REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES
DIRECTORATE OF SPECIAL PROGRAMS

NATIONAL AIDS SPENDING ASSESSMENT (NASA) 2009/10 & 2010/11

September 2012

Ministry of Health and Social Services

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Ministry of Health and Social Services

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Preface

This report presents findings from the Namibia National AIDS Spending Assessment for the financial years 2009/10 and 2010/11. The objective of this project was to collect reliable and consistent data on the origin and use of resources consumed in the HIV response in the country, for the financial years 2009/10 and 2010/11; to complete the National Funding Matrix to report on Global AIDS Response Progress Reporting (GARPR) in 2012 which is a national commitment to the 2011 UN Political Declaration on HIV/AIDS.

The data collected and analysed were from donor organizations and government Ministries. I would like to thank all institutions and our partners for their contribution and support throughout this resource tracking. Special thanks go to PEPFAR, the Global Fund PMU, GIZ and the UN for their time, effort and unending cooperation.

The study was conducted by a team led by the Ministry of Health and Social Services with oversight of the Resource mobilization Technical Advisory Committee of the National AIDS Executive Committee (NAEC). I would like to commend the consultants, Christopher M. Chiwevu and Leonard K. Kamwi for their efforts in finalizing this project. I acknowledge the financial and technical support provided by UNAIDS and Dr Martin Odiit for his input.

My gratitude goes to all the Ministry officials and particularly for the work done by the Directorate of Special Programmes. In this respect I would like to thank the Core Working Group of the project: Ella Shihepo (Ms) Anna Marie Nitschke (Ms.), Joyce Shatilwe (Ms.), Ambrosius Uakurama (Mr.), Muine Samahiya (Mr.), T.T Angula (Mr.), Michael Gawanab (Mr.), N. Nashilongo (Ms.), W Kafita (Ms.), and Liita Naukushu (Ms.).

The production of the National AIDS Spending Assessment Report provides key expenditure information for national policy makers, donors, and other stakeholders to guide strategic planning and dialogue to inform decision making for health and social service delivery.

Mr Andrew Ndishishi

PERMANENT SECRETARY

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CSO	Civil Society Organisation
FDC	Funds Distribution Certificate Report
GARPR	Global AIDS Response Progress Report
GIZ	German Society for International Cooperation
GRN	Government of the Republic of Namibia
HIV	Human Immunodeficiency Virus
IFSM	Integrated Financial Management System
MOHSS	Ministry of Health and Social Services
MTEF	Medium Term Expenditure Framework
NABCOA	National Business Coalition on AIDS
NANASO	Namibia Network of AIDS Service Organisations
NASA	National AIDS Spending Assessment
NGO	Non Governmental Organisation
NPC	National Public Commission
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMU	Project Management Unit
RNM	Resource Needs Model
TSF	Technical Support Facility
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific, and Cultural Organisation
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development

Executive summary

This National Aids Spending Assessment (NASA), 2009/10 and 2010/11 is a task emanating from the declaration of commitment on HIV/AIDS in 2001, in which the UN Secretary-General, with the support of UNAIDS, has been charged with monitoring the global response to the AIDS epidemic and reporting annually on progress made to the UN General Assembly. This Mandate was renewed in 2006 and was recently extended by the UN General Assembly through the adoption of the 2011 Political Declaration on HIV/AIDS.

As in the past, UNAIDS Country Office has been supporting Namibia in preparing their biennial 2012 Global AIDS Response Progress Report (GARPR) (formerly known as UNGASS reports). The core indicators for country progress reporting have been revised to reflect the new targets set out in the 2011 Political Declaration on HIV/AIDS. One of the core indicators to report on is indicator No. 6.1 AIDS Spending.

The main objective NASA is typical to track HIV/AIDS related financial flow of funds into and within the country, from the sources to the beneficiary population. This was also the case with this study.

The assessment was conducted under the NASA framework with some deviation especially pertaining to scope. Whereas the NASA methodology for data collection is designed in a way that would allow the reconstruction of the transaction from a financing source, to a financing agent and to the provider of goods and services, in order to avoid double counting and to reflect actual expenditure (goods and services delivered to an intended beneficiary population), this study only focused on tracking financial flows from the sources (the donors) only. For that reason it has been referred to as a "mini NASA". The Funding Matrix, (usually the final product NASA studies) was the main data collection tool. As such, no data about the financing agents, providers of goods and services beneficiary populations was collected. Consequently, the study could not produce data sets that could be validated from the perspective of each of three different stakeholders, namely donors, financing agents, and the providers of goods and services.

Looking at the data collected, reasonably adequate resources, N$1,888.4 million and N$1,996.6 million was channeled towards Aids and HIV related activities in 2009/10 and 2010/11 fiscal years respectively.

As a percentage of GDP, this represents 2.4 percent and 2.2 percent of GDP at current market prices. The largest proportion of the funds was sourced internally from the public sector. Although funds from international organisations amounted to 50.5 percent of total spending on HIV and AIDS in 2009/10 and 40.3 percent in 2010/2011; public funds formed 49.1 percent of the total expenditure in 2009/10 whilst in 2010/11 the ratio increased to 59.7 percent. Private sources of funding constituted 0.1 percent in both years respectively. However, the study did not collect all private (businesses and household, Medical Insurance or individual out-of-pocket) spending on HIV/AIDS – related activities, hence this total from the private sector does not represent their contribution to the total spending on HIV and AIDS in the periods under study. Comparing the total expenditure on HIV and AIDS in 2010 and what was projected in the National Strategic Framework for 2010/11 of N$1,752.9, there was an additional flow of N$236.7 million.

Most of the funds were spent on treatment and care (46.6 percent in 2009/10 and 43.9% in 2010/11); Orphans and Vulnerable Children (13.4 percent in 2009/10 and 21.4 percent in 2010/11); prevention programmes (15.1 percent in 2009/10 and 10.8 percent in 2010/11) and Programme Management and Administrative Strengthening (9.8 percent in 2009/10 and 9.7 percent in 2010/11). The remaining 0.8 and 0.6 percent of the total funds in 2009/10 and 2010/11 respectively was shared amongst the remaining 3 priority areas. Needless to mention, the three areas receiving least attention are Social Protection and Social Services; Enabling Environment and Research.

In 2009/10, 30.6 percent of funds from International Organisations was spent on Programme Treatment and Care; whilst another 26.5 percent went into the prevention component and 19.4 percent on Incentives for Human Resources. For Public Sector funds, 63.3 percent was spent on treatment and care; only 3.2% percent on prevention; 11.8 percent on programme management and administrative strengthening; and 21.7 percent on Orphans and Vulnerable Children. On the part of the private sector, 45.7 percent of the total funding was spent on prevention; 34.3% on programme management and administrative strengthening; 5.7 percent to provide incentives for recruitment and retention of human resources whilst 14 percent was spent on creating enabling environments programme.

Key Findings and Conclusions

General budget support in Namibia consists of a programme of non-earmarked financial support to the government's public expenditure programme involving multiple donors and multi-year indicative commitments. The overall objective of AIDS budget support is to contribute to the achievement of the government's health and social programme and to halt and reverse the AIDS epidemic through policies set out according to its priorities.

Alignment and Harmonization of Government and other Stakeholder Efforts

Various platforms are in place: The Global Fund meets with the Project Management Unit (PMU) and sub recipients to deliberate on action plans and reporting requirements and mechanisms. PEPFAR discusses U.S. government assistance with partners to ensure that investments are well coordinated and aligned with country priorities for sustainable improvements in health.

However, current systems for recording HIV/AIDS expenditure within government requires some attention. Data was sometimes not readily available and had to be estimated using proxies. For example, financial records are only kept by "expense type" classification, which is not consistent and detailed enough to be helpful in NASA studies. We therefore, made estimates, which could have been over or under the true value. It was not possible, for example, to allocate some medical supplies received by the health centre's pharmacy to inpatient and out-patient departments, as usage of these items was not specified. These costs were therefore only handled using allocation factors, mainly from studies in other countries. Further, it was not immediately possible to allocate certain items, such as staff costs to certain departments, as their usage between departments was not clearly defined. The same personnel who tended to the inpatient wards, attended to patients at the OPD clinics.

According to PPHRD, the motivation now is to pursue program budgeting, first as a pilot in three to four regions and later be rolled-out on a national scale. It is strongly believed that program budgeting could allow for identification of broad expenditure categories across diseases, including AIDS. The hope is that these broad categories can later be connected to the Integrated Financial Management System (IFMS) in the 2011/2012 fiscal cycle. The pilot will assist in PPHRD to learn of challenges and priorities when the project is later rolled out nationally.

Recommendations

While significant progress has been made in HIV/AIDS programming, a national system to help measure HIV/AIDS expenditures in detail has not emerged. Lack of a resource-tracking system that monitors the annual flow of funds used to finance the full continuum of HIV/AIDS activities impedes a rapid collection, analysis and aggregation of expenditures to inform the Multisectoral perspective on HIV/AIDS. For this reason, multiple challenges could be experienced when attempting to undertake a comprehensive resource gap estimation for HIV/AIDS; Monitoring of financial implementation of national strategic plans for HIV/AIDS; Re-allocation of funds in the strategic planning cycle for HIV/AIDS, and Reporting on the financial indicators used to monitor the progress made towards the goals of the Declaration of Commitment on HIV/AIDS.

Given these circumstances, it is recommended that relevant agencies of the Government of the Republic of Namibia consider establishing a well coordinated, useful and reliable national expenditure tracking system from which reports on AIDS spending can be determined, for example, by the 8 main categories and sub categories as identified in the National Funding Matrix Tool. Also, existence of such a tracking system could lead to the production of other detailed expenditure reports for universal application.

Commission a costing study

The study (based on Activity Based Costing (ABC) can be applied to a large spectrum of HIV/AIDS programs and interventions. Such a study will help ensure that the selected interventions to the national AIDS response are realistic and affordable, and can provide vital information to those managing and monitoring the strategy's implementation. Benefits to be realized from such a study include the possibility of addressing program-specific information needs of aid agencies, program designers and implementers; the establishment of a basis for cost comparisons among programs, interventions and activities.

Training on AIDS Spending National Funding Matrices for AIDS Budget Partners

Given the many technical questions paused by partners on the National Funding Matrices for 2009/10 and 2010/11, it is recommend that training workshops be organized in order to equip HIV/AIDS budget partners on the Tool which they are likely to use in upcoming fiscal years to report on Indicator 6.1. Moreover, the training workshops can also be an experience sharing forum where AID Budget partners from government agencies and different organisations can share their expenditure tracking systems and methods, including strengths, weaknesses, opportunities and possible threats to aggregation of HI/AIDS expenditures.

Database

While completion and use of a national database at the National Planning Commission could help track and manage the sums of donor money coming into Namibia, the database is unlikely to provide information on duplication of efforts - possibly by NGO's/Civil Societies in HIV/AIDS program implementation in the 13 regions. A good practice would be to know which organisation is implementing what activities in each district/geographical space and its proportion of contribution in meeting national HIV/AIDS targets.

1. Background

1.1 Context for the Assessment

In 2001, the United Nations (UN) General Assembly passed a declaration on its commitment to tackling HIV/AIDS. The General Assembly renewed this mandate in 2006 and extended it in 2011 by adopting the 2011 Political Declaration on HIV/AIDS. As a result of this renewed commitment, six new global targets were established for the year 2015. These targets are, to halve global sexual transmission of HIV; reduce transmission of HIV among people who inject drugs by 50%; ensure that no children are born with HIV; increase the number of people with access to anti-retroviral treatment (ART) to 15 million; reduce tuberculosis deaths in people with HIV by 50%; and close the global resource gap for AIDS and increase spending by up to US$24 billion. The UN Secretary General with the support of UNAIDS has been tasked with monitoring the progress towards these targets through biennial country progress reports.

The country progress report is an important mechanism for measuring both global and national accountability to lessening the human burden of HIV/AIDS. It is meant to increase the transparency of the health sector response and provide an evidence-based starting point for developing and improving national policies and programmes for addressing HIV/AIDS. The core indicators for the country progress reports were revised in 2011 to reflect the targets set in the Political Declaration on HIV/AIDS. Technical guidance on collecting the indicators is provided in the UNAIDS produced document, *Global AIDS Progress Reporting 2012: GUIDELINES Construction of Core Indicators for monitoring the 2011 Political Declaration on HIV/AIDS.*

1.2 Objectives and Purpose

The objective of this project was to collect reliable and consistent data on the origin and use of resources consumed in the HIV/AIDS response in the country, and to complete the National Funding Matrix to report on Global AIDS Response Progress Reporting (GARPR) indicator 6.1 - Aids Spending.

The assessment aimed to collect and aggregate expenditure data on HIV/AIDS for two fiscal years (2009/2010 and 2010/11) for selected donors.
Another objective of the assessment was to aid the national-level decision-makers to monitor the scope and effectiveness of their programmes as well as evaluate the status of the country response. As for the international community, it helps them evaluate the status of the global response. This piece of strategic information supports the coordination role of the National AIDS Authority in each country and provides the basis for resource allocation and improved strategic planning processes.

Scope of the Assessment

National Aids Spending Assessments typical aims to track the financial flow of funds into and within the country, from the sources to the beneficiary population. This study only focused on tracking financial flows from the sources, the donors. For that reason it has been referred to as a "mini NASA". Nonetheless, data collection covered domestic spending, external aid for HIV /AIDS (including those funds channeled through the government and contributions made by firms in the private sector. However, there was no capture of household out-of-pocket expenditures.

2. Methodology

2.1 Approach

The approach employed in this study was guided by the NASA framework, with some deviation especially pertaining to scope as described above. It is suffice to mention therefore that whereas the NASA methodology for data collection is designed in a way that would allow the reconstruction of the transaction from a financing source, to a financing agent and to the provider of goods and services, in order to avoid double counting and to reflect actual expenditure (goods and services delivered to an intended beneficiary population), the mini assessment instead simply used the

Funding Matrix, (usually the final product NASA studies) as the main data collection tool. As such, no data about the financing agents, providers of goods and services beneficiary populations was collected. Consequently, the study could not produce data sets that could be validated from the perspective of each of three different stakeholders, namely donors, financing agents, and the providers of goods and services.

The main advantages of the adopted approach compared the full NASA framework is that it is economical with resources (time, financial and human resources) while at the same time collecting expenditure data classified according to eight categories of interventions in the fight against AIDS and source of funding, including both government expenditure and international sources.

The other major advantage of the methodology adopted is that like the NASA accounting framework, it is exhaustive, covering entities and expenditures; can be used for periodic reporting, as a result of continuing recording, it is easy to integrate and analyse the data to produce the statutory reports in terms of the United Nations' Core Indicators for Monitoring the 2011 Political Declaration on HIV/AIDS. The major drawback is that renders data validation is almost impossible as there are no corresponding data sets from financing agents and providers.

More importantly, NASA framework requires that the study captures all HIV and AIDS spending according to the priorities or categories found in the National Strategic framework (NSF) and thus allows countries to monitor their own progress towards their goal. In additional, it is not limited to health related spending, but identifies and captures all other spending related to HIV and AIDS, such as social mitigation, legal services, educational and life-skills activities, psychological support, care for Orphans and Vulnerable Children (OVCs), and those efforts aimed at creating a conducive and enabling environment. The adopted approach conformed to the NASA framework in this regard.

Table 1: Process employed in this assessment

Review of Key Documentation	Global AIDS response progress reporting 2012	Namibia NHA NASA report, Jan 2011	NHA methods document, among others
Mapping of Funding Sources	Domestic Public	International	Domestic Private
Meetings with Respondents	Seek support in completing the matrix	Increase awareness of value of Matrix in reporting on Progress	Reach agreement on calculation of national estimates
Data Collection	Face to face meetings	Telephonic	Email/National Funding Matrix(Tool)
Data Analysis	Alignment of respondents data to Namibian FY	Test soundness of assumptions used, including ratios	Recalculation of totals and Quality Assurance
Data Validation	Confirmation of estimates with Technical Coordinators	Further reviews of data & consultations	Certification of national estimates

2.2 Sources of Data

The identified stakeholders were informed in advance about the upcoming data collection activities, and that their cooperation in submitting the requested data on the use of funds and activities carried out on their fight against HIV would be needed. This was done via a letter sent and signed by the Permanent Secretary of the Ministry of Health and Social Services.

The letters included a time-table concerning the deadline for data reporting, and a copy of the data collection form and data collection guide. Further one-on-one meetings were arranged with all the stakeholders, to ensure their full collaboration during the data collection process, and that sufficient time is given to them to collate the data. Data collection was based on interviews with selected institutions delivering services or goods as part of the national response to HIV and AIDS. The forms sent during the preparatory stage were filled with all information available by the institutions, therefore the objective of the interview is to assist the institutions to resolve any questions/doubts concerning the forms to be submitted and to assure a correct filling of the form.
The importance of institutions chosen for interviews in this case were determined in accordance with: Amount of managed funds; Key interventions (ARV, PMTCT, OI treatment, STI treatment, male circumcision and blood banks,) and Key beneficiary populations (e.g. MARPS).

2.3 Data Collection

Data on expenditure for HIV and AIDS was collected using the National Funding Matrix Tool. In a few cases, respondents provided expenditure data in a format other than that prescribed in the National Funding Matrix. Project consultants then entered the data into the National Funding Matrices along with assumptions on allocation of indirect cost rates.

Description of National Funding Matrix Tool

The AIDS Spending National Funding matrix (Annex B) has two basic components: The vertical Comprises AIDS Spending Categories (How funds allocated to the national response are spent) and Financing Sources (Where funds allocated to the national response are obtained). There are eight AIDS Spending categories. Each spending category includes multiple sub-categories. Across the eight spending categories there are a total of 91 sub-categories. It is important to note that all of the spending categories and sub-categories are AIDS-specific; for example, expenditures listed under Enabling Environment and Community Development should only be those that are directly attributable to the AIDS response.

Prevention is the largest category with 22 sub-categories, ranging from voluntary counseling and testing to condom social marketing to blood safety; seven of the remaining eight spending categories have fewer than 10 sub-categories each. The purpose of the categories and sub-categories is to help national governments break out their spending as rationally and consistently as possible. As mentioned above, the matrix was designed to be compatible with common data collection and tracking systems in order to reduce the burden of reporting on national governments.

Financing Sources comprise three major groups: Domestic Public; International and Domestic Private. Similar to the spending categories, each financing source has multiple sub-categories. Public Sources has four sub-categories: Central/National, Sub national, Development Bank Reimbursable (loans) and All Other Public. International Sources has five subcategories: Bilaterals, UN Agencies, Global Fund, Development Bank Grants (Non-reimbursable) and All Other International. Private Sources has two subcategories: Corporations and Consumer/Out-of-Pocket.

2.4 Estimation of some data sets

Data was sometimes not readily available and had to be estimated using proxies. For example, financial records for the Government Ministries and Offices are only kept by "expense type" classification, which is not consistent and detailed enough to be helpful in NASA studies. We therefore, made estimates, which could have been over or under the true value. It was not possible, for example, to allocate some medical supplies received by the health centre's pharmacy to inpatient and out-patient departments, as usage of these items was not specified. These costs were therefore only handled using allocation factors, mainly from studies in other countries. Further, it was not immediately possible to allocate certain items, such as staff costs to certain departments, as their usage between departments was not clearly defined. The same personnel who tended to the inpatient wards, attended to patients at the OPD clinics.

2.5 Double Counting

Correcting for double counting is an important aspect of the data analysis. Double counting occurs when two separate datasets include information relating to the same transaction. For example, consider the following example: Donor A reports in its expenditure submission that N$1,000 was given to Donor X for AIDS Spending. Donor X also completes an AIDS Spending National Funding Matrix and reports that it spent N$1,000 of Donor A's funds on AIDS. This data then is entered into the aggregated datasets. It would appear that N$2,000 was spent on AIDS. However, the same N$1,000 has simply been counted twice. Before aggregation of all datasets, a thorough check was done to ensure there is no double counting.

2.6 Quality Assurance of Data

The Core Working Group, Dr Martin Odiit, M&E Advisior, UNAIDS, helped to review and revise data from the assessment and costing exercises. The few data inconsistencies were reconciled with the Project Consultants and, when necessary, respondents were re-interviewed to clarify any inconsistencies. The Ministry of Health and Social Services also performed a second review of the data and identified potential inconsistencies, which were then addressed where necessary. Finally, a copy of this report was provided to all the stakeholders so that feedback could be addressed.

2.7 Limitations of the Study

Despite the efforts made to collect data from all organisations, some organisations did not respond. These were left out of the NASA, except to the extent that the information could be obtained from the secondary data source.

In the instances where consumption was estimated using number of beneficiaries, there was no estimation of the wastages and losses that naturally occur throughout the distribution channel, thus potentially underestimating the overall cost.

Patient care expenditure constitutes the single largest value contribution to the overall expenditure. The determination of the figure is based on a ratio/percentage that is difficult to determine and has some subjectivity.

Completeness of the private sector data, especially as related to private profit making organisations cannot be vouched for completeness.

Exclusion of household contributions
Data on household contribution to the fight against HIV/AIDS in Namibia was inadequate and has not been included in completing the matrices. Also, because of financial constraints on households brought about by the indirect impacts of the HIV/AIDS epidemic, contributions by households are paltry and cannot significantly change the outcome of the total expenditure on HIV/AIDS for the two fiscal years: 2009/10 – 2010/11.

Legal costs related to AIDS
Legal costs associated with litigation concerning HIV/AIDS related discrimination were not reported by any of the respondents and have therefore not been included in the national Funding Matrices for the two fiscal years.

3. Results of the Mini HIV/AIDS Assessment

3.1 Total Expenditure and Sources of Funding

The average exchange rate with US dollars was 7.8 for 2009/10 and 7.2 for 2010/11.The total expenditure on HIV / AIDS activities for 2009/2010 and 2010/2011 was N$1,889.1 million and N$2,009.1 million respectively. This represents 2.4 percent and 2.3 percent of GDP in 2009/2010 and 2010/2011 respectively. These amounts show a steady increase from the 2007/08 and 2008/09 expenditures (Figure 1).

Figure 1: Total Resource Mobilization

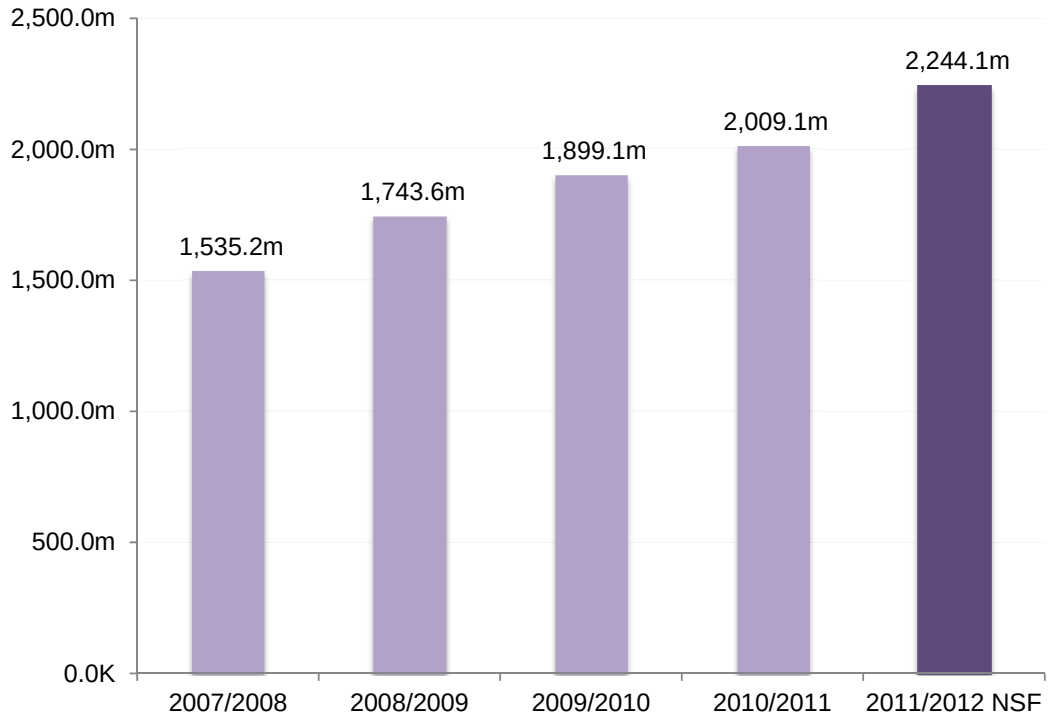


Figure 2 shows that approximately 50.0 percent of the funds were sourced from internally from leaving the other 50.0 percent to be financed through international donor organizations. Funds from international organisations formed 50.2 percent of total spending on HIV and AIDS in 2009/10 and 39.5 percent in 2010/2011; public funds formed 49.7 percent of the total expenditure in 2009/10 whilst in 2010/11 the ratio increased to 60.4 percent. Private sources of funding constituted 0.1 percent in both years respectively. However, as noted, the study did not collect all private (businesses and household, Medical Insurance or individual out-of-pocket) spending on HIV/AIDS – related activities, hence this total from the private sector does not represent their contribution to the total spending on HIV and AIDS in the periods under study. Specifically, what is recorded here is the total private spending from the Namibian Business Coalition against AIDS and Namibia employers Association.

There are no comparative figures from the costing of the latest National Strategic Framework on HIV/AIDS to comment of the adequacy of the mobilized funds. Nonetheless, comparing the total expenditure on HIV and AIDS in 2010/11 and what was projected in the National Strategic Framework for 2011/12 of N$2,244.1 million, there appears to be a need of raising an additional N$240.0 million in 2011/12 to achieve the ideal country response to the epidemic.

Figure 2: Funding by Donor Type

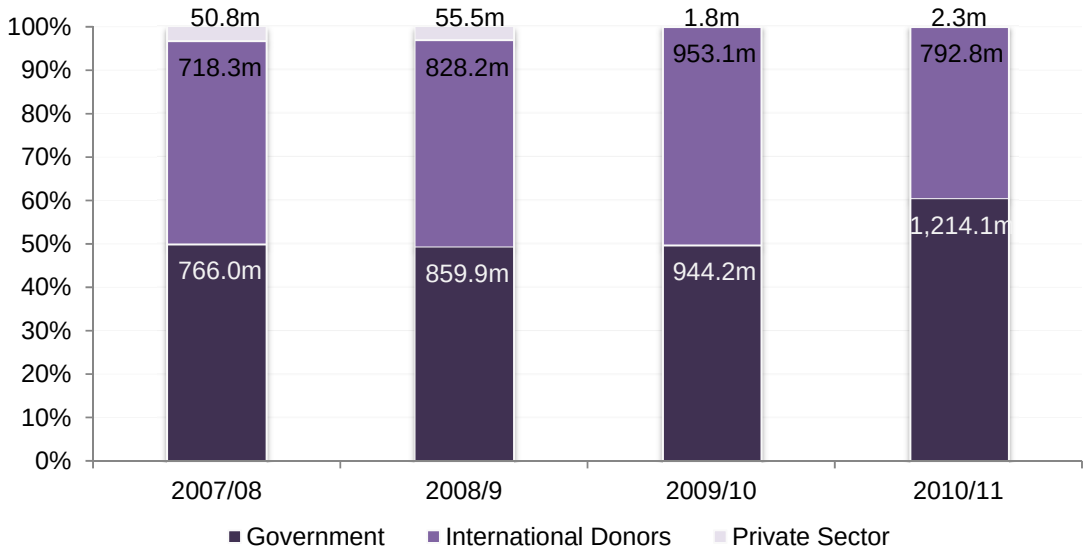


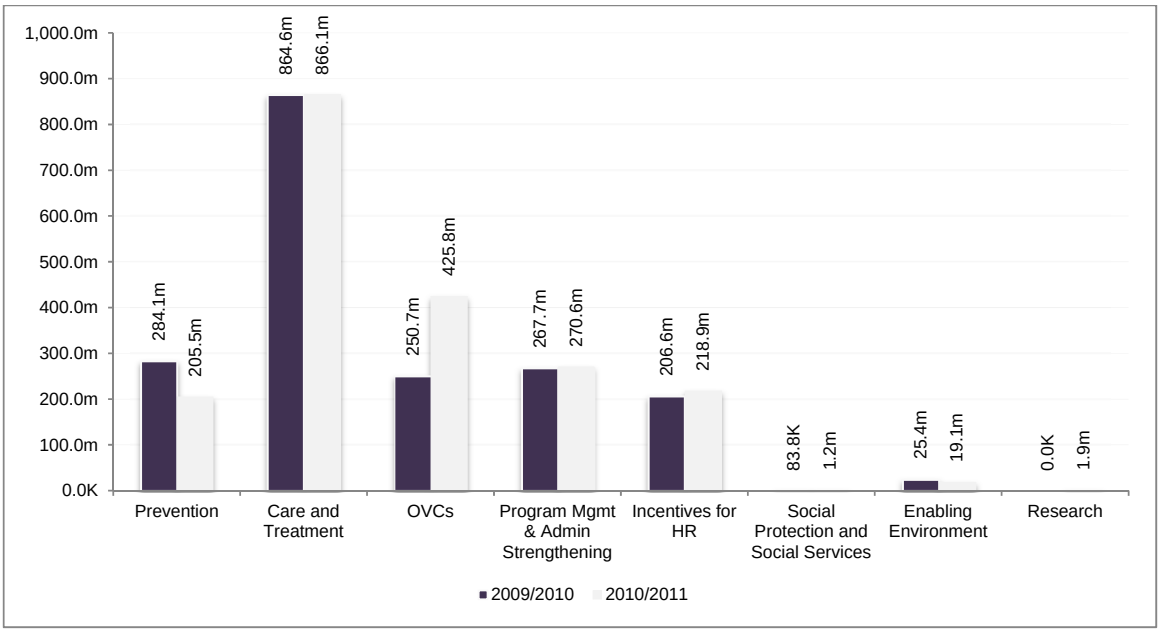
Table 2: List of Institutions Visited and Data Collected on HIV/AIDS Spending

	2009/2010	Contribution	2010/2011	Contribution	% Change
Ministry of Health and Social Services	699.3m	36.8%	791.2m	39.4%	13.1%
Ministry of Gender and Child Welfare	236.0m	12.4%	411.4m	20.5%	74.3%
Ministry of Education	8.9m	0.5%	11.5m	0.6%	29.4%
PEPFAR	681.1m	35.9%	665.1m	33.1%	-2.3%
Global Fund	204.3m	10.8%	67.1m	3.3%	-67.2%
GIZ	2.7m	0.1%	4.0m	0.2%	50.5%
UN Agencies	65.1m	3.4%	56.5m	2.8%	-13.2%
Private Sector	1.8m	0.1%	2.3m	0.1%	30.0%
	1,899.1m		**2,009.1m**		5.8%

3.2 Composition of HIV and AIDS Spending

Figure 3 shows the total spending on the key priority areas of HIV and AIDS in the two periods studied. Most of the funds were spent on treatment and care (45.5 percent in 2009/10 and 43.1 percent in 2010/11); Orphans and Vulnerable Children (13.2 percent in 2009/10 and 21.2 percent in 2010/11); prevention programmes (15.0 percent in 2009/10 and 10.2 percent in 2010/11) and programme management and administrative strengthening (14.1 percent in 2009/10 and 13.5 percent in 2010/11) while 10.9 percent in each year was spent on human resources incentives. The remaining 1.3 percent of the total funds was shared amongst the remaining 3 priority areas, namely Social Protection and Social Services; Enabling Environment and Research.

Figure 3: Total Spending on Key Programmatic Areas



3.3 Key spending Priorities by Funding Agents

In 2009/10, 30.6 percent of funds from International Organisations was channeled towards treatment and care, management and administrative strengthening; whilst another 26.5 percent went into the prevention component and 19.4 percent on Incentives for Human Resources. For Public Sector funds, 63.3 percent was spent on treatment and care; only 3.2% percent on prevention; 11.8 percent on programme management and administrative strengthening; and 21.7 percent on Orphans and Vulnerable Children.

On the part of the private sector, 45.7 percent of the total funding was spent on prevention; 34.3% on programme management and administrative strengthening; 5.7 percent to provide incentives for recruitment and retention of human resources whilst 14 percent was spent on creating enabling environments programme.

Figure 4: Key spending Priorities by Funding Agents 2009/10

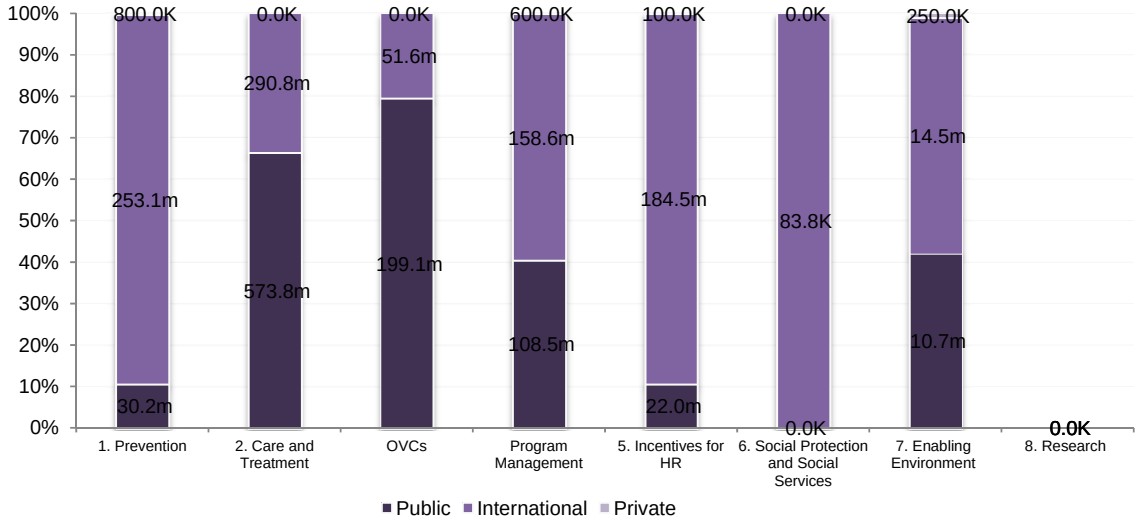
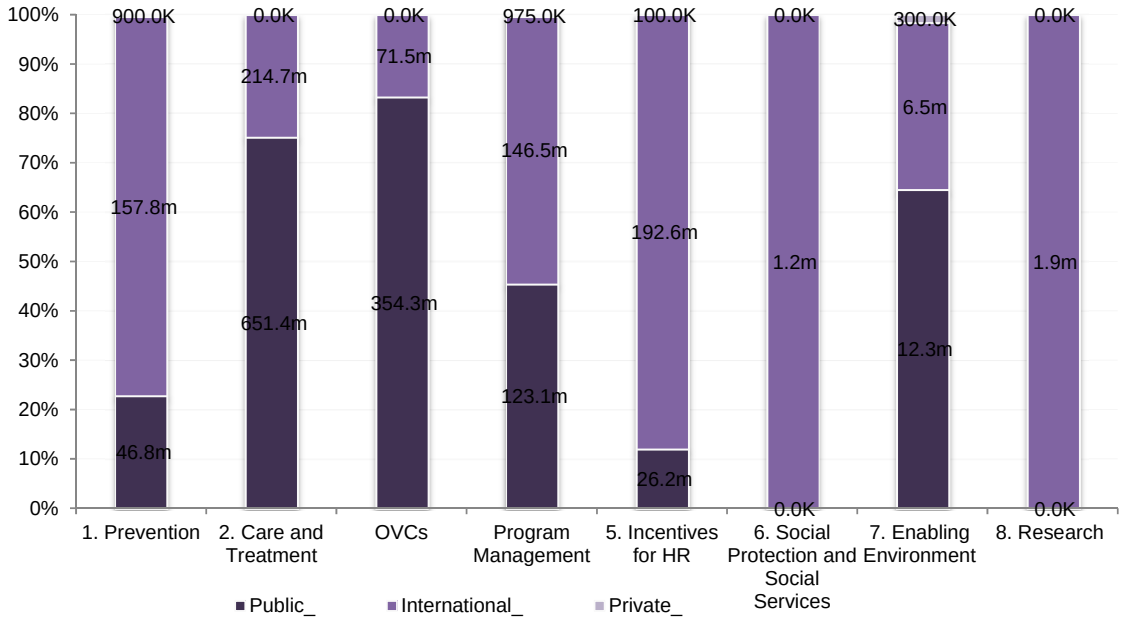


Figure 5: Key spending Priorities by Funding Agents 2010/11

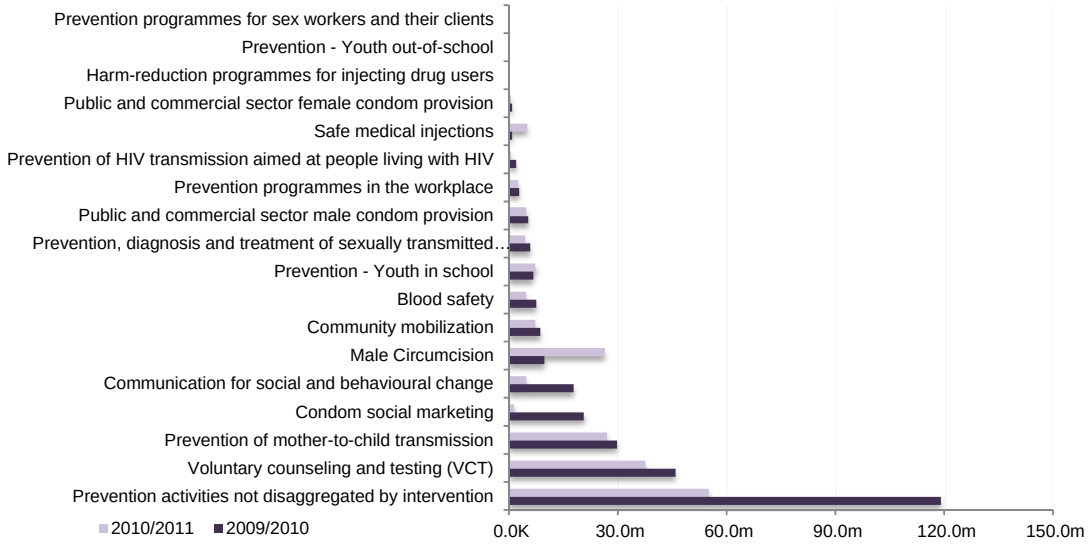


3.4 Prevention Programmes Spending Activities

Prevention remains the cornerstone of the national strategy to overcome the epidemic. However, the trend in spending on prevention is somewhat of concern. Firstly, from 2008/09 to 2009/10, expenditures on prevention declined by 47.4% from N$535.4 million to N$281.8 million. Total expenditures of prevention further declined by 24.1 percent to N$213.9 million in 2010/11. Secondly, 2009/10 figures indicates that prevention activities were funded (90 percent) almost entirely by international organizations. Figure 6 shows which prevention programme areas received funding. From the data collected, 16.3 percent and 17.5 percent of the total spending on prevention

programmes was spent on voluntary counseling and testing, whilst 10.5 percent and 12.6 percent was spent on prevention of mother to child programme in 2009/10 and 2010/11 respectively.

Figure 6: Prevention Programmes Spending Activities



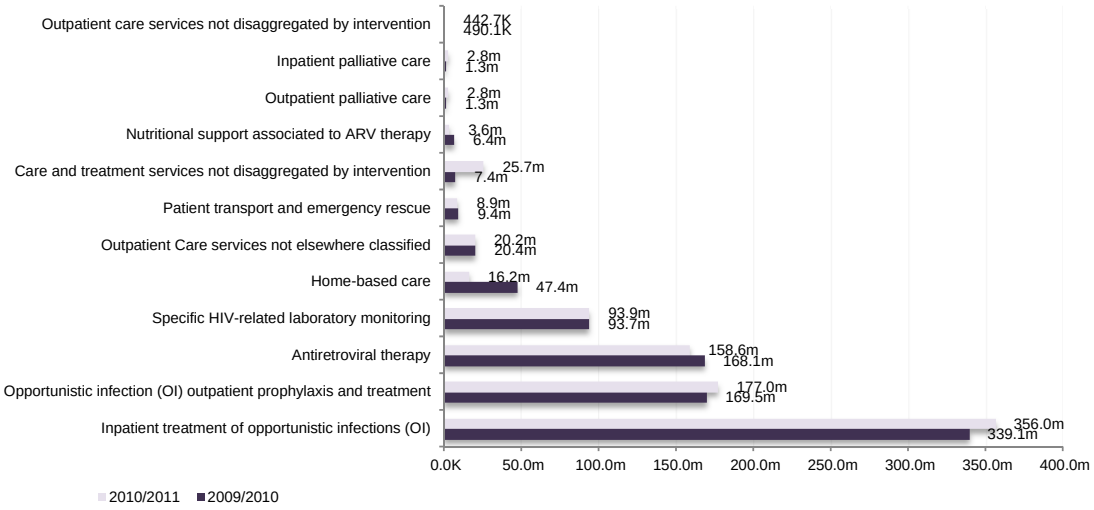
3.5 Treatment and Care Spending Activities

Figure 7 shows the key areas of expenditures in 2009/10 and 2010/11 on treatment and care categories. In 2009/10, total expenditure was N$864.6 million of which 58.5% was spent on outpatient treatment and care while 41.5% was spent in-hospital care. Expenditure on ARVs was about N$168 million or 19.3% of the total expenditure on treatment and care activities. Another 19.2% or N$171.8 million was spent on opportunistic infection outpatient prophylaxis and treatment. Expenditure on in-patient treatment of opportunistic infections was N$343.6 million. This represents about 39.4% of the total expenditure on treatment and care activities.

In 2010/2011, total expenditure was N$866.1 million. The proportion spent at OPD clinics was 54.4% slightly lower than the 58.5% for the previous year. More interesting however is that expenditure on ARVs was about N$158.4 million or 18.1% of the total expenditure on treatment and care activities. This amount neatly compares to N$166.0 million in the National Strategic Framework. Another 20.5% or N$179.3 million was spent on outpatient prophylaxis and treatment. Expenditure on in-patient treatment of opportunistic infections was N$360.7 million. This represents about 41.3% of the total expenditure on treatment and care activities.

The results show that about 66.6 percent of the total expenditure on the treatment and care component was from Public Sector and 33.4 percent from the International Organisations. Total expenditure on home-based care, both non-medical and non-health care was very small, N$47.4 million in 2009/10 and cut to N$16.2 million in 2010/11. There is the need to encourage more funding in this area and also encourage the NGOs and CBOs to be more active in home-based care since they are closer to the communities.

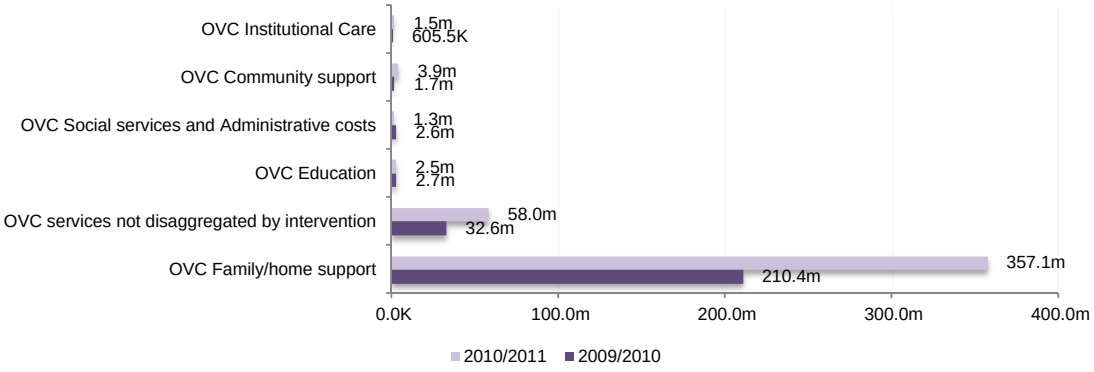
Figure 7: Treatment and Care Spending Activities, 2010



3.6 Spending Activities on Orphans and Vulnerable

The support for activities designed to reduce the economic impact of HIV and AIDS on infected and affected households especially OVCs and other vulnerable groups is a significant objective of the Government. Out of all programmatic areas expenditures on OVCs saw the highest increase. Although total expenditures on OVCs declined by 21.9 percent from N$350 million in 2008/09 to N$250.7 million in 2009/10, it increased by 69.9 percent to N$425.8 million in 2010/11. Expenditure on OVCs formed 13.4 percent and 21.4 percent of total spending on HIV and AIDS related activities in 2009/10 and 2010/11 respectively. Of the total expenditure on OVCs in 2010/11, 83.9 percent was spent on family and household support in the form of grants, 0.55 percent on education while about 13.6 percent could not be desegregated by the respondents (Figure 8).

Figure 8: Total Spending on OVCs



Social protection efforts remain yet to be scaled-up to mitigate the socio-economic effects of the epidemic. In 2009/10, none of the major donors covered in this study reported expenditures on social protection and social services (Table 2). In 2010/11, UNICEF reported expenditures amounting to N$1.1 million on social protection through monetary benefits. This refers to

conditional or unconditional financial support, such as grants and cash transfers (including child social assistance grants, foster care grants, disability grants, "medical pensions", early retirement and disability benefits for people living with HIV, or family members).

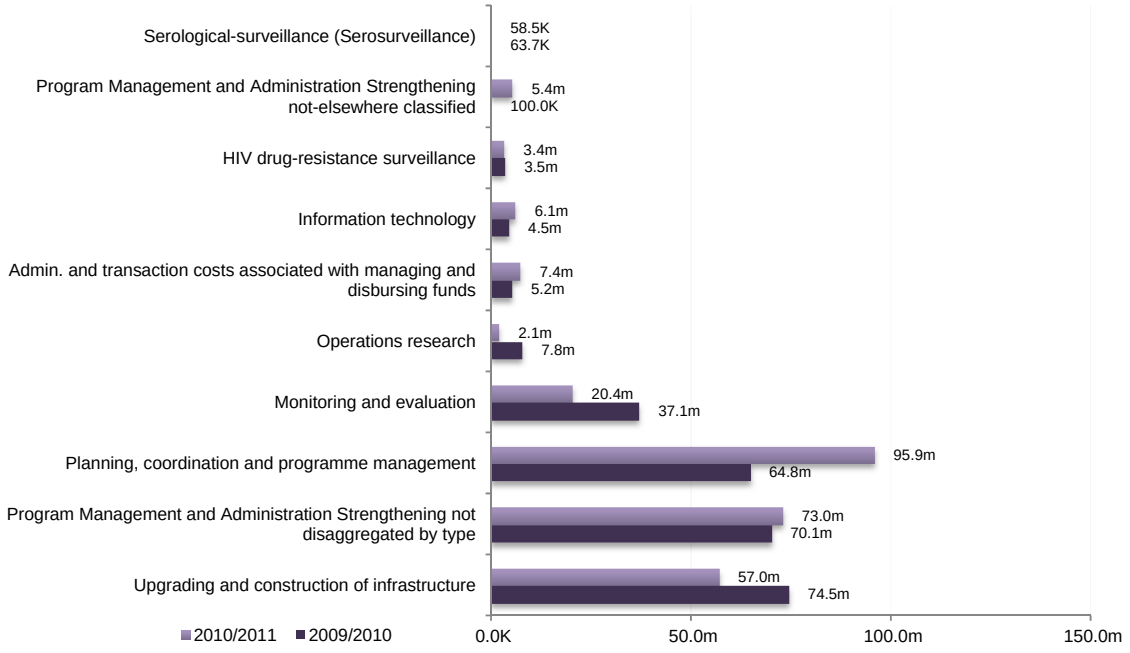
Table 2: Spending on Social Protection and Social Services (excluding OVCs)

	2009/2010	2010/2011
Social protection through monetary benefits	-	1,128,100.00
Social protection through in-kind benefits	-	-
Social protection through provision of social services	83,844.00	59,247.00
HIV-specific income generation projects	-	-
Social protection services and social services not disaggregated	-	-
Social protection services and social services not elsewhere classified	-	-
Grand Total	**83,844.00**	**1,187,347.00**

3.7 Programme Management and Administrative Strengthening.

Coordinating and managing the expanded and decentralized response to the HIV and AIDS epidemic involves diverse and complex processes including joint planning, resource mobilization monitoring, among others. In 2009/10, about N$267.4 million was spent in managing programmes. In 2010/11 this amount increased to N$269.7 million. A significant portion, about 24.6 percent and 35.6 percent was spent directly on planning and coordination, 13.8 percent and 8.1 percent on Monitoring and evaluation and about 27.9 percent and 21.1 percent on upgrading and construction of infrastructure in 2009/10 and 2010/11 respectively (Table 8). Monitoring and Evaluation of HIV and AIDS – related activities is receiving a fair share and therefore appears to be taken seriously. Indeed, without a good M&E system, it will be difficult to assess the progress and redirect resources to areas that need more attention.

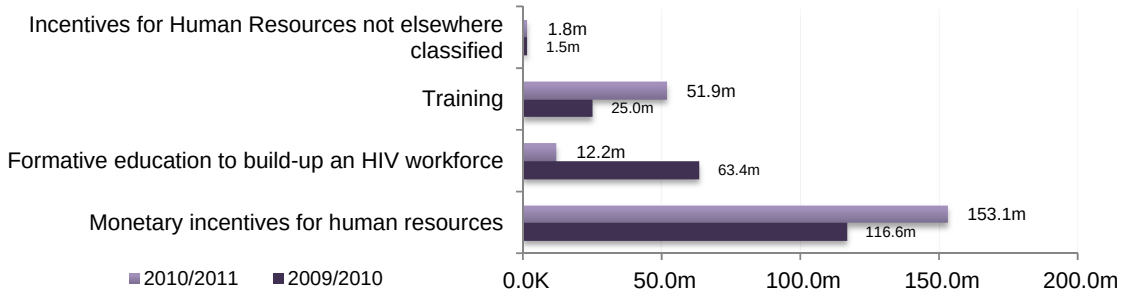
Figure 9: Programme Management Spending Activities



3.8 Human Resources and Retention Incentives

The success of any programme depends on an effective and reliable workforce. Several initiatives have been undertaken to recruit more workers and encourage those already in the system to give off their best. In 2009/10, about N$184.0 million was spent on human resources recruitment and retention incentives, (63.1 percent and 78.7 percent) of which was channeled as monetary incentives for HIV/AIDS staff, (34.5 percent and 6.3 percent) supported formative education to build-up an HIV workforce in 2009/10 and 2010/11 respectively (Table 9). Training was as low as 1.6 percent in 2009/2010 but increased to 14.1 percent of the total human resources and Retention Incentives.

Figure 10: Human Resources Recruitment and Retention Incentives Spending Activities



3.9 Enabling Environment and Community Development

The key role of creating an enabling environment which includes the enforcement of laws and non-discriminatory practices in all spheres of the society cannot be over-emphasized. In 2009/2010, about N$363.4 million was spent on activities in this area (Figure 11). In 2010/11, this amount was scaled down by N$100.9 million to N$262.5 million, of which 78.3 percent was spent on Advocacy. The share of Advocacy activities in the 2009/10 expenditures was 78.2 percent. Other Enabling Environment Activities receiving funding were AIDS-specific programmes focused on women 12.6 percent and 14.3 percent in 2009/10 and 2010/11 respectively.

Figure 11: Enabling Environment and Community Development

3.10 HIV and AIDS-related Research

High quality data from research on HIV and AIDS – related issues helps the process of fine-tuning programmes and also serves as vital tool for monitoring and evaluation. In 2009/10, the NASA

study captured no expenditures for research, which includes biomedical, vaccine –related, clinical and epidemiological research. Most of this research is often multi-disciplinary in nature, cutting across some aspects of behavioral, social and economic issues. They also encourage capacity strengthening efforts to ensure the sustainability of ongoing programmes. In 2010/11, N$3.5 million was spent on Social Science related research while another N$1.1 could not be dissegregated on any of the sub-categories described above bringing the total to N$4.7 million.

4. Conclusions and Recommendations

Key Findings and Conclusions

General budget support in Namibia consists of a programme of non-earmarked financial support to the government's public expenditure programme involving multiple donors and multi-year indicative commitments. The overall objective of AIDS budget support is to contribute to the achievement of the government's health and social programme and to halt and reverse the AIDS epidemic through policies set out according to its priorities.

Donor funding withdrawal is visibly noticeable across the key programmatic areas in both 2009/10 and 2010/11. While government funding appears to have increased, partly due to international donor gradual withdrawal, it is also obvious the spending had to increase in line with increasing number of people on ART.

Alignment and Harmonization of Government and other Stakeholder Efforts
Various platforms are in place: The Global Fund meets with the Project Management Unit (PMU) and sub recipients to deliberate on action plans and reporting requirements and mechanisms. PEPFAR discusses U.S. government assistance with partners to ensure that investments are well coordinated and aligned with country priorities for sustainable improvements in health.

However, current systems for recording HIV/AIDS expenditure within government require some attention. Data was sometimes not readily available and had to be estimated using proxies. For example, financial records are only kept by "expense type" classification, which is not consistent and detailed enough to be helpful in NASA studies. We therefore, made estimates, which could have been over or under the true value. It was not possible, for example, to allocate some medical supplies received by the health centre's pharmacy to inpatient and out-patient departments, as usage of these items was not specified. These costs were therefore only handled using allocation factors, mainly from studies in other countries. Further, it was not immediately possible to allocate certain items, such as staff costs to certain departments, as their usage between departments was not clearly defined. The same personnel who tended to the inpatient wards, attended to patients at the OPD clinics.

According to PPHRD, the motivation now is to pursue program budgeting, first as a pilot in three to four regions and later be rolled-out on a national scale. It is strongly believed that program budgeting could allow for identification of broad expenditure categories across diseases, including AIDS. The hope is that these broad categories can later be connected to the Integrated Financial Management System (IFMS) in the 2011/2012 fiscal cycle. The pilot will assist in PPHRD to learn of challenges and priorities when the project is later rolled out nationally.

Recommendations
While significant progress has been made in HIV/AIDS programming, a national system to help measure HIV/AIDS expenditures in detail has not emerged. Lack of a resource-tracking system that monitors the annual flow of funds used to finance the full continuum of HIV/AIDS activities impedes a rapid collection, analysis and aggregation of expenditures to inform the Multisectoral perspective on HIV/AIDS. For this reason, multiple challenges could be experienced when attempting to undertake a comprehensive resource gap estimation for HIV/AIDS; Monitoring of financial implementation of national strategic plans for HIV/AIDS; Re-allocation of funds in the strategic planning cycle for HIV/AIDS, and Reporting on the financial indicators used to monitor the progress made towards the goals of the Declaration of Commitment on HIV/AIDS.

Given these circumstances, it is recommended that relevant agencies of the Government of the Republic of Namibia consider establishing a well coordinated, useful and reliable national expenditure tracking system from which reports on AIDS spending can be determined, for example, by the 8 main categories and sub categories as identified in the National Funding Matrix Tool. Also,

existence of such a tracking system could lead to the production of other detailed expenditure reports for universal application.

Commission a costing study
The study (based on Activity Based Costing (ABC) can be applied to a large spectrum of HIV/AIDS programs and interventions. Such a study will help ensure that the selected interventions to the national AIDS response are realistic and affordable, and can provide vital information to those managing and monitoring the strategy's implementation. Benefits to be realized from such a study include the possibility of addressing program-specific information needs of aid agencies, program designers and implementers; the establishment of a basis for cost comparisons among programs, interventions and activities.

Training on AIDS Spending National Funding Matrices for AIDS Budget Partners
Given the many technical questions paused by partners on the National Funding Matrices for 2009/10 and 2010/11, it is recommend that training workshops be organized in order to equip HIV/AIDS budget partners on the Tool which they are likely to use in upcoming fiscal years to report on Indicator 6.1. Moreover, the training workshops can also be an experience sharing forum where AID Budget partners from government agencies and different organisations can share their expenditure tracking systems and methods, including strengths, weaknesses, opportunities and possible threats to aggregation of HI/AIDS expenditures.

Database
While completion and use of a national database at the National Planning Commission could help track and manage the sums of donor money coming into Namibia, the database is unlikely to provide information on duplication of efforts - possibly by NGO's/Civil Societies in HIV/AIDS program implementation in the 13 regions. A good practice would be to know which organisation is implementing what activities in each district/geographical space and its proportion of contribution in meeting national HIV/AIDS targets.

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Annex II: National Funding Matrix, AIDS Spending Categories

AIDS Spending Categories 2009/2010	TOTAL (Local Currency)	Sub-Total Public	Central / National	Sub-Total International	Bilaterals	UN Agencies	Global Fund	Private Sub-Total	All Other Private		Public	International	Private
TOTAL (Local Currency - N$) (Av. Exch.rate: 1US$ to 7.8N$)													
1. Prevention (sub-total)	**284,125,932**	**30,198,822**	**30,198,822**	**253,127,110**	**170,841,443**	**32,347,602**	**49,938,065**	**800,000**	**800,000**		**30,198,822**	**253,127,110**	**800,000**
1.01 Communication for social and behavioural change	17,769,219	1,070,152	1,070,152	16,699,067	651,274	4,293,105	11,754,688	-	-		1,070,152	16,699,067	-
1.02 Community mobilization	8,715,774	-	-	8,715,774	-	7,055,485	1,660,289	-	-		-	8,715,774	-
1.03 Voluntary counseling and testing (VCT)	45,856,330	-	-	45,356,330	34,874,493	112,000	10,369,838	500,000	500,000		-	45,356,330	500,000
1.04 Risk-reduction for vulnerable and accessible populations	-	-	-	-	-	-	-	-	-		-	-	-
1.05. Prevention - Youth in school	6,906,117	-	-	6,906,117	-	6,906,117	-	-	-		-	6,906,117	-
1.06 Prevention - Youth out-of-school	50,000	-	-	50,000	-	50,000	-	-	-		-	50,000	-
1.07 Prevention of HIV transmission aimed at people living with HIV	2,078,490	-	-	2,078,490	-	2,078,490	-	-	-		-	2,078,490	-
1.08 Prevention programmes for sex workers and their clients	41,520	-	-	41,520	-	41,520	-	-	-		-	41,520	-
1.09 Programmes for men who have sex with men	-	-	-	-	-	-	-	-	-		-	-	-
1.10 Harm-reduction programmes for injecting drug users	173,000	-	-	173,000	-	173,000	-	-	-		-	173,000	-
1.11 Prevention programmes in the workplace	2,951,791	-	-	2,651,791	432,400	2,219,391	-	300,000	300,000		-	2,651,791	300,000
1.12 Condom social marketing	20,766,593	-	-	20,766,593	-	-	20,766,593	-	-		-	20,766,593	-
1.13 Public and commercial sector male condom provision	5,359,486	-	-	5,359,486	5,359,486	-	-	-	-		-	5,359,486	-
1.14 Public and commercial sector female condom provision	865,000	-	-	865,000	-	865,000	-	-	-		-	865,000	-
1.15 Microbicides	-	-	-	-	-	-	-	-	-		-	-	-
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	6,045,746	6,045,746	6,045,746	-	-	-	-	-	-		6,045,746	-	-
1.17 Prevention of mother-to-child transmission	29,675,757	1,455,991	1,455,991	28,219,766	18,709,847	4,123,262	5,386,657	-	-		1,455,991	28,219,766	-
1.18 Male Circumcision	9,740,413	6,014,742	6,014,742	3,725,671	3,440,671	285,000	-	-	-		6,014,742	3,725,671	-
1.19 Blood safety	7,595,853	1,036,039	1,036,039	6,559,814	3,087,075	3,472,739	-	-	-		1,036,039	6,559,814	-
1.20 Safe medical injections	919,884	-	-	919,884	919,884	-	-	-	-		-	919,884	-
1.21 Universal precautions	-	-	-	-	-	-	-	-	-		-	-	-
1.22 Post-exposure prophylaxis	-	-	-	-	-	-	-	-	-		-	-	-
1.98 Prevention activities not disaggregated by intervention	118,614,960	14,576,153	14,576,153	104,038,807	103,366,313	672,494	-	-	-		14,576,153	104,038,807	-
1.99 Prevention activities not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
2. Care and Treatment (sub-total)	**864,586,557**	**573,786,973**	**573,786,973**	**290,799,584**	**183,883,938**	**1,972,535**	**104,943,111**	**-**	**-**		**573,786,973**	**290,799,584**	**-**
2.01 Outpatient care (sub-total)	**507,369,005**	**225,279,894**	**225,279,894**	**282,089,111**	**177,007,801**	**138,198**	**104,943,111**	**-**	**-**		225,279,894	282,089,111	-
2.01.01 Provider- initiated testing and counseling	-	-	-	-	-	-	-	-	-		-	-	-
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	169,540,935	169,540,935	169,540,935	-	-	-	-	-	-		169,540,935	-	-
2.01.03 Antiretroviral therapy	168,089,831	17,951,303	17,951,303	150,138,529	74,405,849	127,498	75,605,181	-	-		17,951,303	150,138,529	-
2.01.04 Nutritional support associated to ARV therapy	6,425,015	-	-	6,425,015	6,425,015	-	-	-	-		-	6,425,015	-
2.01.05 Specific HIV-related laboratory monitoring	93,720,644	18,582,468	18,582,468	75,138,175	75,138,175	-	-	-	-		18,582,468	75,138,175	-
2.01.06 Dental programmes for PLHIV	-	-	-	-	-	-	-	-	-		-	-	-
2.01.07 Psychological treatment and support services	-	-	-	-	-	-	-	-	-		-	-	-
2.01.08 Outpatient palliative care	1,340,472	-	-	1,340,472	1,340,472	-	-	-	-		-	1,340,472	-
2.01.09 Home-based care	47,364,876	-	-	47,364,876	18,016,246	10,700	29,337,930	-	-		-	47,364,876	-
2.01.10 Traditional medicine and informal care and treatment services	-	-	-	-	-	-	-	-	-		-	-	-
2.01.98 Outpatient care services not disaggregated by intervention	490,124	-	-	490,124	490,124	-	-	-	-		-	490,124	-
2.01.99 Outpatient Care services not elsewhere classified	20,397,108	19,205,187	19,205,187	1,191,920	1,191,920	-	-	-	-		19,205,187	1,191,920	-
2.02 In-patient care (sub-total)	**357,217,552**	**348,507,080**	**348,507,080**	**8,710,473**	**6,876,136**	**1,834,336**	**-**	**-**	**-**		348,507,080	8,710,473	-
2.02.01 Inpatient treatment of opportunistic infections (OI)	339,081,870	339,081,870	339,081,870	-	-	-	-	-	-		339,081,870	-	-
2.02.02 Inpatient palliative care	1,340,472	-	-	1,340,472	1,340,472	-	-	-	-		-	1,340,472	-
2.02.98 Inpatient care services not disaggregated by intervention	-	-	-	-	-	-	-	-	-		-	-	-
2.02.99 In-patient services not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
2.03 Patient transport and emergency rescue	9,425,210	9,425,210	9,425,210	-	-	-	-	-	-		9,425,210	-	-
2.98 Care and treatment services not disaggregated by intervention	7,370,001	-	-	7,370,001	5,535,664	1,834,336	-	-	-		-	7,370,001	-
2.99 Care and treatment services not-elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-

3. Orphans and Vulnerable Children (sub-total)	**250,650,758**	**199,080,783**	**199,080,783**	**51,569,975**	**32,577,917**	**9,506,846**	**9,485,212**	**-**	**-**		**199,080,783**	**51,569,975**	**-**
3.01 OVC Education	2,720,846	-	-	2,720,846	-	2,720,846	-	-	-		-	2,720,846	-
3.02 OVC Basic health care	-	-	-	-	-	-	-	-	-		-	-	-
3.03 OVC Family/home support	210,395,995	199,080,783	199,080,783	11,315,212	-	1,830,000	9,485,212	-	-		199,080,783	11,315,212	-
3.04 OVC Community support	1,730,000	-	-	1,730,000	-	1,730,000	-	-	-		-	1,730,000	-
3.05 OVC Social services and Administrative costs	2,620,500	-	-	2,620,500	-	2,620,500	-	-	-		-	2,620,500	-
3.06 OVC Institutional Care	605,500	-	-	605,500	-	605,500	-	-	-		-	605,500	-
3.98 OVC services not disaggregated by intervention	32,577,917	-	-	32,577,917	32,577,917	-	-	-	-		-	32,577,917	-
3.99 OVC services not-elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
4. Program Management and Administration Strengthening (sub-total)	**267,712,962**	**108,467,674**	**108,467,674**	**158,645,288**	**116,367,996**	**14,392,249**	**27,885,043**	**600,000**	**600,000**		**108,467,674**	**158,645,288**	**600,000**
4.01 Planning, coordination and programme management	64,795,549	39,398,306	39,398,306	25,197,243	17,664,760	4,931,234	2,601,249	200,000	200,000		39,398,306	25,197,243	200,000
4.02 Admin. and transaction costs associated with managing and disbursing funds	5,243,478	1,070,152	1,070,152	3,873,325	380,480	3,492,846	-	300,000	300,000		1,070,152	3,873,325	300,000
4.03 Monitoring and evaluation	37,070,394	4,280,610	4,280,610	32,689,785	23,908,576	735,113	8,046,095	100,000	100,000		4,280,610	32,689,785	100,000
4.04 Operations research	7,838,314	-	-	7,838,314	120,000	1,226,186	6,492,128	-	-		-	7,838,314	-
4.05 Serological-surveillance (Serosurveillance)	63,749	-	-	63,749	-	63,749	-	-	-		-	63,749	-
4.06 HIV drug-resistance surveillance	3,529,624	-	-	3,529,624	-	3,529,624	-	-	-		-	3,529,624	-
4.07 Drug supply systems	-	-	-	-	-	-	-	-	-		-	-	-
4.08 Information technology	4,508,281	-	-	4,508,281	4,444,532	63,749	-	-	-		-	4,508,281	-
4.09 Patient tracking	-	-	-	-	-	-	-	-	-		-	-	-
4.10 Upgrading and construction of infrastructure	74,464,177	63,718,606	63,718,606	10,745,571	-	-	10,745,571	-	-		63,718,606	10,745,571	-
4.11 Mandatory HIV testing (not VCT)	-	-	-	-	-	-	-	-	-		-	-	-
4.98 Program Management and Administration Strengthening not	70,099,395	-	-	70,099,395	69,849,648	249,747	-	-	-		-	70,099,395	-
4.99 Program Management and Administration Strengthening not-elsewhere	100,000	-	-	100,000	-	100,000	-	-	-		-	100,000	-
5. Incentives for human resources (sub-total)	**206,562,827**	**22,004,014**	**22,004,014**	**184,458,813**	**178,849,621**	**3,088,230**	**2,520,962**	**100,000**	**100,000**		**22,004,014**	**184,458,813**	**100,000**
5.01 Monetary incentives for human resources	116,632,534	-	-	116,632,534	112,892,572	1,219,000	2,520,962	-	-		-	116,632,534	-
5.02 Formative education to build-up an HIV workforce	63,407,810	-	-	63,407,810	63,407,810	-	-	-	-		-	63,407,810	-
5.03 Training	25,022,483	22,004,014	22,004,014	2,918,470	2,549,240	369,230	-	100,000	100,000		22,004,014	2,918,470	100,000
5.98 Incentives for Human Resources not specified by kind	-	-	-	-	-	-	-	-	-		-	-	-
5.99 Incentives for Human Resources not elsewhere classified	1,500,000	-	-	1,500,000	-	1,500,000	-	-	-		-	1,500,000	-
6. Social Protection and Social Services (excluding OVC) (sub-total)	**83,844**	**-**	**-**	**83,844**	**-**	**83,844**	**-**	**-**	**-**		**-**	**83,844**	**-**
6.01 Social protection through monetary benefits	-	-	-	-	-	-	-	-	-		-	-	-
6.02 Social protection through in-kind benefits	-	-	-	-	-	-	-	-	-		-	-	-
6.03 Social protection through provision of social services	83,844	-	-	83,844	-	83,844	-	-	-		-	83,844	-
6.04 HIV-specific income generation projects	-	-	-	-	-	-	-	-	-		-	-	-
6.98 Social protection services and social services not disaggregated by type	-	-	-	-	-	-	-	-	-		-	-	-
6.99 Social protection services and social services not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
7. Enabling Environment (sub-total)	**25,399,190**	**10,694,000**	**10,694,000**	**14,455,190**	**1,246,380**	**3,715,622**	**9,493,188**	**250,000**	**250,000**		**10,694,000**	**14,455,190**	**250,000**
7.01 Advocacy	10,741,319	-	-	10,491,319	60,000	2,796,143	7,635,176	250,000	250,000		-	10,491,319	250,000
7.02 Human rights programmes	141,419	-	-	141,419	-	141,419	-	-	-		-	141,419	-
7.03 AIDS-specific institutional development	2,257,231	-	-	2,257,231	257,800	141,419	1,858,012	-	-		-	2,257,231	-
7.04 AIDS-specific programmes focused on women	430,602	-	-	430,602	-	430,602	-	-	-		-	430,602	-
7.05 Programmes to reduce Gender Based Violence	10,800,141	10,694,000	10,694,000	106,141	-	106,141	-	-	-		10,694,000	106,141	-
7.98 Enabling Environment and Community Development not disaggregated by type	928,580	-	-	928,580	928,580	-	-	-	-		-	928,580	-
7.99 Enabling Environment and Community Development not elsewhere classified	99,899	-	-	99,899	-	99,899	-	-	-		-	99,899	-
8. Research excluding operations research which is included under (sub-total)	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**		**-**	**-**	**-**
8.01 Biomedical research	-	-	-	-	-	-	-	-	-		-	-	-
8.02 Clinical research	-	-	-	-	-	-	-	-	-		-	-	-
8.03 Epidemiological research	-	-	-	-	-	-	-	-	-		-	-	-
8.04 Social science research	-	-	-	-	-	-	-	-	-		-	-	-
8.05 Vaccine-related research	-	-	-	-	-	-	-	-	-		-	-	-
8.98 Research not disaggregated by type	-	-	-	-	-	-	-	-	-		-	-	-
8.99 Research not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
TOTAL	**1,899,122,069**	**944,232,266**	**944,232,266**	**953,139,803**	**683,767,295**	**65,106,927**	**204,265,581**	**1,750,000**	**1,750,000**				

AIDS Spending Categories 2010/2011	TOTAL (Local Currency)	Sub-Total Public	Central / National	Sub-Total International	Bilaterals	UN Agencies	Global Fund	Private Sub-Total	All Other Private		Public	International	Private
TOTAL (Local Currency - N$) (Av. Exch.rate: 1US$ to 7.2N$)											**Public**	**International**	**Private**
1. Prevention (sub-total)	**205,545,236**	**46,832,979**	**46,832,979**	**157,812,257**	**123,851,890**	**20,031,631**	**13,928,737**	**900,000**	**900,000**		**46,832,979**	**157,812,257**	**900,000**
1.01 Communication for social and behavioural change	4,741,347	1,269,719	1,269,719	3,471,629	679,288	2,327,674	464,666	-	-		1,269,719	3,471,629	-
1.02 Community mobilization	7,244,527	-	-	7,244,527	-	1,867,716	5,376,810	-	-		-	7,244,527	-
1.03 Voluntary counseling and testing (VCT)	37,411,125	-	-	36,911,125	34,275,053	23,385	2,612,687	500,000	500,000		-	36,911,125	500,000
1.04 Risk-reduction for vulnerable and accessible populations	-	-	-	-	-	-	-	-	-		-	-	-
1.05. Prevention - Youth in school	7,482,450	-	-	7,482,450	-	7,482,450	-	-	-		-	7,482,450	-
1.06 Prevention - Youth out-of-school	60,000	-	-	60,000	-	60,000	-	-	-		-	60,000	-
1.07 Prevention of HIV transmission aimed at people living with HIV	808,742	-	-	808,742	-	808,742	-	-	-		-	808,742	-
1.08 Prevention programmes for sex workers and their clients	131,873	-	-	131,873	-	131,873	-	-	-		-	131,873	-
1.09 Programmes for men who have sex with men	-	-	-	-	-	-	-	-	-		-	-	-
1.10 Harm-reduction programmes for injecting drug users	-	-	-	-	-	-	-	-	-		-	-	-
1.11 Prevention programmes in the workplace	2,601,857	-	-	2,201,857	1,663,000	538,857	-	400,000	400,000		-	2,201,857	400,000
1.12 Condom social marketing	1,570,089	-	-	1,570,089	-	-	1,570,089	-	-		-	1,570,089	-
1.13 Public and commercial sector male condom provision	4,970,762	4,270,000	4,270,000	700,762	700,762	-	-	-	-		4,270,000	700,762	-
1.14 Public and commercial sector female condom provision	778,000	-	-	778,000	-	778,000	-	-	-		-	778,000	-
1.15 Microbicides	-	-	-	-	-	-	-	-	-		-	-	-
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	4,655,615	4,655,615	4,655,615	-	-	-	-	-	-		4,655,615	-	-
1.17 Prevention of mother-to-child transmission	26,857,938	1,722,805	1,722,805	25,135,133	17,738,028	3,492,621	3,904,484	-	-		1,722,805	25,135,133	-
1.18 Male Circumcision	26,323,036	18,847,766	18,847,766	7,475,270	7,451,885	23,385	-	-	-		18,847,766	7,475,270	-
1.19 Blood safety	4,823,025	945,106	945,106	3,877,919	2,298,190	1,579,729	-	-	-		945,106	3,877,919	-
1.20 Safe medical injections	5,015,506	-	-	5,015,506	5,015,506	-	-	-	-		-	5,015,506	-
1.21 Universal precautions	-	-	-	-	-	-	-	-	-		-	-	-
1.22 Post-exposure prophylaxis	-	-	-	-	-	-	-	-	-		-	-	-
1.98 Prevention activities not disaggregated by intervention	54,947,378	-	-	54,947,378	54,030,179	917,199	-	-	-		-	54,947,378	-
1.99 Prevention activities not elsewhere classified	15,121,968	15,121,968	15,121,968	-	-	-	-	-	-		15,121,968	-	-
2. Care and Treatment (sub-total)	**866,105,183**	**651,355,858**	**651,355,858**	**214,749,325**	**187,303,685**	**571,908**	**26,873,732**	**-**	**-**		**651,355,858**	**214,749,325**	**-**
2.01 Outpatient care (sub-total)	**472,749,147**	**286,506,386**	**286,506,386**	**186,242,761**	**159,252,103**	**116,925**	**26,873,732**	**-**	**-**		**286,506,386**	**186,242,761**	**-**
2.01.01 Provider- initiated testing and counseling	-	-	-	-	-	-	-	-	-		-	-	-
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	176,996,293	176,213,136	176,213,136	783,157	-	-	783,157	-	-		176,213,136	783,157	-
2.01.03 Antiretroviral therapy	158,579,198	75,853,839	75,853,839	82,725,359	59,860,224	116,925	22,748,210	-	-		75,853,839	82,725,359	-
2.01.04 Nutritional support associated to ARV therapy	3,614,587	-	-	3,614,587	3,614,587	-	-	-	-		-	3,614,587	-
2.01.05 Specific HIV-related laboratory monitoring	93,925,088	14,276,788	14,276,788	79,648,301	79,648,301	-	-	-	-		14,276,788	79,648,301	-
2.01.06 Dental programmes for PLHIV	-	-	-	-	-	-	-	-	-		-	-	-
2.01.07 Psychological treatment and support services	-	-	-	-	-	-	-	-	-		-	-	-
2.01.08 Outpatient palliative care	2,800,699	-	-	2,800,699	2,800,699	-	-	-	-		-	2,800,699	-
2.01.09 Home-based care	16,227,922	-	-	16,227,922	12,885,557	-	3,342,365	-	-		-	16,227,922	-
2.01.10 Traditional medicine and informal care and treatment services	-	-	-	-	-	-	-	-	-		-	-	-
2.01.98 Outpatient care services not disaggregated by intervention	442,735	-	-	442,735	442,735	-	-	-	-		-	442,735	-
2.01.99 Outpatient Care services not elsewhere classified	20,162,624	20,162,624	20,162,624	-	-	-	-	-	-		20,162,624	-	-
2.02 In-patient care (sub-total)	**393,356,035**	**364,849,472**	**364,849,472**	**28,506,564**	**28,051,582**	**454,982**	**-**	**-**	**-**		**364,849,472**	**28,506,564**	**-**
2.02.01 Inpatient treatment of opportunistic infections (OI)	355,986,133	355,986,133	355,986,133	-	-	-	-	-	-		355,986,133	-	-
2.02.02 Inpatient palliative care	2,800,699	-	-	2,800,699	2,800,699	-	-	-	-		-	2,800,699	-
2.02.98 Inpatient care services not disaggregated by intervention	-	-	-	-	-	-	-	-	-		-	-	-
2.02.99 In-patient services not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
2.03 Patient transport and emergency rescue	8,863,339	8,863,339	8,863,339	-	-	-	-	-	-		8,863,339	-	-
2.98 Care and treatment services not disaggregated by intervention	25,705,865	-	-	25,705,865	25,250,882	454,982	-	-	-		-	25,705,865	-
2.99 Care and treatment services not-elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
3. Orphans and Vulnerable Children (sub-total)	**425,787,694**	**354,257,130**	**354,257,130**	**71,530,564**	**57,953,015**	**10,840,571**	**2,736,978**	**-**	**-**		**354,257,130**	**71,530,564**	**-**
3.01 OVC Education	2,452,465	-	-	2,452,465	-	2,452,465	-	-	-		-	2,452,465	-
3.02 OVC Basic health care	-	-	-	-	-	-	-	-	-		-	-	-
3.03 OVC Family/home support	357,112,029	354,257,130	354,257,130	2,854,899	-	117,921	2,736,978	-	-		354,257,130	2,854,899	-
3.04 OVC Community support	3,890,000	-	-	3,890,000	-	3,890,000	-	-	-		-	3,890,000	-
3.05 OVC Social services and Administrative costs	1,345,985	-	-	1,345,985	-	1,345,985	-	-	-		-	1,345,985	-
3.06 OVC Institutional Care	1,478,200	-	-	1,478,200	-	1,478,200	-	-	-		-	1,478,200	-
3.98 OVC services not disaggregated by intervention	57,953,015	-	-	57,953,015	57,953,015	-	-	-	-		-	57,953,015	-
3.99 OVC services not-elsewhere classified	1,556,000	-	-	1,556,000	-	1,556,000	-	-	-		-	1,556,000	-

4. Program Management and Administration Strengthening (sub-total)	**270,605,912**	**123,108,166**	**123,108,166**	**146,522,746**	**118,260,740**	**16,194,742**	**12,067,264**	**975,000**	**975,000**		**123,108,166**	**146,522,746**	**975,000**
4.01 Planning, coordination and programme management	95,911,116	59,754,035	59,754,035	35,782,081	20,643,218	5,606,943	9,531,920	375,000	375,000		59,754,035	35,782,081	375,000
4.02 Admin. and transaction costs associated with managing and disbursing funds	7,381,546	1,269,719	1,269,719	5,611,828	988,236	4,623,592	-	500,000	500,000		1,269,719	5,611,828	500,000
4.03 Monitoring and evaluation	20,351,849	5,078,875	5,078,875	15,172,974	13,224,821	1,636,035	312,119	100,000	100,000		5,078,875	15,172,974	100,000
4.04 Operations research	2,061,442	-	-	2,061,442	480,000	519,412	1,062,029	-	-		-	2,061,442	-
4.05 Serological-surveillance (Serosurveillance)	58,463	-	-	58,463	-	58,463	-	-	-		-	58,463	-
4.06 HIV drug-resistance surveillance	3,360,725	-	-	3,360,725	-	3,360,725	-	-	-		-	3,360,725	-
4.07 Drug supply systems	-	-	-	-	-	-	-	-	-		-	-	-
4.08 Information technology	6,136,991	-	-	6,136,991	6,078,528	58,463	-	-	-		-	6,136,991	-
4.09 Patient tracking	-	-	-	-	-	-	-	-	-		-	-	-
4.10 Upgrading and construction of infrastructure	57,005,537	57,005,537	57,005,537	-	-	-	-	-	-		57,005,537	-	-
4.11 Mandatory HIV testing (not VCT)	-	-	-	-	-	-	-	-	-		-	-	-
4.98 Program Management and Administration Strengthening not	72,957,525	-	-	72,957,525	71,565,220	231,108	1,161,197	-	-		-	72,957,525	-
4.99 Program Management and Administration Strengthening not-elsewhere	5,380,718	-	-	5,380,718	5,280,718	100,000	-	-	-		-	5,380,718	-
5. Incentives for human resources (sub-total)	**218,929,496**	**26,232,014**	**26,232,014**	**192,597,482**	**181,087,842**	**3,185,338**	**8,324,302**	**100,000**	**100,000**		**26,232,014**	**192,597,482**	**100,000**
5.01 Monetary incentives for human resources	153,065,720	-	-	153,065,720	143,594,618	1,146,800	8,324,302	-	-		-	153,065,720	-
5.02 Formative education to build-up an HIV workforce	12,150,310	-	-	12,150,310	12,150,310	-	-	-	-		-	12,150,310	-
5.03 Training	51,913,466	26,232,014	26,232,014	25,581,452	25,342,914	238,538	-	100,000	100,000		26,232,014	25,581,452	100,000
5.98 Incentives for Human Resources not specified by kind	-	-	-	-	-	-	-	-	-		-	-	-
5.99 Incentives for Human Resources not elsewhere classified	1,800,000	-	-	1,800,000	-	1,800,000	-	-	-		-	1,800,000	-
6. Social Protection and Social Services (excluding OVC) (sub-total)	**1,187,347**	**-**	**-**	**1,187,347**	**-**	**1,187,347**	**-**	**-**	**-**		**-**	**1,187,347**	**-**
6.01 Social protection through monetary benefits	1,128,100	-	-	1,128,100	-	1,128,100	-	-	-		-	1,128,100	-
6.02 Social protection through in-kind benefits	-	-	-	-	-	-	-	-	-		-	-	-
6.03 Social protection through provision of social services	59,247	-	-	59,247	-	59,247	-	-	-		-	59,247	-
6.04 HIV-specific income generation projects	-	-	-	-	-	-	-	-	-		-	-	-
6.98 Social protection services and social services not disaggregated by type	-	-	-	-	-	-	-	-	-		-	-	-
6.99 Social protection services and social services not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
7. Enabling Environment (sub-total)	**19,097,842**	**12,314,000**	**12,314,000**	**6,483,842**	**690,050**	**2,655,661**	**3,138,130**	**300,000**	**300,000**		**12,314,000**	**6,483,842**	**300,000**
7.01 Advocacy	4,594,868	-	-	4,294,868	90,000	1,594,138	2,610,730	300,000	300,000		-	4,294,868	300,000
7.02 Human rights programmes	224,317	-	-	224,317	-	224,317	-	-	-		-	224,317	-
7.03 AIDS-specific institutional development	881,717	-	-	881,717	130,000	224,317	527,400	-	-		-	881,717	-
7.04 AIDS-specific programmes focused on women	471,170	-	-	471,170	-	471,170	-	-	-		-	471,170	-
7.05 Programmes to reduce Gender Based Violence	12,363,277	12,314,000	12,314,000	49,277	-	49,277	-	-	-		12,314,000	49,277	-
7.98 Enabling Environment and Community Development not disaggregated by type	562,493	-	-	562,493	470,050	92,443	-	-	-		-	562,493	-
7.99 Enabling Environment and Community Development not elsewhere classified	-	-	-	-	-	-	-	-	-		-	-	-
8. Research excluding operations research which is included under (sub-total)	**1,869,918**	**-**	**-**	**1,869,918**	**-**	**1,869,918**	**-**	**-**	**-**		**-**	**1,869,918**	**-**
8.01 Biomedical research	-	-	-	-	-	-	-	-	-		-	-	-
8.02 Clinical research	-	-	-	-	-	-	-	-	-		-	-	-
8.03 Epidemiological research	-	-	-	-	-	-	-	-	-		-	-	-
8.04 Social science research	741,818	-	-	741,818	-	741,818	-	-	-		-	741,818	-
8.05 Vaccine-related research	-	-	-	-	-	-	-	-	-		-	-	-
8.98 Research not disaggregated by type	-	-	-	-	-	-	-	-	-		-	-	-
8.99 Research not elsewhere classified	1,128,100	-	-	1,128,100	-	1,128,100	-	-	-		-	1,128,100	-
TOTAL	**2,009,128,627**	**1,214,100,146**	**1,214,100,146**	**792,753,481**	**669,147,221**	**56,537,116**	**67,069,144**	**2,275,000**	**2,275,000**				

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