



# Ethiopian National AIDS Spending Assessment (NASA) Report EFY 2004, 2011/12

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## Foreword

The government of Ethiopia has shown strong commitment in responding to the HIV/AIDS epidemic since the first AIDS case was identified in 1984. The government has led a multi-sectoral response which engages government sectors, development partners, civil societies, and the private sector, for which the required governance structures, policy environment and systems for monitoring and evaluation were established and progressively improved based on lessons learnt from experiences. Emphasis was thus given in addressing HIV and AIDS as part of the country's overall poverty reduction strategy and development agenda. Access to HIV/AIDS prevention, treatment and care and support services has improved alarmingly in all regions of the country.

The response has also required significant resources which have been invested from Government, development partners and civil society. In due effort, the country has succeeded to reduce new infections by 90% and AIDS related deaths by 54% in 2012 compared to the levels in 2000 and 2005 respectively. However prevalence varies considerably by age, sex, and geographical location. According to the 2011 DHS, Gambella region and the urban administrations of Addis Ababa and Dire Dawa had the highest prevalence while SNNPR and Oromia region the lowest and adult prevalence was almost twice as high among females compared to males at 1.9% versus 1.0% respectively.

It is therefore important on the one hand to ensure that the gains of the response so far will be sustained and on the other hand to meet the ambitious targets of eliminating new HIV infection and AIDS related deaths. This requires strong commitment of Government and partners to continue to support HIV financing as well as to improve the allocative efficiencies of resources to maximize the results of investment.

Demonstrating and ensuring value for money, promoting transparency and accountability and ensuring sustainability is therefore critical and even more so in the current era of diminishing resources for HIV. Thus this National AIDS Spending Assessment (NASA), the first of its kind in Ethiopia comes at an opportune moment, providing key insights on the total amount of resources devoted to HIV and AIDS, as well as where funds are allocated both by region and by area of expenditure, sources of finance and importantly where funding gaps lie during the fiscal year 2011/12. It will also inform our future decisions and actions on resource allocation and utilisation as well as provide essential information to guide and inform the national HIV response going forward.

Finally this exercise represents an important first step towards developing a unified resource tracking system that goes beyond HIV and could serve multiple national purposes. We hope this current NASA exercise, by providing a better understanding of the HIV needs in terms of HIV resource tracking will contribute to that end and will ultimately be translated into an enhanced and more effective response.

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## Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
ARVs	Antiretroviral Drugs
ASC	AIDS Spending Category
BCC	Behaviour Change Communication
BP	Beneficiary Population
CBO	Community-Based Organisation
COP	Country operation plan (PEPFAR)
CCT	Currency Conversion Tax
CDC	(US) Center for Disease Control
CHBC	Community and Home-Based Care
CSI	Corporate Social Investment
CSO	Civil Society Organisation
CSW	Commercial Sex Workers
DAC	Department of AIDS Control
DfID	Department for International Development (UK)
DP	Development partners
EA	Expenditure analysis (PEPFAR)
EFR	Ethiopian Financial Year
EHNRI	Ethiopian Health and Nutrition Research Institute
EIFDDA	Ethiopia Interfaith Forum for Development, Dialogue and Action
EU	European Union
FA	Financing Agent
FBO	Faith-Based Organisation
FFT	Financial Transaction Tax
FMoH	Federal Ministry of Health
FS	Financing Source
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOE	Government of Ethiopia
HCT	HIV Counselling and Testing
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immunodeficiency Virus
HTA	High Transmission Area
IDU	Intravenous Drug User
IEC	Information, Education and Communication
IGA	Income Generation Activities
IPT	Isonized Preventive Therapy
M&E	Monitoring and Evaluation
MARP	Most-at-Risk Population or Highly Vulnerable Group
MOE	Ministry of Education
MOH	Ministry of Health
MOF	Ministry of Finance
MSD	Ministry of Social Development
MOT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
MTEF	Medium-Term Expenditure Framework
NASA	National AIDS Spending Assessment
NDPs	National Development Plans

n.e.c.	not elsewhere classified
NEP	Network of Networks of HIV Positives in Ethiopia
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
OIs	Opportunistic Infections
OOPE	Out-of-Pocket Expenditure
OOP	Out-of-Pocket
OPEP	Occupational Post-Exposure Prophylaxis
OTC	Over-The-Counter (medications purchased without a prescription)
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PF	Production Factor
PITC	Provider-Initiated Testing
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnerships
RTS	Resource Tracking System
RTT	Resource Tracking Tool
SES	Socio-Economic Status
SPM	Strategic Plan Management
SPMII	Strategic Plan II for Intensifying Multi-sectoral HIV and AIDS Response in Ethiopia (2010/11-2014/15)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly on HIV/AIDS
USA	United States of America
USAID	United States Agency for International Development
US\$	United States Dollars
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

## EXECUTIVE SUMMARY

The National AIDS Spending Assessment (NASA) (2011/12) is the first attempt to track all the HIV/AIDS spending in Ethiopia from all sources (excluding out-of-pocket) and across all sectors. The NASA provides an in depth examination of the HIV/AIDS by detailed categories of activities, providers of services and the beneficiaries. NASA applies a standardised and comprehensive methodology for collecting, coding and analysing of HIV expenditure. It allows countries to understand if they are allocating funds according to their priorities and for the greatest investment in terms of impact. However, for all the PEPFAR and MOH expenditure, the usual NASA methods were not applied. Rather PEPFAR provided their total spending which they collected through their Expenditure Analysis (EA), and the MOH provided their estimates based on the National Health Accounts (NHA) from the previous year.

The total spending in Ethiopia on HIV/AIDS in 2011/12 (EFY 2004) was US\$ 405 million, of which 86% came from external sources (US\$ 350 million), 13% came from public revenue (US\$ 55 million) and only US\$ 680,000 (less than one percent) came from the private sector (although the business sector's contribution was underestimated and the private health care sector excluded).

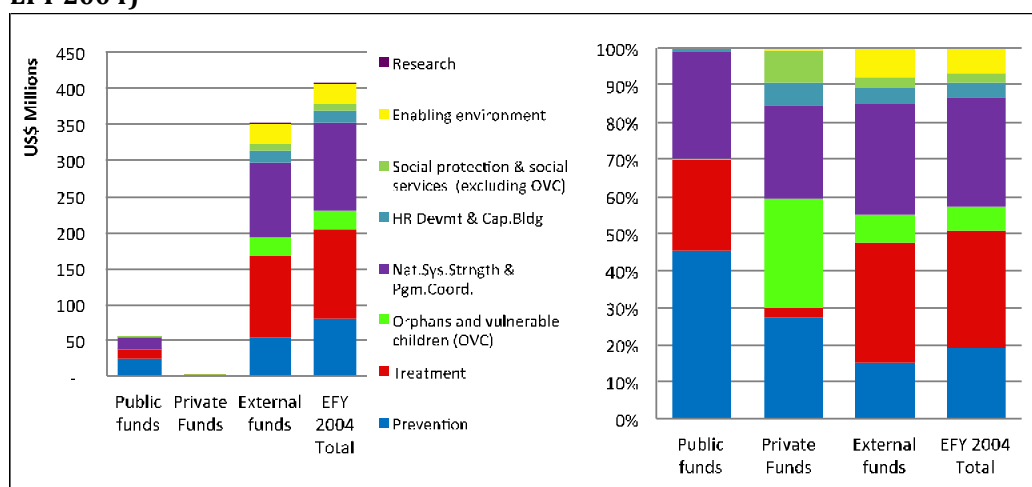
Of the **public funds**, a large portion was the spending through the Ministry of Health, based on the NHA estimates for EFY 2003 (2010/11), which represents an important but usually hidden cost carried by governments. Also of importance are the Mainstreaming Fund to which every Ministry contributes 2% of its total budget, and the AIDS Fund which is a voluntary contribution from the public employees. These are public initiatives that could be explored for future expansion.

Of the **external sources**, PEPFAR was the greatest contributor, forming 51% of total spending on HIV/AIDS (US\$ 206 million excluding their 'above national spending' – or out of the country spending for Ethiopia), and the Global Fund was the next largest contributor (30%) at US\$ 150 million. Numerous other bilateral, multilateral and international foundations also contribute to the response in Ethiopia, all less than 1% each in EFY 2004 (2011/12), but totalling around 10% of total spend.

In terms of the **agents** of the HIV/AIDS spending, that is, who controls how the money is spent, the government managed 37% (US\$ 152 million), while external agents managed 60% (US\$ 242 million).

Considering the breakdown of the HIV/AIDS spending by **thematic area**, Ethiopia spent 19.5% (US\$ 79 million) on prevention in 2004 (2011/12), 31% on treatment and care (US\$ 125 million), 30% on national systems strengthening and programme management (US\$ 120 million), 7% on OVC support (US\$ 28 million), and 6.5% on enabling environment activities (US\$ 26 million). Social protection activities (excluding those for OVCs) took 2.6% (US\$ 11 million), and less than 1% (as was captured by NASA) went to research activities (US\$ 250,000) (noting that surveillance and M&E spending were captured under national systems strengthening). This under-representation of research spending was due to the non-response by the larger research entities and thus is not representative of the actual funds spent for research in the country.

**Fig 1: HIV/AIDS Spending in Ethiopia by broad categories and by source of funds (US\$, %, EFY 2004)**



By source of funds, the largest portion of the total public funds went to prevention activities (45%), followed by national system strengthening and programme management (just under 30%) and then treatment and care (24%). For the two major external sources, PEPFAR's largest portion went to national systems strengthening and programme management (31%), while GF's share for systems strengthening and programme management was 28%. In comparison, the GF money primarily went towards treatment (51%), while their prevention spending was only 9%. PEPFAR's second largest share of funding was for treatment and care (27%) and 17% went towards prevention.

Looking into the thematic areas, the **prevention activities** were dominated by a large amount (51%) that could not be disaggregated i.e. the information provided by the respondents did not indicate the type of prevention activity. This was partly the PEPFAR funding (US\$ 18 million for non-disaggregated prevention) and the MOH's spending on 'prevention and public health' of US\$ 24 million. Thereafter the next largest prevention activity was HIV counselling and testing (HCT) (16%) and then prevention of mother to child transmission (PMTCT) (14%). Other prevention activities received very little (although these activities may be captured under the non-disaggregated share): behavioural change communications (BCC) 3.6%, community mobilisation 2.4%, vulnerable groups 1.8% and other activities less than 1%.

Within the **treatment and care category**, the largest proportion of spending in EFY 2004 went towards ART (55%, US\$ 70 million), followed by HIV laboratory monitoring (11%, US\$ 14 million). However, there was also a large portion (12%, US\$ 15 million) that went towards outpatient services not disaggregated, which was primarily the MOH spending (provided from the NHA). Provider initiated testing and counselling (PITC) received 9% (US\$ 11.6 million), nutritional support for ART received 7% (US\$ 8.7 million), while the other activities received relatively small amounts: psychological support (1.9%), home-based care (1%), and palliative care (0.6%).

Of the total spending (US\$ 120 million) on **national systems strengthening and programme management**, 35% (US\$ 41.4 million) went towards planning and co-ordination activities, 19% (US\$ 23 million) went to upgrading facilities, and 17.5% (US\$ 21 million) went towards transactional costs associated with managing funds. M&E activities took 15% (US\$ 18 million) of this category, while only 2% (US\$ 2.4 million) was reportedly spent on surveillance activities (due to non-reporting of the key research agencies). Considering this category by the sources of funds, the public funds spent 61% (US\$ 9.4 million) on planning and coordination, which would be expected for their national coordination role, and 29% (US\$ 4.5 million) on



infrastructural development. From the PEPFAR funds for this thematic area (national systems strengthening), 35% (US\$ 22 million) went towards planning and coordination, 22% (US\$ 14 million) for M&E, and 20% (US\$ 13 million) was for transactional costs associated with the management of funds. Importantly, the USG contributed to information technology (US\$ 7 million) and drug supply systems (US\$ 5.3 million).

When examining the service providers of the HIV/AIDS services in Ethiopia, the NASA found that the bulk were within the private category (61%), but this was due to all the PEPFAR implementing partners being lumped together in this category since the PEPFAR EA data did not provide the types of service providers. The public providers nevertheless formed a significant portion of the service providers (38%), while the external providers were very small (1%).

Regarding the beneficiaries of HIV/AIDS spending in Ethiopia, the degree of disaggregation of data was somewhat limited, with uncertainty regarding the beneficiaries of the USG data (which were not provided and thus had to be assumed based on the type of activity). Considering the broad categories, people living with HIV/AIDS (PLHIV) received the largest share (40%) of all HIV/AIDS spending in Ethiopia in EFY 2004, followed by non-targeted spending (25%) (primarily due to the large spending on national systems strengthening and programme management), and then those interventions that were targeted towards the general population, such as BCC, HCT etc. The share that went to CSW was very small, less than 1%. Vulnerable and other at-risk groups received 9%, the detailed breakdown by group is provided in the report.

The key recommendations generated from the findings and the feedback from the NASA stakeholder validation meeting were as follows:

#### ***Allocative Decisions for Greatest Impact***

Considering the proportional split between the thematic areas, there appeared to have been adequate spending on treatment in EFY 2004, for about 800,000 PLHIV and the then ART guidelines of eligibility below 200 CD4. The national guidelines have since been changed (December 2013) to extend eligibility to CD4 below 500.

However, preventative spending, when compared with the resource needs estimated in the SPM II, appeared lower than adequate, and therefore enhanced efforts particularly for those more targeted interventions with proven preventative impact may be necessary. The Ethiopian Investment Case being developed will provide strategic guidance in this regard, and the findings from the National and regional HIV Syntheses would enhance planners understanding of the key risk groups in Ethiopia.

Ethiopia had a high share of spending on national systems strengthening and programme management (mostly captured under the Enabling Environment thematic area of the SPM II). Examination of the sub-categories of spending on those activities, particularly transactional costs associated with managing HIV funding, would be useful to ascertain possible areas for greater efficiency gains. In this regard, more detailed information from the development partners, particularly the PEPFAR and UN agencies, regarding their headquarters and operational costs in-country, would increase transparency, accountability and impact.

The low spending on research and surveillance, which was partly due to non-response of some key players, should be examined and ascertained if additional funding is required for strengthening the use of strategic information (SPM II thematic area five), which appeared to be low compared with the estimated resource requirements.

Mitigation spending also appeared low, and it would be useful to examine the outcomes and impact of the existing programmes, and consider increasing or improving strategic efforts in this regard, since they are still critical interventions for OVCs, families and communities that have been negatively affected by HIV/AIDS.

### ***Sustainable, Transparent, Accountable and Aligned Funding***

The development partners and government agencies were willing to share their data on expenditure and available funds for HIV/AIDS in Ethiopia. This shows an important commitment to transparency and accountability. If longer-term future commitments can be shared by all actors, this would enhance longer-term planning and resource mobilisation. Again, the Investment Case being developed should assist in this regard.

Equally the response rate from HIV service providers in Ethiopia was good, and most displayed willingness and ability to share their data. There were a few that did not, and this may have under-represented the spending in certain activities, particularly the research field. Future resource tracking efforts should gradually improve the willingness of all actors to share their data, as they see the usefulness of the information for evidence-based planning.

Regarding long-term financial sustainability and with Ethiopia's progression towards lower middle-income status, there could be consideration of alternative sources of public revenue for increasing health expenditure generally, while also ensuring adequate funding for the HIV/AIDS response.

### ***Improving Financial Information Systems and Institutionalising Routine Expenditure Tracking***

The routine collection and collation of HIV expenditure, at least on an annual basis, would enhance the availability of information to inform allocative decisions and resource mobilisation. It would also lead to improved transparency for all actors in the HIV field in Ethiopia. An option could be the routine submission of expenditure by service providers when submitting their routine M&E indicators/ report.

### ***Additional Research***

Since this was the first NASA in Ethiopia and has provided valuable, in-depth programmatic expenditure information, it could be enhanced with more in depth examination of potential efficiency gains and outputs per programme.

For the development of the Investment Case for Ethiopia, additional information on the impact of interventions would be valuable, to then compare the cost-efficiencies of programmes.

## 1. Introduction and Background

This report presents the findings of the National AIDS Spending Assessment (NASA) undertaken for the first time in Ethiopia for the Ethiopian Financial Year (EFY) 2004 (2011/12).

This NASA has captured the majority of the public spending, all foreign (external) spending, and some of the business sector's contributions. Importantly, the contributions from the Ministry of Health (MoH) for the in-patient and out-patient treatment of opportunistic infections (OI) have been estimated through the National Health Accounts (NHA<sup>1</sup>) for the previous year (EFY 2003) and were adjusted (based on inflation and the health budget increases) for this NASA for EFY 2004. These are usually unacknowledged expenditures carried by the government. However, it is not clear if the NHA might have omitted any other expenditures, but it is normally considered to be comprehensive. The individuals' contributions through out-of-pocket expenditures (OOPE) have not been captured in this NASA and may, or may not, represent a significant share to the total spending on HIV/AIDS in Ethiopia.

### 1.1. Ethiopian Socio-Economic Indicators

The Federal Democratic Republic of Ethiopia is located in East Africa with an estimated population of 83 million (based on projections from the national census of 2007), of which 83.9% live in rural areas. The average life expectancy was 51 years for males and 53 years for females in 2011<sup>2</sup>.

Ethiopia has a low per capita income, estimated at 390 USD per annum in 2010/11, with 32.7% of the population living below the absolute poverty line<sup>3</sup>. However, according to the National HIV Monitoring and Evaluation Report (2012), the country has seen rapid progress in economic growth in recent years, expansion of social infrastructure, and in improving healthcare, with one of the fastest growing economies among the non-oil producing countries in sub-Saharan Africa<sup>4</sup>.

### 1.2. Health Services and Financing in Ethiopia

According to the FMOH and the Ethiopian Health and Nutrition Research Institute (FMOH/EHNRI, 2011)<sup>5</sup>, health service coverage has improved through increased numbers of healthcare facilities and trained health personnel. This has been possible through political commitment and increased allocations to the national health budget, and has resulted in improved health status of the population. FMOH/EHNRI (2011) reported that in 2010 the infant mortality rate had decreased from 77 in 2005 to 59 deaths per 1,000 births. Under-five mortality decreased from 123 to 88 per 1,000 births, and under-five malnutrition declined from 47.6 percent in 1990 to 35% in 2010. The percentage of women who received antenatal care (ANC) from a trained health professional at least once for their last birth increased from 28% in 2005 to 34% in 2010, but still with only 26 percent of rural women accessing one.

<sup>1</sup> MOH, 2014. National Health Accounts in Ethiopia EFY 2003: Preliminary Results.

<sup>2</sup> Ethiopia Demographic and Health Survey. Addis Ababa, Ethiopia, 2011. Ethiopian Population and Housing Census 2007.

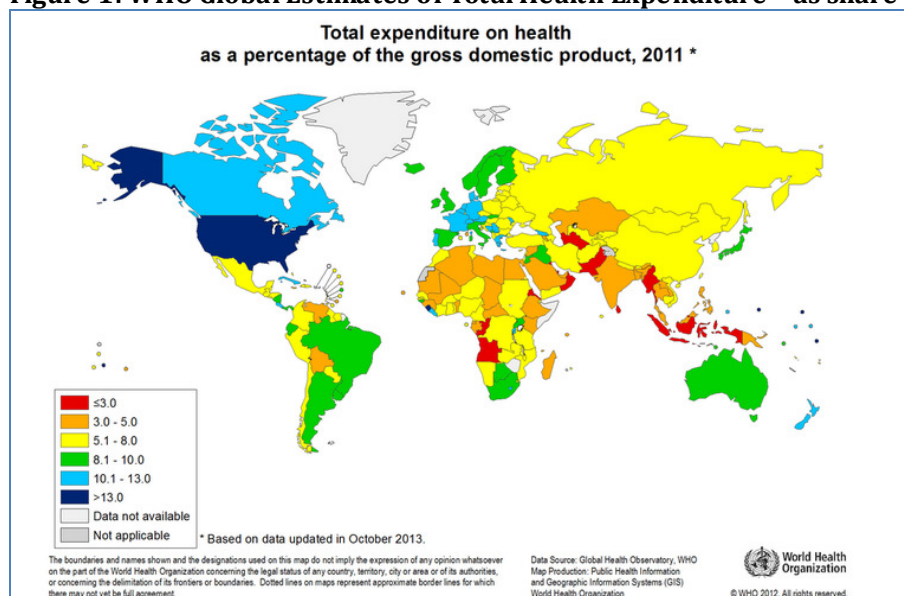
<sup>3</sup> World Bank Report (2010/11).

<sup>4</sup> WB reports, 2010/2011. Quoted in: FHAPCO. 2012. Country Progress Report on HIV/AIDS Response in 2012.

<sup>5</sup> FMOH/EHNRI, 2011. Report on the 2009 Round Antenatal Care Sentinel HIV Surveillance in Ethiopia. Addis Ababa, Ethiopia.

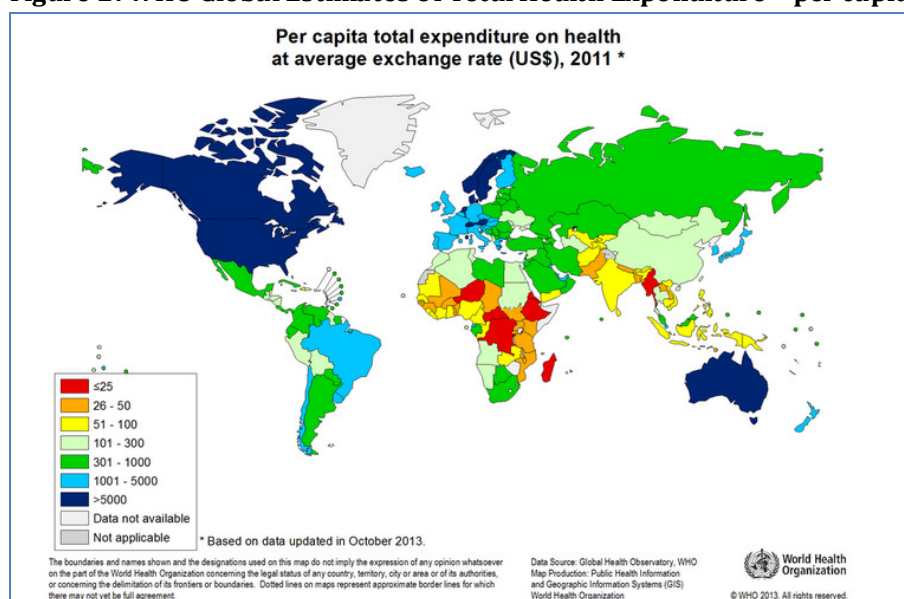
According to the World Health Organisation's database of health financing<sup>6</sup>, Ethiopia spends between 3 and 5 percent of its Gross Domestic Product (GDP) on health (total health expenditure, THE) in 2011, with external sources contributing between 30 and 50%, and government contributing between 13 and 15% of its public expenditure on health. However, the annual per capita health spending was less than US\$25 (refer to figures below).

**Figure 1: WHO Global Estimates of Total Health Expenditure – as share of GDP (% , 2011)**



Source: WHO, 2013. [http://www.who.int/health-accounts/expenditures\\_maps/en/](http://www.who.int/health-accounts/expenditures_maps/en/)

**Figure 2: WHO Global Estimates of Total Health Expenditure – per capita (US\$, 2011)**



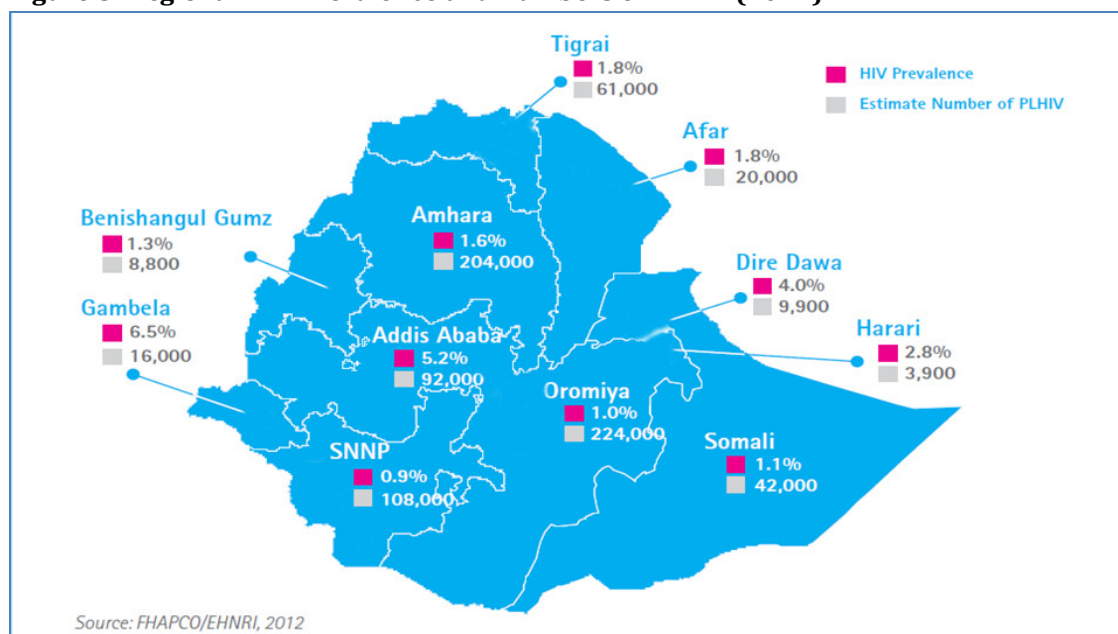
Source: WHO, 2013. [http://www.who.int/health-accounts/expenditures\\_maps/en/](http://www.who.int/health-accounts/expenditures_maps/en/)

<sup>6</sup> WHO, 2013. National Health Accounts Database of World Maps. [http://www.who.int/health-accounts/expenditures\\_maps/en/](http://www.who.int/health-accounts/expenditures_maps/en/)

### 1.3. HIV/AIDS situation and response in Ethiopia

Ethiopia's HIV epidemic is generalized and heterogeneous, with regional variations, as well as between age groups. In 2011, the adult HIV prevalence was estimated at 1.5%, with almost twice as high prevalence among females at 1.9% compared to 1% in males (EDHS, 2011). Spectrum estimated that in 2012 there were 789,300 people living with HIV/AIDS, of which 168,600 were children aged 0-14 years, with 848,300 orphans due to AIDS. The DHS (2011) also found that the urban adult HIV prevalence was 4.2% while rural adult HIV prevalence was 0.6%, and also showed variations between the regions, from 0.9% in SNNPR and 1% in Oromiya region to 5.2% in Addis Ababa and 6.5% in Gambella region (DHS, 2011). The following figure shows the regional HIV prevalence.

**Figure 3: Regional HIV Prevalence and Numbers of PLHIV (2012)**



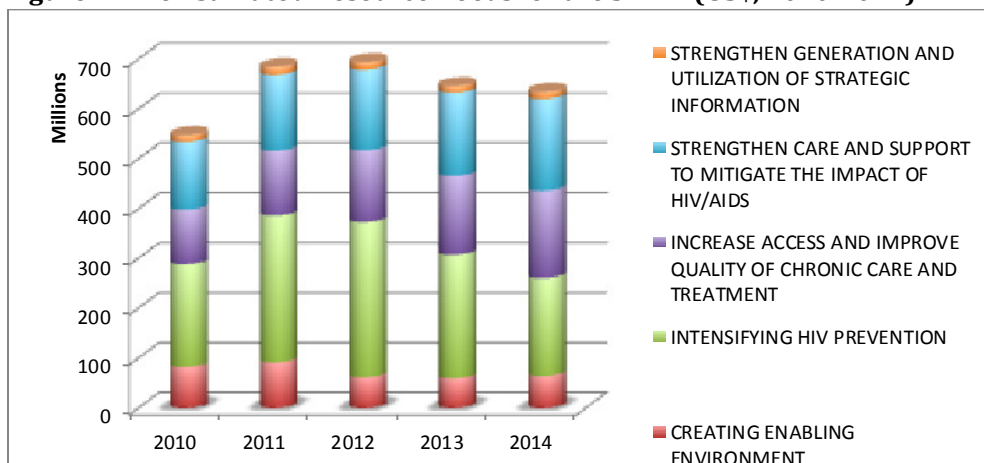
The multisectoral response to HIV/AIDS in Ethiopia is currently guided by the **Strategic Plan II for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) (2010/11-2014/15)**, as well as by the National HIV/AIDS Policy, 1998; and the Road Map for accelerated access to HIV prevention, treatment and care in Ethiopia.

The SPM II focuses on five thematic areas:

1. Creating Enabling Environment;
2. Intensifying HIV Prevention;
3. Increasing Access to and Improving Quality of Chronic Care and Treatment;
4. Intensifying Mitigation Efforts against the Epidemic, and;
5. Strengthening the Generation and Utilisation of Strategic Information.

The resources needed to achieve the SPM II targets were estimated and shown in the figure below.

**Figure 4: The Estimated Resource Needs for the SPM II (US\$, 2010-2014)**



According to FHAPCO's M&E Report for 2011/12 the key achievements for the year were noted as follows:

- 9,733 schools were covered by school peer education, reaching about 1.5 million students;
  - 10,164 schools were covered by life skill education and about 954 thousand students were reached;
  - 10,886 schools were covered by school community conversation, and about 1.6 million students participated;
  - 19,107 government organizations established AIDS funds; 17,827 assigned a focal person for HIV and AIDS activities; 15,205 allocated up to 2% budget from their organisations' budget and, 15,456 incorporated HIV/AIDS activities into their sectoral plan;
  - 147 million condoms were distributed;
  - 2,881 health facilities were providing HCT, and 11.3 million (47.4% male and 52.6% female) people were tested for HIV;
  - 1,901 health facilities were providing PMTCT services - 16,344 HIV positive pregnant women received PMTCT, which represents coverage of about 40% from the estimated number of expected positive pregnancies during the fiscal year;
  - 838 health facilities were providing ART; the cumulative number of PLHIV ever enrolled in pre-ART reached 666,147; the cumulative number of PLHIV ever started on ART was 379,190; and 274,708 were receiving ART (72.4% of the ever started on ART);
  - 140,821 PLHIVs received food support; 263,584 received psychosocial support; 26,013 received IGA training; and 22,569 PLHIVs received IGA startup capital;
  - 293,771 OVC received food support; 450,817 received education support; 539,872 received psychosocial support and 24,704 OVC received IGA startup capital.
- Source: FHAPCO, 2012<sup>7</sup>.

This NASA report seeks to identify and measure the resources that have been spent on these key interventions in EFY 2004 (2011/12).

<sup>7</sup> FHAPCO, 2012. Multi-sectoral HIV/AIDS Response Monitoring & Evaluation Report for 2004 EFY July 2011 - June 2012.



## 2. The National AIDS Spending Assessment in Ethiopia

### 2.1. The Rationale for the NASA

The National AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology to determine flow of resources for the HIV response from the source to the point of service delivery. NASA informs improved resource mobilisation, allocation and utilisation. Where NASA has been implemented successfully, it has provided insights into extent of harmonisation and alignment of the resource envelope and the programmatic priorities. It therefore plays an important role in the development of country Investment Cases, to ascertain if the current funding maximizes the investment outputs, evidence of which is now required in the Global Fund New Funding Model (NFM). The NASA framework is based on standardized methods, accepted definitions and globally accepted and available accounting procedures for National Accounts (NA), National AIDS Accounts (NAA), National Health Accounts (NHA), and AIDS Budget Analysis.

HAPCO, with the support of UNAIDS, agreed to undertake a National AIDS Spending Assessment (NASA) to provide them with important information regarding the total spending on HIV/AIDS in Ethiopia, the sources and agents of these funds, the detailed activities on which they were spent, by whom and for whom, for the year 2004 (EFY). The NASA follows on from the NHA which was conducted for the EFY 2003 (2010/11).

### 2.2. Scope and Objectives of the NASA in Ethiopia

The Ethiopian NASA covered the Ethiopian financial year 2004 (July 2011-June 2012) and included all the public and external (donor) sources for HIV/AIDS, as well as the business sector's contribution. However, the contributions of individuals through out-of-pocket expenditure (OOPE) were omitted. The resource tracking occurred firstly at national level and then at the regional levels, but did not go down to Woreda level. However, much of the spending at Woreda level was captured from the implementing agencies that have national or regional offices, or were included in the public federal and regional records of expenditure, and therefore these expenses were not omitted from the total envelope, but were not verified at the point of service delivery in the woredas. The unit of data collection was the Ethiopian Birr, and all expenditures were converted to United States Dollars (USD), using the annual average exchange rate in EFY 2004 (2011/12).

The objectives of the NASA were:

- ✓ To implement methodology for systematic monitoring of HIV/AIDS financial flows at national and regional level using the NASA in Ethiopia;
- ✓ To develop a strategy involving multi-sectoral and multi-level key partners to track HIV and AIDS spending for EY2004 (2011/12);
- ✓ To adapt the NASA methodology, classification and tools to the Ethiopian context;
- ✓ To build national level capacity for systematic monitoring of HIV/AIDS financing flows with a view to a yearly, fully-institutionalized resource tracking;
- ✓ To conduct an AIDS spending assessment focusing on public and cooperating partner resources, and including some of the larger businesses known to be contributing to HIV activities;
- ✓ To identify the flow of resources for HIV by source, functions, service provider and beneficiary populations, and;

- ✓ To prepare a report of expenditure patterns that will contribute to the development of the Investment Case and inform possible re-prioritization.

## 2.3. NASA Methodology

This NASA applied the methodology developed by UNAIDS, and adapted it to the Ethiopian situation. Primary data was collected from all sources of funding (public, external and private), agents, and providers of services (public and NGOs, excluding private health services), in all regions and at the national level. The data was collected through face-to-face interviews using a structured interview schedule.

However, primary data was not collected from any PEPFAR implementing partner (IP), since PEPFAR provided their total expenditure analysis (EA) data for all their IPs (for all USG agencies). This was not broken down by type of provider.

In addition, no primary data was collected from FMOH since they provided all their expenditure as estimated by the NHA in 2003, and adjusted to 2004 figures (applying an inflation-based increase as well as taking into account the health budget for 2004). More detail will be provided in the NHA report on the methodology and assumptions applied<sup>8</sup>.

According to the NASA methodology, every dollar spent on HIV is identified and measured and the following information is recorded: the funding source, the funding agent, the funded activity, the service provider, the beneficiary and the production factor (cost component/ line-item). These vectors are captured in the financial transactions, aggregated, and the data is then analysed in different ways to obtain a picture of total funds spent, what the funds were spent on, by whom and on whom they were spent, who provided the funds and who controlled them.

## 2.4. NASA Concepts

In NASA financial flows and expenditures related to the national response to HIV are organised according to three dimensions: finance, provision, and consumption/utilisation. Each of these dimensions is broken down into two vectors, making a total of six vectors. The classification of the three dimensions and six vectors constitutes the framework of the NASA system as follows:

### **Financing**

1. Financing sources (FS) are entities that provide money to financing agents.
2. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and make programmatic decisions (purchaser-agent).

### **Provision of HIV services**

3. Providers (PS) are entities that engage in the production, provision and delivery of HIV services.
4. Production factors/resource costs (PF) are inputs (labour, capital, natural resources, “know-how”, and entrepreneurial resources).

### **Utilisation**

5. AIDS spending categories (ASC) are HIV-related interventions and activities.

<sup>8</sup> MOH, 2014. National Health Accounts EFY 2003. Preliminary Results.



6. Beneficiary segments of the population (BP) are key population groups such as men who have sex with men, injecting drug users, etc.

The AIDS spending classification (ASC) 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, that can easily be matched to any National AIDS Strategic Plan thematic area and to the Investment Case categories, and are further broken down into detailed sub-categories:

1. Prevention;
2. Care and treatment;
3. Orphans and vulnerable children;
4. National Programme management and systems strengthening;
5. Human resource capacity building;
6. Social protection and social services;
7. Enabling environment; and
8. Research.

(See Appendix F for the NASA ASC definitions.)

## 2.5. Study Design

The study design was a quantitative survey of all sources, agents and service providers of HIV, using interviews with key respondents and the collection of their expenditure data, and applying the NASA methods of triangulation, reconstruction of financial transactions and analysis.

## 2.6. Study Population

The study was intended to include all sources of funding for HIV, including:

- Public, external (donors) and private (business) sources;
- All agents of funding for HIV – managers of funds, such as HAPCO, MOH, as well as regional HAPCOs and Health Bureaus; and
- Providers of HIV services in Ethiopia – including public facilities (regional levels), NGOs and international NGOs, excluding private for-profit health services.

For each of these organisations/ministries, the Directors, Programme Managers, Finance Directors and Finance Officers were interviewed.

## 2.7. Sampling Frames

FHAPCO provided the NASA team with their databases of all development partners, public entities and NGOs involved in the HIV/AIDS field in Ethiopia. For the business sector, the Ethiopian Business Coalition for HIV/AIDS assisted with details of companies that were providing some HIV/AIDS services, primary workplace programmes, and the names of the bigger companies were also provided by FHAPCO. The NASA team contacted and visited almost all the entities in the database of actors. The response rates are presented below.

## 2.8. Data Collection and Tools

The data have been collected through face-to-face interviews with the relevant persons within the selected organisations, using interview schedules that were administered by data collectors. Appointments with the respondents were made beforehand. Interviewees were also requested to provide their expenditure statements and financial reports for detailed and validated data.

The interview schedules were based upon those developed by UNAIDS, and improved by CEGAA and the research team. The schedules are attached in Appendix B. The tools mostly used quantitative closed-ended questions regarding sources of financing and expenditure, with some open-ended qualitative questions regarding the funding mechanisms, bottlenecks and absorption.

Three interview schedules were developed, as follows:

- Interview schedule 1 – for all sources of financing for HIV
- Interview schedule 2 – for all agents (managers/conduits) of funds for HIV
- Interview schedule 3 – for providers of HIV services
- Appendix A – for the production factors of all the ASC of the service providers

The data collectors and capturers were young economists and underwent a training course in the NASA methodology and use of the data collection tools, provided by the Centre for Economic Governance and AIDS in Africa (CEGAA), in the use of the interview schedules, data cleaning, capturing and analysis.

## 2.9. Data Analysis

The data were captured firstly in the hard copies of the interview schedules. They were then entered into Microsoft Excel spread sheets where they were cleaned and verified, and any missing, incomplete or contradictory data were identified and addressed. Finally they were entered into the NASA Resource Tracking Software (RTS) which is a Microsoft Access-based programme created by UNAIDS. The aggregation and analysis was undertaken in this programme, and further analysis and graphical displays were processed in Excel.

## 2.10. Overview of Data Collected, Challenges and Limitations

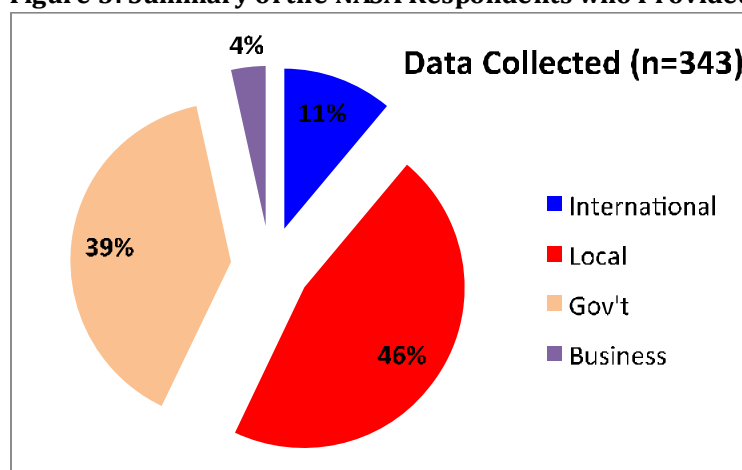
On average, the response rate of the entities interviewed was good at 74%, with the highest amongst the development partners (84%), followed closely by the public entities (81%). The lowest response rate was amongst the business sector (42%), while the local NGO's response rate was 63%. PEPFAR provided their expenditure analysis (EA) which included the spending of all their implementing partners, but without providing the breakdown of their type. Hence they were all lumped together and labelled as PEPFAR providers under the private sector, since many were NGOs. These are shown in the table below in the green column labelled 'USG funded'. The other private sector players, namely businesses, are shown in the last row. The 'local' row refers to local NGOs, as opposed to international NGOs.

**Table 1: The Response Rate amongst the Sectors in the NASA**

	# of Orgs	Intervw'd	Data collected	Data outstng	Not collected	Not Contacted	Don't have HIV activity	USG Funded	% obtained
International	105	69	38	5	5	3	31	24	84%
Local	392	332	158	15	51	35	113	19	63%
Gov't	128	128	104	3	6	0	24	0	81%
Business	22	17	8	2	4	1	3	0	42%
<b>Total</b>	<b>647</b>	<b>546</b>	<b>308</b>	<b>25</b>	<b>66</b>	<b>39</b>	<b>171</b>	<b>43</b>	<b>74%</b>

Further detail of the respondents are provided in Appendix B.

**Figure 5: Summary of the NASA Respondents who Provided Data**



There were usual data collection **challenges** faced by the data collections, but due to the sensitivity of the data being requested, the following were also experienced:

- Suspicions about the process and use of data;
- Refusal to share data;
- Data collection was time consuming and required several visits to most respondents to obtain all data;
- Bureaucracy and protocols (e.g. referred to head offices or head quarters outside the country), and;
- Many development partners (DPs) did not provide their own operational/ head office (in-country) costs.

On the whole, actual expenditure was obtained from the majority of respondents. Only for the few following aspects were **assumptions** applied:

- For in-patient and out-patient MOH spending on Opportunistic Infections (OI) and any other HIV-related expenditure, the NHA applied their assumptions and provided the estimates adjusted (based on inflation and the health budget increases) to EFY2004 for the NASA report.
- USG provided their total expenditure by region, which was assumed to be actual expenditure as it had been collected by PEPFAR from all the principal recipients. However, the type of service providers could not be provided and so all the USG spending was lumped under 'Private - local NGO service providers', which would have distorted the picture of the private sector provision. For example, there may have been some international providers or public providers, which were therefore not labelled as such.

- Where the respondents had differing financial years to the EFY, some adjustments were made to the data so as to match EFY2004, as far as possible.

There are some **limitations and gaps** in the data, as follows:

- The quality of the findings is dependent upon the quality, completeness and accuracy of the data provided by respondents. Since this was not an auditing process, the data could not be validated through auditing techniques.
- Because the financial year of study has to be 'closed' and audited, the final NASA report has timelag of 1½ to 2 years.
- The public spending on the MoH's 'hidden' general operations was difficult to estimate, and the NHA estimates as provided appeared to omit the MOH's infrastructural expenditure. It could not be ascertained if the NHA data included the MOH salaries (please refer to the NHA report<sup>9</sup> for more details of the methodology applied).
- The NHA data of the MOH expenditure indicated a large proportion that was labelled as 'prevention not disaggregated'. This makes it difficult to ascertain the nature of the preventative interventions provided by the MOH.
- TB spending was omitted (since it falls under the NHA's other health expenditures).
- Private health care spending was not included.
- Out-of-pocket was omitted, except for some small individual contributions to local NGOs and the AIDS Fund.
- Businesses – about half of the larger identified businesses did not provide data and therefore this sector's contribution may be underestimated.
- This NASA report only presents one year of data (EFY 2004), since the NHA data for EY2003 (2010/11) was not ready to be included at the time of writing. The two years together will begin to provide important time trend data, and undertaking NASA (or NHA) on a regular basis will provide valuable data for continuous monitoring of the response.

Despite the challenges, assumptions, limitations and gaps mentioned, FHAPCO, UNAIDS and the NASA research team believe that for the first attempt at NASA, the following findings accurately and comprehensively represent the majority of the HIV/AIDS funds in Ethiopia, and that with following NASAs, if the process is institutionalized, will improve the response rate and quality of data collected.

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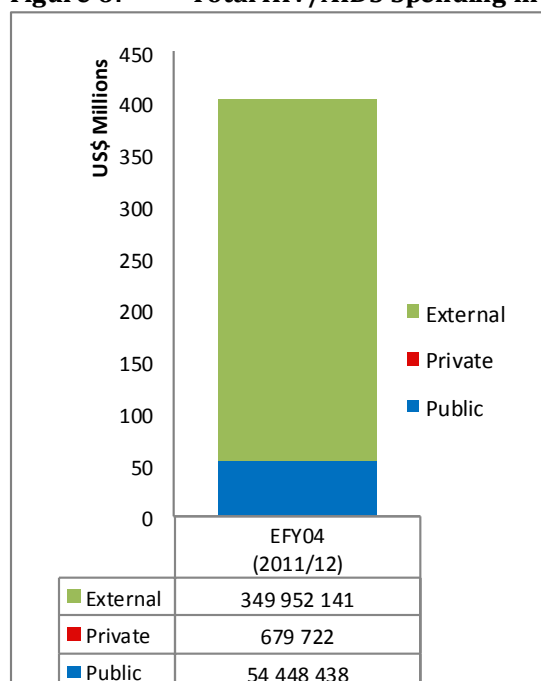
<sup>9</sup> MOH, 2014. National Health Accounts (EFY 2003): Preliminary Results.

### 3. Key Findings

#### 3.1. Total HIV/AIDS Spending in Ethiopia by Source

The total spending in Ethiopia on HIV/AIDS in 2011/12 (EFY 2004) was US\$ 405 million, of which 86% came from external sources (US\$ 350 million), 13% came from public revenue (US\$ 55 million) and only US\$ 680,000 (less than one percent) came from the private sector (although the business sector's contribution was underestimated and the private health care sector was not included).

**Figure 6: Total HIV/AIDS Spending in Ethiopia by Source (US\$ million, EFY 2004)**

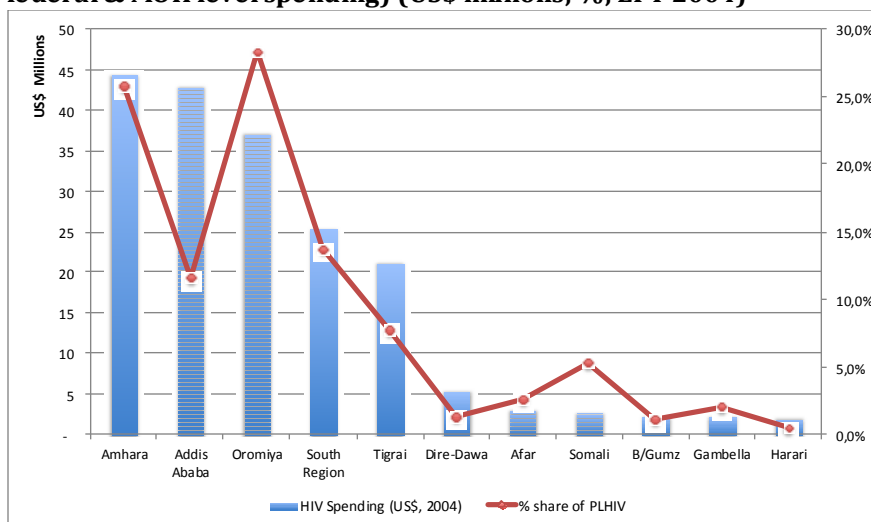


#### 3.2. HIV/AIDS Spending by Regions

The regional split of expenditure shown in the figure below, excluding the federal level and the MOH spending<sup>10</sup>, shows that Amhara had the highest spending in EFY 2004 at just under US\$ 45 million, followed by Addis Ababa at US\$ 43 million. The lowest level of spending occurred in Harari at US\$2 million. When considering the share of HIV-positive persons living in each region, the resources have generally been allocated and spent according to need, with the exception of Addis Ababa which appears to have received a greater than need share. However, this may have been due to expenditure being labelled as Addis because it could not be broken down by the head quarters of organisations, and it is usual for greater expenditure to occur in the capital city. Oromiya appears to be receiving less than its share required by need, as does the Somali region.

<sup>10</sup> The MOH data did not provide the regional split and hence could not be included in the regional comparison.

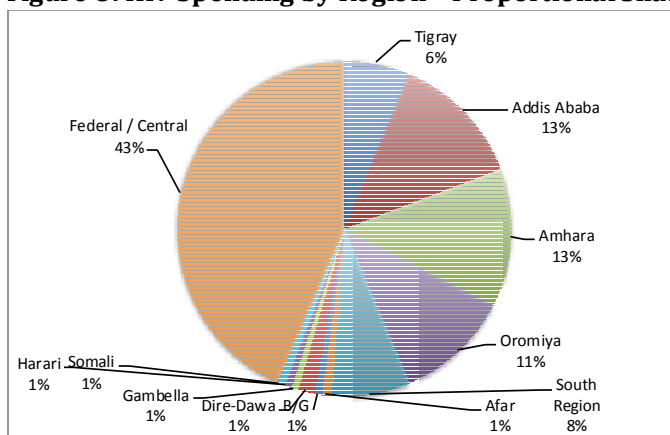
**Figure 7: HIV/AIDS Spending per Region and Share of the Numbers of PLHIV (excluding federal & MOH level spending) (US\$ millions, %, EFY 2004)**



NB. The Above figures exclude the federal level and all MOH spending.

The following figure shows the proportional share of the total spending, including the largest share (43%) being spent at the Federal level.

**Figure 8: HIV Spending by Region – Proportional Shares (% , EFY 2004)**



NB. The figure excludes the MOH spending which was not provided by regional split.

The key sources of funding for HIV/AIDS are discussed in more detail below: public and external. The private sources, namely the business sector and individual contributions, were under-estimated and therefore not discussed further.

### 3.2.1. Public Sources of HIV/AIDS Spending in Ethiopia

The public financing for HIV/AIDS in EFY 2004 came mainly from federal level (99.5%), the largest portion (87%) being the MOH estimated expenditure (NHA, 2003). The MOH expenditure as estimated from the NHA data is shown in the table below. A large portion of the MOH spending was labelled as 'prevention and public health' which could not be broken down into greater detail.

**Table 2: MOH Estimated Expenditure in EFY 2004 (from public revenue only)**

<b>S.No</b>	<b>Health care functions</b>	<b>% to different health care functions</b>	<b>Birr</b>	<b>In USD (1 USD = 17.2 Birr)</b>	<b>Assumed PS</b>
1	Prevention and Public Health <b>ASC.01.98</b>	50.0%	408,386,323	23,742,391	Dept within the MOH
2	Outpatient care <b>ASC.02.01.98</b>	20.8%	169,888,710	9,876,834	Public clinics (ambulatory)
3	Inpatient curative care <b>ASC.02.02.99</b>	2.3%	18,785,771	1,092,150	Public hospitals
4	Research, Education and Training <b>ASC.04.05</b>	2.6%	21,236,089	1,234,604	Public higher facilities
5	Capital formation <b>ASC.04.10.98</b>	9.2%	75,143,083	4,368,600	Dept within MOH
6	Pharmaceuticals and other medical non-durables <b>ASC.02.98</b>	0.0%	0	0	Dept within MOH
7	General Health Administration <b>ASC.04.01</b>	15.1%	123,332,670	7,170,202	Dept within MOH
	<b>Total</b>	<b>100.0%</b>	<b>816,772,646</b>	<b>47,484,781</b>	

The other key sources of public funding for HIV/AIDS are the mainstreaming fund and the AIDS fund. These are important contributions made by the sectoral ministries (2% of their budget) and the voluntary contributions of public employees to a fund to support fellow employees affected by HIV. The following table indicates the budgets and expenditure for each of these funds, by region. In EFY 2004, it was reported that there was some uncertainty about the use of the mainstream funds and hence some under-expenditure was experienced. This hopefully will have improved in the following years. The Mutlisectoral HIV/AIDS Response M&E Report (FHAPCO, 2012) reports some important achievements in some of the sectors, shown in the following table.

**Table 3: Mainstreaming and AIDS Funds – budgets and expenditure (US\$, EFY 2004)**

<b>Region</b>	<b>Mainstreaming Fund (US\$, 2004)</b>			<b>AIDS Fund (US\$, 2004)</b>			<b>Total Share (%)</b>
	<b>Budget</b>	<b>Expenditure</b>	<b>% Spent</b>	<b>Budget</b>	<b>Expenditure</b>	<b>% Spent</b>	
Dire Dewa	1 840 640	1 615 113	88%	69 725	57 723	83%	53%
SNNPR	1 249 278	1 251 907	100%				40%
Oromia	111 327	111 327	100%	5 244	6 411	122%	4%
Amahara	94 880	36 320	38%	19 335	10 327	53%	1%
Addis Ababa	185 140	20 290	11%	1 400	1 400	100%	1%
Harari	11 217	9 524	85%				0%
B/G	3 202	3 202	100%	4 939	2 542	51%	0%
Federal	1 284	683	53%	25 074	23 310	93%	1%
Tigra				4 888	4 888	100%	0%
<b>Overall</b>	<b>3 496 966</b>	<b>3 048 365</b>	<b>87%</b>	<b>130 606</b>	<b>106 601</b>	<b>82%</b>	<b>100%</b>

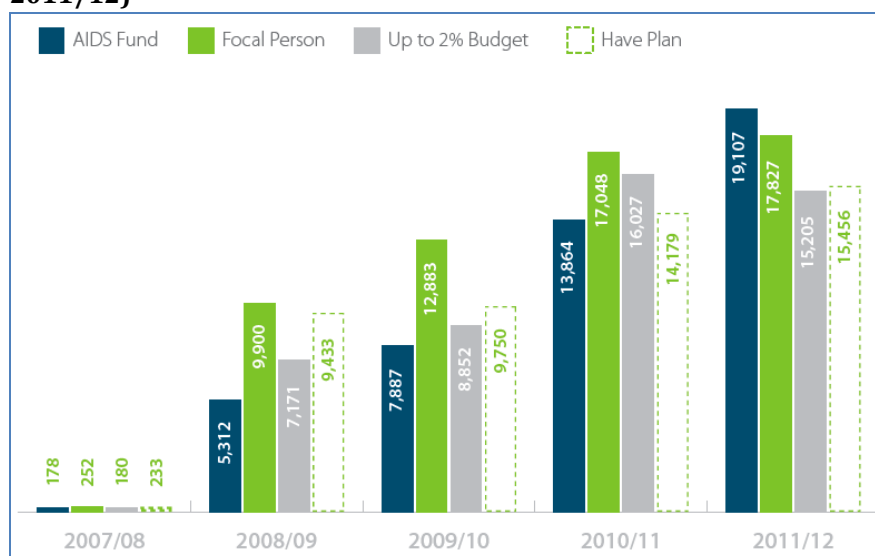
**Table 4: Mainstreaming Achievements (2012)**

- ❖ **Ministry of Defense:** provided IGA training and startup capital to 38 PLHIV and nutritional support to 941 PLHIV, bringing the total number of beneficiaries to 1017.
- ❖ **Transport Authority:** provided psychosocial support to 127 PLHIV.
- ❖ **Federal Police Commission:** provided psychosocial support to 206 PLHIV, nutritional support to 208, bringing the total number of PLHIV supported by the sector to 414.
- ❖ **Federal Prisons Administration:** provided psychosocial support to 475 PLHIV, nutritional support to 475, and medical support to 475 beneficiaries.
- ❖ **Ministry of Agriculture:** provided nutritional support to 1 PLHIV.
- ❖ **Ethiopian Road Authority:** provided nutritional support to 40 PLHIV and psychosocial support to 40 PLHIV.
- ❖ **Federal Prisons Administration:** provided psychosocial support to 475 PLHIV, medical support to 475 beneficiaries and nutritional support to 475 PLHIV.
- ❖ **Ethiopian Airports Enterprise:** provided IGA training support to 31 PLHIV, psychosocial support to 31 PLHIV, nutritional support to 23 and medical support to 31 PLHIV which brings the total number supported to 147.
- ❖ **Ministry of trade:** provided psychosocial support to 3 PLHIV and medical support to 15 PLHIV
- ❖ **Ministry of Water and Energy:** provided psychosocial support to 15 and medical support to 15 PLHIV which brings the total number of beneficiaries to 30.

Source: FHAPCO, M&E Report 2012.

The numbers of organisations which managed to establish AIDS Funds, appoint focal persons, commit up to 2% of their budget and develop their HIV/AIDS plan are summarised in the figure below.

**Figure 9: Mainstreaming Achievements by Numbers of Organisations (2007/08-2011/12)**



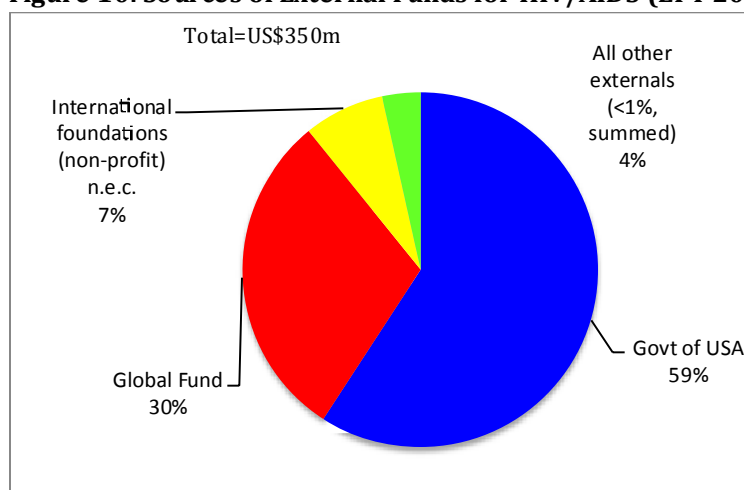
Source: FHAPCO, M&E Report 2012.



### 3.2.2. External Sources

The external sources (totalling US\$350 million) for HIV/AIDS in Ethiopia in EFY 2004 were dominated by the bilaterals, specifically the United States Government through the PEPFAR, which made up 59% of the total external funds. The Global Fund contributed 30% while international foundations made up another 7%. Other sources, all less than 1%, made up the final 4%. The following tables provide more detail of every source.

**Figure 10: Sources of External Funds for HIV/AIDS (EFY 2004,%)**



[n.e.c. – not elsewhere classified]

The bilateral contributors are shown in table 5 below, and the multilateral sources in table 6 following.

**Table 5: Bilateral Sources of HIV/AIDS Funding (US\$, %, EFY 2004)**

Bilateral	US\$ (EFY 2004)	Share of Total External Aid (%)
Govt of Canada	681 339	0,2%
Govt of Denmark	139 426	0,0%
Govt of Finland	289 700	0,1%
Govt of Ireland	450 866	0,1%
Govt of Italy	122 678	0,0%
Govt of Netherlands	18 402	0,0%
Govt of Norway	1 084 876	0,3%
Govt of Spain	78 678	0,0%
Govt of Sweden	3 858	0,0%
Govt of United Kingdom	434 643	0,1%
Govt of USA	207 063 469	59,2%
Other Governments/ bilat agencies	18 834	0,0%
<b>Total Bilateral Aid</b>	<b>210 386 769</b>	<b>60,1%</b>

**Table 6: Multilateral Sources of HIV/AIDS Funding (US\$, %, EFY 2004)**

<b>Multilaterals</b>	<b>US\$ (EFY 2004)</b>	<b>Share of Total External Aid (%)</b>
European Union	22 303	0,0%
Global Fund	105 190 858	30,1%
UNAIDS	353 756	0,1%
UNICEF	1 649 022	0,5%
UNDP	161 883	0,0%
UNESCO	40 000	0,0%
UNODC	107 912	0,0%
UNFPA	576 319	0,2%
World Bank	1 653 508	0,5%
WFP	68 117	0,0%
WHO	246 646	0,1%
Other co-sponsors/ bilats	1 511 583	0,4%
<b>Multilateral Total</b>	<b>111 581 907</b>	<b>31,9%</b>

NB. The UN agencies often act as agents for other sources and those funds are shown in table 8 in the Agents section.

Note that the 'other cosponsors & bi-lats' shown above as having contributed US\$1.5 million are various sources including the European Union, who contributed a total of US\$1.7 million, of which US\$ 1.5 million was spent by UNAIDS. These included funds from: Deutsche Gesellschaft Für Technische Zusammenarbeit (Gtz), Europeaid Cooperation Office (AIDCO), Luxembourg, UA Core Proxy Donor, USAID, DFID.

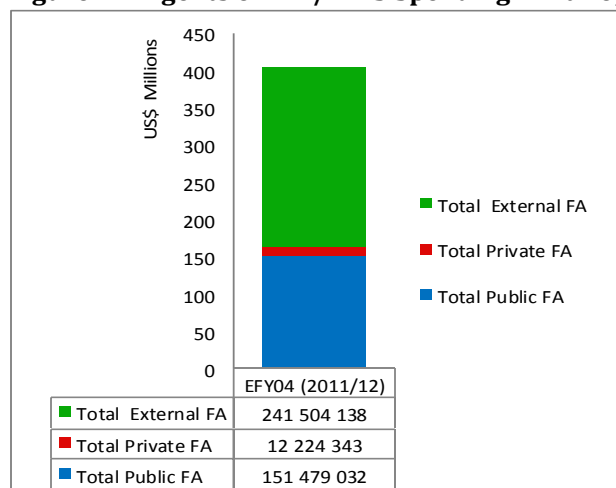
**Table 7: International Foundations Providing of HIV/AIDS Funding (US\$, %, EFY 2004)**

<b>International Foundations &amp; Corporations</b>	<b>US\$ (EFY 2004)</b>	<b>Share of Total External Aid (%)</b>
ActionAID	398 161	0,1%
Bill and Melinda Gates Foundation	256 616	0,1%
Caritas Internationalis/Catholic Relief	188 294	0,1%
Deutsche Stiftung Weltbevölkerung	16 336	0,0%
International Federation of Red Cross	642 102	0,2%
Plan International	42 532	0,0%
PSI (Population Services International)	48 484	0,0%
World Vision	31 974	0,0%
International foundations (non-profit)	25 801 797	7,4%
International for profit organizations	276 328	0,1%
International funds n.e.c.	280 841	0,1%
<b>Internat. Foundations &amp; Corporation:</b>	<b>27 983 465</b>	<b>8,0%</b>
<b>Total External Aid</b>	<b>349 952 141</b>	<b>100,0%</b>

### 3.3. Agents of Funding for HIV/AIDS in Ethiopia

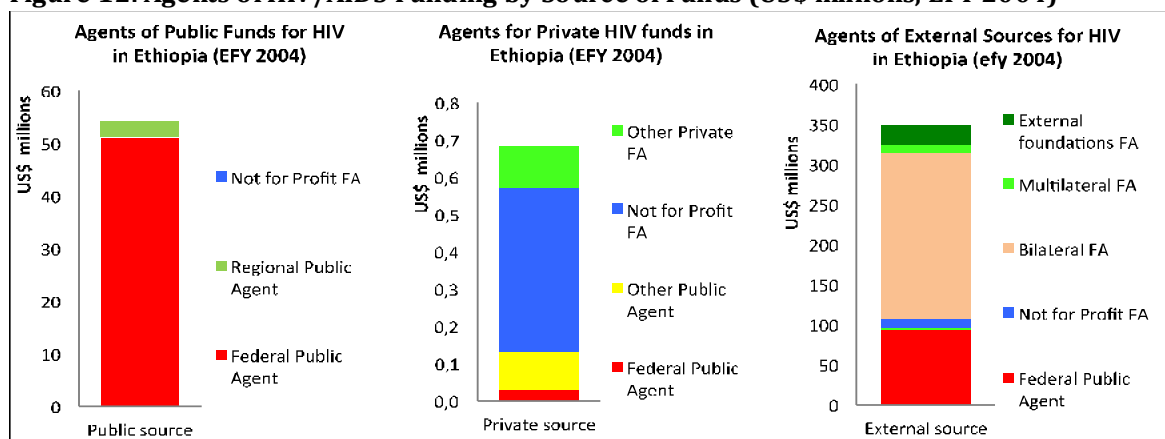
According to the NASA classification system, the Agents are those entities that receive and transfer funds, and also make the key programmatic decisions about what the funds will be spent on, and who should be the service providers. The following analysis therefore gives insight into which entities actually drive the HIV/AIDS response in Ethiopia.

**Figure 11: Agents of HIV/AIDS Spending in Ethiopia (US\$ millions, EFY 2004)**



The figure above indicates that the Government of Ethiopia managed 37% (US\$ 151.5 million), of the total spending on HIV/AIDS in EFY 2004 (2011/12), while the external agents managed 60% (US\$ 241.5 million). The private share was very small, at only US\$ 12 million. Note that for the PEPFAR funds, the agent was coded as an external – the United States Government – since it is the PEPFAR agents (CDC, USAID etc.) who determine how the funds are to be spent. However, for the Global Fund (GF) contributions, usually it is the Country Coordinating Mechanism (CCM) who determines the priorities and develops the GF application in line with those. It is also the CCM who determines the service providers and key interventions, and is therefore labelled as a federal public agent. The following figure shows the agents of the different sources of funding.

**Figure 12: Agents of HIV/AIDS Funding by Source of Funds (US\$ millions, EFY 2004)**



NB. Note the differing axis-scales for each graph i.e. they are not directly comparable.

The largest proportion of the public funds are managed at the federal level (94%), but the split shown earlier found a greater share of spending at provider level in the regions than shown at the agent level above. The largest share of the external funds are managed by bilateral agencies, specifically the USG (PEPFAR), while the GF monies are shown to be managed by the federal public agencies. As expected, the small portion of private sourced funding is managed by the non profit sector: NGOs, CBOs etc.

The UN entities also act as agents for external sources, and these amounts are shown in the table below, with the rows showing the sources, and the columns showing only the UN agent managing these. There were some other funds, labeled as 'other cosponsors & bilats' below,

which UNAIDS also managed, which totaled US\$ 1.7 million of which US\$ 1.5 million was spent, as the NASA tables only show what was actually spent. The UNAIDS co-sponsors were listed under table 6 above. Table 8 only shows UN agents, and not the PEPFAR agents.

**Table 8: UN Agency Management of External Funds (US\$, EFY 2004)**

Source of Funds:	UN AGENCIES acting as agents for funds														
	EU	ILO	Reg.Dev. Banks	UNAIDS	UNICEF	UNDP	UNESCO	UN- HABITAT	UNODC	UNFPA	WB	WFP	WHO	Other Multilats	Total US\$
Govt. of Finland										289 700					289 700
Govt. of Italy										122 678					122 678
Govt. of Norway			43 062		611 222					427 675					1 081 959
European Commission	18 102														18 102
GFATM										40 700				85 061	125 761
UNAIDS				215 716	38 408		66 564						33 069		353 757
UNICEF			15 569		1 250 415									25 072	1 291 056
UNDP						161 883									161 883
UNESCO								40 000							40 000
UNODC									107 912						107 912
UNFPA										528 426	43 899				572 325
World Bank											1 025 288				1 025 288
WFP												68 117			68 117
WHO													246 646		246 646
Other co-sponsors/ bilats				1 262 599										248 983	1 511 582
Gates Foundation													135 785		135 785
Other Int.NPOs		182 191													182 191
<b>TOTAL (US\$)</b>	<b>18 102</b>	<b>182 191</b>	<b>58 631</b>	<b>1 478 315</b>	<b>1 900 045</b>	<b>161 883</b>	<b>66 564</b>	<b>40 000</b>	<b>107 912</b>	<b>1 409 179</b>	<b>1 069 187</b>	<b>68 117</b>	<b>415 500</b>	<b>359 116</b>	<b>7 334 742</b>

NB. The above table does not include any USG (PEPFAR) funds since all the USG funding was labeled as having a bilateral agent, and so it could not be determined if any went to an UN agencies. This explains why large funds managed for instance by UNHCR on behalf of PEPFAR do not appear in the table.

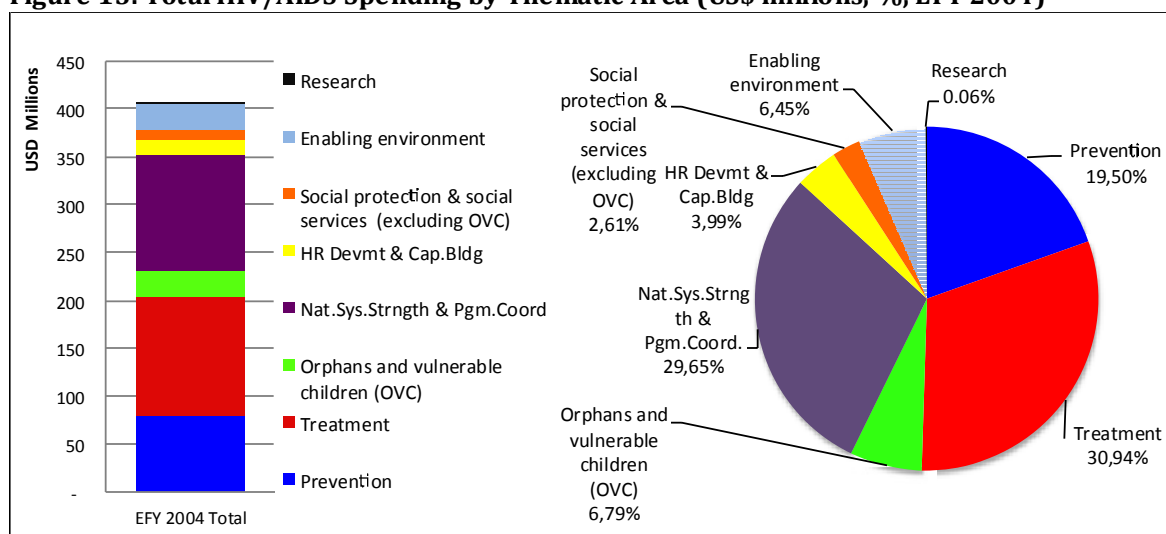
### 3.4. HIV/AIDS Spending Activities in Ethiopia

The total spending on HIV/AIDS in Ethiopia can firstly be broken down into eight broad thematic areas, as follows:

- A. **Prevention** – such as behavioural change communications (BCC), youth programmes, voluntary medical male circumcision (VMMC), elimination (prevention) of mother-to-child transmission (eMTCT), post-exposure prophylaxis (PEP), HIV counseling and testing (HCT), most-at-risk and other vulnerable group interventions (MARPs), condoms etc.
- B. **Treatment** – such as anti-retroviral treatment (ART), home-based care (HBC), palliative care, out- and in-patient costs for opportunistic infections (OI), etc.
- C. **Orphans and vulnerable children (OVC)** – health, family (e.g. food support, IGAs), educational, and social support interventions.
- D. **National systems strengthening & programme coordination** – co-ordination, planning, M&E, surveillance, operational research, drug supply systems, facility upgrading etc.
- E. **Human resource capacity building** – this section includes only training and capacity building for staff, but the actual salaries were captured under the activities the staff performed – where this data was provided.
- F. **Social protection** – cash transfers, HIV-related IGAs, material (in-kind) support, etc. This category excludes any interventions for OVCs.
- G. **Enabling environment** – advocacy, human rights protection, gender-based violence (GBV) prevention, institutional development etc.
- H. **Research** – clinical, social (behavioural/economic) etc. Note that surveillance and M&E expenditure is not captured here but under programme management.

Each of these thematic areas can be further disaggregated into several sub-categories, allowing for great flexibility to represent the country's response. These are presented in the subsequent sections, and are later matched against the SPM II categories.

**Figure 13: Total HIV/AIDS Spending by Thematic Area (US\$ millions, %, EFY 2004)**



As the figures above indicate, the largest share of HIV/AIDS spending in EFY 2004 (2011/12) went to treatment and care activities (31%, US\$ 125 million), closely followed by national systems strengthening and programme management (29.7%, US\$ 120 million). Prevention activities received 19.5% of the funds (US\$ 79 million), followed by OVC interventions at US\$

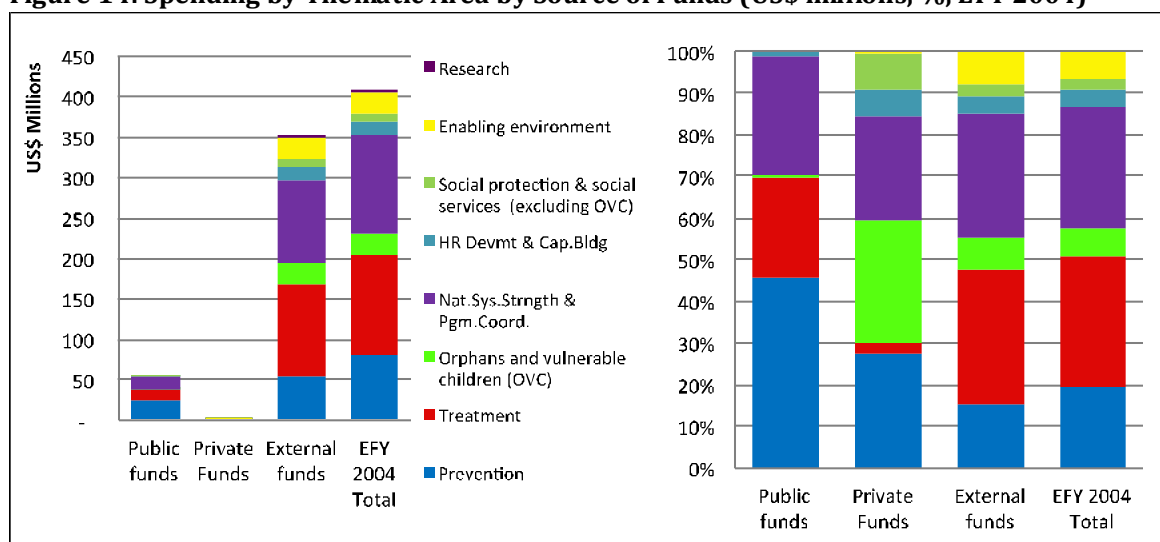
27.5 million (6.8%) and enabling environment activities (6.5%, US\$ 26 million). Human resource capacity building activities took 4% (US\$ 16 million) of the total spending on HIV/AIDS (noting that this category does not include salaries, but only the costs of training, education and incentives). Social protection interventions received 2.6% (US\$ 10.6 million). The research spending was under-reported (less than 1%) due to non-response of the key research institutions, and also due to the fact that the largest contributor was the USG, but the PEPFAR expenditure analysis (EA) data provided did not indicate much expenditure on research or surveillance. The following table provides the detail of spending on the thematic areas, by source or funding.

**Table 9: Spending by Thematic Area by Source of Funds (US\$, %, EFY 2004)**

Activities	Public funds	Private Funds	External funds	Totals (US\$)	% Share
Prevention	24 834 287	188 582	53 974 167	78 997 036	19,5%
Treatment	13 053 804	14 712	112 267 935	125 336 451	30,9%
OVC support	459 284	199 445	26 860 587	27 519 316	6,8%
Nat.Sys.Strngth & Pgm.Coord.	15 526 130	172 729	104 410 138	120 108 997	29,7%
HR Devmt Training / CB	525 996	40 983	15 581 435	16 148 414	4,0%
Social protection & social services (excluding OVC)	48 938	58 173	10 483 172	10 590 283	2,6%
Enabling environment	-	5 097	26 126 758	26 131 855	6,5%
Research	-	-	247 951	247 951	0,06%
<b>Totals</b>	<b>54 448 439</b>	<b>679 721</b>	<b>349 952 143</b>	<b>405 080 303</b>	<b>100,0%</b>
Source by Share	13%	0%	86%	100%	

As the table above and following figure show, in EFY 2004 (2011/12) the bulk (46%) of the **public funds** went towards prevention activities (US\$ 24.8 mill), while 29% (US\$ 15.5 million) went towards national systems strengthening and programme management, and 24% (US\$ 13 million) went towards treatment and care activities. The bulk of **external funds** (32%, US\$ 125 million) went towards treatment and care activities, also followed closely by national systems strengthening and programme management (30%, US\$ 120 million). It was mainly the external funds that covered the OVC and social protection interventions.

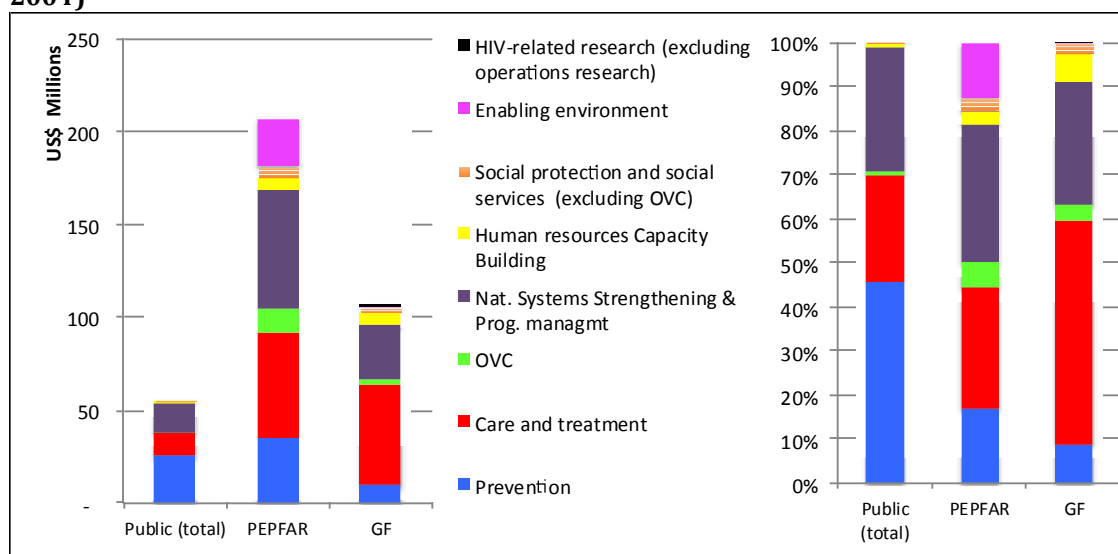
**Figure 14: Spending by Thematic Area by Source of Funds (US\$ millions, %, EFY 2004)**



Breaking the sources of funds down further into the three key sources in Ethiopia, the following figures show the spending specifically by the GoE, PEPFAR and GF. The GOE contributions and proportions are the same as shown in the previous figures, while it can be seen that PEPFAR's

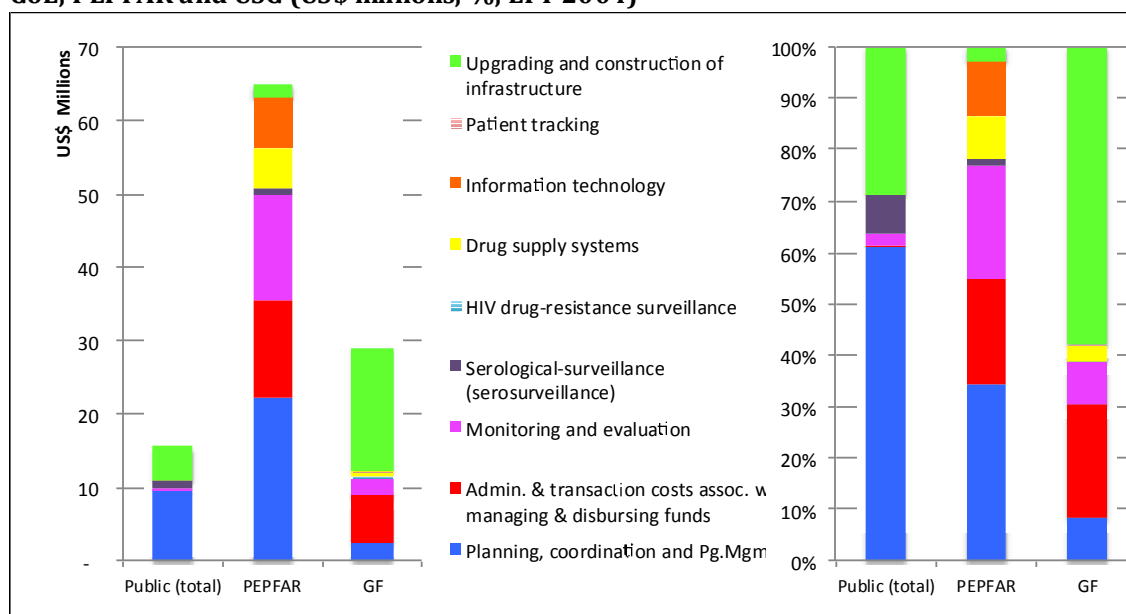
largest contribution went towards national system strengthening (US\$ 65 million, 31% of all USG funding) and GF's went towards treatment and care (US\$ 53 million, 51% of all GF). GF also spent 28% of its funds (US\$ 29 million) on national system strengthening and programme management. Given the large amount of funds going to this thematic area, the following graph looks into the spending on the specific sub-categories.

**Figure 15: Spending by Thematic Area by GoE, PEPFAR and GF (US\$ millions, %, EFY 2004)**



Note that both GF and PEPFAR did not report much spending on research and surveillance – these figures were confirmed by both sources as correct although at the NASA validation meeting partners felt that spending on research was largely underestimated.

**Figure 16: Spending on National System Strengthening and Programme Management by GoE, PEPFAR and USG (US\$ millions, %, EFY 2004)**



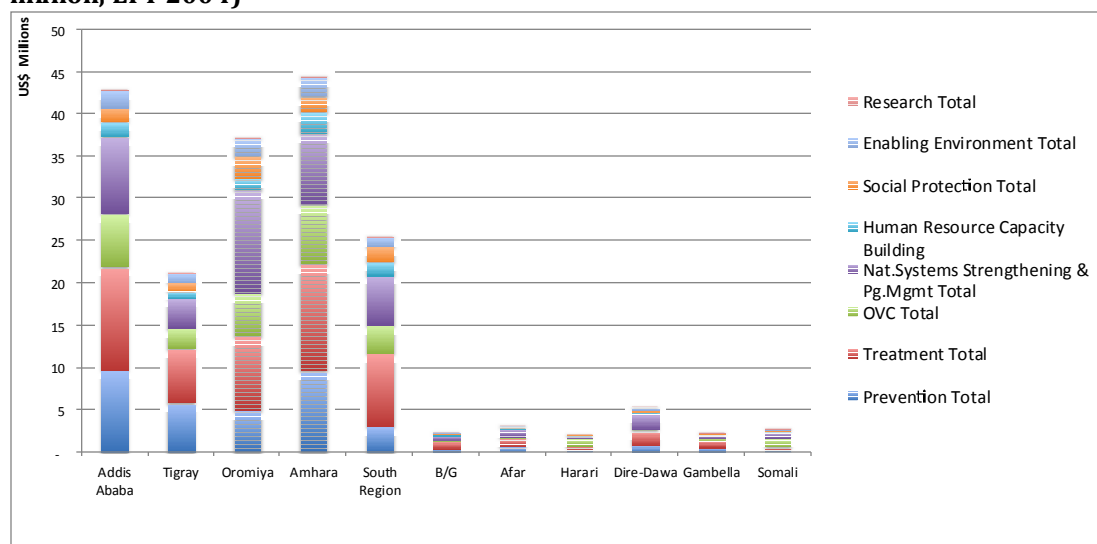
The detail of the spending by GoE, PEPFAR and GF are provided in Appendix A.



### 3.4.1. Regional Spending by Thematic Areas

For the funds that could be broken down by regional area (bearing in mind that some could not, notably the MOH expenditure estimates), the following figures show the regional split between HIV thematic areas, in monetary and proportional terms.

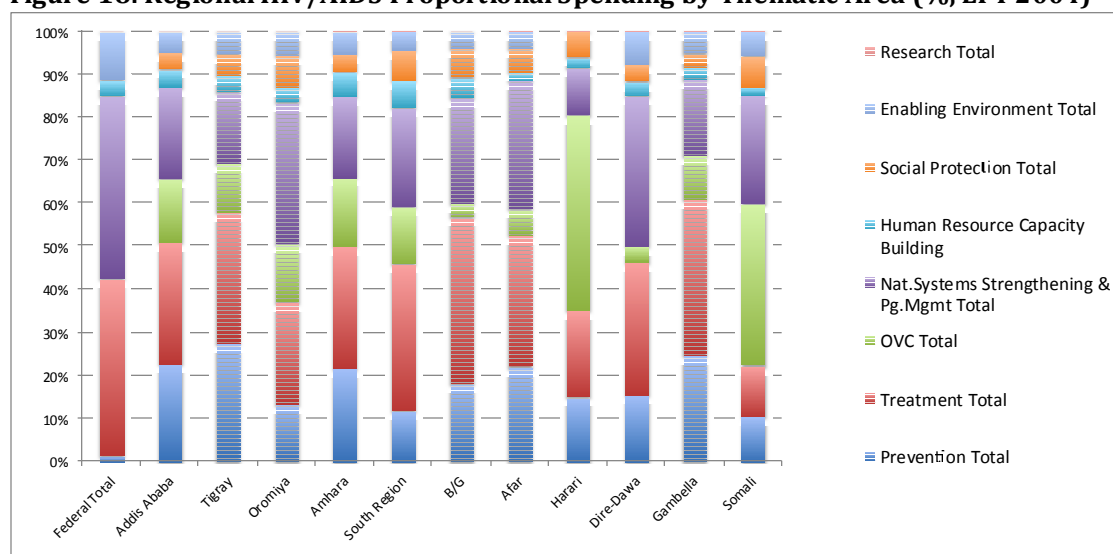
**Figure 17: Regional HIV/AIDS Spending by Thematic Area, excluding federal level (US\$ million, EFY 2004)**



NB. This figure excludes the federal level spending and other spending that could not be broken down by region, such as the MOH data.

The proportional analysis below shows the varying responses in the regions, with no particular pattern.

**Figure 18: Regional HIV/AIDS Proportional Spending by Thematic Area (% , EFY 2004)**



NB. The above figure only includes data that could be split by region. It excludes the MOH expenditure.

The variation between the regional HIV/AIDS spending patterns is shown above with prevention ranging from 10% in Somali to 28% in Tigray (except at the federal level where the prevention share was very low at 1%). The treatment proportional spending ranged from 12%

in Somali to 39% in Benishangul Gumz (B/G), although the federal level showed 41% for treatment due to the fact that the ARVs were purchased at federal level (and spending recorded there) while being consumed in at the regional level. Spending on OVCs was proportionally lowest in B/G at 3% and highest at Harari (45%), and no OVC spending at federal level, which would be expected. Proportional spending on national systems strengthening and programme management was lowest in Harari at 11% and highest in Dire Dawa at 35%, although federal level showed the higher at 41%, again to be expected due to these activities being their primary responsibility. The proportional spending on the remaining thematic areas; social protection, enabling environment and research, were similarly low in all the regions, but with Harari showing no spending on enabling environment activities.

In the following sections, each of the thematic areas is broken down into the sub-category activities, where the data allowed. Some respondents could not disaggregate their spending in this way, and so it had to be captured in the not disaggregated categories. For example, MOH indicated a large amount spent on prevention and public health, with no further detail.

### 3.4.2. Breakdown of Spending on Prevention Activities

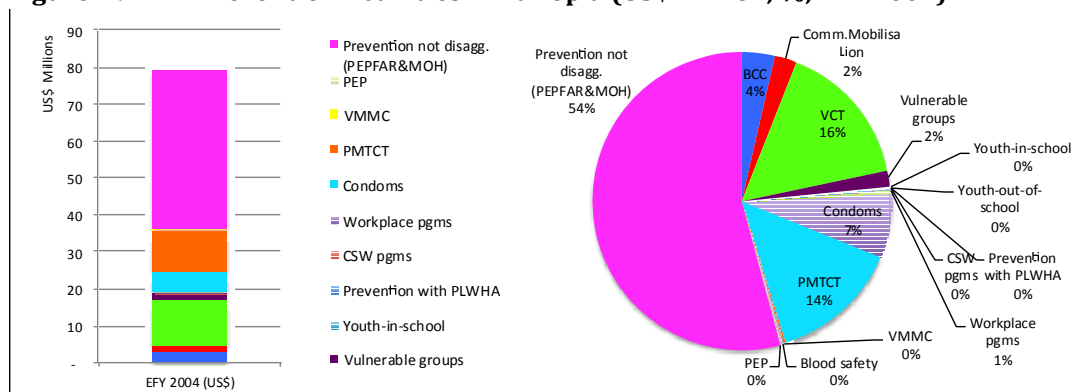
When considering the prevention spending, the following figure and table provide the breakdown by specific activities.

**Table 10: HIV Prevention Activities in Ethiopia (US\$, EFY 2004)**

Prevention Activities	EFY 2004 (US\$)	% Share
BCC	2 871 026	3,6%
Comm.Mobilisation	1 882 059	2,4%
VCT	12 387 991	15,7%
Vulnerable groups	1 437 800	1,8%
Youth-in-school	52 434	0,1%
Youth-out-of-school	1 867	0,0%
Prevention with PLWHA	68 639	0,1%
CSW pgms	35 789	0,0%
Workplace pgms	322 020	0,4%
Condoms	5 568 233	7,0%
PMTCT	11 085 868	14,0%
VMMC	192 009	0,2%
Blood safety	192 490	0,2%
PEP	87 796	0,1%
Prevention not disagg. (PEPFAR&MOH)	42 811 015	54,2%
<b>Total Prevention Spending</b>	<b>78 997 036</b>	<b>100,0%</b>

The total spending on HIV prevention in EFY 2004 almost US\$ 80 million. Note that the largest portion (54.2%) of the prevention spending was not disaggregated, primarily from the MOH and PEPFAR. The latter had US\$ 18.1 million (out of the total PEPFAR US\$ 19 million for prevention) being not disaggregated while MOH indicated US\$ 23.7 million was spent on 'prevention and public health' from which it could not be ascertained which NASA category this might have incorporated. HIV counselling and testing (HCT/ VCT) received 15% of the total spending (US\$ 12.4 million), noting that additional testing spending was captured under treatment as provider-initiated testing and counselling (PITC). Prevention of mother to child spending was the next largest category of 14% (US\$ 11 million) in EFY 2004. Condom distribution formed 7% (US\$ 5.6 million) of the prevention spending. All other prevention activities were very small proportions, with behavioural change communication at 3.65%, community mobilization at 2.4%, interventions for vulnerable groups at only 1.8%, and the rest at less than 1%.

**Figure 19: HIV Prevention Activities in Ethiopia (US\$ million, %, EFY 2004)**



According to the FHAPCO M&E report for 2011/12 this total spending on prevention achieved the following:

- ✓ 146,835,109 condoms were distributed, which might indicate that not all the condom spending was captured or disaggregated.
- ✓ 11,294,426 people were tested. If the spending on HCT (VCT) and the PITC spending are added, then equated to \$3 per person tested.
- ✓ 953,370 youth in school were reached by life skills education.
- ✓ 16,344 HIV-positive pregnant women received PMTCT.

### 3.4.3. Breakdown of Spending on HIV Treatment Activities

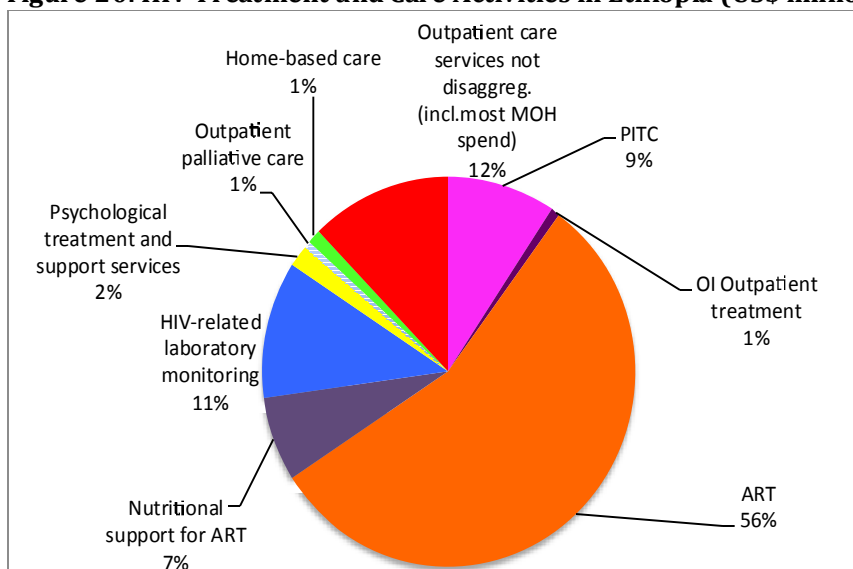
The total spending on treatment activities in EFY 2004 was US\$ 125 million, of which ART was the largest component at 55.2% (US\$ 69 million). Note that this includes all the production factors required to deliver the ART service: salaries, ARVs, laboratory costs etc., assuming that the NHA estimates included all the public salaries. The next largest proportional spending (12.1%, US\$ 15 million) was 'out-patient care services not disaggregated' (a large portion of which came from the MOH estimated expenditure), followed by HIV-related laboratory monitoring at 11.2% (US\$ 14 million) and PITC at 9.2% (US\$ 11.6 million). Nutritional support for ART received almost 7% (US\$ 8.7 million) while the other treatment activities received 2% or less.

**Table 11: HIV Treatment and Care Activities in Ethiopia (US\$, EFY 2004)**

HIV Treatment and Care Activity	US\$ (EFY2004)	% Share
PITC	11 585 718	9,24%
OI Outpatient treatment	971 233	0,77%
ART	69 269 690	55,27%
Nutritional support for ART	8 694 358	6,94%
HIV-related laboratory monitoring	14 066 379	11,22%
Psychological treatment and support services	2 323 782	1,85%
Outpatient palliative care	698 997	0,56%
Home-based care	1 447 031	1,15%
Outpatient care services not disaggreg. (incl.most MOH spend)	15 151 728	12,09%
Care and treatment services not disaggreg.	30 730	0,02%
<b>Total Treatment Spending</b>	<b>125 336 451</b>	<b>100,0%</b>

According to the FHAPCO M&E report for EFY (2004), the spending on ART resulted in 274,708 people on treatment, which might equate to around US\$ 250 per person per annum, but it should not be assumed that all the ART spending has been captured above as some may have been included in the not disaggregated category.

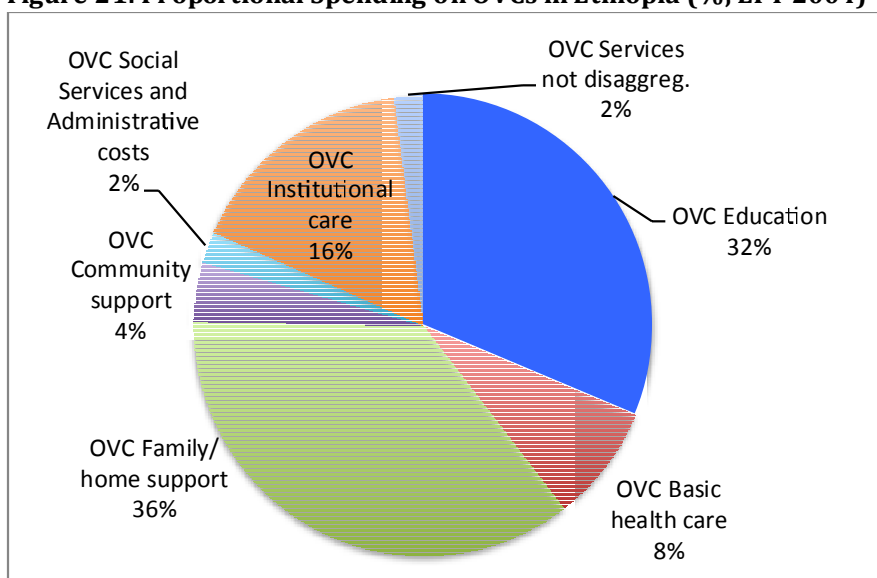
**Figure 20: HIV Treatment and Care Activities in Ethiopia (US\$ million, %, EFY 2004)**



#### 3.4.4. Breakdown of Spending on Activities for Orphans and Vulnerable Children

The spending on orphans and vulnerable children in EFY 2004 totalled US\$ 27.5 million. As the figure below shows, the bulk (36%, US\$ 9.8 million) of this was for family and home support, which includes interventions such as food support, income-generating activities and any other that supports the family as well as the OVC. Educational support was the next largest intervention (31%, US\$ 8.6 million), while institutional support such as orphanages and foster homes received 16% (US\$ 4.5 million).

**Figure 21: Proportional Spending on OVCs in Ethiopia (%, EFY 2004)**



**Table 12: Spending on OVCs (US\$, %, EFY 2004)**

OVC Support Activity	US\$ (EFY2004)	% Share
OVC Education	8 618 605	31,3%
OVC Basic health care	2 267 384	8,2%
OVC Family/home support	9 828 010	35,7%
OVC Community support	1 147 253	4,2%
OVC Social Services and Administrative costs	607 359	2,2%
OVC Institutional care	4 487 201	16,3%
OVC Services not disaggreg.	563 504	2,0%
<b>Total OVC Care and Support</b>	<b>27 519 316</b>	<b>100,0%</b>

According to the FHAPCO M&E report for EFT 2004, a total of 450,817 OVCs were provided with educational support, 22,440 were provided with training, and 24,704 with IGA start-up credit.

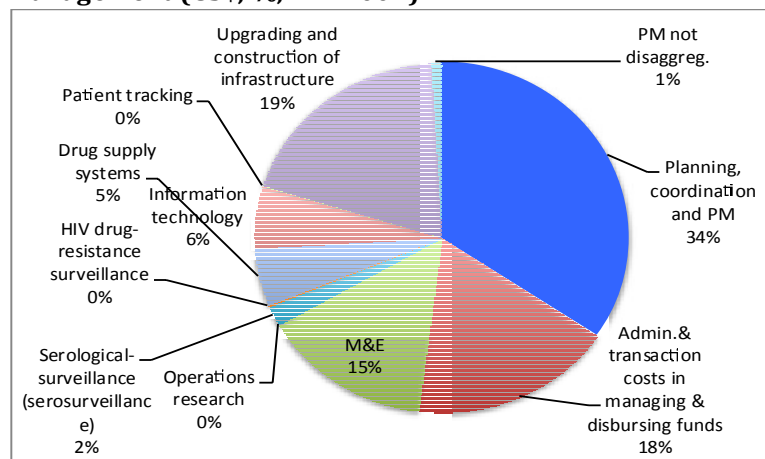
### 3.4.5. Breakdown of Spending on HIV/AIDS National Systems Strengthening & Programme Management

This thematic area was discussed partially earlier where the GoE, GF and PEPFAR specific spending were already presented. Considering the significant total spent (US\$ 120 million) on this category (including all sources), the largest proportion (35%, US\$ 41.4 million) was on national planning and coordination activities, followed by 19% (US\$ 23 million) for infrastructural development and upgrading. Transactional costs related to managing funds was a large share of 18% (US\$ 21 million), and then M&E at 14.7% (US\$ 17.7 million).

**Table 13: Spending on National Systems Strengthening and Programme Management (US\$, %, EFY 2004)**

Programme Management Activities	US\$ (EFY 2004)	% Share
Planning, coordination and PM	41 409 755	34,5%
Admin. & transaction costs in managing & disbursing funds	21 054 885	17,5%
M&E	17 666 561	14,7%
Operations research	7 286	0,0%
Serological-surveillance (serosurveillance)	2 236 217	1,9%
HIV drug-resistance surveillance	170 669	0,1%
Drug supply systems	6 372 171	5,3%
Information technology	6 917 343	5,8%
Patient tracking	53 103	0,0%
Upgrading and construction of infrastructure	23 130 095	19,3%
PM not disaggreg.	1 090 912	0,9%
<b>Total Prog. Management Spending (US\$)</b>	<b>120 108 997</b>	<b>100,0%</b>

**Figure 22: Proportional Spending on National Systems Strengthening and Programme Management (US\$, %, EFY 2004)**



### 3.4.6. Spending on Human Resource Capacity Building, Social Protection, Enabling Environment and Research

The table below provides the limited breakdown of the last four thematic areas.

**Table 14: Spending on Human Resource Capacity Building, Social Protection, Enabling Environment and Research (US\$, EFY 2004)**

HR Capacity Building, Social Protection, Enabling Enviro, Research	US\$ (EFY 2004)
Stipends/ allowances	6 194
Formative education to build-up an HIV workforce	396 450
Training	15 070 468
HR not disaggreg.	675 302
<b>Total HR Capacity Building</b>	<b>16 148 414</b>
Monetary benefits	137 205
In-kind benefits	1 372 341
Income generation projects	9 066 315
Social protection not disagg.	14 422
<b>Total Social Protection</b>	<b>10 590 283</b>
Advocacy	524 314
Human rights programmes	17 044
AIDS-specific institutional development	9 391 138
Enabling environment not disagg.	16 199 359
<b>Total Enabling Environment</b>	<b>26 131 855</b>
<b>Total Research</b>	<b>247 951</b>

### 3.5. Spending within the Investment Framework

The Investment Framework (IF), developed by UNAIDS (Swartlander, 2011) and Partners, assists countries to **maximise the impact of the HIV programmes and interventions on their HIV incidence and deaths<sup>11</sup>**.

The objectives of developing an Investment Case are to:

1. Correct the mismatches between the epidemic and response
  - address emerging trends as well as prevalent risks, burdens and gaps
  - prioritise allocating resources to evidence-based interventions with the greatest impact
2. Identify how to go to, and maintain, required scale/coverage
  - more rapid scale up may save more lives and money in the medium-long term
3. Cut unnecessary costs or diversion of capacity
  - focus on: big issues e.g. procurement; redirect capacity from less effective interventions
4. Generate efficiencies in the HOW of implementation to ensure ability to achieve scale and limit financial burden
  - e.g. systems duplications, technology,
  - scale constraints: service models, HRH etc.
5. Ensure sustainability:
  - manage fiscal space; mobilise domestic and international finance flows; stakeholder support.

Ethiopia is developing its Investment Case, and the NASA findings can provide valuable insight into the current and past funding of programmes, so as to ascertain if reprogramming is

<sup>11</sup> Investing for Results. Results for People. Guidance 2012. UNAIDS/PCB(30)12.CRP.4

necessary. The NASA findings are therefore presented here according to the main categories of the IF:

- ✓ Basic programmes
- ✓ Critical enablers
- ✓ Synergies with the development sector.

The **basic programmes** are those which have a direct effect on HIV transmission, risk, mortality and morbidity, and include the following sub-categories:

1a. Key populations at higher risk with the focus mostly on men having sex with men, commercial sex workers and their clients and injecting drug users. The basic activities for the mentioned groups include condoms, education and communication.

1b. Elimination of new infections in children through biomedical means i.e. PMTCT

1c. Behaviour change programmes

1d. Male and female condom promotion, procurement and distribution

1e. Treatment, care and support for people living with HIV

1f. Voluntary medical male circumcision

The **critical enablers** are less structured and include activities that are necessary to support the effectiveness and efficiency of the basic programme activities. There are two sub-components:

- ✓ Social enablers; which include community mobilization, voluntary counselling and testing, human rights and advocacy and stigma reduction
- ✓ Programme enablers; which include, “capacity building for community based organisations, programme management and strategic planning”.<sup>12</sup>

The **development synergies** include those investments in other sectors that can have a positive effect on HIV outcomes, such as:

- ✓ Social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems and community systems.

Therefore:

*“The point of the Investment Approach is not to supply firm prescriptions for cost allocations but rather to provide conceptual frameworks that may help in shaping country-level discussions... The interventions that are more HIV-specific or have a specific HIV outcome would warrant a greater share of resources for HIV; those that primarily contribute to other health or development outcomes while being HIV-sensitive might cost more overall but would warrant a much smaller share of HIV-specific funding” (UNAIDS & UNDP, 2012) <sup>13</sup>.*

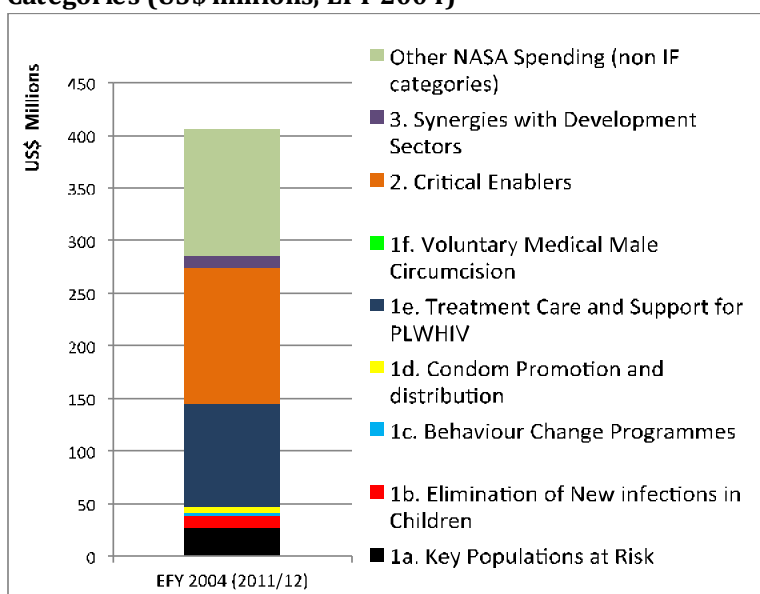
Cross-walking the NASA categories to the Investment Framework categories (see Appendix C for more details), the spending on HIV/AIDS in Ethiopia in EFY 2004 can be seen in the following figure 23 and table 15.

The total spending on the basic programmes was US\$ 145 million, or 32% of the total spending on HIV/AIDS in EFY 2004. The critical enablers made up another 32% (US\$ 129 million), while the development synergies only had 2.7% (US\$ 11 million). However, it is important to note that there was additional spending captured through the NASA process which could not easily be placed into one of the three core categories. These are labelled above as ‘other NASA spending’ and consumed almost 30% of the total (US\$ 120 million), and were mostly training, upgrading and construction of infrastructure, and prevention programmes in the workplace (which was mostly the Mainstreaming Funds). These interventions should also be viewed as important in the Ethiopian HIV/AIDS response.

<sup>12</sup> A New Investment Framework for the Global HIV Response. UNAIDS ISSUES BRIEF . 2011

<sup>13</sup> UNAIDS & UNDP (2012). Understanding and acting on critical enablers and development synergies for strategic investments.

**Figure 23: Ethiopian HIV/AIDS Spending according to the Investment Framework Categories (US\$ millions, EFY 2004)**



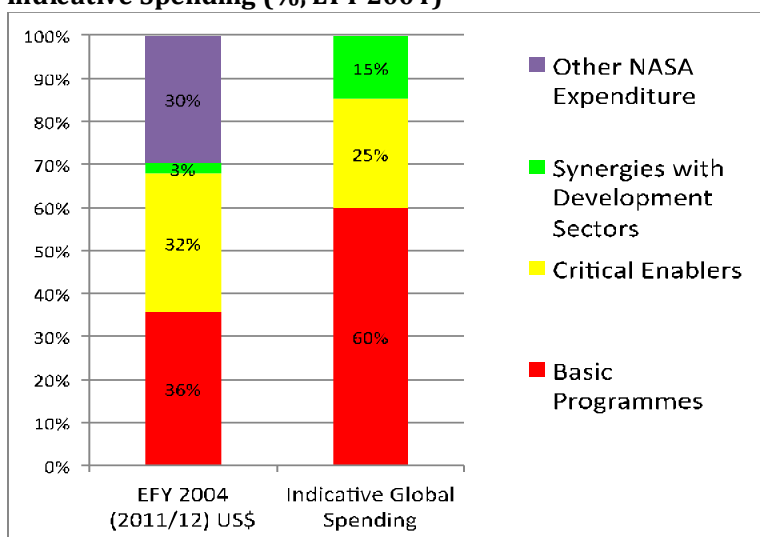
**Table 15: Ethiopian HIV/AIDS Spending according to the Investment Framework Categories (US\$ millions, %, EFY 2004)**

Investment Case Categories	EFY 2004 (2011/12) US\$	% of total
1a. Key Populations at Risk	27 564 671	6,8%
1b. Elimination of New infections in Children	11 085 868	2,7%
1c. Behaviour Change Programmes	3 345 765	0,8%
1d. Condom Promotion and distribution	6 125 988	1,5%
1e. Treatment Care and Support for PLWHIV	97 017 067	24,0%
1f. Voluntary Medical Male Circumcision	192 009	0,0%
2. Critical Enablers	128 886 712	31,8%
3. Synergies with Development Sectors	10 782 773	2,7%
Other NASA Spending (non IF categories)	120 079 450	29,6%
<b>Total IF</b>	<b>405 080 303</b>	<b>100,0%</b>

There is no global golden standard to indicate what might be the best proportional mix of spending on these categories, as every country epidemic and response is different. However, based on global spending trends, Swartlander (2011) proposed some average global proportions, as shown in the figure below, but which would have to be adapted to each country's epidemic and need.



**Figure 24: The Ethiopian HIV/AIDS Proportional Spending Compared with the Global Indicative Spending (% , EFY 2004)**



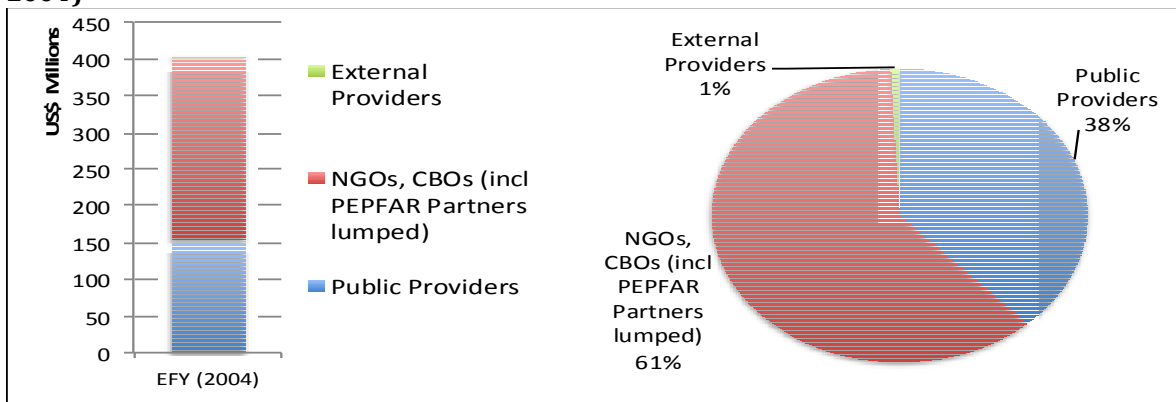
Because the HIV epidemic in Ethiopia has been controlled and the HIV incidence rates kept relatively low, there are lower numbers of people requiring treatment than in some other African countries. Therefore it can be seen above that the proportional spending on treatment (36%) is lower than the possible global average (60%). Importantly, the critical enabler spending is slightly higher at 32% as opposed to 25%. The 'other NASA spending' made up 30% of the total spending on HIV/AIDS in Ethiopia.

The following section looks at the detail of the types of HIV service providers in Ethiopia.

### 3.6. Providers of HIV/AIDS Services in Ethiopia

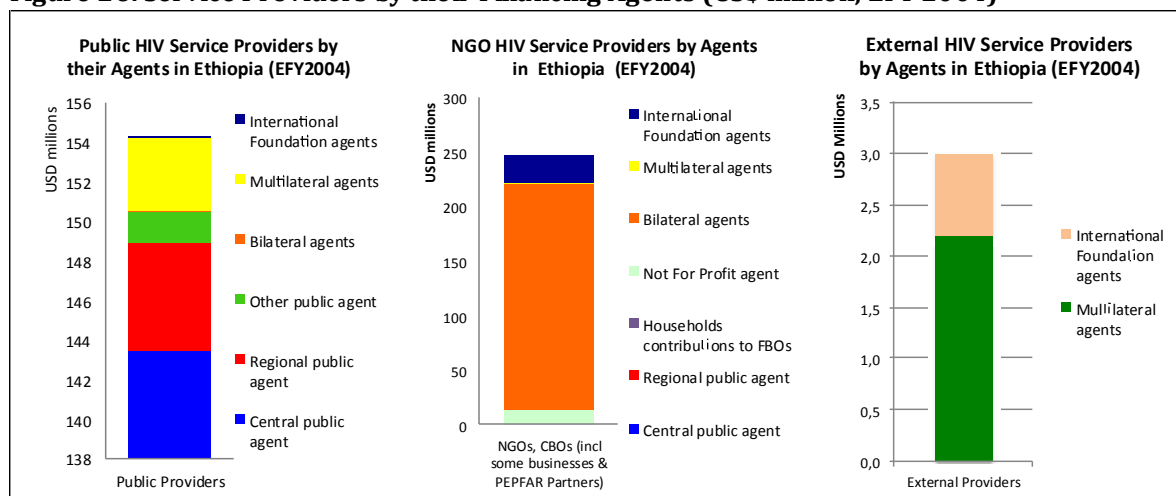
According to the NASA classification, the broad categories of service providers are public, private (NGOs and businesses), and external (where the development partners spend money themselves on programmes or operational costs). These broad categories are shown in the figure below, indicating that the bulk were within the private category (61%). This was due to all the PEPFAR implementing partners being lumped together in this category since the PEPFAR Expenditure Analysis (EA) data did not provide the types of service providers.

**Figure 25: Spending by HIV/AIDS Service Providers in Ethiopia (US\$ million, %, EFY 2004)**



The public providers nevertheless formed a significant portion of the service providers (38%), while the external providers appear very small (1%). Unfortunately the spending by the PEPFAR agencies (headquarters' operational costs) could not be disaggregated from the totalled lump sum (under the private category). The following figures show which financial agents were using which service providers.

**Figure 26: Service Providers by their Financing Agents (US\$ million, EFY 2004)**



NB. Differing axes scales.

As can be expected, the public service providers' funding came primarily from public agents, as well as from the GF (multilateral agent). The bulk of the private providers received funds from bilaterals, specifically the PEPFAR funds since their implementing partners were lumped in this category. The external spending was very small, mainly their in-country office costs.

The following table provides more insight into the types of service providers, showing that after the largest share (51%) going to the PEPFAR implementing partners, the next largest type of provider was the MOH (17%), then public clinics (15%), and then NGOs, CBOs and other non-profit organisations (9.8%). The remaining types of providers were around 1% or less of the spending.

**Table 16: Ethiopian HIV/AIDS Service Providers (US\$, EFY 2004)**

Service Provider	US\$ (EFY2004)	% Share
Public Hospitals	2 712 847,00	0,7%
Public Clinics	61 375 028,00	15,2%
Public Medical Stores	2 741 623,00	0,7%
Public Research institutions	29 755,00	0,0%
FHAPCO	9 884 541,00	2,4%
MOH	70 624 634,00	17,4%
MOE	138 379,00	0,0%
MoSS	10 226,00	0,0%
Ministry of Labour	251 543,00	0,1%
Ministry of Justice	8 573,00	0,0%
Other public entities	6 341 815,00	1,6%
Govmt organizations n.e.c.	1 629 447,00	0,4%
Parastatal organizations n.e.c.	84 041,00	0,0%
NGO Foster homes/shelters	321 745,00	0,1%
NGO Orphanages	683 946,00	0,2%
NGOs, CSOs & CBOs	39 641 244,00	9,8%
FBO Orphanages	70 895,00	0,0%
PEPFAR providers (all lumped)	207 063 469,00	51,1%
For-Profit providers (workplace pgms)	10 330,00	0,0%
Bilateral and multilateral entities – in country offices	2 992 129,00	0,7%
<b>Total</b>	<b>405 080 303,00</b>	<b>100,0%</b>

The following section examines the beneficiaries of HIV/AIDS spending in Ethiopia.

### 3.7. Beneficiaries of HIV/AIDS Spending in Ethiopia

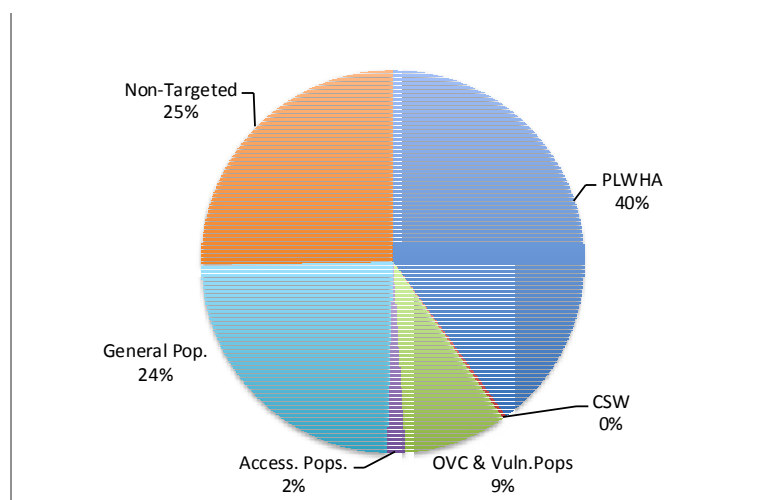
The NASA categories firstly categorises the beneficiaries of HIV/AIDS spending into six broad categories, each of which are then broken down further. However, the depth of the analysis is often hindered by the limited breakdown of the expenditure data by the type of beneficiary.

The six broad categories of beneficiaries are as follows:

- ▶ PLWHA – can be broken down by age and gender, if the expenditure data allows
- ▶ Most at Risk Populations – traditionally men who have sex with men (MSM), commercial sex workers (CSW), and intravenous drug users (IDUs). However, in Ethiopia, only spending on CSW was found
- ▶ OVCs and other vulnerable groups (prisoners, migrants, etc.)
- ▶ Other accessible key populations – school/ university students, police/ army
- ▶ General population – efforts that target the entire population e.g. BCC, mass media, HCT
- ▶ Non-targeted – interventions that are not targeted at any group/person/population e.g. national systems strengthening, programme management, M&E, infrastructural development, and research.

Figure 26 below shows that people living with HIV/AIDS received the largest share (40%) of all HIV/AIDS spending in Ethiopia in EFY 2004, followed by non-targeted spending (25%) (primarily due to the large spending on national systems strengthening and programme management), and then those interventions that are targeted towards the general population, such as BCC, HCT etc. formed 24%. The share that went to CSW was very small, less than 1%. Vulnerable and other at-risk groups received 9% and this is broken down further in the table 17 below.

**Figure 26: Beneficiary Groups of the Total HIV/AIDS Spending in Ethiopia (% , EFY 2004)**



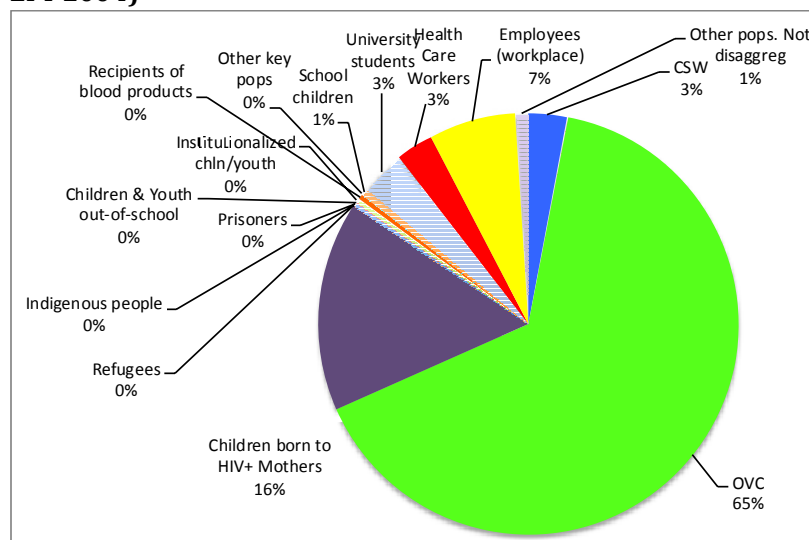
**Table 17: HIV/AIDS Spending on Vulnerable, Most-at-risk and other Key Groups (US\$, %, EFY 2004)**

MARPs/ Key Pops	US\$ (EFY 2004)	% share of Key Pops
CSW	1 285 202	3,0%
MARPs not disaggreg.	4 356	0,0%
OVC	27 975 933	65,3%
Children born to HIV+ Mothers	6 898 022	16,1%
Refugees	3 602	0,0%
Indigenous people	9 371	0,0%
Prisoners	118 435	0,3%
Children & Youth out-of-school	39 976	0,1%
Institutionalized chln/youth	99 087	0,2%
Recipients of blood products	192 490	0,4%
Other key pops	18 582	0,0%
School children	229 323	0,5%
University students	1 420 278	3,3%
Health Care Workers	1 260 894	2,9%
Employees (workplace)	2 853 087	6,7%
Other pops. Not disaggreg	411 456	1,0%
<b>Total MARPS/ Key Pops</b>	<b>42 820 094</b>	<b>100%</b>

NB. This table excludes the other beneficiary groups (PLWHA), general population and non-targeted spending.

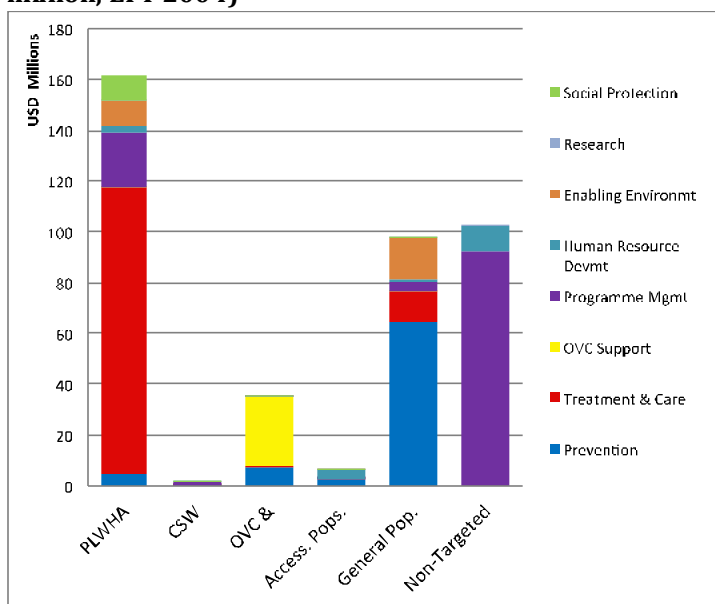
Of the total US\$ 43 million reported as spent on these vulnerable and at risk groups, the largest proportion (65%) benefitted OVCs, then babies to be born of HIV-positive mothers (16% through the PMTCT programme), followed by employees benefitting from workplace or mainstreaming programmes (6.7%). The remaining categories received very little, 3% or less.

**Figure 27: Proportional Spending on Vulnerable, Most-at-risk and other Key Groups (% , EFY 2004)**



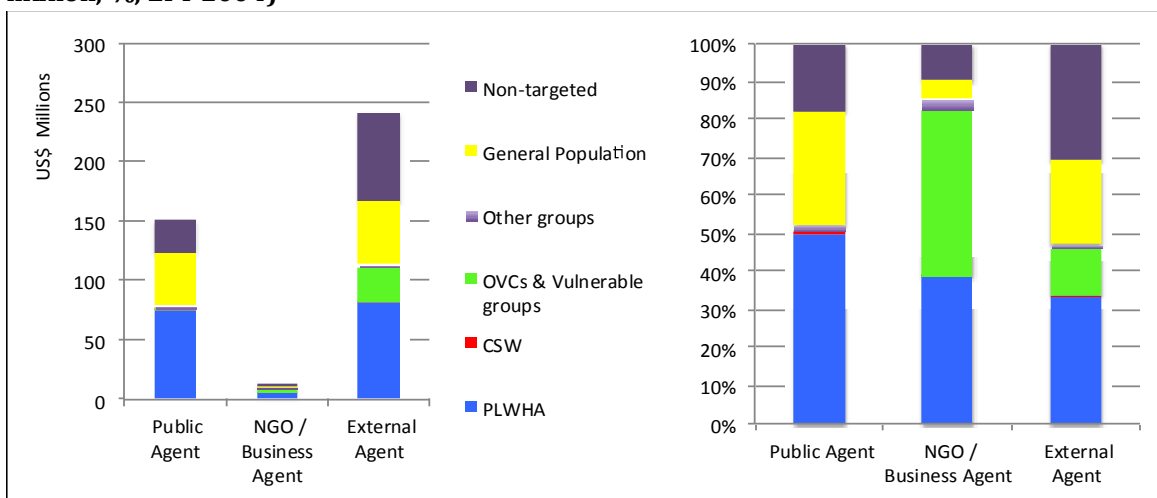
Considering the types of services that the different groups of beneficiaries are benefitting from, the following figures shows that the bulk of PLHIV were reached by treatment and care services, while the bulk of the general population were reached by prevention interventions. This is to be expected. Also as expected, it can be seen that the bulk of the national systems strengthening and programme management spending was non-targeted.

**Figure 27: HIV/AIDS Spending on Beneficiary Groups by the Type of Intervention (US\$ million, EFY 2004)**



When examining the beneficiaries of the spending by the financing agents, it can be seen that the public agent spending benefitted primarily PLHIV, the private agent spending benefitted OVCs, vulnerable groups and PLHIV, while the external agent spending had a large portion non-targeted, then PLHIV, the general population, and also OVCs and other vulnerable groups.

**Figure 28: HIV/AIDS Spending on Beneficiary Groups by the Financing Agent (US\$ million, %, EFY 2004)**



**Table 18: HIV/AIDS Spending on Beneficiary Groups by the Financing Agent (US\$ million, EFY 2004)**

Providers	PLWHA	CSW	OVCs & Vuln.Pops	Accessible pops.	General Pop.	Non-Targeted	Totals (US\$)
Public	75 812 908	68 720	590 880	3 643 205	46 351 445	27 829 387	154 296 545
Private	85 389 586	1 219 307	34 423 296	2 507 072	50 977 680	73 142 518	247 659 459
External	501 231	1 531	341 322	24 761	645 289	1 477 995	2 992 129,00
<b>Totals</b>	<b>161 703 725</b>	<b>1 289 558</b>	<b>35 355 498</b>	<b>6 175 038</b>	<b>97 974 414</b>	<b>102 449 900</b>	<b>405 080 303</b>
% Share	39,9%	0,3%	8,7%	1,5%	24,2%	25,3%	100,0%

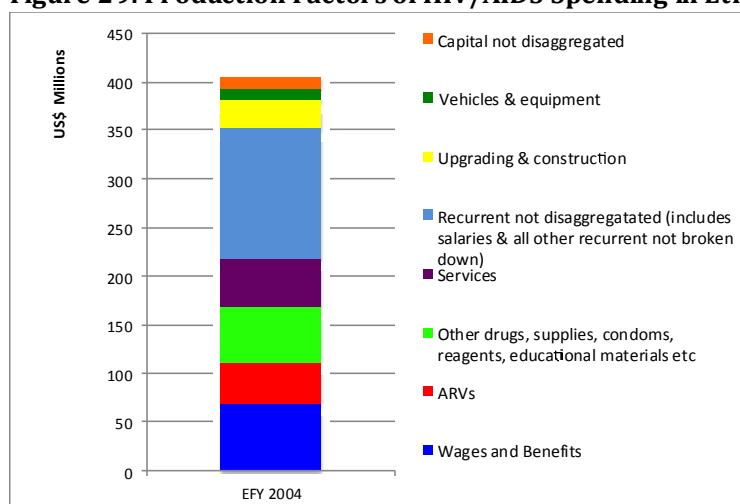
The following section examines the HIV/AIDS spending by production factor (or cost category).

### 3.8. Production Factors of HIV/AIDS Services in Ethiopia

The NASA attempted to collect the production factors (PFs), or cost components, of all the HIV/AIDS spending in Ethiopia. However, not all the respondents could provide this additional level of breakdown. For example, the MOH estimated expenditure from the NHA findings did not provide the PFs, therefore their current expenditure was labelled as 'current non disaggregated' while any infrastructural development or upgrading, was labelled as 'capital not disaggregated'. As the figure and table below indicate, the large proportion of not disaggregated (36% in total) undermines the usefulness of the remaining spending that could be disaggregated since no assumptions can be drawn in terms of efficiencies for specific interventions.

Overall, the recurrent expenditure was 87% of the total spending on HIV/AIDS, and capital was only 13%. This seems a bit low and may have missed some capital investments or infrastructural upgrading. Or it indicates that the investment in capital improvements was low in EFY 2004. As can be seen, the ARV component of ART was US\$ 42 million, but this may be missing some ARV spending that was not disaggregated. Wages and salaries formed 17%, but again further salaries are probably incorporated in the 'recurrent not disaggregated' portion, especially as the NHA estimates of the MOH expenditure did not provide their PFs and hence was lumped in this category.

**Figure 29: Production Factors of HIV/AIDS Spending in Ethiopia (US\$ millions, EFR 2004)**



**Table 19: Production Factors of HIV/AIDS Spending in Ethiopia (US\$ millions, %, EFR 2004)**

<b>CURRENT EXPENDITURES</b>	<b>US\$ (EFY2004)</b>	<b>% Share of Total Spend</b>
Wages & benefits	68 712 203	17%
Antiretrovirals	42 454 972	10%
<i>Other drugs and pharmaceuticals (excluding antiretrovirals)</i>	10 999 483	
<i>Medical and surgical supplies</i>	17 588 900	
<i>Condoms</i>	4 347 706	
<i>Reagents and materials</i>	140 563	
<i>Food and nutrients</i>	10 481 287	
<i>Uniforms and school materials</i>	2 095 476	
<i>Material supplies not disaggregated by type</i>	11 203 733	
Sub-total Other drugs (excl ARVs), supplies, reagents, educational materials	56 857 148	14%
<i>Administrative services</i>	2 759 529	
<i>Maintenance and repair services</i>	152 659	
<i>Publisher-, motion picture-, broadcasting services</i>	1 017 514	
<i>Consulting services</i>	5 522 988	
<i>Transportation and travel services</i>	22 052 264	
<i>Housing services</i>	555 277	
<i>Logistics of events, including catering services</i>	1 018 388	
<i>Financial intermediation services</i>	1 853 441	
<i>Services not disaggregated by type</i>	15 254 084	
Sub-total Services	50 186 144	12%
Recurrent not disaggregated (includes salaries & all other recurrent not broken down)	133 575 142	33%
<b>Sub-Total RECURRENT</b>	<b>351 785 609</b>	<b>87%</b>
<hr/>		
	<b>US\$ (EFY2004)</b>	<b>% Share of Total Spend</b>
<i>Capital expenditures</i>		
<i>Laboratory and other infrastructure upgrading</i>	682 795	
<i>Construction of new health centres</i>	14 368 888	
<i>Buildings not disaggregated by type</i>	13 514 351	
Sub-total Upgrading & construction	28 566 034	7%
<i>Vehicles</i>	6 185 874	
<i>Information technology (hardware and software)</i>	17523	
<i>Laboratory and other medical equipments</i>	19 605	
<i>Equipment not disagg. Or n.e.c</i>	6 626 404	
Sub-total Vehicles and equipment	12 849 406	3%
Capital not disaggregated or n.e.c	11 879 253	3%
Sub-total CAPITAL	53 294 693	13%
<b>TOTAL Production Factors (US\$)</b>	<b>405 080 302</b>	<b>100%</b>

## 4. Comparison of the NASA Expenditure with the Costed NSP Estimates

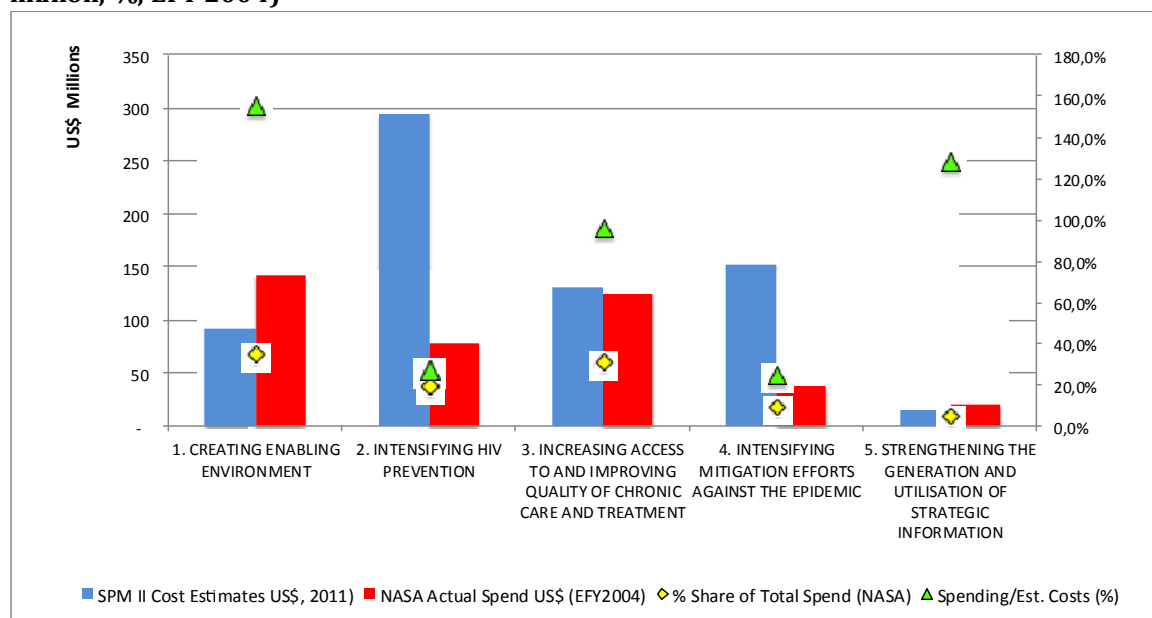
The SPM II, as described in the background section, focuses on five thematic areas, and under each of these are several activities:

1. Creating Enabling Environment;
2. Intensifying HIV Prevention;
3. Increasing Access to and Improving Quality of Chronic Care and Treatment;
4. Intensifying Mitigation Efforts against the Epidemic, and;
5. Strengthening the Generation and Utilisation of Strategic Information.

The total estimated costs for all the activities for the period were shown earlier. Here, the estimated costs for 2011 (EFY 2004) are compared with the NASA actual expenditure for the same year, to ascertain if there were any shortfalls or cover-expenditure. However, it is difficult to make any clear assumptions since the NASA might have captured expenditure on activities that were not included in the SPM II, or vice versa.

The SPM II categories were cross-walked to the NASA categories (refer to Appendix D for this cross-walk). It must be noted that the SPM II category of Enabling Environment contained far more activities than does the NASA enabling environment (several of which fell under the NASA national systems strengthening and programme management), which is why the spending shown here on enabling environment is higher than was shown earlier, under the NASA categorisation. The following figure and table show the summed estimates under each thematic area of the SPM II, and also provide the proportional spending on each theme (share of the total spending), and the share of the actual expenditure out of the estimated resource needs. These give some indication of the prioritisation of the response, and any resource shortfalls. Overall, the NASA found spending on HIV/AIDS that equalled 60% of the resources estimated as needed for the SPM II in 2011/12 (EFY 2004).

**Figure 30: SPM II Resource Needs Estimates compared with Actual Expenditure (US\$ million, %, EFY 2004)**





As can be seen, the actual spending on enabling environment was higher than the estimated resource needs (156%), and formed 35% of the total spending. The spending on prevention activities appeared to be far lower than the estimated resource needs (only 27% spent), and only 20% of the total spend committed to prevention. Care and treatment activities also took close to what was estimated was required (96%), and formed 31% of the total spending. The efforts to mitigate the impact of the epidemic had 25% of the estimated costs that were actually spent, and this category only received 9.4% of the total spend. The final SPM II category of strengthening the use of strategic information had greater spending than was anticipated (129%), but this only formed 5% of the total.

**Table 20: SPMII Resource Needs Estimates compared with Actual Expenditure (US\$ million, %, EFY 2004)**

SPMII Thematic Area	SPM II Cost Estimates US\$, 2011)	NASA Actual Spend US\$ (EFY2004)	% Share of Total Spend (NASA)	Spending/Est. Costs (%)
1. CREATING ENABLING ENVIRONMENT	91 396 579	142 308 533	35,1%	155,7%
2. INTENSIFYING HIV PREVENTION	294 284 350	78 997 036	19,5%	26,8%
3. INCREASING ACCESS TO AND IMPROVING QUALITY OF CHRONIC CARE AND TREATMENT	130 635 293	125 336 451	30,9%	95,9%
4. INTENSIFYING MITIGATION EFFORTS AGAINST THE EPIDEMIC	152 330 694	38 109 599	9,4%	25,0%
5. STRENGTHENING THE GENERATION AND UTILISATION OF STRATEGIC INFORMATION	15 777 257	20 328 684	5,0%	128,8%
<b>Total Spending</b>	<b>684 424 173</b>	<b>405 080 303</b>	<b>100,0%</b>	<b>59,2%</b>

If it can be assumed that the cost estimates for the SPM II were accurate (i.e. reasonable unit costs and quantity estimated) and the annual targets for each intervention for 2011/12 (EFY 2004) were achieved, then the above findings might imply that there was over-spending on enabling environment and strategic information strengthening, adequate spending on treatment and care, while the other categories appeared to be under-funded. However, it should be with caution that such findings be interpreted until it is ascertained that similar categories and accurate costing assumptions have been applied, and that the figures can be compared.

## 5. Conclusion and Recommendations

In conclusion, the National AIDS Spending Assessment sought to identify and measure all sources of funding for HIV/AIDS in Ethiopia in EFY 2004 (2011/12), to identify the agents for these funds, the service providers, the amount spent on the services, their production factors and the beneficiaries of all the spending.

The total spending in Ethiopia on HIV/AIDS in 2011/12 (EFY 2004) was US\$ 405 million, of which 86% came from external sources (US\$ 350 million), 13% came from public revenue (US\$ 55 million) and only US\$ 680,000 (less than one percent) came from the private sector (although the business sector's contribution was under-estimated and the private health care sector excluded).

Of the **public funds**, a large portion was the spending through the Ministry of Health, based on the NHA estimates for EFY 2003 (2010/11), which represents an important but usually hidden cost carried by governments. Also of importance are the Mainstreaming Fund to which every Ministry contributes 2% of its total budget, and the AIDS Fund, which is a voluntary contribution from the public employees. These are public initiatives that could be explored for future expansion.

Of the **external sources**, PEPFAR was the greatest contributor, forming 51% of total spending on HIV/AIDS (US\$ 206 million excluding their 'above national spending' – or out of the country spending for Ethiopia), and the Global Fund was the next largest contributor (30%) at US\$ 150 million. Numerous other bilateral, multilateral and international foundations also contribute to the response in Ethiopia, all less than 1% each in EFY 2004 (2011/12), but totalling around 10% of total spend.

In terms of the **agents** of the HIV/AIDS spending, that is, who controls how the money is spent, the government managed 37% (US\$ 152 million), while external agents managed 60% (US\$ 242 million).

Considering the breakdown of the HIV/AIDS spending by **thematic area**, Ethiopia spent 19.5% (US\$ 79 million) on prevention in 2004 (2011/12), 31% on treatment and care (US\$ 125 million), 30% on national systems strengthening and programme management (US\$ 120 million), 7% on OVC support (US\$ 28 million), and 6.5% on enabling environment activities (US\$ 26 million). Social protection activities (excluding those for OVCs) took 2.6% (US\$ 11 million), and less than 1% (as was captured by NASA) went to research activities (US\$ 250,000) (noting that surveillance and M&E spending were captured under national systems strengthening). This under-representation of research spending was due to the non-response by the larger research entities and thus is not representative of the actual funds spent for research in the country.

People living with HIV/AIDS received the largest share (40%) of all HIV/AIDS spending in Ethiopia in EFY 2004, followed by non-targeted spending (25%) (primarily due to the large spending on national systems strengthening and programme management), and then those interventions that are targeted towards the general population, such as BCC, HCT etc. formed 24%. The reported share that went to CSW was very small, less than 1%.

In comparing the NASA actual expenditure against the SPM II estimated resource needs for 2011/12 (EFY 2004), there appeared to be adequate spending on the treatment and care component of the response, but over-spending on the enabling environment component, under

which most of the national systems strengthening and programme management costs were captured. There appeared to be under-spending on the prevention and mitigation activities.

At the NASA Stakeholder Validation meeting, these findings were presented, discussed and validated, with suggestions for improving as well as explaining the results. The following recommendations were made:

### **Recommendations:**

#### ***Allocative Decisions for Greatest Impact***

Considering the proportional split between the thematic areas, there appeared to have been adequate spending on treatment in EFY 2004, at least considering the eligibility criteria at the time (less than CD4 350). The eligibility criterion has since increased to CD4 count less than 500 (end-2013).

However, preventative spending, when compared with the resource needs estimated in the SPM II, appeared lower than adequate, and therefore enhanced efforts particularly for those more targeted interventions with proven preventative impact may be necessary. The Ethiopian Investment Case being developed will provide strategic guidance in this regard, and the findings from the National and Regional HIV Syntheses would enhance planners understanding of the key risk groups in Ethiopia.

Ethiopia had a high share of spending on national systems strengthening and programme management (mostly captured under the Enabling Environment thematic area of the SPM II). Examination of the sub-categories of spending on those activities, particularly transactional costs associated with managing HIV funding, would be useful to ascertain possible areas for greater efficiency gains. In this regard, more detailed information from the development partners, particularly the PEPFAR agencies and UN, regarding their headquarters and operational costs in-country, would increase transparency, accountability and impact.

The low spending on research and surveillance, which was partly due to non-response of some key players, could be examined and ascertained if additional funding is required for strengthening the use of strategic information (SPM II thematic area five), which appeared to be low compared with the estimated resource requirements.

Mitigation spending also appeared low, and it would be useful to examine the outcomes and impact of the existing programmes, and consider increasing or improving strategic efforts in this regard, since they are still critical interventions for OVCs, families and communities that have been negatively affected by HIV/AIDS.

Further examination of the 'other NASA' spending which was not within the Investment Framework categories may ascertain if these are important supportive activities or if some efficiencies could be achieved.

#### ***Sustainable, Transparent, Accountable and Aligned Funding***

The development partners and government agencies were willing to share their data on expenditure and available funds for HIV/AIDS in Ethiopia. This shows an important commitment to transparency and accountability. If longer-term future commitments can be shared by all actors, this would enhance longer-term planning and resource mobilisation. Again, the Investment Case being developed should assist in this regard.

Equally the response rate from HIV service providers in Ethiopia was good, and most displayed willingness and ability to share their data. There were a few that did not, and this may have under-represented the spending in certain activities, particularly the research field. Future

resource tracking efforts should gradually improve the willingness of all actors to share their data, as they see the usefulness of the information for evidence-based planning.

Regarding long-term financial sustainability and with Ethiopia's progression towards lower middle-income status, there could be consideration of alternative sources of public revenue for increasing health expenditure generally, while also ensuring adequate funding for the HIV/AIDS response.

### ***Improving Financial Information Systems and Institutionalising Routine Expenditure Tracking***

The routine collection and collation of HIV expenditure, at least on an annual basis, would enhance the availability of information to inform allocative decisions and resource mobilisation. It would also lead to improved transparency for all actors in the HIV field in Ethiopia. An option could be the routine submission of expenditure by service providers when submitting their routine M&E indicators/ report.

### ***Additional Research***

Since this was the first NASA in Ethiopia and has provided valuable, in-depth programmatic expenditure information, it could be enhanced with more in-depth examination of potential efficiency gains and outputs per programme.

For the development of the Investment Case for Ethiopia, additional information on the impact of interventions would be valuable, to then compare the cost-efficiencies of programmes.

## Appendices

### Appendix A: Detailed Tables of the Ethiopian HIV/AIDS Spending

**Ethiopian HIV Financing Source by Agent (FS-FA) EFY 2004 (2011/12) US\$**

	Public FA	Private FA	External FA	Totals	%
Public Source	54 321 226	254 424	0	54 575 650	13%
Private Source	130 320	549 402	0	679 722	0,2%
External	97 027 486	11 420 517	241 504 138	349 952 141	86%
Totals	151 479 032	12 224 343	241 504 138	405 207 513	100%
Share of total	37%	3%	60%		

**Ethiopia HIV Funding Sources by Thematic Area (EFY 2004, US\$)**

HIV Thematic Areas (ASC)	Sources			Totals (US\$)	% Share
	Public funds	Private Funds	External funds		
Prevention	24 834 287	188 582	53 974 167	78 997 036	19,5%
Treatment	13 053 804	14 712	112 267 935	125 336 451	30,9%
OVC support	459 284	199 445	26 860 587	27 519 316	6,8%
Nat.Sys.Strngth & Pgm.Coord.	15 526 130	172 729	104 410 138	120 108 997	29,7%
HR Devmt Training / CB	525 996	40 983	15 581 435	16 148 414	4,0%
Social protection & social services (excluding OVC)	48 938	58 173	10 483 172	10 590 283	2,6%
Enabling environment	-	5 097	26 126 758	26 131 855	6,5%
Research	-	-	247 951	247 951	0,06%
<b>Totals</b>	<b>54 448 439</b>	<b>679 721</b>	<b>349 952 143</b>	<b>405 080 303</b>	<b>100,0%</b>
Source by Share	13%	0%	86%	100%	

**Ethiopian Service Providers, by Agent (EFY 2004), US\$**

US\$, EFY2004	Public Providers	NGOs, CBOs (incl PEPFAR Partners lumped)	External Providers
Central public agent	143 453 048	823 550	0
Regional public agent	5 396 283	259 227	0
Other public agent	1 546 924	0	0
Households contributions to FBOs	0	263 915	0
Not For Profit agent	0	11 598 767	0
Total other private agents	0	234 449	0
Bilateral agents	112 810	207 988 385	0
Multilateral agents	3 678 978	1 475 066	2 200 574
International Foundation agents	108 500	25 148 270	791 555
<b>Total (US\$)</b>	<b>154 296 543</b>	<b>247 791 629</b>	<b>2 992 129</b>

**Ethiopian Beneficiaries of HIV Spending, by Agent (EFY 2004, US\$)**

Agent - Beneficiary	PLWHA	CSW	OVCs & Vulnerable groups	Other groups	General Population	Non-targeted	Total (US\$, 2011)
Public Agent	75 962 963	21 636	822 148	2 774 286	44 985 215	26 912 786	151 479 034
NGO / Business Agent	4 704 319	8 802	5 276 490	364 867	565 620	1 177 033	12 097 131
External Agent	81 036 443	1 259 120	29 256 860	3 035 885	52 423 579	74 492 251	241 504 138
<b>Total</b>	<b>161 703 725</b>	<b>1 289 558</b>	<b>35 355 498</b>	<b>6 175 038</b>	<b>97 974 414</b>	<b>102 582 070</b>	<b>405 080 303</b>

## Spending by Thematic Area by GoE, PEPFAR and GF (US\$ millions, %, EFY 2004)

NASA ASC	Public (total)	PEPFAR	GF	Total
BCC	432 228		479 946	912 174
Community mobilization	1 737		779 977	781 714
VCT	15 056	5 400 247	6 701 876	11 954 063
Risk-reduction for vulnerable and accessible populati	454 069		316 953	771 022
Workplace programmes	102 519		4 497	107 016
Condoms	12 424		803 689	816 113
PMTCT	61 043	10 509 431	172 326	10 637 933
VMMC		192 009		192 009
Blood safety			192 490	192 490
Post-exposure prophylaxis (PEP)		87 796		87 796
Prevention activities not disaggreg.	23 755 211	18 747 433		41 920 460
<b>Prevention</b>	<b>24 834 287</b>	<b>34 936 916</b>	<b>9 451 754</b>	<b>68 372 790</b>
PITC		3 983 608	7 602 110	11 421 405
OI outpatient prophylaxis and treatment			828 546	828 546
ART	2 065 883	21 971 388	44 687 248	68 724 519
Nutritional support associated with ART	3 189	8 680 804		8 683 993
HIV-related laboratory monitoring		13 924 221		13 623 261
Psychological treatment and support services		2 298 202		2 298 202
Outpatient palliative care	1 067		160 784	161 851
Home-based care	175	786 246	74 773	861 194
Outpatient care not disagg. (some MOH data)	9 876 834	5 274 894		15 151 728
Inpatient care services not disaggreg. (MOH data)	1 092 150			1 092 150
Care and treatment services not disaggreg.	14 506			14 506
<b>Care and treatment</b>	<b>13 053 804</b>	<b>56 919 363</b>	<b>53 353 461</b>	<b>122 861 355</b>
<b>OVC</b>	<b>429 704</b>	<b>11 994 177</b>	<b>3 691 257</b>	<b>16 089 880</b>
Planning, coordination and Pg.Mgmt	9 441 460	22 402 387	2 438 107	34 281 954
Admin. & transaction costs assoc. with managing & i	92 745	13 077 489	6 377 782	19 548 016
Monitoring and evaluation	307 882	14 310 653	2 522 663	17 141 198
Serological-surveillance (serosurveillance)	1 234 604	941 867		2 176 471
HIV drug-resistance surveillance			29 371	29 371
Drug supply systems	1 456	5 298 646	855 685	6 155 787
Information technology		6 910 123		6 910 123
Patient tracking			53 103	53 103
Upgrading and construction of infrastructure	4 447 493	1 837 620	16 837 923	23 068 358
<b>Nat. Systems Strengthening &amp; Prog. managmt</b>	<b>15 525 640</b>	<b>64 778 785</b>	<b>29 114 634</b>	<b>109 364 381</b>
<b>Human resources Capacity Building</b>	<b>525 996</b>	<b>6 406 760</b>	<b>6 847 243</b>	<b>13 779 999</b>
Monetary benefits	9 230		1 126	10 356
In-kind benefits		611 966	703 116	1 315 082
HIV-specific IGAs		5 945 194	2 006 603	7 951 878
Social protection services not disaggreg.			7 817	7 817
<b>Social protection and social services (excluding OVC)</b>	<b>9 230</b>	<b>6 557 160</b>	<b>2 718 662</b>	<b>9 285 133</b>
<b>Enabling environment</b>		<b>25 470 308</b>	<b>4 931</b>	<b>25 475 239</b>
<b>HIV-related research (excluding operations research)</b>			<b>8 610</b>	<b>8 610</b>
<b>Total</b>	<b>54 378 661</b>	<b>207 063 469</b>	<b>105 190 552</b>	<b>365 237 387</b>
	54 378 742	207 063 469	105 190 860	365 237 695

NB. GF and PEPFAR did not report much on research and surveillance – these figures were confirmed by both sources as correct.

**Ethiopia HIV Providers by Beneficiary groups (EFY 2004)**

Providers	Beneficiary groups						Totals (US\$)
	PLWHA	CSW	OVCs & Vuln.Pops	Accessible pops.	General Pop.	Non-Targeted	
Public	75 812 908	68 720	590 880	3 643 205	46 351 445	27 829 387	154 296 545
Private	85 389 586	1 219 307	34 423 296	2 507 072	50 977 680	73 142 518	247 659 459
External	501 231	1 531	341 322	24 761	645 289	1 477 995	2 992 129,00
<b>Totals</b>	<b>161 703 725</b>	<b>1 289 558</b>	<b>35 355 498</b>	<b>6 175 038</b>	<b>97 974 414</b>	<b>102 449 900</b>	<b>405 080 303</b>
% Share	39,9%	0,3%	8,7%	1,5%	24,2%	25,3%	100,0%

**Ethiopian HIV Activities by Beneficiary groups (EFY 2004, US\$)**

Activities	Beneficiary group						Totals (US\$)
	PLWHA	CSW	OVC & Vuln.Pops	Access. Pops.	General Pop.	Non-Targeted	
Prevention	4 714 245	40 249	7 165 686	2 691 045	64 385 811	-	78 997 036
Treatment & Care	112 653 083	9 518	500 759	24 121	12 073 124	-	125 336 451
OVC Support	103 673	-	27 412 449	-	225	-	27 519 316
Programme Mgmt	21 939 868	1 095 310	85 664	13 009	4 282 857	92 692 289	120 108 997
Human Resource Development	2 554 754	36 631	112 836	3 417 906	317 154	9 655 778	16 148 414
Social protection	10 203 940	107 850	52 925	6 562	219 006	-	10 590 283
Enabling Environmt	9 474 107	-	21 761	15 962	16 620 025	-	26 131 855
Research	60 055	-	3 418	6 433	76 212	101 833	247 951
<b>Totals</b>	<b>161 703 725</b>	<b>1 289 558</b>	<b>35 355 498</b>	<b>6 175 038</b>	<b>97 974 414</b>	<b>102 449 900</b>	<b>405 080 303</b>
% of Total	39,9%	0,3%	8,7%	1,5%	24,2%	25,3%	

**Regional HIV Spending showing Total and PEPFAR Split (US\$, %, EFY 2004)**

Region	Total US\$ (2004)	Total % Share	PEPFAR %
Tigray	21 220 749	6,3%	8%
Addis Ababa	42 965 847	12,8%	12%
Amhara	44 507 678	13,3%	17%
Oromiya	37 220 259	11,1%	18%
South Region	25 498 244	7,6%	10%
Afar	3 126 073	0,9%	2%
B/G	2 359 269	0,7%	1%
Dire-Dawa	5 389 335	1,6%	3%
Gambella	2 320 491	0,7%	1%
Harari	2 070 046	0,6%	1%
Somali	2 774 698	0,8%	2%
Federal / Central	145 100 671	43,4%	24%
<b>Total</b>	<b>334 553 360</b>	<b>100,0%</b>	<b>100%</b>

## Appendix B: NASA Response Rates in the Different Sectors

### Federal Public Entities Interviewed & Data Collected

Public Federal Entities	Interviewed	Data collected
MoFED	Y	Y
MoH	Y	Y - NHA est.
Ministry of Education	Y	Y
Pharmaceuticals Fund and Supply Agency	Y	N
CETU	Y	Y
Ministry of agriculture	Y	Y
Ministry of Mine	Y	Y
Ministry of Water and Energy	Y	Y
Ministry of Transport	Y	Y
National Lottery Administration	Y	Y
Ministry of Women, Children and Youth Affairs	Y	Y
Ministry of Defense	Y	Y
Ministry of Labor and Social Affairs	Y	Y
Federal Police Commission	Y	N
Ethiopian Electric Power Corporation	Y	Y
Ethiopian Roads Authority	Y	Y
Ethiopian Health and Nutrition Research Institute	Y	N
Transport Authority	Y	Y
	<b>18</b>	<b>14</b>
		78%

### Regional Respondents and Data Status

			# of Entities/ 31 Orgs	Interviewed	Data collected
NGOs	Addis Abba	International	105	69	38
		Local	229	179	73
	Oromia	Local	39	37	11
	Tigray	Local	11	10	7
	Amahara	Local	40	38	20
	SNNPR	Local	27	25	23
	Dire Dawa	Local	6	4	4
	Hareri	Local	7	7	3
	Somali	Local	6	6	5
	B/G	Local	5	4	2
	Gambela	Local	18	18	6
	Afar	Local	4	4	4
Government Sectors	Federal Govt Se	18	18	14	
	Addis Ababa Re	10	10	8	
	Oromia Region	18	18	17	
	Tigray	15	15	11	
	Amhara	23	23	19	
	SNNPR	10	10	9	
	Dire Dawa	11	11	11	
	Harari	4	4	2	
	Gambela	1	1	1	
	Somali	8	8	3	
	Afar	3	3	3	
	B/G	7	7	6	
Business	Private	11	9	4	
	Parastatal	11	8	4	
	Total	647	546	308	



## Businesses Interviewed and Data Collected

Businesses Interviewed		Data Provided
Ethiopian Pharnaceutical Mmanufacturing S.C	Private	Y
Mesfin Indestrial Factory	Private	Y
Mosobo Cement Factory	Private	Y
Babile Factory	Private	N
Harrer Beer factory	Private	N
MIDROC	Private	N
MOHA soft drink factory	Private	Y
Awash Winery	Private	N
St. George Beer factory	Private	N
Bahirdar textile Factory	Parastatal	Y
Berhaneena Selam Printing Enterprise	Parastatal	Y
Bahirdar textile Factory	Parastatal	Y
Walia Cross Country	Parastatal	N
Ambesa City Bus	Parastatal	Y
Ethiopian Tele Communication	Parastatal	N
Ethiopian airlines	Parastatal	N
Water works Construction Enterprise	Parastatal	N
<b>Total Interviewed = 17. Total data provided = 8</b>		<b>47%</b>

## Appendix C: Cross-walking the NASA Spending categories to the Investment Approach

2. Critical Enablers	Other NASA expenditure not included in the Investment Framework
ASC.01.02 Community mobilization	ASC.01.07.98/99 Prevention of HIV transmission aimed at PLHIV not disaggregated by type and n.e.c.
ASC.01.03 Voluntary counselling and testing (VCT)	ASC.01.11 Prevention programmes in the workplace
ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations	ASC.01.15 Microbicides
ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible populations	ASC.01.20 Safe medical injections
ASC.01.07.03 STI prevention and treatment as part of prevention of HIV transmission aimed at PLHIV	ASC.01.21 Universal precautions
ASC.01.11.01 VCT as part of programmes in the workplace	ASC.01.22 Post-exposure prophylaxis (PEP)
ASC.01.11.03 STI prevention and treatment as part of programmes in the workplace	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds
ASC.02.01.04 Nutritional support associated to ARV therapy	ASC.04.05 Serological-surveillance (serosurveillance)
ASC.02.01.07 Psychological treatment and support services	ASC.04.06 HIV drug-resistance surveillance
ASC.02.01.08 Outpatient palliative care	ASC.04.07 Drug supply systems
ASC.02.01.09 Home-based care (medical and non medical)	ASC.04.08 Information technology
ASC.02.01.10 Traditional medicine and informal care and treatment services	ASC.04.10 Upgrading and construction of infrastructure
ASC.02.01.98/99 Outpatient care services not disaggregated by intervention	ASC.04.09 Patient tracking
ASC.04.01 Planning, coordination and programme management	ASC.05.02 Formative education to build-up an HIV workforce
ASC.04.03 Monitoring and evaluation	ASC.05.03 Training
ASC.04.04 Operations research	
ASC.07.01 Advocacy	
ASC.07.99 Enabling environment n.e.c.	
ASC.08 HIV and AIDS-related research (excluding operations research )	
<b>3. Synergies with development sectors</b>	
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 disaggregated by type	
ASC.06.99 Social protection services and social services n.e.c.	
ASC.07.04 AIDS-specific programmes focused on women	
ASC.07.05 Programmes to reduce Gender Based Violence	

The 'other NASA' categories for SA were mostly training, Post-exposure prophylaxis, upgrading and construction of infrastructure, prevention programmes in the workplace and for people living with HIV.

## Appendix D: Crosswalk of NASA categories to the SMP II Categories

THEMATIC AREAS, STRATEGIES & INTERVENTIONS	SUGGESTED NASA CODE
<b>1. CREATING ENABLING ENVIRONMENT</b>	ASC.07.98 Enabling environment not disaggregated by type
<i>1.1. Capacity Building:</i>	
Support the expansion of health centres.	ASC.04.10.02 Construction/ upgrading of health centres
Support universities and colleges to provide pre-service training for health science students.	ASC.05.02 Formative education to build-up an HIV workforce
Train health workers on HIV/AIDS.	ASC.05.03 Training
Staff key sectors with experts on prevention and impact mitigation.	Select the appropriate ASC for the function that the expert is supporting
Provide support to federal sectors to build the capacity of regional sectors on HIV.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Prepare health facilities for people with disability.	ASC.04.10.02 Construction/ upgrading of health centres
Build the capacity of networks of associations of PLHIV, OVC, elderly people, people with disability, CSOs and FBOs.	ASC.07.03 AIDS-specific institutional development/ strengthening / support / networking
Provide support to associations of PLHIV, OVC, the elderly, people with disability, CSOs and FBOs.	ASC.07.03 AIDS-specific institutional development/ strengthening / support / networking
	ASC.01.02 Community mobilization / Sensitisation / Awareness / Anti-Stigma
<i>1.2. Community mobilisation and empowerment:</i>	
Train community leaders.	ASC.01.02 Community mobilization / Sensitisation / Awareness / Anti-Stigma
Conduct community conversation.	ASC.01.02 Community mobilization / Sensitisation / Awareness / Anti-Stigma
Enforce relevant community by-laws.	ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment
Train Health Extension Workers (HEW) on Behavioural Change Communication (BCC).	ASC.05.03 Training
Train community anti-AIDS promoters from model households.	ASC.05.03 Training
Train health development armies (DA) on BCC.	ASC.05.03 Training
Strengthen Kebeles to provide support to community anti-AIDS movement.	ASC.01.02 Community mobilization / Sensitisation / Awareness / Anti-Stigma
Document, share and scale-up best practices.	ASC.07.02.03 Capacity & knowledge building in human rights & best practices

<i>1.3.. Leadership and governance:</i>	ASC.05.98 Human resources not disaggregated by type
Provide training on strategic leadership on the fight against HIV/AIDS to leadership and governing bodies.	ASC.05.03 Training
Select and document best practices.	ASC.07.02.03 Capacity & knowledge building in human rights & best practices
Arrange experience sharing visits for leadership and governing bodies from the regions.	ASC.05.03 Training
Disseminate annual performance reports and analytical reports on the epidemic and response.	ASC.04.03 Monitoring and evaluation
Establish AIDS Resource Centres (ARC) in the federal and regional parliament.	ASC.07.03 AIDS-specific institutional development/ strengthening / support / networking
Provide oversight in the inclusion of HIV/AIDS plans in the overall sectors' plans.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Conduct periodic review by the parliament and other governing bodies.	ASC.04.03 Monitoring and evaluation
<i>1.4. Mainstreaming:</i>	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Conduct assessment on vulnerability and impact of HIV/AIDS and the capacity of the existing response.	ASC.08.03 Epidemiological research AND/OR ASC.04.04 Operations research
Develop sector specific policies, strategies and plans on HIV/AIDS.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Establish a unit for mainstreaming HIV/AIDS in both public and non-public sectors.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Ensure allocation of resources by all sectors for HIV/AIDS mainstreaming.	ASC.04.03 Monitoring and evaluation
Incorporate monitoring and evaluation of HIV/AIDS into sectors' MIS.	ASC.04.03 Monitoring and evaluation
<i>1.5. Coordination and partnership:</i>	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Provide training on coordination.	ASC.05.03 Training
Develop a joint annual plan guided by SPM II.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Institute one national multisectoral monitoring and evaluation system.	ASC.04.03 Monitoring and evaluation
Develop partnership guidelines.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Establish/ strengthen partnership forums at national, regional and woreda levels.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Strengthen partnerships for cross-boarder interventions.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Map HIV/AIDS service providers and stakeholders at all levels.	ASC.04.04 Operations research
Establish/ strengthen linkages and networking of HIV/AIDS services.	ASC.07.03 AIDS-specific institutional development/ strengthening / support / networking

<b>2. INTENSIFYING HIV PREVENTION</b>	ASC.01.98 Prevention activities not disaggregated by intervention
<b>2.1. Behavioural HIV Prevention Approach:</b>	
Strengthen community based HIV prevention interventions to address the general population.	ASC.01.02 Community mobilization / Sensitisation / Awareness / Anti-Stigma
Strengthen workplace HIV prevention interventions.	ASC.01.11.1 to ASC.01.11.04 depending on which workplace intervention, or ASC.01.11.98 if not disaggregated
Strengthen school based HIV prevention interventions.	ASC.01.05 Prevention – youth in school
Scale-up comprehensive prevention interventions addressing MARPs.	Depending on which MARP group & which specific intervention: from ASC.01.07.01 to ASC.01.10
Strengthen out-of-school youth HIV prevention programs.	ASC.01.06 Prevention – youth out-of-school
Intensify secondary prevention.	ASC.01.98 Prevention activities not disaggregated by intervention
Intensify HIV prevention in development schemes including new business opportunity locations.	ASC.01.11.1 to ASC.01.11.04 depending on which workplace intervention, or ASC.01.11.98 if not disaggregated
Scale-up HIV prevention among population groups with special needs.	ASC.01.04.01 - ASC.01.04.04 depending on the specific intervention, or ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type
<b>2.2. Structural HIV Prevention Approach:</b>	
Address gender inequality.	ASC.07.04 AIDS-specific programmes focused on women and/or gender
Reduce economic vulnerability.	ASC.06.04 HIV-specific income generation projects
Address socio-cultural factors.	ASC.07.99 Enabling environment n.e.c.
Protect human rights and provide legal support.	ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment
<b>2.3. Biomedical HIV Prevention Approach:</b>	
Ensure access and enhance uptake of HIV counselling and testing services.	ASC.01.03 Voluntary counselling and testing (VCT)
Ensure access and enhance uptake of PMTCT services.	ASC.01.17.99 PMTCT activities n.e.c.
Increase availability and utilization of STI services.	ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)
Increase supply, distribution and utilization of male and female condoms.	ASC.01.13 Public and commercial sector male condom provision OR ASC.01.14 Public and commercial sector female condom provision
Ensure infection prevention and safe blood supplies in health system.	ASC.01.19 Blood safety OR ASC.01.20 Safe medical injections OR ASC.01.21 Universal precautions
Avail post exposure prophylaxis (PEP).	ASC.01.22.01 PEP in health care setting OR ASC.01.22.02 PEP in health care setting OR ASC.01.22.03 PEP after high risk exposure (violence or rape) OR ASC.01.22.03 PEP after unprotected sex OR ASC.01.22.98 Post-exposure prophylaxis not disaggregated by intervention
Accelerate male circumcision, in areas needed.	ASC.01.18 Male circumcision
Provide user-friendly biomedical services to people with special needs and MARPs.	Depending on which MARP group & which specific intervention: from ASC.01.07.01 to ASC.01.10. OR ASC.01.04.01 - ASC.01.04.04 depending on the specific intervention for vulnerable groups, or ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type
Intensify positive prevention.	ASC.01.99 Prevention activities n.e.c. OR if referring to interventions aimed at PLHIV use: ASC.01.07.98 Prevention of HIV transmission aimed at PLHIV not disaggregated by type

<b>3. INCREASING ACCESS TO AND IMPROVING QUALITY OF CHRONIC CARE AND TREATMENT</b>	ASC.02.98 Care and treatment services not disaggregated by intervention
<i>3.1. Expand treatment and care services with strengthened service linkage and integration.</i>	
Provide training of health personnel on chronic care and treatment.	ASC.05.03 Training
Strengthen intra-and inter-facility service linkages by developing standard operating procedures	ASC.04.09 Patient tracking/ management / referral systems
Increase number of health facilities providing ART.	ASC.04.10.02 Construction/ upgrading of health centres
Develop and disseminate ART-related service package and training manual for people with disabilities	ASC.02.99 Care and treatment services n.e.c.
Integrate ART-related service package for people with disability in the existing health facilities.	ASC.02.99 Care and treatment services n.e.c.
<i>3.2. Improve TB/HIV collaborative activities.</i>	
Screen all diagnosed TB patients for HIV.	ASC.02.01.02.01 OI outpatient prophylaxis
Link HIV positive TB cases to HIV services.	ASC.04.09 Patient tracking/ management / referral systems
Screen all HIV positive cases for TB.	ASC.02.01.02.01 OI outpatient prophylaxis
Provide INH prophylaxis for eligible patients.	ASC.02.01.02.01 OI outpatient prophylaxis
Strengthen TB-HIV co-infection management.	ASC.04.09 Patient tracking/ management / referral systems
<i>3.3. Strengthen laboratory and referral systems.</i>	
Avail minimum laboratory services at chronic care sites.	ASC.04.10.01 Upgrading/improving laboratory infrastructure and new equipment
Strengthen preventive and curative maintenance (training, workshop and spare parts).	ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.
Strengthen quality assurance system.	ASC.04.03 Monitoring and evaluation
Strengthen laboratory information system.	ASC.04.10.01 Upgrading/improving laboratory infrastructure and new equipment
Build capacity of laboratory personnel.	ASC.05.03 Training
Strengthen HIV laboratory services.	ASC.04.10.01 Upgrading/improving laboratory infrastructure and new equipment
<i>3.4. Ensure availability of essential OI and ARV drugs and reagents.</i>	
Forecast the need for OI, ARVs and reagents.	ASC.04.07 Drug supply systems
Ensure timely procurement and distribution of OI and ARV drugs and reagents.	ASC.04.07 Drug supply systems
Expand warehouses.	ASC.04.07 Drug supply systems
Strengthen logistics management information system.	ASC.04.08 Information technology
Equip the supply management system with transportation services.	ASC.04.07 Drug supply systems

<b>3.5. Enhance treatment literacy and adherence counselling.</b>	
Develop and enforce guidelines on treatment literacy and adherence.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Strengthen adherence counselling by health care workers, case managers and adherence supporters.	ASC.02.99 Care and treatment services n.e.c.
Disseminate treatment literacy education through mass media.	ASC.01.01.01 Health-related communication for social and behavioural change
Institute periodic monitoring and follow-up of lost to follow-up patients.	ASC.04.09 Patient tracking/ management / referral systems
Provide ART training for service providers on user friendly service provision to people with disabilities.	ASC.02.99 Care and treatment services n.e.c.
Rollout ART services into private health facilities.	SELECT FROM ASC.02.01.03.01.01 TO ASC.02.01.03.02.98 DEPENDING ON IF ADULT OR PEAD, AND WHICH REGIMEN. OR ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment
Strengthen clinical mentoring.	ASC.04.09 Patient tracking/ management / referral systems
Increase number of adult and paediatric service beneficiaries receiving ART.	SELECT FROM ASC.02.01.03.01.01 TO ASC.02.01.03.02.98 DEPENDING ON IF ADULT OR PEAD, AND WHICH REGIMEN. OR ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment
<b>3.6. Strengthen provision of chronic care and treatment services in the private sector.</b>	
Map and create directory of private health facilities.	ASC.04.04 Operations research
Organize public-private partnership forum.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Develop and avail guidelines, which direct the process of providing chronic care and treatment service.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
<b>3.7. Address human resource issues.</b>	
Support higher learning institutions to provide pre-service HIV/AIDS training to all health science students.	ASC.05.02 Formative education to build-up an HIV workforce
Provide in-service training on HIV/AIDS in health sector.	ASC.05.03 Training
Strengthen task-shifting, clinical mentoring and supportive supervision.	ASC.05.99 Human resources n.e.c.
Train health facility leaders on HIV/AIDS program management and integration of services.	ASC.05.03 Training
Promote involvement of staff in health facilities to conduct operational research.	ASC.04.04 Operations research
<b>4. INTENSIFYING MITIGATION EFFORTS AGAINST THE EPIDEMIC</b>	ASC.06.98 Social protection services and social services not disaggregated by type
<b>4.1. Strengthen the involvement of local communities in care and support.</b>	
Strengthen and use existing community structures.	ASC.01.02 Community mobilization / Sensitisation / Awareness / Anti-Stigma
Map care and support needs in each Kebele with existing care and support projects and identify gaps.	ASC.04.04 Operations research
Provide care and support to OVC in their familial networks.	ASC.03.04 OVC Community support
<b>4.2. Enforce the provision of standardized care and support to OVC and PLHIV.</b>	
Develop OVC care and support standard and service delivery guidelines.	ASC.03.99 OVC services n.e.c.
Conduct OVC situational analysis and map OVC services.	ASC.04.04 Operations research
Develop referral networks among service providers.	ASC.07.03 AIDS-specific institutional development/ strengthening / support / networking
Strengthen school-based OVC support activities.	ASC.03.01 OVC Education
Provide home-based care services for PLHIV.	ASC.02.01.09.98 Home-based care not disaggregated by type
<b>4.3. Strengthen income generation activities to sustain the program.</b>	
Provide IGA support.	ASC.06.04 HIV-specific income generation projects
Follow and support IGA beneficiaries and create links to markets.	ASC.06.04 HIV-specific income generation projects

<b>5. STRENGTHENING THE GENERATION AND UTILISATION OF STRATEGIC INFORMATION</b>	ASC.04.03 Monitoring and evaluation
<i>5.1. Build the capacity for monitoring and evaluation.</i>	
Ensure availability of HIV/AIDS M and E HR capacity at multilevel.	ASC.04.03 Monitoring and evaluation
Develop M and E implementation manual and training manual.	ASC.04.03 Monitoring and evaluation
Conduct training for M and E officers.	ASC.04.03 Monitoring and evaluation
Establish/strengthen regional HIV M and E Technical Working Groups.	ASC.04.03 Monitoring and evaluation
<i>5.2. Institute a culture of evidence-based/informed decision-making.</i>	
Establish framework for generation and utilization of strategic information.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Enforce evidenced-based planning and prioritization.	ASC.04.01 Planning, policy devmt, coordination, management, mainstreaming, guideline/framework development
Conduct regular review of HIV programs performance.	ASC.04.03 Monitoring and evaluation
Establish database for HIV/AIDS M and E	ASC.04.03 Monitoring and evaluation
Conduct advocacy workshops on M and E at all levels.	ASC.04.03 Monitoring and evaluation
<i>5.3. Strengthen timely generation of strategic information.</i>	
Work with sectors to include HIV/AIDS indicators within their own monitoring and evaluation systems.	ASC.04.03 Monitoring and evaluation
Conduct HIV surveillance.	ASC.04.05 Serological-surveillance (serosurveillance)
Conduct effectiveness study on interventions.	ASC.04.04 Operations research
Identify priority research agendas and conduct research.	ASC.08.99 HIV and AIDS-related research activities n.e.c.
Develop and implement community based information system to be used at all levels.	ASC.04.03 Monitoring and evaluation
<i>5.4. Enhance dissemination and utilization of strategic information.</i>	
Disseminate research and evaluation findings regularly.	ASC.04.03 Monitoring and evaluation
Prepare, print and distribute HIV/AIDS M and E reports regularly.	ASC.04.03 Monitoring and evaluation
Prepare summary of key HIV evaluation and research findings and post reports on web sites.	ASC.04.03 Monitoring and evaluation
Document and disseminate best practices.	ASC.04.03 Monitoring and evaluation



# Appendix E: NASA Data Collection Tools

AREAS OF OPERATION: REGION/S	
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## HIV/AIDS SPENDING ASSESSMENT IN EHTIOPIA (NASA) FORM 1 FOR ALL SOURCES OF FUNDING FOR HIV/AIDS (External Partners/ Donors / Businesses / Insurance Companies / MOFED))

<b>Year of the expenditure estimate: 2011/ 12 (EFY2004) (NB. Please report years separately)</b>			
<b>Objectives of the form:</b> I. To identify the origin of the funds used or managed by your institution during the year under study. II. To identify the recipients of those funds.			
<b>Name of your Institution (Source of HIV/AIDS funds):</b>			
<b>1. Your organization's Financial Year: (if not calendar year, please provide 6mthly, or quarterly expenditure reports)</b>			
<b>2. Person to Contact (Name and Title):</b>			
<b>3. Address:</b>		<b>4. E-mail:</b>	
<b>5. Phone:</b>		<b>6. Fax:</b>	
	Type of Institution	X	NASA Code
<b>Type of institution:</b> Select category of institution with an "X" and put correct NASA code	6.1 Central (national) government		FS 01.01.01
	6.2 Provincial government office		FS 01.01.02
	6.3 District government office (local government or district)		FS 01.01.03
	6.4 Private-for-profit national (SA) / business / insurance scheme		FS 02.01
	6.5 Private-for-profit international		FS 03.04
	6.6 National / local CSO or CBO and FBO or non-FBO		FS 02.03
	6.7 International Foundation or NGO (eg ActionAid, Save the Children)		FS 03.03._____
	6.8 Bilateral Agency		FS 03.01._____
	6.9 Multilateral Agency		FS 03.02._____

**IF YOU/ THE SOURCE ALSO KNOWS THE DETAILED EXPENDITURES OF YOUR/ THEIR RECIPIENTS THEN ALSO Complete a Providers form (Form # 3) for each institution about what the funds were used for, in order to gain information on Functions, Beneficiary Populations and Production Factors. (NB. One Form 3 per provider/ recipient of funds).**

**Who completed this form?** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Time of starting interview:** \_\_\_\_\_ **Time of ending interview:** \_\_\_\_\_

# **GENERAL QUESTIONS RELATING TO 2011/12 (EFY2004)**

- a. Please briefly describe the key types of HIV/AIDS activities that you fund, support or deliver.  
(Interviewer required to ask specific activities according to the NASA code book and then code accordingly)

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## **2011/12 (EFY2004) Recipients**

<b>7. A. To whom did your Organization give / send funds for HIV/AIDS services in SA (recipients of your funds) in 2011/12 (EFY2004):</b>		
<p>I. List the institutions to which funds were transferred during the year under study.</p> <p>II. Quantify the transferred funds.</p> <p>III. Quantify the transferred funds <i>reported as spent</i> during the period under study. If no information is available regarding the amount spent, state "No Data" in the cell.</p>		
Destination of the funds (Name of the Institution and Person to Contact) <b>2011/12 (EFY2004)</b>	Funds transferred (indicate currency & amount)	Funds <u>spent</u>
i. Institution:  Provinces of Operation:  Contact Person:		
ii. Institution:  Provinces of Operation:  Contact:		
iii. Institution:  Provinces of Operation:  Contact:		
iv. Institution:  Provinces of Operation:  Contact:		
v. Institution:  Provinces of Operation:  Contact:		
<b>TOTAL:</b>		

**2011/12 (EFY2004) Recipients cont.**

<b>7B. Recipients of non financial resources (donated goods):</b> List the institutions to which your agency donated non-financial resources, during <b>2011/12 (EFY2004)</b> .			
Recipients of the non financial resources (Name of the Institution and Person to Contact) <b>2011/12 (EFY2004)</b>	Type of Goods donated & Quantity Received	Monetary Value of One Unit in Year of Assmnt (& Currency)	TOTAL Monetary Value in Year Assmnt (& Currency)
vi. Institution:  Provinces of Operation:  Contact Person:			
vii. Institution:  Provinces of Operation:  Contact:			
viii. Institution:  Provinces of Operation:  Contact:			
ix. Institution:  Provinces of Operation:  Contact:			
x. Institution:  Provinces of Operation:  Contact:			
xi. Institution:  Provinces of Operation:  Contact:   <div align="right"><b>TOTAL VALUE:</b></div>			

**If you know how the funds were spent by your recipients in 2011/12 (EFY2004), please complete a Providers form (Form # 3) for each institution to whom you sent funds, in order to gain information on Functions & Beneficiary Populations.**

#### GENERAL QUALITATIVE QUESTIONS RELATING TO 2011/12 (EFY2004)

- a. Please describe how institutions apply and access funds from your institution. Please describe the funding flow mechanisms.
1. They write a proposal responding to tender adverts in the newspapers and wait to get the funds for implementation when we win the tender
  2. They write a proposal and when we are successful, we are given a contract to start implementation and then get reimbursed as we present invoices & receipts
  3. We request organizations to develop a proposal
  4. Other , please explain \_\_\_\_\_
- b. What are the conditionalities that your institution insists upon in transferring funds to Organizations?
- 1 NPOs must be registered
  - 2 Should have be in operation for not less than 3 years
  - 3 Should have the capacity to implement HIV/AIDS activities in terms of human resources and equipment
  - 4 NPOs should have a coordinator and a finance administrator
  - 5 NPOs should have at least 15 caregivers
  - 6 Should have a clear record of previous financial audited reports
  - 7 Others, please explain \_\_\_\_\_
- c. What are the reporting requirements for organizations receiving funds from your institution (in terms of frequency and content)
1. Report on data collection based on DHIS
  2. Report on a monthly basis and have an annual aggregated report at the end of the year
  3. Report on a monthly, quarterly and annual basis
  4. Report only operational performance, i.e activities implemented
  5. Report both financial and operational performances, i.e expenditure and activities implemented
  6. Others, please explain \_\_\_\_\_
- d. What are the key difficulties faced by recipient organizations in efficiently spending the funds transferred to them by your institution?
1. They struggle to work within allocated budgets
  2. Some organizations do not have the capacity to absorb the funds
  3. Sometimes funds are transferred later than expected
  4. Some organizations do not meet the expected requirement on time thus delay the processes of disbursement and implementation of activities
  5. Others, please explain \_\_\_\_\_
- e. What are the key challenges/ bottlenecks related to funding for HIV/AIDS services?
1. Funds are usually not sufficient for all HIV/AIDS activities
  2. Some funds are ear-marked and specific for particular HIV services
  3. Duplication of resources are common especially when different funders are not harmonizing their activities with the public system
  4. HIV/AIDS funds have been cut down and more many allocated to health systems strengthening
  5. Others, please clarify \_\_\_\_\_

f. Any other comments, suggestions etc.?

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THANK YOU.

**HIV/AIDS SPENDING ASSESSMENT IN ETHIOPIA (NASA)**  
**FORM 2 FOR ALL AGENTS OF FUNDING FOR HIV/AIDS**  
**(Entities which receive funds and transfer them to other service providers.**  
**Eg. CCM, HAPCO, MOH, CDC)**

<b>Year of the expenditure estimate: 2011/12 (EFY2004) (NB. Please report years separately)</b>			
<b>Objectives of the form:</b> I. To identify the origin of the funds used or managed by your institution during the year under study. II. To identify the recipients of those funds.			
<b>Name of your Institution (Agent for HIV/AIDS funds):</b>			
<b>1. Your organisation's Financial Year:</b>			
<b>2. Person to Contact (Name and Title):</b>			
<b>3. Address:</b>		<b>4. E-mail:</b>	
<b>5. Phone:</b>		<b>6. Fax:</b>	
	<b>Type of Institution</b>	<b>X</b>	<b>NASA Code</b>
<b>Type of institution:</b> Select category of institution with an "X" & give correct NASA code	Central (national) government		
	Provincial government office		
	District government office (local government or district)		
	FHAPCO or RHAPCO		<b>FA 01.01.01.10 or FA 01.01.02.06</b>
	Private-for-profit national / business / insurance scheme		<b>FA 02.06</b>
	Private-for-profit international		<b>FA 03.04</b>
	National / local CSO or CBO and FBO or non-FBO		
	International NGO (eg ActionAid, Save the Children)		
	Bilateral Agency		
	Multilateral Agency		

**If the Agent also provides services itself, then these services and expenditures are captured in Form 3. Also all the overhead (operational, running) costs of the AGENTS must be captured in form 3 under the identified activities/ services provided by the Agent.**

**IF THE AGENT KNOWS THE DETAILED EXPENDITURES OF THEIR RECIPIENTS THEN ALSO Complete a Providers form (Form # 3) for each institution about which the Source / Agent has information regarding what the funds were used for (NB. One Form 3 per provider/ recipient of funds).**

**Who completed this form?** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Time of starting:** \_\_\_\_\_ **Time of ending interview:** \_\_\_\_\_

*HIV/AIDS Activities Supported/ Provided*

Please briefly describe to me the kinds of HIV/AIDS activities in Ethiopia that you fund, support or deliver.

**NB. the activities that you deliver yourself must be captured separately in Form 3.**

**(Interviewer required to ask specific activities according to the NASA code book and then code accordingly)**

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**PAGES 3 AND 4 RELATE TO 2011/12 (EFY2004)**

**7. Origin and Destination of the funds transferred to other orgs in 2011/12 (EFY2004):** List the institutions from which your agency received funds during the year under study, and the organization to whom you transferred those funds.

<b>ORIGIN OF FUNDS (2011/12 (EFY2004))</b> (If more sources than rows provided please use another form, labeled clearly)		<b>DESTINATION OF FUNDS (2011/12 (EFY2004))</b> (If there were more than 2 Recipients for a Particular Source, please move to next row)			
Origins of the funds (Name of the Institution and Person to Contact)	Funds received (Indicate currency, BIRR or US\$ or Euros)	Organizations to Whom these Funds were Sent	Amount transferred (Indicate Currency)	Organizations to Whom these Funds were Sent	Amount transferred (Indicate Currency)
i. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
ii. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
iii. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
iv. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
v. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
vi. Institution: Contact:		Institution: Regions of Operation:		Institution: Regions of Operation:	
<b>TOTAL:</b>					

### 2011/12 (EFY2004) Non-Financial Goods

**7b. Origins and Destinations of non financial resources (donated goods) in 2011/12 (EFY2004):** List the institutions from which your agency received non financial resources, during .

Origins of the non financial resources (Name of the Institution and Person to Contact)	Type of Resource provided & Quantity	Total Monetary Value of Items Provided (& Currency)	Destination of the Non-Financial Goods (Name of the Institution and Person to Contact)	
vii. Institution:  Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
viii. Institution:  Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
ix. Institution:  Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
x. Institution:  Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
xi. Institution:  Contact:			Institution: Regions of Operation:	Institution: Regions of Operation:
<b>TOTAL:</b>				

**If you know how the funds were spent by your recipients, please** complete a Providers form (Form # 3) for each institution to whom you sent funds, in order to gain information on Functions, Beneficiary Populations.

**HIV/AIDS SPENDING ASSESSMENT IN ETHIOPIA (NASA)**  
**FORM 3 FOR ALL PROVIDERS OF HIV/AIDS SERVICES**  
**(Public, NPO, Private for Profit Agents which also deliver services)**

<b>Year of the expenditure estimate: 2011/ 12 (EFY2004) (NB. Please report years separately)</b>			
<b>Objectives of data collection from the Provider:</b> III. To identify the origin of the funds spent by the provider in the year under study. IV. To identify in which NASA Functions/ activities the funds were spent. V. To identify the NASA Beneficiary Populations for each NASA Function/ activity. VI. To identify the NASA Production Factors for each Function/ activity.			
<b>Name of the Organization Providing HIV/AIDS Services:</b>			
<b>8. Person to Contact (Name and Title):</b>			
<b>Address:</b>		<b>E-mail:</b>	
<b>Phone:</b>		<b>Fax:</b> <b>NASA code</b>	
<b>9. Type of institution:</b> Select category of institution with an "X" & put NASA code	1. Public central (national) government		
	2. Public provincial government		
	3. Public local government (or district)		
	4. FHAPCO or RHAPCO		<b>PS 01.01.14.01 or PS 01.99</b>
	5. Private-for-profit national (business)		<b>FS 02.01</b>
	6. Private-for-profit international businesses		<b>FS 03.04</b>
	7. Local (Ethiopian) CSO or CBO and FBO or non-FBO		
	8. Non-profit research inst (Ethiopian)		
	9. For-Profit Research inst.		
	10. International NGO/CSO (eg. ActionAid, Save the Children)		
	11. Bilateral Agency		
	12. Multilateral Agency		
	13. Other (specify):		
<b>In which Currency will you present your Expenditure data?</b>			

**Please could all Service Providers ALSO provide electronic or hard copies of their monthly expenditure records for 2011/12 (EFY2004), – presented by source/ funder and by programme / activity.**

**Who completed this form?** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Time of starting:** \_\_\_\_\_ **Time of ending interview:** \_\_\_\_\_

- a. Please briefly identify the key HIV/AIDS activities / services that your organization undertakes / provides.  
 (Interviewer required to ask specific activities according to the NASA code book and then code accordingly)

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### 2011/12 (EFY2004) Income

**10.A. Origin/ Source of the funds your organization received in 2011/12 (EFY2004):** List the institutions that gave your organisation funds which you spent during 2011/12 (EFY2004).  
For each source indicate who was the agent – who decided on what the funds are to be spent.

Source and Agent of the funds (Name of the Institution and Person to Contact)		Funds received during the year under study (Indicate currency for each amount)
xii.	Source:  Agent: (Ask who makes decisions on the use of funds for this source & code accordingly)	
xiii.	Source:  Agent:	
xiv.	Source:  Agent:	
xv.	Source:  Agent:	
xvi.	Source:  Agent:	
TOTAL:		

**3B. Origin of non financial resources (donated goods) in 2011/12 (EFY2004):** List the institutions that granted *non financial* resources during 2011/12 (EFY2004).

Origin of the non financial resources (Name of the Institution and Person to Contact)	Type of Resource received & Quantity	Monetary Value of ONE Item (in Year of Assessment)	Total Monetary Value of Items Received (& Currency)
xvi. Institution:			
xviii. Institution:			
xix. Institution:			
xx. Institution:			
xxi. Institution:			
<b>TOTAL:</b>			

## 2011/12 (EFY2004) Expenditure

<b>11. Use of the funds your organization received for services delivered in 2011/12 (EFY2004):</b> IV. Identify and quantify the NASA Functions in which the funds were spent. V. Identify and quantify the NASA Beneficiary Population(s) of each Function. VI. Disaggregate the beneficiaries by Gender and Adult/Child, if possible VII. Please include your overheads & management/support costs (shared or total)		
<b>Expenditure of the funds received from "i" = Source &amp; Amount =</b>		
<b>Function (Activity) 1 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benef:	
Beneficiary Population:	Nos Of Benef:	
<b>Function (Activity) 2 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benef:	
Beneficiary Population:	Nos Of Benef:	
<b>Function (Activity) 3 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benef:	
Beneficiary Population:	Nos Of Benef:	
<b>Function (Activity) 4 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benef:	
Beneficiary Population:	Nos Of Benef:	
Overheads/ admin /support costs (if not already included in the above)		
<b>Total Expenditure from the amount from 'i'</b>		
<b>Total un/overspent from the amount from 'i'</b>		

**If funds were under- or over-spent from 'i' what are the reasons for this?**

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<b>Expenditure of the funds received from "ii" = Source &amp; Amount =</b>		
<b>Function (Activity) 1 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benef:	

Beneficiary Population:	Nos Of Benefits:	
<b>Function (Activity) 2 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefits:	
Beneficiary Population:	Nos Of Benefits:	
<b>Function (Activity) 3 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefits:	
Beneficiary Population:	Nos Of Benefits:	
<b>Function (Activity) 4 (describe &amp; code later):</b>		Amount spent (BIRR)
<b>District of implementation:</b>	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefits:	
Beneficiary Population:	Nos Of Benefits:	
Overheads/ admin /support costs (if not already included in the above)		
Total Expenditure from the amount from 'ii'		
Total un/overspent from the amount from 'ii'		

**If funds were under- or over-spent from 'ii' what are the reasons for this?**

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**For the other sources (iii etc), please complete additional expenditure sheets and staple to this form.**

**2011/12 (EFY2004) Use of Non-Financial Goods**  
**NON-FINANCIAL (DONATED) GOODS – INDICATE HOW THESE WERE USED in 2011/12 (EFY2004)**

Utilization of the <b>donated goods</b> received from "vi" = Source/ Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (BIRR)
District of implementation:	Total spent on this Activity/ Function:	
Function (Activity) 2 (describe & code later):		Amount spent (BIRR)
District of implementation:	Total spent on this Activity/ Function:	
Utilization of the <b>donated goods</b> received from "vii" = Source/ Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (BIRR)
District of implementation:	Total spent on this Activity/ Function:	
Function (Activity) 2 (describe & code later):		Amount spent (BIRR)
District of implementation:	Total spent on this Activity/ Function:	
Utilization of the <b>donated goods</b> received from "viii" = Source/ Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (BIRR)
District of implementation:	Total spent on this Activity/ Function:	
Function (Activity) 2 (describe & code later):		Amount spent (BIRR)
District of implementation:	Total spent on this Activity/ Function:	

## ASC.01 PREVENTION

Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Results include a decrease in HIV infections among the population and improvements in quality and safety in health facilities with regard to therapies administered exclusively or in large part to HIV patients. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals.

**ASC.01.01 Communication for social and behaviour change:** Programmes that focus on social change and social determinants of individual change. A campaign for social and behaviour change provides general information addressing regions, states or countries. This entry includes, but is not limited to, brochures, pamphlets, handbooks, posters, newspaper or magazine articles, comic books, TV or radio shows or spots, songs, dramas or interactive theatre. This category excludes condom social marketing as a result of an activity coded under *ASC.01.12 Condom social marketing* and any other information services which are part of any of the spending categories described as prevention programmes (mother-to-child transmission prevention programme, to reduce stigmatization or to promote access to voluntary counselling and testing), and any other communication for social and behaviour change recorded in prevention programmes: *ASC.01.04 Risk-reduction for vulnerable and accessible populations*, *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.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*, *ASC.01.11 Prevention programmes in the workplace*, *ASC.01.12 Condom social marketing*, *ASC.01.16 Prevention, diagnosis, and treatment of sexually transmitted infections (STI)* and *ASC.01.21 Male circumcision*.

*ASC.07.01 Advocacy* constitutes the locus for reporting non-health communication for social behaviour change programmes. When joint programmes comprise *health risks avoidance* messages and *non-health risks avoidance* messages which can be separated, additional digits may be introduced (with indication of the pro-rating methodology adopted):

**ASC.01.01.01 Health-related communication for social and behaviour change:** Programmes targeting the health risks of HIV prevention campaigns (e.g. ABC addressing general population<sup>14</sup>); campaigns with an explicit prevention purpose.

**ASC.01.01.02 Non-health-related communication for social and behaviour change:** Programmes targeting the non-health risks; addressed in HIV prevention campaigns and any other mass media-related activities whose contents are not within the boundaries of health (as described in NHA), and whose content is not recorded under ASC.07.

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<sup>14</sup> **ABC** is a set of prevention strategies and activities (including training) to promote abstinence, to delay sexual debut, and to promote fidelity and partner-reduction messages and related social and community norms. “ABC” activities include: (A) abstain from penetrative sexual intercourse (also used to indicate delay of sexual debut); (B) be faithful (reduce the number of partners or have sexual relations with only one partner); and (C) use condoms consistently and correctly. The (A) and (B) Components targeting the general population should be coded under *ASC.01.01 Communication for social and behaviour change*. The (C) component targeting general population should be coded under *ASC.01.12 Condom social marketing*. “ABC” activities targeting specific accessible or most-at-risk populations should be coded under the corresponding ASC’s (e.g. *ASC.01.04 Risk-reduction for vulnerable and accessible populations*, *ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)*, *ASC.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*, *ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes*).

**ASC.01.01.98 Communication for social and behaviour change not broken down by type:** Campaigns for which it is not possible to break down its contents as health or non-health.

**ASC.01.02 Community mobilization:** Activities that create community commitment and involvement in achieving programme goals. This includes, but is not limited to: involvement of community groups (e.g. neighbours of PLHIV or OVC) in programme planning and mobilization of community resources, peer education, including training of peer educators on prevention, support groups, and self-representation. These activities are aimed at behaviour change and risk reduction but are focused mainly on small communities' members rather than on the broader population. These activities are usually performed by the community members to target their own community.

**ASC.01.03 Voluntary counselling and testing (VCT)** (excluding VCT services targeted in: *ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations*, *01.08.01 VCT as part of programmes for sex workers and their clients*, *ASC.01.09 VCT as part of programmes for MSM*, *ASC.01.10.01 VCT as part of programmes for IDUs* and *ASC.01.11.01 VCT as part of programmes in the workplace* and *ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes*). This is the process by which an individual undergoes counselling, enabling them to make an informed choice about being tested for HIV.<sup>15</sup> Client-initiated confidential voluntary counselling and testing includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). All HIV testing must be carried out under the conditions of the three Cs: counselling, confidentiality, and informed consent. The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

Testing to identify people requiring treatment is included in the Treatment and Care section and should be coded as provider-initiated testing.

Counselling and testing in the context of preventing mother-to-child transmission is coded under prevention of mother-to-child transmission (PMTCT).

Tests performed on a mandatory basis as part of the employment policy or visa requirements are not recommended by UNAIDS and should be classified under *ASC. 04.13. Mandatory HIV testing (not VCT)*.

**ASC.01.04 Risk-reduction programmes for vulnerable and accessible populations<sup>16</sup>:** These populations include specific vulnerable groups such as indigenous groups, recruits, truck drivers, prisoners, and migrants. Special attention should be given to those people in situations of conflict, i.e. refugee situation and internal displacement. It excludes most at risk populations (MARPs) activities covered by categories *ASC.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*.

**ASC.01.04.01 VCT as part of programmes for the vulnerable and accessible population** includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

**ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible population** includes all the programme costs related to condom promotion and provision for vulnerable and accessible populations, not only the cost of the fungibles.

**ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible population**

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<sup>15</sup> Voluntary Counselling and Testing (VCT), UNAIDS Technical Update, May 2000.

<sup>16</sup> In the previous drafts of NASA Notebook this category was labelled as "Programmes for vulnerable and special populations".

**ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible population:** interventions aimed to promote risk reduction measures, including peer outreach.

**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 population not elsewhere classified (n.e.c.).**

**ASC.01.05 Prevention – youth in school:** Programmes that focus on young people enrolled in primary and secondary schools. Prevention programmes in school include a full complement of tools to prevent HIV transmission. These comprise a comprehensive, appropriate, evidence-based and skills-based sex education; youth-friendly health services offering core interventions for the prevention of transmission through unsafe drug injecting practices; and consistent access to male and female condoms. A critical element is the integration into school-based settings of life-skills-education programmes. Skills-based health education and interactive teaching methods have been shown to promote healthy lifestyles and to reduce risky behaviour. The life-skills-based HIV education in schools is a didactic and specific learning process that teaches young people to understand and assess the individual, social, and environmental factors that raise and lower the risk of HIV transmission. (Teacher training—when measurement is required—should be measured in accordance with the latest UNICEF guidelines.)<sup>7</sup> To track benefits, the accountant may wish to report expenditure on life-skills activities in both primary and secondary schools as a part of the education system spending (either independent or jointly with the health system). This programme should be coded and cross-classified with the specific beneficiary populations receiving the services, principally young people enrolled in primary and secondary schools (aged 6–11 and 12–15).

**ASC.01.06 Prevention – youth out of school:** Programmes that focus on young people aged between 6 and 15 out of school. The tools of these programmes are comprehensive, appropriate, evidence-based and skills-based sexual education; youth-friendly health services (through drop-in centres or outreach work) offering core interventions for the prevention of the transmission; and consistent access to male and female condoms. The cost of training peer educators for peer outreach working with youth out of school should be included under this category.

**ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV):** Programmes to reduce risky behaviours by infected people are aimed to decrease the rate of infection in the population. The goal is to empower people living with HIV to avoid acquiring new STIs and prevent the transmission of HIV to others. The programmatic interventions should be coded according to their characteristics as follows:

**ASC.01.07.01 Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV:** interventions aimed to promote risk reduction measures, including peer outreach.

**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 PLHIV**

**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 not elsewhere classified (n.e.c.)**

**ASC.01.08 Prevention programmes for sex workers and their clients:** Programmes to promote risk-reduction measures including outreach (including by peers), voluntary and confidential HIV counselling

and testing, prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs) and consistent access to male and female condoms. Interpersonal communication (face-to-face) to reach sex workers at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection. This programmatic activity should be coded and cross-classified with the specific population segment receiving the services: *BP.02.02 Sex workers (SW) and their clients*. The programmatic interventions should be coded according to their characteristics as follows:

**ASC.01.08.01 VCT as part of programmes for sex workers and their clients** includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

**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 sex workers and their clients:** interventions aimed to promote risk reduction measures, including peer outreach.

**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 not elsewhere classified (n.e.c.)**

**ASC.01.09 Programmes for men who have sex with men (MSM).** Programmes that focus on men who regularly or occasionally have sex with other men. These programmes include risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs). Interpersonal communication (face-to-face) to reach MSM at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection. This programmatic activity should be coded and cross-classified with the specific beneficiary populations receiving the services: *BP.02.03 Men who have sex with men (MSM)*. The programmatic interventions should be coded according to their characteristics as follows:

**ASC.01.09.01 VCT as part of programmes for men who have sex with men (MSM)** includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

**ASC.01.09.02 Condom social marketing and male and female condom provision as part of programmes for men who have sex with men (MSM)**

**ASC.01.09.03 STI prevention and treatment as part of programmes for men who have sex with men (MSM)**

**ASC.01.09.04 Behaviour change communication (BCC) as part of programmes for men who have sex with men (MSM):** interventions aimed to promote risk reduction measures, including peer outreach.



**ASC.01.09.98 Programmatic interventions for men who have sex with men (MSM) not broken down by type**

**ASC.01.09.99 Other programmatic interventions for men who have sex with men (MSM) not elsewhere classified (n.e.c.)**

**ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs):** Programmes that focus on reducing harm because of drug use and reducing risk of spread. They include a set of treatment options such as substitution treatment and the implementation of harm-reduction measures (peer outreach, and sterile needle and syringe programmes), voluntary and confidential HIV counselling and testing and prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs). This programmatic activity should be coded and cross-classified with the specific beneficiary populations receiving the services: *BP.02.01 Injecting drug users (IDU) and their sexual partners*. The programmatic interventions should be coded according to their characteristics as follows:

**ASC.01.10.01 VCT as part of programmes for injecting drug users (IDUs)** includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of VCT includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.

**ASC.01.10.02 Condom social marketing and male and female condom provision as part of programmes for injecting drug users (IDUs)**

**ASC.01.10.03 STI prevention and treatment as part of programmes for injecting drug users (IDUs)**

**ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for injecting drug users (IDUs):** interventions aimed to promote risk reduction measures, including peer outreach.

**ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for injecting drug users (IDUs)**

**ASC.01.10.06 Drug substitution treatment as part of programmes for injecting drug users (IDUs)**

**ASC.01.10.98 Programmatic interventions for injecting drug users (IDUs) not broken down by type**

**ASC.01.10.99 Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.)**

**ASC.01.11 Prevention programmes in the workplace:** Programmes that focus on reducing risk factors in the workplace. These provide HIV prevention services for employees and the families of employees including: male and female condom distribution, up-to-date information, education and communication on HIV prevention, peer education, and any other communication for behaviour change activities. The programmatic interventions should be coded according to their characteristics as follows:

**ASC.01.11.01 VCT as part of programmes in the workplace** includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT). The cost of VCT includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.

**ASC.01.11.02 Condom social marketing and male and female condom provision as part of programmes in the workplace**

### **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:** interventions aimed to promote risk reduction measures, including peer outreach.

### **ASC.01.11.98 Programmatic interventions in the workplace not broken down by type**

**ASC.01.11.99 Other programmatic interventions in the workplace not elsewhere classified (n.e.c.)**

**ASC.01.12 Condom social marketing** refers to programmes that make condoms more accessible and acceptable. They include public campaigns to promote the purchase and use of condoms and exclude commercials made by corporations and procurement programmes as a public service. Programmatic interventions to promote the use of condoms as part of programmes for vulnerable, accessible, and most-at-risk populations should be coded in their corresponding ASC (i.e.: *ASC.01.04 Risk-reduction for vulnerable and accessible populations*, *ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)*, *ASC.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*, *ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes*).

**ASC.01.13 Public and commercial sector male condom provision** refers to procurement of male condoms regardless of mode of distribution (cost-free, subsidized or commercially priced; accessibility to the general population or to specific groups). This includes the fungibles (condoms) and any other cost incurred in the distribution and provision. Nonetheless, not all the condoms distributed have a HIV prevention component (some people use condoms exclusively for birth control purposes). There are different approaches to estimate the expenditures on HIV-related condom use. One recommended approach is to use nationally available demographic surveys or sexual behaviour surveys to ascertain the fraction of condoms attributable exclusively to birth control. This fraction or percentage should then be subtracted from the total numbers of condoms estimated for ASC.01.13. Male condoms as part of specific programmes for key populations and populations at higher risk should not be coded in ASC.1.13, but on their corresponding ASC (i.e.: *ASC.01.04 Risk-reduction for vulnerable and accessible populations*, *ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)*, *ASC.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*, *ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes*).

**ASC.01.14 Public and commercial sector female condom provision** refers to procurement of female condoms regardless of the mode of distribution (cost-free, subsidized or commercially priced; accessibility to women). The fraction of female condoms attributable exclusively to birth control should be subtracted from the total numbers of condoms estimated for ASC.01.14 (as described in ASC.01.13). Female condom distribution as part of programmes for vulnerable, accessible, and most-at-risk populations should be coded in their corresponding ASC (i.e.: *ASC.01.04 Risk-reduction for vulnerable and accessible populations*, *ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)*, *ASC.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)*, *ASC.01.11 Prevention programmes in the workplace* and *ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes*).

**ASC.01.15 Microbicides** refers to procurement of compounds applied inside the vagina or rectum to confer protection against STI. Once these become available, the resource tracking team should identify investment in programmes, making microbicides available proven to be safe and an effective complement to prevent, or at least, reduce new HIV infections.

**ASC.01.16 Prevention, diagnosis, and treatment of sexually transmitted infections (STI):** Prevention and care services, including diagnosis and treatment, related to STIs. From a HIV perspective,

the treatment of STIs is coded as preventive (from a health system's perspective, this treatment is curative). The expenses for improved clinical management of STIs include medical consultations, tests, and treatment for syphilis, gonorrhoea, herpes, candidiasis, and trichomoniasis. This entry should be coded and cross-classified with the specific beneficiary populations receiving these services (e.g. *BP.04.01 People attending STI clinics*). The services comprised under this heading are programmes targeting the general population; services targeting specific population segments should be coded under: *ASC.01.04 Risk-reduction for vulnerable and accessible populations*, *ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)*, *ASC.01.08 Prevention programmes for sex workers and their clients*, *ASC.01.09 Programmes for men who have sex with men (MSM)*, *ASC.01.10 Harm-reduction programmes for injecting drug users (IDUs)* or under *ASC.01.11 Prevention programmes in the workplace*.

**ASC.01.17 Prevention of mother-to-child transmission (PMTCT)** refers to services aimed at avoiding mother-to-child HIV transmission. These include counselling and testing for pregnant women, antiretroviral prophylaxis for HIV-positive pregnant women and neonates, counselling and support for safe infant feeding practices. PMTCT-plus ARV-treatments should be coded under antiretroviral therapy (treatment after delivery) *ASC.02.01.03*. When a HIV-positive woman receives antiretroviral therapy before she knows she is pregnant and no change in the antiretroviral prescription occurs, the antiretroviral treatment should be included under *ASC.02.01.03 ARV therapy*. Cultural sensitivity leads some countries to label the service "parent-to-child transmission" to avoid stigmatizing pregnant women and to encourage male involvement in HIV prevention. Prevention of parent-to-child transmission then becomes PTCT. When adequate information is accessible, the position may be split, using another digit, between:

**ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes.** This category includes activities in which both HIV counselling and testing are accessed by pregnant women who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of this activity includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.

**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.** This includes delivery (both vaginal delivery and elective Caesarean section) and postpartum care as a part of PMTCT programmes.

**ASC.01.17.05 Condom social marketing and male and female condom provision as part of PMTCT programmes** performed on PMTCT sites and/or antenatal clinics aimed to prevent mother-to-child HIV or STI transmission during pregnancy or breastfeeding. This includes condoms and any other cost incurred in the distribution and provision.

**ASC.01.17.98 PMTCT activities not broken down by intervention**

**ASC.01.17.99 PMTCT activities not elsewhere classified (n.e.c.).**

**ASC.01.18 Male circumcision** refers to the removal of the prepuce or foreskin covering the tip of the penis. It is important to identify an intention to prevent HIV when performing the male circumcision. Male circumcisions are performed in many countries as a usual practice and not related to a particular HIV programmatic intervention. When male circumcisions are part of country-specific programmatic HIV prevention activities, the cost of these interventions should be recorded here. Expenditures related to the promotion of male circumcision as part of an HIV preventive programme, should also be accounted for here.

**ASC.01.19 Blood safety:** Blood safety (including blood products and donated organs) expenditures and investment in activities supporting a nationally coordinated blood programme to prevent HIV

transmission. This category included policies, infrastructure, equipment, and supplies for testing activities and management to ensure a safe supply of blood and blood products.

**ASC.01.20 Safe medical injections:** Medical transmission/injection safety targets the development of policies, in-service training, advocacy, and other activities to promote (medical) injection safety. They include distribution/supply chain, cost, and appropriate disposal of injection equipment and other related equipment and supplies. Only expenditure targeting the prevention of HIV transmission should be included.

**ASC.01.21 Universal precautions** (when the main or exclusive purpose to implement them is to limit HIV transmission) refer to the use of gloves, masks, and gowns by health care personnel to avoid HIV infection through contaminated blood. These are standard infection control practices to be used universally in health care settings to minimize the risk of exposure to pathogens, e.g. the use of gloves, barrier clothing, masks, and goggles to prevent exposure to tissue, blood and body fluids, waste-management systems (except disposal of injection equipment, tracked under *ASC.01.20 Safe medical injections*). This activity aims to target health care workers (*BP.04.05 Health care workers*). Universal precautions are shared across the health system and are not AIDS-specific. Expenditures within universal precautions are limited to those specifically aimed to prevent the transmission of HIV in health care facilities. Expenditure on safety procedures in blood banks may not be separable from the other costs incurred by that activity and are reported under *ASC.01.19 Blood safety*.

**ASC.01.22 Post-exposure prophylaxis (PEP).** This includes interventions and antiretroviral drugs after exposure to risk, which may be developed adding one digit as:

**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 type**

**ASC.01.22.99 Post-exposure prophylaxis n.e.c.**

**ASC.01.98 Prevention activities not broken down by intervention** includes all preventive programmes, interventions, and activities for which the resource tracking team does not have available information to classify them into a specific two-digit ASC.

**ASC.01.99 Prevention activities not elsewhere classified (n.e.c.)** includes all other preventive programmes, interventions, and activities which the country considers relevant and are not listed above.

## **ASC.02 CARE and TREATMENT**

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. The treatment and care component includes the following interventions and activities.

**ASC.02.01 Outpatient care** is any medical care delivered without requiring admission to a hospital. It refers to expenses aimed at optimizing quality of life for HIV-positive people and their families. They refer to the continuum of care by means of antiretroviral therapy, symptom diagnosis and relief; nutritional support; psychological and spiritual support; clinical monitoring, related laboratory services, and management of opportunistic infections (excluding TB treatment, which should be included on TB sub-accounts) and other HIV-related complications; and culturally-appropriate end-of-life care. Outpatient care comprises the following interventions and activities:

**ASC.02.01.01 Provider-initiated testing and counselling (PITC)** refers to the expenditures related to the delivery of HIV testing for diagnostic purposes. Under certain circumstances, when an individual is seeking medical care, HIV testing may be offered. This may be part of the diagnosis—the patient presents symptoms that may be attributable to HIV or has an illness associated with HIV, such as tuberculosis—or this may be a routine offer to an asymptomatic person. For example, HIV testing may be offered as part of the clinical evaluation of patients with STIs.

The cost of testing includes an initial test, followed by a confirmatory test if reactive. The cost of PITC includes the entire provision process: physician, laboratory, and post-test counselling. PITC excludes the testing under PMTCT coded as *ASC.01.17.01 Pregnant women counselling and testing*. Voluntary counselling and testing is a preventive intervention, and must be coded under *ASC.01.03 Voluntary counselling and testing (VCT)*. Tests performed on a mandatory basis as part of the employment policy or visa requirements are not recommended by UNAIDS and should be classified under *ASC.04.13. Mandatory HIV testing (not VCT)*.

#### **ASC.02.01.02 Opportunistic infections (OI) outpatient prophylaxis and treatment.**

**ASC.02.01.02.01 Opportunistic infections (OI) outpatient prophylaxis:** includes but is not limited to the cost of isoniazid to prevent TB and cotrimoxazole to protect against pathogens responsible for pneumonia, diarrhoea, and their complications. Children born to women living with HIV receive 18 months of treatment with cotrimoxazole on a prophylactic basis.

**ASC.02.01.02.02 Opportunistic infections (OI) outpatient treatment:** refers to a package of medications, diagnoses, and care used for treatment of HIV-related diseases provided on an outpatient basis. OI are illnesses caused by various organisms, some of which do not cause usually disease in people with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic illnesses common in people diagnosed with AIDS include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral, and fungal infections. The total cost of outpatient treatment of opportunistic infections is to be reported, not the AIDS treatment cost.

#### **ASC.02.01.02.98 Opportunistic infections (OI) outpatient prophylaxis and treatment not broken down by type**

**ASC.02.01.03 Antiretroviral therapy.** The specific therapy includes a comprehensive group of recommended antiretroviral drugs, including the cost of supply logistics and the entire ART service delivery (including the cost of human resources involved) for either adults or children.<sup>17,18</sup> The number of people being treated is based on country-specific evidence of current coverage. ART includes all modalities of ARV therapy. When an aggressive therapeutic course is received, which is intended to suppress viral replication and to slow the progress of HIV, the therapy is labelled highly active antiretroviral therapy (HAART); the usual combination of three or more different drugs such as two nucleoside reverse transcriptase inhibitors (NRTIs) and a protease inhibitor, two NRTIs and a non-nucleoside reverse transcriptase inhibitor or other combinations characterize this subclass, which has been shown to reduce the presence of the virus to a point where it becomes undetectable in a patient's blood. Where detailed information is collated, it may be broken down into:

#### **ASC.02.01.03.01 Adult antiretroviral therapy**

##### **ASC.02.01.03.01.01 First-line ART – adults**

##### **ASC.02.01.03.01.02 Second-line ART - adults**

##### **ASC.02.01.03.01.03 Adult multidrug ART after second-line treatment failure**

<sup>17</sup> <http://www.who.int/hiv/pub/guidelines/WHO%20Adult%20ART%20Guidelines.pdf>

<sup>18</sup> <http://www.aidsinfo.nih.gov/>

**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 ART – paediatric**

**ASC.02.01.03.02.02 Second-line ART – paediatric**

**ASC.02.01.03.02.03 Paediatric multidrug ART 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 by line of treatment.**

The term ART (antiretroviral therapy) clearly refers to an antiretroviral combination of at least three drugs. The population of patients with HIV infection may be classified as follows: (a) pre-ART, receiving care and prophylaxis; (b) first-line ART; (c) second-line ART, (d) second-line failure, but still under antiretroviral treatment with a multi-drug regimen called salvage or rescue therapy. Category (a) is coded as *ASC.02.01.08 outpatient palliative care*; (b), (c), and (d) should be coded under *ASC.02.01.03 Antiretroviral category*.

ART should be administered as part of a package of care interventions, including the provision of cotrimoxazole prophylaxis, the management of opportunistic infections and co-morbidities, nutritional support, and palliative care. The cost of human resources involved in the provision of these services should be explicitly recorded under different treatment categories. PMTCT plus ARV-treatment activities should be assigned this code. Among children, other activities should be coded within programmes for orphans and vulnerable children (OVC) affected by HIV. The expenditures associated with this activity should be accounted according to the specific beneficiary populations receiving the services, such as women or children.

**ASC.02.01.04 Nutritional support associated with ARV therapy.** Nutrition plays an important role in maintaining the health of people living with HIV. Adequate nutrition is essential to maintain a person's immune system, to sustain healthy levels of physical activity, and for quality of life. Adequate nutrition is also necessary for optimal benefits from antiretroviral therapy. Nutrition should become an integral part of countries' response to HIV. The consumption of nutrients and all the logistics involved in the delivery process of nutritional support should be accounted under this category.

**ASC.02.01.05 Specific HIV-related laboratory monitoring** includes laboratory expenditures for the delivery of CD4 cell count, viral load determination, and testing for drug resistance aimed to monitor the biological response to antiretroviral therapy and to determine the disease progression for a person with HIV-related disease. The CD4 cell count is a measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV. A CD4 cell count is used by health care providers to determine when to begin, interrupt, or halt anti-HIV therapy; when to administer preventive treatment for opportunistic infections; and to measure response to treatment. A normal CD4 cell count is between 500 cells/mm<sup>3</sup> and 1400 cells/mm<sup>3</sup> of blood, but an individual's CD4 count can vary. In HIV-positive individuals, a CD4 count at or below 200 cells/mm<sup>3</sup> is considered an AIDS-defining condition. The viral load (VL) determines the amount of HIV RNA copies in a blood sample, reported as the number of HIV RNA copies per ml of blood plasma. The VL provides information about the number of cells infected with HIV and is an important indicator of HIV progression and the efficacy of a treatment. The VL can be measured by different techniques, including branched-chain DNA (bDNA) and reverse transcriptase-polymerase chain reaction (RT-PCR) assays. VL tests are usually performed when an individual is diagnosed as HIV-positive and repeated at regular intervals

after diagnosis. Resistance testing consists of a laboratory test to determine whether an individual's HIV strain is resistant to any anti-HIV drugs and to guide their clinical treatment. Other tests to monitor patients, e.g. biochemical and haematological tests should also be included as ASC.02.01.05 Specific HIV-related laboratory monitoring.

HIV drug resistance surveillance is aimed at the epidemiological monitoring of the prevalence and circulation of resistant viral strains among HIV-positive specific populations. The authorities are therefore provided with the number or proportion of HIV-positive people in a given population whose HIV is resistant to particular anti-HIV drugs. The former activity for epidemiological purposes should therefore be coded under *ASC.04.06 HIV drug-resistance surveillance*.

**ASC.02.01.06 Dental programmes for people living with HIV** refers to odontological and related services performed on people living with HIV.

**ASC.02.01.07 Psychological treatment and support service** refers to psychological ambulatory services for people living with HIV including the consultation and antidepressant drugs prescribed in the treatment; e.g. if the National AIDS Programme hires the psychologist to be available for provision of psychological support and treatment to any person with HIV it should be recorded under this AIDS spending category. This category excludes all other psychological support services recorded under VCT activities (i.e.: in *ASC.01.03 Voluntary counselling and testing (VCT)*, *ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations*, *ASC.01.08.01 VCT as part of programmes for sex workers and their clients*, *ASC.01.09.01 VCT as part of programmes for MSM*, *ASC.01.10.01 VCT as part of programmes for IDUs*) or *ASC.02.01.08 Palliative care* and *ASC.02.01.03 Antiretroviral therapy*.

**ASC.02.01.08 Outpatient palliative care** refers to treatment that addresses pain and discomfort associated with HIV. This includes all basic health care and support activities, whether clinic-based, home-based or community-based activities for HIV-positive adults and children and their families aimed at optimizing quality of life for HIV-positive people and their families throughout the continuum of care by means of symptom diagnosis and relief, and culturally-appropriate end-of-life care. Clinic-based, home-based or community-based care and support activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV should be coded under Orphans and Vulnerable Children and the antiretroviral treatment coded under antiretroviral therapy.

**ASC.02.01.09 Home-based care** is external support for individuals chronically ill with AIDS. This may include but is not limited to the home visits of medical or non-medical staff to assess living conditions, address psychological needs, accompany ill people with HIV to the hospital. These visits might include provision of in-family home-based psychological support to the family members, teaching family members basic information on HIV, first aid, nutrition etc.

**ASC.02.01.09.01 Home-based medical care:** minor medical care, supplies for medical care mainly including human resources (nurse, social worker or relevant). This category excludes ARV (ASC.02.01.03), nutritional support for ART (ASC.02.01.04), psychological support and treatment (ASC.02.01.07), and Palliative care (ASC.02.01.08).

**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.** Traditional medicine refers to health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose, and prevent HIV or maintain well-being, e.g. traditional Chinese medicine, homeopathy, naturopathy, herbal medicine, and chiropractic methods. Complementary therapies are additional forms of treatment used as an adjunct to standard therapy,



while alternative therapies are used instead of standard therapy. These services are usually delivered by alternative and informal providers and specifically include AIDS-related activities.

**ASC.02.01.98 Outpatient care services not broken down by intervention** includes all outpatient interventions and services for which the resource tracking team does not have available information to classify it into a specific three-digit ASC.

**ASC.02.01.99 Other outpatient care services not elsewhere classified (n.e.c.).** Includes all other outpatient interventions and activities not recorded above, and considered by the country as a relevant expense.

**ASC.02.02 Inpatient care:** All in-hospital care activities for HIV-positive adults and children aimed at the treatment of HIV-related disease by means of diagnosis procedures, surgery, intensive care, and overall hospital care. Hospital treatment for opportunistic infections should be coded as ASC.02.02.01. Although antiretroviral treatment is usually provided on an ambulatory basis, it should be coded under ASC.02.01.03, regardless of the setting in which is provided; ambulatory clinic or hospital.

**ASC.02.02.01 Inpatient treatment of opportunistic infections (OI):** The treatment of opportunistic infections (OI) refers to a package of medications, diagnoses, and care used for treatment of HIV-related diseases. OI are illnesses caused by various organisms, some of which do not usually cause disease in people with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic illnesses common in people diagnosed with AIDS include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral, and fungal infections.

**ASC.02.02.02 Inpatient palliative care** refers to treatment that addresses pain and discomfort associated with HIV. This includes all inpatient basic health care and support activities aimed at optimizing quality of life for HIV-positive people throughout the continuum of care by means of symptom diagnosis and relief, and culturally-appropriate end-of-life care. Clinic-based inpatient activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV should be coded under Orphans and Vulnerable Children and the antiretroviral treatment coded under antiretroviral therapy.

**ASC.02.02.98 Inpatient care services not broken down by intervention** includes all inpatient interventions and services for which the resource tracking team does not have available information to classify it into a specific three-digit ASC.

**ASC.02.02.99 Inpatient care services not elsewhere classified (n.e.c.).** Includes all other inpatient care interventions, and activities not recorded above and considered by the country as a relevant expense.

**ASC.02.03 Patient transport and emergency rescue:** includes transport by ambulance and all other means of transport used for HIV patients undergoing treatment, and costs incurred by relatives travelling for the purpose of providing company and assistance to these patients.

**ASC.02.98 Care and treatment services not broken down by intervention** includes all care and treatment programmes, interventions, and services for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.02.99 Care and treatment services not elsewhere classified (n.e.c.).** Includes all other care and treatment programmes, interventions, and activities not recorded above and considered by the country as a relevant expense. The resource tracking team will create subheadings to provide a comprehensive picture of all expenditures allocated to the care and treatment of people living with HIV and patients with advanced HIV-related disease and not listed above (e.g. some types of cancers). These services are aimed at people living with HIV and patients with advanced HIV-related disease and should be coded under ASC.02.99.



## ASC.03 ORPHANS and VULNERABLE CHILDREN (OVC)

An orphan is defined as a child aged under 18 who has lost one or both parents regardless of financial support (whether national AIDS programme-related or not). 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. Outside sub-Saharan Africa the resource tracking represents the AIDS contribution to general orphan programmes. 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).

All services aimed at improving the lives of orphans and other vulnerable children and families affected by HIV should be accounted. The “preventive health services for orphans and vulnerable children”, duly identified under *ASC.01 Prevention*, should not be counted twice. Palliative care, including basic health care and support and TB/HIV prevention, management, and treatment, in addition to the related laboratory services and pharmaceuticals, when delivered within programmes for orphans and other vulnerable children affected by HIV, should be coded in this class. Other health care associated with the continuum of HIV illness, including HIV/TB services, when delivered outside a programme for orphans and other vulnerable children affected by HIV, should be coded under the specific care programme. ART for children should be coded under *ASC.02.01.03.02 Paediatric antiretroviral therapy*. The OVC component includes the following interventions and activities.

**ASC.03.01 OVC Education.** Primary school and secondary school (school fees, uniforms, books and supplies, special fees/assessments).

**ASC.03.02 OVC Basic health-care** refers to basic child care services such as immunizations, routine health care, nutritional supplements (e.g. vitamins, proteins etc), sexual and reproductive health services for older children). The expenditures to be included under this code refer to those for any children who in principle should be provided for by the parents; in their absence, social protection programmes pay for their access to basic services. The health services here are not HIV-specific. ART for children should be coded under *ASC.02.01.03.02*.

**ASC.03.03 OVC Family/home support** refers to in-kind support such as bednets, clothes and shoes, blankets and bedding, food (not an ART-related nutritional support), and other support. This category excludes all services as part of institutional care, coded under *ASC.03.06 OVC Institutional care*.

**ASC.03.04 OVC Community support** refers to identification of OVC in the community, outreach for OVC, training and supporting full-time community workers, child care.

**ASC.03.05 OVC Social services and administrative costs** e.g. birth certificates and other administrative and institutional arrangements necessary for implementing OVC care. Child welfare, a term used to refer to a broad range of social programmes that contribute to the well-being of children should be coded under this category.

**ASC.03.06 OVC Institutional care** refers to integrated care provided in an institutional setting, including food (not an ART-related nutritional support), health care, education, clothes, shoes, bedding, psychosocial support and economic self-sufficiency, and all other services addressing the needs of orphaned children. These can be categorized as support services, supplementary programmes, or substitute care. Communal foster care is an integrated service provided by children's homes, orphanages, mission and boarding schools, workhouses, borstals, monasteries, and convents. This category excludes all services as part of support to families with OVC, coded under *ASC.03.03 OVC Family/home support*.

**ASC.03.98 Services for OVC not broken down by intervention** Services addressing the needs of and specifically targeting orphans and vulnerable children, for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.03.99 Services for OVC not elsewhere classified (n.e.c).** All other services addressing the needs of and specifically targeting orphans and vulnerable children, not listed above.

## **ASC.04 PROGRAMME MANAGEMENT and ADMINISTRATION**

Programme expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), 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. The programme management component includes the following interventions and activities:

**ASC.04.01 Planning, coordination, and programme management** refers to expenditure incurred at the administrative level outside the point of health care delivery, including the dissemination of strategic information, on best practice—programme efficiency and effectiveness, planning/evaluation of prevention, care, and treatment efforts; analysis and quality assurance of demographic and health data related to HIV, and the testing of implementation models even though these may be conducted in a delivery institution. Also included are coordination activities, for instance in support of the “Three Ones” principles: Coordination of a single approved AIDS action framework and support to build/strengthen one National AIDS Coordinating Authority. Also included are expenditures related to the conduct of national AIDS strategic planning and of human resource planning (e.g. district level). The resource tracking for human resources under programme costs is different to the disbursements of human resources as reported for personnel providing prevention and treatment—ASC.01 and ASC.02—because they are offered as part of health care delivery services (e.g. salary of a doctor dedicated to PMTCT, which would be a component of PMTCT and should be accounted as a production factor of the ASC related to PMTCT).

**ASC.04.02 Administration and transaction costs associated with managing and disbursing funds.** Costs incurred in managing programmes within the national response to HIV, providing routine and ad-hoc administrative supervision and technical assistance to the programme staff, excluding those under *ASC.04.09 Supervision of personnel and patient tracking*. Expenditures aimed at searching for and contracting a financing agent authorized to assume the purchasing function for a given AIDS spending category, are also included under ASC.04.02. This may be a multiple layer process, identified and monitored or external to the financing process proper. This item attempts to trace the costs of this procedure. This category records a sometimes multi-layered process by which the designer or primary designer of a HIV programme decides to entrust the running of a programme to an agent. Overheads related to the management of funds should be recorded here.

**ASC.04.03 Monitoring and evaluation:** The purpose of M&E is to provide the data required to: 1) guide the planning, coordination, and implementation of the HIV response; 2) assesses the effectiveness of the HIV response; and 3) identify areas for programme improvement. In addition, M&E data are required to ensure accountability to those affected by HIV, in addition to those providing financial resources for the HIV response.<sup>19</sup> M&E therefore includes expenses related to ascertaining the direction and ultimate achievement of measurement of programme progress, the provision of feedback for accountability and quality, and implementation of targeted programmatic evaluation, the implementation and upgrading of information management systems (e.g. other monitoring and health management information systems), the evaluation of prevention, care, and treatment efforts. Expenditures on M&E should include the

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<sup>19</sup> Organizing Framework for a Functional National HIV Monitoring and Evaluation System, UNAIDS/MERG, April 2008.

salaries of the staff who implement M&E programmes. Expenditures to conduct National AIDS Spending Assessments (NASA) should be included under this code.

**ASC.04.04 Operations research.** This refers to investments and expenses incurred in performing applied operations research aimed at improving the management, delivery, and quality of health services. An operations researcher faced with a new problem is expected to determine which techniques are most appropriate given the nature of the system, the goals for improvement, and constraints on time and computing power.

**ASC.04.05 Serological surveillance** (serosurveillance). This category includes expenditure on registry, processing of information to be used to document the incidence, and specific prevalence of the epidemic in the general population as well as in specific populations. Also included are sentinel studies, mandatory reporting of cases, and epidemiological analysis. Surveillance implies ongoing and systematic collection, analysis, and interpretation of data on a disease or health condition. Collecting blood samples for the purpose of surveillance is called serosurveillance. Built upon a country's existing data collection system, second-generation HIV surveillance systems are designed to be adapted and modified to meet the specific needs of differing epidemics. For example, HIV surveillance in a country with a predominantly heterosexual epidemic will differ radically from surveillance in a country where HIV infection is mostly found among MSM or IDUs. Surveillance for drug resistance is to be recorded under *ASC.04.06 HIV drug-resistance surveillance*. The surveillance programmes aim to improve the quality and diversity of information sources by developing and implementing standard and rigorous study protocols, using appropriate methods and tools.

**ASC.04.06 HIV drug-resistance surveillance** includes the setting up of sentinel sites, laboratory operations, materials and goods, and the integration and support for the activities of a National HIV-Drug Resistance Committee. HIV drug resistance surveillance is aimed at the epidemiological monitoring of the prevalence and to determine the circulation of resistant viral strains among specific HIV-positive populations. This provides the number or proportion of HIV positive people in a given population whose HIV is resistant to particular anti-HIV drugs. The genotypic antiretroviral resistance test (GART) determines whether a particular strain of HIV has specific genetic mutations associated with drug resistance. The test analyses a sample of the virus from an individual's blood to identify any genetic mutations associated with resistance to specific drugs. The phenotypic assay is different from a genotypic assay; it uses an indirect method, and determines by a direct experiment whether a particular strain of HIV is resistant to anti-HIV drugs.

**ASC.04.07 Drug supply systems** include the procurement processes, logistics, transportation, and supply of antiretroviral and other essential drugs for the care of people living with HIV. These expenditures aim to increase the capacity of logistics and drug supply systems, including staffing, development of administrative systems, and upgrading of transportation infrastructure. These activities involve support systems for pharmaceuticals, diagnostics, medical equipment, medical commodities, and supplies to provide care and treatment of people living with HIV and related infections. This includes the design, development, and implementation of improved systems for forecasting, procurement, storage, distribution, and performance monitoring of HIV pharmaceuticals, and of relevant commodities and supplies. This includes actual spending to improve ordering, procurement, shipment, and delivery of the full range of HIV-related pharmaceuticals, diagnostics, and other medical commodities. Antiretroviral drugs purchased and delivered, must be coded under *ASC.02.01.03 Antiretroviral therapy*.

**ASC.04.08 Information technology.** Implementation and upgrades of information systems, software, and hardware integrated in information networks to manage HIV-related information.

**ASC.04.09 Patient tracking.** The activities and resources to provide adherence support or treatment preparedness require to be accounted explicitly. Including resources and personnel working in the field on supervision activities or direct tracking of patients ensuring compliance with and preparation of treatment. These activities need to be accounted explicitly for HIV patients and special populations (e.g. IDUs). Salaries for the personnel required to provide treatment and care services are covered to some extent in *ASC.02 Care and Treatment* (e.g. community health workers) and the human resource component in *ASC.05.01 Monetary incentives*.

**ASC.04.10 Upgrading and construction of infrastructure** deals with investments, purchases, and expenses on the construction, renovation, leasing, procurement (equipment, supplies, furniture, and vehicles), overheads and/or installation for the implementation of HIV programmes. They include capital investments for building infrastructure that provide HIV services. The programme investments include high fixed start-up costs (e.g. buying computers and e-mail connectivity), specifically activities for clinical monitoring and for the purchase of new equipment. Also included are development and strengthening of laboratory facilities to support HIV-related activities including purchase of equipment and commodities, provision of quality assurance, staff training, and other technical assistance.

**ASC.04.10.01 Upgrading laboratory infrastructure and new laboratory equipment**

**ASC.04.10.02 Construction of new health centres** includes investment in new facilities to handle the prevention, treatment, and care of people living with HIV.

**ASC.04.10.98 Upgrading and construction of infrastructure not broken down by intervention**

**ASC.04.10.99 Upgrading and construction of infrastructure not elsewhere classified (n.e.c.)**

**ASC.04.11 Mandatory HIV testing (not VCT).** In some countries HIV testing is being performed on a mandatory basis as a part of the employment policy or visa requirements. Although UNAIDS does not recommend mandatory testing as part of prevention or care and treatment strategies, some countries spent significant funds on this intervention.

**ASC.04.98 Programme management and administration not broken down by type** includes all programme expenditures for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.04.99 Programme management and administration not elsewhere classified (n.e.c)** includes all other programme expenditures not listed above.

## **ASC.05 HUMAN RESOURCE CAPACITY DEVELOPMENT**

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)*.

The incentives for human resources currently covers mainly nurses and doctors; in a broader public health approach, the concept should also apply to monetary incentives to counsellors, clinical officers, compliance supporters, and laboratory staff.

**ASC.05.01 Monetary incentives for human resources.**

**ASC.05.01.01 Monetary incentives for physicians.** Wage benefits for doctors incorporated into the total remuneration package as a way of attracting and retaining human resources for health.

**ASC.05.01.02 Monetary incentives for nurses.** Wage benefits for nurses incorporated into the total remuneration package as a way of attracting and retaining human resources for health

**ASC.05.01.03 Monetary incentives for other staff.** Wage benefits for laboratory personnel, and other staff associated with delivering HIV-related services. Strengthening the cadres of community health workers is also covered. This should include the costs for health workers, social workers, especially nurse practitioners, clinical officers, and laboratory technicians.

**ASC.05.01.98 Monetary incentives for human resources not broken down by staff** includes all incentive programmes for human resources expenditures for which the resource tracking team does not have available information to classify it into a specific three-digit ASC.

**ASC.05.02 Formative education to build up an AIDS workforce** includes the provision of education for additional nurses and physicians who will be required in the future. Activities to strengthen or expand pre-service education, such as curriculum development or faculty training, are also coded under this category.

**ASC.05.03 Training.** Pre-service training sessions for all the appropriate professionals and para-professionals, both health and non-health. This includes continuing education delivered through various means, organized specifically for this purpose, such as workshops. Support for building specific skill areas should also be included here, for example, strengthening interpersonal communication, improving laboratory skills, and nutritional education for people living with HIV and their families. This category excludes in-service “learning-by-doing” training and mentoring, which is considered a part of the related service e.g. in-service (when a social worker or a nurse shows family members which particular actions should be performed in terms of care inside the family) training for relatives to carry out home-based care for their family members should be counted as part of *ASC.02.01.09 Home-based care*. This category also excludes training for teachers to build their capacity to provide HIV-related information as a part of school programme (tracked under *ASC.01.05 Youth in school*), and training for peer educators on HIV prevention (tracked under *ASC.01.02 Community mobilization*)—to be consistent with the Resource Needs Model.

**ASC.05.98 Human resources not broken down by type** includes all human resources expenditures for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.05.99 Human resources not elsewhere classified (n.e.c)** includes all other human resources expenditures not listed above.

## **ASC.06 SOCIAL PROTECTION 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.

**ASC.06.01 Social protection through monetary benefits** refers to conditional or unconditional financial support, such as grants and cash transfers (including child social assistance grants, foster care grants, disability grants, “medical pensions”, early retirement and disability benefits for people living with HIV, or family members). Cash transfers and grants aim to reduce [poverty](#) by making [welfare programs](#) conditional or unconditional upon the receivers' actions. Cash transfers and grants provide money directly to poor families via a “social contract” with the beneficiaries—for example, sending children to school regularly or bringing them to health centres. For extremely poor families, cash provides emergency assistance, while the conditionalities promote longer-term investments in human capital.

**ASC.06.02 Social protection through in-kind benefits** refers to food security, food parcels (not associated with ART nutritional support), clothing, school fee rebates, books, transport and food vouchers, and other in-kind support for HIV-positive people.

**ASC.06.03 Social protection through provision of social services** refers to the development of activities aimed at social mitigation for people living with HIV and their families including funeral expenses, burial society fees, day care services, and transportation for patients.

**ASC.06.04 HIV-specific income generation** relates to projects and efforts to develop public work programmes, skills development, sheltered employment, livelihood, micro-credit, and financing. Small grants for business activities for people living with HIV are also included.

**ASC.06.98 Social protection services and social services not broken down by type** includes all social protection services and social services expenditures for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.06.99 Social protection services and social services not elsewhere classified (n.e.c.)** includes all other direct financial support and social assistance to families affected by HIV that comprises a social protection aspect not included above.

## **ASC.07 ENABLING ENVIRONMENT**

**ASC.07.01. Advocacy.**<sup>20</sup> 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.

Also included are promotion and support of the development of a strong HIV constituency at the regional and country level, among civil society, including: community groups, policy-makers, opinion leaders, leaders of faith-based organizations, women's groups, youth leaders, and people living with HIV to strengthen their capacity to advocate for effective HIV prevention, care, and social support. Spending on all advocacy efforts to enhance the national response to HIV. Expenditures related to strategic communication (e.g. distribution of strategic information) and policy development should be recorded under *ASC.04.01. Planning, management and programme coordination*.

**ASC.07.02. 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. Advocacy for human rights should be coded as *ASC.07.01 Advocacy*. Programmes focused on the human rights of women and girls should be coded as *ASC.07.04 AIDS-specific programmes focused on women*.

**ASC.07.02.01 Human rights programmes empowering individuals to claim their rights** by providing knowledge and understanding of their rights and responsibilities under human rights and/or domestic legal systems, including dissemination of information and materials relating to human rights. This includes general human rights programmes aimed at the general population in generalized and concentrated epidemics. This category includes specific stand-alone programmes that aim to empower and enable members of vulnerable groups to participate meaningfully in decision-making processes. When human rights consultation is a part of Behaviour Change Communication (BCC) for specific most-at-risk or other key and vulnerable populations these expenditures should be included in the respective categories in Prevention.

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<sup>20</sup> Previously labelled as ASC.07.01 Advocacy and strategic communication

**ASC.07.02.02 Provision of legal services and advice to promote access to prevention, care, and treatment:** includes cost of legal consultancy, legal representation of the individuals in court and related expenditures.

**ASC.07.02.03 Capacity building in human rights** includes but is not limited to the specific activities targeting national human rights institutions, ombudsmen or other independent bodies aimed at strengthening the protection against human rights violations that are HIV-related or increase vulnerability to HIV.

**ASC.07.02.98 Human rights programmes not broken down by type.**

**ASC.07.02.99 Human rights programmes not elsewhere classified (n.e.c.).**

**ASC.07.03 AIDS-specific institutional development.** This refers to investment in capacity building of nongovernmental organizations (including faith-based organizations). It includes strengthening the ability of key local institutions to implement HIV programmes efficiently with diminishing reliance, over time, on external technical assistance. This includes services that improve the financial management, human resource management, quality assurance, strategic planning, and leadership and coordination of partner organizations. Expenditures on the institutional development of nation-wide organizations, e.g. National AIDS Coordinating Authority, are recorded under ASC.04.01. Planning, coordination and programme management

**ASC.07.04 AIDS-specific programmes focused on women.** Programmes targeting women and girls, in addition to those explicitly included in the spending categories described above, for instance improved reproductive health activities, assistance, and counselling addressing abused women and programmes to protect the property and inheritance rights of women and girls.

**ASC.07.05 Programmes to reduce gender-based violence.** Programmes to reduce violence against women. Also known as violence against women (VAW), this is a major public health and human rights problem throughout the world. VAW has implications for HIV transmission and is often ignored. Expenditures for the response to sexual violence include the design of social and health policies, all the services that provide comprehensive, sensitive, and quality care to victims of sexual violence. The expenditures cover several areas: assistance and counselling addressing abused women, promotion, and policy measures that will support the provision of comprehensive and ethical services to people who have experienced sexual violence; activities of police departments, health services, prosecutors, social welfare agencies, and nongovernmental service providers, such as rape crisis centres. Post-exposure prophylaxis after exposure to risk because of violence or rape should be coded under *ASC.01.22.02 Post-exposure prophylaxis after high-risk exposure*.

**ASC.07.98 Enabling environment activities not broken down by type** includes environmental and community enablement programmes for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.07.99 Enabling environment activities not elsewhere classified (n.e.c.)** includes all other environmental and community enablement programmes not included in the above classes.

## **ASC.08 HIV-RELATED RESEARCH (excluding operations research)**

HIV-related 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. It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS. Managers and administrators should be included when they spend at least 10% of their time supporting research activities. Researchers include postgraduate students but do not include technicians. Technicians and equivalent staff are people whose main tasks require technical knowledge and experience. They participate in R&D by performing scientific and technical tasks involving the application of concepts and operational methods, normally under the supervision of

researchers. 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.

Research—with the exception of operations research—is not directly linked to the provision of services, and therefore, might be considered to be a satellite component of the expanded response to HIV. Care should be taken to correctly classify research activities properly and not to include other activities frequently confused with research, such as population studies for epidemiological surveillance, or monitoring and evaluation of the programmes. The following activities are included when directly related to HIV and the resource tracking activities within the NASA are considered optional.

**ASC.08.01 Biomedical research**, which comprises the study of detection, cause, treatment, and rehabilitation of persons with specific diseases or conditions, the design of methods, drugs, and devices to address these health problems, and scientific investigations in areas such as the cellular and molecular bases of disease, genetics, and immunology.

**ASC.08.02 Clinical research**, which is based on the observation and treatment of patients or volunteers.

**ASC.08.03 Epidemiological research**, which is concerned with the study and control of diseases and exposures and other situations suspected of being harmful to health: care should be taken to exclude epidemiological surveillance.

**ASC.08.04 Social science research**, which investigates the broad social aspects of HIV.

**ASC.08.04.01 Behavioural research**, which is associated with risk factors for ill health and disease with a view to promoting health and preventing disease. Care should be taken to exclude epidemiological surveillance as well as evaluation of preventive interventions.

**ASC.08.04.02 Research in economics**, which investigates a wide range of economic aspects of HIV and the AIDS epidemic.

**ASC.08.04.98 Social science research not broken down by type**

**ASC.08.04.99 Social science research not elsewhere classified (n.e.c.)**

**ASC.08.05 Vaccine-related research**. Specific activities aimed to support basic, laboratory, clinical, and field-related research for developing and testing a HIV vaccine.

**ASC.08.98 HIV-related research activities not broken down by intervention** includes HIV-related research programmes for which the resource tracking team does not have available information to classify it into a specific two-digit ASC.

**ASC.08.99 HIV-related research activities not elsewhere classified (n.e.c.)** includes all other HIV-related research programmes not included in the above classes.



#### Appendix G: Production Factor descriptions (cost components)

Cost Category	Definition
Communication / Messaging / Printing	<ul style="list-style-type: none"> <li>All avenues of communication, including printed materials and media campaigns, for all parties (e.g., ART patients, general population, ANCs, etc.)</li> </ul>
Condoms	<ul style="list-style-type: none"> <li>Funds spend on condoms, excluding delivery or supply chain costs</li> </ul>
Conferences / Workshops	<ul style="list-style-type: none"> <li>All expenses related to non-training conferences or workshops (e.g., per diems, hotel, refreshments, travel reimbursements, etc.)</li> </ul>
Direct Budget Support	<ul style="list-style-type: none"> <li>Money given directly to the Ethiopian government to use at its discretion, though within certain parameters is also acceptable (such as specifically for HIV programmes)</li> </ul>
Domestic travel expenses	<ul style="list-style-type: none"> <li>Funds spent on domestic travel, including vehicles, maintenance, fuel, driver salaries, taxis, airline tickets, domestic hotels, lodging, and per diems</li> </ul>
Drugs	<ul style="list-style-type: none"> <li>Payments for drugs, including ARV's, cotrim or PEP drugs, pills, and drug-eluting implants</li> </ul>
Food Supplies	<ul style="list-style-type: none"> <li>Funds spend on acquiring food supplies, nutritional supplements, or water</li> </ul>
General Operating Expenses	<ul style="list-style-type: none"> <li>General running costs not captured in other categories, such as rent / utilities for a building, but also for administration staff and functions (including salaries)</li> </ul>
International travel expenses	<ul style="list-style-type: none"> <li>Funds spend on international travel, including flights, hotels, visas, per diems, and vehicles (if applicable)</li> </ul>
Lab Equipment and Supplies	<ul style="list-style-type: none"> <li>Lab equipment and consumable (pipettes, gloves, re-agents, etc.) purchases</li> </ul>
Cost Category	Definition
Medical Equipment - Consumables	<ul style="list-style-type: none"> <li>Medical equipment that is one-time use and neither drugs nor lab equipment</li> <li>E.g., test kits, needles, band-aids, catheters, etc.</li> </ul>
Medical Equipment - Reusable or diagnostic equipment	<ul style="list-style-type: none"> <li>Medical equipment that is not lab equipment and is reusable for multiple patients, for example monitoring, therapeutic or life support equipment</li> </ul>
Non-Office Capital Expenditure / Infrastructure	<ul style="list-style-type: none"> <li>Equipment or software that is non-medical, like a computer, printer, or information system, that will likely last longer than 12 months</li> <li>Infrastructure expenses from buildings or projects</li> <li>Excludes lab equipment</li> </ul>
Procurement and Supply Management	<ul style="list-style-type: none"> <li>Transportation costs for all purchases (equipment, commodities, products, medicines) including packaging, shipping, insurance and handling. Warehouse, PSM office facilities, and other logistics requirements. Procurement agent fees.</li> <li>Do not include staff, TA, PSM Information Technology systems, health products or health equipment costs, as these costs should be included in the categories above.</li> </ul>
Program Salaries / Incentives	<ul style="list-style-type: none"> <li>Refers to costs for program staff excluding administrative staff (which is counted in General Operating Expenses) and technical assistance</li> </ul>
Cost Category	Definition
Research / M&E	<ul style="list-style-type: none"> <li>Funds spent on program-related research and M&amp;E expenses, including clinical and survey-based research and all M&amp;E expenses, including salaries</li> </ul>
Technical Assistance	<ul style="list-style-type: none"> <li>Salaries and other related costs for technical assistance projects for the Government of Ethiopia</li> </ul>
Training	<ul style="list-style-type: none"> <li>Training programs, including program allowances, fees, food, etc.; also includes pre-employment training</li> <li>Also includes training workshops and any expenses included</li> </ul>
Other	<ul style="list-style-type: none"> <li>Any costs not included in the above</li> </ul>