National AIDS Spending Assessment

UGANDA

2008/9 – 2009/10

DRAFT REPORT

Uganda AIDS Commission
Salim Bay Road, Ntinda
P. O. Box 10779,
Kampala, Uganda

June 2012

DRAFT Report

Submitted to

Uganda AIDS Commission

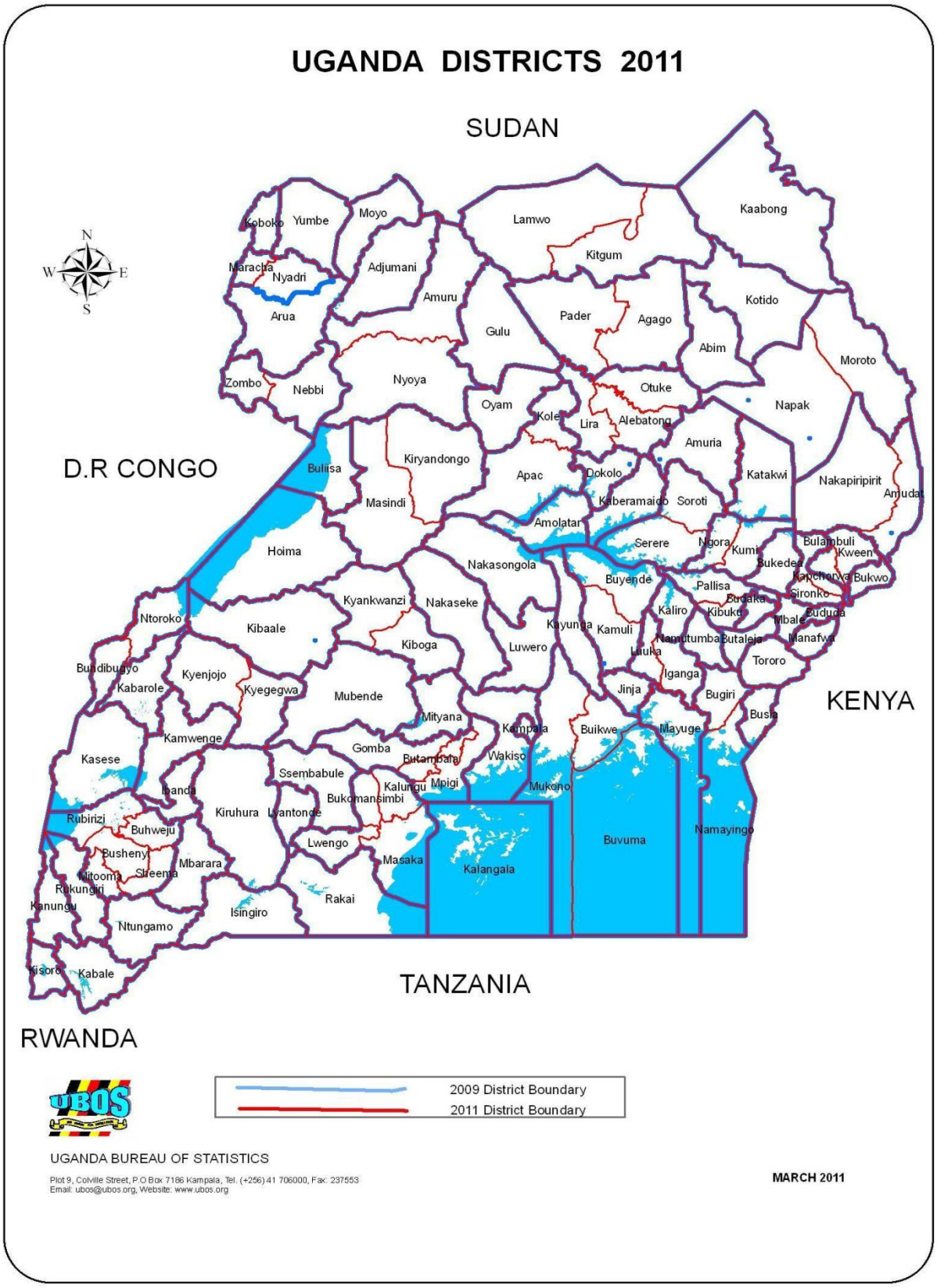
jointly by

HealthNet Consult Ltd

&

Health Systems Development Group

June 2012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2009 District Boundary
2011 District Boundary
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MARCH 2011

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Foreword

To be written by UAC

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Acknowledgments

Uganda AIDS Commission (UAC) wishes to thank and appreciate the contributions and inputs of the members of the NASA Technical Working Group (TWG), given at various stages of the NASA exercise.

UAC is also grateful for the cooperation and participation of various stakeholders through their willingness to provide information that was used for the NASA. Specifically, UAC acknowledges the participation of: AIDS development partners (ADPs), selected NGOs/CSOs/FBOs/International Foundations, studied districts and health facilities (including private-not-for-profit hospitals), Ministry of Health Departments, other line ministries, other public sector entities studied (e.g. parastatals), all other entities that provided information and/or guidance, Uganda Bureau of Statistics for providing the UNHS 2009/10 dataset, and participants at the NASA Validation Workshop for their inputs on the preliminary results.

Further, UAC would like to thank all persons who contributed to the successful implementation and completion of the first comprehensive National AIDS Spending Assessment in Uganda. Specifically, UAC extends its gratitude to the NASA Team members. Their tireless and tremendous efforts to this exercise are applauded. Also, were are appreciative of the efforts of some UAC staff members for guiding and participating in the NASA activities and processes.

The coordination and undertaking of the Uganda NASA was undertaken by a consortium of three firms: *HealthNet Consult*, *Health Systems Development Group* and *Centre for Economic Governance and AIDS in Africa*. These firms invested a lot of time and effort in ensuring a rigorous approach and methodology to undertaking the exercise and to produce high quality outputs.

Government of Uganda, Uganda AIDS Commission:
National AIDS Spending Assessment – UGANDA (2008/9 & 2009/10)

Published by: Uganda AIDS Commission
P.O Box 10779
Kampala, Uganda
Email: uac@uac.go.ug
Website: http://www.aidsuganda.org/

Executive Summary

Over the last decade, the increase in financial resources has greatly empowered the response to HIV/AIDS in Uganda. In addition to the international and national financial resources being spent on the HIV/AIDS response, there is an unmeasured sizeable contribution from the private sector; namely businesses, private insurances as well as individuals and households, the latter spending their own resources through out-of-pocket spending. The fragmentation in the flow of funds and allocation of resources for HIV/AIDS make the total resource envelope difficult to estimate, and by implication such fragmentation makes it hard to establish how these resources are used. Consequently, ensuring the alignment of resource allocation and use to the key priorities of the Ugandan National Strategic Plan (NSP) becomes a challenge.

The Government of Uganda (GoU), with the support of AIDS Development partners and other stakeholders agreed to undertake a comprehensive National AIDS Spending Assessment (NASA). The overall purpose of the first NASA was: to compile and document detailed information on HIV/AIDS financing and expenditure, with the aim to provide information that will guide resource mobilisation, planning, resource allocation for and management of the National Response. The specific objectives of the Ugandan NASA were: to assess the magnitude and structure of HIV/AIDS financing and expenditure in Uganda for the financial year 2009/10; and to strengthen the institutionalisation of HIV/AIDS resource tracking in Uganda's national response. A number of policy questions were agreed at the time of inception which included descriptive and analytical policy questions.

NASA is an international methodology for HIV/AIDS resource tracking and refers to the systematic, periodic, and exhaustive tracking of the actual spending by various HIV and AIDS stakeholders in the international, public and private sectors. The resource tracking methodology is aimed at following the money from the source up to the beneficiaries receiving goods and services. A NASA tracks resources used in provisions of health services, social mitigation, education, labour, justice and other sectors that are part of the multi-sectoral response. NASA comprise specific boundaries around the transactions related to HIV and AIDS, functions that include eight programmatic areas: (1) prevention, (2) care and treatment, (3) orphans and vulnerable children (OVC), (4) Programme management and administration, (5) human resources, (6) Social protection and social services, (7) Enabling environment (8) HIV related research.

The Ugandan NASA comprised several sub-components of resource tracking namely:

- ★ Tracking of HIV/AIDS financing and expenditure by various stakeholders in the public, donor and private sub-sectors;
- ★ **Special** tracking of indirect or system-wide spending by government attributable to HIV/AIDS service provision
- ★ **Special** tracking of spending by households on HIV/AIDS.

Each of these sub-components of the NASA required unique methodologies for estimation of expenditures, and therefore sampling strategies.

The findings of the NASA and the discussion in this report is summarised below under the responses to the Policy Questions agreed for the NASA.

Funding Levels - 1,109 billion UGX (586.6 million US $) was spent on HIV/AIDS control activities in Uganda in 2008/09; and 1,167 billion UGX (579.7 million US $) in 2009/10. This reflects an increase of 5% in shilling terms and a decrease of 1% in US dollar terms – there is therefore no appreciable difference in the total level of expenditure between the 2 years. In comparison with other countries in the region Uganda registered higher total levels of funding for the HIV/AIDS response than the other countries, except South Africa which spent almost four times the amount spent by Uganda in 2009/10. Botswana has the highest funding per capita but also one of the highest HIV prevalence rates in the region and the world. On the other side Mauritius has very low funding and very low prevalence. Uganda is a middle performer with relatively low HIV prevalence for the region and low funding per capita

Source of funds- in 2008/09 Public Sources contributed 11.2%; Private Sources 20.8% and International Sources 68%. Very similar proportions were maintained for the FY 2009/10. The proportion of funding from International Sources is high, with further breakdown showing that this funding comes from Bilateral Entities (50% or more of all expenditure for both years) with only a few donor countries contributing the funds. The private funding at more than 20% is a significant contribution, and is mostly from households, with minimal contributions from business entities. Public funds are mostly from central government with negligible amounts contributed by local governments. South Africa and Botswana show much higher public contribution than Uganda; whereas Kenya and Zambia are quite similar to Uganda in having modest contribution from public sources. Only South Africa, Uganda and Kenya show an appreciable amount of private funding.

Financing Agents - In 2008/09, 56% of the NASA funds were managed by External Financing Agents (FAs), 28% by Private FAs and 16% by Public FAs. The FY 2009/10 noted a bit of improvement for the Public and Private FAs rising to 19% and 32% respectively; the proportion managed by the External FAs though remained more than a half of all spending (at 51%). The bulk of these are Bilateral FAs. The Public Sources passed on funds to Public FAs;

Private Sources passed funds to Private FAs; whereas International Sources passed on the bigger portion of funds to External FAs (at least 75%) and some to Public and Private FAs.

The proportion of funds managed by External FAs is higher in Zambia, Mozambique (both above 60%), Kenya and Swaziland than Uganda. Lesotho, Mauritius, Botswana and South Africa have proportionately less funds managed by External FAs, with South Africa having the least at about 10%. Countries with high International Contribution have a high proportion of the HIV/AIDS resources managed by External and Private FAs, whereas countries with high Public Sources contribution have a high proportion of their resources managed by Public FAs.

Providers of HIV/AIDS services - More than two thirds of the NASA funds in Uganda are spent by Private Providers (71.7% in 08/09, 68.5% in 09/10). The public sector spent about a quarter of the funds (24.4% in 08/09 and 28% in 09/10) while External Providers utilised a negligible proportion of the funds (3.9% in 08/09 and 3.4% in 09/10). The bulk of the spending for the provision of HIV/AIDS services in Uganda is therefore in the private sector.The largest proportion of spending amongst private providers is NGOs, and CBOs (at 75% and more for each year). The funds utilised by the Private Providers are mostly from International (especially bilateral entities) and Private Sources, and managed by External and Private FAs.

The public sector providers spending these resources are largely at national level including Ministry of Health departments, Uganda AIDS Commission and other government ministries utilizing a little less than 70% of these funds, and local governments, public hospitals and health centres utilise just above 30%. The funds utilised by Public Providers are managed by Public FAs, with the source of funds as Public Sources and International Sources (especially multilateral entities); and minimal funding from Private Sources managed by Private FAs.

Uganda has the highest proportion of spending utilised by private providers; while South Africa and Swaziland show the opposite picture with the larger proportion of the expenditure in the public sector; and Zambia and Lesotho show a significant proportion of the spending with external providers.

AIDS Spending Categories (ASCs) -_The NASA estimates show that 18.6% of HIV/AIDS funding in Uganda in the FY 2008/09 was spent on Prevention, 50.8% on Care and Treatment, 4.9% on OVCs, 20.2% on Programme Management, 4% on Human Resources, and less than 1% apiece for Social Protection & Social Services, Enabling Environment and Research – the picture is maintained in 2009/10. Kenya, Lesotho and South Africa like Uganda have Care and Treatment taking up more than 50% of the HIV/AIDS expenditure; with Lesotho, Mozambique and Zambia in the 30-50% range; and Mauritius and Swaziland showing less than 30% of expenditure on this ASCs. Uganda is comparable to other countries in the region on spending

on Programme Management, and a middle performer on prevention where Mauritius spends the highest proportion, and Botswana and South Africa the lowest. Swaziland and Botswana spend more than 20% of their resources on OVCs; whereas Lesotho, Mauritius, South Africa, and Swaziland spend about 10% each on Human Resources Incentives and Training.

Beneficiaries - More than 50% of the HIV/AIDS spending benefitted the PLHWA in both FY 2008/09 and 2009/2010. This is understandable given a large proportion of the funding was spent on Care and Treatment which benefits PLHWA. When the funds benefiting the general population and funds that are not targeted at any particular group are added together, they form more than 40% of all HIV/AIDS spending. This indicates that the other benefitting categories like Most at Risk persons (MARPS) including Sex Workers (SWs), Intravenous Drug Users (IDUs); Key Vulnerable Populations including orphans, children of HIV mothers and truck drivers; and accessible populations including students, STI clinic attendees, health workers and the forces share less than 10% of all spending. Botswana, Kenya, Lesotho, South Africa, Uganda and Zambia all documented more than 50% of the HIV/AIDS spending benefitting PLHWA; while Mozambique and Swaziland documented about 40% for PLHWA. Botswana and Swaziland showed the highest spending on Key Vulnerable Populations with Swaziland noting more than 30% on this category of beneficiaries.

NASA Estimates and Efficiency –The same amount of funds as was costed was available for *Prevention* in both years, however in terms of proportion of all resources available, this was by far less than had been projected: 19 and 18% expended for the two years compared to 30% and 29% projected respectively. For *Care & Treatment* – NASA indicated much more spending both in absolute and proportionate terms than had been costed for the two years for this ASC - in FY 2008/09 at US $ 298.2 million it was more than twice what had been projected, and at 51% of all resources proportionately much higher than the projected 38%.

The NASA showed much less spending on *Mitigation* both in absolute and proportionate terms than the NSP costing for this ASC for both years; with less than half of projected spending for the FY 2008/09; and much more spending on *Programme Support* both in absolute and proportionate terms - with about 5 times the projected amount spent for the FY 2008/09. The HIV/AIDS spending therefore has been very different from what was initially planned in the NSP and could therefore be said to be inappropriate and inefficient.

International Sources provide most of the funding for Prevention activities with more than 90% of funding for Prevention activities in the FY 2009/10 coming from external sources. International Sources tend to pass on money to External FAs who in turn pass the funds to Private Providers, mostly NGOs and CBOs who in most cases operate with time-limited and donor-specific projects. The HIV/AIDS response funding profile as shown by the NASA

indicates poor likelihood of sustainability for prevention activities funding and institutional set up.

NASA Estimates and Equity – In-depth analysis of equity (specifically geographical) was not possible given the methodology used to estimate public spending on HIV/AIDS, whereby only 20% of the districts and given it was noted that large amounts of funds were spent by Ministries and other central level entities (for services and supplies for the benefit of the whole country) that could not be broken down by region or district. However the institutional set up of the public system with processes and formulae for resource allocation to districts, hospitals and health centres across the country provide a framework for fairly equitable distribution of HIV/AIDS resources.

International Sources and Public Sources by providing funds for the national response do make it possible for the households and individuals who require services to access them at no, or as is more often the case, reduced cost. This is equitable as individuals receive services according to the need and not so much according to their ability to pay. Private funding of services however, particularly household Out-of-Pocket (OOP) payments which forms the bulk of the funds from Private Sources is inequitable as it means that services are provided to only those who can afford to pay. This deters some people from getting certain services, but in others cases pushes households into catastrophic payments that send them into (or further into) poverty.

However when International Sources provide funds, mostly managed by External and Private FAs (93% of all funds in 2008/09 and 87% in 2009/10), for specific parts of the country and particular activities/interventions, this promotes inequity. This is likely to lead to islands of excellence on one hand and grossly underserved areas on the other.

The funds targeted at OVCs were only 6% of all expenditure for both FYs 2008/09 and 2009/10; and for MARPS the corresponding figures were 0.1%. This seems rather low but it is difficult to determine what the right level should be – the NSP did not provide any guidnac eon this. Uganda is comparable to Kenya, South Africa and Zambia with less than 10% of HIV/AIDS funds spent on OVCs; whereas Botswana, Lesotho, Mozambique and Swaziland have at least 15% proportion of all HIV/AIDS spending on OVCs. There is generally very low spending on MARPS in the region with only Lesotho registering 2% of all HIV/AIDS funding on this beneficiary category.

NASA Estimates and affordability, sustainability, harmonisation and alignment –The NASA Total Estimates for FY 2008/09 and FY 2009/10 are much higher (about 1.5 times) than what was costed for the NSP, in the "Higher Case Funding Scenario". Possible reasons for this include: much more funding than required for NSP was available; there was under estimate of

NSP requirements, including that changed circumstances may have had implications for the cost of activities. A simple response to the basic question of whether the national response is adequately funded would seem to be yes.

A critical look at the NASA results shows that the Public Sector is playing a marginal role in funding & managing resources for HIV/AIDS in the country – this is consistent over the 2 years. External entities are playing a very big role, both in financing the national response, and in making decisions about the funds for the response. The biggest players, in terms of both financing and management of resources are the bilateral entities. The private sector is playing a big role – may be more than is usually appreciated. National players (public and private) contribute about one third of the resources (32% in 2008/09 and 33% in 2009/10); and manage less than a half (41% in 2008/09 and 46% in 2009/10).

The above picture has major implications for planning especially with regard to predictability and sustainability of funding for the national response. The fact that most of the funding comes from a few bilateral and multilateral entities is a major point of concern, whereby if one entity was to withdraw for whatever reason (domestic or bilateral politics, economic crisis, governance related etc) this would create a major crisis.

The NASA results show that some effort has been made in line with some of the international agreed principles and attributes for increasing Aid effectiveness including: alignment to country national development strategies as indicated by the use of the NSP as a guiding document for the AIDS Development Partners (ADP); and the establishment of basket funds like the Partnership Fund and the Civil Society Fund. However some challenges persist including: the NASA showed that the sector spending profile in terms of the thematic areas/ASCs is quite different from the NSP guidance; the basket funds are managing only a small proportion of ADP funds; and the minimal role of government as a source and manager of funds limits opportunites for leverage yet the public has key responsibilities for stewardship for the national response.

These challenges the funding structure highlighted here may have contributed to failure to achieve some of the targets of the NSP, and the particular goal of keeping new infections of HIV/AIDS and the prevalence among Ugandans down.

Institutionalization of HIV/AIDS resource tracking

Based on lessons and findings of the first Uganda NASA study, understanding of the Ugandan HIV/AIDS context including the stakeholders and structures, and requirements for institutionalization as have been noted elsewhere for NASAs and similar resource tracking processes like National Health Accounts some recommendations have been made for institutionalization of HIV/AIDS resource tracking in the country.

The AIDS Partnership should develop and implement a *governance framework* for HIV/AIDS resource tracking linking NASA production to the use of the data and its translation through further analysis into insights to support policy formulation and decision-making. This would need to take into consideration the three major responsibilities of coordination; policy and technical dialogue; and production of NASA. It is recommended that in a phased manner the UAC takes responsibility for coordination (short term) and production of NASA (medium to long term); and the appropriate bodies within the AIDS Partnership the role of technical and policy dialogue.

In addition some specific activities have been recommended including creation of a central database of all HIV/AIDS stakeholders; establishing harmonized reporting formats and structures; and linking up with entities like UBOS and MoH that routinely carry out community surveys to provide information relevant to HIV/AIDS spending at minimal extra cost. For all these to take place appropriately there is need for planned and strategic approach to capacity building and financing for sustainable and efficient Uganda NASA production.

***In conclusion*,** the first Uganda NASA study has been useful especially for: providing comprehensive information on HIV/AIDS financing and expenditure and various dimensions as provided for by the NASA methodology for the first time; attempting responses to most of the policy questions agreed to by sector stakeholders; and providing some recommendations on institutionalization of HIV/AIDS Resource Tracking in Uganda.

This study recommends that the NASA data should be utilised for policy formulation and decision-making by the AIDS Partnership and the different stakeholders including for planning, resource mobilization and allocation and monitoring and evaluation of the HIV/AIDS response; for reporting to international organisations and fora. It is also recommended that the steps are taken to start planning for the next NASA now.

Particular areas highlighted for dialogue amongst the AIDS Partnership including possibilities and mechanisms for:

a) Adjustment in the proportion of resources contributed by the different sources, with some proposals:

i. increase of the public contribution, to increase ownership and leverage in the national response;

ii. diversification of HIV/AIDS funding - the current dependence on a few bilateral entities for the bulk of the funding is dangerous for the response.

iii. further study and understanding of expenditure for HIV/AIDS by households;

b) Increasing the proportion of funds managed by Public and Private FAs;

c) Increasing funds utilised by Public Providers – and PNFP health facility providers;

Acronyms

ADPs	AIDS Development Partners
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
APF	AIDS Partnership Fund
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Vaccine
ASC	AIDS Spending Categories
ASOs	AIDS Service Organisations
BCC	Behavioral Change communication
BP	Beneficiary Population
CAO	Chief Administrative Officer
CBO	Community Based Organisation
CDC	Centres for Diseases Control and Prevention
CEGAA	Centre for Governance and AIDS in Africa
CPI	Consumer Price Index
CSF	Civil Society Fund
CSO	Civil Society Organisation
DACs	District AIDS Committees
DANIDA	Danish Agency for International Development Assistance
DFID	Department for International Development
DHO	District Health office
DP	Data Processing
ECOSOC	Bureau of the Economic and Social Council
FA	Financing Agents
FAO	Food and Agriculture Organization
FBO	Faith Based Organisation
FS	Financing Sources
FUE	Federation of Uganda Employers
GFATM	Global Fund for AIDS, TB and Malaria
GIPA	Greater Involvement of Persons with HIV/AIDS
GoU	Government Of Uganda
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNC	HealthNet Consult
HPAC	Health Policy Advisory Committee
HR	Human Resource
HSDG	Health Systems Development Group Limited
HSSP	Health Sector Strategic Plan
IDI	Infectious Diseases Institute
IDU	Injecting Drug Users

ILO	International Labour Organisation
IOM	International Organisation for Migration
IRCU	Inter-Religious Council of Uganda
KIIs	Key Informant Interviews
M&E	Monitoring and Evaluation
MARPs	Most-At-Risk-Populations
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Governments
MSM	Men who have Sex with Men
MTEF	Medium-Term Expenditure Framework
n.e.c	not any where else classified
NACs	National Aids Coordinating Authority
NACWOLA	National Community of Women Living with HIV/AIDS
NAFOPHANU	National Forum Of People with HIV/AIDS Networks in Uganda
NASA	National AIDS Spending Assessment
NGOs	Non-Governmental Organisations
NHA	National Health Accounts
NORAD	Norwegian Agency for International Development
NSP	National Strategic Plan
NUSAF	Northern Uganda Social Action Fund
ODA	Official Development Assistance
OI	Opportunistic Infections
OOP	Out of Pocket
OPD	Out Patient Department
OVCs	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PETS	Public Expenditure Tracking Surveys
PF	Production Factors
PHPs	Private Health Practitioners
PITC	Provider Iniated Testing and Counselling
PLWHA/PLHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private-Non-For-Profit
PS	Service Providers
PSI	Population Services International
RHU	Reproductive Health Uganda
RTS	Resource Tracking Software
SACs	Sub-county AIDS Committees
SBWG	Sector Budget Working group
SCE	Self Coordinating Entities

SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infections
SWAp	Sector-Wide Approach
TASO	The AIDS Support Organisation
TOR	Terms of Reference
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASO	Uganda Network of AIDS Service Organisations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	United Nations High Commissioner for Refugees
UNHS	Uganda National Household Survey
UNICEF	United Nations Children's Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNODC	United Nations Office of Drug and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation

A. Background and Introduction

Over the last three decades, the HIV/AIDS epidemic in Uganda has evolved greatly. Initially, the profile of HIV/AIDS showed an exponential increase in the prevalence of HIV to 18% by 1992, followed by a gradual decline to 6.4% by 2005. It has since stagnated within the range of 6.4% and 7% and unfortunately increased in some population groups e.g. the married people (Kirungi et al. 2006; MoH 2006). The incidence of HIV has followed a similar trend. HIV incidence began to decline over the early 1990s and stabilized between 1998 and 2004. The incidence of HIV/AIDS reached an all-time low of 0.25 per 100 in 2005, before it rose again to 0.37 per 100 PY (95% CI 0.23 – 0.58) in 2006 (Uganda AIDS Commission 2008). Recent data from the Ministry of Health (MOH) shows increasing incidence of HIV/AIDS over the last 5 years i.e. from 105,965 in 2005 to 124,261 in 2011. The ongoing AIDS indicator survey is expected to provide more up-to-date incidence and prevalence rates. The recent increase in HIV/AIDS incidence cases have significant implications for future resource needs required for care and treatment, as well as other aspects of the HIV/AIDS response.

In addition, the epidemic is exhibiting marked socio-economic and geographical heterogeneity. Regions like the central region and urban areas like Kampala are the worst hit, with current prevalence estimates as high as 8%, while other areas in the North-West have prevalence as low as 2.3%. Additionally, the epidemic is more concentrated in certain high risk groups, like the mutual monogamous couples, in whom a high rate of discordance has been found (which constituted 35.1%); among people with multiple sexual partners (37.3%); mother to child transmission (18.0%); and among commercial sex workers (8.7%) (Fred Wabwire-Mangen et al. 2009).

Over the last decade, the increase in financial resources has greatly empowered the response to HIV/AIDS in Uganda. In addition to the international and national financial resources being spent on the HIV/AIDS response, there is an unmeasured sizeable contribution from the private sector; namely businesses, private insurances as well as individuals and households, the latter spending their own resources through out-of-pocket spending. In Uganda, the mechanisms and capacity for tracking of resources for HIV/AIDS are weak, not streamlined and not harmonised. Until recently, the total amount of resources available for HIV/AIDS and related activities remained unknown and poorly documented. Existing information on HIV/AIDS funding and expenditure in Uganda is largely partial, and is not generated on a regular basis. Some of the examples of attempts to quantify and document HIV/AIDS resources include the *UNGASS Matrix* (produced once every 2 years) and the *Public Sector Spending Assessment* (conducted as a one-off in 2006), which covered the public sector only; therefore leaving a big information gap on HIV/AIDS spending in other sectors (private and donors) (Lake Sally & Mwijuka Bernard 2006).

More recently, a resource tracking study for orphans and vulnerable children (OVC) was concluded. The findings provide relevant insights on the status of resource tracking systems, but with a focus restricted to resources for OVCs. The fragmentation in the flow of funds and allocation of resources for HIV/AIDS makes the total resource envelope difficult to estimate, and by implication such fragmentation makes it hard to establish how these resources are used. Consequently, ensuring the alignment of resource allocation and use to the key priorities of the the Ugandan National Strategic Plan (NSP) becomes a challenge.

If undertaken properly, a National AIDS Spending Assessment (NASA) can provide key information on financing for and expenditure on the National Response, showing who has funded the response to HIV/AIDS, who has provided the services, what services have been provided, and who benefitted from these. Such information would indicate if the NSP priorities have been matched with adequate allocations, commitments and expenditure, and if funds have been utilized effectively. This means that NASA data would inform the design of the future response, and allow decision-makers to re-allocate resource where necessary and feasible. Most importantly NASA information can provide evidence for additional resource mobilization for the response.

In 2009/2010, the GoU together with partners commissioned a study[1], as a pre-cursor to the NASA, whose main objective was to conduct an assessment of existing resource tracking systems in all sectors, including: public, private and development partners; with the view to obtain information on how the organisations in the different sectors keep records on financing for and expenditure on HIV/AIDS and related activities in Uganda. The findings of the pre-NASA study provided valuable insights for informing the development of the methodology for the NASA.

The Government of Uganda (GoU), with the support of AIDS Development partners and other stakeholders agreed to undertake a comprehensive National AIDS Spending Assessment (NASA). Uganda AIDS Commission put out a call for proposals for firms/individuals to undertake the comprehensive NASA for Uganda. The Terms of Reference (TORs) are attached as **Annex 1**. In response to this call, a consortium of two Ugandan-based consulting firms **HealthNet Consult** (HNC) and **Health Systems Development Group** (HSDG) joined hands in preparing and submitting a proposal to undertake the Ugandan NASA. The proposal by the consortium indicated a further collaboration in the form of support by NASA experts from the **Centre for Economic Governance and AIDS in Africa** (CEGAA), based in South Africa, who have been involved in undertaking several NASA studies in the sub-Saharan African region.

[1] HealthNet Consult 2010: Assessment of existing HIV/AIDS Resource Tracking Sysytems in Uganda

B. Rationale for and Scope of NASA in Uganda

B.1 Purpose and Objectives of Uganda NASA

Overall purpose of Ugandan NASA

The overall purpose of the NASA is: to compile and document detailed information on HIV/AIDS financing and expenditure, with the aim to provide information that will guide resource mobilisation, planning, resource allocation for and management of the National Response. Uganda AIDS Commission envisaged that NASA information would ultimately be used to guide resource mobilization and planning that will ultimately strengthen the effectiveness and efficiency of resource use.

Specific Objectives of NASA

Based on the Terms of Reference (TORs), the stated objectives for the Ugandan NASA were:

1. To assess the magnitude and structure of HIV/AIDS financing and expenditure in Uganda for the financial year 2009/10; and
2. To strengthen the institutionalisation of HIV/AIDS resource tracking in Uganda's national response.

B.2 NASA Policy Questions

NASA serves several purposes for different actors and within different time-frames. Given the discussions between the Consultants and the TWG at inception phase, the following policy questions were agreed to guide the the Ugandan NASA. The policy questions indicated here fall into two categories: (a) descriptive – where the key conclusions are drawn from the NASA data without further manipulation; and (b) analytical – where key results are obtained through more in-depth analyses of the NASA data, taking into consideration other relevant data readily available and/ or some major assumptions for certain conclusions to be reached.

Descriptive Policy Questions:

i. How much money is being spent on the HIV/AIDS response in Uganda for the FYs 2008/09 and 2009/10; is there a marked difference between the 2 years? What is likely to be the cause for this? **Funding Levels**
ii. What is the source of the funds? **Sources**
iii. Which entities are managing/making decisions about the funds? **Financing Agents**
iv. Who is translating the funds into activities? **Providers**
v. What is the money being spent on? **AIDS Spending Categories**
vi. What is the money being spent on? **Inputs/Production Factors**
vii. Who is benefitting from the resources? **Beneficiaries**

Analytical Policy Questions:

Analytical policy questions require additional data and/or assumptions and further analysis of data from the NASA. The level of challenge posed by the different questions depends on availability of the NASA data, and the additional data/assumptions required. These questions include:

i. How efficiently are the resources being used?
   - ★ Are the resources being spent on the priorities of the National Strategic Plan?
   - ★ Comparing current resources spent on prevention vs. medium term resources need for Care & Treatment;

ii. In-depth Analysis for one AIDS Spending Categrory -ART financing or Prevention (to be finally determined given information available)
   - ★ What are the Sources, FAs, Providers in ART/Prevention financing?
   - ★ What are the likely implications (of previous response) for affordability & sustainability – both in the medium and long term?

iii. How equitably are the resources being used?
   - ★ By geographical region?
   - ★ Are vulnerable/at risk group benefiting as required from the AIDS expenditure?

iv. What are the implications for affordability, sustainability, harmonisation and alignment?
   - ★ What are main sources (by proportion) and channels (Financing Agents) and procedures (Financial arrangements) for managing the funds? What is the proportion of funds from public (Ugandan) sources, and what proportion managed by indigenous organisations?
   - ★ What is the level of predictability of HIV/AIDS funding – medium and long term?
   - ★ Harmonization & Alignment – relate to efficiency, equity and sustainability

In addition to addressing the policy questions, it was envisaged that the information provided by NASA in Uganda would be used to:

- Monitor the implementation of the National Strategic Plan, and therefore influence future strategic planning and prioritisation;
- Monitor advances towards completion of internationally or nationally adopted goals such as universal access to treatment or care;
- Provide information on the United Nations General Assembly Special Session on AIDS (UNGASS) indicator for public expenditure; and
- Provide evidence of compliance with the principle of additionality required by some international donors or agencies.

C. NASA Concepts and Principles

The National AIDS Spending Assessment (NASA) is a methodology developed and promoted by UNAIDS as an approach that comprehensively identifies and measures all the spending on HIV within a country. Information from a NASA describes the financial flows and expenditures using the standardised categories of expenditure. Undertaking a NASA has been particularly useful for countries undertaking a review of their AIDS National Strategic Plans and in generating information for the UNGASS reports. The *Guide to producing a National AIDS Spending Assessment* (UNAIDS 2009) provides details on its methodology. This was done in order to provide necessary information on the financial gap between resources available and resources needed, and in order to promote the harmonization of different policy tools frequently used in the AIDS field (UNAIDS, 2009). NASA supports the monitoring of resource mobilization, and should be used as a tool for regular and routine financial information system within the national monitoring and evaluation framework. A NASA is not an accounting system. Rather, it tracks spending on HIV/AIDS as reported by different stakeholders within a country. NASA is not software, nor a needs assessment, nor an economic impact of HIV/AIDS. NASA has **three** well defined dimensions for resource tracking reporting namely:

1. public spending from central, and sub-national governments;
2. international financing from bilateral and multilateral agencies; and
3. private expenditure from corporations, NGOs and households.

NASA Principles

NASA is the systematic, periodic, and exhaustive tracking of the actual spending by various HIV and AIDS stakeholders in the international, public and private sectors. The resource tracking methodology is aimed at following the HIV funds from the source up to the beneficiaries receiving goods and services. This resource tracking must be exhaustive covering all entities, services and expenditures; periodic as a result of continuing recording, integrating and analyzing, to produce annual estimates; systematic, because their categories and record/report structures must be consistent in time and comparable across countries. Other attributes of a NASA include: policy relevance, consistency, comparability and standardization, all of them implicit in the basic National Health Accounts (NHA) model.

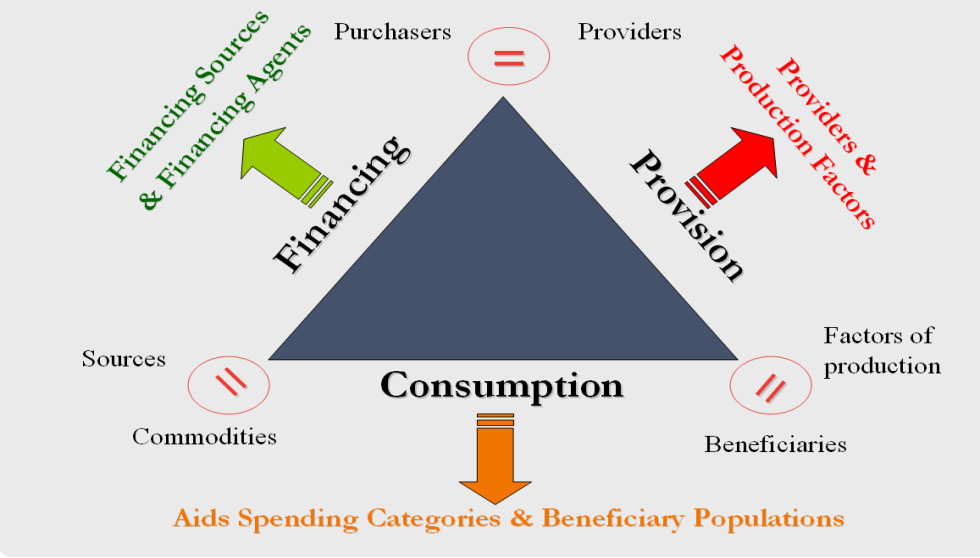
NASA tracks all the spending based on a rigorous classification of the actors as well as the purposes of all expenditures contributing to the multi-sectorial response to HIV and AIDS; a complete accounting of all spending, regardless of the origin, destination, or object of the expenditure; a rigorous approach to collecting, cataloguing, and estimating the flows of money related to all HIV and AIDS programmatic areas.

The resource tracking procedures have to be standardized to assure comparability, within the country over the years and between countries. These tools use internationally accepted standard accounting methods. The accrual method of accounting is considered in the NASA. This accounting approach, unlike the **cash approach**, records revenues and expenses when they are incurred, regardless of when cash is exchanged. Income and expenses are recorded as they occur, regardless of whether or not cash has actually changed hands.

Figure 1 provides an overall illustration of the fundamental areas of inquiry for a NASA. One of the key principles of the NASA is that the resource tracking should balance when resources are looked at from the different points of view. For instance, resources from *sources* should balance with resources managed by *financing agents*, and these should equal to the resources *spent* on the different AIDS spending categories. Put differently, ***financing*** should equal to ***provision***, which in turn should equal to ***consumption***.

According to the *Guide for Producing a NASA* (UNAIDS, 2009), in order to conduct international comparisons, the reporting for any given year, the financial transactions are reconstructed and six dimensions of each transaction are recorded or estimated: (1) financing sources, (2) financing agents, (3) functions (HIV and AIDS related interventions and activities), (4) service providers, (5) components or factors of the production function (budgetary items/objects of expenditure) and (6) beneficiaries .

Figure 1: NASA dimensions and vectors

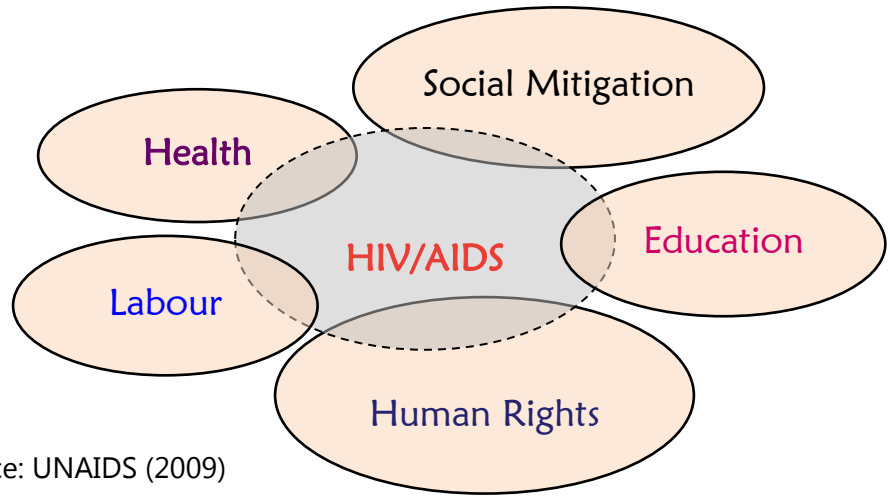


Source: UNAIDS 2009

A NASA is not limited to health expenditures, just as the HIV/AIDS response is not limited to the health sector. A NASA tracks resources used in provisions of health services, social mitigation, education, labour, justice and other sectors that are part of the **multi-sectoral response**. A NASA follows the basic framework and templates of the National Health

Accounts (NHA), but embraces the tracking of social mitigation, education, labour, justice and other sectors' expenditures (**Figure 2**).

Figure 2: Overview of areas for resource tracking in a NASA



Source: UNAIDS (2009)

The UNAIDS-produced NASA guide (2009) emphasises that the transactions in all sectors by all stakeholders should be comprehensibly tracked to determine the actual reach of the beneficiary population. NASA comprise specific boundaries around the transactions related to HIV and AIDS that include eight programmatic areas[2], namely:

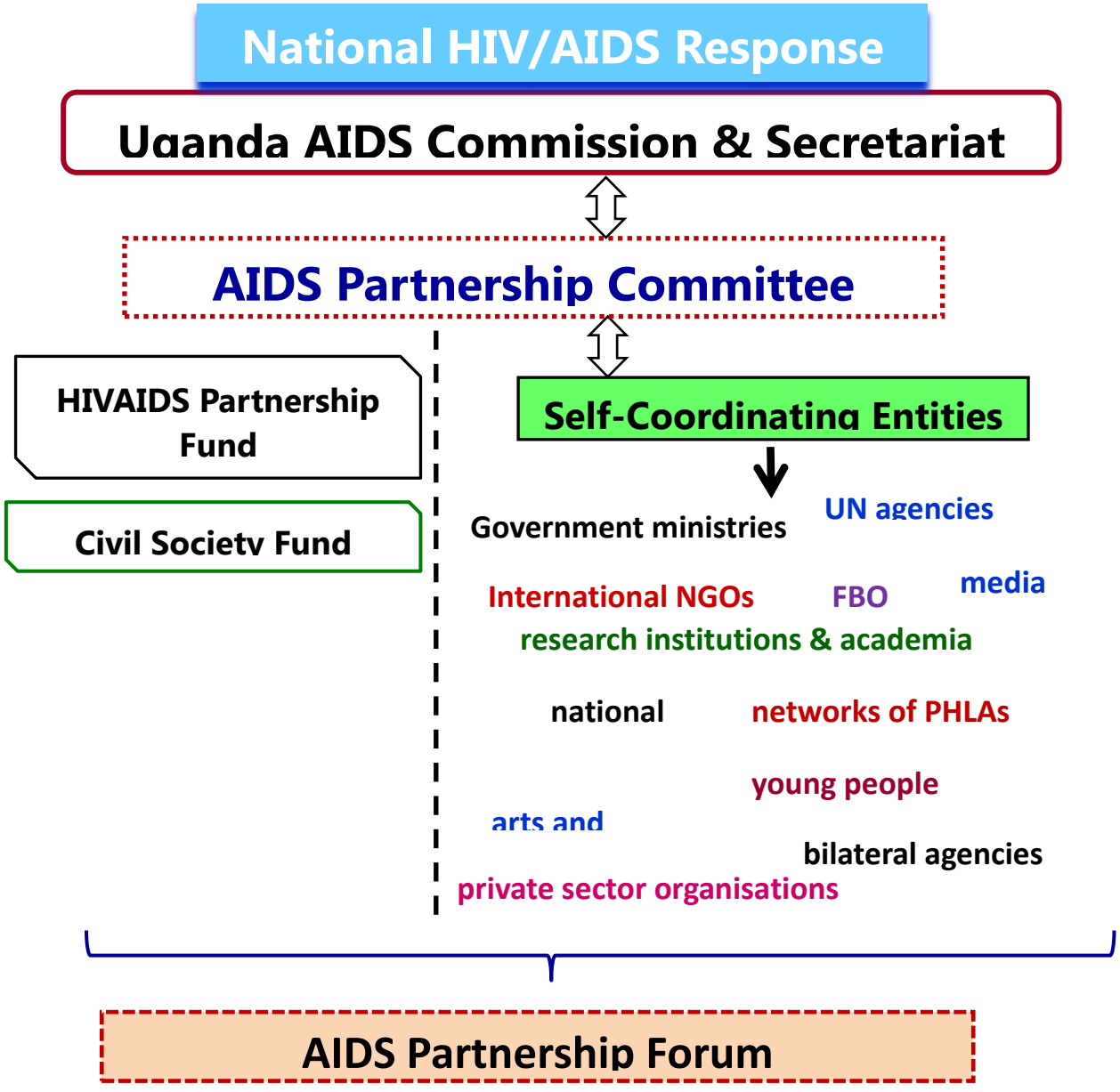
(1) prevention,
(2) care and treatment,
(3) orphans and vulnerable children (OVC),
(4) Programme management and administration,
(5) human resources,
(6) Social protection and social services,
(7) Enabling environment
(8) HIV related research.

[2] Definitions and further breakdowns of these programmatic areas are presented in Annexes 2 and 3.

D. Overview of Uganda's multi-sectoral HIV/AIDS response

Uganda has a multi-sectoral national HIV/AIDS response coordinated by **Uganda AIDS Commission** (under the President's Office), with emphaisis of mainstreaming of HIV/AIDS activities in all sectors. There are many stakeholders (of a heterogeneous nature) involved in the HIV/AIDS response in Uganda. Attempts to coordinate these multiple players have been made under the **AIDS Partnership**, including use of the *Self-Coordinating Entities* (SCEs), the *AIDS Partnership Committee*, and the *HIV/AIDS Partnership Forum*. The SCEs include: Government ministries, international NGOs, media, arts and culture, FBOs, national NGOs, networks of PHLAs, private sector organisations, research institutions and academia, UN agencies and bilateral development group, and the young people (see **Figure 3**).

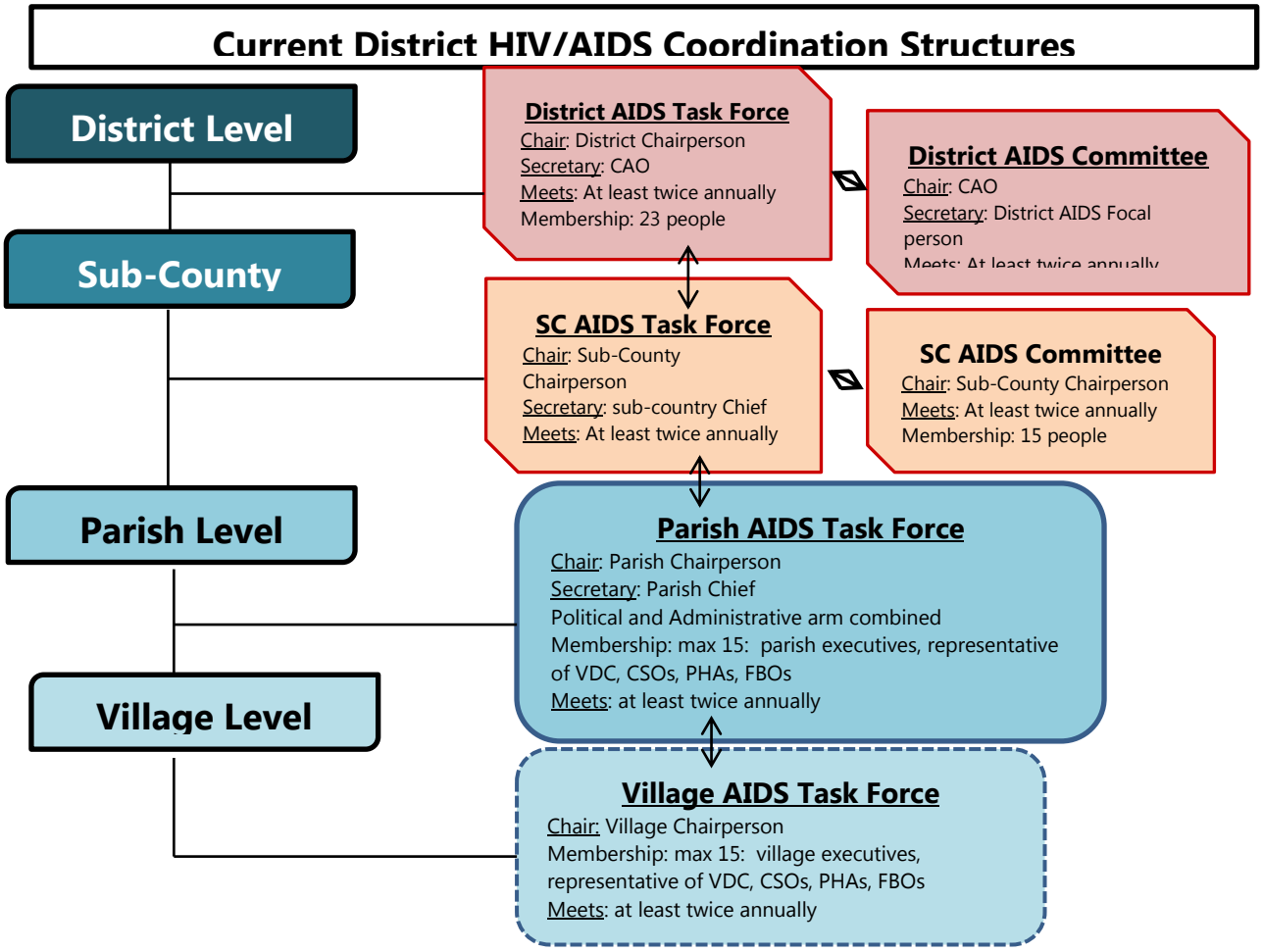
Figure 3: Overview of HIV/AIDS stakeholders in Uganda



The *National Strategic Plan* (NSP) for HIV/AIDS forms the Action Framework that guides implementation, monitoring and evaluation of the national response and programming. Uganda AIDS Commission (UAC) is the supra-sectoral agency responsible for overseeing, planning and coordination of the national Response in the country.

- ★ The **HIV/AIDS Partnership Committee** – a National level committee of representatives from the Self Coordinating Entities. The Partnership Committee has a delegated responsibility from the partnership forum and the UAC Board.
- ★ The **Self Coordinating Entities** (SCEs) – stakeholder groupings that bring together players with related agenda in responding to the impact of HIV/AIDS at national and lower levels. The categories of actors are indicated in Figure 3.
- ★ The **HIV/AIDS Partnership Forum** – a general assembly of all stakeholders in the national response including central government ministries, higher local governments and partners in the civil society, development and private sectors.
- ★ HIV/AIDS **Partnership Fund** and Civil Society Fund – a jointly managed fund for coordination activities and other priority interventions of the NSP and the Annual National Priority Action plan on approval by the Partnership Committee.
- ★ HIV/AIDS **Civil Society Fund** – a pool of funds largely from external sources, put together for the implementation of the national response activities by the different actors represented by each SCE.

Figure 4: District AIDS Coordination structrure



The response is very dynamic, with a large number of actors, and marked heterogeneity even within SCEs. For example the Uganda Network of AIDS Services Organsiations (UNASO) Directory 2010, including NGOs, CBOs and FBOs active in the HIV/AIDS response, has more than 10,000 entities. Yet the UNASO Directory is not exhaustive. There is no single one-stop registry of actors in the HIV/AIDS response in Uganda, although there have been some efforts in mapping of the actors, which are either not comprehensive enough or are overlapping.

The stakeholders under the AIDS Partnership prepare the National HIV Strategic Plan (NSP) and the Annual HIV Priority Action Plan to guide partners on areas that are considered priority and these documents are used to mobilize resources. In addiontion, the health-specific HIV/AIDS activities are also reflected in the *Health Sector Strategic Plan* which is managed under the Health SWAp and its associated structures (e.g. *Health Policy Advisory Committee* (HPAC) and *Sector Budget Working Group* (SBWG).

HIV/AIDS has been mainstreamed across all sectors (ministries) down to the lower decentralized structures such as the districts and sub-counties. Although decentralized governance has generally improved local service delivery, multiple approaches to the HIV/AIDS response has largely challenged institutional capacity of UAC to coordinate resulting multiple actors in the response. The funding arrangements that support the HIV/AIDS response are as complex as the structure of the different actors in the national response. Funds from government entities (at national and sub-national levels), multiple external sources, and private sector (e.g. households and business entities), transferred through multiple channels to the numerous implementers. The mechanisms and capacity for tracking of resources for HIV/AIDS on a regular basis are currently weak, and are not streamlined, harmonised or institutionalised.

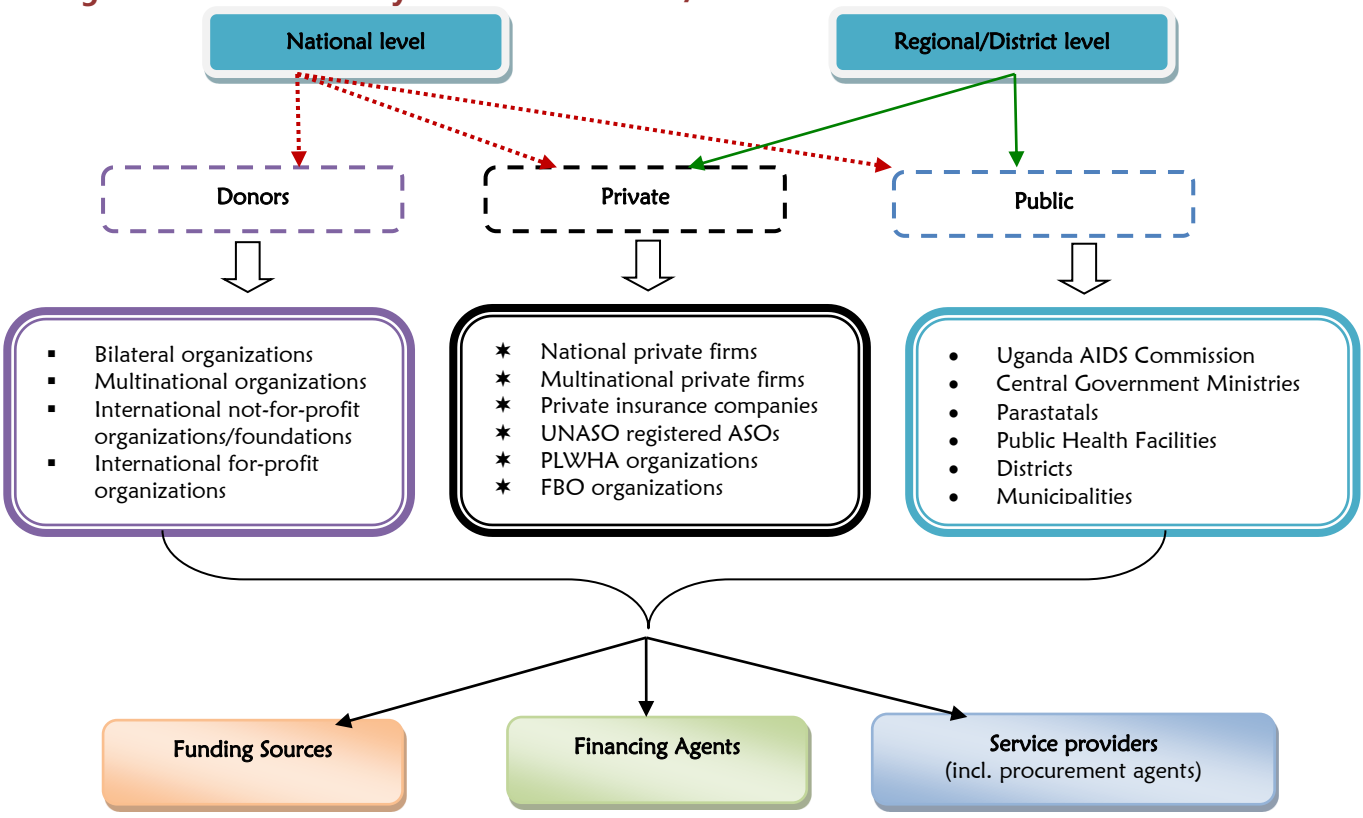
The undertaking of the Uganda 2008/09 and 2009/10 NASA is set in this context – to which the international NASA methodology has to be adapted (see Annex 3 for adaptation of key concepts in the Ugandan context). Section E provides details of the approach to and methods for the first Uganda NASA.

E. Methodology for Uganda NASA

E.1 Conceptual Framework

As noted under the scope of work, the NASA exercise involved collection of data from both national and district levels. In the conceptual framework (see **Figure 5**), thus, at each of these levels, data would be collected from the 3 sub-sectors (public, private and donor). Within each of these sub-sectors there are various players whose roles in the response are not well-documented. The starting point of the conceptual framework is to classify these actors in different groupings that would allow the team to select them properly. For example, within the donor sub-sector, entities were classified to include: bilateral agencies, multilateral agencies, international not-for-profit NGOs/Foundations and international for-profit organisations.

Figure 5: Overview of key stakeholders in HIV/AIDS



The conceptual framework provides the basis for identifying/selecting the entities to be studied within each category/classification. When these entities have been studied, the first task is to determine their role in the response, where they are then classified as being either, (a) sources, or (b) financing agents, or (c) service providers, in line with the international NASA classifications.

E.2 Study Design and Approach

E.2.1 Oversight of NASA Activities

This first NASA has been commissioned and led by Uganda AIDS Commission as part of their role in providing oversight of the HIV/AIDS response in Uganda. Once the study was commissioned, a Technical Working Group TWG) was created to provide guidance to the Consultant and to provide an oversight role on the technical aspects of the study. The TWG was multisectoral in its composition, including: representatives of the AIDS Development Parnters (ADPs) (including bilateral and multilateral donors), Civil Society Organisations (CSOs), as well as Government of Uganda (including UAC, MOPFED, etc.).

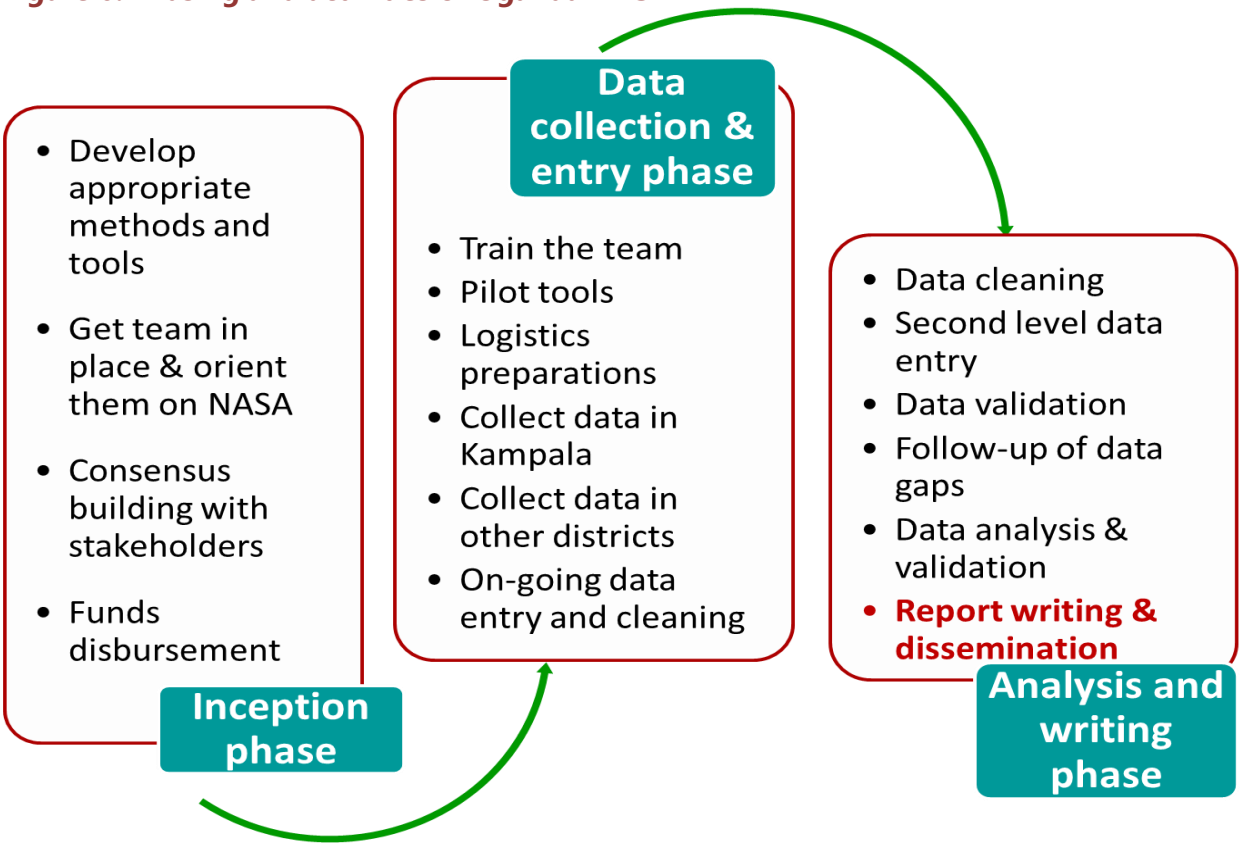
Through a consultative process, both UAC and the TWG together with the Consultants agreed on a number of issues in the inception phase, including: the scope of work, the policy questions for the NASA, and development of the sampling framework.

In addition, both UAC and the TWG provided oversight over the data collection process and in particular, provided much-needed assistance in ensuring easy access to the data through sensitization of stakeholders and leveraging available networks. Progress reports after each phase of the study were presented and submitted to UAC and the TWG, and these formed the basis for monitoring progress on the study. These reports also provided opportunities for both UAC and the TWG to address any challenges that arose. The TWG and UAC reviewed preliminary NASA results and provided inputs for improving the findings of the study. Lastly, TWG and UAC hosted a results-validation workshop where key stakeholders in the HIV response were present.

E.2.2 Process and Approach to undertaking NASA Activities

A phased approach to undertaking the Uganda NASA was adopted. The assignment was undertaken in 3 phases, namely: (a) *inception and preparatory* phase, (b) *data collection and entry* phase, and (c) *data cleaning, analysis, validation and report writing* phase (**see Figure 6**). After all the preparatory activities in the first phase, the second phase involved a quantitative survey of selected sources, agents and service providers of HIV/AIDS, using face-to-face interviews and extensive review of expenditure records, with the aim to collect information on financing and expenditure. Mainly quantitative data were collected, with some additional qualitative data regarding processes and bottlenecks.

Figure 6: Phasing and activities of Uganda NASA



Inception phase: (June 2011 to September 2011)
During this phase, the inception activities included contract signing, development of appropriate methods and tools, getting a team in place and orienting them on NASA, consensus building meetings with stakeholders, the TWG and UAC. This phase was concluded with the submission of an *Inception Report*.

Data Collection and Entry phase (August 2011 to January 2012)
The NASA team was comprehensively trained over 5 days. This training included a piloting od NASA tools. On the last day of the training, the teams reported back their experiences of piloting the tools. The outcomes and experiences of the pilot were used to finalise the tools. Data collection was divided into two categories, namely: (a) data collection at national level data collection (in Kampala), and (b) data collection at sub-national level (i.e. in the selected districts).

At national level: data were collected from several entities. As indicated in the conceptual framework, entities were classified as (a) donor, (b) private, or (c) public (see Figure 5). NASA sub-teams were allocated specific sub-claasifications of entities, so as to promote consistency in data collection. For example one sub-team was allocated to do data collection from all AIDS Development Partners. Similarly, a number of sub-teams were allocated public entities and other sub-teams were allocated private entities. A sub-team consisted of one senior researcher and one or two research assistants. For the first weeks, data collection was focused

at national level, with the intention of closely monitoring the performance of different team members and teams. Once teams were confident with using the tools and collecting relevant data, sub-teams were split into those that would continue data collection at national level, and those that would start data collection in the selected districts. In the meantime, while some teams were sent to district, the sub-team allocated to collected data from ADPs continued with data collection among these entities (at national level).

At district level, data collection started with the District Health Office, and continued to other sampled public entities, as well as the private sector entities (including civil society organisations, faith-based organisations, etc.). Collection of data from districts was done in three sub-phases to ensure high quality and to minimise researcher fatigue. In the first sub-phase, for teams were sent out to do 2 districts each over a period of 2 weeks. This means that the sub-team spent one week in each district. By the end of the first 2 weeks, 8 districts had been studied. The teams were asked to return to Kampala after this first round of data collection at district level. The teams reported back at a NASA Team Workshop. The teams were allowed 2 weeks in Kampala, during which they did data collection at national level. In the second sub-phase, the sub-teams allocated districts went back to collected to another set of 8 districts over a 2-week period. Data collection in the last 4 districts was undertaken by two sub-teams.

In addition, an internal validation of sampled entities was done through the mapping of entities mentioned as having received funding from ADPs. Any entities not previously sampled but which was mentioned as having received significant funding was then included in the sample of the entities to be studied. Also, a mapping of amounts declared by the studied entities was done against the amounts reported by ADPs or financing agents.

Data entry was undertaken concurrently with data collection. A team of 5 research assistants were trained in data entry into DP sheets as well as entry into new templates that had been designed specifically for the Uganda NASA. This team was supervised by two senior resarchers. Data were also entered into RTS by the senior researchers. On a regular basis, the quality of data entry was reviewed through the running of simple analyses to check for consistence in coding and data entry.

Alongside the data collection from and data entry for ADPs, public and private entities (at national and sub-national levels), special sub-teams were tasked with conducting the two special sun-analyses, namely: (a) Out Of Pocket spending on HIV/AIDS by households, and (a) Indirect Government of Uganda Spending on HIV/AIDS. These special analyses involved many meetings of the sub-teams, and lots of debates and review of relevant literature.

This phase was concluded by presenting and submitting a *Progress Report* to UAC and the TWG.

Analysis and writing phase (December 2011 – June 2012)
This was the last phase of the study. The first part of this phase involved data analysis. The first attempt at data analysis was done in a team workshop in December 2012. The purpose of this meeting was to ensure that all data was entered properly and coded correctly. The outputs of this workshop were helpful in bring out the overall picture of the quality of data, and to resolve all technical issues relating to data entry, coding and challenges unique to the Ugandan context. Also, it helped to identify areas where there were still had data gaps.

Data cleaning process was quite involving and was comprehensively done to ensure that there was no double counting. Triangulation of the data was done. This phase also comprised of several analysis workshops that ultimately got to the generation of preliminary NASA result. Preliminary results were then presented to UAC and TWG. A validation workshop with the stakeholders in the HIV / AIDS response was also done at this phase.When consensus with the client, TWG and stakeholders was reached, report writing commenced.

Alongside the process of data cleaning, triangulation and validation, different sections of the report were drafted, especially the first sections and the methodology. The results and last chapters of this report were written after results were validated at the stakeholders validation workshop.

E.3 Sampling Techniques and Estimation Methods

The Ugandan NASA comprised several sub-components of resource tracking namely:

- ★ Tracking of HIV/AIDS financing and expenditure by various stakeholders in the public, donor and private sub-sectors;
- ★ **Special** tracking of indirect or system-wide spending by government attributable to HIV/AIDS service provision
- ★ **Special** tracking of spending by households on HIV/AIDS.

Each of these sub-components of the NASA required unique methodologies for estimation of expenditures, and therefore sampling strategies, which are briefly described here below.

E.3.1 Component 1: Spending by public, donor and private stakeholders

E.3.1.1 Public sector

As has been mentioned above, public sector spending was both direct (on ARVS etc) and indirect (through integrated health system delivery and strengthening). Different approaches were used to estimate these forms of spending. These include:

Direct Public sector spending (ARVS etc)

Uganda is a decentralised country, and in the public sector, there are two levels of government – the central and district levels. All public players at the central level identified as carrying out significant HIV/AIDS activities were studied. There were 80 districts in Uganda in FY 2008/09[3]. To ensure representativeness, 25% (20) of the districts were purposively selected – one urban and one rural district from each of the ten regions as utilised by the Uganda Bureau of Statistics (UBOS) for the Uganda Demographic Surveys and also employed for the Uganda HIV sero-behavioural survey[4]. Within the district, public entities studied included the Chief Administrative Office, the District Health Office, the District Community Development Office and other departments identified as managing or implementing HIV/AIDS activities and funds. Public health facilities studied included: Regional Referral Hospitals; and a sample of one each at the levels of General Hospital, HC IV, III, and II.

Key Informants from government Ministries and Departments like the UAC; Ministry of Internal Affairs; Ministry of Public Services; Ministry of Gender, Labour and Social Development; MoH –Aids Control Programme, Tuberculosis Control Programme; Uganda Blood Transfusion services provided information on aspects of public spending that were deemed directly for HIV/AIDS including policy dialogue, coordination, work-place programmes, safe blood collection and distribution, condom procurement and distribution, ARV procurement and distribution. Data was taken from the various audited accounts for these activities and supplies. Information on these items was largely available at national level. The local governments and health facilities were noted to have received items in kind and provided integrated health services, and so no data was utilised from this level for this estimation. This data was treated as is, with no extrapolation, as all the entities that were deemed to have such activities were studied.

E.3.1.2. External/Donor

The multilateral and bilateral agencies (donors) identified as sources of funds for the HIV/AIDS response in the country over the period under study were all studied. It was agreed that the expenditure information from donors providing Budget Support at the level of Ministry of Finance Planning and Economic Development (MoFPED) should be captured and reported on during this study. Subsequent to MoFPED, these funds would be treated as public funding. These funds would not be indicated against the individual donors as it would not be possible

[3] Some districts were split after 2008/09; for purposes of the NASA districts were studied as they were in 2008/09.

[4] A few differences in nomenclature and regional grouping exist between the 2 surveys which do not have particular implications for this study

to tell how much each of the donors' funds ended up in HIV/AIDS form the general government budget.

Another category of external sources is External Foundations (EF) (like Bill and Melinda Gates) which fund HIV/AIDS activities – ranging from the large (amount of money and/or number recipients) to the small ones. All the EFs with offices that could be traced in Kampala were studied, in addition various entities across the country including public and private (especially) institutions in the 20 districts studied indicated they had received funds from such entities. The information from these various sources was collated and given that 25% of the districts had been studied, a factor of 4 was used to extrapolate this information to the national estimate.

E.3.1.3 Private

The private sector is composed of NGOs/CBOs/FBOS and donor project implementing partners; private health services providers including pharmacies, laboratories, hospitals, nursing homes and clinics; research institutions; business entities with work-place programmes; and households. The different categories of entities under the private sector required different sampling approaches. The private health facilities include Private not for Profit (PNFP) as well as Private Health Practitioners (PHP).

The approach used in this study was to sample and study PNFP health facilities alongside public facilities within the sampled districts. The NGO (non-facility based) category was quite challenging given the numbers and lack of comprehensive and harmonised information. A number of lists of NGOs were accessed from various organizations including Uganda Network for AIDS Service Organizations (UNASO), UAC, President's Emergency Fund for AIDS Relief (PEPFAR), Inter Religious Council of Uganda (IRCU) and Civil Society Fund (CSF) and were used in an effort to come up with composite lists for the international, national and district/community-based organizations. All international and national NGOs (whose offices could be traced) were studied; whereas district-based NGOs and CBOS were studied given whether they were active in the selected districts at the time of data collection. In each district, 20% of all NGOs/CBOs/FBOs were targeted for studying taking into consideration the type of activities that the entity was involved in. The data from the NGOs was useful for triangulation, and for understanding the structure of the Ugandan HIV/AIDS spending – i.e who are the providers, beneficiaries and AIDS Spending Categories. The funds could be traced back to the public, external sources and a few private sources.

A listing of business entities with HIV/AIDS work-place policies/programmes was accessed from Federation of Ugandan Employers (FUE) and 32% of these entities were selected, stratified by size (number of employees) and type of business the entity was involved in. The

data thus collected was extrapolated to cover all business entities using a factor of 3. The approach to studying the PHPs was discussed at length with stakeholders. Given poor documentation of services provided; the sensitivity of expenditure information in many of the facilities; plus the challenges of linking expenditure information in these facilities with diagnoses, it was agreed that data collection would be limited to a few PHP facilities in Kampala for the purpose of documenting availability of data in this sub-sector and thus informing future NASAs, and the process of institutionalization of the NASA in Uganda.

E.3.2 Component 2: (*special sub-analysis*) – Indirect HIV/AIDS Spending by Government

Government not only provides financial support to the HIV/AIDS response directly (e.g. through the purchase of antiretroviral drugs; development of policies; etc) but also indirectly, for example through: (a) provision of infrastructure and equipment; (b) supporting human resources at health facilities, among others. This applies particularly to the health sector where a large proportion of HIV/AIDS response activities are situated. Several discussions were held to develop the methodology for this estimation by the members of a working group put in place for this purpose and included UAC officials, members of the TWG and the NASA Team.

A number of factors were deemed to influence the proportion of health system expenditure that was applied to HIV/AIDS activities including supply side and demand side factors. On the supply side expenditure on HIV/AIDS is influenced by a number of factors including: society's rating of importance of HIV/AIDS as a disease which is in turn affected by the high levels of mortality of those affected and the age (productive and reproductive) of the patients; and the cost of the services and interventions against the disease. On the demand side the factors that have influence include: the prevalence of the disease and the availability/accessibility of interventions and services for the disease.

The discussion was informed by a review of literature from the region on the effect of HIV/AIDS on the utilisation of health services. Articles in peer-reviewed publications from the 90s from Uganda and the East and Southern Africa region indicated that high proportions of patients in health centres and hospitals were due to HIV/AIDS related illnesses ranging from a third to a little over a half of all care-seekers. This was before the wide availability of ART.

In the more recent past with the increase in availability of ART there were not as many publications, and those available indicated a mixed picture, with some showing marked decline in utilisation associated with HIV/AIDS, but some indicating that due to the availability of various HIV/AIDS related services, the proportion of care-seekers for these services were

still high although the pattern (e.g. severity of disease) had changed. Expert opinion was sought from clinicians, health facility managers and managers at various levels of the health system, and information from the HMIS data at the various levels was utilised to reach some assumptions that were built into the following estimates.

Based on the above, the proportion of expenditure at the various levels of the health system referred to as Total HIV Expenditure **(THIVE)** was calculated as:

THIVE= Util* THE + HSS HIV+ OPHIV

where

Util refers to the utilization of for HIV/AIDS related services as a proportion of all health facility utilisation;

THE refers to total Health Expenditure at that level/facility;

HSS HIV refers to the proportion of health system strengthening that HIV specific activities and estimated to consume 10% compared to resource use by clinical activities;

OP HIV refers to non-clinical HIV/AIDS services such as community outreaches – estimated to consume 5% of the resources used by clinical activities;

Given the structure of government budgeting and financial management various aspects of documentation of public funding was available to support the NASA process including approved budgets, disbursement figures and audited accounts. The data collected from the districts and health facilities in the 20 districts, largely from audited accounts, was compared against information on budget releases from the Ministry of Finance for the FYs 2008/09 and 2009/10 and it was found to be similar. This is as expected as districts would have to return funds that they have not spent at the end of a budget year. It was then agreed to use information on MoFPED releases to the local governments and health facilities for the whole country for health sector spending.

Based on the utilisation profiles in the HMIS, and expert opinion (particularly for the managerial levels) estimations were made for the different levels of health care, whereby at the district level (primary and secondary heath care and management) **Util** was taken as 20%; at Regional and National Referral Hospital level at 25%; and at National Policy formulation level (MoH) at 15%.

E.3.3 Component 3: (special sub-analysis) – Spending on HIV/AIDS by Households

As mentioned above, out-of-pocket expenditure (OOPE) is an important source of HIV/AIDS funding in Uganda. Despite this fact however, no attempts have been made in the past to estimate its magnitude. In the absence of resources to conduct a special survey, the NASA exercise relied on existing nationally representative survey data – the Uganda National Household Survey (UNHS 2009/10) – to estimate OOPE for HIV/AIDS. The methodology used for this estimated is briefly described below.

The UNHS collects household information on consumption expenditure, including expenditure on health. The question on health expenditure requires respondents to provide information on health expenditure within a recall period of 30 days (one month). Two sections in the questionnaire are designed to capture this information. They include:

a) **General** Household expenditure: **How much did you spend on health in the last 30 days?**
b) **Health: How much did you spend on the last episode of illness in the last 30 days?**

The NASA special sub-analysis used the responses for the first question (general spending on health) to provide estimates for OOPE. Taking the total amount of health spending for the sampled households, health spending at national levels was estimated (through extrapolation from the sample level to national level). The next step was to extrapolate from health spending (of a 30-day recall period) to annual health spending.

Of the 6797 households that participated in the UNHS, only 4588 (67.5%) provided information on expenditure on health in the general section. Total health spending by 4588 households in 2009/10 was **146,427,530** Shillings (*spending in the 30-day recall period*). To obtain national level spending (from this sample) the study used **"hmult"-** the household multiplier function embedded in the UNHS methodology – ththt to extrapolate to the national level health spending (i.e. UShs 154.7 billion). The "hmult" for a household is the number of households in Uganda that the household is a representative of in terms of socioeconomic status, rurality etc.

The next step was to extrapolate the health spending estimate from that covering the 30-day call period, to annual estimates. To do this, there was need to factor in utilisation of health services, for both outpatient and inpatient services. The Health Management Information System (HMIS) of the Uganda Ministry of Health estimates annual OPD utilization (public and private-not-for-profit) at 0.9 per capita. No estimates exist for private-for-profit utilization or for in-patient utilization. Following expert opinion and debates with the TWG, the assessment assumed annual per capita in-patient utilization of health facilities to be 0.3 and private for profit OPD utilization per capita to be 0.54.

Total annual utilization per capita (**Utilpc**) was estimated as shown below:
Utilisation per capita **(Utilpc)=** 1.74 visits = (0.9 + 0.3 + 0.54)

Given the above annual utilization per capita and an average household size (**AvHH Size)** of 5 (UBOS), we estimated the annual household utilization as below:

Annual Household Utilisation **(An.Hh.Util)** = **AvHH Size** x **Utilpc**
= 4.5 x 1.74 = 8.7 visits per household per year (on average)

With this annual utilization per household health spending based on the 30-day recall period was extrapolated to annual expenditure by multiplying the annual household utilization and the monthly (national) household expenditure as below:

Annual HH spending on health = **Hh.Exp.H** (one visit) x **An.Hh.Util**

Thus:

154,670,492,653 x 8.7 visits **=1,345,633,286,080 Shillings**, which is spending for 2009/10.

Having obtained, the national, annual expenditure on health by households in 2009/10, we used the Consumer Price Index **(CPI)** for medical products to deflate this to 2008/09 expenditure. The estimates for the CPI were obtained from the Uganda Bureau of Statistics.

Once annual expenditure for households in both years was obtained, the team estimated an attribution factor/index for HIV/AIDS spending. In order to do this utilisation factor **(Utilpc.HIV)** for people with HIV/AIDS had to be determined. Estimation of the utilisation factor was done in relation to overall utilisation by HIV-negative persons. The following assumption were considered:

- people who are HIV positive but are NOT on ARVS have 4 visits per person per year,
- people who HIV positive and are eligible but NOT on ARVs have 7 visits per person per year,
- People who are HIV positive and are on ARVS have 6 visits per person per year.

The utilisation factors for the different categories of people who are HIV positive **(Utilpc.HIV),** compared to those who are HIV/AIDS negative were calculated as:

- HIV+ but don't need ART = 4 / 1.74 = **2.3**
- HIV+ eligible but not on ART = 7 / 1.74 = **4.02**
- HIV+ and on ART = 6 / 1.74= **3.45**

Having obtained the utilization factor for patients with HIV/AIDS, the **cost factors**[5] for HIV+ people were estimated. Given the paucity of literature that estimates this in this setting, it was assumed that the **cost of services** for each category of HIV positive people, in relation to the cost of health services for HIV- people was:

- HIV+ but don't need ART = **2** (i.e. cost is twice that of non-HIV services)
- HIV+ eligible but not on ART = **4** (i.e. cost is four times that of non-HIV services)
- HIV+ and on ART = **4** (i.e. cost is four times that of non-HIV services)

[5] This is a set of assumption about the cost of HIV/AIDS-related services and ailments in relation to the cost of health services for HIV- people.

Uing the utilization and cost factors for HIV/AIDS, a composite weight for the different groupings of HIV+ people was calculatedestimating a composite weight for attributing expenditure by PLWHA for all the categories. These are shown below.

- HIV+ but don't need ART = 2.3 x 2 = **4.6**
- HIV+ eligible but not on ART = 4.02 x 4 = **16.1**
- HIV+ and on ART = 3.45 x 4 = **13.8**

The next step was to calculate total utilization burden of HIV/AIDS in relation to total utilization of the general public. The annual Health Sector Performance report of 2009/10 shows that there are 1, 192,372 people with a CD4 below 250 cells/ul which by definition makes them eligible for ART (as per the ART guidelines in 2009/10). The same report provides estimates of the numbers of people living with HIV/AIDS in the above categories as shown below:

- HIV+ but don't need ART = 750,269 (AHSPR 2009/10 – pg. 69 and 70)
- HIV+ eligible but not on ART = 205,033 (AHSPR 2009/10 – pg. 69 and 70)
- HIV+ and on ART = 237,070 (AHSPR 2009/10 – pg. 69 and 70)

The total utilization burden for HIV/AIDS was then determined as below:

- HIV+ but don't need ART = 750,269 x 4.6 = 3,449,513
- HIV+ eligible but not on ART = 205,033 x 16.1 = 3,299,382
- HIV+ and on ART = 237,070 x 13.8 = 3,269,931

TOTAL HIV utilisation burden = 10,018,825

Total utilization burden for the general population was calculated as follows:

Population (in 2009/10) x **Utilpc** = 30,700,000 x 1.74 visits = **53, 418,000**

Therefore, HIV utilisation burden was expressed as a proportion of general population utilisation burden: i.e. 10,018,825 divided by 53,418,000 which comes to 18.8%. Given this, 18.8% of the national annual household expenditure on health for 2008/09 and 2009/10 to HIV/AIDS was attributed to HIV/AIDS.

Therefore, the estimation of OOPE on HIV/AIDS

- OOP spending on HIV/AIDS (in 2008/9) = **1,191,965,287,361** x 18.8 % **= 223,559,324,000**
- OOP spending on HIV/AIDS (in 2009/10) = **1,345,633,286,080** x 18.8 % **= 252,380,561,000**

It should be noted that the methods used to estimate of OOP spending on HIV/AIDS, excludes spending on nutrition, orphans, psychosocial support, burial costs, etc. It is therefore our consideration that the estimates obtained for OOP spending on HIV are an underestimate.

E.4 Data Management

Data collectors and capturers were trained in the NASA methodology, in the use of the interview guide and in general interviewing and research skills. Being a retrospective quantitative study, the NASA mainly relied on a combination of face-to-face Key Informant Interviews (KIIs) – using structured questionnaires – and review of documents in order to obtain information. Researchers used pre-designed questionnaires to obtain and to record their findings. During KIIs, respondents were asked to provide expenditure reports, either in hard or electronic version.

E.4.1 Tools and Data Collection

The data collectors and capturers were trained in the NASA methodology and in the use of the interview schedules. They also conducted "team play roles of interviewer and interviewee" to familiarize themselves with the process. The data collectors were mainly university graduates who were supervised by experienced senior researchers that have worked in the area of HIV/AIDS over the years. Data were collected through face-to-face interviews with the relevant persons within the selected organizations, using interview guides that were administered by data collectors. Interviewees were also requested to provide their expenditure statements and financial reports for detailed and validated data. Questionnaires were completed by the research team, and not by the respondents.

Questionnaires had quantitative open-ended questions and a few open-ended qualitative questions.Four tools were developed, as follows:

- Questionnaire 1- for Financing Sources
- Questionnaire 2 – for Financing Agents/ managers of funds
- Questionnaire 3 – for non-healthy facility providers
- Questionnaire 4 – for Health facilities (providers)

E.4.2 Data entry, cleaning and analysis

Data were first captured in the hard-copies of the questionnaire. They were then entered into Excel® spreadsheets (Data processing/DP sheets). DP sheets were used for translating the raw data into a NASA format that puts in a format that is ready to be entered into the Resource Tracking Software (RTS). The DP sheet template is in a format that follows the six vectors of the NASA methodology right from sources of funds to financing agents to providers of HIV programmes, which programmes are broken down to specific AIDS Spending Categories and production factors that a consumed by a specific beneficiary population. In the DP sheets, data were cleaned and verified, and any missing, incomplete or contradictory data were identified and corrected. In addition, the data were properly classified and coded according to the NASA classification developed by the UNAIDS. It is in the DP sheets that raw data were

processed, calculations of exchange rates, units costs etc were done before they were entered into the NASA RTS which is an Access®-based programme created by UNAIDS. Aggregation and analysis was undertaken in the RTS, and further analysis and graphical diagrams were processed and displayed in Excel®.

The NASA principle of capturing only completed transactions and the processing of the data first in Excel® sheets also assisted the team in undertaking triangulation, and reduced the chances of double-counting. In addition, the Uganda NASA senior supervisors and team leaders kept records of possible cases of double-counting and verified with the sources of data in each case to ascertain which amounts would be kept and which ones would be omitted, so as to avoid repeated capture. The NASA team particularly received support from CEEGA (Centre for Economic Governance and AIDS), a South Afican-based institution that has conducted NASAs in more than 8 countries. There was also an exercise of standardizing coding and ensuring proper and correct coding of all entries. A workshop was convened where team leaders, data entrants and analysts went through transaction by transaction to ensure that organizations and activities were correctly coded and that codes were standardized according to the NASA classification.

E.4.3 Quality assurance and validation of results

Ensuring that high quality data was collected and analysed appropriately, several measures of quality control were built in the whole NASA process.

At the **conceptual and analytical level**, the NASA team drew on regular peer review and/or guidance from different experts. Specifically, the input of expert was sougth during all the 3 phases of the NASA process, namely: inception phase, data collection, cleaning and analysis phase, and results validation and writing phase. The NASA team received technical inputs and review from staff of UNAIDS, Uganda AIDS Commission, the NASA Techinical Working Group, and in special circumstances from senior experts in their individual capacities (e.g. health economists from World Health Organisation and from bilateral and multilateral agencies.

At the level of data collection, entering, collating and cleaning, the study relied on in-house peer review and supervision of activities, as well as supervision from Uganda AIDS Commission and UNAIDS during the data collection in the districts. At data collection level, we ensured high quality data by training all researchers and research assistants on the NASA concepts, as well as the tools for data collection. As part of training, all teams members were

involved in piloting of the data collection tools. Further, we grouped smaller teams (for data collection) headed by a senior researchers. Research assistants were not allowed to collect data without guidance and supervision from the respective senior team leader. All tools with data were reviewed by the team leader before onward submission to the project administrator. In addition, completed tools were reviewed by one of the project coordinators to ensure completeness and robustness of data submitted. The final review process for data from the tools was at the level of data entry. All data entrants were trained on how to identify a tool with incomplete data. Such tools were put aside (because they were not fit for data entry), and the team leaders were asked to pick up those tools and complete them accordingly. Level 1 data entry (i.e. entering data in the DP sheets) was supervised by a senior researcher. Level 2 data entry (i.e. entering into the RTS) was done by a senior researcher who had experience in using the software.

At data analysis level, quality was ensured through review of data by the two project coordinators. This involved both actual review of summaries of the data, as well as running two in-house analysis workshops, with the view to assess the robustness and accuracy of the data. Also, a smaller team was constituted to work through all the coding of data entered into RTS. In the second workshop, a senior expert on the team was available to help the team with interpreting the data and picking up and/or closing data gaps. A first run of analysis for all results was peer-reviewed by the team members from CEGAA (who have extensive experience in conducting NASA in the region).

Lastly, **preliminary results were peer-reviewed three times**, by different groups of people. The first review of results was done by the staff of UAC. Relevant changes were made to the results following their inputs and comments. The second version of results were presented the NASA TWG. This group also provided inputs and guided the team on specific areas of interest. Lastly the revised results were presented for official and final validation to a range of stakeholders including: district officials, representatives from Bilateral and Multilateral angencies, Uganda AIDS Commission, and some members of the TWG.

E.5 Study challenges and limitations

Despite all the efforts to produce high quality information (as mentioned in the preceding section), the team undertaking NASA exercise grappled with various challenges. The limitations of the Uganda NASA include the following:

1. Sampling of entities to be studied

Given the multiplicity and heterogeneous nature of HIV/AIDS players in Uganda, and the lack of an exhaustive directory where they are registered, sampling was a drawn-out complex

process. The team had to continue re-visiting the sampling of entities throughout the process of data collection to ensure that no major actors were left out. Further, it was very challenging to determine the denominator since there is NO exhaustive listing or mapping that shows the total number of organizations/actors involved in the response. As a result, the team can only tell how many entities were studied in the different sub-groups of actors, but was unable to tell what percentage of the total actors (in each sub-group) was studied.

2. Extrapolation of expenditure information to national level estimates

With the challenge noted in (1) above, the team was faced with intractable situation at analysis when results from the sampled entities had to be summarized and extrapolated to national estimates. Innovative ways of estimating national estimates were used, by approaching it from the financing side, where all (100%) AIDS Development partners were studied and the total amounts from their funding formed the basis for extrapolating expenditure by sampled and studied providers.

3. Need to develop new data capturing and analysis tools

At inception, it was agreed that the standard NASA tools for analysis (UNAIDS, 2009) would be adequate for using in the Ugandan context. The actual experience at data entry stage was that a lot of the information collected from actors who are not providers (i.e. sources of funding, and financing agents) could not adequately be entered into the Data Processing (DP) Sheets® that are normally used for NASA data capturing. The complex nature of relationships between the many actors (in terms of flow of funds) therefore required innovative ways of capturing information that could not be capture into the DP Sheets. As such, new templates wre developed for data capture, mainly for *Health Facilities* at district level, *Financing Agents* and external *Financing Sources*.

4. Defining a *Financing Agent* in the Ugandan context

In the Ugandan context the existence of multiple agencies that channel funds and make decisions at multiple levels, required redefinition of what a 'financing agent' is in Uganda.

5. Multiple and different financial reporting formats

Financial reporting systems differ within different HIV / AIDS implementing organizations. This resulted into inability to collect key data like information regarding production factors. According to the standard NASA guidelines, information on production factors is very key to making the NASA exercise complete; however, the team was not able to collect some of this critical information.Though some challenges remain, like the Resource Tracking Software's inability to capture large numbers, existing tools like the DP sheets were made more user-friendly and less error-prone.

F. RESULTS

F.1 Sources of funding for HIV/AIDS

Figure 7 and Table 1 show that a total of 1,109 billion shilling (**586.6 million USD**) and 1,167 billion shillings (**579.7 million USD**) were spent on HIV/AIDS in 2008/9 and 2009/10, respectively. Note that these figures are nominal and not adjusted for inflation. The difference in total funding (basing on the Shilling values) is only a 5.2% increase from 2008/9 funding levels to 2009/10. Of the total HIV funding in these years, about 68% came from external sources, 21% from private sources and 10-11% from public sources.

Figure 7: Sources of funding for HIV/AIDS in Uganda (2008/9 and 2009/10) – UGX Billions

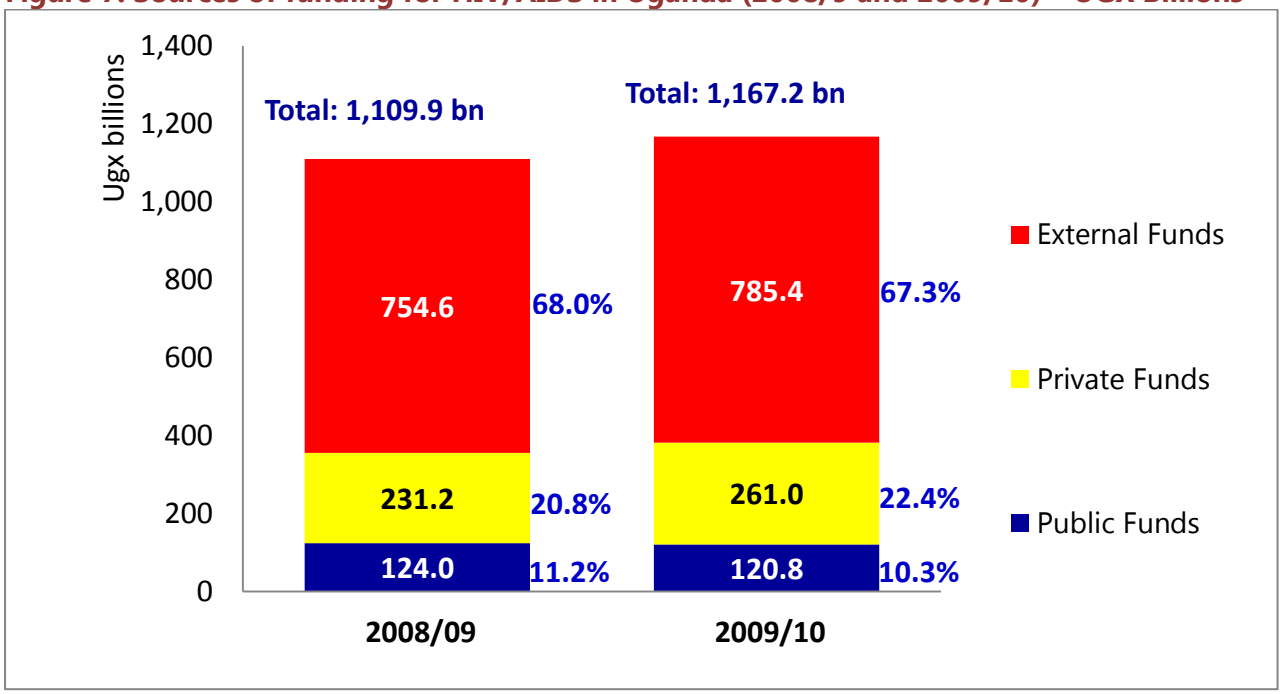


Table 1: Total HIV/AIDS funding by source (2008/9 and 2009/10)

SOURCE	Funding 2008/9 (Million Shillings)	Funding 2009/10 (Million Shillings)
Public Funds	124,029	120,752
Private Funds	231,206	260,998
External Funds	754,622	785,436
TOTAL	**1,109,856**	**1,167,187**

SOURCE	Funding 2008/9 (Million USD)	Funding 2009/10 (Million USD)

Public Funds	65.6	60.0
Private Funds	122.2	129.6
External Funds	398.8	390.1
TOTAL	**586.6**	**579.7**

Figure 8: Sources of funding for HIV/AIDS in Uganda – further disaggregated

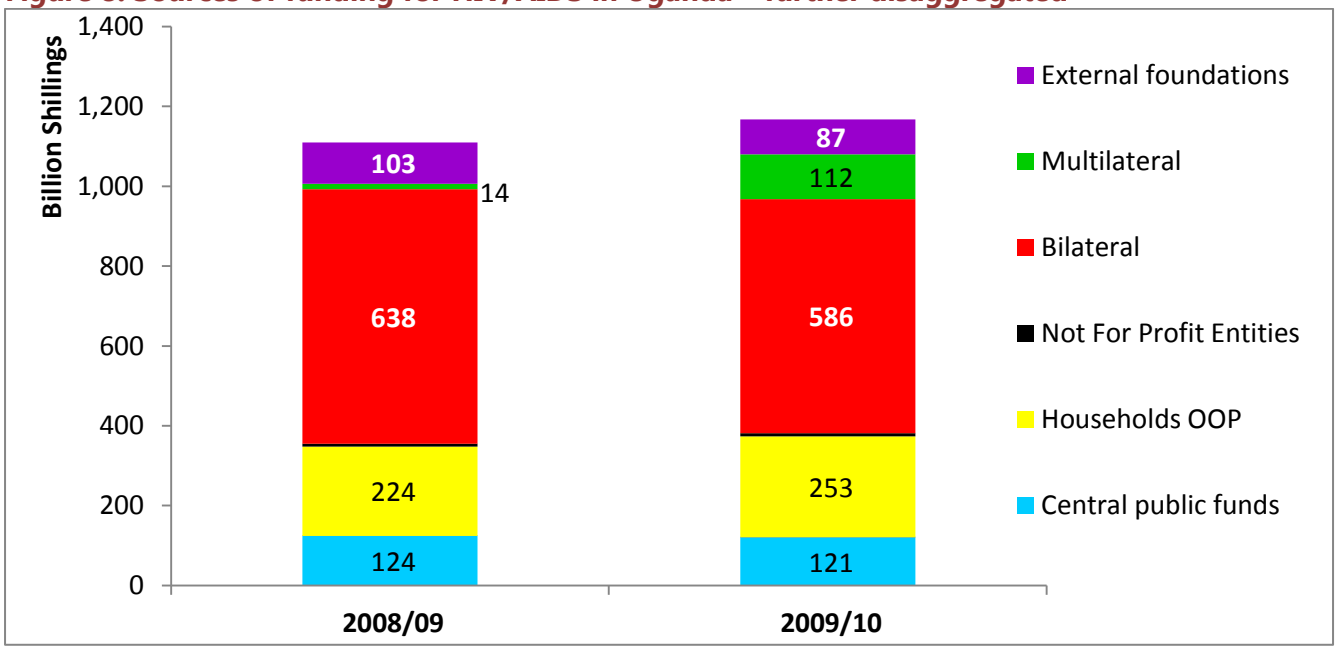


Table 2: HIV/AIDS funding by source (2008/9 and 2009/10) – in Billion Uganda Shillings

Sources	**2008/9 (Bn Shs)**	**%**	**2009/10 (Bn Shs)**	**%**
Central public funds	124.02	11.2%	120.68	10.3%
Local and other public funds	0.01	0.0%	0.01	0.0%
Business Entities/Firms	0.38	0.0%	0.41	0.0%
Households OOP	223.62	20.1%	252.72	21.7%
Not For Profit Entities	7.20	0.6%	7.86	0.7%
Private financing sources nec	0.01	0.0%	0.01	0.0%
Bilateral	637.64	57.5%	586.03	50.2%
Multilateral	13.56	1.2%	112.29	9.6%
External foundations	103.42	9.3%	87.11	7.5%
Totals	**1,109.86**	**100%**	**1,167.13**	**100%**

Results presented in Figure 8 and Table 2 show that:

- The highest proportion of external funds is from bilateral sources – 57.5% of total funding in 2008/9 and 50% of total funding in 2009/10;
- Funding from multilateral sources increased markedly between 2008/09 and 2009/10 (from UShs14 bn to UShs112 bn). This was mainly due to the fact that there were no funding disbursements for HIV/AIDS from Global Fund in 2008/9, while a significant amount of funding from this source was available in 2009/10;
- External foundations are a steady source of funding for HIV/AIDS, contributing up to 9.3% & 7.5% of total funding in 2008/09 and 2009/10, respectively;
- Private sources contribute between 20% and 22% of total funding, and these are largely out-of-pocket spending on HIV/AIDS by households/individuals;
- Public sources contribute the least amount of funds; i.e. 11.2% and 10.3% of total funding in 2008/09 and 2009/10, respectively;
- Public funds are largely from central government

F.2 Financing agents for HIV/AIDS funds

Financing agents are defined as entities/organisations that generate/receive funds for HIV/AIDS, and make important decisions about the management, allocation and use of these funds. Figure 9 shows that more than half of the resources for the HIV/AIDS responses are managed by external financing agents, while the public entities manage between 16% and 19% of the resources. Table 3 provides a summary of the same information in US Dollars.

Figure 9: Financing agents for HIV/AIDS resources in Uganda – 2008/9 & 2009/10

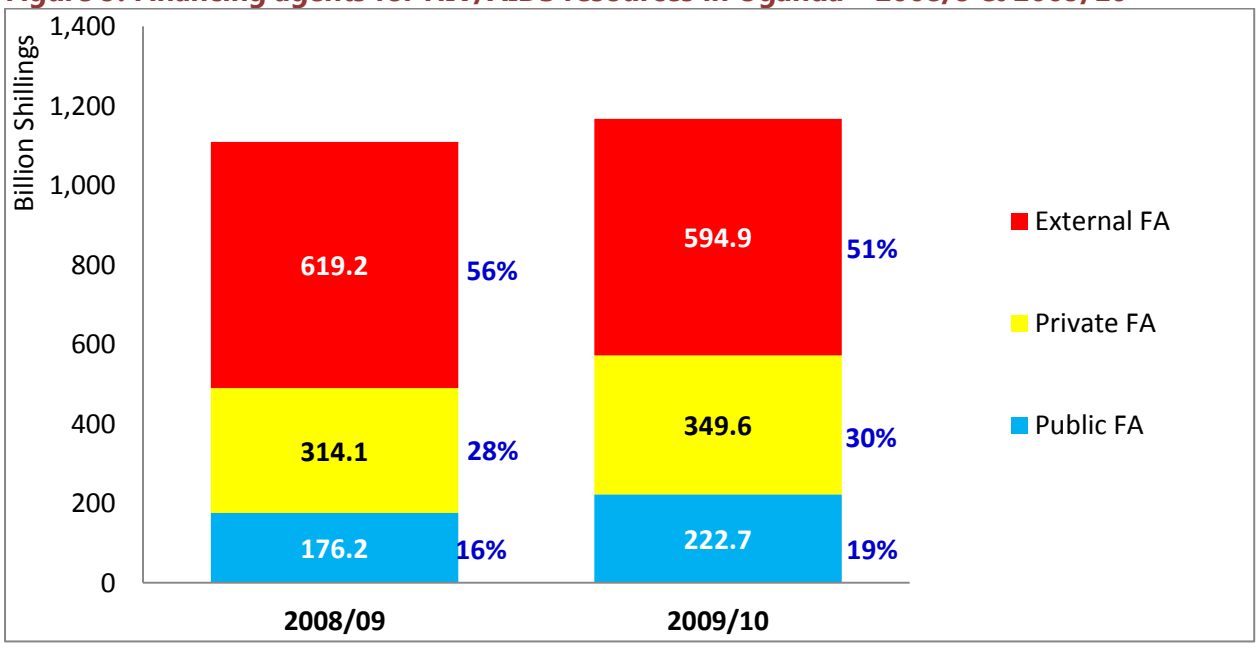
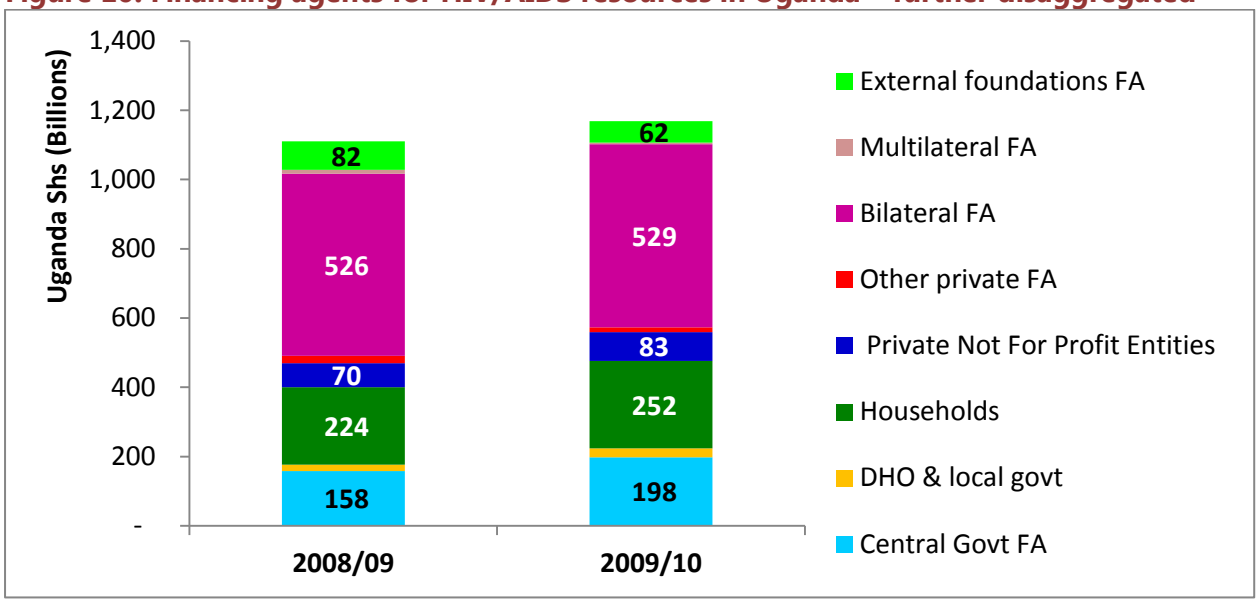


Table 3: Financing agents for HIV/AIDS resources – in Million USD

Financing Agents	Funding 2008/9 (Million USD)	Funding 2009/10 (Million USD)
Public FA	93.3	110.6
Private FA	166.0	173.6
External FA	327.3	295.5
TOTAL	**586.6**	**579.7**

Figure 10: Financing agents for HIV/AIDS resources in Uganda – further disaggregated



Results on financing agents show that:

- More than half of the funds are managed by External Financing Agents for both years; most of these are bilateral agencies which managed about 47.4% of all funds in 2008/09 and 45.3% of total funds in 2009/10;
- Between 28% and 30% of the funds are managed by Private agentss. OOPE – i.e. households make the highest 20% in 08/09, & 21.6% in 09/10;
- Public entities manage less than 20% of the funds; the bulk of funds in the public sector is managed by central government; i.e. 14.3% and 16.9% of total funds were managed by central government entities in 2008/09 and 2009/10, respectively.

Table 4: Flow of funds between Sources and Finacing Agents (2008/9 and 2009/10)

Sources by Agent 2008/09 (Ug shillings Billion)

	Agents			
Sources	**Public**	**Private**	**External**	**Totals**
Public	124.0	-	-	**124.0**
Private	-	231.2	-	**231.2**
External	52.2	83.3	619.2	**754.6**
Totals	**176.2**	**314.5**	**619.2**	**1,109.9**

Sources by Agent 2009/10 (Ug shillings Billion)

	Agents			
Sources	**Public**	**Private**	**External**	**Totals**
Public	120.7	0.1	-	**120.8**
Private	-	261.0	-	**261.0**
External	102.0	88.5	594.9	**785.4**
Totals	**222.7**	**349.6**	**594.9**	**1,167.2**

F.3 PROVIDERS of HIV/AIDS services

Figure 11 shows that the private sector providers play the biggest role in HIV/AIDS service provision. These mainly include the NGOs/CSOs/FBOs, as well as the private for profit health facilities/clinics/pharmacies. External providers play a very minimal role in service provision.

Figure 11: Providers or HIV/AIDS services in Uganda – 2008/9 and 2009/10

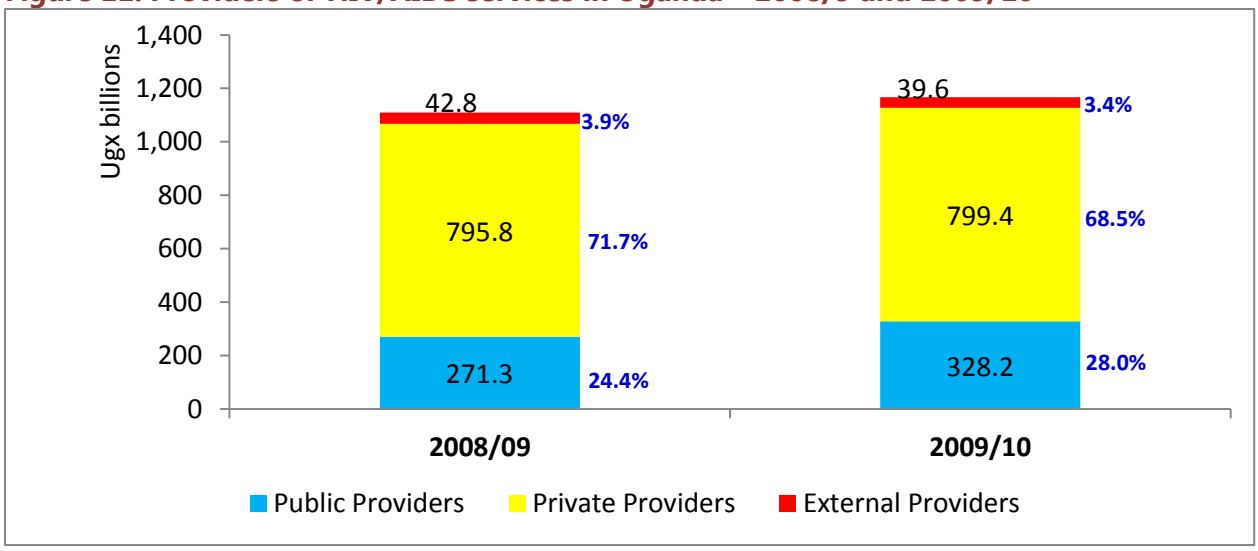


Table 5: Breakdown of PUBLIC Sector service providers (2008/9 and 2009/10)

PUBLIC PROVIDERS	2008/09 (Bn Shs)	2009/10 (Bn Shs)
Public Hospitals	63.9	65.4
Public Clinics	31.8	35.9
Labs	0.3	0.3
Blood banks	5.2	3.8
Higher education	-	0.1
Research institutions	40.8	28.6
Uganda AIDS commission (UAC)	0.2	9.1
Departments within Ministry of Health	75.7	125.2
Ministry of Education	1.6	2.5
Ministry of Gender & social development	0.7	0.2
Departments inside the Ministry of Defence	-	0.3
Other government entities nec	39.2	44.6
Pharmacies	7.8	10.9
Research institutions (Parastatal)	0.1	0.2
Parastatal organizations n.e.c.	0.0	0.2
Public sector providers n.e.c.	3.9	0.9
TOTAL	**271.3**	**328.2**

Table 5 shows that within the public sector (which takes up between 24% and 28% of total resources in service provision – see Figure 11), the key service providers include: public clinics and hospitals, departments within the Ministry of Health, Resarch institutions, and other government entities. The rest of the actors (as presented in Table 5) only play a minimal role in service provision in the public sector.

On the other hand, Table 6 provides details of service providers in the private sector. Note that in Figure 11, private sector entities play the biggest role in service provision (of between 68% and 72% of total resource envelope). Results in Table 6 show that NGOs, CBOs and FBOs take up the largest share (about 60%) of resources for service provision. Private-for-profit clinics take the second largest share of resource within the private sector, followed by pharmacies/drugs shops, and then not-for-profit hospitals.

Table 6: Breakdown of PRIVATE Sector service providers (2008/9 and 2009/10)

PRIVATE PROVIDERS	2008/09 (Bn Shs)	2009/10 (Bn Shs)
Non-profit NGO Hospitals	18.1	18.9
Private Non-profit Clinics	8.3	9.3
Higher education (Non-profit non faith-based)	-	0.1
NGOs, CSOs & CBOs	608.6	601.3
Hospitals (For profit)	0.5	0.7
Clinics (For profit)	107.4	121.2
Pharmacies (For profit)	26.4	29.8
Traditional or non-allopathic care providers (For profit)	2.7	3.1
Consultancy firms (For profit)	23.0	2.1
Workplace	0.3	12.8
Totals	**795.2**	**799.4**

As noted earlier, external agencies play a very minimal role in service provision (taking up only between 3% and 4% of total resource envelope (see Figure 11). Within their limited scope of service provision, the bilateral agencies play a relatively more significant role compared to the multilateral agencies and other external organisations. Since external entities are usually not involved in direct provision of HIV/AIDS services to the population, the activities captured under this section largely relates to short-term technical assistance, direct management of funds for meetings/workshops, and sometimes some limited short-term trainings or capacity enhancement activities.

Table 7: Breakdown of EXTERNAL providers (2008/9 and 2009/10)

EXTERNAL PROVIDERS	2008/09 (Bn Shs)	2009/10 (Bn Shs)
Bilateral agencies	24.6	25.1
Multilateral agencies	2.2	3.5
Rest-of-the world providers	16.0	11.0
Totals	**42.8**	**39.6**

The relation between financing agents and service providers is presented in Table 8 which provides an overview of the flow of funds between FAs and providers. Results in Table 8 show that public sector providers receive their largest funding from public financing agents, with minimal amounts from private and external FAs. On the other hand, private providers (mainly NGOs/CBOs/FBOs) receive their largest share of funfing from external FAs, and in addition

receive significant amounts of funding from private sources (mainly households). Not surprising, given the kind of services provided by the external service providers (see earlier description), all the funding for these activities comes from external financing agents.

Table 8: Flow of funds between Finacing Agents and Service Providers (2008/9 and 2009/10)

Agent by Providers 2008/09 (Ug shillings Billion)

	Providers			
Agents	Public Providers	Private Providers	External Providers	**Totals**
Public	144.7	31.7	0.1	**176.5**
Private	68.0	246.1	0.0	**314.1**
External	58.6	517.9	42.6	**619.2**
Totals	**271.3**	**795.8**	**42.8**	**1,109.9**

Agent by Providers 2009/10 (Ug shillings Billion)

	Providers			
Agents	Public Providers	Private Providers	External Providers	Totals
Public	191.5	30.9	0.3	222.7
Private	75.3	274.2	0.0	349.6
External	61.3	494.3	39.3	594.9
Totals	**328.2**	**799.4**	**39.6**	**1,167.2**

In general, concerning financing agents and service providers, the following are noted:

- The bulk of the providers receiving the funds are in the private sector – i.e. 71% and 68% in 2008/9 and 2009/10, respectively;

- Public providers used between UShs 271 billion and UShs 328 billion for service provision, which is about 24% and 28%, respectively in 2008/9 an 2009/10, of total resource envelope;

- Private providers are largely funded by bilateral FAs and by households;

- External Providers are largely funded by bilateral FAs, and External Foundations; and provide very limited scope of services.

F.4 HIV/AIDS Spending by AIDS Spending Categories

Results in Figure 12 and Table 9 show the details of how the HIV/AIDS resource were spent in 2008/9 and 2009/10, broken down by the standard NASA AIDS Spending Categories.

Figure 12: Expenditure by AIDS Spending Categores – 2008/9 and 2009/10

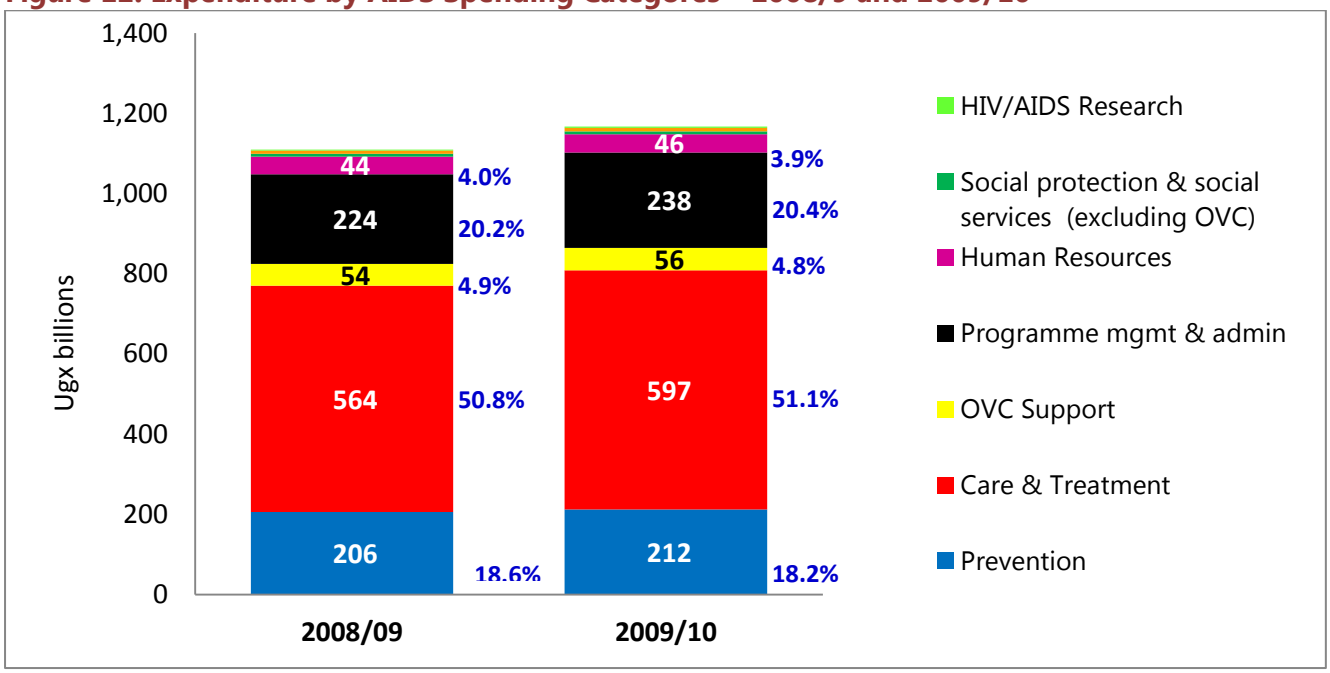


Table 9: Details of spending by AIDS Spending Categores (2008/9 and 2009/10)

	2008/09 (Bn Shs)	%	2009/10 (Bn Shs)	%
Prevention	206.1	*18.6%*	212.0	*18.2%*
Care & Treatment	564.1	*50.8%*	596.5	*51.1%*
OVC Support	54.1	*4.9%*	56.1	*4.8%*
Programme mgmt & admin	223.7	*20.2%*	237.7	*20.4%*
Human Resources	44.2	*4.0%*	45.7	*3.9%*
Social protection & social services (excluding OVC)	7.0	*0.6%*	7.3	*0.6%*
Enabling environment	8.2	*0.7%*	8.8	*0.8%*
HIV/AIDS Research	2.5	*0.2%*	2.9	*0.3%*
TOTAL	**1,109.9**	***100.0%***	**1,167.2**	***100.0%***

Table 9 and Figure 12 show that Care and Treatment (51%), Program management and administration (20%) and Prevention (18%) take up the largest share of the total resources for HIV/AIDS in Uganda. These findings are consistent over the two-year period studied. Note that these three spending categories have small nomimal increases in resources between

2008/9 and 2009/10, with care and treatement receiving the highest increase (of about 32 billion shillings), programme management received a nominal increase of 14 billion shillings, while Prevention received a nominal increase of about 6 billion shillings. Human resources and OVC support each received about 4% of total resource evelope, and each had a nominal increase of about 2 billion shillings between 2008/9 and 2009/10. Lastly, social protection and impact mitigation, enabling environment, and HIV/AIDS research each received very miniminal funding, amount to less than 1% of total resource envelop.

Figure 13: Public Sources: what has the money been spent on? – 2008/9 and 2009/10

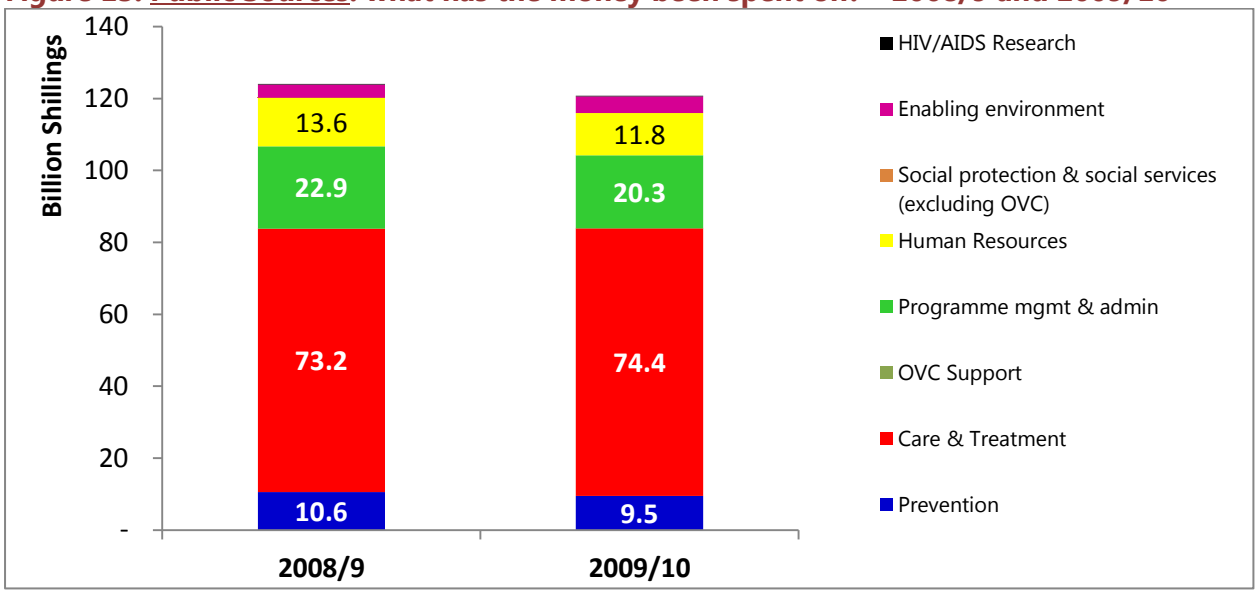
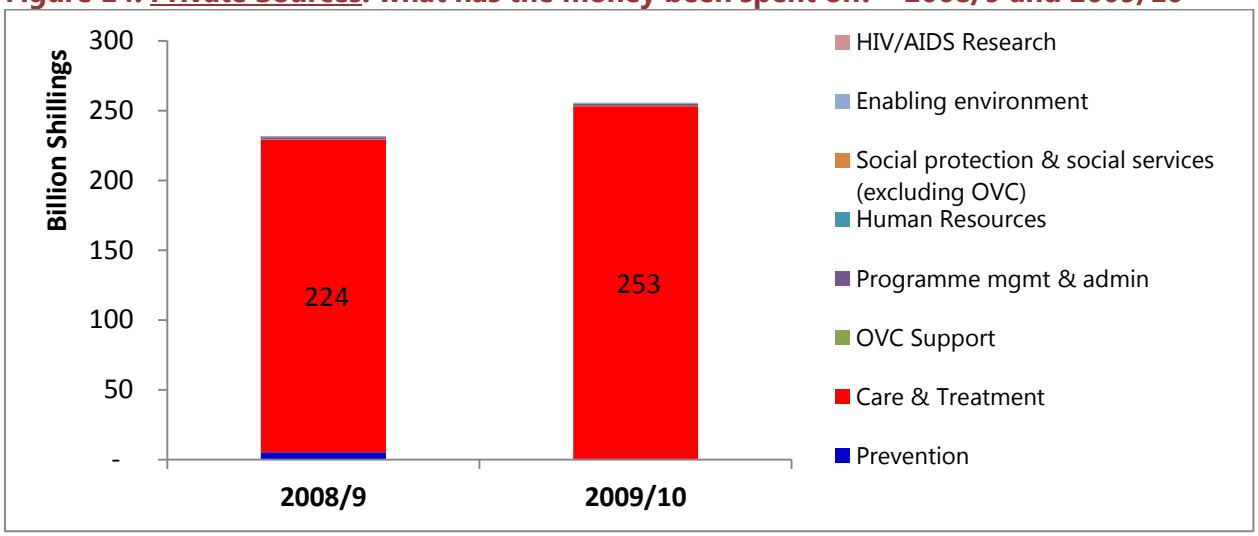


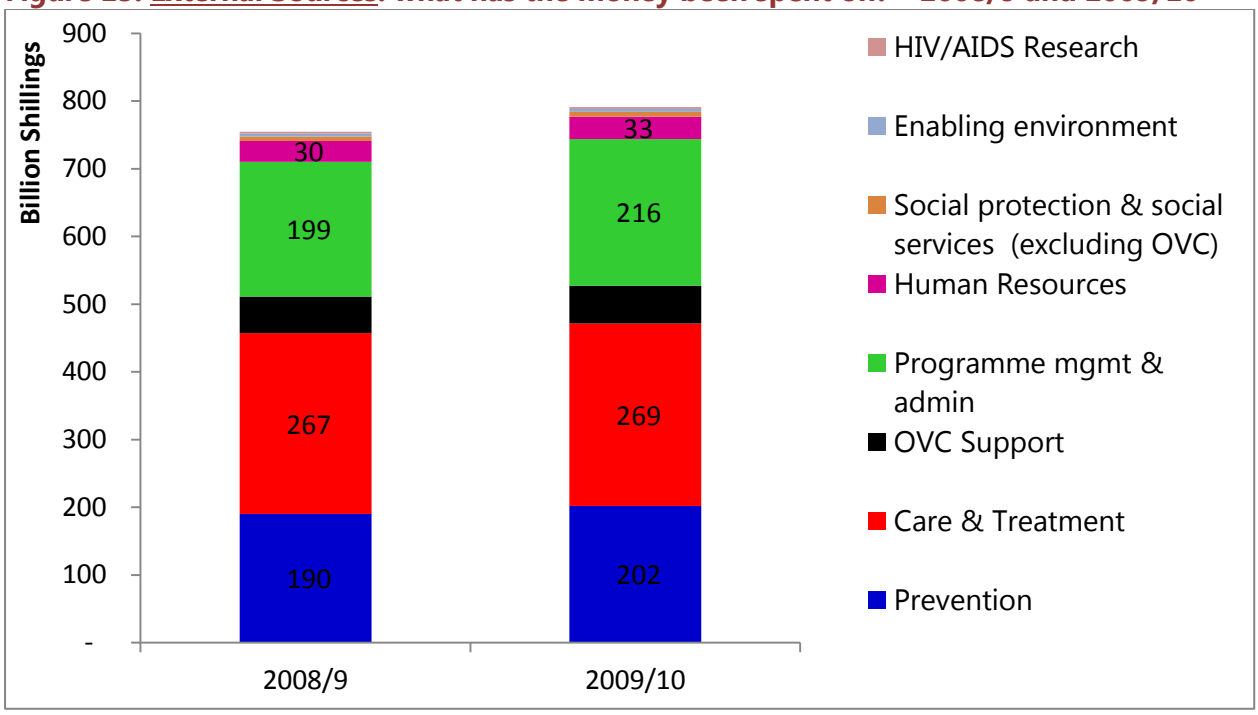
Figure 14: Private Sources: what has the money been spent on? – 2008/9 and 2009/10



Figures 13 – 15 provide a breakdown of what money was spent on in the different sectors (public, private and external). For the **public sector** (see Figure 13), the biggest proportion (about half) of funds were spent on *Care and Treatment*, and about 20% spent on programme coordination, management and adminisation, with a smaller proportion spent on Prevention and other spending categories. In the public sector, the amount of money spent on

Programme management was relatively higher than the amount spent on Prevention. For the **private sector** (see Figure 14), almost all the funds from private sources are used for *Care and Treatment*. This is not surprising given the methodology used for estimating out-of-pocket spending and the assumptions made on how that money is spent. For the external sector (see Figure 15), about a third of the funds were used for *Care & Treatment*, and a significant amount was spent on Programme Management. The amount spent on prevention is slightly less than the amount spent on Program Management and Administraion.

Figure 15: External Sources: what has the money been spent on? – 2008/9 and 2009/10



Results in Figure 15 show the resource allocation priorities within each sector. Clearly, Care and Treatment takes the biggest proportion of resources in each of the sectors. This may partially be due to the existing policies and national response priorities, but it may also be due to the relatively higher unit costs of providing Care and Treatment services (which, in addition to ART include treatment such as palliative care) compared to other priorities or spending categories. The second highest consumer of resources for public and external sectors seems to be Programme management, coordination and administration. It is a bit worrying to note that spending on this category is even higher than spending on Prevention, in both the public and external sectors.

Figure 16: Comparison between sectors: what has the money been spent on? 2009/10

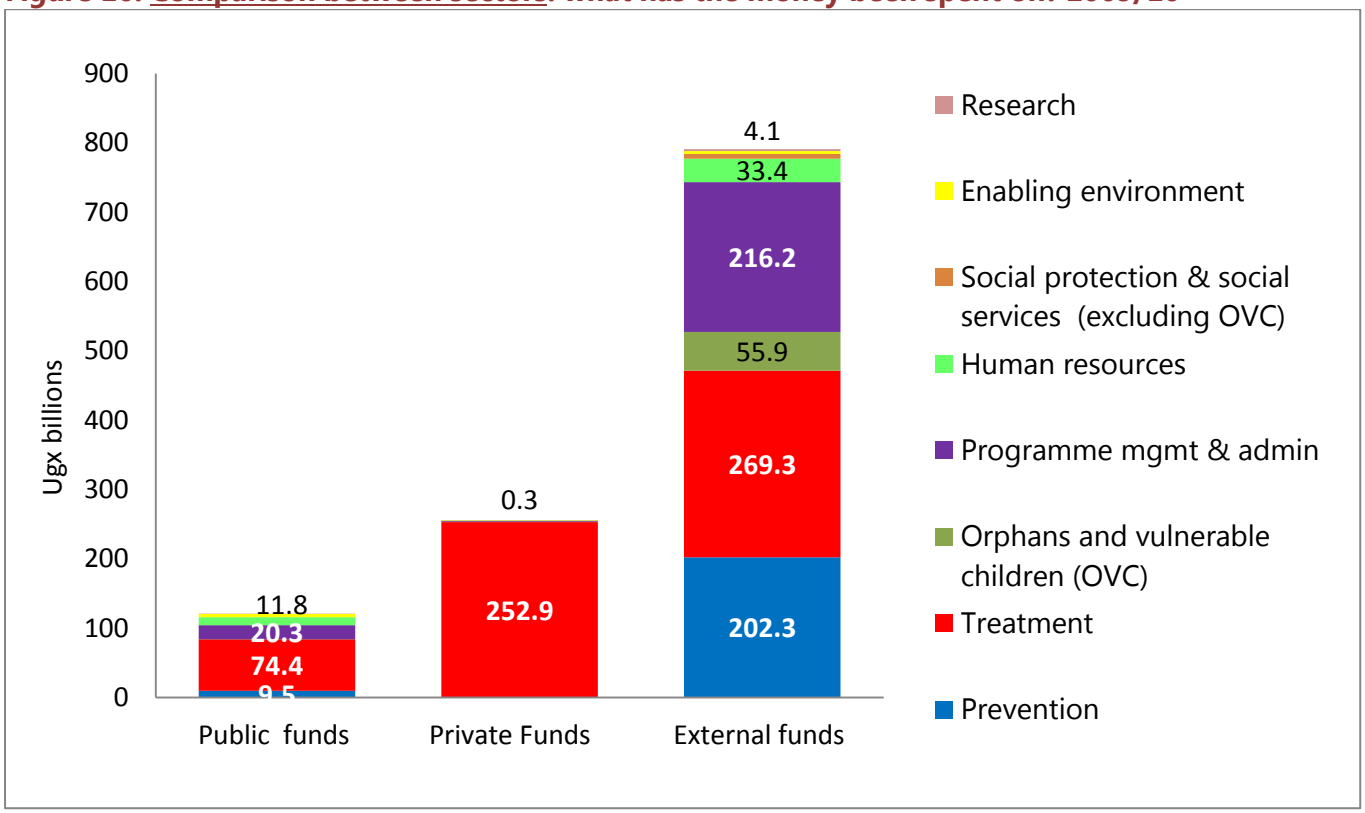


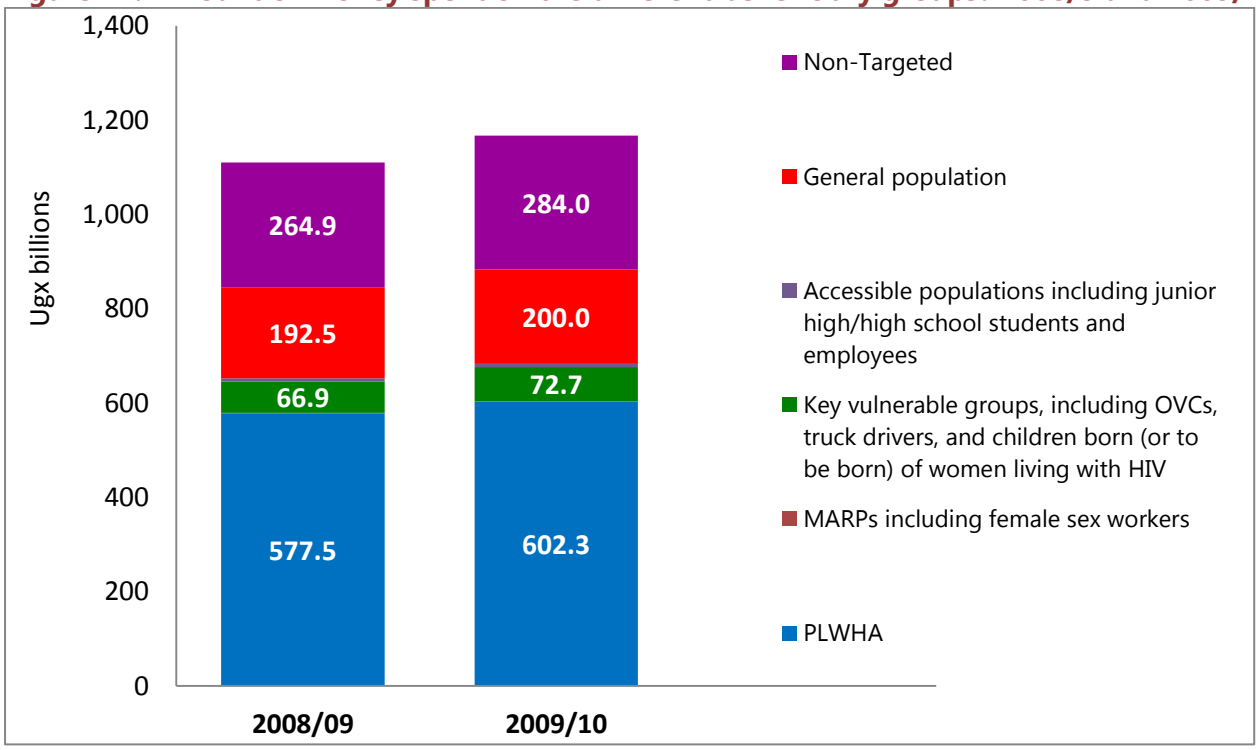
Table 10: Details of spending by AIDS Spending Categores (2008/9 and 2009/10)

Breakdown of PROGRAM MANAGEMENT EXPENDITURE	**2008/09 (Bn Shs)**	**2009/10 (Bn Shs)**
Planning, coord & policy development	35.3	92.2
Admin & transaction costs	4.1	4.4
M&E	1.7	1.8
Operations research	0.0	0.1
Serological-surveillance (serosurveillance)	0.1	0.5
HIV drug-resistance surveillance	0.0	-
Drug supply systems	3.2	0.3
Information technology	0.3	0.2
Patient tracking	0.2	0.2
Prog.Mgmt not disagg.	178.0	137.8
TOTAL	**223.1**	**237.5**

F.5 Beneficiaries of HIV/AIDS spending

Figure 17 shows that more than 50% of the funds benefit the PLHWA. This is not surprising given our earlier result which showed that the biggest proportion of the resource envelop are spent on Care and Treatment in all the sectors (public, private and external). The second group of people benefiting are the general population who largely benefit from the prevention activities and services. A significant amount on money is spent on activities that not necessarily targeted at a specific beneficiary group. Such funds include funds spent on programme management, coordination and administration – and it has already been noted earlier that a significant amount of money is being spent on this.

Figure 17: Amount of money spent on the different beneficiary groups? 2008/9 and 2009/10



Figures 18 and 19 provide a breakdown of the amount of money spent on the different beneficiary groups in the public and private sectors, respectively. As already indicated in Figure 17, the trends are the same in both sectors.

Figure 18: Public providers: Who is benefitting?

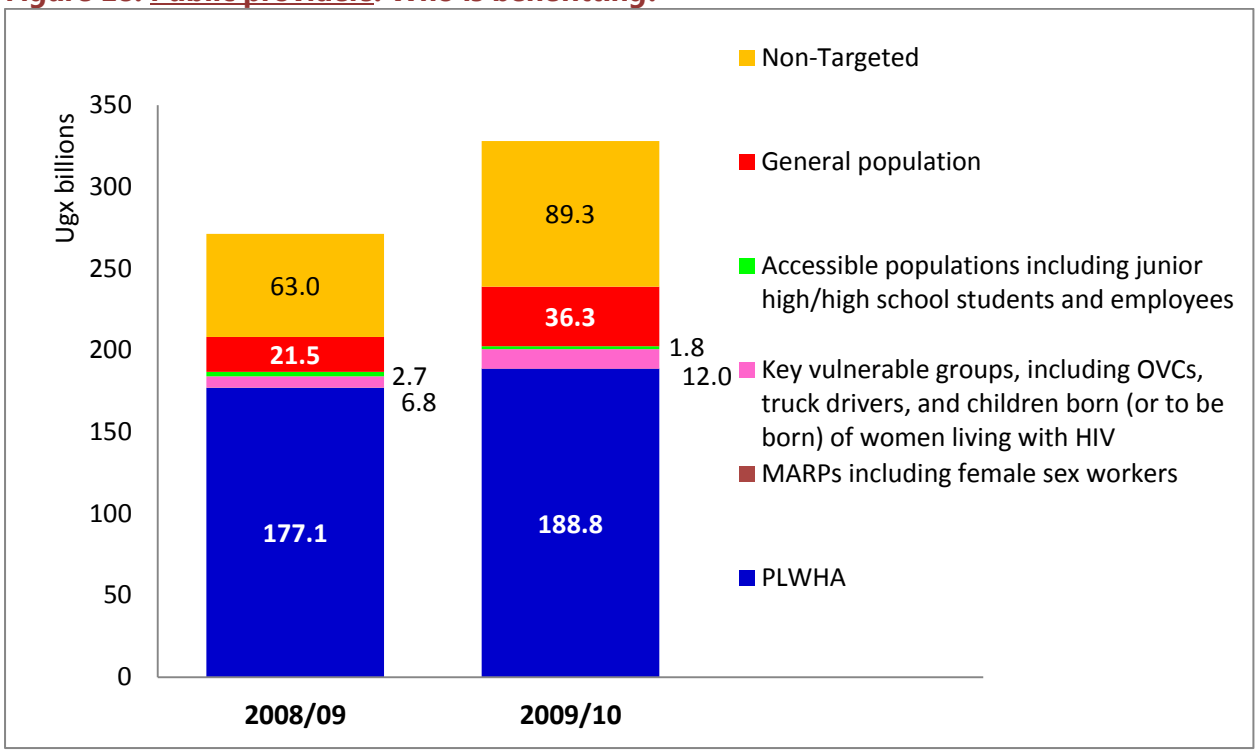


Figure 19: Private Providers: Who is benefitting?

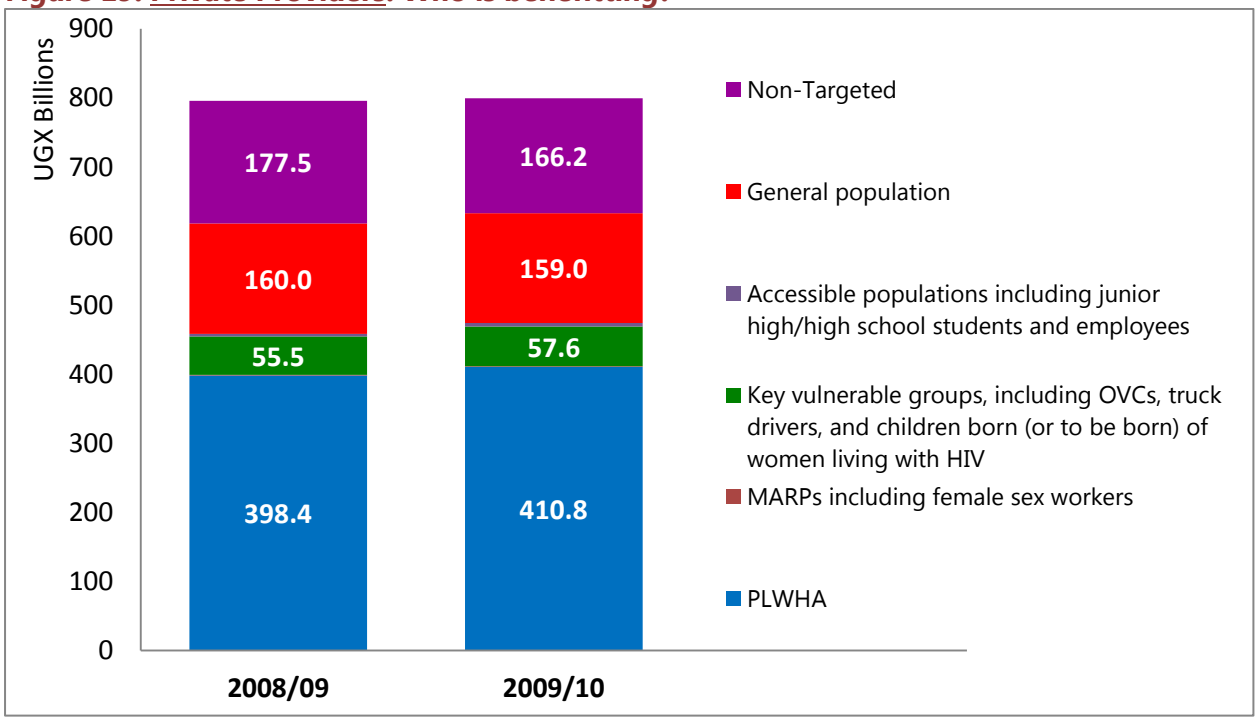


Table 11: Amount spent on different beneficiary groups by sector (2008/9 and 2009/10)

Beneficiaries by Provider 2008/09 Bn shillings

	PLWHA	MARPs	OVCs	Accessible pops.	General Pop.	Non-Targeted	Totals
Public	177.1	0.1	6.8	2.7	21.5	63.0	**271.3**
Private	398.4	0.7	55.5	3.7	160.0	177.5	**795.8**
External	2.0	0.6	4.6	0.2	11.1	24.3	**42.8**
Totals	**577.5**	**1.4**	**66.9**	**6.7**	**192.5**	**264.9**	**1,109.9**

Beneficiaries by Provider 2009/10 Bn shillings

	PLWHA	MARPs	OVCs & Vuln.Pops	Accessible pops.	General Pop.	Non-Targeted	Totals
Public	188.8	0.0	12.0	1.8	36.3	89.3	**328.2**
Private	410.8	0.7	57.6	5.0	159.0	166.2	**799.4**
External	2.6	0.5	3.2	0.1	4.7	28.5	**39.6**
Totals	**602.3**	**1.3**	**72.7**	**7.0**	**200.0**	**284.0**	**1,167.2**

Table 11 provides further details on the amount of money spent on the different beneficiary groups in the three sectors in 2008/9 and 2009/10. Results in Table 11 bring out insight into the results presented in Figure 17-19. It has already been noted that the PLWHAs benefit the most, followed by the general population. It is a serious concern to note that the most-at-risk populations benefit the least, and also that OVCs and other vulnerable groups are not benefiting significantly from the responses. This concern is one of the key areas for further investigation, where affirmative action is needed in order to ensure that these groups are reached effectively within the response.

It is important to note, however, that spending on OVCs may be an under-estimate considering that estimation of household out-of-pocket spending did not capture such spending.

G. Policy implications of NASA Results

The NASA is not an end in itself but rather a means to an end, intended to provide evidence to inform allocative decision-making. The stakeholders in the Uganda HIV/AIDS response planned to have a NASA for a number of reasons, contained in the objectives reproduced below.

The *overall objective* of the first Uganda NASA was to compile and document detailed information on HIV/AIDS financing and expenditure with the aim to provide information that will guide resource mobilisation, planning, resource allocation for and management of the National Response

The *specific objectives* were:

- To assess the magnitude and structure of HIV/AIDS financing and expenditure in Uganda.
- To strengthen the institutionalisation of HIV/AIDS resource tracking in Uganda's national response

The stakeholders during the Inception Phase of the study further agreed to break down these broad objectives into a number of Policy Questions for which the NASA would endeavour to find answers. This section will utilise the NASA Estimates presented in **Section F** to provide responses to the policy questions (and therefore the objectives). Where appropriate and available data/information from other sources like the National Strategic Plan (NSP), will be utilised in responding to Policy Questions and to make judgments about the appropriateness of the Uganda HIV/AIDS financing and expenditure as documented by the NASA.

Over the period 2006 to 2010, a number of countries in the East and Southern Africa (ESA) region compiled information on spending on HIV/AIDS using the NASA methodology, and therefore have comparable data. It is important to note that Uganda has carried out a comprehensive NASA which included estimation of household expenditure for HIV/AIDS and systems spending in the health sector which other countries did not do. The NASA estimates from other countries will be used to make comparisons with the Uganda figures to get a sense of how Uganda is performing at regional level amongst countries with many similarities including high HIV/AIDS prevalence and mature epidemic[6].

[6] CEGAA (2012) Regional Comparisons of HIV/AIDS Spending

G.1 Using NASA results to respond to the study objectives & policy questions

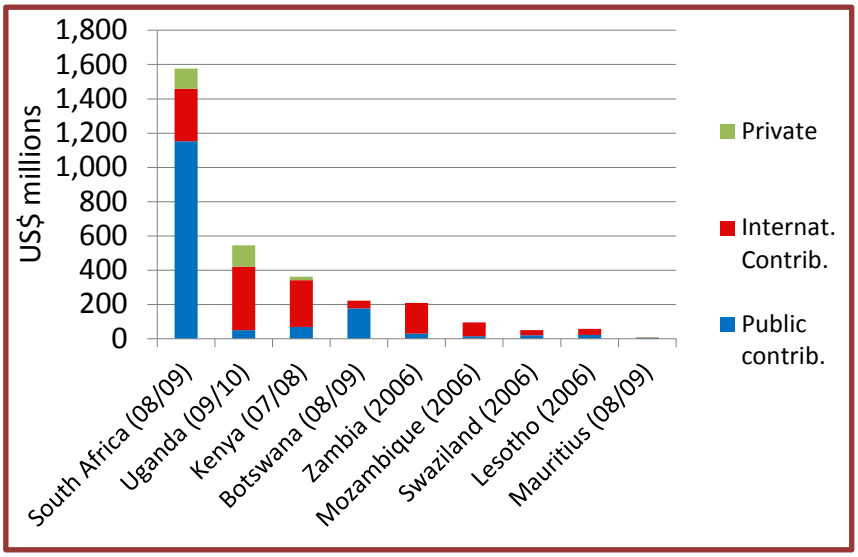
G.1.1 Descriptive Policy Questions

These constitute the basic questions the NASA is supposed to answer and can be answered primarily with the NASA estimates.

a) How much money was spent on HIV/AIDS control activities in Uganda in FY 2008/09; FY 2009/10? Is there marked difference between the 2 years? If so, what is the likely cause for this? Funding Levels

As provided in **Section F.1** of this Report, 1,109 billion UGX (586.6 million US $) was spent on HIV/AIDS control activities in Uganda in 2008/09; and 1,167 billion UGX (579.7 million US $) in 2009/10. This reflects an increase of 5% in shilling terms and a decrease of 1% in US dollar terms – there is therefore no appreciable difference in the total level of expenditure between the 2 years.

Figure 20: Regional Comparison of HIV/AIDS Funding Levels and Sources



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

In comparison with other countries in the region Uganda registered higher total levels of funding for the HIV/AIDS response than the other countries, except South Africa which spent almost four times the amount spent by Uganda in 2009/10 as shown in **Figure 20**. The comprehensive nature of the Uganda NASA including estimation of household expenditure on HIV/AIDS and public health systems funding is likely to have contributed to this difference but does not completely explain it, as **Figure 20** shows, International Contributions to Uganda alone exceed total NASA estimates from other countries in the region.

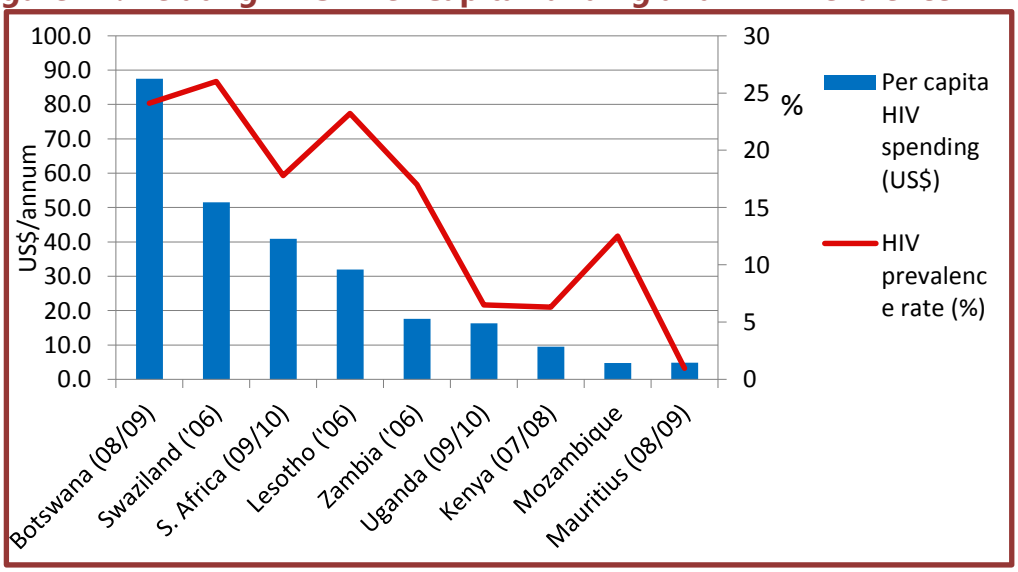
In addition to looking at the absolute amounts of funding it is useful to consider the funding in terms of population size and the HIV/AIDS prevalence in the different countries. This is important as it relates to the actual burden of the diesase. **Figure 21** shows that Botswana has the highest funding per capita (almost US $90) but also one of the highest HIV prevalence rates in the region (24%). On the other side Mauritous extremely low funding and very low prevalence. Uganda is a middle performer with relatively low HIV prevalence (about 7%) and low funding per capita (US $18).

b) What is the Source of the funds?

The NASA provides information on where the funds for the response come from; with Public Sources in 2008/09 contributing 11.2%; Private Sources 20.8% and International Sources 68%. Very similar proportions were maintained for the FY 2009/10. The proportion of funding from International Sources is high, with further breakdown showing that this funding comes from Bilateral Entities (50% or more of all expenditure for both years) with a few donor countries contributing the funds; Multilateral Entities and External Foundations. There was a marked increase in the contribution of Multilateral Entities from 13.56 billion UGX (1.2%) in 2008/09 to 112.29 billion IGX (9.6%) in 2009/10, and is accounted for by the GFATM resuming funding to Uganda in that year. External Foundations were contributing just below 10% for each year, or about 100 billion UGX; this is a substantial amount of money, in the context that many of these are small organisations without offices in Uganda, and therefore not participating in policy dialogue.

The private funding at more than 20% is a significant contribution, and is mostly from households, with minimal contributions from business entities. Public funds are mostly from central government with negligible amounts contributed by local governments.

Figure 21: Relating NASA Per Capita Funding and HIV Prevalence



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

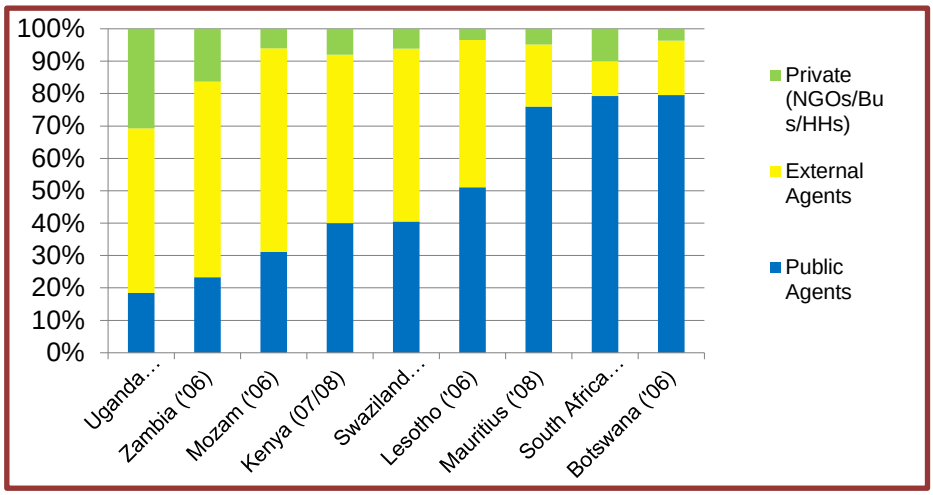
Marked similarities and differences are noted when Uganda data for 2009/10 is compared to recent data from other ESA countries: South Africa and Botswana show much higher public contribution than Uganda; whereas Kenya and Zambia are quite similar to Uganda in having modest contribution from public sources. Only South Africa, Uganda and Kenya show an appreciable amount of private funding. In Uganda this could be partially explained by the methodology with a comprehensive approach to the NASA including estimation of household contributions.

c) Which entities are managing/making decisions about the funds? – Financing Agents

In 2008/09, 56% of the NASA funds were managed by External Financing Agents (FAs), 28% by Private FAs and 16% by Public FAs. The FY 2009/10 noted a bit of improvement for the Private FAs and Public rising to 32% and 19% respectively; the proportion managed by the External FAs though remained more than a half of all expenditure (at 51%). The bulk of these are Bilateral FAs. The Public Sources mostly passed on funds to Public FAs; Private Sources passed funds to Private FAs; whereas International Sources passed on the bigger portion of funds to External FAs (at least 75%) and some to Public and Private FAs.

In the ESA region, the proportion of funds managed by External FAs is higher in Zambia, Mozambique (both above 60%), Kenya and Swaziland than Uganda as shown in **Figure 22**. Lesotho, Mauritius, Botswana and South Africa have proportionately less funds managed by External FAs, with South Africa having the least at about 10%. It is evident that countries with high International Contribution have a high proportion of the HIV/AIDS resources managed by External and Private FAs, whereas countries with high Public Sources contribution have a high proportion of their resources managed by Public FAs.

Figure 22: Regional NASA Comparison of Spending by Financing Agents



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

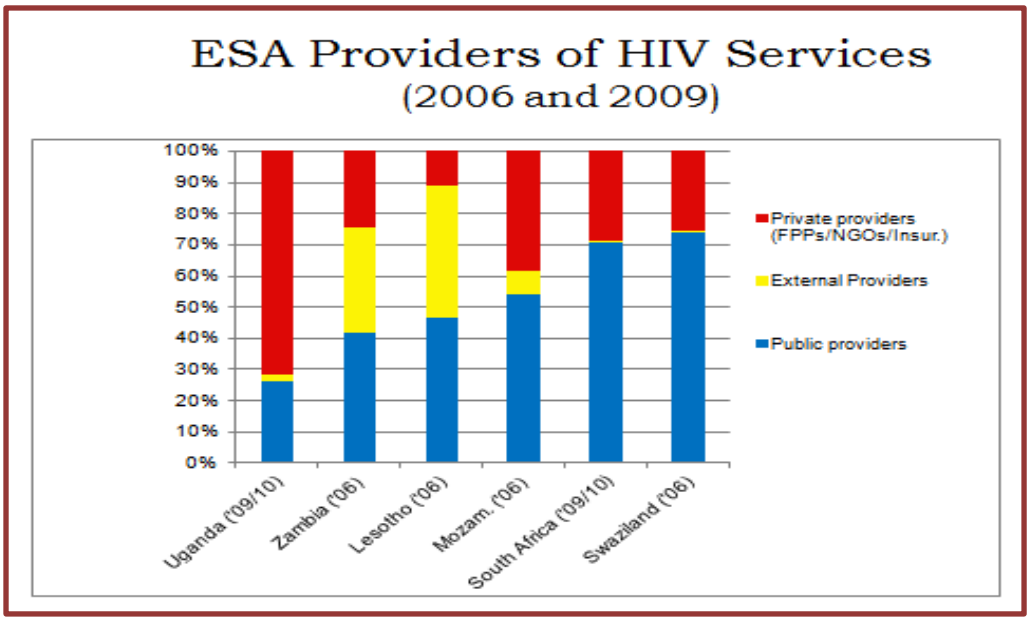
d) Who is translating the funds into activities?- Providers of HIV/AIDS services

More than two thirds of the NASA funds in Uganda are utilised by Private Providers (71.7% in 08/09, 68.5% in 09/10). The public providers utilised about a quarter of the funds (24.4% in 08/09 and 28% in 09/10) while External Providers utilised a negligible proportion of the funds (3.9% in 08/09 and 3.4% in 09/10). The bulk of the expenditure for the provision of HIV/AIDS services in Uganda is therefore in the private sector.

Section F.3 of this Report shows that the largest proportion of expenditure amongst private providers is NGOs, and CBOs (at 75% and more for each year); private for profit health facilities – hospitals, clinics and pharmacies are next (totaling at least 15% for each year); and private not for profit health facilities – hospitals and health centres (a little under 5% each year) - as the main groups of providers of services. The funds utilised by the Private Providers are mostly from International (especially bilateral entities) and Private Sources, and managed by External and Private FAs.

The public sector providers utilizing these resources are largely at national level including Ministry of Health departments, Uganda AIDS Commission and other government ministries utilizing a little less than 70% of these funds, and local governments, public hospitals and health centres utilise just above 30%. The funds utilised by Public Providers are managed by Public FAs, with the source of funds as Public Sources and International Sources (especially multilateral entities); and minimal funding from Private Sources managed by Private FAs.

Figure 23: Regional NASA Comparison of Providers of Services



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

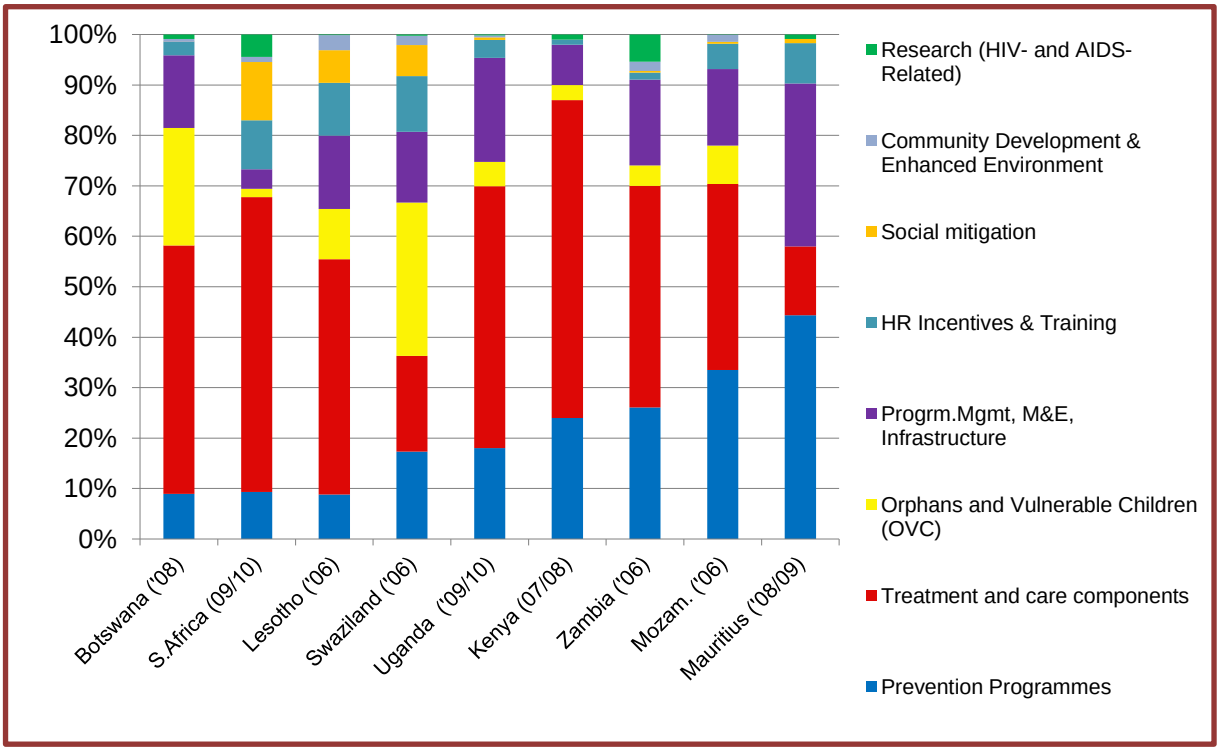
When compared to other countries in the region, Uganda has the highest proportion of spending utilised by private providers; while South Africa and Swaziland show the opposite picture with the larger proportion of the expenditure by public providers; and Zambia and Lesotho show a significant proportion of the spending with external providers as shown in **Figure 23**.

e) What is the money being spent on? - AIDS Spending Categories (ASCs)

The NASA estimates show that 18.6% of HIV/AIDS funding in Uganda in the FY 2008/09 was spent on Prevention, 50.8% on Care and Treatment, 4.9% on OVCs, 20.2% on Programme Management, 4% on Human Resources, and less than 1% apiece for Social Protection & Social Services, Enabling Environment and Research – this picture was maintained in 2009/10.

A number of countries in the ESA region including Kenya, Lesotho and South Africa like Uganda have Care and Treatment taking up more than 50% of the HIV/AIDS expenditure; with Lesotho, Mozambique and Zambia in the 30-50% range; and Mauritius and Swaziland showing less than 30% of expenditure on this ASCs – as shown in **Figure 24**. Uganda is comparable to other countries in the region on spending on Programme Management, and a middle performer on prevention where Mauritius spends the highest proportion, and Botswana and South Africa the lowest. Swaziland and Botswana spend more than 20% of their resources on OVCs; whereas Lesotho, Mauritius, South Africa, and Swaziland spend about 10% each on Human Resources Incentives and Training. This pattern does not seem directly explained by HIV prevalence or the nature of the epidemic in these countries, as high prevalence countries like Botswana, Lesotho, South Africa and Swaziland have differing proportions of expenditure on ASCs like Care and Treatment and OVCs.

Figure 24: Regional NASA Comparisons of Expenditure by AIDS Spending Category



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

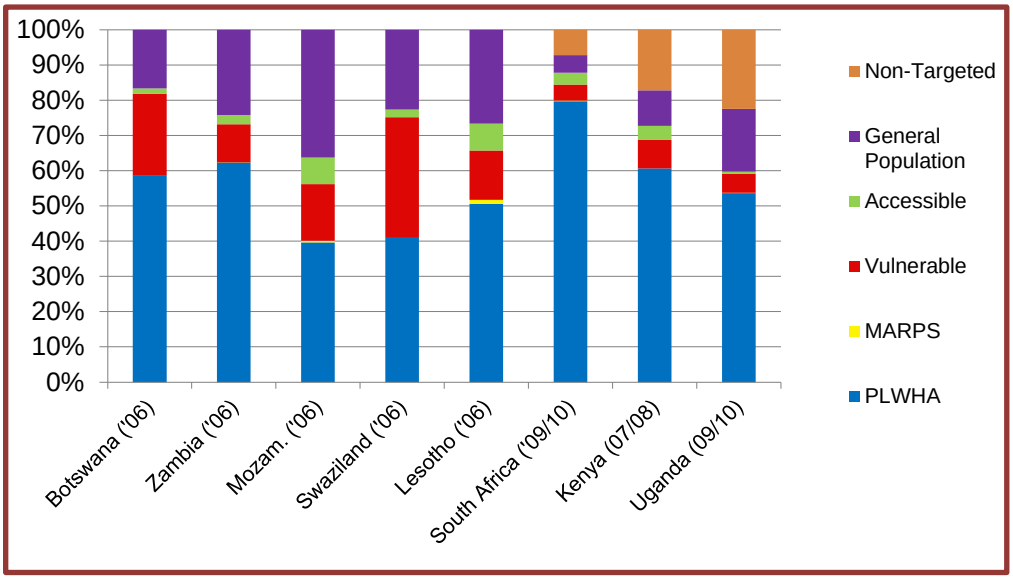
f) What is the money being spent on – Inputs/Production Factors?

The NASA methodology requires that spending information is provided both in terms of the aspect of HIV/AIDS that is being supported, commonly referred to as thematic areas and in NASA nomenclature as AIDS Spending Categories (ASCs), and in the type of inputs purchased with the funds – Production Factors. For Uganda's first NASA although it was possible to collect information form stakeholders especially the Providers of services about the ASCs, it was not possible to get consistent good quality data on Production Factors and analysis along this line was not done. A similar experience was noted in most other ESA countries doing first NASAs.

g) Who is benefitting from the resources –the Beneficiaries?

Section F.5 showed that more than 50% of the HIV/AIDS spending benefitted the PLHWA in both FY 2008/09 and 2009/2010. This is understandable given a large proportion of the funding was spent on Care and Treatment which benefits PLHWA. When the funds benefiting the general population and funds that are not targeted at any particular group are added together, they form more than 40% of all HIV/AIDS spending. This indicates that the other benefitting categories like Most at Risk persons (MARPS) including Sex Workers (SWs), Intravenous Drug Users (IDUs); Key Vulnerable Populations including orphans, children of HIV mothers and truck drivers; and accessible populations including students, STI clinic attendees, health workers and the forces share less than 10% of all spending.

Figure 25: Comparison of HIV/AIDS Funding Beneficiaries in the Region



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

Botswana, Kenya, Lesotho, South Africa, Uganda and Zambia all documented more than 50% of the HIV/AIDS spending benefitting PLHWA; while Mozambique and Swaziland documented about 40% for PLHWA. Botswana and Swaziland showed the highest spending on Key Vulnerable Populations with Swaziland noting more than 30% on this category of beneficiaries.

G.1.2 Analytical Policy Questions

The analytical Policy Questions are those that require additional information other than the NASA estimates, and/or judgment on whether the spending on the Uganda HIV/AIDS response as documented by the NASA is appropriate. A number of questions were raised under this sub-heading, and the responses are indicated here below.

a) How efficiently (appropriately) are the resources being used?

In more specific terms two questions were asked under this Policy Question:

★ Are the resources being spent on the priorities of the National Strategic Plan (in line with NSP costing)?

The overall funding for the national response as documented by the NASA is higher than the "Higher Case Funding Scenario" as estimated by the NSP[7]. There is further discussion on this under d) in this sub-section of the Report. The discussion under this paragraph focuses on the funding scenarios by thematic area.

[7] National Strategic Plan 2007/08 – 2011/12 pages 45-48

Table 12: Comparing Resource Projections for the NSP and NASA Estimates (US $ millions)

Thematic Area/ AIDS Spending Category	2008/2009				2009/2010			
	NSP		NASA		NSP		NASA	
Prevention	104.9	**30%**	108.9	**19%**	114.6	**29%**	105.3	**18%**
Care & Treatment	133.5	**38%**	298.2	**51%**	156.2	**39%**	296.3	**51%**
Mitigation	79.7	**23%**		**0%**	98.5	**25%**		**0%**
Social Protection & Services			3.7	**1%**			3.6	**1%**
OVC Support			28.6	**5%**			27.9	**5%**
Programme Support	28.6	**8%**	118.2	**20%**	33.2	**8%**	118.1	**20%**
Human Resources			23.4	**4%**			22.7	**4%**
Enabling Environment			4.3	**1%**			4.4	**1%**
HIV/AIDS Research			1.3	**0%**			1.4	**0%**
Total Millions of USD	**347**	**100%**	**586.6**	**100%**	**402.0**	**100%**	**579.7**	**100%**
			169%				**144%**	

Source: National Strategic Plan 2007/08 to 2011/12 & NASA Estimates

- *Prevention* – NASA indicates that in absolute terms about the same amount of funds as was costed was available for this ASC in both years – slightly more in 2008/09 and slightly less in 2009/10. However in terms of proportion of all resources available, this was by far less than had been projected: 19 and 18% expended for the two years compared to 30% and 29% projected respectively as shown in **Table 12**.
- *Care & Treatment* – NASA indicated much more spending both in absolute and proportionate terms than had been costed for the two years for this thematic area – for example in FY 2008/09 at US $ 298.2 million it was more than twice what had been estimated as needed, and at 51% of all resources much higher than the projected 38%. Note that this includes funds from household spending which was all under this ASC, and had not been taken into consideration by the NSP estimations.
- *Mitigation*[8] – NASA shows much less spending both in absolute and proportionate terms than the NSP costing for this ASC for both years; with less than half of projected spending for the FY 2008/09. Note that the methodology used to capture household spending did not capture this aspect, whereas it is a major area of spending by individuals, households and communities.

[8] Mitigation here includes the ASCs of Social Protection & Services and Support to Orphans and Vulnerable Children

- *Programme Support*[9] – NASA shows much more spending both in absolute and proportionate terms for this ASC; with about 5 times the estimated amount spent for the FY 2008/09.

This indicates that the spending has been very different from what was initially planned in the NSP and could therefore be said to be inappropriate or imply that the cost estimates were inaccurate in their assumptions.

★ Compare **current resources spent on prevention** vs. *medium term resources need for Care & Treatment*; given projections of HIV prevalence/incidence given various scenarios

All the resources indicated as required for Prevention activities under the NSP were available. However it is difficult to determine whether these resources were used for the intended specific activities within the broader area of prevention, and whether these led to the expected changes in behavior and subsequently reduced HIV incidence and prevalence. Models and Projections of HIV incidence and prevalence given prevention activities to be provided by UAC, together with information about new prevalence figures, so as to consider whether it is possible to answer this query.

a) Financing and Expenditure for Prevention

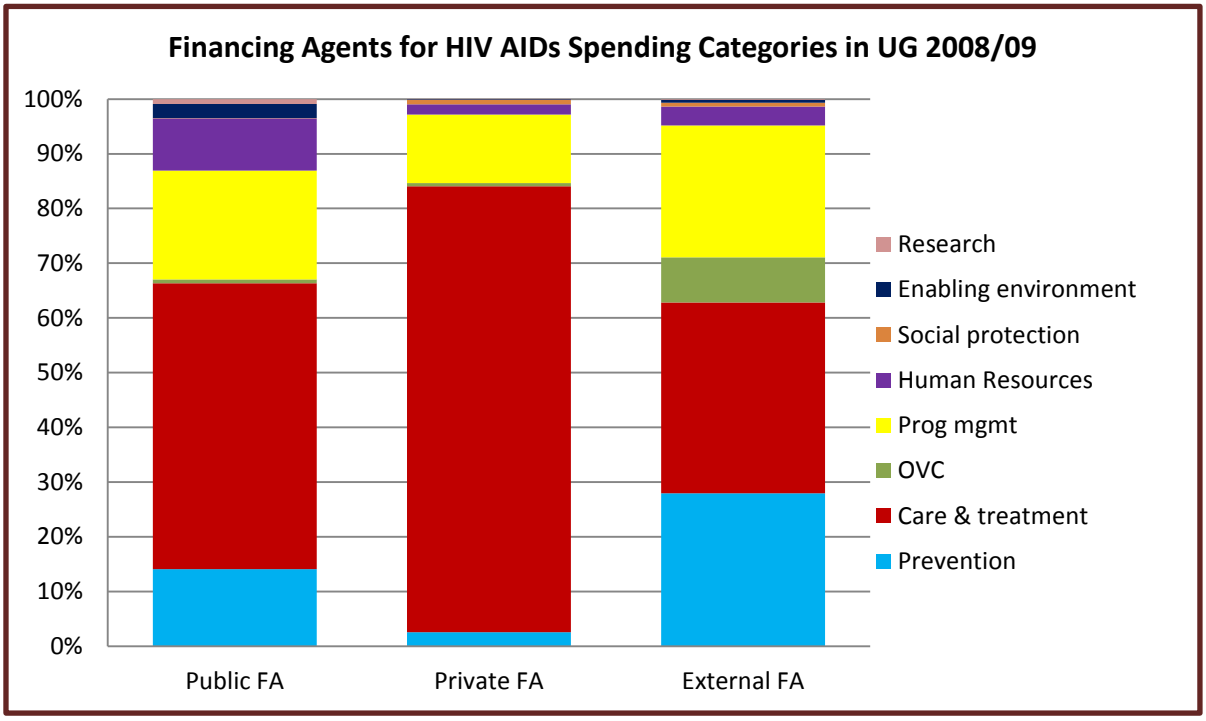
A number of specific questions were asked under this broad Policy Question as follows:

★ What are the Sources, Financing Agents and Providers for Prevention?

International Sources provide most of the funding for Prevention activities with more than 90% of funding for Prevention activities in the FY 2009/10 coming from external sources. The estimation methods used for the NASA though may have contributed to this split as it was not possible to determine household spending on prevention (given household health spending methodology) and therefore could have underestimated the amounts contributed by private sources._As previously noted International Sources tend to pass on money to External FAs who in turn pass the funds to Private Providers. **Figure 26** shows that External FAs spend the higher proportion of their managed funds on prevention, with public FAs as second and a small proportion of funds by Private FAs spent on prevention. Given that the External FAs manage about a half of all HIV/AIDS spending this is indeed where the buls of prevention funds are coming from.

[9] Programme Support here includes the ASCs Human Resources, Enabling Environment & Research

Figure 26: Finacing Agents for HIV/AIDS Spending Categories 2008/09



Source: CEGAA (2012) Regional Comparisons for HIV/AIDS Spending

★ What implications do these findings have for affordability and sustainability for Prevention activities in the medium and long term?

★ Is there heavy reliance on few donors for the key area of Prevention?

The bulk of the funding for Prevention activities is from International Sources which are composed of bilateral and multilateral organisation and external foundations. The current level of funding for Prevention activities is about equivalent to NSP cost estimates in absolute terms but lower in proportional terms, and therefore it could be said that the national response is adequately funded for prevention activities (given NSP assumptions). The very high reliance on International Sources (donors) External FAs and Private Providers (mostly NGOs and CBOs) has marked implications for sustainability of the current efforts. NGOs and CBOs funded by International Sources and External FAs are likely to work on project basis and once this funding for a specific project ends this is likely to lead to discontinuation of the particular activities (this may not be in all cases) and inevitably loss of the developed capacity for the national response. The HIV/AIDS response funding profile as shown by the NASA therefore indicates poor likelihood of sustainability for prevention activities funding and institutional set up.

b) How equitably are the resources being used?

Equity is a very broad subject and the Policy Question was targeting some specific issues under equity namely:

★ Geographic equity – with particular reference to public resources;

In-depth analysis on this issues was not possible given the methodology used to estimate public spending on HIV/AIDS, whereby only 20% of the districts. In addition, large amounts of funds were spent by Ministries and other central level entities (for services and supplies for the benefit of the whole country) that could not be broken down by region or district. However the institutional set up of the public system with processes and formulae for resource allocation to districts, hospitals and health centres across the country provide a framework for fairly equitable (geographical) distribution of HIV/AIDS resources.

★ Benefit by Vulnerable/at risk group like MARPs including Commercial Sex Workers (CSWs) and Orphans and Vulnerable Children (OVCs);

The funds targeted at OVCs were 6% for both FYs 2008/09 and 2009/10; for MARPS the corresponding figures were 0.1%. This seems rather low but it is difficult to determine what the right level should be. The NSP estimates and data from other countries in the region could be used in an effort to provide objective assessment of the appropriateness of this spending. Unfortunately the NSP does not provide guidance on spending proportions by beneficiary group. In comparison with other countries in the region Uganda is comparable to Kenya, South Africa and Zambia with less than 10% of HIV/AIDS funds spent on OVCs; whereas Botswana, Lesotho, Mozambique and Swaziland have at least 15% proportion of all HIV/AIDS spending on OVCs. There is generally very low spending on MARPS in the region with only Lesotho registering 2% of all HIV/AIDS funding on this beneficiary category.

★ Looking at equity from the point of view of different Sources and Financing Agents;

This sub-section will provide a brief comment on the equity implications for the different sources and FAs for the NASA. However it should be appreciated that a basic and simple approach has be used for this analysis, keeping in mind that much more complex and sophisticated approaches can be utilised for equity analysis but this was neither the intention nor the application of this study.

International Sources and Public Sources by providing funds for the national response ,do make it possible for the households and individuals who require services to access them at no, or as is more often the case, reduced cost. This favours equity as individuals receive services according to the need and not so much according to their ability to pay. Private funding of services however, particularly household Out-of-Pocket (OOP) payments which forms the bulk of the funds from Private Sources is inequitable as it means that some services are provided to only those who can afford to pay. This deters some people from getting certain services,

and in others cases pushes households into catastrophic payments that send them into (or further into) poverty. Insurance (for health services in this case) is not developed in Uganda with no funds captured as channeled through insurance or any formal pre-payment system for HIV/AIDS services. The substantial contribution of Private Sources as shown by this study – more than 20% each year, which is suspected to be an underestimate given the methodology utilised, is therefore of concern from an equity point of view.

In addition when International Sources provide funds especially when managed by External and Private FAs (93% of funds from this source in 2008/09 and 87% in 2009/10), choose specific parts of the country and certain packages of services to offer, and due to practical and logistical reasons do not cover the whole country, are likely to promote (geographical) inequity. This is likely to lead to islands of excellence on one hand and grossly underserved areas on the other. The NASA used a sampling approach and therefore does not provide detailed spending information for different parts of the country, but from the picture provided by the spread of service providers, this is a challenge in the national response. Some efforts have been made with different stakeholders, including government and development partners, planning together in determining service coverage across the country. These efforts are likely to have gone some way in neutralizing these potentially inequitable forms of funding.

Public Sources by virtue of the systems and structures of government tend to be relatively more (geographically) equitable with entities like the Ministry of Health (and other concerned Ministries including Ministry of Finance, Ministry of Local Government, Ministry of Gender) having allocation formulae to distribute resources across the country. The minimal funds though provided by Public Sources (about a tenth of all resources) and managed by Public FAs (less than a fifth) makes it practically difficult to use these resources to balance the (inequity) effect of International and Private Sources.

c) What are the implications for affordability, sustainability, harmonisation and alignment?

- ★ What are the main Sources (by proportion) and channels (Financing Agents) and procedures (Financial arrangements) for managing the funds?
- ★ What is the proportion of funds from public (Ugandan) sources and what proportion managed by indigenous organisations?

A key question for the national response is whether the funds available are enough. At the time of development of the NSP the stakeholders in the national response agreed to some costs in what was referred to as the "Higher Case Funding Scenario" which was indicated as not expected to achieve full coverage with all HIV/AIDS response activities, but would: give priority to the most cost-effective prevention interventions; support rapid expansion of ART

coverage; and triple the support that had previously been offered for OVCs. This scenario took into consideration the capacity available in country to scale up services effectively. The NASA Total Estimates for FY 2008/09 and FY 2009/10 are much higher (about 1.5 times) than what was costed for the NSP, in this the "Higher Case Funding Scenario".

Possible reasons for this include: much more funding than required for NSP was available; there was under estimate of NSP requirements, including that changed circumstances may have had implications for the cost of activities. A simple response to the basic question of whether the national response is adequately funded would seem to be yes. However the NASA estimates include 20% contribution from the private sector which was really not structured into this costing/projections and therefore a more appropriate comparison should be less by this amount. Even with the latter scenario, the funds available are still more than the NSP cost estimates. An interesting question is whether what had been planned was achieved and possibly exceeded.

A critical look at the NASA results shows that the Public Sector is playing a marginal role in funding & managing resources for HIV/AIDS in the country – this is consistent over the 2 years– see section **G 2.1** for specifics on this. External entities are playing a very big role, both in financing the national response, and in making decisions about the funds for the response. The biggest players, in terms of both financing and management of resources are the bilateral entities. The private sector is playing a big role – may be more than is usually appreciated. National players (public and private) contribute about one third of the resources (32% in 2008/09 and 33% in 2009/10); and manage less than a half (41% in 2008/09 and 46% in 2009/10).

This picture highlights the fact that Uganda, a developing country with a high burden of disease, is still heavily reliant on support from donors for the funding of provision of basic social services for its people. The support by the international entities (governments, agencies and foundations) has enabled Uganda to massively scale up the HIV/AIDS response. However this is not without some major challenges, some of which have been highlighted already and some here below.

★ What is the level of predictability (and sustainability) of HIV/AIDS funding – in the medium and long term?

The above picture has major implications for planning especially with regard to predictability and sustainability of funding for the national response. The NSP costs and resource projections provide a case in point. At the time of planning for the just ended five year period there was quite poor understanding and uncertainty about the resource envelope (total and by individual source) leading to modest plans and aspirations – see **Table 13.** More funding than was expected was available even for the initial 3 year period. Such circumstances are not

favorable to medium and long term planning, and the planning becomes operational (referred to a explicit and rolling prioritization in the NSP) rather than strategic and visionary. This can lead to inefficient use of available resources.

Table 13: Comparing NSP Resource Projections and NASA Estimates (US $ millions)

Source	2008/09			2009/10		
	NSP	NASA	Difference	NSP	NASA	Difference
Government of Uganda	59.8	65.6	5.8	61.2	60	-1.2
US – PEPFAR	283		-283			0
Global Fund - Rounds 3&7	31.9		-31.9	52.5		-52.5
Civil Society Fund	10.5		-10.5	11.7		-11.7
Partnership Fund	2.5		-2.5	2.8		-2.8
Support to MoLG by DCI	0.9		-0.9	0.5		-0.5
Unallocated[10]			0	269.4		-269.4
Total	**388.6**	**65.6**	**-323**	**398.1**	**60**	**-338.1**

Source: National Strategic Plan 2007/08 to 2011/12 & NASA Estimates

It would be interesting to fill this. However this would contravene the principle that we do not highlight individual contributions as we would do that for PEPFAR & DCI. Opinions?

The fact that most of the funding comes from a few bilateral and multilateral entities is a major point of concern, whereby if one entity was to withdraw for whatever reason (domestic or bilateral politics, economic crisis, governance related etc) this would create a major crisis. It can be noted for example between the 2 years for which the NASA was done although there was no significant difference in the total levels of funding between the two years, there was a marked difference on the proportions from the different sources with bilateral sources providing 58% of all funds in FY 2008/09 and down to 50% in FY 2009/10 (a decrease of more than 50 billion UGX); with multilateral External Sources providing 1.2% in FY 2008/09 and up to 9.6% in FY 2009/10 (an increase of 100 billion UGX). This could be said to have worked out well, but it illustrates the high potential for a crisis. In practical terms also the balancing act is more challenging as funding modalities, activities and implementing partners supported by such funds are not the same as has been seen in the past, this can lead circumstances for example where individuals who have been supported for ART on certain regimens go for weeks or months without medicines, as funding arrangements change.

★ Harmonisation and Alignment – as they relate to efficiency, equity & sustainability

The Paris 2005 High Level Forum remains a land-mark meeting on Aid Effectiveness, with the Declaration from this meeting and subsequent related discussions and documents, including

[10] Includes household spending

from the most recent meeting in Busan, providing guidance to both developing and developed countries that are partners in development. The Partnership Commitments were agreed as: Ownership, with national governments expected to provide effective leadership; Alignment by donors to partner country national development strategies, institutions and procedures; Harmonised, transparent and collectively effective donor actions; Managing (by donors and partner countries) resources and improving decision-making for results; and Mutual Accountability for results by both donors and partner countries. This gives us a framework with which to assess performance of the national HIV/AIDS response in this regard, given the marked reliance on donor support.

The NASA results show that some effort has been made in line with some of the above commitments including:

- ★ Stakeholders in the HIV/AIDS national response come together to develop and agree to the major sector strategies including the National Strategic Plan and other supportive documents. This provides a core framework for all stakeholders. The NSP has been indicated by all the stakeholders as a major guiding document.
- ★ The establishment of the Partnership Fund and the Civil Society Fund has brought together a number of the key funding partners to use one system with close consultation with government entities and in line with national strategies. This has definitely had efficiency gains and improved programming of national response resources.
- ★ The resumption of GFATM disbursements provides a source of funding for which priorities can be determined by a wide range of stakeholders and leveraged by government and thus can be utilised to fill identified gaps.

However on the other hand many challenges still persist including:

- ★ The NASA has shown that the expenditure profile is quite different from NSP prioritisation – by broad levels and proportions for the different ASCs. Particular aspects to note are the very high spending by levels and proportions for Care and Treatment and for Programme Management; and on the other hand the very low spending (by levels and proportion) on Mitigation.
- ★ The Funds (Partnership, Civil Society) established are managing only a very small portion of the resources available, and therefore not having as much effect as they could have on closing gaps in coverage and minimising duplication.
- ★ The situation as shown by the NASA provides limited opportunities for government leverage, given the key responsibility/mandate of stewardship. The very limited resources provided and managed by the government makes it difficult to actually carry out this responsibility.

These challenges the HIV/AIDS funding architecture highlighted here may have contributed to failure to achieve some of the targets of the NSP, and the particular goal of keeping new

infections of HIV/AIDS and the prevalence among Ugandans down despite indications that broad funding levels are not a key deterrent.

G.2 Institutionalisation of HIV/AIDS resource tracking

The information provided by the NASA is considered very important for decision-making in the Uganda HIV/AIDS response. As such during the preparations for this study it was considered important to plan not only for the implementation of this the first Uganda NASA, but also to initiate the process of institutionalizing HIV/AIDS resource tracking in the country. The second specific objective of the study therefore was on institutionalization and so was one of the policy questions. This sub-section is a response to these two and draws upon:

- Lessons and findings of the first Uganda NASA study;
- Understanding of the Ugandan HIV/AIDS context including the stakeholders and structures; and
- Requirements for institutionalization as have been noted elsewhere for NASAs and similar resource tracking processes like National Health Accounts.

With the above background, this study recommends that some key areas need to be addressed/considered for continued and informative production of NASA in Uganda, and in particular we recommend long term strategies in the following:

a) Development and implementation of a governance framework linking NASA production to use of data and its translation through further analysis into insights to support policy formulation and decision-making;
b) Capacity Building – for production, dissemination and effective use; and
c) Development and implementation of a financing strategy for sustained HIV/AIDS resource tracking.

G.2.1 Governance for HIV/AIDS Resource Tracking

The responsibilities to consider under the broad area of governance for HIV/AIDS resource tracking are:

★ Coordination;
★ Policy and technical dialogue; and
★ Production of NASA.

Coordination for HIV/AIDS Resource Tracking

The UAC has the mandate for coordinating and planning the HIV/AIDS response, and it seems reasonable/desirable for the UAC to take on the role of custodian and coordinating body for the NASA process. In so doing, UAC would be responsible for:

- ★ Overseeing the planning and budgeting of the NASA process;
- ★ Overseeing the process of translation and dissemination of data; and
- ★ Overseeing the creation of data repositories data on the types and identity of entities/ players in the HIV/AIDS response, and including financial and activity data,;

For the first NASA, UAC with the participation of stakeholders is handling the planning and budgeting of the NASA process; and is in position to take forward the process of translation and dissemination of the data. It is necessary though to take specific steps (in a practical phased manner) to facilitate UAC to sustain current activities and take on the remaining responsibilities so as to ensure actual ownership and institutionalization of the NASA process. The following broad activities to be undertaken by UAC with the support of all stakeholders are therefore recommended.

a) Creation of a central database of all HIV/AIDS stakeholders

The lack of a central database with information on all players in the HIV/AIDS response was a big challenge for the first NASA requiring a lot of researcher time to bring together various databases with a lot of duplication and gaps and out of date information. It is recommended that such a database should be developed and updated annually with a requirement for Annual Certification like is done for health facilities and health practitioners. The Certification would be considered part of the minimum documentation that an entity would need to be considered eligible for funding for HIV/AIDS activities to government and to bilateral and multilateral agencies. This database would provide a starting point for any data collection whether censuses or to providing the sampling population and basis for sampling and extrapolation as may be required in subsequent NASAs or other forms of data collection.

b) Harmonized reporting mechanisms

Every organization active in the HIV/AIDS would be required to submit to the database as indicated in a) some basic/routine data at an agreed frequency – to begin with possibly once a year, to the UAC. This data it is recommended should include basic information like identity of the entity; ownership; role/comparative advantage within the national response; funding levels, sources and expenditure patterns; and information about key activities and outputs. The details of the financial information to be collected should be agreed to by stakeholders but should be structured as close to the NASA requirement as possible. This would support national decision-making, but would also feed into international reports and databases like the UNGASS and for comparison with other countries.

All stakeholders – public, private and international agencies should be required to provide this information albeit using different formats for the different groups as appropriate. However efforts should be made to avoid duplication and double work for the reporting entities, for example innovational ways of linking up with other sectors and Ministries within the response

like Ministry of Health, Ministry of Local Government and Ministry of Gender Labour and Social Development should be sought. Similarly there should be discussions with funding agencies so that the structure/format of reports thus agreed can be used to report to UAC and to the financiers so as to increase compliance, consistency and quality of reports. Lessons can be learnt from the Health Management Information System (HMIS) that has evolved over the last 20 years, that includes data from public and Private not for Profit (PNFP) facilities and efforts continue to bring Private health Practitioners (PHPs) on board. The HMIS provides quite good quality data for routine decision-making and encourages mutual accountability for results.

c) Link into regular surveys like the UNHS, UDHS, AIDS Indicator Survey and NHA

Given the multi-sectoral nature of HIV/AIDS and the need for information up to the community, household and individual levels, substantial aspects of HIV/AIDS resource tracking require data that can only be collected in surveys. Surveys are very challenging to carry out from both a financial and logistical point of view. The first Uganda NASA has had to make many assumptions to adapt data from other surveys for the purposes of the NASA.

It is the recommendation of this study that the AIDS Partnership led by the UAC should take advantage of routinely occurring surveys like the Uganda National Household Survey (UNHS), the Uganda Demographic and Health Survey (UDHS) and the AIDS Indicator Survey (AIS) to provide answers to some of the questions and/or data on some of the indices. This requires working closely with the entities that are responsible for these surveys like the Uganda Bureau of Statistics (UBOS) for the UNHS and UDHS and the MoH for the AIS. For these consultations to be effective the AIDS Partnership needs to elaborate the questions it would like answered in these surveys. As an example it is important to know what proportion of household spending is related to HIV/AIDS, so as to determine the financial burden the disease is putting on households, and what possible interventions government and donor can put in place. However before this question can be asked in a big survey like the UNHS it is desirable to first have a better appreciation of how HIV/AIDS affects household's dynamics and activities including expenditure. What should be considered a household affected by HIV/AIDS? What is the relevance of HIV prevalence and status in such considerations? It is recommended that smaller surveys on some of these questions should be carried out by the AIDS Partnership which would then lead to elaboration of appropriate questions for the bigger survey. National Health Accounts HIV sub analysis or other sectoral sub analyses would also provide key pieces of information.

The UAC currently has the mandate as the government body mandated to coordinate HIV/AIDS activities. If/When deemed necessary by the stakeholders further legal/policy mandate can be sought from the appropriate bodies.

Policy and Technical Dialogue for HIV/AIDS Resource Tracking

The AIDS Partnership has developed structures for participation of the various groups of stakeholders in Policy and Technical Dialogue for the national response. The arrangement used to oversee the first NASA, comprising of a multi-sectoral TWG is such an example, and it is recommended that a similar set up be used in future. Such a set up it is expected would leverage the available networks and provide opportunities for improved access to data, facilitate quality assurance including maintaining objectivity, provide guidance on policy priorities as well as act as champions for uptake of data for decision-making. This would facilitate the identification of opportunities for the NASA process to feed into other review and planning and budgeting processes like Public Expenditure Review (PER) and the Medium Term Expenditure Framework (MTEF).

Production of Data

it is our recommendation that ultimately, the mandate of production of NASA data should be brought under the purview of UAC. The UAC would do this with guidance from the appropriate policy advisory group. This provides unique opportunities for realizing cost-efficiencies as is detailed below as well increase the frequency with which the NASA data is produced.

The activities/steps indicated in the previous 2 sections are of a medium to long term nature and it is expected would lead to such a set up that the bulk of (good quality) data on financing and expenditure for the HIV/AIDS response can be made available regularly and routinely without too much hassle. This process though is likely to take some time and move through a number steps in the short, medium and long term as proposed below.

- ★ Short to medium term (say within 2 years time) it may be necessary to carry out the NASA along the same lines as the first one with some improvements like a central database providing information on which entities are active where. This is because it takes time to build such systems, and it would be important to maintain the momentum for NASA and make it a must-have for decision-making.
- ★ Medium term (between 2 and 4 or five years) the database is expected to be more functional, and what would then be required would be manipulation of the database at the UAC, and collation of the different pieces of data from other sources into the NASA framework and analysis and translation into policy briefs. This may be done internally within the UAC but may require external support. Similar arrangements are being utilised by the MoH for National Health Accounts;
- ★ Long term (beyond 4 years) the UAC working with partners should be able to use routine and other sources of data to compile, analyse and translate NASA information in-house on a regular basis. This is very desirable but cannot happen as a matter of course, and would

require that other strategies highlighted in this write up are put in place to ensure that this can actually happen.

★ It is expected that some information, even in the long term, would still be only available from surveys – these include small surveys that may be required to provide additional information to answer specific policy questions the stakeholders are posing; or nationwide surveys where the AIDS partnership would benefit from piggybacking or collaborating with other sectors;

For the above to happen, this would require *interalia,* the creation (or strengthening) of a unit within the organizational structures of UAC preferably within the Directorate of Planning and Strategic Information. The capacity building issues related to this are discussed further in the section below.

G.2.2 Capacity Building for HIV/AIDS Resource Tracking

A comprehensive approach is critical to build capacity for the complete cycle of data production, dissemination, translation, and use as opposed to one that focuses on particular aspects of the NASA cycle such as production of the NASA. This comprehensive approach to capacity building should be conducted at the individual and institutional levels. This provides a long term strategy to capacity building that prevents the attenuation of skills due to loss of skilled staff. As a first step, a thorough assessment of the capacity needs at the different levels is required, to aid the identification of critical gaps in the skills set at each stage of the cycle that need to be filled.

Individual Capacity Building

While it may be difficult to exclude external consultants at once, we suggest that ownership of the process of NASA be facilitated by the development/training of health economists, accountants and statisticians as well as HIV/AIDS/health system experts with specific respect to the NASA at the UAC. This should not be limited to the production of NASA but should include the components of translation and use of NASA data. National NASA champions can initiate and accelerate the learning process. Given the fact that the first NASA in Uganda has been conducted by local consultants with some assistance from regional experts, the likelihood of skills transfer to recruited staff is high. This could be achieved by NASA training sessions conducted by the local consultants and the regional experts.

Institutional Capacity Building

This is essential for the long term sustainability of the NASA process. We propose the following for strengthening UACs institutional capacity, both to produce NASA data and to translate it into policy briefs.

- ★ Building of institutional knowledge and skill base in UAC by ensuring that the NASA process is standardized and well-documented, this will enable new staff to learn quickly and reduces the reliance on the knowledge of a few staff;
- ★ Development of tools to facilitate the process, including manuals for the collection of data with an indication of the likely sources of the data as well as modules that contain classification codes for various categories of health expenditure to encode the input data, embedded formulas for calculating output estimates, and functions to generate NASA tables should be developed. This would make training of new staff as well as data collection and analysis easier;
- ★ Linking the NASA process to key events of the HIV/AIDS and National Planning Processes. A mechanism whereby decision makers gain access to the insights that NASA data can provide—sometimes in triangulation with other data instruments and tools—will help bridge the gap between production and use. UAC as the steward of the HIV/AIDS response and the multi-sectoral nature of the response certainly provides good opportunities for linking NASA to planning processes like the Joint Annual Review and regular planning and budgeting processes such as PERs and the MTEF.

G.2.3 Financing Strategy for HIV/AIDS Resources Tracking

The strategies outlined in the sections above are geared at minimizing the cost of a NASA, specifically through:

- ★ Production of the NASA in-house- by the UAC staff. This would cut down on consultancy costs which are big driver of the costs of the NASA process.
- ★ Integration of NASA data collection into routine data collection processes. This could be achieved by routine data collection at the UAC from all HIV/AIDS partners, and liaising with key entities like UBOS and M&E units of stakeholders to enable key information on expenditure and beneficiary groups is routinely collected. This will significantly cut down on survey costs as well as consultancy costs.
- ★ The development or adaptation of data management tools and systems while costly initially, would ultimately result in significant cost savings later by removing the need to depend on expert manipulation of the data. For instance the RTS and DP sheets that were contextualized to capture data in the Uganda NASA could be further simplified to facilitate quick data capture as well as prevent errors.

An approach that has been found effective in similar circumstances to secure funding is to integrate the NASA process as a part of the country's regular budgeting process. A realistic financing approach for Uganda may be to seek partial cost-sharing of recurrent and dissemination costs, and to limit survey complexity to essential data for policy makers. In addition the UAC should stipulate a budget line-item for NASA. This offers a clear mandate to ensure capacity for overseeing NASA activities by the entity that has been allocated

responsibility as the institutional home. A budget line should improve sustainability of these activities. By taking a stake in the financing of activities the government also generates higher demand for the outputs, which in turn should facilitate the linkages between data and policy-relevant insights.

H. Conclusions

The first Uganda NASA study has been useful especially for:

a) Providing comprehensive information on HIV/AIDS financing and expenditure and various dimensions as provided for by the NASA methodology for the first time.
b) Attempting responses to most of the policy questions agreed to by sector stakeholders, but in so doing also raised some more questions; and
c) Providing some recommendations on institutionalization of HIV/AIDS Resource Tracking in Uganda.

This study recommends that the AIDS Partnership should:

a) Utilise data for policy-formulation and decision-making by the AIDS Partnership and the different stakeholders including for planning, resource mobilization and allocation and monitoring and evaluation of the HIV/AIDS response;
b) Use the NASA data for reporting to international organisations and for a like the UNGASS, and benchmarking with other countries in the region and beyond;
c) Plan for the next NASA – this should start soon particularly the initiation of activities for carrying out small exploratory surveys that will facilitate the determination of questions to be incorporated into big surveys like the UNHS. This will make it possible to provide NASA data in a timely manner for planning. It is key that Uganda compiles NASA data for another 2 years – FY 2010/11 and 2011/12 (which ends at end of this June) so as to be able to compare data over 4 years and really determine the trends of financing and expenditures at broad and specific levels.

Based on the findings and the discussion on the policy questions, this study recommends some specific areas for the AIDS Partnership to consider critically for improving the national response.

a) The proportion of resources contributed by the different sources:
   i. There is need to increase the public contribution, to increase ownership and leverage in the national response. All efforts should be made including using the NASA results to advocate for more funding.
   ii. The current dependence on a few bilateral entities for the bulk of the funding is dangerous for the response. Efforts should be made by all stakeholders to diversify.

The appreciable contribution by a variety of international (and possibly in future local) foundations should be explored for increased potential. This would improve predictability and sustainability, as a crisis or withdrawal of one entity would not create a very big impact.

iii. It is necessary to study further and understand expenditure for HIV/AIDS by households – what do they spend on, why and how does it affect the household. This is so as to ensure that HIV/AIDS does not send people into (further into) poverty.

b) Increase the proportion of funds managed by Public and Private FAs:

i. The proportion and levels of HIV/AIDS resources managed by Public FAs including Ministries and agencies, and the Partnership and Civil Society Fund should increase beyond the current 20%. This should be done in such a way that stakeholders can participate in decisions made on these funds, and would be expected to improve alignment to national agreed strategies and priorities and predictability and sustainability.

ii. Private (indigenous) FAs especially the established NGOs and umbrella organisations should be utilised more for the purpose of managing funds and making decisions, and not just as conduits for disbursement;

c) HIV/AIDS is a chronic illness, which has particular implications for some elements of managing the disease like Care and Treatment and Mitigation. NGOs and CSOs have a role for service provision especially in prevention and aspects of Mitigation. It is recommended though that efforts should be made to:

i. Increase funds utilised by Public Providers – including Ministries and other government agencies – MoH; MoLG; MoGLSD; and public health facilities, especially for their role in Enabling Environment, Care and Treatment and Mitigation. This is because there are established units within the public sector which already manage these functions. This would therefore improve capacity of these entities to carry out their work and improve equitable spread of services across the country and sustainability.

ii. The PNFP health facility providers are well distributed across the country and have always provided a complementary service to the public facilities. They should be supported in a more structured manner to provide services.

I. Annexes

Annex 1: Terms of Reference

1.0 Background

Uganda is one of the most successful countries in Africa that was able to significantly reduce the prevalence of HIV/AIDS from 18% in 1992 to 6.4% in 2005. This was due to, among other things, the country's readiness to adopt a multi-sectoral approach to HIV/AIDS in 1992 having realized that HIV/AIDS is not only a health problem but a development challenge as well; affecting all the sectors of the economy. This led to the need for mainstreaming HIV/AIDS in development planning; for ensuring resource mobilization and improved coordination. Nevertheless, the country experiences a generalized, severe and mature epidemic, with geographical, socio-economic implications on women, urban residents and people residing especially in Kampala, central and mid-northern regions being disproportionately affected.

While resources available for the national response from various sources including the MAP/World Bank, the Global Fund and PEPFAR have increased exponentially from around US$40million in 2003/04 to nearly US$170million in 2006/07 the current resource base is not adequate to support the country's universal access agenda. Currently, the national response is primarily funded through external support (about 85-90%) compared to Government contribution of only 7-8%. Besides, the mechanisms and capacity for tracking the utilization and effectiveness of resources for HIV/AIDS are weak and not well-streamlined and harmonized at all levels including the support to civil society sector interventions. Furthermore, there are also challenges related to absorptive capacity and timely financial reporting at all levels. At the same time, the size of resource envelope for HIV/AIDS is not clear and unpredictable; neither is it possible to know how these resources are utilized. This assignment builds on an earlier study conducted in 2006 on the Public Sector Assessment of AIDS Spending which established that information on the financing of the national response and the spending of the public sector remains largely uncoordinated. The study further revealed data deficiencies particularly in relation to consistent, timely and accurate expenditure report by public sector agencies. The assignment will in addition build on the recommendations of the assessment of the existing resource tracking systems (November 2010). This exercise is intended to build national capacity in tracking the utilization and effectiveness of HIV/AIDS resources for national response in the public sector at national and district levels as well as among civil society organizations and the private sector.

It is in light of the above, that the Government (UAC and Ministry of Finance) with the support of UNAIDS, UNDP and the AIDS Development Partners (ADPs) would like to undertake a comprehensive National AIDS Spending Assessment (NASA).

2.0 Rationale

The planned NASA project therefore builds on an earlier study conducted in 2006 on the Public Sector Assessment of AIDS Spending commissioned by MFPED and UAC and funded by European Union which established that information on the financing of the national response and the spending of the public sector remains largely uncoordinated. The study further revealed data deficiencies particularly in relation to consistent, timely and accurate expenditure report by public sector agencies. The Study also recommended the raising of profile of HIV/AIDS in the justified the relevance and desirability of resource tracking recommended: the undertaking of a full NASA; the development and adoption of the standard NASA codes; mainstreaming of HIV/AIDS Spending and; the introduction and creation of budgetary codes for HIV and AIDS Spending. A recent assessment of existing HIV/AIDS resource tracking systems by MFPED and UAC, funded by UNDP (UAC, UNDP: 2010), also recommended a critical need for undertaking a comprehensive National AIDS Spending Assessments (NASA), which undertaking should be given adequate time and preparation. The assessment also specifically recommended, among other programming aspects, the development of harmonized data collection tools and systems of data capture; strengthened regular reporting of financial and expenditure data and; popularizing of soft ware that can inter-operate; / communicate to each other. The NASA project is therefore intended to build national capacity in tracking the availability, utilization and effectiveness of HIV/AIDS resources for national response in the public sector at national and district levels as well as among civil society organizations and the private sector.

3.0 Overall Purpose

To enhance the availability and utilization of data and information on HIV/AIDS resources and Expenditure for National response resource mobilization, planning and management. The main outcome of implementing this comprehensive NASA project is increased utilization of information on HIV/AIDS Financing to guide resource mobilization and planning that will ultimately strengthen the effectiveness and efficiency of resource use in the national response

3.1 Specific objectives

The proposed NASA project will have the following two specific objectives:

a. To assess the magnitude and structure of HIV/AIDS financing and expenditure in Uganda for 2009/10.
b. To strengthen the institutionalization of HIV/AIDS Resource Tracking in Uganda's national response

4.0 Tasks

The principle task of the Consultancy Team will be to conduct a National Aids Spending Assessment (NASA) for the financial year 2009/10. Specifically, the Consultancy Team will;

- Undertake data collection including review of relevant documents.
- Participate in technical working groups and steering committee meetings.
- Facilitate stakeholder workshops/meetings
- Development of a country specific NASA Protocol
- Develop a data base of financial resources, financing agents and service providers.
- Build capacity of the research teams
- Adaptation of a NASA classification and coding and its alignment to the NSP coding
- Building consensus on unit costs within the HIV and AIDS sector
- Prepare progress reports

5.0 Methodology

The NASA will be undertaken through a participatory and consultative process, engaging all key stakeholders. A Task Team, a Steering committee, and a Technical Working Group will be constituted with representation from all the key stakeholders in the national HIV and AIDS response.

Using the NASA methodology, the consultants will carry out:

Desk review of all relevant resource documents

Field visits to collect all the relevant information

Structured interviews with all relevant stakeholders including government ministries, departments and agencies (MDAs); private sector, civil society partners; development partners and Local Governments etc

Workshops/consensus meetings with stakeholders to discuss the findings and recommendations of the study.

6.0 Deliverables

The consultancy team is expected to provide the following deliverables:

An inception report shared and approved

Capacity of the research teams built in HIV/AIDS resource tracking and NASA methodologies

Adapted NASA classification and coding in the Ugandan context.

A schedule of unit costs within the HIV and AIDS sector for all AIDS Spending categories agreed upon.

NASA Report focusing on the financial year 2009/10 in both hard and electronic copies

Consultative and training workshop reports.

Annex 2: Key NASA Definitions and Terminologies

FUNDING SOURCES refer to where the money comes from. The main categories of Funding Sources are: **Public** (Ministry of Finance, Planning and Economic Development, parastatals, etc), **Private** (Households, Corporations, private firms, NGOs, etc) and **International** (Multilateral, Bilateral, NGOs, Foundations, Global health initiatives, etc). Financing sources (FS) are entities that provide money to financing agents.

FINANCING AGENTS refer to organisation which manage, organise and collects the funds. In other words, these are organisations which have the power and control over how funds are allocated and used. Therefore, these entities make programmatic decisions on the use of the resources they receive from the *Financing Sources*. There are financing agents in the public, private and donor sub-sectors. In Uganda, they include Ministry of Health and other line ministries, districts, urban authorities, NGOs, Civil society organisations, bilateral and multilateral organisations, etc. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent)

SERVICE PROVIDERS (PS); refer to the end users of health care funds, entities that actually provide/deliver the health service. These help us answer the question: where did the funds go? The provider is responsible for the final product, but can either sub-contract services or personnel or the delivery of the product, or buy the inputs necessary for producing it itself. In the NASA classifications, service providers are categorized as (a) Government- which are government owned and managed (b) Non-government organisations, including the not-for-profit providers (c) Private-for-profit (d) Bilateral and Multilateral entities, and (e) rest-of-the world providers. Providers (PS) are entities that engage in the production, provision, and delivery of HIV services.

AIDS SPENDING CATEGORIES: Accordingly AIDS spending classification is a functional classification that includes the categories of prevention, care and treatment, and other health and non-health services related to HIV. After review and evaluation of past response strategies to HIV, the programmes and budget lines have been structured into eight classes of spending categories: (1) Prevention, (2) Care and treatment, (3) Orphans and vulnerable children, (4) Programme management and administration, (5) Human resources, (6) Social protections and social services, (7) Enabling environment, and (8) Research. These are briefly defined below.

Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals.

Care and treatment refers to all expenditures, purchases, transfers, and investment incurred to provide access to clinic-based, home-based or community-based activities for the treatment and care of HIV-positive adults and children.

Orphans and vulnerable children: An orphan is defined as a child aged less than 18 who has lost one or both parents. In the NASA context, all expenditures to substitute for the parents taking care of their children because they have died from HIV; expenditures incurred in providing social mitigation to all double orphans and half or single orphans need to be included. In this context, vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them. The resource tracking team should take into consideration that in sub-Saharan Africa the services to all orphans living below the nationally defined poverty line are considered as AIDS-related. This category refers to children living below the poverty line who are dual orphans (children who have lost both parents), near orphans (children who will be orphaned in the following year) and half or single orphans (children who have lost one parent).

Programme and administrative 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), advocacy, 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. It is important to note that when linking

programme expenditure to people's access to treatment and prevention, only the share of investment that contributes to a HIV response and required to finance the services provided as part of the response to the HIV scourge be included.

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 HIV workforce is not limited to the health system. Included in this category is the direct payment of wage benefits for health care workers. These expenditures are aimed at ensuring the availability of human resources from what is currently available in the health sector. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories. For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions—*ASC.01 Prevention* and *ASC.02 Care and treatment*—and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well—ASC.04 (Programme Management).

Social protections and social services: Social protection usually refers to functions of government or nongovernmental organizations relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by requirements such as sickness, old age, disability, unemployment, social exclusion, etc. Social protection comprises personal social services and social security. It includes expenditures on services and transfers provided not only to individual people but also to households, in addition to expenditures on services provided on a collective basis.

Enabling environment: Advocacy in the field of HIV includes a full set of services that generate an increased and wider range of support of the key principles and essential actions to promote HIV prevention and reduce stigma and discrimination. It also includes the promotion of the scaling-up of national, regional HIV programmes by national governments with key partners, such as bilateral and multilateral donors, civil society, and the private sector. **Human rights programmes** cover all the activities and resources invested for the protection of human rights, legislative aspects of a broad number of areas of social life, such as employment and discrimination, education, liberty, association, movement, expression, privacy, legal counselling and services, efforts to overcome discrimination and improve accessibility to social and health services.

HIV-related research (excluding operations research): is defined as the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well-being. This category excludes operations research on health systems aimed to improve health outcomes, including project or programme evaluation, which should be coded under ASC.04.04 (i.e. programme management and administration).

Other key definitions
Targeted/intended beneficiary populations

These are populations specifically designed for to benefit from given interventions and or activities. They include the following;

People living with HIV: Regardless of a diagnosis/medical diagnosis of AIDS, the beneficiary of the intervention/activity should be living with HIV.

Most at Risk Populations-(MARPs); these are grouped based on the behavior they engage in that predisposes them to acquisition of the AIDs virus as compared to other groups. Such groups are more susceptible to having high rates of sexual partner exchange, to practice unprotected sex with multiple partners, or to use non-sterile drug injecting instruments which are in most cases shared. All these activities expose such populations to the risk of exposure to HIV. The groupings under MARPS include sex workers (SW), their clients, injecting drug users (IDUs), fishermen, and men who have sex with men (MSM).

Other key populations; these include groups that cannot be underestimated both in terms of the epidemic's dynamics, vulnerability and the response.

Specific "accessible" populations; Includes populations in organized settings making them easily accessible as children in school, women attending reproductive health clinics, university students, military, factory employees.

General population; Includes interventions aimed at the general population wholly and not any key accessible groupings. Such interventions could include a TV or radio campaign of communication for social and behavior change. The populations include; General adult population aged older than 24 years, children aged under 15 years, youth aged 15 to 24 years.

Non-targeted interventions; these are indirect expenditures through interventions to no explicitly selected or targeted populations.

Specific targeted populations not else where classified (n.e.c); these are classified as the key and targeted populations included in none of the above groupings.

Annex 3: NASA Definitions and their adaptation to the Ugandan context

The international literature (especially UNAIDS documents) provide some definitions and guidelines for the NASA, some of which have been presented here below and more in Annex 2. However these definitions/guidelines are normally adapted/customised for the context within which they are to be used – in this case, they have been adapted to the Ugandan context. Some of the key definitions/guidelines/issues included here below, have been the subject of discussion with the HIV/AIDS response stakeholders represented by the Client/Technical Working Group, with the purpose of gaining consensus on their meaning as applied to the Ugandan context. This aspect is expanded on under Section E: *Methodology for Ugandan NASA*. Contextualisation of key definitions and principles has been useful for this assignment and will be for future NASA exercises, to allow comparison of data across years.

Public spending

Government data are key sources of information for a NASA. The nature, definition and scope of public spending varies in different countries. Firstly, the administrative and political set up of a country will determine how public resources are generated and allocated at the different levels of governance. The nature and structure of the HIV/AIDS national responses largely determine how public resources flow within a given country. For these reasons, it is important for each country undertaking a NASA to contextualise and define '*public spending*' in their own setting. It is important to ensure that data are collected from the sub national levels of government. Such an undertaking requires access to people with the mandate and thorough knowledge of the HIV and AIDS policies and able to identify/make decisions on programmes that should be included in the NASA.

In Uganda, public spending on HIV/AIDS can be categorised into two major groups, namely: (a) direct spending, and (b) indirect spending. **Direct Public Spending** refers to HIV/AIDS-specific financing and expenditure by national level government, as well as HIV/AIDS-specific expenditure by local governements (i.e. districts) using funds generated at local government level (i.e. excluding funding that flows from national level). At national level, this for example includes expenditure on antiretroviral drugs, communication/sensitisation (IEC) through various means, prevention of mother-to-child transmission, etc. On the other hand, **Indirect Public Spending** refers to the proportion of general expenditure by national and local governments on the health sector, which can be attributed to HIV/AIDS. While *direct public spending* can be obtained using traditional methods (such as key informant interviews and review of relevant documents), estimation of *indirect public spending* requires innovative approaches to determining the proportion of general spending on health that could be attributed to HIV/AIDS. It is important to note that for both *direct* and *indirect public spending*, data on **actual spending** should be used (and not information on anticipated/planned expenditure or budget information). For Uganda, we agreed that we would rely on audited accounts of actual government expenditures are considered to be the most reliable.

International financing

External resources include official development assistance (ODA), such as from multilateral agencies, bilateral aid programmes, global health initiatives and loan programmes, where the government is one of the parties to the agreement. When calculating AIDS spending, all cash transfers from international sources are recorded in the equivalent national currency and assistance in kind valued at some appropriate monetary value. Given the complex nature of the relationship between different external organisations, and sometimes the poor coordination of these entities, it was noted that extra care was required by the NASA team in ensuring that double-counting is avoided and some information is not left out. This, therefore, required a clear understanding of the relationships between external organisations and local entities, as well as the flow of funds from and to these players.

In Uganda, we agreed that international funding included all resources from AIDS development partners. We agreed that while partners are well-known within Uganda, there are several international sources of funding who have no physical presence on the ground. These include the charity organisation or faith-based entities or foundations that have no physical offices in Uganda, but who collaborate with and send money to local entities in Uganda, specifically for HIV/AIDS activities. Also included are resources and activities of international non-governmental organizations (iNGOs) (such as the International Committee of the Red Cross) and international foundations (such as Kenny Foundation, Elton John Foundation, etc.). We agreed that actual HIV/AIDS spending by these entities is captured, rather than commitments or budgets. We also agreed that such expenditures should include funds spent outside Uganda (e.g. management costs that may be spent at their headquarters for support that is specific to Uganda). In addition, international funding should include the monetary equivalent of technical assistance provided by AIDS development partners in Uganda. We also note, that for Uganda, there are pooled funds earmarked for HIV/AIDS (e.g. the Partnership Fund and the Civil Society Fund). What remained a challenge is the attribution of a proportion of donor budget support to HIV/AIDS. This aspect was implicitly included by estimation of indirect public spending, since most of the budget support is channelled to different sectors (including the health sector). Since different donors will provide information on funding in their currency, we agreed to have standard exchange rates for the NASA exercise, covering the key currencies (such as USD, GBP, Euro, etc).

Private expenditures

There are two sources of private expenditures; **households** and **businesss entities/firms**. There is lack of data on household spending on HIV and AIDS activities/services and very little is known about the importance of the household as a payer. Household expenditures on HIV/AIDS are usually not available in statistics or other administrative data sources. In countries, like in Uganda, with no (or minimal) health insurance, out-of-pocket spending can account for more than 50% of total health expenditures. The most common and nationally representative source of information about households are household-based surveys (e.g. Income and Expenditure survey, Demographic Health survey and/or Living Standards survey). Although survey data provide the most reliable estimates for household expenditures, they are very expensive to conduct and as such are not conducted on a regular basis. Business entities normally spend on HIV/AIDS through workplace programs or through corporate responsibility activities that are usually short-term and targettig small areas of wotk, usually around the communities where they are situated.

In Uganda, there is no household-based survey that collects specific information on expenditure on HIV/AIDS. The implication of this for the current NASA was to: either (a) conduct a household survey; or (b) completely leave out household spending – which is the most common thing done in most countries that have done NASA; or (c) to do a special analysis using existing household income and expenditure survey and some assumptions. For the Uganda NASA, we agreed to option (c) above. Given the limitations of using this estimation methods, we recommend a household survey (in future) to address the challenges of relying on assumptions. Further, in Uganda, we agreed that it was important to study business entities/firms to obtain information relating to workplace programs or any other HIV/AIDS expenditure by these firms. It is important to note that in addition to being sources of funding for HIV/AIDS, some of these private entities can be financing agents or service providers, as far as HIV/AIDS is concerned. Therefore, sampling of all private-sector entities (NGOs/CSOs/FBOs and other business entities) should be done in a comprehensive and careful manner.

Annex 4: AIDS Spending Categories (ASCs)

ASC.01 Prevention

ASC.01.01 Communication for social and behaviour change
ASC.01.01.01 Health-related communication for social and behaviour change
ASC.01.01.02 Non-health-related communication for social and behaviour change
ASC.01.01.98 Communication for social and behaviour change not broken down by type
ASC.01.02 Community mobilization
ASC.01.03 Voluntary counselling and testing (VCT)
ASC.01.04 Risk-reduction for vulnerable and accessible populations14
ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations
ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations
ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible populations
ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations
ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not broken down by type
ASC.01.04.99 Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c)
ASC.01.05 Prevention – youth in school
ASC.01.06 Prevention – youth out-of-school
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)
ASC.01.07.01 Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV
ASC.01.07.02 Condom social marketing and male and female condom provision as part of prevention of HIV transmission aimed at PLHIV
ASC.01.07.03 STI prevention and treatment as part of prevention of HIV transmission aimed at PLWHIV
ASC.01.07.98 Prevention of HIV transmission aimed at PLHIV not broken down by type
ASC.01.07.99 Other prevention of HIV transmission aimed at PLHIV, n.e.c.
ASC.01.08 Prevention programmes for sex workers and their clients
ASC.01.08.01 VCT as part of programmes for sex workers and their clients
ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients
ASC.01.08.03 STI prevention and treatment as part of programmes for sex workers and their clients
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for SWs and their clients
ASC.01.08.98 Programmatic interventions for sex workers and their clients not broken down by type
ASC.01.08.99 Other programmatic interventions for sex workers and their clients, n.e.c.
ASC.01.09 Programmes for men who have sex with men (MSM)
ASC.01.09.01 VCT as part of programmes for MSM
ASC.01.09.02 Condom social marketing and male and female condom provision as part of programmes for MSM
ASC.01.09.03 STI prevention and treatment as part of programmes for MSM
ASC.01.09.04 Behaviour change communication (BCC) as part of programmes for MSM
ASC.01.09.98 Programmatic interventions for MSM not broken down by type
ASC.01.09.99 Other programmatic interventions for MSM n.e.c.
ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)
ASC.01.10.01 VCT as part of programmes for IDUs
ASC.01.10.02 Condom social marketing and male and female condom provision as part of programmes for IDUs
ASC.01.10.03 STI prevention and treatment as part of programmes for IDUs
ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs
ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for IDUs
ASC.01.10.06 Drug substitution treatment as part of programmes for IDUs

ASC.01.10.98 Programmatic interventions for IDUs not broken down by type
ASC.01.10.99 Other programmatic interventions for IDUs, n.e.c.
ASC.01.11 Prevention programmes in the workplace
ASC.01.11.01 VCT as part of programmes in the workplace
ASC.01.11.02 Condom social marketing and male and female condom provision as part of workplace programmes
ASC.01.11.03 STI prevention and treatment as part of programmes in the workplace
ASC.01.11.04 Behaviour change communication (BCC) as part of programmes in the workplace
ASC.01.11.98 Programmatic interventions in the workplace not broken down by type
ASC.01.11.99 Other programmatic interventions in the workplace n.e.c.
ASC.01.12 Condom social marketing
ASC.01.13 Public and commercial sector male condom provision
ASC.01.14 Public and commercial sector female condom provision
ASC.01.15 Microbicides
ASC.01.16 Prevention, diagnosis, and treatment of sexually transmitted infections (STIs)
ASC.01.17 Prevention of mother-to-child transmission (PMTCT)
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes
ASC.01.17.02 Antiretroviral prophylaxis for HIV-positive pregnant women and neonates
ASC.01.17.03 Safe infant feeding practices (including substitution of breast milk)
ASC.01.17.04 Delivery practices as part of PMTCT programmes
ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT
ASC.01.17.98 PMTCT not broken down by intervention
ASC.01.17.99 PMTCT activities n.e.c.
ASC.01.18 Male circumcision
ASC.01.19 Blood safety
ASC.01.20 Safe medical injections
ASC.01.21 Universal precautions
ASC.01.22 Post-exposure prophylaxis (PEP)
ASC.01.22.01 PEP in health care setting
ASC.01.22.02 PEP after high risk exposure (violence or rape)
ASC.01.22.03 PEP after unprotected sex
ASC.01.22.98 Post-exposure prophylaxis not broken down by intervention
ASC.01.22.99 Post-exposure prophylaxis n.e.c.
ASC.01.98 Prevention activities not broken down by intervention
ASC.01.99 Prevention activities n.e.c.

ASC.02 Care and treatment

ASC.02.01 Outpatient care
ASC.02.01.01 Provider-initiated testing and counselling (PITC)
ASC.02.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment
ASC.02.01.02.01 OI outpatient prophylaxis
ASC.02.01.02.02 OI outpatient treatment
ASC.02.01.02.98 OI outpatient prophylaxis and treatment not broken down by type
ASC.02.01.03 Antiretroviral therapy
ASC.02.01.03.01 Adult antiretroviral therapy
ASC.02.01.03.01.01 First-line antiretroviral therapy – adults
ASC.02.01.03.01.02 Second-line antiretroviral therapy – adults
ASC.02.01.03.01.03 Adult multidrug antiretroviral therapy after second-line treatment failure
ASC.02.01.03.01.98 Adult antiretroviral therapy not broken down by line of treatment
ASC.02.01.03.02 Paediatric antiretroviral therapy
ASC.02.01.03.02.01 First-line antiretroviral therapy – paediatric
ASC.02.01.03.02.02 Second-line antiretroviral therapy – paediatric
ASC.02.01.03.02.03 Paediatric multidrug antiretroviral therapy after second-line treatment failure
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not broken down by line of treatment
ASC.02.01.03.98 Antiretroviral therapy not broken down either by age or line of treatment
ASC.02.01.04 Nutritional support associated with antiretroviral therapy

ASC.02.01.05 Specific HIV-related laboratory monitoring
ASC.02.01.06 Dental programmes for PLHIV
ASC.02.01.07 Psychological treatment and support services
ASC.02.01.08 Outpatient palliative care
ASC.02.01.09 Home-based care
ASC.02.01.09.01 Home-based medical care
ASC.02.01.09.02 Home-based non medical/non-health care
ASC.02.01.09.98 Home-based care not broken down by type
ASC.02.01.10 Traditional medicine and informal care and treatment services
ASC.02.01.98 Outpatient care services not broken down by intervention
ASC.02.01.99 Outpatient care services n.e.c.
ASC.02.02 Inpatient care
ASC.02.02.01 Inpatient treatment of opportunistic infections (OI)
ASC.02.02.02 Inpatient palliative care
ASC.02.02.98 Inpatient care services not broken down by intervention
ASC.02.02.99 Inpatient care services n.e.c.
ASC.02.03 Patient transport and emergency rescue
ASC.02.98 Care and treatment services not broken down by intervention
ASC.02.99 Care and treatment services n.e.c.

ASC.03 Orphans and vulnerable children (OVC)

ASC.03.01 OVC Education
ASC.03.02 OVC Basic health care
ASC.03.03 OVC Family/home support
ASC.03.04 OVC Community support
ASC.03.05 OVC Social services and administrative costs
ASC.03.06 OVC Institutional care
ASC.03.98 OVC Services not broken down by intervention
ASC.03.99 OVC services n.e.c.

ASC.04 Programme management and administration

ASC.04.01 Planning, coordination, and programme management
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds
ASC.04.03 Monitoring and evaluation
ASC.04.04 Operations research
ASC.04.05 Serological-surveillance (sero surveillance)
ASC.04.06 HIV drug-resistance surveillance
ASC.04.07 Drug supply systems
ASC.04.08 Information technology
ASC.04.09 Patient tracking
ASC.04.10 Upgrading and construction of infrastructure
ASC.04.10.01 Upgrading laboratory infrastructure and new laboratory equipment
ASC.04.10.02 Construction of new health centres
ASC.04.10.98 Upgrading and construction of infrastructure not broken down by intervention
ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.
ASC.04.11 Mandatory HIV testing (not VCT)
ASC.04.98 Programme management and administration not broken down by type
ASC.04.99 Programme management and administration n.e.c

ASC.05 Human resources

ASC.05.01 Monetary incentives for human resources
ASC.05.01.01 Monetary incentives for physicians
ASC.05.01.01.01 Monetary incentives for physicians for prevention
ASC.05.01.01.02 Monetary incentives for physicians for care and treatment
ASC.05.01.01.03 Monetary incentives for physicians for programme management and administration
ASC.05.01.01.98 Monetary incentives for physicians not broken down by type
ASC.05.01.01.99 Monetary incentives for physicians n.e.c.
ASC.05.01.02 Monetary incentives for nurses

ASC.05.01.02.01 Monetary incentives for nurses for prevention
ASC.05.01.02.02 Monetary incentives for nurses for care and treatment
ASC.05.01.02.03 Monetary incentives for nurses for programme management and administration
ASC.05.01.02.98 Monetary incentives for nurses not broken down by intervention
ASC.05.01.02.99 Monetary incentives for nurses n.e.c.
ASC.05.01.03 Monetary incentives for other staff
ASC.05.01.03.01 Monetary incentives for other staff for prevention
ASC.05.01.03.02 Monetary incentives for other staff for care and treatment
ASC.05.01.03.03 Monetary incentives for other staff for programme management and administration
ASC.05.01.03.98 Monetary incentives for other staff not broken down by type
ASC.05.01.03.99 Monetary incentives for other staff n.e.c
ASC.05.01.98 Monetary incentives for human resources not broken down by staff
ASC.05.02 Formative education to build-up an HIV workforce
ASC.05.03 Training
ASC.05.98 Human resources not broken down by type
ASC.05.99 Human resources n.e.c.

ASC.06 Social protection and social services (excluding OVC)

ASC.06.01 Social protection through monetary benefits
ASC.06.02 Social protection through in-kind benefits
ASC.06.03 Social protection through provision of social services
ASC.06.04 HIV-specific income generation projects
ASC.06.98 Social protection services and social services not broken down by type
ASC.06.99 Social protection services and social services n.e.c.

ASC.07 Enabling environment

ASC.07.01 Advocacy
ASC.07.02 Human rights programmes
ASC.07.02.01 Human rights programmes empowering individuals to claim their rights
ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment
ASC.07.02.03 Capacity building in human rights
ASC.07.02.98 Human rights programmes not broken down by type
ASC.07.02.99 Human rights programmes n.e.c.
ASC.07.03 AIDS-specific institutional development
ASC.07.04 AIDS-specific programmes focused on women
ASC.07.05 Programmes to reduce Gender Based Violence
ASC.07.98 Enabling environment not broken down by type
ASC.07.99 Enabling environment n.e.c.

ASC.08 HIV-related research (excluding operations research)

ASC.08.01 Biomedical research
ASC.08.02 Clinical research
ASC.08.03 Epidemiological research
ASC.08.04 Social science research
ASC.08.04.01 Behavioral research
ASC.08.04.02 Research in economics
ASC.08.04.98 Social science research not broken down by type
ASC.08.04.99 Social science research n.e.c.
ASC.08.05 Vaccine-related research
ASC.08.98 HIV-related research activities not broken down by type
ASC.08.99 HIV-related research activities n.e.c.

Annex 5: Targeted/ Intended beneficiary populations (BP)

BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)
BP.01.01 Adult and young people (aged 15 and over) living with HIV
BP.01.01.01 Adult and young men (aged 15 and over) living with HIV
BP.01.01.02 Adult and young women (aged 15 over) living with HIV
BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender
BP.01.02 Children (aged under 15) living with HIV
BP.01.02.01 Boys (aged under 15) living with HIV
BP.01.02.02 Girls (aged under 15) living with HIV
BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
BP.01.98 People living with HIV not broken down by age or gender
BP.02 Most-at-risk populations
BP.02.01 Injecting drug users (IDU) and their sexual partners
BP.02.02 Sex workers (SW) and their clients
BP.02.02.01 Female sex workers and their clients
BP.02.02.02 Male transvestite sex workers (and their clients)
BP.02.02.03 Male non-transvestite sex workers (and their clients)
BP.02.02.98 Sex workers, not broken down by gender, and their clients
BP.02.03 Men who have sex with men (MSM)
BP.02.98 "Most-at-risk populations" not broken down by type
BP.03 Other key populations
BP.03.01 Orphans and vulnerable children (OVC)
BP.03.02 Children born or to be born of women living with HIV
BP.03.03 Refugees (externally displaced)
BP.03.04 Internally displaced populations (because of an emergency)
BP.03.05 Migrants/mobile populations
BP.03.06 Indigenous groups
BP.03.07 Prisoners and other institutionalized persons
BP.03.08 Truck drivers/transport workers and commercial drivers
BP.03.09 Children and youth living in the street
BP.03.10 Children and youth gang members
BP.03.11 Children and youth out of school
BP.03.12 Institutionalized children and youth
BP.03.13 Partners of people living with HIV
BP.03.14 Recipients of blood or blood products
BP.03.98 Other key populations not broken down by type
BP.03.99 Other key populations n.e.c.
BP.04 Specific "accessible" populations
BP.04.01 People attending STI clinics
BP.04.02 Elementary school students
BP.04.03 Junior high/high school students
BP.04.04 University students
BP.04.05 Health care workers
BP.04.06 Sailors
BP.04.07 Military
BP.04.08 Police and other uniformed services (other than the military)
BP.04.09 Ex-combatants and other armed non-uniformed groups
BP.04.10 Factory employees (e.g. for workplace interventions)
BP.04.98 Specific "accessible " populations not broken down by type
BP.04.99 Specific "accessible " populations n.e.c.
BP.05 General population
BP.05.01 General adult population (aged older than 24)
BP.05.01.01 Male adult population

BP.05.01.02 Female adult population
BP.05.01.98 General adult population (aged older than 24) not broken down by gender
BP.05.02 Children (aged under 15)
BP.05.02.01 Boys
BP.05.02.02 Girls
BP.05.02.98 Children (aged under 15) not broken down by gender
BP.05.03 Youth (aged 15 to 24)
BP.05.03.01 Young men
BP.05.03.02 Young females
BP.05.03.98 Youth (aged 15 to 24) not broken down by gender
BP.05.98 General population not broken down by age or gender.

BP.06 Non-targeted interventions

BP.99 Specific targeted populations not elsewhere classified (n.e.c.)

Annex 6: Providers (PS)

PS.01 Public sector providers
PS.01.01 Governmental organizations
PS.01.01.01 Hospitals
PS.01.01.02 Ambulatory care
PS.01.01.03 Dental offices
PS.01.01.04 Mental health and substance abuse facilities
PS.01.01.05 Laboratory and imaging facilities
PS.01.01.06 Blood banks
PS.01.01.07 Ambulance services
PS.01.01.08 Pharmacies and providers of medical goods
PS.01.01.09 Traditional or non-allopathic care providers
PS.01.01.10 Schools and training facilities
PS.01.01.10.01 Primary education
PS.01.01.10.02 Secondary education
PS.01.01.10.03 Higher education
PS.01.01.10.99 Schools and training centres n.e.c.
PS.01.01.11 Foster homes/shelters
PS.01.01.12 Orphanages
PS.01.01.13 Research institutions
PS.01.01.14 Government entities
PS.01.01.14.01 National AIDS Coordinating Authority (NACs)
PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including NAPs/NACPs)
PS.01.01.14.03 Departments inside the Ministry of Education or equivalent
PS.01.01.14.04 Departments inside the Ministry of Social Development or equivalent
PS.01.01.14.05 Departments inside the Ministry of Defence or equivalent
PS.01.01.14.06 Departments inside the Ministry of Finance or equivalent
PS.01.01.14.07 Departments inside the Ministry of Labour or equivalent
PS.01.01.14.08 Departments inside the Ministry of Justice or equivalent
PS.01.01.14.99 Government entities n.e.c.
PS.01.01.99 Governmental organizations n.e.c.
PS.01.02 Parastatal organizations
PS.01.02.01 Hospitals
PS.01.02.02 Ambulatory care
PS.01.02.03 Dental offices
PS.01.02.04 Mental health and substance abuse facilities
PS.01.02.05 Laboratory and imaging facilities
PS.01.02.06 Blood banks
PS.01.02.07 Ambulance services
PS.01.02.08 Pharmacies and providers of medical goods
PS.01.02.09 Traditional or non-allopathic care providers
PS.01.02.10 Schools and training facilities
PS.01.02.10.01 Primary education
PS.01.02.10.02 Secondary education
PS.01.02.10.03 Higher education
PS.01.02.10.99 Schools and training facilities n.e.c.
PS.01.02.11 Foster homes/shelters
PS.01.02.12 Orphanages
PS.01.02.13 Research institutions
PS.01.02.99 Parastatal organizations n.e.c.
PS.01.99 Public sector providers n.e.c.
PS.02 Private sector providers
PS.02.01 Non-profit providers

PS.02.01.01 Non-profit non-faith-based providers
PS.02.01.01.01 Hospitals
PS.02.01.01.02 Ambulatory care
PS.02.01.01.03 Dental offices
PS.02.01.01.04 Mental health and substance abuse facilities
PS.02.01.01.05 Laboratory and imaging facilities
PS.02.01.01.06 Blood banks
PS.02.01.01.07 Ambulance services
PS.02.01.01.08 Pharmacies and providers of medical goods
PS.02.01.01.09 Traditional or non-allopathic care providers
PS.02.01.01.10 Schools and training facilities
PS.02.01.01.10.01 Primary education
PS.02.01.01.10.02 Secondary education
PS.02.01.01.10.03 Higher education
PS.02.01.01.10.99 Schools and training centres n.e.c.
PS.02.01.01.11 Foster homes/shelters
PS.02.01.01.12 Orphanages
PS.02.01.01.13 Research institutions
PS.02.01.01.14 Self-help and informal community-based organizations
PS.02.01.01.15 Civil society organizations
PS.02.01.01.99 Other non-profit non-faith-based providers n.e.c.
PS.02.01.02 Non-profit faith-based providers
PS.02.01.02.01 Hospitals
PS.02.01.02.02 Ambulatory care
PS.02.01.02.03 Dental offices
PS.02.01.02.04 Mental health and substance abuse facilities
PS.02.01.02.05 Laboratory and imaging facilities
PS.02.01.02.06 Blood banks
PS.02.01.02.07 Ambulance services
PS.02.01.02.08 Pharmacies and providers of medical goods
PS.02.01.02.09 Traditional or non-allopathic care providers
PS.02.01.02.10 Schools and training facilities
PS.02.01.02.10.01 Primary education
PS.02.01.02.10.02 Secondary education
PS.02.01.02.10.03 Higher education
PS.02.01.02.10.99 Schools and training centres n.e.c.
PS.02.01.02.11 Foster homes/shelters
PS.02.01.02.12 Orphanages
PS.02.01.02.13 Self-help and informal community-based organizations
PS.02.01.02.14 Civil society organizations
PS.02.01.02.99 Other non-profit faith-based private sector providers n.e.c.
PS.02.01.99 Other non-profit private sector providers n.e.c.
PS.02.02 Profit-making private sector providers (including profit-making FBOs)
PS.02.02.01 Hospitals
PS.02.02.02 Ambulatory care
PS.02.02.03 Dental offices
PS.02.02.04 Mental health and substance abuse facilities
PS.02.02.05 Laboratory and imaging facilities
PS.02.02.06 Blood banks
PS.02.02.07 Ambulance services
PS.02.02.08 Pharmacies and providers of medical goods
PS.02.02.09 Traditional or non-allopathic care providers
PS.02.02.10 Schools and training facilities
PS.02.02.10.01 Primary education
PS.02.02.10.02 Secondary education

PS.02.02.10.03 Higher education
PS.02.02.10.99 Schools and training centres n.e.c.
PS.02.02.11 Foster homes/shelters
PS.02.02.12 Orphanages
PS.02.02.13 Research institutions
PS.02.02.14 Consultancy firms
PS.02.02.15 "Workplace"
PS.02.02.99 Profit-making private sector providers n.e.c.
PS.02.99 Private sector providers n.e.c.
PS.03 Bilateral and multilateral entities – in country offices
PS.03.01 Bilateral agencies
PS.03.02 Multilateral agencies
PS.04 Rest-of-the world providers (services received outside the country)
PS.99 Providers n.e.c.

Annex 7: Production Factors (PF)

PF.01 Current expenditures
PF.01.01 Labour income (compensation of employees and remuneration of owners)
PF.01.01.01 Wages
PF.01.01.02 Social contributions
PF.01.01.03 Non-wage labour income
PF.01.01.98 Labour income not broken down by type
PF.01.01.99 Labour income n.e.c.
PF.01.02 Supplies and services
PF.01.02.01 Material supplies
PF.01.02.01.01 Antiretrovirals
PF.01.02.01.02 Other drugs and pharmaceuticals (excluding antiretrovirals)
PF.01.02.01.03 Medical and surgical supplies
PF.01.02.01.04 Condoms
PF.01.02.01.05 Reagents and materials
PF.01.02.01.06 Food and nutrients
PF.01.02.01.07 Uniforms and school materials
PF.01.02.01.98 Material supplies not broken down by type
PF.01.02.01.99 Other material supplies n.e.c.
PF.01.02.02 Services
PF.01.02.02.01 Administrative services
PF.01.02.02.02 Maintenance and repair services
PF.01.02.02.03 Publisher, motion picture, broadcasting and programming services
PF.01.02.02.04 Consulting services
PF.01.02.02.05 Transportation and travel services
PF.01.02.02.06 Housing services
PF.01.02.02.07 Logistics of events, including catering services
PF.01.02.02.08 Financial intermediation services
PF.01.02.02.98 Services not broken down by type
PF.01.02.02.99 Services n.e.c.
PF.01.98 Current expenditures not broken down by type
PF.01.99 Current expenditures n.e.c.
PF.02 Capital expenditures
PF.02.01 Buildings
PF.02.01.01 Laboratory and other infrastructure upgrading
PF.02.01.02 Construction of new health centres
PF.02.01.98 Buildings not broken down by type
PF.02.01.99 Buildings n.e.c.
PF.02.02 Equipment
PF.02.02.01 Vehicles
PF.02.02.02 Information technology (hardware and software)
PF.02.02.03 Laboratory and other medical equipment
PF.02.02.98 Equipment not broken down by type
PF.02.02.99 Equipment n.e.c.
PF.02.98 Capital expenditure not broken down by type
PF.02.99 Capital expenditure n.e.c.
PF.98 Production factors not broken down by type

Annex 8: Financing Agents (FA)

FA.01 Public sector
FA.01.01 Territorial governments

FA.01.01.01 Central or federal authorities
FA.01.01.01.01 Ministry of Health (or equivalent sector entity)
FA.01.01.01.02 Ministry of Education (or equivalent sector entity)
FA.01.01.01.03 Ministry of Social Development (or equivalent sector entity)
FA.01.01.01.04 Ministry of Defence (or equivalent sector entity)
FA.01.01.01.05 Ministry of Finance (or equivalent sector entity)
FA.01.01.01.06 Ministry of Labour (or equivalent sector entity)
FA.01.01.01.07 Ministry of Justice (or equivalent sector entity)
FA.01.01.01.08 Other ministries (or equivalent sector entities)
FA.01.01.01.09 Prime Minister's or President's office
FA.01.01.01.10 National AIDS Coordinating Authority
FA.01.01.01.99 Central or federal authorities' entities n.e.c.
FA.01.01.02 State/provincial/regional authorities
FA.01.01.02.01 Ministry of Health (or equivalent state sector entity)
FA.01.01.02.02 Ministry of Education (or equivalent state sector entity)
FA.01.01.02.03 Ministry of Social Development (or equivalent state sector entity)
FA.01.01.02.04 Other ministries (or equivalent state sector entities)
FA.01.01.02.05 Executive Office (or office of the head of the State/province/region
FA.01.01.02.06 State/provincial/regional AIDS Commission
FA.01.01.02.99 State/provincial/regional entities n.e.c.
FA.01.01.03 Local/municipal authorities
FA.01.01.03.01 Department of Health (or equivalent local sector entity)
FA.01.01.03.02 Department of Education (or equivalent local sector entity)
FA.01.01.03.03 Department of Social Development (or equivalent local sector entity)
FA.01.01.03.04 Executive office (or office of the head of the local/municipal government
FA.01.01.03.05 Local/municipal government AIDS commission
FA.01.01.03.99 Other local/municipal entities n.e.c.
FA.01.02 Public social security
FA.01.03 Government employee insurance programmes
FA.01.04 Parastatal organizations
FA.01.99 Other public financing agents n.e.c.

FA.02 Private sector

FA.02.01 Private social security
FA 02.02 Private employer insurance programmes
FA.02.03 Private insurance enterprises (other than social insurance)
FA.02.04 Private households (out-of-pocket payments)
FA.02.05 Non-profit-making institutions (other than social insurance)
FA.02.06 Private non-parastatal organizations and corporations (other than health insurance)
FA.02.99 Other private financing agents n.e.c.

FA.03 International purchasing organizations

FA.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles
FA.03.01.01 Government of Australia
FA.03.01.02 Government of Austria
FA.03.01.03 Government of Belgium
FA.03.01.04 Government of Canada
FA.03.01.05 Government of Denmark
FA.03.01.06 Government of Finland
FA.03.01.07 Government of France
FA.03.01.08 Government of Germany
FA.03.01.09 Government of Greece
FA.03.01.10 Government of Ireland
FA.03.01.11 Government of Italy
FA.03.01.12 Government of Japan
FA.03.01.13 Government of Luxembourg

FA.03.01.14 Government of Netherlands
FA.03.01.15 Government of New Zealand
FA.03.01.16 Government of Norway
FA.03.01.17 Government of Portugal
FA.03.01.18 Government of Spain
FA.03.01.19 Government of Sweden
FA.03.01.20 Government of Switzerland
FA.03.01.21 Government of the United Kingdom
FA.03.01.22 Government of the United States of America
FA.03.01.23 Government of the People's Republic of China
FA.03.01.99 Other government(s)/other bilateral agencies n.e.c.
FA.03.02 Multilateral agencies managing external resources
FA.03.02.01 Bureau of the Economic and Social Council (ECOSOC)
FA.03.02.02 European Commission
FA.03.02.03 Food and Agriculture Organization of the United Nations (FAO)
FA.03.02.04 International Labour Organization (ILO)
FA.03.02.05 International Organization for Migration (IOM)
FA.03.02.06 Regional Development Banks (Africa, Asia, Latin America and the Carribbean, Islamic Development Bank, etc.)
FA.03.02.07 UNAIDS Secretariat
FA.03.02.08 United Nations Children's Fund (UNICEF)
FA.03.02.09 United Nations Development Fund for Women (UNIFEM)
FA.03.02.10 United Nations Development Programme (UNDP)
FA.03.02.11 United Nations Educational, Scientific and Cultural Organization (UNESCO)
FA.03.02.12 United Nations High Commissioner for Refugees (UNHCR)
FA.03.02.13 United Nations Human Settlements Programme (UN-HABITAT)
FA.03.02.14 United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FA.03.02.15 United Nations Office on Drugs and Crime (UNODC)
FA.03.02.16 United Nations Population Fund (UNFPA)
FA.03.02.17 World Bank (WB)
FA.03.02.18 World Food Programme (WFP)
FA.03.02.19 World Health Organization (WHO)
FA.03.02.99 Other Multilateral entities n.e.c.
FA.03.03 International non-profit-making organizations and foundations
FA.03.03.01 International HIV/AIDS Alliance
FA.03.03.02 ActionAID
FA.03.03.03 Aga Khan Foundation
FA.03.03.04 Association François-Xavier Bagnoud
FA.03.03.05 Bernard van Leer Foundation
FA.03.03.06 Bill and Melinda Gates Foundation
FA.03.03.07 Bristol-Myers Squibb Foundation
FA.03.03.08 Care International
FA.03.03.09 Caritas Internationalis/Catholic Relief Services
FA.03.03.10 Deutsche Stiftung Weltbevölkerung
FA.03.03.11 Diana Princess of Wales Memorial Fund
FA.03.03.12 Elizabeth Glaser Pediatric AIDS Foundation
FA.03.03.13 European Foundation Centre
FA.03.03.14 Family Health International
FA.03.03.15 Foundation Mérieux
FA.03.03.16 Health Alliance International
FA.03.03.17 Helen K. and Arthur E. Johnson Foundation
FA.03.03.18 International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies
FA.03.03.19 King Baudouin Foundation

FA.03.03.20 Médecins sans Frontières
FA.03.03.21 Merck & Co., Inc
FA.03.03.22 Plan International
FA.03.03.23 PSI (Population Services International)
FA.03.03.24 SIDACTION (mainly Francophone countries)
FA.03.03.25 The Clinton Foundation
FA.03.03.26 The Ford Foundation
FA.03.03.27 The Henry J. Kaiser Family Foundation
FA.03.03.28 The Nuffield Trust
FA.03.03.29 The Open Society Institute/Soros Foundation
FA.03.03.30 The Rockefeller Foundation
FA.03.03.31 United Nations Foundation
FA.03.03.32 Wellcome Trust
FA.03.03.33 World Vision
FA.03.03.34 International Planned Parenthood Federation
FA.03.03.35 Order of Malta
FA.03.03.99 Other International non-profit-making organizations n.e.c.
FA.03.04 International profit-making organizations
FA.03.99 Other international financing agents n.e.c.

Annex 9: Financing Sources (FS)

FS.01 Public Funds

FS.01.01 Territorial government funds
FS.01.01.01 Central government revenue
FS.01.01.02 State/provincial government revenue
FS.01.01.03 Local/municipal government revenue
FS.01.01.04 Reimbursable loans
FS.01.02 Social security funds
FS.01.02.01 Employer's compulsory contributions to social security
FS.01.02.02 Employee's compulsory contributions to social security
FS.01.02.03 Government transfers to social security
FS.01.99 Other public funds n.e.c.

FS.02 Private Funds

FS.02.01 Profit-making institutions and corporations
FS.02.02 Households' funds
FS.02.03 Non-profit-making institutions (other than social insurance)
FS.02.99 Private financing sources n.e.c.

FS.03 International Funds

FS.03.01 Direct bilateral contributions
FS.03.01.01 Government of Australia
FS.03.01.02 Government of Austria
FS.03.01.03 Government of Belgium
FS.03.01.04 Government of Canada
FS.03.01.05 Government of Denmark
FS.03.01.06 Government of Finland
FS.03.01.07 Government of France
FS.03.01.08 Government of Germany
FS.03.01.09 Government of Greece
FS.03.01.10 Government of Ireland
FS.03.01.11 Government of Italy
FS.03.01.12 Government of Japan
FS.03.01.13 Government of Luxembourg
FS.03.01.14 Government of Netherlands
FS.03.01.15 Government of New Zealand
FS.03.01.16 Government of Norway
FS.03.01.17 Government of Portugal
FS.03.01.18 Government of Spain
FS.03.01.19 Government of Sweden
FS.03.01.20 Government of Switzerland
FS.03.01.21 Government of the United Kingdom
FS.03.01.22 Government of the United States of America
FS.03.01.23 Government of the People's Republic of China
FS.03.01.99 Other government(s)/other bilateral agencies n.e.c.
FS.03.02 Multilateral Agencies (ii)
FS.03.02.01 Bureau of the Economic and Social Council (ECOSOC)
FS.03.02.02 European Commission
FS.03.02.03 Food and Agriculture Organization of the United Nations (FAO)
FS.03.02.04 International Labour Organization (ILO)
FS.03.02.05 International Organization for Migration (IOM)
FS.03.02.06 Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)
FS.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria
FS.03.02.08 UNAIDS Secretariat

FS.03.02.09 United Nations Children's Fund (UNICEF)
FS.03.02.10 United Nations Development Fund for Women (UNIFEM)
FS.03.02.11 United Nations Development Programme (UNDP)
FS.03.02.12 United Nations Educational, Scientific and Cultural Organization (UNESCO)
FS.03.02.13 United Nations High Commissioner for Refugees (UNHCR)
FS.03.02.14 United Nations Human Settlements Programme (UN-HABITAT)
FS.03.02.15 United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FS.03.02.16 United Nations Office on Drugs and Crime (UNODC)
FS.03.02.17 United Nations Population Fund (UNFPA)
FS.03.02.18 World Bank (WB)
FS.03.02.19 World Food Programme (WFP)
FS.03.02.20 World Health Organization (WHO)
FS.03.02.99 Multilateral funds or development funds n.e.c.
FS.03.03 International non-profit-making organizations and foundations
FS.03.03.01 International HIV/AIDS Alliance
FS.03.03.02 ActionAID
FS.03.03.03 Aga Khan Foundation
FS.03.03.04 Association François-Xavier Bagnoud
FS.03.03.05 Bernard van Leer Foundation
FS.03.03.06 Bill and Melinda Gates Foundation
FS.03.03.07 Bristol-Myers Squibb Foundation
FS.03.03.08 Care International
FS.03.03.09 Caritas Internationalis/Catholic Relief Services
FS.03.03.10 Deutsche Stiftung Weltbevölkerung
FS.03.03.11 Diana Princess of Wales Memorial Fund
FS.03.03.12 Elizabeth Glaser Pediatric AIDS Foundation
FS.03.03.13 European Foundation Centre
FS.03.03.14 Family Health International
FS.03.03.15 Foundation Mérieux
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FS.03.03.18 International Federation of Red Cross and Red Crescent Societies, international Committee of Red Cross and National Red Cross Societies
FS.03.03.19 King Baudouin Foundation
FS.03.03.20 Médecins Sans Frontières
FS.03.03.21 Merck & Co., Inc
FS.03.03.22 Plan International
FS.03.03.23 PSI (Population Services International)
FS.03.03.24 SIDACTION (mainly Francophone countries)
FS.03.03.25 The Clinton Foundation
FS.03.03.26 The Ford Foundation
FS.03.03.27 The Henry J. Kaiser Family Foundation
FS.03.03.28 The Nuffield Trust
FS.03.03.29 The Open Society Institute/Soros Foundation
FS.03.03.30 The Rockefeller Foundation
FS.03.03.31 United Nations Foundation
FS.03.03.32 Wellcome Trust
FS.03.03.33 World Vision
FS.03.03.34 International Planned Parenthood Federation
FS.03.03.35 Order of Malta
FS.03.03.99 Other international non-profit-making organizations and foundations n.e.c.
FS.03.04 International profit-making organizations
FS.03.99 International funds n.e.c.

Annex 10: Entities studied for the NASA

Annex 8.I: Health Centers/Facilities				
	Health Center	**Level**	**District**	**Ownership**
1	Aduku Hospital	HC IV	Apac	Government
2	Akokoro	HC III	Apac	Government
3	Arua Regional Referral Hospital	Hosp.	Arua	Government
4	Awach	HC IV	Gulu	Government
5	Biashara	HC II	Apac	Government
6	Biharwe	HC III	Mbarara	Government
7	Bugamba	HC IV	Mbarara	Government
8	Bugangari	HC IV	Rukungiri	Government
9	Bugembe	HC IV	Jinja	Government
10	Buhaddagazo	HC II	Rukungiri	Government
11	Bukulula	HC IV	Masaka	Government
12	Bulumbi	HC III	Busia	Government
13	Busia	HC IV	Busia	Government
14	Butema	HC III	Hoima	Government
15	Bwera Hospital	Hosp.	Kasese	Government
16	CASE Clinic	Hosp.	Kampala	Private for Profit
17	Church of Uganda Clinic	HC III	Kotido	NGO
18	Danani Hospital	HC IV	Busia	NGO
19	Ediofe	HC III	Arua	NGO
20	Gborokolongo	HC II	Koboko	Government
21	Gome	HC III	Mukono	Government
22	Gulu Regional Referral Hospital	Hosp.	Gulu	Government
23	Hoima Regional Referral Hospital	Hosp.	Hoima	Government
24	Jinja Central	HC III	Jinja	Government
25	Jinja Regional Referral Hospital	Hosp.	Jinja	Government
26	Kakira Sugar Hospital	Hosp.	Jinja	Private
27	Kakuuto HC IV	HC IV	Rakai	Government
28	Kalisizo Hospital	Hosp.	Rakai	Government
29	Kapchorwa Hospital	Hosp.	Kapchorwa	Government
30	Kaproron	HC IV	Kapchorwa	Government
31	Karoli Lwanga Hospital Nyakibale	Hosp.	Rukungiri	NGO
32	Kawolo Hospital	Hosp.	Mukono	Government
33	Kikuube	HC IV	Hoima	Government
34	Kitovu Hospital	Hosp.	Masaka	NGO
35	Koboko	HC IV	Koboko	Government
36	Kotido	HC IV	Kotido	Government
37	Kyetume	HC III	Mukono	NGO
38	Lookorok	HC II	Kotido	Government
39	Ludara	HC III	Koboko	Government
40	Luwero	HC IV	Luwero	Government

41	Madera	HC II	Soroti	NGO
42	Mafubira	HC III	Jinja	Government
43	Maliba	HC III	Kasese	NGO
44	Masafu Hospital	Hosp.	Busia	Government
45	Masaka Municipality Health Center	Hosp.	Masaka	Government
46	Masjid Noor	HC II	Arua	NGO
47	Mayanja Memorial Hospital Foundation	Hosp.	Mbarara	NGO
48	Mbale Regional Referral Hospital	Hosp.	Mbale	Government
49	Mbarara municipality	HC IV	Mbarara	Government
50	Mengo Hospital	Hosp.	Kampala	NGO
51	Mubende Regional Referral Hospital	Hosp.	Mubende	Government
52	Mukono	HC IV	Mukono	NGO
53	Mulago National Hospital	Hosp.	Kampala	Government
54	Muwumba	HC III	Jinja	Government
55	Nabulola Community Medical Center	HC III	Busia	NGO
56	Nambi	HC II	Luwero	Government
57	Namugoona Orthodox Hospital	Hosp.	Kampala	NGO
58	Namungodi	HC II	Busia	Government
59	Nyakagyeme	HC III	Rukungiri	Government
60	Oli	HC IV	Arua	Government
61	Rubaga Hospital	Hosp.	Kampala	NGO
62	Ruhaaro Hospital	HC III	Mbarara	NGO
63	Rukungiri HC II	HC II	Rukungiri	Government
64	Rwesande	HC IV	Kasese	NGO
65	Salem Brotherhood Kolonyi	HC III	Mbale	NGO
66	Soroti Regional Referral Hospital	Hosp.	Soroti	Government
67	St. Joseph Madudu	HC III	Mubende	NGO
68	St. Mary's Hospital Lacor	Hosp.	Gulu	NGO
69	Tiriri Health Center	HC IV	Soroti	Government
70	Tubur	HC III	Soroti	Government
71	Uganda Cares Hospital	Hosp.	Masaka	NGO
72	Zirobwe	HC III	Luwero	Government

Annex 10.II: International Organisations/Donors

	Organisation	**Type of Entity**
1	African Development Bank	multilateral
2	Belgium Embassy	Bilateral
3	Centre for Disease Control	Bilateral
4	Danish International Development Agency-DANIDA	Bilateral
5	Delloitte and Touche Civil Society Fund	Civil Society Fund
6	Delloitte and Touche Partnership Fund	Partnership Fund
7	DFID-Department for International Development	Multilateral
8	DoD-UPDF-Department of Defence	Bilateral
9	European Union	Multilateral
10	Global Fund for AIDS TB and Malaria	Multilateral

11	GTZ-Deutsche Gesellschoft Fur Zusammenarbeit	Bilateral
12	International Labour Organisation	Multilateral
13	International Monetary Fund	Bilateral
14	Irish Aid	Bilateral
15	Italian Co-operation	Bilateral
16	Japan International Corporation Agency (JICA)	Bilateral
17	Norwegian Embassy	Bilateral
18	Peace Corps	Bilateral
19	Small Grants	Bilateral
20	State-Bureau for Population, Refugees & Migration	programme/project
21	Swedish International Development Agency (SIDA)	Multilateral
22	UNAIDS-Joint United Nations Programme on HIV/AIDS	Multilateral
23	UNDP-United Nations Development Programme	Multilateral
24	UNESCO-United Nations Education, Scientific and Cultural Organisation	Multilateral
25	UNFPA-United Nations Population Fund	Multilateral
26	United National High Commissioner for Refugees-UNHCR	Bilateral
27	UNICEF-United National International Children's Educational Fund	Bilateral
28	United States of America / PEPFAR	Bilateral
29	United States Agency for International Development-USAID	Bilateral
30	Walter Reed Project	Multilateral
31	World Bank	Multilateral
31	World Health Organisation	Multilateral

Annex 10.III: Non Governmental Organisations_National Level	
1	ACCORD Uganda
2	Adventist Development and Relief Agency-ADRA
4	AFRICARE Uganda
5	AGAHA- Action Group for Health Human Rights and HIV/AIDS Uganda
6	Agency for Capacity Building
7	AHF Uganda Cares
8	AIDS Information Centre
3	American Refugee Council
9	AMICAALI Uganda
10	AMREF- African Medical and Research Foundation
11	Association Francois-Xavier Bagnoud
12	Build Africa Uganda
13	Capacity Systems Link
15	Care International in Uganda
14	Catholic Relief Services
16	Child Fund International
17	Child Support Africa
18	Clinton Health Access Initiative

19	Compassion International In Uganda
20	Concern World Wide
21	CUAMN Doctors with Africa
22	Dan Church Aid
23	Deutsche Stiftung Weltberulkerung (DSW)
24	Family Health International
25	Federation of Uganda Employers
26	Feed the Children Uganda
27	Goal Uganda
31	Inter-AID Uganda
28	International Community of Women Living with HIV-ICW
29	International Rescue Committee
30	Inter-Religious Council of Uganda-IRCU
32	Joint Clinical Research Center-JCRC
33	Lutheran World Federation
34	Makerere University Joint AIDS Project-MJAP
35	Marie Stopes International
36	Mild May AIDS Center
37	Most At Risk Populations -MARPS Network
38	National Care Center
39	National Community of Women and Orphans Living with AIDS-NACWOLA
40	National Forum for People Living with HIV&AIDS in Uganda (NAFOPHANU)
41	National Union of Disabled Persons in Uganda-NUDIPU
42	Path Finder Uganda
43	PLAN Uganda
44	PREFA-Protecting Families Against HIV/AIDS
45	Programme for Accessible Health, Communication and Education (PACE)
46	Reach the Youth Uganda
47	Red Cross Society of Uganda
48	Reproductive Health Uganda
49	Rural Health Promotion and Poverty Alleviation Initiative
50	Samaritan Purse
51	Save the Children Uganda
52	Straight Talk Foundation
53	Supporting Public Sector Work places to expand action and responses against HIV-SPEAR
54	The AIDS Support Organization-TASO
55	The Uganda Students Association for Prevention of AIDS-TUSAPA
56	THETA
57	Uganda Cares
58	Uganda Health Marketing Group
59	Uganda National AIDS Support Organizations-UNASO
61	Uganda Project Implementation and Management Center-UPIMAC
60	Uganda Protestant Medical Bureau-UPMB
62	Uganda Women's Efforts to Support Orphans-UWESO
63	Uganda Youth Anti-AIDS Association
64	Uganda Youth Forum
65	UGANET- Uganda Networks of People living with HIV/AIDS

66	Watoto Child Care Ministries
67	Well Share International
68	World Vision
69	Young, Empowered and Healthy

Annex 10.IV: District CSOs

Kampala District

1	Action for Community Development
2	Action for Rural Women's Empowerment
3	Adventist Development and Relief Agency-ADRA
4	African Evangelical Enterprises
5	Agency for Capacity Building-ACB
6	AIDS Action Uganda
7	AIDS Care Education and Training-ACET
8	Build Africa Uganda
9	Church of Uganda
10	Coalition for Health promotion and Social Development
11	Community Based AIDS Programme
12	Concern World Wide
13	Huyslink Community Initiative
14	Integrated Community Based Initiatives-ICOBI
15	Integrated Rural Development Initiative-IRDI
16	Kakeeke Development Association (KADEA)
17	Kawempe Division Disabled Community
18	Kisenyi III community Health workers Association (KICHWA)
19	Kisenyi Teenage center
20	Kitebi Teenage Center
21	Makerere Women Development Association
22	Making Positive living attractive to youths(Ma-Play)
23	Mama's Club
24	Mission for All-MFA
25	Mission Uganda
26	Ndeeba Parish Youth Association
27	Nsambya Babies Home
28	Nsambya Home Care
29	Pamoja Africa Reflect Network
30	Pan African Acupuncture Project
31	Reach the youth Uganda
32	Salvation Army
33	Single Parents Association of Uganda
34	Slum Dwellers Federation Central Region
35	Spread Awareness Information and learning in Uganda-SAIL
36	Support on Aids and Life Through Telephone Helpline-SALT
37	The Church of the Province of Uganda

Annex 10.IV: District CSOs	
38	Youth Anti-AIDS Association
Luwero District	
1	Luwero Child Development Centre
2	Luwero District Health Office
3	Luwero District Probation office
4	National Community of Women and Orphans Living with AIDS-NACWOLA
5	Reproductive Health Uganda-Luwero Branch
Rukungiri District	
1	Kinyasano Child Development Center
2	LADA-Literacy Action and Development Agency
3	RUDNET
4	Rukungiri Gender and Development Association-RUGADA
5	Rukungiri District Health Office
Masaka District	
1	Tulina Omubeezi Child Development Center
Mubende District	
1	Children/Wives of Disabled Soldiers-CADOVISA
2	Community Development Office
3	Mubende District Health Office
4	St. Thomas Child Development Center
Rakai District	
1	Community Enterprises Development organization
2	Network for Community Development Services
3	RACHEP
4	Rakai AIDS Information Network-RAIN
Mbarara District	
1	ACCORD Uganda
2	Integrated Development Options-IDO
3	Mbarara District Health Office
4	RUDNET
Mukono District	
1	Action for Development in Underserved Areas
2	AIDS Action Uganda
3	Asika Obulamu PLHA Group
4	Chain Foundation
5	Good Spirit support Action center
6	Integrated Family Care Support Uganda
7	Katoogo Anti-AIDS Initiative
8	Mirembe HIV/AIDS Club
9	Mpoma Community HIV/AIDS Initiative
10	Mukono AIDS Support organization
11	Mukono District Health Office

Annex 10.IV: District CSOs	
12	Mukono District Information Office
13	Mukono District Probation Office
14	Muwumuza Psychosocial Support Group
15	Uganda Reach the Aged Association
16	Uganda Red Cross Society-Mukono Branch
Busia District	
1	Busia District Local Government
2	Busia District Network of PLWHAs
3	Busia Widow and orphans Association
4	Busime Rural Development Association
5	Helping Hands Foreign Missions
6	Hope Care Foundation
Jinja District	
1	Act for Africa
2	AIDS Orphans Education Trust-AOET
3	Child Fund International in Uganda-Jinja
4	Child Restoration Office
5	Family Life Education Programme (FLEP)
6	Jinja District Chief Administrative Office
7	Jinja District Health Office
8	Jinja Municipal Council
9	Slum Women's Initiative for Development
Kotido District	
1	Caritas Kotido
2	District Health Office
3	Warrior Squad Foundation
Soroti District	
1	Community Care services
2	District Health Office
3	Health Need Uganda
4	Soroti District PLWHA Forum
5	Soroti Municipal Council
6	Teso Islamic Development organization
7	Teso Safe Motherhood project
8	Trans-cultural Psychosocial organization-TPO
Koboko District	
1	District Health Office
2	Federation of Community Infected and Affected with HIV/AIDS in Koboko-FECHA-K
3	Koboko Widows Association
4	Koboko Youth in Development
Arua District	
1	Arua District Health Office

Annex 10.IV: District CSOs	
2	Arua District Male Community Living With HIV/AIDS-ADMACHA
3	Arua District Network forum for PLWHAs
4	Caritas Arua
5	Community Empowerment for Rural Development
6	Reproductive Health Uganda
7	Uganda Red Cross Society
8	UMOJA Women living with HIV/AIDS Group
Gulu District	
1	Comboni Samaritans of Gulu
2	District Health Office
3	Kairos Charity Community Development organization
4	Northern Uganda Malaria, AIDS and T.B-NUMAT
5	Waloko-kwo Support organization
6	World Vision Gulu
7	Youth Movers Uganda
Apac	
1	Apac District forum of people living with HIV
2	Campaign Against Domestic Violence in the Community-CADOVIC
3	The AIDS Support organization-TASO
4	WACANE -Women and Child Advocacy in Network
Kapchorwa	
1	All Saints Church-OVC
2	Christ Glorious Ministries
3	Community Based Development Service
4	Community Health Empowerment
5	District Health Office
6	Kapchorwa Child Development Center
7	Kapchorwa Forum for PLWHAs
8	Kapchorwa Integrated Community mobilization
9	REACH Programme
10	Red Cross Society-Kapchorwa
11	Ripka Child Development Initiative-RICDI
12	Sebei Diocese Family Life-Mother's Union
13	Sebei District church of Uganda
Mbale	
1	Abundant Love Integrated Ministries (ALIMS U)
2	Bushikori Child Development Center
3	Bushikori Christian Center
4	Community Development Office
5	District Health Office
6	Foundation for needy communities
7	Jenga Community Development Outreach
8	Mbale Area Federation of Communities

Annex 10.IV: District CSOs	
9	Mbale District PHA Forum
10	Mulyuli HIV AIDs Orphan Care
11	Nakaloke Development Initiative for Communities-NADECO
12	National Community of Women and Orphans Living with AIDS-NACWOLA
13	Reproductive Health Uganda
14	Share an Opportunity Uganda
15	SPEAR-World Vision
16	Uganda Red Cross Society
17	Uganda Women Concern Ministries
Hoima	
1	Bulera Core PTC
2	Bunyoro Kingdom Cultural Development Troupe
3	Bunyoro Kitara Diocese
4	Caritas Development Organisation
5	District Health Office
6	Hoima District Network of AIDS Service Organisations
7	Hoima District Union for People with Disabilities
8	Joint Efforts for Rural Development-JEFORD
9	Kinogozi Women HIV/AIDS Drama Group
10	Kitara Union of Media Practitioner
11	Meeting Point
12	National Community of Women and Orphans Living with AIDS-NACWOLA
Kasese	
1	Action for Community Development Uganda
2	Agape of Hope Female Youth Development Association
3	Foundation for Rural and Urban Advancement
4	Good Hope Foundation for Rural Development
5	Kasese District Community Development Office
6	Kasese District Health Office
7	Kasese District Youth Focus on HIV/AIDS
8	National Community of Women and Orphans Living with AIDS-NACWOLA
9	National Youth Organisation for Development-NAYODE
10	Uganda Reach the Aged Association
11	Young and Powerful Initiative-YAPI

Annex 10. V: Public Entities Studied	
1	AIDS Information Center
2	Central Public Health Laboratory
3	IAVI-International AIDS Vaccine Initiaitive
4	Kalangala District Local Government
5	Kampala City Council Authority-KCCA
6	Makerere School of Population Studies
7	Makerere School of Public Health

Annex 10. V: Public Entities Studied	
8	Makerere Public Health -CDC HIV Fellowship Programme
9	Ministry of Defence
10	Ministry of Education and Sports
11	Ministry of Finance, Planning and Economic Development
12	Ministry of Foreign Affairs
13	Ministry of Gender and Social Development
14	Ministry of Health
15	Ministry of Health AIDS Control Programme
16	Ministry of Health CDC PEPFAR
17	Ministry of Health Planning
18	Ministry of Internal Affairs-Uganda Prisons
19	Ministry of Lands, Housing and Urban Development
20	Ministry of Local Government
21	Ministry of Public Service
22	Ministry of Tourism, Trade and Industry
23	New Vision Limited
24	Office of the Prime Minister
25	Uganda AIDS Commission-UAC
26	Uganda Blood Transfusion Services
27	Uganda Manufacturers Association-UMA
28	Uganda Police
29	Uganda Prisons Service- Health Services Unit
30	Uganda Virus Research Institute

Annex 10. VI: Business Entities	
1	Century Bottling Company Limited
2	Civil Aviation Authority
3	Crown Beverages Limited
4	Entebbe Handling Services
5	Honda Uganda
6	Housing Finance Bank
7	Joint Medical Stores
8	Kampala Pharmaceutical Industries
9	National Medical Stores
10	Roofings Uganda Limited
11	Rwenzori Limited
12	Sadolin Paints
13	Shell Uganda
14	Stanbic Bank
15	TOTAL Uganda
16	Toyota Uganda
17	Tullow Oil
18	Uganda Telecom
19	UMEME Uganda Limited
20	Unilever Uganda Limited
21	Quality Chemicals

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Annex 12: References

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