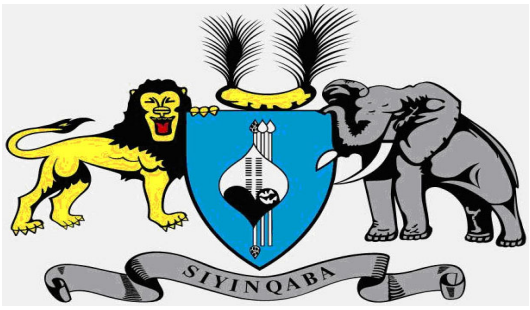
THE KINGDOM OF SWAZILAND



National Emergency Response Council on HIV and AIDS (NERCHA)

Joint United Nations Program on AIDS (UNAIDS)

THE KINGDOM OF SWAZILAND

NATIONAL AIDS SPENDING ASSESSMENT

2005/06 and 2006/07

Joint United Programme on HIV/AIDS
UNAIDS
UNICEF • UNDP • UNFPA • UNDCP
UNESCO • WHO • WORLD BANK

THE KINGDOM OF SWAZILAND NATIONAL AIDS SPENDING ASSESSMENT, 2005/06 and 2006/07:

LEVEL AND FLOW OF RESOURCES AND EXPENDITURES

FOR THE RESPONSE TO HIV/AIDS

National Emergency Response Council on HIV and AIDS (NERCHA)

Joint United Nations Program on AIDS

(UNAIDS)

Contributors to this report:

Dereck Chitama
Mduduzi Ndlovu
Teresa Guthrie
Sanelisiwe Tsela
Helen Odido

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Executive summary

The assessment shows that total expenditure in HIV/AIDS in the Kingdom of Swaziland in 2005/2006 and 2006/2007 was SZL 257,218,500 (USD 38,390,819) and SZL 346,128,488 (USD 49,446,927) respectively. The increment in total HIV/AIDS expenditure for 2006/2007 was approximately 35% of the 2005/2006 total HIV/AIDS expenditure. In 2006/2007, the public funds contributed 40% while the international funds contributed 60%. In 2005/2006, the public funds contributed 30% of the total expenditure while the international funds contributed 70%. In both years the major external (international) funding was from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The analysis of the spending on the core AIDS activities shows that in 2006/2007, a high proportion of the total funds was spent on OVC (30.4%) specifically OVC education, followed by care and treatment (19%) and prevention programmes (17.3 %). Comparing the estimated costs of the 2006/2007 NSP with the actual 2006/2007 HIV/AIDS spending, the results show that the actual spending in prevention, OVC, Human resource's recruitment and retention incentives and programme management and strengthening programmes were higher than the estimated amounts. Care and treatments actual spending was low compared to the estimated amount in the costed 2006/2007 NSP. However, the costed 2006/2007 NSP included the prioritized interventions only and not the full NSP. In addition, the cost estimates in the NSP were not translated into actual funds allocations to prioritized HIV/AIDS interventions.

The main financing agents in the Kingdom of Swaziland included institutions/ organizations from the international purchasing organizations, public sector and private (NGO) sector. In 2006/2007, International purchasing agents managed SZL 184,708,062 (53%), Public sector managed SZL 140,354,392 (41%) and NGO-sector managed SZL 21,066 (6%). In 2005/2006, International purchasing agents managed SZL 177,407,163 (69 %), Public sector managed SZL 79,245,808 (30.8 %) and private sector managed SZL 565,534 (0.22 %). NERCHA as financing agent managed SZL 174,904,265 (50.5%) and SZL 164,380,130(63.9%) out of the total amount spent in year 2006/2007 and 2005/2006 respectively.

The majority of providers of HIV and AIDS services in Swaziland are public providers, accounting for approximately SZL254,929,242(USD 36,418,463) in 2006/07, about 73.6% of HIV/AIDS spending. Other providers included NGOs, spending SZL 82,472,152 (USD 11,781,736 (23.8 %), Bilateral and Multilateral entities spending SZL 2,274,824 (USD 324,475), providers not elsewhere classified spending SZL 5,401,441 (USD 771,635) (1.6%), and Rest of the world providers spending SZL 1,035,956 (USD 147,994) (0.3%).

In 2005/2006, the results again show that majority of providers of services were public providers accounting for SZL 212,595,191 (USD 31,730,626) (82.5%). Other providers included NGOs, spending SZL 42,653,321(USD 6,366,167) (16.5%), Bilateral and Multilateral entities spending SZL 1,397,505 (USD 208,583) (0.5%), providers not elsewhere classified spending SZL 792,597(USD 118,298) (0.3%), and very small amount spent by the rest of the world providers.

Beneficiary of spending results show in 2006/2007 the total HIV/AIDS spending benefited people living with HIV/AIDS the most (almost 41% of funds were targeted to them), which reflects the generalized epidemic in the country, and also that they directly benefited from the spending on treatment and care (including ARVs). The vulnerable population benefited by 34%, mostly the OVCs through educational support. The general population benefited by 23% (for example, from awareness raising and educational campaigns). Accessible population spending (2%) was primarily on youth in school through school educational programmes, and defense forces through condom provision. In 2005/2006, the results show almost the same patterns as 2006/2007 with small variations. PLWHA was the largest beneficiary group (almost 36%) reflecting the prevalence of HIV epidemic in the country. The vulnerable population benefited by 32 % mostly the OVC education. The general population benefited by 28% and there was small reported spending on the most at risk population (almost 3%) such as for commercial sex workers (CSWs), men who have sex with men (MSM), intravenous drug users (IUDs) and so on. Less was spent on accessible population (1%).

With regard to spending rates of the providers of the funds received from agents, the results show that, of all the spending in 2006/07, there was 100% spending in 94% of the funds transferred from agents to providers. Of the remaining funds, 0.67% was under spent and 99.33% were overspent. The overall spending rate in 2006/07 was 96% %. In 2005/06, there was 100% spending in 96% of the funds transferred from agents to providers. Of the remaining funds, 0.57% was under spent and 99.43% were overspent. The overall spending rate in 2005/06 was 97%. However, study did not concentrate on exploring the causes of over or under-spending, since it is the first step in creating data on actual expenditure, but could be further enhanced for analysis of efficiency and effectiveness in the next phases.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BVEs	Bereaved Vulnerable Elderly
CBO	Community Based Organizations
CDC	Center for Disease Control
CEGAA	Centre for Economic Governance and AIDS in Africa
CSO	Central Statistical Office
DHS	Demographic and Health Survey
E	Emalangeni
EU	European Union
FBO	Faith Based Organization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAPAC	HIV and AIDS Prevention and Care Program
HIV	Human Immunodeficiency Virus
INGO	International Non-Governmental Organization
M&E	Monitoring and Evaluation
MoHSW	Ministry of Health and Social Welfare
NAP	National Action Plan
NASA	National AIDS Spending Assessment
N.E.C	Not Elsewhere Classified
RTS	Resource Tracking Software
NGO	Non Governmental Organization
NSP	National Strategic Plan
ORGS	Organization
OVC	Orphan and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PWD	People with Disabilities
RHM	Rural Health Motivators
SNAP	Swaziland National AIDS Programme
SZL	Swaziland Lilangeni
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nation Children's Fund

USD	United States Dollar
USG	United States Government
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

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CHAPTER ONE

Introduction

1.1 Background information

The Kingdom of Swaziland is located in the Southern African region and covers a surface area of 17,364 Km^2. According to the 2007 census preliminary results, the population is approximately 960,000 with almost 70 percent living below the poverty line, despite being classified as a lower middle income country. Recent evidence points to the fact that Swaziland's population growth rate is below zero, with life expectancy falling to 33, rising infant and under five mortality as well as rising HIV incidence. The projected population size in 2015 is estimated at 1.28 million, which is about 21 percent lower than it would have been without HIV/AIDS (Budget speech by Minister of Finance, 2007)

The country is in the sub Saharan region worst hit by the HIV epidemic in the world. Since the first case of HIV was diagnosed in Swaziland in 1986, the prevalence among pregnant women attending ANC has increased dramatically from 3.9 percent in 1992, 42.9 percent in 2004 and slightly dropping to 39.2 percent in 2006. The ANC data further highlight that HIV prevalence among the 15-24 age group stabilized at 39.4% between 2002 and 2004 and declined to 34.6% in 2006. This dropping has been viewed as a positive achievement for the country in the war against HIV/AIDS (NERCHA, 2006/07). Recent estimates and projections however indicate that incidence will continue to rise for the next couple of years.

The country has also recently conducted its first Demographic and Health Survey (SDHS) which included HIV testing at national level. The preliminary results of first Swaziland Demographic and Health Survey (SDHS) 2007 confirmed that Swaziland was in a crisis as the HIV prevalence in the population of women and men aged 15-49 was estimated at 26%, the highest population based HIV prevalence in the world. The findings further revealed that women aged 15-49 were more likely to be HIV positive than men in the same age group (31% and 20%, respectively). The age patterns of HIV infection differ for women and men with HIV prevalence being higher among women than men in age categories younger than 35, while it is higher among men in the age categories 35 years and older. The SDHS also illustrates that in 2006, HIV prevalence peaked at 49 percent among women in the age group 25-29, while among men, the infection rate was at its highest level among those in the 35-39 year age category (45 percent). Surprisingly, HIV prevalence continues to be moderately high among both women and men in the age category 50 and older; for example, around one-quarter of women and men age 50-54 were infected while 7 percent of women and 13 percent of men age 60 and older were infected with HIV in 2006-07. The recent spectrum estimates revealed that about 58,000 adults and children were in need of ART treatment in 2007[1] and this is expected to reach approximately 70,000 in 2010. According to Whiteside et al. (2006), the rollout of ART has been a success with increasing number of facilities offering free ART from 8 in 2004 to 17 in 2005

As the epidemic has progressed towards maturity, its impact is becoming visible through an increasing number of patients suffering from AIDS opportunistic infections, an increase in mortality rates and a rapidly growing population of orphans and vulnerable children (OVC). It has been previously estimated that the number of orphans, which was about 32,000 in 2001, will increase to more than 120,000 (approximately 15% of the population), by 2010 (Stanecki 2001, Swaziland HIV/AIDS Modeling Mission Report). More recent modeling using both ANC and DHS data however puts the number of OVC in the country at approximately 110,000 by 2007/8. The increasing numbers of orphans is already overwhelming the capacity of the extended family to cope, given that majority of families are already poor. This situation has further resulted in increased numbers of child headed households, school drop outs and hunger. The quality of education is reportedly declining due to increased HIV and AIDS-related deaths among teachers, and an increase in destitution and poverty among families, which is a barrier to school attendance. It has also been projected that primary school enrolment of eligible children will decrease from 96.5% in 1999 to 70% by 2015 due to HIV and AIDS(MoE,1999) · However, efforts are being made by both the Government and other development partner to mitigate the impact of OVC. Currently, about 41% of the OVC are getting support from both the government and development partners in forms of food, education, health, psychosocial support and shelter. Notable effort is in education provision where the ratio of school enrolment between orphans and non-orphans was 90:93 in 2006/07 (CSO, 2007).

[1] HIV Estimation and Projections for Swaziland, Workshop Report. October 2007.

A 2004 study of the links between HIV and AIDS, demographic status and livelihood in Swaziland, gave a brief picture of the epidemic in the country[2]. The study showed that HIV was already having a great impact on the country's economy, productivity, food security, and aspects of service delivery. According to the study, the disease was also negatively affecting the social fabric of the country, as well as leading to a collapse of traditional practices and support mechanisms. Also, there have been a decrease in both land cultivated and crop production, directly related to AIDS. The 2007 FAO/WFP Crop and Food Supply Assessment Mission report to Swaziland states that prolonged dry spells and high temperature levels significantly reduced Swaziland's maize crop, making 2007 the lowest annual harvest on record. The high prevalence of HIV exacerbates the already severe impact of adverse livelihoods through ill health, food insecurity, income inequality and poverty.

1.2 National response to HIV/AIDS

Swaziland's response to HIV/AIDS dates back to 1987 through the Ministry of Health. The first HIV/AIDS plan (1987-1988) was developed by an AIDS Task Force. Subsequently the AIDS Task Force was developed into the Swaziland National AIDS Program (SNAP) who remain the key planning and management force for within the Ministry of Health for health sector HIV/AIDS services.

Currently, the national response is operating under its Second National Multi-sectoral HIV and AIDS Strategic Plan (NSP) 2006-2008 which was created after a joint review of the response up until that time. The community consultation process that informed the preparation of the current NSP is lauded as a key strength of what is known as a comprehensive and highly regarded plan. The NSP provides a framework for resource mobilization and coordination of all HIV /AIDS activities in the country. All responding entities to HIV/AIDS pandemic are obliged to act within the parameters of the NSP. In addition, it provides a clear guidance for Ministries, districts, NGOs, CBOs, FBOs, the private sector and individuals to enable them to work in a collaborative manner in achieving the intended goal of the National Response to HIV/AIDS. . Therefore, response to the AIDS epidemic in Swaziland is a collective effort of the government, multilateral and bilateral donors, national and international NGOs, CBOs, faith-based organizations (FBOs), the private sector, PLWHIV organizations and individuals.

The National Emergency Response Council (NERCHA) was established in year 2001 with a mandate to coordinate the national response to HIV and AIDS. NERCHA has become entrenched by decentralizing its activities to regional level to improve coordination of the response. Due to its appointment as Principle Recipient of Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and Government monies; it also assumes the role of a sub-granter in the award and disbursement of funds and in conducting procurement for implementation activities. In addition NERCHA plays an implementation role in some programmes where national capacity maybe lacking such as in Behaviour Change and Communication. NERCHA has introduced the National Minimum Package (NMP) as the basic service delivery package for implementation at community level throughout the country. The NMP is a planning tool for service delivery, resource mobilization and M&E at the community level in the areas of: prevention, care, support and mitigation for the infected and affected. All partners contributing to the national

[2] Assessment of the Impact of HIV and AIDS On The Central Ministries of The Government Of Swaziland, Final Report, June 2002, Impact Assessments of HIV/AIDS on Education 1999, Agriculture 2002 and Health 2

response are encouraged to implement the NMP as the basic package in all communities. However, critical challenges remain in Swaziland's response to HIV. In general, vulnerability to HIV infection continues to be high due to the combined effects of poverty, gender inequality and some harmful cultural practices. Furthermore, the drivers of the epidemic which include multiple concurrent partnerships, intergenerational sex, low condom use, low HIV testing and disclosure levels, high prevalence of sexually transmitted infections, early sex and decline of moral values are yet to be fully strategically addressed.

1.2.1 National Multisectoral Strategic Plan for HIV and AIDS 2006/2008

The purpose of the National Multisectoral Strategic Plan (NSP) is to articulate, disseminate, and educate the public at large on agreed national priorities and strategies within a scope of the National Multisectoral HIV/AIDS policy. The broad goals of the NSP are:

- Prevention of HIV transmission
- Improve the provision of care, support and treatment to all those infected and affected by HIV/AIDS.
- Mitigate the social and economic effects and impacts of the epidemic on Swaziland society.
- Create an enabling environment for the scale up and better coordinated national response to HIV/AIDS.

Details of the targets for each goal are appended in appendix 6.8

1.2.2 Resource mobilization to support the National Multisectoral Action Plan for HIV and AIDS 2006/2008

The NSP 2006-2008 states that NERCHA is responsible for overall resource mobilization for the national response. Other responding partners can also carry their own initiatives to mobilize resources and are obliged to declare secured resources. The resources for the national response can be secured from the government, bilateral and multilateral donors, foundations, international civil society organizations, private corporations, development banks, local communities and individuals.

In efforts to mobilize resources to support the NSP 2006/2008, a full costed National Plan of Action was carried out as key output of the second NSP. The costed National Plan of Action detailed the estimated cost to attain the goals highlighted in the Second NSP for the period 2006/2007. The full NSP was costed to about 9 billion but this was by far beyond the available resources hence not approved. Also, it was observed that the NSP was too broad with prohibitive costs and objectives that would be hard to attain given the budgetary constraints facing Swaziland. This necessitated the move to prioritization of interventions that would make the most impact on the war against the epidemic and costing of the priorities identified. Using evidence based approach priority objectives and strategies were identified within the NSP as areas of focus. The prioritized area of focus were as follow

a) Prevention activities priorities included adult and youth (out of school) Sexual behaviour change, youth in school delay start of sex and Knowledge.

b) Impact mitigation on OVC priorities included physical well being, education and skills, early childhood care and development (ECCD) services, counseling & emotional care and caring for the carer.
c) Health sector priorities included PMTCT, ART & Pre-ART, HIV/TB Co- infection and laboratory services.
d) Coordination and management of the national response priority areas included Institutional arrangements, community mobilization and decentralization, coordination, planning and program development, resource mobilization and management, advocacy and communication and cross- cutting issues.
e) Monitoring and Evaluation priorities included refinement and implementation of a national M&E system, development of national M&E capacity and promote evidence based responses and planning
f) HIV/AIDS research prioritized building research capacity, mobilizing funding for research and facilitate establishment of research and ethics committees

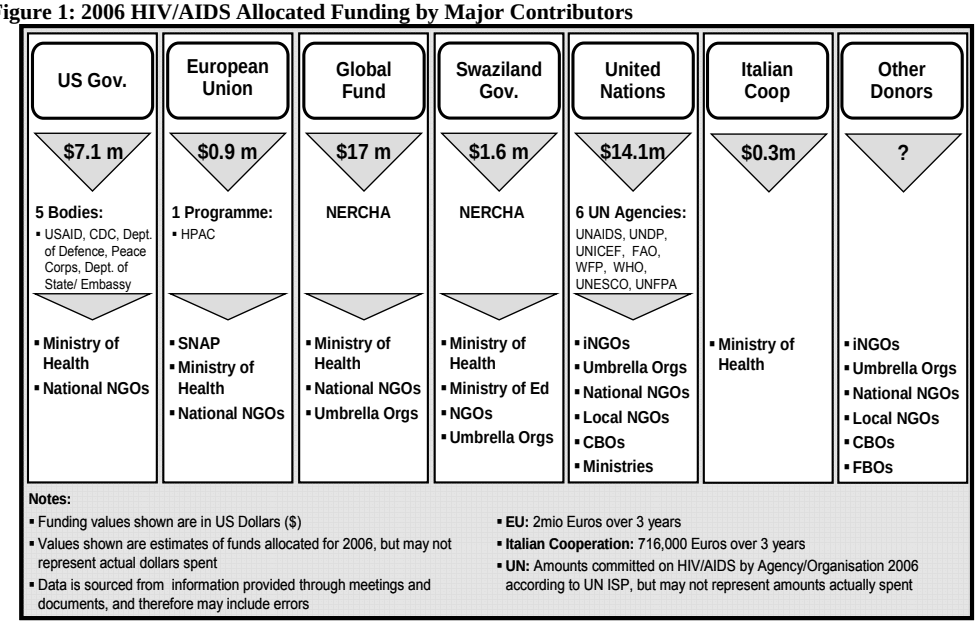
The costing of the prioritized intervention for the period 2006/2007 estimated SZL 270,097,637 were required for the implementation of the prioritized interventions. Fund commitment were NERCHA SZL 57,533,673 Development partners SZL 101,793,748 other sectors SZL 29,003,000 and Outstanding amount SZL 81,250,550 (Appendix 6.9).

1.3 Status of HIV and AIDS Funding

According to UNAIDS (2006) funding for HIV/AIDS has significantly increased in the past several years. One major contributor is the receipt of Global Fund Round 2 and Round 4 in 2006. Other contributors include both multilateral and bilateral donors namely UN agencies (UNAIDS, UNICEF, UNDP, WFP, UNESCO, UNFPA), European Union, the US Government (USG) and the Italian Cooperation. Generally, the both multilateral and bilateral donors are less represented in the Kingdom of Swaziland.

Moreover, UNAIDS (2006) noted that the Swaziland allocated approximately $42 million funding for HIV/AIDS from the Government and donors in 2006. Out of the $ 42 million, major donors (UN agencies, USG, Italian cooperation, EU and Global fund) allocated $ 39.4 million and the Government of Swaziland allocated $ 1.6 million. Government spending on health was estimated to be 7% of the total government expenditure in 2006, falling below the 15% recommended by the ABUJA Declaration (universal access report, 2007). Figure 1 shows the amount of fund allocated to HIV/AIDS in Swaziland in 2006.

Figure 1: 2006 HIV/AIDS Allocated Funding by Major Contributors



Source: UNAIDS, 2006.

Figure 1 shows about $41 million was allocated to HIV/AIDS activities in 2006. However, the figures presented were the estimates or commitments by the contributors and not the actual expenditures on HIV/AIDS activities. The NASA approach aims at filling the gap by tracking the actual HIV/AIDS expenditures information from the sources, agents and the providers.

1.3.1 Challenges on resource flows, mobilization and tracking

UNAIDS (2006) identified the following challenges in terms of resource flow, mobilization and ultimate tracking of the allocated resources in the Kingdom of Swaziland.

i. Funds from donors filter down through a complex process through various intermediary organizations and out through different bureaucracies to recipient organization. At each step certain percentage of money leak or some time a proportion of money available is utilized by intermediary organization for its own activities or lost toward redundant administration process.

ii. There is limited capacity of the response and transparency of funding mechanisms. Sector umbrella bodies have limited resources or process to follow in order to support capacity building, information sharing and mobilization within their sector. In addition, some Civil Society Organizations (CSOs) and other implementers have limited understanding of where and how to apply fund.

iii. There is no mechanism or system in place to track and direct HIV/AIDS funding. Donors do not report or commit their spending through the national system. This makes it difficult to track how much money and for what service HIV/AIDS funds are being spent in the country. Although NERCHA or Ministries may be aware of the general intention of the donor funding, allocations and disbursement of the fund to specific organisations for specific services are done without their knowledge.

1.4 NASA rationale

Resource tracking for HIV and AIDS has gained prominence given the significant amount of funds that are injected into interventions addressing the pandemic. Also, in order to be able to effectively and efficiently allocate resources to different interventions, according to the national priorities, it is important to have a detailed analysis of the sources of financing, distribution and the different uses of the funds, especially in situations of resource scarcity. Based on the above counts, the 2005 joint review report recommended the need for the country to develop resource tracking mechanisms that would complement ongoing monitoring and evaluation of the HIV programme. It was further acknowledged that monitoring of resources is one piece of information that planners, donors and programmers need in order to identify funding gaps, areas that receive insufficient funding, and serve as a tool for resource mobilization. Furthermore, when combined with other information pertaining to know your epidemic and know your response, it yields a powerful analysis that reveals at a glance whether the resources are targeting the most effective interventions.

The NASA will provide some of the data required for future planning, coordination and prioritizing of the HIV/AIDS interventions. Nevertheless, this report makes useful recommendations for the future 'shape' of the NSP, and will hopefully lead to the institutionalization of a system of tracking funds which is extremely valuable to governments, donors and service providers.

1.5 The Kingdom of Swaziland NASA objectives

The objectives of this NASA project were to:

i. To develop the Kingdom of Swaziland's estimates of total flows of financing and expenditures for HIV/AIDS, from all international and public (domestic) sources of financing for the financial years 2005/06 and 2006/07.

ii. To develop a database of each financial transaction supporting HIV/AIDS health and non-health expenditures.

iii. Identification of the flow of expenditures by sources, agent functions, providers of services, and target populations.

1.6 Structure of the report

This report presents the results of the NASA estimates for Swaziland covering the financial years 2005/06 and 2006/07. The report is organized into four chapters. The first chapter presents the introduction detailing the background, HIV situation, response and funding situation and the NASA objectives. The second chapter describes the methodology, the process and the limitations of the NASA exercise. Chapter three presents the results and discussion of the NASA. Finally, recommendations based on the findings are presented in the fourth chapter

CHAPTER TWO

2 Methodology

2.1 The overall methodology and scope

According to UNAIDS (2007), the National AIDS Spending Assessment (NASA) approach is a comprehensive and systematic methodology used to determine the flow of resources intended to tackle this disease in a country or region. It describes the allocation of funds, from their origin to the end point and beneficiary groups among the different institutions dedicated in the fight against the disease. The NASA establishes the level and determinants of expenditure on HIV/AIDS, thus measuring the national response to HIV/AIDS. Also, it facilitates creative efforts in diversifying financial sources as well as identifying areas for improved allocation in a more efficient and equitable way. Information about the existing HIV/AIDS resource sources, allocation and utilisation offers a rationale for reforms in the funding, distribution and use of resources in response to HIV/AIDS. Moreover, NASA generates useful information for the decision-making and policy design process intended to reduce the burden of disease caused by HIV/AIDS. Though not an all-in-one tool, NASA supports the UNAIDS "Three Ones" principle[3] and facilitates a standardized reporting method of indicators that monitor progress towards achieving the targets of the Declaration of Commitment adopted by the United Nations General Assembly Special Sessions on HIV and AIDS (UNGASS I & II)(UNAIDS, 2007).

This tracking of actual expenditures for HIV/AIDS in Swaziland used the NASA methodology, and captured the public and external sources of funds. This phase excluded the private contributions (from business, private health system, individual spending), but these are planned to be included in the next NASA. Also, the productions factors for all the expenditures were not captured because this level data was either not available or would have required extensive additional data collection efforts and estimations. These were beyond the available time of this project and were therefore excluded. Priority was given to actual expenditure records obtained from the service providers, or recipients of the funds, rather than the budgetary allocations of government or the commitments or disbursements of donors. Where the actual expenditure could not be obtained, the disbursements from the source were used.

2.2 Preparatory phase

A short preparatory mission was undertaken in October 2007 by the Centre for Economic Governance and AIDS in Africa (CEGAA), on behalf of the UNAIDS Technical Support Facility (TSF) in order to ascertain NERCHA requirements, to discuss the nature and extent of the NASA estimation, and to determine the terms of reference of the assessment and the roles

[3] The "Three Ones" principle for the coordination of national HIV and AIDS responses relates to One agreed AIDS action framework, that provides the basis for coordinating the work of all partners; One national AIDS coordinating authority with a broad-based multi-sectoral mandate: One agreed AIDS country-level monitoring and evaluation system.

and responsibilities of each involved party. Also, the preparatory phase involved the development of the interview schedules, based on the UNAIDS model, training of the research assistants and stakeholders inception workshop.

2.3 Sampling and sources of data

a database of all the stakeholders involved in HIV/AIDS as sources, agents and providers, was developed using the Swaziland HIV/AIDS Programme Monitoring System (SHAPMoS) database and the HIV Stakeholders' directory. The list of health facilities were sourced from the Service Availability Mapping (MAS) database. The sampling frame included all the donors, governmental and non governmental organizations, faith based organizations and some community based organizations. The final sample included *all* main sources of funds (external and public), *all* agents of funds in Swaziland and all main/ key providers. A total of 88 organizations were sampled for Swaziland 2007 NASA (Refer to appendix 6.1 showing the list of the key stakeholders in the HIV/AIDS field in Swaziland and the extent of captured data and gaps therein). In addition, it was decided that all (seven) 7 hospitals and all (four) 4 health centers would be visited. Eighteen (18) other health care clinics were selected using purposive sampling to obtain representation of urban and rural based as well as public or private facilities. Table 1 shows the health facilities selected for NASA.

Table 1: Health facilities selected for inclusion in this NASA

Category	Total	Rural	Urban
Hospital	6	-	6
Health Centres	5	1	4
Clinics	18	11	7

2.4 Obtaining permissions and access to data

Permission from the Principal Secretary of the Ministry of Health and Social Welfare was sought in order to access the health facilities' data. Other stakeholders were requested to allow access to their expenditure data and to suggest a date for the first data collection visit during a pre-data collection workshop. Those who did not attend the workshop, formal letters from NERCHA were sent to request access to required information.

2.5 Data collection

Both primary and secondary data, quantitative and qualitative data, were collected from the majority of sources, agents and implementers. Primary data included expenditure information at

source as well as qualitative information on various issues around funding and reporting mechanisms for HIV/AIDS spending. Secondary data included audited reports, annual reports and action plans from various organizations. Data collection process used two approaches namely "top down" and "bottom up". Top down approach involved collecting data from the sources and agents. Bottom up approach involved collecting detailed data from the provider on their expenditure activities and the beneficiary groups and linking this back to the agent to source. Triangulation was used to create each complete transaction, so as to avoid double counting. All the data collected were transcribed to the NASA forms (appendix 6.10) designed for this project. For missing data, assumptions were made and estimations undertaken.

2.6 Data processing and analysis

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

2.7 Assumptions and estimates

The following assumptions were made during data processing and analysis

- Differing financial years – It was found that some organization used differing financial years to the one used by the government. The government uses April to March yet some organizations used the calendar year. This made harmonization of the data for the NASA difficult hence assumption for the financial years became necessary. Therefore, where the financial year of any organization was not corresponding to the government financial year, then we assumed an equivalent time period of 12 months was equal to the government financial year.
- Pooled funds – This is where the data indicated the sources of the pooled funds and their contributions, but it was not possible to link each source to specific activities. Therefore, we assumed proportional distribution to the identified activities based on each source's proportional contribution to the total pool.
- Missing expenditure information from implementers - Where the actual expenditure was not obtained from providers according to specific activities, then the amounts reported transferred by the donors were split equally between the key functions of the providers. This was only necessary in a few instances since the expenditure details were mostly captured from the implementers.
- Expenditure on TB treatment that was HIV-related - In a number of cases, information on TB treatment expenditures were generalized and it was difficult to extract the total expenditure on TB that was HIV related. Moreover, the number of TB cases that are HIV related was difficult to get. Therefore, it was assumed that 80%[4] of all TB cases are

[4] Based on testing of TB patients, WHO estimated that in 2004, 80% of adults who had TB were HIV infected in Swaziland (WHO, 2004)

also HIV infected, and thus 80% of total expenditure on TB was captured in this NASA under opportunistic infection treatment and care. This made it possible to estimate the expenditures for TB that was HIV related.

- In the absence of data to the contrary it was assumed that 100 % of condom use was for HIV or STI prevention.
- Non-financial expenditure - In some transactions, values of the non-financial items were not given. In most cases it was computers and accessories donated to providers from various sources. We assumed market price prevailing at the time of issue to ascertain the value to be used in the NASA.
- Exchange rate. The following annual average exchange rates from the Swaziland Central Bank were applied were the information provided were in USD($) instead of Emalangeni(SZL)

  2005/06: 1US$ = SZL6.7
  2006/07: 1US$ = SZL 7

2.8 Validation of results

The preliminary results were firstly presented to the Technical Working Group at NERCHA, and subsequently to representatives of all key HIV/AIDS response stakeholders in Swaziland. Both meetings were well attended and participants provided valuable confirmation of the key findings as well as making useful suggestions for improvements. The main assumptions for all estimations were also presented at the validation meeting. The majority of the assumptions were accepted as valid and suggestions were made for the refinement for the few remaining assumptions. All the suggestions and recommendations have been incorporated in this report.

2.9 Challenges faced

The following are the challenges faced during the NASA process

- Timing of data collection - The NASA data collection started at the end of the year, when most offices are closed for the festive season. This necessitated a break in the data collection, which resumed in January 2008.

- Slow/ no access to key players' data - Some stakeholders were slow in providing the information required for NASA. In the extreme cases, some stakeholders did not give access to the information required. All these called for prolonged negotiations in order to access the information.

- The financial reporting format was not in suitable formats for the NASA classification - the definitions of activities from some organization were different from the NASA spending categories. This necessitated re-processing of the collected information to NASA format, which was time consuming and therefore data entry to the excel sheets were delayed.

2.10 Limitations of the collected data

Despite the efforts made to have all the information required, some interviewees or organizations did not respond. Hence, the expenditure information from these organizations was not included in the analysis, unless where the information could be obtained from secondary sources. The following are the critical gaps in the Swaziland NASA data:

i. United States of America Government (USG) - Did not give any expenditure data (since their commitments in their COP do not translate into actual expenditures). However, much of the actual expenditure was obtained from implementers / recipients of the funds.
ii. UN agencies –Some of the UN agencies gave information for one year only. This amounted to partial information being used.
iii. MoHSW- Only data on disbursement of funds from some of the sources was obtained and not actual expenditure from MoHSW. Also, the portion of salaries and overheads from MoHSW and other hidden costs related to HIV/AIDS could not included,
iv. Other Government Ministries- in most of the ministries it was not easy to access information because of the existence of multiple units that deal with HIV issues. Therefore no one department was able to provide the full information that was required.
v. Research agencies -very few research agencies were included in the study leading to limitations on HIV/AIDS related research spending data.

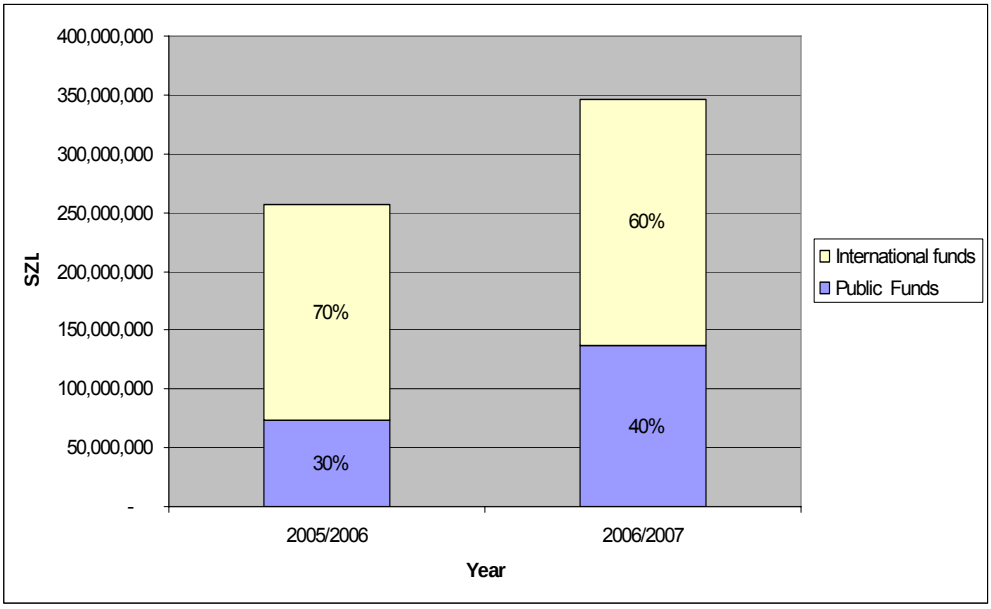
CHAPTER THREE

3 PRESENTATION AND DISCUSSION OF FINDINGS

3.1 Total Expenditure on HIV/AIDS and Sources of Funding for 2005/06 and 2006/07

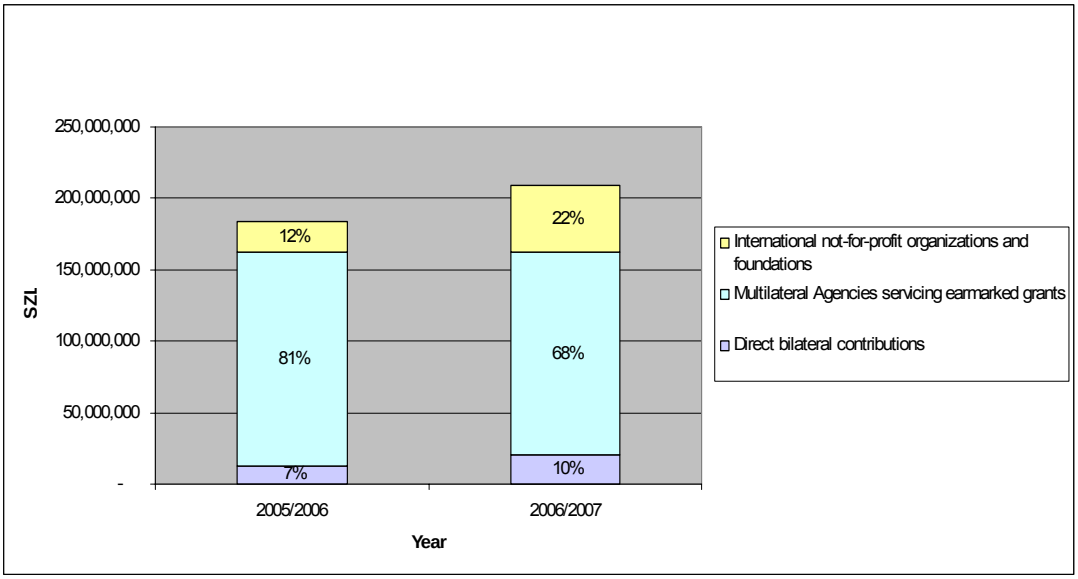
Total expenditure on HIV/AIDS (public and international, excluding private) in The Kingdom of Swaziland increased from Swaziland Langeni (SZL) 257,218,500 (USD 38,390,819) to SZL 346,128,488 (USD 49,446,927) between 2005/06 and 2006/07 respectively (Appendix 6.2). However, some of the organizations had not ended their financial year 2006/2007; therefore, some expenditure may have been omitted. The increment was approximately 35 % of the 2005/2006 total HIV/AIDS expenditure. In both years, major contributor was from international funds. The international fund contributed SZL 184,027,697 (70%) and SZL 209,212,520 (60%) in years 2005/2006 and 2006/2007 respectively. Per capita HIV/AIDS spending for 2005/2006 and 2006/2007 was SZL 270 (USD 40) and SZL 363 (USD 52) respectively. Generally, by comparing the two years, the results show that in 2005/06 the international fund proportional contribution was lower contribution made in 2006/07. Figure 2 shows the total expenditure on HIV/AIDS and sources of these funds for year 2005/2006 and 2006/2007.

Figure 2 Total expenditures on HIV/AIDS interventions by sources of funds 2005/06 and 2006/07 (SZL and %)



In addition, the results show within the international funds for both 2005/06 and 2006/07 year, the major contributors were multilateral agencies. Multilateral agencies contributed SZL 149,847,093 and SZL 142,331,910 (81% and 68%), direct bilateral contributions contributed SZL 12,872,474 and SZL 20,049,518 (7% and 10%) and international not-for-profit organizations and foundations contributed SZL 21,308,130 and SZL 46,831,092 (12% and 22%) for years 2005/2006 and 2006/2007 respectively. The largest share of the multi-lateral funds was from the Global Fund to Fight TB, HIV/AIDS and Malaria (GFATM) which contributed SZL 125,968,473 (85% of the multi-lateral contributions) in 2005/06 and SZL 108,568,051 (77%) in 2006/07. Figure 3 shows the proportional composition of international sources of funds for HIV/AIDS activities in 2005/06 and 2006/07. It is interesting that the largest increase in external funds has been from the international non-profit organizations and foundations.

Figure 3: Composition of international sources of funds for HIV/AIDS activities spending for 2005/0(and 2006/07



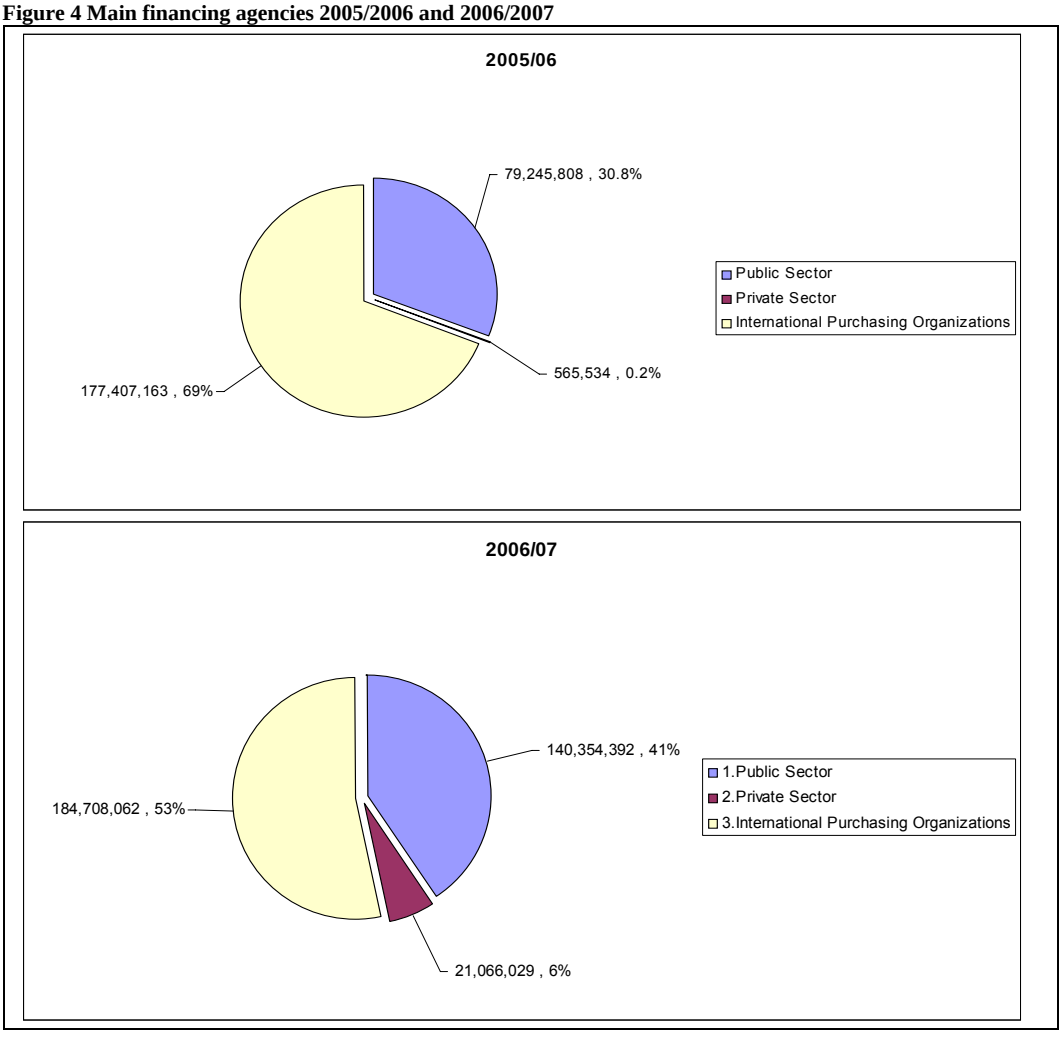
3.2 Financing agencies analysis

Financing agencies are entities which mobilize financial resources from different financing sources and transfer them to pay or purchase health care or other services or goods. The results show that in both years the major financing agencies were from the public sector, private sector and international purchasing organizations. The public sector agencies included MoHSW, MoE, MoF, NERCHA as the National AIDS Commission (NAC) and other Ministries. The private sector agencies included Not for profit Institutions (Other than social insurance) and other private financing agents. International purchasing agents included country offices of Bilateral agencies managing external resources, Multilateral agencies managing externa resources which include the "Principal recipient" of GFATM[5] and international not-for- profit organizations

[5] NERCHA is the principal recipient of GFATM in The Kingdom of Swaziland

and foundations. The public sector agents mobilized SZL 140,354,392 (41%) and SZL 79,245,808(31%) fo year 2006/2007 and 2005/2006 respectively. The Private sector agents mobilized SZL 21,066,029 (6%) and SZL 565,534 (0.21%) and in year 2006/2007 and 2005/2006 respectively. International purchasing organizations mobilized SZL 184,708,062 (53%) and SZL 177,407,163 (69%) for year 2006/2007 and 2005/2006 and 2006/2007 respectively (Appendix 6.4 and 6.5). Figure 4 shows the main financing agencies for year 2005/2006 and 2006/2007

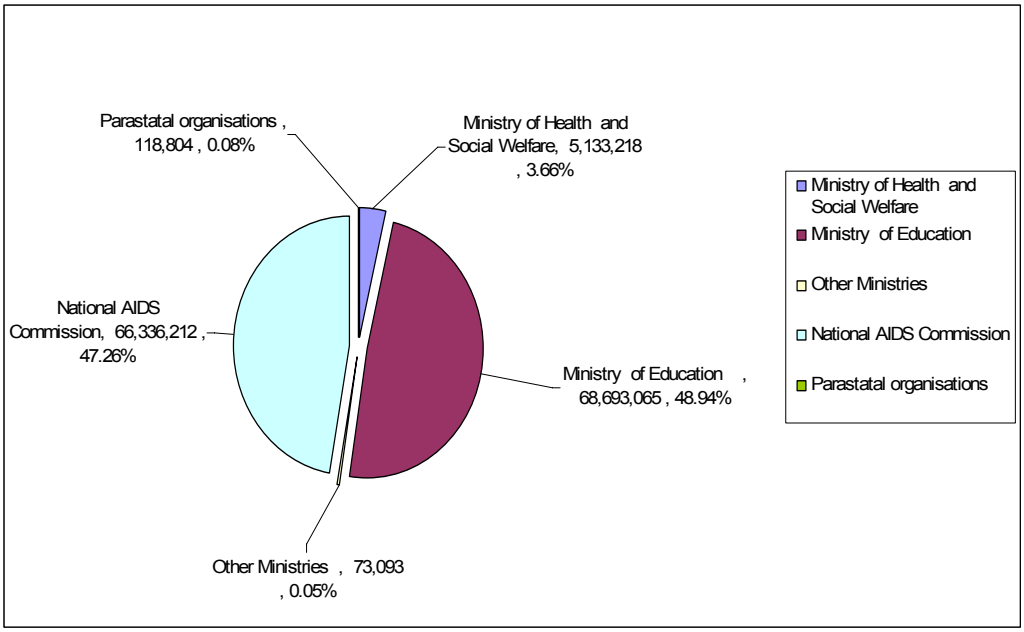
Figure 4 Main financing agencies 2005/2006 and 2006/2007



3.2.1 Public sector financing agencies.

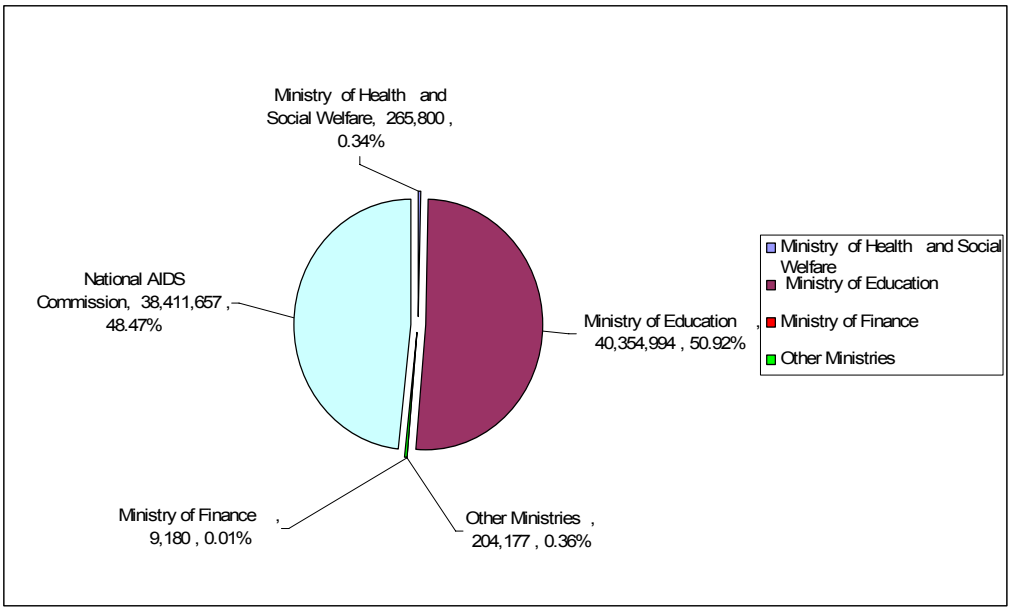
Public sector financing agencies' referred to institutions which are ruled by the government of the Kingdom of Swaziland. Within the public sector agents for both 2005/2006 and 2006/2007, the Ministry of Education (MoE) and NERCHA as the National AIDS Commission (NAC) mobilized the largest share of funds. In 2006/2007, the total amount of funds mobilized by the public sector agents totaled SZL 140,354,392. Out of the total fund mobilized by the public sector, Ministry of Education (MoE) mobilized SZL 68,693,065 (49%) and NERCHA mobilized SZL 66,336,212 (47%). The large amount of funds going through MoE come from the Government for supporting OVCs education. In 2005/2006, the public sector agents mobilized SZL 79,254,808. Out of the total fund mobilized by the public sector agents, MoE mobilized SZL 40,354,994 (52%) while NERCHA/NAC mobilized SZL 38,411,657(48%). Generally, there has been an increase of fund mobilized by the public sector agencies in year 2006/2007 compared to year 2005/2006. Figure 5 and 6 shows the public sector financing agencies for year 2006/2007 and 2005/2006 respectively.

Figure 5 Public sector financing agencies 2006/2007



Note: NAC = NERCHA
Ministry of Health and Social Welfare data were not comprehensive. Therefore, the figure provided may be underesti

Figure 6 Public sector financing agencies 2005/2006



3.2.2 Multilateral financing agencies

Multilateral financing agencies referred to international purchasing organizations managing non-reimbursable international funds that have been earmarked to be used in a recipient country by donors. The results show, in both years 2005/2006 and 2006/2007 NERCHA as the "Principal recipient" of the GFATM managed large sum of funds compared to other agencies under this category. NERCHA managed SZL108, 568,050 (78%) and SZL 125,968,475 (85%) in year 2006/2007 and 2005/2006 respectively. The remaining portions of funds were split among various multilateral financing agencies as shown in figure 7 and 8.

Figure 7 Multilateral financing agencies 2006/2007 (Total amount=SZL 138,440,415)

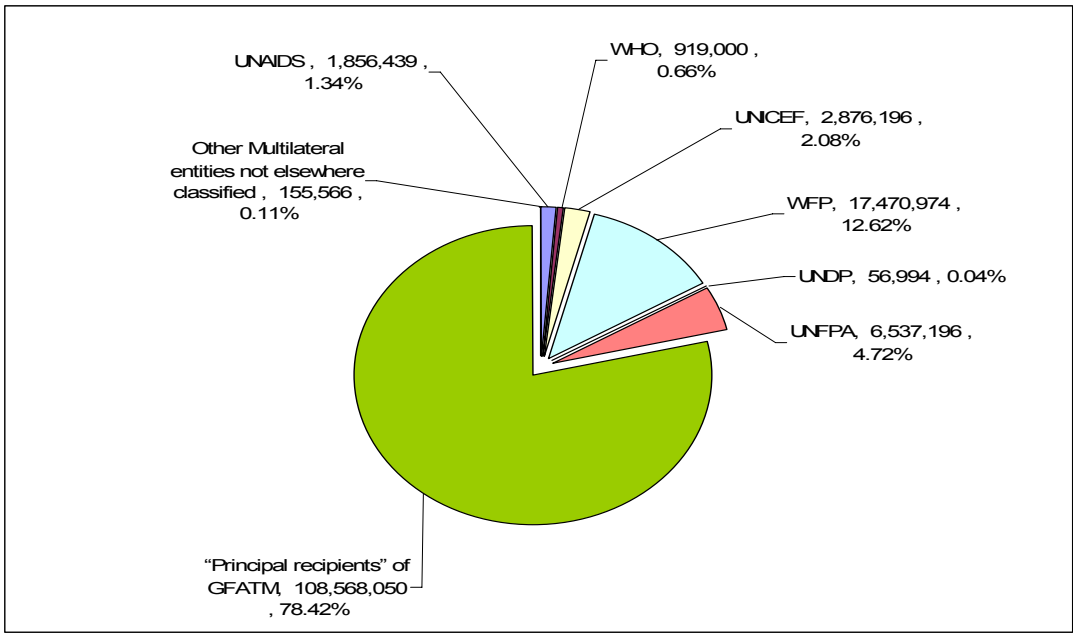
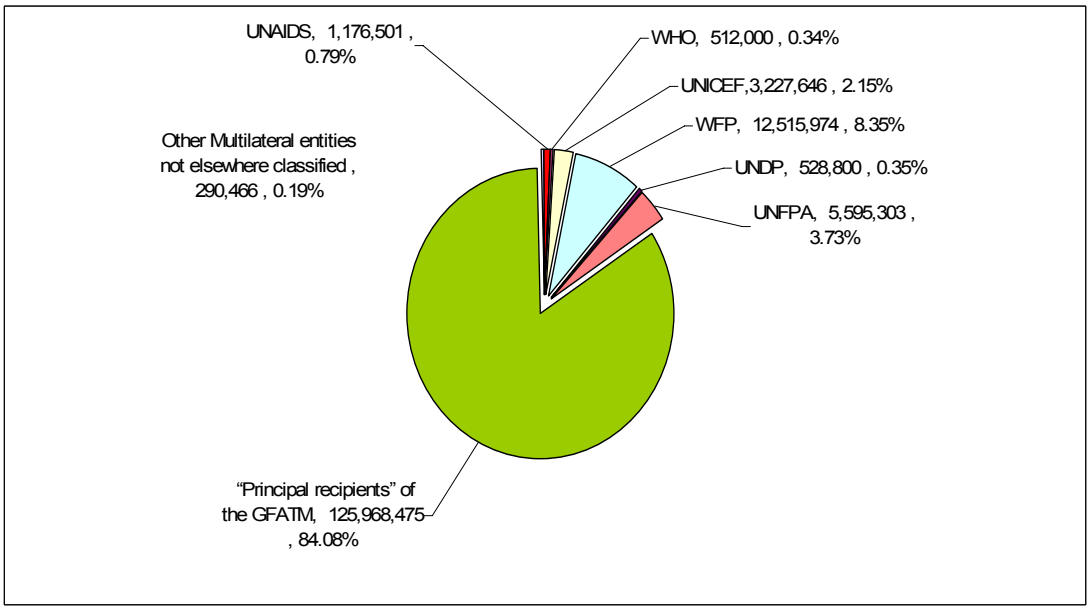


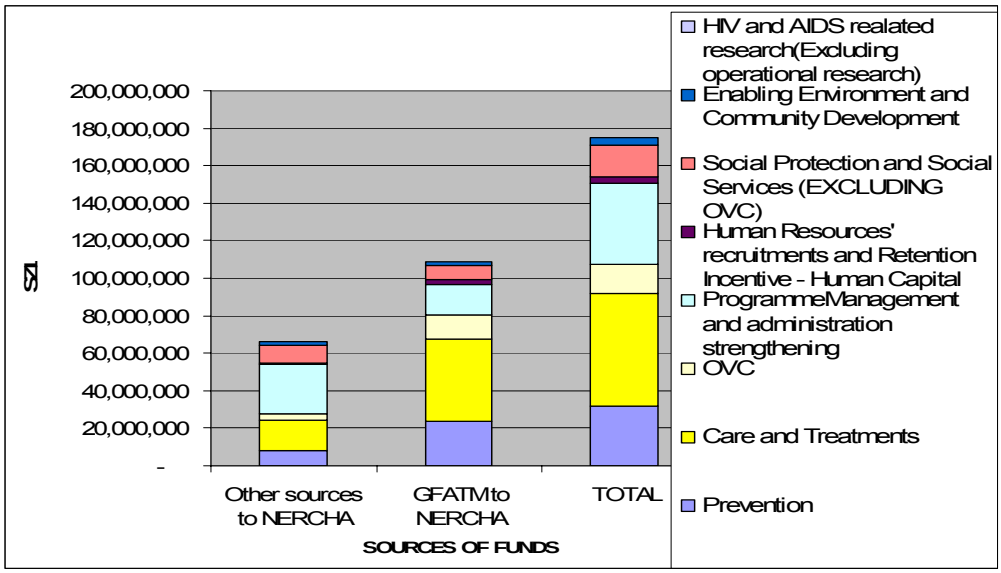
Figure 8 Multilateral financing agents 2005/2006 (Total amount SZL 149,815,165)



3.2.3 Financing agents by core spending categories analysis ~ The case of NERCHA

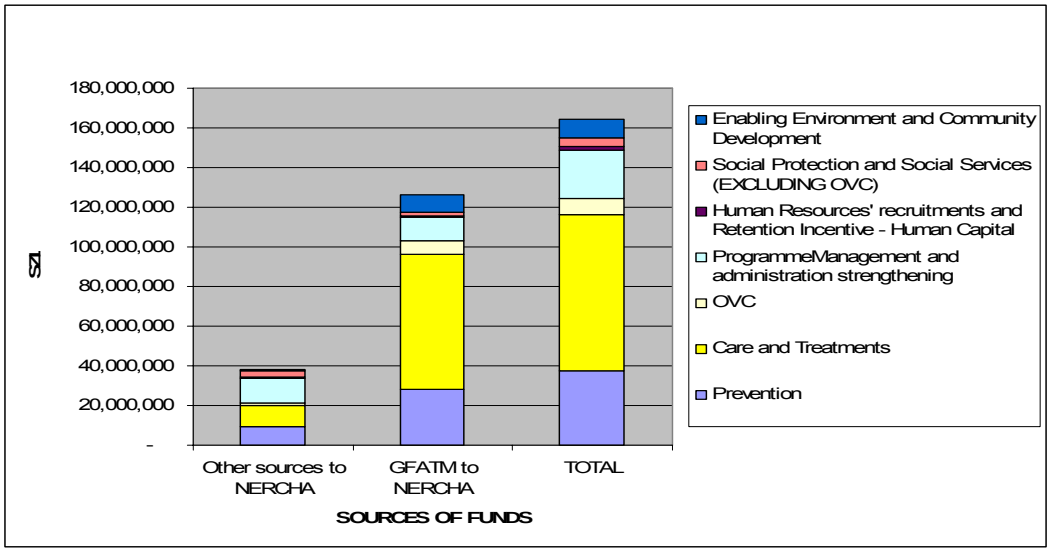
This subsection presents the analysis of funds mobilized from different funds sources and managed by NERCHA. The results show that NERCHA was able to mobilize HIV/AIDS activities funds amounting to SZL 174,904,265 and SZL 164,380,130 from all funds sources for year 2006/2007 and 2005/2006 respectively. Considering the core HIV/AIDS activities spending priorities of NERCHA between 2006/2007 and 2005/2006, the results show changing priorities overtime. While there have been decrease in spending in some thematic programmes, there have been increase in spending in other thematic programmes. Figure 9 and 10 shows NERCHA'S core spending categories in 2006/2007 and 2005/2006 respectively

Figure 9 NERCHA'S overall core spending categories 2006/2007 (from all sources)



Note: Other sources include public funds and funds sources other than GFATM

Figure 10 NERCHA'S overall core spending categories 2005/2006 (from all sources)



By comparing the actual spending in the core spending categories of NERCHA, the results show decreasing spending in care and treatment activities between 2005/2006 and 2006/2007 from SZL 78,274,400 to SZL 59,886,257 respectively. The same trend persisted under prevention activities where the actual spending between 2005/2006 and 2006/2007 decreased from SZL 37,675,271 to SZL 31,675,167 respectively. Social protection and social services (excluding OVC) increased from SZL 4,589,143 to SZL 17,172,189.

Other increases in NERCHA's spending between year 2005/2006 and 2006/2007 were noted in OVC which increased from SZL 8,560,058 to SZL 16,106,439. Notably, the increase in programme management and administration strengthening was almost doubled from SZL 24,106,953 to SZL 42,969,283. Programme management and administration strengthening covered services such as management of AIDS programmes, Monitoring and Evaluation, Advocacy, and facility upgrading through purchase of laboratory equipments, the drug supply system, serological surveillances, operation research, information technology and upgrading and construction of infrastructures. Figure 11 and 12 shows the breakdown on NERCHA's spending on programme management in 2006/07 and 2005/2006 respectively.

Figure 11 NERCHA- Programme Management and administration strengthening 2006/2007

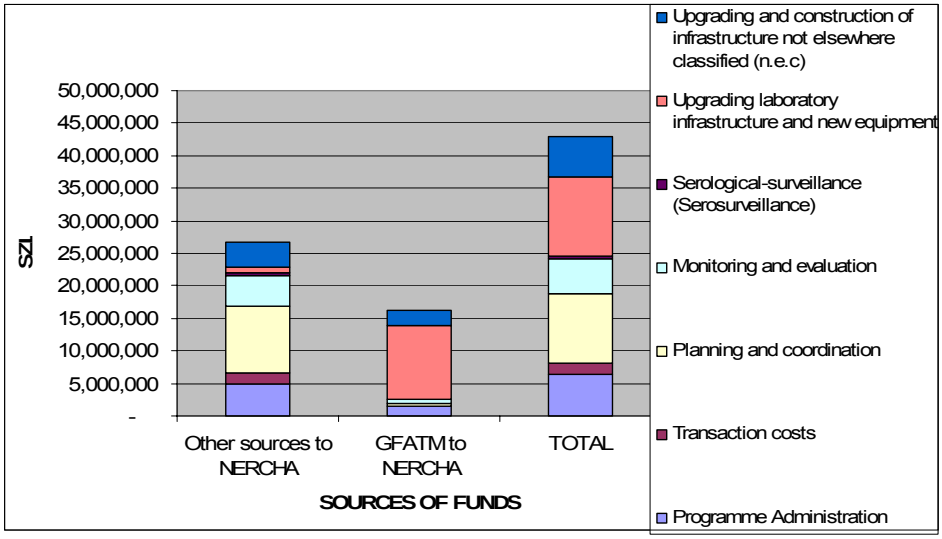
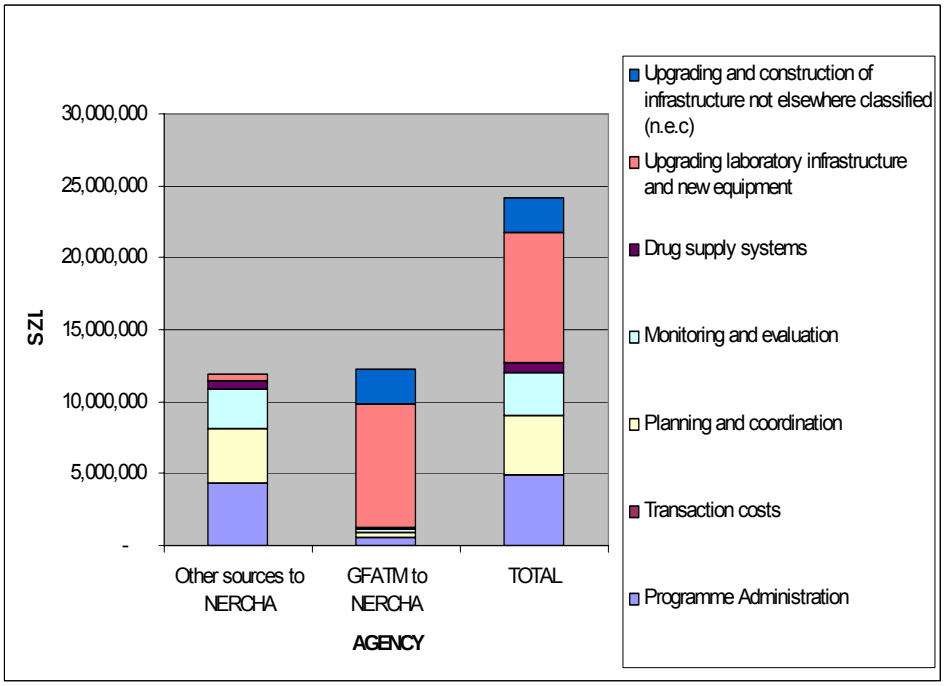


Figure 12 NERCHA- Programme Management and administration strengthening 2005/2006



Comparing programme management and administration spending breakdown between 2006/2007 and 2005/2006, the results show an increase in spending for upgrading laboratory

infrastructure and new equipments from SZL 9,013,112 to SZL 12,074,454 in year 2005/2006 and 2006/2007 respectively. In both years the funds were mainly sourced from GFATM with little contribution from other sources. The same trend persisted for planning and coordination spending where an increase in spending was noted. Planning and coordination spending increased from SZL 4,095,459 in 2005/06 to SZL10, 605,378 in 2006/2007. Major sources of fund were from other sources apart from GFATM. Monitoring and Evaluation spent SZL 5,455,146 and SZL 3,047,055 in year 2005/2006 and 2006/2007 respectively. The funds for monitoring and evaluation were mainly sourced from other sources apart from GFATM.

3.3 Composition of total HIV and AIDS spending from sources of funds ~ priority areas in 2006/2007

Considering the thematic programmes in the response to HIV/AIDS, there are differing priorities when it comes to funding from different sources. Looking first at all source, it can be seen that a large proportion of funds were spent on OVC amounting to SZL 105,191,482 (30.4 %) followed by care and treatment SZL 65,696,767 (19%) and prevention SZL 59,972,039 (17.3 %). A notable finding is the small amount of funds amounting to SZL 897,018 (0.3%) spent on HIV and AIDS related research (excluding operational research). Small amount of the HIV/AIDS related research could be due to the fact that information from some of the research agencies and their related research activities were not included. Figure 13 shows the overall spending priorities as proportions of the total resources mobilized in 2006/2007.

Figure 13: Proportional overall spending priorities 2006/2007 (from all sources)

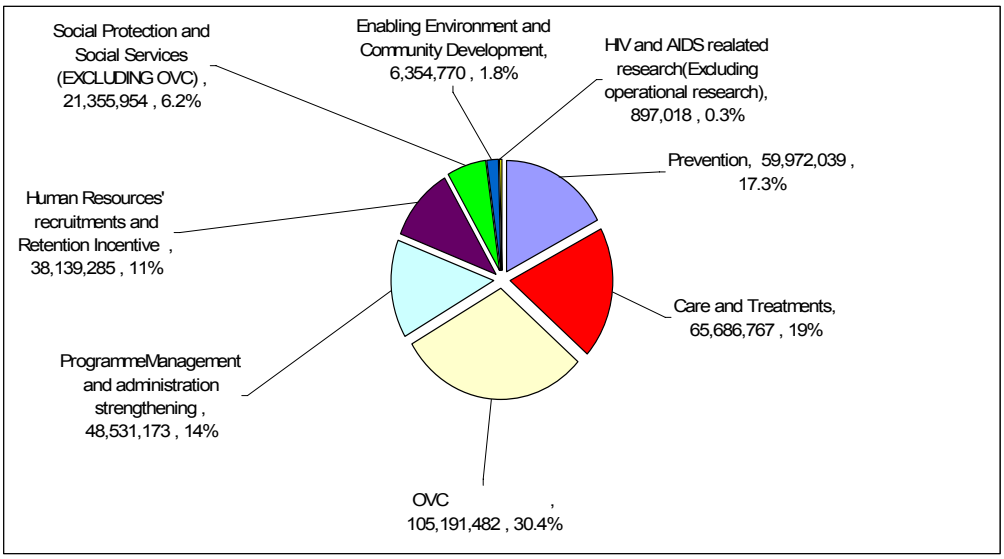
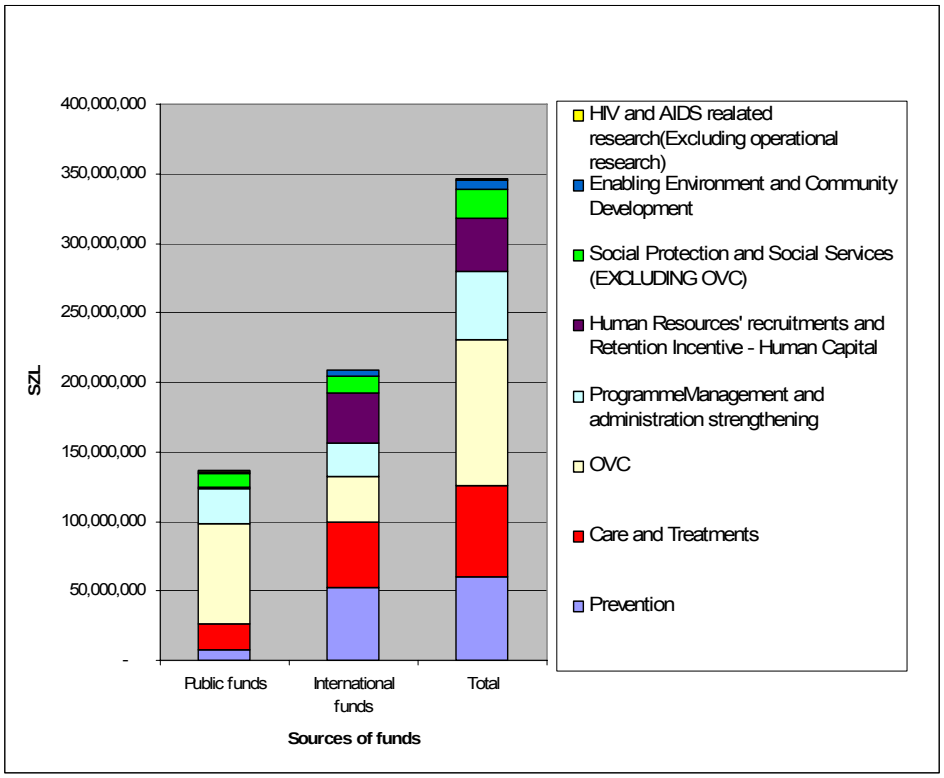


Figure 14 shows the composition of spending by source of funds. A large proportion of funds from international funds were spent on both prevention and care and treatment in 2006/2007.

The amount spent on prevention from the international funds was SZL 51,965,897 against SZL 8,006,142 from the public funds. Notable results were the OVC programmes where the public funds had a big contribution compared to international funds; SZL 72,010,985 and SZL 33,180,497 respectively. The dominance of public funds in OVC programmes explains the Kingdom of Swaziland's Government commitment in serving the OVC. However, from all funds sources there were very little spending in other thematic areas such HIV/AIDS related research, enabling environment and community development.

Figure 14 Composition of HIV and AIDS spending by source of funds 2006/2007(SZL)



3.3.1 Comparison of HIV/AIDS spending with the costed National Strategic Plan (NSP) year 2006/2007 priorities

This section compares the actual HIV/AIDS pending and the costed NSP 2006/07 priorities. However, caution must be taken in interpreting the results because the costed NAP included the priority programmes only and not the full National HIV/AIDS strategic plan (NSP) costing. In addition the costed NSP was costed to give the estimates of spending in HIV/AIDS prioritized activities, but this did not translate into actual allocations or commitments. Table 2 shows the costed NSP 2006/2007 priorities compared to actual 2006/2007 core spending categories (Appendix 6.3 shows a graphical comparison of costed NSP 2006 /2007 priorities against the 2006/2007 core spending categories).

Table 2 Costed NSP 2006/2007 priorities and 2006/2007 core spending categories compared (SZL)

	2006/2007 Costed NSP	2006/2007 HIV/AIDS SPENDING
Prevention	47,260,532	59,972,039
Care and treatement	92,521,647	65,686,767
OVC	28,273,066	105,191,482
Programme management and administration strengthening	34,067,000	48,531,173
Human resources' recruitment and retention incentives	14,582,000	38,139,285
Social protection and social services(excluding OVC)	49,351,400	21,355,954
Enabling environment and community development	1,188,200	6,354,770
HIV and AIDS- related researches	2,918,000	897,018
Total	**270,161,845**	**346,128,488**

When the total actual spending is compared with the costed NSP priorities total allocations, the actual spending was 28% higher of the costed NSP. The total costed NSP priorities amounted to SZL 270,161,845 for 2006/07 and while the actual spending in HIV/AID response was SZL 346,128,488. The comparison of the costed NAP 2006/2007 and actual HIV/AIDS 2006/2007 spending shows The Kingdom of Swaziland spending appears to be meeting its core priorities as selected in the NAP, and that NASA has successfully tracked all additional expenditure in the country.

The NSP achievements in meeting its core priorities spending can be seen in prevention activities specifically in adult and youth out of school sexual behaviour change, Impact mitigation on OVC especially on OVC education and skills caring for Carer, health sector specifically on ART provision, laboratory services and HIV/TB Co-infections. In other priorities areas including PMTCT, M&E and HIV/AIDS research the targeted amount of spending were not met. Table 3 shows the comparison of specific selected 2006/2007 NSP priorities and actual 2006/2007 HIV/AIDS core spending.

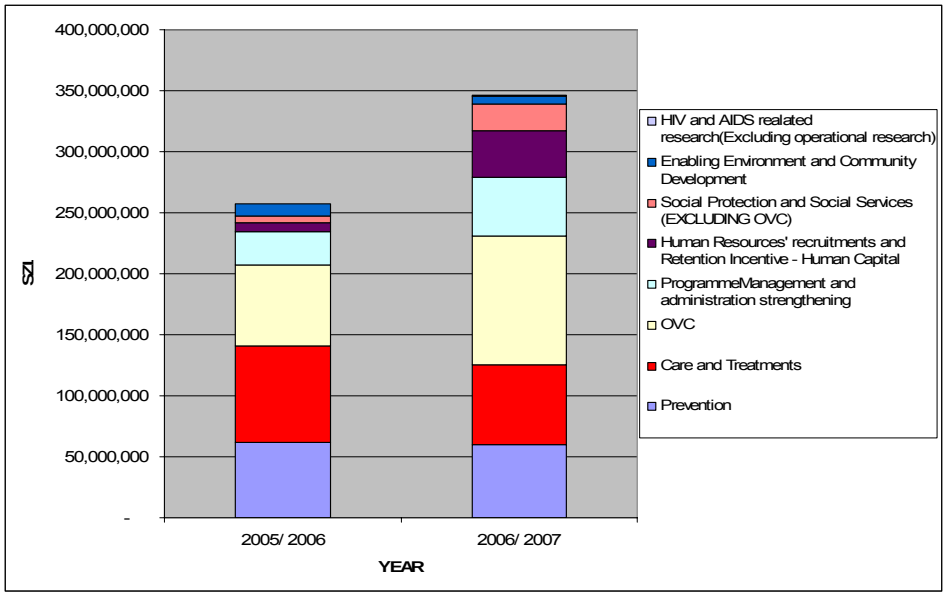
Table 3 Comparison of selected 2006/2007 costed NSP priorities and actual 2006/2007 HIV/AIDS spending

INTERVENTION	Selected 2006/2007 Costed NSP Priorities	2006/2007 HIV/AIDS Spendings
Prevention		
Adult and youth out of school sexual behaviour changes	17,022,380	24,647,079
Youth in school: delay start of sex	-	2,478,800
Impact mitigation on OVCs		
Physical well being	3,250,166	4,053,695
Education and skills	8,561,800	81,967,956
Early childhood care and development services,counselling and Emotional care	249,600	4,571,051
Caring for carer	1,248,000	14,189,276
Health sector		
PMTCT	19,535,044	2,408,023
ART& Pre-ART	77,858,087	43,708,903
HIV/TB Co-infection	5,483,560	7,709,940
Laboratory services	3,000,000	18,319,206
Monitoring and Evaluation	14,870,000	6,152,519
HIV/AIDS Research		
Build Research capacity	2,918,000	887,939
TOTAL	**153,996,637**	**211,094,387**

3.3.2 Comparison of the actual HIV/AIDS spending between year 2005/2006 and 2006/2007

HIV/AIDS core activities spending priorities have been changing over time. The results show in 2005/2006 high priority of spending was placed on care and treatment programmes followed by OVC programmes, prevention, programme management and administration strengthening, enabling environment and community development, and Human capital. Less priority was placed on HIV and AIDS related research. In 2006/2007 priority of spending categories changed to care for OVC followed by treatment and care, prevention activities and programme management and administration. A notable result is that Care and treatment spending was higher in year 2005/2006 compared to year 2006/2007. Figure 15 shows the comparison of HIV/AIDS spending priorities between year 2005/2006 and year 2006/2007.

Figure 15: Comparison of HIV/AIDS spending priorities between year 2005/2006 and 2006/2007 (SZL)



3.4 Detailed analysis of the HIV/AIDS core spending categories

This section presents the detailed analysis of the sub-categories within each of the HIV/AIDS core spending categories for both years 2005/2006 and 2006/2007, and by source of funds.

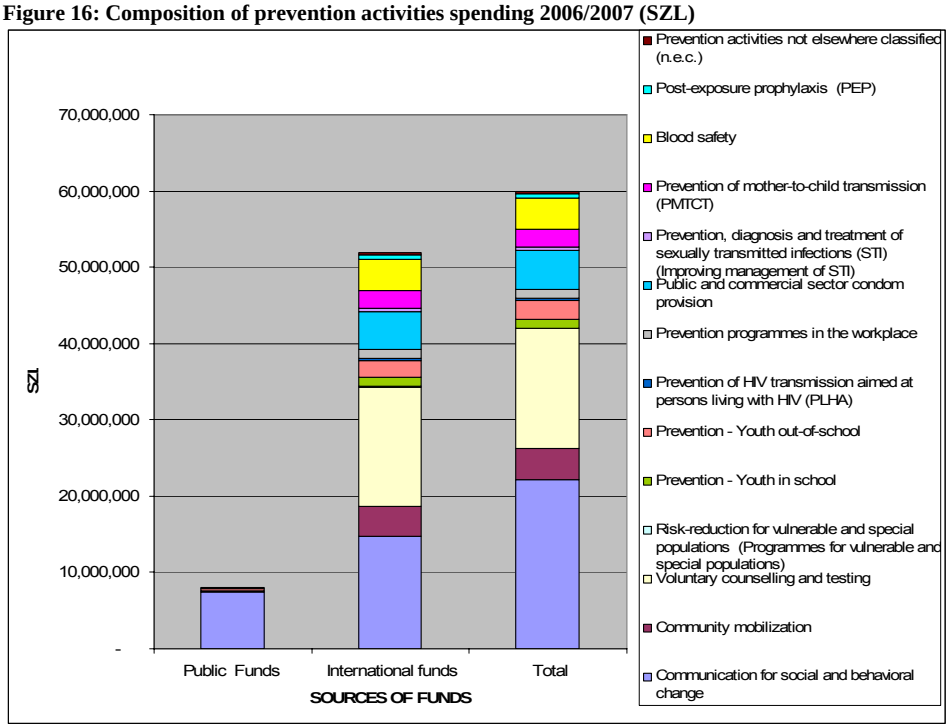
3.4.1 Prevention programmes spending

According to UNAIDS (2007) prevention programmes involve a comprehensive set of activities or programmes designed to reduce risk behavior. The ultimate results of prevention programmes include a decrease in HIV infection among the population. Sub- programmes under prevention activities include communication for social and behavioral change, community mobilization, voluntary counseling and testing, risk reduction for vulnerable and special population, prevention –youth in school and out of school, prevention of HIV transmission aimed at person living with HIV, programme for sex workers and their client, programmes for men who have sex with men, harm reduction programmes for injecting drug users, prevention programme in the work place, condom social marketing, public and commercial sector condom provision, female condom, microbicides, prevention ,diagnosis, and treatments of sexually transmitted infections(STI), prevention of mother-to-child transmission, blood safety, post exposure prophylaxis, safe medical injection, male circumcision, universal precautions and other preventive activities not mentioned above.

The results show that total spending on preventive programme for year 2005/2006 and 2006/2007 were SZL 61,434,631 (USD 9,169,398) and SZL 59,972,039 (USD 8,567,434.14) respectively. Within the preventive activities spending in 2006/2007, the largest amount of

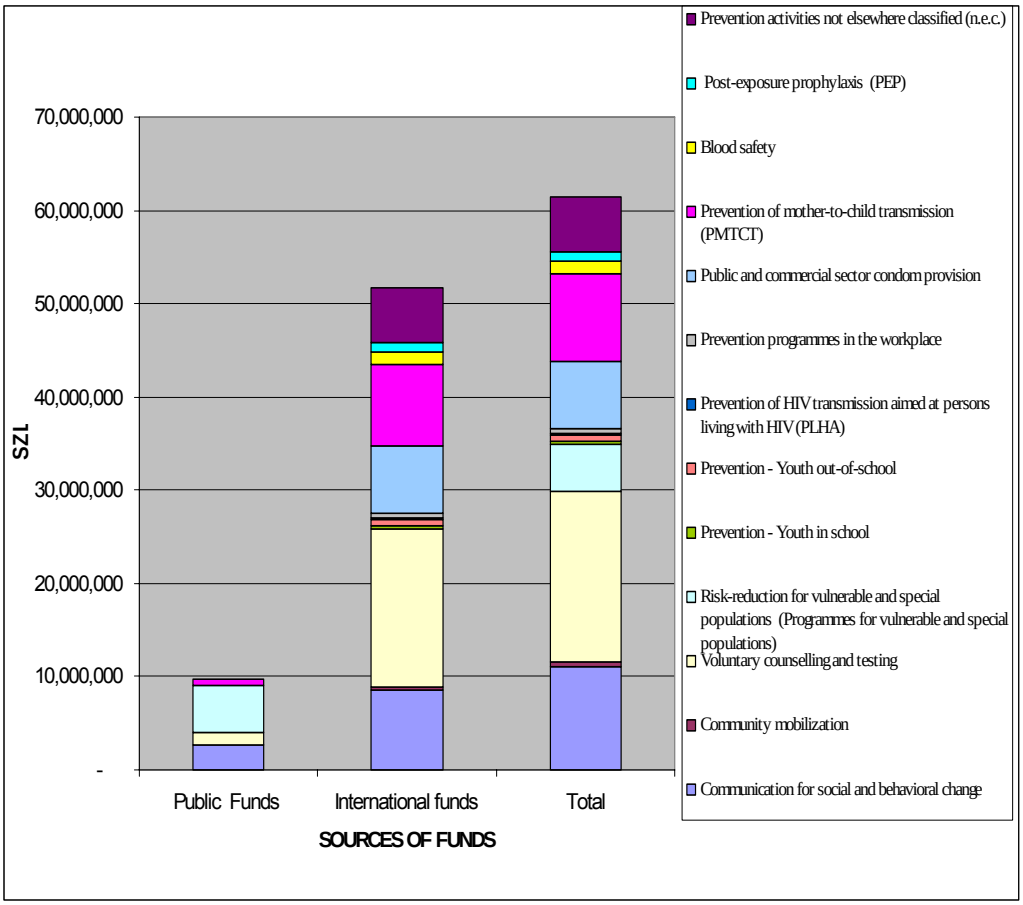
funds was spent on communication for social and behavioral change programme (SZL 22,168,279 or USD 3,166,897), followed by voluntary counseling and testing which amounted to SZL 15,702,609 (USD 2,243,230). Notably most of the public funds spending were directed to communication for social and behavioral change. Figure 16 shows the details of preventive activities spending for 2006/07.

Figure 16: Composition of prevention activities spending 2006/2007 (SZL)



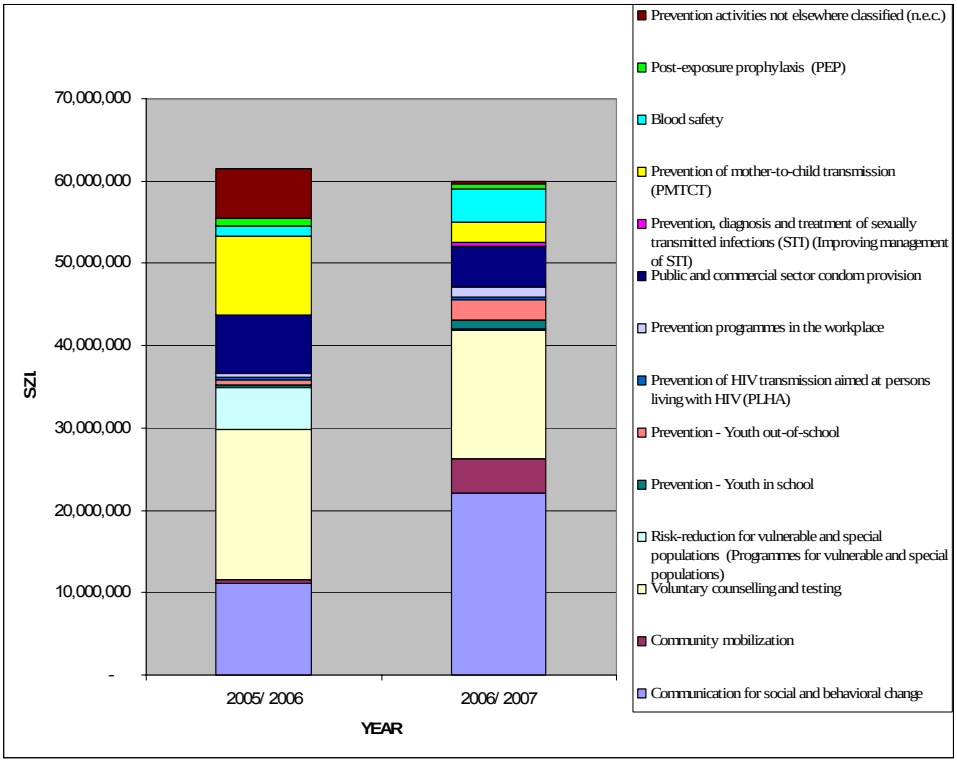
In 2005/2006, large amount of funds from international source were spent on voluntary counseling and testing (SZL 18,336,118 or USD 2,736,734) followed by communication for social and behavioral change (SZL 11, 150,861 or USD 1,664,308). From the public source in 2005/06, the funds were again spent mostly on communications for social and behavioral change. Figure 17 shows the details of preventive activities spending for 2005/06.

Figure 17 HIV Composition of prevention activities spending 2005/2006 (SZL)



Comparing 2005/2006 and 2006/2007 preventive activities spending, the results show changing priorities on preventive activities over the period. In 2006/2007, emphasis was on communication for social and behavioral change followed by voluntary counseling and testing and vice versa for 2005/2006 preventive activities spending. In addition, PMTC spending was high in 2005/2006 compared to 2006/2007. The amount of PMTC spending was SZL 9,536,050(USD 1,423,291) and SZL 2,408,023 (USD 334,003) respectively. Spending on blood safety increased from SZL 1,246,478(USD 186,041) in 2005/2006 to SZL 4,081,000 (USD 583,000) in 2006/2007. Figure 18 shows the comparison of preventive activities between year 2005/2006 and 2006/2007.

Figure 18 Comparison of preventive activities spending between 2005/2006 and 2006/2007

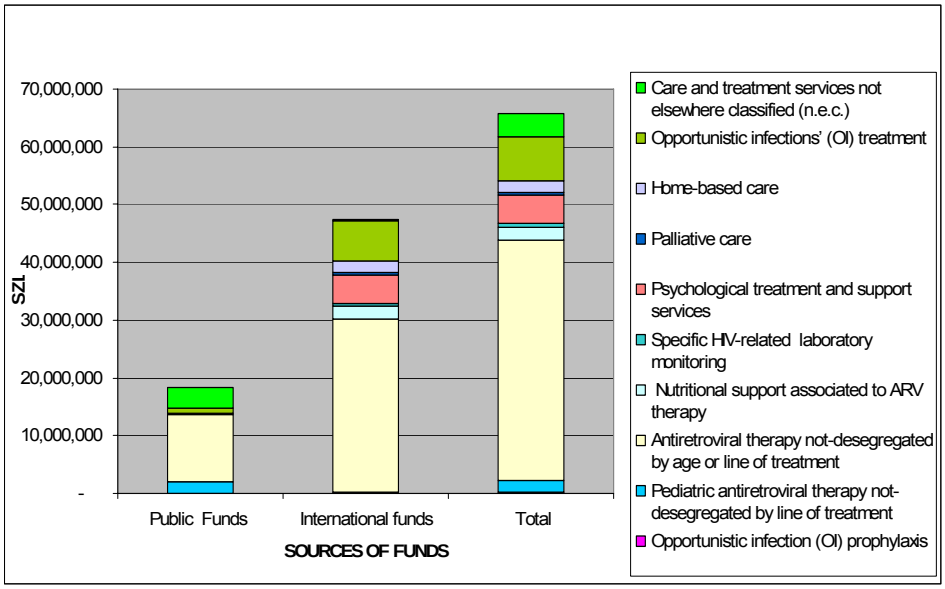


3.4.2 Treatment and care spending activities

UNAIDS (2007) defines care and treatment as all expenditures, purchases, transfer and investment incurred to provide access to clinic and home-based activities for treatment and care of HIV- infected adults and children. The care and treatment component include the following activities: Outpatient care which include provider initiated testing and counseling, opportunistic infection (OI) prophylaxis antiretroviral therapy (Adult and pediatric antiretroviral therapy), Nutritional support associated with ARV therapy, antiretroviral therapy not desegregated by age. In- patient care include all in-hospital care activities for HIV infected adults and children aimed at the treatment of HIV related disease. However, in this assessment it was difficult to estimate the treatment and care spending for out-patient and in-patient care. This was because the total hospital, health centers and clinics costs were not obtained. In addition, the number or ratio of HIV related in-patients to non-HIV-related patients were not obtained. Therefore the spending on in-patient and out-patient is an underestimation.

Generally, results show that total treatment and care[6] spending in 2005/2006 and 2006/2007 were SZL 79,916,160 (USD 11,927,785) and SZL 65,686,767 (USD 9,383,824) respectively. Considering the sources of funds, International funds on treatment and care in 2006/2007 was largely dominated by the provision of ARVs (SZL 29,967,609 or USD 4,281,087) followed opportunistic infections (OI)[7] treatments (SZL 6,960,469 or USD 994,353), psychological treatment and support services (SZL 4,964,649 or USD 709,236), Nutritional support associated to ARV therapy (SZL 2,241,547 or USD 320,221) and Home based care (SZL 1,901,877 or USD 271,697). The public funds on care and treatment were largely spent on ARV therapy provision (SZL 13,741,294 or USD 1,963,042) followed by other care and treatment activities spending not elsewhere classified (SZL 3,685,091 or USD 526,441.57) and opportunistic (OI) infections treatment (SZL 749,471 or USD 107,067.29). Generally, the total amount of funds for care and treatment from public funds was small compared to international funds in 2006/2007. Figure 19 shows the composition of treatment and care programme spending by source in 2006/2007.

Figure 19 Composition of treatment and care programme spending by source in 2006/2007(SZL)



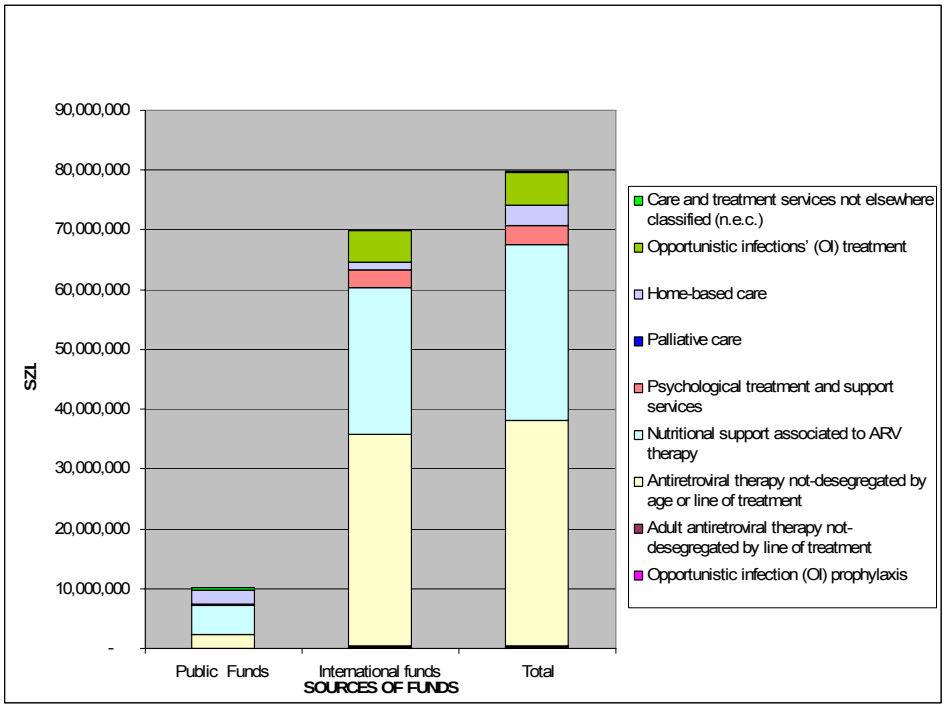
In 2005/2006 ARV therapy provision spending dominated within the HIV/AIDS care and treatment component. However, a big proportion of ARV therapy provision resources came from international funds amounting to SZL 35,678,868 (USD 5,325,204) and public funds made a small contribution of SZL 2,381,418 (USD 355,436). Other priority areas on care and

[6] Note: It was not possible to segregate the treatments and care spending into in-patient and out-patient due to the limitation of data from the public facilities

[7] Opportunistic infection (OI) treatment included the TB drugs cost only. Other costs such as TB related overheads at the hospital and health centers were not available. Therefore, the OI spending might be underestimated. In addition, if spending on OI prophylaxis (especially for TB) was increased, it may decrease the spending on OI (including TB) treatment

treatment by the international funds included nutritional support associated with ARV therapy (SZL 24,509,031 or USD 3,658,064) followed by opportunistic infections' treatment (SZL 5,308,035 or USD 792,244), psychological treatment and support services (SZL 2,909,517 or USD 434,256) and Home based care (SZL 1,175,423 or SZL 175,436). From the public funds, priority areas included nutritional support associated with ARV therapy (SZL 4,773,090 or USD 712,401), ARV therapy provision (SZL 2,381,418 or USD 355,436), home based care (SZL 2,236,622 or USD 333,824) and psychological treatments and support services (SZL 323,686 or USD 48,311). Figure 20 shows the composition of HIV/AIDS care and treatment expenditure by source of funds 2005/2006.

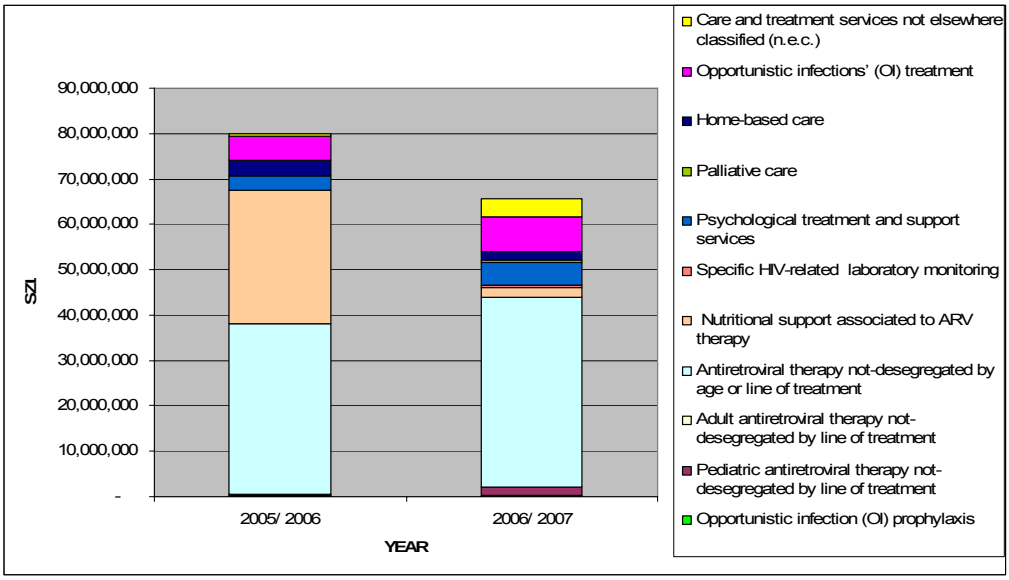
Figure 20 HIV/AIDS care and treatment expenditure by source of funds 2005/2006



Generally, comparing the care and treatment component between year 2005/2006 and 2006/2007, the result shows in both years the stakeholders' were very much committed to provide comprehensive treatment and care to enhance the lives of PLWA. However, there were differing priorities in the care and treatment component between years 2005/2006 and 2006/2007. In 2005/2006, emphasis was on ARV therapy provision (48%) followed by nutritional support associated with ARV therapy (37%) while in 2006/2007, emphasis was on provision of ARV therapy (63%) followed by opportunistic infections' treatments (12%). Although, the total spending on care and treatment component decreased from SZL 79,916,160 (USD 11,927,785) in 2005/2006 to SZL 65,686,767 (USD 9,383,824) in 2006/2007, spending on ARV therapy provision increased from SZL 38,060,286 (USD 5,680,640) in 2005/2006 to SZL 43,708,903 (USD 6,244,129) in 2006/2007. Other spending activities notably nutritional support associated with ARV therapy were affected by the decrease of fund between years

2005/2006 and 2006/2007. Nutritional support associated with ARV therapy spending decreased from SZL 29,282,121(USD 4,370,466) in 2005/2006 to SZL 2,241,547 (USD 320,221). In this assessment, General hospital spending on care and treatments could not be extracted, therefore, the amount presented on care and treatment might be underestimated. Figure 21 shows the comparison of care and treatment component spending between year 2005/2006 and 2006/2007.

Figure 21 Comparison of care and treatment spending between year 2005/2006 and 2006/2007



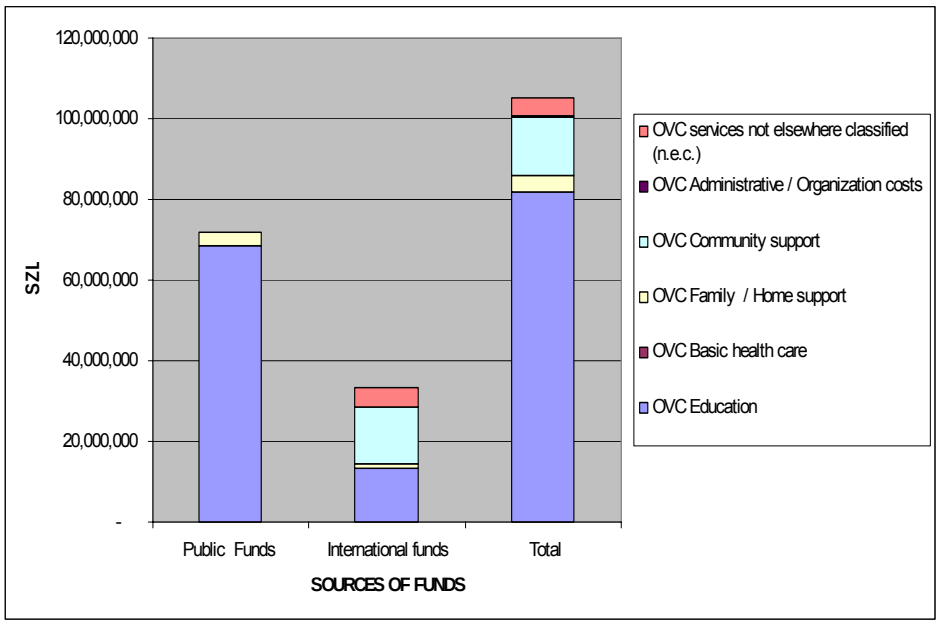
3.4.3 OVC Spending

The OVC spending component included the following activities; OVC education, basic health care, family/home support, community support, administrative/ organizational costs, institutional care and other services for OVC not classified in the previous activities.

The results show that total OVC spending was SZL 66,012,325 (USD 9,852,586) in 2005/2006 and SZL 105,191,482 (USD 15,027,355) in 2006/2007. Considering sources of funds in OVC programmes in 2006/07, public funds contributed SZL 72,010,985 (USD 10,287,284) while the International funds contributed SZL 33,180,497 (USD 4,740,071). In addition, the public funds contributed more on OVC education (SZL 68,693,065, USD 10,252,690) compared to International sources (SZL 13,274,891 or USD 1,896,413). The public funds contributed to OVC family/home support SZL 2,991,034 (USD 446,423) and OVC administration/Organizational cost SZL 326,886 (USD 48,789). The high contributions of public funds to OVC education imply there were deliberate efforts from the public funds source to support OVC education. Spending priorities from the International funds included OVC community support (SZL 14,189,276 or USD 2,027,039) followed by OVC education (SZL 13,274,891 or USD 1,896,413), OVC services which could not be classified amounted to SZL

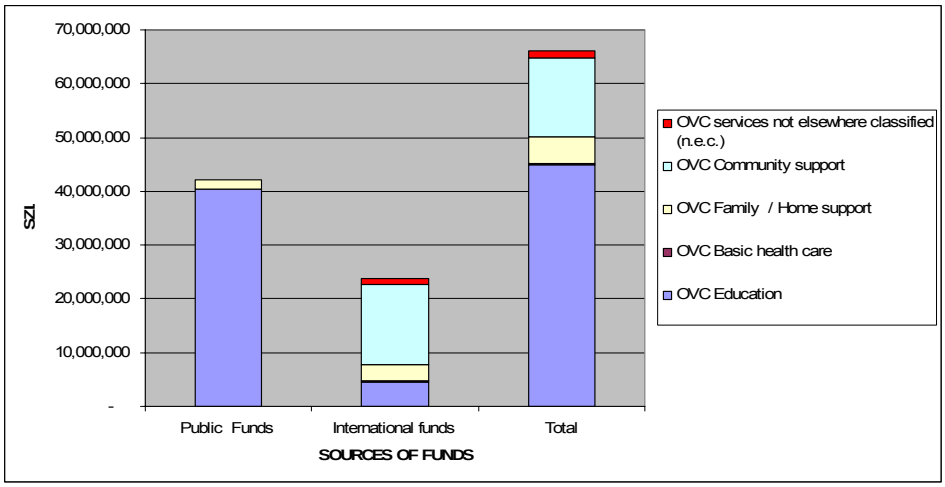
4,571,051(USD 653,007) and family/home support SZL 1,062,661(USD 151,809). Figure 22 shows OVC programmes spending by source of funds in 2006/2007.

Figure 22 OVC programmes spending by source of funds 2006/2007(SZL)



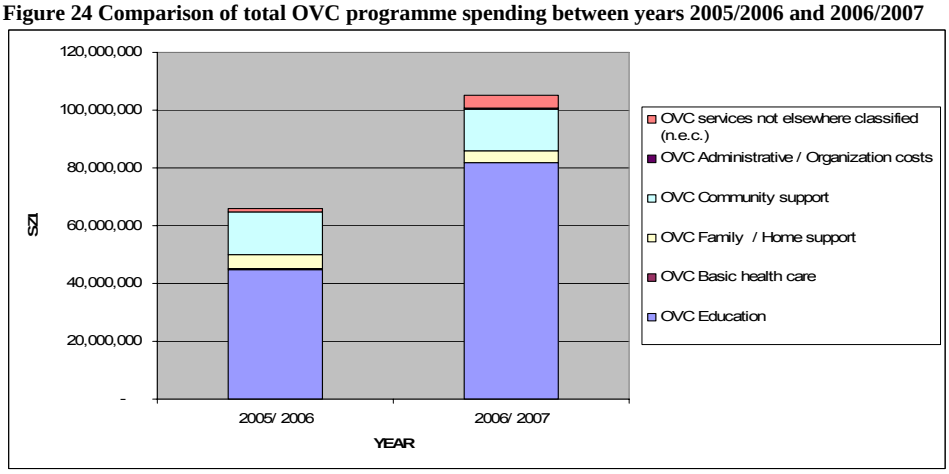
In 2005/2006, the public funds also contributed higher than the International funds in the OVC programmes. While public funds contributed SZL 42,203,072 (USD 6,298,966), the International funds contributed SZL 23,809,253(USD 3,553,620). However, the public fund was priorities OVC education (USD 6,023,133) and OVC family and Home support only (USD 6,023,133). The International funding priorities in 2005/06 were almost the same as in 2006/2007.. High priority was on OVC community support (SZL 14,755,802 or USD 2,202,359) followed by OVC education (SZL 4,477,515 or USD 668,286) and OVC family/home support (SZL 3,159,169 or USD 471,518). Figure 23 shows detailed composition of OVC programme spending in 2005/2006.

Figure 23 OVC programmes spending by source of funds 2005/2006 (SZL)



Comparing the OVC programmes spending between years 2005/2006 and 2006/2007, the results show total OVC programme spending was higher in year 2006/2007 than in year 2005/2006. The OVC programme spending were SZL 66,012,325 (USD 9,852,586) and SZL 105,191,482 (USD 15,027,355). In both years, OVC education accounted for more than half of the total OVC programme spending. Figure 24 shows the comparison of total OVC programme spending between year 2005/2006 and 2006/2007.

Figure 24 Comparison of total OVC programme spending between years 2005/2006 and 2006/2007



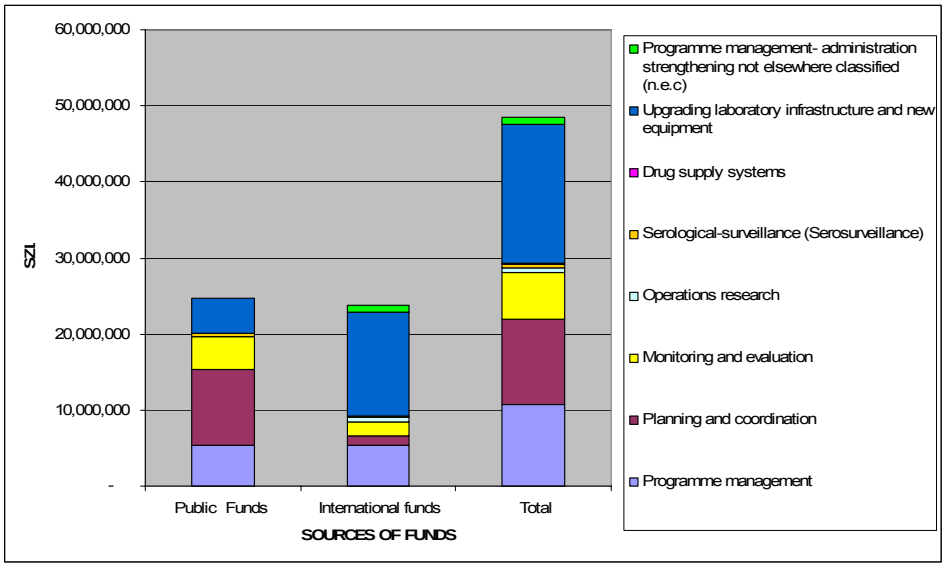
It should be noted that in both years the costs of general health care for all children such immunization cost were etc. were not been captured under NASA since these are general health costs that could not be easily extracted. Hence the health spending component was small.

3.4.4 Programme Management and Administration Spending

These are expenses that are incurred at administrative level outside the point of health care delivery. The results show total programme management and administration strengthening spending were SZL 27,115,940 (USD 4,047,155) in 2005/2006 and SZL 48,4531,173 (USD 6,933,025) in 2006/2007.

In 2006/2007 the results show both sources (public funds and international funds) contributed almost equally to programme management and administration spending. While public funds contributed SZL 24,755,788 (USD 3,536,541), International funds contributed SZL 23,775,385 (USD 3,396,484). There were differing priorities within programme management and administration strengthening activities spending for both sources of funds. Public fund priorities included planning and coordination (SZL 9,901,740 or USD 1,414,534) followed by programme management (SZL 5,412,886 or USD 773,269), upgrading laboratory infrastructures and new equipments (SZL 4,728,465 or USD 675,495) and Monitoring and Evaluation (SZL 4,389,464or USD 627,066). From the international funds, high priority was given to the spending on upgrading laboratory infrastructures and new equipment (SZL 13,590,741 or USD 1,941,534), followed by programme management spending (SZL 5,368,369 or USD 766,910), monitoring and evaluation (SZL 1,763,055 or USD 251,865) and planning and coordination spending (SZL 1,271,358 or USD 181,622). Figure 25 shows composition of programme management and administration spending in year 2006/2007.

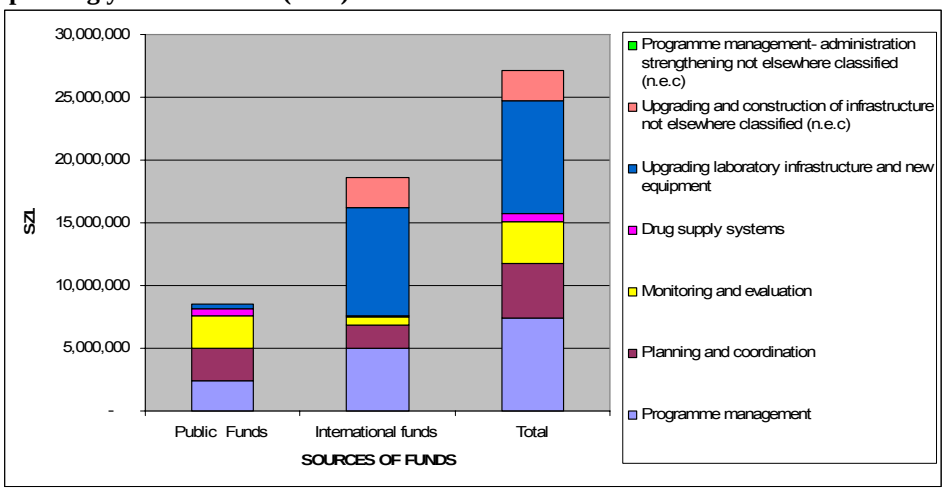
Figure 25 Composition of programme management and administration spending year 2006/07 (SZL)



In 2005/2006, the results show that international sources contributed more than public sources to programme management and administration strengthening. International funds contributed SZL 18,592,139 (USD 2,774,946) and public funds contributed SZL 8,523,801 (USD

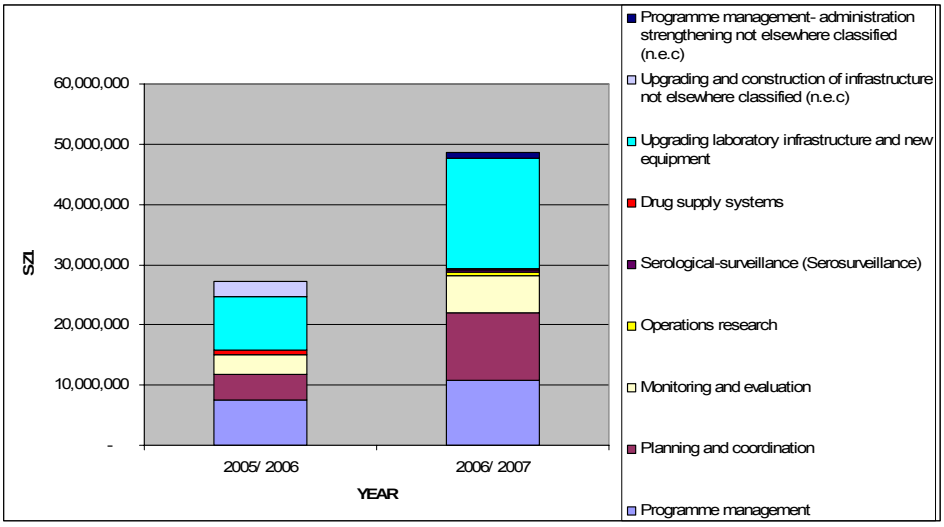
1,272,209). Within the International funds, high spending was in the upgrading of laboratory infrastructures and new equipments amounting to SZL 8,646,240 (USD 1,290,484) followed by programme management activities (Including transactional costs) (SZL 5,041,936 or USD 752,528), upgrading and constructions of other infrastructures (SZL 2,359,839 or USD 352,215), planning and coordination activities (SZL 1,766,707 or USD 263,688) and Monitoring and Evaluation activities spending was SZL 678,084 (USD 101,207). Priorities in the public fund spending were high and almost equally distributed among monitoring and evaluation, planning and coordination and programme management (including transactional costs). Spending in monitoring and evaluation was SZL 2,604,272 (USD 388,697), planning and coordination spending was SZL 2,564,053 (USD 382,694) and programme management spending was SZL2, 404,253 (USD 358,844). Figure 26 shows the composition of programme management and administration strengthening for the year 2005/2006.

Figure 26 Composition of programme management and administration strengthening spending year 2005/2006 (SZL)



Comparing programme management and administration strengthening activities spending between year 2005/2006 and 2006/2007, the results show in both years there were high priority in upgrading of laboratory infrastructures and new equipment spending. Spending in upgrading of laboratory infrastructures and new equipments were SZL 9,013,122 (USD 1,345,240) and SZL 18,319,206 (USD 2,617,029) for 2005/2006 and 2006/2007 respectively. Other priority areas of spending in 2005/2006 included programme management SZL 7,446,189 (USD 1,111,372), planning and coordination SZL 4,330,760(USD 646,382) and Monitoring and Evaluation SZL 3,282,356 (USD 489,903). For 2006/2007, other priority areas of spending included Planning and coordination SZL 11,173,098 (USD 1,596,157), programme management SZL 10,781,255 (USD 1,540, 179) and Monitoring and Evaluation SZL 6,152,519 (USD 878,931). Generally, spending in programme management and administration strengthening was higher in 2006/2007 than in 2005/2006. Figure 27 shows the comparison of programme management and administration strengthening activities spending between years 2005/2006 and 2006/2007

Figure 27 Comparison of programme management and administration strengthening activities spending between year 2005/2006 and 2006/2007 (SZL)

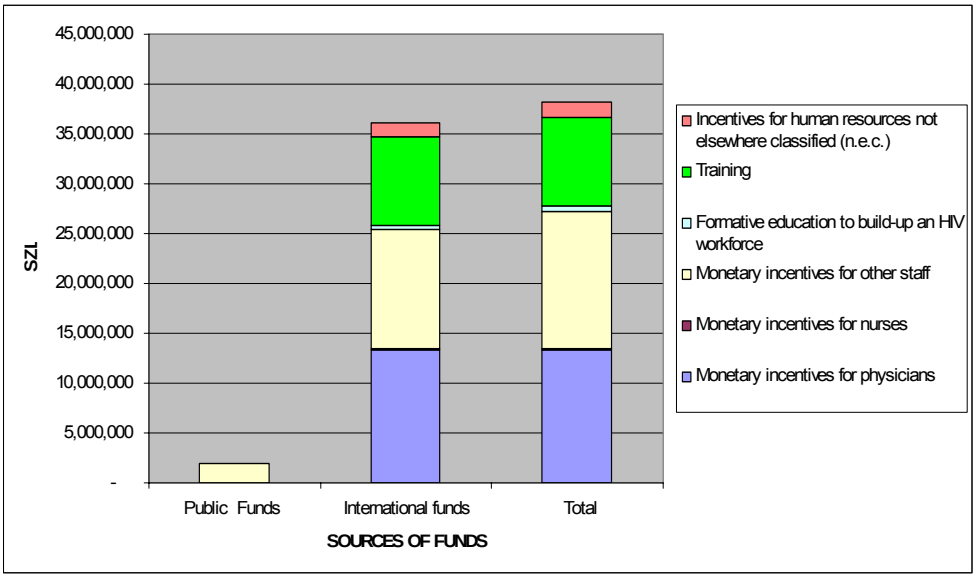


3.4.5 Human resources recruitment and retention incentives

This involves services of the workforce through approaches for recruitment, retention, deployment and rewarding of quality performance of health care workers and managers to work in the HIV and AIDS field. However, general salaries are not included in this spending category but are rather captured under the particular activity which they perform. The human resource recruitment and retention incentives assessed the following activities: monetary incentive for physicians, monetary incentive for nurses, monetary incentive for other staffs, formative education and build up of an AIDS workforce and trainings.

The results show spending on the category of human resources recruitment and retention incentives was SZL 7,553,197 (USD 1,127,343) and SZL 38,139,285 (USD 5,448,469) in years 2005/2006 and 2006/2005 respectively. Further, the results shows that in 2006/2007, the contribution from international funds was much higher than the public funds. The international funds contributed SZL 36,128,908(USD 5,161,273) and public fund contributed just SZL 2,010,377 (USD 287,198). The higher contribution by international funds could be explained by the contributions to top-ups and allowances, as incentives for people working in the HIV/AIDS field paid by international not-for profit organizations and foundations. Considering the priority of spending by sources of funds in 2006/2007, the results show that public funds were spent primarily on monetary incentives to staff other than nurses and physicians SZL1, 877,477 (USD 268,211) and training SZL 132,900 (USD 18,986) while the international funds were spent on incentives to physicians SZL 13,401,328 (USD 1,914,475), incentive for other staffs (SZL 11,903,315 or USD 1,700,474), training SZL 8,826,562 (USD 1,260,937),incentive for human resources not elsewhere classified SZL 1,414,440 (USD 202,063), formative education to build up an HIV workforce SZL 491,393 (USD 70,199) and incentive for nurses SZL 91,870 (USD 13,124). Figure 28 shows the composition of human resource recruitments and retention in year 2006/2007.

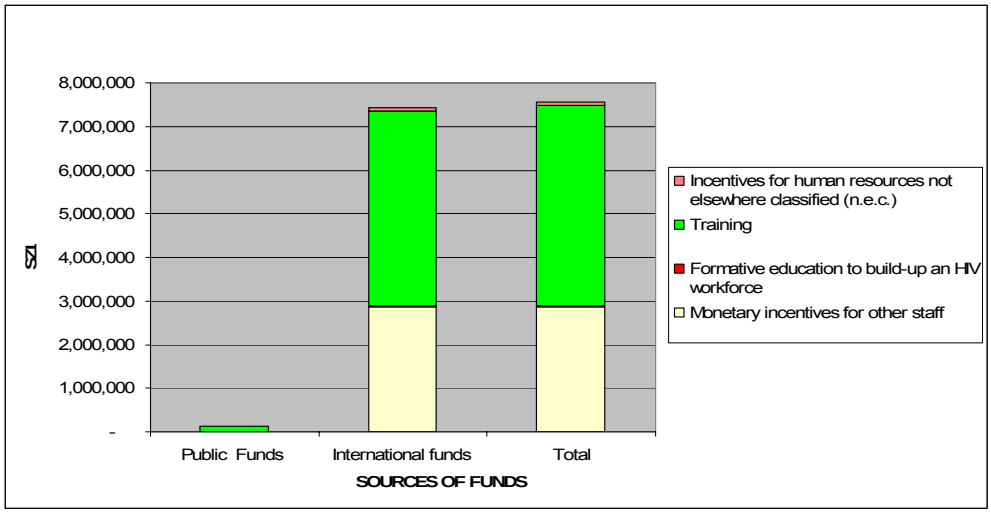
Figure 28 Composition of spending on human resources recruitment and retention incentives -Human capital 2006/2007 (SZL)



In 2005/2006 the major contribution to human resource recruitment and retention incentives came again from international funds at almost SZL 7,432,085 (USD 1,109,266), while the public contribution[8] was only SZL 121,112 (US$ 18,076). Again, to note that this category did not include regular salaries, as these were captured under the programmes/ activities that were delivered by the staff. International funds priority was on the training of staff (SZL 4,466,732 or USD 666,826) followed by monetary incentives for staff other than nurses and physicians (SZL 2,852,665 or USD 425,771). Figure 29 shows the actual spending on human resources' recruitment and retention incentives, by source for 2005/2006.

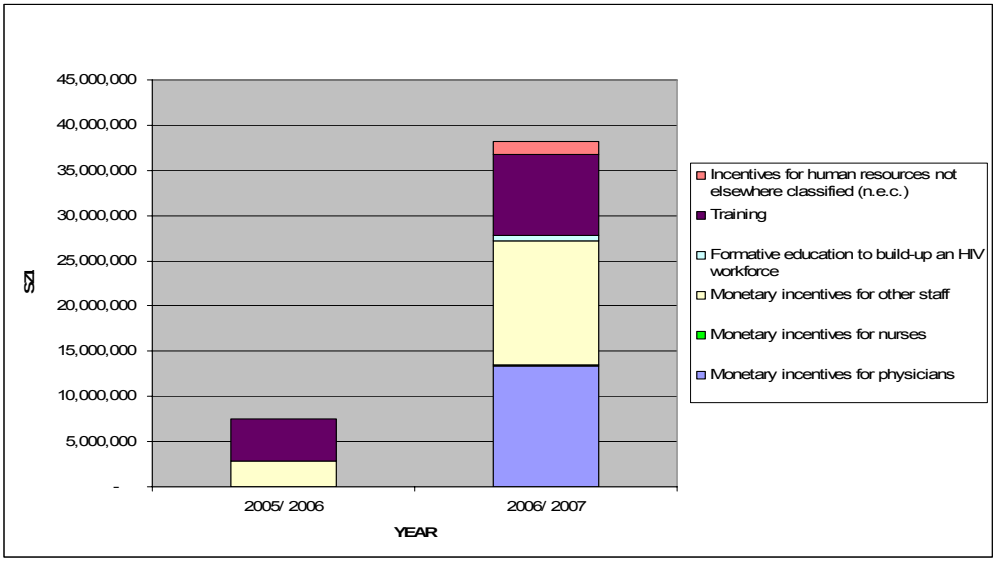
[8] Note that Salaries and overheads from MoHSW were not captured. Therefore, public funds contribution on human resource recruitments and retention might be underestimated.

Figure 29 Composition of human resources recruitments and retention incentives - Human capital 2005/06



Comparing the human resources recruitments and retention spending between years 2005/2006 and 2006/2007, the results show spending in year 2006/2007 was almost five times that in 2005/2006. Spending in 2006/2007 was SZL 38,139,285 (USD 5,448,469) compared to SZL7, 553,197 (USD 1,127,343) in year 2005/2006. Figure 30 shows comparison of human resources recruitments and retention spending between year 2005/2006 and 2006/2007

Figure 30 Comparison of human resources recruitments and retention spending between year 2005/2006 and 2006/2007 (SZL)

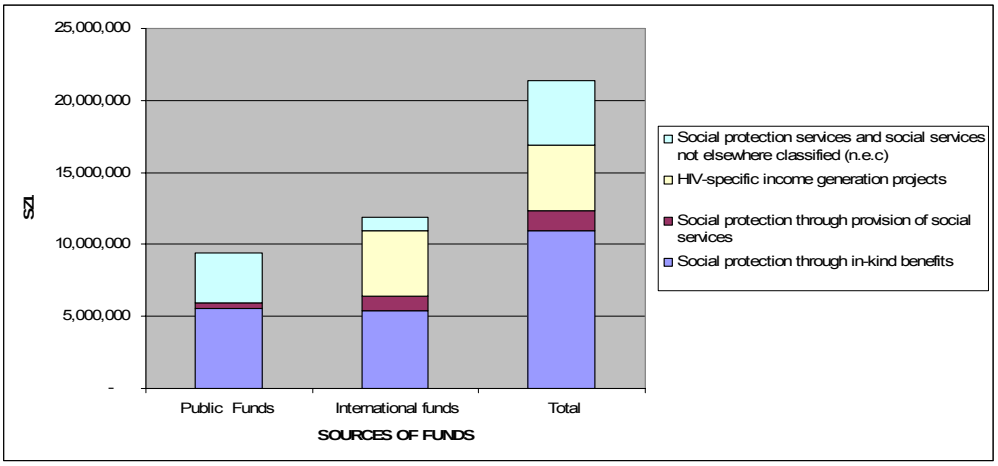


3.4.6 Social Mitigation, Protection and Services

This involved analysis of spending on the provision of cash benefits, benefits in-kind, personal social services and security to categories of individuals affected by HIV/AIDS sickness. However, the support to OVCs and their families is not included here but in the earlier category of OVC spending.

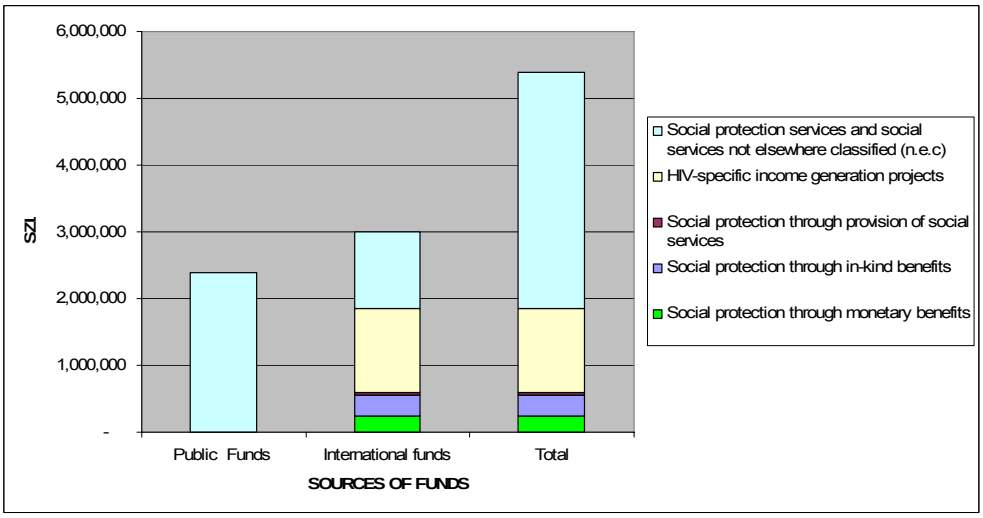
The total spending on this category in 2006/07 was SZL 21,355,954 (USD 3,050,851) and only SZL 5,389,009 (USD 804,330) in 2005/06. By considering the sources of funds in 2006/2007, the results show that public funds contributed SZL 9,445,874 (USD 1,349,411) and International funds contributed SZL 11,910,080 (USD 1,701,440). Spending on social protection through in-kind benefit dominated the priorities of both sources in year 2006/2007. The public funds spending priorities were mainly on social protection through in-kind benefit (SZL 5,583,939 or USD 797,706) followed by other social services which could not be classified (SZL 3,511,346 or USD 501,621). International funds spending priorities included social protection through in- kind benefits (SZL 5,396,610 or USD 770,944) and importantly HIV-Specific income generating activities spending which amounted to SZL 4,571,370 (USD 653,053). These were primarily grants for business activities for people living with HIV. Figure 31 shows the actual spending, by source, on social protection and social services for year 2006/2007.

Figure 31 Composition of social protection and social services spending (Excluding OVC) 2006/2007(SZL)



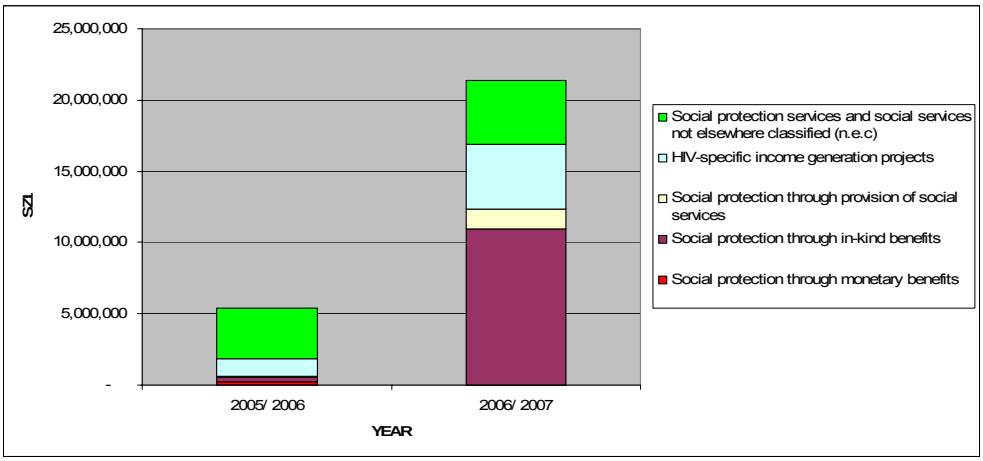
In 2005/2006, public funds contributed SZL 2,381,418 (USD 355,436) and International funds contributed SZL 3,007,591 (USD, 448,894) to social protection and social services, four times less than in 2006/07. There were also variations on the spending priorities compared to 2006/2007 priorities. The public funds were dominated by spending on other (nec?) social support and social assistance to families affected by the HIV amounting to SZL2, 381,418 (USD 355,436). The international funds spending priorities were almost equally dominated by both social protection services and social services not elsewhere classified (SZL 1,157,539 or USD 172,767) and HIV-specific income generating projects for people living with HIV (SZL 1,254,406 or USD 187,225). Figure 32 shows the composition of the actual spending on social protection and social services by source of funds for 2005/2006.

Figure 32 Composition of social protection and social services spending (Excluding OVC) 2005/06 (SZL)



Overall comparison of spending on social protection and social services activities between years 2005/2006 and 2006/2007 shows that generally spending on this component were high in 2006/2007 than in 2005/2006. Spending on social protection through in-kind benefit increased from SZL 324,864 (USD 48,487) in 2005/2006 to SZL 10,980,549 (USD 1,568,650). Also, HIV-specific income generating projects spending increased from SZL 1,254,406 (USD 187,255) in 2005/2006 to SZL 4,571,370 (USD 653,053) in 2006/2007. Figure 33 shows the Comparison of social protection and social services spending between years 2005/2006 and 2006/2007.

Figure 33 Comparison of social protection and social services spending between years 2005/2006 and 2006/2007 (SZL)



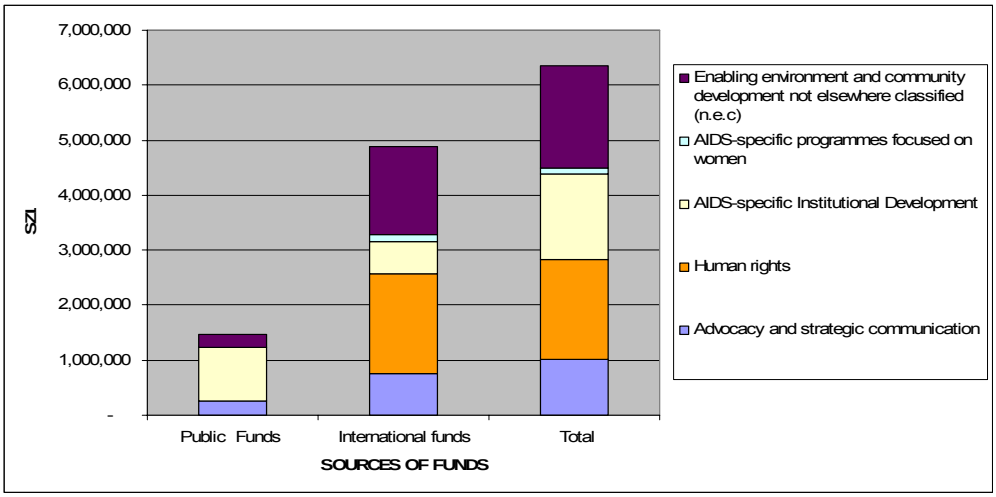
3.4.7 Enabling environment and community development spending

This section involved the analysis of spending on advocacy and strategic communications, human rights, AIDS specific institutional development, AIDS programmes focused on women and other enabling environment activities not mentioned above.

The results show that the total spending on enabling environment and community development amounted to SZL 6,354,770 (USD 907,824) in 2006/2007 and SZL 9,772,491 (USD 1,458,581) in 2005/2006. In 2006/2007, the results show that the public funds contributed SZL 1,462,077 (USD 208, 868) and International funds contributed SZL 4,892,693 (USD 698,956). The Public funds spending were dominated by AIDS–specific institutional development (SZL 964,263 or USD 137,752) followed by spending on advocacy and strategic communication (SZL 258,640 or USD 36,949) and on enabling environment and community development activities not elsewhere classified SZL 339,174 (USD 34,164). From the international funds, high priority was given to human rights (SZL 1,810,038 or USD 258,577), which included legislative aspects of employment and discrimination, legal counseling and services, overcome discrimination and all efforts to improve accessibility to social and health services. It was followed by other environmental and community enablement (SZL 1,614,573 or USD

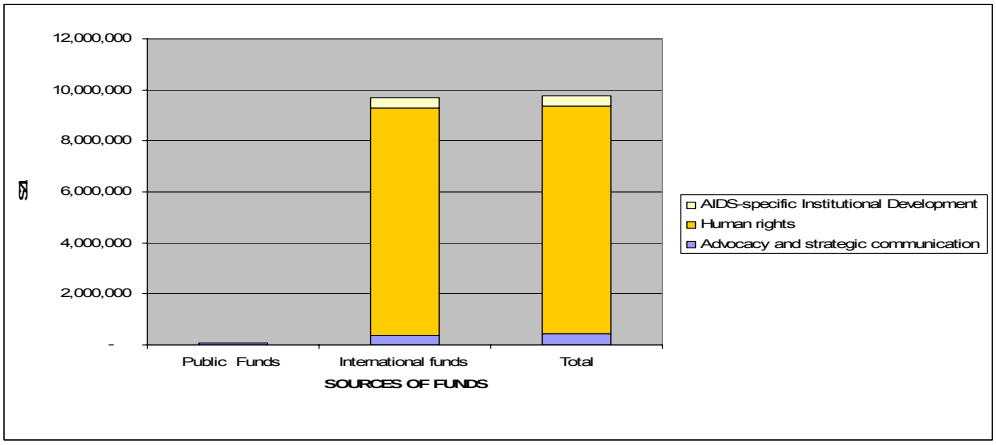
230,653), which could not be classified. Figure 34 shows the composition of actual spending on enabling environment and community development, by source, for the year 2006/2007.

Figure 34 Composition of enabling environment and community development spending 2006/2007 (SZL)



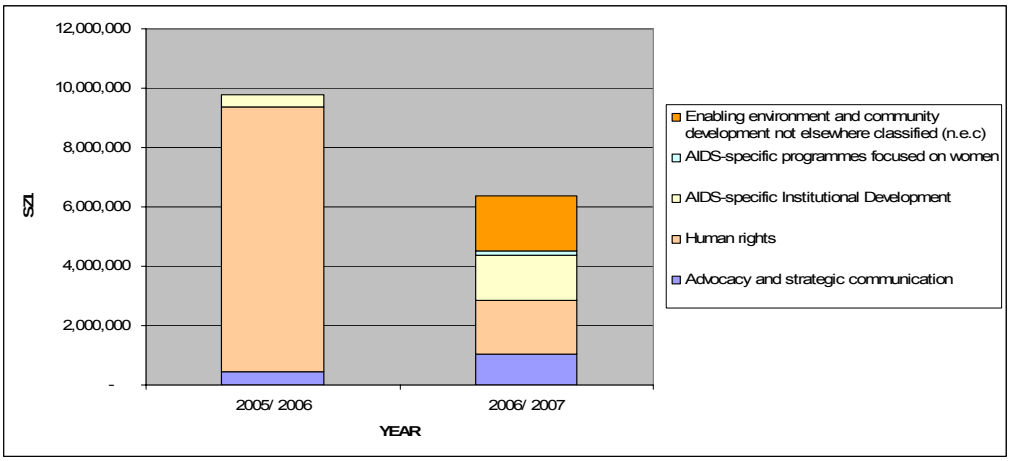
In 2005/2006, the results show that the major contributor in the enabling environment and community development spending were the international funds (SZL 9,692,999 (USD 1,446,716). Almost no funds were contributed from public funds (SZL 79,492 (USD 11,864). The spending priority of the international fund was mainly on Human rights (SZL 8,922,684 or USD 1,331,744) followed by AIDS–specific institutional development (SZL 403,653 or USD 60,247) and advocacy and strategic communication (SZL 366,662 or USD 54,726). Figure 35 shows the spending priorities for enabling environment and community development in the year 2005/2006.

Figure 35 Composition of enabling environment and community development spending 2005/2006



Comparison of spending in both years on enabling environment and community development results show that total spending in 2005/2006 (SZL 9,772,491 or USD 1,458,581) was higher than spending in 2006/2007 (SZL 6,354,770 or USD 907,824). Notable results are the spending on human rights which decreased from SZL 8,922,684 (USD 1,331,744) to SZL 1,810,038 (USD 258,577) and spending on AIDS specific programmes focused on women which increased from nil to SZL 118,804 (USD 19,672). Spending on AIDS specific Institutional development increased from SZL 403,653 (USD 60,247) in 2005/2006 to SZL 1,547,598 (USD 221,085) in 2006/2007. Figure 36 shows the comparison of spending on enabling environment and community development activities between years 2005/2006 and 2006/2007

Figure 36 Comparison of spending on enabling environment and community development activities between years 2005/2006 and 2006/2007 (SZL)



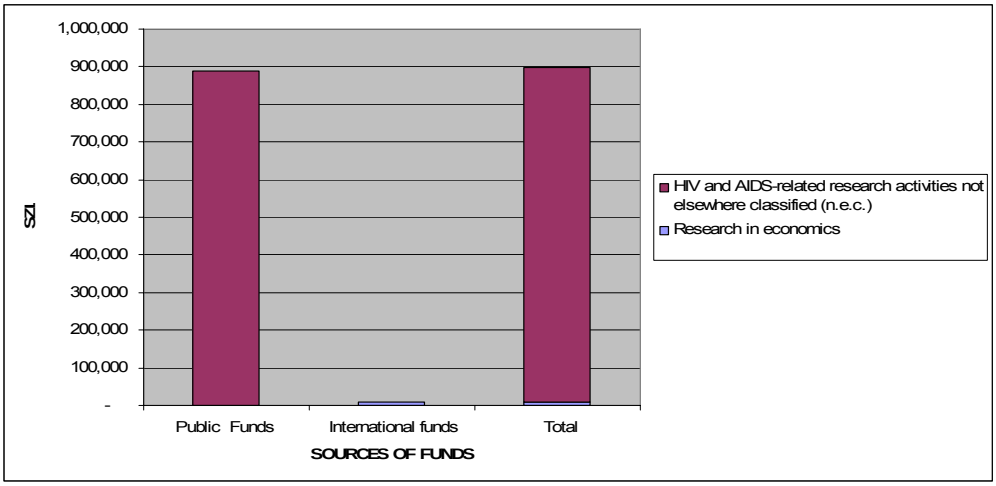
3.4.8 HIV AND AIDS related research spending (Excluding operational research)

This section focused on the analysis of spending on HIV/AIDS related research aiming at the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect and improve the management of HIV/AIDS. It includes research such as biomedical research, clinical research, epidemiological research, social science research, behavioral research, and research in economics, vaccine research and other HIV/AIDS related research not mentioned above. Operational research was not captured here but under Programme Management.

The results show that total spending on HIV and AIDS related research (excluding operational research) activities was SZL 24,747 (USD 3,694) in 2005/2006 and SZL 897,018 (USD 128,145) in year 2006/2007. In 2006/2007, the results show that the major contributor of funds to HIV research was the public fund (SZL887,940 or USD 126,848) and only a small amount came from the international funds (SZL 9,079 or USD 1,297). However, both source's spending was channeled to other HIV/AIDS related research activities (SZL 887,939 or USD 126,848), which included capacity building for research on pediatric HIV and the National Research council. From these results, it appears less is being spent on HIV/AIDS related researches. However, it may not be the case since few research agencies were included in the study. Figure

37 shows the actual spending on HIV/AIDS related research (excluding operational research) in year 2006/2007 by source.

Figure 37 Expenditure on HIV and AIDS related research (excluding operations research) in year 2006/2007



In 2005/2006, the results shows that the finances for HIV/AIDS related research came from international sources only, a total amount of SZL24,747 (USD 3,571). There were no contributions from the public sources and the total amounts from International funds were reported as spent on social science research. This involved research on investigating broad social aspects of HIV/and AIDS.

3.5 PROVIDERS OF HIV/AIDS SERVICES ANALYSIS

This section presents the analysis of the providers of HIV/AIDS services. Providers are entities or person engaged directly in the production, provision and delivery of HIV/AIDS services. HIV/AIDS services are supplied in a wide range of settings outside and inside the health sector. Generally, providers include government (public institutions), private for profit, non-profit organization (both local and international organizations), corporate and non-corporate enterprises, self-employed persons whose activities fall within the NASA boundaries regardless of a formal or informal legal status.

This assessment focused on public providers, private non-profit providers, multilateral agencies[9] and rest of the world providers[10].

[9] Multi-lateral agencies - Besides their main role as financing sources or agents, whenever they are directly involved in the production of goods and services, they are also playing the role of providers. Also in spending funds on their overheads, they act as providers of the co-ordination and other roles they play as agents.

[10] Rest of the world providers includes external (outside of Swaziland) providers delivering goods and services to national residents. Example, PLWHA visiting private physician in a neighboring country. The USG funds pay for many external consultants, which are captured as rest of the world providers.

3.5.1 Providers of HIV and AIDS Services in Swaziland

Table 3 shows providers of HIV/AIDS services in Swaziland. Majority of providers are public providers (82.6% and 73.0% in 2005/06 and 2006/07 respectively), followed by private non-profit providers (16.6% and 23.9% in 2005/06 and 2006/2007 respectively).

Table 4 Providers of HIV and AIDS Services in Swaziland

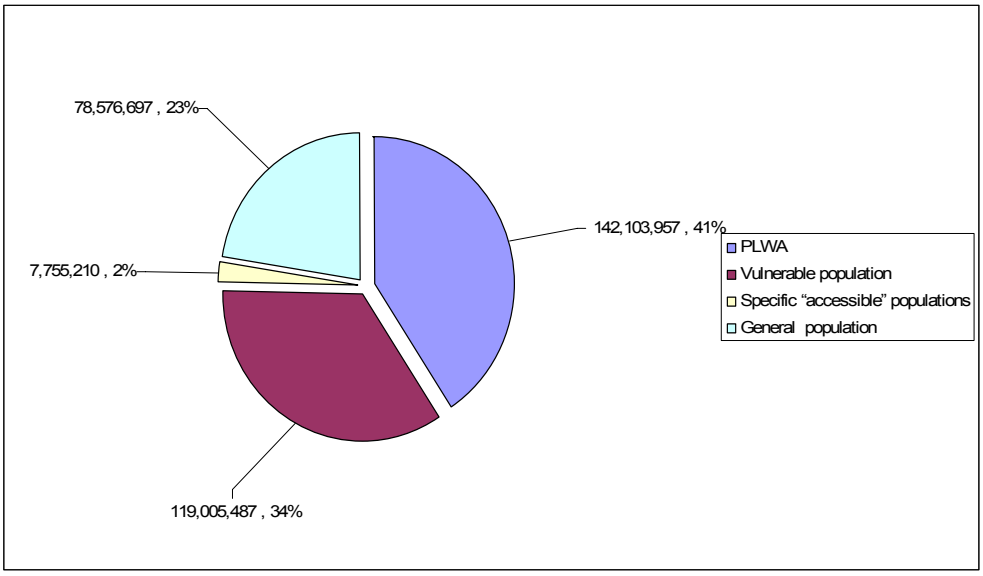
	2005/2006		2006/2007	
	SZL	Total %	SZL	%
Public Providers	212,595,191	82.6	254,929,242	73.9
Private non-profit providers	42,653,321	16.6	82,472,152	23.9
Bilateral and Multilateral entities	1,397,505	0.5	2,274,828	0.7
Providers not elsewhere classified	792,597	0.3	5,401,442	1.6
TOTAL	**257,438,614**	**100.0**	**345,077,664**	**100.0**

3.6 THE BENEFICIARIES OF SPENDING ON HIV AND AIDS ANALYSIS

The analysis of the beneficiaries of spending aimed at quantifying the resources allocated to a particular population as part of the service delivery process. The beneficiary populations were selected according to the intention or target of the expenditure of the particular programmatic intervention. Beneficiaries of spending are broadly categorized as follows; people living with HIV (regardless of having a diagnosis of AIDS), most at risk population and key population at higher risks (i.e. injecting drug users, sex workers, men who have sex with men and their clients), vulnerable population (i.e. OVC, refugees, children born or to be born by HIV mothers and internally displaced migrants), Specific accessible populations (youth in school, factory employee, military and internally displaced migrants), general population , non-targeted interventions and other beneficiaries not classified above.

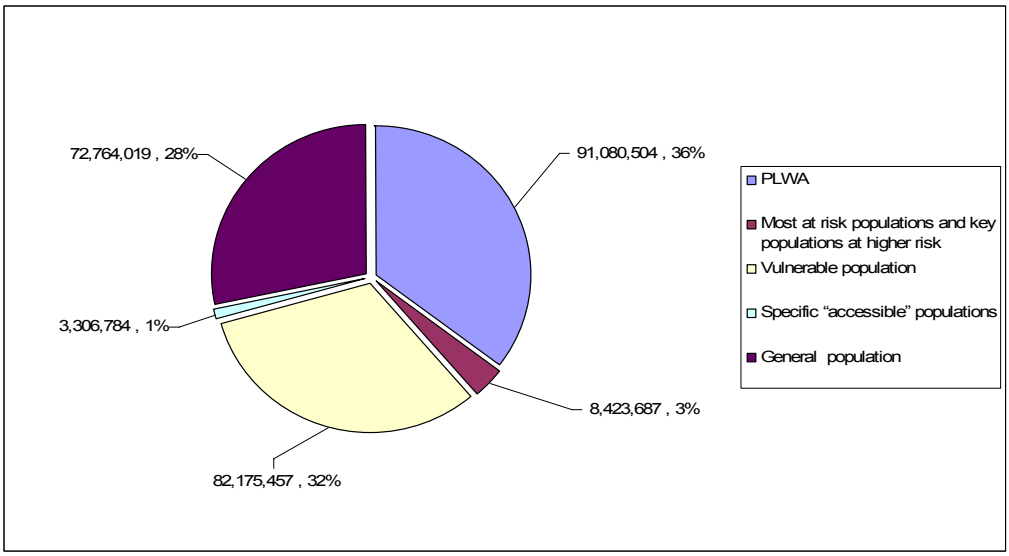
In 2006/2007, the results show that the total spending benefited people living with HIV/AIDS the most (almost 41% of funds were targeted to them), which reflects the generalized epidemic in the country, especially as they directly benefited from the spending on treatment and care (including ARVs). The vulnerable population benefited by 34%, mostly the OVCs the educational support. The general population benefited by 23% of spending (for example, from awareness raising and educational campaigns). Accessible population spending (2%) was primarily on youth in school through school educational programmes, and defense forces through condom provision. Figure 38 show beneficiaries of HIV/AIDS spending 2006/2007.

Figure 38 Overall proportional beneficiaries of total HIV/AIDS spending in 2006/2007



In 2005/2006, the results show almost the same patterns as 2006/2007 with small variations. PLWHA was the largest beneficiary group (almost 36%). The vulnerable population benefited by 32%, through educational support. The general population benefited by 28% of spending and there was small reported spending on the most at risk population (almost 3%) such as for commercial sex workers (CSWs), men who have sex with men (MSM), intravenous drug users (IUDs) and so on. Less benefited accessible populations (1%). Figure 39 show the overall beneficiaries of total HIV/AIDS spending in 2005/2006.

Figure 39 Overall proportional beneficiaries of total HIV/AIDS spending 2005/06

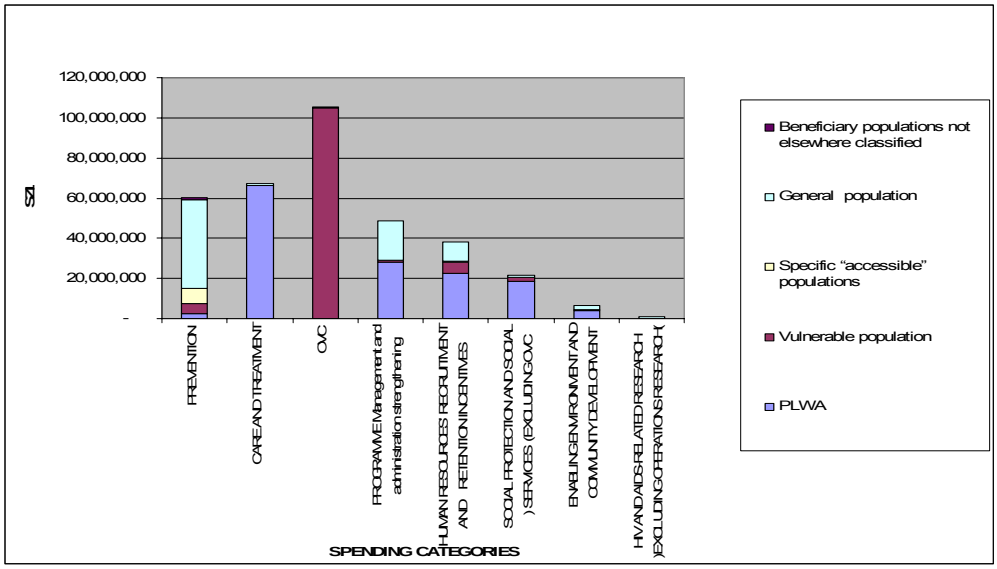


3.6.1 The beneficiaries of the spending activities

This section analyzed the broad categories of programmes in response to HIV/AIDS in relation to their beneficiary populations, in order to answer the question: 'Which population group was targeted by the core spending activities?'

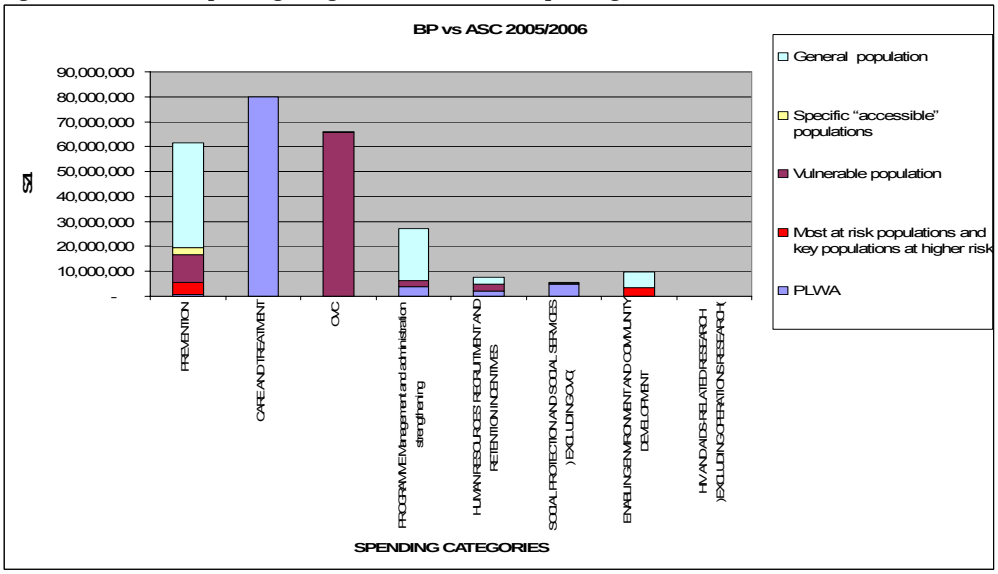
In 2006/2007, the results showed that the actual spending on prevention activities was more directed to the general population, and little preventive activities were done for vulnerable or accessible groups, nor for PLWA. Spending on vulnerable populations was mostly done through the OVC programmes. As would be expected, PLWHA were the primary beneficiaries of the care and treatment activities. For the programme management and administration, the spending by NERCHA was thought to benefit PLWHA, while that of other providers was more for the general population. Figure 40 shows the beneficiaries of the HIV/AIDS functional spending in 2006/2007.

Figure 40 HIV/AIDS functions to beneficiaries spending 2006/2007 (SZL)



Similar trends in programme target groups were revealed in 2005/2006. PLWHA benefited directly from the treatment and care spending, especially ARVs with little preventive activities. Programme management costs were mostly attributed to the general population, except for the expenditure of NERCHA, since their core purpose is to benefit PLWHA. Figure 41 shows HIV/AIDS spending categories to beneficiaries in 2005/2006

Figure 41 HIV/AIDS spending categories to beneficiaries spending 2005/2006



3.7 Absorptive capacity analysis

Absorption capacity refers to the degree to which the recipient institutions/ country is able to effectively and efficiently spend the financial resources received from the donor institution or country. This NASA study did not aim to assess the absorption capacity in terms of efficiency of spending. It attempted to measure the portion of funds that were actually spent of the total funds transferred from agents to providers.

The results show that, of all the spending in 2006/07, there was 100% spending rate of 94% of the funds transferred from agents to providers. Of the remaining funds, 0.67% was under spent and 99.33% were overspent. The overall spending rate in 2006/07 was 96%.

In 2005/06, there was 100% spending rate in 96% of the funds transferred from agents to providers. Of the remaining funds, 0.57% was under spent and 99.43% were overspent. The overall spending rate in 2005/06 was 97%. These appear to be high rates of spending, which might imply that there is good absorptive capacity by the providers for services. However, the NASA methodology tends to focus on the actual expenditure, and therefore may have missed where large sums were transferred and not spent.

3.8 Qualitative results ~ Funding Mechanisms and Challenges Faced

This section presents the qualitative results from the interviews undertaken, with the stakeholders involved in the response to HIV/AIDS epidemic in the Kingdom of Swaziland. The stakeholders included Non-Governmental Organisations and UN Agencies. There were no responses from the public sector and development partners. The key issues were identified during the interview with regard to the funding processes and challenges for NGOs and the UN agencies in response to HIV/AIDS epidemic, and are summarized below.

3.8.1 Non-Governmental organizations

The NGOs operating in the Kingdom of Swaziland receive funding from bilateral and multilateral agencies, international NGOs and foundations, as well as from the Government of the Kingdom of Swaziland.

Funding opportunities and adequacy

Respondents indicated that availability of funding for most of NGOs is limited and for those few opportunities available the competition is high. Limited funding opportunities could be due to the fact that The Kingdom of Swaziland is classified as a lower middle income country, and therefore it is regarded by the donor community as better off economically. Despite its lower-middle income status, the majority of Swaziland people live below the poverty line (Whalley, 2007). In addition, Most of the implementing NGOs complained that the funds disbursed by donor are not adequate to fund their activities and staff salaries.

Funding conditions

Funding conditions vary between donors. The conditions are imposed to insure that the funds provided are not abused. Some of the conditions relate to timely reporting, provision of work plan, spending according to budget and the strategic plan. However, some conditions reduce the effectiveness and efficiency of the programme, such as having to procure drugs and equipment, at greater cost, from the donor country

Reporting requirements for donor funds

The majority of NGOs acknowledged the importance of the reporting requirements for donor funds. This is because they allow for accountability and transparency regarding the fund utilization. However, some donor reporting requirements are excessively demanding because NGOs have to report monthly, quarterly, biannual and annually. Others have special reporting formats which some NGOs and CBOs find too cumbersome. There have been limited efforts at harmonising the reporting formats and timelines between donors so as to allow one report for all donors.

Government funding for NGOs

There are mixed views regarding the accessibility of Government funding. While some NGOs acknowledge that Government funds are accessible, other NGOs see these as inaccessible.

Key challenges in implementing HIV/AIDS services

Several challenges in implementing HIV/AIDS were expressed by NGOs. The challenges vary between NGOs depending on the activities implemented. The following are the key challenges expressed.

- Lack of co-operation between local and donor staff.
- Insufficient bed capacity (in hospitals) as a result of the increasing epidemic in the country.
- Training which is supplied by donors to specific people instead of all staff compromises the continuity of services provided.
- There seems to be competition, rather than coordination, among the implementing organisations and this leads to fragmentation and duplication of programmes.
- Lack of finance and human resources to run the projects, limiting the sustainability of projects.
- High demand for services, while the funding, and thus delivery capacity, is limited.
- Lack of awareness of sources of funds with regard to the issues of disabilities and HIV/AIDS.

3.8.2 UN agencies

This section summarises the qualitative information gained from the interviews undertaken with some United Nation (UN) Agencies.

Funding flow mechanisms

The funding process from UN agencies is standard across all agencies. Its involves the submission of a proposal by the Institution/organization to the agency, the proposal is reviewed, budgetary items identified for support, and quotations (minimum 3) to provide the goods or services are submitted. Memos are submitted to the executing office once approved purchasing orders are raised and payments are made.

UN Agencies reporting requirements.

Organizations requesting funds from UN Agencies are required to submit quarterly expenditure reports directly to the UN agency before additional funds are processed. In addition, annual reports are required indicating the achievements and difficulties, as well as ensuring that progress is aligned to the strategic plan. This appeared to be the standard process for all the UN agencies.

Difficulties faced by UN Agencies' recipient organizations in spending the funds.

Several difficulties faced by recipient organization were highlighted as follows:

- Limited absorption capacity mainly due to limited human resources and poor coordination.
- Unfamiliar with the procedures and reporting requirements of the UN Agencies.
- The amount proposed is inadequate because of price increases in goods and services needed that particular year.
- Activities are sometimes not prioritised leading to exhaustion of resources before the implementation of planned activities. Some activities to be implemented are not in the annual work plan.

CHAPTER FOUR

4 RECOMMENDATIONS

This chapter presents a number of recommendations which flow directly from the analysis made on both quantitative and qualitative information. They are presented below

4.1 The adequacy of funding

It was noted that the funds disbursed by donor to various providers are not adequate to fund provider's activities and staff salaries. Swaziland's under-funding by donor community is partly due the perception by the donor community that Swaziland is better off economically, especially after Swaziland being classified as a lower-middle income country. This is not the case as studies have shown that majority of Swaziland people live below the poverty line. The donor community is advised to change their mind set on Swaziland economic condition and disburse funds like to any other lower income country. On the other hand implementers are advised to spend the available funds on the most cost-effective interventions so as get the best results from the limited available funding.

4.2 Alignment of the actual HIV/AIDS spending to NSP.

There is a need to align the HIV/ AIDS spending to the NSP. NASA tracked all HIV/AIDS expenditure in the country and it was found that some of the expenditures were not aligned to the NSP. Considering the core priorities as selected in the NAP, it was found that while there were achievements in meeting the spending in some priority areas, other priority areas spending were not met. Example, spending on PMTCT, M&E and HIV/AIDS related research. There is a need to consider more spending in these areas.

4.3 Decline in spending in some priority interventions

It is recommended that reasons for decline in spending in some priority areas be investigated and ultimately fixed. Example

i. It was observed that while there was increase in the provision of ARVs, the associated nutritional support spending declined in year 2006/2007 despite increase in the total spending in HIV/AIDS activities Given the fact that majority of Swaziland people are living below the poverty line and since the effectiveness of ARVs is associated with dietary intake of the people using ARVs. Unless checked, the good intention of providing ARVs to majority of PLWHI will be undermined.

ii. Also, the total amount spent on preventive activities in 2006/2007 declined compared to 2005/2006. Decline in preventive activities spending means decline

in preventive activities with the community. In long run, all the achievements obtained in the war against the spread of HIV may be reversed.

4.4 Spending on most at risk population

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

4.5 Improved financial information systems

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

4.6 Improved external funding mechanisms and reporting requirements

Implementers go through the process of tendering for international donor funds once program announcements are made by donor organisations. Reporting requirements vary in terms of format and styles between donor organisations and request progress reports at various intervals. These reports can be requested monthly, quarterly, biannual or annual. This becomes a problem when the implementer receives funds from various donors. In addition, the funding mechanisms have stringent inbuilt procedures and controls which can become bureaucratic and time-consuming causing bottlenecks in transfers and delays in spending and the implementation of services. Therefore, it is recommended that donor organisations must seriously consider realigning their reporting requirements and budget categorisation in order to harmonise the reporting process, or help build the capacity of the implementers in meeting the reporting requirement desired. This would significantly improve the efficient use of funds and simplify the reporting process for implementers.

4.7 Improved Implementers' reporting and alignment

It was noted that many NGOs have low capacity financial reporting leading to many NGOs' inability to report accurately on their expenditures. In addition, the classifications of expenses are based on the donor reporting requirements and thus matching the expenditure to the NASA classifications was the biggest challenge in this study. Therefore, it is recommended that implementers should attempt to link their expenditure records with the outputs of activities, and the NASA classifications might provide a useful framework. This will make it easier to link the reports from the implementers with the NASA if undertaken on a regular basis, thus providing a database of comparable data of the years.

4.8 Improved coordination of implementers' activities

It was noted that there is duplication of activities among implementers competing for the same sources of funds. This has implications in the efficient allocation of resources and effectiveness of the programmes. Therefore it is recommended that the coordination of implementers' activities be improved to avoid duplication of activities. NERCHA could play an important role in aligning all activities, including those of NGOs, with the national priorities, which would avoid duplication and gaps in delivery.

4.9 Institutionalizing NASA – improvements based on this experience and beyond

This NASA has provided an important base-line study of the main public and donor funding going to HIV/AIDS in the Kingdom of Swaziland. It will be a relatively simple process to maintain the NASA database if the expenditures are captured on a routine basis. This calls for the institutionalization of NASA within the Monitoring and Evaluation (M&E) framework. Reporting of NASA information can be integrated with the existing mechanism within the M&E framework. However, these processes require standardization of the expenditure information reporting from all the various organizations. The next phase of NASA should include the private sources of funds, as well as capturing the out-of-pocket spending of individuals and households.

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6 APPENDICES

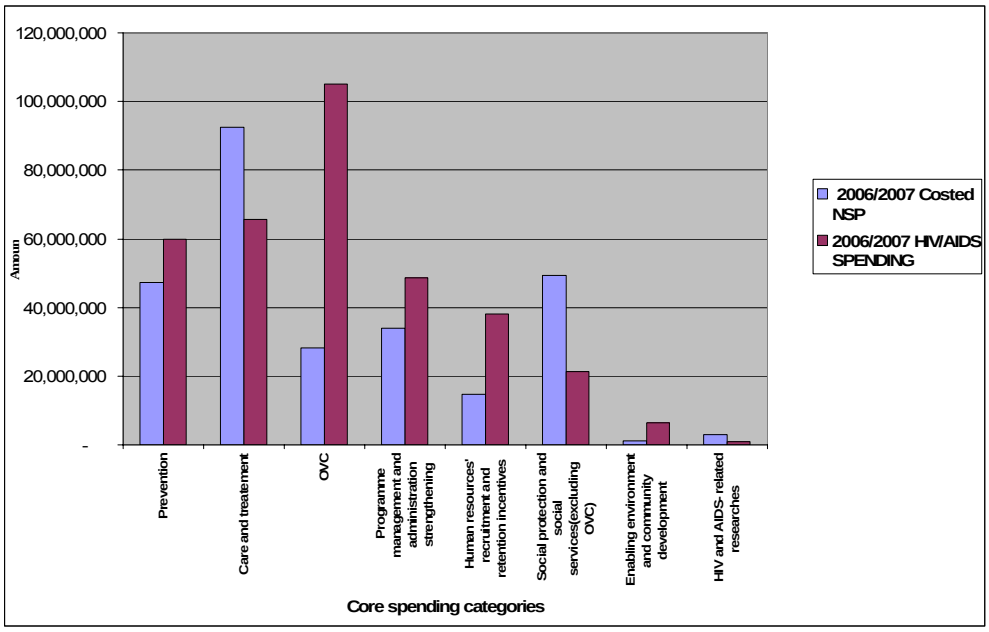
6.1 Source of data

		SOURCE OF DATA FOR SWAZILAND NASA			
		Year of data collected		Type of Data collected	
	STATUS OF DATA	2005/2006	2006/2007	Primary	Secondary
	PUBLIC				
1	NERCHA	✓	✓	✓	
2	HAPAC	✓	✓		✓
4	Ministry of Health and Social Welfare	✓	✓		✓
5	Ministry of Agriculture and Cooperatives	✓	✓	✓	✓
6	Ministry of Education	✓	✓	✓	✓
7	Ministry of Regional Dev & Youth Affairs	✗	✓	✓	✓
8	Ministry of Economic Planning	✗	✗	✗	✗
9	Ministry of Finance	✓	✓	✓	
10	Swaziland National Youth Council	✓	✓	✗	✓
11	USDF	✗	✓	✓	
12	Correctional Services	✓	✓	✓	
13	Central Medial Store	✓	✓	✓	✓
14	Blood Bank	✓	✓	✓	✓
		✓	✓		✓
16	STATUS OF DATA				
17	**EXTERNAL**	✗	✓	✓	
18	UNDP	✗	✓	✓	
19	UNESCO	✓	✓		✓
20	UNFPA	✓	✓	✓	✓
21	UNAIDS	✓	✓	✓	
22	UNICEF	✗	✓	✓	✓
23	USG	✓	✓	✗	✓
24	WFP	✓	✓	✓	✓
25	WHO	✓	✓		✓
26	EU	✓	✓	✓	✓
27	ITALIAN COORPERATION	✓	✓	✓	✓
28	**STATUS OF DATA- NGOs & FBOs**				
31	AMICAALL	✓	✓	✓	✓
33	Baphalali Swaziland Red Cross Society	✓	✓	✓	
34	BCHA	✓	✓	✓	
35	Baylor Centre of Excellence	✓	✓	✓	✓
36	Cabrini Ministries	✓	✓	✓	
37	CANGO	✓	✓	✓	
38	Care Nakekela	✗	✗	✗	
39	Caritas Swaziland	✗	✗	✗	
40	Cheshire Homes of Swaziland.	✓	✓	✓	✓
41	Children's Cup	✗	✗	✗	
42	Church Forum	✓	✗	✓	✓
43	Conference of Churches	✓	✓	✓	
44	Council of Swd. Churches	✓	✓	✓	
45	EGPAF	✓	✓	✓	
47	Family Life Association Swaziland	✗	✗	✗	
50	Hope House	✗	✗	✗	
52	International Community of Women living with HI	✓	✓	✓	
55	Lusweti Programme	✓	✓	✓	
56	Lutheran Development Services	✓	✓	✓	
57	Lutsango LwakaNgwane	✓	✓	✓	✓
61	Nazarene HIV/AIDS Task Force	✓	✓	✓	
62	Nhlangano HIV/AIDS Training, Info & Counselling	✓	✓	✓	
63	PACT	✓	✓	✗	✓
64	Parish Nurse Programme				
65	PSI Swaziland	✓	✓	✓	
67	Salvation Army	✓	✓	✓	
68	Save the Children Swaziland	✓	✓	✓	
71	Sebenta	✓	✓	✓	
73	SNYC	✓	✓	✓	
74	SOS Swaziland.	✗	✗	✗	
75	SWANNEPHA	✓	✓	✓	
76	Swaziland Action Group Against Abuse	✓	✓	✓	
77	Swaziland AIDS Support Organization	✓	✓	✓	
78	Swaziland Hospice at Home	✗	✗	✗	
79	Swaziland Positive Living for Life (SWAPOL)	✓	✓	✓	
80	Swaziland Youth United against HIV/AIDS	✓	✓	✓	
81	The AIDS Information and Support Centre (TASC)	✓	✓	✓	
82	Traditional Healers Organization	✓	✓	✓	
83	Vusumnotfo	✓	✓	✓	
84	Women & Law Swaziland	✓	✓	✓	
85	Women In Development	✓	✓	✓	
87	World Vision	✓	✓	✓	
88	Young Heroes Swaziland	✓	✓	✓	

6.2 Sources of Funds (SZL) (as reported actually spent – not commitments)

	2005/2006	**2006/2007**
1 Public Funds	**73,190,803**	**136,915,968**
1.1 Ministry of Finance	73,190,803	136,915,968
2. International funds	**184,027,697**	**209,212,520**
2.1 Direct bilateral contributions	**12,872,474**	**20,049,518**
2.1.01 Government of Australia	161,600	-
2.1.02 Government of Canada	-	156,450
2.1.03 Government of Finland	-	289,170
2.1.04 Government of Ireland	53,640	52,047
2.1.05 Government of Netherlands	4,783,511	3,210,251
2.1.06 Government of Norway	1,051,021	2,683,313
2.1.07 Government of Sweden	11,330	113,553
2.1.08 Government of United Kingdom	37,689	44,370
2.1.09 Government of United States	6,773,683	13,500,364
2.2. Multilateral Agencies servicing earmarked grants(1)	**149,847,093**	**142,331,910**
2.2.01 UNAIDS Secretariat	1,176,505	1,856,441
2.2.02 World Health Organization (WHO)	512,000	919,000
2.2.04 United Nations Children's Fund (UNICEF)	3,259,579	2,876,196
2.2.05 World Food Programme (WFP)	12,515,974	17,470,974
2.2.06 United Nations Development Programme (UNDP)	528,800	56,994
2.2.07 United Nations Population Fund (UNFPA)	5,595,296	6,537,195
2.2.08 United Nations Educational, Scientific and Cultural Organization (UNESCO)	-	118,804
2.2.09 World Bank (WB)	120,000	467,729
2.2.10 The Global Fund to Fight AIDS, Tuberculosis and Malaria	125,968,473	108,568,051
2.2.11 Commission of the European Communities	-	3,304,960
2.2.10 Multilateral funds or development funds n.e.c.	170,466	155,566
3. International not-for-profit organizations and foundations	**21,308,130**	**46,831,092**
3.01 World Vision	701,919	1,035,956
3.02 ActionAID	3,992,238	2,816,829
3.03 International Federation of Red Cross and Red Crescent Societies, and National Red Cross Societies	5,339,262	8,446,432
3.04 Bristol-Myers Squibb Foundation	1,707,408	1,535,166
3.05 International not-for-profit organizations and foundations not elsewhere classified (n.e.c.)	9,483,736	32,996,709
3.06 International for profit organizations	83,567	-
Total funds	**257,218,500**	**346,128,488**

6.3 Costed NAP 2006/2007 priorities and 2006/2007 core spending categories compared (SZL)



6.4 2005/2006 Financing Agents (SZL)

Fiinancing agents on aggregate 2005/2006	
Public Sector	79,245,808
Private Sector	565,534
International Purchasing Organizations	177,407,163
Country offices of Bilateral Agencies managing external resources	12,273,675
Multilateral Agencies managing external resources*	149,815,165
International not-for-profit organizations and foundations	15,318,323
TOTAL	257,218,505

* Multilateral agencies include principal recipient of Global funds

6.5 2006/2007 financing agents (SZL)

Financing agents on aggregate2006/2007	
1.Public Sector	140,354,392
2.Private Sector	21,066,029
3.International Purchasing Organizations	184,708,062
Country offices of Bilateral Agencies managing external resources	19,644,883
Multilateral Agencies managing external resources	138,440,415
International not-for-profit organizations and foundations	26,622,764
TOTAL	346,128,483

6.6 Financing sources- Core AIDS spending categories (SZL)

2006/2007 FINANCING SOURCES-CORE SPENDING CATEGORIES			
	Public Funds	International fun	Grand Total
PREVENTION	8,006,142	51,965,897	59,972,039
CARE AND TREATMENT	18,336,786	47,349,981	65,686,767
ORPHANS AND VULNERABLE CHILDREN (OVC)	72,010,985	33,180,497	105,191,482
PROGRAMME Management and administration strengthening	24,755,788	23,775,385	48,531,173
HUMAN RESOURCES' RECRUITMENT AND RETENTION INCENTIVES - HUMAN CA	2,010,377	36,128,908	38,139,285
SOCIAL PROTECTION AND SOCIAL SERVICES (EXCLUDING OVC)	9,445,874	11,910,080	21,355,954
ENABLING ENVIRONMENT AND COMMUNITY DEVELOPMENT	1,462,077	4,892,693	6,354,770
HIV AND AIDS-RELATED RESEARCH (EXCLUDING OPERATIONS RESEARCH)	887,939	9,079	897,018
TOTAL	**136,915,968**	**209,212,520**	**346,128,488**

2005/2006 FINANCING SOURCES- CORE SPENDING CATEGORIES			
	Public Funds	International funds	Grand Total
PREVENTION	9,777,299	51,657,332	61,434,631
CARE AND TREATMENT	10,104,609	69,811,551	79,916,160
ORPHANS AND VULNERABLE CHILDREN (OVC)	42,203,072	23,809,253	66,012,325
PROGRAMME Management and administration strengthening	8,523,801	18,592,139	27,115,940
HUMAN RESOURCES' RECRUITMENT AND RETENTION INCENTIVES - HUMAN CAPITAL	121,112	7,432,085	7,553,197
SOCIAL PROTECTION AND SOCIAL SERVICES (EXCLUDING OVC)	2,381,418	3,007,591	5,389,009
ENABLING ENVIRONMENT AND COMMUNITY DEVELOPMENT	79,492	9,692,999	9,772,491
HIV AND AIDS-RELATED RESEARCH (EXCLUDING OPERATIONS RESEARCH)	-	24,747	24,747
TOTAL	**73,190,803**	**184,027,697**	**257,218,500**

6.7 Providers of services -Beneficiary population groups (SZL)

PROVIDERS OF SERVICES vs BENEFICIARRY POPOLATION 2006/2007							
	PLWA	Most at risk populations and key populations at higher risk	Vulnerable population	Specific "accessible" populations	General population	Beneficiary populations not elsewhere classified	Total
Public Providers	**113,322,825**	**-**	**88,326,259**	**2,161,104**	**52,841,999**	**-**	**256,652,187**
Private non-profit providers	**27,901,683**	**-**	**25,071,539**	**5,484,265**	**23,284,016**	**1,217,596**	**82,959,099**
Private For Profit Providers	**335,435**	**-**	**-**	**-**	**-**	**-**	**335,435**
Bilateral and Multilateral entities	**-**	**-**	**-**	**109,841**	**2,164,987**	**-**	**2,274,828**
Rest-of-the world providers	**340,406**	**-**	**409,855**	**-**	**285,695**	**-**	**1,035,956**
Providers not elsewhere classified	**203,608**	**-**	**5,197,834**	**-**	**-**	**-**	**5,401,442**
TOTAL	**142,103,957**	**-**	**119,005,487**	**7,755,210**	**78,576,697**	**1,217,596**	**348,658,947**

PROVIDERS OF SERVICES vs BENEFICIARY POPULATION 2005/2006							
	PLWA	Most at risk populations and key populations at higher risk	Vulnerable population	Specific "accessible" populations	General population	Beneficiary populations not elsewhere classified	Total
Public Providers	91,240,088	4,979,016	62,124,138	299,505	53,922,448	-	212,565,195
Private non-profit providers	2,640,969	-	19,758,892	3,007,279	17,246,181	-	42,653,321
Private For Profit Providers	334,286	-	-	-	-	-	334,286
Bilateral and Multilateral entities	-	-	-	-	1,397,505	-	1,397,505
Rest-of-the world providers	-	-	7,542	-	-	-	7,542
Providers not elsewhere classified	309,832	-	284,885	-	197,885	-	792,602
Total	**94,525,175**	**4,979,016**	**82,175,457**	**3,306,784**	**72,764,019**	**-**	**257,750,451**

6.8 The Kingdom of Swaziland second national multisectoral HIV and AIDS strategic plan 2006-2008 targets

The targets for each goal are presented below.

Goal 1: Prevention of HIV Transmission

Objectives:

- To reduce the proportion of sexually active persons who have sex with more than one sexual partner by 25% in 2008.
- To reduce the proportion of in school youth who are sexually active from 30% in 2002 to 20% in 2008.
- To reduce the proportion of in school youth who are sexually active from 70% in 2002 to 50% in 2008.
- To reduce HIV prevalence among blood donors from 2% in 2004 to 0.5% by 2008.
- To increase the number of donated blood units which are collected per year from 6,000 in 2004 to 10,000 in 2008.
- To increase the availability of 100% safe blood and blood products for transfusion in the country by 2008.
- To reduce the proportion of children(0-4years) who are HIV positive by 30% in 2008
- To increase the proportion of sexual active employees who use condom consistently by 25% by 2008.
- To reduce the proportion of sexually active employees who have sex with more than one sexual partner by 30% by 2008.
- To reduce the proportion of employees who have experienced work place-based sexual abuse by 50% by 2008
- To increase the number of available male condoms from 6,286,800 in 2004 to 10,000,000 by 2008.
- To increase the number of available female condoms from 19,966 in 2004 to 80,000 by 2008.
- To increase the number of sexually active persons who use condoms consistently by 25% in 2008
- To increase the number of new condom outlets per region by 200 by 2008.
- To reduce the prevalence of sexually transmitted infections by 20% by 2008.
- To increase to 100% by 2008 the proportion of high risk occupational service areas that has PEP and Universal precautions interventions.
- To increase to 100% by 2008 the number of persons reported to have been raped or exposed to incest who receives PEP services.

- To ensure that by 2008, all (100%) person who have experienced occupational related accidental exposure receive PEP services.
- To ensure that by 2008, about 100% of people who have been tested for HIV receive pre and post HIV test counseling.
- To increase to 40% by 2008, the proportion of adults(15-49 years) who have ever tested for HIV
- To increase to 30% by 2008, the proportion of adults (15-49 years) who know their HIV status.

Goal 2: Improve the provision of care, support and treatment to all those infected and affected by HIV/AIDS

Objectives

- To increase the number of people living with HIV and AIDS receiving antiretroviral therapy to 75% in 2008.
- To increase the proportion of eligible people living with HIV and AIDS who receive food package as part of HIV and AIDS related clinical management to 100% in 2008.
- To increase the proportion of persons diagnosed with tuberculosis that are tested for HIV from below 50% in 2005 to 100% in 2008.
- To increase the cure rate of tuberculosis from 15.3% in 2003 to 75% in 2008.
- To reduce the incidence of tuberculosis in the country fro 700 cases per 100,000 in 2003 to 350 cases per 100,000 in 2008.
- To establish mechanisms for collaboration of TB/HIV activities at all levels.
- To decrease the burden of TB in people living with HIV/AIDS from 50% to 35% in 2008.
- To decrease the burden of HIV in TB patients from 78% to 45% in 2008.
- To increase the proportion of clients who receive facility-based routine HIV counseling and testing by 25% in 2008.
- To increase by 20% in 2008 the proportion of clients who have had contacts with health care facilities and know their health status.
- To increase by 70% the proportion of chronically ill people that receives quality and appropriate care as well as support within their homes in 2008.
- To increase by 40% the proportion of health care facilities that have arrangement with Community Home Based Care services and communities in 2008.
- To increase by 20% the proportion of health care facilities that offer the basic palliative care services to terminally ill people in 2008.
- To increase by 25% the proportion of Community Home Based care clients receiving appropriate palliative care services (including children) in 2008.

Goal 3: Mitigate the social and economic effects and impacts of the epidemic on Swaziland society.

Objectives:

- To ensure that 100% of draft policies are adopted and 100% of draft bills are enacted by the end of 2006.
- To ensure that 100% of policies are translated into Acts by 2007.
- To ensure that 100% of ratified impact mitigation- related international conventions are domesticated by 2008.
- To increase to at least by 80% public awareness about the rights and obligations of PLWHA and other vulnerable groups by 2008.
- To increase by 50% the proportion of eligible households with child heads, PLWH/A, PWD, BVEs that have access to basic services by 2007.
- To establish National Social Security System by 2008.
- To ensure that 50% of eligible households have access to micro-credit and development finance by 2008.
- To ensure that 50% of registered OVC, PLWHA, BVEs, PWD and caregivers receive counseling and emotional care by 2008.
- To ensure that 50% of registered OVCs, PLWHA, BVEs, PWD and caregivers receive appropriate mental health services by 2008.
- To increase to 100% the proportion of eligible OVCs, PLWHA, BVEs who have access to at least one nutritious meal a day by 2008.
- To ensure that at least 100% of OVC aged 6-14 years have access to free formal or non-formal education by 2008.
- To ensure that at least 100% of OVC and disadvantaged youth have access to formal or non-formal education by 2008.
- To ensure that 100% of chiefdoms and towns have the capacity to provide basic impact mitigation services by 2008.

Goal 4: Create an enabling environment for the scale up and better coordinated national response to HIV/AIDS.

Objectives:

- To improve the co-ordination of HIV and AIDS activities at all levels.
- To increase ownership and support of the national response by all responding partners and members of the general public

- To improve the involvement and participation of grass-root communities, PLWH/A and vulnerable groups in the national response.
- To upscale the national response and strengthen effective priority actions against HIV and AIDS.
- To harmonize and ensure coherence of actions of all cooperating partners, especially development partners, civil society organizations and government sector.
- To increase available funding at all levels on scale capable of making impact to the epidemic.
- To ensure appropriate, effective and swift use of available resources at all levels of the national response.
- To create an enabling social, religious, cultural, political, legal and economic environment for the national response to thrive.
- To improve information availability on the national HIV and AIDS response as well as responsiveness to misinformation.
- To ensure that 100% of responding agencies have integrated human rights, gender, poverty, social-cultural practices and disability into their response activities by 2008.
- To ensure that by 2008, about 100% of registered responding agencies have at least one staff member who has training in HIV and AIDS related areas such as human right, gender, poverty ,social cultural practice and disability.
- To produce accurate information and data on achievement of the objectives and outputs of the national response.
- To promote utilization of available HIV and AIDS data for planning and decision making.
- To increase the number of HIV and related studies that are carried in the country.

6.9 Summary of the costed National Multisectoral Action plan for HIV/AIDS 2006/2007 priorities

Objective	Priority	Budget E	NERCHA E	Sector E	Development Partners E	Total Amount Outstanding E
Objective 1: To reduce the proportion of sexually active persons who have sex with more than one sexual partner by 25% by 2008	Priority strategy 1.1: Promoting positive social change to reduce the practice of multiple, concurrent, sexual relationships	10,614,480	904000	0	3875480	5,835,000
	Priority strategy 1.2: Promoting gender equity to reduce the practice of multiple, concurrent, sexual relationships	1,115,000	0	3,000	390000	722,000
	Priority strategy 1.3: Address cultural practices that contribute to risk of HIV infection	1,181,500	724,000	0	0	457,500
	Priority strategy 1.4: Promote cultural practices that contribute to reduction of risk of HIV infection	65,000	0	0	30,000	35,000
	Priority strategy 1.6: Improving knowledge and understanding of HIV and AIDS	3,100,000	400,000	0	0	2,700,000
Objective 3: To reduce the proportion of out-of-school youth who are sexually active from 70% in 2002 to 50% by 2008	Priority strategy 11: Providing informal education to out-of-school children and youth	702,400	458,400	0	90,000	154,000
	Priority strategy 12: Providing positive social activities for youth-out-of-school	244,000	164000	0	0	80,000

Objective	Priority	Budget E	NERCHA E	Sector E	Development Partners E	Total Amount Outstanding E
Objective 7: To reduce the proportion of children (0 -4 years) who are HIV positive by 30% by 2008	Priority strategy 7.1: Create enabling environment and strengthen national capacity to provide PMTCT services (all four prongs)	585,000	0	0	570,000	15,000
	Priority strategy 7.2: Build capacity of health care workers to provide quality PMTCT services	7,176,522	0	0	7,156,522	20,000
	Priority strategy 7.3 Strengthen capacity of health facilities to provide quality PMTCT services	7,176,522	0	0	7,156,522	20,000
	Priority strategy 7.4: Facilitate provision and uptake of PMTCT services including primary HIV prevention among men and child bearing women at all levels	4,597,000	525,000	0	2,154,000	1,918,000
Objective 22: To increase the number of eligible PLWHAs receiving ART by 75% by 2008	Priority strategy 22.1 : Development of national capacity, including capacity of laboratory services to scale-up and provide quality and affordable ART services that address the needs of both adults and children	74,008,087	33,794,087	29,000,000	11,116,000	98,000
Objective 23: To increase to 100% by 2008, the proportion of PLWHAs who receive food packages as part of HIV and AIDS clinical management (HAART).	Priority strategy 23.1 : Introduction of nutritional support as part of a comprehensive ART package	6,180,000	600,000	0	5,580,000	0

Objective	Priority	Budget E	NERCHA E	Sector E	Development Partners E	Total Amount Outstanding E
Objective 24: To increase by an average of 5 years, the survival of people on ART	Priority strategy 24.1 : Development of both facility and community-based support services for ensuring follow-up and adherence among clients on ART	1,116,000	0	0	1,116,000	0
Objective 25: To increase to an average of 7 years by 2008, the survival of PLWHAs after HIV testing and before ART.	Priority strategy 25.1: Develop and introduce a comprehensive national pre-ART care package, including the use of prophylaxis medication and food packages	5,504,000	0	0	4,104,000	1,400,000
	Priority strategy 25.2 : Improve literacy on pre-ART services among the members of the public	230,000	0	0	120,000	110,000
Objective 30: To decrease the burden of TB in people living with HIV/AIDS from 50% to 35% by December 2008.	Priority strategy 30.1 : Decrease the burden of TB in people living with HIV/AIDS	683,560	541,560	0	132,000	10,000
Objective 31: To decrease the burden of HIV in TB patients from 78% to 45% by 2008.	Priority strategy 31.1: Scaling up of routine HIV testing and counselling among TB patients.	4,800,000	742,176	0	4,050,000	7,824
Objective 40: To ensure that by the end of 2006, 100% of draft policies are adopted and 100% of draft bills are enacted	Priority strategy 13: Identifying policies related to HIV and AIDS and advocating for their adoption	2,905,000	40,000	0	1,032,000	1,833,000

Objective	Priority	Budget E	NERCHA E	Sector E	Development Partners E	Total Amount Outstanding E
Objective 43: To increase to at least 80% by 2008 public awareness about the rights and obligations of PLWHA and other vulnerable groups	Priority strategy 14: Promoting human rights in relation to HIV and AIDS	1,188,200	100,000	0	721,200	367,000
Objective 44: To increase the proportion of eligible households with child heads, PLWHA, PWD and BVEs that have access to basic services (clean water, sanitation and shelter) to 50% by 2007	Priority strategy 15: Developing and implementing a comprehensive food security strategy	54,806,900	7,461,000	0	15,576,000	31,869,400
	Priority strategy 16: Providing basic shelter for OVCs	2,520,166	415100	0	180,000	1,584,900
	Priority strategy 17: Supporting initiatives to provide clothing to OVC	730,000	0	0	630,000	100,000
Objective 40: To ensure that by the end of 2006, 100% of draft policies are adopted and 100% of draft bills are enacted	Priority strategy 40.1: Identifying policies related to HIV and AIDS and advocating for their adoption	217,000	125,000		42,000	50,000
Objective 46: To ensure that by 2008 50% of eligible households have access to micro-credit and development finance	Priority strategy 18: Facilitating and supporting income generation activities for caregivers	17,182,000	1,200,000	0	12,448,000	3,534,000

Objective	Priority	Budget E	NERCHA E	Sector E	Development Partners E	Total Amount Outstanding E
Objective 47: To ensure that by 2008 at least 50% of registered OVC, PLWHA, BVEs, PWD and caregivers receive counselling and emotional care	Priority strategy 19: Developing and implementing a national strategy on counselling and emotional care	1,248,000	0	0	1,230,000	18,000
Objective 52: To ensure that by 2008 at least 80% of OVC and disadvantaged youth have access to formal and non-formal education	Priority strategy 23: Improving the quality and expanding coverage of formal and non-formal education	3,598,000	1,033,200	0	728,400	1,616,400
Objective 52: To ensure that by 2008 at least 80% of OVC and disadvantaged youth have access to formal and non-formal education	Priority strategy 24: Providing access to vocational skills training for OVC and youth-out-of-school	4,963,800	908,000	0	0	3,947,800
Objective 54: To improve co-ordination of HIV and AIDS activities at all levels	Priority strategy 25: Empowering and building the capacity of all designated co-ordinating bodies	18,087,000	2,259,150	0	1,632,000	14,195,850
Objective 59: To upscale the national response and strengthen effective priority actions against HIV and AIDS	Priority strategy 26: Increasing capacity of service delivery organisations to effectively implement and manage the response	14,582,000	1,000,000	0	12,412,000	1,170,000

Objective	Priority	Budget E	NERCHA E	Sector E	Development Partners E	Total Amount Outstanding E
Objective 60: To harmonise and ensure coherence of actions of all cooperating partners especially development partners, civil society organisations, and government sectors	Priority strategy 27: Strengthening design and planning capacity for service delivery organisations to use a program rather than project based approach	150,000	0	0	150,000	0
Objective 64: To improve information availability on the national HIV and AIDS response as well as responsiveness to information	Priority strategy 29: Producing and sharing updated, accurate and evidence-based information on the trends of the epidemic, responses and impact	297,500	0	0	0	297,500
Objective 67: To produce accurate information and data on the achievement of the objectives and outputs of the national response to HIV and AIDS	Priority Strategy 30: Operationalising a programme monitoring system as outlined in the National M&E Operational Plan	14,870,000	3,450,000	0	4,587,624	7,036,376
Objective 68: To promote utilisation of available HIV and AIDS data for planning and decision making	Priority strategy 32: Improving the process of disseminating HIV and AIDS related information, research and products	755,000	155,000	0	600,000	0
Objective 69: To increase the number of HIV and AIDS related studies that are carried out in the country	Priority strategy 33: Developing and implementing a national HIV and AIDS research agenda	2,918,000	534,000	0	2,184,000	48,000
TOTAL		**270,097,637**	**57,533,673**	**29,003,000**	**101,793,748**	**81,250,550**

6.10 Data collection forms

6.10.1 Source/Agent form

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 use and destiny of those funds.			
Indicate what currency will be used throughout the form with an "X":		**Local currency**	**Other (specify): _____**
Name of the Institution:			
1. Person to Contact (Name and Title):			
2. Address:		**3. E-mail:**	
4. Phone:		**5. Fax:**	
6. **7. Type of institution:** Select category of institution with an "X".	6.1 Public central government		
	6.2 Public regional government		
	6.3 Public local government		
	6.4 Private-for-profit national		
	6.5 Private-for-profit international		
	6.6 National NGO		
	6.7 International NGO		
	6.8 Bilateral Agency		
	6.9 Multilateral Agency		

8. Origin of the funds received: List the institutions that granted funds during the year under study.	
Origin of the funds (Name of the Institution and Person to Contact)	Funds received
9.1 Institution: Contact:	
9.2 Institution: Contact:	
9.3 Institution:	

Contact:	
7.1 Institution: Contact:	
7.2 Institution: Contact:	
TOTAL:	

9. Destination of the funds:

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

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

10. Additional information on transferred funds reported as spent: Complete a Providers form (Form # 2) for each institution about which the Source / 0Agent has information regarding what the funds were used for, in order to gain information on Functions, Beneficiary Populations and Production Factors.

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

12.Surveyor:	**13.Date:** / / 0

6.10.2 Providers form

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)	

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 under study. IV. To identify in which NASA Functions the funds were spent. V. To identify the NASA Beneficiary Populations for each NASA Function. VI. To identify the NASA Production Factors for each Function.	

Indicate what currency will be used throughout the form with an "X":	**Local currency**	**Other (specify):** _____	

Name of the Provider:	
14.Person to Contact (Name and Title):	
15.Address:	**16.E-mail:**
17.Phone:	**18.Fax:**

19.Type of institution: Select category of institution with an "X".	6.10 Public central government	
	1. Public regional government	
	2. Public local government	
	3. Private-for-profit national	
	4. Private-for-profit international	
	5. National NGO	
	6. International NGO	
	7. Bilateral Agency	
	8. Multilateral Agency	

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In case of B), complete:

Institution: Person to Contact (Name and Title):

Phone: E-mail:

20. 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 they figure in the notebook for their identification.

8.1 Destination of the funds received from "7.1"

8.1.1 Function (Code and Name) Code: Name:	Amount spent
8.1.1.1 Beneficiary Population (Code y Name): Code: Name:	
8.1.1.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	
8.1.2 Function (Code y Name) Code: Name:	Amount spent
8.1.2.1 Beneficiary Population (Code y Name): Code: Name:	
8.1.2.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	
8.1.3 Function (Code y Name) Code: Name:	Amount spent
8.1.3.1 Beneficiary Population (Code y Name): Code: Name:	
8.1.3.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	

8.2 Destination of the funds received from "7.2"

8.2.1 **Function** (Code y Name) Code: Name:	Amount spent
8.2.1.1 Beneficiary Population (Code y Name): Code: Name:	
8.2.1.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	
8.2.2 Function (Code y Name) Code: Name:	Amount spent

8.2.2.1 Beneficiary Population (Code y Name): Code: Name:	
8.2.2.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	
8.2.3 Function (Code y Name) Code: Name:	Amount spent
8.2.3.1 Beneficiary Population (Code y Name): Code: Name:	
8.2.3.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	

8.3 Destination of the funds received from "7.3"

8.3.1 **Function** (Code y Name) Code: Name:	Amount spent
8.3.1.1 Beneficiary Population (Code y Name): Code: Name:	
8.3.1.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	
8.3.2 Function (Code y Name) Code: Name:	Amount spent
8.3.2.1 Beneficiary Population (Code y Name): Code: Name:	
8.3.2.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	
8.3.3 Function (Code y Name) Code: Name:	Amount spent
8.3.3.1 Beneficiary Population (Code y Name): Code: Name:	
8.3.3.2 Beneficiary Population (Code y Name): Code: Name:	
Total spent on the Function:	

8.4 Destination of the funds received from "7.4"

8.4.1 **Function** (Code y Name) Code: Name:	Amount spent
8.4.1.1 Beneficiary Population (Code y Name): Code: Name:	
8.4.1.2 Beneficiary Population (Code y Name): Code: Name:	

			Total spent on the Function:	
8.4.2 Function (Code y Name)				Amount spent
Code:		Name:		
8.4.2.1 Beneficiary Population (Code y Name): Code: Name:				
8.4.2.2 Beneficiary Population (Code y Name): Code: Name:				
			Total spent on the Function:	
8.4.3 Function (Code y Name)				Amount spent
Code:		Name:		
8.4.3.1 Beneficiary Population (Code y Name): Code: Name:				
8.4.3.2 Beneficiary Population (Code y Name): Code: Name:				
			Total spent on the Function:	

8.5 Destination of the funds received from "7.5"

8.5.1 **Function** (Code y Name)				Amount spent
Code:		Name:		
8.5.1.1 Beneficiary Population (Code y Name): Code: Name:				
8.5.1.2 Beneficiary Population (Code y Name): Code: Name:				
			Total spent on the Function:	
8.5.2 Function (Code y Name)				Amount spent
Code:		Name:		
8.5.2.1 Beneficiary Population (Code y Name): Code: Name:				
8.5.2.2 Beneficiary Population (Code y Name): Code: Name:				
			Total spent on the Function:	
8.5.3 Function (Code y Name)				Amount spent
Code:		Name:		
8.5.3.1 Beneficiary Population (Code y Name): Code: Name:				
8.5.3.2 Beneficiary Population (Code y Name): Code: Name:				
			Total spent on the Function:	

21. 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

7.3 Institution: Contact:	
7.4 Institution: Contact:	
7.5 Institution: Contact:	
7.6 Institution: Contact:	
7.7 Institution: Contact:	
TOTAL:	

22.Production Factors: In order to finish the form, complete ANNEX 1.	
23.Surveyor:	**24.Date:** / / 0