARTNERS

National AIDS Commission;

Ministry of Finance;

Ministry of Health;

Specialised departments of relevant line Ministries and Agencies;

Development partners;

NGOs/CBOs/FBOs working in HIV and AIDS related activities;

UNAIDS providing financial and technical assistance.

THE MALAWI NASA TEAM

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UNAIDS INTERNATIONAL CONSULTANT

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
CBO	Community Based Organisations
CSO	Civil Society Organisation
CSW	Commercial Sex Workers
DFID	Department for International Development.
FBO	Faith Based Organisation
GFATM	Global Fund to fight AIDS, TB and Malaria
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MARP	Most At Risk Populations
MSM	Men having Sex with Men
NAC	National AIDS Commission
NAF	National Action Framework
n.e.c	Not Elsewhere Classified
NGO	Non Governmental Organisation
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis

PLHIV	People Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Project
UNGASS	United Nation General Assembly Special Session on HIV/AIDS
UNHCR	United Nation High Commission for Refugees
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Section 1

Introduction

1.1 Background

Malawi like other countries faced with a high prevalence of HIV and AIDS in the SADC region is feeling the negative impact of the epidemic on levels of its society. Most significantly, AIDS has reduced life expectancy from an estimated 56 years to 36 years presently. The effects of the epidemic on health staff and households is profound and more resources are needed to care for the chronically ill, pay insurance bills, death gratuities and cost of burials. Critical numbers of OVCs add more burden to an otherwise overburdened government. Resources are needed to provide food and education for orphaned children as well as other related costs.

The financial burden on Malawi to combat the HIV and AIDS epidemic is enormous. An estimated 800,000 to 1 million people are living with the disease, including 100,000 children which mean an increased demand for treatment and care services. The national HIV and AIDS response has received substantial funding from donors such as the Global Fund for the Fight against Tuberculosis. HIV and AIDS and Malaria and the World bank's Multilateral AIDS Program (MAP). Development partners in Malawi support national HIV policies by adhering to national priorities in fighting the epidemic. Assistance is given in areas such as empowering leadership, mobilising public, private and civil society, providing strategic information and facilitating access to technical and financial resources. In spite of this, the funding gap for HIV and AIDS activities is growing as the demand for ART increases. Funding shortfalls are expected, as the Global Fund faces an alarming funding gap of US$4 billion based on budget needs through 2010.

It becomes important that funds allocated for HIV and AIDS activities are efficiently used, there are clear measures put in place to monitor resource flows. Indeed, financial resource mobilisation and tracking for the national response is a specific objective in Malawi's Extended National Action Framework (NAF) for the period 2010 to 2012. Undertaking the

National AIDS Spending Assessment (NASA) in Malawi signals the country's readiness to pave the way for a more efficient use of resources for the national response.

1.2 Tracking HIV and AIDS Expenditure

The multi sectoral nature of the national response to HIV and AIDS in Malawi brings together a range of actors from different sectors and a flow of resources mainly from external sources. The funds are not always channelled through the National AIDS Commission (NAC) making it impossible for the NAC to keep track of institutions funding HIV and AIDS activities and those benefiting from these activities. This calls for a resource tracking exercise where all the key stakeholders are mobilised for the tracking of financial flows from all the different sources down to the level of service utilization.

In 2006, costing of the National HIV and AIDS Framework was undertaken in the context of Universal Access and consensus was reached on the amount of financial resources needed to accelerate and achieve the national goal of reducing HIV prevalence and mitigate the effects of AIDS. This exercise was in 2009 updated, with costing of the extended NAF for the period 2010–2012. While this is a necessary and useful process, the implementation of the costed programme will be ineffective in the absence of adequate and sustainable tracking of actual expenditures.

In 2005, efforts to track AIDS spending was done, where the Ministry of Health and the National AIDS Commission (NAC), in collaboration with Malawi Economic Justice Network (MEJN), Action Aid International Malawi (AAIM), UNAIDS, and Partners for Health Reform Plus (PHR*plus*) conducted a National Health Accounts (NHA) and HIV and AIDS Resource Tracking (HART) exercise. This was aimed at estimating the total amount of health and non-health HIV and AIDS spending in Malawi (both public and private); and to map out and describe the flow of funds from sources to ultimate users. The exercise was however skewed towards health spending and therefore lacked a framework and tools for undertaking a comprehensive analysis of actual expenditures for both health and non-health HIV and AIDS spending.

This has been identified as a gap requiring development of a resource tracking mechanism that aligns with the NASA classification, which allows expenditure tracking for the overall

HIV and AIDS (both health and non-health). Such a process would assist Government to have information on resource commitments, disbursements, expenditure categories and actual absorption levels, which are critical for improved resource planning. The results of the NASA on the other hand would allow implementing partners to anticipate needs and strategize for identified funding gaps.

1.3 National AIDS Spending Assessment

The National AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. It describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease. This is tracked by financing source whether it is public, private or foreign and among the different providers and beneficiaries (target groups). It provides a framework and tools for undertaking a comprehensive analysis of actual expenditures for HIV and AIDS which can either be a health or non-health activity such as social mitigation, education, labour, justice and other sectors related to HIV and AIDS.

1.4 Study Objectives

The purpose of the exercise is to conduct a systematic assessment of HIV and AIDS financial, expenditure and actual absorption levels which are critical for improved resource planning, through the application of NASA. This involves developing and securing consensus on the process, methodology and tools to retrospectively collect data in a systematic and comprehensive manner, to assess expenditures on HIV and AIDS interventions including out-of-pocket expenditures at household level.

The specific study objectives are to:

- Advocate with relevant stakeholders from Government Ministries, Development Partners, Civil Society Organisations on the purpose and need of NASA and secure their buy-in;
- Develop tools and systems for tracking of HIV and AIDS resources, which can also be utilized on an on-going basis by the Government of Malawi and its key implementing partners;

- Undertake a full NASA, collecting financial data for the tracking of resources including commitments, disbursements and expenditures;
- Prepare a comprehensive report and synthesize this data into strategic information to inform decision-making and for reporting;
- As part of the full NASA report, propose ways by which the Government of Malawi can institutionalize NASA or a version of NASA, which is able to routinely and systematically track HIV and AIDS commitments, disbursements and expenditures; and
- Prepare a concise advocacy document which can be used as a basis for advocacy efforts of NAC and other key stakeholders for resource mobilization as well as the allocation of financial resources for the national HIV and AIDS response.

1.5 Scope of Study

The NASA will cover the two financial years namely 2007/08and 2008/09, and will include the tracking of expenditure among public sources, external sources and private sources (business, insurances, out-of-pocket). Spending at the national and regional levels will be captured, and where possible, spending at regional level will be reported separately so as to allow for sub-national comparative analysis. The beneficiaries (PLHIV, vulnerable groups, MARPs, etc) of the spending shall be identified and the production factors included. The expenditure data will be collected in Malawi kwacha and be converted to United States Dollars using the same rate of exchange used by NAC Finance Department. The application of the NASA will be done according to the priority areas of the Malawi HIV and AIDS response, as defined in NAF II (2010-2012).

The major sources of data/information include (see Table 3.1 for a more comprehensive list of sources):

(i) National AIDS Commission (NAC);
(ii) Ministry of Health (MOH);
(iii) The Global Fund;
(iv) Selected major donors; and
(v) NGOs/CBOs/FBOs involved in HIV and AIDS related activities.

1.6 Structure of Report

The report is organized in six sections. Following the introductory section is section two which gives an overview of the HIV and AIDS situation in Malawi and the National response (the National Strategic Framework for HIV and AIDS) as well as funding mechanism for HIV and AIDS resources. The third section outlines the methods and techniques applied, as well as the study process, assumptions and limitations faced. The fourth and fifth section contains the results and discussions of the NASA estimates and beneficiary spending, respectively. Summary and recommendations are presented in section six.

Section 2

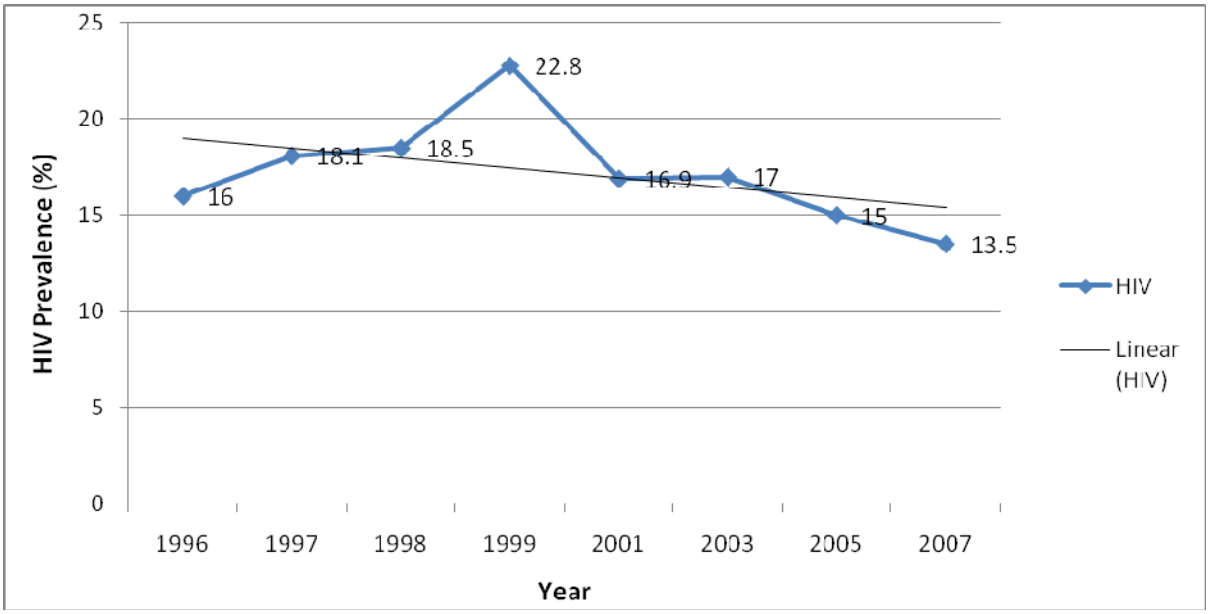
Country Background and HIV and AIDS Situation

2.1 HIV and AIDS Situation in Malawi

2.1.1 Key Features of HIV and AIDS in Malawi

The first AIDS case was reported in 1985 and now, Malawi is experiencing the effects of a mature and generalized HIV epidemic. The trends of HIV prevalence among people aged 15-49 years old increased from 16.0% in 1996 to 22.8% in 1999. It has since been declining and in 2007, the estimation for this age group was 13.5% (Figure 2.1). While there is a decline in prevalence of HIV, the current estimated 12% prevalence is still very high.

Figure 2.1: Trends in HIV Prevalence among pregnant women aged 15-49, 1994 - 2007



Source: Munthali A, Maleta K, Chitonya D., Ndawala J. (2009). The HIV and AIDS epidemic in Malawi: Where is it going? National AIDS Commission.

There are however variations in the prevalence of HIV by age, gender and geographic location. In 2005 the prevalence of HIV was 12.6% among men aged between 15-49 years and for women it was 15.4%. There was a general decline of 2.3% for men to 10.3% and for women it declined by 1.9% to 13.5%. In general, HIV prevalence has tended to be high in the

Southern Region and lowest in the Northern Region. The prevalence rate has remained consistently high in urban centres compared to rural centres. However, there has been a general decline from 15.9% in 2005 to 13.2% in urban areas. The situation in the rural areas is not promising as the prevalence has remained more or less the same (although it has increased slightly) from 10.2% in 2005 to 10.6%.

2.1.2 Contributing Factors to HIV Infections in Malawi

However, the majority of new infections occur in sero-discordant, monogamous couples and among partners of people who have multiple concurrent partners. Mother-to-child transmission is estimated to account for almost a quarter of new infections. A small percentage of infections are transmitted through blood transfusions and injections with contaminated medical injections and skin piercing instruments[1].

Several socio-cultural factors influence the HIV epidemic in Malawi. One such driver is the high prevalence of multiple and concurrent sexual partners. A second driver is low condom use; followed by a high prevalence of STIs in the general population. The low socio-economic status of women and gender inequalities are also contributing forces of the epidemic.

2.2 National Policy on HIV and AIDS

The Malawi Growth and Development Strategy (MGDS) 2006 to 2011 is the overarching development strategy that underpins all the various development policies. The MGDS identifies the 'Prevention and Management of nutrition Disorders, HIV and AIDS' as a major priority area for attention. The National HIV and AIDS Policy[2] developed in 2003 lays down the administrative and legal framework for all programmes and interventions in HIV and AIDS in Malawi. These programmes are clearly outlined in the Malawi HIV and AIDS National Action Framework (NAF) 2005-2009[3]. Currently, there are efforts to pass a HIV and AIDS Bill to ensure the rights of PLHIV and vulnerable people; and enable effective prevention and care interventions.

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[1] Munthali A, Maleta K, Chitonya D., Ndawala J. (2009). The HIV and AIDS epidemic in Malawi: Where is it going? National AIDS Commission.

[2] Government of Malawi, "National HIV/AIDS Policy: A Call to Renewed Action", Lilongwe, 2003.

[3] National AIDS Commission (2005). Malawi HIV and AIDS National Action Framework (NAF) 2005-2009.

2.3 The National Strategic Framework

The National HIV and AIDS Action Framework 2005-2009 (NAF II) was developed after the End of Term Review (ETR) of the National Strategic Framework for HIV and AIDS activities 2000-2004 (NAF I) to identify key achievements, challenges, and emerging issues in the management of the HIV and AIDS response. This enabled the country to redefine the key activities, targets and indicators that should be focussed on during the next five years. Priorities were given to address the emerging issues in the fight against HIV and AIDS that occurred after the first NSF (NSF I) was developed. The NAF II was developed to help translate the several national policies and guidelines that were developed during the NSF into action and take advantage of the conducive policy and planning environment. Malawi is supposed to use the NAF to address the Millennium Declaration and the Millennium Development Goals (MDGs) that are stipulated in the Declaration of Commitment of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS). The sixth goal of MDGs puts emphasis on halting and reversing the trend in the spread of HIV infection by 2015. From the UNGASS, Malawi aims, with the support of the NAF, to reduce HIV prevalence among 15-24 year old pregnant women, increase the condom use rate, and reduce the number of orphaned by HIV and AIDS.

The goal of NAF II is to prevent the spread of HIV infection among Malawians, provide access to treatment and care for People Living with HIV (PLHIV) and mitigate the health, socio-economic and psychosocial impacts of HIV and AIDS on individuals, families, communities and the country. This compliments the overall health sector's goal to raise the health status of all Malawians by reducing the incidence of illness and death through developing a sound delivery system capable of promoting health, preventing, reducing and curing disease, protecting life and fostering general well being and productivity.

NAF II focuses on a multi-sectoral approach to the control of HIV and AIDS, with an overall goal and eight pillars, which at the same time constitute the key priority areas of the NAF. The overall goal of the NAF was based on the goal of the National HIV and AIDS Policy, which brings to the forefront the emerging issue of treatment in the response. The NAF guides the implementation of a multi-sectoral response from 2005 to 2009 and recognizes the importance of high level political support and commitment at all levels; partnerships with a wide range of stakeholders; a coordinated response based on the principle of the "Three

Ones"[4]; consideration for gender, stigma and discrimination and involvement of PLHIV; the use of cost-effective, evidence based interventions.

The eight NAF II priority areas: (i) Prevention and behaviour change, (ii) Treatment, care and support, (iii) Mitigation of socio-economic and psychosocial impact, (iv) Mainstreaming, partnerships and capacity building, (v) Research and development, (vi) Monitoring and evaluation, (vii) Resource mobilization, tracking and utilization and (viii) National policy coordination and programme planning.

The Malawi Extended National Action Framework for the period 2010 to 2012 (NAF III) follows after the NAF 2005-2009 (NAF II). The goal of the Extended NAF is to prevent the spread of HIV infection among Malawians, provide access to treatment to PLHIV and mitigate the health, socio-economic and psychosocial impacts of HIV and AIDS on individuals, families, communities and the nation. The extended NAF (NAF III) has seven pillars as listed below:

1. Prevention and behaviour change
2. Treatment, care and support
3. Impact mitigation
4. Mainstreaming and decentralisation
5. Research, monitoring and evaluation
6. Resource mobilisation and utilisation
7. Policy and Partnerships

2.4 Review of the National Response

There have been several achievements and challenges to the national response such as universal awareness of HIV and AIDS amongst the general population and near universal blood transfusion safety[5]. Successes have been recorded in the scale up of HTC and ART with over 147,000 people alive and on ART out of 276,161 of those in need of ART as of December 2008.[6] In spite of these efforts, overall HIV prevalence remains very high and

[4] UNAIDS, The "Three Ones' – Principles for the Coordination of National AIDS Responses , 2003; www.unaids.org/UNA-docs/Three Ones Key Principles_en.pdf

[5] National Aids Commission, Midterm Review of *Malawi HIV and AIDS National Action Framework (NAF) 2005-2009*, February 2009

[6] Malawi Extended National HIV and AIDS Action Framework (NAF), 2010 - 2012

there are pockets where it is rising rapidly potentially negating the successes chalked. Delusions about HIV transmission, and cultural and gender disparities continue to promote HIV transmission. Evidently, prevention activities need to be increased to keep up with treatment and care efforts but a critical health worker shortage to provide HIV prevention, care and treatment and support services threatens to make this unattainable.

2.5 Institutional Arrangements

National AIDS Commission (NAC)

The approval of the first National HIV and AIDS Strategic Framework (NAF I) in 2000 saw the establishment of the National AIDS Commission (NAC) as a national coordinating authority. The NAC provides leadership and coordination of the response. Principally the NAC guides the development and implementation of the NAF and facilitates the involvement of all key stakeholders through the planning and implementation of HIV and AIDS related activities.

The Office of the President and Cabinet (OPC)

The President of Malawi provides overall leadership on matters relating to HIV and AIDS. He/She appoints the NAC Board of Commissioners. The Department of Nutrition, HIV and AIDS in the OPC is the key national agency responsible for HIV and Nutrition. Other government ministries such as the MOH provides technical direction and service delivery in biomedical areas of prevention and care supported by other central and line ministries such as the Ministry of Finance. Local authorities coordinate the implementation of the national response at the district, city and community levels.

2.6 HIV and AIDS Funding Sources and Funding Modalities

The principal receipts of the National AIDS Commission are grants from funding partners and the Government of Malawi (GOM) (see Figure 2.2). Other funds received by the NAC are internally generated funds from the sale of tender documents, bank interest, among others.

Flow of funds depends on the terms of the Memorandum of Understanding (MOU) between the GOM and Funding Partners. Funding Partners either contribute to a pooled fund that generally caters for programmes agreed in the Integrated Annual Work Plan (IAWP) and Budget, or contribute to discrete funds which are earmarked for specific programmes. The NAC and Funding Partners review progress against the IAWP on a quarterly basis and further

disbursements are made on the basis of Financial Monitoring Reports (FMRs) and Disbursement requests.

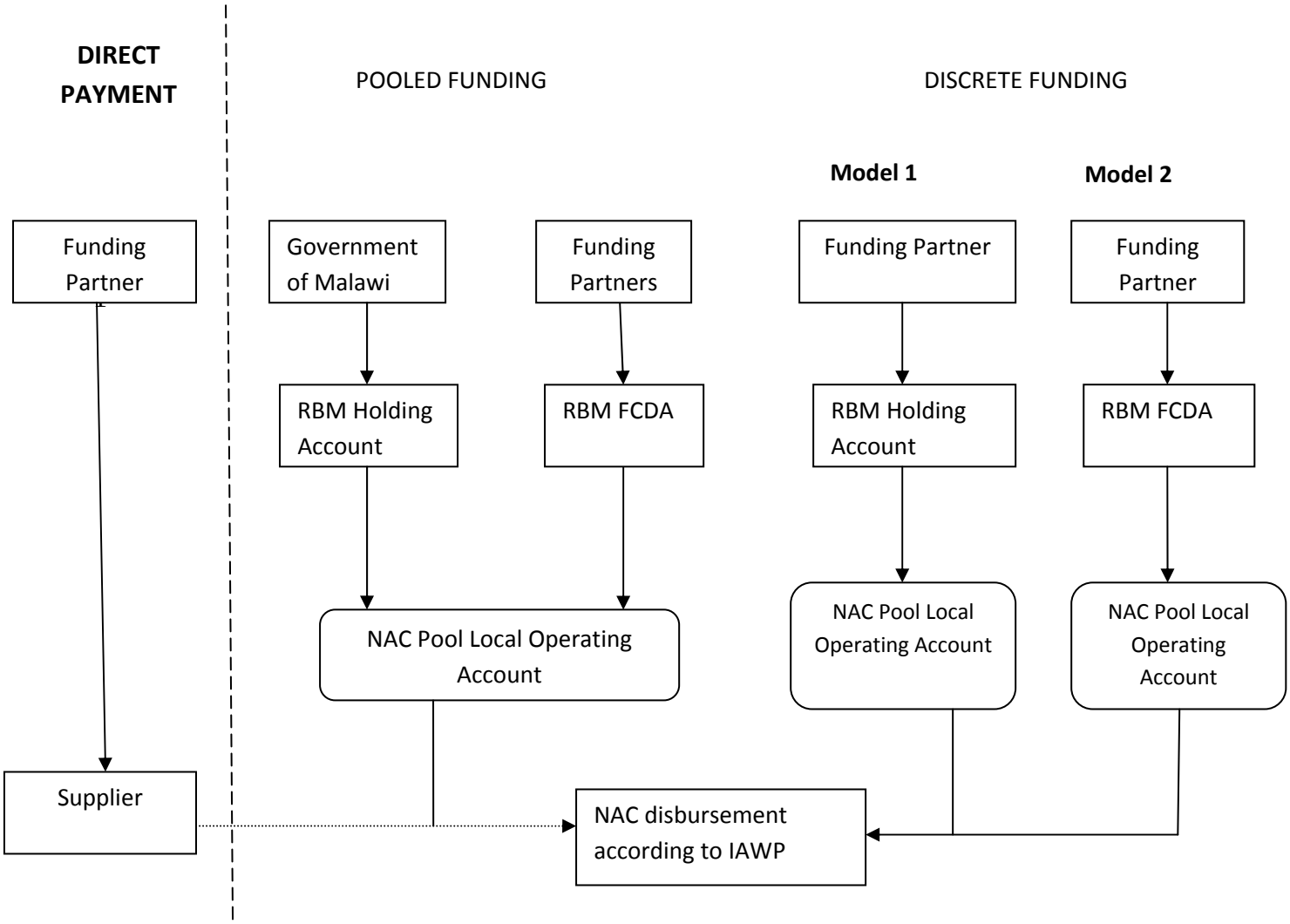
2.6.1 Discrete Funds

Discrete Funding partners deposit their contributions for eligible activities to earmarked U.S dollar and/or Malawi Kwacha accounts, in accordance with their bilateral agreements. Depending on the MOU, the NAC may either open a designated Holding Account or a Foreign Currency Denominated Account (FCDA) with the Reserve Bank of Malawi (RBM) into which funds received are deposited. Funds are withdrawn monthly by the NAC from these earmarked accounts for programme implementation.

2.6.2 Pooled Funds

Pooled Funding Partners deposit their share of the projected funding requirements in a U.S dollar financing account held in the RBM. In addition to the FCDA held in the RBM, GOM counterpart funds are held in a Holding Account in RBM. A pooled Malawi Kwacha operating account is held in a commercial bank to cater for draw downs from both FCDA and RBM Holding Account. Here again, funds are drawn on a monthly basis to allow for the implementation of the IAWP.

Figure 2.2: Funds Flow Mechanism for HIV and AIDS Activities



Source: Financial Management & Accounting Systems Manual, National AIDS Commission, November 2008

Section 3

Methodology

3.1 Overall Approach

The NASA methodology allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors to confront the HIV and AIDS epidemic. This accounting must be exhaustive, covering entities, services and expenditures; periodic, as a result of a continuing recording, integration and analyses, to produce, ideally, annual estimates; systematic, as the structure of the categories and records/reports must be consistent over time and comparable across countries[7].

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

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

This methodology employs double entry tables – matrices - to represent the origin and destination of resources, avoiding double-counting the expenditures by reconstructing the

[7] UNAIDS. 2006. National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level.

resource flows at every transaction point, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS related activities. In addition to establishing a continuous information system of the financing of HIV and AIDS, NASA facilitates a standardized reporting of indicators monitoring progress towards the achievement of the target of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS I & II) (UNAIDS, 2006).

3.2 Data Collection

Preparatory Mission

There was individual consultation with the key stakeholders in HIV and AIDS activities in Malawi to inform them of the NASA process and the benefits that could be derived from conducting a NASA. This was followed with a training workshop organised for participants from the National AIDS Commission (NAC) and other key stakeholders such as the Ministry of Health, Ministry of Education, and other relevant Ministries and the local consultant and his team of data collectors. The aim of the workshop was to enhance participants understanding of the NASA as a resource tracking tool, including its benefits and uses. They were trained on the standard NASA tools (data collection forms, resource tracking system) that will enable collection of regional/district data, public/private sector data and donor. Participants also familiarized themselves with the use of the NASA Resource Tracking System (NASA RTS) software by going through a number of case studies. After the training the local consultant and his team of data collectors were set the task of administering the questionnaires to relevant agencies and institutions.

Obtaining Permissions

Permission from the Directors of the selected Ministries involved was required in order to access the data. Permissions were also required for all the external and internal agencies working in HIV and AIDS related areas. The letters were sent by the NAC to the relevant agencies.

Database of all Stakeholders

A database of all the stakeholders involved in HIV and AIDS related activities by funding source, financing agents and providers of services, was developed using information provided by participants at the training workshop.

Literature Review

In preparation for the NASA data collection analysis, the team relied on background information and literature regarding the HIV and AIDS epidemiological profile of Malawi, the surveillance findings, and the national response from the NAC. A number of key documents such as the following were analysed: relevant National AIDS Commission (NAC) documents, National HIV and AIDS Policies, National HIV and AIDS Strategic Framework, national HIV and AIDS budgets and expenditure reports, among others.

Development and Administering of Questionnaires

The data collection forms used for the Malawi NASA were modified to suit the Malawian national system during the training workshop. It was agreed that qualitative questions regarding funding processes and challenges be included to help identify some of the major bottlenecks faced by providers of funds and implementers of HIV and AIDS programmes. Generally the questionnaires were too complicated to be self-administered so data collectors scheduled times to meet with the focal persons of the institutions which had been identified. Data collection was done over a five week period from 11th January 2010 to 13th February 2010.

3.2.1 Sources of Data

Table 3.1 Lists of Institutions and Status of Data Collected on HIV and AIDS Spending, 2007/2008 and 2008/2009

Institution	2007/2008	2008/ 2009
External/International Institutions		
AFRICARE	❖	❖
AFRICAV DEVELOPMENT BANK		✓
AMERICAN INSTITUTE FOR HEALTH	❖	-
ASSOCIATION SCHOOL OF PUBLIC HEALTH	❖	❖
ACADAMY FOR EDUCATIONAL DEVELOPMENT	❖	-
BAYLOR COLLEGE OF MEDICINE CHILDRENS FOUNDATION (BCMCF)	-	❖
BAOBAB HEALTH PARTNERSHIP	❖	❖
CARE INTERNATIONAL	-	❖
CATHOLIC RELIEF SERVICES (CSR)	✓	✓
CENTRE FOR COMMUNITY ORGANISATION & DEVELOPMENT (CCOD)	❖	❖
CHRISTIAN AID	✓	✓
CPAR	✓	✓
DIGNITAS	❖	❖
DANISH CHURCH AID	✓	✓
Dev Tech	❖	-
DFID	✓	✓
EUROPEAN UNION	✓	✓
THE ELIZABETH GLAZER PAEDIATRIC AIDS FOUNDATION (EGPAF)	❖	❖
FAMILY HEALTH INTERNATIONAL (FHI)	-	✓
FAO	❖	❖
GTZ	-	✓
GH Tech	❖	-
GOAL MALAWI	o	o
HOWARD UNIVERSITY	❖	❖
INTERNATIONAL LABOUR ORGANISATION (ILO)	❖	❖
IRISH AID	-	❖
INTRAHEALTH INTERNATIONAL Inc	-	❖
JOHN HOPKINS UNIVERSITY CENTRE FOR COMMUNICATIONS PROGRAMME	❖	❖
JOHN SNOW Inc	❖	❖
JHPIEGO	-	❖
KNVC TB FOUNDATION	-	❖
LAND O'LAKES	-	❖
MSF-BELGIUM	-	❖

Institution	**Year 2007 -2008**	**Year 2008 – 2009**
MACRO INTERNATIONAL	-	❖
NORWAY (THE KINGDOM OF NORWAY)	-	✓
NORWEGIAN CHURCH AID	❖	❖
OXFARM	✓	✓
PACT Inc	❖	❖
PACT MALAWI	❖	❖
PARTNERS IN HOPE	-	❖ /NAC
PARTNERSHIP FOR CHILDHEALTHCARE Inc	❖	❖
PLAN MALAWI	❖	❖
PROGRESSION	-	❖
PROJECT MALAWI	✓	
PROJECT CONCERN INTERNATIONAL	-	❖
PROJECT PEANUT BUTTER	-	❖
POPULATION SERVICES INTERNATIONAL	❖	❖
PROFESSIONAL AND SCIENTIFIC ASSOCIATION	❖	
SAVR THE CHILDREN	❖	❖
SWAM	-	❖
UNAIDS	-	❖
UNICEF	✓	✓
UNFPA	✓	✓
UNDP	✓	✓
UNIVERSITY OF WASHINGTON	❖	❖
UNIVERSITY OF NORTH CAROLINA	-	❖
THE USG (USAID, PEPFAR, CDC)	✓	✓
WORLD FOOD PROGRAMME (WFP)	✓	✓
WORLD BANK	✓	✓
WORLD HEALTH ORGANISATION (WHO)	❖	❖
WORLD VISION	❖	❖
Public Institutions		
MALAWI POLICE	❖	❖
MALAWI PRISON	❖	❖
MALAWI DEFENCE FORCE	❖	
MALAWI REVENUE AUTHORITY	-	#/NAC
M INISTRY OF LOCAL GOVERNMENT	❖	❖
MINISTRY OF AGTRICULTURE	-	#/NAC
MINISTRY OF EDUCATION SCIENCE AND TECHNOLOGY	❖	❖
MINISTRY OF GENDER	#/NAC	#/NAC
MINISTRY OF HEALTH	❖	❖
MINISTRY OF YOUTH DEVELOPMENT AND SPORTS	N/A	N/A
MINISTRY OF CULTURE AND TOURISM	N/A	N/A
DEPARTMENT OF NUTRITION, HIV AND AIDS	N/A	N/A
MINISTRY OF WOMEN, CHILDREN AND COMMUNITY DEVELOPMENT	N/A	N/A

Institution	Year 2007 -2008	Year 2008 – 2009
MINISTRY OF INFORMATION	N/A	N/A
MINISTRY OF FINANCE	N/A	N/A
BLANTYRE WATER BOARD	❖	❖
LILONGWE WATER BOARD		❖
CENTRAL REGION WATER BOARD		#/NAC
NATIONAL AIDS COMMISSION	❖	❖
UNIVERSITY OF MALAWI	#/NAC	#/NAC
UNIVERSITY OF MALAWI COLLEGE OF MEDICINE		❖
NATIONAL BANK OF MALAWI		❖
Private Institutions		
ALLIANCE ONE TOBACCO (MW)Ltd	❖	❖
LIMBE LEAF TOBACCO		✓
MALAWI BUSINESS COALITION AGAINST AIDS	❖	❖
MALAWI BLOOD TRANSFUSION	❖	❖
SUNBIRD TOURISM		#/NAC
MALAWI RURAL FINANCE COMPANY	❖	❖
MALAWI CONGRESS OF TRADE UNION	❖	❖
UNILEVER SOUTH EAST Ltd		N/A
MALAWI RED CROSS		N/A
SOUTHERN BOTTLERS		o
CATHOLIC UNIVERSITY OF MALAWI		N/A
LIGHTHOUSE	❖	❖
MUSLIM ASSOCIATION OF MALAWI		#/NAC
ACTIVE YOUTH INTERVENTION FOR SOCIAL ENRICHMENT	❖	❖
MACRO	❖	❖
PAKACHERE HEALTH PROMOTION & COMMUNICATION	❖	❖
CONSOL HOMES	❖	❖
FAMILY PLANNING ASSOCIATION	❖	❖
CHISOMO CHILDRENS CLUB	❖	❖
MALAWI INTERFAITH AIDS ASSOCIATION	❖	❖
JOURNALIST ASSOCIATION AGAINST AIDS	❖	❖
GUIDANCE, COUNSELLING & YOUTH DEVELOPMENT FOR AFRICA	❖	❖
FEDOMA	N/A	N/A
BANJA LA MTSOGOLO	#/NAC	#/NAC
ADRA	N/A	N/A
MANASO	❖	❖
NAPHAM		#/NAC
EPISCOPAL CONFERENCE OF MALAWI	❖	❖
CHRISTIAN HEALTH ASSOCIATION OF MALAWI	❖	❖
QUADRIA MUSLIM ASSOCIATION	❖	❖
COALITION OF WOMEN LIVING WITH HIV	❖	❖

Institution	**2007/2008**	**2008/ 2009**
MATINDI YOUTH ORGANISATION	❖	❖
LIFELINE MALAWI		❖
MANET++	❖	❖
BLANTYRE SYNOD HEALTH & DEVELOPMENT COMMISSION	❖	❖
WORD ALIVE COMMISSION FOR RELIEF DEVELOPMENT	❖	❖
MANERALA+	❖	❖
WILSA	N/A	N/A

Key:

N/A Data not given

#/NAC the institutions got money from National Aids Commission (NAC).

❖ Data was collected and is ready for RTS
✓ Institutions were Sources only but data was collected

o Poor quality data

- No HIV and AIDS related activity

3.3 Assumptions and Estimation

The following assumptions and estimation were made:

- Financial year – where the external sources' financial year was NOT equivalent to the Malawian financial calendar year, adjustments were made to estimate the expenditure within the calendar year. The financial calendar in Malawi was from 1st July to 30th June the following year. For the NASA 2007/2008 and 2008/2009 financial years were considered.
- Where funds are pooled, the expenditure contribution of donor to the activities was assumed to be equal in equal proportions as the contribution to the total fund budgeted.
- The annual exchange rate of the US dollar to the Malawi Kwacha (MK) was used in this study. For 2007/2008 and 2008/2009, the rate was MK140 to US$ 1.

3.4 Limitations of the Assessment

- The study did not include ALL private expenditure (except some few private companies/businesses). Private insurance, some businesses, traditional healers, and household out-of-pocket payment expenditures were not included. For the household out-of-pocket expenditure (OOPE), there was no existing information or survey to fall on. A household survey of PLHIV to capture the OOPE was outside the scope of this study.
- Data on salaries of health and non-health personnel working in HIV and AIDS related activities especially from MOH and other institutions surveyed were not easily available given the short period for the study. Also the information on the proportion of time spent by health and non-health personnel in HIV and AIDS related activities was also not available.
- In order to capture the data on salaries, it would take time to disaggregate what percentage of salaries goes into HIV and AIDS related activities and projects. Also one needs to know the proportion of staff time spent on HIV and AIDS related activities so as to be able to factor it in the salary.
- Data on overheads of most of the key agencies were not included. With the exception of the UNAIDS and NAC it was difficult to estimate the proportion of an agency's overheads that could be attributed to its HIV and AIDS activities.
- The study also excluded the proportion of TB treatment expenditure that was related to HIV and AIDS because such information was not easily available and also difficult to collect since current TB treatment information was not disaggregated to the level required for the study.

Section 4

Findings – NASA Estimation

4.1 Total Expenditure on HIV and AIDS and Sources of Funding

Total expenditure on HIV and AIDS related activities in Malawi showed a decrease of 1.36 percent between 2007/2008 and 2008/2009. Expenditure for the two respective financial years was $107,426,244 and $104,534,528. International funding dominated the revenue sources of HIV and AIDS related activities (see Figure 4.1 and Table 4.1). In 2007/2008, funds from International organizations constituted 97.58 percent of total spending compared to 98 percent in 2008/2009. Multilateral institutions were the major contributors among the international agencies in 2007/2008 (71 percent) but their share declined to 64 percent in 2008/2009 (Table 4.2). Resources from the Global Fund in 2007/2008 accounted for 94 percent of multilateral funds decreasing to 87 percent in 2008/2009. Public funds formed a small proportion of total funding. This is because expenditure from public funds in the NASA did not include salaries paid by GOM to health personnel in the public sector and also the cost of public facilities used in the treatment, care and support of HIV and AIDS related activities. This information was not easily available to be included in the study. From the NASA only 1.77 percent of the total expenditure in 2007-2008 and 1.40 percent in 2008-2009 came from the government.

Private funds accounted for less than 1 percent of the total in both 2007/2008 and 2008/2009. This low contribution can be explained by the fact that the study did not capture household Out-of-Pocket Expenditure (OOPE) and private insurance, among others. The study, however reported contributions of some private for organizations (businesses) towards HIV/AIDS related activities. Unfortunately, many were reluctant to provide information. Thus the private share does not reflect the true picture in terms total contribution to HIV and AIDS related activities. A significant proportion (48 percent) of the expenditure of these organizations was directed towards preventive activities.

Figure 4.1

Sources of Funds for HIV and AIDS Expenditure, 2007/2008 and 2008/2009 (US$)

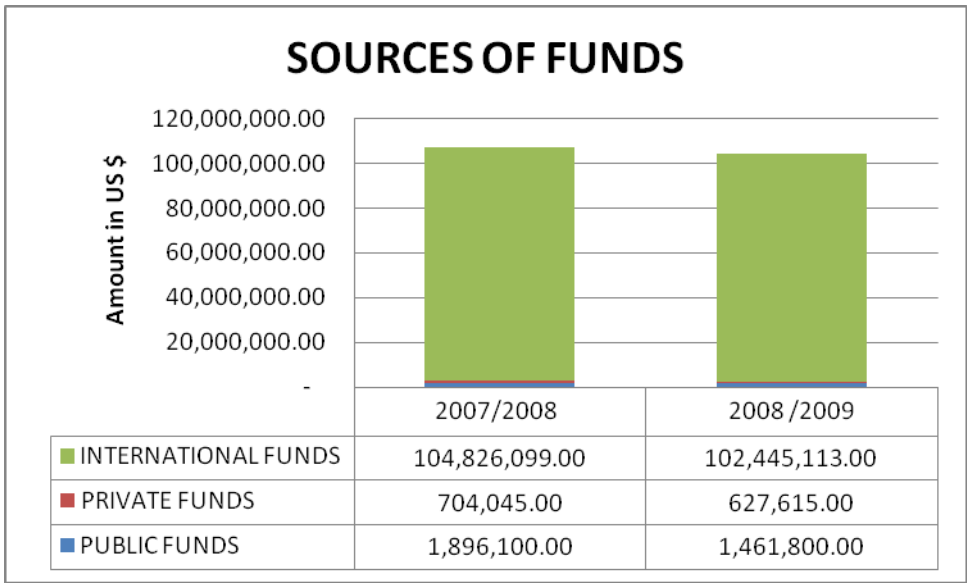


Table 4.1

Sources of Funds for HIV and AIDS Expenditure, 2007/2008 and 2008/2009 (US$)

Source	2007/2008	%	2008 /2009	%
PUBLIC FUNDS	1,896,100	1.77	1,461,800	1.40
PRIVATE FUNDS	704,045	0.66	627,615	0.60
INTERNATIONAL FUNDS	104,826,099	97.58	102,445,113	98.00
TOTAL	**107,426,244**	**100.00**	**104,534,528**	**100.00**

From Table 4.1, Public funds decreased by 22.91 % from 2007/2008 to 2008/2009 while private funds decreased by 10.86% from 2007/2008 to 2008/2009. International funds also decreased by 2.27% from 2007/2008 to 2008/2009.

Table 4.2

Sources of International Funds by Category, 2007/2008 and 2008/2009 (US$)

International Sources	2007/2008	%	2008/2009	%
Direct Bilateral Contributions	21,267,029	20.29	27,476,324	26.82
Multilateral Contributions	74,568,381	71.14	65,727,177	64.16
Other International Funds	8,990,689	8.58	9,241,612	9.02
Total	**104,826,099**	**100.00**	**102,445,113**	**100.00**

In sum,

- Direct Bilateral Contributions increased by 29.20 % from 2007/2008 to 2008/2009;
- Multilateral contributions decreased by11.86 percent between 2007/2008 and 2008/2009; and
- Other international funds decreased by 2.79 % in between 2007/2008 and 2008/2009.

4.2 Composition of HIV and AIDS Spending

Most of the resources on HIV and AIDS in 2007/2008 were spent on activities relating to Treatment and Care (31 percent). Other expenditure categories were Programme Management and Administration (23 percent); Prevention Programmes (20 percent) and Enabling Environment (12 percent); Orphans and Vulnerable Children (7 percent); Social Protection and Social Services excluding OVC (5 percent); Human Resources (2 percent); HIV-AIDS Related Research (1 percent). In 2008/2009, most of the funds (38 percent) were spent on Treatment and Care component, while 22 percent went into Programme Management and Administration. Prevention Programmes also accounted for 17 percent of total funding in the year 2008/2009. In nominal terms, total spending on Programme Management decreased by US$1,043,845 from 2007/2008 to 2008/2009 but still remained the second largest spending category after Treatment and Care components. Spending on the Treatment and Care component (largest spending category) saw a 7 percent upsurge from 2007/2008 to 2008/2009. The proportionate expenditure allocated to funding human resource activities reduced by 1.26 percent between the two years.

Table 4.3 and Figures 4.2a, 4.2b and 4.2c present the total spending pattern on the key priority areas.

Table 4.3

Total Spending on Key Priorities, 2007/2008 and 2008/2009 (US$)

Key areas of Expenditure (Interventions)	2007/2008 (US$)	Percent (%)	2008/2009 (US$)	Percent (%)
Prevention Programmes	20,933,660	19.5	17,766,756	17.0
Treatment and Care	33,488,569	31.2	39,931,108	38.2
Orphans and Vulnerable Children (OVC)	7,787,005	7.3	4,735,504	4.5
Programme Management and Administration	24,305,572	22.6	23,261,727	22.3
Human Resources	2,574,247	2.4	1,190,008	1.1
Social Protection and Social Services (excluding OVC)	4,777,500	4.5	1,814,367	1.7
Enabling Environment	12,387,061	11.5	14,615,472	14.0
HIV and AIDS Related Research	1,172,630	1.1	1,219,586	1.2
Total	**107,426,244**	**100.00**	**104,534,528**	**100.00**

From Table 4.3, there was a decrease (from 19.5 percent to 17 percent) in funds allocated for Prevention Programmes and an increase (from 31.2 percent to 38.2 percent) in funds allotted for Treatment and Care components between 2007/2008 and 2008/2009. This reflected the spending priority of the Global Fund which was a major contributor to HIV and AIDS spending activities in the country.

The percentage share of total expenditure on HIV and AIDS related research was insignificant in both years. Funds alloted to HIV and AIDS related research accounted for 1.1 percent of the total expenditure on HIV and AIDS related activities in 2007/2008. This increased marginally to 1.2 percent in 2008/2009. Total expenditure on Social Protection and Social Services (excluding OVC) decreased by almost two percentage points from 4.5

Figure 4.2a

Total Expenditure Breakdown by Intervention Areas, 2007/2008

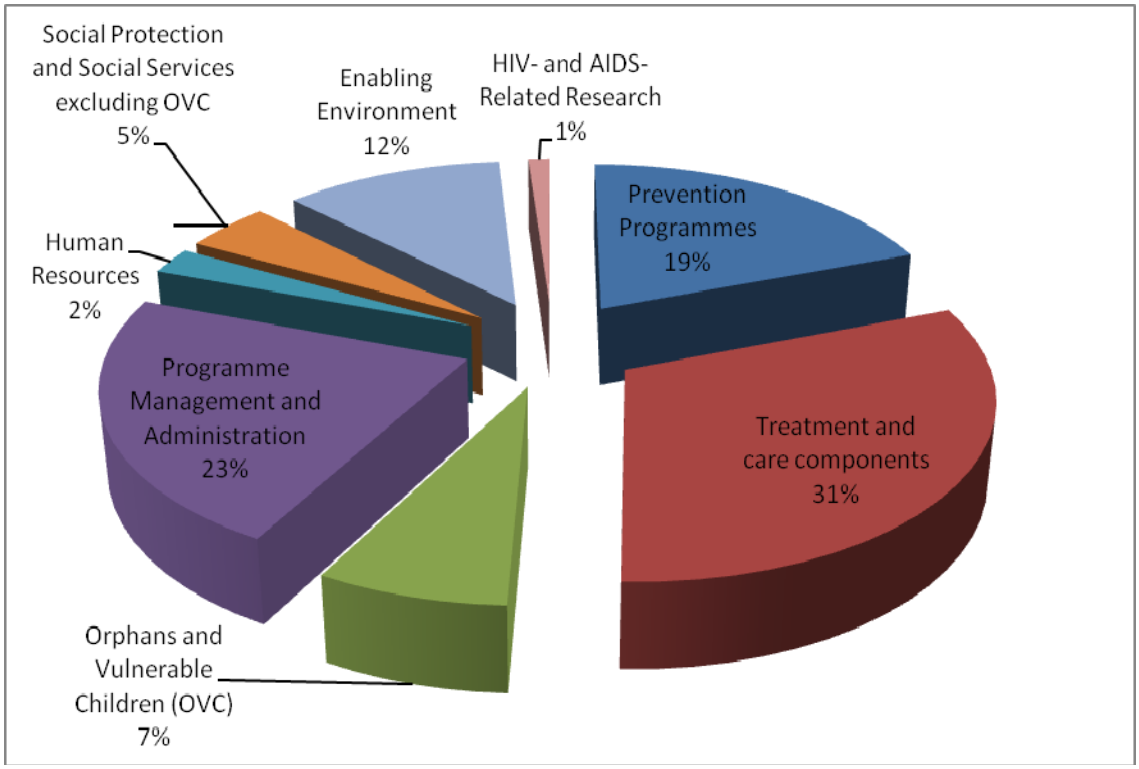


Figure 4.2b

Total Expenditure Breakdown by Intervention Areas, 2008/2009

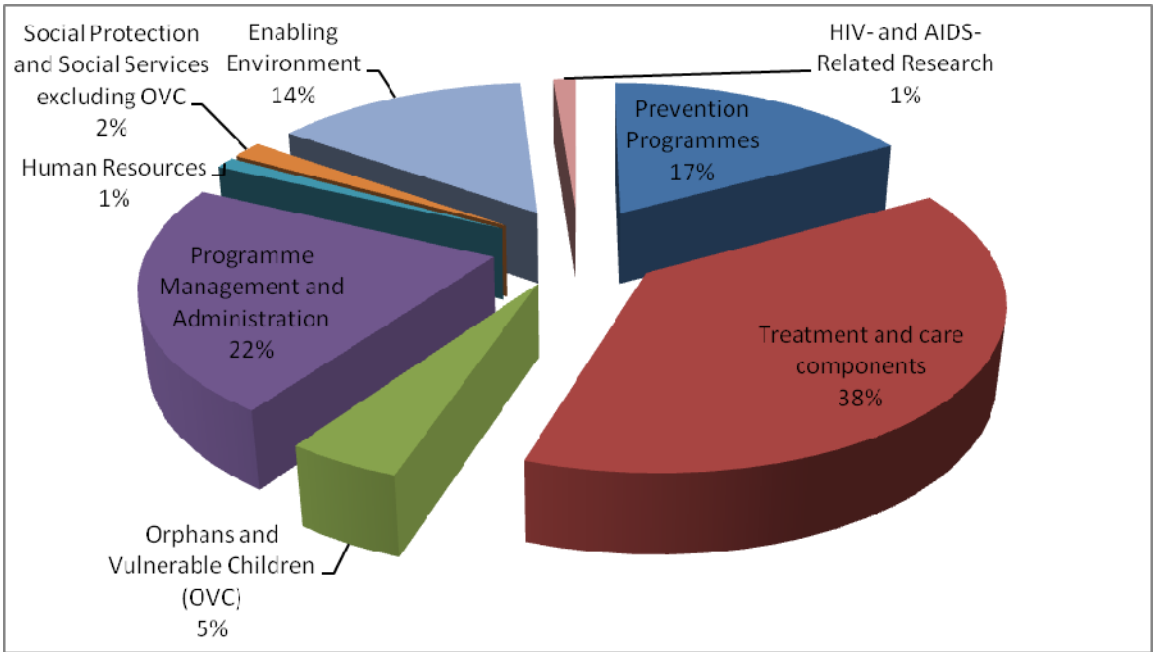


Figure 4.2c

Proportion Spending by Intervention Areas, 2007/2008 and 2008/2009

percent in 2007/2008 to 1.7 percent in 2008/2009. Expenditure on activities to create an enabling environment for the successful implementation of HIV and AIDS programmes in Malawi increased by 18 percent in between the two years but it accounted for 11.5 percent and 14 percent of the total expenditure on HIV and AIDS related activities for 2007/2008 and 2008-2009 respectively. Details of the composition of HIV and AIDS spending are shown in the HIV and AIDS funding matrix in Tables 4.4a and 4.4b.

4.3 Prevention Programmes Spending Activities

There was a 15 percent decrease in expenditure on prevention spending activities between 2007/2008 and 2008/2009. This seems to have been driven by the dramatic decline in funds allocated for Communication for Social and Behavioural Change (from 11.47 percent to 4.89 percent) over the two years and Voluntary Counselling and Testing (from 33.68 percent to 17.21 percent), among others. This notwithstanding, spending on some prevention activities such as Prevention, Diagnosis and Treatment of Sexually Transmitted Infections increased over the years under review (from 0.49 percent to 2.17 percent). The quantum was however not enough to induce a general increase in prevention spending activities between the two fiscal years. A detailed breakdown of the various prevention sub-categories receiving funding for 2007/2008 and 2008/2009 is captured in Table 4.5.

Table 4.4a Funding Matrix for HIV and AIDS in Malawi, 2007/2008 (US$)

YEAR: **2007/2008**
Calendar Year: **No**
Fiscal Year : **1st July 2007 to 30th June 2008**
Currency used in Matrix: **United States Dollar**
Average Exchange Rate for the year: **1 US$=MK140.00**

National Funding Matrix
AIDS Spending Categories by Financing Sources

AIDS Spending Categories	Financing Sources													
	TOTAL	Public Sources			International Sources							Private Sources		
					International Sub-Total	Bilaterals	Multilaterals				All other International			
		Public Sub-Total	Central/National	All Other Public			UN Agencies	Global Fund	World Bank	All Other Multilateral		Private Sub-Total	For-profit institutions/ Corporations	All other private
TOTAL	**107,426,244**	**1,896,100**	**1,798,118**	**97,982**	**104,826,099**	**21,267,029**	**3,430,843**	**69,445,865**	**1,023,393**	**668,280**	**8,990,689**	**704,045**	**17,234**	**686,811**
Prevention (Sub Total)	**20,933,660**	**311,981**	**273,783**	**38,198**	**20,286,234**	**8,716,916**	**514,404**	**10,098,191**	**35,645**	**47,203**	**873,875**	**335,445**	801	**334,644**
Communication for social and behavioural change	2,398,088	11,997	11945	52	2,386,091	380,634	486648	1,457,206	34,038	0	27,565	-		0
Community mobilization	215,160	5,772	5627	145	209,388	18,113	10851	111,928	1,139	0	67,357	-		0
Voluntary counselling and testing (VCT)	7,042,866	154,077	154077		6,888,789	1,522,274	14,669	5,014,071	-	47,203	290,572	-		0
Risk-reduction for vulnerable and accessible populations	306,702	13,072	13071	1	293,630	35,290	319	246,050	468	0	11,503	-		0
Prevention – youth in school	194,062	10,420	10420		183,642	34,773	254	148,615	0	0		-		0
Prevention – youth out-of-school	114,581	2,055	2055		112,526	6,856	50	63,692	0	0	41,928	-		0
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	75,813	-			75,813	42857	-	-	0	0	32,956	-		0
Prevention programmes in the workplace	669,282	10,474	10474		658,115		0	623,948	0	0	34,167	693	357	336
Condom social marketing	444	-			-		-		0	0		444	444	0
Prevention, diagnosis and treatment of sexually transmitted infections (STI)	101,927	651	651		101,276	2,174	16	99,086	0	0		-		0
Prevention of mother-to-child transmission (PMTCT)	4,465,468	62,069	62069		4,070,152	1,569,989	1,514	2,143,275	0	0	355,374	333,247		333247
Blood safety	283,103	3,394	3394		279,709	112,441	83	167,185	0	0		-		0
Universal precautions	23,135	-			23,135		-	23,135	0	0		-		0
Prevention activities not disaggregated by intervention	7,633	-			7,633		0	-	0	0	7,633	-		0
Prevention activities n.e.c.	5,035,396	38,000		38000	4,996,335	4991515	0	-	0	0	4,820	1,061		1061
Care and treatment (Sub Total)	**33,488,569**	**623,638**	**622,284**	**1,354**	**32,835,519**	**3,243,318**	**901,430**	**26,796,434**	**0**	**13,440**	**1,880,897**	**29,412**	**4,313**	**25,099**
Outpatient care	12,062,292	24,514	23,160	**1,354**	12,017,865	176,499	206,066	10,669,884	0	0	965,416	19,913		**19,913**
Patient transport and emergency rescue	4,002	-			-		0	-	0	0		4,002	4,002	0
Care and treatment services not disaggregated by intervention	20,289,992	585,410	585410		19,699,085	1,988,791	695,364	16,116,980	0	13,440	884,510	5,497	311	5186
Care and treatment services n.e.c.	1,132,283	13,714	13714		1,118,569	1,078,028	0	9,570	0	0	30971	-		0
Orphans and vulnerable children (Sub Total)	**7,787,005**	**168,651**	**168,650**	**1**	**7,454,367**	**1,638,254**	**308,675**	**5,228,845**	**909**	**80,305**	**197,379**	**163,987**	**0**	**163,987**
OVC Education	116,407	-			116,407		-	-		-	116,407	-		-
OVC Basic health care	100,000	-			100,000	100,000	-	-		-		-		-
OVC Family/home support	200,000	-			200,000	200,000	-	-		-		-		-
OVC Community support	37,394	-			37,394		37,394	-		-		-		-
OVC Social Services and Administrative costs	6,989	172	171	1	6,817	574	4	5,330	909	-		-		-
OVC Services not disaggregated by intervention	7,059,047	168,479	168,479		6,726,581	1,337,680	4,109	5,223,515		80,305	80,972	163,987		163,987
OVC services n.e.c.	267,168	-			267,168		267,168			-		-		-
Programme management and administration (Sub Total)	**24,305,572**	**223,596**	**210,371**	**13,225**	**24,022,421**	**4,623,279**	**452,811**	**12,442,278**	**854,542**	**527,332**	**5,122,179**	**59,555**	**536**	**59019**
Planning, coordination and programme management	6,449,986	18,553	18436	117	6,431,433	2,461,864	27,255	536,065	67,470	267,398	3,071,381	-		0
Administration and transaction costs associated with managing and disbursing funds	5,495,715	121,239	108291	12948	5,327,365	458,070	31,592	3,645,138	587,031	101,294	504,240	47,111	536	46575
Monitoring and evaluation	3,639,679	62,119	61981	138	3,565,116	1,224,678	240,890	2,075,692		3,187	20,669	12,444		12444
Operations research	443,729	-			443,729	77	30,541	284,733		-	128,378	-		0
Serological-surveillance (serosurveillance)	557,504	410	407	3	557,094	1,600	10	468,690	86,794	-		-		0
Drug supply systems	2,913,804	-			2,913,804		-	2,758,351		155,453		-		0
Information technology	93,848	2,380	2361	19	91,468	5,104	-	73,787	12,577	0		-		0
Upgrading and construction of infrastructure	392,843	-			392,843	392,843	-			0		-		0
Mandatory HIV testing (not VCT)	338,231	-			338,231		-			0	338,231	-		0
Programme management and administration not disaggregated by type	1,132,812	-			1,132,812	4,702	122,523			0	1,005,587	-		0
Programme management and administration n.e.c	2,847,421	18,895	18895		2,828,526	74,341	-	2,599,822	100,670	0	53,693	-		0
Human resources (Sub Total)	**2,574,247**	**113,385**	**68,210**	**45,175**	**2,422,320**	**422,357**	**115,956**	**1,417,805**	**113,633**	**0**	**352,569**	**38,542**	**2,828**	**35,714**
Monetary incentives for human resources	8,559	206	206		8,353	810	5	6,440	1,098	0		-		0
Training	2,528,394	113,179	68004	45175	2,412,387	419,967	115,951	1,411,365	112,535	0	352,569	2,828	2828	0
Human resources not disaggregated by type	36,938	-			1,224	1,224	-			0		35,714	0	35714
Human resources n.e.c.	356	-			356	356	-			0		-	0	0
Social protection and social services excluding OVC (Sub Total)	**4,777,500**	**99,299**	**99,299**	**0**	**4,649,630**	**1,334,291**	**793,217**	**2,348,966**	-	**0**	**173,156**	**28,571**	**0**	**28,571**
Social protection through monetary benefits	132,576	-			132,576		0			0	132576	-	0	0
Social protection through in-kind benefits	1,080,051	36,554	36554		1,014,926	43446	529187	403611		0	38682	28,571	0	28571
HIV-specific income generation projects	2,320,934	62,745	62745		2,258,189	309406	1530	1945355		0	1898	0	0	0
Social protection services and social services not disaggregated by type	1,224,939	-			1,224,939	962439	262500			0		0	0	0
Social protection services and social services n.e.c.	19,000	-			19,000	19000	0			0		0	0	0
Enabling environment Sub Total	**12,387,061**	**330,421**	**330,421**	**0**	**12,008,107**	**1,112,755**	**85,911**	**10,418,807**	**0**	**0**	**390,634**	**48,533**	**8,756**	**39,777**
Advocacy	368,563	-			349,263	10018	26258			0	312987	19,300	7357	11943
Human rights programmes	1,846,485	51,564	51,564		1,794,868	172090	1258	1598693		0	22827	53	0	53
AIDS-specific programmes focused on women	105,600	-			105,600		51594			0	54006	0	0	0
Programmes to reduce Gender Based Violence	175,241	-			175,241		0	174427		0	814	0	0	0
Enabling environment not disaggregated by type	8,525,916	-			8,525,916		0	8525916		0		0	0	0
Enabling environment n.e.c.	1,365,256	278,857	278,857		1,057,219	930647	6801	119771		0		29,180	1399	27781
HIV and AIDS-related research excluding operations research (Sub Total)	**1,172,630**	**25,129**	**25,100**	**29**	**1,147,501**	**175,859**	**258,439**	**694,539**	**18,664**	**0**	**0**	**0**	**0**	**0**
Biomedical research	90,000	-			90,000	90000	0			0	0	0	0	0
Social science research	30,956	-			30,956		30956			0	0	0	0	0
HIV and AIDS-related research activities not disaggregated by type	13,232	118	117	1	13,114	458	8388	3647	621	0	0	0	0	0
HIV and AIDS-related research activities n.e.c.	1,038,442	25,011	24983	28	1,013,431	85401	219095	690892	18043	0	0	0	0	0

Table 4.4b Funding Matrix for HV and AIDS in Malawi, 2008/2009 (US$)

YEAR: **2008/2009**
Calendar Year**: No**
Fiscal Year : **1st July 2008 to 30th June 2009**
Currency used in Matrix: **United States Dollar**
Average Exchange Rate for the year: **1 US$=MK140.00**

National Funding Matrix
AIDS Spending Categories by Financing Sources

AIDS Spending Categories	Financing Sources													
	TOTAL	Public Sources			International Sources							Private Sources		
					International Sub-Total	Bilaterals	Multilaterals				All other International	Private Sub-Total	For-profit institutions/ Corporations	All other private
		Public Sub-Total	Central/National	All Other Public			UN Agencies	Global Fund	World Bank	All Other Multilateral				
TOTAL	**104,534,528**	**1,461,800**	1,455,026	6,774	**102,445,113**	27,476,324	2,644,150	56,826,532	5,691,185	565,310	9,241,612	**627,615**	146,001	421,794
Prevention (Sub Total)	**17,766,756**	**134,782**	**134,276**	**506**	**17,569,319**	**9,622,509**	**497,460**	**5,138,442**	**426,046**	**441,512**	**1,443,350**	62,655	62,655	-
Communication for social and behavioural change	869,202	10,090	10037	53	858,248	37,873	24,459	701,589	44,706	-	49,621	864	864	0
Community mobilization	679,106	10,047	9993	54	669,059	37,201	12,398	448,535	45,619	-	125,306			0
Voluntary counselling and testing (VCT)	3,057,880	19,591	19485	106	3,038,289	1,310,941	13,997	1,005,038	88,955	441,512	177,846			0
Risk-reduction for vulnerable and accessible populations	399,999	6,206	6172	34	393,793	22,977	1,040	277,036	28,177	-	64,563			0
Prevention – youth in school	256,973	2,054	2028	26	254,919	17,616	797	212,394	21,602	-	2,510			0
Prevention – youth out-of-school	112,919	4,743	4732	11	108,176	7,550	342	91,026	9,258	-				0
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	279,355				279,355	121,429	-			-	157,926			0
Prevention programmes in the workplace	590,915	40,707	40707		490,208		-	479,316		-	10,892	60,000	60,000	0
Condom social marketing	1,791				-		-			-		1,791	1,791	0
Prevention, diagnosis and treatment of sexually transmitted infections (STI)	385,351	7,087	7049	38	378,264	26,242	1,188	318,653	32,181	-				0
Prevention of mother-to-child transmission (PMTCT)	3,602,202	24,469	24337	132	3,577,733	1,742,756	4,101	1,167,864	111,103	-	551,909			0
Blood safety	529,054	9,736	9736		519,318	36,244	1,638	436,991	44,445	-				0
Prevention activities not disaggregated by intervention	787,104				787,104	186,555	437,500			-	163,049			0
Prevention activities n.e.c.	6,214,905	52		52	6,214,853	6,075,125	-			-	139,728			0
Care and treatment (Sub Total)	**39,931,108**	**668,481**	**664,950**	**3,531**	**39,256,974**	**5,943,630**	**728,324**	**28,408,470**	**2,966,347**	**-**	**1,210,203**	5,653	653	**5,000**
Outpatient care	5,180,134	64316	64014	302	5110165	986,608	15,718	2,710,091	253,795	-	1,143,953	5,653	653	5000
Care and treatment services not disaggregated by intervention	32,005,974	604165	600936	3229	31401809	2,212,022	712,606	25,698,379	2,712,552	-	66,250			0
Care and treatment services n.e.c.	2,745,000				2745000	2,745,000	-			-	-			0
Orphans and vulnerable children (Sub Total)	**4,735,504**	**51,343**	**51,065**	**278**	**4,396,792**	**1,392,381**	**22,635**	**2,292,107**	**233,124**	**-**	**456,545**	**287,369**	**-**	**287,369**
OVC Education	431,844	582	579	3	431262	17,156	97	25,986	2,643	-	385,380			0
OVC Services not disaggregated by intervention	4,303,660	50761	50486	275	3965530	1,375,225	22,538	2,266,121	230,481	-	71,165	287369		287369
Programme management and administration (Sub Total)	**23,261,727**	**183,448**	**182,568**	**880**	**22,943,459**	**8,391,674**	**397,861**	**7,808,470**	**745,799**	**123,798**	**5,475,857**	**134,820**	**75,000**	**0**
Planning, coordination and programme management	8,408,867	46780	46522	258	8362087	2,842,128	52,851	2,257,752	216,300	123,798	2,869,258			0
Administration and transaction costs associated with managing and disbursing funds	7,028,531	124359	123802	557	6769352	1,193,742	35,436	4,639,360	466,918	-	433,896	134820	75000	0
Monitoring and evaluation	2,940,356	10463	10407	56	2929893	2,076,124	240,774	534,889	53,834	-	24,272			0
Operations research	494,857				494857	16,988	20,000	57,216		-	400,653			0
Serological-surveillance (serosurveillance)	201,988				201988		-	201,988		-				0
HIV drug-resistance surveillance	4,601	18	18		4583	67	3	4,096	417	-				0
Drug supply systems	689,971				689971		-	26,421		-	663,550			0
Information technology	110,837	1747	1738	9	109090	30,788	293	78,009		-				0
Upgrading and construction of infrastructure	1,160,000				1160000	1,160,000	-			-				0
Programme management and administration not disaggregated by type	1,192,509				1192509	1,071,724	-		7,934	-	112,851			0
Programme management and administration n.e.c	1,029,210	81	81		1029129	113	48,504	8,739	396	-	971,377			0
Human resources (Sub Total)	**1,190,008**	**89,408**	**89,392**	**16**	**1,043,457**	**479,696**	**132,972**	**231,467**	**5,373**	**-**	**193,949**	**57,143**	**-**	**57,143**
Training	938,531	89408	89392	16	849123	285,362	132,972	231,467	5,373	-	193,949			0
Human resources not disaggregated by type	251,477				194334	194,334	-			-		57143		57143
Social protection and social services excluding OVC (Sub Total)	**1,814,367**	**49,130**	**49,023**	**107**	**1,731,308**	**130,257**	**484,301**	**883,255**	**89,834**	**-**	**143,661**	**33,929**	**-**	**33,929**
Social protection through monetary benefits	118,214				118,214	57000	0			0	61214			0
Social protection through in-kind benefits	825,523	42286	42216	70	749,308	47915	2169	577708	58758	0	62758	33929		33929
Social protection through provision of social services	343,481	6354	6320	34	337,127	23529	1065	283681	28852	0				0
HIV-specific income generation projects	46,164	490	487	3	45,674	1813	82	21866	2224	0	19689			0
Social protection services and social services not disaggregated by type	480,985				480,985		480985			0				0
Enabling environment Sub Total	**14,615,472**	**270,511**	**269,133**	**1,378**	**14,298,915**	**1,066,307**	**378,133**	**11,379,092**	**1,157,336**	**-**	**318,047**	**46,046**	**7,693**	**38,353**
Advocacy	183,714	621	621		178724	1097	10361			0	167266	4369	4369	0
Human rights programmes	1,779,480	41,283	41,141	142	1734873	218747	78404	1173349	119338	0	145035	3324	3324	0
AIDS-specific programmes focused on women	259,221				259221		253475			0	5746			0
Programmes to reduce Gender Based Violence	178,901	3,310	3,292	18	175591	12255	555	147753	15028	0				0
Enabling environment not disaggregated by type	12,069,799	223,336	222,129	1,207	11846463	826947	35008	9970442	1014066	0				0
Enabling environment n.e.c.	144,357	1,961	1,950	11	104043	7261	330	87548	8904	0		38353		38353
HIV and AIDS-related research excluding operations research (Sub Total)	**1,219,586**	**14,697**	**14,619**	**78**	**1,204,889**	**449,870**	**2,464**	**685,229**	**67,326**	**-**	-	-	-	-
Biomedical research	350,000				350,000	350000	0			0				0
Social science research	65,567	1		1	65,566		35	65531		0				0
HIV and AIDS-related research activities not disaggregated by type	679,364	12725	12658	67	666,639	92569	2098	513599	58373	0				0
HIV and AIDS-related research activities n.e.c.	124,655	1971	1961	10	122,684	7301	331	106099	8953	0				0

Table 4.5

Prevention Spending Activities, 2007/2008 and 2008/2009 (US$)

PREVENTION	2007/2008	%	2008/2009	%
Communication for Social and Behavioural change	2,398,088	11.47	869,202	4.89
Community Mobilization	215,160	1.03	679,106	3.82
Voluntary Counselling and Testing (VCT)	7,042,866	33.68	3,057,880	17.21
Risk-reduction for Vulnerable and Accessible Populations	306,702	1.47	399,999	2.25
Prevention – youth in school	194,062	0.93	256,973	1.45
Prevention – youth out-of-school	114,581	0.55	112,919	0.64
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	75,813	0.36	279,355	1.57
Prevention Programmes in the Workplace	669,282	3.20	590,915	3.33
Condom Social Marketing	444	0.00	1,791	0.01
Prevention, Diagnosis and Treatment of Sexually Transmitted Infections (STI)	101,927	0.49	385,351	2.17
Prevention of Mother-to-Child Transmission (PMTCT)	4,465,468	21.36	3,602,202	20.27
Blood Safety	283,103	1.35	529,054	2.98
Prevention Activities not disaggregated by intervention	7,633	0.04	787,104	4.43
Prevention Activities n.e.c.	5035396	24.08	6,214,905	34.98
Total	**20,910,525**	**100.00**	**17,766,756**	**100.00**

4.4 Treatment and Care Spending Activities

Key areas of spending on Treatment and Care in 2007/2008 and 2008/2009 are presented in Table 4.6. The bulk of the spending in this category in both years went into Care and Treatment Services not disaggregated by intervention and Outpatient Care Services n.e.c. Expenditure on Care and Treatment Services 'not elsewhere classified' remained very small in both years though there was an increase by 4 percentage points (from 3 percent to 7 percent) between 2007/2008 to 2008/2009. Also, total funding for Patient Transport and Emergency Rescue was less than 1 percent in 2007/2008. There was no expenditure for this sub-component in 2008/2009.

Expenditure on Adult Antiretroviral Therapy and Paediatric Antiretroviral Therapy can be found in the "Outpatient Care Services n.e.c" and 'Care and Treatment Services not disaggregated by intervention". Future NASA should have the data on care and treatment component more disaggregated so that adult and paediatric ART expenditure lines can be seen.

Table 4.6

Treatment and Care Spending Activities, 2007/ 2008 and 2008/2009(US$)

CARE & TREATMENT	2007 -2008	%	2008-2009	%
Outpatient Care Cervices n.e.c.	12,062,292	36.02	5,180,134	**12.97**
Patient Transport and Emergency Rescue	4,002	0.01	-	-
Care and Treatment Services not disaggregated by intervention	20,289,992	60.59	32,005,974	**80.15**
Care and Treatment Services n.e.c.	1,132,283	3.38	2,745,000	**6.87**
Total	**33,488,569**	**100.00**	**39,931,108**	**100.00**

4.5 Orphans and Vulnerable Children (OVC)

One of the key mitigation measures against the adverse effects of HIV and AIDS on the population is expenditure on Orphans and Vulnerable Children (OVC). Activities under this broad category accounted for 7.2 percent of the total spending on HIV and AIDS related activities in 2007/2008. There was a reduction of about three percentage ponts to 4.5 percent

in 2008/2009. In 2008/2009, the only expenditure on OVCs was on Education and Services not disaggregated by intervention. The two sub categories accounted for 9.12 percent and 90.88 percent of the expenditure on Orphans and Vulnerable Children (OVC), respectively. Of the total expenditure on OVCs in 2007/2008 , 90.65 percent was spent on Services that could not be disaggregated by intervention. The details of spending on OVC are shown in the Table 4.7.

Table 4.7

Total Spending on OVC, 2007/2008 and 2008/2009 (US$)

ORPHANS AND VULNERABLE CHILDREN (OVC)	2009/2008	%	2008/2009	%
OVC Education	116,407	1.49	431,844	9.12
OVC Basic Health care	100,000	1.28	-	-
OVC Family/Home Support	200,000	2.57	-	-
OVC Community Support	37,394	0.48	-	-
OVC Social Services and Administrative costs	6,989	0.09	-	-
OVC Services not disaggregated by intervention	7,059,047	90.65	4,303,660	90.88
OVC Services n.e.c.	267,168	3.43	-	-
Total	**7,787,005**	**100.00**	**4,735,504**	**100.00**

4.6 Social Protection and Social Services (excluding OVC)

Expenditure on Social Protection and Social Services beside that which went to Orphans and Vulnerable Children ranked among the lowest spending categories in both years. This accounted for 4.4 percent and 1.7 percent of the total expenditure on HIV and AIDS related activities in 2007/2008 and 2008/2009 respectively. Total spending on Social Protection and Social Services (excluding OVC) in 2008/2009 was less than 40 percent of the amount disbursed in 2007-2008. Table 4.8, presents the expenditure profile for the Social Protection and Social Services (excluding OVC) component.

Table 4.8

Social Protection and Social Services (excluding OVC) 2007/2008 and 2008/2009 (US$)

SOCIAL PROTECTION	2007/2008	%	2008/2009	%
Social Protection through Monetary Benefits	132,576	2.78	118,214	6.52
Social Protection through in-kind Benefits	1,080,051	22.61	825,523	45.50
HIV-Specific Income Generation Projects	2,320,934	48.58	46,164	2.54
Social Protection Services and Social Services not disaggregated by type	1,224,939	25.64	480,985	26.51
Social Protection Services and Social Services n.e.c.	19,000	0.40	343,481	18.93
Total	**4,777,500**	**100.00**	**1,814,367**	**100.00**

From Table 4.8, expenditure on HIV specific income generating activities (48.58 percent) dominated the Social Protection and Social Services expenditure (excluding OVC) in 2007/2008. This was up-staged by expenditure on Social Protection through in-kind benefits (45.5 percent) and expenditure on Social Protection Services not disaggregated by type (26.51 percent) in 2008/2009.

4.7 Programme Management and Administrative Strengthening

A number of diverse and complex processes, such as planning, resource mobilization for support groups, monitoring and supervision, are undertaken to ensure the efficient use of resources disbursed for HIV and AIDS activities. The activities include the development, refurbishment and repair of facilities that facilitate effective treatment of PLHIV. In general, there was a 4.29 percent decline in expenditure for Programme Management and Administrative Strengthening activities between 2007/2008 and 2008/2009. The trend in resource allocation to the various sub-categories is presented in Table 4.9.

Table 4.9

Programme Management Spending Activities, 2007/2008 and 2008/2009 (US$)

PROGRAMME MANAGEMENT AND ADMINISTRATION	2007/2008	%	2008/2009	%
Planning, Coordination and Programme Management	6,449,986	26.54	8,408,867	36.15
Administration and Transaction Costs associated with Managing and Disbursing Funds	5,495,715	22.61	7,028,531	30.22
Monitoring and Evaluation	3,639,679	14.97	2,940,356	12.64
Operations Research	443,729	1.83	494,857	2.13
Serological-Surveillance (serosurveillance)	557,504	2.29	201,988	0.87
HIV Drug-resistance Surveillance	-	-	4,601	0.02
Drug Supply Systems	2,913,804	11.99	689,971	2.97
Information Technology	93,848	0.39	110,837	0.48
Upgrading and construction of Infrastructure	392,843	1.62	1,160,000	4.99
Mandatory HIV Testing (not VCT)	338,231	1.39	-	-
Programme Management and Administration not disaggregated by type	1,132,812	4.66	1,192,509	5.13
Programme Management and Administration n.e.c	2,847,421	11.72	1,029,210	4.42
Total	**24,305,572**	**100.00**	**23,261,727**	**100.00**

Within the general decline experienced in Programme Management spending between 2007/2008 and 2008/2009 as observed in Table 4.9, there were significant increments (percentage and absolute figures) in a number of sub components. These include Planning, Coordination and Programme Support (26.54 percent in 2007/2008 as against 36.15 percent in 2008/2009) and Administrative and Transaction Costs associated with managing and disbursing funds (22.61 percent in 2007/2008 and 30.22 percent in 2008/2009). A few expenditure sub categories within this group experienced significant reductions in both absolute and percentage allocation between the two fiscal years. Notable among these were Programme Management and Administration n.e.c and Monitoring and Evaluation.

Monitoring and Evaluation (M&E) accounted for 14.97 percent and 12.64 percent of total expenditure on Programme Management and Administration in 2007/2008 and 2008/2009, respectively. M&E of HIV and AIDS related activities should be taken seriously because without a good M&E system, it will be difficult to assess the progress and redirect resources to areas that need more attention. There was no expenditure on HIV Resilience Surveillance in 2007/2008 and Mandatory HIV Testing in 2008/2009.

4.8 Human Resource and Retention Incentives

A well trained and motivated workforce is a pre-requisite for the successful implementation of any programme. Against this background, part of the expenditure on HIV and AIDS activities are channelled into human resource recruitment and retention programmes. Table 4.10 reveals that expenditure related to training is more than three quarters of the human resource recruitment and retention budget. Training related expenditure for 2008/2009 accounted for 78.87 percent of the entire expenditure on Human Resource and Retention. This figure was less than 40 percent of the 2007/2008 allocation which accounted for 98.22 percent of the total Human Resource and Retention expenditure that year. In general while the total Human Resource Recruitment and Retention expenditure in 2007/2008 was 53.7 percent higher than that of 2008/2009, expenditure on Human Resource not disaggregated by type in 2007/2008 was 5.8 percent lower than the allocation for 2008/2009.

Table 4.10

Human Resources' Recruitment and Retention Incentives Spending Activities, 2007/2008 and 2008/2009 (US$)

HUMAN RESOURCES	2007/2008	%	2008/2009	%
Monetary Incentives for Human Resources	8,559	0.33	-	-
Training	2,528,394	98.22	938,531	78.87
Human Resources not disaggregated by type	36,938	1.43	251,477	21.13
Human Resources n.e.c.	356	0.01	-	-
Total	**2,574,247**	**100.00**	**1,190,008**	**100.00**

4.9 Enabling Environment

Stigmatization impedes the effective rolling out of programmes targeting MARPs and PLHIV. The NSP identifies strongly the key role of creating an enabling environment which includes advocacy, the enforcement of laws and non-discriminatory practices in all spheres of the society. Within a general decline in expenditure experienced in this spending category, expenditure for activities to promote an enabling environment for implementing HIV and AIDS programmes increased by 17.99 percent from US$12,387,061in 2007/2008 to US$14,615,427 in 2008/2009 (Table 44.11).

4.10 HIV and AIDS Related Research (Excluding Operations Research)

Research break new grounds in both medical and social efforts aimed at combating HIV and AIDS. Research expenditure (excluding operational research), however, was the lowest among the key priority activities in 2007/2008 and 2008/2009. It accounted for less than 2 percent of the total expenditure for key priority areas in both 2007/2008 and 2008/2009.

Table 4.11

Enabling Environment Spending, 2007/2008 and 2008/2009 (US$)

ENABLING ENVIRONMENT	2007/2008	%	2008/2009	%
Advocacy	368,563	2.98	183,714	1.26
Human Rights programmes	1,846,485	14.91	1,779,480	12.18
AIDS-Specific Programmes Focused on Women	105,600	0.85	259,221	1.77
Programmes to Reduce Gender Based Violence	175,241	1.41	178,901	1.22
Enabling Environment not disaggregated by type	8,525,916	68.83	12,069,799	82.58
Enabling Environment n.e.c.	1,365,256	11.02	144,357	0.99
Total	**12,387,061**	**100.00**	**14,615,472**	**100.00**

In terms of the sub categories, there were marked disparities in both the amount and proportions expended on each category between the two years. For example, the proportion of expenditure on HIV and AIDS related research activities not disaggregated by type increased from 1.13 percent in 2007/2008 to 55.7 percent in 2008-2009. The lack of consistency in the spending pattern of research related funds was also observed in the area of HIV and AIDS related research activities n.e.c. This sub category experienced a decreased from 88.56 percent in 2007/2008 to 10.22 percent in 2008/2009. Comparatively, social science research received less support than bio-medical research (see Table 4.12).

4.11 Summary of Results

In Malawi, Care and Treatment (not disaggregated by intervention) was the highest priority spending area in both 2007/2008 and 2008/2009 (see Table 4.13 for top ten priority areas). Apart from this sub-category and Monitoring and Evaluation, none of the sub-components retained its position on the chart during 2007/2008 and 2008/2009. All the sub-components within the top ten charts in 2007/2008 however appeared in 2008/2009.

Table 4.12

Spending on HIV and AIDS-Related Research (Excluding Operations Research) 2007/2008 and 2008/2009 (US$)

HIV AND AIDS-RELATED RESEARCH EXCLUDING OPERATIONS RESEARCH	2007/2008	%	2008/2009	%
Biomedical Research	90,000	7.68	350,000	28.70
Social Science Research	30,956	2.64	65,567	5.38
HIV and AIDS-related Research Activities not disaggregated by type	13,232	1.13	679,364	55.70
HIV and AIDS-related Research Activities n.e.c.	1,038,442	88.56	124,655	10.22
Total	**1,172,630**	**100.00**	**1,219,586**	**100.00**

Table 4.13

Summary of Activities (Top 10) with High Spending, 2007/2008 and 2008/2009 (US$)

PROGRAMMES/ACTIVITIES	2007/2008	PROGRAMMES/ACTIVITIES	2008/2009
Care and treatment services not disaggregated by intervention	20,289,992	Care and treatment services not disaggregated by intervention	32,005,974
Outpatient care	12,062,292	Enabling environment not disaggregated by type	12,069,799
Enabling environment not disaggregated by type	8,525,916	Planning, coordination and programme management	8,408,867
OVC Services not disaggregated by intervention	7,059,047	Administration and transaction costs associated with managing and disbursing funds	7,028,531
Voluntary Counseling and Testing (VCT)	7,042,866	Prevention activities n.e.c.	6,214,905
Planning, coordination and programme management	6,449,986	Outpatient care	5,180,134
Administration and transaction costs associated with managing and disbursing funds	5,495,715	OVC Services not disaggregated by intervention	4,303,660
Prevention activities n.e.c.	5,035,396	Prevention of mother-to-child transmission (PMTCT)	3,602,202
Prevention of mother-to-child transmission (PMTCT)	4,465,468	Voluntary Counselling and Testing (VCT)	3,057,880
Monitoring and evaluation	3,639,679	Monitoring and evaluation	2,940,356

Section 5

Findings – NASA Beneficiary Spending

5.1 The Beneficiaries of Spending on HIV and AIDS

The major beneficiary categories captured under NASA are shown in Table 5.1.

Table 5.1 NASA Beneficiary Categories

Main category	**People living with HIV (PLHIV)**	**Most at Risk**	**Accessible Populations**	**Vulnerable Groups**	**General Population**
NASA Code	**BP 01**	**BP 02**	**BP 03**	**BP 04**	**BP 05**
Levels of Disaggregation	Age Sex	IDU; Sex workers; MSMs	STI Clinic patients; Children and youth at school; People at work; Health workers; Migrant workers; Long distance truck drivers; Military; Police	OVCs; Children born from mothers with HIV; Migrants; Refugees; Prisoners; Women & children; Youth at social risk; Partners of people living with HIV	Non-targeted

The General Population group formed the largest beneficiary group in both 2007/2008 and 2008/2009. This beneficiary group accounts for almost half of total expenditures in both years (see Table 5.2 and Figure 5.1). Funding targeted at the Most at Risk Populations was the least expenditure item as less than 1 percent of the total funding went into this sub

category in 2007/2008 and 2008/2009. Expenditure on People Living with HIV (PLHIV) increased from 31.96 percent in 2007/2008 to 37.49 percent in 2008/2009. The 14.14 percent increase in expenditure on PLHIV between 2007/2008 and 2008/2009 is encouraging given the fact in total expenditure on all the beneficiary groups reduced by 2.69 percent over the same period.

Table 5.2

Spending by Beneficiary Groups, 2007/2008 and 2008/2009 (US$)

Beneficiary Groups	2007/2008	%	2008/2009	%
PLHIV	34,334,125	31.96	39,187,437	37.49
Most-at-Risk Populations	243,319	0.23	335,436	0.32
Other Key Populations	12,717,270	11.84	6,597,282	6.31
Specific "accessible" Populations	10,725,104	9.98	12,392,968	11.86
General Population	49,406,426	45.99	46,021,409	44.03
Total	**107,426,244**	**100.00**	**104,534,532**	**100.00**

Figure 5.1

Spending by Beneficiary Groups, 2007/2008 and 2008/2009 (US$)

In terms of disaggregation, PLHIV enjoyed a significant proportion of the HIV and AIDS funding in both years. For example, 41.9 percent and 36.8 percent of the funding in 2007/2008 and 2008/2009, respectively went into activities supporting People Living with HIV not disaggregated by age or gender.

Table 5.3

HIV and AIDS related Spending by Beneficiary Population, 2007/2008 and 2008/2009 (US$)

BENEFICIARY GROUPS	2007/2008	%	2008/2009	%
PLHIV				
Adult and young men (15 years and over) living with HIV	-	-	6,761	0.01
Adult and young women (15 years and over) living with HIV	309,512.00	0.29	510,877	0.49
Adult and young people (15 years and over) living with HIV not disaggregated by gender	8,078,608.00	7.52	85,908	0.08
Children (under 15 years) living with HIV not disaggregated by gender	308,520.00	0.29	306,232	0.29
People living with HIV not disaggregated by age or gender	25,637,485.00	23.87	38,277,659	36.62
Most at Risk Populations				
"Most at risk populations" not disaggregated by type	243,319	0.23	335,436	0.32
Other Key Populations				
Orphans and vulnerable children (OVC)	8,448,834.00	7.86	4,681,536	4.45
Children born or to be born of women living with HIV	222,196.00	0.21	18,631	0.02
Children and youth living in the street	-		13,104	0.01
Other key populations not disaggregated by type	88.00	0.00	60,664	0.06
Other key populations n.e.c.	4,046,152.00	3.77	1,823,347	1.74
Specific "Accessible " Populations				
People attending STI clinics			877,303	0.84
University students			143,814	0.14

Factory employees (e.g. for workplace interventions)			1,071	0.00
Health care workers	2,640,822.00	2.46	57,353	0.05
Military	130,000.00	0.12		-
Police and other uniformed services (other than the military)	70,547.00	0.07	49,272	0.05
Specific "accessible " populations not disaggregated by type	2,255,745.00	2.10	6,082,917	5.82
Specific "accessible " populations n.e.c.	5,627,990.00	5.24	5,181,238	4.98
General Population				
Female adult population	2,622,641.00	2.44	1,750,941	1.67
General adult population (older than 24 years) not disaggregated by gender	911,164.00	0.85	1,909,867	1.83
Boys	-		1,429	0.00
Girls	7,503.00	0.01	5,703	0.01
Children (under 15 years) not disaggregated by gender	7,061.00	0.01	148,691	0.14
Young females	41,928.00	0.04	1,917	0.00
Youth (age 15 to 24 years) not disaggregated by gender	639,255.00	0.06	810,650	0.78
General population not disaggregated by age or gender.	45,176,874.00	42.05	41,392,211	39.8
TOTAL	**107,426,244**	**100.00**	**104,534,532**	**100**

5.2 Areas of Spending by Beneficiary Groups

Tables 5.4 and 5.5 reveal that the general population was the major beneficiary of funding in research, preventive programmes and activities aimed at creating an enabling environment for the implementation of HIV and AIDS programmes. This is expected as the benefits of these activities tend to be distributed widely among Malawians. Apart from this, it is difficult to exclude the wider society from participating in these activities. It is also not surprising that expenditure on Social Protection and Social Services (excluding OVC) as well as Orphans and Vulnerable Children were geared toward other key population categories. This is because spending in these two categories tends to focus on Key Population sub groups such as

children born or to be born to mothers living with HIV. Categories under specific 'accessible' population benefited most from expenditure on human resource while PLHIV were targeted for expenditure on care and treatment.

Table 5.4

Spending by Benficiary Groups, 2007/2008 (US$)

	PLHIV	(%)	Most-at-risk Pop.	(%)	Other Key Populations	(%)	Specific "accessible" populations	(%)	General Population	(%)
Prevention	281,486	1.34	243,319	1.16	7282	0.03	2,364,997	11.30	18,036,576	86.16
Care and Treatment	30,670,706	91.59	-	-	280,019	0.84	72,075	0.22	2,465,769	7.36
Orphans and Vulnerable Children (OVC)	55,047.00	0.71	-	-	7,175,523	92.15		0.00	556,435	7.15
Programme management and Administration	1,452,632	5.98	-	-	10,622	0.04	6,314,595	25.98	16,527,722	68.00
Human resources	16,782	0.05	-	-	222,269	8.63	1,877,529	72.94	457,668	17.78
Social Protection and Social Services (excluding OVC)	1,260,520	3.67	-	-	3,197,950	66.94	49,469	1.04	269,561	5.64
Enabling Environment	596,952	4.82	-	-	1,823,605	14.72	46,439	0.37	9,920,065	80.08
HIV and AIDS-related Research (excluding operations research)	-	-	-	-	-	-	-	-	1,172,630	100.00
Total	**34,334,125**	31.96	**243,319**	**0.23**	**12,717,270**	11.84	**10,725,104**	9.98	**49,406,426**	45.99

Table 5.5

Spending by Benficiary Groups, 2008/2009(US$)

	PLHIV	(%)	Most-at-risk Population	(%)	Other Key Populations	(%)	Specific "accessible" Populations	(%)	General Population	(%)
Prevention	242,308	1.36	335,436	1.89		0.00	2,415,604	13.60	14,773,410	83.15
Care and Treatment	36,854,194	92.29	-	-	192,742	0.48	27,063	0.07	2,857,109	7.16
Orphans and Vulnerable Children (OVC)	201,118	4.25	-	-	4,508,210	95.20	15,000	0.32	11,175	0.24
Programme Management and Administration	380,682	1.64	-	-	-	-	8,835,959	37.98	14,045,088	60.38
Human Resource	10,804	0.91	-	-	148,651	12.49	778,391	65.41	252,162	21.19
Social Protection and Social Services (excluding OVC)	877,936	48.39	-	-	305,558	16.84	49,365	2.72	581,508	32.05
Enabling Environment	620,395	4.24	-	-	1,442,121	9.87	271,586	1.86	12,281,370	84.03
HIV and AIDS-related Research (excluding operations research)	-	-	-	-	-	-	-	-	1,219,587	100.00
Total	**39,187,437**	37.49	**335,436**	**0.32**	**6,597,282**	6.31	**12,392,968**	11.86	**46,021,409**	44.03

5.3 Summary of Results

1. From the NASA it is very difficult to conclude that spending on HIV and AIDS related activities targeted the 'Most at Risk Population'. From the assessment only 1.16 and 1.89 percent of prevention expenditure went into activities that benefited the Most at Risk Population in 2007/2008 and 2008/2009 respectively. A significant proportion (91.59% in 2007/2008 and 92.29% in 2008/2009) of the expenditure for treatment was however spent on PLHIVs.

2. Expenditure on OVCs declined by 31.98 percent between 2007/2008 and 2008/2009. In 2007/2008 total expenditure on OVCs was US$7,787,005 compared to US$ 4,735504 in 2008/2009. OVC Services not disaggregated by type is the key expenditure area accounting over 90% of the expenditure in both years.

3. There was a 16.64% increase in expenditure on PLHIV from US$33, 596,871 in 2007/2008 to US$39,187,437. Total spending on the 'Most at Risk Populations' (**MARPs**) was extremely low and insignificant. The share of this beneficiary group declined from 0.39 percent in 2007/2008 to 0.32 percent in 2008/2009 though expenditure on MARPs increased from US$234,319 to US$335, 436 over the same period.

Chapter 6

Summary and Recommendations

6.1 Summary

Malawi has made efforts to enforce a multi sectoral approach in dealing with the HIV epidemic. The establishment of the National AIDS Commission (NAC) under the Office of the President and Cabinet (OPC) the past decade has created an enabling environment for policy formulation, effective implementation of the national response and monitoring and evaluation of programmes relating to HIV and AIDS. In spite of these landmarks, the NAC has been unable to track HIV and AIDS expenditure by all key stakeholders to date. Reported cases of new infections annually and high prevalence rate necessitated the NASA to track expenditures on HIV programmes and activities from the source of funds right down to the intended beneficiaries.

The National AIDS Spending Assessment (NASA) study for 2007/2008 and 2008/2009 showed that total expenditure on HIV and AIDS activities in Malawi decreased from US$107,426,244 in 2007/2008 to US$104,534,528 in 2008/2009, representing a fall of 1.36 percent. The NASA revealed that in both years the largest source of the funds for HIV and AIDS related activities was from international organisations (97.58 percent in 2007/2008 and 98 percent in 2008/2009). This has raised the issue of sustainability of the flow of funds for the national response. Given the high prevalence rate, new infections cropping up and PLHIV being sustained on ARVs, more funding is needed to expand treatment and prevent others from getting infected. The question is can Malawi continue to rely on international organisations for its national response and for how long.

Indeed, the results of the Malawi NASA serve as a basis for a rethink on resource mobilization strategies and a reshaping of future plans in the national response. Clearly, the financial burden on the domestic economy is enormous and reliance on external support will be required but steps must be made to find alternative sources of funding given the current

global economic crisis. The government could consider introducing and enforcing clear budget lines for HIV and AIDS spending at departmental levels. It is hoped that efforts to mainstream HIV and AIDS into the national developmental plan will ensure a regular inflow of domestic spending on HIV and AIDS related activities.

A breakdown of the total expenditure by intervention areas show that the bulk of funding in both years was spent on Treatment and Care. In 2007/2008, most of the funds were spent on Treatment and Care (31.2 percent); Programme Management and Administration (22.6 percent); Prevention Programmes (19.5 percent) and; Enabling Environment forming 11.5 percent. In 2008/2009, Treatment and Care accounted for 38.2 percent of total spending, while 22.3 percent went to Programme Management and Administration and Prevention Programmes accounted for 17 percent of total funding. It is worth highlighting the fact that total expenditure on Prevention programmes decreased from US$20,933,660 in 2007/2008 to US$17,766,756 in 2008/2009 whilst total expenditure on Treatment and care increased from US$33,488,569 in 2007/2008 to US$39,931,108 in 2008/2009. It is expected that in subsequent years, expenditure on treatment and care will grow as more PLHIV are put on ARVs but this must not be at the expense of prevention programmes. Spending on prevention programmes is important in decreasing the number of new infections.

The analysis by beneficiary groups shows that the General Population formed the largest beneficiary group in both 2007/2008 and 2008/2009. General Population benefitted from 45.99 percent of total spending in 2007/2008 and 44.03 percent of the total in 2008/2009. PLHIV was the second most important beneficiary group of HIV and AIDS spending with 31.96 percent and 37.49 percent of total expenditure in 2007/2008 and 2008/2009, respectively. However, there was minimal reported spending on Most at Risk Populations (MARPs), such as male commercial sex workers, men who have sex with men (MSM), and intravenous drug users (IUDs) in both years. The spending pattern shows that there is some targeting especially with the “other key population” category but there is the need to improve on targeting in general. Clearly, there is the need to know who the drivers of the epidemic are and how they can be reached with effective messages and support.

6.2 Recommendations

Recommendations from the study are structured around two main issues following from the NASA study:

1. Sustainability of Resource Flows

i) The NAC should develop a resource mobilization strategy in order to diversify funding portfolio;

ii) Government has to commit more funds to all line ministries by mainstreaming HIV and AIDS workplace activities in annual plans and budget;

iii) Private for profit businesses must be encouraged to provide fund for HIV related activities especially at workplace as part of their corporate social responsibilities; and

v) Improve efficiency in spending of funds by ensuring that the population that need the services are reached, that is targeting.

2. Institutionalisation of NASA

- The key issues that need to be addressed to facilitate the institutionalisation of the NASA in Malawi are (i) greater advocacy to relevant stakeholders and (ii) streamlining of financial disbursements and reporting mechanisms;
- Standardisation of budget line items/codes and their reported expenditure, using the main categories of NAF, and sub-categories of NASA;
- Simplify data collection tools to allow ease in providing data by relevant institutions;
- The NAC should insist that institutions working in HIV and AIDS activities should present their expenditures according to the NAF priorities and identify intended beneficiary or target groups. This will help remove double counting and also make assessment of HIV and AIDS activities easy; and
- Enough capacity has been built in the local consultant in the area of data collection and he should be able to organize the training and data collection for the next NASA study. The local consultant will however need support in the data processing (NASA RTS) and analysis of results.

Appendix 1

NATIONAL AIDS SPENDING ASSESSMENT

DATA COLLECTION – FORM # 1 (SOURCES / AGENTS)

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

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

For all AGENTS ask about their operational/ running costs/ overheads and capture these in form 2 under the identified activities.

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

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

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

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

Contact:			
7.9 Institution: Contact:			
7.10 Institution: Contact:			
TOTAL:			

9. Destination of the funds:

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

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

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

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

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

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

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

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

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

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

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

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

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

g. Any other comments, suggestions etc?

12.Surveyor:	**13.Date:** / / 20__

National AIDS Spending Assessment

DATA COLLECTION – FORM # 2 (PROVIDERS)

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

Year of the expenditure estimate:_____			
Objectives of data collection from the Provider: III. To identify the origin of the funds spent by the provider in the year understudy. IV. To identify in which NASA Functions/ activities the funds were spent. V. To identify the NASA Beneficiary Populations for each NASA Function/ activity.			
Indicate what currency will be used throughout the form with an "X":	**Local currency**	**US$ Exchange rate in Year of Assessment**	**Other (specify):** _____
Name of the Provider:			
14.Person to Contact (Name and Title):			

15. Address:		**16. E-mail:**
17. Phone:	**18. Fax:**	
19. Type of institution: Select category of institution with an "X".	1. Public central government	
	2. Public regional government	
	3. Public local government	
	4. Private-for-profit national	
	5. Private-for-profit international	
	6. National NGO/CBO/CSO	
	7. International NGO/CSO	
	8. Bilateral Agency	
	9. Multilateral Agency	

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

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

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

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

Contact:			
TOTAL:			

21. Destination of the funds:

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

8.1 Expenditure of the funds received from "7.1"

8.1.1 Function (Code and Name) Code: Name:	Amount spent
8.1.1.1 Beneficiary Population (Code and Name): Code: Name:	
8.1.1.2 Beneficiary Population (Code and Name): Code: Name:	
Total spent on the Function:	
8.1.2 Function (Code and Name) Code: 1.1 Name: Mass media	Amount spent
8.1.2.1 Beneficiary Population (Code and Name): Code: 6 Name:	
8.1.2.2 Beneficiary Population (Code and Name): Code: Name:	
Total spent on the Function:	
8.1.3 Function (Code and Name) Code: Name:	Amount spent
8.1.3.1 Beneficiary Population (Code and Name): Code: Name:	
8.1.3.2 Beneficiary Population (Code and Name): Code: Name:	
Total spent on the Function:	
Total Expenditure from the amount from '7.1'	
Total un/overspent from the amount from '7.1'	

8.1.a If funds were un/overspent from '7.1' what were the key reasons for under/over-spending?

8.2 Destination of the funds received from "7.2"				
8.2.1 **Function** (Code and Name)				Amount spent
Code:		Name:		
8.2.1.1 Beneficiary Population (Code and Name): Code: Name:				
8.2.1.2 Beneficiary Population (Code and Name): Code: Name:				
Total spent on the Function:				
8.2.2 Function (Code and Name)				Amount spent
Code:		Name:		
8.2.2.1 Beneficiary Population (Code and Name): Code: Name:				
8.2.2.2 Beneficiary Population (Code and Name): Code: Name:				
Total spent on the Function:				
8.2.3 Function (Code and Name)				Amount spent
Code:		Name:		
8.2.3.1 8.2.3.2 Beneficiary Population (Code and Name): Code: Name:				
8.2.3.3 Beneficiary Population (Code and Name): Code: Name:				
Total spent on the Function:				

Total Expenditure from the amount from '7.2'	
Total unspent from the amount from '7.2'	

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

8.3 Destination of the funds received from "7.3"	
8.3.1 **Function** (Code and Name) Code: Name:	Amount spent
8.3.1.1 Beneficiary Population (Code and Name): Code: Name:	
8.3.1.2 Beneficiary Population (Code and Name): Code: Name:	
Total spent on the Function:	
8.3.2 Function (Code and Name) Code: Name:	Amount spent
8.3.2.1 Beneficiary Population (Code and Name): Code: Name:	
8.3.2.2 Beneficiary Population (Code and Name): Code: Name:	
Total spent on the Function:	
8.3.3 Function (Code and Name) Code: Name:	Amount spent
8.3.3.1 Beneficiary Population (Code and Name): Code: Name:	
8.3.3.2 Beneficiary Population (Code and Name): Code: Name:	
Total spent on the Function:	
Total Expenditure from the amount from '7.3'	

Total unspent from the amount from '7.3'	

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

8.4 Destination of the funds received from "7.4"

8.4.1 **Function** (Code and Name)				Amount spent
Code:		Name:		
8.4.1.1 Beneficiary Population (Code and Name): Code: Name:				
8.4.1.2 Beneficiary Population (Code and Name): Code: Name:				
Total spent on the Function:				
8.4.2 Function (Code and Name)				Amount spent
Code:		Name:		
8.4.2.1 Beneficiary Population (Code and Name): Code: Name:				
8.4.2.2 Beneficiary Population (Code and Name): Code: Name:				
Total spent on the Function:				
8.4.3 Function (Code and Name)				Amount spent
Code:		Name:		
8.4.3.1 Beneficiary Population (Code and Name): Code: Name:				
8.4.3.2 Beneficiary Population (Code and Name): Code: Name:				
Total spent on the Function:				
Total Expenditure from the amount from '7.4'				

Total unspent from the amount from '7.4'	

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

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

Total unspent from the amount from '7.5'	

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

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

Additional Qualitative Information Required:

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

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

3. What are the key bottlenecks to spending?

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

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

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

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

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

9. How could these be addressed or reduced?

23. Interviewer:	**24. Date:** / / 20__

TREATMENT AND CARE

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

1. Example on Antiretroviral therapy.

FN 2.2. ***Antiretroviral therapy.*** The specific therapy includes a comprehensive set of recommended antiretroviral drugs, including the cost of supply logistics for either

adults or children. The number of people being treated is based on country-specific evidence of current coverage.

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

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

2.1 Data available: Actual Expenditure.

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

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

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

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

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

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

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

1. List the ARV consumed during the year under study.

2. Define the unit (presentation, quantity, doze).

3. Complete data on the number of units consumed.

4. Complete data on the price of each ARV. (Consult the NASA notebook for a detailed explanation on prices and costs).

5. Calculate total expenditure using the PxQ approach (Prices by Quantities).

6. Identify the Source of the information.

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

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

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

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

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

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

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

Capture the number of adults and children under ARV therapy.

Beneficiary Population	Quantity
Adults under Antiretroviral therapy	
Children under Antiretroviral therapy	
Source of information.	

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

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

ARV Therapy - Antiretroviral drugs and the cost of supply logistics.				
Activitie	Unit definition	Number of Units Consumed	Unit Price	Expenditure (PxQ)
			TOTAL	

Source of information.

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

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

Activitie	NASA Profuction Factor (Code and Name)	Expenditure

	TOTAL	

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

2. Example on Monitoring Tests.

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

2.1 Data available: number of tests delivered.

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

Number of CD4 Tests done in the year under study:	
Number of Viral Load Tests done in the year under study:	

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

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

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

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

Institutional Role

Year/s of the expenditure estimate:_____	
Objective of the Questionnaire: VI. To identify the role or roles of the institution to determine the most suitable form to use for data collection.	
Name of the Institution:	
1. Person to Contact (Name and Title):	
2. Address:	**3. E-mail:**
4. Phone:	**5. Fax:**

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

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

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

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

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

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

Forms:

1. Source / Agent
2. Provider

9. **Investigator**	10. **Date:** / /