The Kingdom of Swaziland

NATIONAL AIDS SPENDING ASSESSMENT

2007-2010

I

NERCHA

Foreword

This report is part of NERCHA analytical work looking at the resources invested in the multisectoral response to HIV and AIDS. The response has grown over the years and with it the need for resources. This increase in resource requirements comes against a backdrop of increasingly scarce resources as a result of a global recession. This has made it vital to track the resources spent on the country's HIV and AIDS activities. This enables the country to meet its obligations of reporting on progress made in the response including finances invested, to the UNGASS and Abuja declarations of which it is a signatory.

In line with international trends, NERCHA uses the National AIDS Spending Assessment (NASA) as a tool to comprehensively track this expenditure. The main aim of the NASA is to undertake a comprehensive analysis of actual expenditures for HIV and AIDS activities in both health and non health settings. This report tells us who the sources of funds for the national response are, the levels of expenditure in each of the 8 HIV and AIDS programmatic classifications as determined by UNAIDS and which population groups benefitted from these funds for the financial years 2007/8, 2008/9 and 2009/2010.

The report demonstrates the commendable commitment from the government of Swaziland, the private sector and international partners in providing resources for coordinating and implementing the national response to a disease that has proven to be one of the greatest challenges of our times. The proportion of financial contribution by the government in particular, has been increasing for the past few years to be in line with international trends, signaling the placing of health as one of the top priorities of the government's programme and the political will displayed by the country's leadership to halt the spread of HIV. The contribution of the private sector is an indicator of the willingness of the business community to come to the party in assisting government to respond to a situation that has been shown to have adverse effects on the economy.

The results of the assessment also confirm what has been known for some time now; there is low expenditure on prevention programmes and reinforces the call for partners to review strategies around prevention if we are to close the tap of new HIV cases.

Derek von Wissell
National Director

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BCC	Behavioral Change Communication
CSO	Central Statistical Office
DPs	Development Partners
EHCP	Essential Healthcare Package
EU	European Union
FBO	Faith Based Organization
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IDU	Intravenous Drug Users
MARPs	Most at Risk Populations
MoH	Ministry of Health
MOT	Modes of Transmission
MSM	Men who have sex with men
NGO	Non Governmental Organisation
NASA	National AIDS Spending Assessment
NSF	National Strategic Framework
NSP	National Strategic Plan
OIs	Opportunistic Infections
OOPE	Out of pocket expenditure
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Programme for AIDS Relief
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
RTS	Resource Tracking System
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SDHS	Swaziland Demographic and Health Survey

STD/STI	Sexually Transmitted Diseases/Sexually Transmitted Infections
SZL	Swaziland Lilangeni
TB	Tuberculosis
THP	Traditional Health Practitioners
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Project
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children Fund
USD	United States Dollar

Basic Factsheet on The Kingdom of Swaziland HIV and AIDS Expenditure
for the Period 2007/2008 – 2009/2010

HIV and AIDS Expenditure by Funding Sources						
	2007/2008		2008/2009		2009/2010	
	Amount (SZL)	%	Amount(SZL)	%	Amount(SZL)	%
Total Spending	**308,006,541**		**435,374,505**		**582,670,706**	
Public Funds	102,612,949	**33.31**	182,905,780	**42.01**	231,521,283	**39.74**
Private Funds	3,255,027	**1.06**	13,926,289	**3.20**	19,585,536	**3.36**
International Funds	202,138,565	**65.63**	238,542,436	**54.79**	331,563,887	**56.90**

HIV and AIDS Expenditure by Programmatic Area

PREVENTION (in 2007/2008 – 9.9% of total Expenditure; in 2008/2009 - 6.4% of total Expenditure; in 2009/2010 -11.6% of total Expenditure)

- Total Expenditure: SZL30,494,117 in 2007/2008; SZL 27,766,947 in 2008/2009 and SZL67,302,843 in 2009/2010
- Main Item: Communication for social and behavioural change in 2007/2008 and 2008/2009; Risk-reduction for vulnerable and accessible populations in 2009/2010.

TREATMENT & CARE (in 2007/2008 – 17.8% of total Expenditure; in 2008/2009 – 16.9% of total Expenditure; in 2009/2010 -18.8% of total Expenditure)

- Total Expenditure: SZL54,679,582 in 2007/2008; SZL73,852,736 in 2008/2009 and SZL109,412,198 in 2009/2010
- Main Item: Antiretroviral therapy in all three years

OVC (in 2007/2008 – 17.8% of total Expenditure; in 2008/2009 – 20.9% of total Expenditure; in 2009/2010 – 17.5% of total Expenditure)

- Total Expenditure: SZL54,791,456 in 2007/2008; SZL91,006,923 in 2008/2009 and SZL102,182,062 in 2009/2010
- Main Item: OVC Education in all three years

PROGRAMME MANAGEMENT(in 2007/2008 – 27.6% of total Expenditure; in 2008/2009 – 35% of total Expenditure; in 2009/2010 – 28% of total Expenditure)

- Total Expenditure: SZL85,126,798 in 2007/2008; SZL152,428,214 in 2008/2009 and SZL163,254,283 in 2009/2010
- Main Item: Administration and transaction costs in 2007/2008 and 2008/2009 and Planning, coordination and programme management in 2009/2010

HUMAN RESOURCES (in 2007/2008 – 16.4% of total Expenditure; in 2008/2009 – 13.7% of total Expenditure; in 2009/2010 – 15.5% of total Expenditure)

- Total Expenditure: SZL50,358,113 in 2007/2008; SZL59,727,147 in 2008/2009 and SZL90,155,328 in 2009/2010
    - Main Item: Human Resources not disaggregated by type in 2007/2008 and 2008/2009;Monetary incentives for other staff in 2009/2010

SOCIAL PROTECTION AND SERVICES (in 2007/2008 – 8.6% of total Expenditure; in 2008/2009 – 5.6% of total Expenditure; in 2009/2010 – 7.1% of total Expenditure)

- Total Expenditure: SZL26,584,490 in 2007/2008; SZL24,422,674 in 2008/2009 and SZL41,530,607 in 2009/2010
- Main Item: Social protection through in-kind benefits in 2007/2008 and 2009/2010; Social protection services and social services not disaggregated by type in 2008/2009

ENABLING ENVIRONMENT (in 2007/2008 – 1.8% of total Expenditure; in 2008/2009 – 1.4% of total Expenditure; in 2009/2010 – 1.2% of total Expenditure)

- Total Expenditure: SZL5,640,609 in 2007/2008; SZL6,141,497 in 2008/2009 and SZL7,239,189 in 2009/2010
- Main Item: Enabling environment not disaggregated by type in 2007/2008 and 2008/2009; capacity building in human rights in 2008/2009

HIV-RELATED RESEARCH (in 2007/2008 – 0.1% of total Expenditure; in 2008/2009 – 0.01% of total Expenditure; in 2009/2010 – 0.3% of total Expenditure)

- Total Expenditure: SZL331,376 in 2007/2008; SZL28,367 in 2008/2009 and SZL1,594,196 in 2009/2010
- Main Item: HIV and AIDS-related research activities not elsewhere classified in 2007/2008; Behavioural research in 2008/2009 and Social science research in 2009/2010

HIV and AIDS Expenditure by Beneficiary groups

	2007/2008		2008/2009		2009/2010	
Beneficiary groups	**Amount (SZL)**	**%**	**Amount (SZL)**	**%**	**Amount (SZL)**	**%**
Total spending	**308,006,541**		**435,374,505**		**582,670,706**	
PLHIV	113,950,594	**36.99**	122,665,632	**28.17**	159,182,278	**27.32**
Most-at-risk population	317,321	**0.10**	626,796	**0.14**	395,058	**0.07**
Other key population	59,865,796	**19.44**	93,635,601	**21.51**	106,157,531	**18.22**
Specific "accessible" population	79,459,881	**25.80**	160,135,680	**36.78**	171,908,545	**29.5**
General population	54,412,949	**17.67**	58,310,796	**13.39**	145,027,294	**24.89**

Executive Summary

The Kingdom of Swaziland currently has generalised hyper-endemic HIV prevalence, with HIV firmly established in and spreading through the general population. According to the HIV Sentinel Surveillance conducted in 2010, 41% of ANC clients were HIV positive showing a rapid increase from 4% in 1992, to 42.2% in 2005, slight reduction to 39% in 2007 and rising back to 41.1 % in 2010. Although Swaziland has one of the highest HIV prevalence rate in the world of 26% and a high estimated HIV incidence rate of 2.9% in 2008 (2.3% in 2011 from Estimates and Projections report 2010) compared to other countries in the region, the country has made significant strides in the fight against HIV and AIDS. Progress has been made in the area of prevention and treatment with the keen participation of civil society in the HIV response.

Swaziland's HIV response mirrors the globally approved principles of "The Three Ones", that is One National HIV Strategic Framework (National Multisectoral Strategic Framework for HIV and AIDS 2009-2014), One Coordinating Structure (NERCHA) and One Monitoring and Evaluation System (National Monitoring and Evaluation Framework (2009-2014). Swaziland's national response to HIV and AIDS dates back to 1987 through the Ministry of Health to the current National Strategic Framework, 2009-2014. In spite of this, the country is still faced with a major challenge of halting the spread of HIV and reversing its negative impact on the society. Resource mobilization remains at the forefront of the current response. The dependence on international funds as shown in the previous NASA results has necessitated a review of how funds are mobilized into key strategic areas of the response.

In the face of the global recession in the past years and limited sources of funding for HIV and AIDS related programmes, it has become expedient for the country to strengthen its monitoring and evaluation efforts to efficiently use funds and reprogramme activities that are not on track, to guarantee that the response achieves its intended goals. Thus the effort to conduct a second round of NASA assessment for the period 2007/2008 to 2009/2010 serves as a positive step in assessing the use of resources for HIV and AIDS related activities and also planning effectively for future activities.

The focus of the study as in the previous round was at the national level. Data collection covered the domestic spending on HIV and AIDS, the external sources of funds for HIV and AIDS (including those funds channeled through the government) and contributions made by private entities in the years 2007/08 to 2009/10. The study employed the NASA methodology which

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

Results from the NASA study shows a progressive growth of the funds made available for HIV and AIDS related activities in the past three years, increasing by 41% from 2007/2008 to 2008/2009 and by 34% from 2008/2009 to 2009/2010. The National AIDS Spending Assessment estimates that the total expenditure on HIV and AIDS activities in the Kingdom of Swaziland was **SZL308,006,541 (US$43,503,749)**, **SZL435,374,505 (US$49,362,189)** and **SZL582,670,706 (US$75,280,453)** for the periods 2007/2008, 2008/2009 and 2009/2010 respectively. The largest proportion of the funds was sourced from international organisations accounting for about 60% of the total funds spent on the average within the three year period rising from SZL202, 138,565 in 2007/8, SZL238, 542,436 in 2008/9 to SZL331563887 in 2009/10. Public funds which accounted for 38% of the total funds within the period under consideration increased from SZL102,612,949 in 2007/2008 to SZL182,905,780 in 2008/2009 and then to SZL231,521,283 in 2009/2010. The private sector, mainly businesses (excluding households) accounted for between 1 to 3%of the total funds spent over the study period. It increased from SZL3,255,027 in 2007/2008 to SZL13,926,289 in 2008/2009 and to SZL19,585,536 in 2009/2010. In all three years, majority of the funds were spent on Treatment and Care, Programme Management and Administrative Strengthening and Orphans and Vulnerable Children. Total expenditure on HIV and AIDS related research has been very low in the three year period (averaging less than 1 percent of the total).

This second round of the NASA study allows us to expand the trend analysis of HIV and AIDS expenditure captured in the NASA RTS from 2005/2006 to 2009/2010. The results show that there has been a systematic increase in funding for HIV and AIDS related programmes during this period, although there was a dip in 2007/2008. Total expenditures increased from **SZL257,218,500 (US$38,390,819)** in 2005/2006 to **SZL346,128,488 (US$49,446,927)** in 2006/2007, falling by 11% to **SZL308,006,541 (US$43,503,749)** in 2007/2008; increasing by 41% to **SZL435,374,505 (US$49,362,189)** in 2008/2009 and a further increase by 34% to **SZL582,670,706 (US$75,280,453)** in 2009/2010. Again, funding from International Organisations has remained the major source of finance for HIV and AIDS related programmes. Unfortunately, total expenditure on prevention programmes had been on the decline from

2005/2006 but there has been a notable improvement in 2009/2010. Also, the expanded programme for treatment and care continues to increase after a drop in 2007/2008.

NASA assessment groups beneficiary populations of the HIV and AIDS related programmes and activities into six broad areas. The analysis show that in 2007/2008 PLHIV benefited from most of the funds (37% of the total) followed by the specific "accessible" group (26%), mainly OVC; other key population groups accounted for 19%; general population group (18%) and Most at Risk Populations (MARPs) the least at 0.1%. In 2008/2009 and 2009/2010, majority of funds was spent on the specific "accessible" group followed by PLHIV and other key population groups showing an improvement in targeting specific population groups for HIV and AIDS programmes. Indeed, the trend analysis over the five year period shows a decline in the share of the funds targeted to general population from 2007/2008 to 2009/2010. The proportion expended on MARPs remains low, from 2% of the total share in 2005/2006 to less than 1 percent for the remaining four years under review.

In addition to the quantitative assessment, the Kingdom of Swaziland's NASA study comprises of a qualitative part where in depth interviews are conducted with the major stakeholders who finance and implement HIV and AIDS related activities in the country. The results of these interviews highlight the challenges faced by all parties in the funding and implementation process. Most NGOs were concerned with inadequate funding to cover programmes as well as delay in accessing funds once they were approved. Coupled with this is the high staff turnover due to the fact that funds are often inadequate to provide proper enumeration for their services.

On the part of the public sector, most government agencies suffer from inadequate funding of HIV and AIDS related programmes. Most of them argued that the 5% government allocation for HIV and AIDS does not provide enough funds for all the planned activities for the year. Interviews with the the private sector businesses highlighted the fact that since HIV and AIDS activities did not form part of their overall core businesses, funding remained limited making it difficult to have a regular budget from year to year.

1. INTRODUCTION

1.1 Context for the Assessment

The Kingdom of Swaziland borders Mozambique to the East and the Republic of South Africa to the South, North and West. It occupies a surface area of 17, 364 km^2. The country is divided into four administrative regions: Hhohho, Manzini, Lubombo and Shiselweni. According to the 2007 Population Census, the current population of Swaziland is about 1,018,449. The inter-censal growth rate is 0.38%, indicating decline in fertility coupled with an increase in mortality.

Although Swaziland has one of the highest HIV prevalence rate in the world of 26% (SDHS, 2007) and a high estimated HIV incidence rate of 2.9% compared to other countries in the region (MOT, 2009), the country has made significant strides in the fight against HIV and AIDS. Progress has been made in the area of prevention and treatment with the keen participation of civil society in the HIV response. Swaziland's national response to HIV and AIDS dates back to 1987 through the Ministry of Health; yet the country is still faced with a major challenge of halting the spread of HIV and reversing its negative impact on the society. The country relies on funding from foreign, public and private sources with 70% of the funding coming from international sources in 2005/2006 and 60% in 2006/2007 (Swaziland NASA, 2007). Apart from sustainability issues arising from dependency on foreign funds, there are challenges with regards to resource flow to implementing agencies; limited capacity of key stakeholders in the application of funds and a lack of transparency of the funding mechanisms.

Prior to the implementation of the first National AIDS Spending Assessment (NASA) in 2007, there was no mechanism or system in place to track and direct HIV and AIDS funding. There was also very little information on how much money was spent on HIV and AIDS related activities and which groups were targeted and reached by these programmes. Resource tracking for HIV and AIDS has since gained prominence in the Kingdom of Swaziland stemming from the need to be able to effectively and efficiently allocate resources to different interventions, according to the national priorities.

In a nutshell, the results of the NASA for Swaziland covering the financial years 2005/2006 and 2006/2007 showed an increase of total expenditure in HIV and AIDS over the period; increasing by 35% from SZL257,218,500 (USD38,390,819) in 2005/2006 to SZL346,128,488

(USD49,446,927) in 2006/2007. In 2005/2006, the priorities in spending were care and treatment (30%), followed by Orphan and Vulnerable Children (26%), and prevention programmes (24%). The key expenditure areas in 2006/2007 were on Orphan and Vulnerable Children (31%), care and treatment (19%) and prevention programmes (17%). There was little spending on HIV and AIDS related research in both years. The results showed that the priority of spending on various core activities changed with care, treatment and prevention activities receiving proportionally less funding in 2006/2007.

The country mainly depends on few funding sources, among which are but not limited to: the Swaziland Government, GFATM (referred to as Global Fund), UN Agencies, PEPFAR, EU and Italian Cooperation. In the face of the global recession in the past years and limited sources of funding for HIV and AIDS related programmes, it has become expedient for the country to strengthen its monitoring and evaluation efforts to efficiently use funds and re-programme activities that are not on track, to guarantee that the response achieves its intended goals. Thus the effort to conduct a second round of NASA assessment for the period 2007/2008, 2008/2009 and 2009/2010 serves as a positive step in assessing the use of resources for HIV and AIDS related activities and also increasing the resource base. The routine collection of this data will facilitate the effective monitoring and evaluation of work plans and provide an integrated national database of expenditure patterns in the sector.

1.2 Objectives of the NASA

The overall goal of NASA is to contribute to the strengthening of exhaustive tracking of actual spending (from international, public and private sources) that comprises the National Response to HIV and AIDS in Swaziland.

The main purpose of the NASA is:

- To update the Swaziland's estimates of resource flows and expenditures in support of the multisectoral response to HIV and AIDS in the country.
- Following mainstreaming of resource tracking in national monitoring and evaluation framework, provide practical mechanism for implementation and institutionalization of resource tracking for HIV and AIDS.
- Provide analytical update on developments in the multisectoral financing of HIV and AIDS since the baseline report was produced in 2007.
- Prepare a comprehensive report and synthesize data into strategic information to inform decision-making and for reporting.

- Make recommendations on how to improve resource flows from national level to community based institutions.

1.3 Scope of the Assessment

The focus of the study was at the national level. Data collection covered the domestic spending on HIV and AIDS, the external aid for HIV and AIDS (including those funds channeled through the government) and contributions made by firms in the business sector in 2007/2008, 2008/2009 and 2009/2010.

The major sources of data/information include (see Table 3.1 and Appendix 3 for a more comprehensive list of sources):

(i) The National Emergency Response Council on HIV and AIDS (NERCHA);
(ii) Ministry of Health (MOH)
(iii) The Global Fund;
(iv) Selected major in country development partners;
(v) Key ministries; and
(vi) Non-Governmental Organisations (NGOs)/ Civil Society Organisations (CSOs)/Faith based Organisations (FBOs).

1.4 Structure of the Report

The report has been organized in six sections. Following section one is section two which gives a brief overview of the HIV and AIDS situation in the Kingdom of Swaziland and the National response (the National Strategic Framework for HIV and AIDS, 2009 - 2014). The third section outlines the method and technique applied, as well as the study process and limitations faced. The fourth and fifth sections contain the results and discussions of the NASA estimates and findings from the qualitative part of the questionnaire. Summary and recommendations of the study including the institutionalisation of NASA in Swaziland are made in section six.

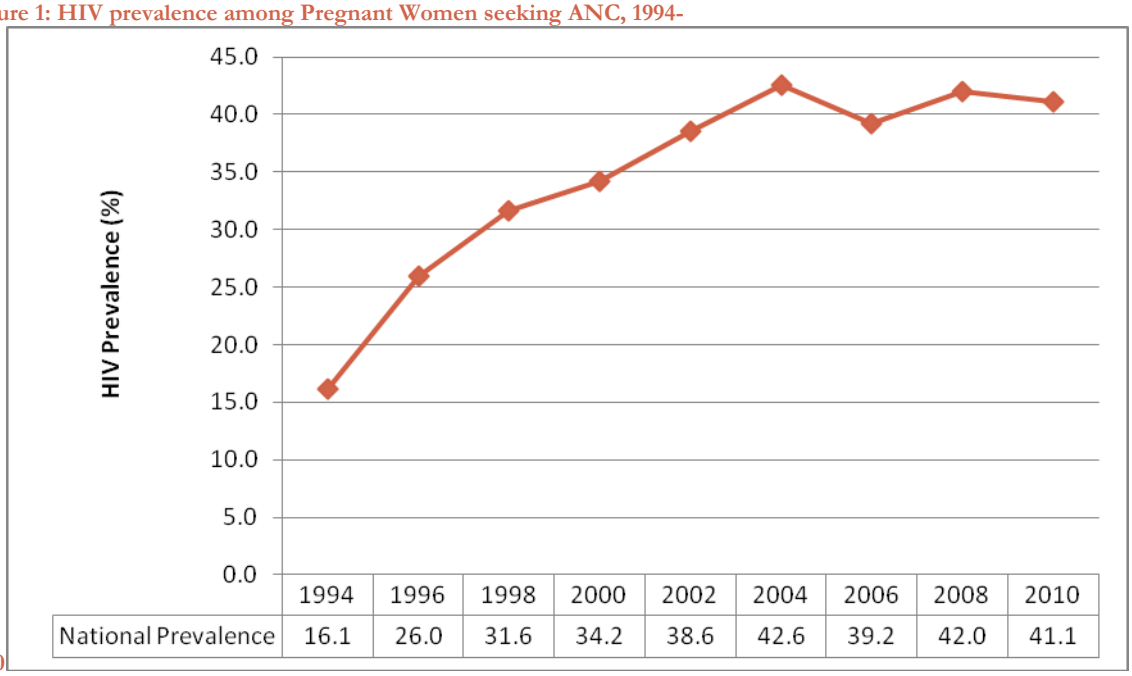
2. OVERVIEW OF COUNTRY CONTEXT

2.1 HIV and AIDS Situation

The National Multisectorial Strategic Framework for HIV and AIDS (NSF 2009-2014) states that the country has a generalised hyper-endemic HIV prevalence, with HIV firmly established in and spreading through the general population. According to the most recent Demographic and Health Survey (SDHS, 2007), the HIV prevalence in the population varied significantly by sex and age but then women and men aged 15-49 had the highest prevalence which was estimated at 26%. In this group however, female prevalence was 31% whilst male prevalence was 20%.

HIV prevalence among pregnant women seeking antenatal care in government health facilities is even higher. According to the HIV Sentinel Surveillance conducted in 2010, 41.1% of ANC clients were HIV positive. This shows a rapid increase from 16.1% in 1994, to 42.6% in 2004, slight reduction to 38.6% in 2006 and 41.12% in 2010 (see figure 1).

Figure 1: HIV prevalence among Pregnant Women seeking ANC, 1994-2010



Source: **12th National HIV Serosurveillance among women attending antenatal care services in Swaziland, 2011**

According to the Mode of Transmission report (MOT 2009), the major mode of HIV transmission is through heterosexual contact. The MOT showed that 94% new infections are likely to occur in adults aged 25 years and above, many of whom are assumed to be married or cohabit with a steady partner. Furthermore, the majority of new infections (62%) occur in

females, confirming the pattern shown by the antenatal sentinel surveillance results. The impact of HIV has permeated every facet of the society, giving rise to a large number of orphans and vulnerable children (OVC), child-headed families, grand-parent headed families and single parent families.

2.2 National Response to the AIDS Epidemic

Swaziland's HIV response mirrors the globally approved principles of "The Three Ones" [1], that is One National HIV Strategic Framework (NSF 2009-14), One Coordinating Structure (NERCHA) and One Monitoring and Evaluation System (National M&E 2009-14). The national response to HIV in Swaziland has been driven through the implementation of five consecutive plans: an initial Short Term Plan (STP) 1987-1988; Medium Term Plans I (1990-1992) and II (1993-1996), and two National Multi-sectoral HIV and AIDS Strategic Plans (NSP I 2003-2005 and NSP II 2006-2008) and currently implementing the National Strategic Framework, 2009-2014. In 2003 the National Emergency Response Council on HIV and AIDS (NERCHA) was established to coordinate the multi-sectoral response.

In 2006 the National Multi-sectoral HIV and AIDS Policy was adopted and HIV and AIDS decentralised coordinating structures established in line with the National Decentralisation Policy of 2005. The objective of the National Strategic Plan 2006-2008 was to guide implementation of the response to prevent the spread of HIV, decrease vulnerability of individuals and communities to HIV and to care for those living with HIV and reduce the adverse socio-economic effects of the epidemic. A joint review of the NSP was undertaken in 2008 and culminated in the development of the National Strategic Framework (NSF) 2009-2014. The goal of the NSF is to improve the Swaziland Human Development Index, from 0.542 in 2008, to 0.55 in 2014. The NSF outlines the role and responsibilities or all partners who are contributing in the fight against HIV and AIDS in the country.

2.2.1 National Strategic Framework 2009-2014

[1] The principles involve the following:

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

The current national multisectoral strategic framework for HIV and AIDS, NSF 2009-2014 was developed by the active involvement of key sectors such as: Health, Education, Labour, Military/Police, women and young people. Thus, the NSF is evidence based and results focused, having mainstreamed gender and human rights dimensions, and links planning to monitoring through the NSF's Results Framework. It sets out clear and quantified results that the national HIV response aims to achieve by 2011 and 2014. It identifies the drivers of the epidemic as; poverty, multiple and concurrent sexual partnerships, low and inconsistent condom use, intergenerational sex, early sexual debut, and low HIV testing and disclosure. Reducing the incidence rate, promoting safer sexual behaviour, improving the quality of life for PLHIV and enabling households to cope with the effects of HIV and AIDS are some of the key target areas identified.

The NSF Thematic and Programme Areas

The NSF programmes are grouped under the four thematic areas of (a) Prevention, (b) Treatment, Care and Support, (c) Impact Mitigation; and (d) Response management. Specific interventions under each of the programmes were selected based on evidence of their effectiveness, their feasibility, the availability of resources (financial, technical and human) to support implementation, and their potential to address one or more of the key epidemic drivers.

(a) Prevention

Prevention remains critical for the national response to HIV as the implementation of effective prevention programmes will also have long term collateral benefits for treatment, care and support and impact mitigation. The prevention interventions are designed to reduce exposure to HIV, reduce the probability of transmission when exposed, and influence change in societal norms, values and practices.

To achieve these results, the following strategies and programme have been prioritised.

- Social and behaviour change communication programmes;
- Reduction of multiple concurrent partners among sexually active population;
- Increased and comprehensive knowledge of HIV and AIDS;
- Scaling up of Prevention of Mother to Child Transmission (PMTCT) of HIV; and
- Male circumcision of HIV negative men, with 15-24 being a priority age group, including infant circumcision.

(b) Treatment, Care and Support

Treatment, care and support of PLHIV remain an important part of the national response to HIV and AIDS. The thematic area consists of six programme areas: HTC, pre-ART and Opportunistic Infections (OIs), ART (including paediatric ART), management of TB/HIV co-infection, provision of community-based care services (including palliative care), care and support by Traditional Health Practitioners (THP). The treatment, care and support priority interventions are the provision of ART and treatment of TB/HIV co-infection. Treatment, care and support interventions will improve quality of life through the provision of comprehensive treatment, care and support programme for people with HIV and TB/HIV co-infection.

(c) Impact Mitigation

The core focus of impact mitigation is to reduce the negative impact associated with HIV and AIDS on society, in particular on homesteads, households and individuals by addressing strategic issues of vulnerability. Social and economic circumstances such as poverty, abuse, violence, prejudice and ignorance increase an individual's susceptibility to HIV infection and therefore fuel HIV transmission. On the other hand, those with HIV positive status have worsening quality of life due to stigma. Vulnerable groups that the programme will focus on include OVC, PLHIV and the elderly. Interventions will focus on homesteads, households and individuals. With the criteria for vulnerability firmly established, notably: death of an adult in the household in the past 12 months, presence of an ill adult who requires care, presence of an orphaned child it is hoped that such groups will be not be neglected.

(d) Response Management

This component, response management, focus on six key areas: (i) coordination and partnerships; (ii) strategic and action planning, programme development and project management; (iii) capacity development; (iv) mainstreaming, policy development and advocacy; (v) resource mobilisation; and (vi) monitoring and evaluation. The strategic direction is to ensure effective overall coordination, equitable distribution of quality and comprehensive services and the decentralisation of the planning processes. It also aims towards mainstreaming the HIV response at all levels and creation of an enabling policy environment.

2.2.2 Resource Mobilisation and Management

Access to government funding is based on annual budgets submitted to government by NERCHA and key ministries. Additional resources have been mobilised from development

partners on the basis of proposals submitted. Donor funding has been project specific, and a mix of single-year and multi-year. Individual sectors have mobilised their own resources from a variety of donors. It is anticipated that all these sectors will continue resource mobilisation for sector specific interventions.

According to the NASA (2007), funds from international sources came mainly from the GFATM (85%), Italian Cooperation, and European Union (EU), United States Government (USG) / PEPFAR and United Nations (UN) system. Some funding was received from international NGOs such as SAFAIDS, and Action AID.

The joint review noted that non-governmental organisations were under-resourced in spite of the overall increase in financing for HIV and AIDS. The potential for civil society had not been realised due to lack of resources and inadequate capacity for resource mobilisation. Given the challenges in tracking resources, it is evident that there is need to institutionalise resource tracking for HIV and AIDS to better manage supply and monitor demand. It is anticipated that by using the NSF as the core tool for resource mobilisation at all levels, Swaziland will be able to mobilise resources required for implementing the planned programmes.

3. STUDY DESIGN AND METHODOLOGY

3.1 Approach

The NASA methodology allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors to confront the HIV and AIDS epidemic. This accounting must be exhaustive, covering entities, services and expenditures; periodic, as a result of a continuing recording, integration and analyses, to produce, ideally, annual estimates; systematic, as the structure of the categories and records/reports must be consistent over time and comparable across countries[2].

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

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

This methodology employs double entry tables – matrices - to represent the origin and destination of resources, avoiding double-accounting the expenditures by reconstructing the resource flows at every transaction point, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS activities. In addition to establishing a continuous information system of the financing of HIV and AIDS, NASA facilitates a standardized reporting of indicators monitoring progress towards the achievement of the target

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

of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS I & II) (UNAIDS, 2006).

3.2 NASA Classifications

The NASA programme and budget lines are structured on eight spending classes namely: Prevention; Care and treatment; Orphans and vulnerable children; Programme management and administration strengthening; Human Resources' Recruitment and Retention Incentives; Social protections and Social services; Enabling Environment and Community Development; and HIV and AIDS-Related Research.

The beneficiary populations are classified under five main categories with a number of sub-groups in each category to enable a further disaggregating of the data collected. The full description of beneficiary groupings is presented in Appendix 1.

3.3 Data Collection and Processing

Development and Administering of Questionnaires

The study used the UNAIDS NASA questionnaires which were slightly adjusted to suit the country's condition. The adjusted questionnaires (see Appendix 2) were sent to the key respondents and appointments made during which the data was requested and the forms completed. Data collection was done by the national NASA Team with a team of data collectors and coordinated by NERCHA.

3.3.1 Sources of Data

Most of the key sources of data (detailed expenditure records) for 2007/2008, 2008/2009 and 2009/2010 were obtained from primary sources. For the purposes of this study a financial year was taken as the Government of Swaziland calendar year from 1st April to 31st March. Only a few data sources were either obtained from secondary sources, or were estimated using the best available data and most suitable assumptions. Table 1 shows the response rate of organizations/institutions sampled for the HIV and AIDS expenditure data collection and appendix 3 shows the sampled organizations/institutions and the status of data collected. Overall, the study had 85.71% response rate. The visited institutions were grouped into the following categories; Public (government), External (donors), CSOs/NGOs/FBOs and Private Sector Businesses.

Table 1: Response Rate of Organizations/Institutions Sampled

Target Group	Number Targeted	Number Responded	Response Rate (%)
Development Partners	13	12	92.31
Government Sector	25	24	96.00
CSOs/NGOs/FBOs	58	48	82.76
Private Sector (Businesses)	23	18	78.26
Total	**119**	**102**	**85.71**

3.3.2 Data Processing

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

3.4 Assumptions and Estimations

The following assumptions and estimations were made:

- Financial year – where the external sources' financial year was NOT equivalent to the calendar year of Swaziland, adjustments were made to estimate the expenditure within the calendar year of Swaziland for 2007/2008, 2008/2009 and 2009/2010 (ie. 1st April to 31st March).

- Where funds are pooled, the expenditure contribution of donor to the activities was assumed to be equal in equal proportions as the contribution to the total fund.

- The average annual exchange rate of the US (US$) dollar to the Swazi Lilangeni SZL was used in this study. These are as follows for the years under study:
    - 2007/2008 - US$ 1 = SZL 7.08
    - 2008/2009 - US$ 1 = SZL 8.82
    - 2009/2010 - US$ 1 = SZL 7.74

- Expenditure on TB treatment that was HIV-related – information on TB treatment was generalized. The prevalence of HIV among TB patients is 79.6% (NERCHA, annual report for 2008/09), therefore 79.6% of total expenditure on TB was captured as TB/HIV treatment expenditure.

- Salary of Doctors and Nurses in HIV and AIDS treatment – the average percentage time spent by the doctor and nurse in treating an HIV and AIDS patient per year was estimated using information from the Essential Healthcare Package (ECHP) and multiplied by total personnel expenditure for doctors and nurses obtained from the Ministry of Health.

- Education of OVC – 75% of all expenditures going to the education of OVC was assumed to be expenditure for OVC education due to HIV and AIDS. Assumption was based on the fact that about 75%[3] of all deaths are HIV and AIDS related.

[3] This figure is a mid-point between two estimates of the proportion of all deaths attributed to HIV (64%-HIV Estimates and Projections Report and 85%-Reviewing 'Emergencies' for Swaziland).

3.5 Limitations of the Assessment

The study had the following limitations:

- The study did not include ALL private sector expenditure – some businesses, traditional healers, and household out-of-pocket payment expenditures were not included.

- Data on salaries of non-health personnel working in HIV and AIDS related activities was difficult to disaggregate from Administrative cost expenditure given by some organisations/institutions.

- HIV and AIDS related expenditure for 2007/2008 was underestimated because some of the organisations/institutions visited could not provide the data for that year mainly because records were not easily available due to change in staff/personnel and the time lag between then and the timing of the assessment.

- The study did not include ALL sexual reproductive health spending share that might be related to HIV and AIDS because data/information was not easily available and where available there were problems with disaggregation.

- Grants from the Government of Swaziland going to the Elderly were not included in the NASA even though it was available because the grants are given to all the elderly and not exclusively HIV related. This made it difficult disagregating it to get the amount going to those with HIV and AIDS.

- The expenditure on In-patient care of PLHIV from public health facilities was not included because information was not easily available.

- Some expenditure items using the NASA codes were assigned zero not because there were no expenditure but because of limited information to disaggregate the expenditure data or a misclassification of the NASA codes by providers/implementers when visited for data collection.

4. FINDINGS - NASA ESTIMATIONS

4.1 Total Expenditures on HIV and AIDS and Sources of Funding

The National AIDS Spending Assessment estimates that the total expenditure on HIV and AIDS related activities in the Kingdom of Swaziland was **SZL308,006,541 (US$43,503,749)**, **SZL435,374,505 (US$49,362,189)** and **SZL582,670,706 (US$75,280,453)** for the periods 2007/2008, 2008/2009 and 2009/2010 respectively. Figure 2 shows a progressive growth of the spending on HIV and AIDS related activities in the past three years, increasing by 41% from 2007/2008 to 2008/2009 and by 34% from 2008/2009 to 2009/2010. The largest proportion of the funds was sourced from international organisations accounting for about 60 percent of the total funds spent on the average within the three year period (65.63% in 2007/8, 54.8% in 2008/9 and 56.9% in 2009/2010).

Public funds which accounted for 38% (33.3% in 2007/8, 42% in 2008/9 and 39.7% in 2009/2010) of the total funds within the period under consideration increased from SZL102,612,949 in 2007/2008 to SZL182,905,780 in 2008/2009 and then to SZL231,521,283 in 2009/2010. The private sector, mainly businesses (excluding households) accounted for between 1 to 3%of the total funds spent over the study period. It increased from SZL3,255,027 in 2007/2008 to SZL13,926,289 in 2008/2009 and to SZL19,585,536 in 2009/2020. Private funds consist of funding mainly from private businesses, excluding households (Table 2).

International Financing Sources

International organisations are mainly development partners (both bi- and multi-lateral) active in HIV and AIDS related programmes in the Kingdom of Swaziland. As seen in Table 3 below, in 2007/2008 multilateral funds were the largest contributor at 70% of the total internationally sourced HIV and AIDS expenditure followed by direct bilateral contributions at 16%. In 2008/2009 multilateral and bilateral funds had an almost equal share of about 40% each followed by 13% from international not for profit organisations. The share of multilateral funds increased to 53% in 2009/2010 driven mainly by increases in the share of Global Funds (GFATM) in the overall funding resource. Direct bilateral contributions fell from 42.8% in 2008/2009 to 36.0% in 2009/2010. During the same period share of international not-for-profit organizations and foundations and International funds n.e.c also declined from 12.8% to 10.7% and 0.4% to 0.3% respectively between 2008/2009 and 2009/2010.

Figure 2: Sources of Funds for HIV and AIDS Expenditure, 2007/2008 - 2009/2010 (SZL)

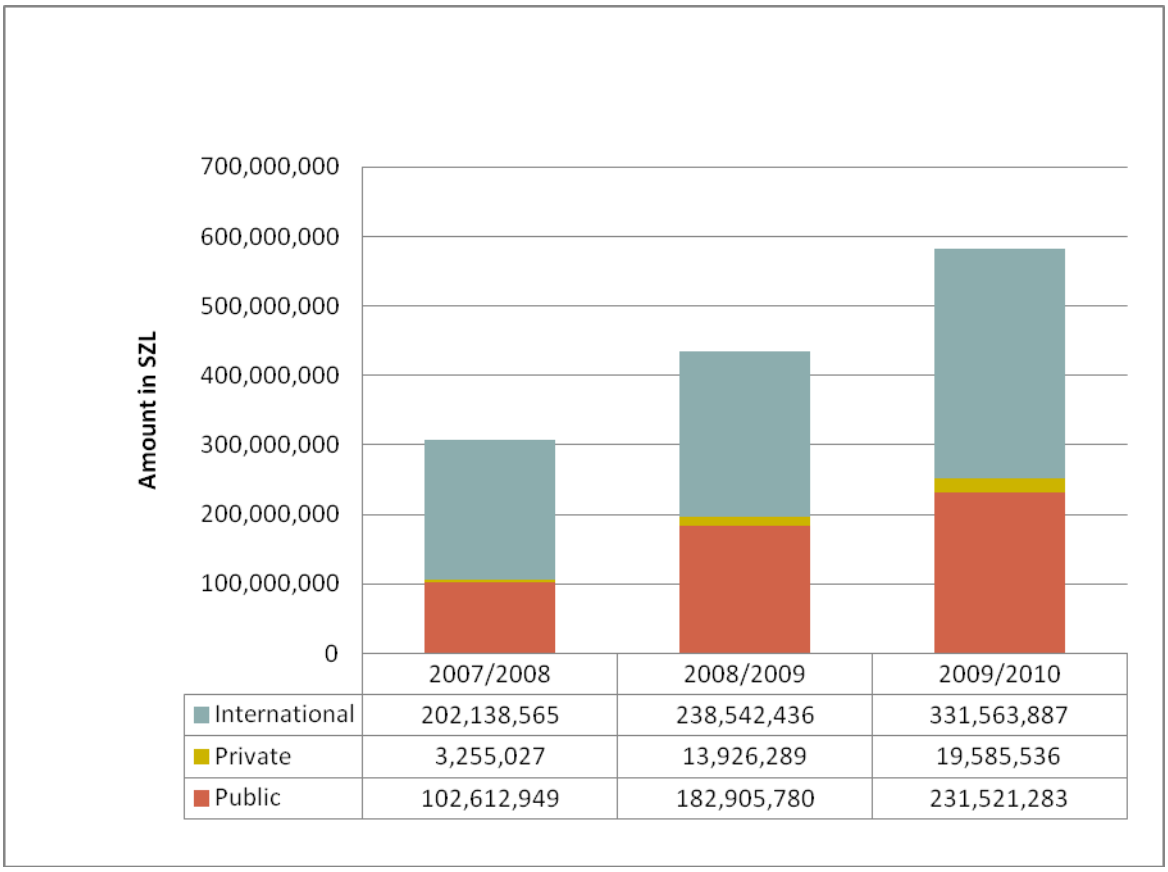


Table 2: Sources of Funds for HIV and AIDS Expenditure, 2007/2008 - 2009/2010 (SZL)

Source	2007/08	(%)	2008/09	(%)	2009/10	(%)
Public Funds	102,612,949	**33.32**	182,905,780	**42.01**	231,521,283	**39.73**
Private Funds	3,255,027	**1.06**	13,926,289	**3.2**	19,585,536	**3.36**
International Funds	202,138,565	**65.63**	238,542,436	**54.79**	331,563,887	**56.9**
Grand Total	**308,006,541**	**100**	**435,374,505**	**100**	**582,670,706**	**100**

Table 3: Summary of HIV and AIDS International Financing Sources, 2007/2008 - 2009/2010 (SZL)

Type of International Fund	2007/08	(%)	2008/09	(%)	2009/10	(%)
Direct bilateral contributions	33,172,423	16.4	102,103,706	42.8	119,210,429	36.0
Multilateral contributions	141,567,518	70.0	104,821,893	43.9	176,062,336	53.0
International not-for-profit organizations and foundations	26,614,138	13.2	30,617,859	12.8	35,333,783	10.7
International funds n.e.c.	784,486	0.4	998,978	0.5	957,339	0.3
Total	**202,138,565**	**100.0**	**238,542,436**	**100.0**	**331,563,887**	**100.0**

4.1.1 Key Spending Areas

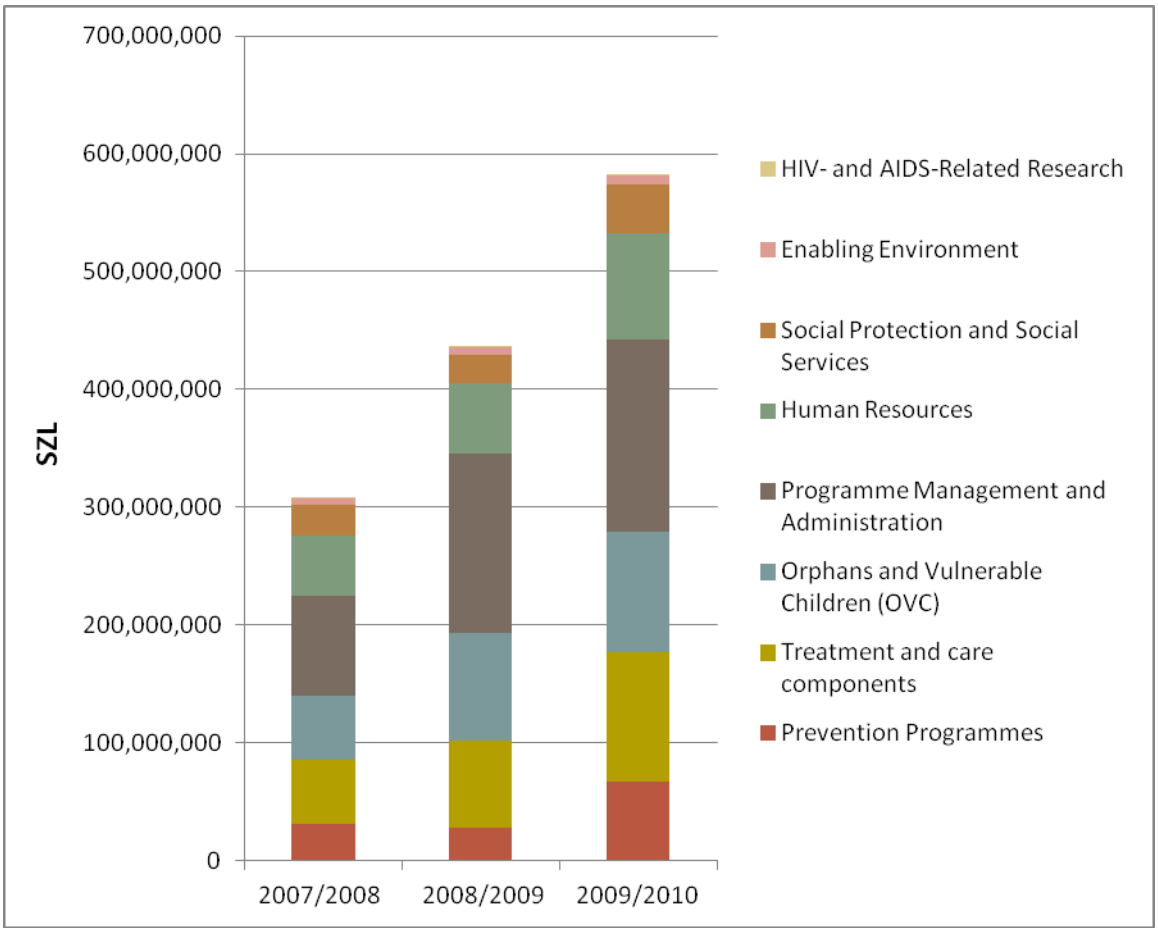
Table 4 and Figure 3 show the total HIV and AIDS spending on the key priority areas from 2007/2008 to 2009/2010. In all three years under study, majority of the funds were spent on Treatment and Care, Programme Management and Administrative Strengthening and Orphans and Vulnerable Children. The remaining 35% of the total funds on average was shared amongst the remaining 4 priority areas. Nominally, funds spent on prevention programmes more than doubled from 2007/2008 to 2009/2010 after a decline in 2008/2009. Total expenditure on HIV and AIDS related research has been very low in the three year period (averaging less than 1 percent of the total a year).

Table 4: Total Spending on Key Priorities or Intervention Areas, 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	2008/09	2009/10
Prevention Programmes	30,494,117 (9.90)	27,766,947 (6.38)	67,302,843 (11.55)
Treatment and care	54,679,582 (17.75)	73,852,736 (16.96)	109,412,198 (18.78)
Orphans and Vulnerable Children (OVC)	54,791,456 (17.79)	91,006,923 (20.90)	102,182,062 (17.54)

Programme Management and Administration	85,126,798 (27.64)	152,428,214 (35.01)	163,254,283 (28.02)
Human Resources	50,358,113 (16.35)	59,727,147 (13.72)	90,155,328 (15.47)
Social Protection and Social Services	26,584,490 (8.63)	24,422,674 (5.61)	41,530,607 (7.13)
Enabling Environment	5,640,609 (1.83)	6,141,497 (1.41)	7,239,189 (1.24)
HIV- and AIDS-Related Research	331,376 (0.11)	28,367 (0.01)	1,594,196 (0.27)
Grand Total	**308,006,541 (100)**	**435,374,505 (100)**	**582,670,706 (100)**

Figure 3: Total Expenditure Breakdowns by Intervention Areas, 2007/2008 to 2009/2010 (SZL)



4.2. Key Spending Priorities by Funding Agents

This section highlights the key priority or intervention areas by the various funding agents captured in the NASA RTS (Tables 5 – 7 and Figures 4 – 6). In 2007/2008 of the total services provided through public funding, 37% went into human resources' recruitment and retention incentives and 34% on orphans and vulnerable children (OVC); 14% on programme management and administrative strengthening and 11% on treatment and care. In 2008/2009, the share of the total towards incentives for recruitment and retention of human resources decreased to 25%; with about 41% of the public funds directed to orphans and vulnerable children followed by 20% on the provision of treatment and care services and 10% on programme management and administrative strengthening. In 2009/2010, the proportions remained the same as the previous year but a notable change was a decrease in the share spent on programme management and administrative strengthening (a decline of 7.1% between 2008/2009 and 2009/2010).

In the case of the private sector, of the total in 2007/2008, OVC took up 36% and 20% on prevention and 16% on programme management. In 2008/2009 the share of prevention services reduced to 6%, whilst treatment and care increased to 63%, programme management decreased to 13% and 10% was spent on OVC. In 2009/2010, the share of prevention services increased to 25%, treatment and care reduced to 50%, OVC accounting for 10% of the total resources provided and the programme management category remaining the same at 12%.

The general trend in the case of international funds is the concentration of funds on programme management and administrative strengthening. The results show that in 2007/2008, 35% of the total was spent in this category increasing to 55% of the total spent in 2008/2009 and 43% in 2009/2010. In nominal terms the total spent on programme management and administrative strengthening from international funds increased by 87% from 2007/2008 to 2008/2009 and by 10% from 2008/09 to 2009/10. Treatment and care accounted for 22% of the total in 2007/2008 decreasing to 12% in 2008/2009 and 11% in 2009/2010. Prevention programmes accounted for 12% of services provided in 2007/2008 decreasing to 9% in 2008/2009 and increasing to 17% in 2009/2010. Overall, an average of about 12% was spent on social protection and social services, OVC received less funds from international sources compared to public funds.

Table 5: Spending Priorities by Funding Agents, 2007/2008 (SZL)

Key Priority Areas	Public sector	%	Private sector	%	International Organizations	%	Grand Total
Prevention Programmes	4,761,036	**4.6**	635,326	**19.5**	25,097,755	**12.4**	30,494,117
Treatment and care components	10,939,487	**10.7**	159,686	**4.9**	43,580,409	**21.6**	54,679,582
Orphans and Vulnerable Children (OVC)	34,560,968	**33.7**	1,168,955	**35.9**	19,061,533	**9.4**	54,791,456
Programme Management & Administrative Strengthening	14,060,968	**13.7**	528,930	**16.2**	70,536,900	**34.9**	85,126,798
Human Resources' Recruitment & Retention Incentives	38,030,048	**37.1**	443,406	**13.6**	11,884,659	**5.9**	50,358,113
Social Protection and Social Services(excluding OVC)	108,819	**0.1**	287,674	**8.8**	26,187,997	**13.0**	26,584,490
Enabling Environment and Community Development	151,623	**0.1**		**0.0**	5,488,986	**2.7**	5,640,609
HIV- and AIDS-Related Research (excluding operations research)	0	**0.0**	31,050	**1.0**	300,326	**0.1**	331,376
Grand Total	**102,612,949**	**100.0**	**3,255,027**	**100.0**	**202,138,565**	**100.0**	**308,006,541**

Table 6: Spending Priorities by Funding Agents, 2008/2009 (SZL)

Key Priority Areas	Public sector	%	Private sector	%	International Organizations	%	Grand Total
Prevention Programmes	6,311,775	**3.5**	796,824	**5.7**	20,658,348	**8.7**	27,766,947
Treatment and care components	36,999,261	**20.2**	8,701,801	**62.5**	28,151,674	**11.8**	73,852,736
Orphans and Vulnerable Children (OVC)	75,420,222	**41.2**	1,428,859	**10.3**	14,157,842	**5.9**	91,006,923
Programme Management & Administrative Strengthening	18,941,954	**10.4**	1,752,231	**12.6**	131,734,029	**55.2**	152,428,214
Human Resources' Recruitment & Retention Incentives	44,789,873	**24.5**	501,131	**3.6**	14,436,143	**6.1**	59,727,147
Social Protection and Social Services(excluding OVC)	70,785	**0.0**	693,720	**5.0**	23,658,169	**9.9**	24,422,674

Enabling Environment and Community Development	371,910	**0.2**	23,356	**0.2**	5,746,231	**2.4**	6,141,497
HIV- and AIDS-Related Research (excluding operations research)		**0.0**	28,367	**0.2**		**0.0**	28,367
Grand Total	**182,905,780**	**100.0**	**13,926,289**	**100.0**	**238,542,436**	**100.0**	**435,374,505**

Table 7: Spending Priorities by Funding Agents, 2009/2010 (SZL)

Key Priority Areas	Public sector	%	Private sector	%	International Organizations	%	Grand Total
Prevention Programmes	6,895,124	**3.0**	4,949,928	**25.3**	55,457,791	**16.7**	67,302,843
Treatment and care components	62,585,440	**27.0**	9,750,903	**49.8**	37,075,855	**11.2**	109,412,198
Orphans and Vulnerable Children (OVC)	95,336,242	**41.2**	1,882,053	**9.6**	4,963,767	**1.5**	102,182,062
Programme Management & Administrative Strengthening	16,357,417	**7.1**	2,385,709	**12.2**	144,511,157	**43.6**	163,254,283
Human Resources' Recruitment & Retention Incentives	47,982,589	**20.7**	204,732	**1.0**	41,968,007	**12.7**	90,155,328
Social Protection and Social Services(excluding OVC)	2,238,177	**1.0**	342,710	**1.7**	38,949,720	**11.7**	41,530,607
Enabling Environment and Community Development	50,115	**0.0**	41,021	**0.2**	7,148,053	**2.2**	7,239,189
HIV- and AIDS-Related Research (excluding operations research)	76,179	**0.0**	28,480	**0.1**	1,489,537	**0.4**	1,594,196
Grand Total	**231,521,283**	**100.0**	**19,585,536**	**100.0**	**331,563,887**	**100.0**	**582,670,706**

Figure 4: Proportional Spending Priorities by Funding Agents, 2007/2008 (SZL)

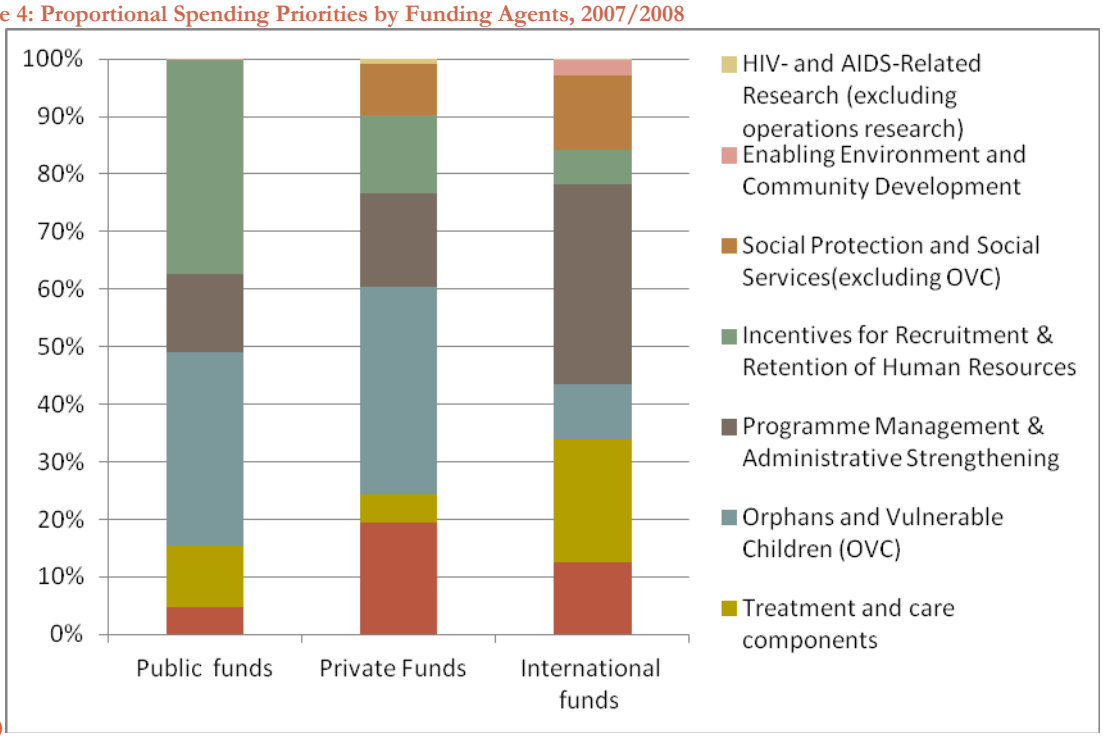


Figure 5: Proportional Spending Priorities by Funding Agents, 2008/2009 (SZL)

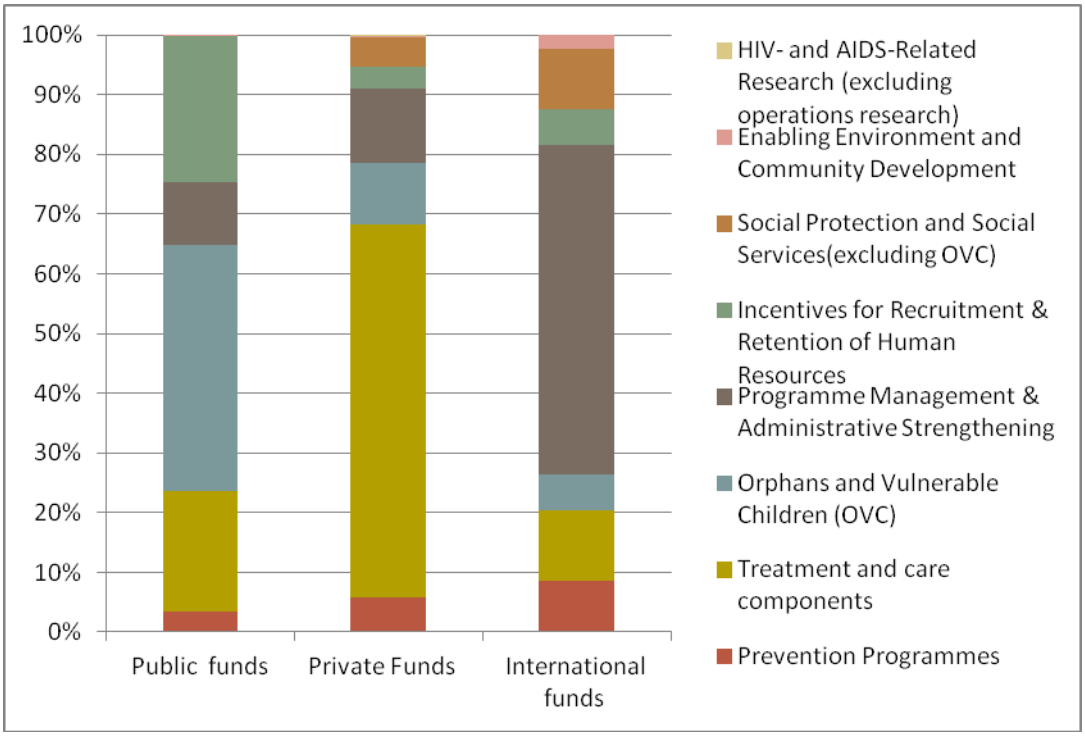
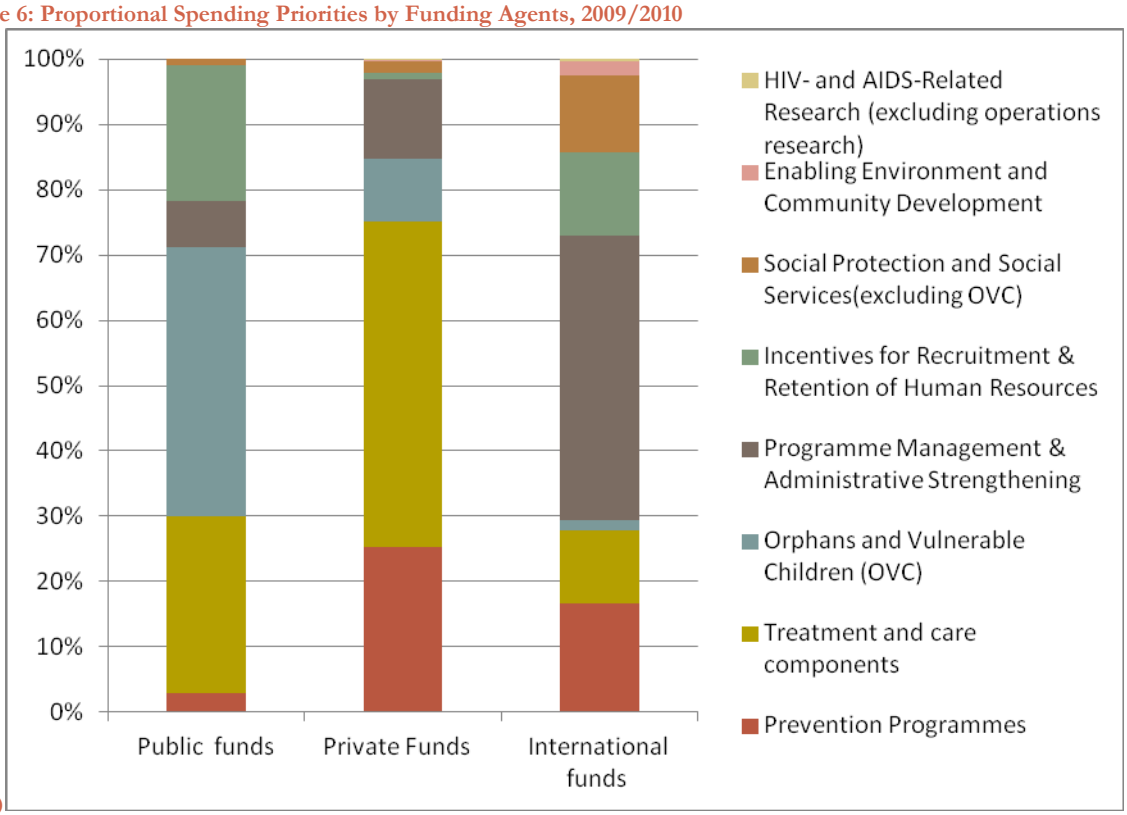


Figure 6: Proportional Spending Priorities by Funding Agents, 2009/2010



(SZL)

4.2.1 Prevention

Reducing the incidence rate and promoting safer sexual behaviour are some of the priorities identified in the NSF, 2009 - 2014 and therefore prevention remains the critical part of the national strategy to overcome the epidemic. In 2007/2008, the total amount spent on prevention was **SZL30, 494,117 (US$4,307,079)**, fell to **SZL27,766,947 (US$3,148,180)** in 2008/2009 and increased to **SZL67,302,843 (US$8,695,458)** in 2009/2010. Table 8 shows which prevention programmes areas received funding in the three year period. In 2007/2008, 25% of the total was spent on communication for social and behavioural change programmes, 21% on community mobilization and 18% on VCT. In 2008/09, the share of ccommunication for social and behavioural change increased to 30% whilst risk reduction programmes for vulnerable groups received 20% and 18% on BCC. The trend changed in 2009/2010, perhaps as a result of a new direction in prevention strategy in the NSF. Male circumcision which received as little as SZL177,940 in 2008/2009 saw a huge increase in funding in 2009/2010. This represents a marked growth in spending on male circumcision in 2009/2010. Risk reduction programmes for vulnerable groups received 31% and 19% of the funds was spent on community mobilisation.

Table 8: Prevention Spending Activities, 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	(%)	2008/09	(%)	2009/10	(%)
Health-related communication for social and behavioural change	128,148	0.1	39,519	0.1	10,112,850	15.0
Communication for Social and behavioural change not disaggregated by type	7,659,269	25.1	8,495,816	30.6	4,956,721	7.4
Community mobilization	6,483,124	21.3	2,234,487	8.0	12,494,668	18.6
Voluntary counselling and testing (VCT)	5,352,149	17.6	343,408	1.2	798,419	1.2
Risk-reduction for vulnerable and accessible populations	3,085,017	10.1	5,690,703	20.5	21,048,349	31.3
Prevention – youth in school	716,059	2.3	1,586,622	5.7	31,554	0.0
Prevention – youth out-of-school	330,957	1.1	0	0.0	0	0.0
Harm-reduction programmes for injecting drug users (IDUs)	0	0.0	0	0.0	650	0.0
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	0	0.0	0	0.0	199,670	0.3
Prevention programmes for sex workers and their clients	184,630	0.6	134,551	0.5	0	0.0
VCT as part of programmes in the workplace	174,022	0.6	289,486	1.0	268,015	0.4
Condom social marketing and male and female condom provision as part of programmes in the workplace	74,360	0.2	60,046	0.2	111,217	0.2
Behaviour change communication (BCC) as part of programmes in the workplace	276,198	0.9	4,994,944	18.0	4,155,409	6.2
Programmatic interventions in the workplace not disaggregated by type	32,900	0.1	10,253	0.0	36,246	0.1
Condom social marketing	2,906,140	9.5	1,748,854	6.3	829,856	1.2
Prevention, diagnosis and treatment of sexually transmitted infections (STI)		0.0	9,488	0.0		0.0
Pregnant women counselling and testing in PMTCT programmes	10,976	0.0		0.0		0.0
Safe infant feeding practices (including substitution of breastmilk)	1,840	0.0		0.0		0.0
Antiretroviral prophylaxis for HIV-infected pregnant women and newborns		0.0	141,632	0.5		0.0
Delivery practices as part of PMTCT programmes		0.0	309,333	1.1		0.0
PMTCT activities n.e.c.		0.0	305,027	1.1		0.0
PMTCT not disaggregated by intervention	1,602,556	5.3		0.0	545,494	0.8
Male circumcision	887,413	2.9	177,940	0.6	10,723,061	15.9

Blood safety	455,668	1.5	1,182,821	4.3	820,831	1.2
Prevention activities not disaggregated by intervention	132,691	0.4	12,017	0.0	168,000	0.2
Universal precautions		0.0		0.0	1,833	0.0
Grand Total	**30,494,117**	**100.0**	**27,766,947**	**100.0**	**67,302,843**	**100.0**

4.2.2 Treatment and Care

Table 9 shows the key areas of expenditures on Treatment and Care components. The expenditure patterns show that for all the three years majority of the funds were designated for ARV therapy – both adult and paediatric ARVs (**67%, 42%** and **64%** in 2007/2008, 2008/2009 and 2009/2010 respectively). Opportunistic infection (OI) outpatient prophylaxis and treatment accounted for 8% of funding in 2007/2008¸ 7% in 2008/2009 and 6% in 2009/2010. This is mainly the treatment of TB in HIV patients. Specific HIV-related laboratory monitoring received about 13% of total funds in 2008/2009.

Table 9: Treatment and Care Spending Activities, 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	(%)	2008/09	(%)	2009/10	(%)
Provider- initiated testing and counselling (PITC)		**0.0**	32,798	**0.0**		**0.0**
Opportunistic infection (OI) outpatient prophylaxis and treatment	4,077,245	**7.5**	5,313,433	**7.2**	7,000,486	**6.4**
Antiretroviral therapy	36,765,331	**67.2**	31,317,225	**42.4**	69,763,403	**63.8**
Nutritional support associated to ARV therapy	1,325,138	**2.4**	3,109,547	**4.2**	2,358,964	**2.2**
Specific HIV-related laboratory monitoring	1,231,342	**2.3**	9,803,936	**13.3**	49,929	**0.0**
Psychological treatment and support services	884,679	**1.6**	1,372,356	**1.9**	1,223,469	**1.1**
Outpatient palliative care	341,451	**0.6**	284,333	**0.4**	717,204	**0.7**
Home-based care	3,331,353	**6.1**	1,920,188	**2.6**	3,816,405	**3.5**
Outpatient care services not disaggregated by intervention	1,230,713	**2.3**	1,576,993	**2.1**	884,000	**0.8**
Inpatient care services not disaggregated by intervention		**0.0**		**0.0**	19,800	**0.0**
Care and treatment services not disaggregated by intervention*	5,492,330	**10.0**	19,121,927	**25.9**	23,578,538	**21.6**
Grand Total	**54,679,582**	**100.0**	**73,852,736**	**100.0**	**109,412,198**	**100.0**

***** Treatment and care expenditure that could not be disaggregated or assigned to a key area because of limited information available in this category.

4.2.3 Orphans and Vulnerable Children (OVC)

Support for OVC received a a big share of public sector funds. About 85% of total OVC funds on average was spent on OVC education and the rest on OVC family/home support and institutional care. (Table 10). Generally spending on OVC has been increasing over the 3 years from **SZL54,679,582 (US$7,723,105)** in 2007/2008 to **SZL73,852,763 (US$8,373,326)** in 2008/2009, an increase of 35.1% and then to **SZL109,412,198 (US$14,135,943)** in 2009/2010, an increase of 48.2%.

Table 10: Total Spending on OVCs, 2007/2008 - 2009/2010 (SZL)

OVC Spending Categories	2007/08	(%)	2008/09	(%)	2009/10	(%)
OVC Education	46,049,499	**84.0**	79,126,893	**86.9**	91,431,275	**89.5**
OVC Basic health care	347,399	**0.6**	641,426	**0.7**	502,448	**0.5**
OVC Family/home support	4,342,313	**7.9**	5,884,071	**6.5**	3,935,574	**3.9**
OVC Social Services and Administrative costs	0	**0.0**	0	**0.0**	2,311,108	**2.3**
OVC Community Support	907,308	**1.7**	1,027,216	**1.1**	0	**0.0**
OVC Institutional Care	1,867,871	**3.4**	1,867,871	**2.1**	1,867,871	**1.8**
OVC Services not disaggregated by intervention	1,277,066	**2.3**	1,813,452	**2.0**	2,133,786	**2.1**
OVC n.e.c	0	**0.0**	645,994	**0.7**	0	**0.0**
Grand total	**54,679,582**	**100.0**	**73,852,736**	**100.0**	**109,412,198**	**100.0**

4.2.4 Social Protection and Social Services (excluding OVC)

Social protection efforts either through monetary benefits or in-kind have been scaled-up from **SZL24,422,674 (US$2,769,011)** in 2008/2009 to **SZL41,530,607 (US$5,365,712)** in 2009/2010, an increase of 70% to protect individuals from socio-economic effects of the epidemic. Social protection through monetary benefits occupies a small share of the total funding, averaging about 6% in all three years (Table 11).

Expenditure on social protection for the Elderly was available but was not included in the NASA because it was difficult to disaggregate it or find the share of the Elderly grant going to PLHIV or as a result of someone having HIV and AIDS in their household. Spending on Elderly grant

for the country as a whole increased from SZL21,639,876 in 2007/2008 to SZL59,981,086 in 2008/2009 and then to SZL134,952,975 in 2009/2010.

Table 11: Social Protection and Social Services (excluding OVC), 2007/2008 - 2009/2010 (SZL)

OVC Spending Categories	2007/08	(%)	2008/089	(%)	2009/10	(%)
Social protection through monetary benefits	999,584	**3.8**	1,724,614	**7.1**	3,507,226	**8.4**
Social protection through in-kind benefits	22,329,220	**84.0**	4,969,313	**20.3**	32,022,608	**77.1**
Social protection through provision of social services	630,438	**2.4**	17,068,694	**69.9**	2,039,923	**4.9**
HIV-specific income generation projects	2,625,248	**9.9**	157,704	**0.6**	3,960,850	**9.5**
Social protection services and social services not disaggregated by type	0	**0.0**	502,349	**2.1**		**0.0**
Grand Total	**26,584,490**	**100.0**	**24,422,674**	**100.0**	**41,530,607**	**100.0**

4.2.5 Programme Management and Administration

Programme expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), pre-service training, and facility upgrading through purchases of laboratory equipment and telecommunications. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole.

Programme management and administrative strengthening receives on average about 30% of funding for HIV and AIDS related activities. In 2007/2008, about 41% of total funding in this category was spent on administration and transaction costs associated with managing and disbursing funds and this increased to 58% in 2008/2009, decreasing to 13% in 2009/2010. Also the share spent directly on planning, coordination and management rose from 15% in 2007/2008 to 23% in 2008/2009 and 59% in 2009/2010. Upgrading laboratory infrastructure and new equipment and building new health centres are also other areas of expenditure (Table 12).

The proportion of spending on monitoring and evaluation in total was very low over the 3 years. It ranged from as low as 1.5% in 2008/2009 to 2.5% in 2009/2010 with 2007/2008 receiving a share of 1.7%.

Table 12: Programme Management Spending Activities, 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	(%)	2008/09	(%)	2009/10	(%)
Planning, coordination and programme management	12,381,822	**14.5**	35,046,970	**23.0**	96,500,950	**59.1**
Administration and transaction costs associated with managing and disbursing funds	34,710,362	**40.8**	88,268,401	**57.9**	21,479,771	**13.2**
Monitoring and evaluation	1,439,392	**1.7**	2,233,009	**1.5**	4,092,795	**2.5**
Operations research	298,941	**0.4**	1,071,572	**0.7**	372,929	**0.2**
Serological-surveillance (serosurveillance)	3,047,681	**3.6**	0	**0.0**	90,000	**0.1**
Drug supply systems	11,467,373	**13.5**	6,565,539	**4.3**	6,909,118	**4.2**
Information technology	2,861,378	**3.4**	962,708	**0.6**	183,585	**0.1**
Patient Tracking	0	**0.0**	0	**0.0**	1,225,346	**0.8**
Programme management and administration n.e.c	0	**0.0**	80,000	**0.1**	0	**0.0**
Upgrading laboratory infrastructure and new equipment	13,228,313	**15.5**	15,291,892	**10.0**	497,733	**0.3**
Construction of new health centres	95,400	**0.1**	90,000	**0.1**	29,135,947	**17.8**
Upgrading and construction of infrastructure not disaggregated by intervention	9,851	**0.0**	1,200,757	**0.8**	2,154,464	**1.3**
Upgrading and construction of infrastructure n.e.c.	5,586,285	**6.6**	1,617,366	**1.1**	611,645	**0.4**
Grand Total	**85,126,798**	**100.0**	**152,428,214**	**100.0**	**163,254,283**	**100.0**

4.2.6 Human Resources

This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. The results show that expenditure pattern for human resources have been on the incline from 2007/2008. About 16% of funds on average are spent on training and over 35% on monetary incentives for staff involved in HIV and AIDS programmes (Table 13).

Table 13: Human Resources Spending Activities, 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	(%)	2008/09	(%)	2009/10	(%)
Formative education to build-up an HIV workforce	616,440	**1.2**	1,854,399	**3.1**	694,507	**0.8**
Training	8,022,930	**15.9**	10,197,952	**17.1**	13,487,138	**15.0**
Human resources not disaggregated by type	26,994,239	**53.6**	33,160,873	**55.5**	32,521,091	**36.1**
Human resources n.e.c.	24,675	**0.0**	0	**0.0**		**0.0**
Monetary incentives for nurses	0	**0.0**	0	**0.0**	40,000	**0.0**
Monetary incentives for other staff	14,661,956	**29.1**	14,302,858	**23.9**	43,022,478	**47.7**
Monetary incentives for human resources not broken down by staff	37,873	**0.1**	0	**0.0**	390,114	**0.4**
Monetary incentives for physicians n.e.c.	0	**0.0**	211,065	**0.4**	0	**0.0**
Grand Total	**50,358,113**	**100.0**	**59,727,147**	**100.0**	**90,155,328**	**100.0**

4.2.7 Enabling Environment

The role of creating an enabling environment cannot be underestimated and therefore the NSF 2009-2014 sets as its target a social mitigation effort to ensure that vulnerable groups in the society are supported against violent activities and stigma. The level of disaggregation for this category was very low in 2007/2008 and 2008/2009 but advocacy is one of the key activities where a lot of funds were spent in 2007/2008 and 2009/2010. In 2009/2010 about 28% of total funding was spent on capacity building in human rights, 18% on AIDS-specific institutional development and 15% on AIDS-specific programmes focused on women (Table 14).

4.2.8 HIV and AIDS Related Research (excluding operations research)

The data shows that research activities received a very small portion of the funds in all the three years of the study although funds for this category increased by 380% from 2007/2008 to 2009/2010 (Table 15).

Table 14: Enabling Environment, 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	(%)	2008/09	(%)	2009/10	(%)
Advocacy	1,716,699	**30.4**	593,395	**9.7**	1,729,443	**23.9**
Provision of legal and social services to promote access to prevention, care and treatment	384,000	**6.8**	488,462	**8.0**	296,527	**4.1**
Capacity building in human rights		**0.0**	0	**0.0**	2,052,879	**28.4**
Human rights programmes not disaggregated by type	250,490	**4.4**	0	**0.0**	0	**0.0**
AIDS-specific institutional development	158,088	**2.8**	192,282	**3.1**	1,287,876	**17.8**
AIDS-specific programmes focused on women		**0.0**	0	**0.0**	1,098,652	**15.2**
Programmes to reduce Gender Based Violence	408,853	**7.2**	480,228	**7.8**	675,434	**9.3**
Enabling environment not disaggregated by type	2,565,118	**45.5**	2,318,155	**37.7**	77,949	**1.1**
Enabling environment n.e.c.	157,361	**2.8**	2,068,975	**33.7**	20,429	**0.3**
Grand Total	**5,640,609**	**100.0**	**6,141,497**	**100.0**	**7,239,189**	**100.0**

Table 15: Spending on HIV and AIDS-Related Research (Excluding Operations Research), 2007/2008 - 2009/2010 (SZL)

Key Areas of Expenditure	2007/08	(%)	2008/09	(%)	2009/10	(%)
Epidemiological research	0	**0.0**	0	**0.0**	74,250	**4.7**
Behavioural research	32,550	**9.8**	28,367	**100.0**	224,956	**14.1**
Social science research not disaggregated by type	0	**0.0**	0	**0.0**	993,061	**62.3**
HIV and AIDS-related research activities not disaggregated by type	9,625	**2.9**	0	**0.0**	1,929	**0.1**
HIV and AIDS-related research activities n.e.c.	289,201	**87.3**	0	**0.0**	300,000	**18.8**
Grand Total	**331,376**	**100.0**	**28,367**	**100.0**	**1,594,196**	**100.0**

4.3 Beneficiaries of HIV and AIDS Spending

NASA groups beneficiary populations of the HIV and AIDS related programmes and activities into six broad areas (shown in Appendix 1). In analyzing the dataset, the results show that in 2007/2008 PLHIV benefited from most of the funds (37% of the total) followed by the specific "accessible" group (26%); other key population groups accounted for 19%; general population group (18%) and MARPs (0.1%). In 2008/2009 and 2009/2010, majority of funds was spent on the specific "accessible" group followed by PLHIV and other key population groups. Detailed spending by sub beneficiary grouping is shown in Tables 16 and 17 and Figures 7 and 8

Spending on MARPs was too low because IDUs and MSM are not common in Swaziland. The amount spent under this sub category is mainly on activities of sex workers and their clients. There is the need to undertake studies to identify who the MARPs are in Swaziland to help acknowledge the resources going to this category.

Table 16: Spending by Beneficiary Group, 2007/2008 - 2009/2010 (SZL)

Beneficiary Groups	2007/2008	%	2008/2009	%	2009/2010	%
PLHIV	113,950,594	**36.99**	122,665,632	**28.17**	159,182,278	**27.32**
Most-at-risk populations (MARPs)	317,321	**0.10**	626,796	**0.14**	395,058	**0.07**
Other key population	59,865,796	**19.44**	93,635,601	**21.51**	106,157,531	**18.22**
Specific "accessible" population	79,459,881	**25.80**	160,135,680	**36.78**	171,908,545	**29.5**
General population	54,412,949	**17.67**	58,310,796	**13.39**	145,027,294	**24.89**
Total	**308,006,541**	**100**	**435,374,505**	**100**	**582,670,706**	**100**

Figure 7: Spending by Beneficiary Group, 2007/2008 - 2009/2010 (SZL)

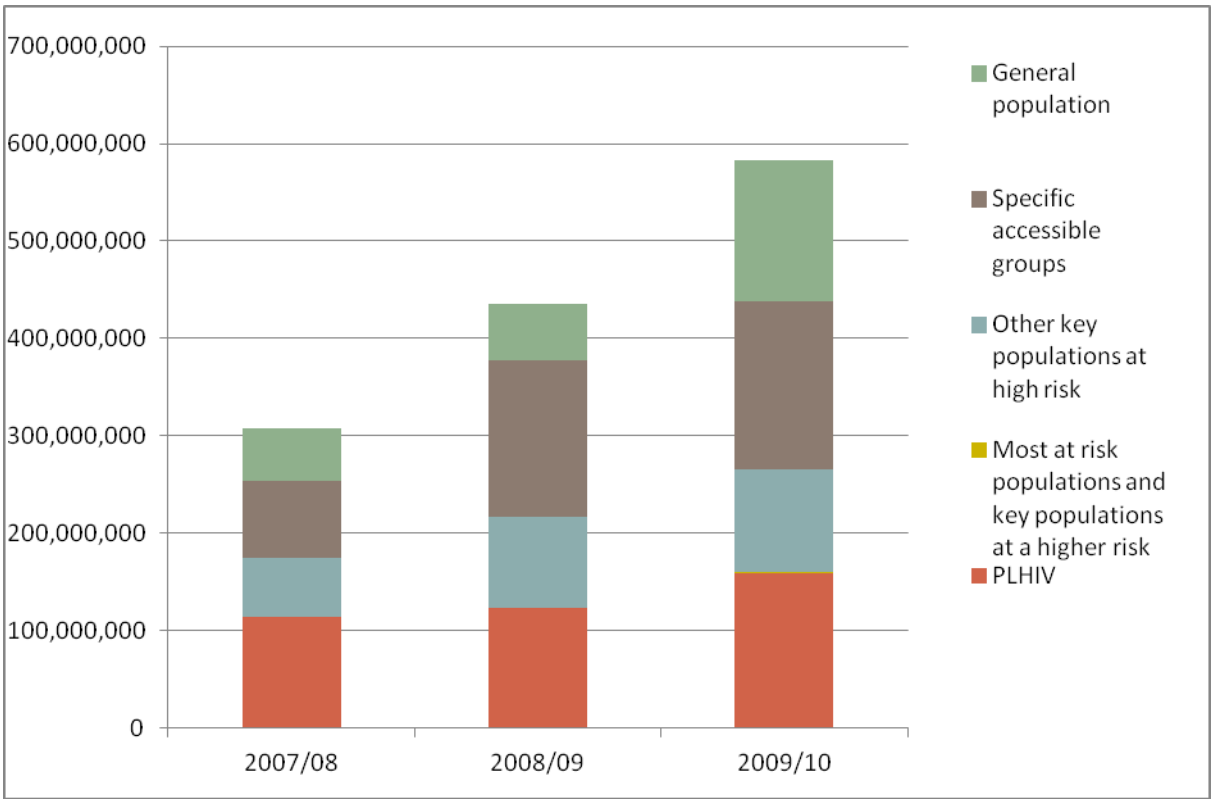


Figure 8: Proportional Spending by Beneficiary Group, 2007/2008 - 2009/2010 (SZL)

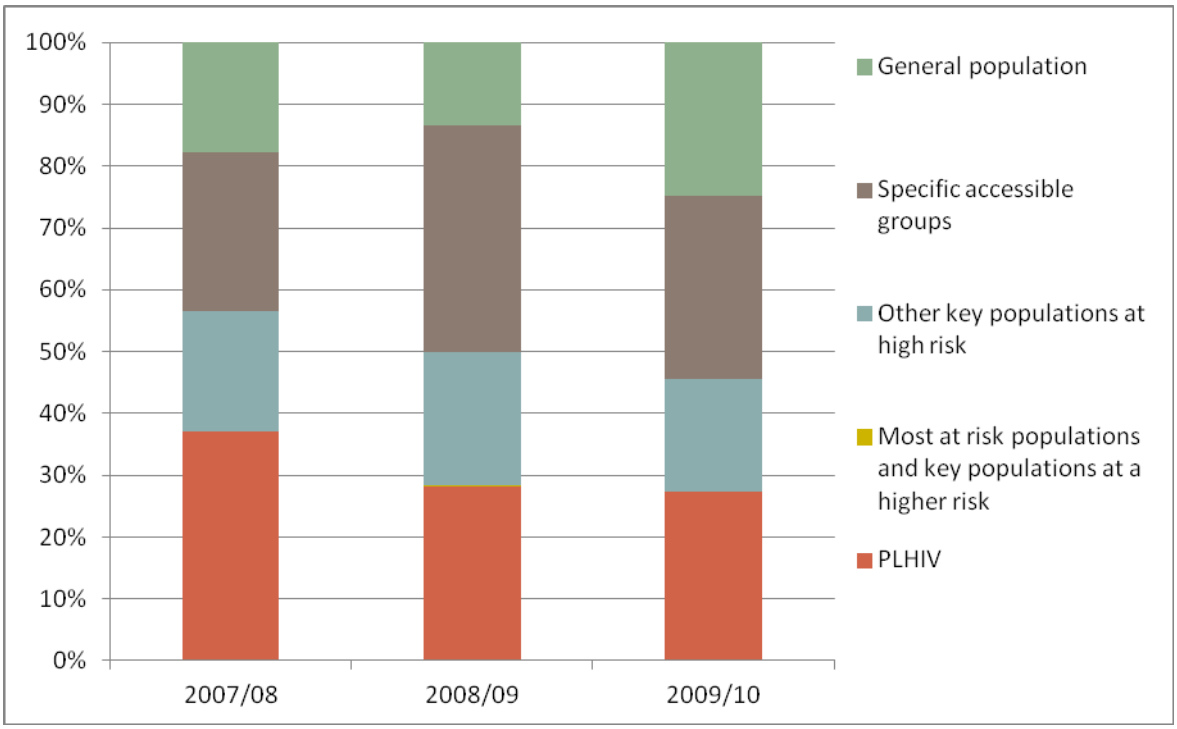


Table 17: HIV and AIDS related Spending by Beneficiary Groups, 2007/2008 - 2009/2010 (SZL)

BENEFICIARY GROUPS	2007/08	2008/089	2009/10
PLHIV			
Adult and young men (15 years of age and over) living with HIV	1,965,191	1,916,172	
Adult and young women (15 years and over) living with HIV	3,136,329	2,591,384	395,290
Boys (under 15 years) living with HIV	7,217,007	5,994,848	17,022,729
Girls (under 15 years) living with HIV	7,373,986	6,270,260	
People living with HIV not disaggregated by age or gender	94,258,081	105,892,968	141,764,259
Most at Risk Populations			
Injecting drug users (IDU) and their sexual partners			123,031
Sex workers, not disaggregated by gender, and their clients	317,321	146,568	
"Most at risk populations" not disaggregated by type		480,228	272,027
Other Key Populations			
Orphans and vulnerable children (OVC)	57,128,713	93,301,519	105,467,845
Children born or to be born of women living with HIV	1,264,811	141,632	
Migrants/mobile populations	20,702	20,702	137,100
Prisoners and other institutionalized persons			379,321
Children and youth out of school	1,442,594	171,748	
Other key populations not disaggregated by type			173,265
Other key populations n.e.c.	8,976		
Specific "Accessible " Populations			
Elementary school students	344,750	381,245	394,184
Junior high/high school students	64,803	975,583	32,746
University students	103,530	112,854	136,026
Health care workers	33,577,927	36,879,662	50,822,704
Military	55,000		
Police and other uniformed services (other than the military)		80,000	142,359

Ex-combatants and other armed non-uniformed groups			5,110
Factory employees (e.g. for workplace interventions)	1,407,012	1,056,675	1,174,083
Specific "accessible " populations not disaggregated by type	37,054,088	35,356,720	32,360,957
Specific "accessible " populations n.e.c.	6,852,771	85,292,941	86,840,376
General Population			
Male adult population	1,221,212	1,659,101	
Female adult population	371,014	621,247	1,361,750
General adult population (older than 24 years) not disaggregated by gender	1,573,664	1,659,102	
Boys	887,413	177,940	2,935,064
Girls		133,314	
Children (under 15 years) not disaggregated by gender	1,566,110	978,072	6,285,319
Young females	1,355,688	502,551	688,755
Youth (age 15 to 24 years) not disaggregated by gender	4,409,554	2,802,494	24,316,099
General population not disaggregated by age or gender.	43,028,294	49,776,975	109,440,307
Grand Total	**308,006,541**	**435,374,505**	**582,670,706**

4.3.1 Key Areas of Expenditure by Beneficiary Group

Tables 18, 19 and 20 shows the main population groups and their share of the main intervention areas captured in NASA. In 2007/2808, PLHIV benefited most from treatment and care, social protection and programme management and administrative strengthening. All the spending on treatment and care was received by PLHIV. General population was targeted for most of the prevention programmes. MARPs had expenditure only on prevention. This trend follows through the remaining two years but what is most interesting and welcoming is the fact that PLHIV are actively targeted for prevention programmes in 2009/2010 (SZL18,068,784) and to a lesser extent in 2007/8 (SZL357,577) . See also Figures 9, 10 and 11 for more details on spending on beneficiary groups.

Table 18: Spending on Beneficiary Groups by Key Priority Areas, 2007/2008 (SZL)

Beneficiary Population	Prevention	Treatment and care	Orphans and vulnerable children (OVC)	Programme management and administration	Human resources	Social protection and social services (excluding OVC)	Enabling environment	HIV and AIDS-related research	Grand Total
PLHIV	357,577	54,679,582	110,301	34,026,038	2,053,539	22,458,306	38,251	227,000	**113,950,594**
Most-at-risk	317,321								**317,321**
Other key population	1,702,989		54,681,155	1,771,339	780,379	929,934			**59,865,796**
Specific "accessible" population	8,016,417			21,808,833	45,413,553	3,154,024	962,678	104,376	**79,459,881**
General population	20,099,813			27,520,588	2,110,642	42,226	4,639,680		**54,412,949**
Grand Total	**30,494,117**	**54,679,582**	**54,791,456**	**85,126,798**	**50,358,113**	**26,584,490**	**5,640,609**	**331,376**	**308,006,541**

Table 19: Spending on Beneficiary Groups by Key Priority Areas, 2008/2009 (SZL)

Beneficiary Population	Prevention	Treatment and care	Orphans and vulnerable children (OVC)	Programme management and administration	Human resources	Social protection and social services (excluding OVC)	Enabling environment	HIV and AIDS-related research	Grand Total
PLHIV		72,773,351	271,514	32,681,766	119,685	16,772,664	46,652		**122,665,632**
Most-at-risk	146,568						480,228		**626,796**
Other key population	158,782	7,737	90,089,415	1,549,191	90,262	1,740,214			**93,635,601**
Specific "accessible" population	7,629,610	385,288		91,955,802	53,929,099	5,082,677	1,153,204		**160,135,680**
General population	19,864,785	653,562	645,994	26,241,455	5,588,101	827,119	4,461,413	28,367	**58,310,796**
Grand Total	**27,799,745**	**73,819,938**	**91,006,923**	**152,428,214**	**59,727,147**	**24,422,674**	**6,141,497**	**28,367**	**435,374,505**

Table 20: Spending on Benficiary Groups by Key Priority Areas, 2009/2010 (SZL)

Beneficiary Population	Prevention	Treatment and care	Orphans and vulnerable children (OVC)	Programme management and administration	Human resources	Social protection and social services (excluding OVC)	Enabling environment	HIV and AIDS-related research	Grand Total
PLHIV	18,068,784	109,378,948		12,330,929	181,255	17,199,606	2,022,756		**159,182,278**
Most-at-risk					123,031		272,027		**395,058**
Other key population	146,700		102,177,062	2,375,865	173,265	1,269,049	15,590		**106,157,531**
Specific "accessible" population	2,081,827		5,000	92,335,599	74,211,528	2,250,119	1,024,472		**171,908,545**
General population	47,005,532	33,250		56,211,890	15,466,249	20,811,833	3,904,344	1,594,196	**145,027,294**
Grand Total	**67,302,843**	**109,412,198**	**102,182,062**	**163,254,283**	**90,155,328**	**41,530,607**	**7,239,189**	**1,594,196**	**582,670,706**

Figure 9: Proportional Spending on Beneficiary Groups by Key Priority Areas, 2007/2008

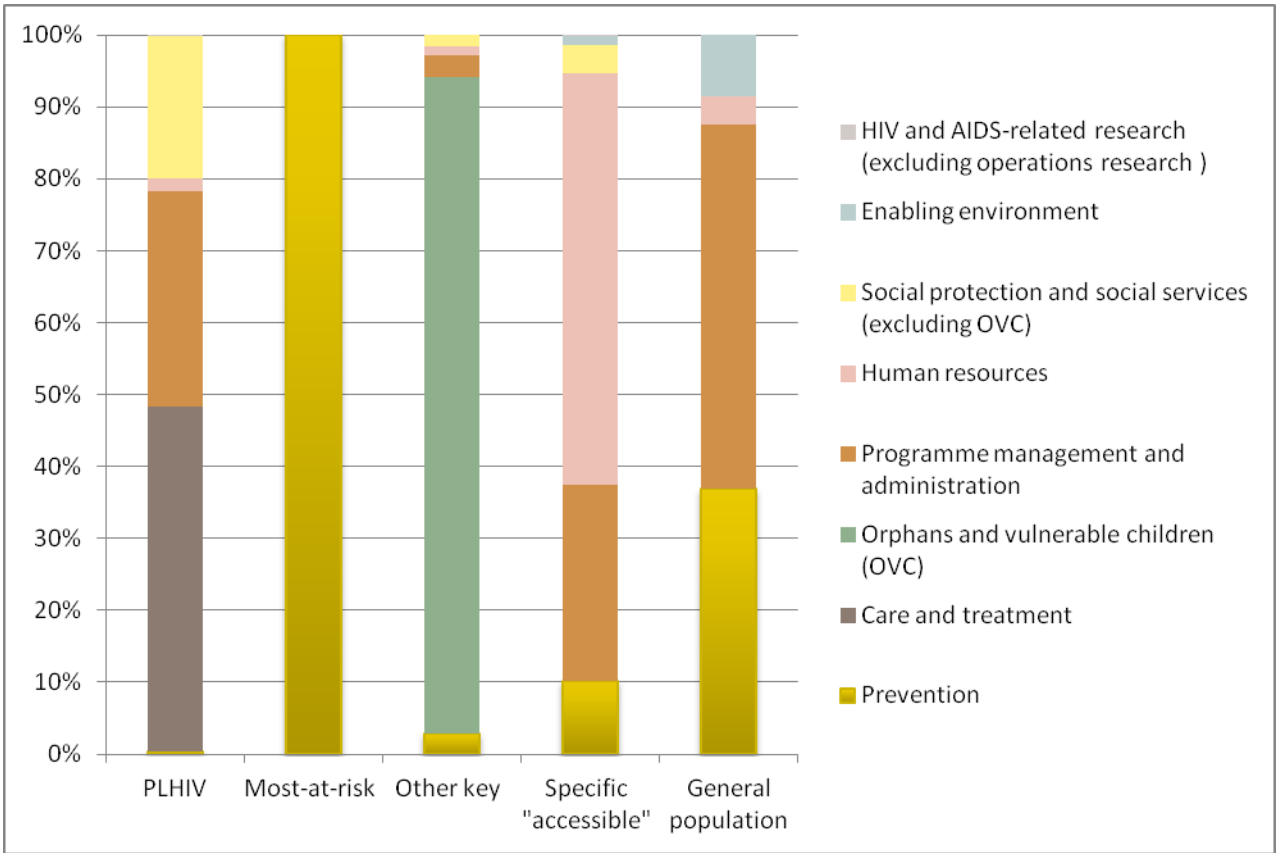


Figure 10: Proportional Spending on Beneficiary Groups by Key Priority Areas, 2008/2009

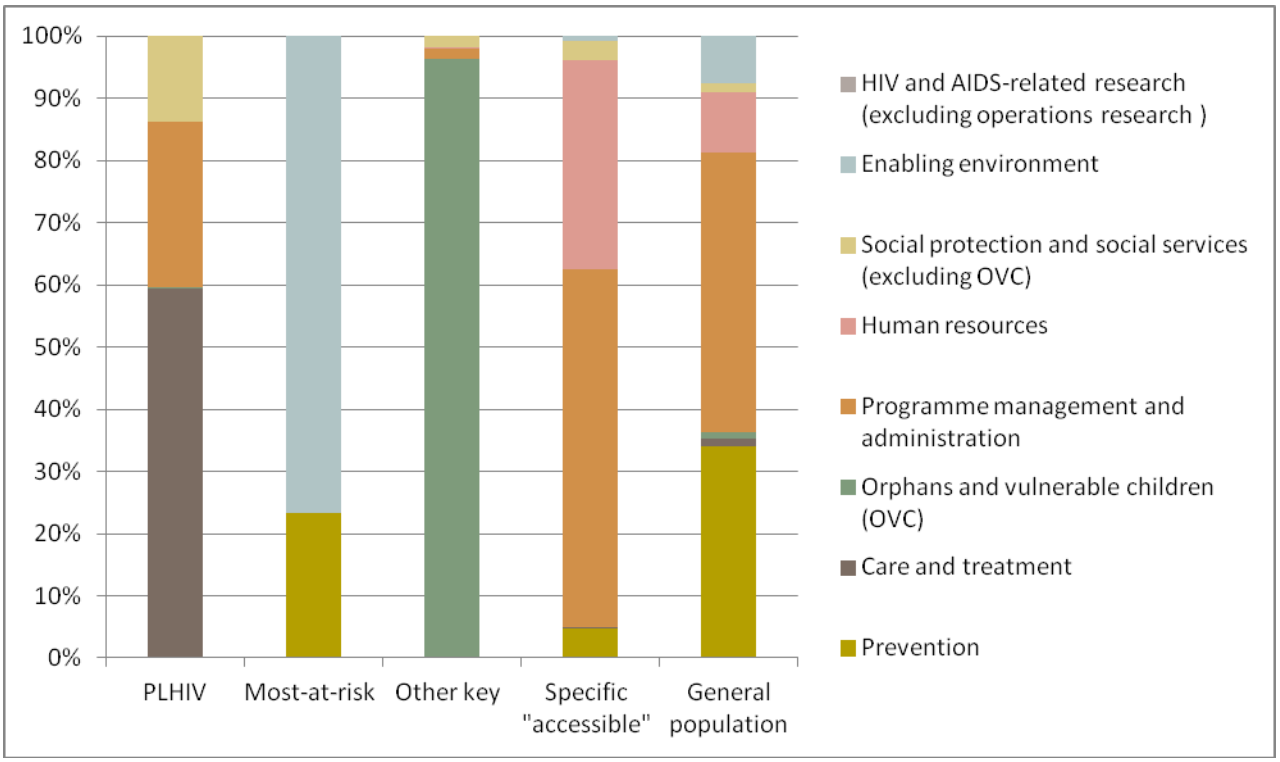
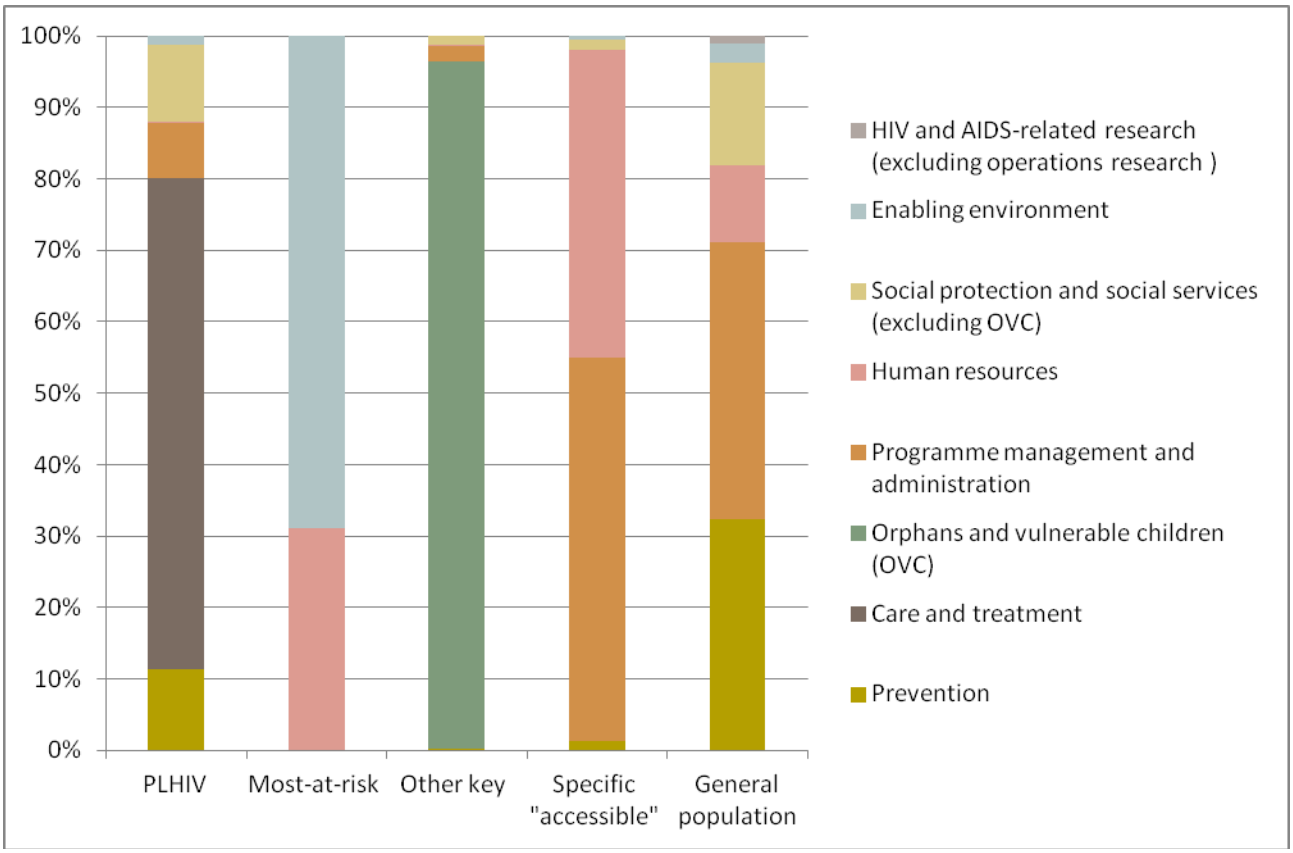


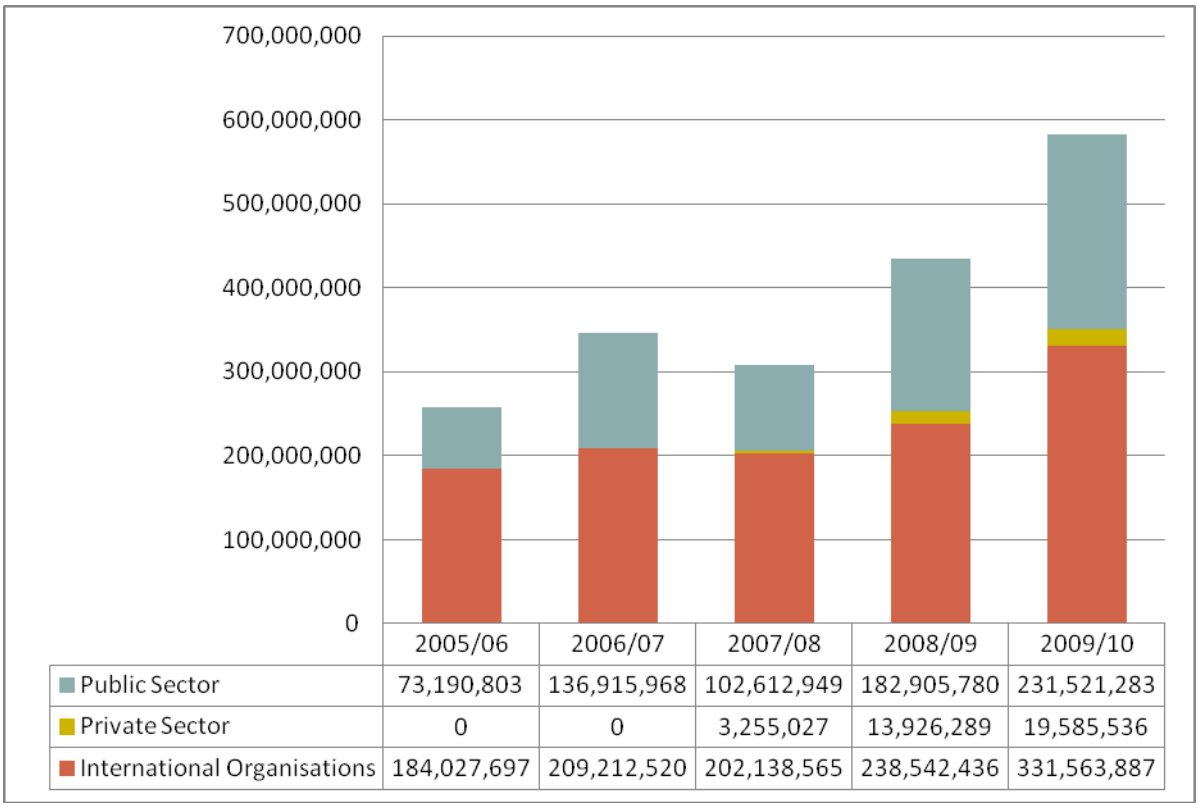
Figure 11: Proportional Spending on Beneficiary Groups by Key Priority Areas, 2008/2009



4.4 Trend Analysis of HIV and AIDS Expenditure, 2005/2006 to 2009/2010

This second round of the NASA makes it possible to have a trend analysis of HIV and AIDS expenditure from 2005/2006 to 2009/2010. This sub section gives an overview of HIV and AIDS related expenditures over the last five years. Although there has been a systematic increase in funding for HIV and AIDS related programmes during this period, there was a fall in 2007/2008. Total expenditures increased from **SZL257,218,500 (US$38,390,819)** in 2005/2006 to **SZL346,128,488 (US$49,446,927)** in 2006/2007, falling by 11% to **SZL308,006,541 (US$43,503,749)** in 2007/2008; increasing by 41% to **SZL435,374,505 (US$49,362,189)** in 2008/2009 and a further increase by 34% to **SZL582,670,706 (US$75,280,453)** in 2009/2010 (Figure 12). Funding from International Organisations has remained the major source of finance for HIV and AIDS related programmes and activities over the years. In 2005/2006, funds from international organisations accounted for 70% of total expenditure; 60% in 2006/2007; 66% in 2007/2008; 55% in 2008/2009 and 57% in 2009/2010.

Figure 12: Source of Funds by Financing Agents, 2005/2006 – 2009/2010 (SZL)



	2005/06	2006/07	2007/08	2008/09	2009/10
Public Sector	73,190,803	136,915,968	102,612,949	182,905,780	231,521,283
Private Sector	0	0	3,255,027	13,926,289	19,585,536
International Organisations	184,027,697	209,212,520	202,138,565	238,542,436	331,563,887

***** In 2005/2006 and 2006/2007, the private sector was not included in the data collection for the NASA.

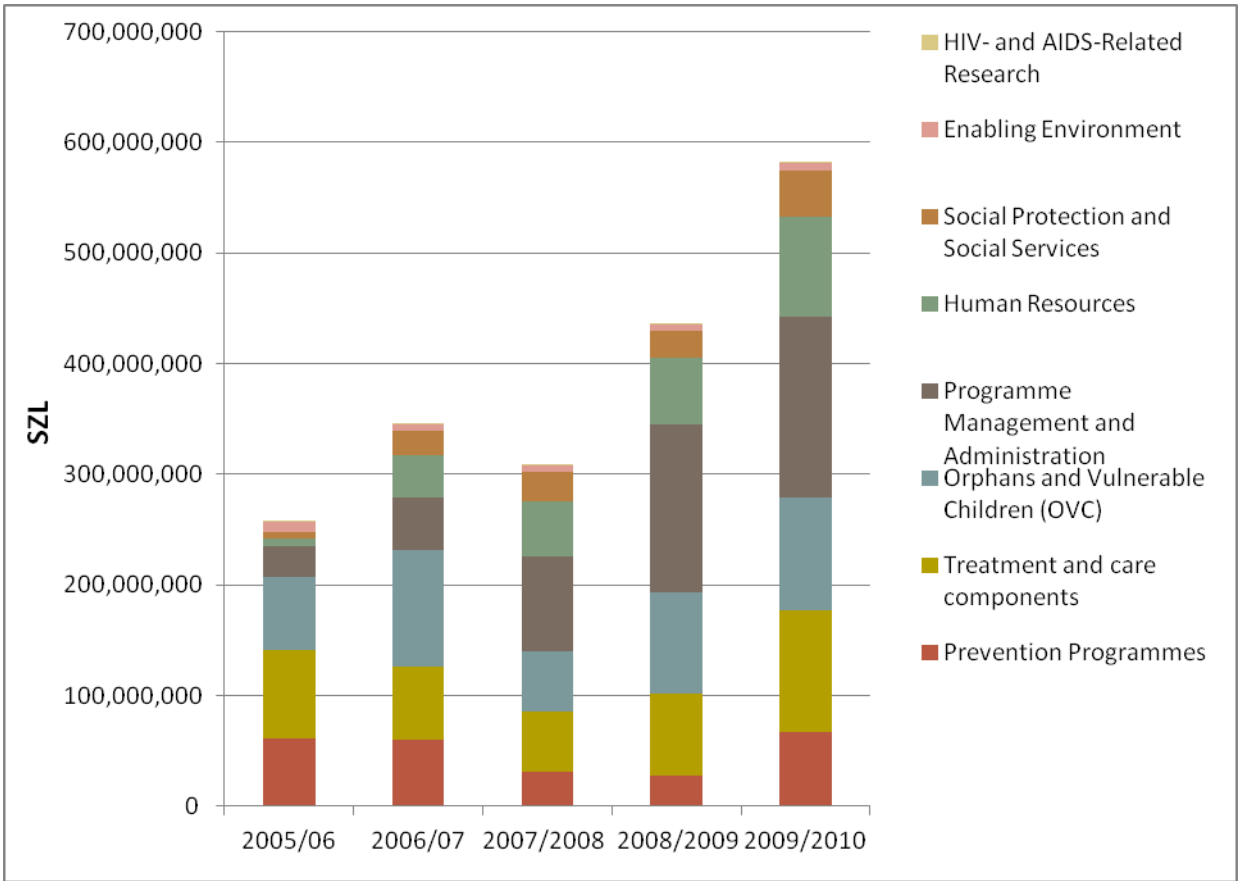
4.4.1 Key Spending Areas

Total expenditure on prevention decreased consistently from 2005/2006 to 2008/2009 but saw a sharp rise in 2009/2010. The expanded programme for treatment and care generally has being increasing except for a drop in expenditure in 2007/2008. A similar upward trend is seen in almost all the categories of expenditure with the exception of HIV and AIDS-related research (Table 21 and Figure 13).

Table 21: Total Spending on Key Priorities, 2005/2006 – 2009/2010 (SZL)

Key Areas of Expenditure	2005/06	2006/07	2007/08	2008/09	2009/10
Prevention Programmes	61,434,631	59,972,039	30,494,117	27,766,947	67,302,843
Treatment and care components	79,916,160	65,686,767	54,679,582	73,852,736	109,412,198
Orphans and Vulnerable Children (OVC)	66,012,325	105,191,482	54,791,456	91,006,923	102,182,062
Programme Management and Administration	27,115,940	48,531,173	85,126,798	152,428,214	163,254,283
Human Resources	7,553,197	38,139,285	50,358,113	59,727,147	90,155,328
Social Protection and Social Services	5,389,009	21,355,954	26,584,490	24,422,674	41,530,607
Enabling Environment	9,772,491	6,354,770	5,640,609	6,141,497	7,239,189
HIV- and AIDS-Related Research	24,747	897,018	331,376	28,367	1,594,196
Grand Total	**257,218,500**	**346,128,488**	**308,006,541**	**435,374,505**	**582,670,706**
Nominal growth (%)		**34.57**	**-11.01**	**41.35**	**33.83**

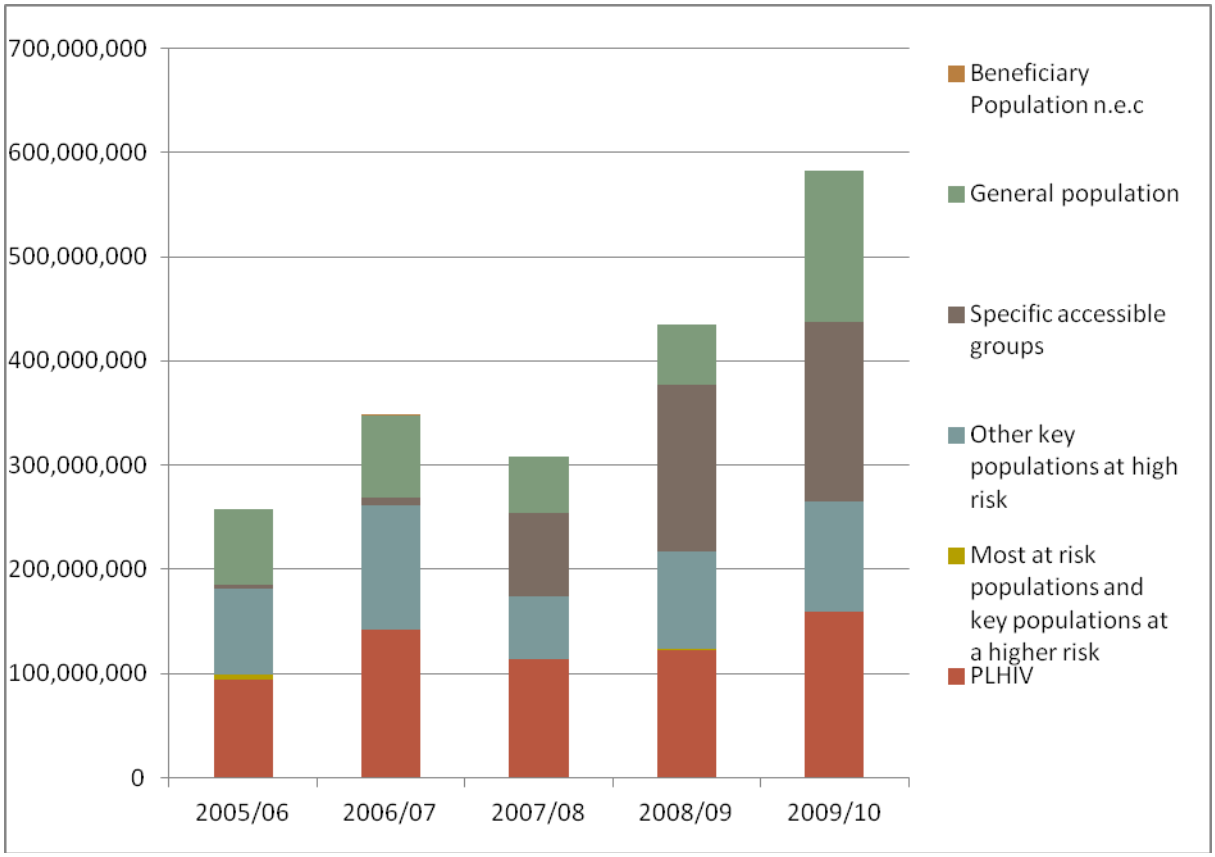
Figure 13: Total Spending on Key Priorities, 2005/2006 – 2009/2010 (SZL)



4.4.2 Spending on Beneficiary Groups

Programmes related to HIV and AIDS have mainly targeted the PLHIV population from 2005/2006 to 2007/2008 but from 2008/2009 to 2009/2010 the specific accessible groups benefitted from a higher proportion of the funds followed by PLHIV. In 2007/2008 and 2008/2009 saw a decline of the share by the general population which could imply increased targeting. The proportion expended on MARPs remains low, from 2% of the total share in 2005/2006 to less than 1 percent for the remaining four years under review (Figure 14).

Figure 14: Spending by Beneficiary Group, 2005/2006 -2009/2010 (SZL)



5. FINDINGS - QUALITATIVE SECTION OF NASA QUESTIONNAIRE

5.1 Introduction

In addition to the collection of information on spending on HIV and AIDS programmes and activities, the NASA assessment had a subsection which aims to assess the funding processes and reporting requirements of the various stakeholders and the challenges and bottlenecks they face in accessing funds or disbursing funds for HIV and AIDS related activities and programmes.

5.2 Non-Governmental Organisations

NGOs in Swaziland are mostly implementing agencies although some serve as financing agents especially the international NGOs. Their role in ensuring that HIV and AIDS related activities are carried out effectively in communities throughout the country with government and donor funds should therefore not be overlooked.

Challenges and Recommendations

Many of the NGOs interviewed reported inadequate funding. Most were concerned with inadequate funding to cover programmes as well as delay in accessing funds once they are approved. The unstable exchange rates also remain unfavourable in the funding process. High staff turnover is a problem faced by many of the NGOs due to the fact that funds are inadequate to provide proper enumeration for their services. Donors were often reluctant to provide funds for capacity building or cover the cost in engaging office personnel. Even though reporting requirements were strict and demanding given the limited staff, NGOs agreed that these requirements were very essential in curbing the misuse or abuse of funds.

It is recommended that Development Partners (DPs) and the government provide more funds to cover administrative costs and payment of staff to retain more highly skilled personnel. HIV and AIDS related programmes should be clearly prioritized to enable specific population groups to be reached.

5.3 Public Sector

Public sector funding for HIV and AIDS in Swaziland is mostly from the Government of The Kingdom of Swaziland. According to the data from the qualitative survey, most government agencies suffer from inadequate funding of HIV and AIDS related programmes. Most of them argued that the 5% government allocation for HIV and AIDS does not provide enough funds for all the planned activities for the year. There is also no budget line for these projects making it difficult to access funds from governments and donors.

It is recommended that specific budget item code is given for HIV and AIDS related activities at the workplaces. There is also the need to increase the number of staff working on these projects and adequate funding provided to support them.

5.4 Private Sector

The private sector cuts across both the informal and formal sectors and the role of the sector in the management of HIV and AIDS is important. The private sector businesses involved in providing HIV and AIDS services also complained of inadequate funding for programmes. Since HIV and AIDS activities did not form part of their core businesses funding remained limited. As in the case of the public sector, there were no budget lines for HIV spending making it difficult to have a regular supply of funds from year to year and also for planning purposes.

It is recommended that businesses are encouraged to participate fully in HIV and AIDS related activities as part of their social corporate responsibilities to the wider society.

6. SUMMARY AND RECOMMENDATIONS

6.1 Summary

The NASA has been beneficial in providing much needed data on HIV expenditures by all the major stakeholders from 2007/2008 to 2009/2010. This second round of the NASA has shown a consistent increase in the total expenditure on HIV and AIDS related expenditure in the period under review. The National AIDS Assessment estimates that the total expenditure on HIV and AIDS activities in the Kingdom of Swaziland was **SZL308,006,541 (US$43,503,749)**, **SZL435,374,505 (US$49,362,189)** and **SZL582,670,706 (US$75,280,453)** for the periods 2007/2008, 2008/2009 and 2009/2010 respectively. The largest proportion of the funds was sourced from international organisations accounting for about 60% of the total funds spent on the average within the three year period. The Kingdom of Swaziland like most sub-Saharan African countries are heavily reliant on donor funding and this raises questions in regards to sustainability of HIV and AIDS related activities in the country.

Public funds accounted for 38% of the total funds within the period under consideration with private funds ranging between 1% and 3%. Private expenditure captured excluded household out of pocket expenditures (OOPE) which has been a key limitation in the study. If these expenditures were included, the overall picture would have been much different.

The spending patterns in terms of expenditure on the key priority areas show that in all three years under study, majority of the funds were spent on Treatment and Care, Programme Management and Administrative Strengthening and Orphans and Vulnerable Children. Reducing the incidence rate and promoting safer sexual behaviour are some of the targets identified in the NSF 2009-2014 and therefore prevention remains the critical part of the national response to overcome the epidemic. It is encouraging therefore seeing an increase in spending on prevention programmes from **SZL30,494,117** in 2007/2008 to **SZL67,302,843** in 2009/2010 and especially expenditure on male circumcision increasing from SZL887,415 in 2007/2008 to SZL10,723,061 in 2009/2010. Total expenditure on HIV and AIDS related research has been very low in the three year period (averaging less than 1 percent of the total).

One of key targets in the NSF 2009-2014 is impact mitigation with the core focus of reducing the negative impact associated with HIV and AIDS on society. Those with HIV positive status

have worsening quality of life due to stigma and the aim is to reduce this stigma and fear through awareness and education campaigns. The results of the NASA study show a slight increase in the level of expenditure on creating an enabling environment through advocacy and other channels. Total expenditure for creating an enabling environment increased from SZL5,640,609 in 2007/2008 to SZL7,239,189 in 2009/2010 with about 28% of the total expenditure in 2009/2010 in this category geared towards capacity building in human rights.

On the beneficiary side, the analysis show that in 2007/2008 PLHIV benefited from most of the funds (37% of the total) followed by the specific "accessible" group (26%); other key population groups accounted for 19%; general population group (18%) and Most at Risk Populations (MARPs) the least at 0.1%. In 2008/2009 and 2009/2010, majority of funds were spent on specific "accessible" group followed by PLHIV and other key population groups showing an improvement in targeting specific population groups for HIV and AIDS programmes. The study clearly shows limited attention to the most at risk groups such as sex workers and their clients, men who have sex with men and injecting drug users. It seems from the results that more work is needed to reach the most at risk populations (MARPs) and other vulnerable groups since they have been discovered as one of the drivers of the epidemic from the Mode of Transmission (MOT) study conducted in 2009.

The qualitative assessment of the funding processes, reporting requirements, bottlenecks and challenges faced by funding and implementing agencies shows that overall, funding agencies as well as the implementers agree that funding remains inadequate to cover all the programmatic areas stipulated in the NSF 2009-2014. Administrative capacity is severely lacking and given that the success of these programmes depends on skilled workers, more resources is needed to retain them in the service.

6.2 Recommendations

The second round of the NASA indicates that the data collected in some categories requires further disaggregation and some implementing agencies were not able to provide the target groups for their programmes. The following are key recommendations coming out of the study:

- NERCHA's coordinating role – NERCHA needs to be aware of all funding going to HIV and AIDS related activities in the country especially funds that go directly from the

- Agencies and implementers should be clearer on their target population where possible to give a more accurate picture of which groups are truly benefitting from the HIV and AIDS related expenditures.
- Agencies and implementers should routinely present simple spreadsheets of their total expenditures and target groups at the end of each fiscal year to the NERCA to simplify the data collection process for future NASA assessments.
- Spending on Monitoring and Evaluation was very low and this might reflect the status of M&E activities. NERCHA will have to improve and/or increase its M&E activities because HIV and AIDS programmes go beyond the efficient use of resources. NERCHA should be able to monitor outcomes against intended targets on a regular basis.
- HIV and AIDS related research had the least spending in the 3 years under review. High quality data from research on HIV and AIDS related issues helps the process of fine-tuning programmes and also serves as a vital tool for monitoring and evaluation. Some of the research that the study identified as a gap are as follows:
    - Household Out of Pocket payment study on people living with HIV;
    - Cost of HIV and AIDS Adult and Paedratic Clinical Care and Treatment;
    - Impact of the social mitigation programmes on PLHIV; and
    - Study to identify who the MARPs are.
    - Health spending on traditional health practitioners (a sizeable percentage of the population use their services)
- NERCHA should develop a resource mobilisation strategy to diversify funding portfolio;

Also, private sector involvement in the national response is limited and there is need to galvanize private sector entities to help in the mobilization of funds for HIV and AIDS related activities.

In addition if possible, proper line items should be designated for HIV and AIDS programmes in the public sector to ensure a constant and sustainable flow of funds for HIV and AIDS work related activities.

6.2.1 Institutionalisation of NASA

Given that this is the second round of the NASA in Swaziland, the key lessons learnt regarding institutionalisation is the need for increasing awareness of the NASA process and usefulness among key stakeholders through training workshops. This will help in the collection of accurate and disaggregated data for subsequent NASA activities.

NERCHA should be the main institution to institutionalise the NASA in Swaziland. Thus it should be able to conduct training and capacity building for stakeholders. It should also make sure that the NASA is incorporated into the national HIV and AIDS M&E system for HIV and AIDS assessment. Specific recommendations for the institutionalisation of the NASA are as follows:

- The key issues that need to be addressed to facilitate the institutionalisation of the NASA in Swaziland are (i) greater advocacy to relevant stakeholders and (ii) streamlining of financial disbursements and reporting mechanisms.
- Standardisation of budget line items/codes and their reported expenditure, using main categories of the NSF, and sub-categories of NASA.
- Simplify data collection tools to allow ease in providing data.
- NERCHA should insist that institutions working in HIV and AIDS related activities should present their expenditures according to the NSF priorities and identify intended target groups. This will help remove double counting and also make assessment of HIV and AIDS activities easy and
- There should be a forum every year whereby resource commitments by development partners are shared with NERCHA for them to know which part of the NSF they plan or are implementing and with what resources. This will help reduce duplication and also compare budget (commitment) with actual expenditures from the NASA.

Enough capacity has been build in NERCHA in the area of NASA data collection and it should be able to organise training and data collection for the next NASA. NERCHA will however need support in data processing especially in the NASA RTS software and analysis of the results.

APPENDICES

Appendix 1: NASA Beneficiary Categories

Code	Main category	Disaggregated
BP.01	**People living with HIV (PLWH)**	Age Sex
BP.02	**Most-at-Risk Populations**	IDU Sex workers MSMs
BP.03	**Other Key Populations**	OVCs Children born from mothers with HIV Migrants, refugees Prisoners Women & children: trafficking and violence Youth at social risk, out of school, in streets Partners of people living with HIV Etc.
BP.04	**Specific "Accessible" Populations**	STI Clinic patients Children and youth at school People at work Health workers Migrant workers Long distance truck drivers Military, police Etc.
BP.05	**General Population**	General adult population Children Youth Etc.
BP.06	**Non-targeted Interventions**	
BP.99	**Specific targeted populations not elsewhere classified (n.e.c)**	

Appendix 2: National AIDS Spending Assessment – Data Collection Forms

Form 1 - Institutional Role

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

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

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

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

1. Central government	
2. Regional Administration	
3. Local government (including municipalities and city councils)	
4. Private-for-profit national	
5. Private-for-profit international	
6. National NGO/CSO/FBO/CBO	
7. International NGO/CSO/FBO/CBO	
8. Bilateral Agency	
9. Multilateral Agency	
10. Parastatal Organisation	

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

8.1 If Institution is Source and/or Agent – complete form #1
8.2 If Institution is a Provider – complete form #2
8.3 If Institution is an Source/Agent and Provider – complete forms #1 and #2

Forms:

1. Source / Agent
2. Provider

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

Form 2 - DATA COLLECTION (SOURCES / AGENTS)

Year of the expenditure estimate:_____

Objectives of the form:

II. To identify the origin of the funds used or managed by the institution during the year under study.
III. To identify the recipients of those funds.

Indicate what currency will be used throughout the form with an "X":	**Local currency**	**US$ Exchange rate in Year of Assessment**	**Other (specify):**

Name of the Institution:

Financial Year: **(if not April-March year, please ask for quarterly expenditure reports)**

1. **Person to Contact (Name and Title):**

2. **Address:**	**3.** **E-mail:**
4. **Phone:**	**5.** **Fax:**

6. **Type of institution:** Select category of institution with an "X".	6.1 Central government	
	6.2 Regional Administration	
	6.3 Local government (municipality and city council)	
	6.4 Private-for-profit national	
	6.5 Private-for-profit international	
	6.6 National NGO/FBO/CSO/CBO	
	6.7 International NGO/FBO/CSO/CBO	
	6.8 Bilateral Agency	
	6.9 Multilateral Agency	
	6.10 Parastatal Organisation	

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

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

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

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

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

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

8. Destination of the funds:

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

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

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

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

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

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

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

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

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

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

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

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

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

g. Any other comments, suggestions etc?

11. Interviewer:	**12. Date:** / / 20__

Form 3 - DATA COLLECTION (PROVIDERS)

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

Year of the expenditure estimate:_____			
Objectives of data collection from the Provider: IV. To identify the origin of the funds spent by the provider in the year understudy. V. To identify in which NASA Functions/ activities the funds were spent. VI. To identify the NASA Beneficiary Populations for each NASA Function/ activity.			
Indicate what currency will be used throughout the form with an "X":	**Local currency**	**US$ Exchange rate in Year of Assessment**	**Other (specify):** _____
Name of the Provider:			
7. Person to Contact (Name and Title):			
8. Address:		**9. E-mail:**	
10. Phone:		**11. Fax:**	

12. Type of institution: Select category of institution with an "X".	11. Central government	
	12. Regional Administration	
	13. Local government (municipality and city council)	
	14. Private-for-profit national	
	15. Private-for-profit international	
	16. National NGO/FBO/CSO/CBO	
	17. International NGO/FBO/CSO/CBO	
	18. Bilateral Agency	
	19. Multilateral Agency	
	20. Parastatal Organisation	

13. 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 for HIV and AIDS related activities
7.10Institution: Contact:	
7.11Institution: Contact:	
7.12 Institution: Contact:	
7.13Institution: Contact:	
7.14Institution: Contact:	
TOTAL:	

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

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

14. 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 in the notebook for their identification.

8.1 Expenditure of the funds received from "7.1"

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

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

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

8.2.a If funds were under/overspent from '7.2' what were the key reasons for under/over-spending?

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

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

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

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

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

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

Additional Qualitative Information Required:

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

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

3. What are the key bottlenecks to spending?

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

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

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

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

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

9. How could these be addressed or reduced?

15.Interviewer:	**16.Date:** / / 20__

Appendix 3. List of Organisations/Institutions visited and Status of Data Collected

Institutions Visited	2007/2008	2008/2009	2009/2010
1.AMICAALL	✓	✓	✓
2.Ministry of Public Works & Transport	✓	✓	✓
3.Ministry of Justice	✓	✓	✓
4.Ministry of Foreign Affairs	no records	no records	no records
5.Ministry of Economic Planning	✓	✓	✓
6.Treasury	No records	No records	✓
7.Ministry of Commerce Industry & Trade	✓	✓	✓
8.Ministry of Housing & Urban Development	✓	✓	✓
9.Ministry of Finance	No records	No records	✓
10.Ministry of Tourism & Environmental Affairs	?	✓	✓
11.Ministry of Agriculture	✓	✓	✓

12.Correctional Services	No records	No records	No records
13.Ministry of Public Service	No records	No records	✓
14.Ministry of Information, Communication & Technology	No records	No records	✓
15. PSHACC	Organization not in existence	Organization not in existence	✓
16. Ministry of Education	✓	✓	✓
17. Ministry of Defence	✓	✓	✓
18. Ministry of Natural Resources	✓	✓	✓
19. Sebenta	✓	✓	✓
20. SBIS	✓	✓	✓
21. Ministry of Home Affairs	✓	✓	✓
22. SNYC	✓	✓	✓
23. DPM'S Office	✓	✓	✓
24. SWADE	No activities	No activities	✓
25. FINCORP	No activities	No activities	No activities
26. SNHB	No activities	No activities	No activities
27. Department of Audit	No records	No records	✓
28. MTAD	✓	✓	✓
29. RSP	✓	✓	✓
30. SWABCHA	✓	✓	✓
31. Nedbank	X	✓	✓
32. SwaziMed	X	✓	✓
33. Imphilenhle	X	X	✓
34. Macmillan	✓	X	✓
35. Parmalat	✓	✓	✓
36. Swaziland Beverages	✓	✓	✓
37. FNB	X	✓	✓
38. Illovo Big Bend	X	✓	✓
39. SEC	X	X	✓
40. Swaziland Milling	✓	X	✓
41. Palfridge	X	X	✓
42. Tambuti Estates	X	X	✓
43. CONCO	✓	✓	✓
44. Swaziland Railways	✓	✓	✓
45. SPTC	X	✓	✓
46. Swazibank	✓	✓	✓
47. Lusweti	X	✓	✓
48. ICW	?	?	?
49. RSSC	?	?	?
50. Tabankulu Estates	?	?	?
51. Standard Bank	?	?	?

52. SWSC	?	?	?
53. MTN	?	?	?
54. Inyatsi Construction	?	?	?
55. ACAT	✓	✓	✓
56. ADRA		✓	✓
57. AMICAALL	✓	✓	✓
58. Baylor (BiPAI)	✓	✓	✓
59. Caritas	✓	✓	✓
60. Children's Cup	✓	✓	✓
61. Church Forum	✓	✓	✓
62. COSPE	Not in existence	✓	✓
63. Council of Churches	✓	✓	✓
64. EGPAF	✓	✓	✓
65. ESI	Not in existence	✓	✓
66. FLAS	✓	✓	✓
67. Gone Rural	✓	✓	?
68. Hand in Hand	Not in existence	✓	✓
69. ICAP	Not in existence	✓	✓
70. Imphilo Isachubeka	✓	✓	✓
71. Khulisa Umntfwana	✓	✓	?
72. LDS	✓	✓	?
73. Lusweti	Not in existence	✓	✓
74. Membatsise	No records	✓	✓
75. MSF	✓	✓	✓
76. NATTICC	✓	✓	✓
77. CANGO	?	?	✓
78. SWANNEPHA	✓	✓	✓
79. Vusumnontfo	No records	✓	✓
80. Women Together	No records	✓	✓
81. Scripture Union	✓	✓	✓
82. Lutsango	✓	✓	✓
83. Red Cross	✓	✓	✓
84. Salvation Army	✓	✓	✓
85. SASO	No records	No records	✓
86. Save the Children	✓	✓	✓
87. Sebenta	✓	✓	✓
88. SHAPE	No records	✓	✓
89. SNYC	✓	✓	✓
90. SWAGAA	✓	✓	✓
91. TASC	No records	✓	✓
92. UNISWA	✓	✓	✓
93. World Vision	✓	✓	✓
94. Young Heroes	✓	✓	✓
95. Clinton Foundation	✓	✓	✓
96. URC	✓	✓	✓
97. WLSA	No records	No records	✓
98. SWAPOL	No records	No records	✓
99. Imbita	No records	No records	✓
100. SACRO	No activities	No activities	No activities

101. Cabrini Ministries	✓	✓	✓
102. UNFPA	✓	✓	✓
103. UNICEF	✓	✓	✓
104. FAO	✓	✓	✓
105. ILO	No records	No records	✓
106. EU	✓	✓	✓
107. UNDP	✓	✓	✓
108. WHO	✓	✓	✓
109. WFP	✓	✓	✓
110. ITALIAN COOPERATION	✓	Not in existence	Not in existence
111. US GOVERNMENT	✓	✓	✓
112. Baphalali Swaziland Red Cross	✓	✓	✓
113. UNODC	Not in existence	Not in existence	✓
114. UNESCO	No records	✓	✓
115. Traditional Healers' Organization	?	?	?
116. Swaziland Hospice at Home	✓	✓	✓
117. SOS	?	?	?
118. Ministry of Health	✓	✓	✓
119. NERCHA	✓	✓	✓

?- visited but no data given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