



LESOTHO

NATIONAL AIDS SPENDING ASSESSMENT
(NASA)

PERIOD: 2005/06 TO 2006/07

Draft version 12



UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNICEF
WFP
UNDP
UNFPA
UNODC
ILO
UNESCO
WHO
WORLD BANK

NASA Team:

| | |
|---------------------|-------------------------|
| Khobotle Mokete | Section Head M&E NAC |
| Lineo Mahula | Data Officer M&E NAC |
| Lineo Seitlheko | Research Officer NAC |
| Thenjiwe Jankie | Research Officer NAC |
| Mohau Mokoatsi | Research Officer UNAIDS |
| Pheello Pompong | Research Officer UNAIDS |
| Dlamini Mosele | Research Officer UNAIDS |
| Abhimanyu Chitoshia | Consultant UNAIDS |

Table of Contents

| | |
|--|----|
| Abbreviations | 6 |
| Acknowledgements | 7 |
| Executive Summary..... | 8 |
| Introduction..... | 9 |
| Global and Regional Epidemic..... | 9 |
| National Status of the Epidemic..... | 9 |
| Lesotho National Strategic Plan for HIV and AIDS 2006-2011..... | 10 |
| Resource Mobilization for the Fight against HIV and AIDS | 10 |
| Lesotho's NASA..... | 11 |
| Study Objectives | 11 |
| Definition of Concepts..... | 13 |
| Methodology..... | 14 |
| Overall Approach..... | 14 |
| Preparatory Phase..... | 15 |
| Data Collection | 16 |
| Qualitative Data Collection and Analysis | 16 |
| Estimation of Expenditure on STI and AIDS through Health System..... | 16 |
| Drug Procurement & Supply Costs | 16 |
| Data Processing..... | 17 |
| Assumptions..... | 17 |
| Limitations | 17 |
| Findings of the NASA..... | 19 |
| Total Expenditure on HIV and AIDS in Lesotho..... | 19 |
| Total Expenditure on HIV and AIDS with Sources of Funding..... | 20 |
| Expenditure Breakdown by AIDS Spending Category..... | 21 |
| Expenditure Breakdown by NSP Categories | 22 |
| Spending Priorities of Public and International Sources in 2005/06 | 24 |
| Spending Priorities of Public and International Sources in 2006/07 | 25 |
| Expenditure on Prevention Activities | 26 |
| Expenditure on Treatment & Care Activities | 28 |
| Expenditure on Beneficiary Populations | 30 |

| | |
|---|----|
| Expenditure through Providers of Services | 32 |
| Qualitative Data Findings | 33 |
| Process of Funding | 33 |
| Reporting Requirements | 33 |
| Funding Envelopes and Disbursals | 33 |
| Communication Gaps..... | 34 |
| Human Resource Capacity | 34 |
| Recommendations | 35 |
| Recommendations Relating to Reporting and Information Systems | 35 |
| Recommendations to NAC..... | 35 |
| Recommendations to Ministry of Health and Social Welfare..... | 36 |
| Recommendations to Development Partners and UN Agencies | 36 |
| Recommendation relating to subsequent NASA | 37 |
| Appendix I: Status of Data Collected with Comments..... | 38 |
| Appendix II: ASC Priorities vs NSP Priorities | 41 |
| Appendix III: Preliminary 2007 Expenditure Figures | 42 |
| Appendix IV: Total Spending by Expanded Categories for 2005/06 and 2006/07 | 46 |
| Appendix V: NASA Matrices for 2005/06 and 2006/07 | 48 |
| Appendix VI: Estimation of Expenditure on STI and AIDS through Health System..... | 50 |
| Appendix VII: NASA Data Collection Forms and Processing Tools | 57 |

Figures

| | |
|--|----|
| Figure 1: Total Expenditure on HIV and AIDS in Lesotho for the financial years 2005/06 and 2006/07..... | 19 |
| Figure 2: Total Expenditure with Sources of Funding for 2005/06 and 2006/07 | 20 |
| Figure 3: Expenditure Breakdown by ASC for 2005/06 and 2006/07..... | 22 |
| Figure 4: Actual Spending Priorities based on NSP categories for 2005/06, 2006/07 and 2007/08 | 23 |
| Figure 5: Planned NSP Spending Priorities for 2006/07 and 2007/08 | 23 |
| Figure 6: ASC based Expenditure Breakdown for Public and International Sources for 2005/06 | 24 |
| Figure 7: ASC based Expenditure Breakdown for Public and International Sources for 2006/07 | 25 |

| | |
|---|----|
| Figure 8: Prevention Expenditure Percentage Breakdown for 2005/06 from all sources | 26 |
| Figure 9: Prevention Expenditure Percentage Breakdown for 2006/07 from all sources | 27 |
| Figure 10: Prevention Expenditure Breakdown for all sources in 2005/06 and 2006/07 | 27 |
| Figure 11: Treatment & Care Expenditure Percentage Breakdown for 2005/06 from all sources | 28 |
| Figure 12: Treatment & Care Expenditure Percentage Breakdown for 2006/07 from all sources | 29 |
| Figure 13: Treatment & Care Expenditure Breakdown for all sources in 2005/06 and 2006/07 | 29 |
| Figure 14: Beneficiary Population based Programmatic Expenditure Breakdown for 2005/06 | 30 |
| Figure 15: Beneficiary Population based Programmatic Expenditure Breakdown for 2006/07 | 31 |
| Figure 16: Programmatic Expenditure Breakdown based on class of Providers for 2005/06 and 2006/07..... | 32 |
| Figure 17: Total Expenditure with Sources of Funding for 2007/08 | 42 |
| Figure 18: Expenditure Breakdown by ASC for 2007/08..... | 42 |
| Figure 19: ASC based Expenditure Breakdown for Public and International Sources for 2007/08 | 43 |
| Figure 20: Prevention Expenditure Percentage Breakdown for 2007/08 from all sources | 43 |
| Figure 21: Prevention Expenditure Breakdown for all sources in 2007/08..... | 44 |
| Figure 22: Treatment & Care Expenditure Percentage Breakdown for 2007/08 from all sources | 44 |
| Figure 23: Treatment & Care Expenditure Breakdown for all sources in 2007/08 | 45 |
| Figure 24: Beneficiary Population based Programmatic Expenditure Breakdown for 2007/08 | 45 |

Tables

| | |
|--|----|
| Table 1: General targets from the National Strategic Plan 2006 - 2011..... | 10 |
| Table 2: National Strategic Plan and AIDS Spending Category Mapping..... | 41 |
| Table 3: Service types with unit cost and quantity availability..... | 51 |
| Table 4: Matrix with Unit Cost Availability and Gaps..... | 53 |
| Table 5: HIV +ve Patient Proportion for Hospitals | 55 |

Abbreviations

| | | | |
|--------|--|--------|---|
| AIDS | Acquired Immunodeficiency Syndrome | NDSO | National Drug Supply Organization |
| ALAFA | Apparel Lesotho Alliance to Fight AIDS | NGO's | Non-Governmental Organizations |
| ART | Antiretroviral Therapy | NSP | National Strategic Plan |
| ARV | Antiretrovirals | OI | Opportunistic Infections |
| BHA | Boston Health Alliance | OOPE | Our-Of-Pocket Expenditure |
| CHAL | Christian Health Association of Lesotho | OPD | Out Patient Department |
| CRS | Catholic Relief Services | PEP | Post-Exposure Prophylaxis |
| DFID | UK Department for International Development | PEPFAR | Presidential Emergency Plan for AIDS Relief |
| FBO | Faith Based Organization | PLWHA | People living with HIV/AIDS |
| FIDA | Federation of Women Lawyers in Lesotho | PMTCT | Prevention of Mother-to-Child Transmission |
| GFATM | Global Fund to Fight TB, AIDS and Malaria | PSI | Population Services International |
| GoL | Government of Lesotho | PU | Pharmaceutical Unit, MoHSW |
| GTZ | German Technical Cooperation | SIPAA | Support to International Partnership against AIDS in Africa |
| HBC | Home Based Care | STI | Sexually Transmitted Infections |
| HIV | Human Immunodeficiency Virus | TB | Tuberculosis |
| HPSU | Health Planning Statistics Unit, MoHSW | TSF | Technical Support Facility |
| IPD | Inpatient Department | TTL | Touching Tiny Lives |
| LIRAC | Lesotho Inter Religious AIDS Consortium | UN | United Nations |
| LPPA | Lesotho Planned Parenthood Association | UNAIDS | Joint United Nations Program on HIV/AIDS |
| LSC | Lesotho Save the Children | UNDP | United Nations Development Programme |
| LRC | Lesotho Red Cross | UNGASS | United Nations General Assembly Special Session on HIV and AIDS |
| M | Maloti (Lesotho Currency) | UNICEF | United Nations Children's Fund |
| MoAFS | Ministry of Agriculture and Food Security | USAID | United States Agency for International Development |
| MoET | Ministry of Education and Training | URC | University Research Co., LLC |
| MoGYSR | Ministry of Gender Youth Sports and Recreation | VCT | Voluntary Counseling and Testing |
| MoHSW | Ministry of Health and Social Welfare | WFP | World Food Programme |
| MSF | Medecins Sans Frontieres | WHO | World Health Organization |
| NAC | National AIDS Commission | | |
| NASA | National AIDS Spending Assessment | | |

Acknowledgements

The team would like to thank the National AIDS Commission for its support for the NASA in Lesotho. It led the process by obtaining permissions, providing staff, guidance and meeting logistical requirements.

The German Technical Cooperation (GTZ) provided funding to help UNAIDS provide technical support for the NASA.

The UNGASS committee provided much needed guidance in carrying out the NASA and helped remove roadblocks to accessing data.

The Principal Secretary and Director General of MoHSW helped us access information that was available in the ministry. The STI, HIV and AIDS Directorate at the ministry provided immense amount of assistance during the NASA data collection. The Health Planning and Statistics Unit (HPSU) of the MoHSW provided support with the data collection and designing of certain aspects of the study. Constant consultations with HPSU were essential for achieving the goal of reporting the expenditure on HIV and AIDS through the health system. It is also important to acknowledge the assistance of the line ministries in providing expenditure information on HIV and AIDS.

The team would also like to appreciate the continued support of the development partners and the UN family. They not only provided data, but also helped motivate their grantees to assist the team.

We would also like to thank TSF for providing technical assistance during the NASA.

This acknowledgement would not be complete without thanking the civil society organizations in Lesotho that have been some of the most keep respondents. Last, but not the least, we are grateful and thank all the respondents who took time to be interviewed and provided us with their expenditure records. Each one of the respondents tried their best to give whatever information they could to assist in carrying out this assessment.

Executive Summary

Lesotho in Southern Africa has an estimated population of 1.8 million people. Out of this population approximately 270,000 are HIV positive as per estimates carried out towards the end of 2007. Also there are an estimated 62 new HIV infections and 50 deaths due to AIDS per day. The National AIDS Commission decided to carry out what is known as a National AIDS Spending Assessment (NASA) in 2007. The results of this assessment were to be used for in-country policy and UNGASS's reporting requirements. The data on expenditure shows a percentage of the real expenditure on the ground. In some cases, such as prevention and OVC support, it is estimated to show approximately 80% of the overall expenditure on HIV and AIDS. This round of the NASA looked at expenditure from public and international sources. Private expenses were *not* included in this report.

Overall expenditure captured for 2005/06 was M257.43 million and for 2006/07 was M189.04 million. At the time of writing of the report, 2007/08 expenditure was at M259.89 million. Expenditure of funds from national sources was steady during 2005/06 and 2006/07 at approx. M76 million. While international sources of funding saw a reduction from M164.85 million to M104.62 million during the period 2005/06 to 2006/07. Most areas of expenditure on HIV and AIDS saw a decline going into 2006/07 when compared to the levels in 2005/06. At the same time, overall spending priorities in percentage terms were maintained as per the National Strategic Plan during the two years. However, whether these percentage levels gave adequate absolute funding is another issue altogether. Public funds were largely spent on care and treatment, OVC education and coordination. There was no targeted social protection programmes for HIV and AIDS, which is evident in the lack of expenditure information. International funds were spent on a wider spread of areas.

Prevention expenditure for 2005/06 at M38.53 million and for 2006/07 at M19.24 million was focused on wide range of issues. There was a drop in expenditure in the area, and the biggest drops in expenditure was in condoms, communication for social and behavioral change, voluntary counseling and testing and prevention targeted at youth. Sustained funding was available for PMTCT and STIs since they were part of the health systems funding.

Care and treatment saw a lesser pronounced funding drop, from M73.95 million in 2005/06 to M62.43 million in 2006/07. The decreased expenditure was due to a reduction in nutritional support for ARV therapy and a drop in a key variable¹ used for estimating OI treatment expenditure.

For both 2005/06 and 2006/07, PLWHA saw the largest expenditure directed towards them as a beneficiary and OVCs saw the second largest expenditure. While in both the years, the general population saw the largest expenditure on prevention directed at them.

It is interesting to note that three faith based organizations (World Vision, CRS and CHAL) spend more money in Lesotho on HIV and AIDS than all national NGOs (incl. Lesotho Red Cross Society and Lesotho Save the Children) put together. Also, international NGOs provide more services, in terms of monetary value, than parastatal agencies.

¹ The number of HIV positive inpatients in 2006 saw a large decline in Quthing Hospital. This may be due to practices on diagnosis recording and not actual HIV positive patients admitted. The estimation method used Quthing as a proxy for other District hospitals. To validate and moderate the effect, data was also collected from Butha Buthe Hospital used to adjust the proxy.

Introduction

Global and Regional Epidemic

HIV and AIDS epidemic continues to pose the greatest threat to human health and development, and managed to destroy both the social and economic fabric of societies. The epidemic has already claimed 2.1 million lives each year and another 33.2 million people are currently living with HIV and AIDS world wide. Most of HIV and AIDS cases are reported in the developing world with the Sub-Saharan nations being the worst affected. The epidemic has caused a shift in the resource allocation globally and nationally, with more resources at national and household level being re-directed to health expenditure.

The world has to cope with this devastating situation and immediate efforts are needed to curb the spread of the epidemic and improve the livelihood of the people. The epidemic has called for a global action to fight against HIV and AIDS epidemic, and these lead individual countries to align their national policy frameworks with the international agenda. The action plans to fight the epidemic were set at all levels, international, regional and national arenas as a way of governments to show their political commitment

In 2001 during the United Nation General Assembly Special Session, a Declaration of Commitment on HIV/AIDS was endorsed by the leaders of 189 countries. The Declaration is the first global "battle plan" against AIDS and was also a global call for the resources that were (and are) so urgently needed. The declaration established the necessity of a monitoring process which requires the submission of periodic reports to UNAIDS on national progress focusing on domestic HIV programs. A set of indicators were established to allow the General Secretariat and member states to follow-up on the accomplishment of the different goals of the declaration.

The declaration rests on three principles and they are as follows;

- one coordinating authority
- one multi-sectoral strategic policy framework
- one monitoring and evaluation framework

National Status of the Epidemic

The population of Lesotho is estimated at 1,880,661 of which males constitute 916,282 and females 964,379². Lesotho is ranked third with adult HIV prevalence rate of 23.2% in the world. The estimations reveal that there are 62 new HIV infections and about 50 deaths due to AIDS each day. So there is an estimated 270,000 people living with HIV in Lesotho in the latter part of 2007. Of these, there are 11,809 infected children and 258,472 adults. Females continue to be more infected with HIV with an estimated 153,581 infected as compared to their male counter parts with an estimated 116,692 infected. There has been no significant change in the national adult HIV prevalence since 2005 and this shows that the prevalence is stabilizing. The sentinel surveillance conducted in 2007 showed that there is no major difference in HIV prevalence among women attending ANC clinics³.

² Bureau of Statistics, Census 2006 Preliminary Report

³ UNGASS Report 2007

Lesotho National Strategic Plan for HIV and AIDS 2006-2011

Given the intensity of the epidemic and both the national and international commitments made by the country there was a need to develop one strategic policy framework backed up by a comprehensive national HIV and AIDS monitoring and evaluation framework. The purpose of the National Strategic Plan (NSP) is firstly to articulate, disseminate, and educate the public at large on agreed national priorities and strategies within a five year period (2006-2011). Another purpose is to provide a clear guidance for Ministries, districts, NGOs, the private sector and other stakeholders to enable them to work in collaboration towards achieving the intended goal of the National Response to HIV and AIDS, which is to:

“scale up universal access to information, knowledge and services to enable individuals to protect themselves from HIV infection and access treatment, care, support and impact mitigation services, and emphasize with those affected by HIV and AIDS”⁴

Key Strategic targets and focus areas:

- Management, coordination and support;
- Prevention
- Treatment, care and support; and
- Impact mitigation

Table 1: General targets from the National Strategic Plan 2006 - 2011

| <i>Impact Indicator</i> | <i>Baseline Year</i> | <i>Target Year</i> |
|--|-----------------------------|---------------------------|
| | 2005/2006 | 2011 |
| New infections reduced from 2.9% per year in 2005 to less than 2.0% per year | 2.9% | 2.0% |
| Prevalence of mother to child transmission of HIV reduced | 25% | 10% |
| Percentage of AIDS orphans identified and accessing OVC services increased | Not available | 90% |
| Persons needing ART and able to access free ART services increased | Not available | 80% |
| PLWHAs have disclosed their status and are involved in reinforcement of positive living for those living with HIV/AIDS | Not available | 30% |

Resource Mobilization for the Fight against HIV and AIDS

The declaration of commitment serves as a platform for global resource mobilization for the fight against HIV and AIDS, and also enables countries to increase financial resources available for the HIV and AIDS. Since the adoption of the declaration of commitment in 2001, the global financial resources increased from 1623 million USD to an estimated 10 billion USD by the end of 2007. It is evident that the resources allocated for HIV and AIDS have increased globally.

⁴ National Strategic Plan 2006 - 2011

As a response, it was necessary for the country to mobilize resources for the fight against HIV and AIDS and comply with its commitments. With the aim to reduce HIV prevalence in Lesotho, it is estimated that a minimum of USD 547⁵ million will be required for the period 2006-2011. There are many partners committing resources to fight the epidemic, which include Irish Aid, United States Government-PEPFAR, European Union, GTZ, DFID, and the Global Fund for AIDS, TB and Malaria, World Bank as well as UN family.

For the decision making process and formulation of policies aimed to reduce the spread of HIV and AIDS epidemic there is a need for tracking the use of the funds. It is crucially important on the basis that it reflects precisely which areas need more funding and which has been overlooked during allocation of the funds. In a nutshell, it indicates how resources can be effectively and efficiently allocated to all areas targeted to combat and reduce HIV infections. Thus, to perform this task, it was found worthwhile to collect financial information from donor partners, governments departments, multilateral agencies, foundations and NGOs, CHAL and other stakeholders involved in the fight against HIV and AIDS.

Lesotho's NASA

The National AIDS Spending Assessment (NASA) is a tool designed to track the HIV and AIDS financial flows and actual expenditure at a country level. In essence, this systematic methodology captures all HIV expenditures, namely, health and non-health expenditures such as social mitigation, education, labour, justice and sectors related to HIV and AIDS. In addition, it follows the flow of funds from their origin down to the final destination being the beneficiaries receiving goods and services. NASA is one of the data sources for UNGASS indicators that are used to collect accurate and consistent data on how funds are spent at the national level and where those funds are sourced. This is tracked by financing source whether it is public, private or foreign and among the different providers and beneficiaries (target groups). It is utmost importance on the grounds that it furnishes the results that would be used to analyze the efficiency and the effectiveness of resource allocations for all HIV and AIDS programmatic areas.

The Lesotho NASA will include the tracking of expenditure for public sources, external sources, flow of funds from their origin all the way to the beneficiaries and will cover the financial years 2005/06 to 2006/07, and whatever data available for 2007/08. The HIV and AIDS spending will be captured at the national and district levels and the beneficiaries of spending will be identified in as far as the data allow. The production factors will not be included, except if easily available for the ARV program.

It should be noted that the data for private sector and financial year 2007/08 will not be part of the analysis but will be included under the annexes

Study Objectives

The overall goal of NASA is to contribute to the strengthening of comprehensive tracking of actual spending (from international/external and public sources) that comprises the national response to HIV and AIDS in Lesotho, to leverage both technical and financial support for the development, implementation, management, monitoring and evaluation of the national response.

⁵ The resource need does not include the new WHO guidelines for ART that have increased the ART needs in the country to approx. 81,000

The overall aim of the project is to implement the NASA in Lesotho, for the years 2005, 2006 and 2007.

Specific objectives of the assessment are:

- To identify and measure all domestic/public and international/external expenditure on HIV and AIDS in Lesotho for the years of assessment, and to present these according to the thematic AIDS Spending Categories.
- To build the capacity of NAC's NASA research team to undertake the NASA.
- To develop tools and systems for tracking of resources for all implementers on an ongoing basis within NAC.
- To catalyze and facilitate actions which strengthen and institutionalize country level tracking of expenditure, and co-ordination by NAC.
- To synthesize this data into strategic information products to inform decision-making.

Definition of Concepts

Most of the terms used in the study would be clearly understood by the reader. There are however some terms that form definitions inside the NASA classifications. To make sure all the readers have a similar understanding and understand the scope of terms such as Human Capital, their definitions are listed below:

AIDS Spending Category (ASC) – it is the broad categories to which the assessment assigns expenditure on HIV and AIDS. Any expenditure captured has to be for a function / an ASC (used interchangeably). The basic 8 ASCs or functions are defined below.

Prevention – set of activities or programmes designed to reduce risky behaviour. Results include a decrease in HIV infections among the population and improvements in the quality and safety in health facilities in regard of therapies administered to HIV and AIDS patients.

Care and Treatment – all expenditures, purchases, transfers and investment incurred to provide access to clinic and home/community-based activities for the treatment and care of HIV-infected adults and children.

Programme Management and Administration Strengthening – expenses that are incurred at administrative levels outside the point of health care delivery e.g. M&E, management of AIDS programmes, facility upgrading through purchases of laboratory equipment and of telecommunications, etc.

Human Capital – expenditure on health care workers and managers who work in the HIV and AIDS field through their recruitment, retention, deployment and rewarding of quality performance.

Social Protection and Social Services – functions of government relating to the provision of cash-benefits and benefits-in-kind to categories of individuals defined by needs such as sickness, old age, disability, unemployment, social exclusion, and so on.

HIV and AIDS-related research – generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well being.

Out of Pocket Expenses – it is expenditure carried out by households and individuals to get services related to HIV and AIDS. For example, household income spent on treatment and care services and pooled funds of support groups to provide support.

Methodology

This section contains a description of the approach, methods and limitations of the National AIDS Spending Assessment (NASA) conducted in Lesotho.

Overall Approach

NASA's methodology supports the compilation of consistent estimates, reasonably comparable over time and across countries. Robustness to inter-temporal comparison is critical. A key concern of the international community and national decision makers is to track the degree of effectiveness of the efforts to increase overall resource availability. Consistency of the measurement concepts, captured at different points in time, is essential to ensure that valid comparisons are possible. The equitable and efficient distribution of resources between countries constitutes a key concern of the international community⁶.

The multi-sectoral approach without efficient and effective central coordination leads to an uncoordinated and fractured response. Unless there are very few financiers of the response, it is extremely difficult to get a single view of the final outcome of the cumulative financing in a country. Thus the NASA looks to provide a view of the combined effect of the individual responses of the different sectors. This is important for directing the national response and enables a coordinating body to carry out its function.

NASA is aimed at capturing most of the financial transactions occurring in relation to HIV and AIDS. NASA identifies the financing sources, financing agents and service providers, that is, it follows the financial transaction from its source down to the final destination (i.e. the beneficiaries receiving goods and services). Financing sources are entities that provide money to financing agents, financing agents are entities that pool financial resources to finance programmes of provision of services, and providers are entities that engage in the production, provision and delivery of HIV and AIDS services. 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.

NASA methodology combines both the bottom-up and the top-down procedures. Bottom-up procedure involves building up expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts, whereas top-down procedure involves breaking down expenditures from sources of funds e.g. donor reports, commitment reports and governmental budgets. This matrix reflects the ability of many low-per-capita income countries to deliver – for their own goals as well as for those of the community of nations – appropriate information about the resource flows, the costs and the price of services and goods delivered for hundreds of activities contributing to the fight against the HIV and AIDS epidemic.

NASA serves several purposes within different time-frames. In the short term, NASA might be used to provide information on the UNGASS indicator for public, international and private expenditure: in the longer-term, the full information provided by NASA may be used to:

⁶ UNAIDS. 2007. National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level. Joint United Nations Programme on HIV/AIDS (UNAIDS). UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, World Bank, 2007

- Monitor the implementation of National Strategic Plan
- Monitor advances towards completion of internationally or nationally adopted goals such as universal access to treatment and care
- Provide evidence of compliance with the principle of additionality required by some international donors or agencies; and
- Lead to evidence based programming

Preparatory Phase

Team Formation & Training

On 1st October 2007 the Section Head for Monitoring and Evaluation (M&E) attended a five day training workshop on NASA in Johannesburg. On 19th November 2007 a consultant joined to carryout the assessment. The recruitment process at UNAIDS for research assistants was carried out in early December after which on 12th December the research assistants joined to form the Lesotho NASA team. Training for them was conducted in the second week of December 2007 for one day. The NAC also recruited another two research assistants who attended trainings, but were only able to join the team in early January. The NASA team comprised of members from NAC and UNAIDS.

Database of all Stakeholders

A database of all the stakeholders involved in HIV and AIDS was developed using the NAC's information (e.g. NAC grantees) and UNAIDS database. This database was further built upon during the course of the fieldwork. Based on our interactions with NGOs and development partners about their implementing partners, we kept going on level down till we reached the agency that actually implemented the program on the ground.

Obtaining Permissions

Letters asking for the permission to collect the data were sent to selected government ministries, external and internal agencies working on HIV and AIDS by NAC. The letters were delivered during the month of November. The office of the Principal Secretary of the Ministry of Health and Social Welfare prepared a memo to all the health centers in an effort to facilitate the data collection. Since it was the first NASA, some of the larger agencies with multiple departments that deal with the pandemic, did not have clear guidance through the letter on where to circulate within the organization.

Finance Personnel Workshop on NASA

The NASA requires detailed information that functionally fits between the finance and programme staff of an organization. Since the larger agencies would need a long lead time to report on the data the finance personnel from these agencies were trained on the NASA process, while the recruitment of the research assistants was being carried out. Some government ministries and NGOs were invited and trained on the NASA. It involved giving them a rundown of the NASA followed by practical filling of the questionnaire by using test cases. A number of agencies showed interest in getting a copy of the NASA classification document. They were given a copy and provided with the link where they could access the latest versions in the future.

Data Collection

Adoption and Administration of Questionnaires

The UNAIDS NASA questionnaires were sent to the key respondents and appointments then made during which the data was requested and the forms completed. Generally the questionnaires were too complicated to be self administered, therefore researchers undertook extensive searches for the information and held interviews with key persons, which were necessary to unearth the information required. In a number of cases, donors requested simplified forms of the questionnaires to be sent to them so that they could reply to key questions through mail. Thus sections of the questionnaires were adapted into excel sheets that some donors and NGOs duly filled and sent back.

Sources of Data

Detailed expenditure records were obtained from the majority of primary sources of data for all the three financial years 2005/06, 2006/07 and 2007/08. For the purposes of this study the government's financial year was used (from 1st April to 31st March). In some cases data was not available or was obtained from secondary sources (e.g. expenditure of some NAC grantees and GFATM Grantees was captured from NAC and GFATM reports respectively). A detailed list is available in appendix I. The objective of the assessment was to capture all expenditure on HIV and AIDS, thus *all* agencies that were known to work in the field were contacted. Only in the case of line ministries were five ministries targeted. The criterion was the size of their HIV and AIDS programs. The list of ministries is:

- Ministry of Health and Social Welfare,
- Ministry of Gender, Youth, Sports and Recreation,
- Ministry of Education
- Ministry of Local Government and Chieftain Affairs
- Ministry of Agriculture and Food Security

Qualitative Data Collection and Analysis

The qualitative questions were extracted from the questionnaires seen in appendix VI. There were separate questions for sources and providers/agents. These questions were circulated to the agencies part of the assessment. The responses were analyzed based on qualitative data analysis principles and some key points are mentioned.

Estimation of Expenditure on STI and AIDS through Health System

The expenditure on STI and AIDS through the health system has been captured through estimations. The unit costs for each of these services were available for some hospitals. Based on the location, management and size of the hospitals, the unit costs for the others were estimated. These unit costs were then multiplied with the number of time these services were used. In the case of STI services, it was the number of out patient visits. While in the case of AIDS patients in IPD, the proportion of total patients that were AIDS patients were used. For a more detailed methodology, please refer to appendix IV.

Drug Procurement & Supply Costs

The procurement of drugs for the health system in Lesotho is through a nodal agency called the National Drug Supply Organization (NDSO). Its procurement activities are controlled through the Pharmaceutical Unit (PU) of the MoHSW. A committee at the MoHSW sits to assess the ARV needs of the country on a periodic basis. Its outcome is to maintain sufficient

stock levels within the country. For the purpose of the NASA, expense was considered to be accrued at the NDSO. This meant that stocks procured by NDSO were recorded as expenditure in the given period.

It is the job of the NDSO to provide central warehousing and logistics facility. Thus the operating expenses of the NDSO were accounted towards the drug supply system (DSS). After conducting interviews with the finance manager and operations manager, it was ascertained that 14% of the operating stock handled by NDSO was HIV and AIDS related. Thus 14% of the operating expenses were accounted as DSS expenditure.

Data Processing

The data was received in form of both hard and soft copies from donor reports and providers' expenditure reports. The data collected was first captured in the primary excel sheets. The data was verified at the primary excel sheet stage to ensure its validity from the records of the source, the agents and the providers and also to avoid double counting. After verification, the data was moved to the data processing file to ensure completeness of the data. The entered data was checked, discussed by the team to ensure correct classification and cleared for entry at this stage. The data was then transferred to the NASA Resource Tracking Software (RTS), which has been developed to facilitate the NASA data analysis. The RTS outputs were exported to Excel to produce summary tables and graphics describing HIV and AIDS financial flows in several combinations for analysis.

Assumptions

A few development partners had different financial year periods from that used by the government. Effort was made to capture the actual expenditure according to the government's fiscal year (from 1st April to 31st March). However, for some partners (e.g. UNICEF, World Vision, and ActionAid) that proved very difficult. Given the shortage of time, it was decided to assume that the expenditures fell into the government's fiscal year, and that the slight inaccuracies would be corrected for in the following year.

Where the funds are pooled, the specific contribution of donor to the activities was assumed to be proportional to their contribution to the total income. The same rationale was also applied to any other spending.

Limitations

This report is the first attempt to show national picture of all expenditure on HIV and AIDS. It has a number of limitations, and a majority of them stem from the financial record keeping and monitoring and evaluations systems in the country. Key limitations that impacted the report are listed below:

- The data collection process was carried out during the months of December, January and February which were not ideal. Thus the actual time available to capture data was not adequate for the timelines set.
- Only five ministries were interviewed based on the size of their HIV/AIDS programs, the Office of the Prime Minister and First Lady were asked for expenditure on public funds. The team attempted to focus its resources given the time constraints.
- Expenditures that could not be definitively classified were recorded under programme management.
- Estimations on expenditure on AIDS through the health system were not able to capture the resources spent on TB other than inpatients diagnosed with TB and AIDS.

It is known that there are other expenditures on TB, such as drugs and DOTS, but these were not captured.

- Expenditure on STIs in 2006/07 is based on patient data for only one quarter. Thus there may be an almost three times increase in STI expenditure in said year.
- The only out of pocket expenditure on HIV and AIDS captured in this report was consultation fees paid by users for prevention, diagnosis and treatment of STIs.
- No other private source of funds spent on HIV and AIDS were captured in this report.
- In order to capture data on salaries of both health and non-health personnel, it would take time to disaggregate what percentage of salaries goes to HIV and AIDS related activities and what proportion of staff time is spent on HIV and AIDS activities. Therefore, given the short timeframe of the study, such data was not included.
- Finally, it is known that the GoL through the MoHSW provides CHAL hospitals with funds for providing care and treatment services. These funds are provided as salaries for some staff in CHAL hospitals. However, since the actual amounts and positions funded are not known, these amounts are shown as CHAL funds.

Findings of the NASA

The output of the assessment is a set of pivot tables that are crossed between the sources of funding, programming agents, implementing agencies and the category they fund or the beneficiary that gets the fund. The findings below would take these matrices and present some basic information on funding flows. The NASA is also meant to provide information for policy makers. As such the basic matrices are the best sources for them to mine for specific information. At the same time the NASA team during its consultations has had an opportunity to be a part of the current policy level discussions in the country. Therefore some of the findings would be presented to provide evidence for these discussions. ***All the figures mentioned in this section are in Maloti unless specified.*** Also the reader must keep in mind that unless reported to the NASA team, the expenditure would not be present in these findings.

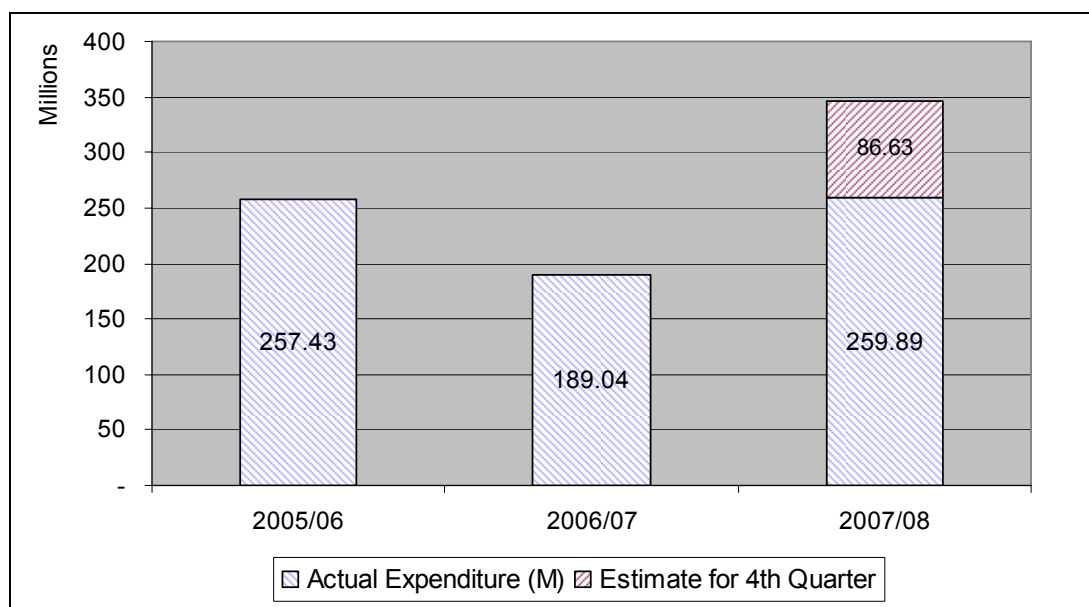
Total Expenditure on HIV and AIDS in Lesotho

The expenditure on HIV and AIDS was assessed for the year 2005/06, 2006/07 and 2007/08. Since the study was conducted during the financial year 2007/08, most agencies reported till the last quarter or first half of the financial year.

The total expenditure during the financial year 2005/06 was M 257.43 million which reduced to M 189.04 million in 2006/07, as shown in Figure 1. There are a number of causes for the reduction in expenditure. The major causes are listed below:

1. There was an underestimation of the expenditure on STI (prevention), since OPD STI data was available for only one quarter in 2006.
2. The expenditure by the GFATM reduced substantially due to 2006/07 being declared an interim period of the Round 2. Though expenditure continued, it dropped by M 24.32 million.
3. WFP's distributions to OVC and PLWHA reduced in the financial year 2006/07.
4. Lack of bursary disbursement data from MoET for 2006/07.

Figure 1: Total Expenditure on HIV and AIDS in Lesotho for the financial years 2005/06 and 2006/07



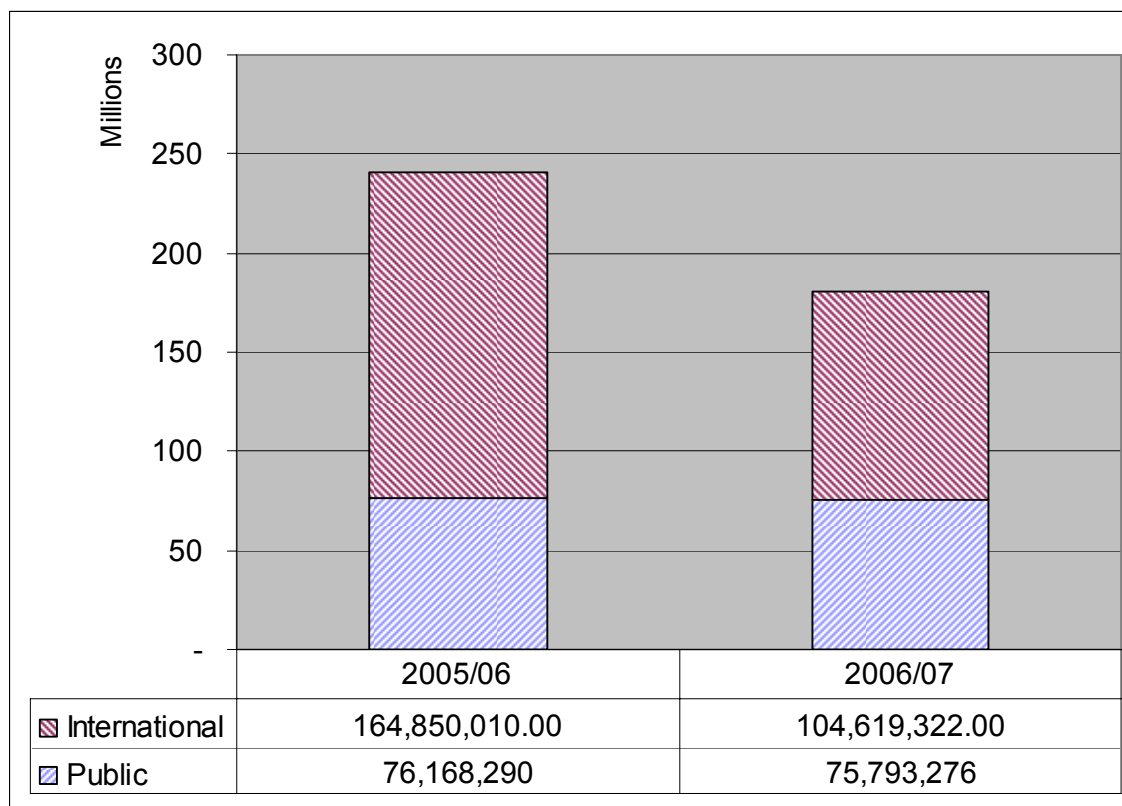
The expenditure on HIV and AIDS in 2007/08 in the above figure is M 259.89 million. A quarter of that expenditure has been added to Figure 1 as an estimate to give an idea of where expenditure is likely to reach for 2007/08 once the final set of figures are included. The total of the estimate and actual expenditure is M 324.86 million.

Total Expenditure on HIV and AIDS with Sources of Funding

The overall expenditure shown in Figure 2 is less than Figure 1 since a few of the expenditure items did not have clear sources of funding. This was in the case of estimates of the hospital costs which included OI treatment (T&C) and STI treatment (Prevention).

As can be seen from the figure below, the overall spending on HIV and AIDS from public sources remained sustained over the period 2005/06 to 2006/07. At the same time the expenditure from international sources decreased during the said period. This can be attributed to the reasons stated in the previous section. The private sources captured during this assessment are the amount spent by NDSO on the drug supply system through its earnings and the fees paid by HIV +ve patients at facilities for OPD services. The amount stated in 2006/07 reduces due to the unavailability of three quarters of STI OPD data.

Figure 2: Total Expenditure with Sources of Funding for 2005/06 and 2006/07⁷



⁷ The shortfall in the expenditure reported for 2005/06: M 15,536,547 and 2006/07: M 8,440,518. This is due to the design of the hospital estimation method that uses unit costs to estimate expenditure on OI and STI Treatment. The sources of funding when using this method are not clear

As was mentioned in the study objectives, this assessment does not capture private expenditure on HIV and AIDS. However, while carrying out the assessment, a private source of expenditure was recorded in the form of out of pocket expenses (OOPE). This is the fees paid by users of STI out patient services at hospitals of GoL and CHAL. The total amount for 2005 was M 872,375 and 2006 (only one quarter) was M 189,952.

Expenditure Breakdown by AIDS Spending Category

The spending on the eight ASC is given in Figure 3. It gives a national perspective of the overall spending outcomes. It shows the spending on treatment & care being sustained over the two years. Expenditure on prevention, OVC, enabling environment reduced over the period 2005/06 to 2006/07. While the expenditure on Research, Human Capital and Programme Management increased. Each of these trends is analyzed below.

The reduction in expenditure on prevention from M 38 million to M 19 million can only partly be attributed to incomplete STI figures. To a large extent the reduction was indeed due to fewer funds being actually spent on it.

The reduction in the expenditure on OVC shows the reliance on one development partner in this crucial mitigation area, reduced movement of tonnage by WFP in 2006/07 lead to a gap being created in the expenditure. To some extent this situation has been mended through the EU's and GFATM Round 7's long term focus on OVC. Another aspect of OVC funding during the period under study has been discussed later in the report.

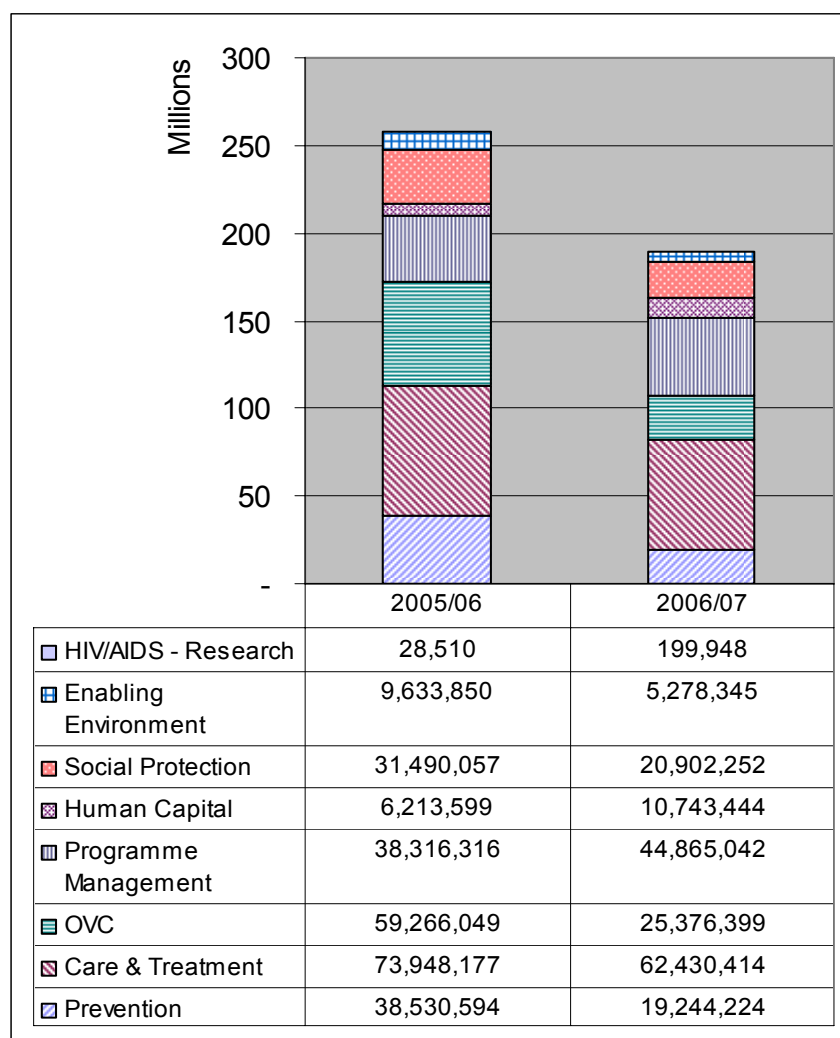
Research, Human Capital and Programme Management and Administration has seen increase in expenditure during the said period. Human Capital in this context is the expenditure on nurses, physicians and their training. It must be accepted that the expenditure captured under Research is not very representative of the actual expenditure in the country. We are quite certain the expenditure reported in Figure 3 is an underestimation. However, the answer to the question of adequacy of expenditure is clear. A number of limitations of this study stem from the unavailability of studies and research on some key indicators.

Enabling Environment has seen a decrease of almost 50% in expenditure. It shows the reduction in the expenditure on issues such as advocacy, strategic communication, human rights and institution development. This can be attributed to the phasing out of ActionAID's SIPAA project funded by DFID.

For treatment & care, despite the increased caseload, there was a slight decrease in expenditure. This decrease is inspite of the increased outlay by GoL through the STI/HIV Directorate. The reasons are listed below:

1. The GFATM Round 2 interim period saw reduced expenditure on ARV and other treatment components
2. There was a drastic decrease in procurement of pediatric ARV by NDSO using GoL funds
3. Specific to the NASA methodology, the proportion of patients admitted which were HIV +ve showed a decrease in 2006/07.

Figure 3: Expenditure Breakdown by ASC for 2005/06 and 2006/07



Expenditure Breakdown by NSP Categories

Lesotho has a costed National Strategic Plan in which the resource requirements are modeled. When we look at the expenditure required by the NSP in percentage terms we get Figure 5. To assist with in-country policy, it is important to take the NASA expenditure data and map it to NSP's programmatic categories. This was done as per Appendix II and the results are in Figure 4. However, care must be taken in drawing conclusions since the NSP costs from 2006 onwards and the NASA data is only relevant for 2006 for comparison. The priorities shown for the 2007/08 in Figure 4 come from incomplete data and may at this stage be misleading.

For expenditure in 2006/07, the absolute levels of expenditure show that there is a 50% shortfall in prevention expenditure. This may be due to lower commitments from financing sources on prevention activities, but the team also feels that it is indicative that the country's BCC strategy is still being formulated. Capacity to implement has been seen to have an impact on the overall funding flows. Even for areas such as treatment, care and support and impact mitigation, there is a shortfall in expenditure reported in the NASA; however, it is not as pronounced as in case of prevention.

Figure 4: Actual Spending Priorities based on NSP categories for 2005/06, 2006/07 and 2007/08

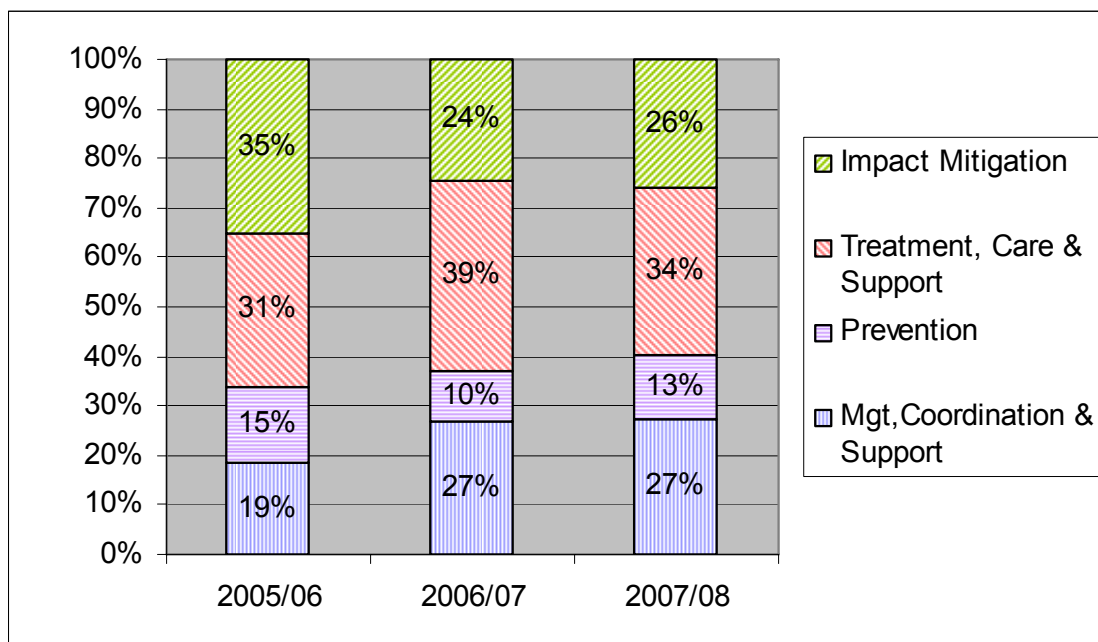
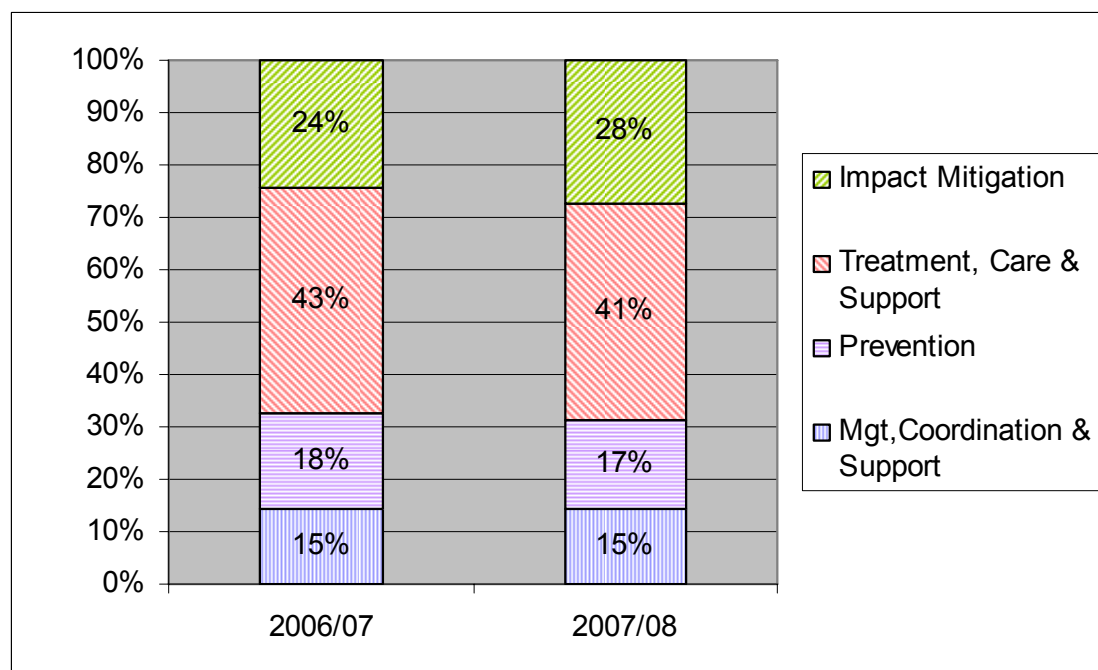


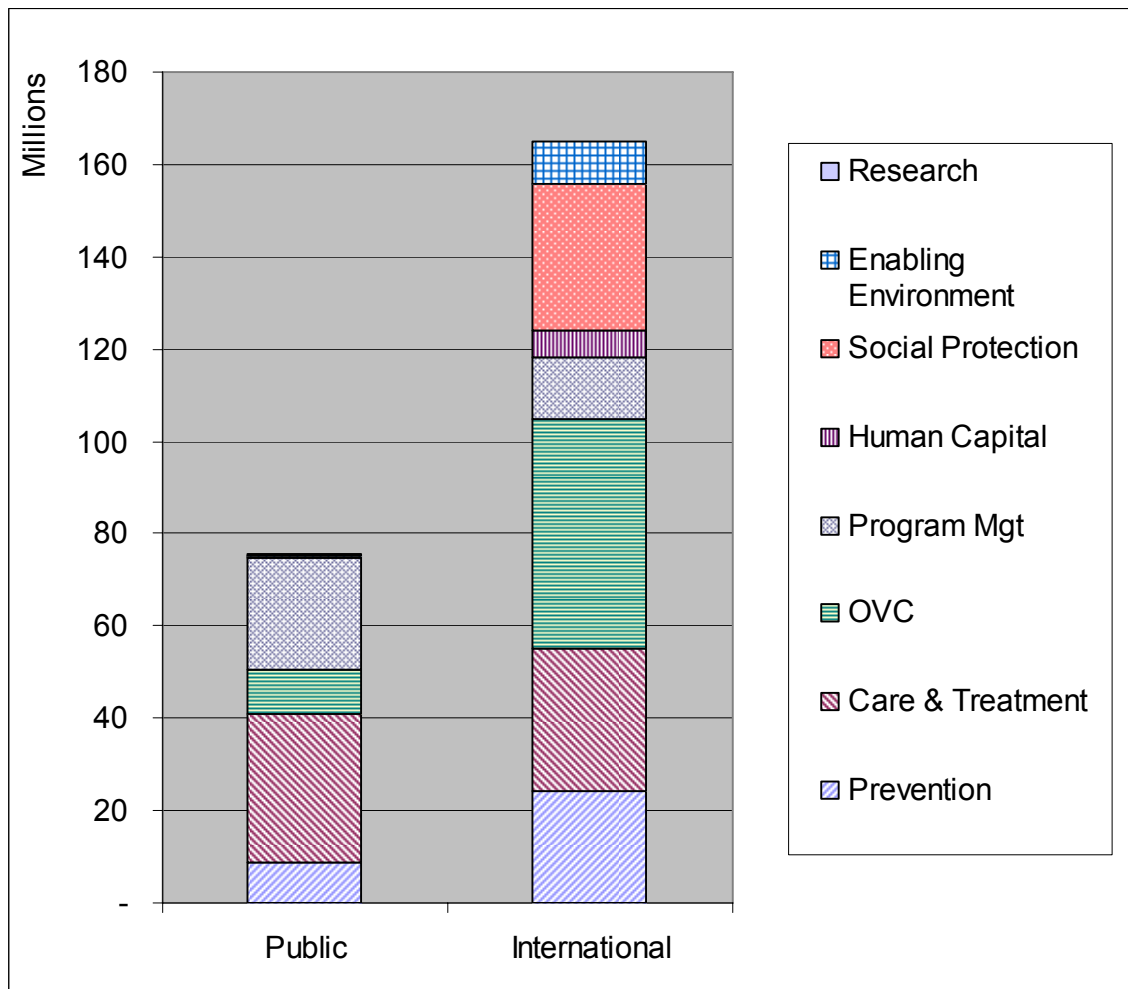
Figure 5: Planned NSP Spending Priorities for 2006/07 and 2007/08



Spending Priorities of Public and International Sources in 2005/06

As can be seen from the graph below, a larger part of the prevention expenditure comes from international sources. Also, expenditure on treatment and care is supported by both international sources and public sources of funding. Majority of the expenditure on OVC is through international sources. These sources include UN agencies, GFATM and disparate multilateral sources. Expenditure by public sources shows the bursaries given by the MoET. Spending on social protection is primarily through the WFP which provides complete household rations for PLWHA and OVC.

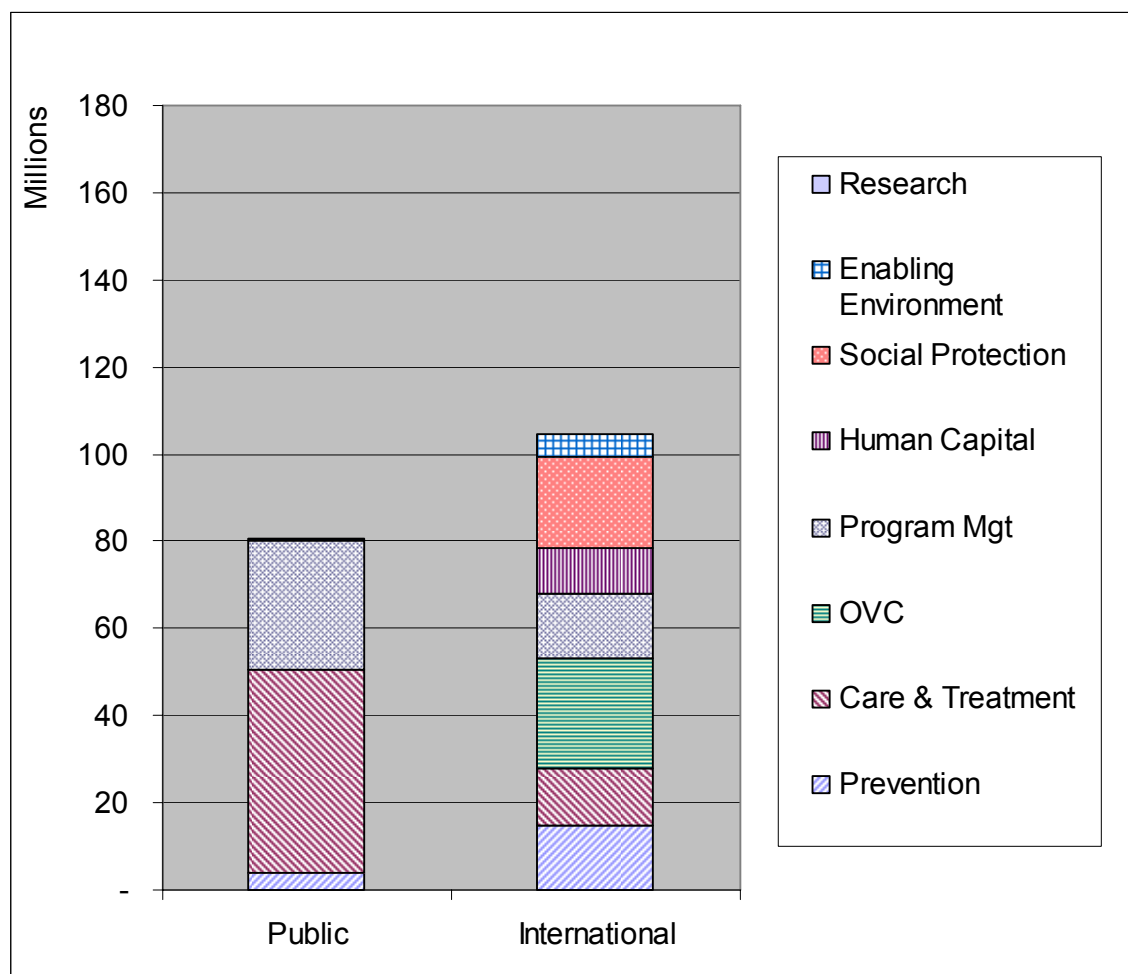
Figure 6: ASC based Expenditure Breakdown for Public and International Sources for 2005/06



Spending Priorities of Public and International Sources in 2006/07

Due to the sustained funding from GoL and reduced funding from international sources in the financial year 2006/07, the overall contribution from GoL has increased. Again the 2006/07, the spending on prevention came from international sources. More importantly, the overall expenditure decreased in both actual and percentage terms over 2005/06. The expenditure on treatment and care was sustained by the GoL despite decreases in expenditure from international sources (GFATM Round 2) over the fiscal year. Thus its percentage in the overall pie increased in light of overall decrease in expenditure. Information related to disbursal of bursaries by MoET in 2006/07 was unavailable which led to unreported expenditure on OVC by GoL.

Figure 7: ASC based Expenditure Breakdown for Public and International Sources for 2006/07

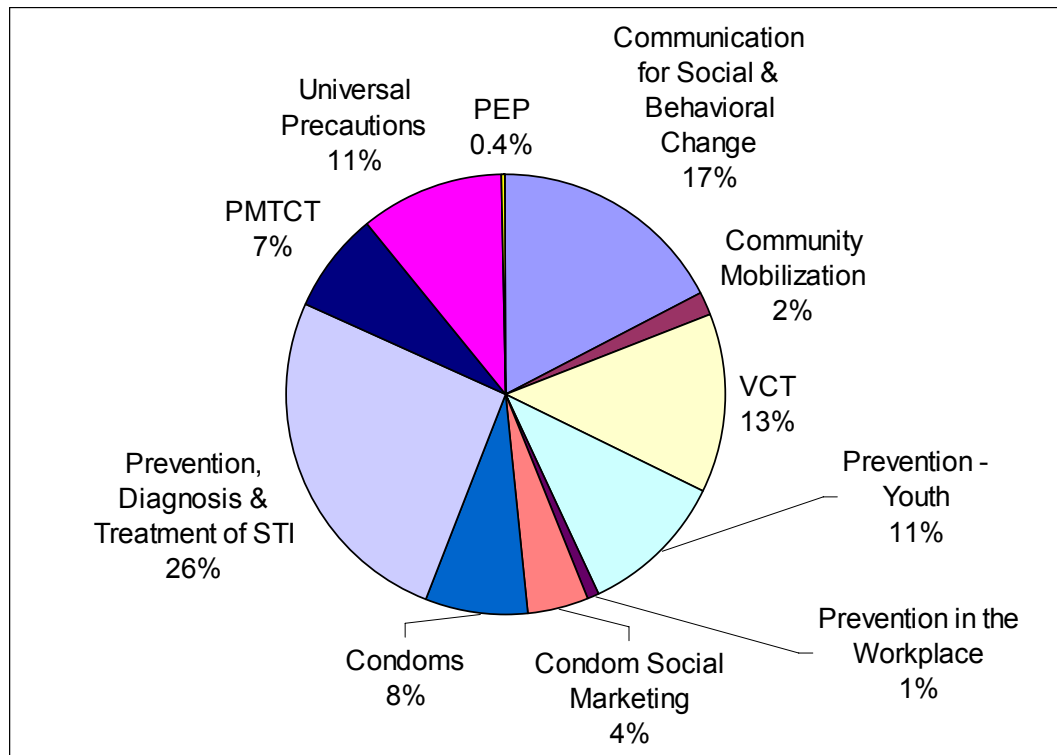


The scales in figures 5 and 6 were kept the same to allow for visual comparison of actual expenditure levels by observing the height of the individual blocks for both public and international sources.

Expenditure on Prevention Activities

The largest amounts of spending in the financial year 2005/06 were in the areas of STI management (26%), communication for social and behavioral change (17%) and VCT (13%). There is no reported expenditure on prevention activities targeted at PLWHA. This is an important area of programming given the nature of the pandemic in Lesotho. The overall breakdown is provided in Figure 7 below.

Figure 8: Prevention Expenditure Percentage Breakdown for 2005/06 from all sources



Similarly for expenditure during 2006/07 in the area of prevention, the priorities are PMTCT (30%) followed by VCT (13%) and STI management (12%) and condom social marketing (12%). Even in 2006/07, there is no reported prevention expenditure on PLWHA and MARPs. This shows little specifically targeted prevention interventions for these populations.

It would be important that the reader does not look at Figures 7 and 8 and try to assess priorities across financial years 2005/06 and 2006/07. Figure 9 on the facing page would be the current place to do such analysis.

The largest spender on prevention activities for social and behavioral change, youth, condoms and VCT in the year 2005/06 was the GFATM. The drop in expenditure from GFATM Round 2 led to reduction in actual expenditure in these areas in 2006/07. Community mobilization and PMTCT saw increased expenditure. Larger amount of expenditure can be attributed to both the governments scale up of the PMTCT intervention and expenditure by UNICEF. Spending on condom social was scaled up over the two years. It was due to sustained sourcing and expenditure through agencies such as PSI. The expenditure on PEP was largely due to procurement of drugs meant for PEP by NDSO. Its actual usage in the field however is not clear. The prescribed drug for PEP has a number of side-effect and thus a different regimen is used in the facilities.

Figure 9: Prevention Expenditure Percentage Breakdown for 2006/07 from all sources

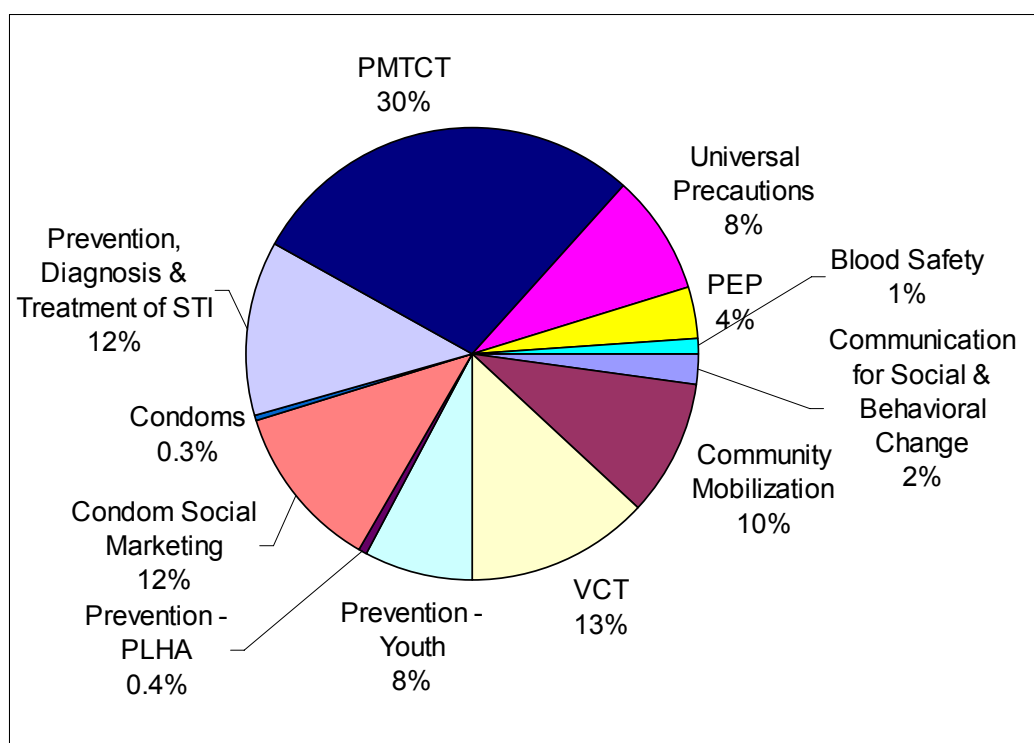
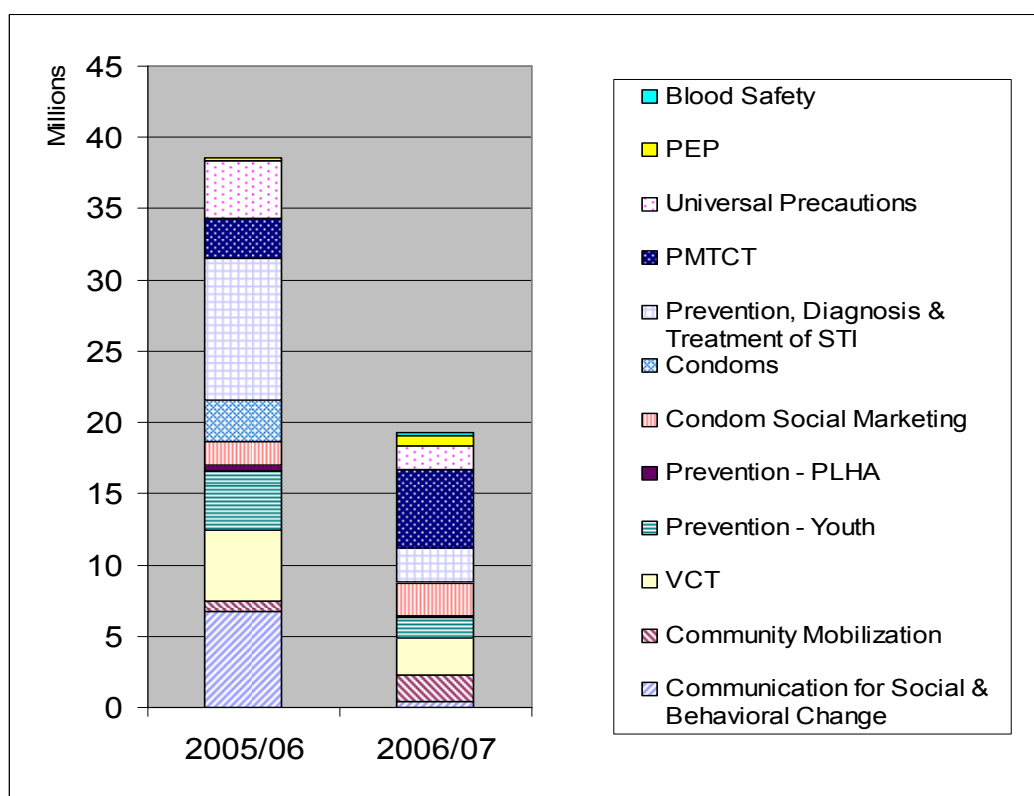


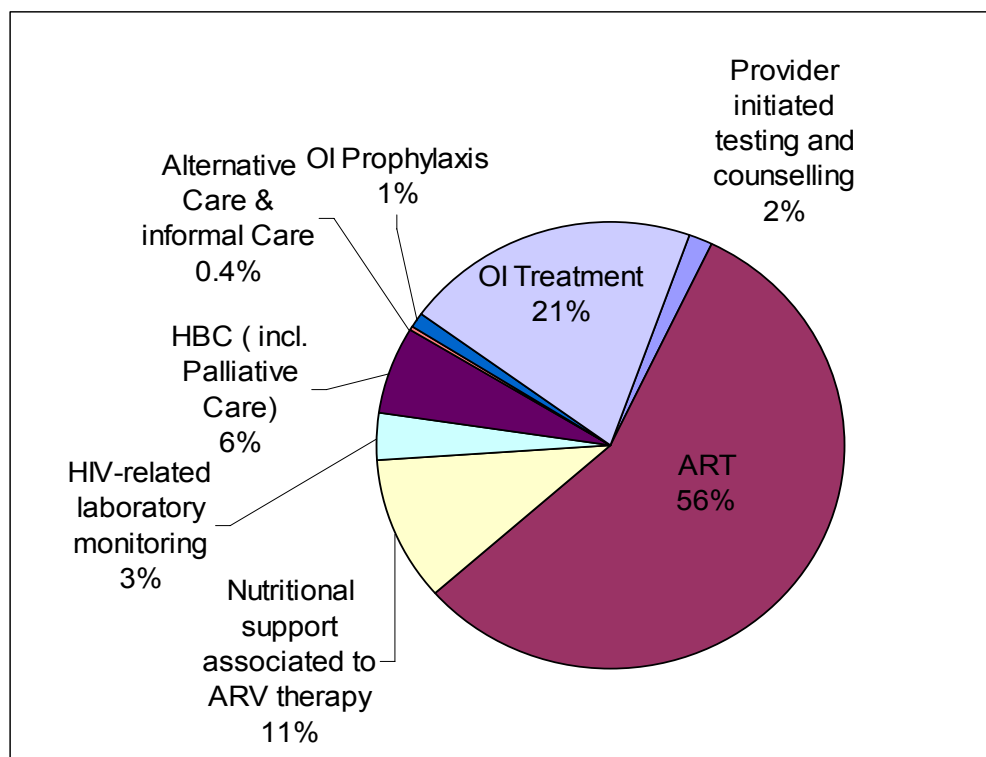
Figure 10: Prevention Expenditure Breakdown for all sources in 2005/06 and 2006/07



Expenditure on Treatment & Care Activities

The largest portion of the expenditure under treatment and care in the financial year 2005/06 was on ART. In this assessment it shows the expenditure on ARVs (56%) by the GoL and other donors. The next highest reported spending is on OI treatment (21%). This primarily consists of the expenditure on drugs and inpatient care provided to HIV +ve patients. Nutritional support (11%) has been provided largely by the WFP and in some small measure for pediatrics by UNICEF. WFP provides the family rations to food insecure HIV +ve patient's households that access the ART clinics. The expenditure captured for provider initiated testing (2%), HIV-related laboratory monitoring (3%), HBC (6%) and OI prophylaxis (1%) is from the inputs procured. These would include test kits, drugs and HBC kits, but not human resources or capital expenditure.

Figure 11: Treatment & Care Expenditure Percentage Breakdown for 2005/06 from all sources



There are definitely much better methods possible for accounting of the HIV-related laboratory monitoring. However, they are dependent on a more robust accounting and unit cost estimation of the tests carried out for HIV +ve patients at the central laboratory and those sent to South Africa.

For expenditure in 2006/07, the largest expenditure again was on ART (68%). OI Treatment saw a reported expenditure of 13.6% from the overall amount spent in Lesotho on treatment & care. These were followed by nutritional support (9%), HIV-related laboratory monitoring (4%) and HBC (3%). Patient transport was a small part of the expenditure in 2006/07 which was reported by the Baylor's pediatric facility. A small proportion of expenditure remained in both the years on alternative care and informal care.

Figure 12: Treatment & Care Expenditure Percentage Breakdown for 2006/07 from all sources

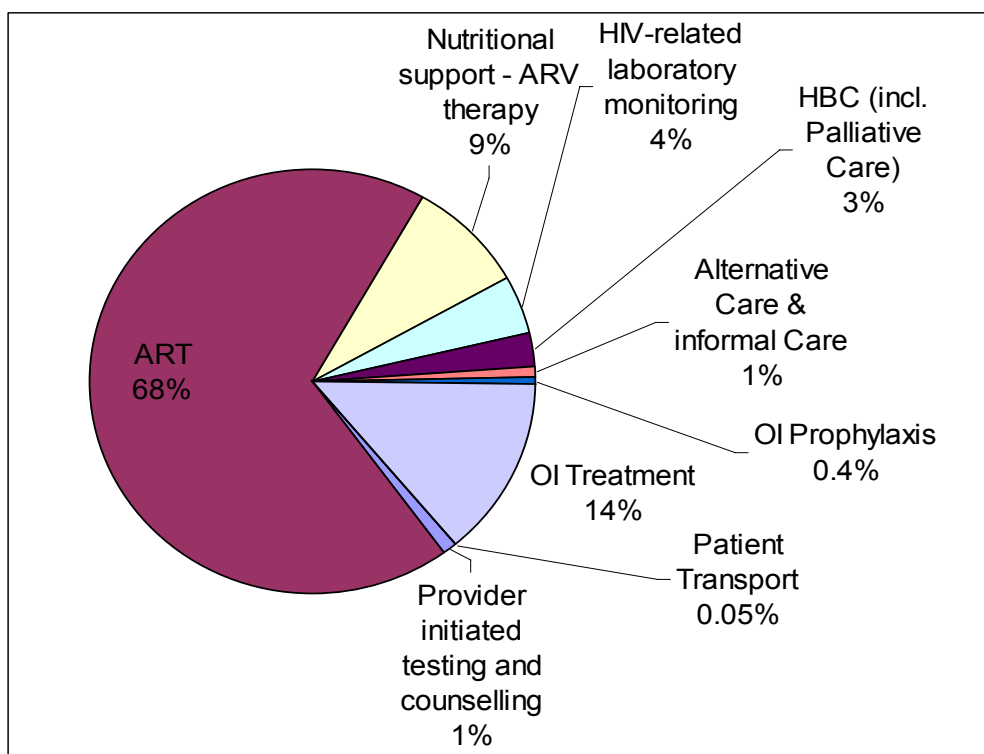


Figure 13: Treatment & Care Expenditure Breakdown for all sources in 2005/06 and 2006/07

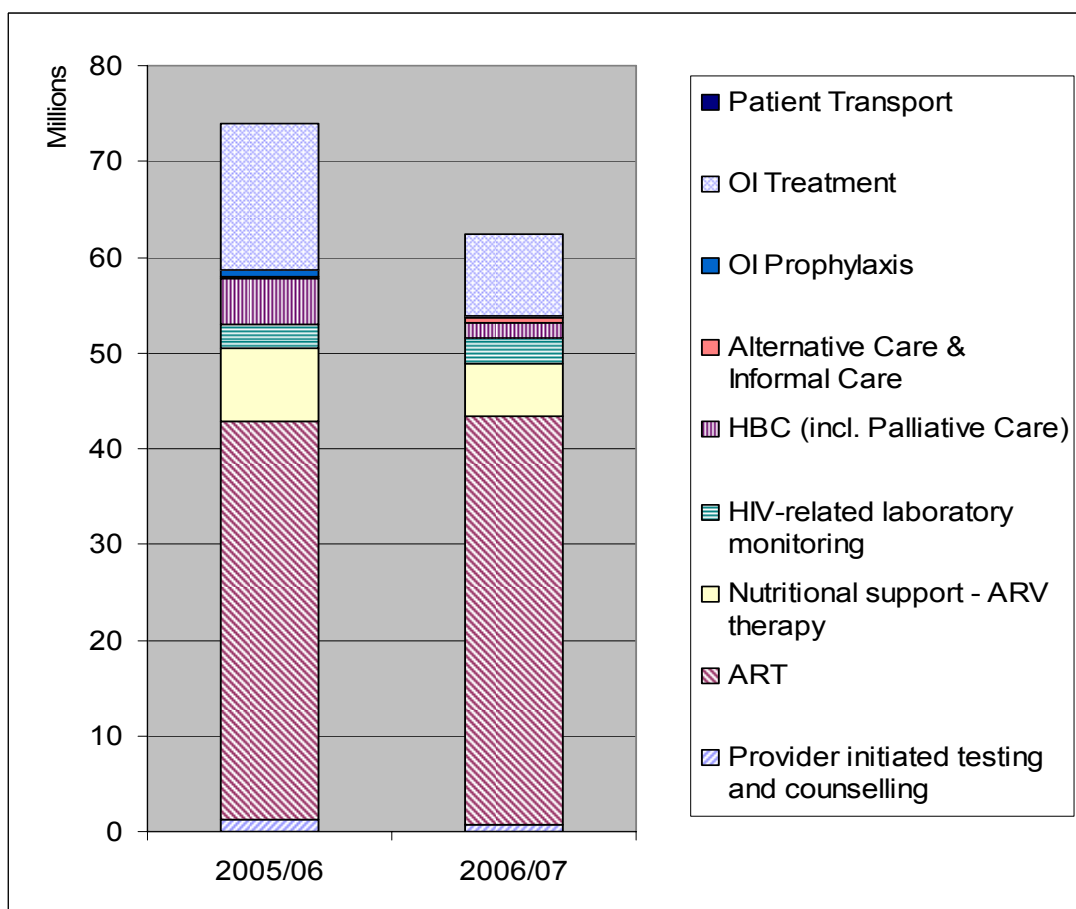


Figure 12 shows the actual expenditure levels in the two fiscal years. It is clear from the above that ART expenditure was sustained despite reduced allocations from GFATM. Provider initiated testing and counseling expenditure was reduced over the period, which means fewer test kits were bought and fewer counselors were supported or trained. The spending on nutritional support was reduced due to reduction in the distribution by WFP, as indicated earlier also. There are a number of disparate sources of donations and funding for the Laboratory Services at the MoHSW. The reduction in expenditure from the GFATM had its impact in the HBC area also, which is evident from the reduction in expenditure. OI treatment was a reduction in expenditure also. But since it was based on a model, it is reliant on the proportion of inpatients that are HIV +ve in the hospitals. This proportion saw a decrease in almost all hospitals that were visited in 2006/07.

It is felt that the expenditure on HIVAIDS through treatment & care is one of the most under-reported. The under-reporting is both on part of the international NGOs that work in the country and the MoHSW. A number of international NGOs that work in the country do not have good in-country support systems. Given the nature of the NASA, it is not possible to record a lump sum amount spent on treatment & care.

Expenditure on Beneficiary Populations

This section will look at expenditure on different beneficiary populations.

Figure 14: Beneficiary Population based Programmatic Expenditure Breakdown for 2005/06

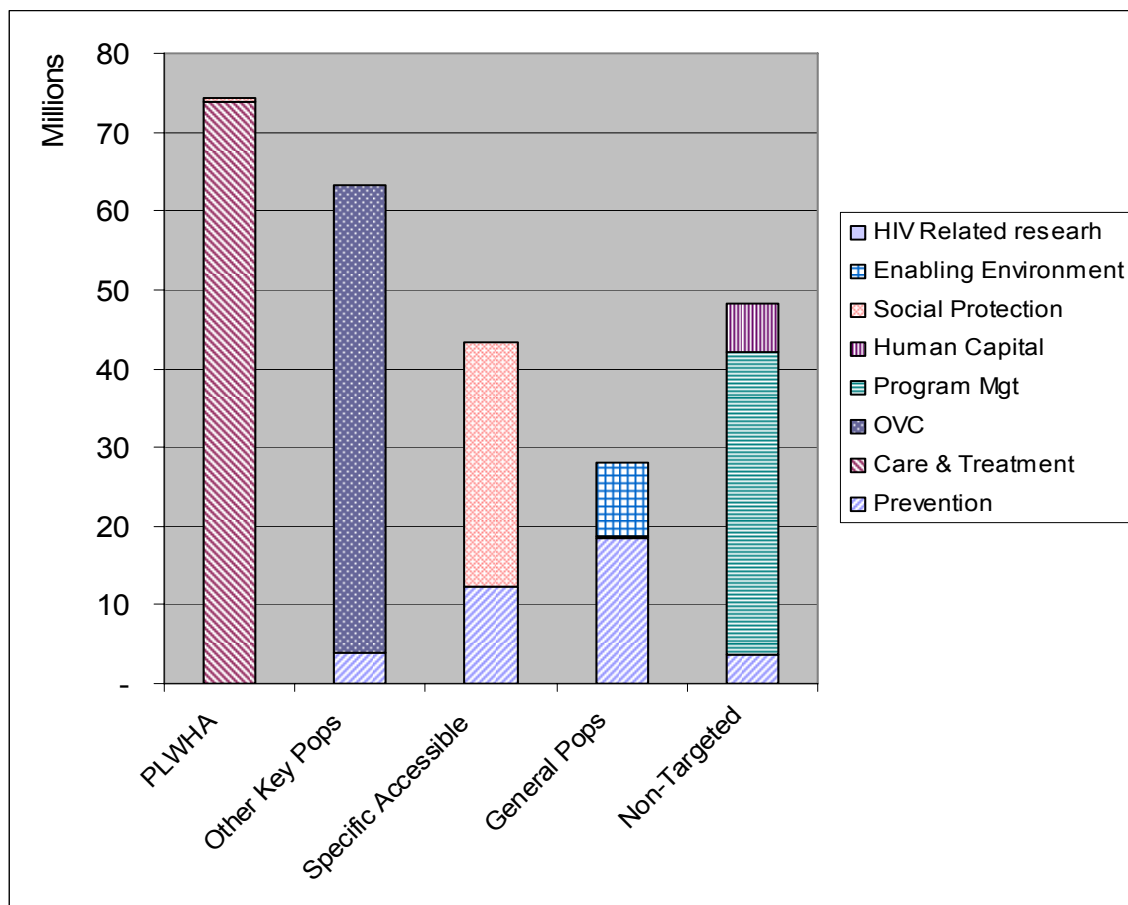
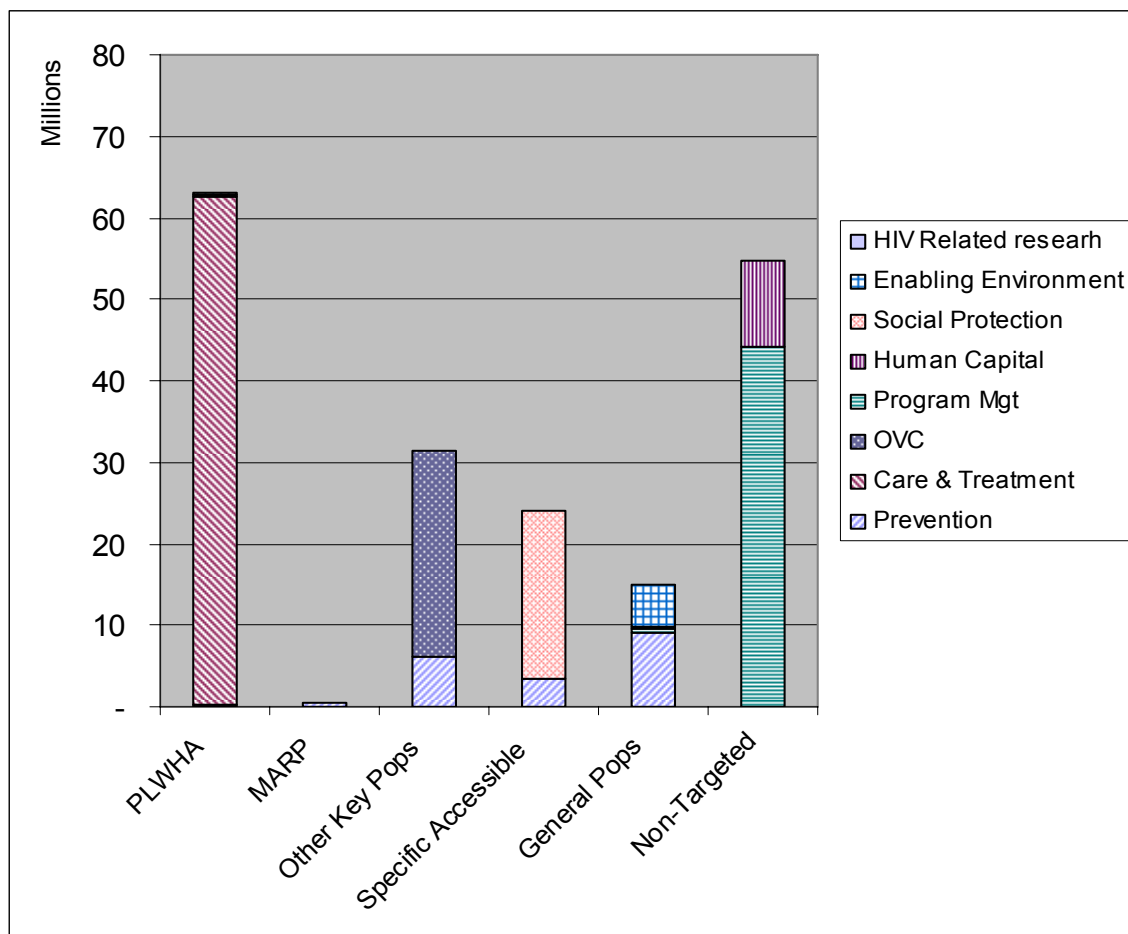


Figure 13 above shows the expenditure on five set of populations. The first bar shows the expenditure on PLWHA. The largest expenditure on PLWHA is on providing them care and treatment. While this is expected, the only other reported expenditure on this population is a small amount providing them social protection and building an enabling environment. It is worth noting that there is no reported expenditure on positive prevention in 2005/06. Other key populations primarily comprise of OVCs, children born to HIV mothers and children out of school. Since OVC form a part of this population, a large part of the expenditure is directed at them. The prevention expenditure is directed mainly at children out of school and at children born to HIV mothers through PMTCT. The specific accessible population primarily consists of people attending STI clinics, children and youth at school, women attending reproductive health clinics and any other accessible populations. The expenditure on accessible populations is primarily in the areas of prevention and social protection. People attending STI clinics and children and youth at school are the major beneficiaries. In the case of social protection, the expenditure captures the rations given to food insecure households which have atleast one member on ART. The general population sees an expenditure on prevention and enabling environment.

Figure 15: Beneficiary Population based Programmatic Expenditure Breakdown for 2006/07

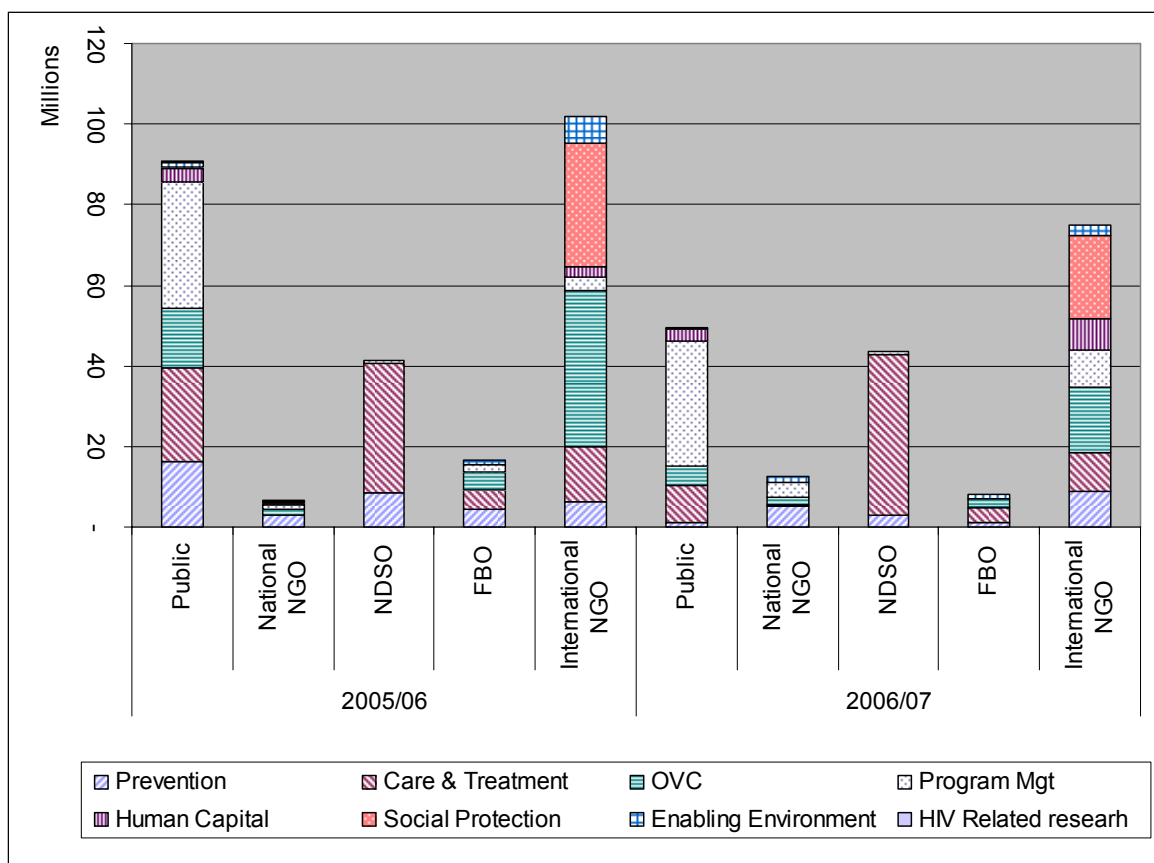


The expenditure levels in Figure 14 show the reduction in the expenditure levels for 2006/07. From a beneficiary population point of view the largest impact was felt on other key, specific accessible and general populations. Some level of sustenance of funding was maintained for PLWHA since one of their largest source of funding, GoL, was sustained over the period 2005/06 to 2006/07. Specific accessible populations, mainly children and youth in school, saw the largest drop in prevention expenditure.

Expenditure through Providers of Services

Providers of services are agencies that actually provide the beneficiaries with the aid that sources program. These agencies also take independent programmatic decisions based on their strengths or align themselves to funding opportunities. In figure 15 below we have tried to classify the different providers into a set of categories and show the funding that flows through them. The public provider category consists of parastatal agencies and government ministries that implement projects on the ground. FBO are faith based organizations that operate in the country including World Vision International, Catholic Relief Services, Christian Health Association of Lesotho and other church bodies. The most difficult to classify were the international and national NGOs. There is no particular principle on which this classification could be done. As in all real life situations, the lines are quite blurred. This report will classify based on the autonomy of the NGOs. However it is fair to expect the reader to want classification based on funding sources. A number of agencies that are autonomous have, due to their affiliations, access to international sources of funding.

Figure 16: Programmatic Expenditure Breakdown based on class of Providers for 2005/06 and 2006/07



The team does accept that the actual levels shown in the figures above will always be under-reported. The problem of under-reporting is even more severe for local NGOs since no directory of local NGOs exist. The more visible international NGOs are easily accessed and more robust in their reporting.

Whichever way one looks at it the overall picture that comes through is that the funding flows through national NGOs are the lowest. This presents a classic chicken and egg problem, do we channel funds through local NGOs so that they capacitate or do we wait for the local NGOs to capacitate before we channel funds through them.

Qualitative Data Findings

Process of Funding

As per the response of donor organizations, they require the organizations they fund to sign a contract that includes the timeframe for the use of funds, and to demonstrate performance in terms of progress on targets set as per the contract.

The implementing agencies stated that the conditions set in the agreement are clear. They have to spend the funds as per the original proposal and meet the objectives set.

NGOs mention that most donors have extremely long proposal vetting and funding timelines. Donors even state that for larger program sums the proposal must go for approval to regional authorities that further delay the process.

Reporting Requirements

The reporting requirements are set in the contract before the transfer of funds to the implementing agency. However, there are a few concerns mentioned:

1. For organizations with multiple donors, the reporting requirements are varied and thus present a tedious task of preparing varied reporting formats on a regular basis.
2. For small organizations the detailed reporting requirements put immense pressure on their support staff.

A suggestion was made to have a unified reporting standard, however it was feared that the most stringent reporting standard would be enforced. Instead they wanted any unification to lead to a negotiated medium complexity standard for reporting.

Smaller organizations were seen to have multiple donors with small disbursement amounts and short funding envelopes. This was coupled with weak administrative capacity of these organizations due to their size. The result is a poor implementation record that leads to them not being able to scale up to meet the needs of the community they serve.

At the end of the contract period, a complete activity report has to be submitted for the bulk of funds.

Funding Envelopes and Disbursements

The disbursement of the funds is on an annual, semi-annual, quarterly or cash-flow requirements basis. It is linked to the reporting cycle. Thus disbursement is generally made only after the report for the previous period is submitted.

As would be clear, there is always a risk of the reporting being delayed that in turn leads to delayed disbursement. In any case there would always be a short envelope of precarious cash flows for an organization between two disbursements. Again, this risk would be more likely for smaller agencies, further deepening their disadvantage.

Another aspect of the funding is that most donors would like to tie the expenditure to a few items that meet their program objectives. There is little contribution to the administrative running of the agencies which forms the basic support to the implementation.

Communication Gaps

There is a communication breakdown at multiple levels between donors and implementing agencies. When donor agencies begin their funding cycle, there is little communication of their funding priorities to the NGO community. Thus it is not clear to NGOs where they can access funds. At the same time, it would be difficult for donors to get information on each and every NGO in a thematic area. This would explain why some NGOs feel that a selected few have access to funding. An information portal, like letsema.org or the NAC website, could assist with this information being exchanged.

Often times, when the right donor and NGO connect and a proposal is submitted, the timelines and process of the approvals is not clear to the NGOs. This creates uncertainty for NGOs dealing with depleted cash flows. The cash flow issues make the organizations very vulnerable at this time and they may lose their support or program staff.

A clear staged, deadline driven approval mechanism from the donors would be useful for smaller NGOs to plan and prepare for contingencies.

Human Resource Capacity

In a country where everyone mentions the problem of capacity, it would be far to assume that this issue affects both donors and NGOs. It would explain a number of concerns that both NGOs and donors are having with each other.

The above sections show how funding envelopes, disbursement delays and communication gaps lead to such concerns. It is most definitely not the only problem, but tackling this issue of capacity would have to be from multiple angles, with donors taking the lead. A method suggested by an NGO was to have more international and national experts work in the country. Once they work in the field, the staff would pick up some of the skills needed to operate effectively, efficiently and with good technical understanding.

While the processes for information exchange are being setup, NASA would be a means to facilitate information exchange between the different stakeholders in Lesotho.

Recommendations

This section has recommendations based on the findings of this assessment and on the teams experience with accessing expenditure information. We would also like to inform the user about what can and should be done to better inform the NASA process so that the image it portrays is as close to the reality of the HIV and AIDS response in Lesotho.

Recommendations Relating to Reporting and Information Systems

During the NASA team's interaction with the NGOs working in the country, it was found that a number of them had a strong reporting mechanism that broke the expenditure into highly disaggregated items for every quarter split per donor.

It would be interesting to know that for approx. M 700 an NGO can purchase one of the best small business ERPs (e.g. Pastel).

Many donors ask for the reporting to be inline with their financial year and this requirement is understandable. However it is important for a donor to understand how many similar donors with varying financial periods put similar reporting requirements on an NGO. The periods of reporting could include the calendar year, April-March, October-September, etc.

Matters can be even more complicated by donors when they ask the quarterly reporting process to begin from the date of disbursement of funds. It should be the responsibility of the donor to understand the reporting commitments of the NGO it funds.

Another interesting finding of the team was that smaller NGOs have a larger set of donors that provide small amounts of funding for short and unconfirmed commitment periods. This creates a cycle of high staff turnover, low capacity, and slow operations, which then leads to the NGO being unattractive to better sources of funding which leads to high staff turnover and so on. This is a vicious cycle in which a number of local NGOs are stuck today.

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

Recommendations to NAC

The National AIDS Commission has taken the leadership in implementing a resource tracking mechanism through the NASA. After the completion of the first report, it is important that it takes a step back and looks at what NASA can do for its role in the national HIV and AIDS response. This analysis would involve looking at two points of view:

1. What processes of the NAC's coordination role can be helped by the information given by the NASA?
2. What information already gathered by the NAC through its data officers, technical support officers, grant managers, etc. can be used by the NASA to make it more robust?

There is a considerable effort involved in the NASA process. Maintaining the services of the resources that carried out the NASA previously is important for the process to be sustained. Local ownership would operationally translate into maintaining the trained resources that can implement.

Recommendations to Ministry of Health and Social Welfare

The MoHSW is a key part of the response against HIV and AIDS. It has an implementation reach second to none in the country. In terms of funding flows captured by the NASA, the ministry acts as the channel for the largest resource flows in the country.

It is thus important that it takes an independent decision on the utility of NASA. The support of the ministry during the course of the assessment was a positive signal. There have been a few instances in which it has even been able to make use of the process. This synergy must be recognized and the ministry must position the NASA as a measure of programmatic resource flows on HIV and AIDS in the country. As of the writing of this report no such programmatic expenditure recording is known to the team.

Support and strengthening of the NASA in terms of research, robust statistics, M&E and technical discussions would help create a true picture of the situation on the ground. The ministry's participation is important to unravel its own structures. Questions such as, what is the role of the Family Health Division in providing PMTCT? How can the M&E systems at the STI, HIV & AIDS Directorate be used to capture OI treatment expenditure at ART clinics?, are best answered from within the ministry.

There are a number of interesting analyses that can be done based on these figures. For example, adequacy of resources can be checked by multiplying unit costs with the overall units of care provided. Also the reverse, taking a bulk of the resources spent on a particular element of care and dividing it with the number of units of care to get unit costs.

Recommendations to Development Partners and UN Agencies

The information and support available from development partners and UN agencies was quite encouraging. It even extended to GTZ, a development partner, to actually fund the technical support to the NASA via UNAIDS.

Going forward it is important that development partners ask the NASA team questions on information they specifically need, help strengthen the process by criticism and provide their continued support by asking their partners to report to the assessment for it to be a success.

An important test for this will be the implementation of the ERP funded by the European Commission. Accurate recording of programmatic expenditure with line items that are inline with NASA classifications would go a long way in making the reporting the public expenditure on HIV and AIDS more robust.

While interacting with agencies that get support from UN agencies, it was found that the sustenance of programs was weak amongst a number of UN agencies. This meant that programmes funded by UN agencies have a short envelope of funding, with push for fund disbursement at the end of their funding cycles.

Another interesting aspect of some UN agencies expenditure on HIV and AIDS is mainstreaming. It is known that a number of agencies advised for it, however it was felt by the team that mainstreaming has happened to an extent that agencies are not able to report on what expenditure has been directed at HIV and AIDS.

Recommendation relating to subsequent NASA

The next assessment requires updated numbers for unit costs of services so that they can be accurate. Also the team has to continuously work towards improving the quality of information during collection, entry and analysis. This would involve consultations within the team, attending information sessions on NASA in the region to share and learn from others experiences and building an understanding of the HIV and AIDS response in the country.

The scale-up of NASA must be measured and deliberate steps towards a goal. The team must not rush to include spending from private agencies and record production factors in the next assessment. It is more important to stabilize the assessment and improve the reach and quality of data currently captured. At the same time thought should go into deciding the benefits of capturing expenditure from private agencies. Also, we should first assess the capacity of the spenders in the country to report on production factors.

The NASA provides a lot of information related in highly disaggregated financial flows. It is nearly impossible to generate a graph that meets everyone's requirements. Therefore access to this disaggregated information must be provided to anyone who wants to analyze the information.

For the NASA to be a success, it is important that the team does not restrict itself to funding flows. Any small policy level change ends up having an impact on financial flows. Thus it is important that the team is cued into the national response to better prepare itself. Also a number of opportunities are available to improve the NASA by being a part of a restructuring process. Two examples of such opportunities that the team has already identified are listed below:

1. Changes in the financial systems of the government through the use of ERP. This would allow us to introduce line items that fit with the NASA spending categories.
2. Flow of funding through the community councils as part of the Gateway Approach. Thus would allow us to make sure the community councils ask for disaggregated reporting that matches the NASA spending categories through contracts signed.

Appendix I: Status of Data Collected with Comments

| <u>PUBLIC</u> | 2005 | 2006 | 2007 | PRIMARY | SECOND. | SOURCE | ESTIMATION |
|--------------------------------|-------------|-------------|-------------|----------------|----------------|--------------------------------|-------------------|
| MoHSW- Hospitals | ✓ | ✓ | ✓ | ✓ | | Hospital Inpatient Register | Step Down |
| MoHSW- PMTCT | ✓ | ✓ | ✓ | ✓ | | NDSO | |
| MoHSW- ARVs | ✓ | ✓ | ✓ | ✓ | | NDSO | |
| MoHSW-STIs | ✓ | ✓ | ✓ | ✓ | | MoHSW | Unit Cost |
| MoHSW - Labs & Research | ✓ | ✓ | ✓ | ✓ | | MoHSW - Labs & Research | |
| MoHSW - Mental Health | ✗ | ✗ | ✓ | ✓ | | MoHSW - Mental Health | |
| MoHSW - Recurrent Budget | ✓ | ✓ | ✓ | ✓ | | MoHSW - Recurrent Budget | |
| MoHSW-STI Directorate* | ✗ | ✗ | ✓ | | ✓ | NAC | |
| MoHSW- Blood Bank | ✗ | ✓ | ✓ | ✓ | | MoHSW-Blood Bank | |
| MoAFS | ✓ | ✗ | ✗ | ✓ | | MoA | |
| MoET | ✓ | ✓ | ✓ | ✓ | | MoET | |
| MoLG | ✓ | ✗ | ✓ | ✓ | | MoLG | |
| MoGYSR | ✗ | ✓ | ✓ | ✓ | | MGYSR | |
| Senkatana | ✓ | ✓ | ✓ | ✓ | | Senkatana | |
| NAC | ✓ | ✓ | ✓ | ✓ | | NAC | |
| <u>EXTERNAL</u> | 2005 | 2006 | 2007 | PRIMARY | SECOND. | SOURCE | ESTIMATION |
| UNAIDS | ✓ | ✓ | ✓ | ✓ | | UNAIDS | |
| UNICEF | ✓ | ✓ | ✓ | ✓ | | UNICEF | |
| WHO | ✓ | ✓ | ✓ | ✓ | | WHO | |
| GFATM | ✓ | ✓ | ✓ | ✓ | | GFATM | |
| Action AID | ✓ | ✗ | ✗ | ✓ | | Action AID | |
| Clinton Foundatin | ✗ | ✓ | ✓ | ✓ | | Clinton Foundation | |
| CRS | ✗ | ✓ | ✓ | ✓ | | CRS | |
| GTZ | ✓ | ✓ | ✓ | ✓ | | GTZ | |
| SolidarMed | ✓ | ✓ | ✓ | ✓ | | SolidarMed | |

| | | | | | | | |
|-----------------------|-------------------------------------|-------------|-------------|----------------|----------------|-------------------|-------------------|
| Skillshare | ✓ | ✓ | ✓ | ✓ | | Skillshare | |
| TEBA* | ✗ | ✗ | ✓ | | ✓ | NAC | |
| World Vision | ✓ | ✓ | ✓ | ✓ | | World Vision | |
| Baylor Colledge | ✓ | ✓ | ✓ | ✓ | | Baylor Colledge | |
| UNDP | ✗ | ✓ | ✓ | ✓ | | UNDP | |
| WFP | ✓ | ✓ | ✓ | ✓ | | WFP | |
| PSI | ✓ | ✓ | ✓ | ✓ | | PSI | |
| URC | Data not disaggregated sufficiently | | | | | URC | |
| MSF | □ | □ | □ | ✓ | | MSF | |
| BHA | □ | □ | □ | ✓ | | BU | |
| NGOs | 2005 | 2006 | 2007 | PRIMARY | SECOND. | SOURCE | ESTIMATION |
| CHAL | ✓ | ✓ | ✓ | ✓ | | CHAL | |
| ALAFA | ✓ | ✗ | ✓ | ✓ | | ALAFA | |
| Help Lesotho | ✗ | ✓ | ✓ | ✓ | | HELP LESOTHO | |
| Peace Corps | Data not disaggregated sufficiently | | | | | PEASE CORPS | |
| LSC | ✓ | ✓ | ✓ | ✓ | | LSC | |
| FIDA | ✗ | ✓ | ✓ | ✓ | | FIDA | |
| LPPA | ✓ | ✓ | ✓ | ✓ | | LPPA | |
| Sentebale | ✗ | ✗ | □ | ✓ | | Sentebale | |
| LENEPHWA | ✓ | ✓ | ✓ | ✓ | | LENEPHWA | |
| LRC | ✓ | ✓ | ✓ | ✓ | | LRC | |
| GROW | ✓ | ✓ | ✗ | ✓ | | GROW | |
| Beautiful Gate | ✓ | ✓ | ✗ | ✓ | | BEAUTIFUL GATE | |
| TTL | ✗ | ✓ | ✓ | ✓ | | TTL | |
| Scripture Union* | ✓ | ✓ | ✓ | | ✓ | Global Fund & NAC | |
| LIRAC* | ✗ | ✗ | ✓ | | ✓ | NAC | |
| Ts'anelo Care Center* | ✗ | ✗ | ✓ | | ✓ | NAC | |
| Crossroads* | ✓ | ✗ | ✗ | | ✓ | Global Fund | |
| Lebone consultant* | ✓ | ✗ | ✗ | | ✓ | Global Fund | |
| LBPB | ✓ | ✗ | ✗ | | ✓ | Global Fund | |
| ALE* | ✓ | ✗ | ✗ | | ✓ | Global Fund | |
| IDM* | ✓ | ✗ | ✗ | | ✓ | Global Fund | |

| | | | | | | | |
|--------------------------|-------------|-------------|-------------|----------------|----------------|--------------------------|-------------------|
| LCN* | ✓ | ✗ | ✗ | | ✓ | Global Fund | |
| Paballong Trust | ✗ | ✗ | ✗ | ✗ | ✗ | | |
| PRIVATE | 2005 | 2006 | 2007 | PRIMARY | SECOND. | SOURCE | ESTIMATION |
| Healthy Lifestyle Clinic | ✗ | ✓ | ✓ | ✓ | | Healthy Lifestyle Clinic | |
| NDSO | ✓ | ✓ | ✓ | ✓ | | NDSO | |

| |
|---|
| ✓ Data available and captured in NASA RTS |
| ✗ No data available |
| □ Data available but not captured in NASA RTS |

Appendix II: ASC Priorities vs NSP Priorities

As part of the NASA, the expenditure is captured across different spending categories. There are 8 broad categories in the NASA. These categories and their mapping to the NSP categories are provided below for reference.

Table 2: National Strategic Plan and AIDS Spending Category Mapping

| <i>National Strategic Plan (NSP) Categories</i> | <i>AIDS Spending Category (ASC) from NASA</i> | <i>ASC Number</i> |
|--|--|--------------------------|
| Prevention | Prevention | ASC 1 |
| Treatment & Care | Treatment & Care | ASC 2 |
| | Human Capital & Incentives | ASC 5 |
| Impact Mitigation | Orphan and Vulnerable Children (OVC) | ASC 3 |
| | Social Protection and Social Services | ASC 6 |
| Coordination | Programme Management and Administrative Strengthening | ASC 4 |
| | Enabling Environment and Community Development | ASC 7 |
| | HIV and AIDS related Research | ASC 8 |

Appendix III: Preliminary 2007 Expenditure Figures

The data in this section is incomplete and does not represent the full year's expenditure.

Figure 17: Total Expenditure with Sources of Funding for 2007/08

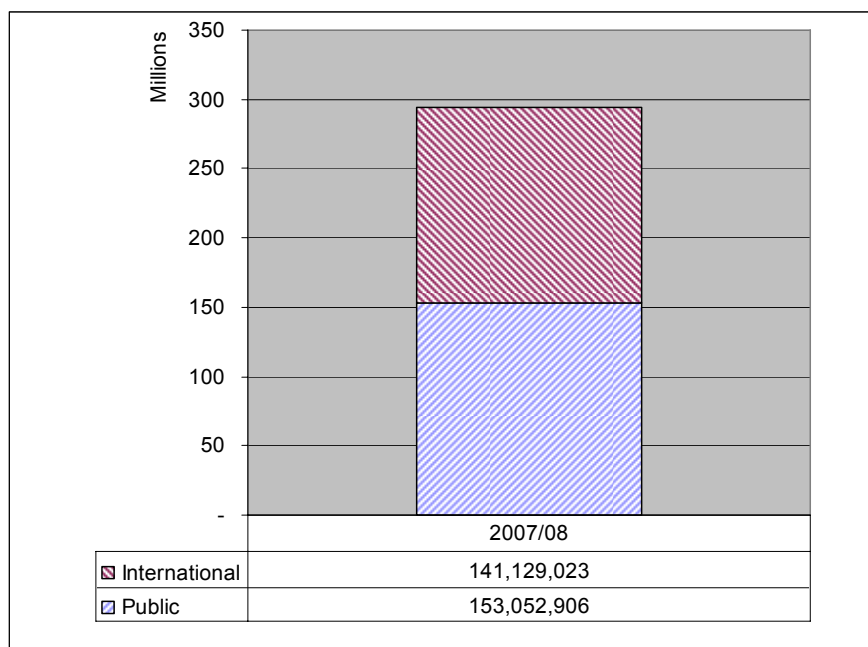


Figure 18: Expenditure Breakdown by ASC for 2007/08

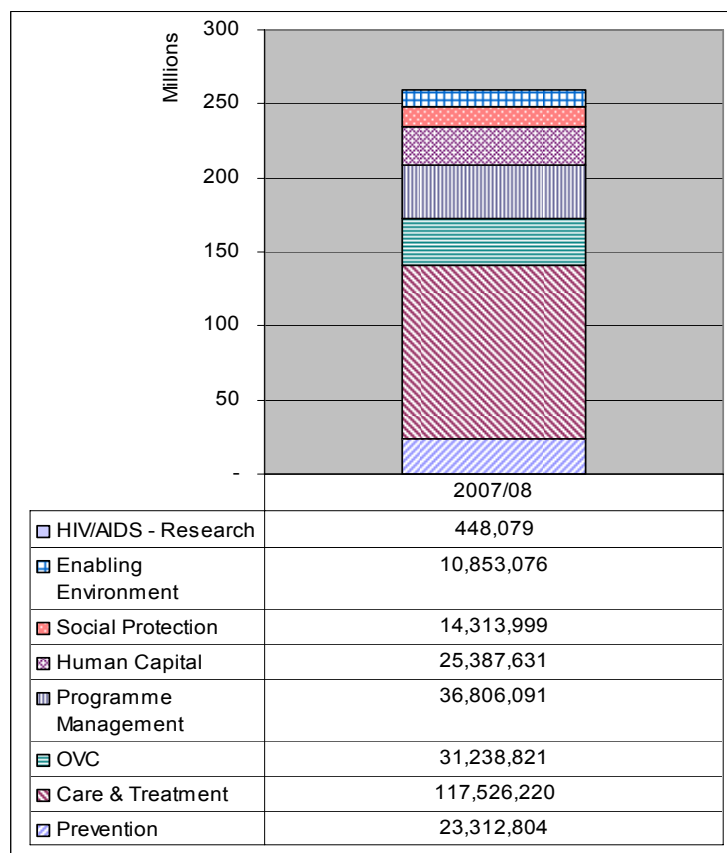


Figure 19: ASC based Expenditure Breakdown for Public and International Sources for 2007/08

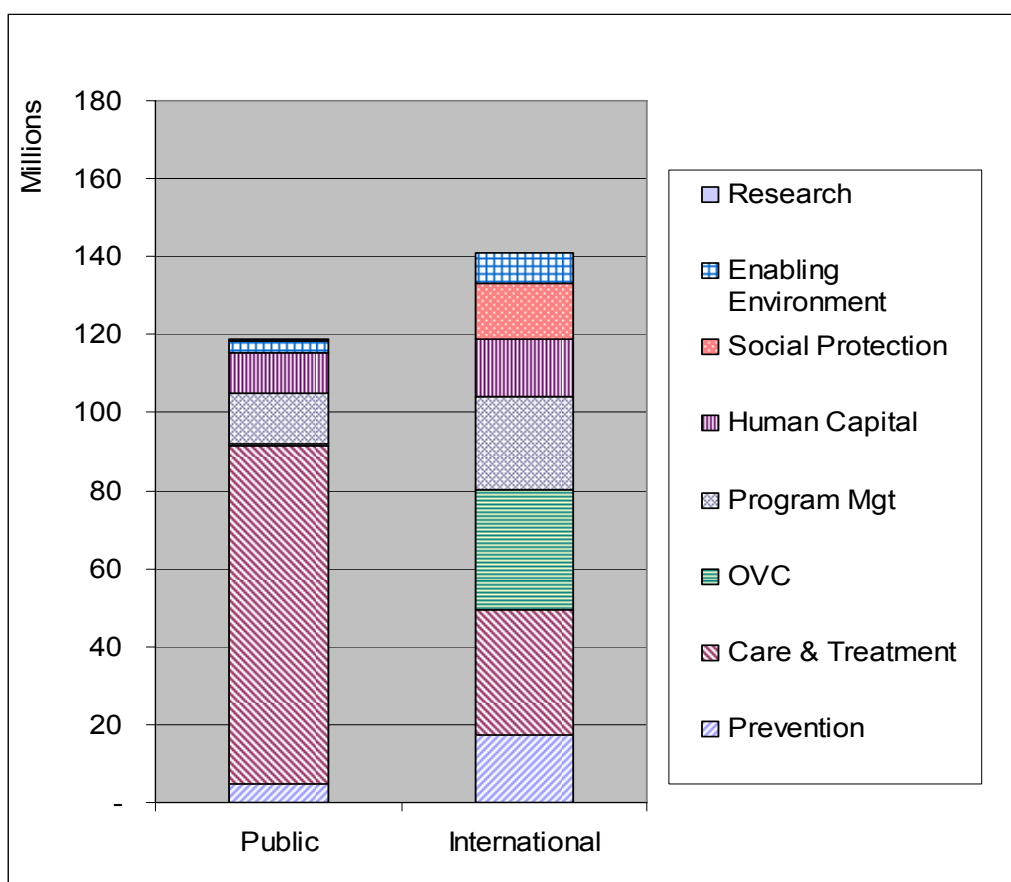


Figure 20: Prevention Expenditure Percentage Breakdown for 2007/08 from all sources

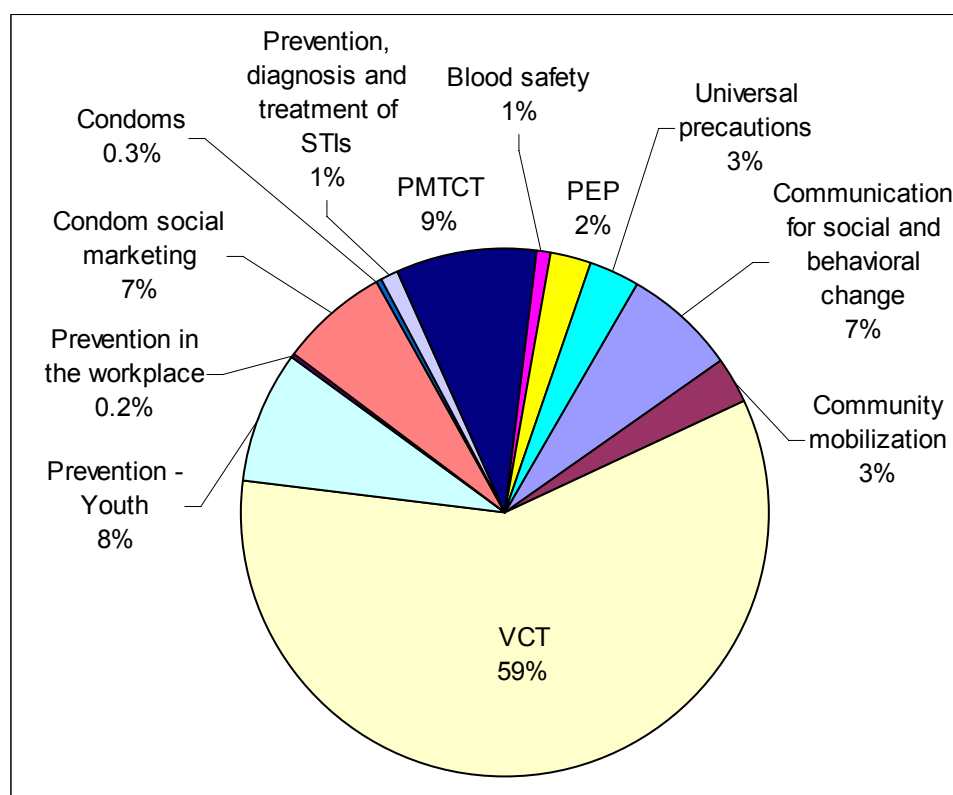


Figure 21: Prevention Expenditure Breakdown for all sources in 2007/08

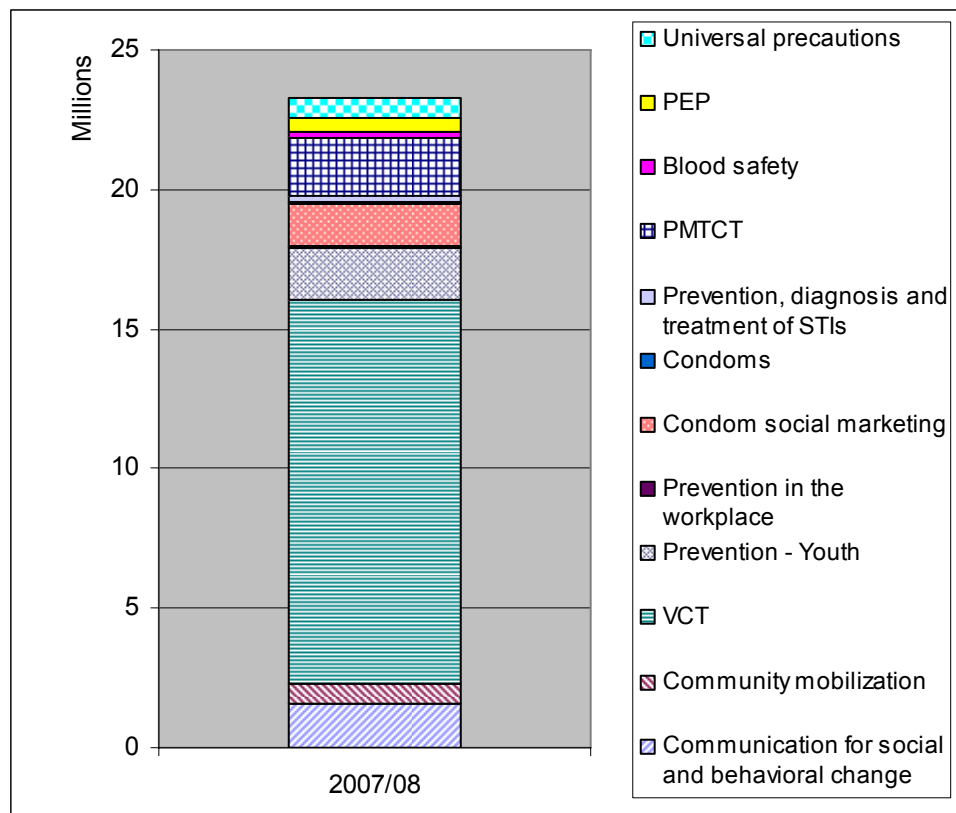


Figure 22: Treatment & Care Expenditure Percentage Breakdown for 2007/08 from all sources

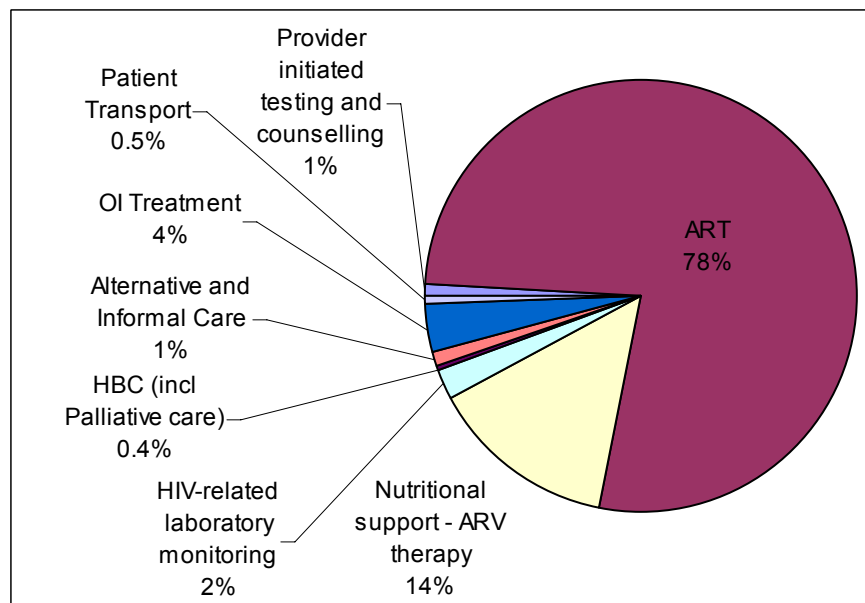


Figure 23: Treatment & Care Expenditure Breakdown for all sources in 2007/08

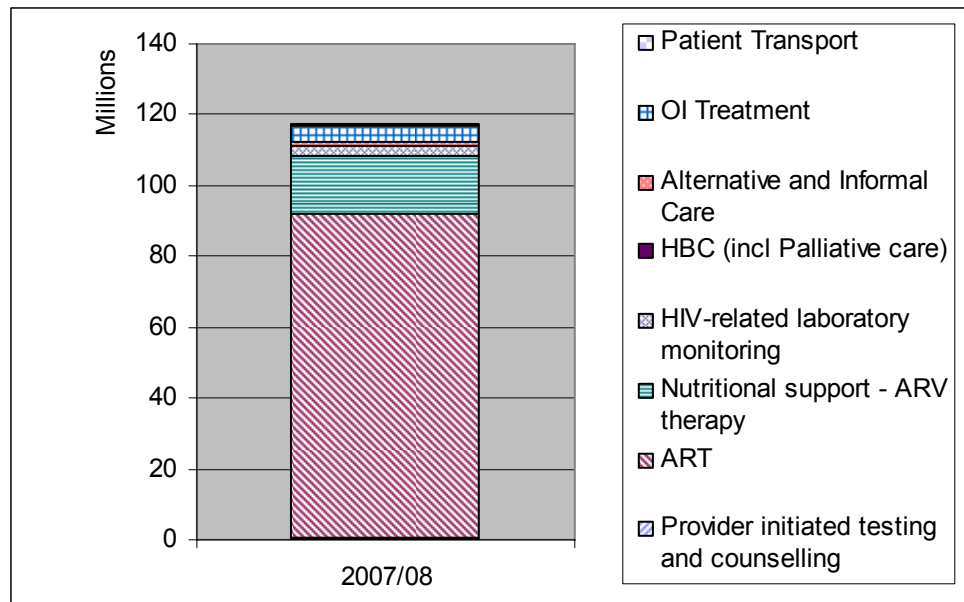
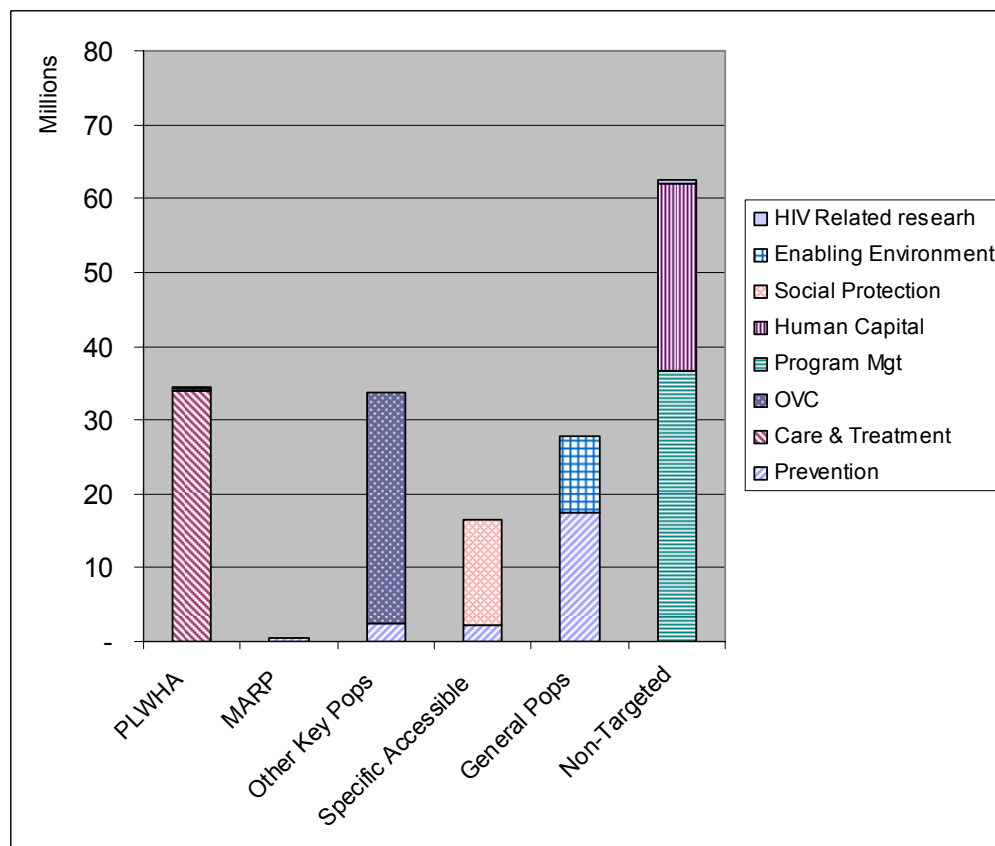


Figure 24: Beneficiary Population based Programmatic Expenditure Breakdown for 2007/08



Appendix IV: Total Spending by Expanded Categories for 2005/06 and 2006/07

| <i>Lesotho Spending by Expanded Categories</i> | <i>2005/06</i> | <i>2006/07</i> |
|--|----------------|----------------|
| PREVENTION PROGRAMMES | | |
| Community for social & behavioural change | 6,741,632.00 | 436,648.00 |
| community mobilisation | 681,284.00 | 1,862,949.00 |
| Voluntary Counselling & Testing | 5,015,029.00 | 2,537,431.00 |
| Prevention - PLWHA | | 79,365.00 |
| Prevention - Youth | 4,184,538.00 | 1,480,585.00 |
| Prevention in workplace | 330,296.00 | |
| Prevention, Diagnosis & Treatment of STI | 9,942,676.00 | 2,394,006.00 |
| Condom Social Marketing | 1,672,509.00 | 2,315,399.00 |
| Condoms | 2,928,184.00 | 57,271.00 |
| Prevention of Mother to Child Transmission | 2,819,887.00 | 5,525,552.00 |
| Universal Precautions | 4,075,821.00 | 1,620,430.00 |
| Post - Exposure Prophylaxis | 138,738.00 | 728,164.00 |
| Blood Safety | | 206,424.00 |
| TREATMENT & CARE | | |
| Provider initiated Testing & Counselling | 1,267,288.00 | 694,968.00 |
| ART | 41,510,229.00 | 42,743,815.00 |
| Nutritional Support associated to ARV therapy | 7,777,634.00 | 5,362,648.00 |
| Specific HIV - related laboratory monitoring | 2,429,256.00 | 2,722,236.00 |
| HBC(incl. Palliative Care) | 4,750,054.00 | 1,573,502.00 |
| Alternative Care & informal Care | 265,187.00 | 543,183.00 |
| OI Treatment (incl. IO Propylaxis) | 15,946,753.00 | 8,758,966.00 |
| Inpatient Care | 1,776.00 | 31,096.00 |
| ORPHANS & VULNERABLE CHILDREN (OVC) | | |
| OVC-Education | 15,382,239 | 5,662,832 |
| OVC- Basic Health Care | 227,185 | 427,318 |
| OVC- Family/ Home Support | 41,439,011 | 15,332,927 |
| OVC- Community Support | 1,177,755 | 1,269,120 |
| OVC- Administrative / Organisation Costs | 776,934 | 1,854,341 |
| OVC- Services not else where classified | 262,925 | 829,861 |
| PROGRAM MANAGEMENT & ADMINISTRATION | | |
| STRENGTHENING | | |
| Program Administration | 31,398,446 | 38,295,657 |
| Planning & Coordination | 511,985 | 135,282 |
| Monitoring & Evaluation | 1,426,291 | 462,501 |
| Serological- Surveillance | | 80,050 |
| Drug Supply System | 1,516,220 | 1,361,174 |

| | | |
|--|------------|------------|
| Information Technology | 500,463 | 69,861 |
| Upgrading laboratory infrastructure & new equipment | 2,750,507 | 4,016,595 |
| Construction of new health centre | 14,824 | 48,806 |
| Upgrading & construction of infrastructure not else where classified | 196, 880 | 39,066 |
| Program management - administration strengthening n.e.c | 700 | 356,050 |
| HUMAN RESOURCES | | |
| Monetary incentives for physicians | 56,856 | 177,301 |
| Monetary incentives for nurses | 376,229 | 386,599 |
| Monetary incentives for other staff | 2,062,850 | 2,142,328 |
| Formative education to build up an HIV workforce | | 17,631 |
| Training | 3,708,006 | 3,256,856 |
| Incentives for Human Resources n.e.c | 9,658 | 4,762,729 |
| SOCIAL PROTECTION AND SOCIAL SERVICES (EXCLUDING OVC) | | |
| Social protection through provision of social services | | 4,500 |
| HIV-specific income generation project | 524,297 | 304,312 |
| Social protection and services n.e.c | 30,965,760 | 20,593,440 |
| ENABLING ENVIRONMENT AND COMMUNITY DEVELOPMENT | | |
| Advocacy and strategic community | 2,783,131 | 2,937,316 |
| Human Rights | | 244,034 |
| AIDS- Specific Programs focused on woman | 915,829 | |
| HIV AND AIDS - RELATED RESEARCH (EXCLUDING OPERATIONS RESEARCH) | | |
| Social science Research | | 128,839 |
| Research and Capacity strengthening - Private entities | 4,010 | 67,701 |
| HIV and AIDS - Related Research activities n.e.c | 24,500 | 3,408 |

Appendix V: NASA Matrices for 2005/06 and 2006/07

| 2005/06 | | Lesotho Sources to Agents | | | |
|-----------------------------------|---|---------------------------|---------------|---------------------|-------------|
| Amount in Maloti | | Sources | | | |
| Agents | | Public funds | Private funds | International Funds | Grand Total |
| Agents | Sub Agents | MoFDP | | | |
| Public sector | Central or Federal Authorities | 82,742,510 | 636,900 | 31,019,805 | 114,399,215 |
| | Local/Municipal Authorities | | | 263,632 | 263,632 |
| Public sector Total | | 82,742,510 | 636900 | 31,283,437 | 114,662,847 |
| | Private households' virtual fund for out-of-pocket payments | | | | |
| | Not-for-profit institutions (other than social insurance) | 2,105,907 | 7,074,965 | 2,193,540 | 11,374,412 |
| | Private non-parastatal organizations and corporations (other than health insurance) | | | | |
| Private sector Total | | 2,105,907 | 7,074,965 | 2,193,540 | 11,374,412 |
| International Organizations | | | | | |
| | Country offices of Bilateral Agencies Total | | | 1,002,000 | 1,002,000 |
| | Multilateral Agencies Total | | | 111,331,004 | 111,331,004 |
| | International not-for profit organizations | 16,860 | 144,906 | 18,895,118 | 19,056,884 |
| | International for-profit bodies | | | | |
| International Organizations Total | | 16,860 | 144,906 | 131,228,122 | 131,389,888 |
| Grand Total | | 84,865,277 | 7,856,771 | 164,705,099 | 257,427,147 |

| 2006/7 | | Lesotho Sources to Agents | | | |
|-----------------------------------|---|---------------------------|---------------|---------------------|-------------|
| Amount in Maloti | | Sources | | | |
| Agents | | Public funds | Private funds | International Funds | Grand Total |
| Agents | Sub Agents | MoFDP | | | |
| Public sector | Central or Federal Authorities | 75,978,712 | 142,720 | 12,169,953 | 88,291,385 |
| Public sector Total | | 75,978,712 | 142,720 | 12,169,953 | 88,291,385 |
| | Private households' virtual fund for out-of-pocket payments | | | | |
| | Not-for-profit institutions (other than social insurance) | 4,186,812 | 3,745,117 | 3,697,866 | 11,629,795 |
| | Private non-parastatal organizations and corporations (other than health insurance) | | | | |
| Private sector Total | | 4,186,812 | 3,745,117 | 3,697,866 | 11,629,795 |
| International Organizations | | | | | |
| | Country offices of Bilateral Agencies Total | | | 1,469,133 | 1,469,133 |
| | Multilateral Agencies Total | | | 68,030,826 | 68,030,826 |
| | International not-for profit organizations | 367,385 | 1,240,587 | 18,010,955 | 19,618,927 |
| | International for-profit bodies | | | | |
| International Organizations Total | | 367,385 | 1,240,587 | 87,510,914 | 89,118,886 |
| Grand Total | | 80,532,909 | 5,128,424 | 103,378,733 | 189,040,066 |

Appendix VI: Estimation of Expenditure on STI and AIDS through Health System

The government of Lesotho and other non governmental agencies provide healthcare services in the country. The patients include HIV positive people who access a range of services through a number of facilities like hospitals and health centers. Since this expenditure is on HIV and AIDS, it forms a part of the NASA.

Background

An HIV positive person can access the healthcare system through various facility types and for a number of different services. The facilities are listed below:

1. Hospital (Inpatient & OPD)
 - a. Primary
 - b. District
 - c. Local
 - d. Regional
 - e. Referral
2. ART Clinic (embedded in hospital)
3. Health Center (stand-alone)
4. Filter Clinic

There are also a basic set of services that would be accessed by the patients:

1. Inpatient Care
 - a. OI treatment
 - b. STI treatment
2. Outpatient Care
 - a. ART
 - b. OI treatment
 - c. STI treatment
3. Antenatal Care
 - a. PMTCT

The above services are not broken down into categories of diseases or age groups, such as TB treatment or pediatric care.

An HIV positive person can access the healthcare system at any of the facility types to use any service available there. There are a number of ways in which the consumption of resources can be captured. One of the methods is the price multiplied by quantity (PXQ). This means that to capture the overall expenditure of a particular service the cost of that service is multiplied with the number of times that service is used. Thus to capture the resource usage, unit cost for each of the service types and the number of people (or visits/patient days) that used it would be required. As would be clear from the above, the overall expenditure would depend on the unit costs being available for each of the services and correct recording of patient statistics at different facilities for each type of service.

There is a lot of scope for discussion regarding what parameters should be used for deciding the type of service. For example, should inpatient TB OI costs be separated from other OIs since TB patients have a long average stay in hospital? During this assessment, the simplest

method was used due to lack of adequate time. However, such questions would need to be raised after the first NASA, to move towards continuous improvement of the figures. This aspect is discussed further in the recommendation section.

Services and Facility Type Selection

For each of the services listed in the previous section, a suitable unit cost and quantity used would be required. Based on this requirement, a number of care services could not be accounted for. In addition, the NASA requires traceability of expenditure from source of funding to provider or services. This puts an added requirement to be met before these services to be included in the NASA.

The matrix below lists the requirements discussed above for each of the service types:

Table 3: Service types with unit cost and quantity availability

| <i>Service Type</i> | <i>Unit Costs (P)</i> | <i>Quantity (Q)</i> | <i>Remarks</i> |
|---------------------------------|---|--|---|
| Inpatient Care (OI Treatment) | Unit costs for certain hospital's inpatient departments | Data recorded in inpatient register at facility | Quantity collection is not systemic and a likely underestimation |
| Inpatient Care (STI Treatment) | Unit costs for certain hospital's inpatient departments | Data recorded in inpatient register at facility | Quantity collection is not systemic and a likely underestimation |
| Outpatient Care (ART) | No unit costs study, may be considered similar to OPD or health centers | Patient records collected by regimen | Drugs form a major cost element that has been included |
| Outpatient Care (OI Treatment) | Unit costs for certain hospital's OPDs and for health centers | Data recorded in patient cards at facility | Dispersed data that is not centrally captured |
| Outpatient Care (STI Treatment) | Unit costs for certain hospital's OPDs and for health centers | Data recorded and reported centrally for STIs | Data collection systemic. However, 2006 has data for only first quarter |
| Antenatal Care (PMTCT) | Unit costs unavailable. Maternity/Obstetrics costs available | Number of clients available and reported centrally | Drug costs separately available. OB costs could be extracted. |

It is accepted that there are a number of other, more disaggregated levels of service provided to an HIV positive person that can be captured and used for accounting. These levels could be based on the CD4 count and other clinical information of a patient. It would be difficult to get unit costs (P) and patient numbers (Q) for these states. Thus a basic set of services was used to capture significant differences in unit costs and availability of unit costs and utilization statistics.

Based on the above matrix, the decisions for inclusions and brief methodologies are listed below:

Inpatient Care (OI Treatment)

Inpatient figures for each hospital were taken from the Health Statistics Tables of the Health Planning Statistics Unit. Unit costs for nine hospitals in Lesotho are available. To calculate a usage statistic inline with the unit costs, we multiplied the inpatient statistics with the average

stay to make it patient-days. We then calculated the same for inpatients that are HIV positive to get their patient-days. By dividing the two numbers, the proportion of HIV positive patients for a hospital was calculated. Due to the shortage of time, the actual HIV positive patient stay figures for each hospital could not be collected. Thus a proportion method was used.

Proportion of HIV Positive Patients = (Patient-days of HIV positive inpatients) / (Patient-days of all Inpatients)

By using averaging methods, the patient-days and unit cost (IPD) statistics were applied to other hospitals. Thus the *estimates were included*. The detailed methodology is provided in later sections.

Inpatient Care (STI Treatment)

Inpatient figures with the STI diagnosis required similar patient-day and unit costs figures to be calculated and proportions applied for the reasons discussed above. However, from the central statistics the actual figures for each hospital were found to be very few. Overall figures for the STI inpatients for 2006 were under 300 for all hospitals put together. Thus collection of the average patient stay for fewer patients was not considered feasible.

A large proportion of the costs would be drugs, which had been included through data from NDSO. Thus the *estimates were NOT included*.

Outpatient Care (ART)

While accounting for the source of funding for ART outpatient care, it was unclear who pays for certain elements of the costs of running an ART clinic, for example, nurse's salary, etc. It was our understanding that part of the amount paid comes from the STI, HIV & AIDS Directorate's recurrent budget and part from the recurrent budget of other directorates under the MoHSW. Also there were elements such as the Health Sector Reform project and GFATM grants. Thus it was concluded that since the source of funding for ART outpatient care was not clear and there was risk of double counting, it *would NOT be included* in the NASA.

A major part of the cost element is the ARVs. The NDSO was able to provide the team with ARV & prophylaxis drug procurement information which was included in the NASA.

Outpatient Care (OI Treatment)

HIV positive patients who need treatment for an opportunistic infection access the ART clinics or health centers. Also, if a HIV positive patient comes to the OPD of a hospital, they are directed to access the ART clinics. The records of OI treatment are captured in the patient cards and in a register at the facility level. There is no central aggregation of the figures carried out as of the writing of this report. This is primarily due to constraints in the system and no specific need being present for investing in aggregating such information. However, there is an intention to capture these records in the future, given the needs being communicated recently by various partners.

Based on the above reasons it was *decided to NOT capture* this amount in the NASA.

Outpatient Care (STI Treatment)

Patient records for STI treatment were available from the HPSU. It contained age-wise breakup of the patient visits. Also, unit costs for the OPD could be applied to other hospitals,

as discussed previously. The unit costs obtained from the model had to be modified to remove drug costs since the procurement data for STI drugs was already available from NDSO.

Since the number of patients and corresponding unit costs were available, a simple PXQ method was used. Thus *this cost element was captured*.

Antenatal Care (PMTCT)

A major part of the antenatal care related to HIV is PMTCT. Specific data on patient figures is available. There were no unit costs available for the maternity ward. Since estimates could not be drawn, the PMTCT costs were included only as drugs.

Based on the above reasons it was *decided to NOT capture* this amount in the NASA.

Calculation of Expenditure through the health system

In the sections below, the estimation methods used will be discussed in detail, beginning with the calculation of the unit costs for all the hospitals and their different departments. This will be followed by the calculation of the patient figures (Q) for STI outpatient visits and HIV positive inpatients. Finally the method used for calculating the out of pocket expenses (OOPE) incurred by patients accessing these services

Of the total 17⁸ hospitals, only 9 hospitals had unit costs available for them. Thus the available costs had to be extrapolated to the other 8 hospitals. It was assumed that the major contributing factors to the unit cost were:

1. Management: CHAL or GoL
2. Type of Hospital: Referral, Regional, Local, District or Primary
3. Geographical Location: Lowlands or Highlands

Based on the above criteria, a matrix was created to find the gaps in the unit cost data.

Table 4: Matrix with Unit Cost Availability and Gaps

| <i>Matrix – Unit Costs</i> | | | | | | |
|-----------------------------------|------------------------------|-------------------------|-----------------------|--------------|--------------------------|-----------------------------|
| Management | Geographical Location | Type of Hospital | Unit Available | Costs | No Unit Available | Costs |
| GoL | Lowlands | Districts | Mafeteng | | | <i>Qacha's Nek, Quthing</i> |
| GoL | Lowlands | Local | Berea | | | |
| GoL | Lowlands | Regional | Leribe, Hoek | Mohale's | | |
| GoL | Lowlands | Referral | | | | <i>QE II</i> |
| GoL | Highlands | Districts | | | | <i>Mokhotlong</i> |
| GoL | Highlands | Local | | | | <i>Butha-Buthe</i> |
| CHAL | Lowlands | Districts | Maluti, Scott | | | <i>St. Josephs</i> |
| CHAL | Lowlands | Local | | | | <i>Tebellong</i> |
| CHAL | Highlands | Districts | Paray | | | <i>Seboche</i> |
| CHAL | Highlands | Local | St. James | | | |
| CHAL | Highlands | Primary | Mamohau | | | |

⁸ Mokanyane and LFDS have been excluded from the overall analysis

In cases where a hospital of the same type had a unit cost available, the unit costs of that hospital was used. For example, Qacha's Nek and Quthing had similar characteristics to Mafeteng; hence its unit cost was used. In cases where there were two hospitals with unit costs, the average of the two was used. For example, for St. Josephs, the average of the unit costs of Maluti and Scott were used. In some cases there were no unit costs available in the same classification. In this case, another hospital from the same geographical region and similar type, but different management was used. For example, Butha Buthe is a local hospital in the highlands and so is St. James. Hence the unit costs of the two hospitals were considered to be similar. Using the above methods, the average unit costs of all the hospitals were estimated for the different services.

Since the unit costs available applied to the year 2005, inflation at 7% was applied to the unit costs to estimate the unit costs for the fiscal year 2006. Also, since the drugs for STI were already captured from the NDSO, the unit costs were modified for the STI cost estimation to remove the drugs element. Thus the unit costs used to STIs do not have the drugs element of the expenditure.

The number of STI patients seen in the OPD of the hospital is available from the health statistics table, as previously mentioned. Thus the overall expenditure on STI at the hospital OPD was captured as:

$$\text{STI OPD Costs} = \frac{\text{Unit costs for OPD at Hospitals (w/o Drugs)}}{\text{(Number of STI Patient Visit at respective hospital)}}$$

There is no central statistic of the number of inpatients that are HIV positive. Thus to capture the expenditure on AIDS in the Inpatient department, a proportion of the load of AIDS had to be established. This was done by using the patient-day metric. Field visits were conducted in Butha-Buthe, Leribe, QE II, Quthing and Mafeteng hospitals to capture the number of inpatients that are HIV positive. This capturing was based on the final diagnosis recorded in the Inpatient register. The actual register used differed depending on the type of hospital. Each record captured consisted only of patient days. Thus each record entry that was captured represented one patient and the number captured represented the number of days spent by the patient in the facility. This process was strictly followed due to ethical reasons.

Due to paucity of time, a small sample of hospitals were used that could be easily accessed. There is little understanding of the reasons for higher/lower admittance of HIV positive patients in different facilities. Therefore ideally proportions from all the hospitals would need to be captured.

Average patient stay for each of the facilities above was calculated for all and HIV positive patients. This was multiplied with number of patients in each type to get the patient-days. Dividing the two gives the proportion of positive patient-days.

$$\text{Proportion} = \frac{\text{(Number of HIV Positive Inpatients X Average Patient Stay)}}{\text{(Total Number of Inpatients X Average Stay of all Patients)}}$$

The proportions calculated for 5 hospitals above were applied to 11⁹ other hospitals based on the type of hospital. In the case of Quthing and Mafeteng, an average of the two was taken for all the other hospitals in the same classification.

Table 5: HIV +ve Patient Proportion for Hospitals

| <i>Mafeteng Hospital</i> | | | |
|---------------------------------|---------|---------|---------|
| Item | 2005/06 | 2006/07 | 2007/08 |
| HIV+ admissions | 234 | 219 | 295 |
| HIV+ patient days | 1580 | 1630 | 2057 |
| HIV+ average stay | 7 | 7 | 7 |
| Total admissions | 2327 | 1488 | 2429 |
| Total patient days | 18616 | 11904 | 19432 |
| Total average stay | 8 | 8 | 8 |
| % HIV admissions | 10% | 15% | 12% |
| % HIV patient days | 8% | 14% | 11% |

| <i>Butha-Buthe Hospital</i> | | | |
|------------------------------------|---------|---------|---------|
| Item | 2005/06 | 2006/07 | 2007/08 |
| HIV+ admissions | 87 | 172 | 277 |
| HIV+ patient days | 539 | 1170 | 1889 |
| HIV+ average stay | 6 | 7 | 7 |
| Total admissions | 785 | 1160 | 1001 |
| Total patient days | 4710 | 6960 | 6006 |
| Total average stay | 6 | 6 | 6 |
| % HIV admissions | 11% | 15% | 28% |
| % HIV patient days | 11% | 17% | 31% |

| <i>Leribe Hospital</i> | | | |
|-------------------------------|---------|---------|---------|
| Item | 2005/06 | 2006/07 | 2007/08 |
| HIV+ admissions | 430 | 427 | 315 |
| HIV+ patient | 2739 | 2714 | 1958 |
| HIV+ average stay | 6 | 6 | 6 |
| Total admissions | 2412 | 2854 | 1846 |
| Total patient days | 19296 | 22832 | 14768 |
| Total average stay | 8 | 8 | 8 |
| % HIV admissions | 18% | 15% | 17% |
| % HIV patient days | 14% | 12% | 13% |

| <i>Quthing</i> | | | |
|-----------------------|---------|---------|---------|
| Item | 2005/06 | 2006/07 | 2007/08 |
| HIV+ admissions | 233 | 89 | 130 |
| HIV+ patient days | 2796 | 1513 | 1430 |
| HIV+ average stay | 12 | 17 | 11 |
| Total admissions | 879 | 1009 | 467 |
| Total patient days | 7032 | 8072 | 3736 |
| Total average stay | 8 | 8 | 8 |
| % HIV admissions | 27% | 9% | 28% |

⁹ Mamohau was excluded since it is a Primary hospital and no data was available.

| | | | |
|--------------------|-----|-----|-----|
| % HIV patient days | 40% | 19% | 38% |
|--------------------|-----|-----|-----|

| <i>Queen II Hospital</i> | | | |
|----------------------------------|---------|---------|---------|
| Item | 2005/06 | 2006/07 | 2007/08 |
| HIV+ admissions | | | 654 |
| HIV+ patient days | | | 4294 |
| HIV+ average stay | | | 7 |
| Total admissions | | | 7007 |
| Total patient days | | | 56056 |
| Total average stay | | | 8 |
| % HIV admissions | | | 9% |
| % HIV Patient Days ¹⁰ | 6% | 5% | 8% |

Thus the overall expenditure estimate for HIV positive Inpatients at 16 hospitals was captured based on the below formulae:

$$\text{Expenditure}^{11} = (\text{Proportion of HIV +ve patients}) \times (\text{Total Inpatients}) \times (\text{Average Stay})^{12} \times (\text{Unit Cost for Inpatient})$$

User fees are charged for the OPD facilities provided at the hospitals, outside the ART clinics and for patient admission. These user fees form an OOPE for the HIV positive patient. Since they form a separate source of funding, NASA requires them to be captured separately. The estimation method used for calculating the expenditure on HIV and AIDS makes the extraction of OOPE element difficult if there is a lack of standardization of user fees. For STI expenditure, the per visit fees for each facility was used. In the case of inpatient expenditure, the fees were variable and depended on period of stay. Since estimations were used for patient stays, we could not extract the OOPE component in this case.

¹⁰ Number of HIV positive patient in IPD data is available for 2005/06 and 2006/07 is only for one quarter. Since the patient numbers are very large and manually recorded it would be very time consuming to capture these statistics. Hence the patient stay proportions are calculated based on trends from other hospitals.

¹¹ This is a per facility calculation, thus the elements of the formulae are different for each hospital.

¹² Calculated for all patients in each type of hospital.

Appendix VII: NASA Data Collection Forms and Processing Tools

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 (M) | US\$ Exchange rate in Year of Assessment | Other (specify): |
| | | | |
| Name of the Institution: | | | |
| 1. Person to Contact (Name and Title): | | | |
| 2. Address: | | 3. E-mail: | |
| 4. Phone: | | 5. Fax: | |
| 6. Type of institution: Select category of institution with an “X”. | 6.1 Public central government | | |
| | 6.2 Public regional government | | |
| | 6.3 Public local government | | |
| | 6.4 Private-for-profit national | | |
| | 6.5 Private-for-profit international | | |
| | 6.6 National NGO | | |
| | 6.7 International NGO | | |
| | 6.8 Bilateral Agency | | |
| 6.9 Multilateral Agency | | | |

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

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

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

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

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

8. Destination of the funds:

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

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

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

| Recipients of the non financial resources (Name of the Institution and Person to Contact) | Type of Goods donated | Quantity Received | Moneta ry Value in Year Assess ment |
|--|--------------------------|----------------------|--|
| 8.6 Institution: Contact: | | | |
| 8.7 Institution: Contact: | | | |
| 8.8 Institution: Contact: | | | |
| 8.9 Institution: Contact: | | | |
| 8.10 Institution: Contact: | | | |

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

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

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

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

| |
|--|
| |
| |
| |

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

| |
|--|
| |
| |

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

| |
|--|
| |
| |
| |

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

| |
|--|
| |
| |
| |

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

| |
|--|
| |
| |
| |

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

| |
|--|
| |
| |
| |

- g. Any other comments, suggestions etc?

| |
|--|
| |
|--|

| | |
|----------------------|-------------------------------|
| 11. Surveyor: | 12. Date: / / 20__ |
|----------------------|-------------------------------|

DATA COLLECTION – FORM # 2 (PROVIDERS)

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

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

| | |
|---|---|
| 7. 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 <i>non financial</i> 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 | Monetar y Value in Year of Assessm ent |
| 7.15 Institution: Contact: | | | |
| 7.16 Institution: Contact: | | | |
| 7.17 Institution: Contact: | | | |
| 7.18 Institution: Contact: | | | |
| 7.19 Institution: Contact: | | | |
| TOTAL: | | | |

8. Destination of the funds:

IV. Identify and quantify the NASA Functions in which the funds were spent.

V. Identify and quantify the NASA Beneficiary Population(s) of each Function.

VI. Use NASA notebook to classify Functions and Beneficiary Populations, using the name and code as the figure in the notebook for their identification.

| 8.1 Expenditure of the funds received from "7.1" | | | | |
|--|-------|-------|--|--------------|
| 8.1.1 Function (Code and Name) | | | | Amount spent |
| Code: | Name: | | | |
| 8.1.1.1 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| 8.1.1.2 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| Total spent on the Function: | | | | |
| 8.1.2 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.1.2.1 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| 8.1.2.2 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| Total spent on the Function: | | | | |
| 8.1.3 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.1.3.1 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| 8.1.3.2 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| Total spent on the Function: | | | | |
| Total Expenditure from the amount from '7.1' | | | | |
| Total unspent from the amount from '7.1' | | | | |

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

| 8.2 Destination of the funds received from "7.2" | | | | |
|--|-------|-------|--|--------------|
| 8.2.1 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.2.1.1 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| 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: | | |

| | | | | |
|--|-------|---------|---|--------------|
| Code: | Name: | 8.2.2.1 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.2.2.2 | Beneficiary Population (Code and Name): | |
| Total spent on the Function: | | | | |
| 8.2.3 Function (Code and Name) | | | | Amount spent |
| Code: | Name: | 8.2.3.1 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.2.3.2 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.2.3.3 | Beneficiary Population (Code and 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): | |
| Total spent on the Function: | | | | |
| 8.3.2 Function (Code and Name) | | | | Amount spent |
| Code: | Name: | 8.3.2.1 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.3.2.2 | Beneficiary Population (Code and Name): | |
| Total spent on the Function: | | | | |
| 8.3.3 Function (Code and Name) | | | | Amount spent |
| Code: | Name: | 8.3.3.1 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.3.3.2 | Beneficiary Population (Code and Name): | |
| Total spent on the Function: | | | | |
| Total Expenditure from the amount from '7.3' | | | | |
| Total unspent from the amount from '7.3' | | | | |

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

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

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

| 8.5 Destination of the funds received from “7.5” | | | | |
|--|-------|-------|--|--------------|
| 8.5.1 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |
| 8.5.1.1 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| 8.5.1.2 Beneficiary Population (Code and Name): | | | | |
| Code: | Name: | | | |
| Total spent on the Function: | | | | |
| 8.5.2 Function (Code and Name) | | | | Amount spent |
| Code: | | Name: | | |

| | | | | |
|--|-------|---------|---|--------------|
| Code: | | Name: | | |
| Code: | Name: | 8.5.2.1 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.5.2.2 | Beneficiary Population (Code and Name): | |
| Total spent on the Function: | | | | |
| 8.5.3 Function (Code and Name) | | | | Amount spent |
| Code: | Name: | 8.5.3.1 | Beneficiary Population (Code and Name): | |
| Code: | Name: | 8.5.3.2 | Beneficiary Population (Code and Name): | |
| 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?

9. 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?

| | |
|-------------------------|-------------------------------|
| 10. Interviewer: | 11. Date: / / 20__ |
|-------------------------|-------------------------------|

Primary Excel Sheet

| Year | Item Description | Amount | ASC | BP | Donor | Remarks |
|------|------------------|--------|-----|----|-------|---------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |