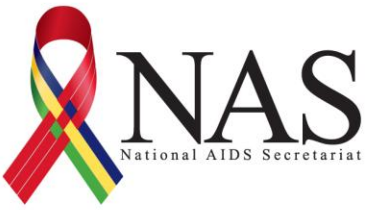

National AIDS Spending Assessment Report 2012

Prime Minister's Office, Mauritius

MAURITIUS

NATIONAL AIDS SPENDING

ASSESSMENT, 2012

LEVEL AND FLOW OF RESOURCES AND

EXPENDITURES

FOR THE RESPONSE TO HIV/AIDS

Contents

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ART	Antiretroviral Treatment

ARV	Antiretroviral (anti-HIV drug)
BCC	Behaviour Change Communication
CBO	Community Based Organization
CD4	Cluster Difference 4
CHC	Community Health Centre
CHL	Central Health Laboratory
CSW	Commercial Sex Worker
CYC	Correctional Youth Center
FBO	Faith Based Organization
FGD	Focus Group Discussion
FSW	Female Sex Worker
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria Round 8
HCT(HTC)	HIV counselling and testing
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
IOC	Indian Ocean Commission
IBBS	Integrated Behavioural and Biological Surveillance Survey
KABP	Knowledge Attitude Behaviour and Practice
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MFPWA	Mauritius Family Planning and Welfare Association
MOGE	Ministry of Gender Equality
MOH&QL	Ministry of Health and Quality of Life
MSM	Men having Sex with Men
MST	Methadone Substitution Therapy
MTR	Mid Term Review
MYS	Ministry of Youth & Sports
NAC	National AIDS Committee
NAS	National AIDS Secretariat
NASA	National AIDS Spending Assessment
NATReSA	National Agency for the Treatment & Rehabilitation of Substance Abusers
NDCCI	National Day Care Centre for Immuno-suppressed
NEP	Needle Exchange Programme
NGO	Non Governmental Organization
NMSTC	National Methadone Substitution Treatment Centre
NSF	National Strategic Framework

NWC	National Women's Council
PBB	Project Based Budgeting
PCR	Polymerase Chain Reaction
PI	Prison Inmates
PILS	Prevention Information et Lutte contre le SIDA
PLHIV	People Living With HIV & AIDS
PMO	Prime Minister's Office
PMTCT	Prevention of Mother to Child Transmission
PWID	People Who Inject Drugs
RAU	Rodrigues AIDS Unit
RNSF	Revised National Strategic Framework
RRA	Rodrigues Regional Assembly
SADC	South African Development Community
SDP	Service Delivery Points
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Programme on HIV & AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Special Session on HIV &AIDS
VCT	Voluntary Counselling & Testing (for HIV)
WHO	World Health Organization

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The National AIDS Coordinator, Prime Minister's Office wishes to thank the Regional Office of the UNAIDS for providing the services of Teresa Guthrie and her team from Centre for Economic Governance and AIDS in Africa (CEGAA) to conduct the training in the methodology to conduct a National AIDS Spending Assessment.

Especial thanks go to all the Government Ministries and Departments, as well as to Non–Governmental Organisations and Private Companies who contributed to the project by extending their assistance to the data collectors.

The assessment was conducted by Mr Navin Rughoonundun, Finance Manager at the National AIDS Secretariat (NAS.

EXECUTIVE SUMMARY

This National AIDS Spending Assessment (NASA) covers the year 2012 (I January 2012 to 31 December 2012). It follows upon the third spending assessment which were undertaken in 2010 and year 2008/2009. The primary currency of reporting expenditure in this report is the Mauritian Rupee.

As per the findings, spending on HIV/AIDS in Mauritius for the year 2012 from all sources of funding was Rs 225,015,695 (US$7.434 million). The main source of funding was the Government of Mauritius (public) accounting for Rs 161,248,617

(US$5.4million) (72%). The funding by the government has increased over the past years from Rs 141.9m in 2010 to Rs 161.2, due to increased number of patients under MST programme and ART. Spending over the period was dominated by Prevention with expenditure in the Harm Reduction Programme being the major component of the AIDS spending category. Total expenditure on prevention amounted to Rs 86.5million (US$ 2.98 million) (39.5%). This was followed by spending on Care and Treatment at Rs 68.9million (US$2.37million) (32%), Program management at Rs 50.245 million (US$1.73 million) which accounted for 23% of total expenditure.

Public funds were spent mainly on Care & Treatment, followed by programme management and prevention. Funds from international sources were spent mainly on prevention and program management.

Public entities are the service providers that consume the most financial resources. In 2010, 80% was spent by public entities, mainly hospitals, the AIDS Unit of the Ministry of Health and Quality of Life, the Central Laboratory and the Harm Reduction Unit, accounting for 63% of total spending; the National AIDS Secretariat, which operates under the aegis of Prime Minister's office, accounted for 17% of the total spending. Public service providers' funds are managed by government financing agents. Private sector providers received funding from both the government, private sector agents, country offices of bilateral agencies and international non-profit making organisation and foundations. In 2010 Rs 43.4 million was spent by private sector providers representing 20% of total spending.

According to the National Strategic Framework (NSF), estimated resources needed between 2009 to 2010 was put at Rs187,874,000 as opposed to actual expenditure of Rs 218,196,431. Thus, there is a variance of 16% based on the targeted proportional spending of the NSF, which is due to the fact that programme management, administration, care and treatment have been understated.

The population group that benefited the most from spending on HIV/AIDS is people living with HIV and AIDS, consuming approximately 40% of the spending over the year 2010. The next population group to benefit the most is the Key Affected Populations (People Who Inject Drugs, Sex Workers, Men who have Sex with Men, Prison Inmates and Seafarers); PWID account for the greater part of this funding. This group consumed 30% of the financial resources over the year.

With regard to the budgetary items, the cost category that consumed the most resources was labour at 35%, followed by spending on supply of materials such as antiretroviral drugs, methadone, laboratory reagents etc. accounting for 27% of the total.

In conclusion, it should be noted that NASA, as a monitoring and evaluation tool, can only be effective if it provides accurate information in a timely manner. This calls for the process of gathering the NASA information to be institutionalised within the NAS so that data can be collected on a regular basis. It is possible for NAS to design simple forms that implementers can use to make returns on a quarterly basis. This can be done through the adaptation of UNAIDS designed forms used during the current NASA.

CHAPTER 1: INTRODUCTION

1.1 Global Background

According to the UNAIDS 2010 Report on the Global AIDS Epidemic, an estimated 33.3 million people were infected with HIV/AIDS worldwide. Over two thirds of these people living with HIV were from Sub-Saharan Africa (22 milion). This being a region with approximately only 12,5% of the world's population, Southern Africa had a disproportionate share of the global burden, with 35% of the people living with HIV and 38% of all AIDS death occurring within the sub-region. The UNAIDS report notes that the incidence of HIV appears to have stabilized in Sub-Saharan Africa, but at very high levels, especially in Southern Africa were most of the countries reported prevalence rates of over 15%.

Since 1999, the year in which it is thought that the epidemic peaked, globally, the number of new infections has fallen by 19%. Of the estimated 15 million people living with HIV in low and middle-income countries who need treatment today, 5.2 million have access—translating into fewer AIDS-related deaths. For the estimated 33.3 million people living with HIV after nearly 30 years into a very complex epidemic, the gains are real but still fragile. Future progress will depend heavily on the joint efforts of everyone involved in the HIV response.

1.2 Mauritius Background Information

The first case of HIV and AIDS was reported in Mauritius in 1987. As at end of December 2011, the estimated prevalence rate of HIV and AIDS among the Mauritian adult population was 0.97 percent, equivalent to some 8000-10000 people living with the HIV virus. Out of this estimated number, only 5188 had been detected at the end of December 2011.

The HIV epidemic in Mauritius is said to be 'concentrated' in nature, with a high prevalence among certain Key Affected Populations. Surveillance data and Integrated Behavioural and Biological Studies show a prevalence of 19.9 per cent among as Prison Inmates, 51.6 per cent among People Who Inject Drugs, 8.1 per cent among Men having Sex with Men, 28.9 per cent among Commercial Sex Workers and 6.9 per cent among Seafarers (2008).

HIV/AIDS is placed high on the social development agenda of the Government of Mauritius. Health services, including prevention services to reduce the prevalence of HIV infection among the population and antiretroviral treatment to PLWHAs, are provided, free of any user cost, at the point of use. The Ministry of Health and Quality of Life has included both a financial statement and a non-financial statement with specific outputs, outcome and targets in its Programme-Based Budgeting.

Mauritius started responding to HIV/AIDS even before the first case was detected in 1987. A National AIDS Control Programme (NACP) focusing on primary prevention of HIV transmission through blood transfusion safety awareness and condom promotion campaigns, education and communication activities for the population at large and for the most vulnerable groups, including sex workers and men having sex with men, prison inmates and injecting drug users was established and implemented. Several short term and medium term plans were devised and implemented.

The first Multi-Sectoral HIV/AIDS Strategic Framework was developed in 2001 and its implementation, which ended in 2005 was followed by the implementation of the

National Multi-Sectoral HIV/ AIDS Strategic Framework (NSF) for the period 2007-2011. A Joint Annual Review (JAR) of NSF (2007-2011) was carried in 2011. The National AIDS Secretariat has recently developed the NSF for period 2012-2016.

The institutional framework is in line with the Three Ones Principles and is headed by the National AIDS Committee (NAC), a multi-sectoral body established in 1987; its main function is to provide policy guidance. The NAC operates under the aegis of the Prime Minister's Office .The National Aids Secretariat (NAS) which is the executive arm of NAC was set up in 2006 under the aegis of the Prime Minister's Office. The mandate of NAS includes, amongst others,

- tracking of resource allocation, expenditure and accountability,
- planning and facilitation of NSP development process,
- developing policy guidelines for approval by NAC and
- monitoring and evaluation.

Health care services, including VCT, dispensing of anti-retroviral drugs to PLWHAS, induction in methadone, implementation of the Needle Exchange Programme and other services related to HIV and AIDS, in Mauritius, are provided free of any user cost, at the point of use to health consumers.

There were 1523 patients on ART as at 31 December 2012. ARV therapy is provided free of any user cost at the point of use to all patients since April 2002. This service is provided at the National Day Care Centre for the Immuno-suppressed (NDCCI) at Jeetoo Hospital, Victoria Hospital, SSRN Hospital, Jawaharlal Nehru Hospital Prison Department and the Rodrigues AIDS Secretariat.

In line with the overall goal of the NSF 2012-2016, the Harm Reduction Strategy (HRS) is being implemented; this includes the Methadone Substitution Therapy (MST) and the Needle Exchange Programme (NEP). The aims of the Harm reduction Programme are as follows:

- reducing transmission rate of the HIV virus among injecting drug users,

- minimizing the co-morbidity rate in respect to hepatitis B and hepatitis C
- preventing complications associated with injecting practices.

The Needle Exchange Programme (NEP) was introduced and implemented by NGOs in November 2006. In May 2008, the Ministry of Health and Quality of Life embarked into the implementation of the NEP in order to improve access to a greater number of the targeted population. At present, this programme is being implemented throughout the country and covers fifty-one sites (35 Government and 16 NGO) .

The Methadone Substitution Therapy Programme (MSTP) was launched exclusively for male clients in November 2006. It was extended to female clients in March 2008. During the year of this study, 2010, daily maintenance doses were being dispensed through a network of sixteen dispensing units, including a dispensing service in the prison. By 31 December 2012, 5,442 clients had been induced on methadone.

Mauritius remains one among the very few countries in the Region to have legislation on HIV/AIDS. The HIV/AIDS Act was passed in Parliament in December 2006 and proclaimed in August 2007. The Act ensures an effective legal framework to eliminate all forms of discrimination and to ensure the full enjoyment of human rights by PLWHAs. It also provides an effective legal framework for voluntary counselling and testing, for confidentiality of test results and for the implementation of NEP.

Non Government Organizations (NGOs), including religious bodies and the private sector support Government's programme and activities to deal with the HIV/AIDS epidemic in the country. Financial support through the form of grants is provided to some of the NGO's on an annual basis.

1.3 NASA Objectives and Scope

The National AIDS Spending Assessment (NASA) is an HIV/AIDS resource tracking methodology, whose purpose is to track and report on the flow of resources intended to combat HIV and AIDS. It is not an audit; it provides a framework and

tools for undertaking a comprehensive analysis of actual expenditure for HIV/AIDS, describing the allocation of resources from their origin, down to the end point of service delivery, among the various institutions engaged in the HIV and AIDS fight. Given the significant amount of resources being invested in the fight against the disease, NASA helps countries reflect on actual spending against set national priorities. NASA information should thus assist to inform programme and policy level decision makers, among others.

The purposes of NASA are as follows:

- To provide indicators of the country's financial response to HIV/AIDS.
- To support monitoring and resource mobilisation.
- To obtain information in order to improve decision making.
- To define priorities regarding distribution of resources .

The objectives of the Mauritius NASA are:

- To prepare country estimates of total flow of financing and expenditures for HIV/AIDS, from all international and public (domestic public, private and NGOs) sources.
- To develop a database of key financial transactions supporting HIV/AIDS health and non-health expenditures.
- To identify the flow of expenditures by source, function, provider of services, target population
- To prepare a written report of the international, private and public expenditures for HIV/AIDS in Mauritius for evidence based decision-making.

This is the second assessment of AIDS spending in Mauritius. The first spending assessment, undertaken in 2010, covered the financial year 2008/2009. However, as from January 2010 the financial year has been aligned to the calendar year.

Traditionally, Government was using line budgeting. Since July 2008, Government has embarked on a new method of preparing its Budget: the Programme Based Budget (PBB). The PBB is a budgeting system that describes and gives the detailed cost of every programme and sub-programme that is carried out in a budget. The

focus is changed from an input–based activity to a result-based multi-annual activity exercise that clearly links the fund voted by National Assembly to output and outcomes.

This second NASA covered the financial year 2010, tracking actual expenditure among public, external (international) and domestic sources. It was not intended to cover out of pocket expenditure. Like in the first assessment, the current NASA was also expected to assess and possibilities for the NASA to be institutionalized.

The Three Dimensions that Integrate NASA

In NASA, the financial flows and expenditures related to the National Response to HIV are organised according to three dimensions; finance, provision and consumption.

These three dimensions incorporate six categories:

Financing

i. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and also make programmatic decisions.
ii. Financing sources (FS) are the entities that provide money to financing agents.

Provision of HIV Services

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

Use

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

vi. Beneficiary populations (BP) are the targeted segments of the population intended to benefit from the service, e.g. sex workers, men who have sex with men, people leaving with HIV, etc.

1.4 Structure of the report

This report has been organised into four (4) chapters. The first chapter presents background information on HIV and AIDS status globally and in Mauritius. It also discusses Mauritius' response to the epidemic through the National Strategic Framework 2007-2011. Chapter 2 looks at the methodology followed in gathering the data for the report and the key assumptions made in preparing the report. Chapter 3 presents the findings of the NASA in detail. Chapter 4 discusses some of the challenges faced by the stakeholders and makes recommendations based on the findings.

1.5 The National Strategic Framework 2012-2016

The purpose of the National Strategic Framework (NSF) is firstly, to articulate, disseminate, and educate the public at large on agreed national priorities and strategies within a scope of vision and secondly, to provide a clear guidance for Ministries, and NGOs to enable them to work in a collaborative manner in achieving the intended goal of the National Response to HIV/AIDS.

CHAPTER 2: THE METHODOLOGY

The National AIDS Spending Assessment (NASA) resource tracking methodology is designed to describe the financial flows and expenditures using the same categories as the globally estimated resource needs. This alignment was conducted in order to provide necessary information on the financial gap between resources available and resources needed, and in order to promote the harmonization of different policy tools frequently used in the AIDS field[1].

The tracking of spending on HIV and AIDS in Mauritius followed the NASA resource tracking methodology. The processes followed are explained in the following paragraphs.

2.1 Preparatory Work

The process began in February 2012 with the request for data from service providers and financing sources.

2.2 Permission Letters

Formal letters requesting permission to access data were sent to all stakeholders with HIV/AIDS programmes.

2.3 Data Collection

a) Database of all Stakeholders

Using information from NAS, a primary database of all stakeholders involved in HIV and AIDS was developed.

b) Development of Questionnaires

The UNAIDS NASA format for the questionnaires was adjusted to suit the Mauritius situation. These were used by the data collectors during the data collection (Refer to Appendix VI).

c) The Approach to Data Collection

The data collection process used two approaches, namely "top down" and "bottom up". Top down approach involved collecting data from the primary sources and agents. Bottom up approach involved collecting detailed data from the providers and linking this back to the agent and the source. Triangulation was used to create each complete transaction, so as to avoid

double counting. Triangulation implies ensuring that data captured is balanced between that from sources, agents and service providers.

d) Sources of Data

Primary financial data was collected from NAS, Ministry of Health and Quality of Life, international donor agencies and all NGOs. The data also assisted with the identification of all the stakeholders involved in the provision of AIDS services.

The primary sources of data, in most cases provided detailed expenditure incurred by them and disbursements to other organisations, the intention being to trace the funds to the level of the service provider and to use the service providers' detailed data to prepare the NASA.

e) Sites Visits

Site visits were conducted to provide more detailed expenditure information from the service providers at the various level, as well as provide insight into the funding mechanism and implementation challenges.

2.4 Data Processing

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

HIV and AIDS Expenditure Estimations

The following were subject to estimates:

a) ARV Drugs/Medicine Consumption

The objective was to arrive at the cost of drugs/medicine actually consumed. The approach was to obtain the number of patients on ARVs each year and multiply this by the average cost of drugs per year. This information was readily available at the Monitoring and Evaluation unit of the National AIDS Secretariat. ARV drugs given to pregnant women were included under ARVs and hence not calculated separately.

b) Cost of Methadone and cost of inpatient

This was calculated as follows

Number of patients on methadone (5,442) X daily dosage (15ml per patient per day) X price per litre.

c) Patient Care in patient & outpatient

The cost of outpatient was not calculated separately so as to avoid double counting as these cost were already accounted for in terms of salaries of Doctors and cost of ARV.

The cost of inpatient was based on the actual number of patients who attended Hospital and the numbers of births from HIV positive mothers.

Estimates of cost of inpatients were obtained from the report costing of Hospitals services at Victoria and J. Nehru Hospitals which was prepared by Dr Mark Bura.

d) Sexually Transmitted Infections (STI) Drugs

The cost of HIV related STI patients were not accounted for in the NASA 2012.

e) Laboratory Reagents

Viral loads and CD4 counts - were obtained the number of tests per year and cost per unit from VH Laboratory.

Serological test – were based on the number of tests per year from the M&E unit of the NAS and the unit costs from the Procurement unit at the MOH&QL. The estimated spending was calculated by multiplying the number of test per year by the unit cost of each test.

Exchange Rates

Where there is reference to the USD, the following rates of exchange were used for translation of RS to USD: (Rs/USD= Rs 30)

2.6 Limitations of the Collected Data

a) Despite the efforts made to collect data from all organisations, some organisations did not respond. However, information could be obtained from the secondary data source.

b) Completeness of the domestic sources of fund for NGOs cannot be vouched for completeness.

2.7 Challenges Faced

Data Collection and Analysis Related Challenges

1. Slow/ no access to key players' data - Some stakeholders were slow in providing the information required for NASA. All these called for prolonged negotiations in order to access the information.
2. Some organisations, especially NGO's, had problems unveiling their expenditures on accounts. This delayed the process of data collection.
3. Data was available in diverse financial reporting formats that are different from the NASA classifications. It thus took time to customise the data for the NASA.
4. Organisations carry out activities that are difficult to classify according to the NASA spending categories, especially programmes cutting across different

spending categories. In some instances organisations did not provide enough information to enable classification of their activities.

2.8 Validation of Results

The preliminary results of the NASA were presented to NAS on 29 March 2013. Valuable feedback was received, relevant comments have been incorporated in this report.

CHAPTER 3:- NASA MATRICES AND BOUNDARIES

NASA Matrices

NASA is also described as a set of matrices which exhibit the multi-arrayed flow of HIV and AIDS spending, from financing sources to beneficiaries through the financing agents, providers and Aids Spending Categories. The present NASA study incorporates the following three NASA matrices with their respective classification schemes and which are compatible with those proposed by the 2009 UNAIDS NASA Notebook:-

1. HIV and AIDS Spending by Financing Source and type of Financing Agent
2. HIV and AIDS Spending by Financing Agent x Provider
3. HIV and AIDS Spending by Financing Agent x Aids Spending Categories

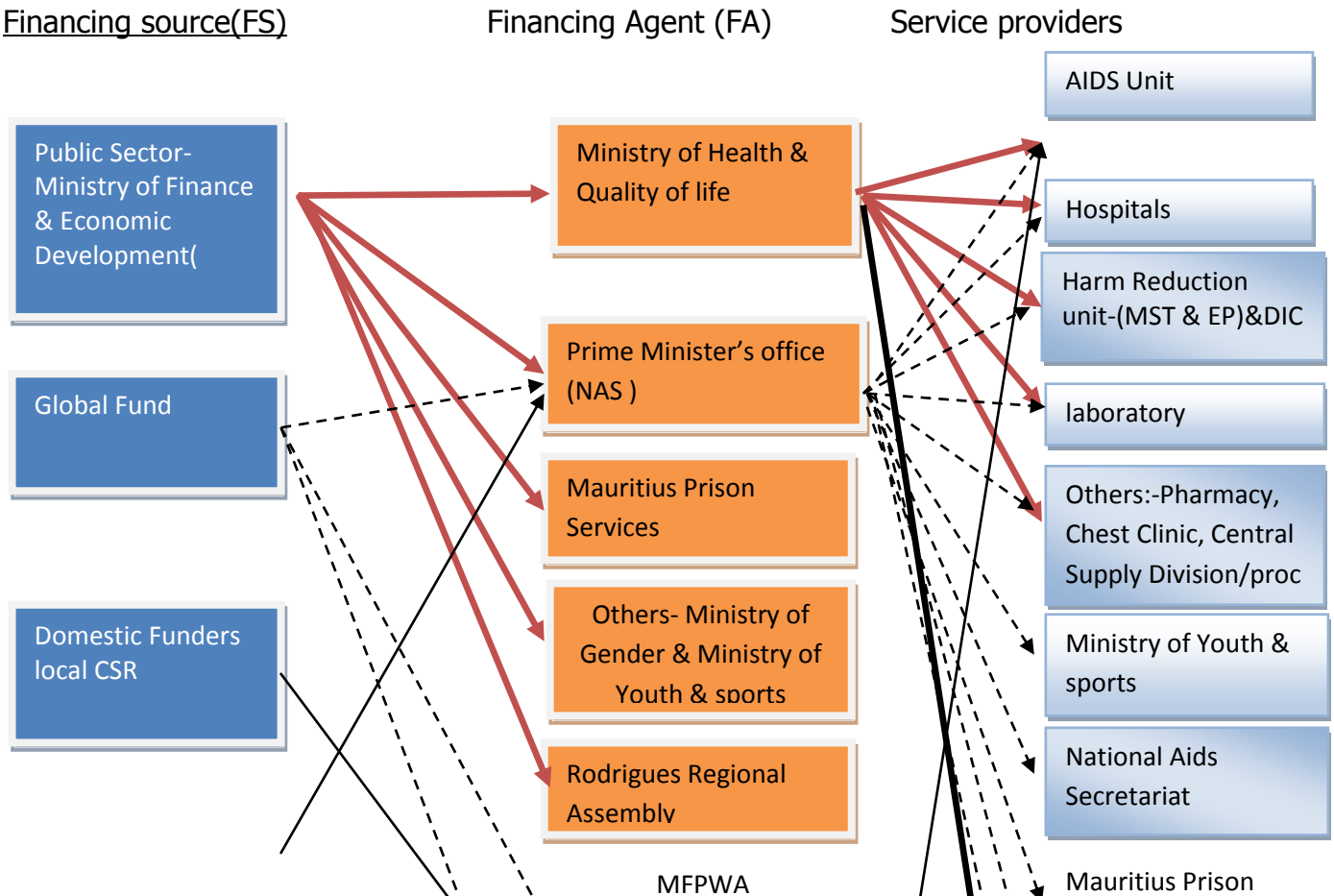
Space and Time Boundaries

For the purpose of the current NASA Study in Mauritius, the boundary of HIV and AIDS expenditure has been defined as follows:-

'Health expenditure on HIV and AIDS encompasses all expenditures whose primary purpose is to restore, improve and maintain the health of the nation, including People Living with HIV during the Financial Year 2012, starting 1 January 2012 and ending 31 December 2012

The space boundary for the NASA exercise has been the tracking of HIV and AIDS spending within Mauritius and Rodrigues.

Figure 3.1: Funding flow for HIV and AIDS



CHAPTER 4: PRESENTATION AND DISCUSSION OF KEY FINDINGS

4.1 Analysis of Matrix on Financing sources by Financing Agents (FS by FA)

The government remains the major source of HIV and AIDS funding in the country, accounting for 72 % of spending in 2012. The increased proportion of spending on HIV in Mauritius from the Multilateral source can be attributed to the Global Fund Round 8 Grant in 2010. **Table 4.1 and figure 4.1**

Table 4.1 : Contribution by Financing Source

	2012		2010	
Financing Source	Value (MRU)	Value in (USD)	Value (MRU)	Value in (USD)
DOMESTIC SOURCES				
Public Fund-National Funding Resource	161,148,617	5,371,621	141,944,274	4,731,476
Private Sector Contributions	3,666,238	122,208	7,698,567	256,619
MULTILATERAL/Bilateral				
European Union	1,683,193	56,106		
The Global Fund to Fight AIDS, Tuberculosis and Malaria	46,643,370	1,554,779	48,586,079	1,619,536
UNAIDS	3,093,378	103,113	4,148,949	138,298
United Nations Development Programme (UNDP) & UNFPA	592,000	19,733	4,296,619	143,221
World Health Organization (WHO)	2,768,610	92,287	345,940	11,531
US Government(GMS)			3,000,000	100,000
World Bank			1,327,391	44,246
Indian Ocean Commission	600,000	20,000	3,857,086	128,570
Ambassade de France & Fight AIDS Monaco			403,028	13,434
INTERNATIONAL NGO'S				
Alliance	233,706	7,790	936,002	31,200
SIDACTION	1,508,760	50,292	1,535,584	51,186
Other NGO's	1,077,823	35,927	116,912	3,897
TOTAL	**223,015,695**	7,433,857	**218,196,431**	7,273,214

Figure 4.1: Contribution as a % Total Financing Source (2012).

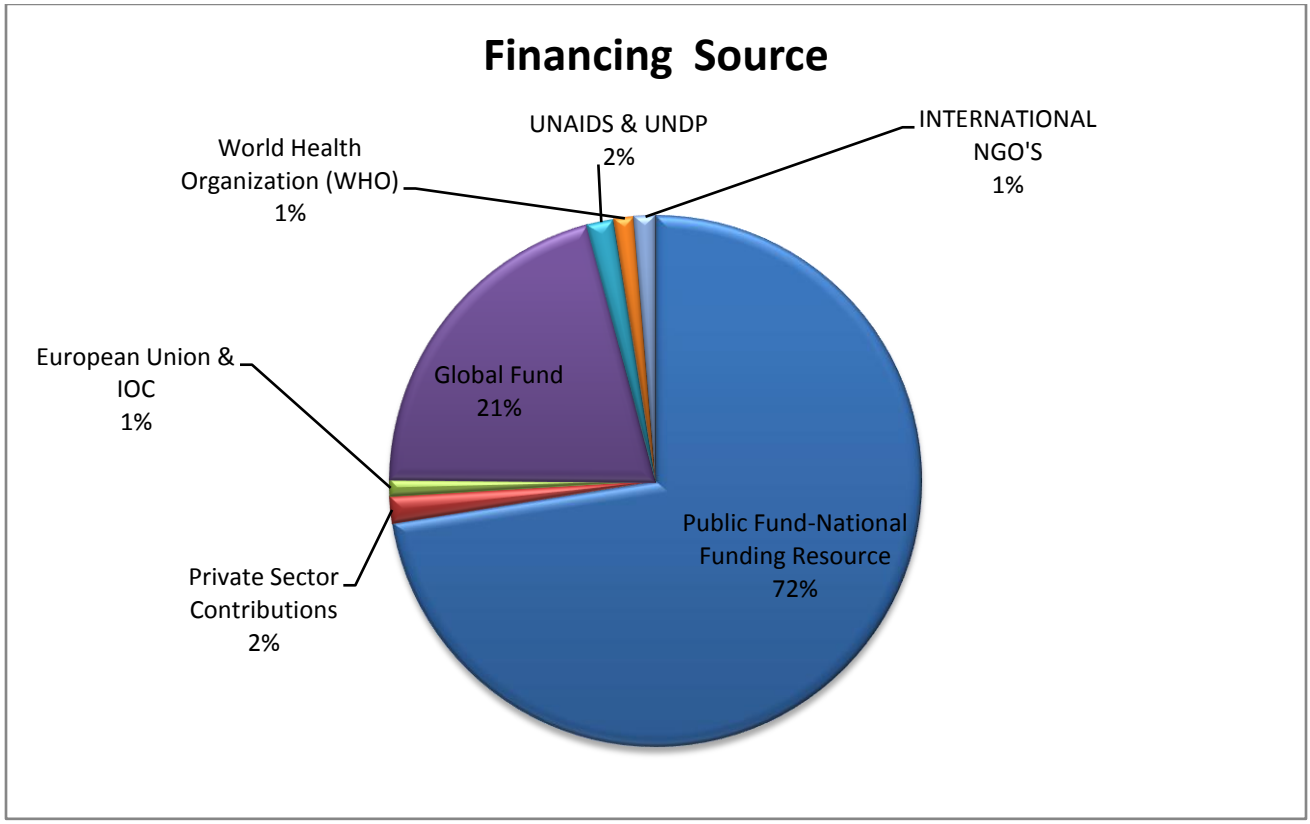


Table 4.1 and **Figure 4.1** show the sources of all funding for HIV/AIDS in Mauritius, split between public, private and external sources. In 2012 public sources contributed 72 % of total HIV/AIDS funds, Domestic private sector contribution was 2 % while external sources contributed 26% of the total national response to HIV spending.

In 2012, externally sourced funds decreased from Rs 68,553,590 in 2010 to Rs 58,200,840. As shown in figure 3.1, the bulk of the external finance was from The Global Fund to Fight AIDS, Tuberculosis and Malaria, which represented 21% of the external finance out of 26 %. External aid overwhelmingly came from the Global Fund against HIV and AIDS, TB and Malaria (GFATM). In response to a proposal submitted by the Country Coordinating Mechanism, led by the National AIDS Secretariat (NAS) in 2009, the Global Fund agreed to support the expansion of HIV collaborative activities over a period of five years (2010 to 2014). Therefore, in 2010 Mauritius was the recipient of the GFATM Round 8 grant. The phase 1 which was for a period of two years

(2010&2012) has been successfully completed. The phase two approval was the result of remarkable performance of the programme and the grant was further renewed to three years (2012 to 2014).

International Sources:

International donor organisations also spent significant funds on care and treatment (through purchase of ARV drugs by the Global fund) but spent a relatively high proportion on program management related to capacity building of NGOs and community programs and health systems strengthening.

A decrease of Rs 10.3 million is noted in year 2012 compared to 2010, which is due to the fact that in 2010 substantial amount were received in the form of technical assistance for national capacity building .

In 2010, The United state Government through the Grant Management Solutions (GMS), responded favourably to the request of the NAS to provide technical support to Mauritius in preparation of the Round 8 Grant and to put in place systems and mechanism for the implementation of the grant. The GMS was instrumental in national Capacity building; the estimated cost of consultancy amounted to Rs 3 million (USD$103,448).

Furthermore, Rs 4,148,949 were received from UNAIDS (USD$143,067). However, out of this, Rs 3,283,583 (USD$113,227) were mobilised directly by the NAS through AIDS Strategic & Action Plan Service (ASAP) amounting to USD$ 51,280 for the Medium Term Review and from TSF amounting to Rs1,796,463 (USD$61,947) for the elaboration of the Round 10 proposal.

Private Sources

Private sector contribution amounted to 2% of total sources of fund. The funds were channelled directly to NGOs and were used mainly for prevention and programme management.

4.2 Analysis of Matrix on Financing Agents by Service providers (FA by SP)

Financing agents are entities that pool financial resources to finance service provision programmes and also make programmatic decisions.

Table 4.2 & **Figure 4.2** indicate that government acts as the major funding agent for HIV and AIDS expenditure. In 2012, 87% of funds were managed by government entities (including NAS). The private sector managed 13% of the total funds.

Table 4.2: HIV Spending Summary 2012 (MUR) by Financing Agent

Financing Agents	Total
Ministry Of Health& Quality of Life	**144,827,375.00**
Other Ministries-MYS , Mauritius prison Services, Ministry of Gender Equality	**9,100,000.00**
National AIDS Secretariat	**40,417,631.00**
PILS & NGO's	**27,724,693.00**
Multilateral/Bilateral	**945,996.00**
Total	**223,015,695.00**

Figure 4.2- HIV spending by Financing Agents

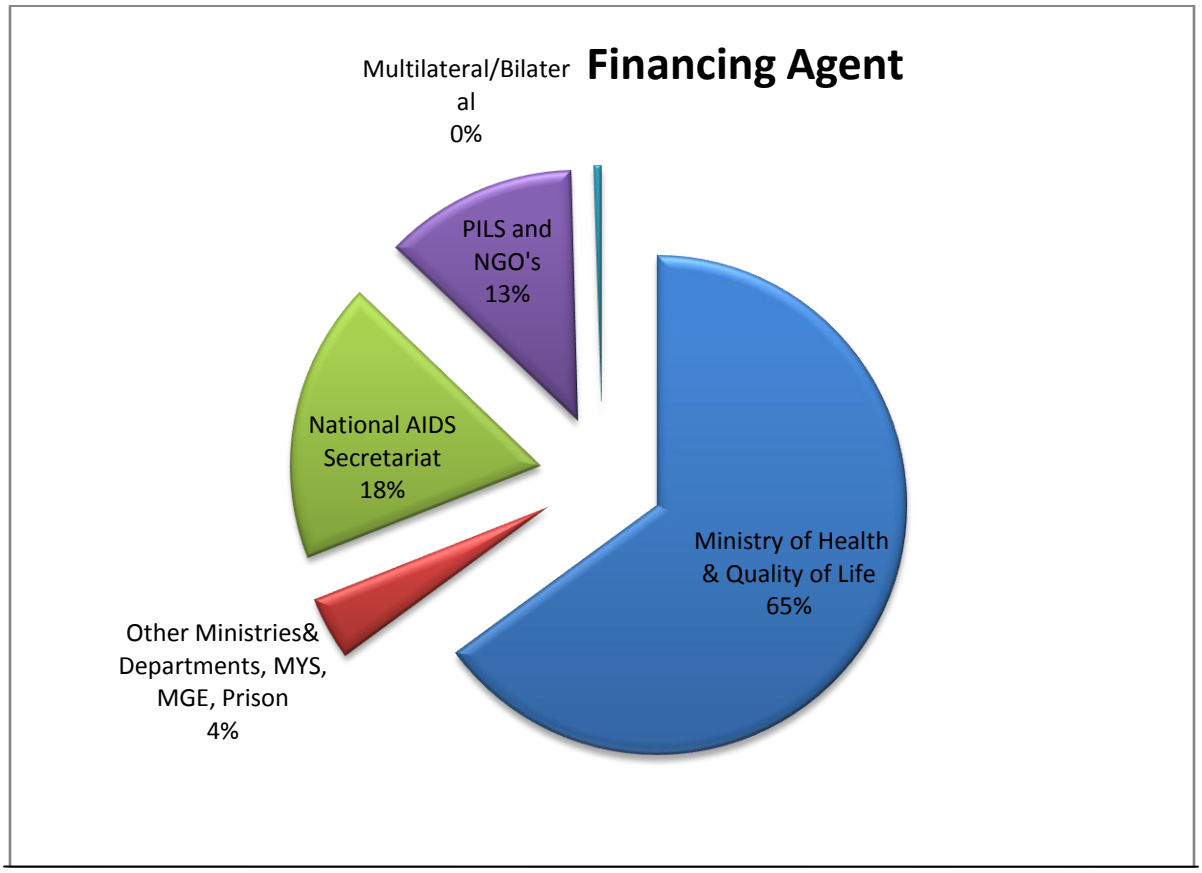


Table 4.2 and figure 4.2 refer to entities that pool financial resources to fund service providers. National AIDS Secretariat has been instrumental in obtaining fund from several sources in response to HIV intervention in Mauritius. Apart from Global Fund Grant, the National AIDS Secretariat successfully received consultancy services from various sources for the development of NSF 2012-2016.

The Non Governmental organisation represented 13% of the share as financing agents, coming mainly from Global Fund (7.4 %), the PILS being the financing agents.

4.3 Summary of Expenditure by AIDS Spending Categories (ASC)

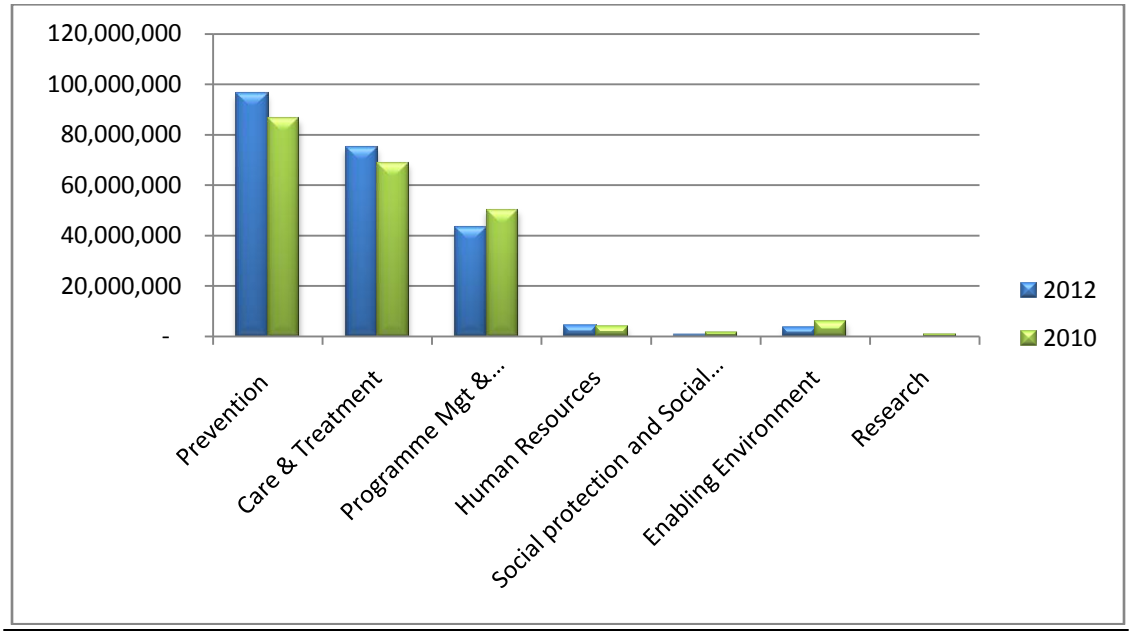
This section presents the activities on which funds were spent in Mauritius, by broad categories (Prevention, Care and Treatment, Programme management and Administration, Human Resources etc.), further disaggregated into specific activities/interventions.

Table 4.3: Breakdown of the main categories of HIV/AIDS activities in Mauritius for 2010 and 2012

AIDS Spending Categories	2012	Share of Total-%	2010	Share of Total-%
Prevention	96,479,263	43	86,560,864	39.5
Care & Treatment	74,850,113	34	68,943,060	32
Programme Mgt & Administration	43,266,177	19	50,245,233	23
Human Resources	4,258,827	2	3,895,850	2
Social protection and Social Services	668,000	0	1,673,455	1
Enabling Environment	3,493,375	2	5,852,782	3
Research			1,025,187	0.5
TOTAL	223,015,695	100	218,196,431	100

As per table 4.3, Rs 96,479,263 was spent on prevention, essentially on the Harm Reduction programmes (MST & NEP). Care and treatment increased by Rs 5.9m in 2012. Prevention remained the largest consumer during the two years under review, there was a increase from 39.5% to 43 % of the total national spending. It is to be noted that relatively low expenditure went to other categories.

Figure 4.3.1: Comparison of NASA 2012 and 2010 by AIDS spending categories



With regard to Mauritius spending activities of 2010 and 2012, **Figure 4.3.1** shows that Prevention was the major consumer in both years and confirms the high spending on Harm Reduction. However, care and treatment has increased from 32 % to 34 % largely due to the increased in number of patients on ART from 1115 as at December 2010 to 1523 in December 2012.

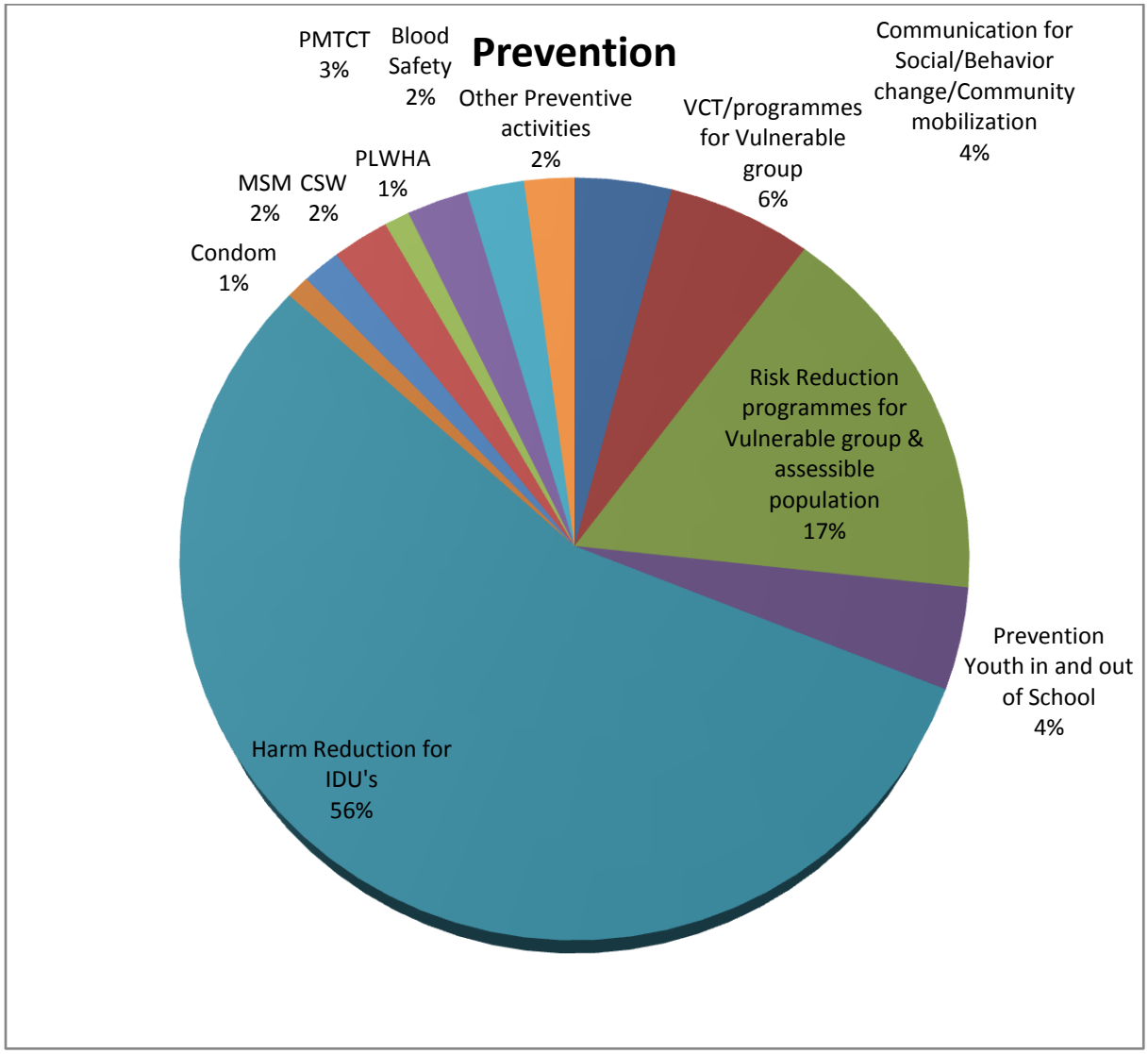
4.4. Breakdown of Spending on Prevention Activities

Overall, funds spent on prevention activities increased from Rs 86,560,864 to Rs 96,479,263. The spending pattern on prevention activities is largely driven by increased expenditure on VCT/programme for vulnerable group, community mobilization and prevention youth in and out of school. In both 2010 and 2012,the largest component was spent on Drug substitution treatment as part of programmes for IDUs .

Table 4.4.1 Summary of Expenditure by AIDS Spending Categories (Prevention)- 2012

Prevention Activities	Exp in Rs 2012
Communication for social and behavioural change & Community mobilization	5,424,939
Voluntary counselling and testing (VCT)	6,825,828
Risk-reduction for vulnerable and accessible populations	9,526,948
Prevention – youth in school	3,766,909
Prevention – youth out-of-school	1,062,788
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	2,044,182
Prevention programmes for sex workers and their clients	2,702,000
Programmes for men who have sex with men (MSM)	1,793,000
Harm-reduction programmes for injecting drug users (IDUs)	53,929,838
Prevention programmes in the workplace	1,000,000
Condom social marketing	1,116,850
Prevention of mother-to-child transmission (PMTCT)	2,902,788
Blood safety	2,700,000
Prevention activities not disaggregated by intervention	1,683,193
Total	*96,479,263*

Figure 4.4.1-Prevention Activities Year 2012



4.5. Breakdown of Spending on HIV –Care and Treatment

There was a significant growth in expenditure on treatment, from Rs 69 million in 2010 to Rs 75 million in 2012. HIV-related monitoring and ART constituted the bulk of spending, Rs 27.6 million. The cost of ART include cost of ARV amounting to Rs 20 million and cost of physicians and nurses amounting to Rs7 million . HIV-related laboratory monitoring represents laboratory expenditures on determining CD4 cell count and viral loads etc. It is to be noted that cost of outpatient care is not accounted separately so as to avoid double counting , the medical care delivered without requiring admission is included in the cost of ARVs and the human cost for physician for treatment and care. The estimated cost for out-patient HIV treatment for 2012 was Rs 20.4 million. There were approximately 883 in-patients in 2012 and 60 deliveries out of which 45 were by caesarian section.

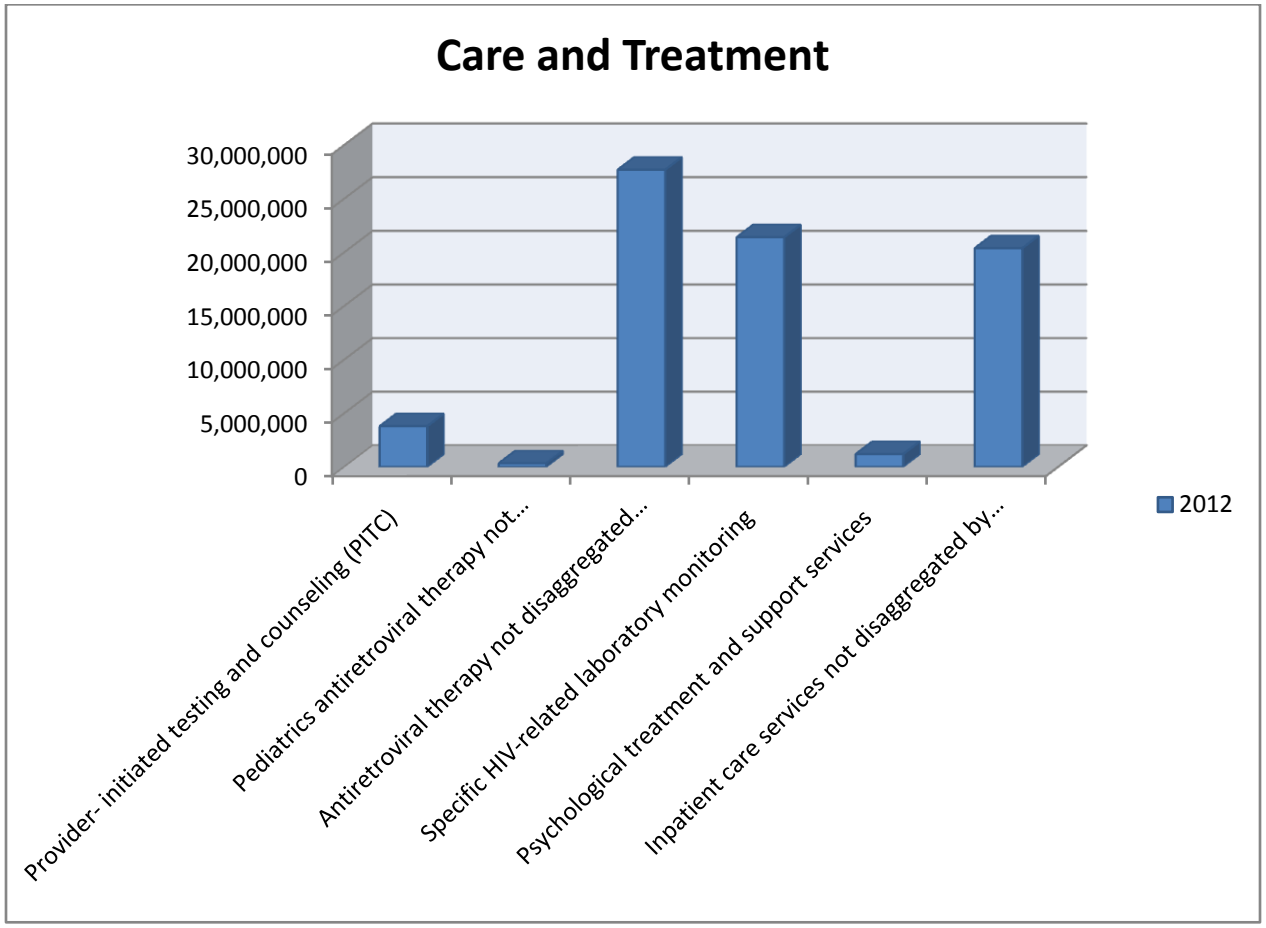
The cost of ARV's are based on actual consumption of ARV which were calculated taking into consideration the number of patients on ARV. During 2012, 1563 adults and 15 children were receiving ARV treatment.

. **Table 3.5.1** Summary of Expenditure by AIDS Spending Categories Care & Treatment-2010 & 2012

Treatment and Care Activities	2012 Amount In Rs
Provider- initiated testing and counseling (PITC)	**3,800,000**
Pediatrics antiretroviral therapy not disaggregated by line of treatment	**337,228**
Antiretroviral therapy not disaggregated neither by age nor by line of treatment	**27,707,128**
Specific HIV-related laboratory monitoring	**21,415,087**
Psychological treatment and support services	**1,200,000**
Inpatient care services not disaggregated by intervention	**20,390,670**

Total	**74,850,113**

Figure 3.5.1: Care and treatment spending- 2012



4.5. Breakdown of Spending on Programme Management and Co-ordination

The overall spending on programme management and coordination category decreased from Rs 61.3 million, representing 34% of total expenditure in 2008/09 to Rs 50.2 million in 2010 (23% of total Expenditure). As shown in **Table 4.5,** planning, co-ordination and management constituted the main activity in this category. Of concern is the drop in M&E funds from Rs 16 million (2008/9) to Rs 4.8 million in 2010. It is possible that the data in 2008/2009 was not well disaggregated, as in the later years. Also some of the expenditure in the category "M&E" includes planning and co-ordination. Investments were made for upgrading laboratory infrastructure and new equipment amounting to Rs 12.6 million, which included the procurement of PCR amounting to Rs 3.5 (financed by UNDP), automated methadone dispensing machines (Rs 7.6 million) and CD4 apparatus (Rs 2.5) both financed by GFATM.

Table 3.5-Programme Management and Administration

Programme Management and administration	**2012 Expenditure**
Planning, coordination and programme management & programme administration	**28,959,143**
Administration cost	**1,089,878**
Monitoring and evaluation	**5,981,373**
Serological	**2,560,016**
Patient Tracking	**774,234**
Upgrading & construction of infrastructure	**3,901,473**
Total	**43,266,117**

4.5 Other AIDS Spending categories

A total sum of Rs 8,420,202 (4% of total spending) was spent on Human Resources, social protections and social services, enabling environment and research. The cost of Human Resources amounted to Rs 4,258,827 which included monetary incentives for human resources and expenditure incurred in respect of training and workshops. The salary paid to staff are accounted for in the separate identifiable ASC whereby they are providing services. Furthermore Rs 3,493,375 were spend on enabling environment in terms of strengthening the ability of key local institutions to implement HIV programmes efficiently and capacity building. This was provided by UNAIDS in terms of services provided by international experts for the development of NSF and RBM.

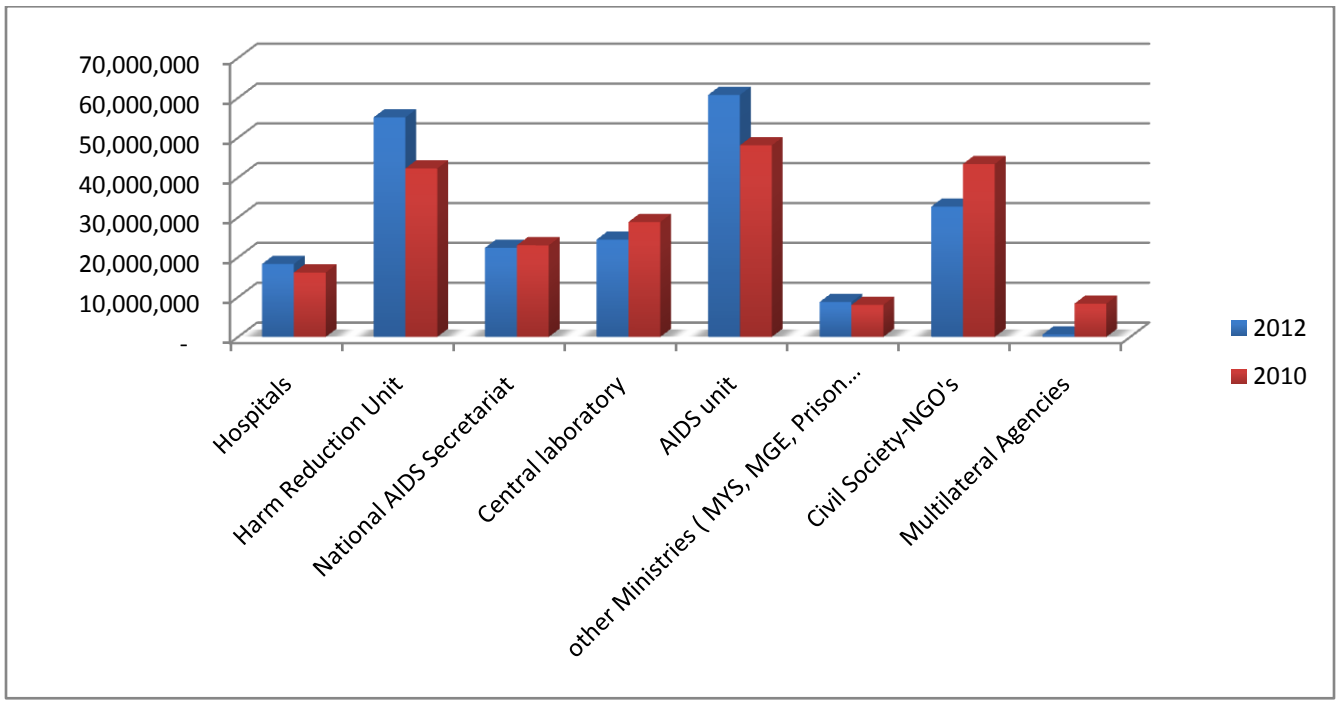
4.6. Providers of HIV/AIDS in Mauritius

Table 4.6 &Figure 4.6 shows the value of services offered by the various providers. However, when viewing this data, it is important to note that in the services provided by hospitals do not include the expenditure in respect of opportunistic infections. This may contribute to an under-reporting of expenditure at the level of the hospitals. The civil society provided 20% of HIV related services which comprised of prevention programmes.

Table 3.6: HIV/AIDS Spending by Service Providers (2012) & Comparative (2010)

	2012	2010
Service providers	**Total(Rs)**	**Total(Rs)**
Hospitals	18,304,022	16,164,048
Harm Reduction Unit	55,113,882	42,288,323
National AIDS Secretariat	22,376,280	22,997,465
Central laboratory	24,424,820	28,850,940
AIDS unit	60,747,425	48,099,870
other Ministries (MYS, MGE, Prison Dept)	8,755,973	8,026,299
Civil Society-NGO's	32,693,293	43,414,332
Multilateral Agencies	600,000	8,355,154
Total	223,015,695	218,196,431

Figure 4.6:HIV/AIDS spending by service providers (2012)



- **Public Hospital Funding Activities and Processes**

The funding for the core activities of hospitals is by the government, through the Ministry of Health and Quality of Life. All drugs and reagents are purchased centrally, through the Central Supply Division of MOH & QL,

Hospitals services can broadly be classified into inpatient and outpatient care and treatment.

The cost of outpatient is not calculated separately to avoid double counting, these cost are included in cost of ARVs and salaries of physicians and nurses. The service providers by hospitals include only the cost of inpatients.

Hospitals order all drugs/medicine from the Central Supply Division of the Ministry of Health and Quality of life, therefore the cost of ARVs are included in the budget of Ministry of Health & QL under programme based budget line 584: Multisectoral Response to HIV/AIDS.

- **Harm Reduction unit**

  The Harm Reduction Unit manages the MST and the needle exchange programmes. Similarly methadone and needles & syringes are centrally procured by MOH &QL. The cost of methadone is calculated multiplying the average cost per dose by the number of patients. It is assumed that the average daily dose is 15ml per patient. The cost of methadone per litre is Rs 645.

  There are 2 drop-in centres namely Cassis (Bouloux), Mahebourg and 2 residential Centres at Barkly (one for males and one for females).

  Methadone is delivered through 16 dispensing points at 5 hospitals, 7 sites per day through the caravan service, 2 drop in centres, one residential and at the prison.

- **National AIDS Secretariat**

  NAS coordinates all HIV activities funded using public funds and is also Principal Recipient of the Global Fund Grant. NAS also coordinates all funding from international sources namely the GFATM and other sources of Fund and it is instrumental in strategic decision-making and implementation of HIV interventions in Mauritius. The NAS operates under the aegis of Prime Minister's Office and therefore these funds follow the government procedures .

- **The Central laboratory**

  Blood samples are sent to Central laboratory at Victoria Hospital for testing and diagnosis purpose. Reagents and test kits are procured centrally by MOH & QL. The cost for laboratory includes the entire testing process; physician, laboratory , cost of test and reagents and post-test counselling.

- **AIDS unit**

  The AIDS unit comprised of several service delivery points for care, treatment and prevention namely, NDCCI, SSRN Hospital, Jawaharlal Nehru Hospital and Victoria

Hospital which provide both prevention & treatment whereas Flacq Hospital provides only prevention services.

- **Civil Society and NGO's**

  The PILS is the Principal recipient of Global Fund Grant for Civil Society as from 2011. There were 11 NGO's involved in the HIV intervention carrying out mainly prevention activities. Thus PILS is the Financing Agent under the Global Fund project and the NGO's acted as service providers.

  NGOs normally go through the process of tendering for international donor funds and domestic funds. NGOs receiving funding from the government have to submit proposals which go through the government funding procedures before approval.

4.7 Beneficiaries of HIV Spending in Mauritius

The NASA classification allows for the identification of the beneficiaries of every service delivered. These are broken down into six general groups, with various sub-categories, as follows:

1. People Living with HIV/AIDS (PLWHA)
    - Disaggregated by age and gender, where data allow
2. Key Affected Populations (KAPs)
    - Commercial Sex Workers (CSW)
    - People Who Inject Drug (PWID)
    - Men who have sex with men (MSM)
3. Orphans and vulnerable children (OVCs) and vulnerable groups
    - Babies to be born of HIV-positive mothers
    - Migrants
    - Refugees
    - Children living on the street
    - Truck drivers
4. Accessible populations
    - Children in school or college
    - Patients of STI clinics
    - Health care workers
    - Sailors
    - Police and military forces
    - Workplace employees
5. General population
    - Disaggregated by age and gender, if such data were given by the service providers
6. Non-targeted interventions (with no specific beneficiary group).

Figure 4.7 shows the amount of expenditure targeted to each of the five main categories of beneficiaries of HIV services. Throughout the period, people living with HIV/AIDS (PLWHA) consumed the largest part of the HIV/AIDS funds as the beneficiary group. Spending on programmes targeted KAPs represent 35% of the total Expenditure. In 2012, Rs 77.8 million targeting KAPs were allocated as follows: Rs 67.9 million to PWID as beneficiary, Rs 5.6 million to commercial sex workers (CSW) and Rs 4.3 million to men who have sex with men (MSM).

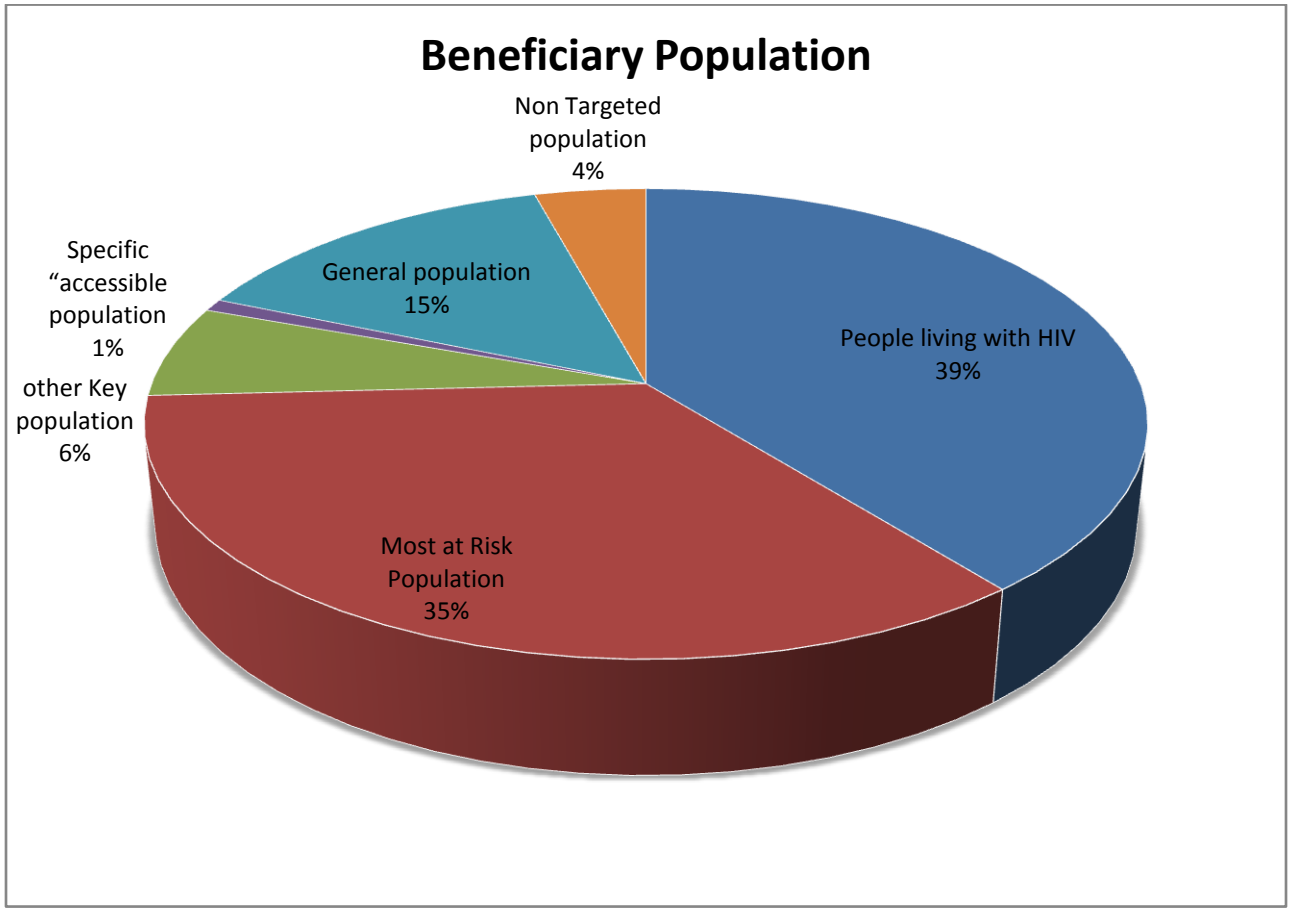
There is no targeted intervention for orphans and vulnerable children (OVC) and vulnerable groups. However, one of the key organization (NATReSA) involved in rehabilitation programme did not provide details of expenditure or targeted beneficiary population for HIV programme. It is to be noted that NATReSa received a grant of Rs 51 million in 2012 under programme 584, Multi-sectoral Response to HIV, for rehabilitation programme for alcoholics and drugs addicts.

As per the information gathered from NATReSa , there is a immaterial proportion of the grant is targeted to HIV.

Table 4.7: Beneficiary population of HIV services

	2012	2010
Beneficiary Population	**Amount Rs**	**Amount Rs**
People living with HIV	87,568,586	86,026,216
Most at Risk Population	77,862,033	66,619,915
other Key population	14,143,988	15,559,401
Specific "accessible population	1,904,282	3,954,139
General population	32,110,978	31,248,031
Non Targeted population	9,425,828	14,788,729
Total	**223,015,695**	**218,196,431**

Figure 4.7 Beneficiary population of HIV Services (2012)

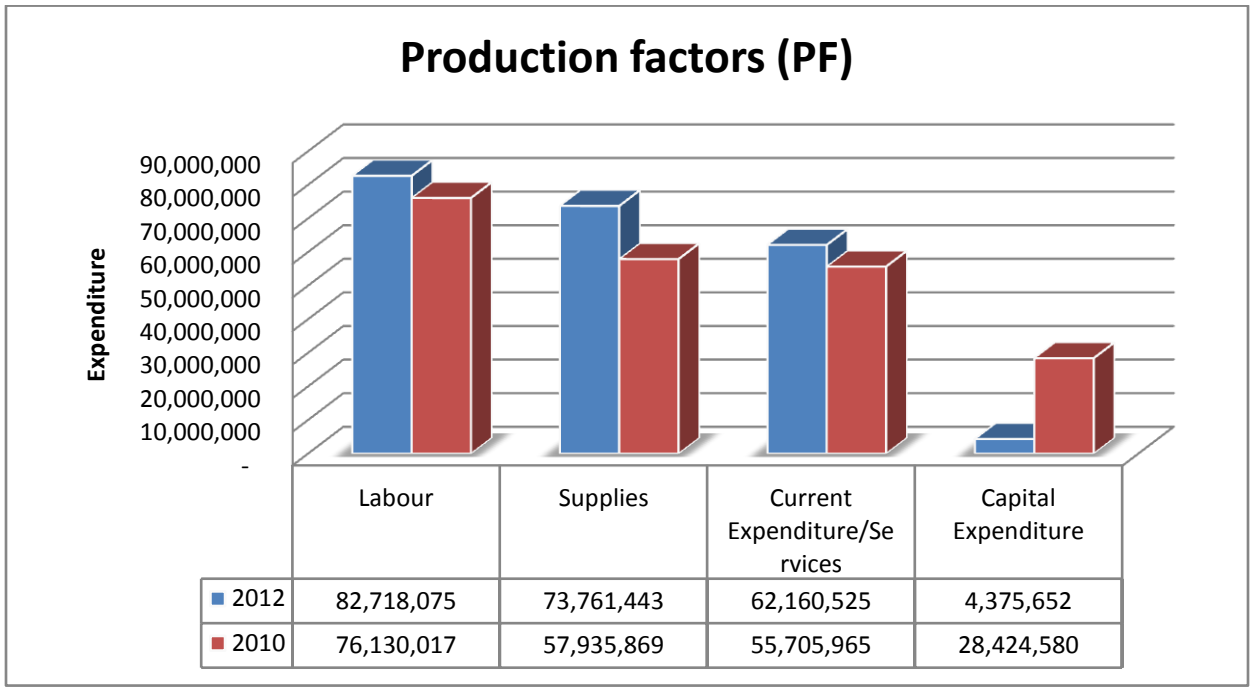


4.8 Breakdown by Production Factor

In NASA the classification of production factors categorizes expenditures in term of resources used for the production. These are classified under 4 broad categories namely labour income, supplies, services/current expenditure and capital expenditure. The current NASA went one step beyond the first one by breaking down the spending for each service provider into production factors/budgetary items. Labour cost is the largest consumer of the resources, followed by supplies and services. The labour income represent wages and salaries and other forms of compensation in kind, overtime and bonuses and various allowances in providing HIV services. The supplies and services comprised of mainly the payment for ARV (Rs14.6 million), Methadone (Rs 11.7 million) and reagents(Rs 22.2million). The cost of services amounted to Rs 56 million which consisted of consultancy services and other current expenditures not broken by type.

Capital expenditure comprised of procurement of vehicles (Rs 4 million), Information Technology (Hardware and Software) Rs 4 million and laboratory equipment amounting to Rs 13 million.

Figure 4.8 Spending by production factors



CHAPTER 4: RECOMMENDATION AND CONCLUSIONS

4.1 Improved financial information systems

There is the need to improve the financial information system in terms of the quality and accuracy of HIV/AIDS expenditure data. For instance, under the Programme Based Budget, programme 584 of Ministry of Health &Quality of life funds are earmarked for the multisectoral response to HIV/AIDS. However, this programme is not representative of all HIV interventions in Mauritius. The salaries of physicians, nurses and other staff who are directly involved in the programme are not shown under programme 584.

On the other hand grant to Natresa amounting to Rs 52 million is included under programme 584, multisectoral response to HIV, thereby overstating the national response to HIV.

All expenditure under government programme for HIV should be included under programme 584.

4.2 Institutionalisation of NASA

The usefulness of any information for decision making purposes is based on its timely production. Thus for policy and decision makers to make appropriate use of the NASA findings, it ideally should be undertaken regularly (annually). This is possible if NASA is institutionalised within the Monitoring and Evaluation (M&E) framework. Reporting of NASA information can be integrated with the existing mechanism within the M&E framework. However, these processes require standardization of the expenditure information reporting from all the various organizations.

4.3 Statistics for HIV patients & OI

One of the biggest challenges associated to this exercise is the estimated expenditure with regard to HIV at hospital level. With the health statistics excluding HIV co–infections reporting, there is need to reinforce monitoring of patients with HIV related complications using hospitals services. It will provide a better basis for the allocation of patient care spending.

4.4 Grant allocated to NATReSA

An annual grant of Rs 51 million was allocated to NATReSA for the year 2010 by MOH & QL under programme 584 "Multi Sectoral response to HIV/AIDS". In respect to the actual NASA exercise, they were unable to report the cost of interventions related to HIV.

The Ministry of Finance & Economic should consider the classification of grant to NATReSA to other programme based budget instead of Multi Sectoral response to HIV/AIDS

References

The National Strategic Framework for HIV/AIDS 2012-2016

Central Statistics Office

Ministry of Finance- Government Budget

NASA 2010

UNAIDS: National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions

UNAIDS (2008): Report on the Global AIDS Epidemic

www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp

Report costing of Hospitals services at Victoria and J.Nehru Hospitals by Mark BURA

APPENDICES

APPENDIX I– Spending Matrix 2012 (Financing source by financing Agents)

APPENDIX II– spending Matrix- Financing Agents by Service Providers

Appendix III– Spending Categories by Service Providers 2012

HIV/AIDS SPENDING ASSESSMENT IN Mauritius (NASA)

FORM 3 FOR ALL PROVIDERS OF HIV/AIDS SERVICES

(Government, Private Sector, NGO's, Bilateral, Multilateral)

Year of the expenditure estimate:2010 (January 2010 to December 2010)			
Objectives of data collection from the Provider: I. To identify the origin of the funds spent by the provider in the year understudy. II. To identify in which NASA Functions/ activities the funds were spent. III. To identify the NASA Beneficiary Populations for each NASA Function/ activity. IV. To identify the NASA Production Factors for each Function/ activity.			
Name of the Organization Providing HIV/AIDS Services:			
1. Person to Contact (Name and Title):			
Address:	**E-mail:**		
Phone:	**Fax:** **NASA code**		
2. Type of institution: Select category of institution with an "X" & put NASA code	1. Ministry of Health & Quality of life, specify unit……		
	2. Ministry of Youth&Sports		
	3. National AIDS Secretariat-PMO's office		
	4. Mauritius Prison services		
	5. National Women Council		
	6. Other Govt Body, Specify……		
	7. Country Coordinating Mechanism		
	8. PILS		
	9. Local NGO's, specify……		
	10. International NGO/CSO (Solidarity SIDA, SIDACTION,etc) Please Specify……		
	11. Bilateral Agency, specify……		
	12. Multilateral Agency(UNDP,EU,COI,WHO,UNFPA , please specify……		

	13. Other (specify):.....		
In which Currency will you present your Expenditure data?		**RS**	

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)**

2010 Income(Jan 2010 to Dec 2010)

3. A. Origin/ Source of the funds your organization received in 2010: List the institutions that gave your organisation funds which you spent during 2010.
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 (Amount in Rs)
7.1 Source: Agent: (Ask who makes decisions on the use of funds for this source & code accordingly)	
7.2 Source: Agent:	
7.3 Source: Agent:	
7.4 Source: Agent:	
7.5 Source: Agent:	
TOTAL:	

3B. Origin of non financial resources (donated goods) 2010: List the institutions that granted *non financial* resources during 2010

Origin of the non financial resources (Name of the Institution and Person to Contact)	Type of Resource received & Quantity -Qty	Monetary Value of ONE Item (in Year of Assessment) -Unit cost	Total Monetary Value of Items Received Rs
7.6 Institution:			
7.7 Institution:			
7.8 Institution:			
7.9 Institution:			
7.10 Institution:			
TOTAL:			

2010 Expenditure

4. Use of the funds your organization received for services delivered in 2010:

I. Identify and quantify the NASA Functions in which the funds were spent.
II. Identify and quantify the NASA Beneficiary Population(s) of each Function.
III. Disaggregate the beneficiaries by Gender and Adult/Child, if possible
IV. Please include your overheads & management/support costs (shared or total)

Expenditure of the funds received from "i" = Source & Amount =

Function (Activity) 1 (describe & code later):	Amount spent

		(Rs)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 2 (describe & code later):		Amount spent (RS)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 3 (describe & code later):		Amount spent (Rs)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 4 (describe & code later):		Amount spent (Rs)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	

Beneficiary Population:	Nos Of Benefs:	
Overheads/ admin /support costs (if not already included in the above)		
Total Expenditure from the amount from 'i'		
Total un/overspent from the amount from 'i'		

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

2010 Expenditure cont.

Expenditure of the funds received from "ii" = Source & Amount =		
Function (Activity) 1 (describe & code later):		Amount spent (Rs)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 2 (describe & code later):		Amount spent (Rs)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	

Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 3 (describe & code later):		Amount spent (Rs)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
Function (Activity) 4 (describe & code later):		Amount spent (ZAR)
District of implementation:	Total spent on this Activity/ Function:	
Beneficiary Population:	Nos Of Benefs:	
Beneficiary Population:	Nos Of Benefs:	
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?

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

2010 Use of Non-Financial Goods

NON-FINANCIAL (DONATED) GOODS – INDICATE HOW THESE WERE USED in 2010

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

QUALITATIVE QUESTIONS

For the following questions, the interviewer should NOT read the possible responses. Rather allow the person to explain and then choose the option that best captures their response. If there is no suitable option, then indicate in the other section what the response was.

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

1. Funds from the Ministry of Health are very limited and specific

2. Reimbursement methods are used to secure funding, i.e spend first and claim later and at times we run out of funds

3. Process for application is difficult. There are many bureaucratic procedures & technical proposal requirements

4. Securing external funds is very difficult because donors have restrictions and requirements that are stringent. Securing donor funds is not easy

5. Usually less funds are received compared to what was applied for

6. Linking activities to expenditures with respect to the performance based budget is difficult

OTHER:

_____

_____

_____

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

1. Management and staff are only trained when service level agreement is signed

2. Different donors have different reporting requirements

3. At times funding comes in late and harmonizing reporting times becomes very difficult

4. Staff members are not trained in report formats and how to report, therefore errors often occur

6. Latest report is required before release of funds. At times funds are released late, so reporting automatically becomes shifted to a later date

7. At times there are overspending challenges

8. M&E systems are not standardized and some organizations do not even have them in place

9. Some funds i.e DOH come with conditionalities. i.e funds are for specific activities leaving out some activities that are necessary for the communities

OTHER:

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

1. Funding is so limited

2. The processes of releasing funds from public sources i.e DOH & SDS are often slow thus delaying implementation

3. Payments to suppliers especially in procurement processes is slow.

4. Infrastructures for service delivery are poor

5. Shortage of HBC materials and nutritional supplements

6. Lack of well-trained health workers due to low wages paid

7. Stigma is still a problem in communities, so many people shy away from interventions because people do want to be associated with an organization dealing in HIV/AIDS activities

OTHER:

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d. How could these be addressed or reduced?

1. Increase health worker salaries
2. Should try to allocate funds according to budgeted activities
3. Increase stipends for volunteers
4. Put proper systems and infrastructure for better service delivery
5. Training is crucial in HIV/AIDS implementation and report writing
6. Streamline and harmonize reporting times, procedures and formats
7. Release funds on time
8. Deposit the funds directly to the beneficiaries accounts.
9. Making the funding proposals in more friendly-user manner
10. Improve procurement procedures and pay suppliers on time

OTHER:

e. Any other problems or suggestions for improving financing for HIV/AIDS?

1. Increase HIV/AIDS funds in all sectors the public, private and external source
2. Public sources should increase its funding support to the NGO work
3. External sources/donors should target their funding more to NGOs than government facilities
4. Increase sources of HIV/AIDS funds by mobilizing other sources of financing other than government and donors
5. Funds for HIV/AIDS supplies should be released on time for better implementation
6. Departments should finance more direct programmes in the community i.e HBC
7. Monitoring and evaluation should be implemented closely by sector department in every community project funded
8. The DOH should increase its funds in the ART programme in order to improve the salaries of Doctors as they are paid at a lower level.

OTHER:

_____

_____

****

THANK YOU!