ZAMBIA NATIONAL AIDS SPENDING ASSESSMENT (NASA) - 2005 AND 2006

MINISTRY OF HEALTH

NATIONAL HIV AND AIDS/STI/TB COUNCIL

ZAMBIA

NATIONAL AIDS SPENDING ASSESSMENT FOR 2005 AND 2006

FINAL DRAFT TECHNICAL REPORT

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PREFACE

The Government of the Republic of Zambia has prioritised the national response to HIV and AIDS. To this end, it has placed emphasis on mainstreaming HIV and AIDS into the national development agenda. This is evidenced by the prominence that HIV and AIDS have been given in critical national documents such as the Fifth National Development Plan (FNDP). Government has also continued to devote resources to the response and is grateful for the continuing support of its cooperating partners in the response. The cooperation demonstrates that we need to work together if we are to make significant progress in the fight against HIV and AIDS. Our Republican President has stated that Government has already taken steps to reduce the socio-economic impact through support for reduced discrimination and mobilisation of local and foreign resources to combat the disease.

We need to ensure that we obtain value for money from the resources that we continue to deploy towards the fight against HIV and AIDS. It behoves us, therefore, to ensure that we have a sound resource management and tracking system. Public Expenditure Tracking Systems (PETS) suggest that significant portions of resources being deployed are not getting to the intended populations with as much as 70% of disbursed resources being utilised in costly administrative and bureaucratic management systems. There is need to shift focus from commitments made by partners to actual disbursements and expenditure in order to make better informed action plans and decisions. Only then will we be able to assess the efficiency and effectiveness of our efforts.

The National AIDS Spending Assessment (NASA) has, therefore, been conducted at an opportune time when we as a country are planning to undertake a mid term review of the implementation of the National Health Strategic Plan (NHSP) and the National AIDS Strategic Framework (NASF) 2006 – 2010. This document has guided the national response. Its review will benefit greatly from the NASA and will assist in informing strategies and actions for the second term of the implementation of the NASF. It also comes at a time when we are focusing on "Knowing and Owning Our Epidemic" so that our efforts and actions are guided by international knowledge and generally accepted practices tempered by local experiences. This will encourage the active participation of our people in every part of Zambia in meeting the public health and socio-economic challenges that HIV and AIDS pose.

As above, I would like to encourage everyone to take note of the observations and findings of this report. The challenge of the response to HIV and AIDS requires the unflinching commitment from everyone from urban centres to the most remote villages.

Hon. Brigadier General Dr Brian Chituwo (Rtd.), MP

Chairman, Cabinet Committee of Ministers on HIV and AIDS

FOREWORD

AIDS is a public health and social economic problem of unprecedented proportion in our country. The pandemic calls for commitment of corresponding proportions. It calls for all of us to respond and stand together as one human army moving together in massed ranks to face the pandemic head on. Together, we can win the fight. We have noted, with some satisfaction, the commitment shown by the Government and partners in responding to the epidemic. This is evident in the rapid increase of the resources available to the response to HIV and AIDS. We remain forever grateful to Government and our partners for this commitment. We note, however, that to provide an optimal response to the pandemic, more resources are needed to close the financing gap. Increased commitment by providers of support and resources calls for equal commitment from the recipients of the same to apply them with probity, proper stewardship and accountability. The frontline of the response is in the homes of the Zambian people where, each day, our people take time to care for those affected by HIV.

The NASA is, therefore, a wonderful opportunity to provide an insight into how we are applying the resources at our disposal and get a feel of how much of the resources are getting to the frontline of the response. It also provides us with an opportunity to assess how much of the commitments made translate into services at the frontline. Further, it provides us with an opportunity to get a feel of the resources that are really available for the response as it shows us a link between the commitments made by financing agencies and the actual disbursements made. The assessment should inform our future decisions and actions on resource allocation and utilisation. This is necessary for mounting an effective response to HIV and AIDS. Our desire is that an increased amount of the resources committed to the response should be made available at the service delivery level; the level at which treatment, care and support are made available to the infected and the affected.

Council colleagues, and I, therefore, look forward to productive responses to the findings of the assessment in order to help inform our future actions in an enhanced response to the national crisis of HIV and AIDS.

Bishop Joshua H.K. Banda

Chairman, National HIV/AIDS/STI/TB Council

ACKNOWLEDGEMENTS

The National AIDS Spending Assessment (NASA) Report is a product of a lot of hard work and collaboration between National HIV/AIDS/STI/TB Council (NAC) and institutions working in the HIV and AIDS sector in Zambia.

The National AIDS Spending Assessment was funded by World Bank/ZANARA and UNAIDS and implementation was coordinated by the National AIDS Council in collaboration with the Ministry of Health. The NASA and the National Health Account (NHA) was performed as a joint effort with the Ministry of Health

I would like to express profound gratitude to all those institutions and individuals that participated by sharing their views and perspectives and providing information that made the success of the assessment possible. The study benefited greatly from the interviews conducted with the many institutions and individuals.

While I may not be able to mention all the institutions that provided valuable information and critical comment in the production of this work, I would like to put on record the invaluable support of the Ministry of Health in the assessment. May I also take this opportunity to express gratitude to the quality assurance term made of representatives from the NAC, Cooperating partners, line ministries and Civil society organizations including the Network of Zambian People Living with HIV (NZP+) for the support and technical input to the process. The list of the institutions and individuals interviewed is provided in Annex 1.

Finally, I would like to thank the team that formed the NASA Secretariat and Centre for Economic Governance and AIDS in Africa (CEGAA) that made this report possible. This exemplifies the kind of cooperative initiatives that the response to HIV and AIDS demands. I hope that this publication will assist in informing our resource mobilisation, actions and priorities as we focus our efforts in the national multisectoral response to HIV and AIDS.

Dr B U Chirwa

Director General, National HIV/AIDS/STI/TB Council

NATIONAL HIV/AIDS/STI/TB COUNCIL (NAC), ZAMBIA IN COLLABORATION WITH MINISTRY OF HEALTH AND THE UNITED NATIONS, LUSAKA, ZAMBIA

National Institutional Counterparts:

Dr Ben U Chirwa	–	Director General, National AIDS Council, Zambia
Mr Joseph N Ngulube	-	Finance Manager, NAC
Dr Paulina Chiwangu	–	Monitoring and Coordination Advisor, NAC
Dr Michael F Gboun	-	UNAIDS M&E Advisor, Zambia
Mr Patrick Banda	–	NASA Consultant

NASA Quality Assurance Team:

Mr Davies Chimfwembe	-	Director of Planning, Ministry of Health
Dr Godfrey Biemba	-	Ministry of Health
Mr Collins Chansa	-	Ministry of Health
Dr. Alex Simwanza	-	NAC
Mr. Osward Mulenga	-	NAC
Dr. Geoffrey Chishimba	-	NAC
Mr. John Grove	-	USG/CDC
Dr Catherine Sozi	-	UNAIDS Zambia Country Coordinator
Dr Rosemary Sunkutu	-	World Bank Zambia Country Office
Dr Rosemary Kumwenda	-	Poverty and HIV/AIDS Advisor UNDP
Mrs Maureen Daura	-	HSSP
Ms Mirriam Banda	-	National Chairperson, NZP+
Mr Ian Membe	-	M&E Advisor, CDC
Mrs Elizabeth Serlemitsos	-	Chief Advisor, National AIDS Council
Dr Eric Sattin	-	Advisor, ART National AIDS Council
Ms Stephanie Topp	-	Global Health Policy Adviser, Independent

CEGAA Technical support

Ms Teresa Guthrie - Centre for Economic Governance and AIDS in Africa (CEGAA)

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ABBREVIATIONS AND ACRONYMS

ADB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retro Viral Drug
ASC	AIDS Spending Categories
CBO	Community Based Organisation
CDC	Centres for Disease Control and Prevention (USG)
CEGAA	Centre for Economic Governance and AIDS in Africa
CIDA	Canadian International Development Agency
CIDRZ	Centre for Infectious Diseases Research in Zambia
CMP	Country Managed Programme (PEPFAR Funds)
CP	Cooperating Partner
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DBS	Direct budget support
DFID	Department for International Development (UK)
DGIS	Directorate General for International Cooperation (Netherlands)
EU	European Union
FBO	Faith Based Organisation
GFATM	Global Fund for the fight against AIDS, TB and Malaria
GFHR	Global Forum for Health Research
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
JICA	Japanese International Cooperation Agency
MDG	Millennium Development Goal
MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health
NAC	National HIV/AIDS/STI/TB Council
NAISP	National AIDS Intervention Strategic Plan 2002 - 2005
NASA	National AIDS Spending Assessment
NASF	National AIDS Strategic Framework 2006 - 2010

NGO	Non Governmental Organisation
ODA	Official Development Assistance
OI	Opportunistic infection(s)
OOPE	Out Of Pocket Expenditure
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PMTCT	Prevention of Mother to Child Transmission of HIV and AIDS
SFH	Society for Family Health
SIDA	Swedish International Development Agency
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organisation
ZDHS	Zambia Demographic Health Survey
ZINGO	Zambia Inter-faith Networking Group on HIV and AIDS

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DEFINITIONS

Agents

Entities which mobilise financial resources collected from different financing sources (pools) and transfer them to pay for or to purchase health care or other services or goods. These entities directly purchase from providers or steer in full or as co-guarantors of payment resources earmarked for the provision of commodities (services and/or goods) to satisfy a need. Financing agents may pool resources that pay directly for resources they consume (principally households) and may comprise entities that buy on behalf of specific beneficiaries (mainly intermediaries such as insurers or donors). If a financial agent assigns resources to confront AIDS, for NASA purposes, it becomes a financial source as well e.g. Ministry of Health, National HIV/AIDS/STI/TB Council.

AIDS Spending Categories

These categories measure commodities consumed or invested for a specific purpose (e.g. prevention of HIV/AIDS or care and treatment of HIV/AIDS). When products cannot be readily defined, they are defined as the counterpart of the activities implemented to address an HIV and AIDS target.

Sources

These are organisations or pools of funding that provide funds for HIV and AIDS services. Sources may include government ministries, bilateral funding, multilateral organisations and international NGOs.

Providers

These are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution e.g. Blood bank - Ambulatory care centre (OPD) - Hospital

Beneficiaries

This is the population which demands or has been serviced by spending on HIV and AIDS commodities (goods and services). Beneficiaries are the actual number of people making use of a service or covered by a scheme. This represents an outcome linked to the resources spent, regardless of the effectiveness or the actual use of resources (effective coverage).

EXECUTIVE SUMMARY

In recent years, Zambia has seen a dramatic increase in financial resources dedicated to HIV and AIDS activities. In 2006, for example, actual expenditure of HIV/AIDS came to $207,909,244, a sixty seven million dollar (48%) increase on 2005 alone. Despite this rapid escalation in HIV/AIDS funds, or perhaps because of it, it has become increasingly challenging to track sources of funding and spending patterns across the multiple public and non-government stakeholders. Without a good understanding of such funding flows, it has become difficult to assess where there are gaps in resources relative to Zambia's needs, and whether some areas are receiving too little or too much funding. The *Zambia National AIDS Spending Assessment for 2005 and 2006* report represents the first effort to capture this critical information. It provides insights into current structure of HIV/AIDS spending and a platform for improved strategic planning in the future.

Overall Allocations And Spending

Zambia experienced a 20% increase in resource allocation to HIV/AIDS activities from $196 million in 2005 to $235 million in 2006. Of the total allocation, actual expenditure was 72% ($141 million) in 2005 and 88% ($208 million) in 2006. This represented a 48% increase in actual spending from 2005 to 2006, indicating an improved absorptive capacity for HIV/AIDS funding during this period. While overall allocation and expenditure both saw increases, the sources of the allocations and composition of HIV/AIDS spending shifted. The following sections summarise these differences.

Public And External Allocations And Expenditure

In 2005 the total expenditure on HIV/AIDS was $140,566,646 and in 2006, it increased by 68% to $207,909,244. The public contribution to the total was 4% in 2005, and 14% in 2006. Therefore Zambia's HIV/AIDS response was predominantly donor driven. External sources accounted for 96% of total HIV/AIDS expenditure in 2005 and 86% in 2006. In 2005, multilateral and bilateral sources each accounted for 48% of total externally sourced expenditure, while international non-government organisations (INGOs) accounted for the remaining 4%. In 2006, bilateral sources increased to account for 56% of total externally sourced expenditure, with multilaterals and INGOs accounting for 26% and 5% respectively.

External funding was dominated by three main sources, the Global Fund to Fight HIV and AIDS, Tuberculosis and Malaria (GFATM), the World Bank Multi-country AIDS Programme (MAP), and the US Government through the Presidents Emergency Plan for AIDS Relief (PEPFAR).

GLOBAL FUND AGAINST HIV/AIDS, TB AND MALARIA (GFATM)

The spending of the GFATM increased from US$18 million in 2005 to almost US$26 million. Principal recipients of the GFATM funding in 2005 and 2006 were the Ministry of Health (MoH), Churches Association of Zambia (CHAZ), Zambia National AIDS Network (ZNAN) and the Ministry of Finance and National Planning (MoFNP). Between 2005 and 2006 the MoH disbursement as a percentage of the total GFATM disbursement fell from 36% to 5%, and the disbursement rate[1] fell from 28% to 4%. For the same two years, the MoFNP disbursement rose slightly from 7% of total GFATM disbursement to 9% with a slight increase in the disbursement rate from 24% in 2005 to 28% in 2006. ZNAN saw a slight decline in its disbursement from 30% of the 2005 GFATM total, to 27% in 2006, but a rise in the disbursement rate from 42% to 56%. By contrast, CHAZ saw a significant increase

[1] The amount disbursed as a percentage of the grant approved to that organisation or department.

in both the amount disbursed (from 27% of total GFATM funds in 2005 to 59% in 2006) and in the disbursement rate from 28% in 2005 to 69% in 2006. These figures suggest that of the major GFATM recipients, CHAZ has been most successful in translating approved grant funding into actual disbursements. The MoH has been least effective in securing disbursements from GFATM against approved grants. Further research is needed to understand why CHAZ has been most successful and why the MoH has been less successful to facilitate the implementation of lessons learnt to ensure better disbursement rates in the future.

World Bank Multi Country AIDS Programme (Zanara Project)

The ZANARA project defines the World Bank MAP in Zambia and comprises four components:

i) community response to HIV/AIDS (CRAIDS),

ii) support to the National AIDS Council (NAC) and its Secretariat,

iii) support to line ministries and

iv) the Programme Administration Unit (PAU).

The World Bank committed $42 million over five years with GRZ counterpart funding of $4 million. In 2005 total funding commitments of the ZANARA Project, across all four areas, totalled $14 million, while total disbursement came to $13 million (a disbursement rate of 90%), and actual expenditure, according to this NASA was US$10 million. In 2006 total commitments came to $12 million while total disbursements exceeded this at over $14 million (disbursement rate of 118%), and actual expenditure was found also at US$14 million.

Presidents Emergency Plan For AIDS Relief (PEPFAR)

The U.S. government (USG) through PEPFAR remains the highest contributor to the HIV/AIDS response annually in Zambia. Total planned funding allocations were $115 million in 2005 and $149 million in 2006 and PEPFAR funding constituted 89% of off-budget spending in Zambia in 2006. The total actual expenditure from the United States Government (USG) that was captured in this NASA expenditure the increased from US$42 million in 2005 to just over US$100 million in 2006.

Four main areas of spending under PEPFAR include: prevention, care, treatment and other costs[2] . In 2005, the PEPFAR funds were distributed proportionately between prevention (21.2%), care and support (22.5%), treatment (41.4%) and other costs (14.9%). There was no data on the planned funding allocations and disbursement rates for PEPFAR 2006 for this period. However, analysis of Country Operations Plans (COP) for 2005 and 2006 suggested that the actual expenditure in Zambia as a percentage of the total allocation was between 60 and 70%. The balance was spent indirectly from partners based outside Zambia. Funds were disbursed through direct project financing to 45 primary partners in 2005, and 51 primary partners in 2006.

Funding Arrangements

Findings showed that funds were channelled through the following arrangements:

i) Pooled resources (where external Development Partners combine resources for direct budget support to government, or through common funds for specific aspects);

[2] 'Other costs' encompass strategic information, policy analysis and systems strengthening and management and staffing.

ii) On-budget (through government and to government institutions, and from external Development Partners direct to government departments)

iii) Off budget, (where funds were spent through vertical programmes including NGOs)

In 2005 and 2006 off-budget arrangements accounted for 52% and 42% respectively of total HIV/AIDS expenditure. On the other hand, on-budget expenditure saw a significant increase from 8% in 2005 to 41% in 2006, possibly indicating a trend by external sources to provide more on-budget funding. These changes were reflected in the shifting structure of expenditure between 2005 and 2006 in which:

- Spending from **government** to **government** increased from 3% to 14% of total spending;
- Spending from **external sources** to **NGO** decreased from 69% to 17%;
- Spending from **external through government** to **NGO** increased from 1% to 3%
- Spending from **external sources to government** increased from 27% to 66%.

Of concern are the decreasing funds reaching NGOs and CBOs which are providing valuable services, particularly social and economic mitigation efforts, where spending has dramatically decreased.

AIDS Spending Categories

AIDS spending categories (ASC) are a measure of commodities consumed or invested for the purpose of alleviating the suffering induced by HIV or some of its consequences or to prevent its diffusion. Comparing categorical HIV/AIDS expenditure in Zambia between 2005 and 2006 is a challenge due to the transition from the *National AIDS Intervention Strategic Plan 2002-2005* to the *National AIDS Strategic Framework 2005-2010.* Different objectives and spending categories were stipulated in the two documents. Nonetheless, prevention spending doubled between 2005 and 2006, but proportionally stayed the same: $39,344,478 (28% of total HIV/AIDS expenditure) in 2005, and $64,161,434 in 2006 (26%). Treatment, care and support saw a significant rise in expenditure increasing from $50,784,104 (36%) in 2005 to $109,630,004 (52%) in 2006. Mitigation of impact decreased significantly from $27,374,195 (10% of total expenditure) to $9,060,892 (5%) in 2006. Advocacy and Coordination slightly increased in amounts but decreased proportionally from $13,327,501 (10%) to $14,487,461 (7%) in 2006. Monitoring, Evaluation and research saw a slight increase from $7,296,803 (5%) in 2005 to $16,914,297 (8%) in 2006. Mainstreaming and decentralisation remained consistent at 2% of total spending in both 2005 ($2,439,883) and 2006 ($3,664,957).

AIDS Spending Categories By Funding Agents

In 2005, expenditure funded through public sources focused heavily on treatment, care and support (58%), followed by prevention (24%) and advocacy and coordination (14%). In 2006 this pattern became more accentuated with spending on treatment care and support increasing to 66% of total public expenditure. Prevention, advocacy and coordination shrank to 12% and 5% of total public expenditure respectively. Between 2005 and 2006 a slight increase in public expenditure was seen in monitoring, evaluation and Research (from 1.5% to 8%), mainstreaming and decentralisation (0.5% to 6%).

Expenditure funded by external sources in 2005 focused mainly on treatment, care and support (31%), Prevention (29%) and Mitigation of Socio-economic Impact (24%). This emphasis shifted in 2006 with increased external funding for treatment, care and support (48%) at the expense of mitigation of social and economic Impact (5%). Externally funded prevention spending remained steady at 30% of total expenditure.

AIDS Spending Categories by Providers of Services

Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. The major provider of HIV and AIDS services in Zambia is the MoH through its health care delivery points. Other key players include line ministries, civil society organisations and INGOs such as the Red Cross Society, World Vision and Care International. Overall, providers received and spent an increased amount of funds in 2006 ($208 million) in comparison to 2005 ($141 million). In 2005, public providers were responsible for 35% of expenditure, rising to 41% in 2006. Other local providers were responsible for 39% of actual expenditure in 2005 declining to 25% in 2006. External providers (INGOs) were responsible for 26% of total actual expenditure in 2005, rising to 34% in 2006. The decline in spending by 'Other Local' providers and increase in 'External Providers' is indicative of an increased proportion of *external source funds* being channelled through INGOs (from 38% in 2005 to 56% in 2006) and public providers (from 22% in 2005 to 33% in 2006) rather than local non-governmental organisations (down from 40% in 2005 to 11% in 2006).

Spending Patterns By Targeted / Intended Beneficiary Populations

Beneficiary populations are classified as: People Living with HIV/AIDS (PLHIV), Most-at-risk Populations (MARP), Other Key Populations (including orphans and vulnerable children (OVC), migrants, prisoners, refugees and partners of PLHIV), Specific Accessible Populations and the General Population. The main beneficiaries of the HIV and AIDS response in Zambia in 2005 and 2006 were PLHIV with 56% and 62% of spending. Spending on the general population was 31.3% in 2005 and 24% in 2006, while Other Key Populations received 10% in 2005 and 11% in 2006. Accessible Populations received 2% and 3%, while MARP received 0.7% and 0.05% in 2005 and 2006 respectively. These spending patterns reflect the generalised nature of the HIV/AIDS epidemic and high incidence and prevalence of the disease in Zambia as well as the inapplicability of the 'MARP[3]' classification to this setting.

Qualitative Results

Results from qualitative interviews conducted with a range of stakeholders indicated a number of common themes which provided context to the data presented above. These included difficulties and delays in securing, accessing, spending and funds; limited availability and adequacy of funds; conditions attached to funds; donor reporting requirements.

Establishing a committee / working group within the NAC to provide technical assistance in this area would facilitate a centralised point of assistance for all government and non-government bodies seeking to apply for donor funding, or needing assistance with on-going reporting requirements.

[3] Most-at-risk Populations is a classification most applicable settings of concentrated epidemics where sex workers, injection drug users and men who have sex with men are more at risk than the general population of transmitting or becoming infected with HIV.

Recommendations

Following the above findings, the following recommendations are made:

Policy Recommendations

- Develop a legal framework to ensure all partners report through a national resource tracking system – for example through the institutionalisation of a NASA reporting mechanism.
- Ensure this framework is linked to the National Resource Mobilisation and Management Strategy.
- Use this framework to harmonise standards of costing among different partners.
- Use this framework to mobilise local resources to better coordinate external funding sources to meet Zambian national HIV/AIDS priorities.
- Review (and compare with NASF) areas for public spending that will strengthen the sustainability of Zambia's HIV/AIDS mitigation efforts – for example in the areas of developing coordination across agents and providers, and strengthening national and sub-national monitoring and evaluation mechanisms.

Programmatic Recommendations

- Review the split between the administrative costs and expenditure, and programme costs and expenditure with a view of reducing administrative and over-head costs and to release more resources for programmatic work.
- Conduct context-specific cost-benefit analyses of increased spending in thematic areas other than treatment.
- Scale-up spending around thematic areas along the NSF priority theme areas, particularly to increase spending on prevention, impact mitigation, and vulnerable groups.
- Increase funding for sub-national response.
- Increase funding for civil society organizations.
- Review and document successful approaches by agencies and NGOs in achieving high allocation-to-disbursement and expenditure/ absorption rates, and disseminate these findings to other applicants.

Recommendations for Future NASAs

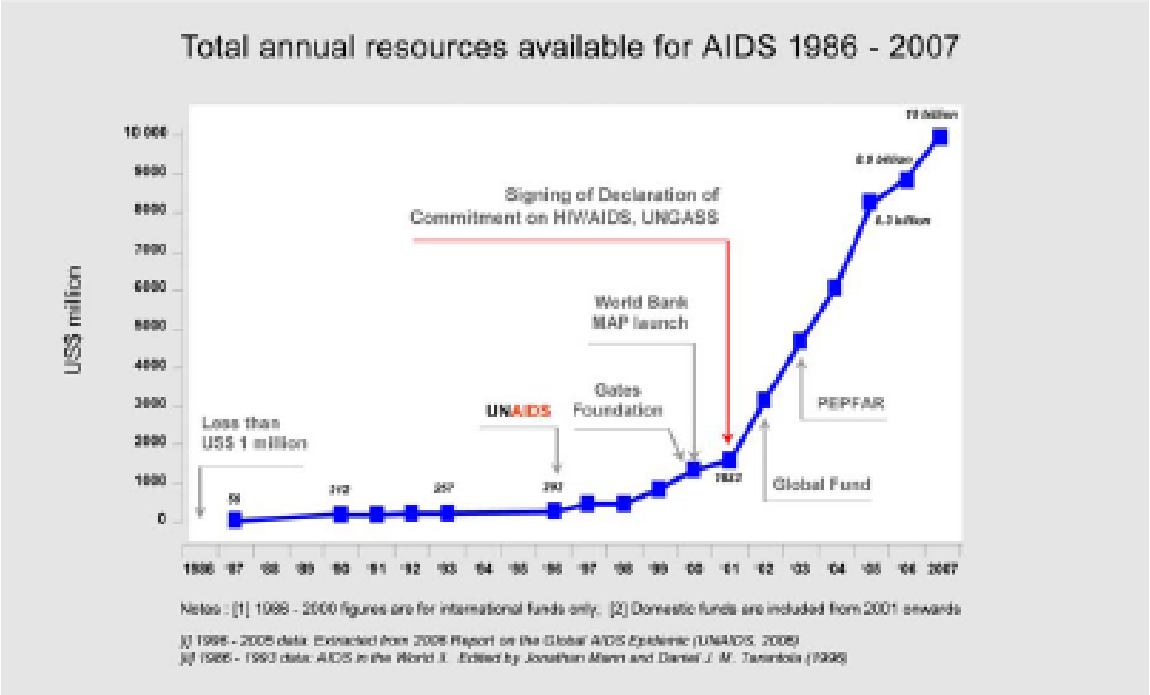
- Plan for improved geographical coverage and disaggregation of data (e.g. rural-urban comparisons) for future NASAs.
- Plan for improved monitoring of sub-national spending for future NASAs.
- Develop mechanisms to assess actual expenditure linked to annual JAPR.

1. INTRODUCTION

1.1 Global HIV and AIDS Situation

According to the 2007 UNAIDS Global Report on HIV and AIDS[4], an estimated 33.2 million [30.6 million–36.1 million] people worldwide were living with HIV at the end of 2007. An estimated 2.5 million [1.8 million–4.1 million] became newly infected with HIV and an estimated 2.1 million [1.9 million–2.4 million] lost their lives to AIDS. Overall, the HIV incidence rate (the proportion of people who have become infected with HIV) is believed to have peaked in the late 1990s and to have stabilised subsequently, notwithstanding increasing incidence in several countries. In response, the commitment of resources to HIV and AIDS has accelerated since the 2001 United Nations Special Assembly on HIV and AIDS (UNGASS), with an annual average increase of US$ 1.7 billion between 2001 and 2004, compared with an average annual increase of US$ 266 million between 1996 and 2001. Available funding in 2005 reached US$ 8.3 billion (UNAIDS, 2006).

Figure 1: Estimated total annual global resources available for AIDS 1996-2005



Source: UNAIDS (2007:6).

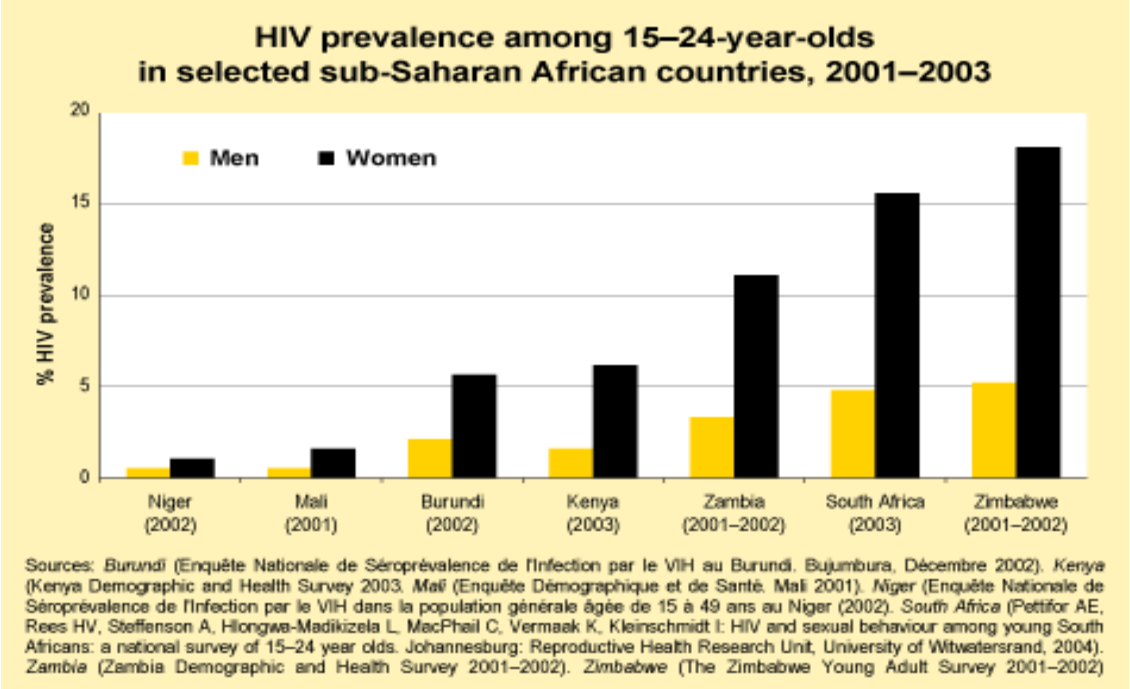
1.2 Sub-Saharan HIV And AIDS Situation

The burden of the epidemic in developing countries has been described as the "single greatest reversal in human development" (Human Development Report, 2005). The epidemic has shortened average life expectancy by more than two decades in several countries. In sub-Saharan Africa, the region with the largest burden of the AIDS epidemic, data indicate that the HIV incidence rate has peaked in most countries. However, the epidemics in this region are highly diverse and especially

[4] UNAIDS, 2007. 2007 Report on the Global AIDS Epidemic.
http://data.unAIDS.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

severe in Southern Africa. The Southern Africa sub-region accounts for 35% of all people living with HIV and almost one third (32%) of all new HIV infections and AIDS deaths globally in 2007. National adult (15-49 years) HIV prevalence exceeded 15% in eight countries in 2005 (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, and Zimbabwe). The epidemics in most of the sub-region have either reached or are approaching a plateau.

Figure 2: HIV prevalence among 15-24 year olds in sub-Saharan Africa



Sources: *Burundi* (Enquête Nationale de Séroprévalence de l'Infection par le VIH au Burundi. Bujumbura, Décembre 2002). *Kenya* (Kenya Demographic and Health Survey 2003. *Mali* (Enquête Démographique et de Santé. Mali 2001). *Niger* (Enquête Nationale de Séroprévalence de l'Infection par le VIH dans la population générale âgée de 15 à 49 ans au Niger (2002). *South Africa* (Pettifor AE, Rees HV, Steffenson A, Hlongwa-Madikizela L, MacPhail C, Vermaak K, Kleinschmidt I: HIV and sexual behaviour among young South Africans: a national survey of 15–24 year olds. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand, 2004). *Zambia* (Zambia Demographic and Health Survey 2001–2002). *Zimbabwe* (The Zimbabwe Young Adult Survey 2001–2002)

In many of the Sub-Saharan countries, the funding for prevention, treatment and care has depended largely on external sources. However, it is important to note that domestic public expenditure from governments has also significantly increased in low-income Sub-Saharan African countries, and more moderately in middle-income countries. In 2005, domestic resources for sub-Saharan Africa reached US$ 2.5 billion[5].

The African Summit on HIV and AIDS, Tuberculosis and other Related Infectious Diseases, held in Abuja, Nigeria in April 2001, attended by Heads of States of the Organisation of African Unity, gave occasion to the United Nations Secretary-General, Kofi Annan, to launch the initiative for a Global Fund on HIV and AIDS and other infectious diseases[6].

The major sources of funding for HIV and AIDS in the region remain: the Global Fund to Fight HIV and AIDS, Tuberculosis and Malaria (GFATM), the World Bank through the Multi-country HIV and AIDS Programmes (MAP), the President's Emergency Plan for AIDS Relief (PEPFAR), as well as many other cooperating agencies who are allocating resources in the region. Most of it comes as bilateral assistance to development. In relatively few years, the availability of resources has dramatically increased for many of these countries, outstripping the absorptive capacity of national health care systems and other institutional arrangements. However, according to the recently

[5] UNAIDS, 2006

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

released UNAIDS estimates of the financial resources required for universal access to prevention, treatment, care and support, there was a global funding gap of US$8.1 billion in 2007 (UNAIDS, 2007).

1.3 Zambia - Country HIV and AIDS Situation

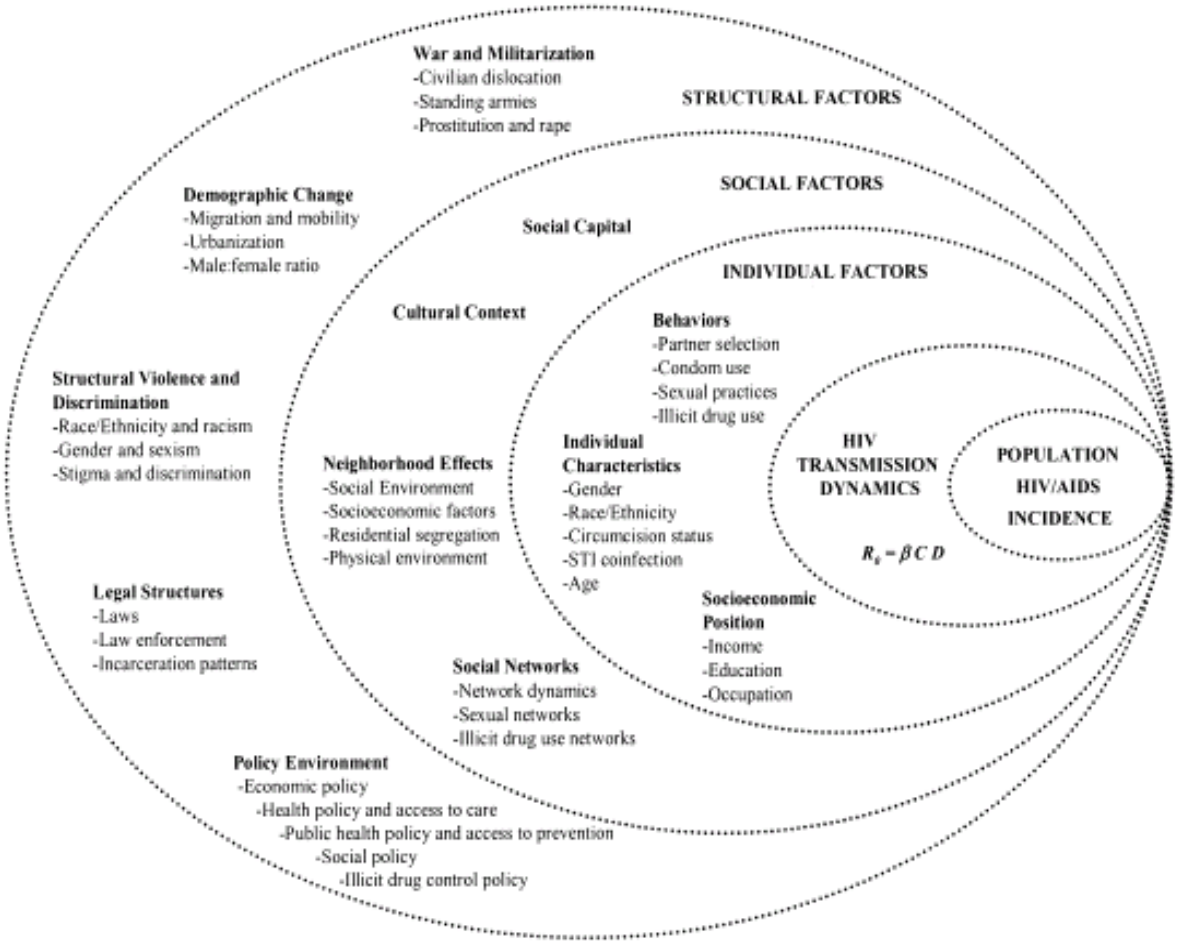
Zambia is one of the Sub-Saharan countries worst affected by the HIV and AIDS pandemic and is at the epidemiological epicentre of the epidemic. Estimates put the prevalence rate at about 15.6% among 15-49 years age group and about 1 million Zambians are infected with HIV. Out of these, over 210,000 were in need of antiretroviral therapy in 2005 (ZDHS 2002). HIV prevalence rates vary significantly according to sex and geography. While for both sexes there are higher HIV prevalence rates in urban areas, women aged 15-24 years are four times more likely to be infected than men in rural areas. However, Zambia is striving to gain control over the spread of HIV and to treat, care and support those infected and affected.

The Zambian Government, Cooperating Partners and programme implementers agree that HIV and AIDS are more than a health problem and require a broad-based, multisectoral and multi-level approach to address the many facets of the epidemic. There is further agreement that HIV and AIDS are very much inter-liked with poverty, social and economic inequities between men and women and long standing cultural behaviours and beliefs

Understanding the various factors fuelling the spread of HIV is critical. In this regard, the national response is structured to deal with issues of poverty, gender and sexual violence, economic, socio-cultural, legal and physiological factors that are different for men and women. In addition, the national response has also looked at factors such as inadequate access to information on prevention, low levels of negotiation skills and inadequate protection under statutory and customary laws and traditions. A list (not hierarchical but interrelated) of key influencing factors in the spread of HIV is illustrated in Figure 3 below.

Using the social epidemiological framework, the population HIV incidence is determined by structural factors, social factors, individual as well as the transmission dynamics of the epidemics. This is as shown in figure three in details.

Figure 3: Key Influencing factors to the spread of HIV



SOURCE: The Social Epidemiology of Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome.' *Epidemiologic Reviews*, Vol. 26, pp.22-35.

1.4. National Response to HIV And AIDS

The Government of the Republic of Zambia developed a strategic plan for addressing HIV and AIDS as early as the mid-1980s. The current National HIV and AIDS Strategic Framework (NASF) finalised in 2005, covers the period 2006–2010. The goal of the framework is to reduce the rate of new infections and to mitigate the effects of the epidemic by working in partnership with all ministries, non governmental organisations, and bilateral and multilateral cooperating partners. A number of support structures aimed at planning and coordinating the multisectoral response to the epidemic have been established. The Cabinet Committee of Ministers on HIV and AIDS devises policy direction, and the National HIV/AIDS/STI/TB Council (NAC) aims at coordinating the national multisectoral response. The latter was established as a statutory entity under the Ministry of Health through Act of Parliament No 10 of 2002 and is intended to function as the sole national HIV and AIDS coordinating authority accountable to Government through the Cabinet Committee on HIV and

AIDS. NAC is composed of broad representation from several government ministries, civil society, and the private sector. NAC provides the foundation for moving forward the process of harmonisation of cooperating partners around a single national coordinating authority, one national strategic framework and monitoring system as envisaged in the "Three Ones" principle. NAC provides national leadership, coordination, policy guidance, and resource mobilisation for the HIV and AIDS effort. The vision of the national response to AIDS is articulated in three documents:

i) the National HIV /AIDS/STI/TB Policy of 2005,

ii) the Fifth National Development Plan 2006-2010 (FNDP) and

iii) the NASF, which also incorporates the targets on universal access to HIV prevention, treatment, care and support.

The NASF has been mainstreamed into the FNDP where it is reflected as a sector but each sector has also mainstreamed HIV and AIDS. This provides an opportunity to further the process of implementing appropriate measures and strategies to control the crisis. There are also national costed annual work plans for HIV and AIDS for 2007 and 2008. These documents interpret the intentions of Millennium Development Goal (MDG) number six. The goal states the intention of the signatory countries as to, by 2015, begin to halt and reverse the spread of communicable diseases. Zambia was one of the countries that signed the Millennium Declaration in 2001 at which the MDGs were formulated.

1.5 National Health Account and National AIDS Spending Assessment

National Health Accounts (NHA) is designed to give a comprehensive description of resource flows in a health system, showing where resources come from and how they are used. The Ministry of Health (MoH) has recognised the importance of documenting the overall flow of health funds and has initiated the process of producing NHA with a view to generating data that can assist the formulation of health policies that improve access to health care and efficiency in resource allocation. Unless policy makers are able to analyse the sources of funds, and how finances are being used they will not be able to plan, budget and manage the delivery of health services effectively. If information generated by the NHA is utilised, resource allocation is likely to be based on relative need and not on historical patterns. The Ministry of Health (MoH), therefore, recognises the importance of the availability of quality health expenditure data in order to inform the development of sound health care financing policies in the health sector as a means of addressing the growing disease burden. Since 1999, four NHA studies have been undertaken to establish the sources and uses of total health care expenditure in Zambia. National Health Accounts (NHA) provides evidence to monitor trends in health spending for all sectors, public and private, different health care activities, providers, diseases, population groups and regions in a country. It helps in developing national strategies for effective health financing and in raising additional funds for health.

The 2004 NHA findings revealed that total health expenditure nominally increased by 7 percent from ZMK 1, 082 billion in 2002 to ZMK1, 860 billion in 2004. Per capita health expenditure increased from US$23.3 to US$34.2. This is inclusive of expenditure on HIV/AIDS interventions. This should be compared to the World Health Organisation (WHO) recommendation of at least US$34 per capita. The WHO recommendation excludes expenditure on HIV/AIDS treatment. However, as a percentage of total government expenditure, government health expenditure declined from 6.7 percent in 2002 to 4.7 percent in 2004. This is far below the 15 percent commitment of the Abuja and Maputo Declarations by African Heads of States.

The 2004 NHA study also found that donors remained the most important source of health expenditure. They accounted for almost half, 42.5 percent, of total health expenditure in 2004. They were followed by households at 28.4 percent. The government share declined from 32.5 percent in 2002 to 17.3 per cent in 2004. Most of the external resources are disease or project specific and mainly linked to HIV and AIDS interventions, TB treatment and malaria prevention and treatment. This finding raises the important question of the sustainability of health care financing especially at a time that most donors are migrating to direct budget support with no assurance that the MoH will receive the same level of funding.

Finally the 2004 NHA study found that, consistent with the policy to devote more resources to prevention rather than curative care, Primary Health Care (PHC) received the largest share of expenditure at 42 percent of total health expenditure. Tertiary and secondary care received 15 and 7 percent respectively. Information provided by the NHA is usually highly aggregated for diseases and does not disaggregate data in detail to capture expenditure by AIDS spending categories. This current NASA is the first time Zambia is conducting a comprehensive assessment of actual AIDS spending in the country, in conjunction with the NHA. In addition, the NHA is health focused and the response to HIV and AIDS is increasingly a multisectoral one. This means that HIV and AIDS related expenditure will be incurred in sectors other than the health sector. This necessitated the undertaking of a concurrent complimentary AIDS Spending Assessment to capture information in all the sectors that are involved in the HIV and AIDS response in Zambia.

In order to avoid duplication and respondent fatigue, partners in the Ministry of Health and National AIDS Council and United Nations as well as other cooperating partners agreed to remove the HIV and AIDS component of the NHA and add it to the NASA tool. This meant that the NASA tool was capturing all AIDS related expenditure whereas the NHA tool was capturing the other disease expenditure as required by the NHA. Both tools were administered simultaneously, which was more efficient and cost-effective, while also providing the opportunity to build in-country capacity on both NHA and NASA methods. Many lessons were learnt regarding the coordination and management of the two processes.

1.6 Rationale for an HIV And AIDS Spending Assessment

Zambia has, in recent years, seen a dramatic increase in the flow of financial resources going to HIV and AIDS activities. In addition to the contributions of the Government of the Republic of Zambia (GRZ), other major providers of funding to AIDS include the Global Fund, PEPFAR, and the World Bank, as well as traditional bilateral cooperating partners including DfID, GTZ, USAID, Irish Aid, SIDA, Norway, Netherlands and DANIDA. The UN agencies (WHO, UNICEF, UNDP, UNFPA) also provide support to specific activities.

The 2004 UNAIDS Annual Report notes that “even though more and more money has become available to respond to AIDS, in many heavily affected countries it is clear there are serious bottlenecks to spending it effectively’. These blockages include lack of human and institutional capacity, the persistent negative effects of stigma and discrimination, shortfalls in political commitment, slow transfer of funds from national to local and community levels, inadequate accounting and auditing mechanisms, and inconsistent bureaucratic funding processes of the global cooperating partner community”.

At the national level, there has also been an ever more rapid multiplication of fund recipients which include international and national NGOs, faith-based organisations, community-based organisations,

professional societies, and other forms of civil society groups and community based organisations. The increasing number of funding agents and recipients pose a challenge to resource management.

i) The actual level of AIDS spending in Zambia is not currently known with any certainty, much less the level of spending for specific line items or activities. As a result, it has not been ascertained whether there is a gap in resources relative to need, nor whether specific line items/activities are being over or under-funded.

ii) Scaling up activities has become more difficult with additional resources due to possible funding duplications and overlaps.

iii) In the absence of a comprehensive mapping of the multiple players and their coverage areas, there is no assurance that AIDS resources are being allocated as efficiently as possible, nor is there assurance that these resources are being used for intended purposes.

iv There is an increasing information disconnect between multiple local "service providers/fund recipients" and central "resource managers" such as the National AIDS Council (NAC).

It is imperative, therefore, to continually undertake resource and benefit tracking and analysis, as well as to develop systems for the collection of data on HIV and AIDS related expenditure and services at various levels of financing and service delivery in all sectors. This would provide the necessary evidence to inform a more rational basis for AIDS resource planning, allocation and management. This would, in turn, strengthen the national response to the epidemic. This NASA was the first attempt to collect and collate disaggregated information on the HIV and AIDS spending activities happening in Zambia, identifying the sources of funds, the agents and the providers of services, as well as the beneficiaries of these services.

2.0 SCOPE AND OBJECTIVES OF THE STUDY

2.1 Scope

This NASA covered the identification and measurement of resources by source, agent, provider and beneficiary based at the central level and in selected districts covering the period 2005 and 2006. Data collection covered the domestic spending (GRZ) on HIV and AIDS, and the external aid for HIV and AIDS (including those funds channelled through the government) but did not cover the business sector or out-of-pocket/household expenditure by members of the public and families affected by HIV and AIDS. In addition, the NASA does not explore the effectiveness of spending, bottlenecks, the financial management systems, and absorptive capacity issues in detail. The assessment did not examine the quality of services provided nor the outputs and impact of spending. The above notwithstanding, the report provides the first data requirement of an accurate assessment of what was actually spent, in order to undertake the output/impact analysis at a later stage.

2.2 Objectives

The objectives of the study were:

a) To undertake an accurate assessment of what was actually spent on HIV and AIDS in Zambia

b) To collect data on domestic/public and external/ international expenditure on HIV and AIDS in Zambia for 2005 and 2006;

c) To use the data to contribute to the development of a national multisectoral resource tracking system

d) To use the data for evidence based resource mobilisation and advocacy, in order to scale up the response to HIV and AIDS

2.3 Structure Of The Report

The report has been organised in seven sections as follows:

a) Introduction

b) Financing and Resource Tracking of the National Response

c) Scope and Objectives of the study

d) Methodology

e) Key findings

f) Conclusion and Recommendations

g) Annexes

3. COSTING AND FUNDING MECHANISMS IN ZAMBIA

3.1 Costing Of National HIV/AIDS/STI/TB Intervention Strategic Plan (2002 – 2005)

The first National AIDS Intervention Strategic Plan (NAISP) provided a framework to guide an effective national response to HIV and AIDS for the period 2002 – 2005, and is presented here to enable comparison with actual spending for 2005 and 2006. The guiding principles for the plan were:

a) The development of an appropriate legal framework essential to the attainment of the vision of a nation free from HIV and AIDS;

b) The promotion of integrated approaches to interventions covering health, society and economic growth;

c) Promoting the involvement of the Zambian people in the fight against HIV and AIDS while remaining culturally sensitive;

d) Giving priority to high risk groups and associated geographical areas.

The plan was structured around the objectives and estimated budget shown in Table 1 below.

Table1: Estimated Budget for Achieving the Objectives of the NAISP 2002-2005

Objective	Estimated Budget
Objective 1. To promote the implementation of multisectoral behavioural change communication campaigns by encouraging safe sex practices and good health-seeking behaviours so as to reduce HIV/AIDS prevalence in the 15-19 age group from 15-11 percent by 2005.	$195,918,000
Objective 2. To decrease the mother-to-child transmission rate of HIV from 40% to 32% by increasing access to quality prevention of mother-to-child transmission services in all districts of the country.	$37,704,000
Objective 3. To make all blood, blood products and body parts safe for transfusion and to promote the use of sterile syringes, blades, needles by strengthening all (100%) screening centres and adopting infection control measures by 2005.	$6,723,000
Objective 4. To improve the quality of HIV/AIDS infected persons by encouraging positive living, good nutrition, prevention of opportunistic infections and avoiding high risk behaviour.	$12,908,000
Objective 5. To provide appropriate care, support and treatment of HIV/AIDS infected persons and those affected by HIV/AIDS, TB, STIs and other opportunistic infections by the year 2005.	$194,850,000
Objective 6. To provide improved care and support services for orphans and vulnerable children (OVCs) and others affected and at risk such as refugees, prisoners and disabled people.	$69,475,000
Objective 7. To improve HIV/AIDS information management and decision-making by developing well-co-ordinated databases by 2005.	$13,300,000
Objective 8. To assure impartial, transparent and effective programme operations by improving the coordination of multisectoral implementation of interventions.	$27,824,000
Total	**$558,702,000**

3.2 Costing of the National AIDS Strategic Framework (2006 – 2010)

With the end of the NAISP, the country formulated a National Strategic Framework for the period 2006 – 2010 to guide the next phase of the national response to HIV and AIDS, and is presented here to enable the comparison with actual expenditure for 2006 and 2007. The National AIDS Strategic Framework

(NASF) provides the framework for the operationalisation and coordination of the national response which is focused on three main areas:

- Prevention Programmes;
- Universal Access to treatment;
- Socio-economic Impact Management and Mitigation.

These areas are reflected as six themes in the NASF which represent the national priority action areas for 2006-2010:

- Intensifying Prevention of HIV infection
- Expanding treatment, care and support for people affected by HIV and AIDS
- Mitigating the socio-economic impact of HIV and AIDS
- Strengthening the decentralised response and mainstreaming HIV and AIDS in development programmes
- Improving the monitoring of the multisectoral response
- Integrating advocacy and coordination of the multisectoral response. One of the goals of this theme is to improve and resolve areas of duplication and gaps in the multisectoral response

Table 2 broadly illustrates the estimates of available resources for the NASF 2006 -10 which were based on an optimistic scenario in which we have assumed the levels of commitment to HIV and AIDS in 2006 remain constant over the following years. It is hoped these would increased over the period. Estimates have also been included for contributions from private foundations and sources not captured currently by any of the tracking studies.

Table 2: Estimated funding for NASF 2006-10

	2006	2007	2008	2009	2010	2006-10
UN Family (Includes WB)	20,000,000	20,000,000	20,000,000	11,600,000	11,600,000	83,200,000
JICA	3,205,785	3,205,785	3,205,785	3,205,785	3,205,785	16,028,925
USG*	149,000,000	149,000,000	149,000,000	74,000,000	74,000,000	595,000,000
NORAD	2,850,000	2,850,000	2,850,000	2,850,000	2,850,000	14,250,000
Netherlands	1,210,090	1,210,090	1,210,090	1,210,090	1,210,090	6,050,450
DCI (Ireland)	3,751,279	3,751,279	3,751,279	3,751,279	3,751,279	18,756,395
SIDA	3,933,333	3,933,333	3,933,333	3,933,333	3,933,333	19,666,667
Global Fund**	52,800,000	52,800,000	52,800,000	19,800,000	19,800,000	198,000,000
DFID (UK)	7,065,200	7,065,200	7,065,200	7,065,200	7,065,200	35,326,000
EU	4,033,633	4,033,633	4,033,633	4,033,633	4,033,633	20,168,167
Private Charities & Foundations	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	50,000,000
GRZ***	15,000,000	15,000,000	15,000,000	15,000,000	15,000,000	75,000,000
TOTAL	**272,849,320**	**272,849,320**	**272,849,320**	**156,449,320**	**156,449,320**	**1,131,446,600**

Source: NASF 2006-10

* The USG is uncertain of the precise level of commitment after 2008; estimates have included 2006 levels up to 2008 and 50% thereafter.

** Although Zambia will apply for Round 6 Global Funds, estimates have been made on current level of funding available and no additional funding is projected beyond 2008

*** The Government of Zambia is expected to significantly increase inputs for this planning period due to the Debt Dividend to a maximum of US$30,000,000 per year. Conservatively, estimates are made at 50% of the maximum

In keeping with the strategic intent to mainstream into the National Development Plan and the District Development Plans, costing by theme[7] was completed based on the submissions of the Districts and Line Ministries as well as the review of a sample of Civil Society and Private Sector organisations plans for HIV and AIDS. The costing was cross-checked against available cost norms and used to estimate resources needed, assuming 50% scale up from a base scenario which had projected full scale up. This is as shown on table 3.

[7] Analysis of the NASF 2006-10 Database compiled from samples District Development Plans, District HIV and AIDS Strategic Plans, Civil Society Organisations Plans, Private Sector NGOs Strategic Plans
Costs and Financing of the NASF 2006-2010: Report to the Joint Financing Technical Working Group: January 2006

Table 3: Estimates of Resources Required for NASF 2006-10 based on 50% scale up and Funding Gap

	2006	2007	2008	2009	2010	2006-10
50% full Scale Up	124,853,452	116,702,712	88,556,876	89,761,768	90,304,000	510,178,808
All Districts & Provinces	84,038,459	86,058,507	87,324,942	96,008,093	94,000,449	447,430,451
Line Ministries	11,862,009	12,609,316	13,227,172	13,875,304	14,555,194	66,128,995
NAC	14,427,831	14,990,345	16,664,145	17,497,352	18,372,220	11,951,894
CSOs	24,120,517	25,640,110	26,896,475	28,214,403	29,596,908	134,468,414
Private Sector	8,923,592	9,485,778	9,950,581	10,438,160	10,949,630	49,747,741
Estimated Expenditure	**268,225,861**	**275,486,769**	**242,620,193**	**255,795,080**	**257,778,401**	**1,289,906,303**
Estimated Funding	**272,849,320**	**272,849,320**	**272,849,320**	**156,449,320**	**156,449,320**	**1,131,446,600**
Gap	**4,623,460**	**7,362,552**	**30,229,129**	**99,345,760**	**101,329,081**	**-158,459,700**

Source: NASF 2006-10

Table 4 illustrates the broad allocation of estimated available resources by NASF themes based on the analysis of the districts and feedback from the consultative process of developing the new NASF 2006-10.

Table 4: Intended Proportional Funding for Themes of NASF 2006-10 (US$million)

	THEME	% Allocation	2006	2007	2008	2009	2010	2006-10
	ESTIMATED FUNDING		**273.0**	**273.0**	**273.0**	**157.6**	**157.6**	**1,134.4**
I	Intensifying Prevention	25	68.3	68.3	68.3	39.4	39.4	**283.6**
II	Expanding treatment, care, support	30	81.9	81.9	81.9	47.3	47.3	**340.3**
III	Mitigating S/E Impact	15	41.0	41.0	41.0	23.6	23.6	**170.2**
IV	Strengthening decentralized response and Mainstreaming	15	41.0	41.0	41.0	23.6	23.6	**170.2**
V	Improving Monitoring	10	27.3	27.3	27.3	15.8	15.8	**113.4**

VI	Integrating Advocacy & Coordination	5	13.7	13.7	13.7	7.9	7.9	**56.7**

Source: NASF 2006-10

3.3 FUNDING MECHANISMS

3.3.1 PUBLIC FUNDING MECHANISMS

In Zambia, the preference of the national authorities seems to be for all domestically financed expenditure and external support (in terms of direct budget support, sector support, project support, etc) to go through the national budget. Hence, all domestic resources and as much of external resources as possible – i.e. as much as negotiations between the MOFNP and respective donors (or Cooperating Partners, CPs) will allow – are planned for through national budgeting systems. This means that the annual budget, which is traditionally presented in terms of the Annual Estimates of Revenue and Expenditure, is a comprehensive account of expenditure allocations for any given year. It defines the country's priority; setting principles in allocating both domestic and aligned external resources to various sectors and activities.

Since 2004, the government has provided the national budget on an activity basis. Estimates are presented by programme and activity for each budget head and sub-head. The Activity Based Budgeting (ABB) that was adopted together with the Medium Term Expenditure Planning Framework (MTEF) format, provides more detail on the purpose of budgetary spending, making it possible to pick out and classify very specific (disaggregated) spending intentions such as funding allocations for HIV and AIDS sub-heads (or activities) over a three year period as opposed to what previously was provided for - only on an annual basis. Table 4 below provides a summary of these allocations (it may include some donor resources passed through DBS):

Table 5: National Allocations[8] to Health and HIV and AIDS (2000-2007)[9] (USD)

	2000	2001	2002	2003	2004	2005	2006	2007
Total National Budget ($ million)	787.7	1,302.3	1,284.4	1,504.6	1,934.6	2,444.8	2,858.3	2,937.2
Total Health (MoH) Budget ($ million)	68.88	130.2	158.83	174.17	154.11	224.95	296.77	297.14
Total HIV and AIDS Allocation ($ million)	2.98	9.05	3.42	13.65	42.53	48.65	86.48	43.52
Total HIV funds in Health (MoH) Budget ($ million)	2.95	9.02	2.83	5.64	29.06	23.45	59.96	28.03
Total Health budget as share of total budget	8.9%	10%	12.4%	11.6%	8%	9.2%	10.4%	10.1%
HIV and AIDS in health (% of Total Health Budget)	4.3%	6.9%	1.8%	3.2%	18.9%	10.4%	20.2%	9.4%
Health HIV and AIDS (% of Total HIV and AIDS funds in budget)	99.2 %	99.7%	82.7%	41.3%	68.3%	48.2%	69.3%	64.4%

[8] These are intended allocations indicated in the National Estimates of Revenue and Expenditure. They are not actual expenditures.

[9] The data from the Yellow Books (given in Kwacha) were converted to US dollar figures using exchange rate data obtained from various Bank of Zambia (BOZ) databases [I assume this accounts for the different ER for 2005/6?]

Source: Authors' construction using GRZ "Estimates of Revenue and Expenditure (Yellow Books)"; *Various: for the Years 1st January, 2000 to 31st December, 2007*.

3.3.2 DONOR FUNDING MECHANISMS

There are three funding mechanisms for donor funds available in the Zambia HIV and AIDS Response:

1. *On-budget (Direct Budget Support (DBS)*

   On – budget funding is done through the Ministry of Finance and National Planning and is included in the Yellow Book (The National estimates of revenue and expenditure). Generally, DBS entails donors giving funds to Governments with capacity and good governance structures, and the governments then spending those funds as per national priorities. Thus DBS gets rid of 'tied-aid' altogether. Line Ministries apply for funds through the normal channels for public funds, i.e. Annual Plans. Line Ministries bid for those funds and negotiate allocations with MOFNP on an annual basis which includes funds from GRZ own revenue.

2. *Off-budget*

   Off-budget funding does not go through the MOFNP, but is direct from donor to recipient/service implementer, which may be either public or private (usually NGOs).

3. *Basket and pool funding*

   Basket and pool funding are funding instruments normally associated with SWAPs, or situations where donors want to pool financial resources to fund particularly large programmes. Government contribution is part of this pooled or basket funding.

The questions that arise are whether GRZ should increase its contribution and whether debt relief funds or foreign reserves should be directed to certain national priorities like HIV and AIDS. On one hand, because Zambia has committed itself to fiscal prudent policies, and its macroeconomic stability has satisfied international donors resulting in the debt cancellation at the end of 2005, advocating an increase in public spending would have to be within the Government's macroeconomic framework and fiscal policy targets agreed upon by the IMF and World Bank. On the other, national priorities have to be addressed by the Government and not by CPs. Could the GRZ take over some of the funding by CPs then? Could this be possible for PEPFAR, for instance? Revising the required resource envelope together with the targets, and finding alternative ways of financing the social sectors increasingly through internal resources may be options that GRZ cannot afford to ignore. Already the Cabinet Office is in the process of exploring ways to fund the HIV and AIDS response in the public service through social insurance schemes. The private sector may be able to follow this example.

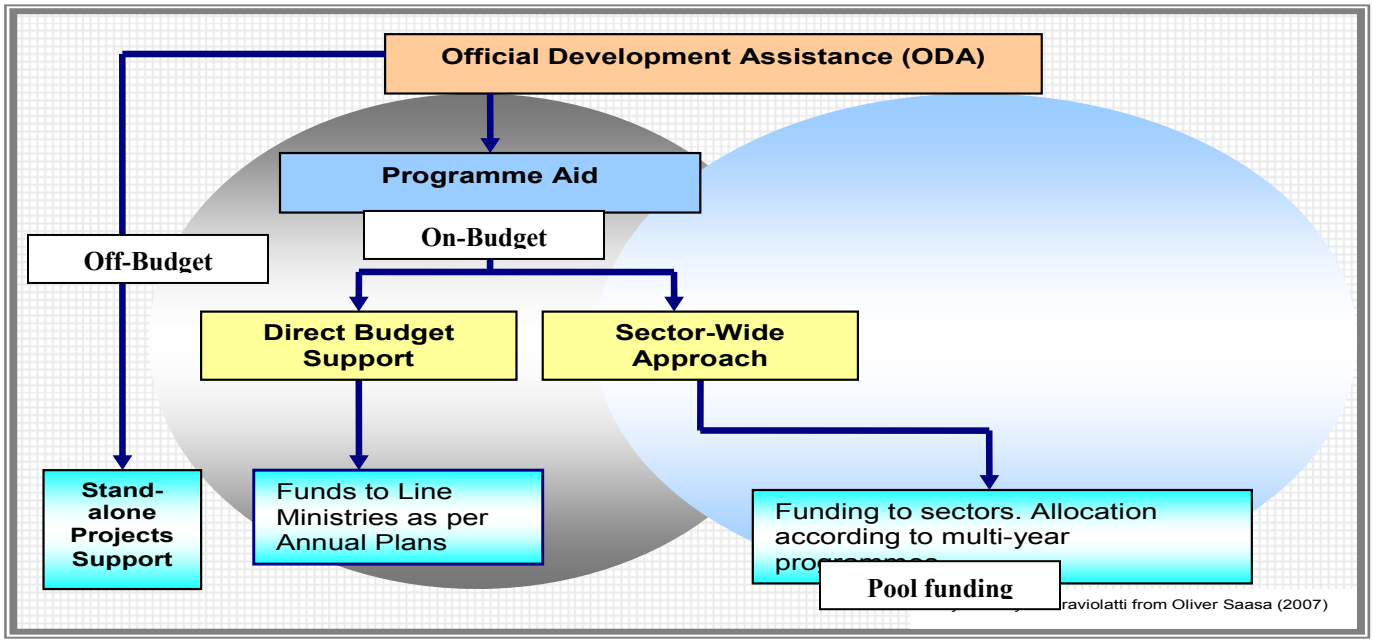
Table 6: Summary of Funding Available (2006 - 2008)

Summary Funding Commitments - USD				
Cooperating Partners		**2006**	**2007**	**2008**
On-Budget				
GFATM[1]	HIV/AIDS	29,361,047	16,009,259	
World Bank	ZANARA	8,415,440	16,035,293	
GRZ and other CPs		21,506,400	12,729,799	
DFID		3,589,000	3,589,000	3,589,000
Basket Funding	JFA	1,853,031	1,854,949	
Irish Aid		4,029,300	4,162,400	
Joint UN Programme[2]	All UN agencies		19,419,000	
TOTAL		**68,754,219**	**73,799,700**	**3,589,000**
On-Budget as % of Grand-Total		29%	30%	
Off-Budget				
PEPFAR	CDC, USAID etc.	149,022,150	150,000,000	180,000,000
DFID (STARZ)	STARZ	15,045,822	21,042,145	6,982,097
JICA		1,514,496	1,646,800	
Int. NGOs (not included in other funding allocation)	CARE	1,610,000	2,795,800	1,185,800
CHAZ	(Non-GFATM)			
TOTAL		**167,192,468**	**175,484,745**	**188,167,897**
Off-Budget as % of Grand-Total		71%	70%	
Grand-Total		**235,946,687**	**249,284,445**	**191,756,897**

Notes: [1] GFATM grants (round 4) for 2008 and 2009 have not been approved yet;[2] the joint UN programme cover the period 2007-2010. Source: UNAIDS Annual Report (2007).

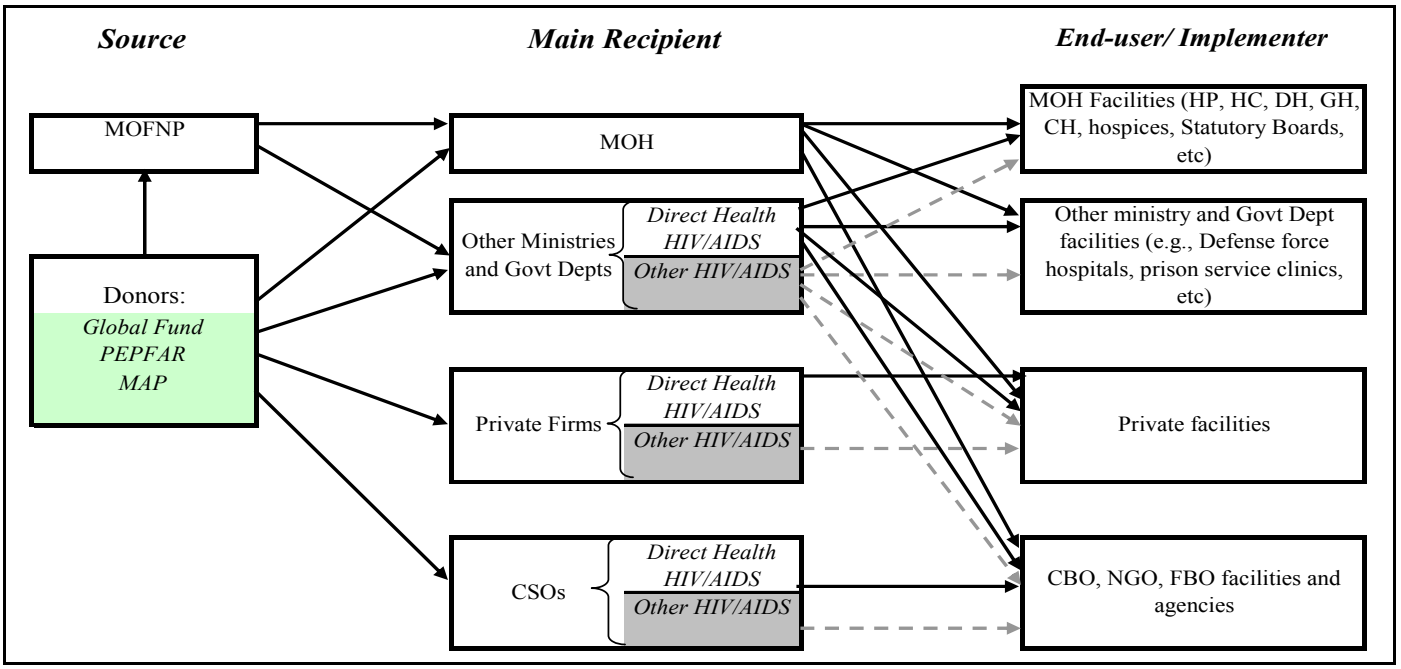
The three mechanisms for ODA funds are illustrated below:

Figure 4: Financing mechanisms in the national response to HIV and AIDS



An example of existing funding flows under direct budget support is illustrated as follows:

Figure 5: Funding flow under DBS for HIV



Source: Authors' own construction, drawing on De and Dmytraczenko (2004)

3.3.3 HIV AND AIDS MAJOR SOURCES OF FUNDS

There are various external sources for HIV and AIDS in Zambia, including multilateral/, bilateral partners and foundation. The key ones are discussed here in further detail.

Global Fund To Fight HIV And AIDS, Tuberculosis And Malaria (Gfatm)

GFATM resources for HIV and AIDS are managed through four principal recipients:

i) the Ministry of Health,

ii) the Ministry of Finance and National Planning,

iii) the Churches Health Association of Zambia and

iv the Zambia National AIDS Network.

Global Fund approved grants are based on Rounds of collective proposal from a country's would-be Principal Recipients (PR) while disbursements are formally (though not strictly) made through Phases per Round. In principle, the idea is for a country to apply for funding through a country proposal prepared by a Country Coordination Mechanism (CCM), secure approval of the total or a proportion of the amount applied for, and on a quarterly basis secures disbursements from the Global Fund. After the first disbursement, all subsequent disbursements are based on performance.

The table below summarises the annual Global Fund allocations and releases to Zambia's HIV and AIDS programme during the period 2003-2006.

Table 7: Global Fund Disbursements rates (2003-2006)

	2003	2004	2005*	2006
Total Approved Grant (or balance on Approved Grant) ($)	90,325,778	87,826,636	88,250,806	61,322,506
Total disbursements (all Principal Recipient) ($)	2,499,142	25,953,905	26,928,300	22,083,817
Balance on grant	*87,826,636*	*61,872,731*	*61,322,506*	*39,238,689*
Disbursement rate (disbursement/approved grant):	*3%*	*30%*	*31%*	*36%*

* Sum of Rounds 1 balance brought forward and Round 4 Approved Grants

Source: Authors' construction using Global Fund data

The actual disbursements to Principal Recipients over the period 2003 – 2006 are illustrated below:

Table 8: Global Fund Disbursements & approval of Grants by Principal Recipients (2003-2006)

Principal Recipient (PR)	2003	2004	2005*	2006*
MoH disbursement ($)	1,692,382	15,243,925	9,670,762	1,116,674
MoH Approved Grant ($)	40,884,928	39,192,546	34,647,560	24,976,798
Disbursement rate (disbursement/Grant approved):	*4%*	*39%*	*28%*	*4%*
CHAZ disbursement ($)	381,585	5,132,673	7,160,582	12,935,275
CHAZ Approved Grant ($)	22,840,611	22,459,026	25,814,273	18,653,691
Disbursement rate (disbursement/Grant approved):	*2%*	*23%*	*28%*	*69%*
CHAZ disbursement to SRO ($)		2,166,190	4,482,529	4,259,946
ZNAN disbursement ($)	425,175	5,577,307	8,018,794	6,140,734
ZNAN Approved Grant ($)	20,204,481	19,779,306	19,016,839	10,998,045
Disbursement rate (disbursement/Grant approved):	*2%*	*28%*	*42%*	*56%*
ZNAN disbursement to SRO ($)		2,725,584	6,054,004	4,060,091
MOFNP disbursement ($)	0	0	2,078,162	1,891,134
MOFNP Approved Grant ($)	6,395,758	6,395,758	8,772,134	6,693,972

Disbursement rate (disbursement/Grant approved):	*0%*	*0%*	*24%*	*28%*
Total disbursements (all PR) ($)	2,499,142	25,953,905	26,928,300	22,083,817
Total Grant Approved (or balance on,) ($)*	90,325,778	87,826,636	88,250,806	61,322,506
Disbursement rate (disbursement/Grant approved):	*3%*	*30%*	*31%*	*36%*

Source: Authors' construction using Global Fund data

* Approved Grants in this year sum of Round 1 outstanding balance (i.e., amount not yet disbursed) and Round 4 Approved Grants (or balance thereof in 2006)

World Bank-Map (Zanara Project)

The ZANARA project defines the World Bank Multi country AIDS Programme (MAP) in Zambia. The development objective of the ZANARA Project is to significantly increase access to, and use of, HIV and AIDS prevention, care and impact mitigation programmes with particular emphasis on vulnerable populations (e.g. youth, women of childbearing age, orphans, widows and widowers, child or women-headed households, people living with HIV and other groups at increased risk of infection or being affected). Project support comprises four components namely:

i) the Community Response to HIV/AIDS (CRAIDS),

ii) support to the National AIDS Council (NAC) and its Secretariat,

iii) support to Line Ministries, including Ministry of Health, and

iv) the Programme Administration Unit (PAU) - Ministry of Finance and National Planning (MoFNP).

The project was financed under a World Bank grant of US$ 42 million, over 5 years. This grant required counterpart funding from the Zambian government of US$ 4 million. During 2004, a memorandum of understanding was signed for co-funding with the Department for International Development (DFID) resulting in the financing component called the Strengthening of the AIDS Response in Zambia (STARZ) being attached to the Project. Thus, the Zambian MAP has been financed from three sources namely:

i) The World Bank (IDA) grant,

ii) The Zambian Government's contribution and

iv) DFID.

The World Bank has been the major funding source, providing 89 percent of the ZANARA funds during 2003-2006 (government and DFID contributions were 9 and 2 percent, respectively). The four components of the ZANARA project are elaborated below:

ZANARA Community Response to HIV and AIDS (CRAIDS)

CRAIDS was established to support community based initiatives through financing of community based projects which are identified, planned, implemented, managed and maintained by communities themselves. It supports the district response to HIV/AIDS through capacity building activities to community members and district level institution staff to enable a district response to HIV/AIDS. Such responses are designed to support, facilitate, coordinate, monitor and evaluate the community response

in the treatment, care, support, control and prevention of the epidemic by supporting non-governmental organisations through strengthening the capacity of NGOs, CBOs and FBOs.

ZANARA Support To The National Hiv/AIDS Council (Nac) And Its Secretariat

The main objective is to support the NAC and its Secretariat to carry out its institutional mandate of programme coordination, monitoring and evaluation of the national response. The NAC has the role of monitoring, evaluating, and coordinating the activities of the ZANARA Project as part of its overall mandate of coordinating monitoring and evaluating the national HIV/AIDS programme. The Provincial AIDS Task Forces (PATFs) and District AIDS Task Forces (DATFs), comprising all sectors including CBO and NGO representation, were set up so as to supervise project activities at provincial and district/sub-district levels, respectively. They serve as subordinate coordination bodies under the NAC.

Support to the Line Ministries, including Ministry of Health (MoH)

The main objective of the Line Ministries is to expand the public sector multisectoral response to the HIV/AIDS epidemic by initiating, facilitating and supporting the mainstreaming of the HIV/AIDS-related activities into the work-plans of line Ministries as well as support the National Health Service delivery programme of the Ministry of Health. The Ministry of Health sub-component has a special role compared to other line ministries; this role is therefore worth mentioning. The role of MoH is to implement activities to strengthen service delivery and build capacity in health institutions and in the health sector in general. ZANARA funds contribute to the MoH mandate in a number of ways. The main areas of ZANARA project support to MoH have been the following:

- Strengthening of Youth Friendly Health Services,
- Expansion of VCT,
- Provision of Safe Blood and Safe Health Waste Management,
- Support to PMTCT,
- Support to Post Exposure Prophylaxis,
- Treatment of opportunistic infections,
- Strengthening Laboratory Services, Support to IEC,
- Support to the development of workplace policies and Partnering with Traditional Healers,
- Research and Strengthening Monitoring and Evaluation.

ZANARA Support To The Programme Administration Unit (Pau).

This component has the mandate to facilitate the multisectoral response to HIV/AIDS by providing managerial and administrative support to the project implementing and coordinating agencies in carrying out activities under the MAP. The PAU is responsible for the administration of the project-components which include the financial management, procurement and disbursement functions of MAP activities and the day-to-day interactions with the World Bank. The PAU is also responsible for the management of the logistical aspects of the project and consolidation of progress reports on activities for all stakeholders on procurement plans, implementation progress and resource use.

Zanara Funding Sources And Disbursements

Table 7 below summarises the financial commitments and disbursements (also called "payments") under ZANARA by sources between 2003 and 2006.

Table 9: World Bank (ZANARA) Funding commitments and grants (2003-2006)

Source of Funds	2003	2004	2005	2006
IDA Grant ($)	1,575,505	6,188,024	12,673,450	10,752,639
IDA (% of total financing)	80%	97%	88%	89%
GRZ Counterpart Funds ($)	367,559	209,122	1,162,791	600,985
GRZ (% of total financing)	19%	3%	8%	5%
STARZ/DFID ($)			523,280	546,009
STARZ (% of total financing)	0%	0%	4%	5%
Others–Exchange differences ($)	28,233	-36,712	25,590	158,155
Total Financing (Commitment) ($)	1,971,297	6,360,434	14,385,111	12,057,788
Total Payments ($)	1,373,700	6,792,397	13,010,671	14,178,153
Disbursement rate (payments as % of allocation)	70%	107%	90%	118%

Source: Authors' construction using ZANARA (2006) data

President's Emergency Plan For AIDS Relief (PEPFAR)

PEPFAR was set up as a United State Government (USG) five-year US$ 15 billion global initiative to combat the HIV and AIDS epidemic[10]. In Zambia, the PEPFAR programme is managed through five USG agencies – namely the Centre for Disease Control and Prevention (CDC), Department of State, Peace Corps, the US Agency for International Development (USAID) and the US Department of Defense (DOD) – that are also collectively called the USG mission in Zambia. The vision of PEPFAR is to help "reverse the tide of HIV and AIDS in Zambia through universal access to and use of a full range of high quality HIV/AIDS services and resources". The Emergency Plan in Zambia is implemented through a process of identifying and co-opting principle funding recipients – referred to as prime partners in the PEPFAR context – who receive funding directly from the USG to implement shared components of the Plan (Five-Year Strategy for Zambia: 2004). The USG channels PEPFAR funds directly to the prime partners through the USG agencies in Zambia. This is based on obligations. Under these obligations the USG places an order, signs a contract, awards a grant, purchases a service, provides incremental funding or takes other actions that require the government to make payments to the prime partner.

The profile of PEPFAR prime partners in Zambia includes local and international NGOs, FBOs, academic and research institutions, the Zambian government, private contractors, etc (full list of prime partners

[10] [The bill is currently being considered by the Conference Committee]

included in Annex 1). The National AIDS Council (NAC) and the Ministry of Health (MoH) which are nationally mandated with oversight of all HIV/AIDS and health sector activities, respectively, are among the PEPFAR prime partners.

Details on PEPFAR resources and programme support can be accessed on the USAID website (www.usaid.gov/zm/hiv/pepfar.htm)[12]. Areas of support by PEPFAR in 2005 were directed towards the following areas:

Table 10: PEPFAR Planned Funding Amount and Percentage by Programme Area in Zambia (2005)

Programme Area	Total Dollars Planned USD	% of Prevention, Care & Treatment Budgets	% of Grand Total Funding Planned
Prevention			
PMTCT	6,504,000	5.9%	5.0%
Abstinence/Be Faithful	6,957,390	6.3%	5.3%
Blood Safety	4,108,623	3.7%	3.2%
Injection Safety	2,054,163	1.9%	1.6%
Condoms and related activities	7,949,600	7.2%	6.1%
Prevention Subtotal	27,573,776	24.9%	21.2%
Care			
Palliative Care: Basic health care & support	10,104,148	9.1%	7.8%
Palliative Care: TB/HIV	1,190,000	1.1%	0.9%
OVC	7,733,455	7.0%	5.9%

[11] The estimations from the USAID graph involved (with help of staff at the Central Statistical Office) placing the graph onto a digital grip and using the grip to estimate the intermediate figures in the intervals on the y-axis of the graph. This yielded the 2006 figure (amounts) in Section A in Table 5.2 and all the figures presented in Section C of the table. The two limitations with this approach are that: firstly, there could be errors with the grip estimation from the graph, and secondly that beyond the data being posted on the official USAID website, there is no way of validating the authenticity of the original graph. The actual funding figures should therefore be interpreted with caution with these limitation in mind

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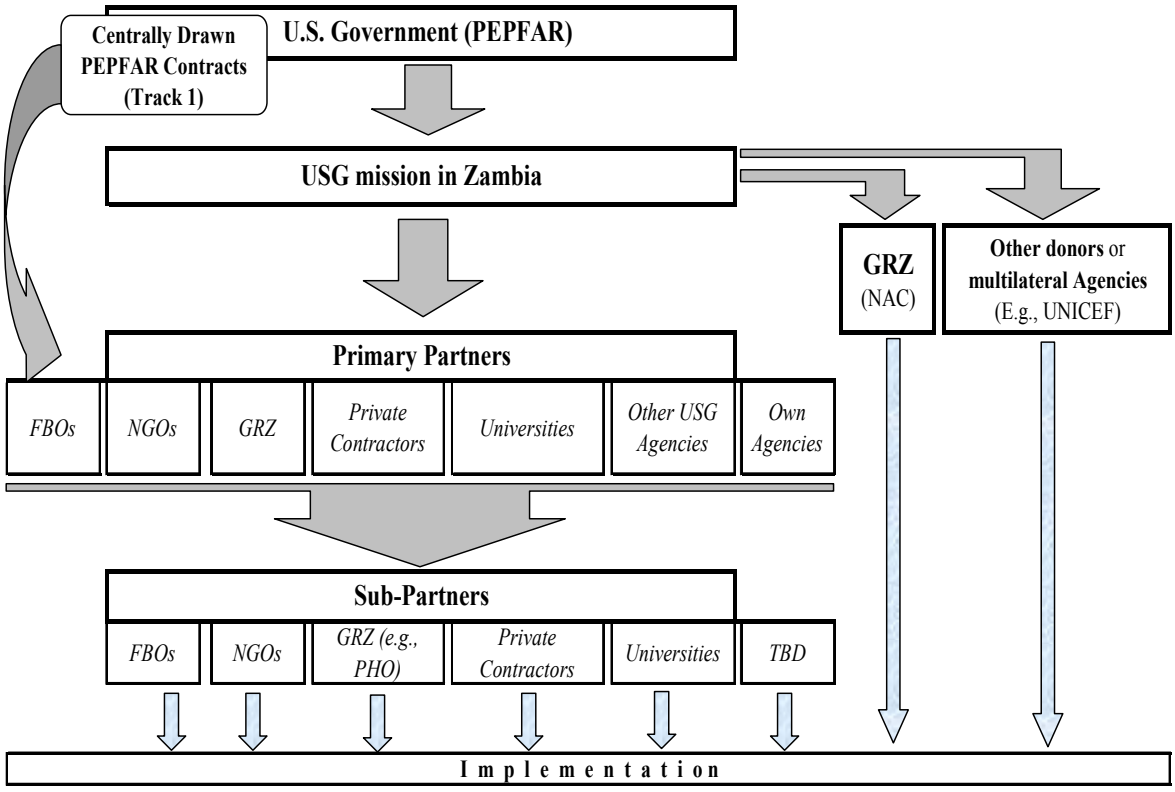
Counselling and Testing	10,225,500	9.2%	7.9%
Care Sub-total	29,253,103	26.4%	22.5%
Treatment			
Treatment: ARV Drugs	12,760,000	11.5%	9.8%
Treatment: ARV Services	37,718,690	34.1%	29.0%
Laboratory Infrastructure	3,357,244	3.0%	2.6%
Treatment Sub-total	53,835,934	48.6%	41.4%
Prevention, Care & Treatment Sub-Total	**110,662,813**	**100.0%**	**85.1%**
Other Costs	**Total Dollar Planned**	**% of Other Costs**	**% of Grand Total Funding Planned**
Strategic Information	5,290,000	27.2%	4.1%
Other/policy analysis and system strengthening	7,506,938	38.6%	5.8%
Management and Staffing	6,628,854	34.1%	5.1%
Other Costs Sub-total	**19,425,792**	**100.0%**	**14.9%**
TOTAL, Including Other Costs	**130,088,605**		**100.0%**

Source: http://www.state.gov/s/gac/progress/other/data/programme/index.htm with modifications

It must be noted that the above figures are PEPFAR's planned commitments to these activities and are not actual expenditures. This NASA presents the actual spending of PEPFAR in section 5.

Figure 6: PEPFAR Funding Flows



Source: Authors' construction based on information in various PEPFAR documents

4. NASA METHODOLOGY

This assessment applied the National AIDS Spending Assessment (NASA) methodology. The NASA methodology involves a rigorous classification of the types and purposes of all HIV and AIDS expenditure and for all the actors in the HIV and AIDS sector; a complete accounting of all spending for HIV and AIDS, regardless of the origin, destination, or object of the expenditure; a rigorous approach to collecting, cataloguing, and estimating all those flows of money related to HIV and AIDS expenditure. The NASA seeks to accurately reflect what has been spent on HIV and AIDS in the country, and on which functions and beneficiary groups. This information is critical for assessment of progress towards national priorities and identification of key gaps in spending which require attention. Thus, this chapter outlines the preparation for field work, data collection methods, tools used, data analysis and quality assurance issues. Apart from the aspect of rigour and the level of desegregation, the principle behind the NASA is the use of a set of tables to analyse the various aspects of a nation's HIV and AIDS expenditure on AIDS Spending Categories (ASC) and the subsequent beneficiary populations. However it should be noted that the NASA methodology does not aim at providing audited accounts of expenditure, and does not highlight cases of wrongful spending or corruption.

4.1 Preparation

The planning of the field work involved the establishment of the NASA/NHA taskforce, selection of an integrated NASA/NHA team of five (5) supervisors and thirty (30) research assistants; adaptation of the research tools, training of team members which was facilitated by resource persons from the University of Zambia (UNZA), Ministry of Health (MoH), Centre for Economic Governance on HIV and AIDS in Africa (CEGAA), Health Systems and Services Programme (HSSP), development and adaptation of data collection guidelines. In addition, mapping of data sources was done. This was followed by obtaining permission from the office of the Permanent Secretary, MoH, to have district and provincial offices facilitate interviews for the task force and make the data collection exercise run smoothly.

4.2 Tool Development

The generic NASA tools developed by UNAIDS were reviewed and adapted to the Zambian situation by a combined team made up of National AIDS Council, UNAIDS, NASA consultant and supervisors, Ministry of Health, Health Sector Support Project (HSSP), University of Zambia and the Centre for Economic Governance on HIV and AIDS in Africa (CEGAA). In this way, the NASA tools were expanded to enable any additional information required for the NHA. The data collection forms used were as follows:

i) Institutional role form: This was used to select institutions based on their category. That is, whether they were Sources, Providers or an Agents;

ii) NASA form 1: This was used for institutions that were either Sources or Agents; and

iii) NASA form 2 was used to collect data from Providers.

The major revision involved the adjustment of the tools for simultaneous administration with the NHA tools. This helped to avoid the potential problem of respondent fatigue because the target population for both the NASA and NHA were largely the same. It also ensured that the data was collected with

sufficient as required for the NASA analysis, and included all the aggregate information required for the NHA.

4.3 Training

Thirty Research Assistants were selected for the assignment. Training for the Research Assistants was done in two phases; from the 5th to 7th of November 2007 and from 14th and 15th of November 2007. The Assistants were trained in NASA Methodology and Data Collection Techniques. The training covered a number of issues including:

- Administration of the data collection tools and questionnaires
- How to collect data from institutions and how to capture the data into data processing file.

4.4 Sampling

Data for NASA was collected from all known funding institutions. All major funding sources, funding agents and providers - domestic and international - based in the respective central offices in Lusaka were included in the assessment. This NASA, however, did not cover the private-for-profit business sector and private insurances companies and expenditure by individuals and households. The NASA process included:

i) Sources: These are the funding agencies that provided finances for the implementation of activities;

ii) Agents: These are institutions that received and distributed funds for HIV and AIDS, and decided on how the finances would be spent;

iii) Providers: These are the institutions that provided services to the people that were affected by HIV and AIDS.

4.4.2 Sampling Frame

Although there was no comprehensive sampling frame of HIV and AIDS stakeholders in Zambia, the assessment team was able to develop a comprehensive list of partners for inclusion in the study, based on any existing databases and other sources of information.

4.4.3 Survey Techniques

Survey at National Level

At the national/central level, a survey was undertaken of ALL sources, agents and providers. Thus, sampling was not used for those based in Lusaka. In some cases, agencies and organisations did not submit information in time for publication. It could therefore be assumed that the information collected centrally would cover most of the spending in all provinces where those institutions had branches or HIV and AIDS activities. For example, the central spending records of the Ministry of Health included ALL the provincial and district spending. It was, therefore, unnecessary to get this from the provinces. Similarly, for NGOs operating nationally and provincially, their national records included the spending of their provincial and district branches.

Sampling at Provincial and District Levels

In addition, central information was also validated with sub-national data by sampling five out of the nine provinces - Western, Northern, Lusaka, Copperbelt and Southern provinces. In each of these provinces, three districts were sampled based on the presence of funded activities.

A total of one hundred and six institutions (106) were selected for the study – seventy (70) in Lusaka, twelve (12) in Copperbelt Province, seven (7) in Southern Province, eleven (11) in Western Province, and four (4) in Northern Province.

4.5 DATA COLLECTION

4.5.1 Data Sources and Types

Primary Data Sources

The major sources of data/information included the Ministry of Health and other line ministries, statutory bodies, major cooperating partners and any other sources of funds, and all providers of services, including NGOs. As far as possible, their expenditure records were obtained as the primary source of information. The major sources of data were:

(i) Public sector

(ii) The Global Fund principal recipients in Zambia;

(iii) United Nations agencies in Zambia

(iv) Major non UN cooperating partners;

(v) Major NGOS

(vi) Service providers at the district level.

Secondary Data Sources

Primary sources were supplemented with the desk review of audited accounts, financial reports on actual spending and annual reports of activities and outputs.

Data Types

Both quantitative and qualitative data were collected. The quantitative data included the expenditure data while the qualitative data was collected from key personnel at the institution that were visited. This was done through the use of open-ended questions included in the NASA data collection tools. All the qualitative information was collected in English with the help of the research assistants. The data was collected to elicit information from various key partners involved in the fight against HIV and AIDS in order to understand and characterise the funding flow mechanism, reporting formats and to ascertain if the funds for HIV and AIDS activities were adequate for the fight against this deadly pandemic. Furthermore, the qualitative tool was designed to collect information on the conditions for accessing and spending the funds and the key challenges and bottlenecks faced in the implementation of HIV and AIDS activities at different levels.

4.5.2 Data Collection Tools

Data was collected using the three tools developed, based on the NASA generic tool (as described above). They included mainly close-ended questions for the quantitative data, and open-ended questions for the qualitative data. The forms were administered as interview schedules by research assistants as a way of avoiding inappropriate responses as well as ensuring that good quality data was collected, since the NASA forms are complex and not suitable for self-administration.

4.5.3 Data Collection Process

Data collection was conducted by five teams with each team covering one province. Each team comprised of a supervisor and at least five research assistants. The data collection exercise covered the period from 5th December, 2007 to 15th January, 2008 but data was still being accepted until March 2008. It involved the use of structured questionnaires to collect data from financing sources, agents, and providers and other implementing agencies.

4.6 Data Entry

The quantitative data collected were cleaned, verified and checked, then edited for inconsistencies and entered into an excel spreadsheet before being transferred into the NASA software. The questionnaires that were identified for inconsistencies were adjusted after verifying with the particular institutions from where the data was collected. The qualitative data was captured in Microsoft word.

4.7 Data Analysis

After data entry, the data was analysed using the NASA Resource Tracking Software and MS Excel. The objective of the analysis was to ascertain the areas where the HIV and AIDS expenditure was being targeted as well as ascertain the HIV and AIDS spending categories and the ultimate beneficiary populations of the finances being spent. The tables or matrices generated in data analysis link the various sources of fund to financing agents, and from financing agents to service providers and finally to functions.

The qualitative data was thematically coded and analysed in Microsoft Word. Thereafter, the transcripts were reviewed to draw common themes arising from the qualitative interviews.

4.8 Supervision And Quality Assurance

At every stage of the process, the NASA Consultants and the Task Team ensured that there was adequate supervision and quality assurance. Backstopping support from CEGAA at all key points of the assessment was also done. CEGAA was involved at the initial planning phase, at the training of research assistants, data capture and analysis, data validation, and in the reviewing of the draft and final reports. Other quality assurance measures utilised in the assessment included:

- Training for all Research Assistants for consistent use and interpretation of the data collection tools and techniques
- At data collection stage, all forms completed by Research Assistants were quality checked by a Supervisor.
- Before the data entry process, a team of three supervisors and a member of the NASA Task team from NAC and UNAIDS reviewed all the completed forms for completeness and accuracy. The data entry process was done by five research assistants, with the process

overseen by three supervisors and a member of the NASA Task Team from NAC and UNAIDS.

- A Quality Assurance team was also formed comprising members from MoH, NAC, UNDP, UNAIDS, World Bank Country Office, CDC and HSSP. The terms of reference of this team included quality review of the output from the various stages of the assessment.
- An expanded Quality Assurance team made up of 18 key organisations mainly major donors, funding agents and government counterparts were also involved in the pre-validation of the outputs.
- A Validation workshop was organised to enable all the data producers and users to make input into the preliminary findings. The respondents were invited to a half day meeting to review the output from the process and validate the data that had been collected from their respective institutions. Their suggestions were all incorporated into the analysis and the report.
- The draft (almost final) report was circulated to key international people for an external review, and their contributions further ensured the validity and international standard of the report.

4.9 Key Assumptions

The following key assumptions were made. These assumptions were also important for the NHA process in order to avoid double counting on cost for TB, condoms, hospital/clinic cost etc.

- In cases where funds were pooled from various sources, it was impossible to link the sources to specific activities except where funds were earmarked. It was assumed that the amount attributable to the funding source for each activity was proportional to their contribution to the total pool. For example, for the pooled arrangement (JFA) of NAC, each cooperating partner's percentage contribution to the total pool was then attributed to the four key programmes at NAC.
- Where the actual expenditure on activities could not be obtained from the implementer/ provider on spending categories, it was assumed that the amounts reported as transferred by the cooperating partners were split between the key functions of the implementer, either equally or based on some other allocation factor (such as the share of salaries going to each activity).
- For multiple year funding cycles – efforts were made to obtain the actual dates of expenditure, but it was not possible. Thus, equal consumption over the years of the project period was assumed.
- It was assumed that 70% of all TB cases were HIV-related and therefore 70% of the TB spending was attributed to opportunistic infection (OI) treatment. Seventy percent (70%) of the TB awareness campaign costs were attributed to OI prevention.
- It was assumed that 95% of condom use was for HIV or STI prevention while 5% was for birth control.[13]

[13] More than 95% of funding for the purchase of condoms comes directly from HIV and AIDS funding delivered through programmes related to HIV and AIDS

- It was assumed that 60% of hospital bed occupancy was HIV-related and therefore 60% of the hospital expenditure (including salaries in 2006) was apportioned to the in-patient care, in addition to capturing 100% of the hospital HIV specific programmes, their ARVs, and 70% of TB costs.
- 70% of clinic expenditure was captured under OI treatment because 70% of OPD visits were assumed to be HIV related and 100% visits for ART clinics.
- PMTCT spending appears low, since much of the spending is absorbed in maternal health, but no proportion of this was applied.
- Due to absence of detailed expenditure from the USG team, it was agreed that 60% of the COP for 2005 and 2006 was used as expenditure. The 60% was derived from an analysis of the COP for both years from which it was observed that about 40% of the total resources related to human resource costs were spent outside Zambia.
- It was decided not to include a portion of (non-specific) health systems strengthening expenditure as benefiting HIV positive patients. This was because there was no agreement on a reasonable allocation factor to use.
- Where detail was not available on the beneficiaries of programme spending, assumptions were made. For example, the spending of NAC on programme administration was assumed to benefit PLWHA. The administration costs of other organisations were assumed to be non-targeted. Any educational programmes were assumed to be targeted at the general population.
- Exchange rates used: Reserve Bank annual average:
  - 2005: 1US$ = ZMK 4500
  - 2006: 1US$ = ZMK 3500

4.10 Limitations and Challenges

The assignment encountered a number of challenges:

- Because the assignment was conducted as a joint NASA/NHA exercise, it was jointly funded by a number of partners. The delay in release of funds affected motivation among the field workers.
- The data collection period also posed challenges; being in the rainy season, mobility of researchers in some areas was restricted;
- Some institutions were breaking off for the festive season and could, therefore, not give information promptly. This caused the data collection process to last longer than had initially been planned.
- Different organisations had different reporting systems and some systems could not be adjusted to the NASA requirement. In addition, some institutions could not disaggregate data to the level required by the NASA. As far as possible, a good understanding of the expenditures assisted in the classifying according to the NASA categories. Where not possible, some assumptions about the main activities and beneficiaries of spending had to be applied.

- The study tried to get as much expenditure data as possible, although in some cases the data collectors could not verify the accuracy of the data given through a check of actual expenditure records.
- In some cases, some beneficiary populations were not easy to classify into the agreed classification (PLHIV, MARP, Vulnerable Groups and General Population). Further disaggregation by age and gender was also difficult where such output data was not available.
- Collecting information from a few major partners, especially the USG was difficult due to their reluctance to release expenditure data.
- Unfortunately the expenditure data for 2006 from some UN agencies and JICA was received too late to be included in the database.
- No disaggregated information was available at the Medical Stores Limited regarding the sources of funding for commodities and supplies.
- There was no information on HIV and AIDS related laboratory costs from the MoH and major institutions providing laboratory services in the country. Thus laboratory services spending presented here are underestimated.

5. KEY FINDINGS

The findings from the assessment are categorised as follows:

a) Expenditure on HIV and AIDS by source of funding
b) Expenditure on HIV and AIDS by agent;
c) Spending pattern by providers of services
d) Spending pattern by AIDS spending category
e) Spending pattern by targeted/intended beneficiary populations
f) Spending priorities
g) Qualitative results

5.1 Actual Spending On HIV And AIDS By Public And External Sources Of Funds

The main sources of funds for HIV and AIDS in Zambia are government (local revenues), multilateral agencies (GFATM, UN), bilateral agencies and International NGOs. This NASA did not capture the private sector sources of funds for HIV, which would include businesses, household and individual spending**.** Table 12 below demonstrates that the national response is mostly donor driven with the vast majority of the funds coming from external sources.

Table 11: Sources of Funds for Actual Expenditure for the National Response (US$)

Year	Public (US$)	External (US$)	Total (US$)
2005	**5,749,195.00 (4%)**	**134,817,451.00 (96%)**	**140,566,646**
2006	**29,084,407.00 (14%)**	**178,824,837.00 (86%)**	**207,909,244**

5.1.1 Comparison Of Annual Proportional Contributions To HIV And AIDS Expenditure (US$) By Source

In 2005, public expenditure was US$ 7 million (4%) and external expenditure was US$ 135 million (96%). In 2006, the public contribution increased to US$30 million (14%) and the external funds were US$ 179 million (86%). This is as shown on Figures 8 and 9, and Table 13 below.

Figure 7: Comparison of public and external sources of spending in 2005 and 2006 (US$)

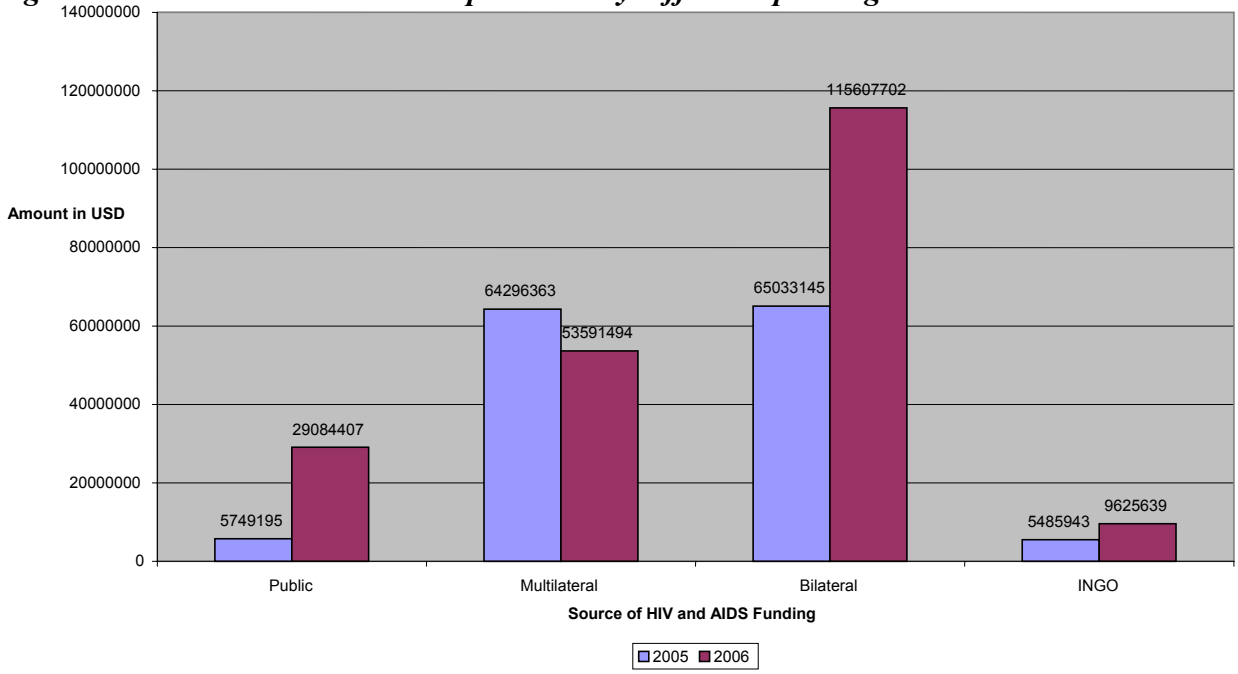
Significant changes were seen in the disaggregated HIV and AIDS data on expenditure by funding source between 2005 and 2006. Public spending increased from 4% to 14% of the total expenditure on HIV and AIDS, bilateral funding increased from 46% to 56% and International NGOs (INGO)[14] increased from 4% to 5%. However, multilateral funding decreased from 46% to 26%. The actual amounts spent by each source, and their proportional contributions to the total spending for both years are outlined in Table 13 and Figure 9 below.

Table 12: Comparison of expenditure by funding sources

	2005 (USD)	% of Total	2006 (USD)	% of Total
Public	5,749,195	4%	29,084,407	14%
Multilaterals	64,298,363	46%	53,591,496	26%
Bilaterals	65,033,145	46%	115,607,702	56%
Int'l NGO	5,485,943	4%	9,625,639	5%
Total	140,566,646	100%	207,909,244	100%

[14] INGOs are non-profit organisations including foundations such as Gates Foundation and head bodies of global NGOs such as Action Aid, Red Cross etc.

Figure 8: Annual trend in actual expenditure by different spending sources



5.1.3 Disaggregation of HIV And AIDS Spending By Sources From Multilateral, Bilateral And INGO

External funding during 2005 and 2006 came from International NGOs, bilateral and multilateral sources. In 2005, 51% of the funding was sourced from multilaterals, 44% from bilateral and 4% from International NGOs. In 2006, these proportions shifted with 65% coming from bilateral, 29% from multilaterals and 5% from International NGOs.[15] Among the bilateral support received, the US Government[16] contribution doubled while Ireland increased by fivefold during the reporting years.

Table 13: Expenditure by external sources (US$)[17]

External sources	2005 (USD)	2006 (USD)
International NGO		
World Vision	2,963,061.00	1,704,518.00
Caritas International /Catholic Relief Services	1,459,490.00	3,975,166.00
International not-for-profit organisations and foundations not elsewhere classified (n.e.c.)	1,039,942.00	3,945,955.00

[15] Note that data from JICA and UN for 2006 was not included at the time of conducting this exercise due to late submission.
[16] Please note that only 60% of USG funds were assumed to be actual expenditure in Zambia based on the 2005 and 2006 COP analysis.
[17] Please note that the figures in table above are not commitments nor allocations but as far as possible, were actual expenditure as reported by the recipients/ implementers/ providers.

Bilateral		
Government of Canada	141,191.00	108,825.00
Government of Ireland	293,575.00	1,680,567.00
Government of Netherlands	1,734,394.00	1,220,456.00
Government of Norway	566,758.00	933,097.00
Government of Sweden	1,130,846.00	1,332,106.00
[18] Government of Japan	14,222.00	NA
Government of United Kingdom	13,887,449.00	8,968,478.00
Government of United States	41,778,767.00	101,364,173.00
Multilaterals		
World Health Organisation (WHO)	22,000.00	NA[19]
United Nations High Commissioner for Refugees (UNHCR)	1,330,000.00	NA
United Nations Children's Fund (UNICEF)	265,250.00	NA
World Food Programme (WFP)	20,000,000.00	NA
International Labour Organisation (ILO)	116,651.00	NA
UNAIDS Secretariat	674,673.00	873,858.00
United Nations Development Programme (UNDP)	2,580,167.00	4,245,802.00
United Nations Population Fund (UNFPA)	276,694.00	599,410.00
World Bank (WB)	10,068,195.00	14,623,163.00
The Global Fund to Fight AIDS, Tuberculosis and Malaria	18,329,362.00	25,684,006.00
Commission of the European Communities	-	363,352.00
Other Multilateral funds or development funds n.e.c.	15,606,996.00	7,201,905.00
	134,680,276.00	178,824,837.00

[18] JICA submitted 2006 data after the RTS database was closed
[19]UN submitted 2006 data after the RTS database was closed

USG Expenditure According To The Country Operational Plans (COP)

The USG remains the highest contributor to the AIDS response annually in Zambia as demonstrated by Table 14. However, analysis of their 2005 and 2006 COP respectively suggested that the actual expenditure in Zambia is estimated to be about 60-70% of the official allocation/commitment. The balance of 30-40% is also spent on the response indirectly but from partners based outside the country as can be seen in figures 10 and 11 below which analyse the 2005 and 2006 COP. It is clear from this analysis that about 42% of COP funds were spent through PEPFAR agents based outside the country. This analysis is based on the following assumptions:

i) actual expenditure was direct spending based on consumption through secondary or primary partners based in Zambia including all administrative, human resources, operational and programme delivery costs;

ii) spending through partners based outside Zambia was not included in direct expenditure;

iii) procurement of goods, supplies and drugs were considered as direct spending included irrespective of the location of partners involved (in-country or out of the country), as consumption was understood to be in Zambia.

Figure 9 below indicates that the actual expenditure was on average 65% of the intended commitments. Figure 10 shows that only 58% of the total PEPFAR funds were spent in Zambia, based on the analysis of the 2005 COP.

Figure 9: Comparisons of funding allocations and estimated spending according to USG COP 2005 and 2006

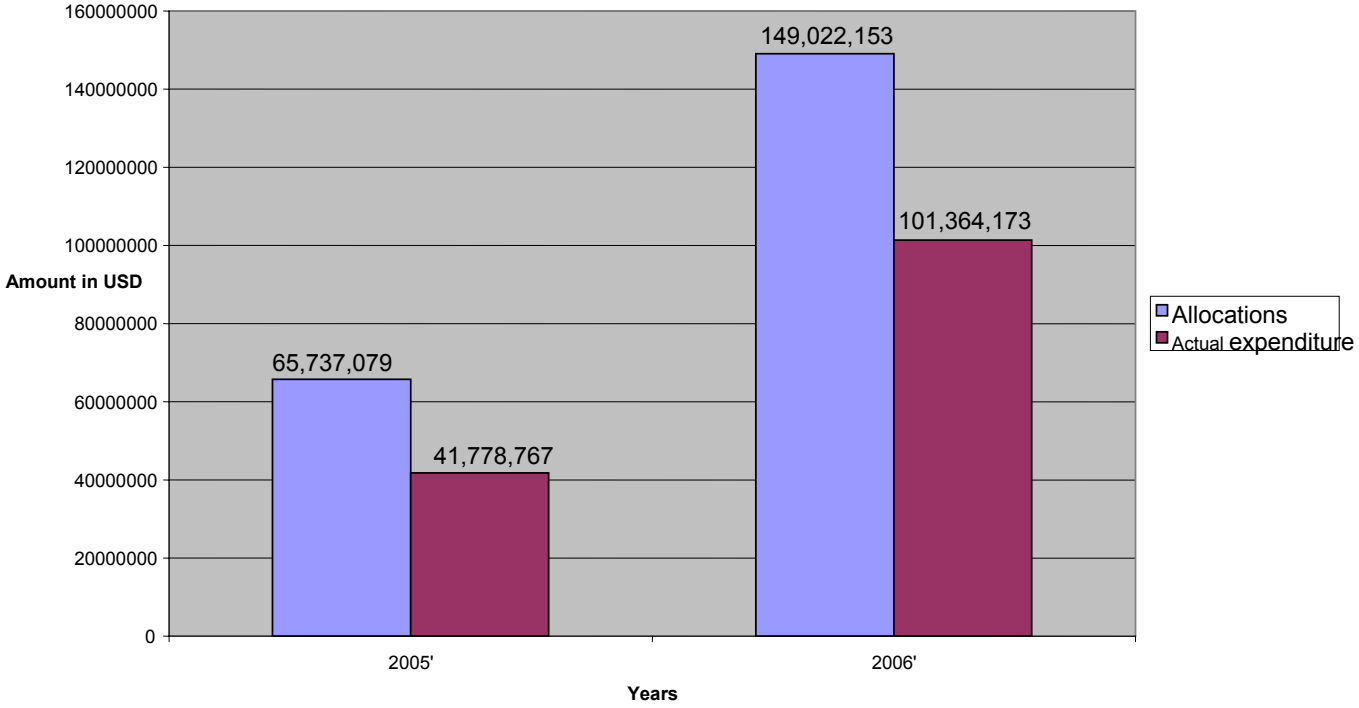
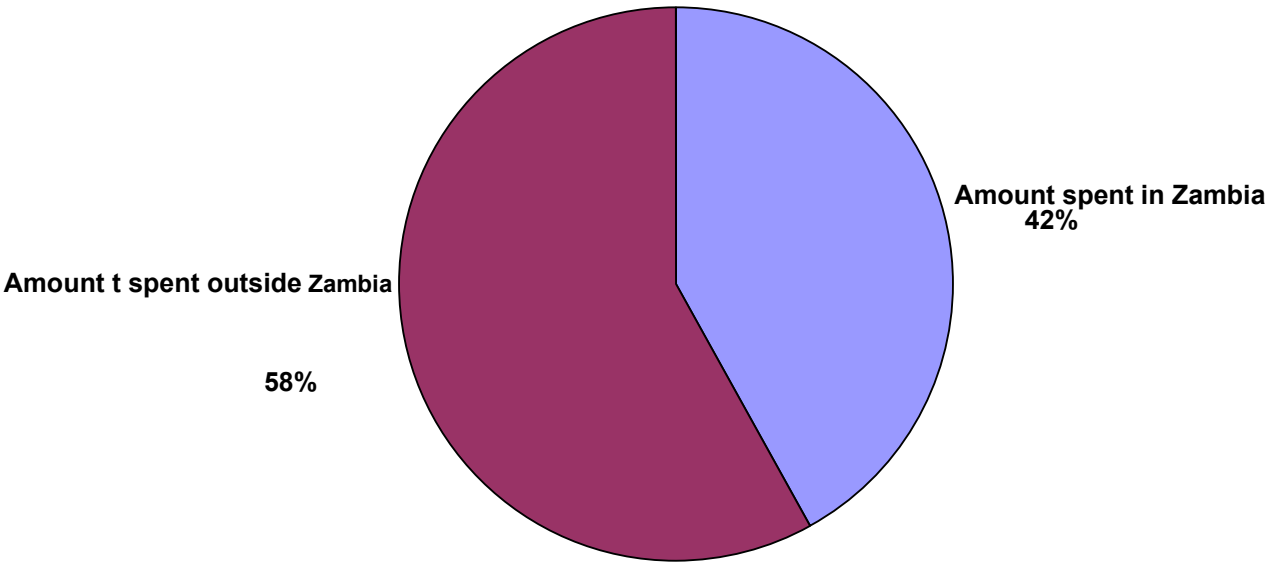


Figure 10: USG support to the Zambian AIDS Response based on COP 2005 analysis



The NASA methodology captures consumption and expenditure in country. Funds that are spent out of the country and not consumed in Zambia are not included here, as they would over represent the funds benefiting the country.

5.1.4 Funding Mechanisms By Sources

As stated earlier, public funds are allocated through the Ministry of Finance and National Planning to other line ministries and public agencies while external funding are distributed through off budget, pooled funds and on-budget arrangements. Based on the findings, four main mechanisms for flow of funds for HIV and AIDS spending were observed as outlined below:

1. External support through government institutions to government departments
2. External support through government institutions to NGO
3. External support through NGO to support NGO projects
4. Government support through Government institutions to government departments

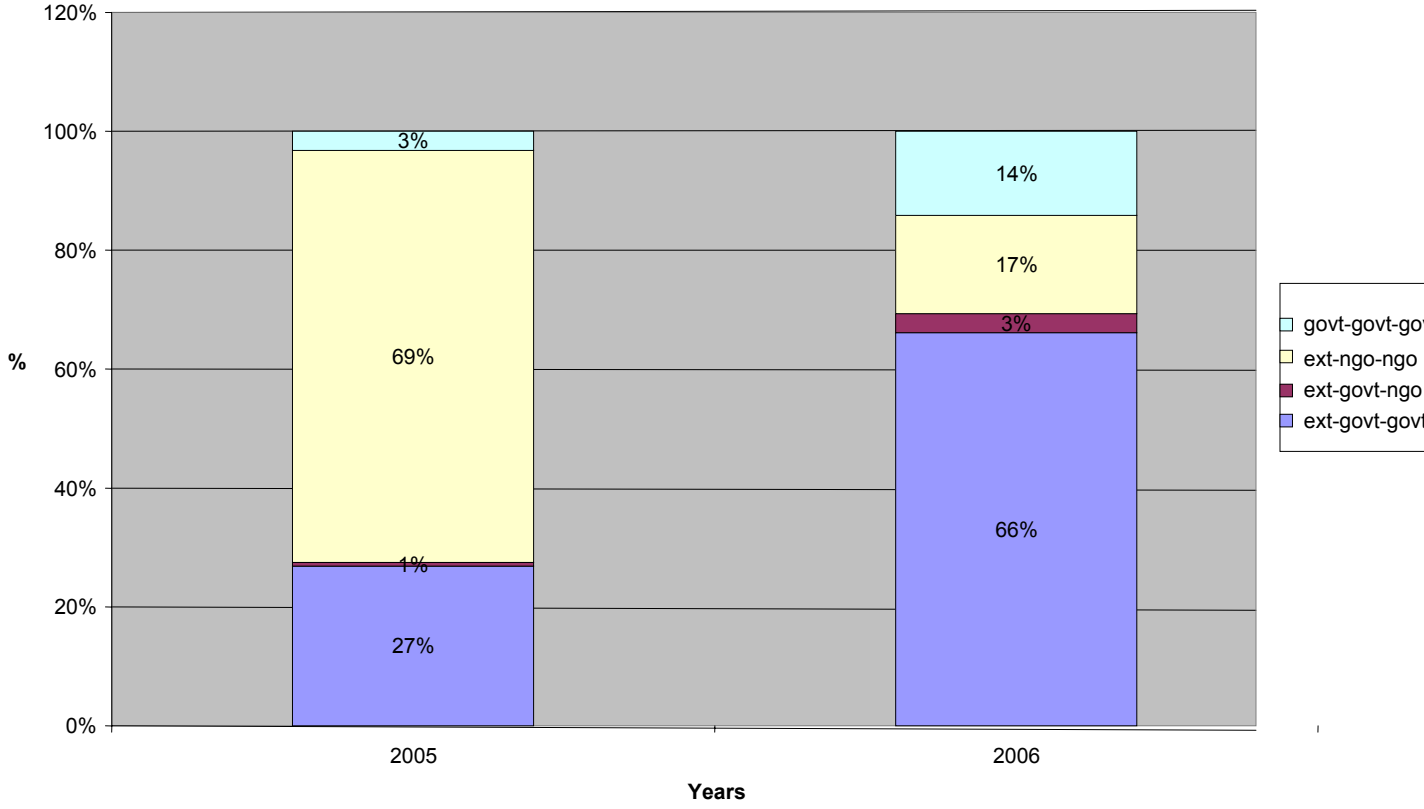
It is important to clarify here that on-budget means funding from external sources through government budget while off-budget is vertical funding of programmes outside government systems.

For the total spending on HIV and AIDS in both 2005 and 2006, find the information below:

- Funding from **external sources to government** increased from 27% to 66%.
- Funding from **external through government** to **NGO** increased from 1% to 3%.
- Funding from **external sources** to **NGO** decreased from 69% to 17%.
- Spending from **government** to **government** increased from 3% to 14%.

This indicates that external partners have begun alignment to government systems using the direct budget support. However, this has implications for funding access by civil society organisations as this appears to be decreasing as shown on Figure 12.

Figure 11: Spending streams in 2005 and 2006



5.1.5 Funding Channelling Arrangements

Findings also showed that funds were channelled through the following arrangements:

- Pooled resources[20] (both for government and NGO spending): For example, the Joint Funding Agreement (JFA) where bilateral partners and government allocate financial resources into a common account to support coordination of the response at the national and sub-national levels. While basket funding occurs within the ministry of health on similar arrangement. Pool funding

[20] In Zambia, pooled resources refer chiefly to GFATM monies, which are pooled through an NGO consortium which all local NGO are encouraged to access.

within NGOs revolves around the GFATM resources where ZNAN, CHAZ and CRAIDS are principal recipients from the World Bank resources.

- On-budget through government to government institutions, including external funds direct to departments.
- Off-budget, where funds are spent through vertical programmes.

As can be seen from below, figures 13 and 14 below show that the off-budget spending decreased from 52% of the total in 2005 to 42% in 2006. This may show increasing alignment with the national funding mechanisms, which is also demonstrated by the increase in 'on budget' spending from 8% to 41% of the total. It is important to reiterate that the NASA only captured actual expenditure and mostly included specific amounts received by Providers from Sources through Agents.

Figure 12: Categories of spending channels in 2005

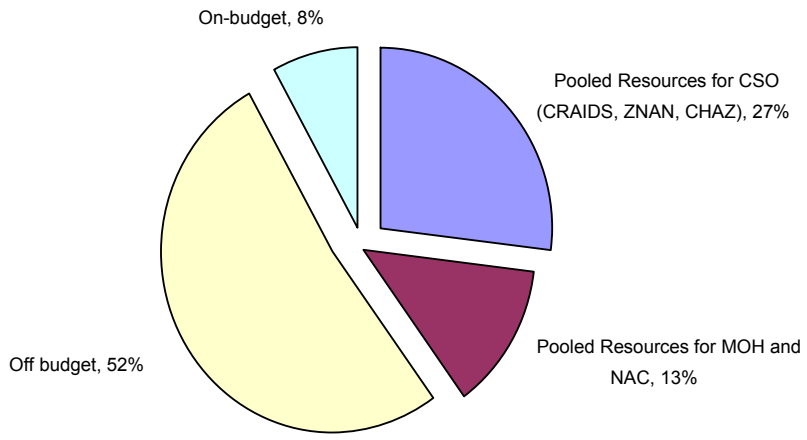
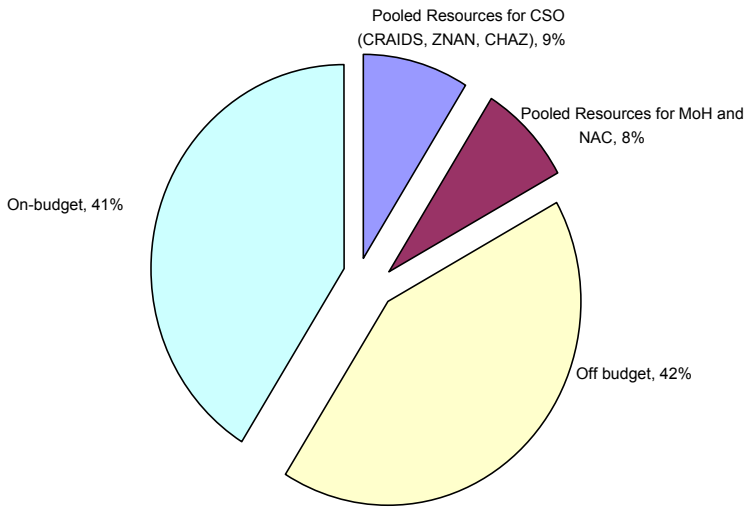


Figure 13: Categories of funding channels in 2006

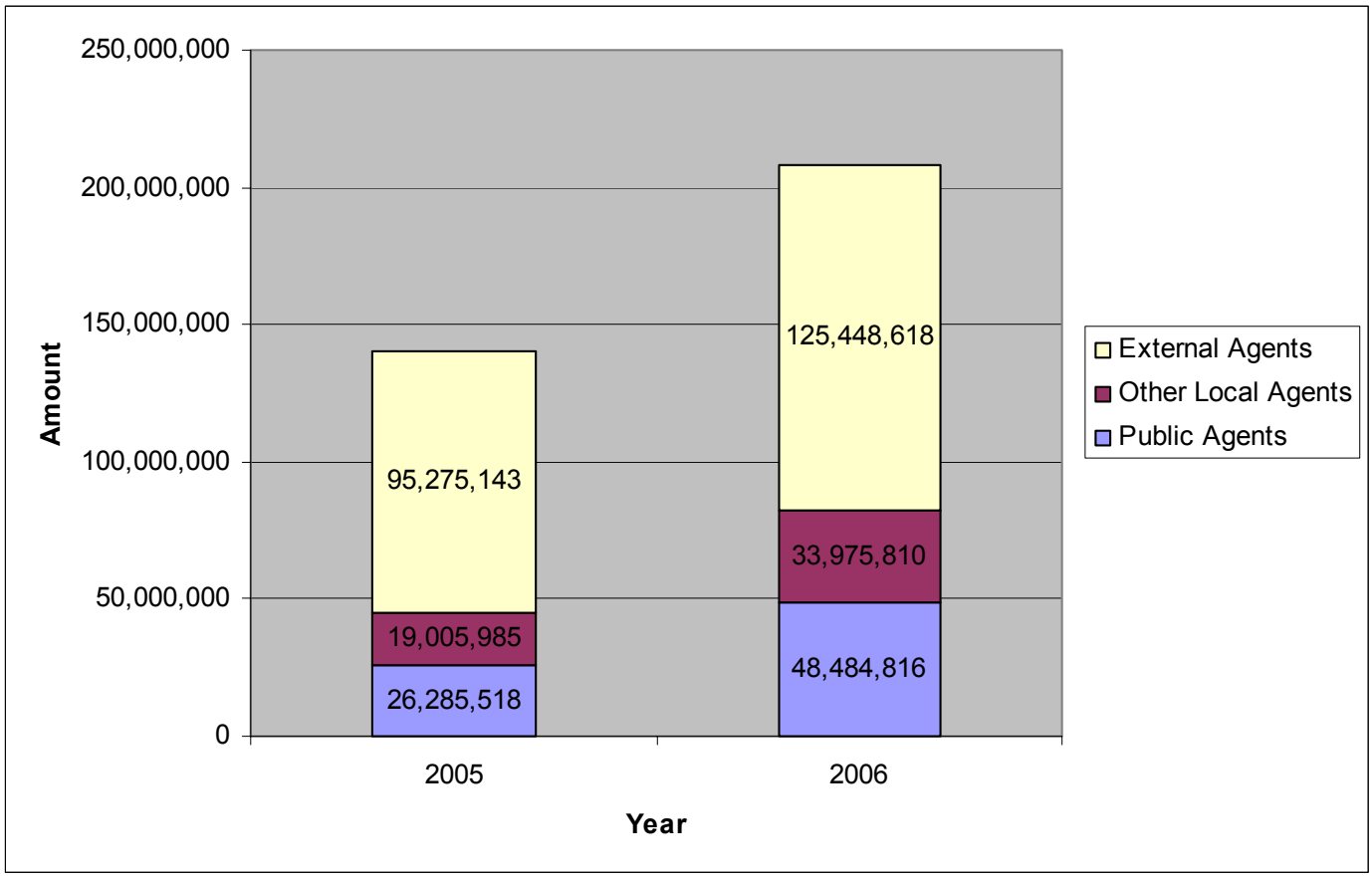


5.2 Funds Managed And Spent By Financing Agents In Zambia

Financing agents are entities who mobilise financial resources collected from different financing sources (pools) and transfer them to pay for or purchase health care or other services or goods. Financing agents may pool resources that pay directly for resources they consume (principally households) and may comprise entities that buy on behalf of specific beneficiaries (mainly intermediaries such as insurers or donors). Financing agents of the national AIDS response are both from government institutions and external agents based in the country. The public financing agents were mainly NAC and the line ministries for the workplace programme funds; and MoH for the health-related HIV spending. The external agents were the bi-lateral country offices, and international non-government organisations. Examples of key external financing agents are ZANARA, CDC, USAID and UN agencies in Zambia. GFATM has four principal recipients (agents) in the country which are MoH, MOFNP, ZNAN and CHAZ.

The spending and management of funds among both public and external agents increased in the reporting years. However, external agents managed the greatest proportion, approximately $114M (81%) in 2005 and $120M (58%) in 2006 while public funding agents managed $26M (19%) in 2005 and $48M (23%) in 2006 (inclusive of all funding sources). This indicates that there is a slight increase in the access to and management of available resources for the AIDS Response by public agents. This is primarily due to major cooperating partners such as the GFATM, PEPFAR, World Bank which are beginning to disburse funds through public sector agents.

Figure 14: Comparison of expenditure by agents[21]



5.2.1 Comparison Of Spent Funding By Agents In 2005 And 2006

Agents from this NASA are classified into public, other local agents (local NGO), bilateral government agencies, multilateral agencies and international NGO. Where the source of funds (such as a bi- or multi-lateral) actually determines the use of funds, then they have been captured as the agent. Where an institution (such as MOH) received funds and determines their use, then MOH has been captured as the agent. In many cases, it is the bi- or multi-lateral agents that determine the use of funds. Table 15 below illustrates how funds were disbursed by agents according to the different sources of funds.

Table 14: Expenditure analysed by Agents

		Sources				
Agents	**Year**	**Public**	**Bilaterals**	**Multilaterals**	**INGOs**	**Total**
Public	2005	4,747,505	5,572,762	15,696,365	268,889	26,285,521

[21] Local agents as indicated in Figure 15 described local NGO such as CHAZ and ZNAN who manage funds on behalf of government and donors.

	2006	28,413,731	5,329,348	14,657,217	84,519	48,484,815
Other local agents	2005	0	1,750,712	16,670,337	585,014	19,006,063
	2006	2,226,413	3,102,393	24,797,828	3,934,515	34,061,149
Bilateral Government	2005	0	47,922,187	0	0	47,922,187
	2006	0	90,205,529	0	0	90,205,529
Multilateral	2005	1,001,690*	1,977,541	36,825,227	0	39,804,458
	2006	670,390*	14,011,442	14,136,451	22,975	28,841,258
INGOs	2005	0	2,324,000	215,234	5,009,183	7,548,417
	2006	0	2,958,990	0	3,357,503	6,316,493
Grand Total	**2005**	**5,749,195**	**59,547,202**	**69,407,163**	**5,863,086**	**140,566,646**
Grand Total	**2006**	**31,310,534**	**115,607,702**	**53,591,496**	**7,399,512**	**207,909,244**

* These are World Bank funds channelled through Ministry of Finance and Planning to the ZANARA Project as an multi-lateral agents.

The public agent management of funds increased in 2006. The table indicates that funds from bilateral and multilaterals going through public agents actually decreased especially from government revenues. This is because all of the bilateral funds are managed by the bilateral agents e.g. CDC/PEPFAR) and most of the multilateral funds are managed by multilateral agents e.g. UN offices. NGOs are managing some of the funds from bilateral partners and direct funding from International NGOs. Greater detail on the above is provided in table 16 below.

Public Agents

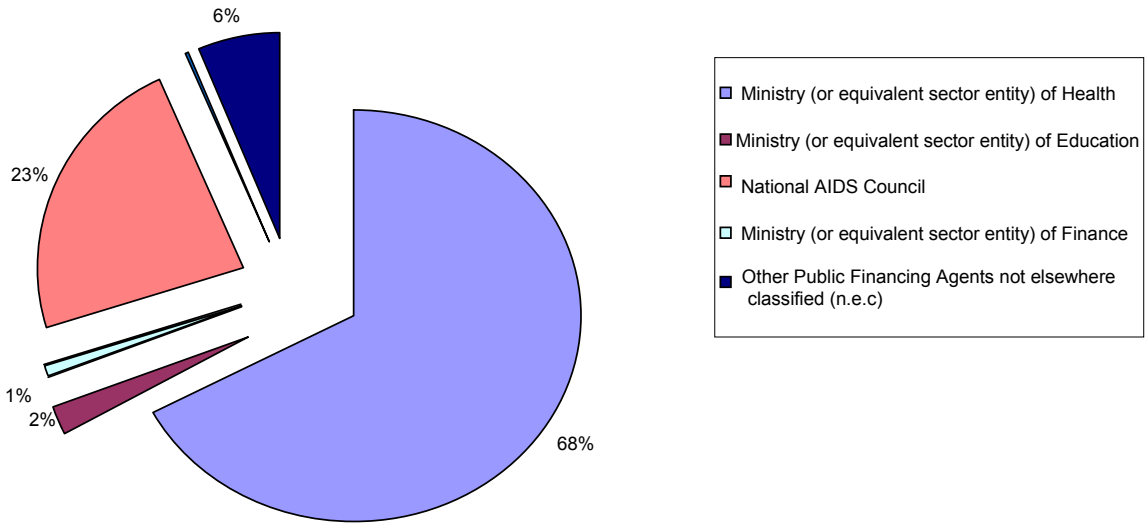
As already mentioned, the funds spent by public agents increased from US$26 million in 2005 to US$48 million in 2006. Most of the spending by public agents is done by Ministry of Health and National AIDS Council. The amounts being spent by line ministries have increased largely due to the scale up of Global Fund financed activities in the ministries. NAC received an increased amount of funds from the multilaterals (mainly GFATM, World Bank) and bilateral sources. There was an observable decrease in multilateral funds going to MoH especially from GFATM due to the low absorption rate of funds. The details of spending by public agent are shown below:

Table 15: Expenditure by Public Agent and by Source of Funds

			Sources			

Agents		Public	INGOs	Bilaterals	Multilaterals	Total
Ministry of Health	2005	4,411,022	N/A	-	14,792,968	**19,203,990**
	2006	26,700,479	N/A	-	5,956,876	**32,657,355**
Ministry of Finance and National Planning	2005	228,243	N/A	-	668,965	**897,208**
	2006	102,721	N/A	-	276,192	**378,913**
National AIDS Council	2005	108,240	268,889	5,572,762	234,432	**6,184,323**
	2006	449,948	84,519	5,329,348	5,347,887	**11,211,702**
Other line ministries	2005	-	-	-	268,889	**268,889**
	2006	1,160,583	-	-	3,076,262	**4,236,845**
Total	**2005**	**4,747,505**	**53,408**	**5,572,762**	**15,965,254**	**26,554,410**
	2006	**28,413,731**	**84,519**	**5,329,348**	**14,657,217**	**48,484,815**

Figure 15: Comparison of AIDS spending by public agents - irrespective of financing source



External Agents

The funds spent by external agents increased from US$95 million in 2005 to US$125 million in 2006. The external agents comprise the development arms of bilateral governments (e.g. DFID for the UK Government and Irish Aid for the Irish Government) or embassies of these governments where these are involved in expenditure and disbursement. Other external agents are the country offices of UN agencies and international NGOs.

5.3 AIDS Spending Categories Of Financing By Agents

AIDS Spending Categories (ASC) are a measure of commodities consumed or invested in the delivery of services for the purpose of alleviating the suffering induced by the HIV virus or some of its consequences or to prevent its diffusion. Globally, ASC are classified according to eight categories: prevention, care and treatment, orphans and vulnerable children, programme management and administration strengthening, incentives for human resources, social protections and social services, enabling of environment and community programmes and research. In order to harmonise the spending categories or themes of the 2002-2005 NAISP, the 2006-2010 NASF and the eight globally recognised ASC, a consultative process was undertaken. For the purposes of this NASA, the six NASF spending categories were adopted. These are:

i) prevention,

ii) treatment, care and support,

iii) mitigation of social economic impact,

iv) mainstreaming and decentralization,

v) advocacy and coordination and

vi) monitoring and Evaluation and research.

Those activities and/or categories of spending that were not directly translated into the six NASF categories were allocated to the thematic area to which they had the best fit. This was to assist interpret the results of the NASA in the Zambian context.

Table 16: Summary of annual spending according to the NSF Priorities and Agents

	2005			2006		
Area of Intervention	**Public**	**External**	**Total**	**Public**	**External**	**Total**
1. Prevention	6,405,584	32,938,894	**39,344,478**	1,437,564	52,723,870	**54,161,434**
2.Treatment Care and Support	15,374,702	35,409,402	**50,784,104**	26,999,480	82,639,524	**109,639,004**
3.Mitigation of social economic impact	425,782	26,948,413	**27,374,195**	128,484	8,932,408	**9,060,892**
4.Advocacy and coordination	3,757,273	9,570,228	**13,327,501**	282,713	14,184,748	**14,467,461**
5.Mainstreaming & decentralisation	170,199	2,269,684	**2,439,883**	136,183	3,528,774	**3,664,957**
6.Monitoring, Evaluation and research	272,222	7,024,581	**7,296,803**	99,981	16,814,316	**16,914,297**
Total	**26,405,762**	**114,161,202**	**140,566,964**	**34,949,418**	**178,823,640**	**207,908,045**

Figure 16: AIDS spending categories by funding agents in 2005 and 2006

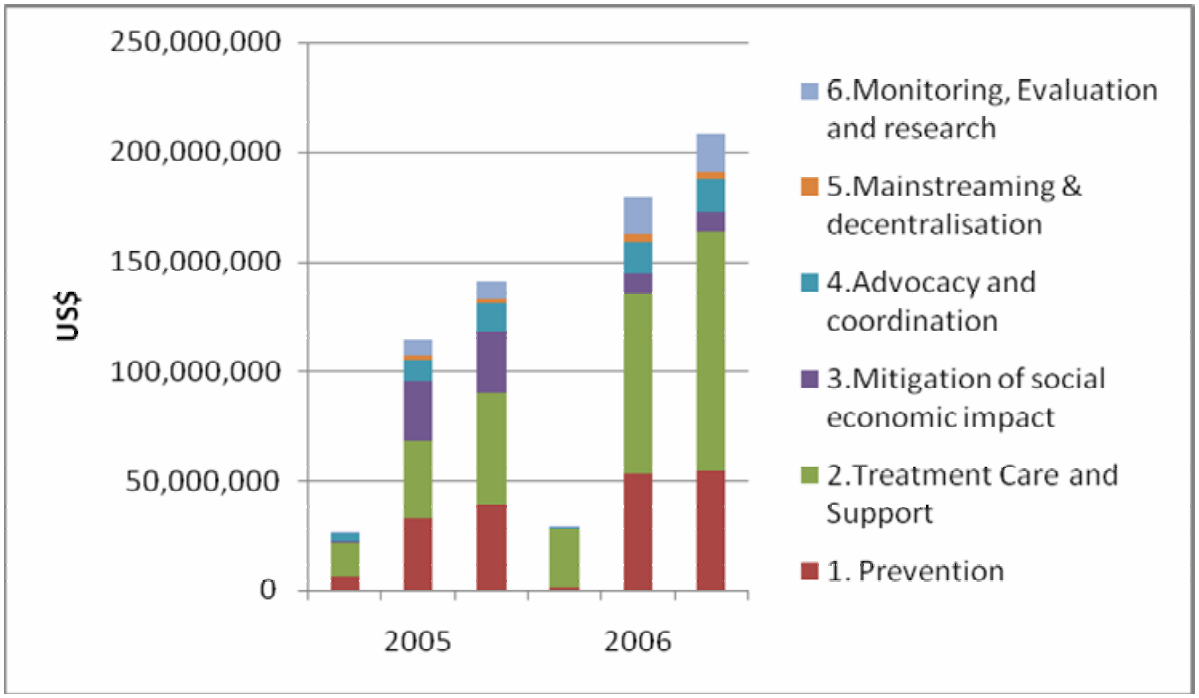
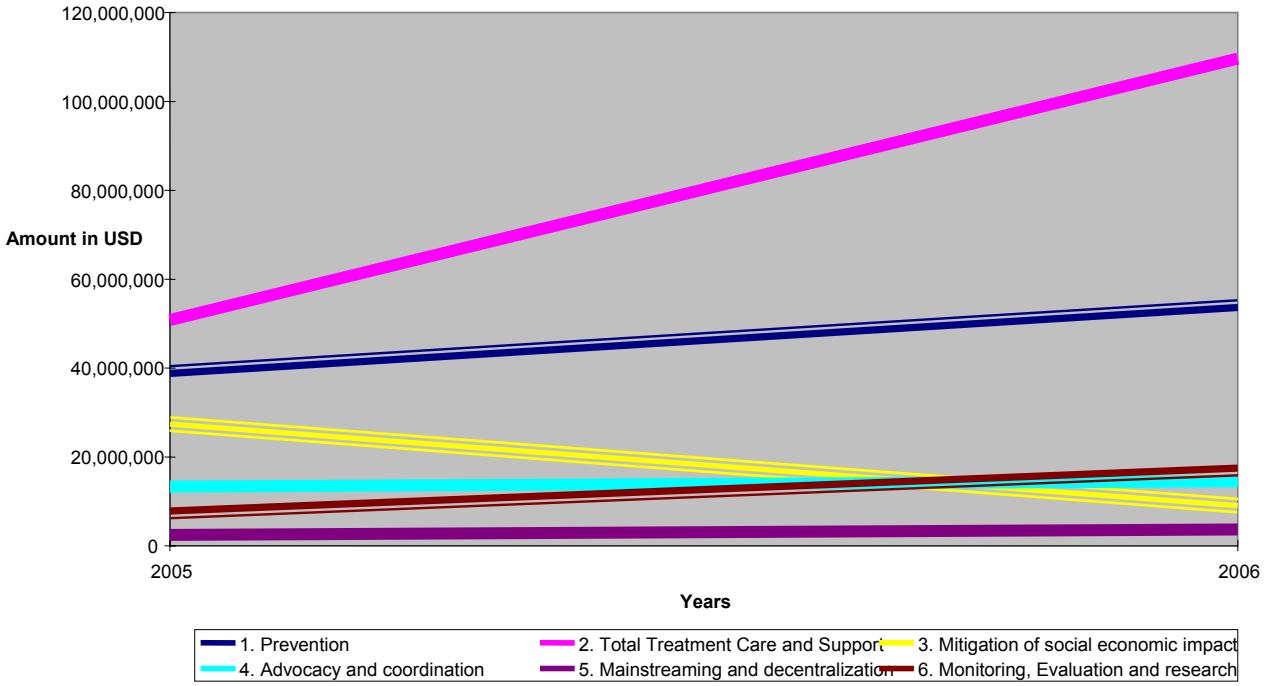


Figure 17: Trends of spending according to NASF priorities for 2005 and 2006 in US$



Zambia saw increased spending between 2005 and 2006. However a review of expenditure by the six

NASF AIDS Spending Categories shows different patterns for each priority area. Expenditure on mitigation of the Socio-economic impact reduced in 2006, while there was increase in the absolute amounts spent in all the other categories. As a percentage of the total expenditure, treatment, care and support increased from 36% of total expenditure in 2005 to 53% in 2006. On the other hand, monitoring and evaluation increased from 5% to 8%. Expenditure on mitigation services decreased proportionally from 19% to 4% and advocacy and coordination from 9.5% to 7%.

5.3.1 AIDS Spending Categories of Financing By Agents In 2005 & 2006

Table 16 and Figures 16 and 17 below describe the spending pattern by the public and external financing agents in 2005 and 2006 according to the six AIDS Spending categories laid down in the NASF.

Figure 18: AIDS Spending Categories by funding agents in 2005

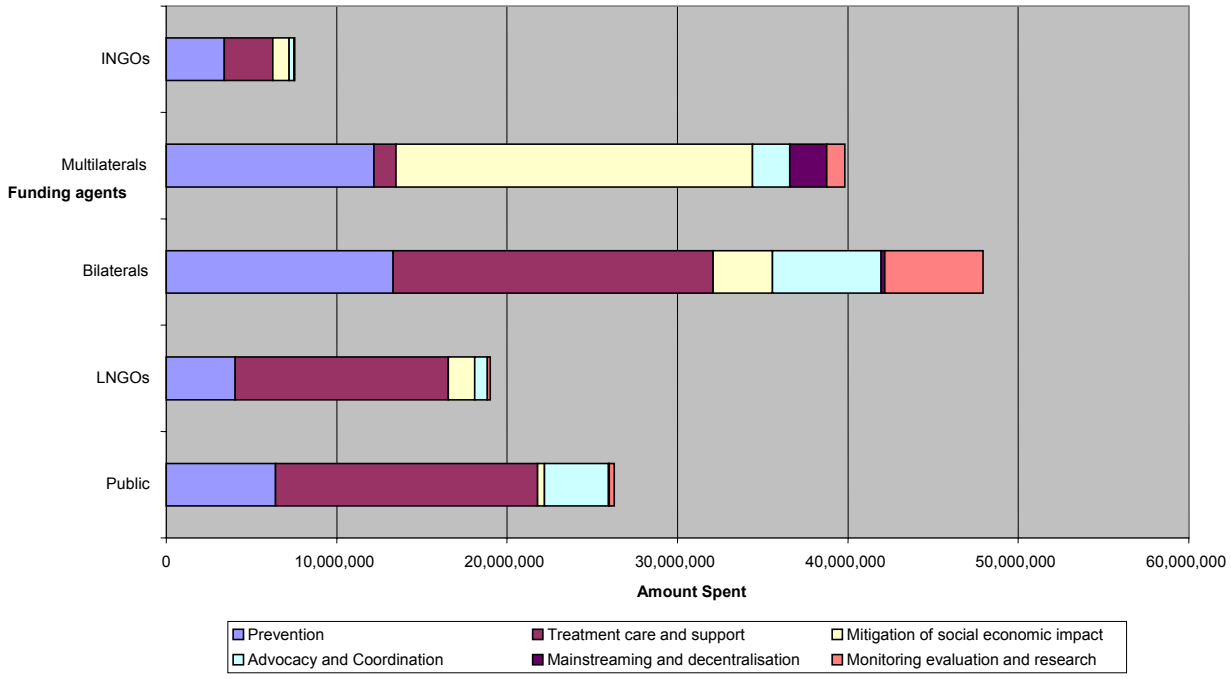
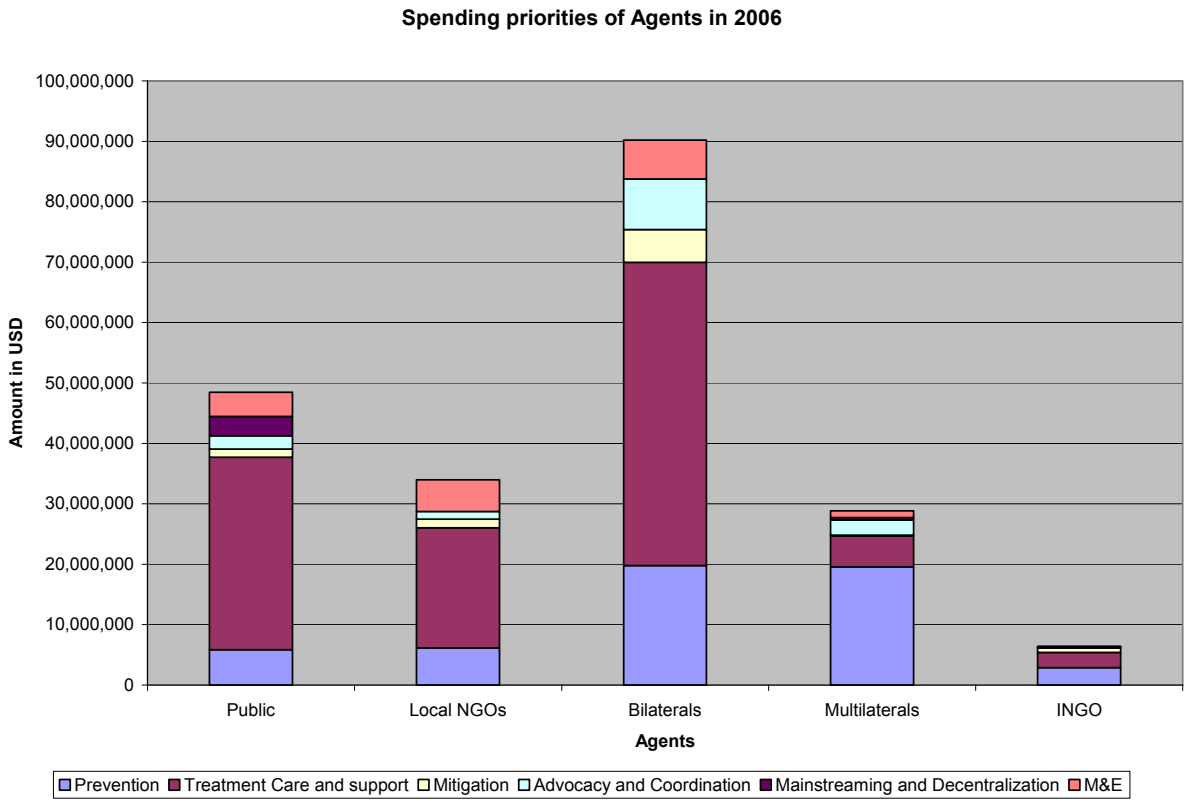


Figure 19: AIDS Spending Categories by funding agents in2006



Funding agents of the national response are from both government institutions and external agents based in the country. The Ministry of Health and the National AIDS Council are the major public funding agents in the country. Spending by funding agents, irrespective of whether public or external indicated that in 2005, 36% of the spending was on treatment, 28% on prevention and 9% on advocacy and coordination; 19% on Mitigation of Socio-economic impact and 2% for mainstreaming and decentralisation. External agents spending patterns were different from public agents in that 31% was spent on treatment, 29% on prevention and 24% on mitigation in 2005. Public agents spent more than 77% of the resources available to them on treatment, care and support in both years. This is reflective of the Government policy of free ART. Between 2005 and 2006, the share of public spending in the areas other than treatment, care and support decreased: Prevention (16% to 3%), Advocacy and Coordination (28% to 2%) and M & E and research (4% to1%) from 2005 and 2006. Between 2005 and 2006 external agents spent most on treatment (increasing from 30% of total spending in 2005 to 50% in 2006). Prevention spending also increased by approximately 30% in 2006 based on previous years expenditure.

5.4 AIDS Spending Priorities by Agents

5.4.1. AIDS Spending Categories: Prevention

Prevention Spending In 2005

Spending on prevention interventions include all interventions targeting sexual transmissions, mother to child transmission, blood and blood products behavioural change, counselling and testing, condoms, STI prevention, PMTCT and other targeted interventions.

Tables 17: Prevention Spending 2005

Prevention	Total Public	Total External	Grand Total
Communication for social and behavioural change programmes targeting the health risks of HIV prevention campaigns	188703	4727990	4916693
Communication for social and behavioural change programmes targeting the non-health risks of HIV prevention campaigns	0	3794408	3794408
Communication for social and behavioural change not disaggregated according to the content as health or as non-health activities.	141893	155012	296905
Community mobilisation	557892	6716275	7274167
Voluntary counselling and testing	40732	3522655	3563387
VCT as part of programmes for vulnerable and special populations	0	30000	30000
Programmatic interventions for vulnerable and special populations not disaggregated by type	512	3038495	3039007
Other programmatic interventions for vulnerable and special populations not elsewhere classified (n.e.c.).	222	1331889	1332111
Prevention - Youth in school	0	184232	184232
Prevention - Youth out-of-school	0	2007278	2007278
Prevention of HIV transmission aimed at persons living with HIV (PLHA)	0	1666667	1666667
Programmatic interventions for sex workers and their clients not disaggregated by type	98673	930277	1028950
Prevention programmes in the workplace	208449	2491482	2699931
Condom social marketing	0	1131760	1131760
Public and commercial sector condom provision	0	1321412	1321412
Prevention, diagnosis and treatment of sexually transmitted infections (STI) (Improving management of STI)	0	767045	767045
Pregnant women counselling and testing	0	100000	100000

PMTCT not-disaggregated by intervention	287	1061029	1061316
PMTCT activities not elsewhere classified (n.e.c.)	0	1368	1368
Blood safety	11991	739648	751639
PEP in health care setting	0	164298	164298
Safe medical injections	0	1080000	1080000
Prevention activities not elsewhere classified (n.e.c.)	0	1131904	1131904
Total Prevention	1249354	38095124	39344478

Overall spending on prevention in 2005 was mainly around behavioural change, PMTCT, VCT, blood safety and STI. No spending was seen in the most-at-risk population (MSM and IDU). Public expenditure focused mainly on PMTCT, universal precautions and safe medical injections while external expenditure covered prevention on CSW, blood safety and VCT. Prevention activities of most-at-risk groups mainly MSM and IDU do not have any funds spent around it.

Prevention Spending In 2006

Overall spending increased on prevention in 2006, and the focus of spending remained the same - behavioural change communication, community mobilisation, PMTCT, VCT etc. At the same time, the gaps observed in 2005 with spending on most-at-risk groups remained the same in 2006. Public and external spending followed the same pattern.

Table 18: Prevention spending in 2006

NASF Priority Interventions	Public	External	Total
PREVENTION			
Communication for social and behavioural change programmes targeting the health risks of HIV prevention campaigns	1,214,858	5,007,715	6,222,573
Communication for social and behavioural change programmes targeting the non-health risks of HIV prevention campaigns	8,100	10,882	18,982
Communication for social and behavioural change not disaggregated according to the content as health or as non-health activities.	0	111,853	111,853
Community mobilisation	0	6,075,197	6,075,197
Voluntary counselling and testing	965,360	7,333,427	8,298,787
Risk-reduction for vulnerable and special populations (Programmes for vulnerable and special populations)	0	0	0

VCT as part of programmes for vulnerable and special populations	0	0	0
Condom provision as part of programmes for vulnerable and special populations	0	0	0
STI prevention and treatment as part of programmes for vulnerable and special populations	0	0	0
BCC/IEC as part of programmes for vulnerable and special populations	0	0	0
Programmatic interventions for vulnerable and special populations not disaggregated by type	14,286	2,686	16,972
Other programmatic interventions for vulnerable and special populations not elsewhere classified (n.e.c.).	0	0	0
Prevention - Youth in school	1,076,584	598,249	1,674,833
Prevention - Youth out-of-school	0	502,889	502,889
Prevention of HIV transmission aimed at persons living with HIV (PLHA)	0	2,346,287	2,346,287
Prevention programmes for sex workers and their clients.	0	0	0
VCT as part of programmes for sex workers and their clients	0	0	0
Condom provision as part of programmes for sex workers and their clients	0	0	0
STI prevention and treatment as part of programmes for sex workers and their clients	0	0	0
BCC/IEC as part of programmes for sex workers and their clients	0	0	0
Programmatic interventions for sex workers and their clients not disaggregated by type	0	2,686	2,686
Other programmatic interventions for sex workers and their clients not elsewhere classified (n.e.c.)	0	0	0
Programmes for men who have sex with men (MSM)	0	0	0
VCT as part of programmes for men who have sex with men (MSM)	0	0	0
Condom provision as part of programmes for men who have sex with men (MSM)	0	0	0

STI prevention and treatment as part of programmes for men who have sex with men (MSM)	0	0	0
BCC/IEC as part of programmes for men who have sex with men (MSM)	0	0	0
Programmatic interventions for men who have sex with men (MSM) not disaggregated by type	0	0	0
Other programmatic interventions for men who have sex with men (MSM) not elsewhere classified (n.e.c.)	0	0	0
Harm-reduction programmes for injecting drug users (IDUs)	0	0	0
VCT as part of programmes for injecting drug users (IDUs)	0	0	0
Condom provision as part of programmes for injecting drug users (IDUs)	0	0	0
STI prevention and treatment as part of programmes for injecting drug users (IDUs)	0	0	0
BCC/IEC as part of programmes for injecting drug users (IDUs)	0	0	0
Programmatic interventions for injecting drug users (IDUs) not disaggregated by type	0	1,429	1,429
Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.).	0	115,715	115,715
Prevention programmes in the workplace	86,429	1,286,514	1,372,943
Condom social marketing	0	0	0
Public and commercial sector condom provision	170,942	1,213,724	1,384,666
Female condom	0	0	0
Microbiocides	0	0	0
Prevention, diagnosis and treatment of sexually transmitted infections (STI) (Improving management of STI)	233,429	0	233,429
Prevention of mother-to-child transmission (PMTCT)	0	0	0
Pregnant women counselling and testing	0	220,000	220,000
Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	0	2,719,429	2,719,429

Safe infant feeding practices (including substitution of breast milk)	0	0	0
PMTCT not-disaggregated by intervention	14,621	14,909,844	14,924,465
PMTCT activities not elsewhere classified (n.e.c.)	0	0	0
Blood safety	319,630	0	319,630
Post-exposure prophylaxis (PEP)	0	0	0
PEP in health care setting	0	0	0
PEP after high risk exposure (violence or rape)	0	0	0
PEP after unprotected sex	0	0	0
Post-exposure prophylaxis not-disaggregated by intervention	0	0	0
Safe medical injections	0	210,000	210,000
Male circumcision	0	0	0
Universal precautions	0	0	0
Prevention activities not elsewhere classified (n.e.c.)	1,737,854	5,650,815	7,388,669
Total	5,842,093	48,319,341	54,161,434

5.4.2 AIDS Spending Categories- Treatment, Care And Support

Treatment, care and support cover a number of sub-categories including:

1 Outpatient care: This sub category includes a number of areas including opportunistic infection prophylaxis, antiretroviral therapy, nutritional support associated with ART, HIV-related laboratory monitoring, palliative care and home-based care. In the 2006 assessment, the costs of clinic human resources that could be attributed to HIV-positive patients was estimated and included, thus increasing the out-patient spending. This is important as it better reflects the actual hidden contribution of the MOH.

2 In-patient care: The sub category encompasses Opportunistic infections' (OI) treatment and other HIV related In-patient services, also including the human resource costs attributable to HIV/AIDS care; and

3 Patient transport and emergency rescue.

In 2005, most of the spending on ASCs by agents was on the provision of ART, followed by palliative care, and in-patient care, where the costs incurred by the Ministry of Health in provision of hospital care for HIV positive patients were captured[22]. This amount included the hospital staff salaries. For the

[22] It was assumed that 70% of hospital bed-occupancy was HIV-related.

spending by external agents, in addition to ART expenditure was distributed to other areas such as palliative care and drug supply systems. In 2006, the pattern of expenditure remained similar to that observed in 2005. Public spending was shown to be focused on ART, in-patient care and out-patient care, also where a portion of the hospital and clinic costs that were related to HIV were captured.

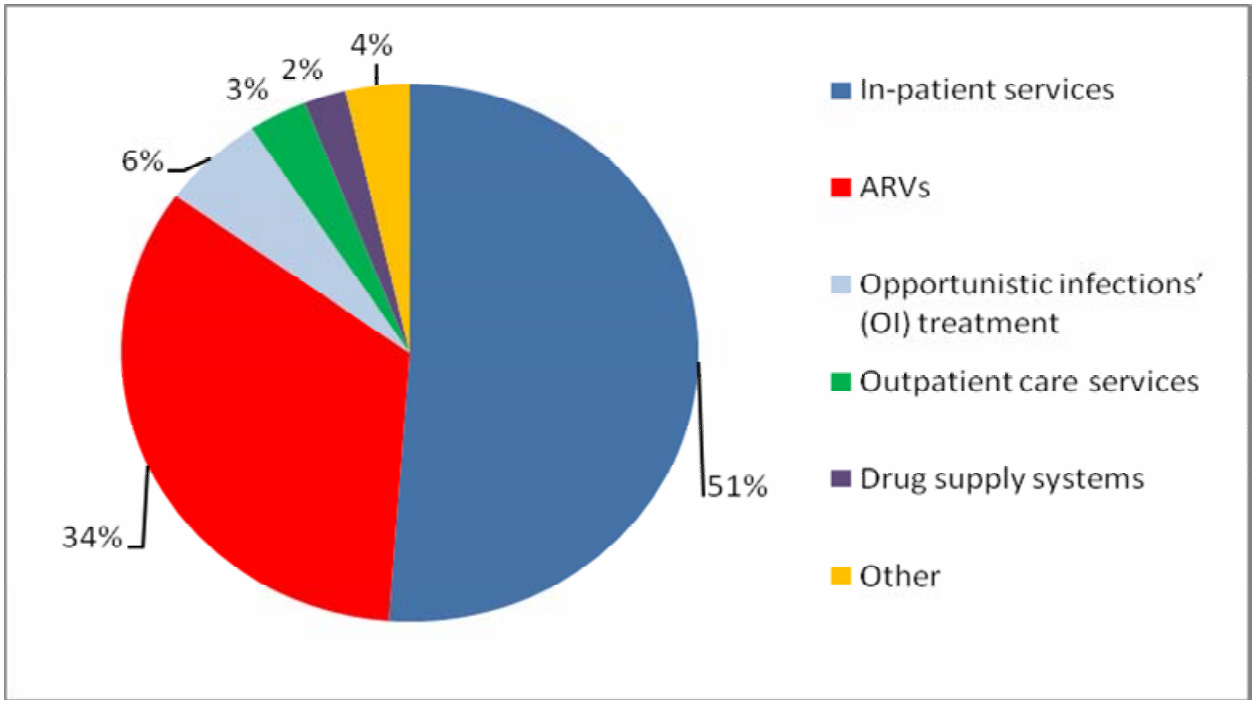
In 2005, most of the spending was on treatment and procurement of ART.

Table 19: Spending on Treatment, Care and Support activities for 2005 in USD

Treatment	Public	External	Total
Provider initiated testing and counselling	0	45,224	45,224
Opportunistic infection (OI) prophylaxis	0	597,333	597,333
First line ART – Adults	6,324	3,125,542	3,131,866
Antiretroviral therapy not-disaggregated by age or line of treatment	1,458,116	21,295,703	22,753,819
Nutritional support associated to ARV therapy	204	165,206	165,410
Psychological treatment and support services	0	19,033	19,033
Palliative care	0	8,904,910	8,904,910
Home-based medical care	0	894,993	894,993
Home-based care not-disaggregated	22	2,634,394	2,634,416
Alternative and informal care and treatment services	50	376	426
Outpatient care services not elsewhere classified (n.e.c.)	142,161	0	142,161
Opportunistic infections' (OI) treatment	252,091	50,305	302,396
In-patient services not elsewhere classified (n.e.c.)	2,218,364	0	2,218,364
Patient transport and emergency rescue	23,378	56,483	79,861
Care and treatment services not elsewhere classified (n.e.c.)	0	3,824,122	3,824,122
Drug supply systems	102,119	1,158,962	1,261,081
Information technology	0	11,866	11,866
Upgrading laboratory infrastructure and new equipment	0	1,387,793	1,387,793
Formative education to build-up an HIV workforce	12,337	84,437	96,774
Training	935	961,321	962,256

Incentives for human resources not elsewhere classified (n.e.c.)	0	1,350,000	1,350,000
Total treatment care and support	4,233,856	53,920,583	58,154,439

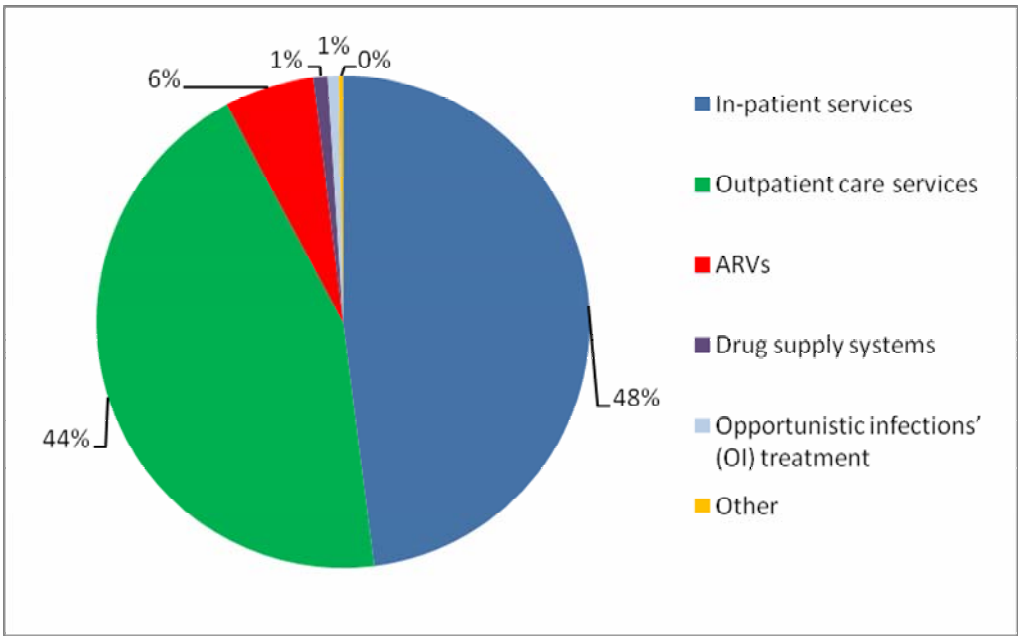
Figure 20: Public Treatment and Care Spending in 2005



The figure shows the public commitment to the provision of ARVs, and captures the MOH hospital costs, mostly hidden personnel costs, in the delivery of in-patient services to HIV-positive patients.

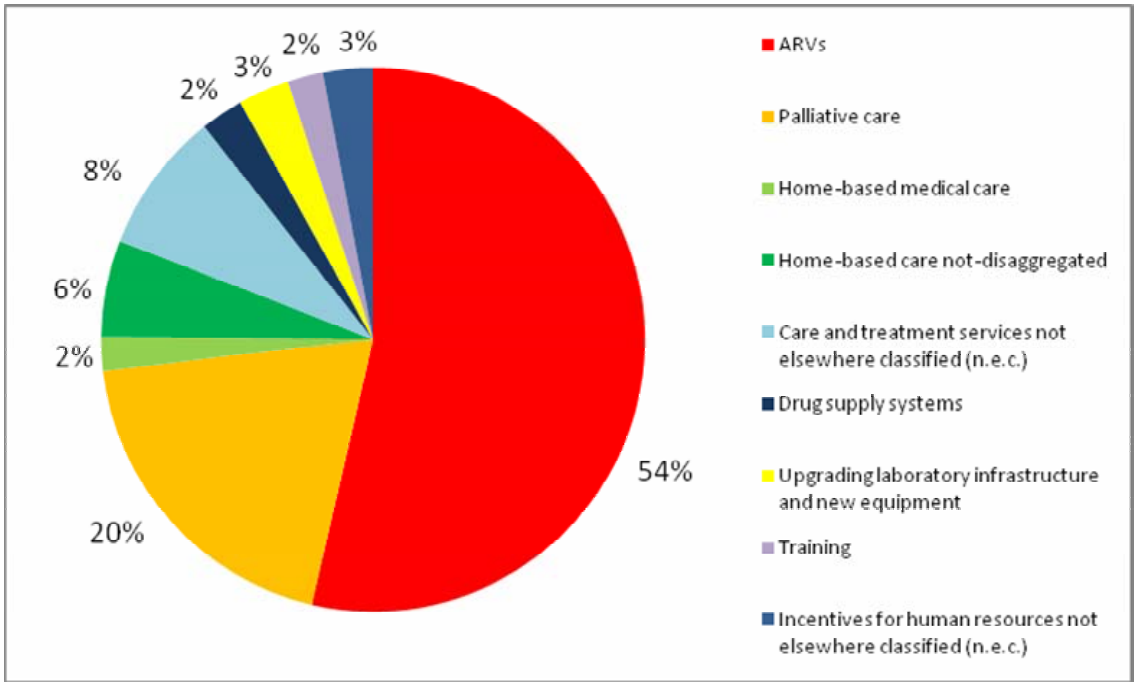
The public spending on treatment, care and support increased from US$ 4,233,856 in 2005 to US$26,999,480 in 2006. This was primarily due to the fact that the 2006 assessment was able to include the proportion of clinic staff salaries attributable to HIV/AIDS because the 2006 data provided the necessary disaggregation.

Figure 21: Public Treatment and Care Spending in 2006



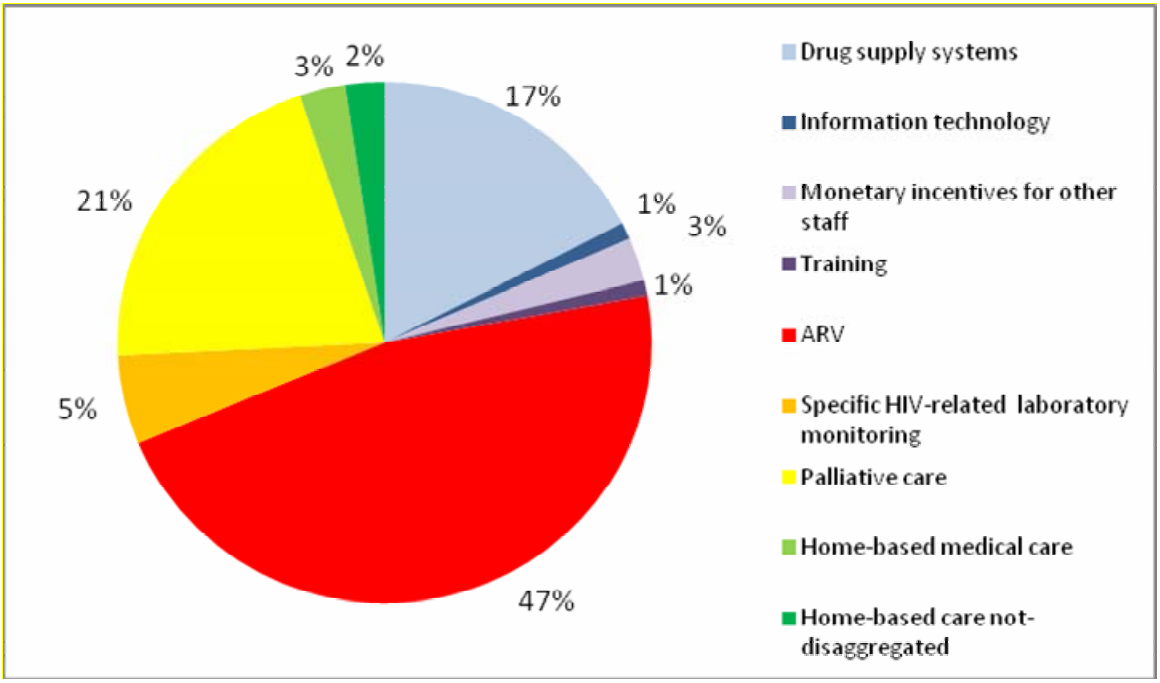
The actual amounts being spent on ARVs by the public sector increased from US$1,464,440 in 2005 to US$1,591,400 in 2006, but proportionally decreased from 34% to 6%, purely because the 2006 assessment included the hidden costs of the out-patient care at clinic level. These could not be included in the 2005 assessment because the personnel salary data was insufficiently disaggregated.

Figure 22: External Spending on Treatment and Care Categories in 2005



The figure shows the external commitment to the provision of ARVs, followed by palliative care.

Figure 23: External Spending on Treatment and Care Categories in 2006



The figure shows continuing external commitment to the provision of ARVs, palliative care and drug supply systems.

Table 20: Spending on Treatment, Care and Support activities for 2006 (USD)

TREATMENT SUPPORT AND CARE	Public	External	Total
Opportunistic infection (OI) prophylaxis	0	600,857	600,857
First line ART – Adults	23,913	6,090,400	6,114,313
Adult antiretroviral therapy not-disaggregated by line of treatment	0	10,401,963	10,401,963
Drug supply systems	252,724	14,009,239	14,261,963
Information technology	0	826,447	826,447
Upgrading laboratory infrastructure and new equipment	0	115,562	115,562
Monetary incentives for other staff	9,257	2,152,424	2,161,681
Formative education to build-up an HIV workforce	23,200	35,596	58,796
Training	0	775,854	775,854
Incentives for human resources not elsewhere classified (n.e.c.)	0	9,573	9,573
Upgrading and construction of infrastructure not elsewhere	21,938	17,168	39,106

classified (n.e.c)			
Antiretroviral therapy not-disaggregated by age or line of treatment	1,567,487	20,937,880	22,505,367
Nutritional support associated to ARV therapy	19,971	509,542	529,513
Specific HIV-related laboratory monitoring	0	4,403,400	4,403,400
Psychological treatment and support services	0	187,720	187,720
Palliative care	0	16,595,159	16,595,159
Home-based medical care	0	2,223,571	2,223,571
Home-based care not-disaggregated	0	1,904,580	1,904,580
Outpatient care services not elsewhere classified (n.e.c.)	11,931,063	0	11,931,063
Opportunistic infections' (OI) treatment	195,401	0	195,401
In-patient services not elsewhere classified (n.e.c.)	12,954,526	0	12,954,526
Care and treatment services not elsewhere classified (n.e.c.)	0	842,589	842,589
Sub-Total	**26,999,480**	**82,639,524**	**109,639,004**

5.4.3 AIDS Spending Categories- Mitigation Services

Expenditure on mitigation of the socio-economic impact covers several sub-categories including:

- OVC Education
- OVC Basic health care
- OVC Family/Home support
- OVC Community support
- OVC Administrative/Organisation costs
- OVC Institutional care
- Social protection through in-kind benefits
- HIV-specific income generation projects

Expenditure on mitigation of the socio-economic impact saw a decline from 2005 to 2006. This is attributable to the large decline in expenditure on social protection through in-kind benefits from US$ 20 million in 2005 to US$0.2 million in 2006, which is of particular concern and may reflect the decrease in funding to NGOs which primarily deliver social impact services.

Figure 24: Annual spending on mitigation services in 2005 and 2006

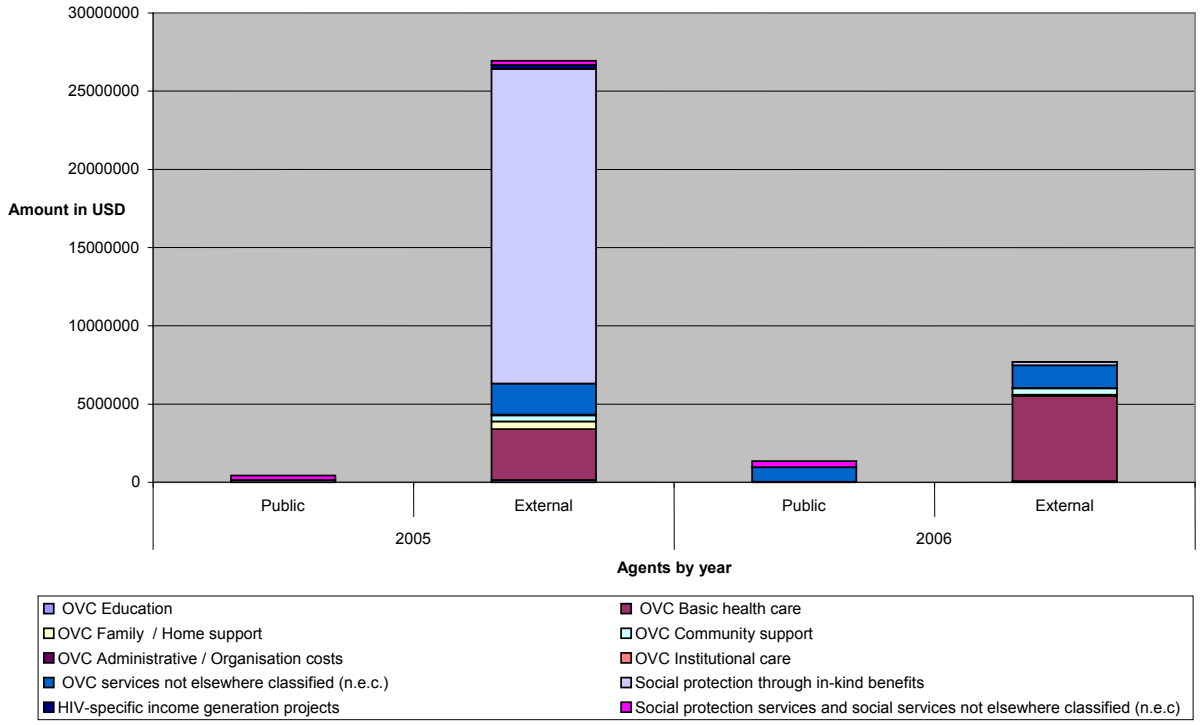


Table 21: Spending on Mitigation for social support by agent in 2005 in USD

	Public	External	Total
OVC Education	0	292,835	292,835
OVC Basic health care	0	3,261,083	3,261,083
OVC Family / Home support	405	480,063	480,468
OVC Community support	0	399,500	399,500
Administrative / Organisation costs	0	46,570	46,570
Services not elsewhere classified (n.e.c.)	0	1,984,695	1,984,695
Social protection through in-kind benefits	0	20,104,400	20,104,400
HIV-specific income generation projects	0	252,673	252,673
Social protection services and social services not elsewhere classified (n.e.c)	27,681	524,290	551,971
3. Mitigation of social economic impact	28,086	27,346,109	27,374,195

The minimal public spending on mitigation services in 2006 was focused on social protection on in-kind benefits and OVC basic health care. The external aid decreased dramatically.

Table 22: Spending on Mitigation of social support by agent for 2006

	Public	External	Total
Mitigation of Social Economic Impact	0	0	0
OVC Education	38,895	83,915	122,810
Social protection through in-kind benefits	0	213,121	213,121
HIV-specific income generation projects	0	12,857	12,857
Social protection services and social services not elsewhere classified (n.e.c)	36,446	354,137	390,583
OVC Basic health care	0	5,436,518	5,436,518
OVC Family / Home support	0	80,160	80,160
OVC Community support	0	400,857	400,857
OVC Administrative / Organisation costs	6,857	0	6,857
OVC Institutional care	0	30,501	30,501
OVC services not elsewhere classified (n.e.c.)	46,286	2,320,342	2,366,628
Sub-Total	128,484	8,932,408	9,060,892

5.4.4 AIDS Spending Categories- Advocacy and Coordination In The National Response

Expenditure on coordination and advocacy encompasses several spending sub-categories. These include:

- Programme Administration costs
- Transaction costs
- Planning and coordination costs
- Advocacy and strategic communication
- Human rights programme costs

Overall expenditure showed little change over the two years with the major portion of the expenditure remaining focused on programme management and administration while advocacy, strategic communication and human rights remained low. The expenditure pattern is illustrated in figure 33 below.

Table 23: Spending on Advocacy and Coordination by Agent for 2005 and 2006

Public	External	Total	Public	External	Total
2005			2006		

Programme Administration	0	4,556,480	4,556,480	61,517	4,956,142	5,017,659
Planning and coordination	67,699	1,206,812	1,274,511	217,025	3,161,573	3,378,598
Programme management	17,755	7,352,580	7,370,335	4,171	5,927,681	5,931,852
Advocacy and strategic communication	0	54,000	54,000	0	11,252	11,252
Human rights	0	72,175	72,175	0	127,158	127,158
Advocacy and coordination	67,699	5,889,467	5,957,166	0	0	0
Transaction cost	0	0	0	0	942	942
Total	155,158	19,133,519	19,286,672	284,719	14,186,754	14,469,467

Overall spending by public agents increased in the two years but decreased by external agents.

5.4.5 Spending On Mainstreaming And Decentralisation In 2005

Mainstreaming and decentralisation covered activities that are required for the multisectoral response at the non-health and sub-national sectors to take responsibility on the HIV and AIDS response according to the comparative advantages of the different sectors. The tables below show a slight increase in overall spending on mainstreaming over the two years. This was applicable to both public and external funding. The main focus was training and institutional development.

It should be noted that the NASA classifications did not easily discern multi-sectoral activities, and thus those captured below do not adequately reflect the efforts at mainstreaming, most of which would have been absorbed in programme management and presented above under Coordination.

Table 24: Spending on Mainstreaming and Decentralisation by Agent for 2005

Mainstreaming and decentralisation	Public	External	Total
AIDS-specific Institutional Development	170,199	2,128,493	2,298,692
Enabling environment and community development not elsewhere classified (n.e.c)	0	141,191	141,191
Sub-Total	170,199	2,269,684	2,439,883

Table 25: Spending on Mainstreaming and Decentralisation by Agent for 2006

Mainstreaming and decentralisation	Public	External	Total0
AIDS-specific Institutional Development	136,183	3,282,397	3,418,580
AIDS-specific programmes focused on women	0	175,026	175,026
Enabling environment and community development not elsewhere classified (n.e.c)	0	71,351	71,351
Sub-Total	136,183	3,528,774	3,664,957

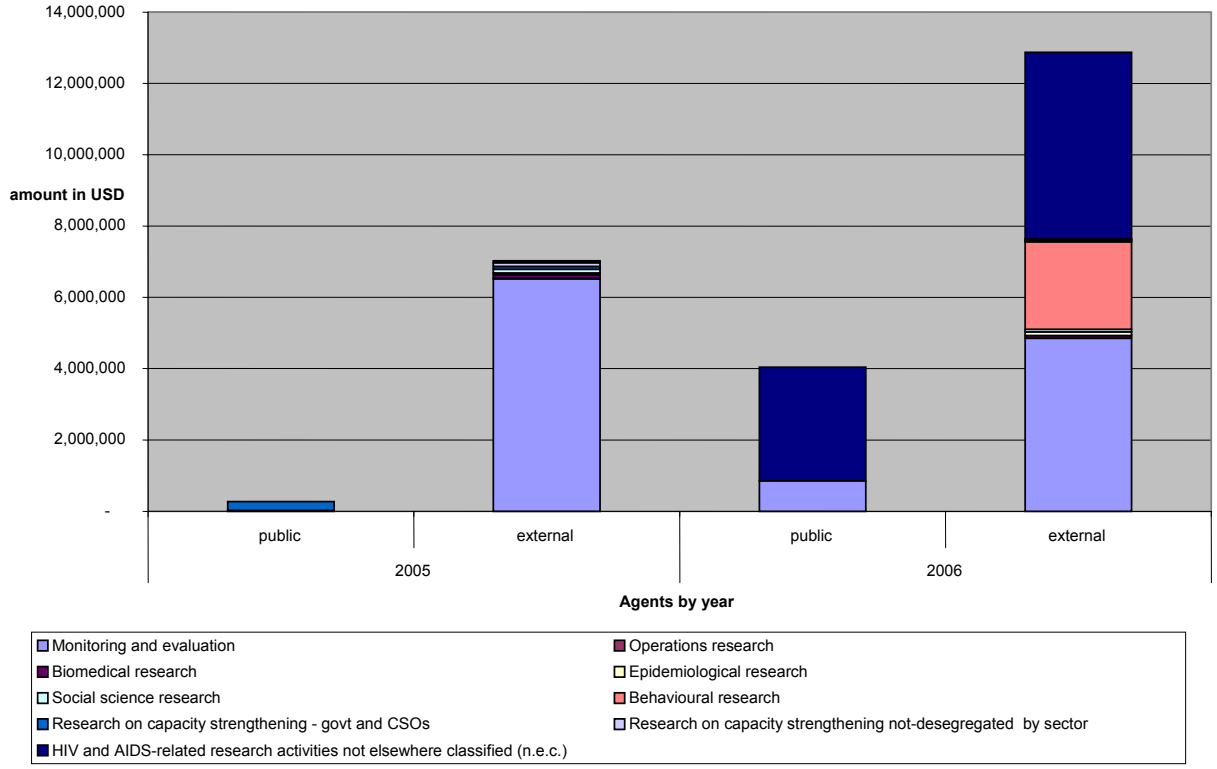
5.4.6 AIDS Spending Categories- Monitoring And Evaluation And Research

Monitoring and evaluation and research comprises of a number of AIDS Spending sub-categories including:

- Monitoring and evaluation
- Operations research
- Biomedical research
- Epidemiological research
- Social science research
- Behavioural research
- Research on capacity strengthening - govt and CSOs
- Research on capacity strengthening not-disaggregated by sector

While the expenditure in 2005 was largely M&E related, 2006 saw higher expenditure on other areas, principally on research activities. Most of the expenditure in this area was by external agents with public agent expenditure remaining at very low levels.

Figure 25: Spending on Monitoring and Evaluation by Agent in 2005 & 2006 (in US$)



In 2005, most of the spending was by external agents and was focused on M&E systems development.

Table 26 Spending on Monitoring and Evaluation by Agent in 2005

Monitoring and evaluation	0	6,550,591	6,550,591
Operations research	0	13,738	13,738
Biomedical research	0	100,000	100,000
Epidemiological research	0	50,000	50,000
Social science research	0	100,000	100,000
Research on capacity strengthening - government and civil society institutions	0	324,444	324,444
Research on capacity strengthening not-disaggregated by sector	0	100,000	100,000
HIV and AIDS-related research activities not elsewhere classified (n.e.c.)	0	58,030	58,030
Total	**0**	**7,296,803**	**7,296,803**

Spending on monitoring and evaluation was mainly channelled through external agents in 2006. Most of the expenditure was on behavioural research and support for monitoring and evaluation system.

Table 27: Spending on Monitoring and Evaluation by Agent for 2006

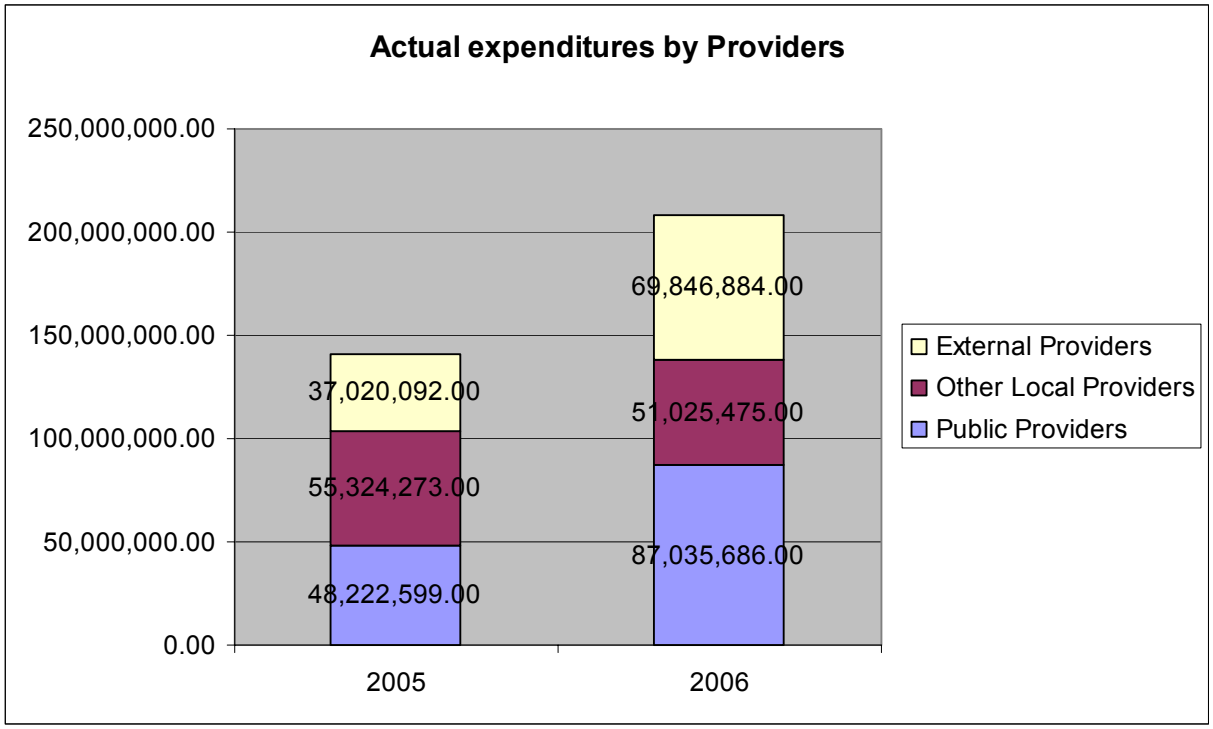
Monitoring and Evaluation	Public	External	Total
Biomedical research	0	86,000	86,000
Monitoring and evaluation	99,981	5,603,906	5,703,887
Operations research	0	1,371	1,371
Epidemiological research	0	100,000	100,000
Social science research	0	65,000	65,000
Behavioural research	0	2,456,400	2,456,400
Research on capacity strengthening - government and civil society institutions	0	39,222	39,222
Research on capacity strengthening not-disaggregated by sector	0	37,425	37,425
HIV and AIDS-related research activities not elsewhere classified (n.e.c.)	0	8,424,992	8,424,992
Sub-Total	99,981	16,814,316	16,914,297

5.5 Spending Pattern By Providers Of Services

Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution e.g. Blood bank, Ambulatory care centre (OPD) or Hospital.

The major provider of HIV and AIDS services in Zambia is the Ministry of Health through its health care delivery points throughout the country. Other key players include other line ministries, civil society organisations and international NGOs which have local branches, such as the Red Cross Society, World Vision and Care International. Overall, providers received and spent an increased amount of funds. This pattern was observed within public providers and external providers. However, a decreased amount of spending was seen among other local providers (civil society organisations). The reason for this decrease may have been the implementation of the direct budget support policy of government.

Figure 26: Comparison of actual expenditure by providers in 2005 and 2006 (in USD)



The distribution of the amounts reflected in Figure 22 above according to the financing agent from whom the providers received financing is shown below.

Table 27: Expenditure by Providers based on funds received from Financing Agents

		Agents			
Providers		Public agents	Other local agents	External	**Total**
Public providers	2005	26,285,521	47,444	21,889,635	**48,222,600**
	2006	45,342,723	11,263	41,681,696	**87,035,682**
Other local providers	2005	-	17,823,467	37,580,887	**55,404,354**
	2006	3,142,092	33,964,546	13,918,840	**51,025,478**
External providers	2005	-	-	36,939,692	**36,939,692**
	2006	-	-	69,848,084	**69,848,084**
Total	**2005**	**26,285,521**	**17,870,911**	**96,410,214**	**140,566,646**
	2006	**48,484,815**	**33,975,809**	**125,448,620**	**207,909,244**

5.5.1 Spending By Public Providers

Public providers spent a total of US$135 million in the two years. In 2005, the expenditure was US$48 million rising to US$ 87 million in 2006. Most of the expenditure is made at the hospital, Public Outpatient Care Centres, NAC and the Ministry of Education. The funds spent in other line ministries are quite low and may need further validation.

Figure 27: Expenditure distribution for public providers

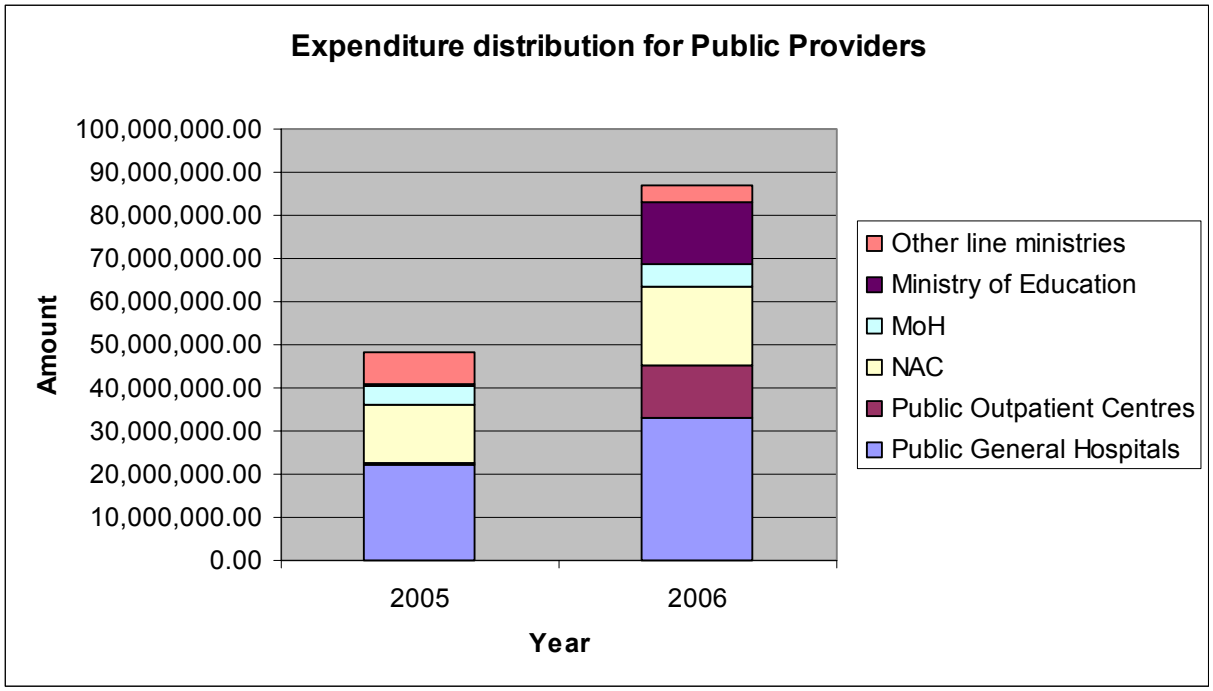


Table 29: Expenditure by public providers

	2005	2006
Public general hospitals	22,178,058	33,217,597
Public outpatient care centres	571,207	12,118,221
Public blood banks	11,991	47,454
Schools and Training centres not elsewhere classified	65,000	63,589
NAC	13,127,744	18,278,901
MoH	4,731,451	5,167,271
MOE	234,577	14,380,684

MOCDSW	87,000	N/A
MOFNP (workplace programmes)	48,849	25,857
MOL	112,222	42,908
Others	2,566,590	3,693,200
Total	**43,736,694**	**87,037,688**

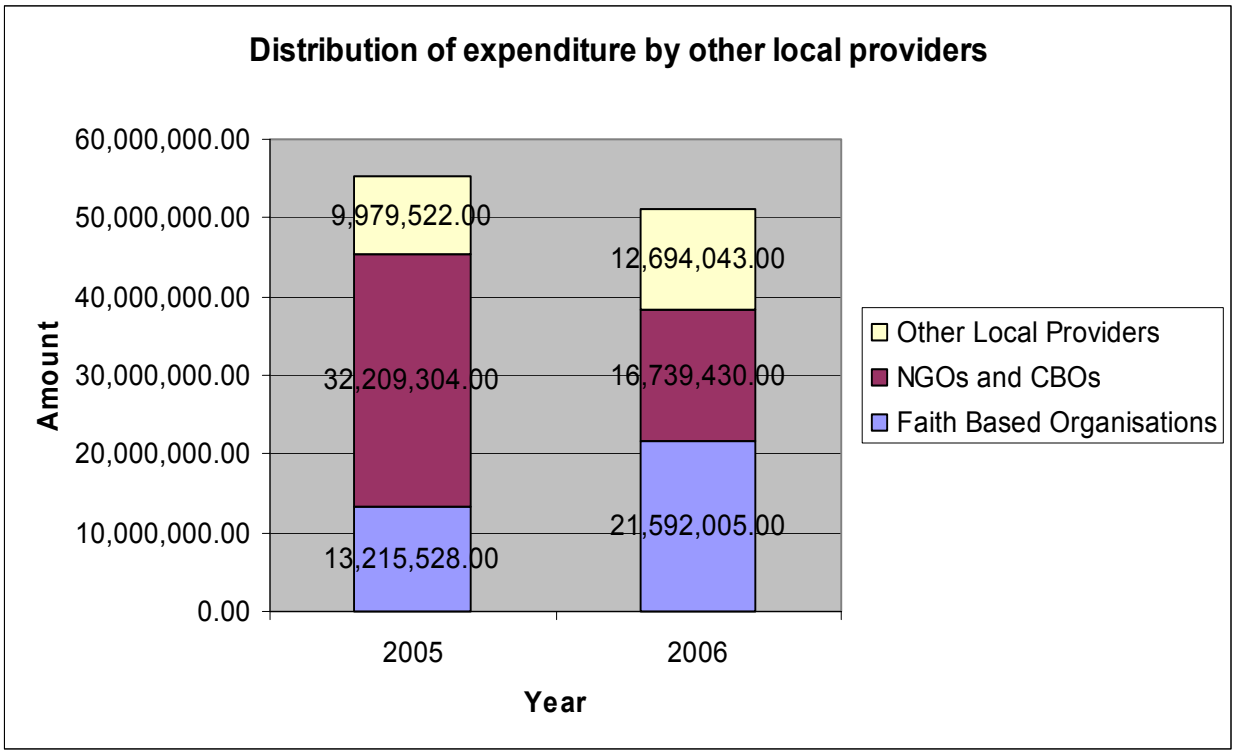
5.5.2 Spending By Other Local Providers

Expenditure by other Local Providers decreased from US$55 million in 2005 to US$51 million in 2006. An increase was only found in the expenditure of FBOs while NGOs and CBOs saw a decrease in the expenditure over the period as shown in table 21 and figure 24. Because NGOs and CBOs are the organisations that are doing the majority of the work in this area, the decrease in their expenditure may compromise mitigation efforts.

Table 30: Expenditure by Other Local Providers

Category	2005	2006
Faith Based Organisations	13,215,528.00	21,592,005
NGO and community-based organisations	32,209,304.00	16,739,430
Others	9,979,522.00	12,694,043
Total	**55,404,354.00**	**51,025,478.00**

Figure 28: Expenditure distribution for other Local Providers (USD)



5.6: COMPARISON OF 2005 NAISP AND 2006 NASF PRIORITIES AND EXPENDITURE

5.6.1 AIDS SPENDING PRIORITIES ACCORDING TO NAISP IN 2005

The NAISP was costed and then the intended allocations and sources were planned for the 5 year period. For purposes of this analysis, it was assumed that the total amount required would be spread equally over the five years. Also the proportional priorities given to each theme was then used to estimate each theme's share of the annual amount. Therefore the annual figures are rough guides that did not become actual allocations nor expenditures, and were generally considered as underestimations of the total resources required. Using these figures as a comparison against the actual expenditure figures is not very accurate nor useful. Nevertheless, the figures below provide a rough indication of the progress towards achieving the NAISP objectives in terms of spending.

Comparison of actual expenditure against the estimated required allocations on ASC/thematic areas in the two years is illustrated in figures 38 and 39. In both years, the focus of national spending is treatment, care and support with impact mitigation areas receiving low amounts. This is due to the government policy of free ART.

Table 31: Comparison of NAISP estimated resources required with the actual expenditure

	Estimated Cost (US$)	Expenditure (US$)	Expenditure as % of estimated cost
Objective 1. To promote the implementation of multisectoral behavioural change communication campaigns by encouraging safe sex practices and good health-seeking behaviours so as to reduce HIV/AIDS prevalence in the 15-19 age group from 15-11 percent by 2005.	$48,979,500	$31,047,694	63%
Objective 2. To decrease the mother-to-child transmission rate of HIV from 40% to 32% by increasing access to quality prevention of mother-to-child transmission services in all districts of the country.	$9,426,000	$1,162,684	12%
Objective 3. To make all blood, blood products and body parts safe for transfusion and to promote the use of sterile syringes, blades, needles by strengthening all (100%) screening centres and adopting infection control measures by 2005.	$1,680,750	$1,995,937	118%
Objective 4. To improve the quality of HIV/AIDS infected persons by encouraging positive living, good nutrition, prevention of opportunistic infections and avoiding high risk behaviour	$3,227,000	$3,694,819	114%
Objective 5. To provide appropriate care, support and treatment of HIV/AIDS infected persons and those affected by HIV/AIDS, TB, STIs and other opportunistic infections by the year 2005.	$48,712,500	$38,939,554	80%
Objective 6. To provide improved care and support services for orphans and vulnerable children (OVCs) and others affected and at risk such as refugees, prisoners and disabled people.	$17,368,750	$40,603,653	234%
Objective 7. To improve HIV/AIDS information management and decision-making by developing well-co-ordinated databases by 2005.	$3,325,000	$7,308,669	220%
Objective 8. To assure impartial, transparent and effective programme operations by improving the coordination of multisectoral implementation of interventions.	$6,956,000	$15,813,954	227%
Total	$139,675,500[23]	$140,566,964	101%

Overall, 101% of the estimated costs for 2005 was spent which due primarily to the underestimation of the resources is required (as explained above). Of the eight NAISP priorities, Table 24 demonstrates that

[23] This amount was generated by equally divided the total estimated budget for the NAISP by the four years to derived the estimates for 2005.

only Objective 2 had actual expenditure absorption rate of 12% compared with planned budget. Objectives 3,4,6, 7 and 8 scored over 100%. This may have been due to underestimation and under costing of the NAISP as well as success in resource mobilisation efforts. Despite rigorous planning for the NAISP, there was minimal attention to strictly abide by the agreed priorities. This may reflect slightly different priorities of cooperating partners as well as a failure to translate national spending priorities at the local provider level. The 'over-spending' on ARVs was indicative of the shift in government policy with regard to free treatment and subsequent allocations based on that.

5.6.2 AIDS Spending Priorities According to NASF In 2006

Figure 40 confirms the proportionate spending in 2006 on HIV and AIDS according to the percentage distribution of resources in the NASF. It was observed that we overspent on treatment and prevention and advocacy at the expense of mitigation, decentralisation and mainstreaming.

Table 32: Comparison of NASF estimated costs to actual expenditure (US$)

	THEME	Estimated Budget (US$)	Expenditure (US$)	Expenditure as % of estimated costs
I	Intensifying Prevention	68,300,000	54,161,434	79
II	Expanding treatment, care, support	81,900,000	109,639,004	134
III	Mitigating S/E Impact	41,000,000	9,060,892	22
IV	Strengthening decentralised response and Mainstreaming	41,000,000	14,467,461	35
V	Improving Monitoring and Evaluation	27,300,000	3,664,957	13
VI	Integrating Advocacy and Coordination	13,700,000	16,914,297	123
	Total	273,200,000	207,908,045	76

Overall in 2006, actual spending came to 76% of the estimated costs. In treatment, care and support (Theme II) and in Integrating Advocacy and Coordination (Theme VI), actual spending exceeded the estimated budget by 34% and 23% respectively. In all other thematic areas, actual spending fell significantly below the estimated necessary budget. Expenditure on improving monitoring, evaluation and mitigating socio-economic effects fell well short of the estimated funds at 13% and 22% respectively. This analysis suggests a need to improve mechanisms that ensure the allocations reach thematic areas other than treatment, care and support , and advocacy and coordination. Increased allocations and spending on Monitoring and Evaluation (Theme V) and facilitating decentralisation and mainstreaming of HIV and AIDS activities (Theme IV) will both directly and indirectly facilitate this goal.

5.7 SPENDING PATTERN BY TARGETED/INTENDED BENEFICIARY POPULATIONS

The analysis of the Beneficiary Population (BP) aims at quantifying the resources specifically allocated to a population as part of the service delivery process of a programmatic intervention (UNAIDS, 2007). As a principle, the identification of the BPs is dictated by the intention of the use of the funds. Beneficiaries are the population which demands or has been serviced by spending on HIV and AIDS commodities (goods and services). These are the people making use of a service or covered by a scheme. This represents an outcome linked to the resources spent, regardless of the effectiveness or the actual use of resources (effective coverage). For the purposes of this assessment, beneficiary populations are classified into the following categories:

1. People Living with HIV
2. Most-at-Risk Populations[24]
3. Other Key populations at high risk[25]
4. Specific Accessible Populations[26] General Population

The main beneficiaries of the National AIDS response for both years were people living with HIV, taking more than 50% of the expenditure. This conforms to the 52% expenditure on treatment, care and support as shown on figure 31 under AIDS Spending Categories. The General Population takes up 25 – 30% of the expenditure. While expenditure on Other Key Populations has increased, Most-at-Risk Populations (MARP) and Accessible Populations still have low expenditure with the MARP category showing a significant drop.

Table 33: Expenditure by Provider According to the Beneficiary Groups (2005 & 2006) (US$)

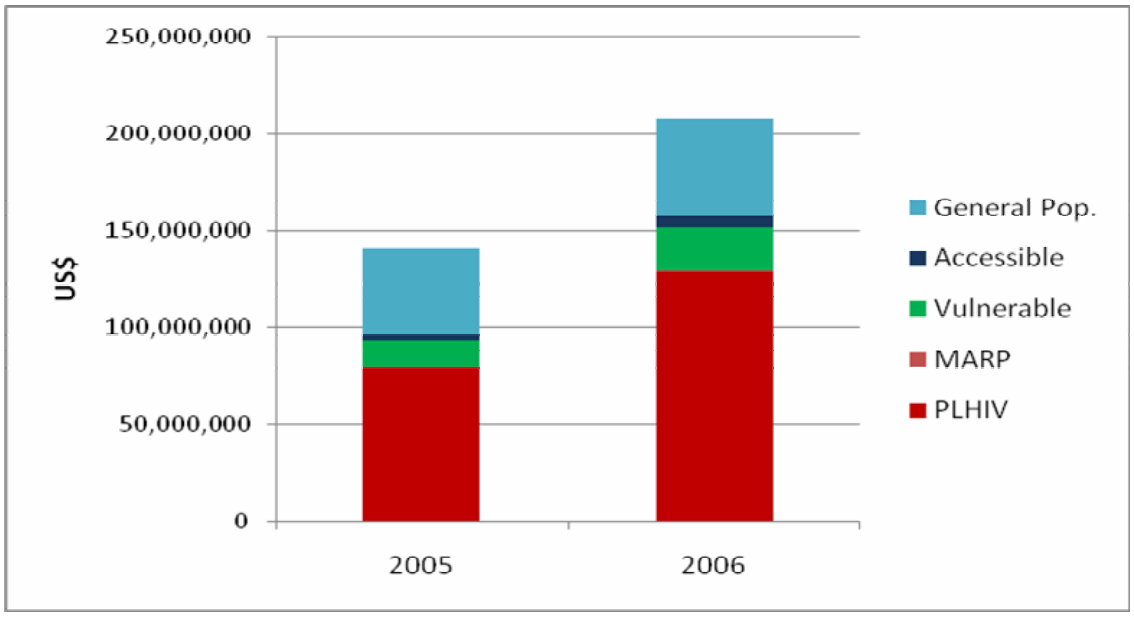
		Beneficiary Population					
Provider category		**PLHIV**	**MARP**	**Vulnerable Populations**	**Accessible Populations**	**General Population**	**Total**
Public	2005	33,182,859	0	895,311	704,889	13,393,574	48,176,633
	2006	40,820,500	0	1,031,434	2,480,762	4,102,117	48,434,813
Other Local Providers	2005	41,803,354	920,133	6,708,980	317,780	5,654,026	55,404,273
	2006	20,048,492	8,230	1,762,666	491,508	11,666,247	33,977,143
External	2005	3,706,628	0	5,922,706	1,847,046	25,463,713	36,940,093
	2006	68,752,384	86,710	19,608,120	2,493,735	34,556,339	125,497,288
Total	**2005**	**78,692,841**	**920,133**	**13,526,997**	**2,869,715**	**44,511,313**	**140,520,999**
	2006	**129,621,376**	**94,940**	**22,402,220**	**5,466,005**	**50,324,703**	**207,909,244**

[24] The most-at-risk populations can be grouped based on the behaviour they engage in that put them at great risk for HIV infection. This, in turn, identifies those populations that should be a priority for monitoring and evaluations efforts of national and sub-national programmes. These groupings of most-at-risk populations generally include the following: sex workers, their clients, injecting drug users, and men who have sex with men. These are populations more likely to have high rates of sexual partner exchange, to practice unprotected sex with multiple partners, or to use non-sterile drug injecting equipment, all of which puts them at risk of exposure to HIV (UNAIDS, 2007)

[25] Including OVC, children born to be born to HIV positive mothers, migrants, prisoners, refugees, partners of PLHIV.

[26] For example children in school, STI clinic patients, truck drivers, police and army officers.

Figure 29: Beneficiary Spending in 2005 and 2006 (USD)



5.7.1 Spending Pattern by Targeted/Intended Beneficiary Populations - PLHIV

The proportion of spending going to PLHIV increased in actual amounts and in proportion of the total spending from 56% to 62%, reflecting the increasing spending on ARVs, which directly benefits PLWHA.

However, the lack of disaggregated financial and output data in terms of the gender and ages of beneficiaries of services makes it difficult to further disaggregate the category of PLWHA. The table below shows no spending on male adults, boys and girls, but this reflects the lack of disaggregated data. The services provided to them are captured un PLHIV not disaggregated by age or gender.

Table 34: Spending on PLHIV

Categories	2005 (USD)	2006 (USD)
Male adults (25 years of age and over)	-	-
Female adults (25 years and over)	584,205	201,050
Young men (15-24)	90,000	2,905
Young women (15-24)	350,000	3,143,571
Boys (5-14)	-	-
Girls (5-14)	-	-
Infants (under 5)	770	571

People living with HIV not-disaggregated by age or gender	77,667,866	127,194,931
Total	**78,692,841**	**130,543,028**

5.7.2 Spending Pattern By Targeted/Intended Beneficiary Populations - Marp

The expenditure on MARP remains very low. In 2006, there was a significant reduction in expenditure. It was skewed towards sellers of sexual services and their clients.

Table 35: Spending on MARP in 2005 and 2006 (US$)

Categories	2005	2006
Injecting (IDU)and other drug users and their sexual partners	0.00	2,858.00
Sellers of sexual services (SW) and their clients	872,200.00	5,372.00
Men who have sex with men (MSM)	0.00	0.00
Most-at-risk populations" not elsewhere classified	47,933.00	86,710.00
Total	**920,133.00**	**94,940.00**

5.7.3 Spending Pattern By Targeted/Intended Beneficiary Populations - Accessible Populations

More than 50% of the expenditure is targeted at children born or to be born to HIV positive mothers through the PMTCT programmes. This is followed by OVCs. Other areas have little or no expenditure as illustrated in Table 28 and figure 36 below:

Figure 30: Expenditure distribution for Beneficiaries in 2005 and 2006

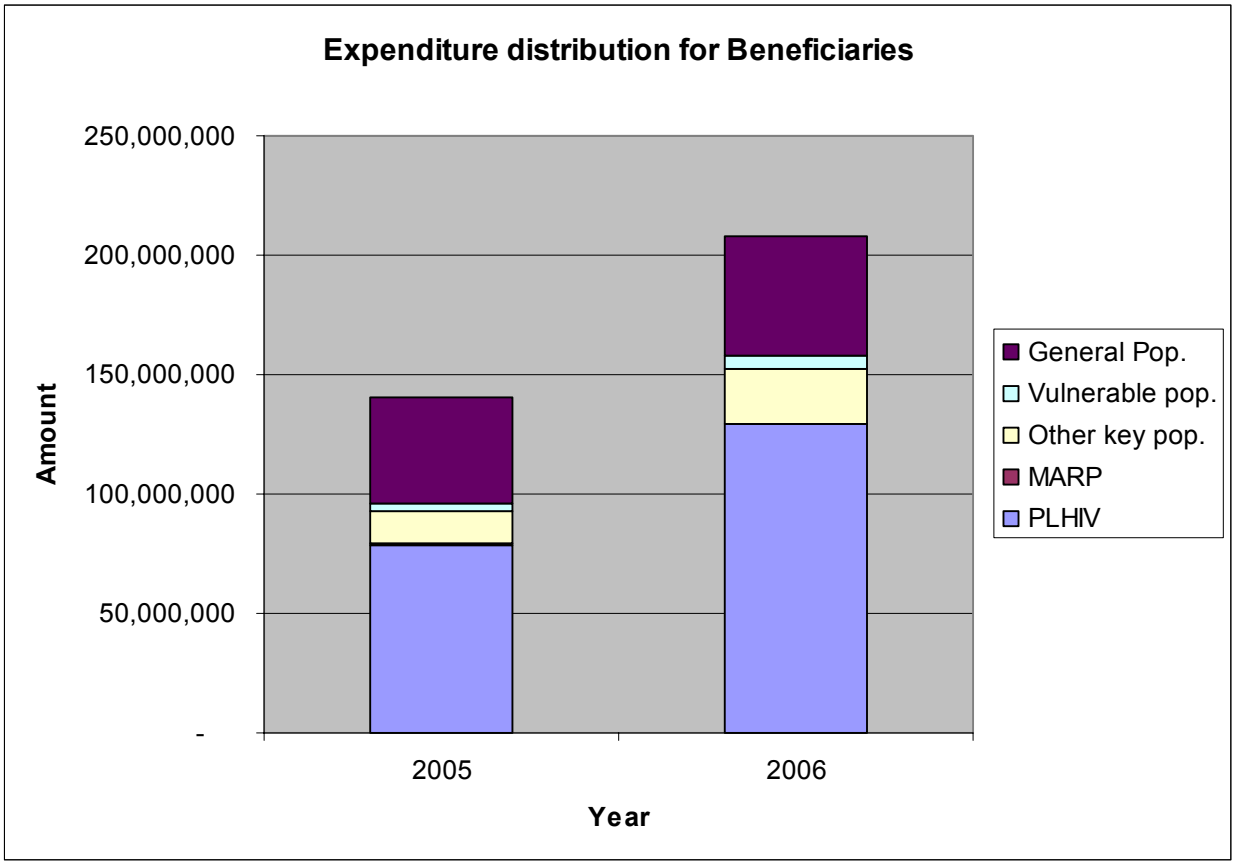
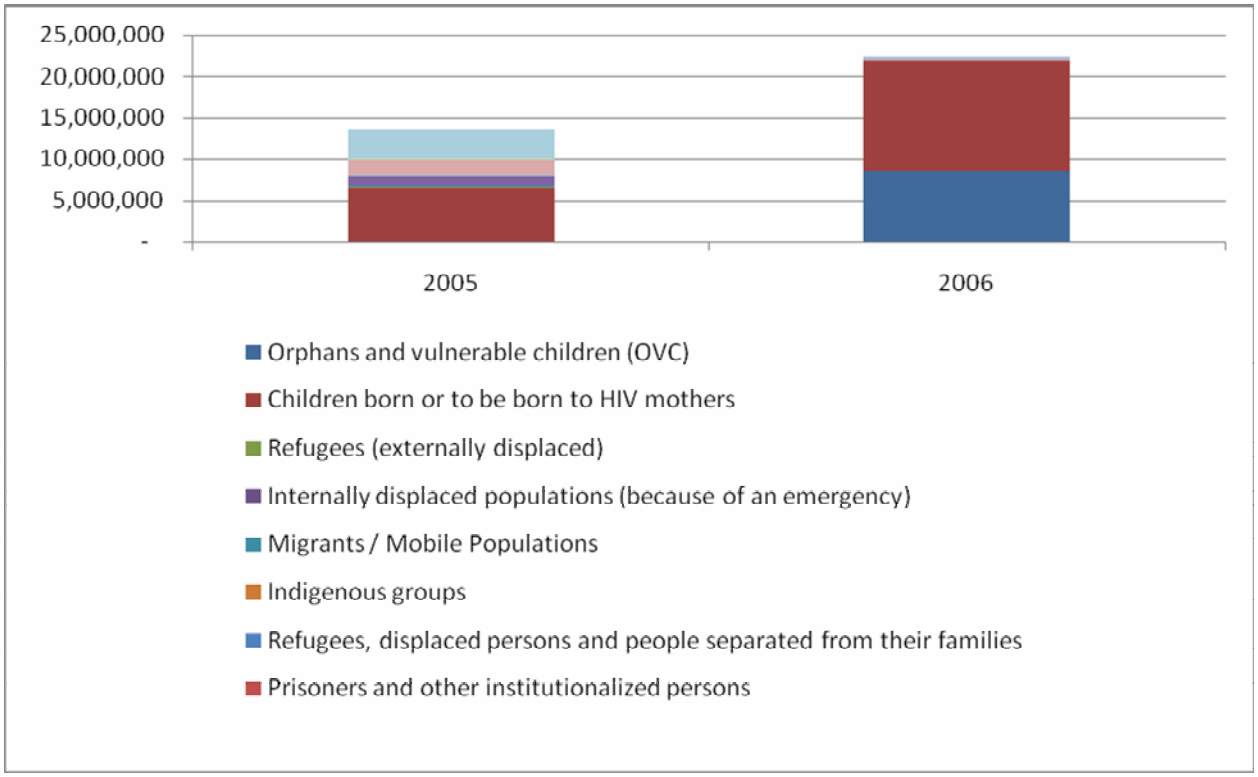


Table 36: Spending according to Vulnerable Populations in 2005 and 2006 (USD)

Vulnerable Group	2005 (USD)	2006 (USD)
Orphans and vulnerable children (OVC)	-	8,494,875
Children born or to be born to HIV mothers	6,506,139	13,410,644
Refugees (externally displaced)	67,617	-
Internally displaced populations (because of an emergency)	180,000	-
Migrants / Mobile Populations	-	-
Indigenous groups	-	-
Refugees, displaced persons and people separated from their families	54,000	-

Prisoners and other institutionalised persons	-	76,300
Truck drivers / Transport workers & commercial drivers	-	
People affected by trafficking and violence	1,150,000	
Youth at social risk	45,938	42,799
Children and youth living in the street	-	2,118
Children and youth gang members	5,152	46,585
Children and youth out of the school	2,007,278	125,250
Institutionalised children and youth	63,311	35,739
Partners of persons living with HIV	-	714
Populations at high risk" not elsewhere classified	3,447,562	167,196
Total	**13,526,997**	**22,402,220**

Figure 31: Spending on Vulnerable Populations



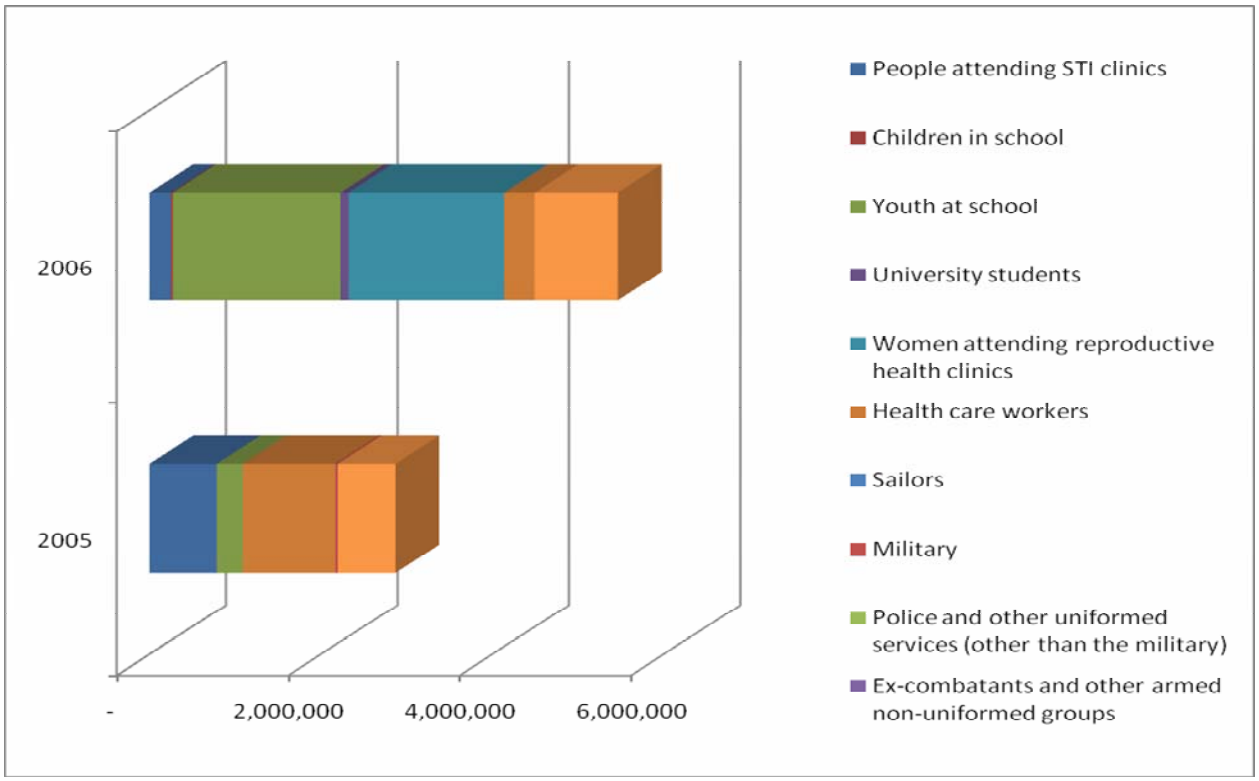
5.7.4 Spending Pattern by Targeted/Intended Beneficiary Populations - Accessible Populations

Under the key populations, expenditure is low. The key areas of focus are people attending STI clinics, youth at school, women attending reproductive health clinics and health workers.

Table 37: Spending on Accessible groups

	2005	2006
People attending STI clinics	784,780	50,485
Children in school	-	21,001
Youth at school	301,521	956,619
University students	-	95,891
Women attending reproductive health clinics	-	815,224
Health care workers	1,080,000	352,344
Sailors	-	-
Military	30,000	-
Police and other uniformed services (other than the military)	-	
Ex-combatants and other armed non-uniformed groups	-	2,165
Factory Employees	-	-
"Accessible populations" not elsewhere classified	673,414	972,276
Total	2,869,715	5,466,005

Figure 32: Spending by Accessible Populations (2005 & 2006) (US$)



5.7.5 Spending Pattern By Targeted/Intended Beneficiary Populations, General Population And Non Targeted Groups

While there is an increase in spending on the general population, the data show that expenditure targeted at young people is negligible. This is more likely due to the fact that disaggregated data was not available. Therefore, the data needs to be disaggregated further at delivery of services, and at allocation stage prior to spending to enable a more detailed analysis of the expenditure on the general population. In addition, greater detail on the outputs of spending, in terms of gender and ages of beneficiaries would enhance this analysis.

Table 38: Spending by General Population

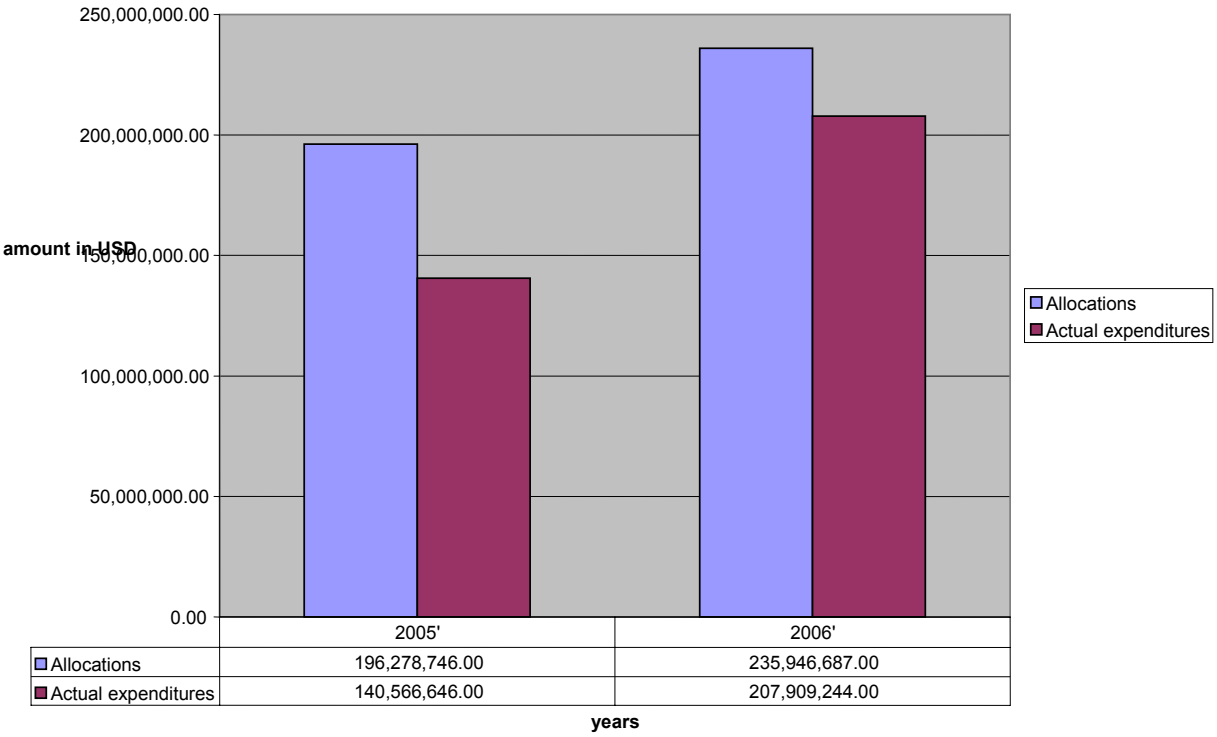
Categories	2005	2006
Male adult population	-	-
Female adult population	261,067	103,000
General Adult population (over 24) not discriminated by Gender	16,730,555	12,642,200
Children (under 15)	-	-
Boys	-	-
Girls	-	-

Children (under 15) not discriminated by gender	4,000	7,232
Youth (age 15 to 24)	-	-
Young men	-	30,712
Young females	116,234	216,274
Youth (age 15 to 24) not discriminated by gender	514,195	1,412,978
General population not disaggregated by age or gender.	11,703,368	9,697,525
Unspecified	14,706,707	25,378,677
Beneficiary populations not elsewhere classified	475,187	836,105
Total	44,513,318	50,326,709

5.7.6 Financial Absorption Rate

Figure 34 compares the total annual public allocations and external commitments with the actual total expenditure and shows an annual absorption rate of 71% in 2005 to 88% in 2006. Allocations captured here were the public and external intended commitments or budgetary allocations. However, the NASA process did not capture in detail all the intended allocations, so this absorptive rate may be overestimated.

Figure 33: Annual absorption rate for in 2005 and 2006 (USD)



The collected data indicated a better than expected absorption rate, which may have been overestimated due to the fact that the NASA method focused more on collecting the actual expenditures rather than also capturing the allocations or intended commitments.

5.8 QUALITATIVE FINDINGS

Results from qualitative interviews conducted with a range of stakeholders indicated a number of common themes which provide context to the data presented above. These included:

i) Difficulties and delays in securing, accessing, spending and funds;

ii) Bottlenecks in spending;

iii) Availability and adequacy of funds;

iv) Conditions attached to funds;

v) Donor reporting.

5.8.1 Difficulties, Delays in securing, accessing and spending of HIV and AIDS Funds

International and local providers (including public providers, local NGOs and international NGOs) noted difficulties in both applying for and subsequently accessing and spending funds. Reasons given included:

- Difficulty in communicating and justifying operations, plans and budgets made at the local level to international and national funding bodies.
- Complication of application processes - they required a significant investment of time and financial resources
- Differences in funding/budgetary cycles from funding agent to funding agent further complicated applications and reporting procedures
- Delayed disbursement of international and public funds often made it difficult for providers/recipients to execute their budgets, often forcing them to spend large sums in a truncated time-period
- Significantly delayed spending at the local level often due to extended tendering processes
- Centralisation of public funding (through permanent secretaries) forces providers to gain approval for all spending; this creates delays in reporting of current spending, which creates delays in future disbursements
- Centralisation of public funds approval was cited as making government funding generally more difficult to access by comparison to donor funding although some public institutions indicated that public funds are more accessible than donor funds if budgeted for and approved. These are released through monthly Recurrent Departmental Charges (RDCs) from the MOFNP.
- Fluctuations of the exchange rate have made budgeting for external funds more difficult
- Lack of coordination across local and international NGOs has created funding gluts in some ASCs (e.g. training treatment supporters in urban primary health care clinics) while other ASCs are receiving relatively little attention
- Remote-area providers face logistical challenges in terms of accessing banking services and maintaining adequate financial records to meet reporting requirements for some agents.
- Lack of human resources and/or appropriate technical capacity has affected the ability of local NGOs to access funds from major international funding sources.

5.8.2 ADEQUACY OF FUNDS

Some HIV/AIDS organisations (public and private) indicated that the available funding was not adequate to carry out the scope of HIV and AIDS programmes necessary. Reasons listed for this included:

- HIV/AIDS funds are often used to bolster non-HIV/AIDS specific services (e.g. primary health care centres) and in isolation, are insufficient for to cover both HIV-specific activities and more general health and other systems-strengthening.
- Increased demand for HIV and AIDS services across all areas is putting pressure on service providers to further scale-up services while funds are not increasing adequately to match this demand.
- Funding received often does not match the activity plans which have had costs factored in. This forces providers to cut activities and/or services.
- Increasing demand for provider services is making it difficult for providers to accurately project future targets for funding applications leading to under-funding relative to actual need.
- Delays in disbursement of funds create irregular cash flow, forcing providers to compensate with reduced activities and/or services.
- Delays in disbursement can mean prices in goods and services increase beyond the budgeted amount, contributing to funding shortfalls.
- Both public and private funding bodies tend to be urban-based and centralised, contributing to an urban-bias in funding.

5.8.3 CONDITIONS AND REPORTING REQUIREMENTS

Donor reporting requirements and conditions indicate the way local and international implementers apply for, spend and report on planned activities. Reporting requirements may vary from source to source, and are designed in part to ensure transparency and efficiency of funding flows. Some of the stakeholders interviewed noted that donor reporting formats did promote efficiency and clarity of spending patterns. However, strict conditions, the proliferation of reporting requirements and the number of different funding sources may also be creating a complicated and expensive administrative burden on local implementing organisations.

Typical reporting and accounting requirements imposed by donors include:

- Preparation and agreement on a work plan and spending according to that work plan
- Obtaining comparison quotations of costs of activities to be implemented and numbers of participants
- Implementing the programme within a specific period and submitting a report
- Demonstrating efficiency of spending
- Accountability of funds through submission of payment vouchers, retirement of receipts, bank reconciliation statements, etc

More stringent conditions imposed by bilateral and multilateral organisations have included:

- Funding transfers which are dependent on implementers reporting against a log frame activities and deliverables

- Funding transfers dependent on the submission of on-time external audits and progress and financial reports including quarterly financial and narrative activity reports
- Any departure from budgeted expenditure requires prior-approval by the funding body
- For the UN, funding transfers may be dependent on the creation of a Terms of Reference agreed to in a letter of agreement between the UN agency and the DRG.

Given the increasing diversity of HIV and AIDS programming and the proliferation of funding sources, there is need for enhanced training among local and international NGOs on reporting requirements for donor funds. Local NGOs, in particular, characteristically lack familiarity with the style, format and scope of reporting necessary to secure and maintain donor funding. Inadequately trained members of staff in local NGOs make efficient implementation and reporting of activities to funding bodies difficult. This contributes to delays in the reporting-funding-disbursement cycle. Orientation in these areas, and capacity building to develop the technical skills in order to make use of this knowledge will be necessary to ensure that local NGOs are able to continue providing important HIV and AIDS services. In addition, while many public providers of HIV and AIDS services have experience in government-style reporting procedures, the increased complexity of donor reporting and the attendant conditions makes it important that public providers be familiarised with the detail necessary to meet donor requirements. Establishing a committee/working group within the NAC to provide technical assistance in this area would facilitate a centralised point of assistance for all government and non-government bodies seeking to apply for donor funding, or needing assistance with ongoing reporting requirements.

6. SUMMARY OF KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In recent years, Zambia has seen a dramatic increase in financial resources dedicated to HIV and AIDS activities. In 2006, for example, actual expenditure of HIV/AIDS came to $207,909,244, a sixty seven million dollar (48%) increase on 2005 alone. Despite this rapid escalation in HIV/AIDS funds, or perhaps because of it, it has become increasingly challenging to track sources of funding and spending patterns across the multiple public and non-government stakeholders. Without a good understanding of such funding flows, it has become difficult to assess where there are gaps in resources relative to Zambia's needs, and whether some areas are receiving too little or too much funding. The *Zambia National AIDS Spending Assessment for 2005 and 2006* report represents the first effort to capture this critical information. It provides insights into current structure of HIV/AIDS spending and a platform for improved strategic planning in the future.

6.1 Summary of Key Findings

6.1.1 TOTAL SPENDING ON HIV/AIDS IN ZAMBIA AND SOURCES OF FINANCING

In 2005 the total expenditure on HIV/AIDS was $140,566,646 and in 2006, it increased by 68% to $207,909,244. The public contribution to the total was 4% in 2005, and 14% in 2006. Therefore Zambia's HIV/AIDS response was predominantly donor driven. External sources accounted for 96% of total HIV/AIDS expenditure in 2005 and 86% in 2006. In 2005, multilateral and bilateral sources each accounted for 48% of total externally sourced expenditure, while international non-government organisations (INGOs) accounted for the remaining 4%. In 2006, bilateral sources increased to account for 56% of total externally sourced expenditure, with multilaterals and INGOs accounting for 26% and 5% respectively.

External funding was dominated by three main sources, the Global Fund to Fight HIV and AIDS, Tuberculosis and Malaria (GFATM), the World Bank Multi-country AIDS Programme (MAP), and the US Government through the Presidents Emergency Plan for AIDS Relief (PEPFAR).

6.1.2 GLOBAL FUND APPROVED GRANTS VS DISBURSEMENTS VS EXPENDITURE

In 2003/4/5/6 respectively, the total disbursements by the Global Fund to Zambian principal recipients was only 3%, 30%, 31% and 36% of the total approved grant. On the other hand in 2006, CHAZ and ZNAN achieved the highest rate of disbursement to approved grant at 69% and 56% respectively, as compared with the MoH and MOFNP who achieved 4% and 28% respectively. These figures suggest that GFATM needs to revisit the mechanisms in place for disbursement to ensure more timely distribution. They also suggest that the MoH and MOFNP need to reassess the quarterly processes/protocols in place for securing disbursements against approved funds. In this respect it appears that MoH could learn from the approach of CHAZ and ZNAN. In addition, since GFATM is on-budget support, failure to secure the total approved grant represents a lost opportunity in terms of strengthening responses in government-listed priorities. In terms of the actual spending of the GFATM funds, expenditure increased from US$18 million in 2005 to almost US$26 million.

6.1.3 WORLD BANK – MAP (ZANARA PROJECT)

The World Bank committed $42 million over five years with GRZ counterpart funding of $4 million. In 2005 total funding commitments of the ZANARA Project, across all four areas, totalled $14 million, while total disbursement came to $13 million (a disbursement rate of 90%), and actual expenditure, according to this NASA was US$10 million. In 2006 total commitments came to $12 million while total disbursements exceeded this at over $14 million (disbursement rate of 118%), and actual expenditure was found also at US$14 million.

The CRAIDS project increased access to funds significantly especially at the community level through the CRAIDS project and strengthened spending on community prevention, care and impact mitigation programmes with emphasis on vulnerable people.

6.1.4 PEPFAR

The U.S. government (USG) through PEPFAR remains the highest contributor to the HIV/AIDS response annually in Zambia. Total planned funding allocations were $115 million in 2005 and $149 million in 2006 and PEPFAR funding constituted 89% of off-budget spending in Zambia in 2006. The total actual expenditure from the United States Government (USG) that was captured in this NASA expenditure increased from US$42 million in 2005 to just over US$100 million in 2006.

6.1.5 AIDS SPENDING CATEGORIES

AIDS spending categories (ASC) are a measure of commodities consumed or invested for the purpose of alleviating the suffering induced by HIV or some of its consequences or to prevent its diffusion. Comparing categorical HIV/AIDS expenditure in Zambia between 2005 and 2006 is a challenge due to the transition from the *National AIDS Intervention Strategic Plan 2002-2005* to the *National AIDS Strategic Framework 2005-2010.* Different objectives and spending categories were stipulated in the two documents.

Treatment, care and support saw a significant rise in expenditure increasing from $50,784,104 (36%) in 2005 to $109,630,004 (52%) in 2006. Prevention spending doubled between 2005 and 2006, but proportionally stayed the same: $39,344,478 (28% of total HIV/AIDS expenditure) in 2005, and $64,161,434 in 2006 (26%). Mitigation of impact decreased significantly from $27,374,195 (10% of total expenditure) to $9,060,892 (5%) in 2006. Advocacy and Coordination slightly increased in amounts but decreased proportionally from $13,327,501 (10%) to $14,487,461 (7%) in 2006. Monitoring, Evaluation and research saw a slight increase from $7,296,803 (5%) in 2005 to $16,914,297 (8%) in 2006. Mainstreaming and decentralisation remained consistent at 2% of total spending in both 2005 ($2,439,883) and 2006 ($3,664,957).

Comparing the spending on the categories with the NSF priority themes, it was found that there was generally a good balance of spending among the NSP thematic areas. There was proportionally low expenditure on prevention and concerns around issues of sustainability of treatment, care and support. Limited expenditure on mitigation of the impact of the epidemic is worrisome as it will affect the beneficiary population groups, specifically children and women. Under-funding of mainstreaming and

decentralisation process was also of concern, but was partly due to the difficulty of defining and identifying these activities from other general programme coordination spending.

6.1.6 AIDS SPENDING CATEGORIES BY PROVIDERS OF SERVICES

Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. The major provider of HIV and AIDS services in Zambia is the MoH through its health care delivery points. Other key players include line ministries, civil society organisations and INGOs such as the Red Cross Society, World Vision and Care International. Overall, providers received and spent an increased amount of funds in 2006 ($208 million) in comparison to 2005 ($141 million). In 2005, public providers were responsible for 35% of expenditure, rising to 41% in 2006. Other local providers were responsible for 39% of actual expenditure in 2005 declining to 25% in 2006. External providers (INGOs) were responsible for 26% of total actual expenditure in 2005, rising to 34% in 2006. The decline in spending by 'Other Local' providers and increase in 'External Providers' is indicative of an increased proportion of *external source funds* being channelled through INGOs (from 38% in 2005 to 56% in 2006) and public providers (from 22% in 2005 to 33% in 2006) rather than local non-governmental organisations (down from 40% in 2005 to 11% in 2006).

6.1.7 SPENDING PATTERNS BY TARGETED / INTENDED BENEFICIARY POPULATIONS

Beneficiary populations are classified as: People Living with HIV/AIDS (PLHIV), Most-at-risk Populations (MARP), Other Key Populations (including orphans and vulnerable children (OVC), migrants, prisoners, refugees and partners of PLHIV), Specific Accessible Populations and the General Population. The main beneficiaries of the HIV and AIDS response in Zambia in 2005 and 2006 were PLHIV with 56% and 62% of spending. Spending on the general population was 31.3% in 2005 and 24% in 2006, while Other Key Populations received 10% in 2005 and 11% in 2006. Accessible Populations received 2% and 3%, while MARP received 0.7% and 0.05% in 2005 and 2006 respectively. These spending patterns reflect the generalised nature of the HIV/AIDS epidemic and high incidence and prevalence of the disease in Zambia as well as the inapplicability of the 'MARP[27]' classification to this setting. Geographical coverage of the interventions and expenditure (e.g. between rural and urban) could not be ascertained in this NASA. It should be planned for next NASA.

6.1.8 FUNDING MECHANISMS AND ACCESSIBILITY

Actual spending of AIDS responses are through four major mechanisms: pooled, off and on budget and direct budget. Committed funds are inadequate to cover all the components of the response spending categories. Funding priority in most cases is defined according to specific outputs. The priorities are determined by the sources of funding. Agents and providers experience late disbursement and/ or withholding of funds. Direct funding (external to NGOs) is affected by strict requirements, extreme for community level organisations, and bureaucratic systems of government and donors. This is also applicable for replenishment of funds as it is based on acceptable financial reports leading to delays in

[27] Most-at-risk Populations is a classification most applicable settings of concentrated epidemics where sex workers, injection drug users and men who have sex with men are more at risk than the general population of transmitting or becoming infected with HIV.

disbursements. It was also observed that funds available to the response rarely cover institutional development, infrastructure and human resources. Sub-national level partners rarely access information on funding opportunities and availability.

The National resource tracking system is overwhelmed by the existence of parallel financial management systems within and without govt (e.g. WB- ZANARA programme) as well as affected by differing financial years and multiple year funding cycles.

6.1.9 SUMMARY OF FUNDING CHANNELS 2005-2006

In 2005 and 2006 off-budget arrangements accounted for 52% and 42% respectively of total HIV/AIDS expenditure. On the other hand, on-budget expenditure saw a significant increase from 8% in 2005 to 41% in 2006, possibly indicating a trend by external sources to provide more on-budget funding. These changes were reflected in the shifting structure of expenditure between 2005 and 2006 in which:

- Spending from **government** to **government** increased from 3% to 14% of total spending;
- Spending from **external sources** to **NGO** decreased from 69% to 17%;
- Spending from **external through government** to **NGO** increased from 1% to 3%
- Spending from **external sources to government** increased from 27% to 66%.

Of concern are the decreasing funds reaching NGOs and CBOs which are providing valuable services, particularly social and economic mitigation efforts, where spending has dramatically decreased.

6.1.10 ADEQUACY OF FUNDING – PUBLIC & EXTERNAL

Adequacy of funding by public and external sources is affected by the following factors:

- Public commitments are still very low but increasing
- External commitments – including or excluding overheads, local personnel costs and external consultancy costs – affects the amount available in-country for project spending
- Much centralised funding and spending with low funds for the sub-national level
- The data presented in this analysis was not disaggregated according to national and sub-national levels – the next NASA should do so

6.1.11 ABSORPTION OF FUNDS

Generally better absorption was observed than anticipated but the accuracy of analysis may have been undermined by the respondents' reported amounts received. Dumping funds at the end of the financial year was found to be common. This undermined efficiency of spending. Many bureaucratic, tedious, time-consuming, repetitive, systems may have slowed disbursement and absorption of funds.

6.1.12 COORDINATION, HARMONISATION AND ALIGNMENT

Evidence of Harmonisation and alignment through mechanisms of partnership forums, JASZ, health basket was observed. However, some donors still operate independently/ according to their own agenda, these use parallel systems characterised by duplication, fragmentation and priorities that are not national. It was observed that the strong desire for accountability and transparency through the use of annual auditor - general reports as a condition for further accountability coupled with multiple reporting demands and systems affected effectiveness of resources. It was also observed that, financial information and monitoring systems were not yet fully institutionalised. This included financial reporting mechanisms.

6.2 Conclusions

Between 2005 and 2006, Zambia's national response to HIV/AIDS was characterised by a 48% increase in spending with public commitments low (14% in 2006) but increasing. Zambia's HIV/AIDS spending remained primarily externally sourced (86% in 2006) with spending above all increasing in care and treatment activities (from 36% in 2005 to 52% in 2006) targeted at people living with HIV/AIDS. Prevention spending remained proportionally steady at 28% and 26% of total spending in 2005 and 2006. However, impact mitigation, decentralised response and the mainstreaming of HIV and AIDS in the development agenda received relatively little in contrast with the emphasis placed on their importance in the 2005 NAISP and 2006 NASF. HIV/AIDS funding from external sources to NGOs decreased from 69% in 2005 to 17% in 2006 reflecting a proportional decrease in funding received by civil society organisations (CSOs) who work predominantly with and through communities. This trend is likely to intensify if direct budget support increases over time as indicated by the increase in funding from external sources to government from 27% to 66% between 2005 and 2006.

Analysing the role of 2005 and 2006 HIV/AIDS spending in strengthening the long-term Zambian institutional response and building human capacity did not fall under the remit of this NASA. Nonetheless, low and/or uneven rates of disbursement from both public and external funding sources complicated efforts to generate an even and sustained response to HIV and AIDS across various ASCs, particularly in key areas of prevention and the mitigation of impact on women and vulnerable children.

Analysis of different funding mechanisms demonstrates that external commitments – including or excluding overheads, local personnel costs and external consultancy costs – affected the amount available in country for project-spending. Multiple reporting mechanisms and differences in donor and partner reporting systems continued to obfuscate monitoring and evaluation efforts, as for example some partners included the costs incurred at the head offices in their home countries as allocations to Zambia while other partners included only direct disbursements and excluded head office costs and personal emoluments of staff both in the country and at head offices. The differences in reporting systems between different partners made it difficult to compare performance of partners and/or funding mechanisms, pointing to the need for a harmonised accounting system to provide the basis for on-going monitoring and evaluation of the national HIV/AIDS response.

Generally, better absorption of funds was found than anticipated but the ccuracy of analysis may have been undermined by respondents' reports of amounts received. Dumping of funds at the end of the financial year was found to be common. This further undermined efficiency, absorption and distribution

of spending. Further work is needed to analyse entities who have achieved high rates of disbursement against grant commitments and to disseminate those lessons to other agencies and NGOs.

This NASA demonstrates low levels of spending at the sub-national level, and further work is needed to capture sub-national data including the geographical coverage of interventions and expenditure (for example between rural and urban settings) in order to assess the importance of decentralising some areas of service delivery. The next NASA should allow for disaggregation by level of service delivery.

Although harmonisation and alignment of partners was found to improve through 2005 and 2006, this NASA suggests that some donors still operate independently and fail to adopt national priorities. Improved accountability and transparency and greater harmonisation of reporting requirements are necessary to reduce the crippling effects of report-duplication and information fragmentation. The future development of a NASA reporting tool, overseen by the NAC could assist with this.

6.3 Recommendations

Following the above findings, the following recommendations are made:

6.3.1 POLICY RECOMMENDATIONS

- Develop a legal framework to ensure all partners report through a national resource tracking system – for example through the institutionalisation of a NASA reporting mechanism.
- Ensure this framework is linked to the National Resource Mobilisation and Management Strategy.
- Use this framework to harmonise standards of costing among different partners.
- Use this framework to mobilise local resources to better coordinate external funding sources to meet Zambian national HIV/AIDS priorities.
- Review (and compare with NASF) areas for public spending that will strengthen the sustainability of Zambia's HIV/AIDS mitigation efforts – for example in the areas of developing coordination across agents and providers, and strengthening national and sub-national monitoring and evaluation mechanisms.

6.3.2 PROGRAMMATIC RECOMMENDATIONS

- Review the split between the administrative costs and expenditure, and programme costs and expenditure with a view of reducing administrative and over-head costs and to release more resources for programmatic work.
- Conduct context-specific cost-benefit analyses of increased spending in thematic areas other than treatment.
- Scale-up spending around thematic areas along the NSF priority theme areas, particularly to allow greater proportional spending on prevention, impact mitigation, and vulnerable groups.

- Reprogramme the funds available in the national response to release a greater proportion at sub-national level.
- Reprogramme centralised public funding mechanisms to enable access to CSOs.
- Review and document successful approaches by agencies and NGOs in achieving high allocation-to-disbursement and expenditure/ absorption rates, and disseminate these findings to other applicants.

6.3.3 RECOMMENDATIONS FOR FUTURE NASAS

- Plan for improved geographical coverage and disaggregation of data (e.g. rural-urban comparisons) for future NASAs.
- Plan for improved monitoring of sub-national spending for future NASAs.
- Develop mechanisms to assess actual expenditure linked to annual JAPR.

ANNEXES

1. List of Institutions interviewed

Institution	Contact Person	District
	LOCAL NGOs	
Planned Parenthood Association of Zambia (PPAZ) - (Provider)	Mr. Henry Kaimba - 02211256283 ppaz@zamtel.zm	Lusaka
Makeni Ecumenical Centre (Provider)	Christine A. Allen - 272853	Lusaka
Youth Alive Zambia yaz@zamnet.zm	Mwila George 293559	Lusaka
ZARAN (Provider) zaran@zamtel.zm	Malala Mwondela 229648	Lusaka
CCF (Provider)	Luwaya E. - 290354 Edgar@ccfzambia.org.zm	Lusaka
CHAZ (agent)	Dr. Mphuka S.	Lusaka
Invesco Limited (Provider) Philip@invesco.co.zm	Ngowa Philip 02 650650	Lusaka
Copperbelt Energy Plc (Provider)	Chafumampunda 21 22 44 197	Lusaka
Family Health Trust (Provider)	Harson Chibale - 0977 7703380	Lusaka
Youth Alive Zambia-Kaoma (Provider)	Mubanga E. Fatherchandacmm@yahoo.com 07 360063/0979 304 810	Kaoma
YWCA – Kaoma (Provider)	Ngombo 0979 404 508	Kaoma
YMCA-Kaoma (Provider)	Mrs Nyambe 0978 226568	Kaoma
Iluka Community Support Group (Provider)	Harry Lombe 0955 910276	Mufulira

CINDI Mufulira (Provider)	Mumba Stephen 0977 594 557	Mufulira
Diocese of Mongu- Caritas (Provider) hbcwc@zamnet.zm	Sister Rodriguez P. 07 221431	Mongu
St. Francis Care Centre (Provider) sfhbc@zamnet.zm	Sr. Mary 03321655	Mongu
Adolescent Reproductive Health (Provider)	Brian Kayongo 0977, 580045	Mongu
Maranatha Grassroots Institute (Provider) maranathagr@yahoo.com	Mr. Mugandi 0977 300986	Mongu
Adolescent Reproductive Health (Provider)	Kayongo B. 0977 580 045 briankayongo@yahoo.co.uk	Mongu
Legends Trust (Provider) legendstrust@yahoo.com	Yataba M. N.	Livingstone
Zambia Interfaith Network Group on HIV AND AIDS (Provider) zingosouth@zamnet.zm	Mr. Timothy Regional director	Livingstone
The Lifestyles Health Foundation (Provider) lhfoundation@zamnet.zm	Pastor J. Moyo 323994/93)	Livingstone
Archdiocese of Kasama – Home Based Care (Provider) e-katongo@yahoo.co.uk	Edward Katongo 0977, 939, 233	Kasama
YWCA- Kasama (Provider)	Kasobaso 0979 581 999	Kasama
DAPP Humana (Provider)	Peter Chelemu 0955 434879 peterchelemu@yahoo.com	Ndola
Children In Distress (provider)	Mumba S. 0977 594557	Kitwe

PUBLIC SECTOR		
Ministry of Community Development (Provider)	Sakanga L. 07 222 156 lubisakanga@yahoo.com	Mongu
Ministry of Agriculture (Provider)	Lubasi L. 0977749440 lubasiluswaliso@yahoo.com	Lusaka
Ministry of Education (Provider)	Chilumba Nalwamba - 097 7 706494 cnalwamba@moe.gov	Lusaka
Ministry and Natural Resources (Provider)	Chabala C. 251707 Chachabala2000@yahoo.co.uk	Lusaka
Ministry of Finance (Provider)	Nganjo C. 0977 886902 Cnganjo10@yahoo.co.uk	Lusaka
Ministry of Foreign (provider)Affairs	S. Banda	Lusaka
Ministry of Labour (Provider)	Tonga G. 0977 874338 mutetegrace@yahoo.com	Lusaka
Ministry of Mines (Provider)	Mwiche S. 02 11 237306 chakafumbelo@yahoo.com	Lusaka
Ministry of Science and Technology (Provider)	Phiri E. 0977 802534 Eliud-phri@yahoo.com	Lusaka
Ministry of Youth Sport and Child Development (Provider)	Muzyamba C. – 224011 minsport@zamnet.zm	Lusaka
Ministry of Tourism (Provider)	Banda G. 0977 889080 givenakazwe@mtenr.gov.zm	Lusaka
Ministry of Transport and Communication (Provider)	Chanda J. 0966 452899 Jchanda2003@yahoo.co.uk	Lusaka
National AIDS Council (Agent)	Joseph N Ngulube. 253366 jngulube@nacsec.org.zm	Lusaka
ZNAN (Source) **znan@zamnet.com**	Mataka E. 256791/287512	Lusaka

ZANARA (Agent)	Mr. Vincent Nyambe	Lusaka
INTERNATIONAL ORGANISATIONS		
Irish AID-Kasama (Agent)	Nyanga S. 0214221260 Fsnyanga-dci@zamnet.zm	Kasama
UNAIDS (Source) **silungwec@zm.afro.who.int**	Silungwe 02 252645	Lusaka
CIDA	Laurie Rogers 0966 860960 laurierogers@international.gc.ca	Lusaka
JHPIEGO (Source)	Sikazwe C. - 256257 csikazwe@jhpiego.net	Lusaka
EU (Source)	Dr. Paul Kalinda - 250711 paulkalinda@eceropa.eu	Lusaka
DFID (Source)	Dr. Dyness Kasungami - 251164 d-kasungami@dfid.gov.uk	Lusaka
CIDRZ (Provider)	A. Degroot 293783 amabelle.degroot@cidrz.org	Lusaka
Africare Zambia (Agent)	Brian Harinham - 01 264406	Lusaka
Embassy of Sweden (Source)	Audrey Mwendapole - 51711 audrey.mwendapole@foreign.ministry.se	Lusaka
Embassy of the Kingdom of Netherlands (Source)	Peter de haan 253819 Peter_de.haan@minbuza.nl	Lusaka
UNFPA (Source)		Lusaka
HOSPITALS & CLINICS		
Ronald Ross Hospital (Provider)	Nsama 0212410166	Mufulira
Chibolya Clinic (Provider)	Mrs. Banda - 0966 152855	Mufulira
Butondo Clinic (Provider)	Mrs. D. Simwanza - 0955 910738	Mufulira
Twapia Clinic (Provider)	Mary Sichula - 0955 759553	Ndola

Chipulukusu Clinic (Provider)	Mr. Katebe	Ndola
Arthur Davison Hospital (Provider)	0977 854209	Ndola
Satyam Clinic Ltd (Provider)	Dr. P. R. Gajera - 614274	Ndola
MEF Clinic (Provider)	Mr. Makangila - 0979 768173	Ndola
Lubuto Clinic (Provider)	Mr. Siluyele - 0977 856927/0977 773844	Ndola
Beverly Medical Centre (Provider)	Mrs. Phiri - 0966 926530	Ndola
Dr. Bhatt's Surgery (Provider)	Dr. B. Bhatt - 620156	Ndola
Riverside Clinic (Provider)	R. Ngoma - 0966 276756	Kitwe
Ndeke Health Centre (Provider)	Urban Seketi - 0966 108903	Kitwe
Chimwemwe Clinic (Provider)	Mrs. Biemba M. - 0977 780545	Kitwe
Kitwe Surgery Ltd (Provider)	Swart Mulela - 0955 906604	Kitwe
Copperbelt University Clinic (Provider)	Mrs. Ngosa	Kitwe
Medcross Medical Clinic (Provider)	Dr. Saida - 610463	Copperbelt
Kamuchanga Clinic (Provider)	Mr. A. Kabwe - 0955 910741	Copperbelt
Chawama Clinic (Provider)	Ms. Mulenga A. - 0966 818460	Lusaka
Bauleni Clinic (Provider)	R. Mutemwa	Lusaka
Matero Clinic (Provider)	N. Mumbi	Lusaka
Victoria Hospital (Provider)	Mr. Besa	Lusaka
Chelstone Clinic (Provider)	P. Lukwesa - 0977 464701	Lusaka
Kanyama Clinic (Provider)	Ms. Mubiana	Lusaka
Mtendere Clinic (Provider)	Ms. Phiri - 0966 450305	Lusaka
Livingstone Police Clinic (Provider)	Silume Lishebo	Livingstone

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3. PEPFAR Obligation and Partners – 2005

Table A1.a: PEPFAR Prime partners and Sub-Partners in 2005

Prime Partner	Location	# of Sub-Partners (US based)	2005 Obligation to PP ($)	# of Sub-Partners (ZM based)
ABT Associates	NON-ZM	0	4,060,000	0
Academy for Educational Development	NON-ZM	1	800,000	0
American Institutes for Research	NON-ZM	0	4,000,000	0
American International Health Alliance	NON-ZM	0	139,837	0
American Society of Clinical Pathology	NON-ZM	0	99,203	0
Boston University	NON-ZM	0	150,000	0
Centre for Development & Population Activities	NON-ZM	0	500,000	0
Chemonics	NON-ZM	0	1,654,163	0
Chest Diseases Laboratory	NON-ZM	0	200,000	0
Children's AIDS Fund	NON-ZM	0	687,512	0
Christian Aid	NON-ZM	0	1,034	0
Columbia University Mailman School of Public Health	NON-ZM	0	300,000	0
Crown Agents	NON-ZM	0	164	0
Elizabeth Glaser Paediatric AIDS Foundation	NON-ZM	0	7,914,000	1
Elizabeth Glaser Paediatrics AIDS Foundation	NON-ZM	0	14,488,177	0
Emory University	NON-ZM	0	380,000	0
Hope Worldwide	NON-ZM	0	66,153	0
International Federation of Red Cross and Red Crescent Societies	NON-ZM	0	80,000	0
International Youth Foundation	NON-ZM	0	254,878	0
John Snow Research and Training Institute	NON-ZM	1	4,725,000	5
John Snow, Inc.	NON-ZM	0	12,850,000	0
Johns Hopkins University Centre for Communication Programmes	NON-ZM	0	3,080,000	1
Johns Hopkins University Institute for International Programmes	NON-ZM	0	70,000	0
Macro International	NON-ZM	0	340,000	0

Prime Partner	Location	# of Sub-Partners (US based)	2005 Obligation to PP ($)	# of Sub-Partners (ZM based)
National Alliance of State and Territorial AIDS Directors	NON-ZM	0	40,250	0
Oak Ridge Institute of Science and Education	NON-ZM	0	400,000	0
Opportunity International	NON-ZM	0	333,333	0
Pact, Inc.	NON-ZM	0	525,000	19
Plan USA	NON-ZM	0	346,196	0
Population Services International	NON-ZM	0	4,280,000	0
Project Concern International	NON-ZM	0	100,000	1
Project Concern International	NON-ZM	0	313,030	0
Public Health Institute	NON-ZM	0	145,000	0
Regional Procurement Support Office/Frankfurt	NON-ZM	0	1,400,000	0
Sanquin Blood Consulting	NON-ZM	0	676,438	0
Tropical Diseases Research Centre	NON-ZM	0	304,394	0
University of North Carolina Population Centre	NON-ZM	0	575,000	0
CARE International	ZM	0	200,000	0
Catholic Relief Services	ZM	0	6,959,500	11
Catholic Relief Services	ZM	0	346,847	0
Catholic Relief Services	ZM	0	4,355,513	0
Central Board of Health	ZM	0	205,000	0
Family Health International	ZM	0	15,999,300	10
Family Health International	ZM	0	438,005	0
JHPIEGO	ZM	0	1,720,398	0
Ministry of Health, National Blood Transfusion Services	ZM	0	3,382,185	0
National AIDS Council, Zambia	ZM	0	100,000	0
Provincial Health Office - Southern Province	ZM	0	200,000	0
University Teaching Hospital	ZM	0	125,000	0
World Vision International	ZM	0	8,589,492	40
Zambia National Blood Transfusion Service	ZM	0	50,000	0
Total (All PP)			**108,950,002**	

Table A1.b: PEPFAR Prime partners 2005–2006

Prime Partner	Location of Partner	Type of Partner	2005 (USD)	2006** (USD)
University Teaching Hospital (MoH)	ZM	MoH	125 000	350 000
Central Board of Health (MoH)	ZM	MoH	205 000	200 000
Provincial Health Office - Eastern Province (MoH)	ZM	MoH	-	200 000
Provincial Health Office - Southern Province (MoH)	ZM	MoH	200 000	300 000
Provincial Health Office - Western Province (MoH)	ZM	MoH	-	250 000
Zambia National Blood Transfusion Service (MoH)	ZM	MoH	3 432 185	-
National AIDS Council, Zambia	ZM	NAC	100 000	100 000
US Agency for International Development*	Non-ZM	USG	-	1 441 485
US Centres for Disease Control and Prevention*	Non-ZM	USG	-	7 450 830
US Department of Defence*	Non-ZM	USG	-	750 000
US Department of State*	Non-ZM	USG	-	239 681
Zambia Institute of Mass Communication	ZM	LAI	-	60 915
ABT Associates	Non-ZM	IAI	4 060 000	4 084 000
Emory University	Non-ZM	IAI	380 000	-
John Snow Research and Training Institute	Non-ZM	IAI	4 725 000	5 130 000
John Snow, Inc.	Non-ZM	IAI	12 850 000	1 853 000
Johns Hopkins University Centre for Communication Programmes	Non-ZM	IAI	3 080 000	2 917 791
Johns Hopkins University Institute for International Programmes	Non-ZM	IAI	70 000	150 000
Oak Ridge Institute of Science and Education	Non-ZM	IAI	400 000	-
Public Health Institute	Non-ZM	IAI	145 000	-
Social and Scientific Systems	Non-ZM	IAI	-	50 000
The American Society for Microbiology	Non-ZM	IAI	-	130 000
Tropical Diseases Research Centre	Non-ZM	IAI	304 394	337 324
Academy for Educational Development	Non-ZM	IAI	800 000	1 150 000
Tulane University	Non-ZM	IAI	-	1 650 000
University of Nebraska	Non-ZM	IAI	-	280 000
University of North Carolina Population Centre	Non-ZM	IAI	575 000	200 000
Christian Aid	Non-ZM	IFBO	1 034	-
Catholic Relief Services	ZM	IFBO	11 661 860	9 270 000
American International Health Alliance	Non-ZM	INGO	139 837	471 322
CARE International	ZM	INGO	200 000	550 000
Centre for Development and Population Activities	Non-ZM	INGO	500 000	145 000
Children's AIDS Fund	Non-ZM	INGO	687 512	-
Cooperative League of the USA	Non-ZM	INGO	-	100 000

Prime Partner	Location of Partner	Type of Partner	2005 (USD)	2006** (USD)
American Institutes for Research	Non-ZM	IAI	4 000 000	4 000 000
Development Aid People to People, Namibia	Non-ZM	INGO	-	250 000
Family Health International	ZM	INGO	16 437 305	12 145 000
Hope Worldwide	Non-ZM	INGO	66 153	-
International Federation of Red Cross and Red Crescent Societies	Non-ZM	INGO	80 000	-
International Youth Foundation	Non-ZM	INGO	254 878	-
JHPIEGO	ZM	INGO	1 720 398	1 405 000
Opportunity International	Non-ZM	INGO	333 333	-
Pact, Inc.	Non-ZM	INGO	525 000	1 000 000
World Vision International	ZM	INGO	8 589 492	10 437 000
American Society of Clinical Pathology	Non-ZM	IAI	99 203	-
Association of Schools of Public Health	Non-ZM	IAI	-	489 606
Boston University	Non-ZM	IAI	150 000	-
Chest Diseases Laboratory	Non-ZM	IAI	200 000	200 000
Columbia University Mailman School of Public Health	Non-ZM	IAI	300 000	950 000
Elizabeth Glaser Paediatric AIDS Foundation	Non-ZM	IAI	22 402 177	11 100 000
Churches Health Association of Zambia (CHAZ)	ZM	LFBO	-	300 000
Development Alternatives, Inc	Non-ZM	ONP	-	100 000
Regional Procurement Support Office/Frankfurt	Non-ZM	ONP	1 400 000	250 000
Sanquin Blood Consulting	Non-ZM	ONP	676 438	-
International Executive Service Corp	Non-ZM	ONP	-	600 000
M-Films Production	Non-ZM	ONP	-	41 545
National Alliance of State and Territorial AIDS Directors	Non-ZM	ONP	40 250	230 000
National Department of Social Development	Non-ZM	ONP	-	50 000
Partnership for Supply Chain Management	Non-ZM	ONP	-	15 600 000
Plan USA	Non-ZM	ONP	346 196	-
Population Services International	Non-ZM	ONP	4 280 000	3 580 000
Project Concern International	Non-ZM	ONP	413 030	-
Chemonics	Non-ZM	PFP	1 654 163	-
Comforce	Non-ZM	PFP	-	165 000
Crown Agents	Non-ZM	PFP	164	-
IAP Worldwide Services, Inc.	Non-ZM	PFP	-	360 625
Macro International	Non-ZM	PFP	340 000	600 000
Central Contraceptive Procurement	Non-ZM	USG	-	500 000
Total (all prime partners)	68		108 950 002	104 165 124

Summary Information and notes on Table A1.b

Total number of partners listed in A1.b	68
Of which:	
Number of Prime partners with no physical presence in Zambia (i.e., no fixed aboard, so working through other international or local partners only)	*54*
Number of Prime partners with physical presence in Zambia (i.e., with direct aboard in Zambia):	*14*
Abbreviations:	
International Academic Institution	IAI
International Faith Based Organisations	IFBO
International Non-Governmental Organisation	INGO
Local Academic Institution	LAI
Local Faith Based Organisation	LFBO
Local Health care Provider	LHP
Ministry of Health	MoH
National AIDS Council	NAC
Other Non-profit Private (organisation)	ONP
Private For-Profit (Organisation)	PFP
United States Government	USG
Undefined	###

Notes:

* USG agencies are typically not defined as prime partners but appears as such in 2006 data

** Data for 2006 are preliminary only

4. Global Fund Sub-Recipients

Table A2: Global Fund Sub-Recipients under CHAZ

Name of Sub-Recipient	Type of SR	Funding Round	Grant Amount (USD)			
			2004	2005	2006	Total
Campus Crusade	FBO	R1	6 867			6 867
Central Action on HIV/AIDS	FBO	R1		6 952		6 952
Chabbobboma Mission Health Centre	HF	R1	10 711	11 131		21 842
Chadiza Orphanage	FBO	R1		60 979		60 979
Cheshire Homes	FBO	R1			7 725	7 725
Chikankata Health Services	FBO	R1		15 080		15 080
Chikuni Mission Hospital	HF	R1	13 096	21 558	10 063	44 717
Chilanga Hospice Lusaka	HF	R4			113 337	113 337
Chilonga Mission Hospital	HF	R1	14 930			14 930
Chilubula Mission	HF	R1		16 333	13 580	29 913
Chinika House	FBO	R1		36 075	2 575	38 650
Chinyingi Mission Hospital	HF	R1	4 353			4 353
Chipembi Mission Hospital	HF	R1	5 284	1 953	9 952	17 189
Chipembi Mission hospital	HF	R4			22 974	22 974
Chipili Mission Station	FBO	R1		10 701		10 701
Chitokoloki Mission Hospital	HF	R1	4 387			4 387
Chivuna Health Centre	HF	R1	5 367	12 031		17 398
Compassion Christian Counselling	FBO	R1	11 588			11 588
Coptic Hospital Lusaka	HF	R1			9 540	9 540
Coptic Hospital Lusaka	HF	R4			131 160	131 160
Council of Churches in Zambia	FBO	R1	58 115	228 914	74 331	361 360
Dawn Trust Community Care	FBO	R1		3 156	5 509	8 665
DEC Chingola	FBO	R1	6 438			6 438
Diocese of Chipata	FBO	R1	137 356	182 890	78 451	398 697
Diocese of Mansa	FBO	R1	96 154	263 528	136 410	496 092
Diocese of Mongu	FBO	R1	96 154	157 901	107 188	361 243
Diocese of Monze	FBO	R1	96 154	336 210	115 750	548 114
Diocese of Ndola	FBO	R1	84 213	301 441	338 629	724 282
Diocese of Solwezi	FBO	R1	96 154	151 693	21 492	269 339
Dove Christian Care Centre	FBO	R1	8 682	51 498		60 180
Enviro Green Care Association of Zambia	FBO	R1	34 237	68 887	32 398	135 522
Evangelical Fellowship of Zambia (EFZ)	FBO	R1	53 466	314 281	103 789	471 535
Expanded Church Response Trust (ECR)	FBO	R1	47 549	165 073	71 344	283 966

Name of Sub-Recipient	Type of SR	Funding Round	Grant Amount (USD)			
			2004	2005	2006	Total
Fiwale Mission Hospital	HF	R1	4 521	4 444	6 823	15 788
Grace Ministries Mission	FBO	R1		10 951		10 951
Henwood Foundation	FBO	R1		124 980	66 400	191 380
Hope Community Care Initiative	FBO	R1	9 023	25 115		34 138
Hope For Africa Inter denomination	FBO	R1	6 438			6 438
Ibenga Community HBC	FBO	R1	1 250	15 302	20 526	37 078
ICOZ	FBO	R1			9 888	
Immanuel Mercy Reachout Ministries	FBO	R1	15 662	2 118		17 780
In community Care	FBO	R1		12 800	2 058	14 858
Islamic council of Zambia	FBO	R1		9 237		9 237
Isubilo	FBO	R1			4 120	
Jesus Cares Ministries	FBO	R1		2 778		2 778
Kabwata Baptist Church	FBO	R1	21 458			21 458
Kabwe Adventist Family Health Institute (KAFHI)	FBO	R1	110 209	327 025	219 922	657 156
Kafue Gospel Singers	FBO	R1		10 008		10 008
Kafue Mission Hospital	HF	R1	5 233			5 233
Kafulafuta Mission	FBO	R1		4 759	1 906	6 665
Kalene Mission Hospital	HF	R1	2 970	4 637	1 789	9 396
Kamoto Mission Hospital	HF	R1	8 523	6 179		14 703
Kanyanga Zonal RHC	HF	R1	1 732			1 732
Kaparu Mission Hospital	HF	R1	3 352		618	3 970
Katondwe Mission Hospital	HF	R1	5 648	4 844	9 952	20 445
Kayambi Health Centre	HF	R1	5 446		4 511	9 957
Kid Pre and Primary School	EF	R1		5 933		5 933
Kubeleka Aba Muchaala	FBO	R1	8 077	42 369		50 446
Kuku Baptist Church	FBO	R1		7 535		7 535
Kwenuha Women	FBO	R1		28 187	6 015	34 202
Libuyu HBC	FBO	R1		1 732		1 732
Life Healing Word Ministries	FBO	R1	13 948			13 948
Loloma Mission Health Centre	HF	R1	10 836		20 693	31 529
Loloma mission hospital	HF	R4			135 116	135 116
Lourdes Home craft Centre	FBO	R1		6 867		6 867
Loveliness Crisis Centre	FBO	R1		3 300		3 300
Lubwe Mission Hospital	HF	R1	11 325		18 849	30 174
Lubwe Mission hospital	HF	R4			108 983	108 983
Lumezi Mission Health Centre	HF	R1	5 974			5 974
Lwawu Health Centre	HF	R1	9 083		4 172	13 255

Name of Sub-Recipient	Type of SR	Funding Round	Grant Amount (USD)			
			2004	2005	2006	Total
Maamba HBC	FBO	R1		22 977		22 977
Maamba Youth Project	FBO	R1		2 065		2 065
Macha Mission Hospital	HF	R1		2 569	9 952	12 521
Mambilima Mission Hospital	HF	R1	11 097	17 493	13 236	41 825
Mangango HBC	FBO	R1		11 593		11 593
Masuku RHC	HF	R1			2 266	2 266
Mbereshi Mission Hospital	HF	R1		4 844	25 866	30 710
Mbereshi mission hospital	HF	R4			117 482	117 482
Mindolo Ecumenical Foundation	FBO	R1		179 309	198 755	378 064
Minga Mission Hospital	HF	R1	34 081		5 253	39 334
Monze mission hospital	HF	R1		9 044		9 044
Monze mission hospital	HF	R4			206 789	206 789
Mother Hughes - African Methodist	FBO	R1		12 932		12 932
Mpanshya Mission Hospital	HF	R1	3 645	13 081	6 077	22 803
Mpongwe Mission Hospital	HF	R1	7 940	12 261	20 362	40 562
Mpongwe mission hospital	HF	R4			158 930	158 930
Mpunde Mission	FBO	R1	12 017	7 777	16 738	36 531
Mtendere Mission Hospital	HF	R1	6 502	15 600	10 776	32 878
Mudzi wa Moyo	FBO	R1		15 851		15 851
Mukinge Mission	FBO	R1		16 775	11 121	27 896
Mulanga Mission RHC	HF	R1	4 234		1 751	5 985
Multi Media Zambia	FBO	R1	8 694			8 694
Mulungushi Rural Health Centre	HF	R1	4 218		5 232	9 450
Mumbezi Mission Health Centre	HF	R1	14 372			14 372
Mungwi Baptist RHC	HF	R1	5 365			5 365
Muzeyi Kalichero	FBO	R1	13 402			13 402
Mwami Mission Hospital	HF	R1			6 813	6 813
Mwami Mission hospital	HF	R4			191 285	191 285
Namwala HBC	FBO	R1		6 364		6 364
Namwianga Mission Health Centre	HF	R1	525			525
Nangoma Mission Hospital	HF	R1		5 476	10 084	15 560
Nangoma mission hospital	HF	R4			140 844	140 844
National Baptist Church	FBO	R1	28 890			28 890
Nchelenge Dist. HIV Task force	FBO	R1		4 126		4 126
Nchelenge Inter-denomination	FBO	R1		13 488		13 488
Ndola Ecumenical Hospice Ass.	FBO	R1		7 321		7 321
Neelam	FBO	R1			19 181	19 181
New Apostolic Church	FBO	R1		40 758		40 758

Name of Sub-Recipient	Type of SR	Funding Round	Grant Amount (USD)			
			2004	2005	2006	Total
Ngombe Pentecostal Holiness	FBO	R1		4 414		4 414
Nthilima AIDS Group	FBO	R1		9 541		9 541
Nyamphande Mission Hospital	HF	R1	3 170	19 619	9 888	32 677
Nyanje mission Hospital	HF	R1	3 170		10 218	13 388
Nyanje Mission Hospital	HF	R4			137 804	137 804
Praise Christian Centre	FBO	R1		9 650		9 650
Prisons Fellowship of Zambia - Lusaka	FBO	R1			10 506	10 506
Prisons Fellowship of Zambia - Ndola	FBO	R1			10 506	10 506
Radio Breeze FM	FBO	R1	7 654			7 654
Radio Chikuni	FBO	R1	41 002	69		41 071
Radio Ichengelo	FBO	R1	7 159			7 159
Radio Lyambai	FBO	R1	2 705			2 705
Radio Maria	FBO	R1	4 222			4 222
Radio Unza	FBO	R1	35 926			35 926
Radio Yatsani	FBO	R1	4 297			4 297
RCZ Chunga Congregation	FBO	R1	10 246	4 258		14 504
Rural Media Foundation	FBO	R1		11 303		11 303
Sachibondu Mission Hospital	HF	R1	5 283			5 283
Seventh Day Adventist	FBO	R1	2 954			2 954
Sichili Health Centre	HF	R1	5 706			5 706
Simwatachela RHC	HF	R1			6 056	6 056
Sioma Mission RHC	HF	R1	13 948			13 948
Sishemo Foundation	FBO	R1	9 109			9 109
Sitoti mission	FBO	R1		6 558		6 558
St Andrews Congregation Kabwe	FBO	R1		5 642		5 642
ST Fidelis Chilubula	FBO	R4			169 116	169 116
St Luke's mission hospital	HF	R4			111 402	111 402
St Paul's Kashikishi mission hospital	HF	R4			190 678	190 678
St. Anthony's Mission Health Centre	HF	R1	1 265	7 719	10 676	19 661
St. Domincs Major Seminary	FBO	R1	2 782			2 782
St. Joseph Mission	FBO	R1	1 650	18 339		19 989
St. Kalemba Mission Health Centre	HF	R1	9 324	6 911		16 235
St. Margaret's Mission Hospital	HF	R1	11 541			11 541
St. Mary's Mission RHC	HF	R1		46 500	7 344	53 844
St. Paul's Consistory	FBO	R1		63 012		63 012
St. Paul's Kashikishi	FBO	R1			7 720	7 720
The Saviours Miss. Centre	FBO	R1		12 846		12 846
Tithandizane Buddhist Community Care	FBO	R1	5 096			5 096

Name of Sub-Recipient	Type of SR	Funding Round	Grant Amount (USD)			
			2004	2005	2006	Total
Tsidzkenu Charities	FBO	R1		3 121		3 121
Twafwane Christian Community Care	FBO	R1	6 742	20 117		26 859
UCZ	FBO	R1	21 727	84 684	46 455	152 866
Yatsani Studios- TV HIV series	FBO	R1		17 432		17 432
YMCA Refuge Project	FBO	R1	28 830			28 830
Young Kids Nursery School	EF	R1		3 567		3 567
Young Women Christian Association	FBO	R1	150 047	82 261	54 864	287 171
Youth Alive Zambia	FBO	R1	271 435	234 549	43 869	549 854
Youth Training Centre - Livingstone	FBO	R1	18 733			18 733
Youth with a vision	FBO	R1		12 630		12 630
Zambia Anglican Council	FBO	R1		24 269		24 269
Zambia Interfaith Networking Group on HIV/AIDS (ZINGO)	FBO	R1	152 790	259 464	57 130	469 384
Zambia Isipo Support Group	FBO	R1			2 584	2 584
Zilonde Early Childhood Centre	FBO	R1	5 096			5 096
Zimba Mission Hospital	HF	R1	15 638	12 987	14 956	43 581
Zimba mission hospital	HF	R4			130 842	130 842
TOTAL			**2 166 190**	**4 482 529**	**4 259 946**	**10 894 656**

Notes:

R1 is HIV/AIDS Round 1: ZAM-102-G04-H-00 funding

R4 is HIV/AIDS Round 4 : ZAM-405-G10-H funding

FBO = Faith based organisation

HF = Health Facility (hospital or health centre)

EF = Educational Facility

Blue highlight shows CHAZ members; the other SROs are GF recipients that are not CHAZ members

Table A3: Global Fund Sub-Recipients under ZNAN

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
[[NGO/CBO Name not in original database]]	-	5 293	-
5 fm Radio	-	5 941	-
Action for Positive change	-	5 098	-
Africare Zambia	120 447	306 740	154 853
Afya Mzuri	-	18 124	45 109
Alliance for Nutrition & Reconstruction	12 825	5 605	-
Anti Poverty & Ignorance (PIMO)	2 321	-	-
Association for AID and Relief Japan	-	-	11 369

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Better Tomorrow	-	-	2 741
Bibusa Support Group	-	-	11 730
Breeze 99.6FM	-	11 555	-
Buseko Widows and Female Headed Homes	-	-	5 649
Buwame Youth and Women Vocation Skills	-	4 795	-
Cavmont Capital Bank Ltd	-	13 093	-
Central Action on HIV/AIDS	-	-	15 951
Centre for Infectious Disease Research in (Z)	-	-	31 069
Chainama Hills College Hospital	-	-	21 661
Chawama Support Group	-	-	4 626
Chengelo Association of Orphans & Women	-	5 039	-
CHICHIWABABILI Support Group	-	-	6 609
Chifundo Orphanage Community School	-	6 611	-
Chikupili Health Centre Committee	-	1 250	-
Chilangwa Support Group	-	-	5 713
Child Care and Adoption Society of Zambia	-	27 034	-
Child Hope	-	9 650	-
Children In Crisis	-	30 776	-
Chilenga Support Group	-	-	6 125
Chimulambe Community School	-	-	6 222
Chindwin Hope Support Group	-	-	1 612
Chingalala Support Group	-	-	6 431
Chinsali District Business Association	-	16 377	-
Chinsali Women's Group HBC	-	16 381	-
Chipata Care Preventive and Support Team	4 082	8 101	19 602
Chisamu HIV/AIDS Group	3 895	-	-
Chisela Gender & Development Club	-	-	2 226
Chisengu Care Group	-	3 317	-
Chisomo Support Group	-	-	5 345
Chitamba HBC	-	-	4 767
CINCI WA Babili	-	-	22 080
CINDI - Kalomo	-	71 659	-
CINDI Chimasuko - Katete	-	23 022	-
CINDI Kitwe	19 680	35 394	-
Circles of Hope Support Group	-	5 605	-
Community for Human Development	-	20 851	8 501
Copperbelt Health Education Project (CHEP)	119 749	992 150	417 073
Copperbelt University	-	62 302	-

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Development Aid from People to People	221 444	526 230	173 692
EDUSPORT-Education Through Sport Foundation	16 697	22 060	-
Facing the Challenge	33 027	38 533	142 619
Family Health Trust	404 659	309 817	199 449
Family Health Trust - AIDS Action Project	-	-	13 222
Family Health Trust - Monze	-	-	12 059
Finance Bank	-	20 067	33 611
Foundation for Community Action	-	-	4 422
Franciscan of Assisi	-	-	32 227
George Madaliso Cooperative	-	-	6 658
Girl Guides	-	49 938	-
Global Compact Zambia	73 261	-	270 780
HIV/AIDS Poverty Alleviation	4 963	-	4 777
Hope A Support Group	-	-	8 771
Ifimbusa Traditional Marriage Encounter	-	-	10 190
Immanuel's OVC Project	-	-	6 595
In But Free	101 580	-	-
Indeni Oil Refinery	28 119	-	-
Indeni Petroleum Company	-	-	9 892
International HIV/AIDS Alliance	434 498	494 842	377 531
Isubilo Day Care Centre	4 834	3 709	-
ITEZO	-	-	19 173
Jesus Cares Ministries	-	4 842	-
John Laing Community HBC (JLCHBC)	-	-	14 578
John Laing Community HBC (JLCHBC)	-	-	15 823
JohnLaing Community HBC (JLCHBC)	-	5 415	-
JohnLaing Community HBC (JLCHBC)	-	9 553	-
JohnLaing Community HBC (JLCHBC)	-	10 869	-
JohnLaing Community HBC (JLCHBC)	-	25 836	30 401
Kabisonga Anti-AIDS Club	-	5 600	-
Kabompo Rural OVC	5 031	-	-
Kabuta OVC Community School	-	5 673	-
Kafue Community Stop HIV/AIDS International	-	-	6 067
Kakanga Community HIV/AIDS Group	5 176	-	-
Kamijiji Support Group	-	-	6 146
Kamoto Hospital	-	-	77 017

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Kampemba Support Group	-	-	16 803
Kanfumbu Support Group	-	-	5 534
Kanona Basic School OVC Association	-	4 537	-
Kapupulu Community School	-	2 986	-
KARA Counselling and Training Trust	489 893	662 597	277 025
Kasaka Child and Family Project	-	5 737	-
Kasama Arts Theatre Production	-	-	6 605
Kasangenji Prevention HIV/AIDS Care Project	-	-	6 658
Kasempa Amateur Football Association	-	5 073	-
Kasempa Community Health Care Providers	-	4 585	6 658
Kashitu HIV/AIDS	3 995	-	-
Kasonde Mutokwa Cultivating Club	-	-	9 594
Katuba Child and Family Helper Programme	-	4 835	-
Kawiko Safe Motherhood	-	4 626	-
Kayebela Support Group	-	-	12 982
Kazomba Support Group	-	-	3 987
Kimiteto NZP+ Support Group	-	-	12 322
Kivuku HBC	-	4 753	-
Kivuku Youth Peer Group	-	9 502	3 580
Konkola Copper Mines HIV/AIDS Prevention Care & Support Programme	-	195 560	79 291
Kosapo Farmers Group	-	-	6 123
Kubeleka Aba Muchaala Project (KAMU)	-	10 507	-
Kukenanai Support Group	-	-	3 669
Kukenanana	-	-	5 082
Kukwashana HIV/AIDS Project	2 607	-	-
Kulikafwa HIV/AIDS Group	4 002	-	-
Kuvuna Youth Foundation	5 412	-	-
Kuwunda Support Group	-	-	8 313
Legend Trust	-	-	3 093
Luanshya PLWHAs	-	-	1 669
Luapula Families in Distress	6 519	-	-
Lundazi PLWHAs	-	20 124	-
Lunga A Support Group	-	-	5 827
Luo and Associates	114 646	-	-
Lupande Youth Development Project	-	5 210	-
Lusapila Women's Support Group, Mandevu	-	5 962	-
Luyandano Women's Group	-	6 936	3 046

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Luyeye Twafwane Women's Club	-	5 353	-
LWACIDRA	-	3 532	-
Lwende Women Nutrition Club	-	5 605	-
Madaliso Support Group	-	-	8 621
Malimba Community School	-	39 910	-
Mapalo Outreach HIV.AIDS	-	-	1 029
Masukani HIV/AIDS/TB Support Group	-	-	4 915
Maureen Mwanawasa C.I.(for Banda family)	-	967	-
Maureen Mwanawasa Community Initiative	56 225	-	139 454
Maveve Home Based Care	5 300	-	-
Maveve OVC & Home Based Care	-	5 493	-
Mazabuka NZP+	-	19 738	-
Mbula Farming Club	-	-	2 438
Mbuluyenji Community School	-	-	6 658
Messenger Support Group	-	-	13 241
Mgwazo Anti-AIDS Club	-	5 157	6 658
MHUNZ (Mental Health Users Network of Zambia	2 751	-	-
Mikwela Tailors & Farming Society	-	-	4 994
Milambo Fili Uko Tuya HBC	-	3 017	3 468
MMCI (Choma Environmental Conservation)	-	-	54 055
Mpalandala Buseko Health Club	-	2 753	-
Mpapa Community School	-	-	4 697
Mpongwe Development Company	-	4 575	-
Mtuzi Development Foundation	-	-	19 640
Mudyanama HIV/AIDS Project	4 756	-	-
Mukinge AIDS Prevention Prog.	-	5 622	-
Mukulima Farmers Group	-	5 588	-
Mulenga Hill Orphans Care Association	-	4 250	-
Mulila Care Farming Group	-	4 082	-
Munkanya Community School	-	-	16 366
Musela Hills HIV/AIDS Support Group	-	-	9 694
Mushona Support Group	-	-	5 995
Mwabombeni OVC School	5 073	1 627	-
Mwapona Youth HIV/AIDS Support Group	-	-	6 480
Mwika Tubombele pamo	-	-	3 754
Mwinilunga Women Marketeers	5 176	-	-
Nachi Orphans and Vulnerable Children	-	3 000	-

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Nakonde DHMT	5 352	-	-
Nakonde Post Test Club	5 352	5 605	-
Namposya Support Group	-	-	6 560
Namulundu Kasama HBC	5 153	-	-
Namumu Orphanage	-	-	16 788
Namushakende	3 866	-	-
Network of ARV Users in Zambia	7 583	-	-
New Horizon Ministries	-	5 605	-
New Renato Community Society	-	11 487	9 370
Ngala HIV/AIDS Group	5 340	-	-
Nsenga Farmers Group	-	5 605	-
Nutritional Musenga Community Care Group	-	4 537	-
Nyikotukotu Support Group	-	-	10 126
Nyimba Community HIV/AIDS	-	5 479	2 754
NZP+ Zambezi	4 218	17 257	-
NZP+ Mwinilunga	7 332	-	-
NZP+ Kabwe	-	23 088	-
NZP+ Livingstone	2 715	-	-
NZP+ Mongu	2 715	-	-
NZP+ Mwinilunga	-	20 937	-
NZP+ Ndola	-	20 309	-
NZP+ Solwezi	7 560	17 332	-
Org. for Promotion of Meaningful Dev.(OPAD)	-	5 600	-
Parven Foundation	-	4 461	-
People's Participation Services	36 932	93 162	-
Petauke Nutritional Group	-	5 605	-
PPAZ	-	-	6 658
PPAZ - Mongu	4 820	-	-
Prevention Community Mobilisation in Swamps	-	11 130	-
Pride Community Health Club	-	5 608	5 160
Pride HBC Project	-	-	6 619
Rimon Youth Talent Development	-	12 658	-
Roadshow Anti AIDS Project in School	5 239	43 341	-
Rural & Agricultural Development Project	-	5 345	3 383
SABABA NHC Community Care & Support	-	3 948	-
SAFAIDS	-	-	177 288
Sampa Home Based Care	-	5 508	-

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Sangulukani Support Group	-	-	6 537
Sengenu Charity HBC Club	-	12 530	5 981
Shading the Shame Association	-	15 358	-
Shiwa Ngandu rural Development	-	5 381	-
Simalelo	-	36 791	-
Single Parents' Association	5 352	-	-
Society for Family Health	-	-	103 941
Solwezi District Business Association	4 042	-	-
Southern Africa HIV/AIDS Information(SAFAIDS)	-	-	202 337
Special Community Care	-	5 336	-
Sport in Action	34 040	25 019	-
Steadfast Action Foundation	23 436	51 935	-
Sukumuna Centre for the Needy, Orphans	-	11 046	-
Sunga Support Group	3 784	-	6 577
SWAAZ Kasempa	16 723	3 811	-
SWESTA	5 299	-	-
Tafimbwa Lubilo Women's Club	-	-	4 878
Tazwane Support Group	-	-	6 658
Thandizani Community Based Prev. & Care	9 547	509 309	12 563
Three Pillars Loans and Credit Association	-	5 729	-
Tigwirizane Care and Support Group	-	-	11 016
Tikondane Home-Based Foundation	-	28 432	-
Tithandizeni Titukuke Rural	-	-	5 004
Tiyende Pamodzi Support Group	-	-	6 493
Tiyeseko Five star Theatre	-	-	6 125
Traditional Health Practitioners Ass. (THAPAZ)	-	273 614	58 013
Tubombeshe Support Group	-	-	6 658
Tukwantankane Support Group	-	-	5 929
Tukwashe	-	4 680	-
Tulipamo Post - Test Club	5 190	5 380	3 599
Tunvwananai Support Group	-	-	12 415
Tusungane HBC	-	-	2 072
Twaambe Support Group	-	-	4 494
Twafwane HBC	-	-	6 658
Twafwane Poverty Alleviation Proj.	-	3 631	-
Twafwane Support Group	-	-	2 822

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Twafwane Women Care and Support	-	3 802	-
Twampane Care and Support Group	-	-	4 787
Twashuka Orphanage School	-	4 417	3 481
Twavwane Day Care Centre	5 024	1 267	7 190
Twesheko Support Group	-	-	4 447
Twesheko Women Club	-	-	6 378
Twikatane Club for the disabled	-	-	3 568
Twikatane Mutale Mwamba	4 378	5 359	3 561
Twikatane Nutritional Club	-	5 569	-
Twishibane Neighbourhood	-	-	3 123
Twisunge Orphans and Widows Support Group	-	5 596	6 605
Twisunge OVC	-	5 350	-
Umweo Kanani Care & Support Group	-	3 315	5 945
Victory Support Group	-	-	3 427
Welfare Concern International	-	9 877	-
Women Empowerment - Mazabuka	3 347	-	-
Women in Sustainable Development	-	4 217	13 226
Young Women & Men Integral Movement	177	4 484	-
Youth Activists Organisation	-	-	19 987
Youth and Child Care Foundation	4 555	-	-
Youth Cultural Promotion Association(YOCUPA)	-	12 894	-
Youth Media	46 705	-	-
Youth Team	-	2 480	-
Youth Women and Men Integral Movement	5 352	-	-
Zambia Association for Research &Develop.	-	1 614	-
Zambia Business Coalition for HIV/AIDS	121 818	120 533	101 497
Zambia Federation of The Disabled	-	41 110	-
Zambia Health Education & Comm. (ZHECT	-	41 883	22 616
Zambia Media Women Association	-	34 175	-
Zambia Medical Association	-	-	31 851
Zambia National Association of the Deaf	-	5 785	-
Zambia Nsunga Community without Borders	-	-	985
Zambia Open Community Schools	-	35 963	-
Zambia Shanty Community Development	-	12 348	5 679
Zambia State Insurance Cooperation	-	19 312	-
Zambia Wildlife Authority	-	16 895	-

Name of NGO/CBO	Funded Amount (USD)		
	2004	**2005**	**2006**
Zambia Youth Development	-	-	3 479
Zambian Youth for Development (ZAYODE)	-	5 619	-
TOTAL AMOUNT FUNDED:	2 725 584	6 054 004	4 060 091
	Exchange rates (ZK per USD)		
	4 671	4 460	3 755
TOTAL NUMBER OF SROs	267		

Table A4: Summary of CHAZ Global Fund HIV/AIDS Spending, by SRO Programme

	2003	2004	2005	2006
FUNCTION/PROGRAMME/ ACTIVITY:	USD			
Prevention (outreach and BCC activities)	0.00	174 742.00	475 269.63	910 769.46
VCT	0.00	207 164.00	94 674.88	206 819.08
Condom procurement and distribution	0.00	0.00	862.00	16 696.73
Blood screening	0.00	0.00	3 902.00	0.00
Improving STI management and treatment	0.00	28 329.00	15 288.04	97 440.40
Treatment of Opportunistic Infections	0.00	0.00	0.00	512 854.76
PMTCT	0.00	105 221.00	57 304.77	160 655.04
ARV treatment	0.00	0.00	5 373.00	1 416 761.97
Nutrition support	0.00	0.00	0.00	238 507.85
Home based care	0.00	904 708.00	1 522 502.26	1 272 764.08
Income Generation	0.00	59 833.00	38 890.12	34 685.56
OVC	0.00	1 109 955.00	2 449 836.95	1 162 465.97
Programme Coordination	41 786.00	243 521.00	470 808.63	382 761.77
Monitoring and Evaluation	54 000.00	177 010.00	935 533.31	1 018 597.15
Strengthening facilities	150 633.00	237 683.00	645 194.25	558 686.89
Monetary incentives for Health workers/non health workers	0.00	0.00	0.00	382 800.17
Training for Health Workers	0.00	17 621.00	49 040.15	1 084 685.45
TOTAL (All Functions/Programmes)	246 419.00	3 265 787.00	6 764 480.00	9 457 952.33

Note:

Only minor adjustments made to the data to clarify the programme areas. Otherwise, present as provided by CHAZ

Table A5: Summary of ZNAN Global Fund HIV/AIDS Spending, by SRO Service Area

	Funded Amount (USD)		
Service Area	2004	**2005**	**2006**
!Programme/area not specific	13 412.66	0.00	1 180 769.51
ART	0.00	195 560.28	1 009 147.25
Behavioural change	597 195.57	0.00	0.00
Behavioural change, HBC, OVCs	404 659.45	0.00	0.00
Behavioural change, High risk, PMTCT, PLHA	344 937.98	0.00	0.00
Building capacity, Advocacy	0.00	41 109.61	0.00
Care & Support	0.00	3 314.63	0.00
Chronically ill	0.00	0.00	8 990.30
Chronically ill and Families, PLHA	0.00	4 082.37	0.00
Community Outreach STI & OVC	0.00	11 201.70	0.00
Condom distribution	0.00	0.00	103 940.77
Condom distribution, VCT, PLHA, Prolonging lives of PLHA, HBC	0.00	216 878.92	0.00
Education	0.00	4 450.73	0.00
Education, Prevention	0.00	41 883.41	0.00
Education, workplace	0.00	19 311.66	0.00
HBC	78 507.61	172 317.19	97 875.00
HBC & OVC	0.00	24 832.56	0.00
HBC & VCT	0.00	3 630.94	0.00
HBC, OVC & PMTCT	0.00	157 165.47	0.00
HBC, OVC, Special groups & PLHA	0.00	0.00	139 453.69
HBC, OVC, Youths	0.00	25 283.24	0.00
High risk, PLHA, HBC, OVC	110 706.62	0.00	0.00
High Risk	119 425.81	5 605.38	23 157.02
High Risk & PLHA	0.00	5 737.11	13 629.43
High Risk & Youth	0.00	0.00	26 193.97
High risk (women & Girls)	0.00	5 493.27	0.00
High Risk Groups	0.00	34 174.78	0.00
High Risk, VCT & STI	0.00	0.00	15 951.40
OVC	125 564.66	343 172.60	150 075.28
OVC & HBC	0.00	0.00	5 679.25
OVC & High risk	0.00	19 532.01	25 296.80
OVC & PLHA	0.00	14 810.39	5 648.93
OVC, PLHA, HBC	0.00	5 039.09	0.00
OVC, PLHA, Support	0.00	5 345.18	0.00

	Funded Amount (USD)		
Service Area	2004	**2005**	**2006**
OVC, STI diagnosis & treatment	0.00	5 605.38	0.00
OVC, Youth, Women	0.00	23 022.42	0.00
PLHA	396 357.88	352 732.18	574 848.11
PLHA & CHRONICALLY ILL	0.00	0.00	2 303.06
PLHA & OVC	0.00	154 472.69	0.00
PLHA, OVC & HBC	0.00	0.00	4 877.71
PLHA, Specific group	0.00	4 610.88	0.00
PLHA, STI	0.00	10 636.21	9 958.65
PLHA, VCT, HBC	0.00	201 173.17	0.00
PLHA, Youths, PMTCT & OVC	0.00	227 468.79	0.00
PLHA, Youths, VCT	0.00	4 834.64	0.00
PMTCT	89 559.96	7 158.60	14 911.72
PMTCT, PLHA	0.00	48 791.48	0.00
Prevention, Care and Support	0.00	8 627.26	0.00
Prevention, OVC	0.00	42 052.35	0.00
Specific Groups	0.00	17 321.86	0.00
Specific groups (Peer education)	0.00	4 460.76	0.00
Specific groups (sex workers)	0.00	4 680.45	0.00
Specific groups (Traditional Healers)	0.00	52 690.58	0.00
Specific groups (women & disabled)	0.00	4 795.26	0.00
Specific groups (women, children)	0.00	3 532.06	0.00
Specific groups (young girls)	0.00	49 938.05	0.00
Specific objective (women)	0.00	29 294.05	0.00
STI	0.00	0.00	6 604.53
STI Programme, Specific groups	0.00	103 641.26	0.00
TB	0.00	0.00	127 407.00
VCT	379 186.52	74 154.09	3 598.54
VCT & PLHA	0.00	41 822.89	0.00
VCT & STI diagnosis & treatment	0.00	5 492.15	0.00
Workplace	66 068.93	109 545.51	399 808.16
Workplace, Condom distribution, VCT, PMTCT, PLHA, Prolonging Lives of PLHA	0.00	171 276.77	0.00
Workplace, High risk, VCT, PLHA, HBC & OVC	0.00	264 465.61	0.00
Workplace, PLHA, HBC, & OVC	0.00	393 210.86	0.00
Workplace, PLHA, HBC, VCT & OVC	0.00	244 544.65	0.00
Workplace, PLHA, PMTCT, HBC	0.00	171 826.68	0.00
Workplace, PMTCT	0.00	117 281.92	0.00
Workplace, VCT	0.00	120 533.09	38 587.48

	Funded Amount (USD)		
Service Area	2004	**2005**	**2006**
Youth	0.00	268 098.15	198 611.23
Youth & Condoms	0.00	0.00	30 082.98
Youth education	0.00	97 650.67	0.00
Youth, High risk, VCT, PLHA, PMTCT, HBC, OVC, Prolonging lives of PLHA	0.00	446 050.85	0.00
Youth, OVC, PLHA, HBC	0.00	230 146.07	0.00
Youth, workplace	0.00	62 302.20	72 198.14
Youth, Workplace, Condom distribution, VCT, PMTCT, PLHA, Prolonging lives of PLHA, HBC, OVC	0.00	180 316.59	0.00
Youths, Condoms distribution, HBC, OVC	0.00	143 638.14	0.00
Youths, HBC, PLHA	0.00	112 402.50	0.00
Youths, OVC, Specific groups	0.00	51 935.43	0.00
TOTAL AMOUNT FUNDED:	2 725 583.66	6 028 167.76	4 289 605.91
Exchange rates (ZK per USD):	*4671*	*4460*	*3755*

Notes:

Programmes or service areas have been taken as they were presented in the original data with no adjustment to the areas.

All service areas that were seen to be identical were aggregated (summed) while those that were different were left as such.