

GHANA

NATIONAL AIDS SPENDING ASSESSMENT 2009 LEVEL AND FLOW OF RESOURCES AND EXPENDITURES TO CONFRONT HIV and AIDS



**A Report Prepared for the Ghana AIDS Commission (GAC) and the Joint United Nations
Programme on HIV/AIDS (UNAIDS)**

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APOW	Annual Programme of Work
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
CBO	Community Based Organisations
CCE	Community Capacity Enhancement
CRIS	Country Response Information System
CRS	Catholic Relief Services
CSW	Commercial Sex Workers
DAC	District AIDS Committees
DACF	District Assembly Common Fund
DANIDA	Danish International Development Agency
DFID	Department for International Development.
DPs	Development Partners
DRMT	District Response Management Team
DSW	Department of Social Welfare
FBO	Faith Based Organisations
FHI	Family Health International
GAC	Ghana AIDS Commission
GARFUND	Ghana AIDS Response Fund
GDHS	Ghana Demographic Health Survey
GFATM	Global Fund to fight AIDS, TB and Malaria
GHANET	Ghana HIV/AIDS Network
GHS	Ghana Health Services
GSMF	Ghana Social Marketing Foundation
GTZ	German Technical Cooperation
HAART	Highly Active Antiretroviral Therapy
HACI	Hope for African Children Initiative

HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ILO	International Labor Organization
IMAI	Integrated Management of Adolescent and Adult Illnesses
JAPR	Joint Annual Programme Review
JICA	Japan International Cooperation Agency
MARG	Most At Risk Group
MDA	Ministries, Departments and Agencies
MDBS	Multi Donor Budget Support
MICS	Multi-Indicator Cluster Survey
MLGRD	Ministry of Local Government, Rural Development
MMDA	Metropolitan Municipal and District Assembly
MMR	MSHAP Monitoring Reports
MOH	Ministry of Health
MOWAC	Ministry of Women and Children Affairs
MP	Member of Parliament
MSHAP	Multi Sectoral HIV and AIDS Project
MSM	Men having Sex with Men
NACP	National AIDS Control Programme
NAP+	National Association of People Living with HIV/AIDS
NASA RTS	National AIDS Spending Assessment Resource Tracking System
NDPC	National Development Planning Commission
NGO	Non Governmental Organisation
NHIS	National Health Insurance Scheme
NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PAF	Programme Acceleration Fund
PEP	Post Exposure Prophylaxis
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission

POW	Programme of Work
PPP	Public-Private Partnership
PSM	Procurement and Supply Management
RAAR	Rural Alliance Action Programme
RAC	Regional AIDS Committees
RCC	Regional Coordinating Council
RNE	Royal Netherlands Embassy
RTS	Resource Tracking System
STD/STI	Sexually Transmitted Diseases/Sexually Transmitted Infections
TRIPS	Trade Related Intellectual Property Rights
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Project
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
UNISP	United Nations Implementation Support Plan
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Treatment
WAPCAS	West Africa Project to Combat AIDS and STIs
WHO	World Health Organization
YARO	Youth Action on Reproductive Order

Basic Fact sheet on Ghana HIV and AIDS Expenditure, 2008 – 2009

HIV and AIDS Expenditure by Funding Sources

Source of funds	2008		2009	
	Amount (US\$)	%	Amount(US\$)	%
Total Spending	38,850,940		54,228,388	
Public	5,339,318	13.74	6,051,970	11.16
International	32,588,547	83.88	40,544,316	74.77
Private	923,075	2.38	7,632,102	14.02

HIV and AIDS Expenditure by Programmatic Area

PREVENTION (in 2008 -22% of total Expenditure; in 2009 -17% of total Expenditure)

- Total Expenditure: US\$ 8,550,916 in 2008 and US\$ 9,231,209 in 2009
- Main Item: Voluntary Counselling and Testing (VCT) in 2008 and Communication for social and behavioural change in 2009

TREATMENT & CARE (in 2008 - 25% of total Expenditure; in 2009 - 31% of total Expenditure)

- Total Expenditure: US\$ 9,544,075 in 2008 and US\$ 17,046,501 in 2009
- Main Item: Outpatient care in 2008 and Nutritional support associated to ARV therapy in 2009

OVC (in 2008 – 1.10% of total Expenditure; in 2009 -1.15% of total Expenditure)

- Total Expenditure: US\$ 425,999 in 2008 and US\$ US\$ 621,251 in 2009
- Main Item: OVC Social Services and Administrative costs in 2008 and OVC Family/home support 2009

PROGRAMME MANAGEMENT(in 2008 - 30% of total Expenditure; in 2009 -32% of total Expenditure)

- Total Expenditure: US\$ 11,603,866 in 2008 and US\$ US\$ 17,315,220 in 2009
- Main Item: Planning, coordination and programme management in 2008 and Drug supply systems in 2009

HUMAN RESOURCES (in 2008 - 12% of total Expenditure; in 2009 -11% of total Expenditure)

- Total Expenditure: US\$ 4,661,299 in 2008 and US\$ US\$ 5,813,156 in 2009
- Main Item: Training in 2008 and Formative education to build-up an HIV workforce in 2009

SOCIAL PROTECTION AND SERVICES (in 2008 – 1.94% of total Expenditure; in 2009 – 1.34% of total Expenditure)

- Total Expenditure: US\$ 754,620 in 2008 and US\$ 724,284 in 2009
- Main Item: Social protection through monetary benefits in 2008 and Social protection services and social services not disaggregated by type in 2009

ENABLING ENVIRONMENT (in 2008 – 5.5% of total Expenditure; in 2009 4.21% of total Expenditure)

- Total Expenditure: US\$ 2,138,620 in 2008 and US\$ 2,283,057 in 2009
- Main Item: AIDS-specific institutional development in 2008 and Enabling environment not

disaggregated by type in 2009

HIV-RELATED RESEARCH (in 2008 – 3.0% of total Expenditure; in 2009 -2.2% of total Expenditure)

- Total Expenditure: US\$ 1,161,545 in 2008 and US\$ 1,193,710 in 2009
- Main Item: HIV and AIDS-related research activities not disaggregated by type in 2008 and 2009

HIV and AIDS Expenditure by Beneficiary groups

Beneficiary groups	2008		2009	
	Amount (US\$)	%	Amount(US\$)	%
Total spending	38,850,940.00		54,228,388.00	
PLHIV	14,205,670	36.56	22,061,822	40.68
Most-at-risk populations	361,738	0.93	490,720	0.90
Other key populations	1,068,919	2.75	740,563	1.37
Specific "accessible" populations	7,761,602	19.98	14,067,609	25.94
General population	15,453,011	39.78	16,967,674	31.10

Executive summary

Currently, Ghana's HIV epidemic seems to have stabilised and continues to have prevalence much lower than other countries in the Sub Saharan African region but it follows a cyclical pattern that proves worrisome. After a steady decline from 2.6 percent in 2007 to 2.2 percent in 2008, it increased to 2.9 percent in 2009. In spite of this comparatively low prevalence in the sub region, the rate of new infections each year seems to frustrate efforts to lower the prevalence even further. The estimated national adult prevalence of HIV in Ghana increased to 1.9 percent in 2009 from 1.7 percent in 2008 (GHS, 2010).

The response to HIV and AIDS poses major and complex fiscal challenges at the national level and it becomes for important for policymakers to understand the nature and scale of these fiscal challenges and how best to mobilise resource to meet the response. Ghana has successfully conducted four rounds of the National AIDS Spending Assessment (NASA) and previous results have helped the direction of funding and ensured better targeting of programmatic interventions. The NASA assessment also incorporates a qualitative aspect which allows an assessment of key challenges in the funding process from the view point of all the major stakeholders. Results from these assessments have thrown light on the challenges faced by local implementers in accessing funds and meeting reporting deadlines. One such challenge is the lack of a skilled HIV workforce and the current drive to build the capacity to deliver services promptly and to ensure reduction in delays in the release of funds stemming from lack of administrative capacity.

A major limitation in tracking the overall spending on HIV and AIDS in the last three rounds has been the lack of data from households as well as government's contribution in regards to salaries and overheads. In this fourth round these limitations have been minimized to a large extent. The study has been able to incorporate a larger proportion of private contributions to HIV and AIDS expenditure consisting mainly of households out-of- pocket expenditure on HIV and AIDS related activities and some private businesses. Using costing techniques the study also includes the salaries of health personnel offering ART services increasing to an extent the share of public sector funding to the national response.

The focus of the study as in previous rounds was on the national level. Data collection covered the domestic spending on HIV and AIDS, the external sources of funds for HIV and AIDS (including those funds channeled through the government) and contributions made by private entities in the year 2009. The

study employed the NASA methodology which allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors to confront the HIV and AIDS epidemic.

Results from the 2009 NASA indicate that funds from external sources accounted for 75 percent of the total expenditure on HIV and AIDS related activities. This follows a similar pattern from previous results. Domestic financing of the response still remains very low and exposes the vulnerability of the implementation of programmes outlined in the national response to external pressures. A trend analysis of the expenditure patterns from 2005 to 2009 shows that funding for HIV and AIDS related activities has been consistently increasing from 2005 to 2009 but with a significant dip in 2008. Total expenditures increased from US\$28.4 million in 2005 to US\$32.6 million in 2006 and to US\$52.5 million in 2007 decreasing to US\$38.8 million in 2008 and increasing from there to US\$54.2 million in 2009. Uncertainties regarding the availability of external financing mean that a sudden withdrawal or reduction of external financing would result in a major shock to the implementation of the national response.

The analysis of beneficiary groups shows a clear improvement in the targeting of programmes and consistency in efforts to expand care and treatment offered to People Living with HIV (PLHIV). In 2009, PLHIV formed the largest beneficiary of the total spending on HIV and AIDS related activities, accounting for a 41 percent share whilst the Most at Risk Populations (MARPs) have the least with 0.9 percent of total spending. The general population group formed 31 percent and specific 'accessible' group, 26 percent of the total spending. The general population account for the largest share of expenditure on prevention programmes (83.9 percent).

In addition to the quantitative assessment, the Ghana NASA study comprises of a qualitative part where in-depth interviews are conducted with the major stakeholders who finance and implement HIV and AIDS related activities in Ghana. These are the Development Partners, NGOs/CSOs, the private and public sectors agencies. The results of these interviews highlight the challenges faced by all parties in the funding process. In a nutshell, implementers bemoan the inadequacy of funds to meet programme activities, delays in releasing these funds and the stringent technical and financial reporting requirements by financing agencies. Funding agencies admit that some of their requirement involve some amount of

bureaucratic processes but are of the view that implementers lack the capacity to implement the programmes they outline in their proposals which lead to subsequent delays in implementation and reporting.

Section 1

Introduction

1.1 Context for the Assessment

Globally, the HIV epidemic appears to have stabilized in most regions but the World Epidemic Report (2009) indicates that HIV prevalence continues to increase in Eastern Europe, and parts of Asia. In spite of this trend, Sub Saharan Africa remains the most heavily affected region and accounts for 71 percent of new infections in 2008. The main challenge is the continuing rise in the population of People Living with HIV and AIDS (PLHIV) and the implication this has on funding services for HIV and AIDS.

Many countries may have succeeded in the last year in expanding access to antiretroviral therapy but the increased evidence of risk among key populations mean that coverage of prevention programmes has been limited. The financial crisis and resulting economic recession has led to a reassessment of commitments and funding for HIV programmes and this in no doubt affects the steady progress made so far. It is also evident that developing countries rely extensively on global funds to achieve the targets set out in their national responses to HIV and AIDS. Global funding shortfalls have revealed how very little country health systems support the HIV and AIDS response and raises the need for health delivery systems that embrace HIV and AIDS as part of their activities in disease prevention as a whole.

Ghana has made considerable progress in creating a good environment for increased partnerships and a stronger coordination of stakeholder activities for more effective response to the HIV and AIDS epidemic. The Ghana AIDS Commission has in its role as the coordinating and planning arm of the national response has engaged the wider society in its activities but there have been number of challenges associated with these efforts. A key challenge regards the funding of priority activities for HIV and AIDS.

Although the results of the National AIDS Spending Assessment (NASA) conducted over the last four years (2005 to 2008), generally reveal an increase in funding for HIV and AIDS, funds for HIV and AIDS related programmes remain insufficient. This is mainly as a result of rapid expansion in priority areas for the prevention programmes, care and treatment and support for PLHIV, OVCs, MARPs and other

vulnerable groups. To overcome this difficulty with funding, the Ghana AIDS Commission in the last year has initiated actions towards an innovative way of financing the national response. The main objective is to establish a mechanism for soliciting contributions mainly from internal sources to complement funding from the development partners. The NASA assessment shows that external organizations have accounted for between 70 percent and 80 percent of total funding on HIV and AIDS related activities from 2005 to 2008.

The success of the National AIDS Spending Assessment (NASA) in Ghana over the past three years is a reflection of the importance given by the GAC and key development partners to ensure the tracking and collation of all expenditures in HIV and AIDS related activities in a more consistent manner. The results from the NASA assessments help to ensure that funding is being channelled to areas where they are most needed and enables the GAC to ensure that all funding for HIV and AIDS are in line with the national response. The overall objective of the assessment was to track transactions of total public, private and foreign spending on HIV and AIDS across different sectors. The assessment tracks expenditure across eight programmatic areas namely: Prevention; Care and treatment; Orphans and vulnerable children; Programme management and administration strengthening; Incentives for human resources; Social protections and social services; Enabling environment and community programmes; and Research.

NASA is currently being institutionalized and the results are systematically fed into the Country's UNGASS report and serves to some extent as a monitoring and evaluation tool for some aspects of GAC's activities. In the fourth round of the NASA (NASA 2009), efforts have been made to overcome some of the limitations encountered in the previous NASA studies. The 2009 NASA assessment includes out of pocket payments made by PLHIV and the proportion of salaries of health workers engaged in HIV and AIDS activities in the country. This is to help present a more balanced view of HIV and AIDS expenditure by various sectors than has been the case in the previous reports.

1.2 Objectives and Purpose

Specifically the aims of the study are to:

- (i) Conduct a national NASA; and
- (ii) Build national level capacity for systematic monitoring of HIV and AIDS financing flows.

The specific study objectives are to:

- Analyse the structure of HIV and AIDS-related services and organizations in Ghana in the public and private sector, including bi- and multilateral organizations active in Ghana;
- Develop a data collection plan for the national level;
- Validate, enter and analyse financial data for national level data; and
- Document and share the NASA process and findings with stakeholders.

1.3 Scope of the Assessment

The focus of the study was at the national level. Data collection covered the domestic spending on HIV and AIDS, the external aid for HIV and AIDS (including those funds channelled through the government) and contributions made by firms in the business sector and households in 2009.

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

- (i) Ghana AIDS Commission (GAC);
- (ii) Ministry of Health (MOH) and the National AIDS/STIs Control Programme (NACP);
- (iii) The Global Fund;
- (iv) Selected major development partners;
- (v) Key ministries, such as MOFEP, MOE and MLGRD; and
- (vi) Non-Governmental Organizations (NGOs)/ Civil Society Organizations (CSOs); and
- (vii) Households of PLHIV.

1.4 Structure of the Report

The report has been organized in six sections. Following section one is section two which gives a brief overview of the HIV and AIDS situation in Ghana and the National response (the National Strategic Framework for HIV and AIDS). The third section outlines the method and techniques used, as well as the study process and limitations faced. The fourth and fifth sections contain the results and discussions of the NASA estimates and findings of the qualitative part of the NASA questionnaire, respectively. Summary and recommendations of the study is made in section six.

Section 2

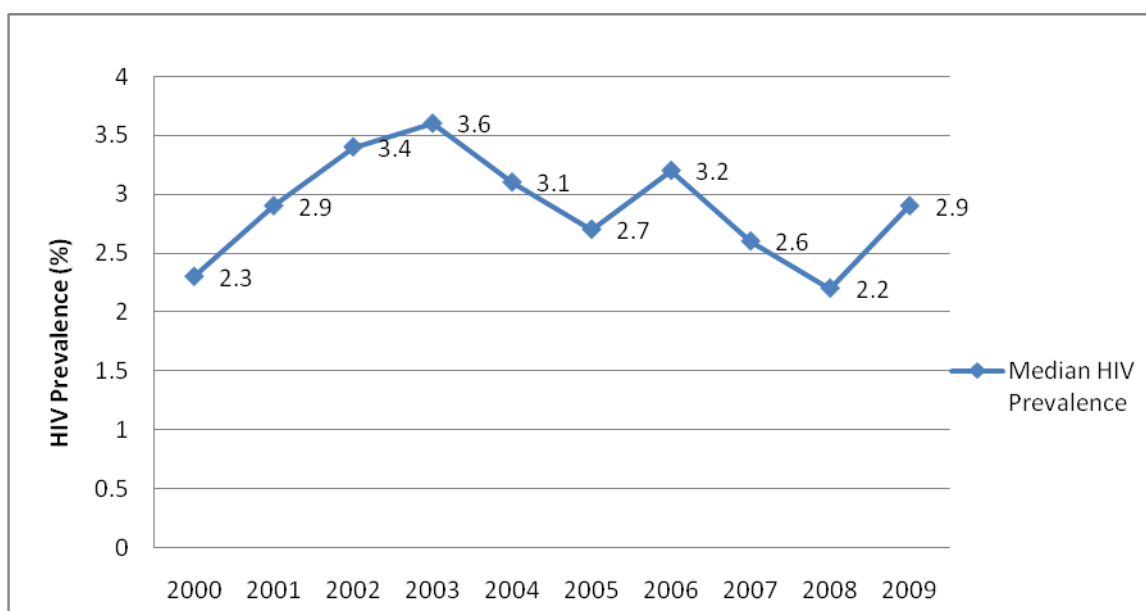
Overview of Country Context

2.1 HIV and AIDS Situation

Ghana has remained a comparatively low prevalence country. The HIV Sentinel Survey (HSS) data has been used as the primary source for the national HIV and AIDS estimate in Ghana. It is a cross-sectional survey targeting pregnant women attending antenatal clinics (ANC) in selected ANC sites in Ghana. The 2009 HIV Sentinel Survey indicated that the median HIV prevalence increased from 2.2 percent in 2008 to 2.9 percent in 2009. Since 2000, the median HIV prevalence increased from 2.3 percent to 3.6 percent in 2003, declined to 2.7 percent in 2005, rose to 3.2 percent in 2006 before falling to 2.2 percent in 2008 (Figure 2.1). The cyclical movement is worrying and even in spite of these low prevalence, the rate of new infections each year seems to frustrate efforts to lower the prevalence of the epidemic even further. The estimated national adult prevalence of HIV in Ghana increased to 1.9 percent in 2009 from 1.7 percent in 2008.

According to the 2009 HIV Sentinel Survey, the 15-19 year group had the least prevalence of 1.9 percent and this has been the case since 2005 with the exception of 2007. The age group 40-44 years recorded the highest prevalence of 4 percent. There are also regional variations as has been the case in previous years. Some regions recorded an increase in prevalence from 2008 while others saw a decline. The Eastern region continues to be the region with the highest prevalence. Overall, HIV prevalence in urban areas was higher than in rural areas (GHS, 2010).

Figure 2.1: Median HIV Prevalence among Pregnant Women, 2000-2009



Source: GHS (2010). HIV Sentinel Surveillance Report 2009, National AIDS/STI Control Programme, Accra.

2.2 National Response to the AIDS Epidemic

Ghana's national HIV response is currently based on the "Three Ones" principles endorsed in April 2004, at the Consultation on Harmonization of International AIDS Funding¹. In 2005, the Ghana AIDS Commission in agreement with partners and key stakeholders agreed on a National Strategic Framework 2006-2010 in addition to a Five-year Programme of Work (POW). Both documents essentially provide the framework for the national response from 2006 – 2010. The GAC has the mandate to oversee all the activities outlined in the POWs and also ensure a broad participation in the development, review and periodic updating of the National AIDS action framework.

As part of encouraging broad participation, GAC focuses on a multi-sectoral approach to the national response and this is based on the following:

¹ The principles involve the following:

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and
- One agreed country-level monitoring and evaluation system.

- Defining national HIV and AIDS prevention, care and treatment mitigation strategies and implementation plans through **participatory** processes;
- Empowering stakeholders from the community up to the national level;
- Using existing decentralised administrative structures to monitor and supervise HIV and AIDS activities; and
- Channeling funds to Ministries, Departments, Agencies, communities and civil society organizations for HIV/AIDS intervention activities.

The national response addresses the epidemic as a developmental and human rights issue and does not consider HIV and AIDS as a disease to be treated with only bio-medical methods. Hence it adopts social mobilization and behaviour communication change strategies to increase prevention coverage.

To date the National Response has benefited from improved strategic planning; wider stakeholder involvement and improved planning processes at the national level. The GAC has made considerable progress in its functions of advocacy, policy formulation, resource mobilization, monitoring and evaluation and research as well as coordination of HIV and AIDS interventions. The current drive to scale up prevention, care, treatment and support means that GAC must expand its capacity to deal with this change on all levels.

2.2.1 Policy Context

The guiding principle of Ghana's national policy on HIV and AIDS and STIs is based on the following:

- (i) the 1992 Constitution of Ghana, Ghana Government's medium term strategy document, the revised Population Policy (1994) and the Millennium Development Goals (MDGs);
- (ii) Principles of social justice and equity; and
- (iii) Recognition that adequate health care is an inalienable right of every Ghanaian including those affected with HIV or other STIs.

Also, the policy takes account of International Human Rights Conventions, particularly, the Convention on Economic, Social and Cultural Rights, the African Charter on Human and People's Rights all of which affirm the right to the highest attainable standard of health. In addition, Ghana is committed to goals agreed upon at various international fora on issues regarding the HIV epidemic.

The policy covers all sectors of the economy with emphasis placed on workplace and the external (target population served) environment of each sector. The important role of the NGOs was acknowledged and therefore NGO activities were incorporated in the sector plans. Since the adoption of this multi-sectoral approach, there has been a marked improvement in the national HIV and AIDS response, creating better conditions for stronger partnerships, effective coordination of stakeholder activities and steady harmonization of efforts and resources.

2.2.2 The 2009 Programme of Work (POW)

In 2005, the Ghana AIDS Commission in collaboration with partners and representatives of key stakeholders agreed on a National Strategic Framework 2006-2010 (NSF II) and an accompanying Five-year Programme of Work both of which provide the framework for the national response from 2006 to 2010. The 5 Year POW spells out the Strategic Objectives, Key Interventions and Priority Activities for the HIV and AIDS agenda. The Annual Programme of Work for 2009 is derived from the 5 year POW.

The 7 intervention areas of the NSF II are:

- Policy, Advocacy and Enabling Environment;
- Coordination and Management of the decentralised response;
- Mitigation of the Economic, Socio-cultural and Legal impacts;
- Prevention and Behavioural Change Communication;
- Treatment, Care and Support;
- Research, Surveillance, Monitoring and Evaluation; and
- Resource Mobilisation and Funding Arrangements;

In addition to these broad areas, the 2009 POW sets out specific areas where more attention would be given. These are:

- Activate resource mobilization committee;
- Support activities for the establishment of the Ghana HIV and AIDS Fund;
- Organise financial training for sub project implementers in the ten regions;
- Review and print 1,500 financial and procurement manuals for Internal Partners (IPs);
- Provide support to Compliance Consultants as and when necessary;

- Engage external auditors to carry out annual auditing; and
- Organise internal audit of IPs.

The emphasis of the 2009 POW is on “*sustainability, complementarity and working for results*”. This emphasis attempts to identify the link between sustaining programmes that have worked, enhancing complementarity of interventions and focusing on outcomes and results.

2.3 HIV and AIDS Funding Process in Ghana

2.3.1 Financing Sources and flow of funds

The financing of sub-projects are done by the Government of Ghana and either directly by development partners or through the GAC funding mechanisms; pooled and earmarked funding. Sub-projects funded under the pooled funding arrangement are to be in line with the 2009 POW, and allocation of funds made available through six (6) main windows, as defined in the operational manual for the national response as follows:

Window 1	will fund proposals from Ministries, Departments and Agencies (MDAs), Regional Coordinating Councils (RCCs), Private Sector Organisations including trade and professional associations and uniformed services i.e. Ghana Police Service, Ghana Customs, Excise and Preventive Service, Ghana Armed Forces, Ghana Fire Service, Ghana Immigration Service and Ghana Prisons Service.
Window 2	will fund Metropolitan, Municipal and District Assemblies (MMDAs) who will be required to submit their work plans to the Regional Coordinating Councils detailing their proposed activities which should centre on i. Coordination of district response ii. Workplace programmes for staff iii. Monitoring of district response. Funding will be provided by GAC based on a pre-determined funding level.
Window 3	will fund proposals from PLHIV Associations, Civil Society Organizations and Traditional Associations.

Window 4	will fund proposals from tertiary, vocational and technical institutions. Relevant proposals will be endorsed by MOESS. Civil Society Organizations are allowed to apply for funding under this window.
Window 5	Proposals under this window were aimed at achieving positive behaviour among MARPs and therefore will fund proposals from Civil Society Organizations.
Window 6	will fund proposals from the academia, research institutions, CSOs, MDAs and the private sector. Under this window an M&E firm will be engaged to support GAC, IPs and sub-national structures to develop and effectively manage M&E systems.

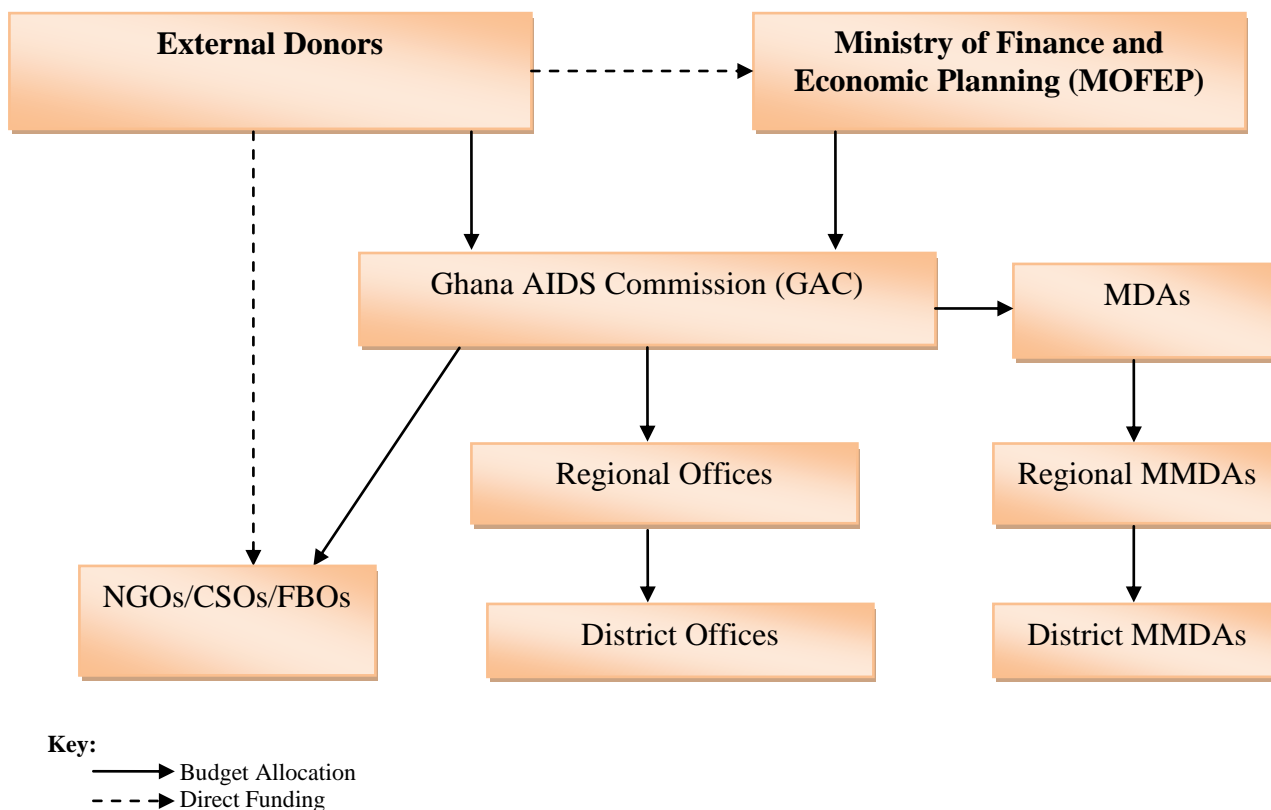
2.3.2 Financing Agents

The Government of Ghana (GOG) and the development partners are channeling funds for the implementation of the APOW through three main funding mechanisms. The pooled, earmarked and direct funding mechanisms and their levels of funding are as follows:

- **Pooled funding;** where funds are pooled by development partners and are given directly to GAC for the implementation of the national HIV and AIDS programme.
- **Earmarked funding;** funds earmarked by development partners to be used for special programmes and channeled through the GAC or a specified Government institution.
- **Direct funding;** funding given directly to the implementing agencies by development partners or GOG.

While GAC has control over the pooled funds, the GAC secretariat and the task team for APOW 2009 work on the allocations between the intervention areas, giving attention to the emerging priorities and the existing allocation from the different partners under earmarked and direct funds. The earmarked and direct funding channels may not be in line with the national priorities and as such the GAC stands by its commitment to encourage more donor inflows into the pooled funding, in order to avoid duplication of efforts and concentration of resources in some area of intervention or region. Figure 2.2 shows the distributional channels for HIV and AIDS.

Figure 2.2 Distributional channels for HIV and AIDS Activities



2.3.3 Distribution of HIV and AIDS Funds, APOW 2009

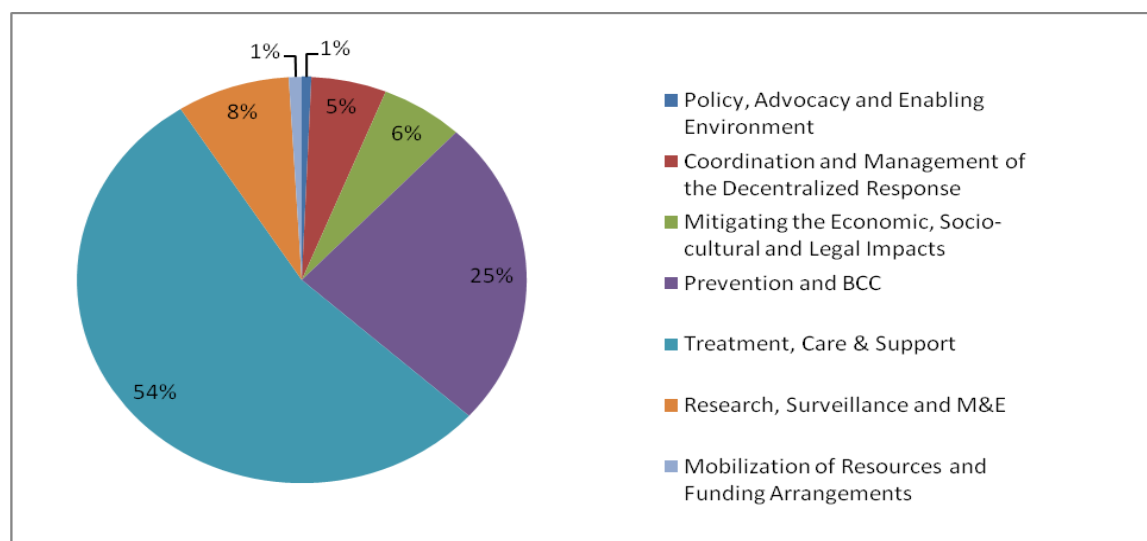
In the 2009 POW, of the total funds budgeted, the largest proportion was allocated to two intervention areas: Prevention and Behavioral Change Communication (BCC) (25 percent), and Treatment, Care and Support (54 percent). The high percentage allocated to treatment, care and support was mainly due to the high investments required to continue with the scale up of the ART programme especially for children living with HIV and also the need to scale up collaboration with regards to AIDS/TB treatment. Funding sources for treatment, care and support was mainly from the Global Fund. The other intervention areas received the following allocations: 6 percent to impact mitigation, 1 percent to policy, advocacy and enabling environment, 5 percent to coordination and management, and 8 percent to research, surveillance, monitoring and evaluation. The percentage distribution of total fund allocations is captured in Figure 2.3 and specific amounts allocated to the various thematic areas by funding type are also shown in Table 2.1.

Table 2.1 Breakdown of 2009 APOW Budget by Funding Source and Intervention Area

Intervention Areas	Pooled funding	Earmarked funding	Direct funding	Total	Total %
Policy, Advocacy and Enabling Environment	290,000	0	25,000	315,000	1
Coordination and Management of the Decentralized Response	1,196,500	1,100,000	209,157	2,505,657	5
Mitigating the Economic, Socio-cultural and Legal Impacts	1,580,000	200,000	971,900	2,751,900	6
Prevention and BCC	3,838,800	1,250,000	6,260,308	11,349,108	25
Treatment, Care & Support	20,000	300,000	24,754,351	25,074,351	54
Research, Surveillance and M&E	1,662,780	508,100	1,596,305	3,767,185	8
Mobilization of Resources and Funding Arrangements	360,000	0	69,200	429,200	1
Total	8,948,080	3,358,100	33,886,220	46,192,400	100

Source: APOW, 2009.

Figure 2.3 National Response Budget by Intervention Areas, 2009



Section 3

Study Design and Methodology

3.1 Approach

The NASA methodology allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors to confront the HIV and AIDS epidemic. This accounting must be exhaustive, covering entities, services and expenditures; periodic, as a result of a continuing recording, integration and analyses, to produce, ideally, annual estimates; systematic, as the structure of the categories and records/reports must be consistent over time and comparable across countries².

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

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

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

² UNAIDS. 2006. National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level. (draft- work in progress).

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

3.2 NASA Classifications

The NASA classifications that were adopted for the 2007 study have been slightly changed. After an evaluation of past response to the drivers of the HIV epidemic, and the ways to address these drivers, the sub-programmes under the main spending categories have been modified. However, the NASA programme and budget lines have remained structured on eight spending classes used in the previous studies namely: Prevention; Care and treatment; Orphans and vulnerable children; Programme management and administration strengthening; Incentives for human resources; Social protections and social services; Enabling environment and community programmes; and Research.

The beneficiary populations are classified under seven main categories (an expansion from the previous study where there were five) with a number of sub-groups in each category to enable a further disaggregating of the data collected. The full description of beneficiary groupings is presented in Appendix 1.

3.3 Data Collection and Processing

Development and Administering of Questionnaires

The study used the UNAIDS NASA questionnaires which were slightly adjusted in the first NASA study conducted in 2007. The adjusted questionnaires (see Appendix 2) were sent to the key respondents and appointments made during which the data was requested and the forms completed.

3.3.1 Sources of Data

Most of the key sources of data (detailed expenditure records) for 2009 were obtained from primary sources. For the purposes of this study a financial year was from 1st January to 31st December. Only a few data sources were either obtained from secondary sources (e.g. expenditure of small NGOs were captured from GAC and other donor reports), or were estimated using the best available data and most suitable assumptions. Table 3.1 shows the list of institutions visited for the HIV and AIDS expenditures and the

status of data collected. The institutions were grouped into the following categories; Public, External, NGOs and Businesses.

Table 3.1 List of Institutions and Status of Data Collected on HIV and AIDS Spending, 2009³

INSTITUTION	2009	INSTITUTION	2009
<u>PUBLIC</u>		United States Government	✓
Ghana AIDS Commission	✓	JICA	✓
National AIDS Control Program (NACP)	✓	GTZ	✓
TB Control Program	□	Center for Disease Control (CDC)	✓
GHS – Salaries of Health personnel at ART sites	✓	DFID	✓
MoH – Health Fund	✓	Royal Netherlands Embassy	✓
MoH - Central Medical Stores	✗	WAPCAS	✓
MoH – Health Research Unit	✗	OICI (Int. & Ghana)	✓
Min. Local Government & Rural Development	✓	PLAN (Int. & Ghana)	✓
Ministry of Education	✓	Family Health Int. (& Ghana)	✗
Min. of Women and Children	✓		
Dept. of Social Welfare, Min. of Labour & Employment	✓	<u>NGOs</u>	
Inst. of Local Government (ILGS)	□	CARE	□
District Assembly Common Fund (DACF)	✓	CRS	*
Noguchi Memorial Inst. for Med. Research	✓	NAP +	✓
Blood Bank, Korle bu	✗	GHANET	✓
<u>EXTERNAL</u>		ARHR	✓
USAID (Ghana)	✓	AWARE	□
GLOBAL FUND	✗	Family Health Int. (FHI)	✓
DANIDA	✓	GSMF	✓
UNICEF	✓	Action Aid Int. & Ghana	✓
UNFPA	✓	YARO	✓
UNAIDS	✓	World Vision – Ghana	□
World Bank	✓	Reach the Children - GH	✓

³ Key for the table can be found at the bottom

WHO	✓	RAAR	✓
UNHCR	✓	PPAG	✓
UNESCO	✓	All MSHAP transfers to NGOs (via GAC)	✓
WFP	✓	West Africa AIDS Foundation	✓
UNIFEM	✓	ISODEC	✓
ILO	✓	<u>BUSINESS</u>	
Quality Health Partners	✓	Ghana Business Coalition against AIDS	✓
IOM	✓	Ghana Employers Association	✓
		Narh Bitra Hospital	✗

- Data was not available
- ✗ Data was available but not captured in RTS to avoid double-counting
- ✓ Data was available and captured in NASA RTS
- * Institution visited but confirmed no spending on HIV and AIDS in 2008

3.3.2 Data Processing

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

3.4 Assumptions and Estimations

A few development partners had different financial year periods from that used by the Government of Ghana (1st January to 31st December). Thus, effort was made to capture the actual expenditure within each fiscal year, January to December. In this case we relied mainly on monthly or quarterly expenditures from the development partners to make the necessary adjustments.

Where funds are pooled, the expenditure contribution of donor to the activities was assumed to be equal in equal proportions as the contribution to the total fund. The same rationale was also applied to any under

spending. Also where detailed expenditure records of providers were not available, we assumed equal split of funds between the key activities, unless instructed otherwise.

GAC funds goes to NGOs, CBOs and private organisations. The actual recipient's data was provided by GAC but the total number was too large for us to document each individual institution in the NASA software. Hence funds received by these institutions and used were treated as one entity. Also the GAC's pooled funds indicated sources, but could not be linked specifically to activities given the large number of recipients, hence the total expenditure from GAC was split across the seven intervention areas in the NSF II according to the proportion intended for each category in the budget as shown in Table 2.1 (APOW, 2009).

Public sector spending in this study includes pooled funds to GAC from the IDA of the World Bank. This is because the IDA fund was a credit to Ghana at an interest rate of zero percent. This year's study also included the 0.5 percent allocation of each District's Assembly Common Fund (DACF) to HIV and AIDS activities.

The average interbank annual exchange rate of the US dollar to the cedi was used in this study. For 2009, the rate was GH¢1.428 to US\$1 (ISSER, 2010)⁴.

3.4.1 Estimation of Out-of-Pocket Payment for HIV and AIDS

The estimation of the household out-of-pocket expenditure on HIV and AIDS was assessed within the framework of the Cost of Illness (COI) approach. The COI for HIV and AIDS in the household was expressed as: $C = X + Y$, where C = Cost of illness of HIV and AIDS in the household, X = direct cost of care, and Y = indirect costs associated with HIV and AIDS illness (productivity cost). For the NASA only the direct cost is used.

The direct cost of illness for this study includes the following:

- (i) direct cost of hospitalization (includes expenditure on bed, medical, clinical tests, transport cost, tips and diet/lodging for caregivers);

⁴ ISSER (2010). The State of the Ghanaian Economy in 2009. Published by the Institute of Statistical, Social and Economic Research (ISSER), University of Ghana, Legon.

- (ii) amount spent on ARVs;
- (iii) spending on other medicines taken on a regular basis (includes prophylaxis and others); and
- (iv) spending on additional nutrition.

The average expenditure on the above direct cost (unit cost) was obtained through a household survey of People Living with HIV (PLHIV) in 6 sentinel sites between March and August 2010 using 2009 as the reference period. Table 3.2 shows the sites visited for the household survey. The 6 sites were selected based on the 2008 sentinel survey. The highest, average and lowest prevalence rates for the urban and rural sentinel sites were selected.

Table 3.2 Selected Sites (Districts) for Household Survey of PLHIV

Region	Site	District	HIV High	HIV Low	Average HIV	Urban	Rural
Central	Assin Fosu	Assin Fosu		1.2		X	
Upper West	Nadwoli	Nadwoli		0.3			X
Greater Accra	Mamobi				2.8	X	
Western	Eikwe	Nzema East			2.8		X
Eastern	Agomanya	Manya Krobo	8.0			X	
Eastern	Fanteakwa	Begoro	4.6				X

Source of data: National AIDS/STI Control Programme (2009). HIV Sentinel Surveillance Report, 2008.

In each of the selected sites 100 PLHIV households were interviewed using a structured household questionnaire (see Appendix 3 for household out-of-pocket payment questionnaire for PLHIV). Thus the total households surveyed were 600. The National Association of PLHIV (NAP+) at the various selected sites was contacted to help identify respondents to be interviewed.

The month unit cost of the various direct cost items in the out-of-pocket expenditure (see Table 3.3) were multiplied by 12 to get a yearly figure and then multiplied by the relevant proportion of HIV and AIDS

patients making that expenditure times the total number of clients on ART in 2009 in the country to get an estimate of the various components of the household out-of-pocket expenditure for HIV and AIDS in the country.

Table 3.3 Unit cost of Household Expenditure Components of PLHIV

Expenditure Component	Unit Cost (GH¢)	Percentage making expenditure
Direct cost of hospitalisation last year	172.0	17.6
Monthly expenditure on ARVs	4.94	73.3
Monthly expenditure on other medicines (prophylaxis and others)	5.6	65.1
Monthly expenditure on additional nutrition	13.5	94.6

Source: Out-of-Pocket Payment Survey of PLHIV, 2010.

3.4.2 Estimation of Health Personnel (Clinical and Non-Clinical) Time and Salaries for ART Services

Salaries of health personnel were estimated by knowing the time spent by the health personnel on an HIV and AIDS patient in a visit to the health facility. The time spent (in minutes) was then be multiplied by the salary of the personnel to get the cost of the personnel's time in treating or looking after an HIV and AIDS patient and multiplied by 12 (it was assumed the patient visits the health facility 12 times in a year for ART services). The Unit cost of the health personnel in treating an HIV and AIDS patient was obtained by averaging the total number of minutes per health worker multiplied by cost per minute and summed across type of worker.

Information on the time spent by health personnel was obtained through an interview with health facility staff at selected ART service sites. The ART sites in districts where the household survey was conducted was visited. This was complemented with data also collected from 15 selected ART sites across the country by agroecological zones in Rosen and Asante (2010)⁵ study. Using the above information the unit cost for the health personnel in treating an HIV and AIDS patient per year is the sum of the follows:

⁵ Rosen, J. and Asante F. (2010). Cost of HIV/AIDS Adult and Pediatric Clinical Care and Treatment in Ghana. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

- (i) cost of staff working in direct service delivery (doctors, nurses, etc) (GH¢42);
- (ii) administrative staff cost (GH¢9); and
- (iii) supervision staff cost (GH¢3).

Thus the average total health personnel cost per HIV and AIDS client per year is GH¢54. This is then multiplied by the number of HIV and AIDS clients on ART in 2009 to get the total national cost for service delivery personnel at the ART sites.

3.5 Limitations of the Assessment

The study could not include ALL private expenditure except that provided by the Ghana Business Coalition against AIDS (GBCA), the Ghana Employers Association (GEA) and out- of-pocket payment by households with PLHIV. Contributions from businesses outside GBCA and traditional healers could not be provided.

The overheads of many institutions were not captured due to the fact that many of them were engaged in other activities besides HIV and AIDS programmes, thus making it difficult to estimate the proportion of their overheads used for HIV and AIDS related activities. However, the direct administrative costs incurred in the running of the programmes were captured.

We were unable to carry out a detailed comparison of the key priority areas of the NSF II with that produced by the NASA RTS software since some categories were very similar and others slightly different. However we do not see it as a limitation of the NASA software or the priority areas outlined in the Ghana's NSF II. It is important that stakeholders agree on a way by which the two key spending or priority areas could be harmonized. The study also excluded the sexual reproductive health spending share that might be related to HIV and AIDS because it was difficult to collect such information/data.

Section 4

Findings - NASA Estimations

4.1 Total Expenditures on HIV and AIDS and Sources of Funding in Ghana

The total expenditure on HIV and AIDS activities in Ghana captured in the NASA RTS for 2009 was **US\$54,228,388**. Figure 4.1 shows that in 2009 the largest proportion of the funds was sourced from international organisations. Comparing the total expenditure on HIV and AIDS in 2009 and what was budgeted in the APOW for 2009 of US\$46,192,400 there was an over spend of US\$8,035,988. When the households' fund is removed from the total expenditure, US\$48,490,424 is left and this results in an over spending of US\$2,298,024.

Funds from international organizations formed 75 percent of total spending on HIV and AIDS; public funds formed 11 percent of the total expenditure whilst private sources of funding constituted 14 percent. Private funds consist of funding from private businesses and household out-of-pocket spending on HIV and AIDS related activities, with house-hold spending constituting 75 percent of the total (Table 4.1).

Figure 4.1 Sources of Funds for HIV and AIDS Expenditure, 2009

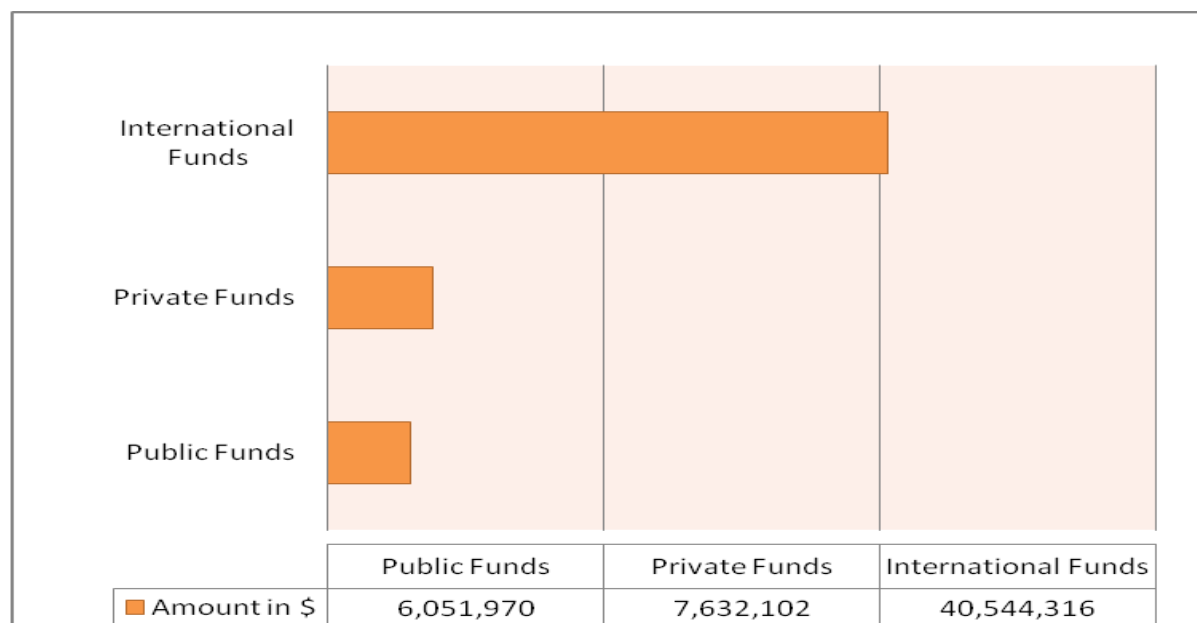


Table 4.1 Private funds for HIV and AIDS related activities by type, 2009

Type of Private Fund	(US\$)	Percent (%)
Households' funds	5,737,964	75.18
Private not-for-profit institutions	36,840	0.48
Other private financing	1,857,298	24.34
Total	7,632,102	100.00

Households' fund (out-of-pocket payment) formed 10.58% of the total expenditure on HIV and AIDS related activities in 2009. The breakdown is as follows:

- Inpatient care services not broken down by intervention, US\$641,404.42;
- ART not broken down by line of treatment, US\$922,531.50;
- OI outpatient prophylaxis and treatment not broken down by type, US\$926,917.53; and
- Nutritional support associated with ART, US\$3,247,109.90

The public sector spending includes Government of Ghana (GOG) funds and pooled funds to GAC from the IDA of the World Bank. Since this is a credit to the Ghana Government it was considered as part of government's spending. The public sector spending also includes salaries of health personnel attached to the ART sites in Ghana. This had been a major limitation in the previous NASA studies.

International organisations are mainly the UN agencies and development partners active in HIV and AIDS programmes in Ghana. Multilateral funds formed 65 percent of the total funds from international organisations followed by 34 percent from bilateral partners (Table 4.2). The Global Funds formed 94 percent of the total funds from multilaterals and the remaining 6 percent from the UN agencies in Ghana. Out of the total funding by international organisations of US\$40,544,316 only 32 percent (US\$12,841,150) was sent to the pooled or earmarked fund overseen by the GAC, the remaining 68 percent were funds sent directly to implementing agencies. This is an improvement from 2007 where direct funds constituted 77 percent of the total. In spite of this the GAC being mandated to oversee the

efficient implementation of the National response needs to ensure that funding be it pooled or sent directly to implementing agencies are in line with the response and also avoid duplication of efforts

Table 4.2 International funds for HIV and AIDS related activities by type, 2009

Type of International Fund	(US\$)	Percent (%)
Direct bilateral contributions	13,957,671	34.43
Multilateral contributions	26,421,981	65.17
International not-for-profit organizations and foundations	164,664	0.41
Total	40,544,316	100.00

4.1.1 Key Spending Areas in 2009

Table 4.3 and Figure 4.2 show the total spending on the key priority areas in 2009. Most of the funds were spent on Treatment and Care (31 percent); Programme Management and Administrative Strengthening (32 percent); Prevention Programmes (17 percent) and Human Resources (11 percent). The remaining 9 percent of the total funds was shared amongst the remaining 4 priority areas.

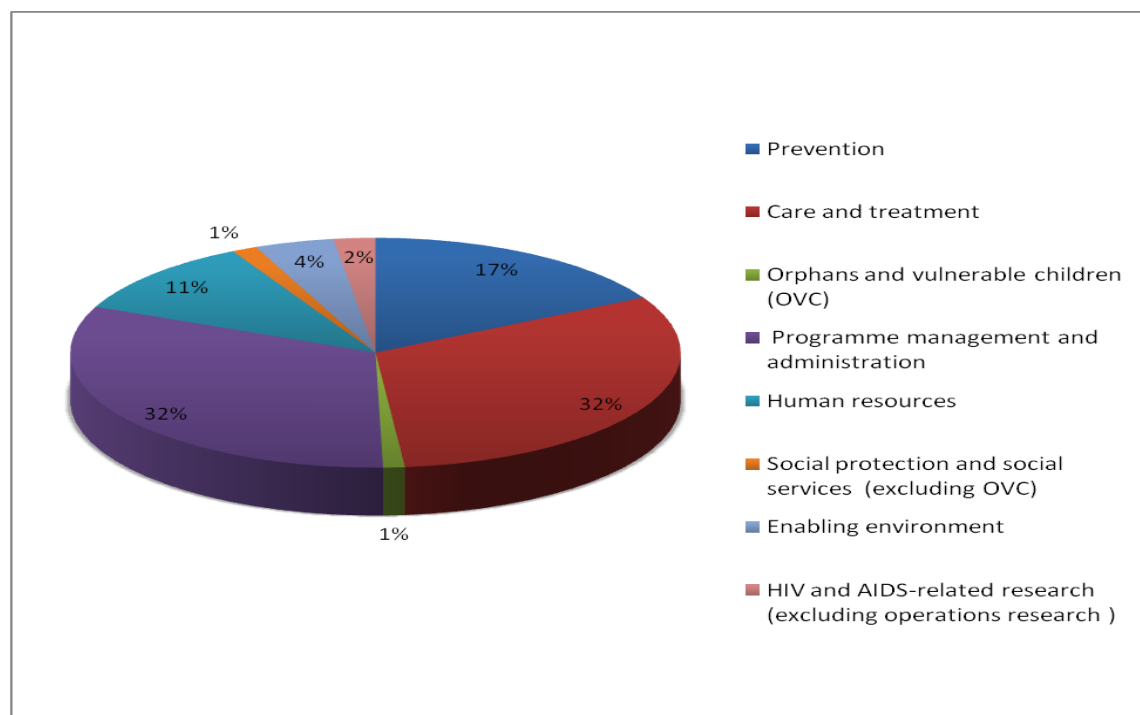
4.2. Key Spending Priorities by Funding Agents

This section highlights the key priority or intervention areas by the various agents captured in the NASA RTS (Table 4.4). In 2009, 40 percent of funds from International Organisations were spent on programme management and administrative strengthening; whilst 25 percent went into Treatment and Care component; 17 percent on Prevention programmes and 11 percent served as incentives for the Recruitment & Retention of Human Resources for HIV and AIDS related activities. For Public Sector funds, 21 percent served as incentives for the Recruitment & Retention of Human Resources for HIV and AIDS related activities; 20 percent was spent on treatment and care; 20 percent on prevention; 17 percent on creating an Enabling Environment and Community Development; 16 percent on Programme Management and 6 percent on HIV and AIDS Related Research. Although there is no direct public spending on OVCs related to HIV and AIDS, the government has since July 2008

Table 4.3 Total Spending on Key Priorities or Intervention Areas, 2009

Key areas of Expenditure	(US\$)	Percent (%)
Prevention	9,231,209	17.02
Care and treatment	17,046,501	31.43
Orphans and vulnerable children (OVC)	621,251	1.15
Programme management and administration	17,315,220	31.93
Human resources	5,813,156	10.72
Social protection and social services (excluding OVC)	724,284	1.34
Enabling environment	2,283,057	4.21
HIV and AIDS-related research (excluding operations research)	1,193,710	2.20
Grand Total	54,228,388	100

Figure 4.2 Total Expenditure Breakdown by Intervention Areas, 2009



made provision for OVCs through the implementation of the Livelihood Empowerment against Poverty (LEAP) programme. This programme provides cash transfers or social grants to targeted, extremely poor and vulnerable households which include the OVCs.

On the part of the private sector, 77 percent of the total funding was spent on Care and treatment (mainly spent by households as Out-of-Pocket expenditure on HIV and AIDS related activities); 13 percent on Prevention programmes (from funds sourced from private institutions and private businesses) and 6 percent creating an Enabling Environment and Community Development (Figures 4.3a and 4.3b).

Table 4.4 Spending Priorities by Agents, 2009 (US\$)

Key Priority Areas	Public sector	%	Private sector	%	International Organizations	%	Grand Total
Prevention Programmes	1,213,527	20	1,018,074	13	6,999,608	17	9,231,209
Treatment and care components	1,212,043	20	5,845,475	77	9,988,983	25	17,046,501
Orphans and Vulnerable Children (OVC)	-	0	385	0	620,866	2	621,251
Programme Management & Administrative Strengthening	968,922	16	201,086	3	16,145,212	40	17,315,220
Incentives for Recruitment & Retention of Human Resources	1,254,964	21	55,655	1	4,502,537	11	5,813,156
Social Protection and Social Services(excluding OVC)	-	0	-	0	724,284	2	724,284
Enabling Environment and Community Development	1,019,282	17	492,792	6	770,983	2	2,283,057
HIV- and AIDS-Related Research (excluding operations research)	383,232	6	18,635	0	791,843	2	1,193,710
Grand Total	6,051,970	100	7,632,102	100	40,544,316	100	54,228,388

Figure 4.3a Spending Priorities by Agents, 2009 (US\$)

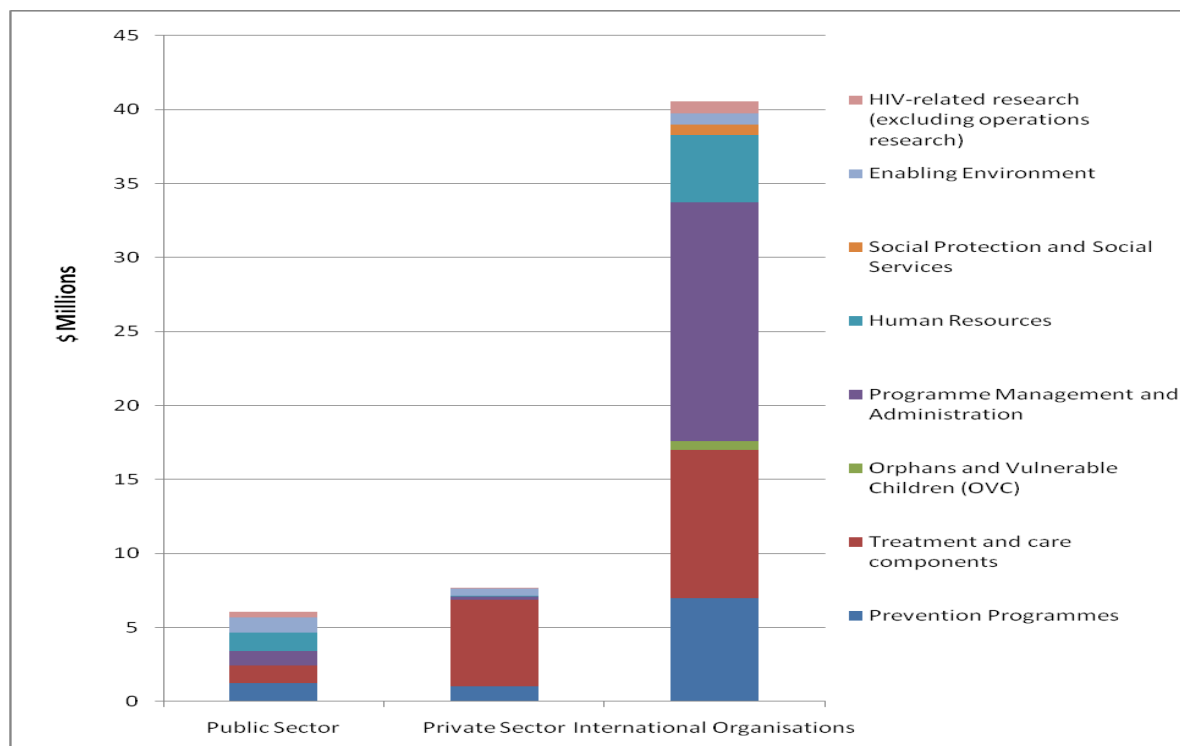
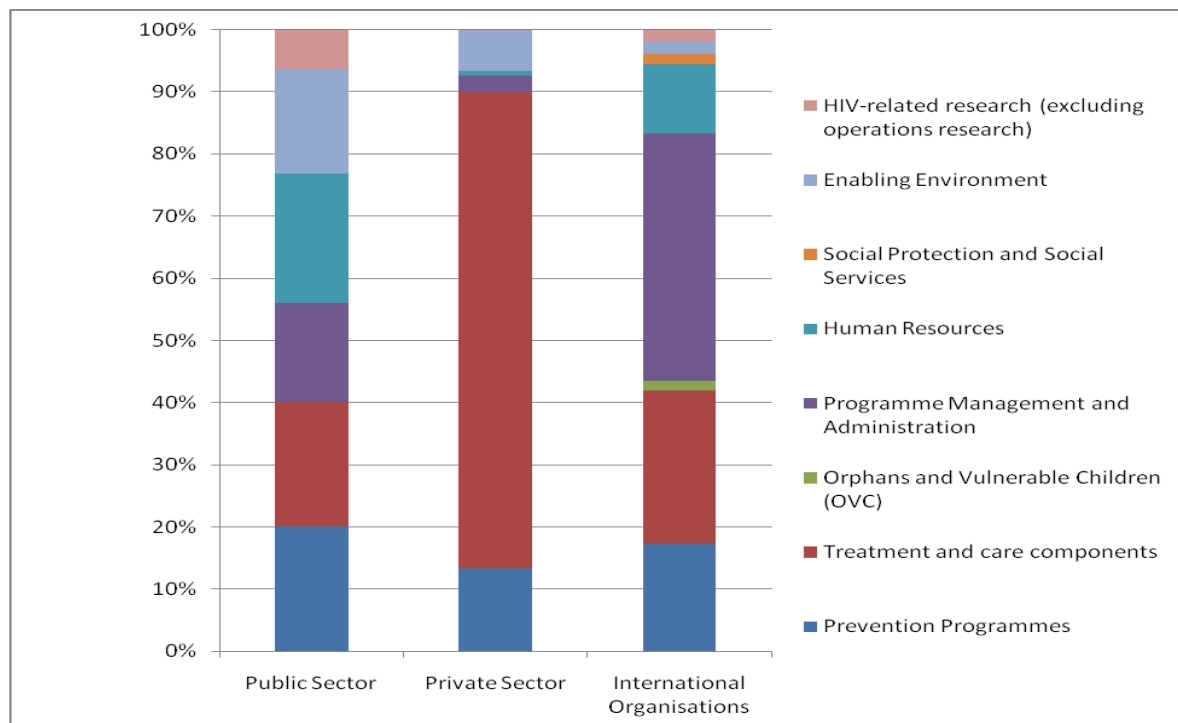


Figure 4.3b Proportional Spending Priorities by Agents, 2009 (US\$)



4.3 Prevention

Prevention remains the cornerstone of the national strategy to overcome the epidemic and transforming awareness into attitudinal and behaviour change and the adoption of positive life styles that reduce risk of HIV/STI infection remains a key task of the national response. Some of the activities outlined in the APOW 2009 included increasing mass communication efforts to educate people on how to reduce their risk and vulnerability; procurement and distribution of male and female condoms to promote safer sexual practices; support workplace HIV and AIDS programmes and sustain focus on youth (in and out of school) prevention programmes to name a few.

In 2009, the total amount spent on prevention was **US\$9,231,209**, which fell short by almost US\$2.1 million of the total budget for that category in the 2009 POW budget (US\$11,349,108). Thus 81.33 percent of the budgeted amount was spent in 2009. Table 4.5 shows which prevention programme areas benefited from the total spending in this category. About 63 percent of the total was spent on communication for social and behavioural change programmes and about 25 percent on VCT as part of programmes for vulnerable and accessible populations.

4.4 Treatment and Care

Some of the key strategies outlined in the APOW 2009 for care and treatment focus primarily on improving the nutritional and living support to PLHIV and OVCs; procuring HIV and AIDS related commodities including ARVs, CD4 machines, chemical and hematological analysers and also expand treatment of OIs and ART services in public and private facilities. Table 4.6 shows the key areas of expenditures in 2009 on Treatment and Care categories. The expenditure patterns show that funds were spent on these key strategic areas. About 22 percent of the total expenditure on the Treatment and Care component was spent on Nutritional support associated to ARV therapy (mainly by households, contributing 87 percent of total); 19.72 percent on ART and 17.74 percent on OI outpatient prophylaxis and treatment.

In 2009, the total amount spent on Treatment and Care was US\$17,046,501 a shortfall of US\$8,027,850 of the total budgeted for this category in 2009 POW budget of US\$25,074,351. This represents about 68 percent of the budgeted amount spent in 2009.

Table 4.5 Prevention Spending Activities, 2009

Key Areas of Expenditure	2009 (US\$)	Percent (%)
Community mobilization	124,326	1.35
Voluntary counselling and testing (VCT)	43,681	0.47
Prevention – youth in school	4,090	0.04
Prevention – youth out-of-school	60,152	0.65
Condom social marketing	19,000	0.21
Public and commercial sector female condom provision	145,595	1.58
Prevention activities not disaggregated by intervention	240,410	2.60
Health-related communication for social and behavioural change	1,442,470	15.63
Non-health-related communication for social and behavioural change	1,030,000	11.16
Communication for Social and behavioural change not disaggregated by type	3,358,748	36.38
VCT as part of programmes for vulnerable and accessible populations	2,279,403	24.69
Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	4,117	0.04
Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	358,367	3.88
Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients	5,601	0.06
Behaviour change communication (BCC) as part of programmes for MSM	31,697	0.34
Condom social marketing and male and female condom provision as part of programmes for IDUs	652	0.01
Condom social marketing and male and female condom provision as part of programmes in the workplace	19,712	0.21
Programmatic interventions in the workplace not disaggregated by type	61,927	0.67
Other programmatic interventions in the workplace	1,261	0.01
Grand Total	9,231,209	100.00

Table 4.6 Treatment and Care Spending Activities, 2009

Key Areas of Expenditure	Amount (US\$)	Percent (%)
OI outpatient prophylaxis and treatment not disaggregated by type	3,023,513	17.74
Adult antiretroviral therapy	2,438,233	14.30
Antiretroviral therapy not disaggregated neither by age nor by line of treatment	923,756	5.42
Nutritional support associated to ARV therapy	3,733,234	21.90
Inpatient care services not disaggregated by intervention	645,484	3.79
Care and treatment services not disaggregated by intervention	5,070,238	29.74
Care and treatment services.	1,212,043	7.11
Grand Total	17,046,501	100.00

4.5. Orphans and Vulnerable Children (OVCs)

The support for activities designed to reduce the economic impact of HIV and AIDS on infected and affected households especially OVC and other vulnerable groups is shared by all key stakeholders. Total expenditure on OVCs formed 1.15 percent of total spending on HIV and AIDS related activities in 2009. Of the total expenditure on OVCs in 2009, 78 percent was spent on OVC family or home support and 10 percent on education (Table 4.7).

Table 4.7 Total Spending on OVCs, 2009

OVC Spending Categories	Amount (US\$)	Percent (%)
OVC Education	64,330	10.35
OVC Basic health care	3,955	0.64
OVC Family/home support	486,299	78.28
OVC Social Services and Administrative costs	16,667	2.68
OVC Services not disaggregated by intervention	50,000	8.05
Total	621,251	100.00

4.6 Social Protection and Social Services (excluding OVCs)

Social protection efforts either through monetary benefits or in-kind have been scaled-up to mitigate the socio-economic effects of the epidemic. In 2009, US\$724,284 was spent on offering social protection mainly through offering social services (Table 4.8).

Table 4.8 Social Protection and Social Services (excluding OVCs), 2009

Key Areas of Expenditure	Amount (US\$)	Percent (%)
Social protection through monetary benefits	42,230	5.83
Social protection through in-kind benefits	18,103	2.50
Social protection through provision of social services	606	0.08
Social protection services and social services not disaggregated by type	663,345	91.59
Total	724,284	100.00

4.7 Programme Management and Administrative Strengthening

Coordinating and managing the expanded and decentralised response to the HIV and AIDS epidemic involves diverse and complex processes including joint planning, meetings with community groups, implementers and the evaluation and monitoring of the response. In 2009, about US\$17 million was spent in managing programmes, 10 percent of which was spent directly on planning, coordination and management and 6 percent on administration and transaction cost. Majority of the expenditure in this category (56.52 percent), made up of Drug Supply (40.12 percent) and Upgrading laboratory infrastructure and new equipment (16.49 percent), was spent in the procurement of CD4 machines, HIV test kits, chemical and hematological analysers and other laboratory equipment and supplies. This was mainly as a result of the expansion of ART sites and the refurbishment of new sites in a drive by the NACP to bring the ART sites nearer to the communities (Table 4.9). Monitoring and Evaluation (excluding M&E as part of programme) formed 5.92 percent of Programme Management while administrative and transaction cost associated with managing and disbursing funds formed 6.05 percent.

Table 4.9 Programme Management Spending Activities, 2009

Key Areas of Expenditure	Amount (US\$)	Percent (%)
Planning, coordination and programme management	1,703,536	9.84
Administration and transaction costs associated with managing and disbursing funds	1,047,059	6.05
Monitoring and evaluation	1,024,883	5.92
Operations research	50,699	0.29
Serological-surveillance (serosurveillance)	894,533	5.17
HIV drug-resistance surveillance	32,256	0.19
Drug supply systems	6,946,566	40.12
Information technology	286,017	1.65
Programme management and administration n.e.c	556,924	3.22
Upgrading laboratory infrastructure and new equipment	2,855,839	16.49
Construction of new health centres	1,343,640	7.76
Upgrading and construction of infrastructure not disaggregated by intervention	573,268	3.31
Total	17,315,220	100.00

4.8 Human Resources

The expenditure pattern for 2009 reveals an increase in funds expended on building a sustainable HIV and AIDS workforce. Specific programmes were aimed at equipping health personnel, administrators and implementers with skills that would ensure effective planning and coordination of programmes and generally improve the administrative capacity of the workforce. In 2009, about US\$5.8 million was spent on human resources with about 70 percent of this total spent on formative education to build-up an HIV workforce, 6 percent on training and 2 percent on monetary incentives for staff involved in the management and administration of HIV and AIDS programmes (Table 4.10). Training was as low as 0.1 percent. The salary component of health workers time at the ART sites formed about 21 percent of total human resources expenditure in 2009.

Table 4.10 Human Resources, 2009

Key Areas of Expenditure	Amount (US\$)	Percent (%)
Formative education to build-up an HIV workforce	4,090,528	70.37
Training	339,568	5.84
Human resources not disaggregated by type	1,213,801	20.88
Human resources	42,820	0.74
Monetary incentives for other staff for programme management and administration	126,439	2.18
Total	5,813,156	100.00

4.9 Enabling Environment and Community Development

The 2009 POW identifies strongly the key role of creating an enabling environment which includes the enforcement of laws and non-discriminatory practices in all spheres of the society. Some of the programmes implemented in 2009 tackled negative socio-cultural practices that increase HIV related stigma and discrimination. In 2009, US\$2,283,057 was spent on activities in this area (Table 4.11). Data collected for the NASA was not disaggregated to get the various sub-components under this priority or intervention area but about 9 percent was spent on advocacy and 14 percent of the total was spent on AIDS-specific institutional development.

Table 4.11 Enabling Environment, 2009

Key Areas of Expenditure	Amount (US\$)	Percent (%)
Advocacy	195,195	8.55
AIDS-specific institutional development	327,108	14.33
Enabling environment not disaggregated by type	1,044,118	45.73
Enabling environment	716,636	31.39
Total	2,283,057	100.00

4.10 HIV and AIDS Related Research

The national response highlights the need for high quality research that would inform policy and programming. In order to achieve one of the areas of focus is to enhance the capacity of research institutions by engaging them in HIV and AIDS related research. In 2009, US\$1,193,710 was spent on research which includes behavioural and social science research (Table 4.12).

Table 4.12 Spending on HIV and AIDS-Related Research (Excluding Operations Research), 2009

Key Areas of Expenditure	Amount (US\$)	Percent (%)
Behavioural research	283,585	23.76
Social science research not disaggregated by type	2,900	0.24
HIV and AIDS-related research activities not disaggregated by type	907,225	76.00
Total	1,193,710	100.00

4.11 Beneficiaries of HIV and AIDS Spending

NASA RTS groups beneficiary populations of the HIV and AIDS related programmes and activities into six broad areas (shown in Appendix 1). In analyzing the dataset, the results show that PLHIV benefited from most of the funds (41 percent of the total) followed by the General Population group (31 percent) and specific “accessible” group (26 percent) whilst MARPS and other key population groups accounted for 1 percent each (Figure 4.4). Table 4.13 gives a more detailed version of the beneficiary groups and this is driven by the level of disaggregated data received from implementers.

Figure 4.4 Spending by Beneficiary Group, 2009

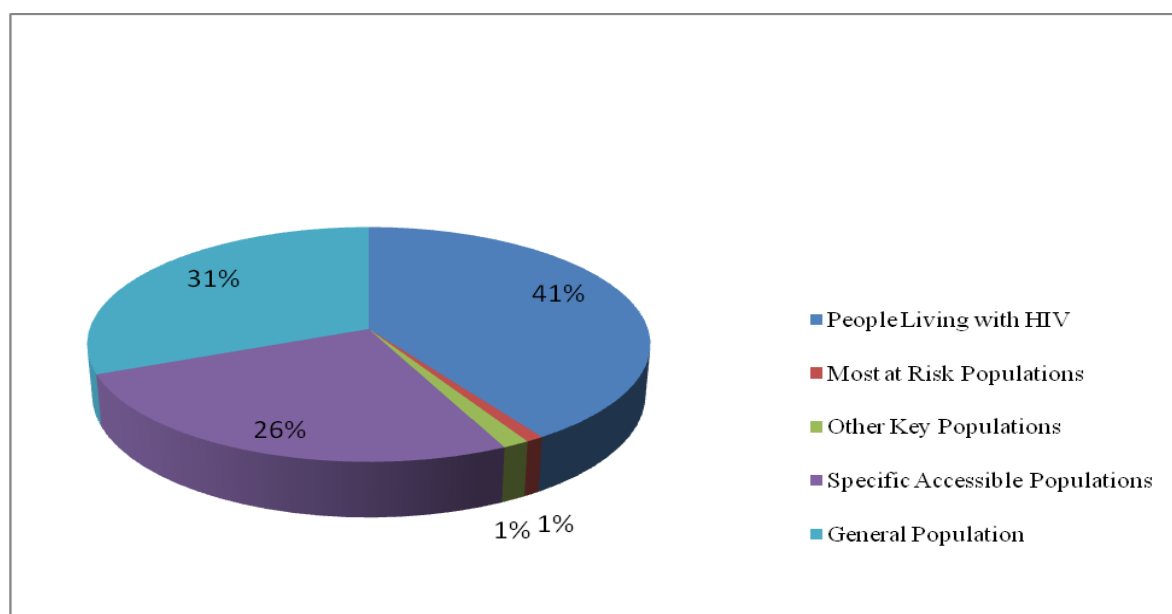


Table 4.13 HIV and AIDS related Spending by Beneficiary Groups, 2009

BENEFICIARY GROUPS	Amount (US\$)	% Within Beneficiary Group	% Within Total Expenditure
PLHIV			
People living with HIV not disaggregated by age or gender	22,061,822		
Sub Total	22,061,822	100.00	40.68
Most at Risk Populations			
Female sex workers and their clients	177,835	36.23	
Men who have sex with men (MSM)	312,885	63.77	
Sub Total	490,720	100.00	0.90
Other Key Populations			
Orphans and vulnerable children (OVC)	722,722	97.59	
Migrants/mobile populations	1,820	0.25	
Refugees (externally displaced)	10,490	1.42	
Children and youth out of school	5,531	0.75	
Sub Total	740,563	100.00	1.37
Specific “Accessible ” Populations			
Junior high/high school students	13,643	0.10	
Police and other uniformed services (other than the military)	14,747	0.10	
Specific “accessible ” populations not disaggregated by type	7,092,653	50.42	
Specific “accessible ” populations not elsewhere classified	6,946,566	49.38	
Sub Total	14,067,609	100.00	25.94
General Population			
Female adult population	22,495	0.13	
Youth (age 15 to 24 years) not disaggregated by gender	895,915	5.28	
General population (older than 24 years) not disaggregated by age or gender	54,667	0.32	
General population not disaggregated by age or gender.	15,894,597	93.68	
Sub Total	16,967,674	100.00	31.10
TOTAL	54,228,388		100.00

4.11.1 Key Areas of Expenditure by Beneficiary Group

Table 4.14 shows the main population groups and their share of the main intervention areas captured in NASA. Overall, in 2009, PLHIV benefited most from treatment and care programmes (87 percent) and capacity building programmes to build an effective HIV workforce (87 percent) whilst the general population was targeted for most of the prevention programmes (84 percent). MARPs accounted for about 5 percent of total expenditure on prevention and more needs to be done to reach this group if they are known. See also Figures 4.5a and 4.5b

Table 4.14: Spending on Beneficiary Groups by Key Priority Areas, 2009 (US\$)

Key Expenditure Area	PLHIV	Most-at-risk Pop.	Other key populations	Specific "accessible" populations	General population
Prevention	16,602 (0.18)	471,542 (5.11)	7,351 (0.08)	987,227 (10.69)	7,748,487 (83.94)
Care and treatment	14,787,728 (86.75)			2,204,106 (12.93)	54,667 (0.32)
Orphans and vulnerable children (OVC)			621,251 (100)		
Programme management and administration	1,576,069 (9.10)			10,059,955 (58.10)	5,679,196 (32.80)
Human resources	5,061,730 (87.07)		111,961 (1.93)	166,897 (2.87)	472,568 (8.13)
Social protection and social services (excluding OVC)	612,462 (84.56)			111,822 (15.44)	
Enabling environment	7,231 (0.32)			490,461 (21.48)	1,785,365 (78.20)
HIV and AIDS-related research (excluding operations research)		19,178 (1.61)		47,141 (3.95)	1,127,391 (94.44)
Grand Total	22,061,822	490,720	740,563	14,067,609	16,867,674

Note: figures in parentheses are percentage expenditure on beneficiary groups within the key expenditure area

Figure 4.5a: Spending on Beneficiary Groups by Key Priority Areas, 2009

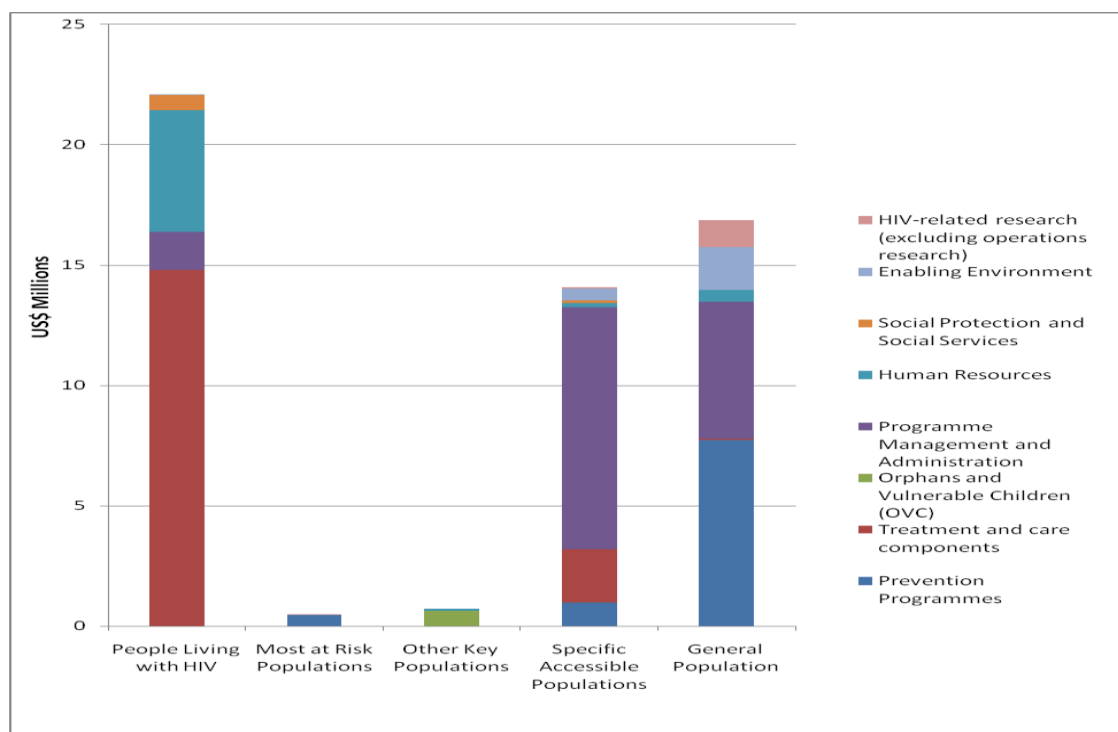
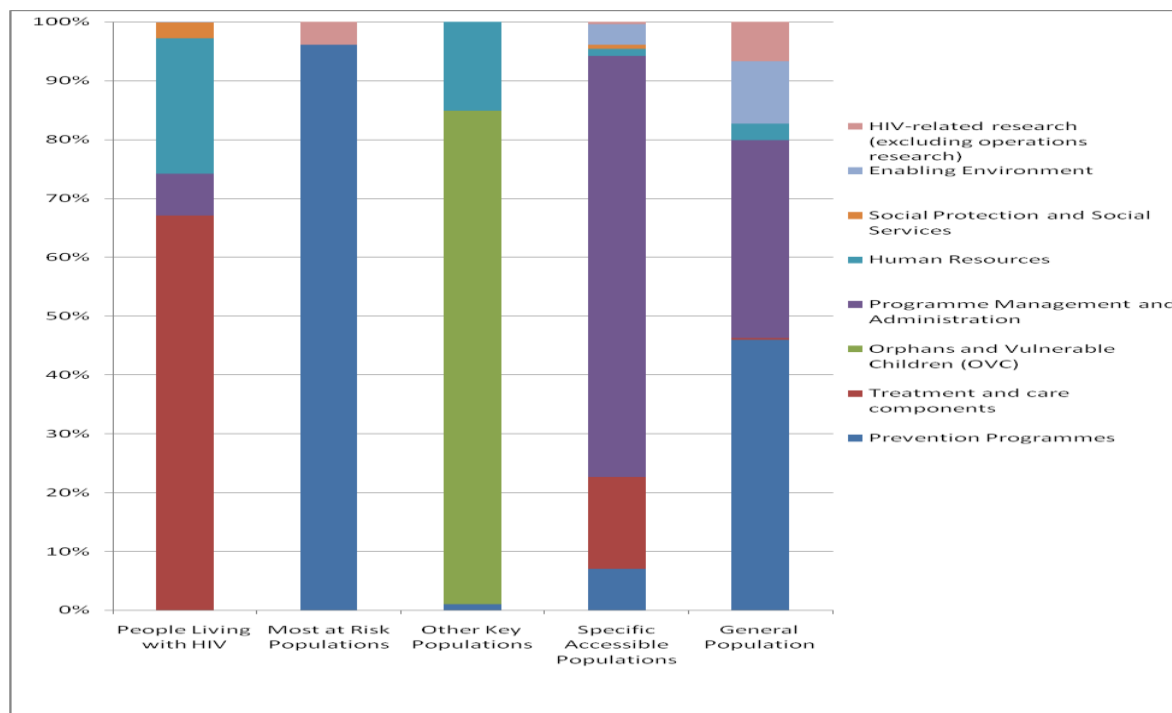


Figure 4.5b Proportional Spending by Beneficiary Group, 2009



4.12 Trend Analysis of HIV and AIDS Expenditure, 2005 to 2009

This fourth round of the NASA study allows us to expand the trend analysis of HIV and AIDS expenditure captured in the NASA RTS in previous studies. This section therefore gives an overview of HIV and AIDS related expenditures over the last four years (2005-2009). Although there has been a systematic increase in funding for HIV and AIDS related programmes during this period, there was a dip in 2008. Total expenditures increased from US\$28.4 million in 2005 to US\$32.6 million in 2006 and to US\$52.5 million in 2007 decreasing to US\$38.8 in 2008 and then increasing to US\$54.2 million in 2009. Funding increased by 40 percent from 2008 to 2009 (Figure 4.6). Funding from International Organisations has remained the major source of finance for HIV and AIDS related programmes. In 2005, funds from international organisations accounted for 71 percent of total expenditure; 68 percent in 2006; 78 percent in 2007; 84 percent in 2008 and 75 percent in 2009.

Figure 4.6: Source of funds for HIV and AIDS Related Activities, 2005 – 2009



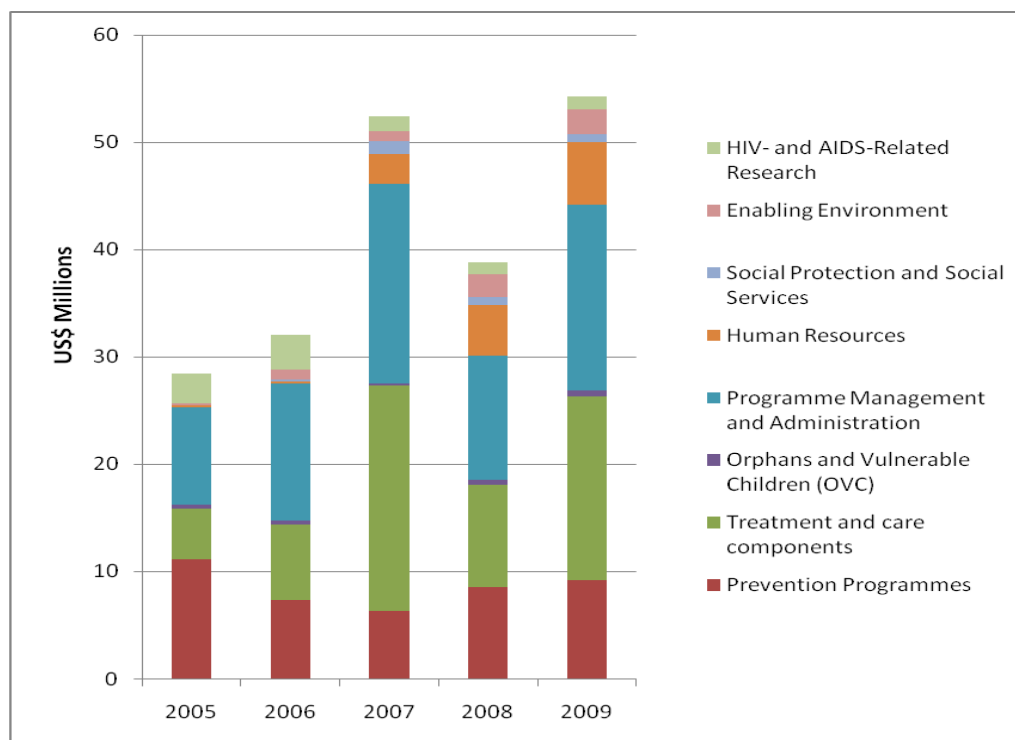
4.12.1 Key Spending Areas

Total expenditure on prevention programmes has been consistently increasing after a dip in 2007. It shows the importance given to prevention activities in the national response given the current drive to expand treatment and care activities. The expanded programme for care and treatment continues after a significant drop in expenditures on this component in 2008, increasing from US\$ 9,554,075 in 2008 to US\$17,315,220 in 2009. It is worth highlighting the fact that since 2005, funds for creating an enabling environment have been increasing from US\$214,902 in 2005 to US\$ 2,283,057 in 2009. On the other hand, there has been a steady decline in expenditure on HIV and AIDS-related research (Table 4.15 and Figure 4.7).

Table 4.15 Total Spending on Key Priorities, 2005 – 2009

Key Areas of Expenditure	2005(US\$)	2006(US\$)	2007(US\$)	2008(US\$)	2009(US\$)
Prevention Programmes	11,157,054	7,352,150	6,339,069	8,550,916	9,231,209
Treatment and care components	4,682,149	7,050,088	21,026,047	9,554,075	17,046,501
Orphans and Vulnerable Children (OVC)	354,865	344,997	153,233	425,999	621,251
Programme Management and Administration	9,133,721	12,820,701	18,566,509	11,603,866	17,315,220
Human Resources	130,246	130,620	2,788,821	4,661,299	5,813,156
Social Protection and Social Services	46,669	164,425	1,256,559	754,620	724,284
Enabling Environment	214,902	995,591	902,332	2,138,620	2,283,057
HIV- and AIDS-Related Research	2,695,102	3,209,063	1,412,521	1,161,545	1,193,710
Grand Total	28,414,708	32,067,635	52,445,091	38,850,940	54,228,388
Nominal growth (%)		12.86	63.55	-25.92	39.58

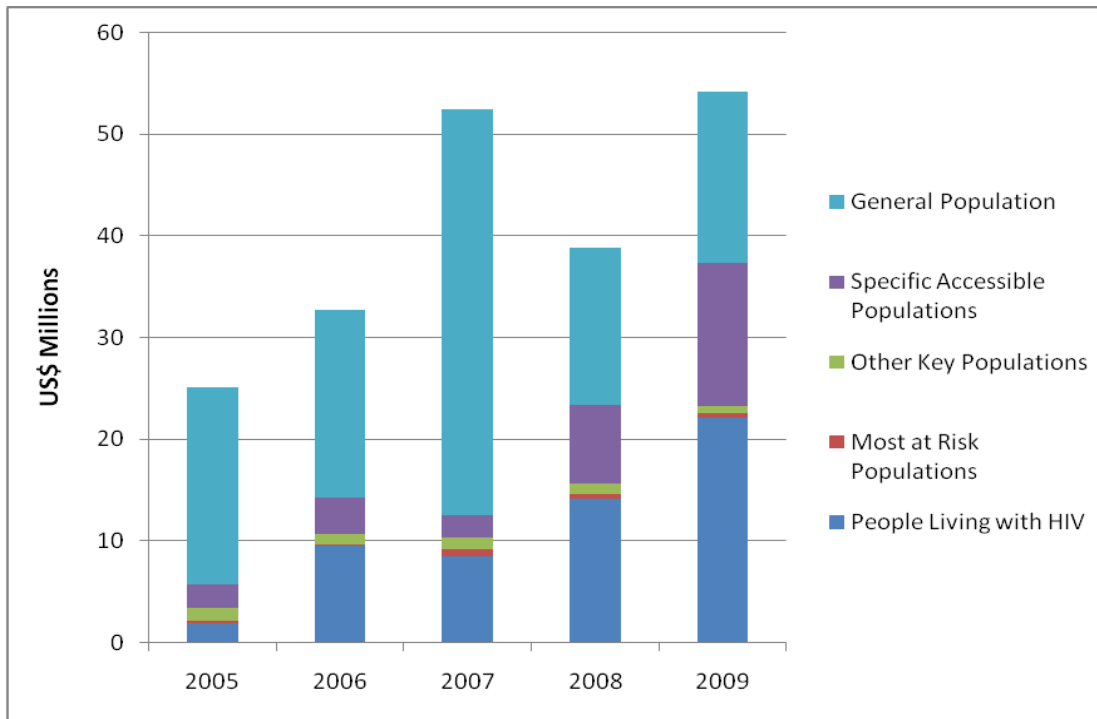
Figure 4.7 Total Spending on Key Priorities, 2005 – 2009



4.12.2 Spending on Beneficiary Groups

Programmes related to HIV and AIDS have mainly targeted the general population since 2005 with more than half of total funds going into this group. Between 2005 and 2007, programmes targeting the general population took between 56 percent and 76 percent of total funds meant for implementing programmes related to HIV and AIDS. In 2008, the general population took the largest share (40 percent). However, increased targeting and a more disaggregated data have changed the share of the three main groups. In 2009, PLHIV accounted for 41 percent from 37 percent in 2008 and 21 percent in 2007. The share of the general population dropped significantly from 76 percent in 2007 to 40 percent in 2008 to 31 percent in 2009. The proportion expended on MARPs remains low as in previous years, less than 1 percent in the review period (Figure 4.8) but in nominal terms the amount has been increasing.

Figure 4.8 Spending by Beneficiary Group, 2005-2009



Section 5

Findings - Qualitative Section of NASA Questionnaire

5.1 Introduction

In addition to the collection of information on spending on HIV and AIDS programmes and activities, the NASA assessment had a subsection which aims to assess the funding processes and reporting requirements of the various stakeholders and the challenges and bottlenecks they face in accessing funds or disbursing funds for HIV and AIDS related activities and programmes. The main stakeholders are the Development Partners (DPs), NGOs/CSOs, the private and public sectors.

5.2 Funding process

Generally, organisations making requisitions for funds from development partners and government agencies must be legally registered and must have the capacity to implement the programmes. Costed proposals are received, reviewed and recommended for funding and if the activities fit into the funding agencies work plan they are supported. On financial and technical reporting, institutions being funded are often required to submit quarterly expenditure reports directly to the financing agency before additional tranches are processed or released. Reports are expected to be timely to curtail any delays in the transfer of additional funds.

Table 5.1 Summary of key challenges and recommendations from stakeholders

	Main challenges	Recommendations
1. Development partners	<ul style="list-style-type: none">• Funds not sufficient to meet all competing needs.• Delays in release of funds due to delays in submission of reports.• Cumbersome bureaucratic processes, requiring several stages of approval.• Reporting not meeting standards	<ul style="list-style-type: none">• Less bureaucracy to speed up the implementation of programmes.• Streamline some of their operations to reduce these bottlenecks.• Simplify reporting requirements.

	<p>due to inadequate technical and administrative capacity of the implementers (IPs).</p>	<ul style="list-style-type: none"> • Build capacity of implementers.
<p>2. Non-Governmental Organisations (NGOs)/ Civil Society Organisations (CSOs)</p>	<ul style="list-style-type: none"> • Reporting requirements from donor organisations were often cumbersome. • Competitive bidding make it difficult for smaller NGOs to access funds. • Inadequate funds to implement projects. • High staff turnover. • Donors require separate accounts and reporting formats which make it difficult to meet reporting deadlines. • Beneficiary fatigue in participating in HIV programmes. • Communities demand financial incentives to participate or support HIV programmes. • Limited funding for MARPs, OVCs, and other vulnerable groups. 	<ul style="list-style-type: none"> • Development partners should build capacity training into projects to help staff acquire the necessary skills. • DPs should build community motivation packages into programme design and budgeting. • DPs should build partnerships to avoid duplication of efforts. • More programmes targeted at MARPs and other vulnerable groups
<p>3. Public sector agencies</p>	<ul style="list-style-type: none"> • Funds for workplace HIV activities are inadequate. Budgets often slashed making it impossible to meet targets. • Internal bureaucracy which is a 	<ul style="list-style-type: none"> • Government must increase funding for HIV and AIDS workplace activities. • Streamline funding processes to reduce delays

	major bottleneck in the implementation of programmes.	in the disbursement of funds.
4. Private Sector	<ul style="list-style-type: none"> • Difficulty in securing funding since there is a general apathy for work place HIV and AIDS activities. • Government contribution to private workplace activities nonexistent. 	<ul style="list-style-type: none"> • Advocacy needed to motivate private institutions to contribute to workplace HIV programmes and other programmes as part of their corporate social responsibility.

Section 6

Summary and Recommendations

6.1 Summary

After four rounds of the NASA assessment, it has become apparent that in spite of the consistent increase in total expenditure, resources are still inadequate for programme implementation. The NASA assessments have been beneficial in providing much needed data on HIV expenditures by all the major stakeholders. In 2009, the results show that the total expenditure on HIV and AIDS related activities in Ghana was US\$54,228,388.00, an increase by 40 percent from 2008. As has been the case in the previous years, the largest proportion of the funds was sourced from international organisations accounting for 75 percent of total funds in 2009. Most sub-Saharan African countries are heavily reliant on donor funding (around 80 percent of funding for HIV and AIDS programmes in the region comes from foreign donors) and Ghana is no exception.

There has also been a substantial difference in the proportion of private expenditure as a share of the total. This is because this round of NASA incorporates household out of pocket expenditures which has been missing in previous studies. This was calculated by using costing and estimation techniques based on data from six sentinel sites in Ghana. Public sector funding was also expanded to include the salaries of health personnel offering services at ART sites.

The spending patterns in terms of expenditure on the key priority areas show that in 2009, most of the funds were spent on Treatment and Care (31 percent); Programme Management and Administrative Strengthening (32 percent); Prevention Programmes (17 percent) and Human Resources (11 percent). The expanded programme for care and treatment continues after a significant drop in expenditures on this component in 2008, increasing from US\$ 9,554,075 in 2008 to US\$17,315,220 in 2009. Total spending on human resources has seen a considerable increase following the drive to build a sustainable HIV and AIDS workforce. In 2009, about US\$5.8 million was spent on human resources with about 70 percent of this total spent on formative education to build-up an HIV workforce.

Another major obstacle is reluctance to be tested for HIV, which is fuelled by stigma and fear. Awareness and education campaigns can counter stigma and increase the demand for testing and one positive sign

discovered is the increasing levels of expenditure on creating an enabling environment through advocacy and other channels. Total expenditure for creating an enabling environment has increased from US\$214,902 in 2005 to US\$ 2,283,057 in 2009.

On the beneficiary side, increasingly people living with HIV (PLHIV) are being properly targeted for treatment and care services. Total funding expended on PLHIV formed 41 percent of total share in 2009. Other groups who benefitted from HIV and AIDS spending included accessible groups such as the youth, OVC and prisoners; most at risk groups such as female sex workers and their clients and men who have sex with men. However more work is needed to reach the most at risk group (MARG) and other vulnerable groups.

The qualitative assessment of the funding processes, reporting requirements, bottlenecks and challenges faced by funding and implementing agencies shows that overall, the implementers maintain that funding remains inadequate to cover all the programmatic areas stipulated in the NSF II. Also the stringent reporting requirements by DPs and the lack of administrative capacity of implementing agencies delays the preparation of financial reports which further delays the disbursement of funds. There is also beneficiary fatigue in participating in HIV programmes and communities demand financial incentives to participate or support HIV programmes which make it difficult to implement programmes when funding is limited.

6.2 Recommendations

The fourth round of the NASA yielded better disaggregated data on HIV and AIDS activities and many of the key stakeholders were very willing to grant access to their expenditure data. However, data on beneficiary groups were not disaggregated as expected and estimation techniques had to be applied in some cases. Hence we make the following key recommendations:

- Agencies and implementers should be clearer on their target population where possible to give a more accurate picture of which groups are truly benefitting from the HIV and AIDS related expenditures.
- Private sector and public sector involvement in the national response is limited. This raises issues of sustainability of the national response so alternative avenues for funding programmes must be found.

- GAC should find innovative ways of bring on board the private sector especially the private-for-profit institutions in financing HIV and AIDS related activities since their contribution to total resources for the national response is still very low.
- Even though government contribution to the national response is very important through the provision of infrastructure and health workers among others, its contribution to programmes are still very low. GAC should engage the government so as to increase its funds for HIV and AIDS programmes.
- The newly developed NSP 2011 to 2015, should have its priority areas aligned with the 8 NASA key spending areas to make the assessment of the NSP strategies easy and also improve on the M&E of the NSP. This will also help institutionalize the NASA.

Appendix

Appendix 1: NASA Beneficiary Categories

	Main category	Disaggregated
1	People living with HIV (PLWH)	Age Sex
2	Most at Risk	IDU Sex workers MSMs
3	Accessible Populations	STI Clinic patients Children and youth at school People at work Health workers Migrant workers Long distance truck drivers Military, police
4	Other Key Groups	OVCs Children born from mothers with HIV Migrants, refugees Prisoners Women & children: trafficking and violence Youth at social risk, out of school, in streets Partners of people living with HIV
5	General Population	Non-targeted

Appendix 2

NATIONAL AIDS SPENDING ASSESSMENT DATA COLLECTION – FORM # 1 (SOURCES / AGENTS)

Year of the expenditure estimate: _____			
Objectives of the form: I. To identify the origin of the funds used or managed by the institution during the year under study. II. To identify the recipients of those funds.			
Indicate what currency will be used throughout the form with an “X”:	Local currency	US\$ Exchange rate in Year of Assessment	Other (specify):
Name of the Institution:			
1. Financial Year: (if not calendar year, please ask for quarterly expenditure reports)			
2. Person to Contact (Name and Title):			
3. Address:		4. E-mail:	
5. Phone:		6. Fax:	
7. Type of institution: Select category of institution with an “X”.	6.1 Public central government		
	6.2 Public regional government		
	6.3 Public local government		
	6.4 Private-for-profit national		
	6.5 Private-for-profit international		
	6.6 National NGO/CBO		
	6.7 International NGO		
	6.8 Bilateral Agency		
6.9 Multilateral Agency			

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

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

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

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

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

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

7.9 Institution:			
Contact:			
TOTAL:			

9. Destination of the funds:

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

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

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

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

Contact:			
8.7 Institution:			
Contact:			
8.8 Institution:			
Contact:			
8.9 Institution:			
Contact:			
8.10 Institution:			
Contact:			
TOTAL:			

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

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

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

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

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

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

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

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

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

g. Any other comments, suggestions etc?

12.Surveyor:

13.Date: / / 20__

National AIDS Spending Assessment
DATA COLLECTION – FORM # 2 (PROVIDERS)

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

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

Name of the Provider:			
14.Person to Contact (Name and Title):			
15.Address:		16.E-mail:	

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

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

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

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

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

21. Destination of the funds:

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

8.1 Expenditure of the funds received from “7.1”

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

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

8.2 Destination of the funds received from “7.2”			
8.2.1 Function (Code and Name)			Amount spent
Code:		Name:	
8.2.1.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.2.1.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
8.2.2 Function (Code and Name)			Amount spent
Code:		Name:	
8.2.2.1 Beneficiary Population (Code and Name):			
Code:		Name:	
8.2.2.2 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
8.2.3 Function (Code and Name)			Amount spent
Code:		Name:	
8.2.3.1			
Code:		Name:	
8.2.3.2 Beneficiary Population (Code and Name):			
Code:		Name:	
8.2.3.3 Beneficiary Population (Code and Name):			
Code:		Name:	
Total spent on the Function:			
Total Expenditure from the amount from ‘7.2’			
Total unspent from the amount from ‘7.2’			

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

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

8.3.2 Function (Code and Name)				Amount spent
Code:		Name:		
Code:	8.3.2.1	Name:	Beneficiary Population (Code and Name):	
Code:	8.3.2.2	Name:	Beneficiary Population (Code and Name):	
Total spent on the Function:				
8.3.3 Function (Code and Name)				Amount spent
Code:		Name:		
Code:	8.3.3.1	Name:	Beneficiary Population (Code and Name):	
Code:	8.3.3.2	Name:	Beneficiary Population (Code and Name):	
Total spent on the Function:				
Total Expenditure from the amount from '7.3'				
Total unspent from the amount from '7.3'				

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

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

Code:	8.4.3.1	Beneficiary Population (Code and Name):	
Name:			
Code:	8.4.3.2	Beneficiary Population (Code and Name):	
Name:			
Total spent on the Function:			
Total Expenditure from the amount from '7.4'			
Total unspent from the amount from '7.4'			

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

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

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

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

Additional Qualitative Information Required:

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

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

3. What are the key bottlenecks to spending?

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

Explain your answer.

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

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

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

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

9. How could these be addressed or reduced?

23. Interviewer:	24. Date: / / 20__
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TREATMENT AND CARE

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

1. Example on Antiretroviral therapy.

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

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

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

2.1 Data available: Actual Expenditure.

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

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

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

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

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

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

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

1. List the ARV consumed during the year under study.
2. Define the unit (presentation, quantity, dose).

3. Complete data on the number of units consumed.
4. Complete data on the price of each ARV. (Consult the NASA notebook for a detailed explanation on prices and costs).
5. Calculate total expenditure using the PxQ approach (Prices by Quantities).
6. Identify the Source of the information.

ARV	Unit definition	Number of Units Consumed	Unit Price	Expenditure (PxQ)
TOTAL				
Source of information.				
Institution:		Person to Contact (Name and Title):		
Phone:		E-mail:		

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

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

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

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

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

Capture the number of adults and children under ARV therapy.

Beneficiary Population	Quantity
Adults under Antiretroviral therapy	

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

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

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

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

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

2. Example on Monitoring Tests.

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

2.1 Data available: number of tests delivered.

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

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

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

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

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

Institutional Role

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

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

6.1 Does the institution provide funds for HIV/AIDS (Source)	YES	NO
6.2 Does the institution transfer funds to other institutions for activities	YES	NO

connected with the fight against HIV/AIDS? (Agent)		
6.3 Does the institution produce goods and/or services for the fight against HIV/AIDS? (Provider)	YES	NO

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

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

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

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

Forms:

1. Source / Agent
2. Provider

9. Investigator	10. Date: / /
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Appendix 3

OUT-OF-POCKET PAYMENT FOR HIV AND AIDS IN GHANA (HOUSEHOLD LEVEL QUESTIONNAIRE)

Consent statement

The Ghana AIDS Commission (GAC) and UNAIDS, Ghana Office with support from the Royal Netherlands Embassy are carrying out a study on the “Socio-economic impact of HIV/AIDS in Ghana. We would like to ask you a few questions regarding your economic, educational and health status. The same questions are being asked to a number of households in six sites of the country. However, the participation of households/persons in this survey is voluntary. Even if you agree to respond to these questions, you can refuse to answer any question that you do not wish to answer. We would like to assure you that the information provided by you would only used for the purpose of research and your identity will not be revealed to anyone either in the final report or in any other way. Through this study people will learn about the status of HIV/AIDS in this country and the well-being of the people of this country but your personal information will not be divulged. This study is likely to result in formulation of policies and programmes that benefit the people particularly those affected by HIV/AIDS.

Do you agree to be interviewed?

Yes-1/ No- 2 ☐

Name of the interviewer: -----

Signature of the interviewer:-----

Date:----- Time of interview:-----

Place of interview:-----

Socio-Economic impact of HIV/AIDS on households

Study number	<input type="text"/>	<input type="text"/>	<input type="text"/>	Region	<input type="text"/>	Type of household	<input type="text"/>
Interview number	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	District	
Sentinel site							<input type="text"/>
Type of settlement							<input type="text"/>
Name of the village/city							<input type="text"/>

Part 1: Household details

Section 1: Household Characteristics

1.1 Place of interview: VCT – 01 Community care centre – 04 Antenatal clinic – 07 ARV collection centre – 10 NGO office – 12	TB hospital – 02 Hospital (inpatient) – 05 Maternity ward – 08 Network of positive Peoples Office – 11 Residence - 13	Care & support home - 03 Hospital (outpatient) – 06 Drop in centres - 09 Others (Specify) – 99	<input type="text"/> <input type="text"/>
1.2 Name of the household head Address (excluding the door number):			
1.3 Religion of the head of the household Muslim1 Catholic.....2 Anglican.....3 Presbyterian.....4 Methodist.....5 Pentecost.....6 Spiritualist.....7 Charismatic.....8 Traditional9 No religion... 10 Other (specify).....11			<input type="text"/>
1.4 Household size			<input type="text"/> <input type="text"/>
1.5 Type of house Several Huts/Buildings (same cpds).....1 Room(s) (Compound house).....3 Apartment/Flat.....5 Several Huts/Buildings (diff. cpds).....2 Single family house.....4 Others (specify).....6			<input type="text"/>

1.6 Is there electricity in the house? Yes – 1 No – 2	<input type="checkbox"/>
1.7 What is the main source of drinking water? River, lake, spring, pond.....1 Rain water.....2 Well with pump.....3 Well without pump.....4 Stand pipe/tap.....5 Public stand pipe.....6 Indoor plumbing.....7 Inside standing pipe.....8 Water vendor.....9 Water truck/tanker service....10 Neighbouring household...11 Other (specify)12	<input type="checkbox"/>
1.8 Is there a separate space for cooking? Yes – 1 No - 2	<input type="checkbox"/>
1.9 Type of fuel mostly used for cooking: Firewood – 1 Coal – 2 Kerosene – 3 LPG (Gas) – 4 Cow dung – 5 Electricity – 6 Bio-gas – 7 Other (specify) - 8	<input type="checkbox"/>
1.10 Does the household have a toilet? Yes – 1 No – 2	<input type="checkbox"/>
1.11 If yes, type of toilet: Service latrine – 1 Septic tank – 2 Flush system – 3 Any other - 9	<input type="checkbox"/>
1.12a Does your household own any agricultural land? Yes – 1 No – 2	<input type="checkbox"/>
1.12b If yes, how much land does the household own (Acres)?	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>
1.13 Does the household own any livestock? (eg cow, etc.) Yes – 1 No – 2	<input type="checkbox"/>
1.14 How many household members have been tested HIV-positive? Yes – 1 No – 2	<input type="checkbox"/>
1.15a Did your household change the place of residence after one of your family Members was detected HIV-positive? Yes-1 No-2	<input type="checkbox"/>
1.5b If yes, where did you move? a) Within the same city/village ----- 1 b) From city to village (within the state) ----- 2 c) From village to city (within the state) ----- 3 d) From one city to another city (within the state) -- 4 e) From one village to another village (within the state) ---5 f) One state to another state ----- 6	<input type="checkbox"/>

1.16 What were the reasons for changing residence? (Multiple answers possible)

☐

- a) Search of employment/transfer ----- 1
- b) Could not afford earlier place of residence ----- 2
- c) To seek medical treatment-----3
- d) Loss of agricultural land/property-----4
- e) Reasons of anonymity – -----5
- f) Asked to vacate by the house owner because of HIV status ----- 6
- g) Any other (specify)----- 7

Section 2: Demographic characteristics of household members								
P.I.D No	Name	Age (in comp. years)	Sex (Male-1) (Female-2)	Relationship to the head (See codes)	Marital Status (See codes)	Education (in comp. Years) Graduate/ diploma-13 Post graduate-14 2.7	Occupation (See codes)	Sector (See codes)
2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9

Codes:

Marital status	Relationship to the head of the household	Occupation	Sector
Married-1 Separated/divorced-2 Abandoned-3 Widowed-4 Living together-5 Unmarried/no live-in partner-6 Age <1 year Code = 00 >99 Code = 99	Head-1 Wife/Husband-2 Son/Daughter-3 Son-in-law/Daughter-in-law-4 Grand child-5 Parent/Parent-in-law-6 Brother/Sister-7 Brother-in-law/Sister-in-law-8 Other relatives/Friends-9	Farmer/Cultivator-01 Agricultural labourer-02 Construction and related work-03 Skilled/Semi-skilled/Other non-agricultural labourer-04 Service (Govt./Pvt.)-05 Petty business/Small shop-06 Large business/medium to large shop owner-07 Small artisan in household and cottage industry-08 Self-employed/professional-09 Truck drivers/Cleaners-10 Other transport workers (Bus drivers, auto rickshaw driver, rickshaw puller-11 Pensioner/Retired-12 Domestic servant-13 Rentier (rental earnings from agricultural land-14 Rentier (rental earnings from house property)-15 Housewife-16 Student-17 Unemployed-18 Others-99	Agriculture and allied activities-01 Mining and quarrying-02 Manufacturing-03 Electricity, gas and water-04 Construction-05 Trade-06 Transport, storage and Communication-07 Hotels and restaurants-08 Finance, insurance, real estate and business services-09 Health (Hospitals/Nursing home, clinics, laboratories, diagnostic centres etc.)-10 Community, social and personal services-11 Tourism (Tour operators, travel agents etc.)-12 Not available-13 Others-99

Section 3: Prevalence of acute and chronic diseases and hospitalisation

[illegible]

Section 4: Household income and expenditure

4A. Total household income during the last one year

Source of Income	Amount (GH¢)																																	
4.1 Income from agriculture and allied activities																																		
(a) Income from farm, orchards etc. (Income is derived by deducting the expenses from production)																																		
(b) Income from livestock, poultry, sericulture etc.																																		
(c) Income from renting of tractors/pump sets & other implements																																		
Total Income from agriculture and allied activities (4.1)																																		
4.2 Income from trade/business/petty shops etc.																																		
4.3 Income from self employment like artisan																																		
4.4 Salary income (of all the household members who have salaried income)																																		
4.5 Wage income earned by the household members (Calculate the wage income earned during the year by all the members by Asking the wage rate and the number of days worked in a normal month)																																		
<table><tr><td>I.D.</td><td>No. of days worked</td><td>Average daily</td><td>Monthly</td></tr><tr><td>Annual</td><td>in a month</td><td>wage</td><td></td></tr><tr><td>income</td><td>income</td><td></td><td></td></tr><tr><td>1.</td><td></td><td></td><td></td></tr><tr><td>2.</td><td></td><td></td><td></td></tr><tr><td>3.</td><td></td><td></td><td></td></tr><tr><td>4.</td><td></td><td></td><td></td></tr><tr><td>Total wage income</td><td></td><td></td><td></td></tr></table>	I.D.	No. of days worked	Average daily	Monthly	Annual	in a month	wage		income	income			1.				2.				3.				4.				Total wage income					
I.D.	No. of days worked	Average daily	Monthly																															
Annual	in a month	wage																																
income	income																																	
1.																																		
2.																																		
3.																																		
4.																																		
Total wage income																																		
4.6 Income from rent, interest, dividends, etc.																																		
4.7 Transfer income (remittances from household members living in other places)																																		
4.8 Any other income (e.g. pension)																																		
Total income from all sources (4.1 to 4.8)																																		

4.9 Did the household liquidate any assets or borrow any money after one of the family members test positive in order to cope with the financial burden/loss of income etc?

Yes-1/No-2

If yes, what did they sell? (Multiple answers possible)

- (a) Agricultural land-1 (b) House property-2 (c) Jeweller6 etc-3 (d) Sale of bonds, shares etc.-
 (e) Vehicles-5 (f) Households goods-6 (g) Livestock-7 (h) Borrowings-8
 (i) Other (specify)-9

How much money they raised?

¢

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4B Household savings, borrowings and lendings during the last one year

4.10 Did the household save in the following forms during the last one year? Yes-1/No-2 <input type="text"/> If yes, how much did the HH save?		
Type of savings	Amount in ¢	
Cash/bank deposit		
Purchase of Jewellery		
Purchase of agricultural land		
Purchase of house/flat/plot		
Shares, bonds, chit fund etc.		
Total (¢)		
4.11 Did the household dissave in the following forms during the last one year? Yes-1/No-2 If yes, how much did the HH dissave?		
Type of dissavings	Amount in ¢	
Cash		
Sale of jewellery		
Sale of house/flat/plot		
Sale of shares, bonds, chit fund etc.		
Total		
4.12 Did the household borrow any money in the last one year? Yes-1/No-2 If yes, how much <input type="text"/><input type="text"/><input type="text"/><input type="text"/>		
4.13 Did the household lend/make remittance to outsiders? <input type="text"/> Yes-1/No-2 Yes, lent money-1 Yes, made remittance-2 both-2 No-4 <input type="text"/><input type="text"/><input type="text"/><input type="text"/> If yes, how much?		

4.14 Does the household own any of the following items? (Yes - 1 No - 2)			
Fan	<input type="checkbox"/>	Computer	<input type="checkbox"/>
Bicycle	<input type="checkbox"/>	Moped/M. cycle/Scooter	<input type="checkbox"/>
Radio/Transistor	<input type="checkbox"/>	House/Flat/Plot	<input type="checkbox"/>
Tape recorder	<input type="checkbox"/>	Car/Jeep/Van	<input type="checkbox"/>
Television B/W	<input type="checkbox"/>	Bullock cart	<input type="checkbox"/>
Television colour	<input type="checkbox"/>	Tractor	<input type="checkbox"/>
Refrigerator	<input type="checkbox"/>	Thresher	<input type="checkbox"/>
Telephone	<input type="checkbox"/>	Tube Well	<input type="checkbox"/>
Washing Machine	<input type="checkbox"/>	Any other (specify)	<input type="checkbox"/>
Mobile Phone	<input type="checkbox"/>		



4C. Total household consumption expenditure

I. Expenditure on food items during last month

	Unit of measurement	Quantity Consumed	Approx. price per unit	Total Value GH¢
4.15 Cereals				
a) Rice				
b) Wheat				
c) Coarse cereals (jawar, bajra, maize etc.)				
4.16 Pulses				
4.17 Edible oil and vanaspati				
4.18 Milk and milk products				
4.19 Sugar				

4.20 Vegetables and fruits
4.21 Meat, fish and eggs
4.22 Beverages (Tea, coffee etc.)
4.23 Processed food like bread, biscuits, namkin snacks etc.
4.24 Spices
4.25 Other food items
4.26 Total I

Total value (GH¢)

II. Expenditure on non-food items during last month

4.27 Fuel (LPG, kerosene, firewood etc.)
4.28 Electricity
4.29 House rent
4.30 Transport (including own vehicle)
4.31 Entertainment
4.32 Telephone cable TV
4.33 Toilet articles (toothpaste, soap, detergents, shaving cream etc.)
4.34 Alcohol
4.35 Bidi/cigarette/hukka/tobacco
4.36 Total II

Total value (GH¢)

III. Other annual consumption expenditure during the last one year

	Total value (GH¢)
4.37 Clothing	
4.38 Footwear	
4.39 Durable goods a) Automobiles b) Electronic appliances c) Other durable goods (e.g. furniture, pressure cooker, utensil etc.	
4.40 Education of children	
4.41 Medical (OPD)	
4.42 Medical (Hospitalisation)	
4.43 Travel	
4.44 Repairs and maintenance of house, vehicles etc.	
4.45 House tax, vehicle insurance etc.	
4.46 Other major expenditure (e.g. wedding, social events etc.)	
4.47 Total III (Other annual exp.)	

Part II: Details about PLHIV

(Interviewer: In every household a maximum of one HIV-positive persons would be interviewed. Respondent in the following sections should be a HIV-positive adult male or a female)

Section 6: Information on HIV/AIDS status

I.D of HIV positive

person: _____

6.1	Source of HIV infection (interviewer: Do not ask/fill if the respondent tells on his/her own)	
a)	Sexual contact – heterosexual-1	<input type="checkbox"/>
b)	Sexual contact – homosexual-2	
c)	Blood transfusion/donation-3	
d)	Needle sharing (IDU)-4	
e)	Any others (specify)-4	
6.2	How did you discover your HIV status?	<input type="checkbox"/>
a)	Voluntary testing-1 → If 1 go to Q6.4	<input type="checkbox"/>
b)	After prolonged illness, symptomatic-2→ If 2, Skip Q6.3	
c)	While donating blood-3	
d)	During pregnancy-4	
e)	Blood test at the time of joining a job-5) Skip to Q6.5	
f)	Others (specify _____)-9)	
6.3	If prolonged illness – Can you tell what the illness was? (See codes)	<input type="checkbox"/> <input type="checkbox"/>
6.4	If you had gone for voluntary testing, why did you choose to obtain an HIV test?	<input type="checkbox"/>
a)	Sickness-1	<input type="checkbox"/>
b)	Health provider suggestion-2	
c)	Knew others with HIV-3	
d)	Partner infected-4	
e)	Any other (specify)-9	
6.5	When was it detected? _____ (No. of years back For less than or equal to one year, code 01)	<input type="checkbox"/> <input type="checkbox"/>
6.6	Where was the test done? Govt.-1 Private Place: _____ -2	

6.7	What was cost of testing in ¢	<input type="text"/> <input type="text"/> <input type="text"/>
6.8	After you were tested positive, did you take any precaution to avoid transmitting the Infection to others? Yes-1 No-2 (If No, skip to 6.10)	<input type="text"/>
6.9	If yes, what efforts did you take? (multiple answers possible)	<input type="text"/> <input type="text"/>
a)	Abstain from having sex-01	
b)	Started using condom consistently-02	
c)	Stopped sharing needles-03	<input type="text"/> <input type="text"/>
d)	Stopped donating blood-04	
e)	Decided not to have a child-05	
f)	Nevirapine during pregnancy-06	<input type="text"/> <input type="text"/>
g)	C-section during delivery-07	
h)	No breastfeeding-08	
i)	AZT to the infant-09	
j)	Do not share blades for shaving with other-10	
k)	Others (specify)_____99	

Stigma and discrimination the family and community in the family

6.10	What was your initial reaction to your HIV-positive status? (Multiple answers) (Interviewer-write the reply in his own words)
a)	Shocked-1
b)	Embarrassed-2
c)	Could not believe-3
d)	Didn't want to face the family-4
e)	Decided to stay away from the family & spouse-5
f)	Decided to keep HIV status a secret-6
6.11	You said that you were _____ then how did you cope with the situation?
6.12	When did you inform your spouse?
a)	Immediately after diagnosis-1
b)	Within six months-2
c)	Within one year-3
d)	Within two years-4
e)	Within five years-5
f)	Not informed the spouse-6
g)	Not applicable-7
(If 7, ask 6.13 otherwise go to 6.14)	
6.13	If unmarried, do you intend to get married?

Yes-1 No-2	
6.14	<p>What was the initial reaction of your spouse and other family members to your HIV status? (Multiple answers)</p> <ul style="list-style-type: none"> a) Shocked-1 b) Denied/Disappointed-2 c) Emphathised-3 d) Embarrassed-4 e) Supportive-5 f) Was thrown out of the house/disowned by the family-6 g) Spouse deserted-7 h) Not informed anybody-8 i) Any other (specify)-9 <p>(If 8, skip to Q.6.20)</p>
6.15	<p>Now, what is the attitude of spouse/family members towards you? (Multiple answers possible)</p> <ul style="list-style-type: none"> a) Neglected, isolated, avoided-1 b) Verbally.physically teased-2 c) Deprived of using basic amenities at home-3 d) Property taken away-4 e) Asked to leave home-5 f) All are supportive-6 g) Family is not but spouse is supportive-7 h) Initial hesitation, but then supportive-8 i) Others (specify)-9

At the community level in the neighbourhood

6.16	<p>Are you or your children being treated badly or differently by others in the community/neighbourhood because of having HIV positive person in the family?</p> <p>Yes-1 No-2 Status not known to others -3 (If 2, skip to 6.18 & if 3, skip to 6.20)</p>
6.17	<p>If yes, how do they treat you or your children differently? (Multiple answers possible)</p> <ul style="list-style-type: none"> a) Neglected, isolated, avoided-1 b) Verbally abused, teased-2 c) Your children are nto allowed to play with their children-3 d) Socially boycotted/not invited for social functions-4 e) Debarred from using public well/tap-5 f) Children nto allowed in anganwadi centre-6 g) Not allowed to participate in Mahila Mandal/Panchayat-7 h) Refused house for renting-8 i) Any other (specify)-9
6.18	<p>Has your HIV status affected the marriage prospects of your sisters/brothers?</p> <p>Yes-1 No-2 HIV Status not known to others-3 Not applicable-4</p>
6.19	<p>Has your HIV status affected the job prospects of other family members?</p> <p>Yes-1 No-2 Status not known to others-3 Not applicable-4</p>

6.20 Have you joined any support group? Yes-1 No-2 (if no, skip to section 9)	
6.21	If yes, name of the organisation Name_____
6.22	What kind of support are you getting 1. _____ 2. _____ 3. _____

Section 7: Impact of HIV/AIDS on employment

After HIV Status was Discovered	
7.1	Did you change your job after you were tested HIV Yes-1 No-2 If No, skip to 7.9
7.2	If yes what was the nature of your occupation at that time (see codes)
7.3	Sector (see codes)
7.4	What was your monthly income?
7.5	Reason for leaving the job? a) Too will to work-1 b) Dismissed from work-2 c) Factory/office closed-3 d) Took voluntary retirement-4 e) Reasons of anonymity-5 f) Discriminated at workplace-6 g) Any other (specify)-9
7.6	Did you receive any b enefit at the time of leaving the job Yes-1 No-2 a) P.E-1

b) Gratitude-2 c) Compensation-3 d) Pension-4 e) Other (specify)-9							
7.7	Total amount received at the time of leaving the job <table border="1" style="float: right;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						
7.8	How many times did you change your job after being tested HIV Positive No of times _____						

7.9	Are you currently working/engaged in an income earning activity? Yes-1 No-2
Currently Working	
7.10	If currently employed, what is the nature of your occupation? (see codes)
7.11	Sector (see codes)
7.12	Does your employer know about your HIV status? Yes-1 b) No-2 c) Self-employed-3 If 3 skip to Question 7.19
7.13	If no, what is the reason for not disclosing your HIV status? a) Social discrimination and isolation ----1 b) Lowered prestige ---2 c) Fear of job loss -----3
7.14	If yes, are you facing any discrimination at the workplace? Yes-1 No-2
7.15	If yes, how are you discriminated (Multiple answers possible) a) Promotion denied-1 b) Being forced to take-up voluntary retirement-2 c) Benefits are not given-3 d) Being forced to resign-4 e) Refused loan facilities-5 f) Withdrawal of health/insurance/medical benefits-6 g) Denied access to shared facilities, like canteen, toilet etc.-7 h) Shifted from one dept. to another-8 i) Any other (specify)-9
7.16	What is the attitude of co-workers at the workplace? (Multiple

answers possible) a) Neglected, isolated, avoided-1 b) Verbally abused, teased-2 c) Labelling and name calling-3 d) Avoid sharing utensils in the canteen-4 e) Avoid drinking water from the same glass-5 f) Avoid sitting in close proximity-6 g) Was looked after well & supportive-7 h) Other (specify)-9	
7.17	Do you get any kind of support from your employer? Yes-1 No-2
7.18	If yes, specify the form of employer's support a) Reimbursement of medical expenditure----1 b) Paid leave----- 2 c) Employer has purchased group Insurance---3 d) Flexibility in working hours-----4 e) Others (specify_____) -----9
7.19	How many days were you absent from work or unable to work in the last one year due to illness?
7.20	Did you lose wage/income due to leave/absence in the last one Year? Yes-1 No-2
7.21	If yes, how much wage/income did you lose in the last one year?
7.22	What was the amount of fringe (overtime, paid leave etc.) Benefits lost if any during last one year? Type of Benefits Please specify the nature of fringe benefits 1. Amount ϕ 2. 3.
7.23	If agricultural household, how many days you could not go to work in the last one year due to illness?
7.24	In your absence, how was the work managed? a) Other family members -----1 b) Hired labourers -----2 c) Both -----3 d) None -----4
7.25	If you have hired labourers, how much are you spending on hired

Labourers(s) in a year ¢

Currently not working	
7.26	If not working since when you have stopped working (no. of years back) Never employed-99 (If 99, Skip to Section 8)
7.27	What was the nature of your occupation (see codes) <div style="float: right;">□</div>
7.28	Sector (see codes) <div style="float: right;">□ □</div>
7.29	Reason for stop working? a) Too ill to work-1 b) Dismissed from work-2 c) Factory/office closed-3 d) Took voluntary retirement-4 e) Discriminated at workplace-5 f) Any other (specify)-9
7.30	If you were in salaried employment/self employed/business, what was your income per month? <div style="float: right;">¢ □ □</div>
(a)	If you were a wage earner, what was your average wage rate per day? <div style="float: right;">¢ □</div>
(b)	Average no. of days you were working in a year? <div style="float: right;">□</div>
7.31	If agricultural household, who is compensating for your not going to the farm? a) Other family members-1 b) Hired labourers-2 c) Both-3 d) None-4
7.32	If you have hired labourers in lieu of your not going to work, how much are You spending on hired labourer(s) in a year? <div style="float: right;">□ □</div>

Section 8: Impact of HIV/AIDS on health status and expenditure

I Non-hospitalised illness episodes

8.1	How many times did you fall ill in the last one year for which You were not hospitalized ? (No. of illness episodes)	[Frequently ill-98 [Continuously ill-99
8.2	How many times did you fall ill in the last one month for which you were not hospitalized ?	[Frequently ill-98 [Continuously Ill-99

Ask details of last two episodes during last one month

	Episode 1	Episode 2
8.3	Nature of illness (Describe) if possible (code)	
8.4	No. of days ill [Frequently ill-98] [Continuously ill-99]	
8.5	Did you seek treatment? Yes-1 No-2	
8.6	If no, reasons for no treatment? (see codes)	
	If treatment was sought, give details	
	Episode 1	Episode 2
8.7	Source of treatment (see codes)	
8.8	Duration of treatment (No. of days)	
8.9	No. of days bedridden	
8.10	No. of days not going to work (Not applicable-99)	
8.11	Expenditure incurred during last month (¢)	
a)	Fees and medicine	
b)	Clinical tests	
c)	Transport cost	
d)	Bribes and tips	
8.12	Total Expenditure (¢)	

II. Hospitalised illness episodes

8.13	Were you ever hospitalized after you were detected HIV-positive? Yes-1 No-e, If no, skip to 8.26
8.14	If yes, number of times
8.15	Were you hospitalized in the last one-year ? Yes-1 No-2, If no, skip to 8.23
8.16	If yes, number of times hospitalized in the last one year?

Ask details about all the episodes of hospitalization during last one year

	Episodes 1	Episode 2	Episode 3
8.17 Nature of illness			
8.18 No. of days hospitalised (Code 99 if currently hospitalised)			
8.19 Source of treatment (see codes)			
8.20 Expenditure incurred (¢)			
a) Room rent			
b) Medical expenditure			
c) Clinical tests			
d) Transport cost			
f) Bribes and tips			
g) Diet/lodging expenses for caregivers			
8.21 Total Expenditure (¢)			

Codes:

Reasons for no treatment Illness not considered serious-1 replies) No medical facility nearby-2 No doctor was willing to treat me-3 Financial constraints-4 No doctor was willing to treat me-4 Lack of time/long waiting-5 Any other (specify)-9 Source of Treatment SC/PHC/CHC-1 financial Institutions-8 Government hospital-2 Private hospital/Nursing home-3 Private doctor-4 Charitable institution/NGO-5 Chemist shop-6 Faith healer/religious person-7 Home remedy-8 Any other (specify)-9	Source of financing (Code upto two Past savings-1 Employer reimburses-2 Medical insurance-3 Medical insurance-3 Mortgage assets-4 Liquidation of assets/durables-5 Loan from employer-6 Borrow from friends and relatives-7 Borrow from moneylender and other NGO support-9
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8.22	Source of financing hospitalization (see codes)
8.23	Did you undergo any surgery after you were diagnosed HIV-positive? Yes-1 No-2 If No, Skip to 8.26
8.24	If yes, were you charged extra for AIDS kits and fumigating O.T. used for your surgery? Yes-1 No-2
8.25	If yes, how much did you pay?
8.26	Are you taking ARV on a regular basis? If no, Skip to 8.29 Yes-1 No-2
8.27	If yes, source of obtaining ARV (see codes for source of treatment)
8.28	Total amount spent per month on ARV (¢)
8.29	Are you taking any other medicine on a regular basis? Yes-1 No-2
8.30	If yes, how much are you spending per month (¢)

8.31	Have you been advised to take nutritious diet to improve Your health condition? Yes-1 No-2
8.32	If yes, how much are you spending on these additional food items per month?

Discrimination of health facilities

8.33	Have you ever been discriminated at a health facility? Yes-1 No-2
8.34	If yes, where? a) PHC/CHC-1 b) Government hospital-2 c) Private doctor-3 d) Private hospital-4 e) Any other (specify)-9
8.35	In what way were you discriminated? (Multiple answers possible) a) Neglected/isolated-01 b) Verbally abused, teased-02 c) Physically abused-03 d) Refused medical treatment-04 e) Referred to another health facility-05 f) Refused access to facilities like toilets and common eating and drinking utensils-06 g) Unnecessary use of protective gear (gown, masks etc.) by healthcare staff-07 h) Excuses given for non-admission-08 i) Shunting between wards/doctors/hospitals-09 j) Doctor did not touch-10 k) Doctor/paramedical gave wrong information about HIV-11 l) Any other (specify)-99
8.36	What was the attitude of other patients towards you? (Multiple answers possible) a) Isolated/avoided-1 b) Verbally abused, teased-2 c) Physically abused-3 d) Refused to seek treatment along with HIV-positive person-4 e) Restrictions on movement in ground, ward or room-5 f) Status not known to others-6 g) Not discriminated-7 h) Others (specify)-9
8.37	Were you ever denied admission in a health facility? a) Yes-1 b) No-2

Section 9A: : Coping mechanism and Social Security

9.1	How are you coping with the additional expenditure/loss of income? What additional responsibilities are taken up by other family members of the infected to cope up with the additional expenditure/loss of income/burden of work?
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<p>(Multiple answers possible?)</p> <p>a) Use past savings ----- 01</p> <p>b) Employer reimburses ----- 02</p> <p>c) Medical insurance ----- 03</p> <p>d) Mortgage assets ----- 04</p> <p>e) Liquidation of assets/durable goods/livestock ----- 05</p> <p>f) Loan from employer of other family members ----- 06</p> <p>g) Borrow from friends and relatives ----- 07</p> <p>h) Borrow from moneylender and other financial institutions ----- 08</p> <p>i) NGO support ----- 09</p> <p>j) Support from extended family ----- 10</p> <p>k) Wife had to take up job in order to support the family ----- 11</p> <p>l) Children had to take up job in order to support the family ----- 12</p> <p>m) Had to take up additional job to meet the increasing expenditure --13</p> <p>n) Not applicable -----14</p> <p>o) Any other (specify) ----- 99</p>	
9.2	<p>Do you/did you have any medical insurance cover?</p> <p>Yes - 1 No - 2</p>
9.3	<p>If yes, what is the insurance cover?</p>
9.4	<p>Are you holding any life insurance policy?</p> <p>Yes-1 No-2 Discontinued-3</p>
9.5	<p>Are you entitled to the employees state insurance scheme (ESIS)?</p> <p>Yes-1 No-2</p>
9.6	<p>Are you receiving any pension?</p> <p>Yes-1</p> <p>No-2</p>
9.7	<p>If yes, what type of pension?</p> <p>Widow pension-1 Family pension-2 From the previous employment-3</p>
<p>9.8 Have you ever been denied any loan facility?</p>	
9.9	<p>If yes, what type of loan?</p> <p>a) Housing loan from banks-1</p> <p>b) Loan from employer-2</p> <p>c) Education loan for children-3</p> <p>d) Agricultural loan from rural banks/cooperative societies-4</p> <p>e) Kisan Credit Card-5</p> <p>f) Car/scooter loan-6</p> <p>g) Any other (specify)-9</p>
9.10	<p>Have you made any arrangement (financial or otherwise) for the Future of your child/children?</p> <p>a) Yes-1</p>

- b) No-2
- c) Not applicable-3

If yes, what kind of arrangements?

Section 9B: Information on Caregiver

9.11	Do you need anyone to take care of you? Yes-1 No-2 If no, End Interview
9.12	If yes, since when? (No. of months)
9.13	If yes, who takes care of you? (Multiple answers possible) a) Spouse ----- 1 b) Children ----- 2 c) Parents ----- 3 d) Siblings ----- 4 e) Other relatives ----- 5 f) Hospital staff ----- 6 g) Care & support centre --- 7 h) Paid nurse ----- 8 i) Others (specify) ----- 9
9.14	Are you satisfied with the care given by them? Yes – 1 No – 2

If the Caregiver is an household member, then ask about him/her

	Person1	Person 2	Person 3
PID No. of household member			
9.15 Is the caregiver employed? (Yes-1 No-2) If no, skip to 9.20			
9.16 If yes, write the occupation code from Section 2.			
9.17 Write the sector code from Section 2.			
9.18 Did the caregiver lose any income due to absence from work? (Yes-1 No-2)			

9.19	If yes, how much income lost? (¢.)		
9.20	If not currently employed , was he/she employed before? (Yes-1 No-2) If no, End Interview		
9.21	Did he/she give up the job to take care of you (HIV/AIDS Patient)?		
9.22	If yes, what was his/her occupation?		
9.23	In which sector was he/she employed?		
9.24	How much was she/he earning per month? (¢)		

Code List

Codes for nature of illness/causes of death

- 01 Common cold, nose and throat discomfort (running nose, sore throat, tonsillitis etc.) pneumonia, bronchitis, whooping cough, respiratory infection.
- 02 Malaria
- 03 Fever
- 04 Headache, body ache etc.
- 05 Weakness, dizziness/anemia
- 06 Loose motion, with/without vomiting, diarrhea, dysentery, vomiting, chronic ameobiosis, Guinea worm
- 07 Stomach problems without loose motion: indigestion, gas, acidity, constipation, ulcer
- 08 Cholera and acute gastroenteritis
- 09 Typhoid
- 10 Jaundice/cirrhosis of liver/liver related problems
- 11 Eye problems
- 12 Ear problems

- 13 T.B. (Tuberculosis)
- 14 Measles, chicken-pox, mums
- 15 Skin diseases/infections (eczema, ringworm, boils abscess, skin itching)
- 16 Leprosy
- 17 Urinary/genital infection, burning sensation while urinating urinary tract infection, enlarged prostate gland
- 18 Diseases of kidney/stones in the bladder
- 19 Gynaecological problems (irregular and painful menstruation, excess bleeding, white discharge-leucorrhea etc.
- 20 Aches and pains – arthritis, spondylitis, rheumatism, other disorders of bones
- 21 Breathing problems/breathlessness/asthma
- 22 Diabetes
- 23 High/low blood pressure
- 24 Diseases related to pregnancy and childbirth
- 25 Diseases of nerves, cerebral stroke
- 26 Disease of mouth, teeth and gum
- 27 Polio
- 28 Tetanus, diphtheria
- 29 Filariasis (elephantiasis)
- 30 Meningitis and viral encephalitis
- 31 Epilepsy/convulsions/fits
- 32 Goitre and thyroid disorders
- 33 Heart problems
- 34 Cancer
- 35 Toxoplasmosis strokes
- 36 Accidents/violence/injury

- 37 Mental psychological problems
- 38 Dog bite/snake bite/insect bite etc.
- 39 Sexually transmitted infections (STIs)
- 40 Old age problems including loss of memory etc.
- 41 Others