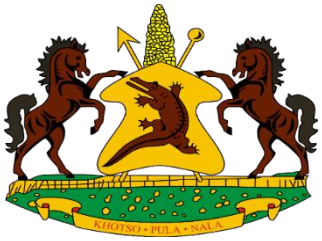

Government of Lesotho

NATIONAL AIDS SPENDING ASSESSMENT (2015/2016 – 2017/2018)

NATIONAL AIDS COMMISSION

UNAIDS

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ABBREVIATIONS AND ACRONYMS

ADR	Acquired Drug Resistance
AGYW	Adolescent Girls and Young Women
AMR	Analytical Measurement Range
ART	Anti-retroviral Therapy
BCC	Behaviour Change Communication
CAGs	Community Antiretroviral Groups
CBO	Community Based Organizations
CHAL	Christian Health Association of Lesotho
CHEAL	Comprehensive HIV Epidemic Analysis Study for Lesotho
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DBS	Dry Blood Sample
DHIS 2	District Health Information System 2
DRS	Drug Resistant-TB Survey
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
FBC	Full Blood Count
FSW	Female Sex Workers
GHO	Global Health Observatory
GOL	Government of Lesotho
HCW	Health Care Worker
HIVDR	HIV Drug Resistance
HRH	Human Resources for Health
HTS	HIV Testing Services
IMR	Incidence Mortality Ratio
INH	Isoniazid
IPC	Infection Prevention and Control
IPM	Incidence Pattern Model
IPT	Intermittent Preventive Therapy
LAM	Lipoarabinomannan Assay
LDHS	Lesotho Demographic Health Survey
LePHIA	Lesotho Population-based HIV Impact Assessment
LOMSHA	Lesotho Output Monitoring System for HIV and AIDS
LF	Lumefantrine
LF-LAM	Lateral Flow Urine Lipoarabinomannan Assay
LMPS	Lesotho Mounted Police Service
LRF	Lab Request Form
LTFU	Lost to Follow Up
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant Tuberculosis
MOA	Ministry of Agriculture and Food Security
MOE	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOPS	Ministry of Public Service
MOSD	Ministry of Social Development
MoT	Modes of Transmission
MSM	Men Having Sex with Men

MTCT	Mother to Child Transmission
MMG	Mother to Mother Support Groups
NAC	National AIDS Commission
NDSO	National Drug Service Organization
NISSA	National Information System for Social Assistance
NPT	New Prevention Technologies
NRL	National Reference Laboratories
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
PCR	Polymerase Chain Reaction
PDR	Pre-treatment Drug Resistance
PEPFAR	Presidents Emergency Fund for AIDS Relief
PHC	Primary Health Care
PI	Protease Inhibitor-based antiretroviral therapy
PLHIV	People Living with HIV
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People who Inject Drugs
QA	Quality Assurance
RSSH	Resilient and Sustainable Systems for Health
SBCC	Social and Behaviour Change Communication
SCMD	Supply Chain Management Directorate
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health Rights
SOPs	Standard Operating Procedures
SRMNCAHN	Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
TLD	Tenofovir/ lamivudine/ dolutegravir
TLE	Tenofovir/ lamivudine/ efavirenz
TOR	Terms of Reference
UNAIDS	Joint United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
VDRL	Venereal Disease Research Laboratory test
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WDI	World Development Indicators
WHO	World Health Organization

FOREWORD

ACKOWLEDGEMENTS

EXECUTIVE SUMMARY

Background

The multi-sectoral approach in the national HIV response without efficient and effective central coordination leads to an uncoordinated and fragmented HIV response. It is therefore imperative that national HIV responses routinely track HIV expenditures to determine if funding is directed to the most need, helping to reduce duplications and increase efficiencies. Tracking expenditures for the response to the AIDS epidemic is a prerequisite for effective allocation of domestic and international funding towards those interventions that will have an optimal impact. This is increasingly critical so as to optimize the response.

It is against this background that the aim of undertaking the current NASA is to introduce an effective tool of financial monitoring of HIV and AIDS programmes and activities, to better understand the spending patterns for HIV related activities, analyse HIV spending priorities so as to improve the effectiveness, efficiency and sustainability of the country's HIV responses. NASA therefore generates useful information to assist with the planning and financing of HIV services will be used to measure the potential financial gap and thus to mobilize for additional resources. The NASA will provide useful insights on the extent of harmonization and alignment of the resource envelope to the programmatic priorities.

Purpose and scope

This NASA report covered three government financial years, 2015/16, 2016/17 and 2017/18, and focused on domestic (only public) and external sources of financing. The key objective for the assignment was to collect data on HIV expenditures in Lesotho using the National AIDS Spending Assessment methodology. The data were analysed to provide a picture of expenditure by sources, financing agents and purchasers, providers of services and HIV interventions.

Methodology

The National HIV and AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The methodology tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV. It applies standard accounting methods to reconstruct all transactions in a given country, 'following the "money" from the funding sources to agents/ purchasers and providers, and eventually to beneficiary populations. The NASA is expected to provide information that contributes to a better understanding of a country's total HIV and AIDS spending, spending by priority areas, and how equitable the funding is.

In this report, new NASA classifications were used, whereby HIV spending was mapped into three dimensions and nine vectors. The three dimensions, which encompass the nine dimensions, are financing, provision and utilization. The financing dimension has four vectors for mapping HIV and AIDS spending, namely, financing entities (FE), financing schemes (SCH), revenue into the financing schemes (REV) and financing agents and purchasers (FAP). The provision dimension involves three vectors; providers of services (PS), service delivery mechanisms (SDM) and factors of production (PF). In the utilization dimension, there two classes for capturing expenditure, entailing the services referred as AIDS spending categories (ASC) and beneficiary populations.

The main sources for financing HIV and AIDS services in Lesotho were identified and were approached to obtain the required data on HIV spending. They were the Government of Lesotho; United States Government (USG)- USAID; the Global Fund for AIDS, Malaria and Tuberculosis (GTATM) through Programme Management Unit at the Ministry of Finance and UN Agencies (UNAIDS, WHO, UNICEF, UNFPA, UNDP, IOM and WFP. In addition to the financing sources, some financing agents were sampled for the survey and data collection, These included the following: Ministry of Health, Ministry of Education and Training, and Ministry of Social Development, Ministry

of Finance-Project Management Unit (MOF-PMU), National Drug Supply Organisation (NDSO), UN Agencies, PACT Lesotho, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). All of the large providers in the country were included in the sample but during the data collection, not all of them were approach directly since the data for them were readily obtainable from some financing entities as well financing agents and purchasers.

Findings

The results showed that there are four sources of funding the national HIV and response in Lesotho namely: Government of Lesotho, United States Government, Global Fund for Tuberculosis, AIDS and Malaria and United National agencies. The total expenditure from the main financing sources was LSL 1023.23 million (US$ 105.98 million) in 2015/16, LSL 1,394.61 million (US$ 128.50 million) in 2016/17, LSL 1,764.97 million (US$ 138.33 million) in 2017/18. The emerging trend is that of steady increase in the expenditure between the period under consideration. The growth in the expenditure was 36.3 percent between 2015/16 and 2016/17 and 26.56 percent between 2016/17 and 2017/18. The per capita expenditure increased from LSL 509.78 (US$ 52.88) in 2015/16 to LSL 690.15 (US$ 63.59) in 2016/17 and LSL 867.57 (US$ 68.00) in 2017/18.

In financial year 2015/16, the Government of Lesotho was the largest source of funding for HIV response, contributing LSL 436.08 million (US$ 45.17 million) and accounting for 42.6 percent. This contribution increased modestly over the three years, but with declining government's percentage in the total expenditure. Government of Lesotho's share in total expenditure was 32.6 percent in 2016/17 and 26.3 percent in 2017/18. The Government of Lesotho contribution included indirect expenditure on health care workers and operating costs at government health facilities. The Government of United States was the main funding source in all the years, contributing LSL 346.11 million (US$ 35.85 million) in 2015/16, LSL 687.69 million (US$ 63.37 million) in 2016/17, LSL 815.11 million (US$ 63.89 million) in 2017/18. These translated to 33.8 percent of total expenditure in 2015/16, 49.3 percent in 2016/17 and 46.2 percent in 2017/18. The expenditure from Global Fund for Tuberculosis, AIDS and Malaria fluctuated, being LSL 200.73 million (US$ 20.79 million) and accounting for 19.6 percent in 2015/16, LSL 155.97 million (US$ 14.37 million) (11.2%) in 2016/17,andLSL 397.12 million (US$ 31.12 million) (22.5%) in 2017/18. Overall, international financing entities accounted for 57.4 percent of total expenditure in 2015/16, 67.4 percent in 2016/17 and 73.7 percent in 2017/18. These results underscore the importance of international sources and point to the problem of sustainable financing of HIV in Lesotho.

Although all the financing entities had expenditure across all the ten districts, the Government of United States as a financing entity prioritized five districts, consisting Berea, Leribe, Mafeteng, Maseru and Mohale's Hoek. These five districts accounted for much of the burden of HIV, contributing about 74% of the total people living with HIV in the country. The Government of Lesotho and GFATM had a relatively more equitable expenditure across all the ten districts, with amount of expenditure seemly related to burden of the disease in the ten districts. There were significant variations in the expenditure per person in the districts. In 2015/16, Maseru had the highest per capita of LSL 907.06, followed by Leribe (LSL 533.6), Berea (LSL 442.15), Mafeteng (LSL 315.65), Mohale's Hoek (LSL 256.62), Thaba-Tseka (LSL 138.09), Botha-Bothe (LSL 134.61), Quthing (LSL 93.11), Mokhotlong (LSL 89.47) and Qacha's Nek (LSL 68.67). Addtionaly, the five districts consisting of Berea, Leribe, Mafeteng, Maseru and Mohale's Hoek recorded increasing per capita expenditure over the period under consideration. . The remaining five districts had a decline in per capita expenditure between 2015/16 and 2016/17 and this scenario was reversed with increase per capita expenditure between 2016/17 and 2017/18. Inequity analysis using concentration index showed inequality in funding, where districts in the lowlands were better-off as they received more of the funding for HIV response than those in the highlands.

Internal transfers and grants reflecting the revenue that Government of Lesotho disbursed to different domestic entities to finance the HIV and AIDS interventions accounted for 31 percent of the total expenditure. Direct bilateral financial transfers encompassing financing from Government of

United States mainly was the largest type of revenue taking 44 percent of the total expenditure in the three year period. The direct multilateral financial transfers stood at 20 percent and other direct foreign transfers (4%). Government of Lesotho financing schemes were the only financing scheme in the NASA households and the private sector were not included.

The funds from the different revenue scheme were transferred to the various financing agents and purchasers, who make decisions of which activities to be funded. In 2015/16, Ministry of Health took the largest share (60%) of the total expenditure as financing agent and purchaser The International NGOs, as financing agents and purchasers took the second largest share (23.0%) of the funds spent followed by foreign universities (12.6%) in 2015/16. The distribution remained the same for the years 2016/17 and 2017/18. The Ministry of Health accounted for 45 percent in 2016/17 and 49 percent in 2017/18. The percentage of expenditure through international NGOs as financing agents and purchasers, increased significantly in 2016/17 (40%) ad 2017/18 (43%).

The government health facilities, as providers of HIV and AIDS services, accounted for the leading share of the total expenditure at 43.8 percent in 2015/16, 37.6 percent in 2016/17 and 37.5 percent in 2017/18.This was followed by faith-based health facilities led by CHAL facilities, taking 25.9 percent of total expenditure in 2015/16, 19.1 percent in 2016/17 and 21.3 percent in 2017/18. The third largest providers of HIV services were international NGOs taking up 18.0 percent of total expenditure in 2015/16, 27.7 percent in 2016/17 and 23.5 percent in 2017/18. Other providers were civil societies organizations, private for-profit health facilities and government entities consisting of National AIDS Commission, Department of HIV at the Ministry of Education and Departments within the Ministry of Social Development.

Care and treatment took the highest share of expenditure in each of the years, at about 57 percent in 2015/16, about 43 percent in 2016/17 and 43 percent in 2017/18.. In 2015/16, the expenditure on care and treatment was LSL 512 million (US$ 53.01 million), LSL 514 million (US$ 47.37 million) in 2016/17 and LSL 617 million (US$ 48.34 million) in 2017/18. Programme enablers and systems strengthening encompassing programme administration, strategic information, M&E, public system strengthening and community system strengthening accounted for the second largest share of total expenditure, being 22 percent in 2015/16, 36 percent in 2016/17 and 23 percent in 2017/18, showing fluctuating trend in the three years. HIV prevention, which included, prevention interventions for key population, condoms for general population, VMMC, PMTCT, and social and behavioural communication for change (SBCC), came third in terms of the amount and share of expenditure in each of the three years. Another broad area of intervention was HIV testing and counselling (HTC) which accounted for 7 percent in 2015/16, 6 percent in 2016/17 and 11 percent in 2017/18.

The expenditure on HIV prevention was 10 percent of the total expenditure in 2015/16, 11 percent in 2016/17 and about 19 percent in 2018/19. Attempt was made to estimate the effect of prevention expenditure on new infections and the results showed that prevention expenditure is associated with reduction in new infections, underscoring that need to continue to prioritize HIV prevention as a way of bringing down new HIV infections. Efficiency analysis on provision of care and treatment services at public health facilities suggested that the country can reduce resources for care and treatment by about 30 percent without affecting the level of ART service delivery.

In terms of the factors of production, recurrent components took huge share being 92.5 percent in 2015/16, 91.8 percent in 2016/17 and 93.8 percent in 2017/18. Medical products and supplies consisting mainly of ARVs, laboratory reagents and materials, HIV tests diagnostics as well non-medical supplies took accounted for 48.5 percent total expenditure in 2015/16, 27.5 percent in 2016/17 and 27.5 in 2018/19. The largest component of the medical supplies was ARVs which accounted for 36.4 percent of total expenditure in 2015/16, 17.3 percent in 2016/17 and 19.1 percent in 2017/18. Personnel as an input took significant share of the total expenditure, increasing from

25.7 percent in 2015/16 to 39.6 percent in 2016/17 and 37.2 percent in 2017/18. Operational and programme management cost consisting of administrative and programme management, travel, rent and utilities was the third component of the total expenditure accounting for 13.3 percent of the total expenditure in 2015/16,19.7 percent in 2016/17 and 11.1 percent in 2017/18. Other notable factor of production was training that accounted for 2.4 percent, 3.3 percent and 1.7 percent of total expenditure in 2015/16, 2016/17 and 2017/18, respectively.

Findings Concussions and Recommendations

The following conclusion can be drawn from the results:

a) The resources for HIV response have been increasing, mainly attributes to PEPFAR programme.
b) There is high risk of sustaining the funding of the HIV response because of bulk of the funding come from external sources.
c) The contribution of the Government of Lesotho is critical and important. The fact the GoL finances about 80 percent of ARV as well providing human resources for service provision, themselves will reduce problem of financial sustainability of the response.
d) There is inequality in funding the HIV response in the districts district with higher HIV burden had more than proportionate share of the expenditure than the districts with lower burden. This may suggest inequity in the financing.
e) Children -related interventions are less prioritised. In terms of beneficiary population, relatively minimal expenditure was realised for the children and youth.
f) Low priority given to community system strengthening as compared to public system strengthening.

(i) Sustainability

The GoL should prioritize effort toward finding cost effective sustainable financing options for the response in the very near future. Since the government is already funding the ARVs and human resources, improving sustainability may not require huge resources implications. It is recommended that government should continue to increase its contribution in order to ensure sustainability of the national response to HIV and AIDS.

(ii) Optimization of Response

A balance between funding prevention, and care and treatment need to be undertaken. The expenditure assessment seemed to point to underfunding of prevention interventions, specially targeted at key populations. The same applied to interventions for general population. However, it is noteworthy that the five pillars were shown to exhibit increasing expenditure over the three years.

(iii) Equity consideration

There is a strong need to improve equality allocation of funding to all the districts. However, there is need for analysis into the impact of a more equalized funding across the districts compared to concentrating funding on high burden districts.

(iv) Institutionalising Routine Expenditure Tracking

This is because data availability routine would assist the country to assess the performance of the response on regular basis. This is also a key component in monitoring whether funding is aligned to the priority interventions and if not aligned corrective measures can be put in place.

1. INTRODUCTION AND BACKGROUND

1.1 National Development Context for the Assessment

The Kingdom of Lesotho is a small, mountainous and landlocked country covering 30,555 square kilometres, surrounded by South Africa. It has a population of 2 million[1] people, of which 49.9 per cent are males and 51.1 per cent are females. Sixty-six per cent of the population lives in rural areas compared to 34 percent in urban areas. Lesotho has a young population with 45.3% under 20 years of age, of which 33.3% are under 15 years of age and 10.0% under 5 years of age[2].

Lesotho is classified as a lower-middle-income country with a GDP per capita of LSL 17,534.70 in 2018 with 57.1 percent of the population living below the poverty line. There has been modest increase in GDP per capita from LSL 15,550.37 in 2015 to LSL 16,470.63 in 2016, declining slightly to LSL 16,437.73 in 2017 and an increase to LSL 17,534.70 in 2018 Lesotho's overall national poverty and extreme poverty head- count (food poverty) ratios declined from 56.6 percent to 49.7 percent and from 34.1 to 24.1 percent. Poverty rates have remained high in rural areas, household headed by females and those with low levels of education. Over the past four years, Lesotho's economy has been negatively affected falling Southern Africa Customs Union (SACU) revenue and liquidity challenges. Between 2015 to 2018 economic growth averaged 1.4%. Real gross domestic product (GDP) is projected to grow by 2.6% in 2019 and is projected to average 1.5% in the next two years. Lesotho's inflation rate was estimated at 4.8% in 2018[3]. The economy is based on agriculture, livestock, manufacturing and mining industries, with workers' remittances from South Africa another major source of inflows. Services comprise 60% of the country's GDP, while industry (mining, manufacturing, construction, energy production) comprise 34.6% and agriculture 5.3% (World Bank 2017 Estimates). Most formal employees are women working in the garments sector, while men are mostly migrant labourers in South African mines, working under inadequate health conditions and away from their families for long periods. The Government of Lesotho (GoL) is another significant employer. Females comprise 51.3 percent of the population in the labour force and male comprise 48.7 percent.

Unemployment remains high at 32.8%, with relatively higher rate among the youth. Youth unemployment rate increased from 31.2 percent in 2014/15 to 35.8 percent in 2015/16. The high rate of unemployment among youth is mainly due to limited job opportunities in the private sector and the mismatch between skills demand and supply[4]. Levels of inequalities are high, with the Gini coefficient estimated at 44.6 in 2017/2018 though falling from 51.9 in 2002/2003.

Lesotho's Human Development Index for 2018 was 0.518, placing the country amongst low human development category positioning it at 164 out of 189 countries and territories. Between 1990 and 2018, Lesotho's HDI value increased from 0.488 to 0.518, an increase of 6.2 percent. Between 1990 and 2018,

[1] Population and Housing Census, Bureau of Statistics, Lesotho, 2016

[2] id

[3] Consumer Price Index, Bureau of Statistics, Lesotho, 2019

[4] Lesotho Voluntary National Review, Government of Lesotho, 2019

Lesotho's life expectancy at birth decreased by 6.1 years but has started to increase with life expectancy at birth at 56 years, mean years of schooling increased by 1.9 years[5].

Table 1.1 summarizes Lesotho's key demographic, health including HIV and economic indicators.

Table 1.1: Summary of Demographic, Health, HIV and Economic Indicators

Parameter	Value	Data Source, year
Population	2,007,201	Lesotho Housing and Population Census 2016
Popn. In extreme poverty	57.8%	World Bank, 2017
GDP Per Capita (PPP $)	$1020	World Bank, 2017
Life Expectancy at Birth	56 Years (F 59.5; M 51.7)	Lesotho Housing and Population Census 2016
Maternal Mortality	618/ 100000 live births	Lesotho Census Housing and Population Census 2016
Under-5 Mortality	80.2 /1000 live births	Lesotho Housing and Population Census 2016
HIV prevalence among adults aged 15 to 59 years	25.6%	LePHIA (2017)
Paediatric HIV prevalence	2.1%	LePHIA (2017)
TB-HIV co-infection rate	72%	LePHIA (2017)
Health Budget as % Total Budget	13%%	Government of Lesotho Budget Speech 2018/2019
Health Expenditure % GDP	10.6%	World Bank (2015)
Public Health Expenditure	76%	World Bank (2015)
Out of Pocket Expenditure	16.5 %	World Bank (2015)

1.2 Health and HIV Situation in Lesotho

The Government of Lesotho allocated 13% of public resources to the Health Sector in 2018/19 (one of the highest in Sub-Saharan Africa but below the Abuja Agreement of 15%). The highest budget allocation of 14% was reached in the financial years of 2010/11, 2011/12 & 2013/14 and since then, budget allocations as a percentage of the national budget have been declining with allocations at 2015/16, 2016/17 at 11% and in 2017/18 slightly increasing to 12%. The investment in health is over 9% of GDP, with a per capita total health expenditure of close to $756 which is above the World Health Organization (WHO) recommended minimum of $34. However, the health outcomes are not commensurate with the resource input. Maternal mortality and child mortality remain high, with MMR at 1,024 per 100,000 live birth and under five and infant mortality at 85 and 59 per 1,000 live births in 2014.

The high rates of communicable diseases and the HIV and AIDS pandemic put a lot of pressure on the health infrastructure and resources. Life expectancy, which peaked at 59 years in 1990, fell to 41 years

[5] Human Development Report, UNDP, 2019

[6] Annual Joint Health Sector Review 2017-2018 FY, Ministry of Health, Lesotho, 2018

in 2006 and recent 2016 population census showed an increase in life expectancy to 56 years, with that of males being 51.7 years and females at 59.5 years. The Government budget cycle starts with approval of the Budget Strategy Paper by Cabinet and this stipulates key national priorities. Ministry of Finance disseminates a circular with budget ceilings for each Ministry. Ministry of Health develops its annual operational plans at central and district levels using bottom-up and top-down approaches, involving hospitals, DHMTs and health centres. Budget allocation decisions within the Ministry of Health are made at central level.

HIV and AIDS is a burden to the health sector and is one of the factors that have contributed to the slow economic growth and development progress in Lesotho. AIDS is the leading cause of morbidity and mortality in Lesotho. The Lesotho Population-Based HIV Impact Assessment (LePHIA, 2017), a nationwide cross-sectional household survey, estimated HIV prevalence among adults aged 15 to 59 years at 25.6% (30.4% females and 20.8% males); and as high as 49.9% among women aged 35-39. More than 330,000 people live with HIV[7] in 2019. Incidence remains high at 1.47% in adults 15 to 59 years;1.74% in females and 1.22% in males, with more than 13,000 new adult infections annually. Population-level viral load suppression (VLS) rates were at 67.6%. Estimated at 2.1%, paediatric HIV prevalence is among the highest in the world. Surveys of key and vulnerable populations estimated prevalence at 71.9% among female sex workers, 43.3% among Factory Workers, 32.9% for MSM and 31% among prisoners. Additionally, HIV prevalence is higher in border towns, indicating the effect of migration in increasing risk of new HIV infections. Transactional sex and intergenerational sex may lead to new infections possibly due to challenges in condom negotiations compounded by power dynamics. Multiple concurrent sexual partnerships remain leading factors increasing risk of infection[8]. One out of four new HIV infections occur among adolescent girls and young women, where discordancy, gender-based violence and gender inequities disempower and disenfranchise women leading to increased HIV risk. HIV is the main driver of Lesotho's twin epidemic of Tuberculosis, while TB is a leading cause of comorbidity and deaths among people living with HIV. The country ranks high in TB-HIV comorbidity with a co-infection rate of 72%; and has the world's second highest HIV prevalence and fourth highest TB burden.

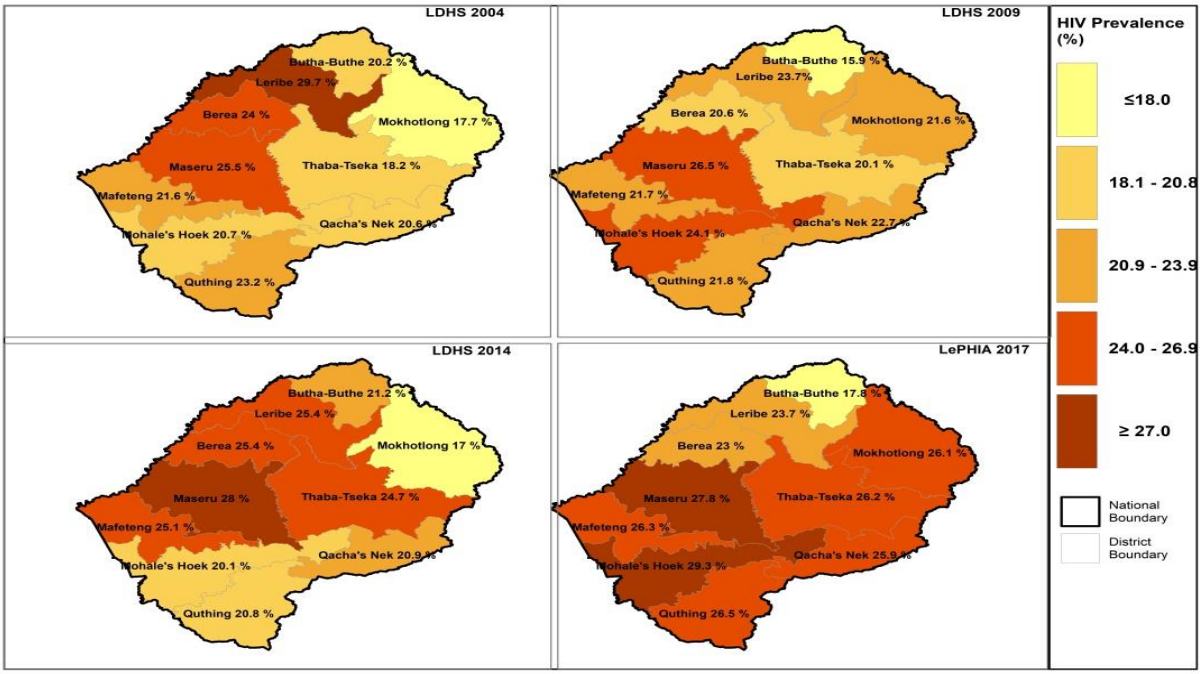
HIV prevalence by district varies, with high prevalence at 29.3% in Mohale's Hoek and low prevalence at 17.8% in Butha Buthe in 2017[9]. Shifts in prevalence have however, been observed over the years as the map below shows.

[7] Ministry of Health Lesotho, 2015; LDHS, 2014; PERFAR, 2016; WHO, 2014

[8] Comprehensive HIV Epidemic Analyses of Lesotho, Government of Lesotho & UNAIDS, 2018

[9] Lesotho Population-Based HIV Impact Assessment (LePHIA), Ministry of Health, Lesotho, 2017

Figure 1.1: District HIV Prevalence in 2004, 2009, 2014 and 2017



Lesotho's HIV response is guided by the National HIV and AIDS Strategic Plan, of which a new one covering the period 2018 to 2023 was launched in December 2018. The previous National HIV/AIDS Strategic Plan 2011-2016 was extended to 2018 to align with the National Strategic Development Plan and respond to the UN Political Declaration on HIV and AIDS of 2016 which identified Lesotho as a 'Fast Track Country' with a severe epidemic. Lesotho adopted the Test and Treat Strategy and was officially launched in 2016. Within the new National HIV and AIDS Strategic Plan (2018 – 2023), the country commits to Ending AIDS by 2030; with an expanded treatment programme to reach the 95-95-95 targets. To galvanize political commitment and build strong partnerships to scale-up combination HIV prevention, the country signed up to and adopted the "HIV Prevention 2020 Road Map for Accelerating HIV prevention to reduce new infections by 75%".

1.3 Rationale for Tracking Expenditure on HIV and AIDS in Lesotho

The multi-sectoral approach in the national HIV response without efficient and effective central coordination leads to an uncoordinated and fragmented response. It is therefore imperative that national HIV responses routinely track HIV expenditures to determine if funding is directed to the most need, helping to reduce duplications and increase efficiencies. Tracking expenditures for the HIV response is a prerequisite for effective allocation of domestic and international funding towards those interventions that will have an optimal impact. The country had made tremendous progress towards achieving the Abuja Declaration Target with national allocation to the health budget reaching 13% in 2018/19 financial year.

It is against this background that the National AIDS Spending Assessment (NASA) was undertaken in order to introduce an effective tool of financial monitoring of HIV and AIDS programmes and activities. This was done to also understand the spending patterns for HIV related activities and to improve the effectiveness, efficiency and sustainability of the country's HIV response. NASA therefore generates

useful information to assist with the planning and financing of HIV services and will be used to measure the potential financial gap for mobilization of additional resources. The NASA will provide useful insights on the extent of harmonization and alignment of the resource envelope to the programmatic priorities.

1.4 Purpose and Objectives

The key objective for the assignment was to collect data on HIV expenditure in Lesotho for the financial years April 2015 – March 2016, April 2016 – March 2017 and April 2017 – March 2018 the NASA methodology.

Specifically, the NASA aims to:

1. Implement a methodology for systematic monitoring of HIV financial flows at national and district level using the NASA methodology in Lesotho.
2. Adapt the NASA methodology, classification and tools to the Lesotho context.
3. Build national level capacity for systematic monitoring of HIV and AIDS financing flows using the NASA methodology, with a view to a yearly, fully institutionalized NASA.
4. Conduct an HIV spending assessment focusing on public and external partner resources and including some of the larger businesses known to be contributing to HIV activities.
5. Identify the flow of resources for HIV by source, functions, service provider and beneficiary populations.
6. Prepare a report of expenditure trends that will contribute to efficient allocation of resources as per defined resource needs in the National HIV Strategic Plan (2018 – 2023).

Additionally, the NASA addresses the following policy questions:

- Detailed description of financing flows by each of the key programme areas (e.g. ART, or prevention etc.).
- How sustainable or donor dependent are the financing sources for specific key programmes?
- Have the government investments changed in what they finance (i.e. comparability with prior exercises)?
- Do they finance human resources for some programmes but not all?
- Are government funds distributed equally across all core programmes?
- Is there a concentration of resources from a given source in selected services, production factors, beneficiaries, or providers of services?
- What is the expenditure per unit (or unit cost) per key service and variations across districts, providers, funders or managers of the funds?
- Are there different patterns of production factors explaining variation in the expenditure per unit? (entry point to technical efficiency analysis)
- How is the allocation of funds as related to the burden of disease or to new HIV infections for each district? Are services for populations with lower HIV prevalence financed? If so, who is making such decisions, e.g. the funders –FS- or the providers? (entry points for allocative efficiency analysis)

- Are there any noticeable changes in the financing flows and expenditures in the years since the NASAs started? Are they explained by a policy change? Have the results from previous NASA influenced any decisions made?

1.5 Scope of the Assessment

This NASA report covered three government financial years 2015/16, 2016/17 and 2017/18, and focused on domestic (only public) and external sources of financing. Government financial year starts on the 1st of April and ends on 31st of March the following year. The assessment was done at the national level, with district expenditures only estimated. The Lesotho Loti is the currency used for the report, with equivalent US dollar amount also shown.

2. STUDY DESIGN AND METHODOLOGY

2.1 The Approach

The National AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The methodology tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprise the National Response to HIV. The methodology was developed using the national health accounts framework and principles. It applies standard accounting methods to reconstruct all transactions in a given country, 'following the "money" from the funding sources to agents/ purchasers and providers, and eventually to beneficiary populations'. The need to track HIV expenditure stems from the fact that decisions regarding allocations for HIV and AIDS related activities must be based on previous expenditure patterns and profile of the epidemic in the country. The NASA is expected to provide information that contributes to a better understanding of a country's total HIV and AIDS spending, spending by priority areas and how equitable the funding is. The data from NASA can also be utilized to assess financial absorptive capacity, as well as on issues about the equity, the efficiency and the effectiveness of the resource allocation process.

In addition to institutionalizing the resource tracking for HIV and AIDS, NASA facilitates reporting of indicators monitoring progress towards the achievement of targets in the 2016 "Political Declaration on HIV and AIDS: on the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030".

The NASA follows a system of expenditure tracking that involves systematic capturing of the flow of resources by different financial sources to service providers, through diverse mechanisms of transaction. A transaction comprises of all the elements of the financial flow, the transfer of resources from a financial source to a financing agent or service provider, which spends the money in different budgetary items to produce functions (or interventions) in response to addressing HIV and AIDS to the benefit of specific target groups or to address unspecific populations (or the general population). NASA can apply either top-down or bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from donor reports, commitment reports and government budgets whilst the bottom-up tracks expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts. In this assignment, both top-down and bottom-up approaches were adopted.

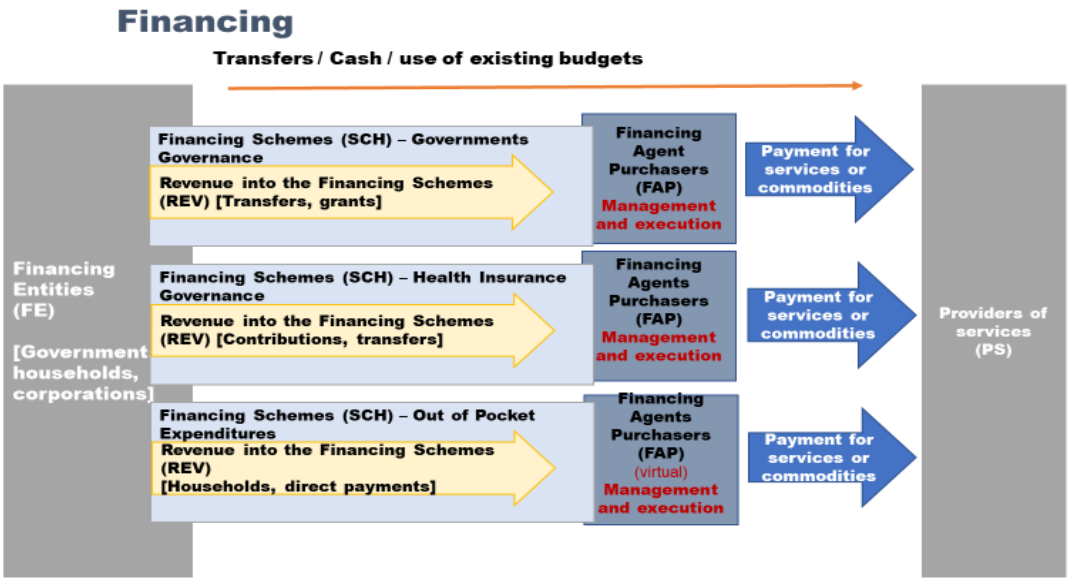
Given that the service providers, especially the health facilities might not have data on actual expenditures on HIV and AIDS, costing techniques were used to estimate expenditure based on internationally accepted costing methods and standards used to retrogressively measure past actual expenditure. Ingredient and step-down costing are used for direct and shared expenditure for HIV and AIDS, whilst shared costs are allocated on the most appropriate utilization factor.

As part of its methodology, the NASA employs double entry tables or matrices to represent the origin and destination of resources, avoiding double-accounting the expenditures by reconstructing the resources flows for every transaction from funding source to service provider and beneficiary population, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS activities.

2.2 The New NASA Classifications

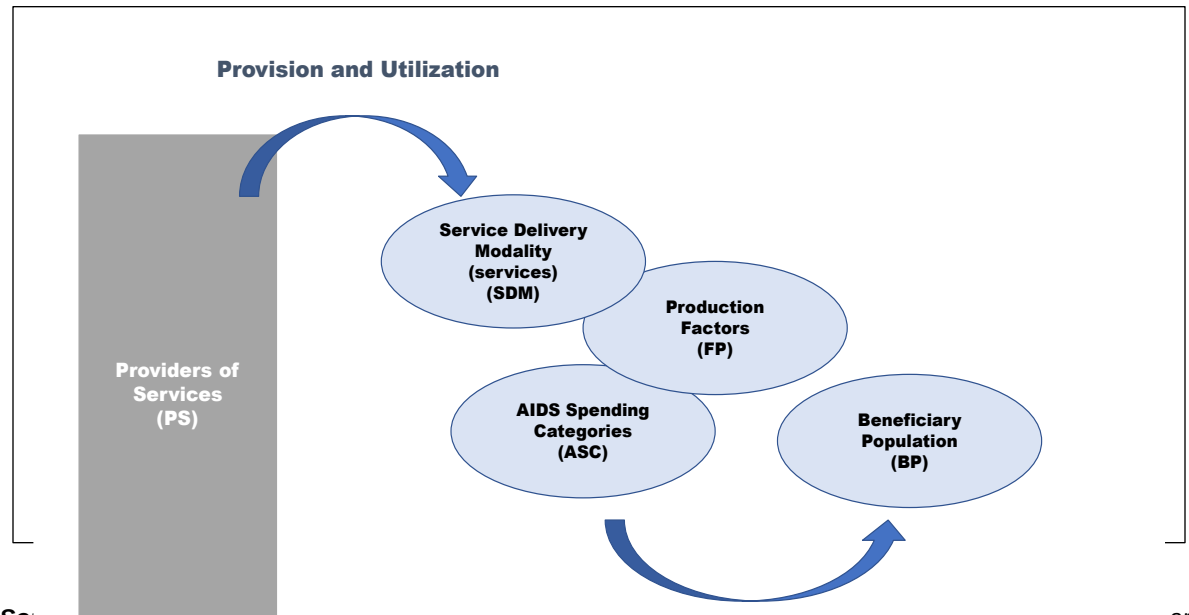
In this report, new NASA classifications were used, whereby HIV spending was mapped into three dimensions and nine vectors. The three dimensions, which encompass the nine vectors, are financing, provision and utilization. Figure 2.1 and Figure 2.2 provide representations of these spending matrices.

Figure 2.1 Financing Dimensions



***Source**: Adopted from presentation made by Jose Antonio Izazola-Licea, Special Adviser, Resource Tracking and Finances, UNAIDS: Regional Planning, Tracking and Costing Workshops, Radisson Blu, Johannesburg, South Africa February25-March 8, 2019.*

Figure 2.2 Provision and Utilization Dimensions



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The financing dimension has four vectors for mapping HIV and AIDS spending, namely, financing entities (FE), financing schemes (SCH), revenue into the financing schemes (REV) and financing agents and purchasers (FAP). FE are financing entities or pools which are sources of financing HIV and AIDS interventions. Health care financing schemes (SCH) are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Revenue (REV) embody the different financing types, that are pooled into the different financing schemes. FAP are entities which mobilize financial resources collected from different financing sources (pools) and transfer them to pay for or to purchase health care or other services or goods.

The provision dimension involves three vectors; providers of services (PS), service delivery mechanisms (SDM) and factors of production (PF). Providers are defined as institutional entities that produce and provide health care goods and services, which benefit individuals or population groups. These providers use inputs, called factors of production, such as human resources, materials, and utilities to produce HIV and AIDS services.

In the utilization dimension, there two classes for capturing expenditure, entailing the services referred as AIDS spending categories (ASC) and beneficiary populations. The beneficiary populations are explicitly targeted or intended to benefit from specific activities, the intended recipients of the various services. When there is no explicit intention of directing the benefits to a specific population, the expenditures are labelled non-targeted interventions. There are eight broad spending categories. The eight spending categories have been modified in the new NASA classifications as compared to the pervious NASA classes. In the previous NASA classifications, the eight broad spending categories were: 1) prevention; 2) care and treatment; 3) orphans and vulnerable children; 4) programme management and administration strengthening; 5) incentives for human resources; 6) social protections and social services; 7) enablement of environment and community programs; and 8) research. In the new classifications, the broad spending categories are: i) prevention; ii) HIV testing and counselling (HTC); iii) HIV care and treatment care; iv) social protection and economic support for PLHIV, their families, for key populations (KPs) and for orphans and vulnerable children; v) social enablers, excluding the efforts for KPs; vi) programme enablers and systems strengthening; vii) development synergies; and viii) HIV-related research.

There is a further disaggregation of each of the eight broad spending categories into sub-spending categories. In the case of prevention ASC, for instance, the sub-spending categories, such as the Five Pillars for achieving less than 500 000 new infections annually by 2020. The five prevention pillars are delivered through a people-centred, combination approach, consisting:

1. Combination prevention, including comprehensive sexuality education, economic empowerment and access to sexual and reproductive health services for young women and adolescent girls and their male partners in high-prevalence locations.
2. Evidence-informed and human rights-based prevention programmes for key populations, including dedicated services and community mobilization and empowerment.
3. Strengthened national condom programmes, including procurement, distribution, social marketing, private-sector sales and demand creation.
4. Voluntary medical male circumcision in priority countries that have high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for boys and men

5. Pre-exposure prophylaxis for population groups at higher risk of HIV infection.

2.3 Data Sources and data collection

2.3.1 Financing entities

The main sources consisting of different entities for financing HIV and AIDS services in Lesotho were identified and were approached to obtain the required data on HIV spending. They were the Government of Lesotho; United States Government (USG)- PEPFAR Program; the Global Fund for AIDS, Malaria and Tuberculosis (GTATM) through MOF-PMU and PACT, and United Nation Agencies.

2.3.2 Financing agents and purchasers, and financing intermediaries

In addition to the financing sources, all the financing agents were sampled for the survey to be surveyed for the data collection, included the following: Ministry of Health, , Ministry of Education and Training, , MOF - PMU in the Ministry of Finance, National Drug Supply Organisation (NDSO), Parliament of Lesotho, Prime Minister's office, UN Agencies, PACT Lesotho, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), , Population Services International, Lesotho and AIDS Health Foundation.

2.3.3 Main service providers

All the large providers in the country were included in the sample but during the data collection, not all of them were approached directly since the data for them were readily obtainable from the financing agents and purchasers. The list of all the providers in the country had been developed by the NAC and was used to select the providers. The proposed covered over 90 percent of the providers.

2.4 Data Collection

Table 2.1: Institutions that provided data

Government Entities	Ministry of Health, Ministry of Education, Ministry of Social Development, National Drug Service Organization, National AIDS Commission, Programme Management Unit at Ministry of Finance
Partners	USAID, UNAIDS, UNICEF, UNFPA, UNDP, WFP, UNESCO, IOM)
International NGOs and Foundations	EGPAF, PACT, PSI, JSI, World Vision and CHAI
Local NGOS and CSOs	LENASO, LENEPWHA, LPPA, LIRAC, Lesotho Red Cross, WILSA, Solidermed, Riders for Health, Sentebale, Limkomkwing, Care for Basotho, PIH

2.5 Estimation of Indirect Government Expenditure

Government of Lesotho makes significant contribution to the national response through provision of health personnel and other recurrent inputs. The FBO, especially through facilities owned by Christian Health Association of Lesotho (CHAL) also incur indirect expenditure in the provision of HIV services at district levels. However, Government of Lesotho pays for the health personnel and other recurrent inputs especially overhead costs for the CHAL facilities. Additionally, Government provides space and equipment in the provision of HIV related health services.

Indirect contribution by the Government, through public and CHAL health facilities was estimated in this NASA report. Only recurrent expenditure on human resource and overhead (operations and maintenance) was considered for each of the three financial years. The HIV interventions services that were considered for estimation of government spending were ART, PMTCT, HIV testing, and VMMC. The data on utilization of these services in health facilities were obtained from the DHIS II at the Ministry of Health. Table 2.2 shows the assumptions used in the estimation based on the utilization data.

Table 2.3: Expenditure Estimation Assumptions

	2015/16	2016/17	2017/18
OPD	1451325	1,456,410	1609718
Adults ART visits 2016	610,000	709,000	777,000
Pead ART visits 2016	31,700	36,500	35,200
PMTCT visits	61,650	55,800	50,100
VMMC	68,314.00	72,162	72,438.00
Testing	77,982	98,127	116,437
Total OPD	2,824,683	2,885,027	3,412,745
All ART (% of all OP visits)	22.72%	25.84%	23.80%
Adult ART (% of all OP visits)	22%	24.58%	22.77%
Paediatric ART (% of all OP visits)	1.10%	1.27%	1.03%
PMTCT visits (% of all OP visits)	2.20%	1.93%	1.47%
Testing (% of all OP visits)	3%	2.50%	3%
VMMC (% of all OP visits)	2.40%	3.40%	2.10%
Allocation to all HIV services	30%	33.68%	31%

The data for 2015/16 showed that about 95 percent of those on ART were adults and about 5 percent were children. These percentages were used also for 2016/17 and 2017/18. The data on actual visits were obtained from DHIS II from the Ministry of Health.

2.6 Data Processing

The expenditure data collected were captured initially in Excel sheets, and checked and cleaned. All the data obtained/collected were verified as far as possible, to ensure the validity of data from the records of the source, the agents and the providers and to avoid double counting. The data from individual Excel files were then combined in the Data Consolidation Tool (DCT), which is a data processing in Excel file with sheets to enter the NASA project data using the corresponding version of new NASA classifications.

The expenditure data obtained for PEPFAR programme in Lesotho were not in the form that allowed easy crosswalk to NASA classifications, especially with respect to mapping the expenditure by financing agents and purchasers, and by providers of services. This problem necessitated use of the country operational plans (COP 2015, COP 2016 and COP 2017) to extract the FAP and PS as well ASC. The information from these county plans were very useful in mapping expenditure to the NASA classes not given in the PEPFAR data provided.

The data for GFATM financing from PMU was also to aggregative to easily map into the NASA. Tracking the expenditure from financing agents was used but information from MOH that received bulk of the GFATM financing was not adequate to map the data. This notwithstanding, serious attempts were made to map the expenditure from the different modules of expenditure into the NASA classes. The data on GFATM expenditure on HIV commodities (ARVs, reagents, etc) were easily assignable into the NASA classifications. Additionally, the expenditure data from GFATM through PACT was filled in the NASA format and hence was mapped to NASA classifications without problems. Finally, the data from the other institutions including UN Agencies were mapped to the classifications since they were provided in the required format.

2.7 Quality Assurance

To ensure quality control of the data collection, the International Consultant and the Local Consultant supervised data collection in the field. The Local Consultant checked the filled data collection tool on daily basis and where there were gaps, then the research assistants would visit the organisation where the data was collected for verification and clarification. USAID directly provided the expenditure on PEPFAR programme in the country while the GFATM expenditure data were obtained from the two principal recipients in the country – Ministry of Finance (MOF) and PACT. Additionally, government expenditure was estimated using actual expenditure from the Ministry of Health.

3. NASA EXPENDITURE RESULTS

3.1 Total Expenditure on HIV Activities

In Lesotho, there are four main sources of funding HIV and AIDS national response, namely: Government of Lesotho (GoL), United States Government (USG), Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and United Nations (UN) agencies. Figure 3.1 shows trend total expenditure in the three financial years. Further, Table 3.1 shows the total amount in local currency and US dollars.

Figure 3.1: Total HIV and AIDS expenditure

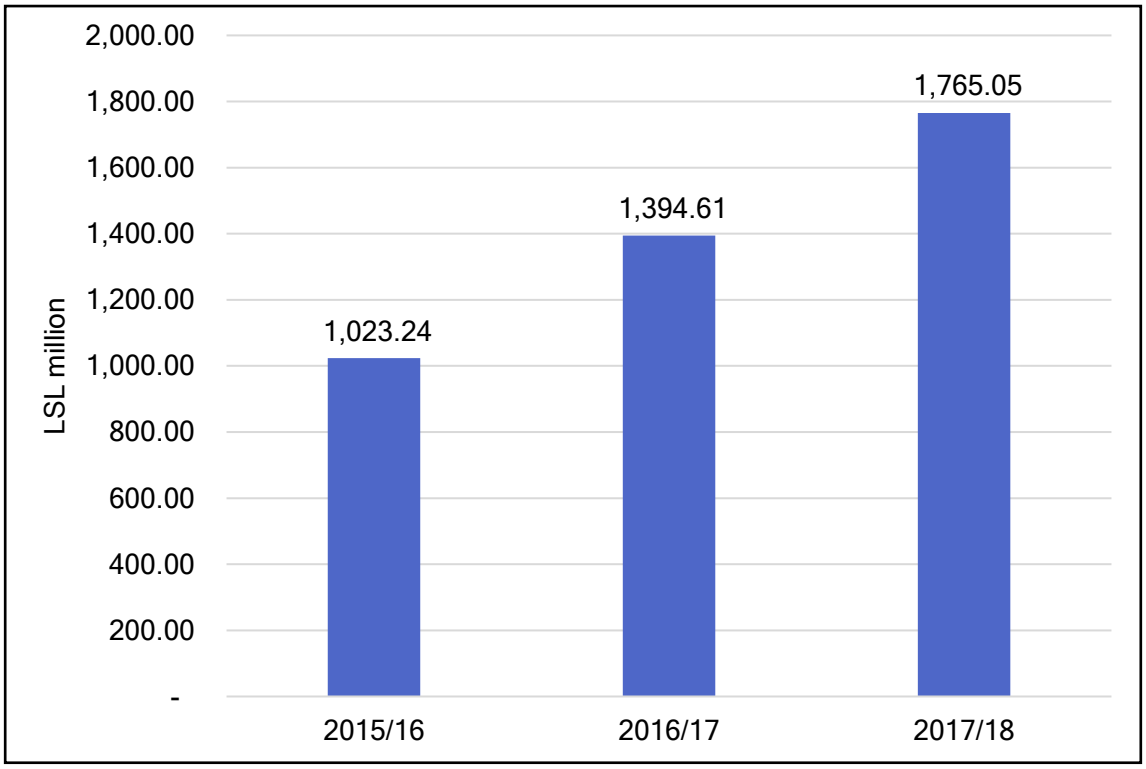
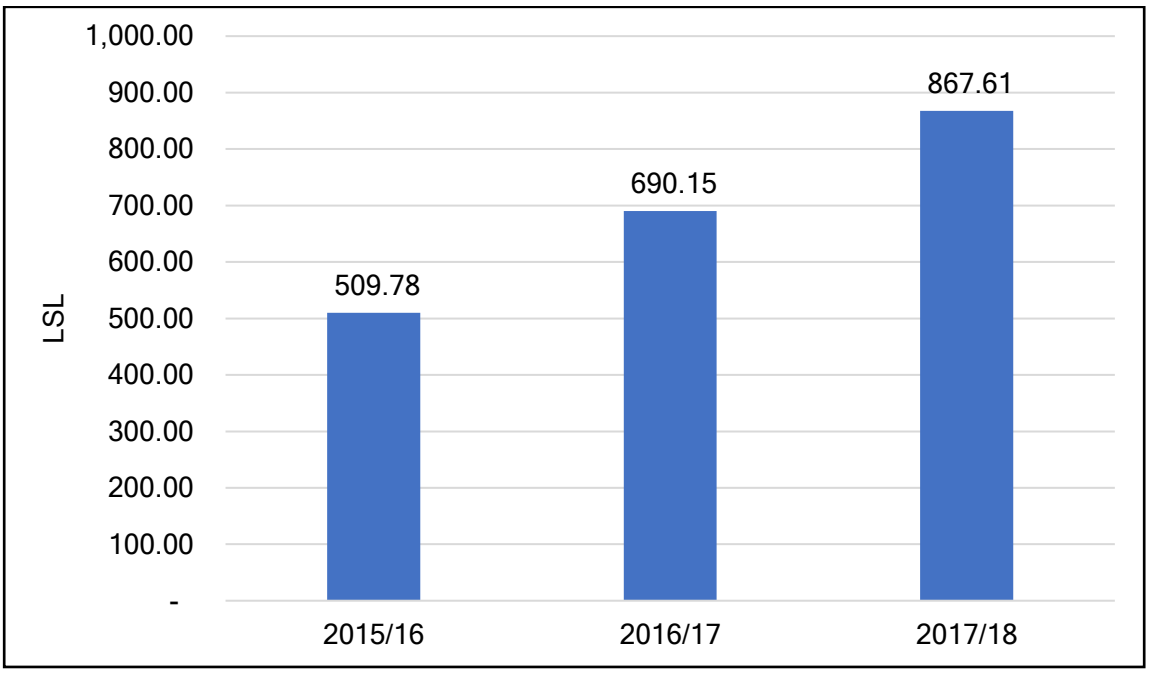


Table 3.1: Total expenditure for HIV and AIDS activities

Year	Amount (LSL)	US$ million
2015/16	1,023,235,225	105,979,211
2016/17	1,394,613,292	128,504,335
2017/18	1,765,049,228	138,338,333

Figure 3.1 shows that total expenditure from the main financing entities was LSL 1023.23 million (US$ n 105.98 million)[10] in 2015/16, LSL 1,394.61 million (US$ 128.50 million) in 2016/17, LSL 1,764.97 million (US$ 138.33 million) in 2017/18. The emerging trend is that of steady increase in the expenditure between the period under consideration. The growth in the expenditure was 36.30 percent between 2015/16 and 2016/17 and 26.56 percent between 2016/17 and 2017/18. The per capita HIV spending in the country is shown in Figure 3.2.

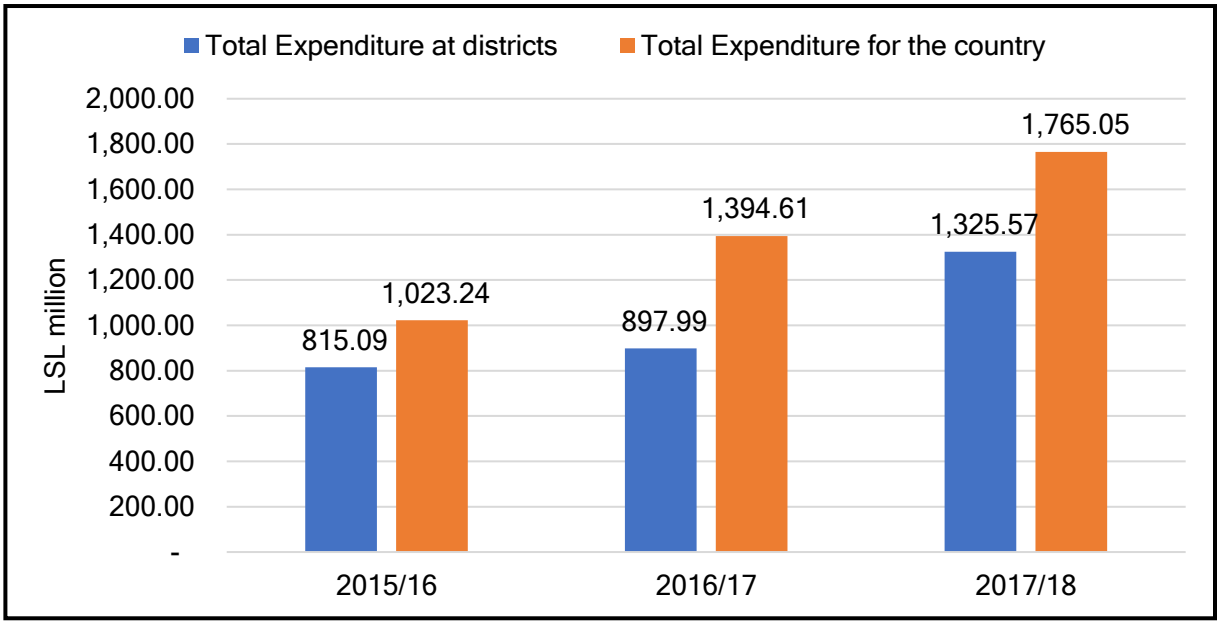
Figure 3.2: Trend in per capita expenditure



10 Exchange rate of LSL 9.66 = US$ 1 in 2015/16, LSL 10.85 = US$ 1 in 2016/17 and LSL 12.76 = US$ 1 in 2017/18.

Figure 3.2 shows that per capita expenditure increased from LSL 509.78 (US$ 52.88) in 2015/16 to LSL 690.15 (US$ 63.59) in 2016/17 and LSL 867.57 (US$ 68.00) in 2017/18. In terms of the local currency, these figures translated to annual growth in per capita expenditure of 35.38 percent and 25.71 percent, respectively, between 2015/16 and 2016/17 and between 2016/17 and 2017/18. The trend in Figure 3.2 provides evidence of steadily increasing trend per capita expenditure in the three years, suggesting general increase in resources spent on the HIV and AIDS activities in the country. The distribution of expenditure at the districts and the overall expenditure in the country is shown in Figure 3.3.

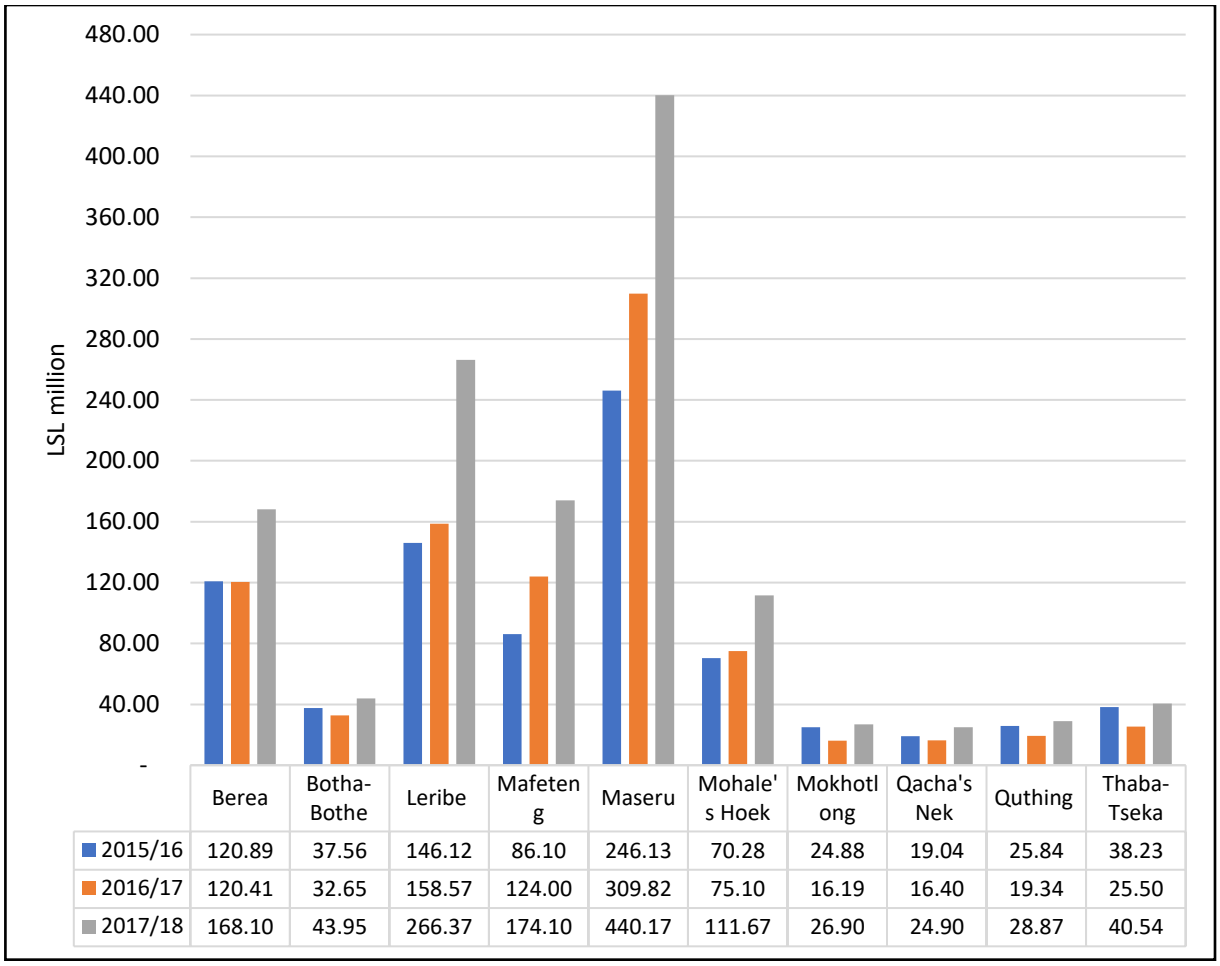
Figure 3.3: Comparison of expenditure at districts and at country level



The expenditure at the districts covered actual implementation of the interventions but excludes expenditure on programme management at national, monitoring and evaluation at the national, drugs supply system strengthening among others. The total expenditure for the country is the sum of

expenditure at the districts and at the national level. Figure 3.3 shows that the bulk of the total expenditure in the country went to districts. In 2015/16, the total expenditure at the ten districts was LSL 782.34 million (US$ 81.03 million) in 2015/16, LSL 900.94 million (US$ 83.02 million) in 2016/17 and LSL 1325.11 million (US$ 103.86million) in 2017/18. The expenditure at the districts stood at 76.5 percent of the total HIV spending in 2015/16, 64.6 percent in 2016/17 and 75.1 percent in 2017/18.

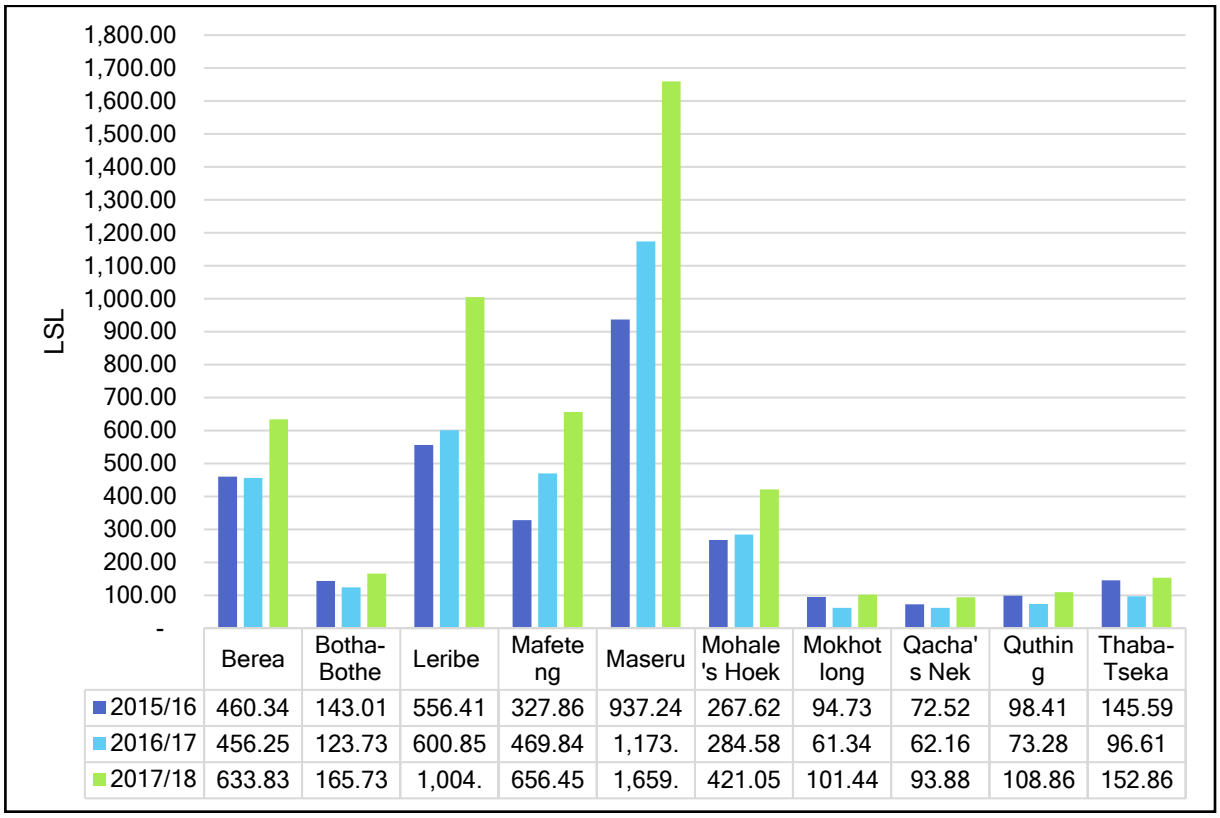
Figure 3.4: Trends in expenditure at the district level



	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
2015/16	120.89	37.56	146.12	86.10	246.13	70.28	24.88	19.04	25.84	38.23
2016/17	120.41	32.65	158.57	124.00	309.82	75.10	16.19	16.40	19.34	25.50
2017/18	168.10	43.95	266.37	174.10	440.17	111.67	26.90	24.90	28.87	40.54

Figure 3.4 shows that five districts of Maseru, Leribe, Berea, Mafeteng and Mohale's Hoek took a largest share of the expenditure at the district level. In addition, these districts are also shown to have exhibited increasing trend in expenditure over the entire period. In order to make further comparison of the expenditure, per capita expenditure in the districts was calculated. The results are shown in Figure 3.5.

Figure 3.5: Per capita expenditure by district



	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
2015/16	460.34	143.01	556.41	327.86	937.24	267.62	94.73	72.52	98.41	145.59
2016/17	456.25	123.73	600.85	469.84	1,173.	284.58	61.34	62.16	73.28	96.61
2017/18	633.83	165.73	1,004.	656.45	1,659.	421.05	101.44	93.88	108.86	152.86

It is apparent that there were significant variations in the expenditure per person in the districts. In 2015/16, Maseru had the highest per capita of LSL 907.06, followed by Leribe (LSL 533.6), Berea (LSL 442.15), Mafeteng (LSL 315.65), Mohale's Hoek (LSL 256.62), Thaba-Tseka (LSL 138.09), Botha-Bothe (LSL 134.61), Quthing (LSL 93.11), Mokhotlong (LSL 89.47) and Qacha's Nek (LSL 68.67). Overall, the five districts consisting Berea, Leribe, Mafeteng, Maseru and Mohale's Hoek recorded increasing per capita expenditure over the period under consideration. The remaining five districts had a decline in per capita expenditure between 2015/16 and 2016/17 and this scenario was reversed with increase per capita expenditure between 2016/17 and 2017/18. There was significant increase in per capita expenditure in Berea, Leribe and Maseru in 2017/18 as compared to the same in 2016/17. These results point to possibility of inequity in the financing of the HIV and AIDs interventions among the districts in country. The comparison of the trend in the three-year average per capita expenditure in the districts is shown in Figure 3.6.

Figure 3.6: Average per capita expenditure in the 3 Financial Years

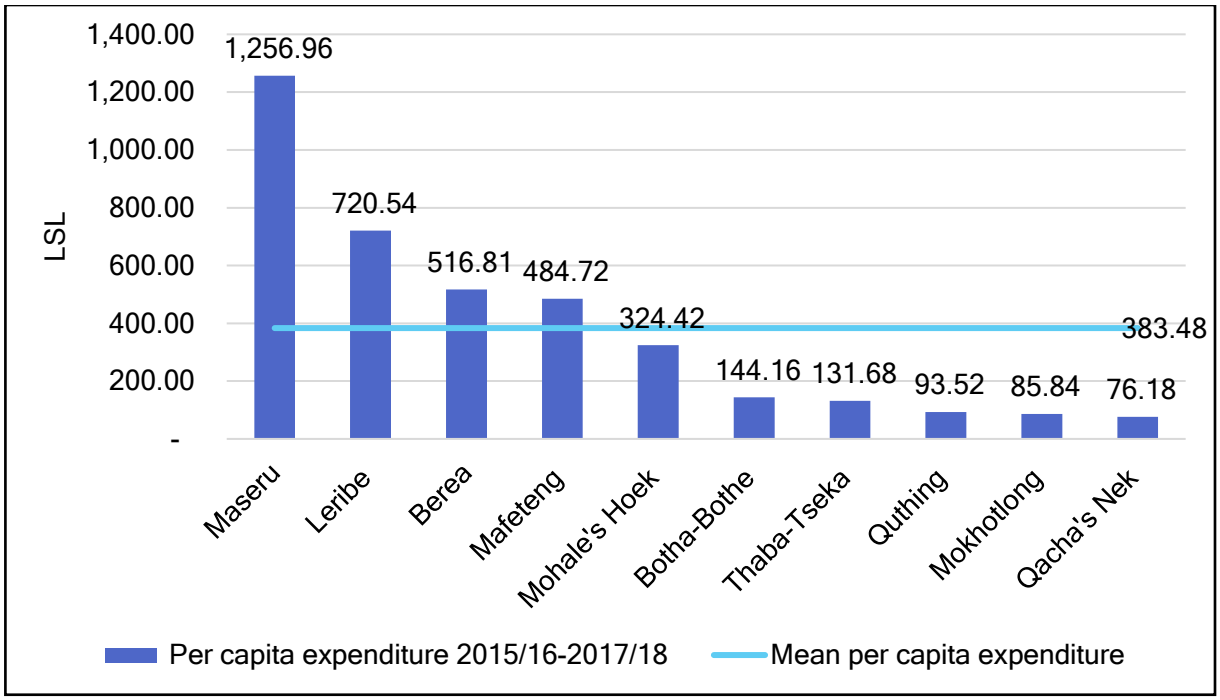
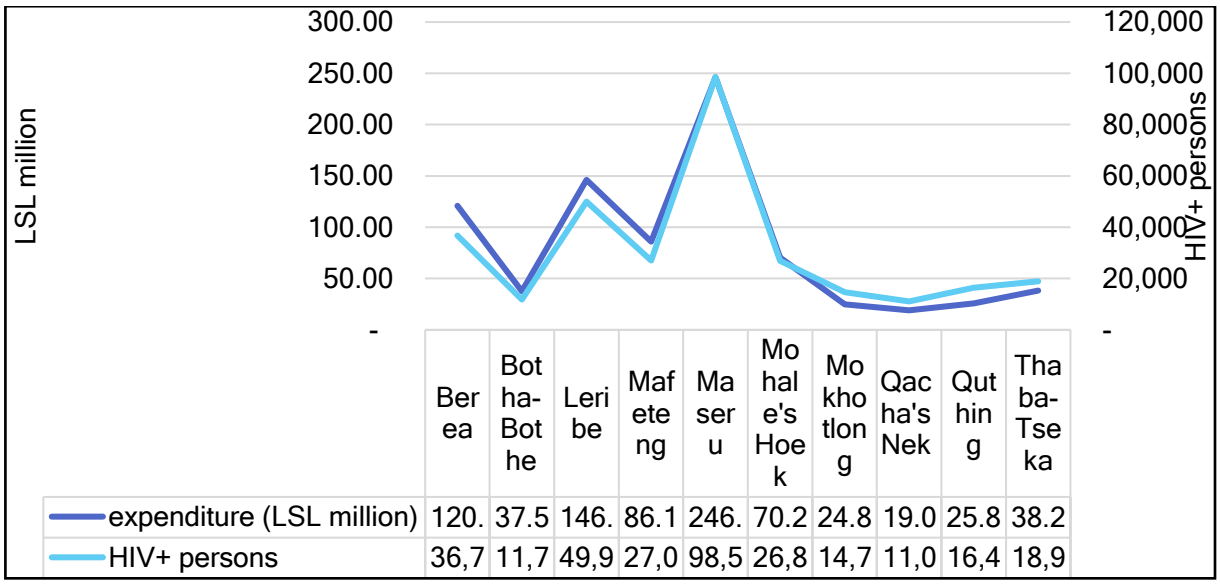


Figure 3.6 indicates that four districts, Maseru, Leribe, Berea and Mafeteng had their individual three-year per capita expenditure above the average per capita of LSL 379.64 for all the ten districts during the period. The remaining six districts recorded less than the group average per capita expenditure. These results show wide variations of the district mean per capita expenditure around the average, suggesting inequality in financing of the HIV response in the districts.

Further analysis of the district expenditure was carried out to relate the HIV spending and the burden of HIV at the districts measured by the number of PLHIV[11].. The comparisons are given in Figure 3.7, Figure 3,8 and Figure 3.9, respectively, for the years 2015/16. 2016/17 and 2017/18.

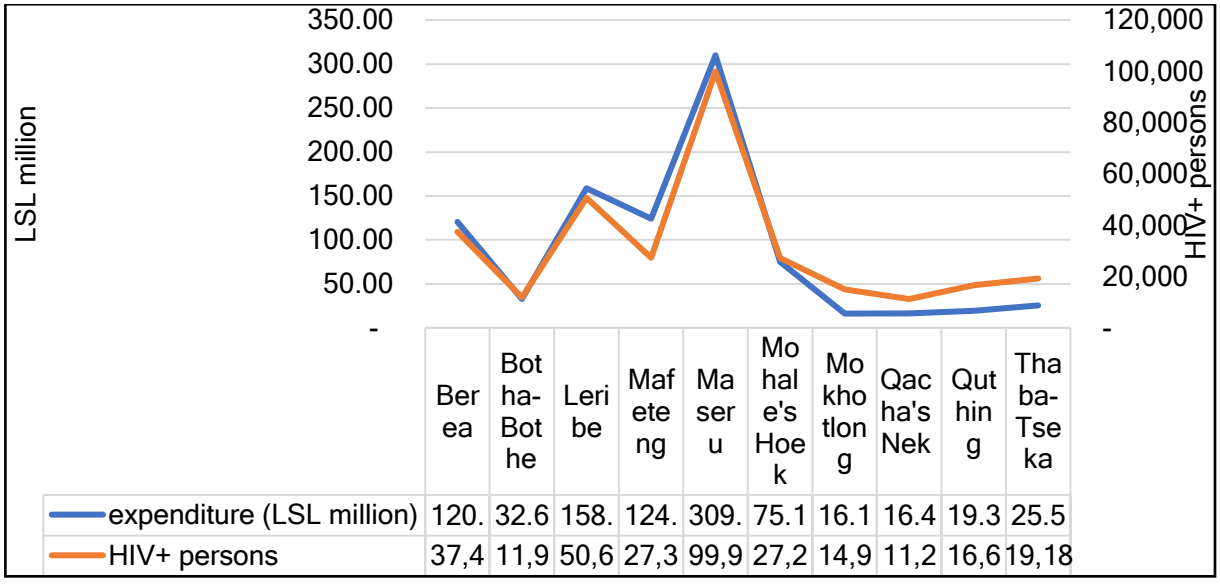
[11] Data on PLHIV obtained from Lesotho's validated HIV estimates for February 2018.

Figure 3.7: ***Comparison of expenditure and burden of HIV - 2015/16***



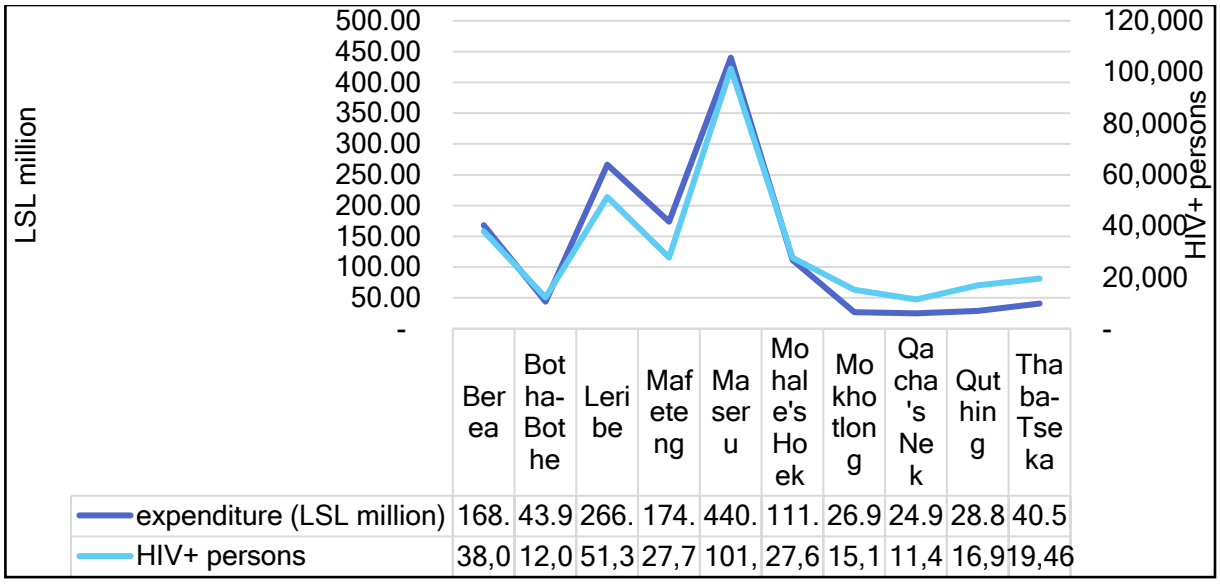
	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
expenditure (LSL million)	120.	37.5	146.	86.1	246.	70.2	24.8	19.0	25.8	38.2
HIV+ persons	36,7	11,7	49,9	27,0	98,5	26,8	14,7	11,0	16,4	18,9

Figure 3.8: ***Comparison of expenditure and burden of HIV - 2016/17***



	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
expenditure (LSL million)	120.	32.6	158.	124.	309.	75.1	16.1	16.4	19.3	25.5
HIV+ persons	37,4	11,9	50,6	27,3	99,9	27,2	14,9	11,2	16,6	19,18

Figure 3.9: ***Comparison of expenditure and burden of HIV - 2017/18***



The trends for 2015/16 as shown in Figure 3.7 imply that the expenditure on HIV and AIDS activities was relatively in favour of Berea, Leribe and Mafeteng districts. In the same year, the expenditure in four districts of Mokhotlong, Qacha's Nek, Quthing, and Thaba-Tseka was proportionately low relative to the burden of HIV given by the number of PLHIV in these districts. Further, there was an increasing and unfavourable divergence between the trend in the expenditure and the burden of HIV in these four districts in 2016/17 and 2017/18, as shown in Figure 3.8 and Figure 3.9. On the other hand, the trends over the three years, show increasing spending relative to the number of PLHIV in Leribe, Mafeteng and Maseru. It was in only two districts of Botha-Bothe and Mohale's that the trends in expenditure and number PLHIV remained relatively stable. The results again indicate inequality in financing that may warrant attention of the Government and the other stakeholders. The data in Figure 3.7, Figure 3.8 and Figure 3.9 were used to estimate average expenditure per HIV+ person in the districts in the three fiscal years and the results are presented in Figure 3.10.

Figure 3.10: Three-year average expenditure per HIV+ person by district

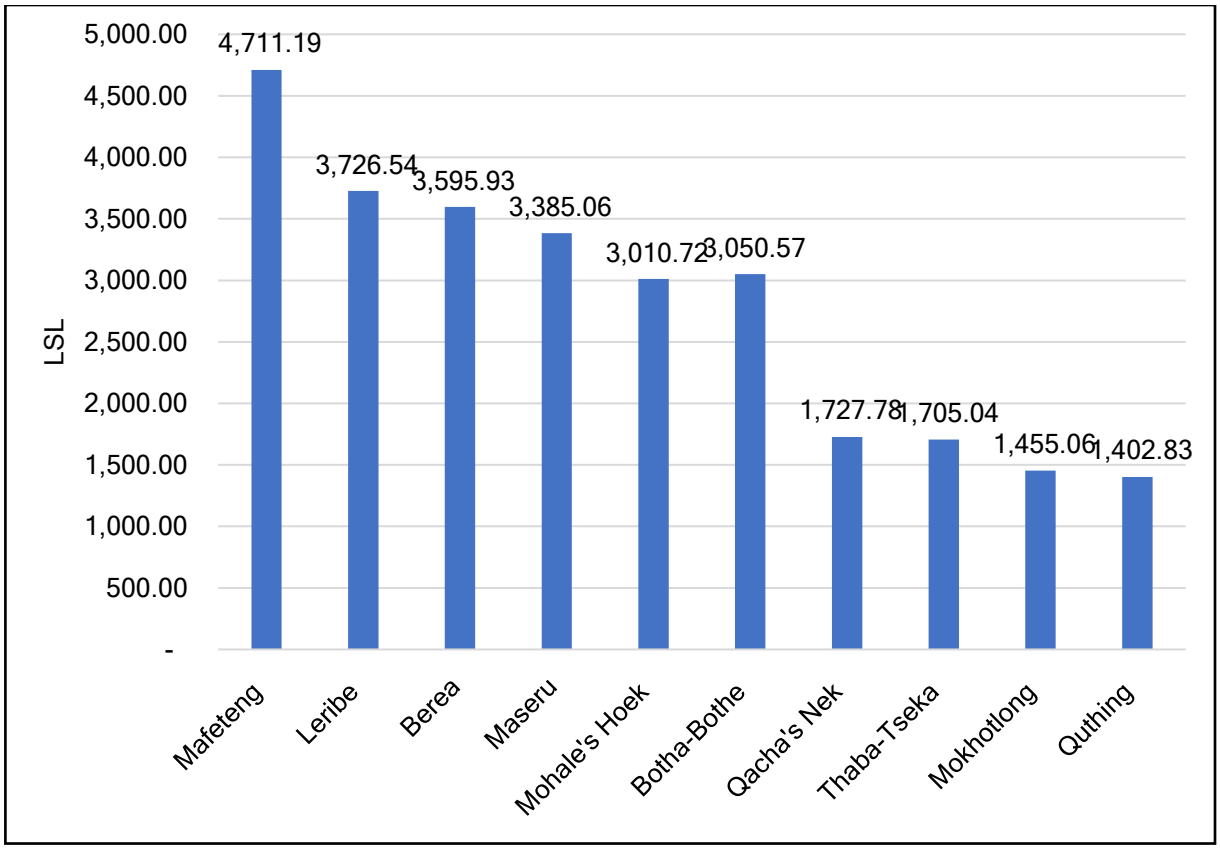


Figure 3.10 indicates variations in expenditure per HIV+ person across the districts, providing further evidence of possible inequality in HIV spending at the districts. The three-year average expenditure per HIV+ person was LSL 4,674.94 (US$ 412.99) in Mafeteng, LSL 3,690.64 (US$ 326.60) in Leribe, LSL 3556.48 (US$ 319.05) in Berea, LSL 3,361.21 (US$ 298.37) in Maseru, LSL 2,977.87 (US$ 265.43) in Mohale's Hoek, LSL 2,9992.65 (US$ 270.41) in Botha-Bothe, LSL 1,698.29 (US$ 152.62) in Qacha's Nek, LSL 1,675.04 (US$ 152.01) in Thaba-Tseka, LSL 1,427.57 (US$ 129.37) in Mokhotlong and LSL 1,380.56 (US$ 124.96) in Quthing. Although it was shown that Maseru District had the highest per capita expenditure in Figure 3.6, Mafeteng District had the highest expenditure per HIV+ person as shown in Figure 3.10. The results show similar variability in the expenditure per HIV+ person as was the case with per capita expenditure for the total population in the districts as indicated in Figure 3.6.

A much deeper analysis was carried out to assess the inequality in expenditure per HIV+ person. This was achieved by use of concentration curve and concentration indices. In the concentration curve, the variable of interest was total expenditure per district, and this was assessed against the number of HIV+ persons in districts. The concentration curves are depicted in Figure 3.11, 3.12 and 3.13 for the years, respectively, 2014/15, 2015/16 and 2017/18.

Figure 3.11: Concentration curve for expenditure per HIV+ person – 2015/16

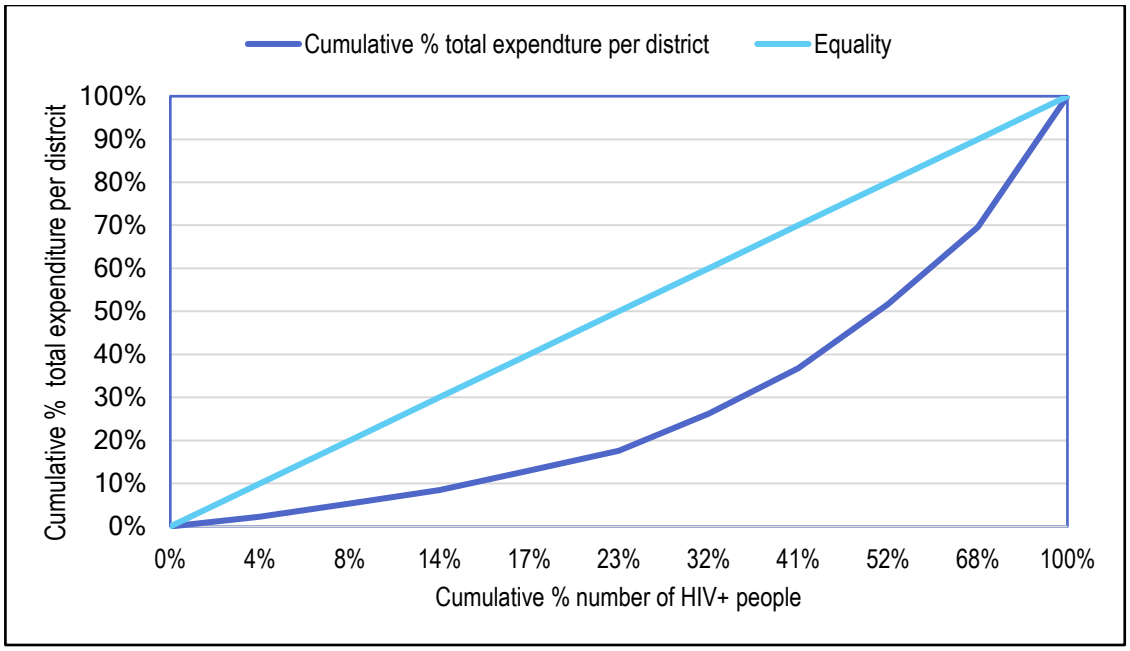


Figure 3.12: Concentration curve for expenditure per HIV+ person – 2016/17

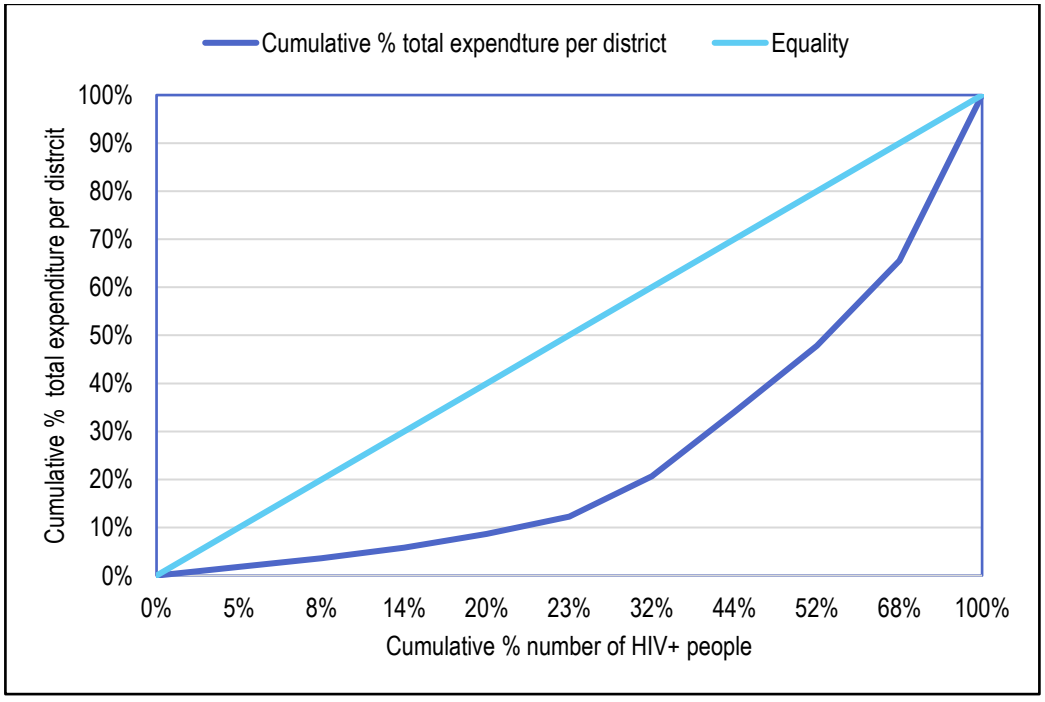
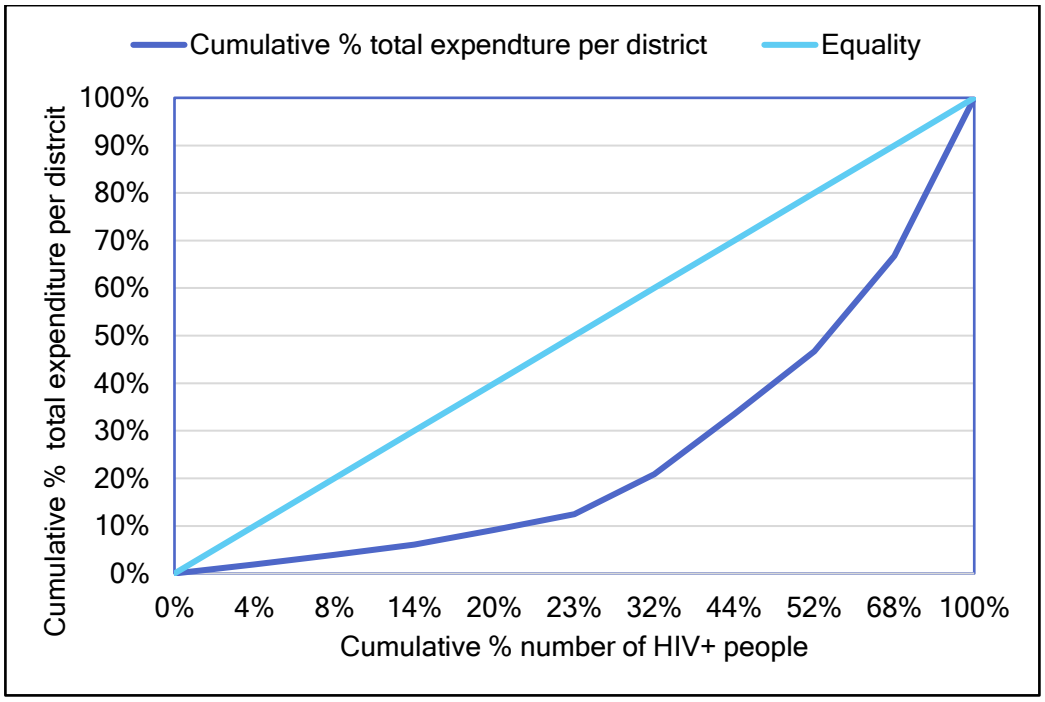
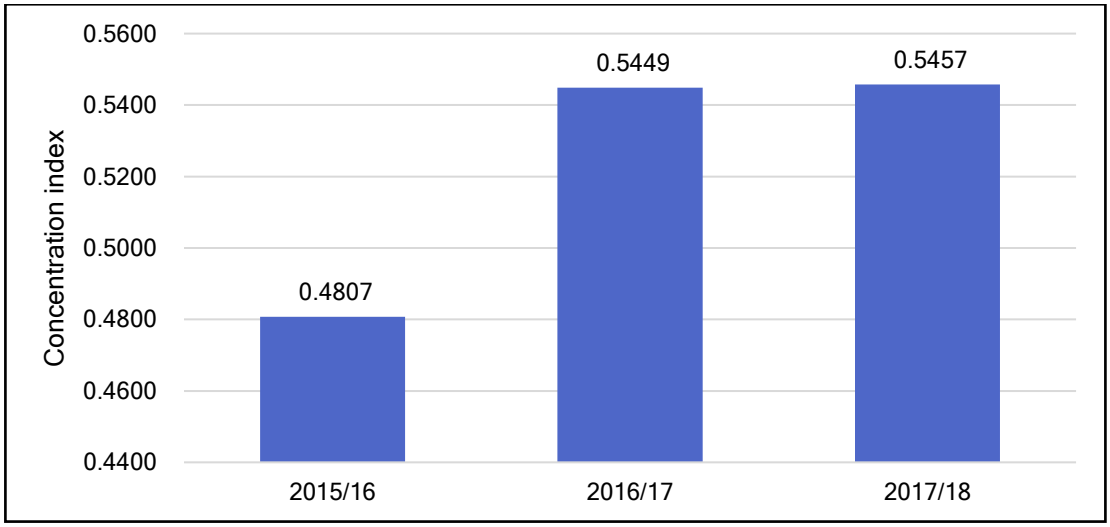


Figure 3.13: Concentration curve for expenditure per HIV+ person – 2017/18



The results show that the concentration curves for total expenditure per district were below the equality line showing inequality in financing HIV and AIDS activities in the districts, with the districts in the highlands given relatively low priority in spending compared to the districts in the lowlands part of the country. Additional analysis was carried out to determine if the inequality was similar or varying in the years. This was achieved using the concentration index. The results are shown in Figure 3.14.

Figure 3.14 Trend in inequality in HIV funding given by concentration index



The positive value in each year, indicates inequality in funding, where districts in the lowlands were better-off as they received more of the funding for HIV response than those in the highlands. The inequality accounted for the HIV positive persons in each of the districts. It is also apparent the inequality increased over the years, though by small margin between 2016/17 and 2017/18.

3.2 HIV and AIDS Expenditure by Financing Entities

The main financing entities (FE), which are sources of funds for HIV and AIDS interventions in Lesotho, provide financial and non-financial resources for HIV related activities. The total expenditure classified by financing entities is presented in Table 3.2, Figure 3.15, Figure 3.16 and Figure 3.17.

Table 3.2: Expenditure on HIV and AIDS by financing entities

	2015/16		2016/17		2017/18	
Financing entity	LSL million	Percent	LSL million	Percent	LSL million	Percent
FE.01.01.01 Government of Lesotho	436.08	42.6%	455.05	32.6%	464.03	26.3%
FE.03.01.30 Government of United States	346.11	33.8%	687.69	49.3%	815.11	46.2%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	200.73	19.6%	155.97	11.2%	397.12	22.5%
FE.03.02 United Nation Agencies	12.99	1.3%	26.72	1.9%	31.41	1.8%
FE.03.03 International not-for-profit organizations and foundations	27.31	2.7%	69.19	5.0%	57.38	3.3%
Total	**1,023.23**	**100%**	**1,394.61**	**100%**	**1,765.05**	**100%**

	2015/16		2016/17		2017/18		Total	
Financing entity	LSL million	Percent	LSL million	Percent	LSL million	Percent	LSL million	Percent
FE.01.01.01 Central government	436.08	42.6%	455.05	32.6%	464.03	26.3%	1,355.16	32.4%
FE.03.01.30 Government of United States	346.11	33.8%	687.69	49.3%	815.11	46.2%	1,848.91	44.2%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	200.73	19.6%	155.97	11.2%	397.12	22.5%	753.82	18.0%

FE.03.02.08 UNAIDS Secretariat	13.70	1.3%	30.55	2.2%	34.75	2.0%	79.00	1.9%
FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	26.61	2.6%	65.36	4.7%	54.04	3.1%	146.00	3.5%
Total	1,023.24	100.0%	1,394.61	100.0%	1,765.05	100.0%	4,182.89	100.0%

In financial year 2015/16, the Government of Lesotho was the largest source of funding for HIV response, contributing LSL 436.08 million (US$ 45.17 million) and accounting for 42.6 percent. This contribution is shown to have increased modestly over the three years, but with declining percentage in the total expenditure. For instance, in 2016/17, the government expenditure on HIV was LSL 455.05 million (US$ 41.93 million) being 32.6 percent of total expenditure in that year. Similarly, in 2017/18, the Government of Lesotho contributed LSL 464.03 million (US$ million), which was 26.3 percent of the total expenditure. It should be pointed out the government expenditure included indirect expenditure on health care workers (MoH and CHAL) and operating costs at government health facilities, which were apportioned to the HIV services.

The Government of United States as a financing entity, contributed LSL 346.11 million (US$ 35.85 million) in 2015/16, LSL 687.69 million (US$ 63.37 million) in 2016/17, LSL 815.11 million (US$ 63.89 million) in 2017/18. These translated to 33.8 percent of total expenditure in 2015/16, 49.3 percent in 2016/17 and 46.2 percent in 2017/18.Therefore, in the last two financial years, USG was the leading financing entity in Lesotho. The expenditure from GFATM showed fluctuations, being LSL 200.73 million (US$ 20.79 million) and accounting for 19.6 percent in 2015/16, LSL 155.97 million (US$ 14.37 million) (11.2%) in 2016/17,andLSL 397.12 million (US$ 31.12 million) (22.5%) in 2017/18.

Overall, international financing entities accounted for 57.4 percent of total expenditure in 2015/16, 67.4 percent in 2016/17 and 73.7 percent in 2017/18. These results underscore the importance of international sources and point to the problem of sustainable financing of HIV in Lesotho. Further analysis of the financing by the entities was done in terms of the prioritization of expenditure by districts and results are shown in Figure 3.15, Figure 3.16 and Figure 3.17.

Figure 3.15: Priority districts by financing entities in 2015/16

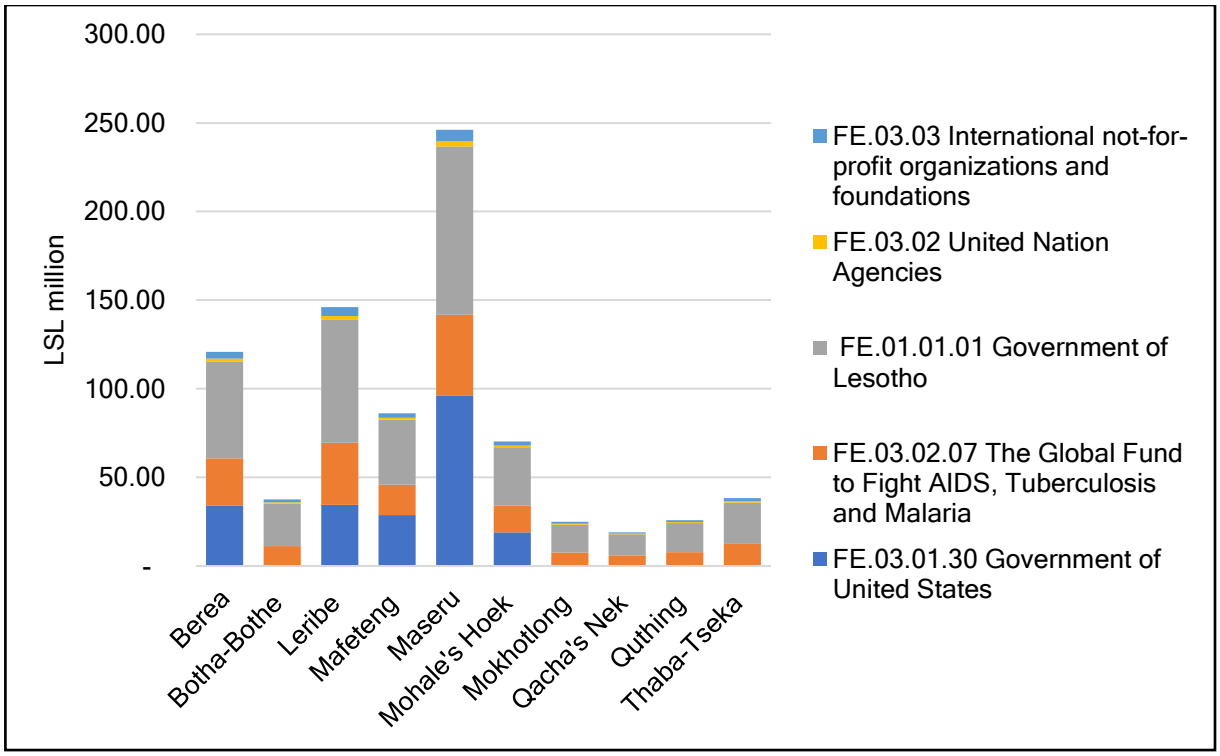


Figure3.16: Priority districts by financing entities in 2016/17

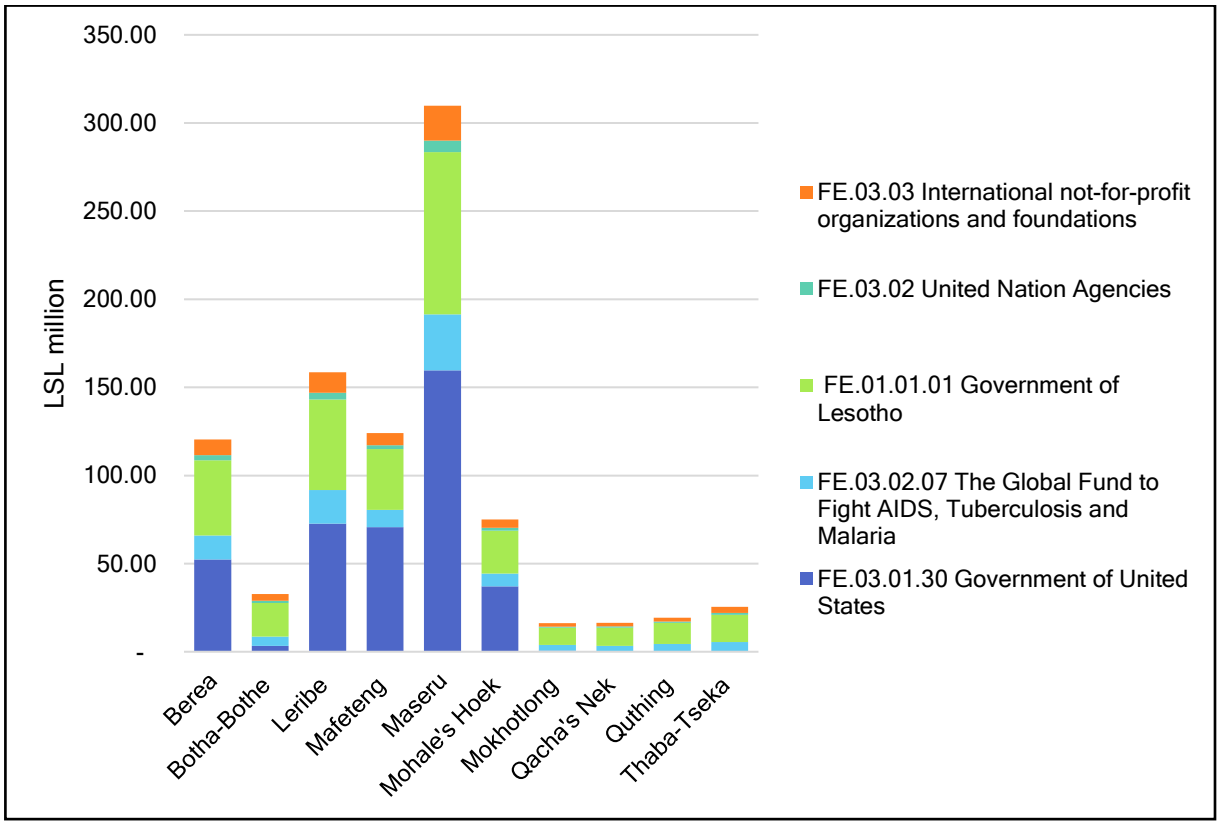
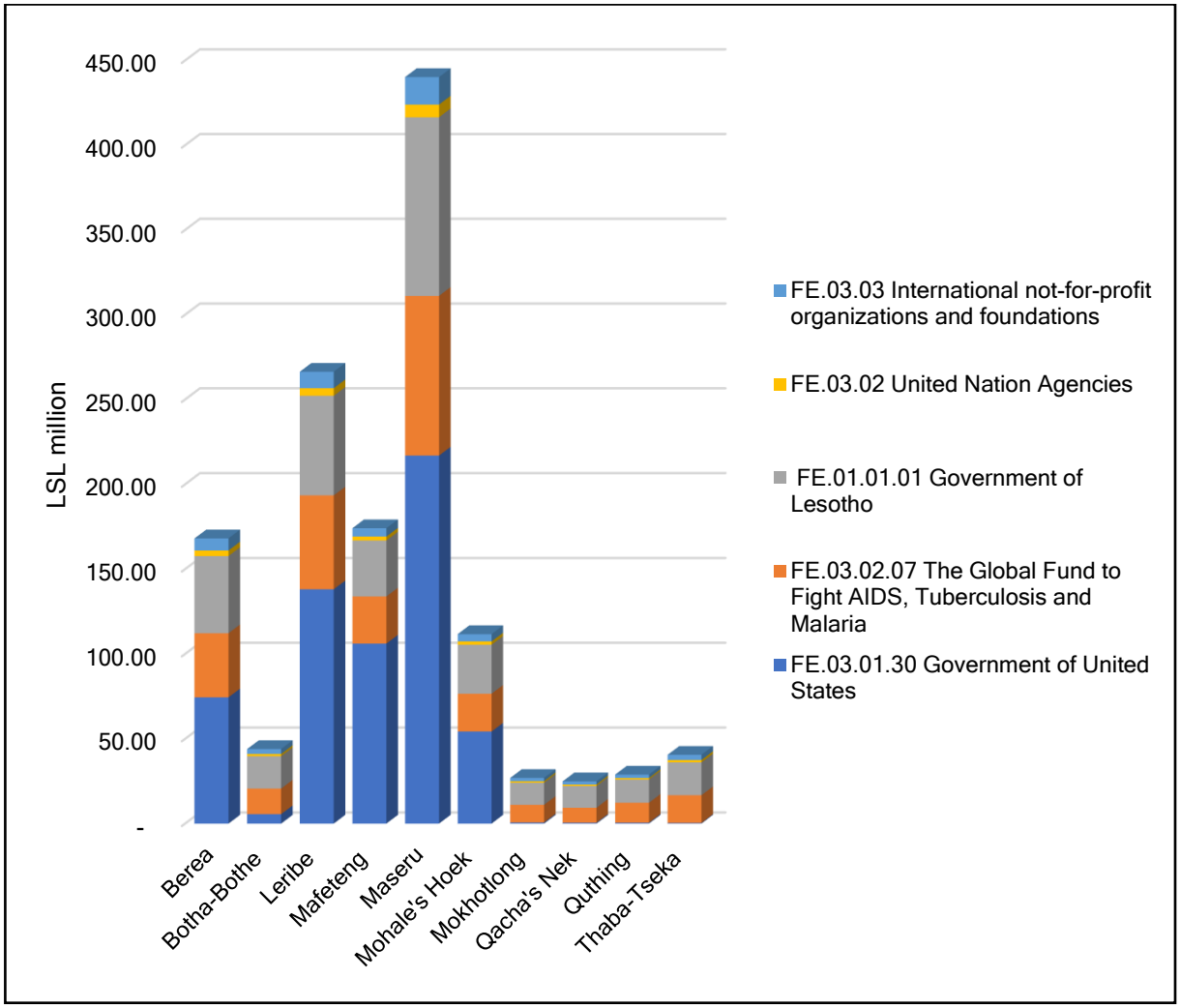


Figure 3.172: Priority districts by financing entities in 2017/18



Although all the financing entities had expenditure across all the ten districts, the USG as a financing entity prioritized five districts, consisting of Berea, Leribe, Mafeteng, Maseru and Mohale's Hoek. These five districts accounted for much of the burden of HIV, contributing about 74% of the total people living with HIV in the country. The Government of Lesotho and GFATM are shown to have had a relatively more equitable expenditure across all the ten districts, with amount of expenditure seemly related to burden of the disease in the ten districts.

3.3 HIV and AIDS Expenditure by Revenue Types

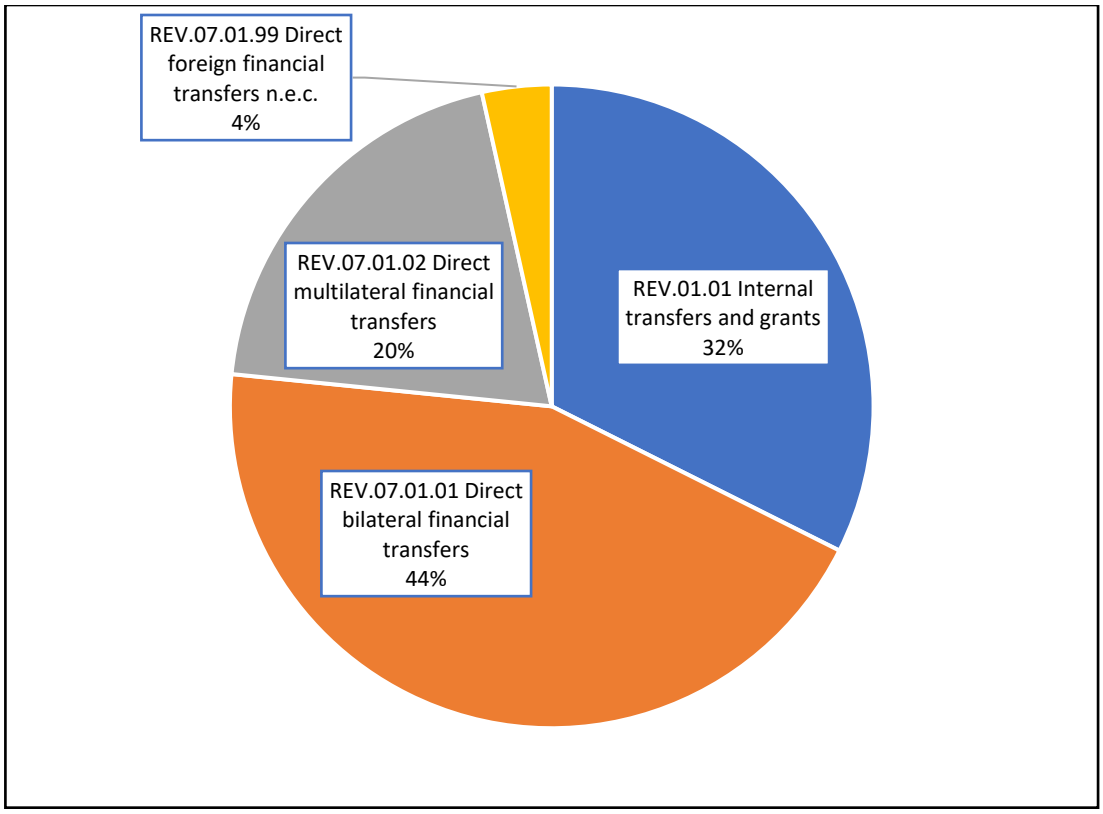
The NASA analysis showed that there were three main types of revenue that formed the funds transferred from the financing entities to financing agents and purchasers (Table 3.3 and Figure 3.18).

Table 3.3: Spending (LSL million) on HIV and AIDS by revenue type

	2015/16	2016/17	2017/18	Total	Percent
REV.01.01 Internal transfers and grants	436.08	455.05	464.68	1,355.81	32.4%
REV.07.01.01 Direct bilateral financial transfers	360.70	711.12	839.95	1,911.77	44.2%
REV.07.01.02 Direct multilateral financial transfers	213.72	182.69	428.53	824.95	19.7%
REV.07.01.99 Direct foreign financial transfers n.e.c.	12.73	45.75	31.89	90.37	3.7%
Total	1,023.23	1,394.62	1,765.05	4,182.90	100.0 %

	2015/16	2016/17	2017/18	Grand Total
REV.01 Transfers from government domestic revenue including reimbursable loans (allocated to HIV purposes)	436.08	455.05	464.03	1,355.16
REV.01.01 Internal transfers and grants	436.08	455.05	464.03	1,355.16
REV.07 Direct foreign transfers	587.15	939.56	1,301.02	2,827.74
REV.07.01 Direct foreign financial transfers	587.15	939.56	1,301.02	2,827.74
REV.07.01.01 Direct bilateral financial transfers	346.11	687.69	815.11	1,848.91
REV.07.01.02 Direct multilateral financial transfers	214.43	186.52	431.87	832.82
REV.07.01.99 Direct foreign financial transfers n.e.c.	26.61	65.36	54.04	146.00
Total	**1,023.24**	**1,394.61**	**1,765.05**	**4,182.89**

Figure 3.18: Percentage distribution of the revenue types for the 3 years



Internal transfers and grants reflected the type of revenue that Government of Lesotho disbursed to different institutions such as government ministries and entities in order to finance the HIV and AIDS interventions. Direct bilateral financial transfers encompassed financing from Government of United States, while direct multilateral financial transfers constituted financing from GFATM and UN agencies. Other direct foreign transfers reflect funding from international NGOs and foundations transferring resources for the HIV response in the country. Table 3.3 and Figure 3.18 show that, in the period of the three years, direct bilateral transfer was the leading type of revenue, followed by internal transfers and grants and direct multilateral.

3.4 HIV and AIDS Expenditure by Financing Schemes

UNAIDS defines health care financing schemes are structural components of health care financing systems: they are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Third party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health and social services and the rules on raising and then pooling the revenues of the given scheme. The financing from the different entities in Lesotho in the three years fell into three classes of financing schemes as shown in Table 3.4.

Table 3.4: Expenditure on HIV and AIDS by financing schemes

	2015/16		2016/17		2017/18		Grand Total	
	LSL million	Percent	LSL million	Percent	LSL million	Percent	LSL million	Percent
SCH.01 Government schemes and compulsory contributory health care schemes	629.57	61.5%	647.07	46.4%	904.80	51.3%	2,181.45	52.2%
SCH.01.01 Government schemes	629.57	61.5%	647.07	46.4%	904.80	51.3%	2,181.45	52.2%
SCH.01.01.01 Central government schemes	629.57	61.5%	647.07	46.4%	904.80	51.3%	2,181.45	52.2%
SCH.02 Voluntary payment schemes	393.66	38.5%	747.54	53.6%	860.25	48.7%	2,001.45	47.8%
SCH.02.02 Not-for-profit organisation schemes	393.66	38.5%	747.54	53.6%	860.25	48.7%	2,001.45	47.8%
SCH.02.02.01 Not-for-profit organisation schemes (excludin	343.00	33.5%	712.23	51.1%	830.05	47.0%	1,885.29	45.1%

g SCH.2.2.2)								
SCH.02.02.02 Resident foreign agencies schemes	50.66	5.0%	35.30	2.5%	30.19	1.7%	116.16	2.8%
Total	1,023.24	100.0%	1,394.61	100.0%	1,765.05	100.0%	4,182.89	100.0%

Table 3.4 shows only government financing schemes were considered in this study since households OOP data were not included.

3.5 Expenditure Breakdown by Financing Agents and Purchasers

This section highlights the key priority areas by the various agents of HIV and AIDS funds in Lesotho. Financing agents and purchasers refer to entities that manage and use the funds for payment or purchase of health services, medical supplies and other HIV/AIDS related activities. The financing agents and purchasers also decide the type of activity or product to fund or purchase. Table 3.5, Table 3.6 and Table 3.7 present total expenditure broken down by the FAPs and FEs. Furthermore Figure 3.19 show the distribution by the percentage of expenditure accounted for the different FAPs in the three years.

Table 3.5: Total expenditure (LSL million) by FAPs and FEs -2015/16

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The GFATM	FE.03.02 UN Agencies	FE.03.03 International NGOs and foundations	Total	Percent of Total
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	418.01	3.03	186.98	5.26	-	613.28	59.9%
FAP.01.01.01.10 National AIDS Commission	2.21	-	-	-	-	2.21	0.2%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	1.11	-	-	0.77	-	1.88	0.2%
FAP.01.01.01.03 Ministry of Social Development (or equivalent sector entity)	14.74	-	-	-	-	14.74	1.4%
FAP.02.05 Not-for-profit institutions (other than social insurance)	-	-	-	4.61	22.31	26.92	2.6%
FAP.03.03.99 Other International not-for-profit organizations n.e.c.	-	170.13	13.75	2.35	5.23	191.46	18.7%
FAP.03.04 Projects within Universities	-	127.27	-	-	-	127.27	12.4%
FAP.03.99 Other international financing agents n.e.c.	-	45.69	-	-	-	45.69	4.5%
Total	**436.08**	**346.11**	**200.73**	**12.99**	**27.55**	**1,023.47**	**100**

Table 3.6: Total expenditure (LSL million) by FAPs and FEs – 2016/17

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The GFATM	FE.03.02 UN Agencies	FE.03.03 International NGOs and foundations	Total	Percent of Total
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	439.87	59.19	124.45	4.31	-	627.82	45.0%
FAP.01.01.01.10 National AIDS Commission	8.13	-	-	-	-	8.13	0.6%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	1.34	-	-	0.65	-	1.99	0.1%
FAP.01.01.01.03 Ministry of Social Development (or equivalent sector entity)	5.7	-	-	-	-	5.70	0.4%
FAP.02.05 Not-for-profit institutions (other than social insurance)	-	-	-	21.75	30.72	52.47	3.8%

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The GFATM	FE.03.02 UN Agencies	FE.03.03 International NGOs and foundations	Total	Percent of Total
FAP.03.03.99 Other International not-for-profit organizations	-	486.2	31.52	-	39.28	557.00	39.9%
FAP.03.04 Projects within Universities	-	92.63	-	-	-	92.63	6.6%
FAP.03.99 Other international financing agents	-	49.67	-	-	-	49.67	3.6%
Total	**455.05**	**687.69**	**155.97**	**26.72**	**70**	**1,395.42**	100.0%

Table 3.7: Total expenditure (LSL million) by FAPs and FEs – 2017/18

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The GFATM	FE.03.02 UN Agencies	FE.03.03 International NGOs and foundations	Total	Percent of Total
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	437.02	87.18	346.54	3.25	-	873.99	49.5%
FAP.01.01.01.10 National AIDS Commission	7.03	-	-	-	-	7.03	0.4%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	3.92	-	-	0.77	-	4.69	0.3%
FAP.01.01.01.03 Ministry of Social Development (or equivalent sector entity)	16.06	-	-	-	-	16.06	0.9%
FAP.02.05 Not-for-profit institutions (other than social insurance)	-	-	-	27.32	34.23	61.55	3.5%
FAP.03.03.99 Other International not-for-profit organizations n.e.c.	-	680.91	50.58	-	24.78	756.27	42.8%
FAP.03.04 Projects within Universities	-	20.16	-	-	-	20.16	1.1%
FAP.03.99 Other international financing agents n.e.c.	-	26.85	-	-	-	26.85	1.5%
Total	**464.03**	**815.11**	**397.12**	**31.34**	**59.01**	**1,766.60**	100.0%

In 2015/16, Ministry of Health (MoH) took the largest share (60%) of the total expenditure as financing agent and purchaser This meant that MoH made programmatic decisions on how those funds were spent. International NGOs took the second largest share (18.7%) followed by foreign universities (12.4%). The trend remained the same for the years 2016/17 and 2017/18 . Most of the international NGOs were funded by USG through PEPFAR programme. The MoH accounted for 45 percent in 2016/17 and 49 percent in 2017/18. The percentage of expenditure through international NGOs as FAP increased significantly in 2016/17 (40%) ad 2017/18 (43%).

3.6 Providers of HIV and AIDS Services

This section presents the analysis of providers of HIV and AIDS services. According to the NASA guidelines, service providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. HIV and AIDS services are provided by several providers that include the government and other public entities, international NGOs and universities, and domestic private for profit and non-profit organizations. Table 3.8, Table 3.9 and Table 3.10 provide broad picture of the main providers of HIV and AIDS related services in Lesotho.

Table 3.8: Total expenditure (LSL million) by providers of services – 2015/16

Service providers	FE.01.01 .01 Central government	FE.03.01 .30 Government of United States	FE.03.02 .07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02 .08 UNAIDS Secretariat	FE.03.03 .99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
PS.01 Public sector providers	270.58	105.06	102.25	6.56	-	484.45	47.3%
PS.01.01 Governmental organizations	270.58	105.06	102.25	6.56	-	484.45	47.3%
PS.01.01.01 Hospitals (public)	249.20	103.04	91.16	1.93	-	445.33	43.5%
PS.01.01.13 Government entities (public)	21.38	2.02	11.09	4.63	-	39.12	3.8%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	-	-	-	0.91	-	0.91	0.1%
PS.01.01.13.02 Departments inside the	-	2.02	6.02	2.35	-	10.39	1.0%

Ministry of Health or equivalent							
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	6.63	-	-	1.38	-	8.01	0.8%
PS.01.01.13.04 Departments inside the Ministry of Social Development or equivalent	14.74	-	-	-	-	14.74	1.4%
PS.01.01.13.06 Departments inside the Ministry of Finance or equivalent	-	-	5.07	-	-	5.07	0.5%
PS.02 Private sector providers	165.50	68.69	93.27	4.07	21.37	352.90	34.5%
PS.02.01 Non-profit providers	149.31	51.24	93.27	4.07	21.37	319.26	31.2%
PS.02.01.01 Non-profit non-faith-based providers	3.19	1.72	27.53	4.06	21.37	57.86	5.7%
PS.02.01.01.01 Hospitals (private non-profit non-faith based)	-	-	16.84	-	-	16.84	1.6%
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	3.19	1.72	10.69	4.06	21.37	41.03	4.0%
PS.02.01.02 Non-profit faith-based providers	146.12	49.52	65.74	0.01	-	261.40	25.5%
PS.02.01.02.01 Hospitals (private non-profit faith based)	146.12	49.52	65.74	-	-	261.39	25.5%
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	-	-	-	0.01	-	0.01	0.0%
PS.02.02 Profit-making private sector providers	16.19	17.45	-	-	-	33.64	3.3%

PS.02.02.01 Hospitals (profit-making private)	16.19	17.45	-	-	-	33.64	3.3%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	-	172.37	5.22	3.07	5.23	185.88	18.2%
PS.03.01 Bilateral agencies	-	6.60	-	-	-	6.60	0.6%
PS.03.02 Multilateral agencies	-	-	-	0.71	-	0.71	0.1%
PS.03.03 International NGOs and foundations	-	165.77	5.22	2.36	5.23	178.57	17.5%
Total	436.08	346.11	200.73	13.70	26.61	1,023.24	100.0%

Table 3.9: Total expenditure (LSL million) by providers of services – 2016/17

	FE.01.01.01 Government of Lesotho	**FE.03.01.30 Government of United States**	**FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria**	**FE.03.02 United Nations Agencies**	**FE.03.03.99 Other International not-for-profit organizations and foundations**	**Total**
PS.01.01.01 Hospitals (public)	269.69	194.77	32.40	0.21	-	497.06
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	8.43	-	-	1.86	-	10.29
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	2.88	30.92	28.41	2.08	-	64.28
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	9.77	-	-	0.65	-	10.42
PS.01.01.13.04 Departments inside the Ministry of Social Development or equivalent	5.70	-	-	-	-	5.70

PS.01.01.13.06 Departments inside the Ministry of Finance or equivalent	-	-	7.44	-	-	7.44
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	3.22	4.63	41.65	21.85	26.08	97.45
PS.02.01.02.01 Hospitals (private non-profit faith based)	138.13	103.25	22.04	-	-	263.43
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	-	-	-	0.03	-	
PS.02.02.01 Hospitals (profit-making private)	17.21	37.58	5.98	-	-	60.78
PS.03.02 Multilateral agencies	-	-	-	-	3.83	3.83
PS.03.03 International NGOs and foundations	-	316.54	18.04	0.03	39.28	373.89
Total	455.05	687.69	155.97	26.72	69.19	1,394.61

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
PS.01 Public sector providers	296.47	225.69	68.25	8.22	-	598.63	42.9 %
PS.01.01 Governmental organizations	296.47	225.69	68.25	8.22	-	598.63	42.9 %
PS.01.01.01 Hospitals (public)	278.12	194.77	32.40	1.19	-	506.47	36.3 %
PS.01.01.13 Government entities (public)	18.35	30.92	35.85	7.03	-	92.16	6.6%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	-	-	-	1.86	-	1.86	0.1%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	2.88	30.92	28.41	4.52	-	66.73	4.8%
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	9.77	-	-	0.65	-	10.42	0.7%

PS.01.01.13.04 Departments inside the Ministry of Social Development or equivalent	5.70	-	-	-	-	5.70	0.4%
PS.01.01.13.06 Departments inside the Ministry of Finance or equivalent	-	-	7.44	-	-	7.44	0.5%
PS.02 Private sector providers	158.57	145.47	69.68	18.46	26.08	418.26	30.0 %
PS.02.01 Non-profit providers	141.36	107.88	63.69	18.46	26.08	357.48	25.6 %
PS.02.01.01 Non-profit non-faith-based providers	3.22	4.63	41.65	18.43	26.08	94.02	6.7%
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	3.22	4.63	41.65	18.43	26.08	94.02	6.7%
PS.02.01.02 Non-profit faith-based providers	138.13	103.25	22.04	0.03	-	263.46	18.9 %
PS.02.01.02.01 Hospitals (private non-profit faith based)	138.13	103.25	22.04	-	-	263.43	18.9 %
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	-	-	-	0.03	-	0.03	0.0%
PS.02.02 Profit-making private sector providers	17.21	37.58	5.98	-	-	60.78	4.4%
PS.02.02.01 Hospitals (profit-making private)	17.21	37.58	5.98	-	-	60.78	4.4%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	-	316.54	18.04	3.86	39.28	377.72	27.1 %
PS.03.02 Multilateral agencies	-	-	-	3.83	-	3.83	0.3%

PS.03.03 International NGOs and foundations	-	316.54	18.04	0.03	39.28	373.89	26.8 %
Total	455.05	687.69	155.97	30.55	65.36	1,394.61	100.0 %

Table 3.10: Total expenditure (LSL million) by providers of services – 2017/18

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02 United Nations Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations	Total
PS.01.01.01 Hospitals (public)	251.58	251.79	145.09	-	-	648.46
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	9.89	-	0.45	2.98	-	13.31
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	2.88	42.64	51.78	0.27	-	97.57
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	13.81	-	-	0.84	-	14.65
PS.01.01.13.04 Departments inside the Ministry of Social Development or equivalent	16.06	-	-	-	-	16.06
PS.01.01.13.06 Departments inside the Ministry of Finance or equivalent	-	-	22.83	-	-	22.83
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	3.69	-	30.35	27.32	29.26	90.63
PS.02.01.02.01 Hospitals (private non-profit faith based)	147.05	135.76	104.48	-	-	387.28
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	-	5.77	-	-	-	5.77

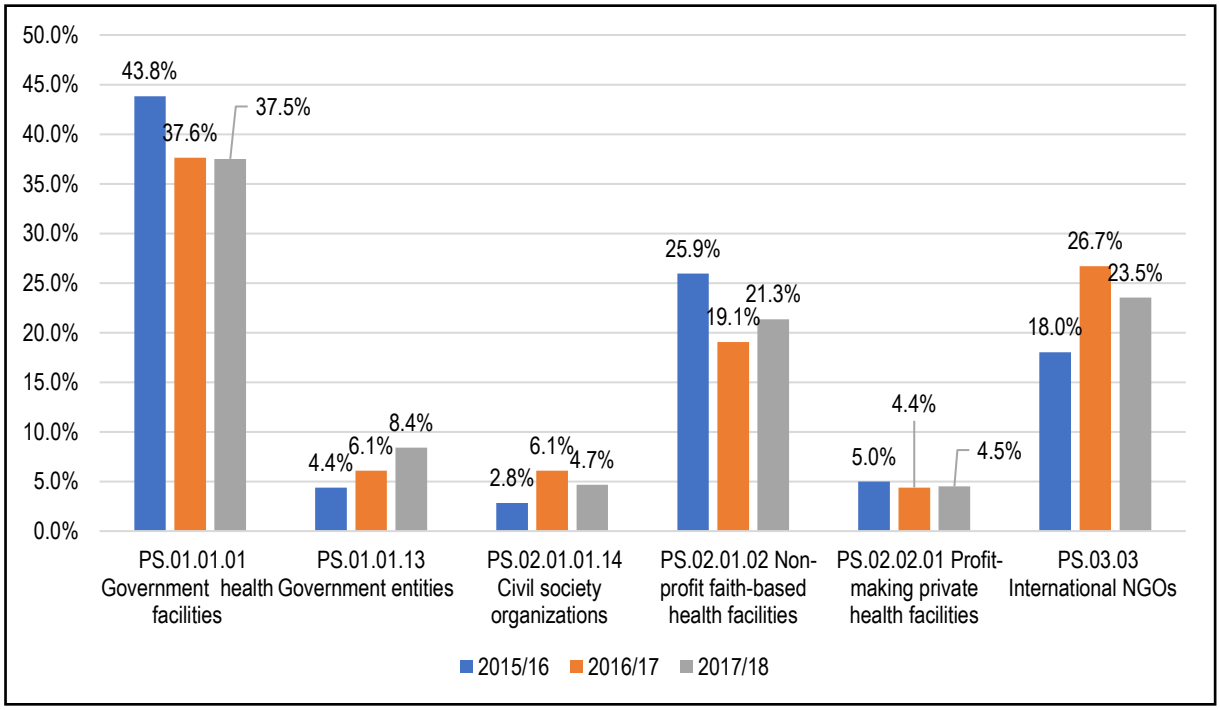
PS.02.02.01 Hospitals (profit-making private)	19.08	49.15	6.33	-	-	74.55
PS.03.02 Multilateral agencies	-	-	-	-	3.34	3.34
PS.03.03 International NGOs and foundations	-	330.01	35.81	-	24.78	390.61
Total	**464.03**	**815.11**	**397.12**	**31.41**	**57.38**	**1,765.05**

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
PS.01 Public sector providers	294.21	294.42	220.15	7.05	-	815.83	46.2 %
PS.01.01 Governmental organizations	294.21	294.42	220.15	7.05	-	815.83	46.2 %
PS.01.01.01 Hospitals (public)	261.46	251.79	145.09	-	-	658.34	37.3 %
PS.01.01.13 Government entities (public)	32.75	42.64	75.05	7.05	-	157.49	8.9%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	-	-	0.45	2.98	-	3.43	0.2%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	2.88	42.64	51.78	3.23	-	100.53	5.7%
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	13.81	-	-	0.84	-	14.65	0.8%
PS.01.01.13.04 Departments	16.06	-	-	-	-	16.06	0.9%

inside the Ministry of Social Development or equivalent							
PS.01.01.13.06 Departments inside the Ministry of Finance or equivalent	-	-	22.83	-	-	22.83	1.3%
PS.02 Private sector providers	169.82	190.67	141.16	24.36	29.26	555.27	31.5%
PS.02.01 Non-profit providers	150.74	141.52	134.83	24.36	29.26	480.72	27.2%
PS.02.01.01 Non-profit non-faith-based providers	3.69	5.77	30.35	24.36	29.26	93.43	5.3%
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	3.69	5.77	30.35	24.36	29.26	93.43	5.3%
PS.02.01.02 Non-profit faith-based providers	147.05	135.76	104.48	-	-	387.28	21.9%
PS.02.01.02.01 Hospitals (private non-profit faith based)	147.05	135.76	104.48	-	-	387.28	21.9%
PS.02.02 Profit-making private sector providers	19.08	49.15	6.33	-	-	74.55	4.2%
PS.02.02.01 Hospitals (profit-making private)	19.08	49.15	6.33	-	-	74.55	4.2%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	-	330.01	35.81	3.34	24.78	393.95	22.3%

PS.03.01 Bilateral agencies	-	3.42	-	-	-	3.42	0.2%
PS.03.02 Multilateral agencies	-	-	-	3.34	-	3.34	0.2%
PS.03.03 International NGOs and foundations	-	326.60	35.81	-	24.78	387.19	21.9 %
Total	464.03	815.11	397.12	34.75	54.04	1,765.05	100. 0%

Figure 3.19: Providers of services



The results in Table 3.8, Table 3.9, Table 3.10 and summarised in Figure 3.19 show that the government health facilities accounted for the leading share of the total expenditure at 43.8 percent in 2015/16, 37.6 percent in 2016/17 and 37.5 percent in 2017/18.This was followed by faith-based health facilities led by CHAL facilities, taking 25.9 percent of total expenditure in 2015/16, 19.1 percent in 2016/17 and 21.3 percent in 2017/18. The third largest providers of HIV services were international NGOs taking up 18.0 percent of total expenditure in 2015/16, 27.7 percent in 2016/17 and 23.5 percent in 2017/18.Other providers were civil societies organizations, private for-profit health facilities and government entities

consisting of National AIDS Commission, Department of HIV at the Ministry of Education and Departments within the Ministry of Social Development.

3.7 Expenditure by Service Delivery Mechanisms

Table 3.11 shows that main service delivery mechanism SDM, with community-based mechanisms taking minimal expenditure.

Table 3.11: Expenditure by SDM

	2015/16		2016/17		2017/18		Grand Total	
Service delivery mode	**LSL million**	**Percent**	**LSL million**	**Percent**	**LSL million**	**Percent**	**LSL million**	**Percent**
SDM.01.01 Facility-based: Outpatient	556.17	54.4%	725.64	52.1%	982.30	55.7%	1,992	47.6%
SDM.02.05 Community-based: outreach	225.78	22.1%	293.19	21.0%	377.26	21.4%	1,035	24.7%
SDM.03 Non applicable (ASC which does not have a specific SDM)	241.28	23.6%	374.49	26.9%	405.49	23.0%	1,155	27.6%
Total	1,023.23	100.0%	1,393.32	100.0%	1,765.05	100.0%	4,182	100.0%

	2015/16		2016/17		2017/18		Total	
	LSL million	**Percent**	**LSL million**	**Percent**	**LSL million**	**Percent**	**LSL million**	**Percent**
SDM.01 Facility-based service modalities	658.15	64.3%	687.23	49.3%	976.34	55.3%	2,321.71	55.5%
SDM.01.01 Facility-based: Outpatient	658.15	64.3%	687.23	49.3%	976.34	55.3%	2,321.71	55.5%
SDM.02 Home and community based service modalities	61.02	6.0%	63.04	4.5%	138.11	7.8%	262.17	6.3%

SDM.02.01 Community-based: center	18.69	1.8%	26.61	1.9%	58.16	3.3%	103.46	2.5%
SDM.02.02 Community-based: pick up points (CPUP)	-	0.0%	-	0.0%	6.51	0.4%	6.51	0.2%
SDM.02.05 Community-based: outreach	0.29	0.0%	0.38	0.0%	0.39	0.0%	1.06	0.0%
SDM.02.98 Home and community based not disaggregated	42.04	4.1%	36.04	2.6%	73.05	4.1%	151.13	3.6%
SDM.03 Non applicable (ASC which does not have a specific SDM)	227.25	22.2%	499.98	35.9%	409.00	23.2%	1,136.22	27.2%
SDM.98 Modalities not disaggregated	76.82	7.5%	144.36	10.4%	241.11	13.7%	462.29	11.1%
SDM.99 Modalities n.e.c.	-	0.0%	-	0.0%	0.49	0.0%	0.49	0.0%
Total	1,023.24	100.0%	1,394.61	100.0%	1,765.05	100.0%	4,182.89	100.0%

3.8 Expenditure by Broad AIDS Spending Categories

The AIDS spending categories capture interventions in which the expenditure was incurred. Table 3.12, Table 3.12 and Table 3.13. Figure 3.20 show the percentage expenditure on interventions areas by each financing entity in the three years.

Table 3.12: Total expenditure (LSL million) by interventions – 2015/16

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02 UN Agencies	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
ASC.01 Prevention	29.47	49.68	6.99	11.93	7.19	105.26	10.3
ASC.02 HIV testing and counselling (HTC)	13.16	34.97	-	21.98	3.17	73.28	7.2
ASC.03 HIV Care and Treatment Care	322.32	100.33	3.65	146.86	4.82	577.98	56.5
ASC.04 Social protection and economic support	15.03	12.91	-	-	12.05	39.98	3.9
ASC.05 Social Enablers	-	-	0.25	-	-	0.25	0.0
ASC.06 Programme enablers and systems strengthening	56.11	148.23	2.09	19.96	0.05	226.44	22.1
ASC.07 Development synergies	-	-	-	-	0.03	0.03	0.0
Total	436.08	346.11	12.99	200.73	27.31	1,023.23	100.0

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total
ASC.01 Prevention	8.68	49.68	11.93	7.09	6.57	83.96

ASC.02 HIV testing and counselling (HTC)	13.16	34.97	21.98	-	3.17	73.28
ASC.03 HIV Care and Treatment Care	343.11	100.33	146.86	3.65	4.82	598.77
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	15.03	12.91	-	-	12.05	39.98
ASC.05 Social Enablers (excluding the efforts for KPs above)	-	-	-	0.25	-	0.25
ASC.06 Programme enablers and systems strengthening	56.11	148.23	19.96	2.49	-	226.78
ASC.07 Development synergies	-	-	-	0.21	-	0.21
Total	436.08	346.11	200.73	13.70	26.61	1,023.24

Table 3.11: Total expenditure (LSL million) by interventions – 2016/17

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02 UN Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent of Total
ASC.01 Prevention	26.27	67.58	35.78	12.64	13.64	155.91	11.2
ASC.02 HIV testing and counselling (HTC)	17.28	60.92	2.99	-	0.80	81.99	5.9
ASC.03 HIV Care and Treatment Care	298.68	232.39	57.04	3.51	4.98	596.61	42.8

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02 UN Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent of Total
ASC.04 Social protection and economic support	5.87	11.47	-	3.52	42.21	63.07	4.5
ASC.05 Social Enablers	-	-	-	0.14	-	0.14	0.0
ASC.06 Programme enablers and systems strengthening	106.94	315.34	60.15	6.91	6.95	496.29	35.6
ASC.07 Development synergies	-	-	-	-	0.41	0.41	0.0
Total	455.05	687.69	155.97	26.72	68.99	1394.41	100.0

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total
ASC.01 Prevention	11.86	67.58	35.78	13.18	10.15	138.54
ASC.02 HIV testing and counselling (HTC)	17.28	60.92	2.99	-	0.80	81.99
ASC.03 HIV Care and Treatment Care	313.10	232.39	57.04	3.51	4.98	611.02
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for Orphans and Vulnerable	5.87	11.47	-	3.52	42.21	63.07

Children) (where HIV ear-marked funds are used)						
ASC.05 Social Enablers (excluding the efforts for KPs above)	-	-	-	0.14	-	0.14
ASC.06 Programme enablers and systems strengthening	106.94	315.34	60.15	9.06	6.93	498.41
ASC.07 Development synergies	-	-	-	1.15	0.29	1.44
Total	455.05	687.69	155.97	30.55	65.36	1,394.61

Table 3.14: Total expenditure (LSL million) by interventions – 2017/18

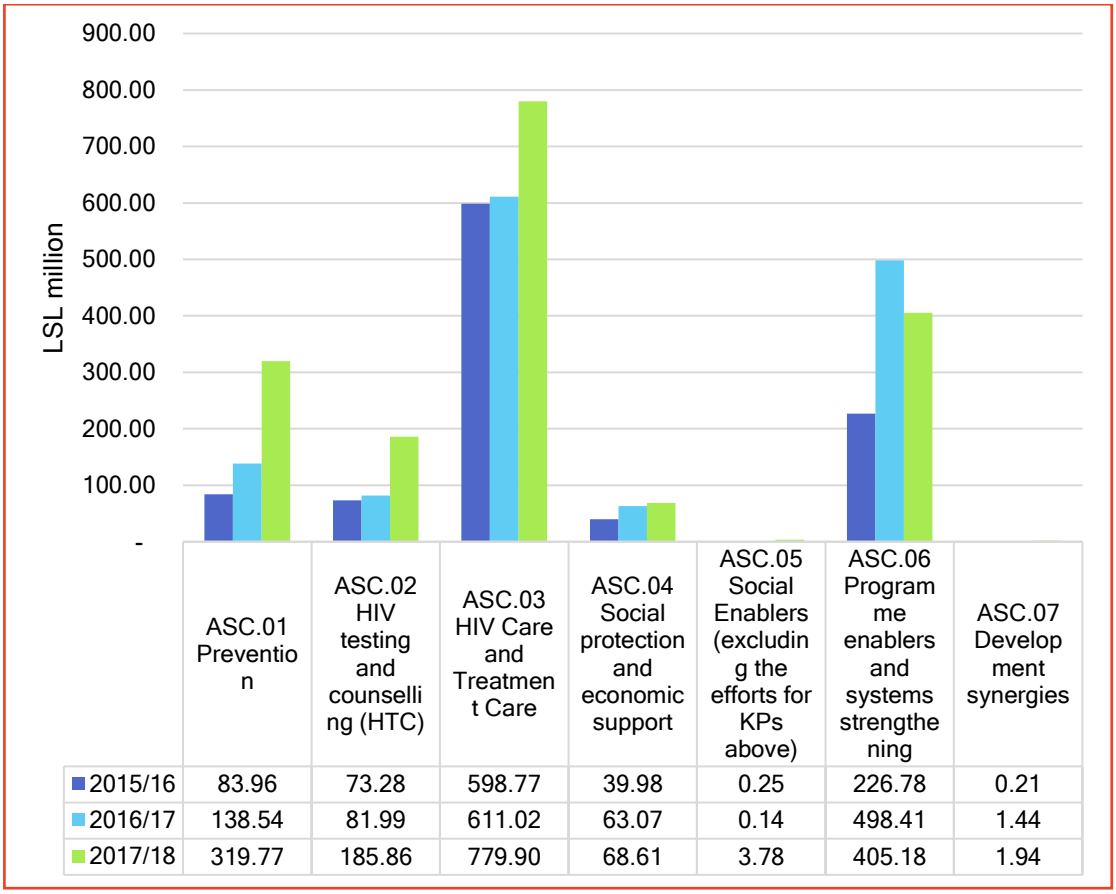
	FE.01.01.01 Government of Lesotho	**FE.03.01.30 Government of United States**	**FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria**	**FE.03.02. UN Agencies**	**FE.03.03.99 Other International not-for-profit organizations and foundations**	**Total**	**Percent of Total**
ASC.01 Prevention	25.82	145.51	125.69	18.75	19.91	335.68	19
ASC.02 HIV testing and counselling (HTC)	20.6	150.61	10.64	-	4.02	185.86	10.5
ASC.03 HIV Care and Treatment Care	329.94	280.97	153.93	0.42	1.28	766.53	43.4
ASC.04 Social protection and economic support	16.22	16.38	-	4.17	31.84	68.61	3.9
ASC.05 Social Enablers	-	3.77	-	0.01	-	3.78	0.2

ASC.06 Programme enablers and systems strengthening	71.45	216.93	106.86	8.07	0.21	403.52	22.9
ASC.07 Development synergies	-	0.94	-	-	0.11	1.06	0.1
Total	**464.03**	**815.11**	**397.12**	**31.41**	**57.38**	**1,765.05**	**100**

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total
ASC.01 Prevention	12.45	145.51	125.69	19.22	16.90	319.77
ASC.02 HIV testing and counselling (HTC)	20.60	150.61	10.64	-	4.02	185.86
ASC.03 HIV Care and Treatment Care	343.30	280.97	153.93	0.42	1.28	779.90

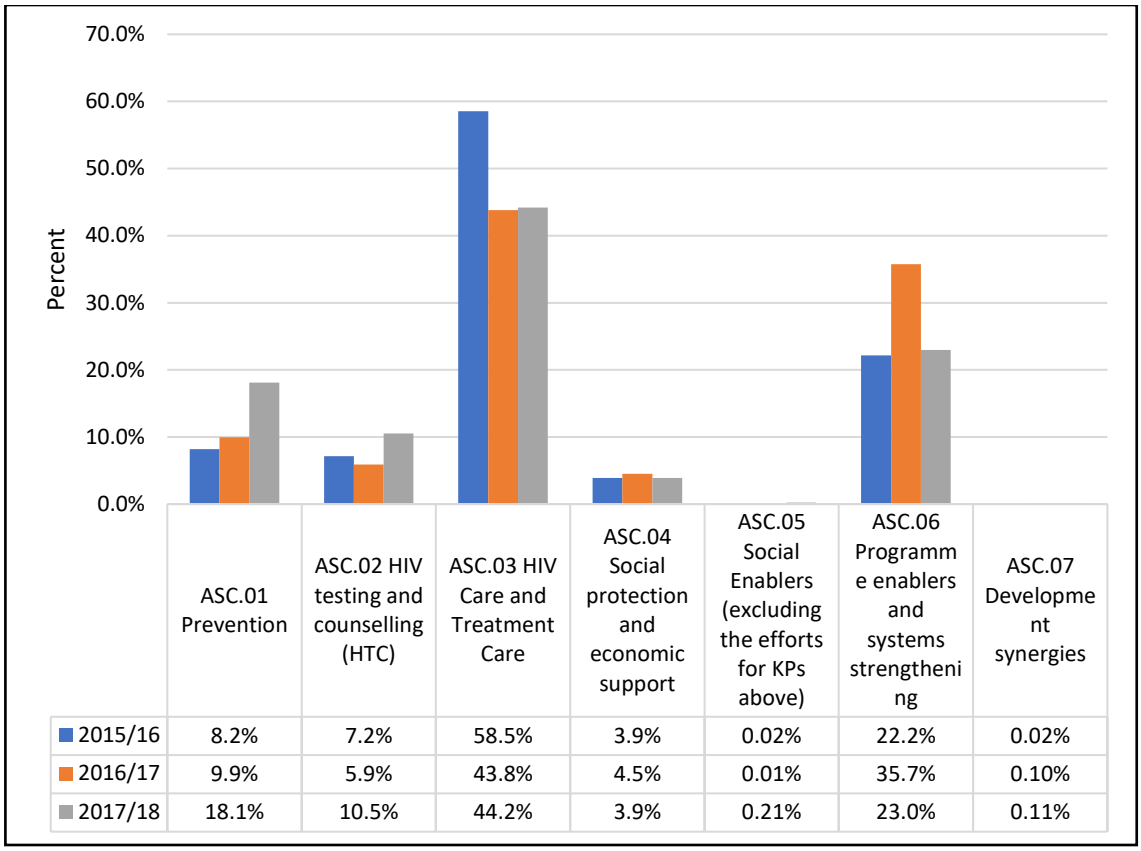
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	16.22	16.38	-	4.17	31.84	68.61
ASC.05 Social Enablers (excluding the efforts for KPs above)	-	3.77	-	0.01	-	3.78
ASC.06 Programme enablers and systems strengthening	71.45	216.93	106.86	9.94	-	405.18
ASC.07 Development synergies	-	0.94	-	1.00	-	1.94
Total	464.03	815.11	397.12	34.75	54.04	1,765.05

Figure 3.20: Trends in expenditure of main AIDS spending categories



	ASC.01 Prevention	ASC.02 HIV testing and counselling (HTC)	ASC.03 HIV Care and Treatment Care	ASC.04 Social protection and economic support	ASC.05 Social Enablers (excluding the efforts for KPs above)	ASC.06 Programme enablers and systems strengthening	ASC.07 Development synergies
2015/16	83.96	73.28	598.77	39.98	0.25	226.78	0.21
2016/17	138.54	81.99	611.02	63.07	0.14	498.41	1.44
2017/18	319.77	185.86	779.90	68.61	3.78	405.18	1.94

Figure 3.20: Trends in expenditure percentage of main AIDS spending categories



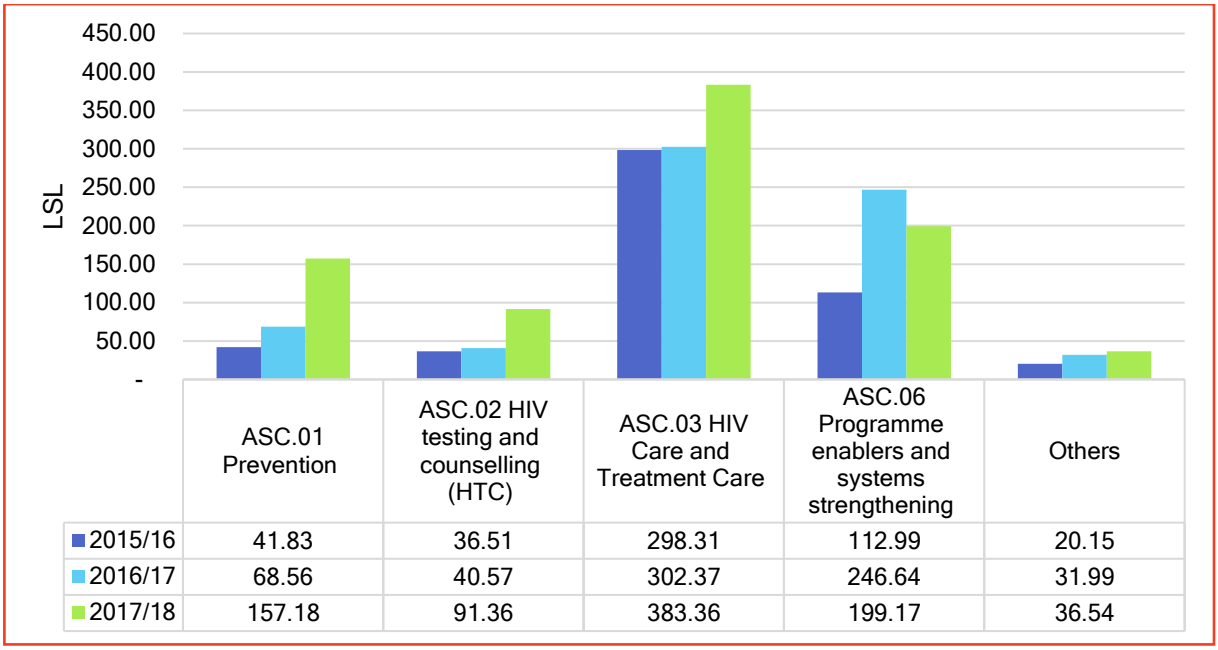
	ASC.01 Prevention	ASC.02 HIV testing and counselling (HTC)	ASC.03 HIV Care and Treatment Care	ASC.04 Social protection and economic support	ASC.05 Social Enablers (excluding the efforts for KPs above)	ASC.06 Programme enablers and systems strengthening	ASC.07 Development synergies
2015/16	8.2%	7.2%	58.5%	3.9%	0.02%	22.2%	0.02%
2016/17	9.9%	5.9%	43.8%	4.5%	0.01%	35.7%	0.10%
2017/18	18.1%	10.5%	44.2%	3.9%	0.21%	23.0%	0.11%

The tables above and Figure 3.20 provide the pattern of expenditure on the interventions implemented by the different providers in Lesotho during the three years. Care and treatment took the highest share of expenditure in each of the years, at about 57 percent in 2015/16, about 43 percent in 2016/17 and 43 percent in 2017/18. These percentages were consistent to trend in the absolute expenditure on care and treatment which showed declining spending in 2016/17 and 2017/18 as compared to 2015/16, in term of dollar amounts. In 2015/16, the expenditure on care and treatment was LSL 512 million (US$ 53.01 million), LSL 514 million (US$ 47.37 million) in 2016/17 and LSL 617 million (US$ 48.34 million) in 2017/18.

Programme enablers and systems strengthening encompassing programme administration, strategic information, M&E, public system strengthening and community system strengthening accounted for the second largest share of total expenditure, being 22 percent in 2015/16, 36 percent in 2016/17 and 23 percent in 2017/18, showing fluctuating trend in the three years. HIV prevention, which included, prevention interventions for key population, condoms for general population, VMMC, PMTCT, and social and behavioural communication for change (SBCC), came third in terms of the amount and share of expenditure in each of the three years. The total expenditure on HIV prevention was 10 percent of the total expenditure in 2015/16, 11 percent in 2016/17 and about 19 percent in 2018/19, likewise showing fluctuations in the trend. Another broad area of intervention was HIV testing and counselling (HTC) which accounted for 7 percent in 2015/16, 6 percent in 2016/17 and 11 percent in 2017/18.

The expenditure by the Government of Lesotho was mainly concentrated on care and treatment, programme enablers, prevention, HIV testing and social protection and economic support over the entire period of the three years. The Government of Lesotho made significant contribution to care and treatment mainly through provision of ARVs, and human resources as well overhead costs to support service provision in both Government and CHAL health facilities. It also provided ARVs and other HIV medical supplies for service provision in private health facilities. The financing from USG through PEPFAR in the three years, covered all the programme areas. The GFATM financing during the three years were on four programme areas, namely, distributed as care and treatment, programme enablers, HIV prevention and HIV testing. Per capita expenditure for the main interventions is shown in Figure 3.21.

Figure 3.3: Trends in per capita expenditure of main AIDS spending categories



	ASC.01 Prevention	ASC.02 HIV testing and counselling (HTC)	ASC.03 HIV Care and Treatment Care	ASC.06 Programme enablers and systems strengthening	Others
2015/16	41.83	36.51	298.31	112.99	20.15
2016/17	68.56	40.57	302.37	246.64	31.99
2017/18	157.18	91.36	383.36	199.17	36.54

The per capita expenditure on care and treatment interventions was slightly stagnant in 2015/16 and 2016/17 and increased in 2017/18 to reach LSL 377. The per capita expenditure on programme enablers and systems strengthening was the second largest in all the three years and it followed similar pattern as that of treatment and care. Per capita expenditure on prevention is shown to have steadily increased over the period. The details of expenditure within these programme areas are shown in the following sections.

3.9 Expenditure on HIV Prevention

The expenditure composed prevention for general population, prevention activities for key population (SW and MSM), PMTCT, and VMMC. The detailed results are shown in Table 3.15, Table 3.16 and Table 3.17.

Table 3.125: Expenditure on prevention interventions (LSL million) 2015/16

Intervention	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02 UN Agencies	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
ASC.01.01 Five Pillars of Prevention	8.50	38.21	2.02	1.65	1.01	51.39	48.8%
ASC.01.01.02 Services for key populations	-	1.78	0.43	1.65	-	3.86	3.7%
ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	-	1.04	0.35	0.49	-	1.88	1.8%
ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	-	0.74	0.08	1.15	-	1.98	1.9%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	-	-	1.59	0.61	1.01	3.21	3.1%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	8.50	36.42	-	-	-	44.93	42.7%
ASC.01.02 Other Prevention activities	20.97	11.47	9.91	-	6.18	48.52	46.1%
ASC.01.02.01.98 PMTCT not disaggregated by activity	20.79	-	1.29	2.09	-	24.17	23.0%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	-	-	-	1.23	0.01	1.25	1.2%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	3.73	0.67	4.07	8.47	8.0%
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	-	-	3.34	-	2.09	5.43	5.2%
ASC.01.02.07 Prevention and wellness programmes in the workplace	0.18	-	-	-	-	0.18	0.2%
ASC.01.02.98 Prevention activities not disaggregated	-	11.47	1.55	0.74	-	13.76	13.1%
ASC.01 Prevention	**29.47**	**49.68**	**11.93**	**6.99**	**7.19**	**105.26**	100.0%

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
ASC.01.01 Five Pillars of Prevention	8.50	38.21	2.02	2.25	0.41	51.39	61.2%
ASC.01.01.02 Services for key populations	-	1.78	0.43	1.65	-	3.86	4.6%
ASC.01.01.02.01 Programmatic activities for sex workers and their clients	-	1.04	0.35	0.49	-	1.88	2.2%
ASC.01.01.02.01 .98 Programmatic activities for sex workers and their clients not disaggregated by type	-	1.04	0.35	0.49	-	1.88	2.2%
ASC.01.01.02.02 Programmatic activities for gay men and other men who have sex with men (MSM)	-	0.74	0.08	1.15	-	1.98	2.4%
ASC.01.01.02.02 .98 Programmatic activities for MSM not disaggregated by type	-	0.74	0.08	1.15	-	1.98	2.4%

ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	-	-	1.59	0.61	0.41	2.61	3.1%
ASC.01.01.03.02 Social marketing of condoms for HIV prevention (excluding for KPs and AGYW)	-	-	-	0.61	-	0.61	0.7%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	-	-	1.59	-	0.41	2.00	2.4%
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	8.50	36.42	-	-	-	44.93	53.5%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	8.50	36.42	-	-	-	44.93	53.5%
ASC.01.02 Other Prevention activities	0.18	11.47	9.91	4.84	6.16	32.56	38.8%
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)	-	-	1.29	2.09	-	3.39	4.0%

ASC.01.02.01.02 Delivery practices as part of PMTCT programmes	-	-	-	0.34	-	0.34	0.4%
ASC.01.02.01.98 PMTCT not disaggregated by activity	-	-	1.29	1.76	-	3.05	3.6%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	-	-	-	0.10	-	0.10	0.1%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	3.73	-	4.07	7.80	9.3%
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations	-	-	3.34	-	2.09	5.43	6.5%
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	-	-	3.34	-	2.09	5.43	6.5%

ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	-	-	-	1.91	-	1.91	2.3%
ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type	-	-	-	1.91	-	1.91	2.3%
ASC.01.02.07 Prevention and wellness programmes in the workplace	0.18	-	-	-	-	0.18	0.2%
ASC.01.02.98 Prevention activities not disaggregated	-	11.47	1.55	0.70	-	13.73	16.3%
ASC.01.02.99 Other prevention activities n.e.c.	-	-	-	0.04	-	0.04	0.0%
ASC.01 Prevention	8.68	49.68	11.93	7.09	6.57	83.96	100.0 %

Table 3.136: Expenditure on prevention interventions (LSL million) 2016/17

Intervention	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
ASC.01.01 Five Pillars of Prevention	11.29	49.38	3.21	3.43	4.22	71.52	45.9%
ASC.01.01.02 Services for key populations	-	2.45	2.55	-	-	5.00	3.2%
ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	-	1.66	0.93	-	-	2.59	1.7%
ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	-	0.79	1.62	-	-	2.42	1.6%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	-	-	0.65	3.43	4.22	8.30	5.3%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	11.29	46.93	-	-	-	58.21	37.3%
ASC.01.02 Other Prevention activities	14.99	18.20	32.57	9.21	9.41	84.38	54.1%
ASC.01.02.01.98 PMTCT not disaggregated by activity	14.41	-	0.71	1.62	-	16.74	10.7%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	0.22	18.20	19.33	6.13	0.06	43.93	28.2%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	7.41	1.42	3.73	12.56	8.1%
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	-	-	0.43	-	5.37	5.81	3.7%
ASC.01.02.07 Prevention and wellness programmes in the workplace	0.35	-	-	-	-	0.35	0.2%
ASC.01.02.98 Prevention activities not disaggregated	-	-	4.69	0.04	0.26	4.99	3.2%
ASC.01 Prevention	**26.27**	**67.58**	**35.78**	**12.64**	**13.64**	**155.91**	**100.0%**

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
ASC.01.01 Five Pillars of Prevention	11.29	49.38	3.21	3.43	0.80	68.10	49.2%
ASC.01.01.02 Services for key populations	-	2.45	2.55	-	-	5.00	3.6%
ASC.01.01.02.01 Programmatic activities for sex workers and their clients	-	1.66	0.93	-	-	2.59	1.9%
ASC.01.01.02.01.02 STI/SRH services for sex workers (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent	-	-	0.01	-	-	0.01	0.0%
ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	-	1.66	0.92	-	-	2.58	1.9%
ASC.01.01.02.02 Programmatic activities for gay men and other men who have sex with men (MSM)	-	0.79	1.62	-	-	2.42	1.7%

ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	-	0.79	1.62	-	-	2.42	1.7%
ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	-	-	0.65	3.43	0.80	4.88	3.5%
ASC.01.01.03.02 Social marketing of condoms for HIV prevention (excluding for KPs and AGYW)	-	-	-	3.43	-	3.43	2.5%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	-	-	0.65	-	0.80	1.45	1.0%
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	11.29	46.93	-	-	-	58.21	42.0%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	11.29	46.93	-	-	-	58.21	42.0%
ASC.01.02 Other Prevention activities	0.57	18.20	32.57	9.75	9.36	70.45	50.8%
ASC.01.02.01 Prevention of vertical transmission of	-	-	0.71	1.62	-	2.33	1.7%

HIV infection (PMTCT)							
ASC.01.02.01.98 PMTCT not disaggregated by activity	-	-	0.71	1.62	-	2.33	1.7%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	-	-	19.33	0.54	-	19.87	14.3%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	7.41	1.42	3.73	12.56	9.1%
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations	-	-	0.43	3.52	5.37	9.33	6.7%
ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	-	-	-	3.52	-	3.52	2.5%
ASC.01.02.04.98 Programmatic activities for vulnerable and	-	-	0.43	-	5.37	5.81	4.2%

accessible population not disaggregated by type							
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	0.22	-	-	2.61	-	2.83	2.0%
ASC.01.02.05.01 Prevention activities implemented in school	0.22	-	-	-	-	0.22	0.2%
ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type	-	-	-	2.61	-	2.61	1.9%
ASC.01.02.07 Prevention and wellness programmes in the workplace	0.35	-	-	-	-	0.35	0.3%
ASC.01.02.98 Prevention activities not disaggregated	-	18.20	4.69	0.04	0.26	23.19	16.7%
ASC.01 Prevention	11.86	67.58	35.78	13.18	10.15	138.54	100.0 %

Table 3.147: Expenditure on prevention interventions (LSL million) 2017/18

Intervention	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	UN	FE.03.03 International not-for-profit organizations and foundations	Total	percent
ASC.01.01 Five Pillars of Prevention	9.32	117.19	7.37	2.96	3.52	140.36	41.8%
ASC.01.01.02 Services for key populations	-	-	5.85	-	-	5.85	1.7%
ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	-	-	3.26	-	-	3.26	1.0%
ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	-	-	2.58	-	-	2.58	0.8%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	-	-	0.69	2.96	3.52	7.17	2.1%
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	9.32	67.74	0.84	-	-	77.90	23.2%
ASC.01.01.04.01 Voluntary medical male circumcision (VMMC) programmes	9.32	67.24	0.42	-	-	76.98	22.9%
ASC.01.01.04.02 Demand generation for VMMC programmes	-	0.49	-	-	-	0.49	0.1%
ASC.01.01.05 Pre-Exposure Prophylaxis (PrEP)	-	49.45	-	-	-	49.45	14.7%
ASC.01.01.05.01 PrEP as part of programmes for AGYW	-	13.04	-	-	-	13.04	3.9%
ASC.01.01.05.02 PrEP as part of programmes for sex workers and their clients	-	3.67	-	-	-	3.67	1.1%
ASC.01.01.05.03 PrEP as part of programmes for gay men and other men who have sex with men (MSM)	-	1.47	-	-	-	1.47	0.4%
ASC.01.01.05.98 PrEP not disaggregated by key population	-	31.28	-	-	-	31.28	9.3%
ASC.01.02 Other Prevention activities	16.50	28.32	118.32	15.79	16.39	195.32	58.2%
ASC.01.02.01.98 PMTCT not disaggregated by activity	13.36	-	23.15	1.31	-	37.82	11.3%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	0.22	28.06	69.53	12.53	0.05	110.40	32.9%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	-	1.95	9.23	11.18	3.3%
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations	-	0.25	13.68	-	7.11	21.04	6.3%

Intervention	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	UN	FE.03.03 International not-for-profit organizations and foundations	Total	percent
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	-	-	13.68	-	7.11	20.79	6.2%
ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type	-	-	11.96	-	-	11.96	3.6%
ASC.01.02.07 Prevention and wellness programmes in the workplace	2.91	-	-	-	-	2.91	0.9%
ASC.01 Prevention	25.82	145.51	125.69	18.75	19.91	335.68	100.0%

	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
ASC.01.01 Five Pillars of Prevention	9.32	117.19	7.37	2.96	0.56	137.41	43.0%
ASC.01.01.02 Services for key populations	-	-	5.85	-	-	5.85	1.8%
ASC.01.01.02.01 Programmatic activities for sex workers and their clients	-	-	3.26	-	-	3.26	1.0%
ASC.01.01.02.01.02 STI/SRH	-	-	0.10	-	-	0.10	0.0%

services for sex workers (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent							
ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	-	-	3.16	-	-	3.16	1.0%
ASC.01.01.02.02 Programmatic activities for gay men and other men who have sex with men (MSM)	-	-	2.58	-	-	2.58	0.8%
ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	-	-	2.58	-	-	2.58	0.8%
ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	-	-	0.69	2.96	0.56	4.21	1.3%
ASC.01.01.03.02 Social marketing of condoms for HIV prevention (excluding for KPs and AGYW)	-	-	-	2.96	-	2.96	0.9%
ASC.01.01.03.98 Condom activities (for HIV	-	-	0.69	-	0.56	1.25	0.4%

prevention) not disaggregated							
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	9.32	67.74	0.84	-	-	77.90	24.4%
ASC.01.01.04.01 Voluntary medical male circumcision (VMMC) programmes	-	67.24	0.42	-	-	67.66	21.2%
ASC.01.01.04.02 Demand generation for VMMC programmes	-	0.49	-	-	-	0.49	0.2%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	9.32	-	0.42	-	-	9.74	3.0%
ASC.01.01.05 Pre-Exposure Prophilaxis (PrEP)	-	49.45	-	-	-	49.45	15.5%
ASC.01.01.05.01 PrEP as part of programmes for AGYW	-	13.04	-	-	-	13.04	4.1%
ASC.01.01.05.02 PrEP as part of programmes for sex workers and their clients	-	3.67	-	-	-	3.67	1.1%
ASC.01.01.05.03 PrEP as part of programmes for gay men and other	-	1.47	-	-	-	1.47	0.5%

men who have sex with men (MSM)							
ASC.01.01.05.98 PrEP not disaggregated by key population	-	31.28	-	-	-	31.28	9.8%
ASC.01.02 Other Prevention activities	3.13	28.32	118.32	16.26	16.34	182.37	57.0%
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)	-	-	23.15	1.31	-	24.45	7.6%
ASC.01.02.01.98 PMTCT not disaggregated by activity	-	-	23.15	1.31	-	24.45	7.6%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	-	16.91	-	0.47	-	17.38	5.4%
ASC.01.02.03 Community mobilization for populations other than key populations	-	-	-	-	9.23	9.23	2.9%
ASC.01.02.04 Programmatic activities for vulnerable and	-	0.25	13.68	4.17	7.11	25.21	7.9%

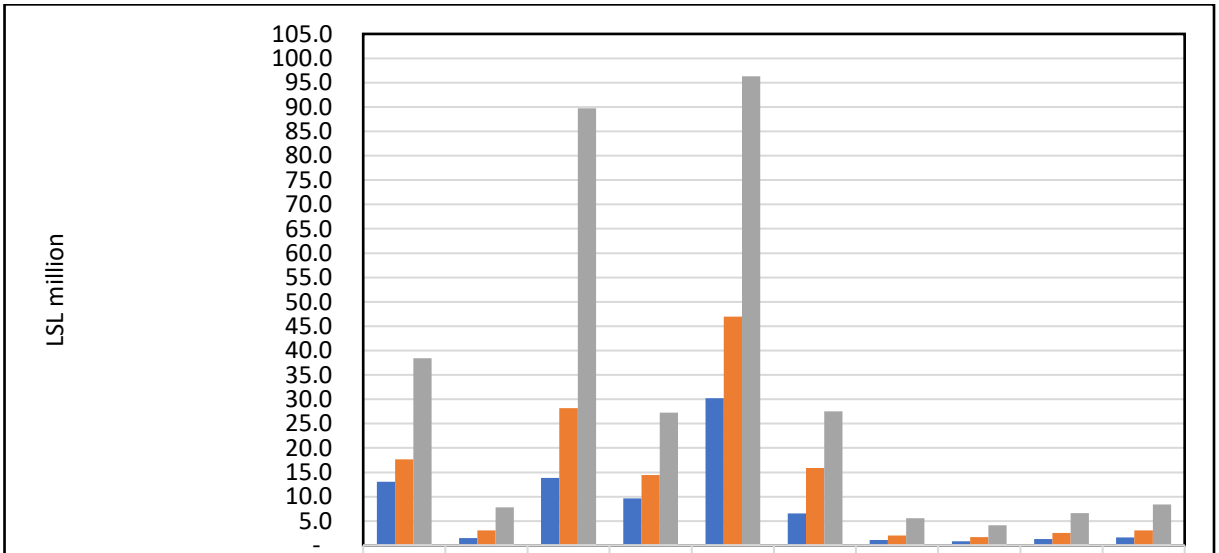
accessible populations							
ASC.01.02.04.01 Condom and lubricant promotion and provision as part of programmes for vulnerable and accessible populations	-	0.25	-	-	-	0.25	0.1%
ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	-	-	-	4.17	-	4.17	1.3%
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	-	-	13.68	-	7.11	20.79	6.5%
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	0.22	-	11.96	5.54	-	17.72	5.5%
ASC.01.02.05.01 Prevention activities implemented in school	0.22	-	-	-	-	0.22	0.1%

ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type	-	-	11.96	5.54	-	17.50	5.5%
ASC.01.02.07 Prevention and wellness programmes in the workplace	2.91	-	-	-	-	2.91	0.9%
ASC.01.02.98 Prevention activities not disaggregated	-	11.15	69.53	4.78	-	85.46	26.7%
ASC.01 Prevention	12.45	145.51	125.69	19.22	16.90	319.77	100.0 %

Table 3.15, Table 3.16 and Table 3.17 shows that there was a steady increase in total expenditure on prevention over the three years. In all the years, VMMC accounted for the largest at share of the expenditure on prevention, at 43 percent of the total expenditure in 2015/16, 37 percent in 2016/17 and 23 percent 2017/18.This was followed by PMTCT, whose share of expenditure in each year was as follows: 2015/16 (23%), 2016/17 (11%) and 2017/18 (11%). The recently launched Pre-Exposure Prophylaxis (PrEP) accounted for 14,7 percent in 2017/18. Expenditure on social and behavioural communication for change (SBCC) for populations other than key populations was significant part of prevention taking 12 percent, 28 percent and 33 percent in 2015/16, 2016/17 and 2017/18, respectively. Other intervention with significant percentage of resources was programmatic activities for vulnerable and accessible populations.

The five pillars of prevention were being given increasing priority, with of the total prevention expenditure at 49 percent of total prevention expenditure in 2015/16, 46 percent in 2016/17 and 42 percent in 2017/18. The percentages notwithstanding, the absolute amount of expenditure on the five pillars had a steadily rising trend over the three years. The comparison of expenditure on prevention by districts in shown in Figure 3.22.

Figure 3.22: Expenditure on HIV prevention by districts



	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
2015/16 ASC.01 Prevention	13.1	1.5	13.9	9.6	30.2	6.6	1.1	0.9	1.3	1.6
2016/17 ASC.01 Prevention	17.7	3.1	28.2	14.4	47.0	15.9	2.0	1.7	2.6	3.1
2017/18 ASC.01 Prevention	38.4	7.8	89.7	27.2	96.3	27.5	5.6	4.1	6.6	8.4

The expenditure in the financial years 2015/116 and 2016/17 did not vary very much in each of the districts. It is apparent that the five districts of Berea, Leribe, Mafeteng, Maseru and Mohale's Hoek accounted for most of the expenditure for prevention activities in the three years. More insight into the comparison of the prevention expenditure was done by estimating the HIV prevention expenditure per capita in the districts as shown in Figure 3.24.The results show some inequity in the expenditure on HIV

prevention in the country which the five prioritised districts had over three times per capita expenditure as compared to other districts of Botha-Bothe, Mokhotlong, Qacha's Nek, Quthing, and Thaba-Tseka.

Figure 3,23: Per capita expenditure on prevention by district 2015/16-2017/18

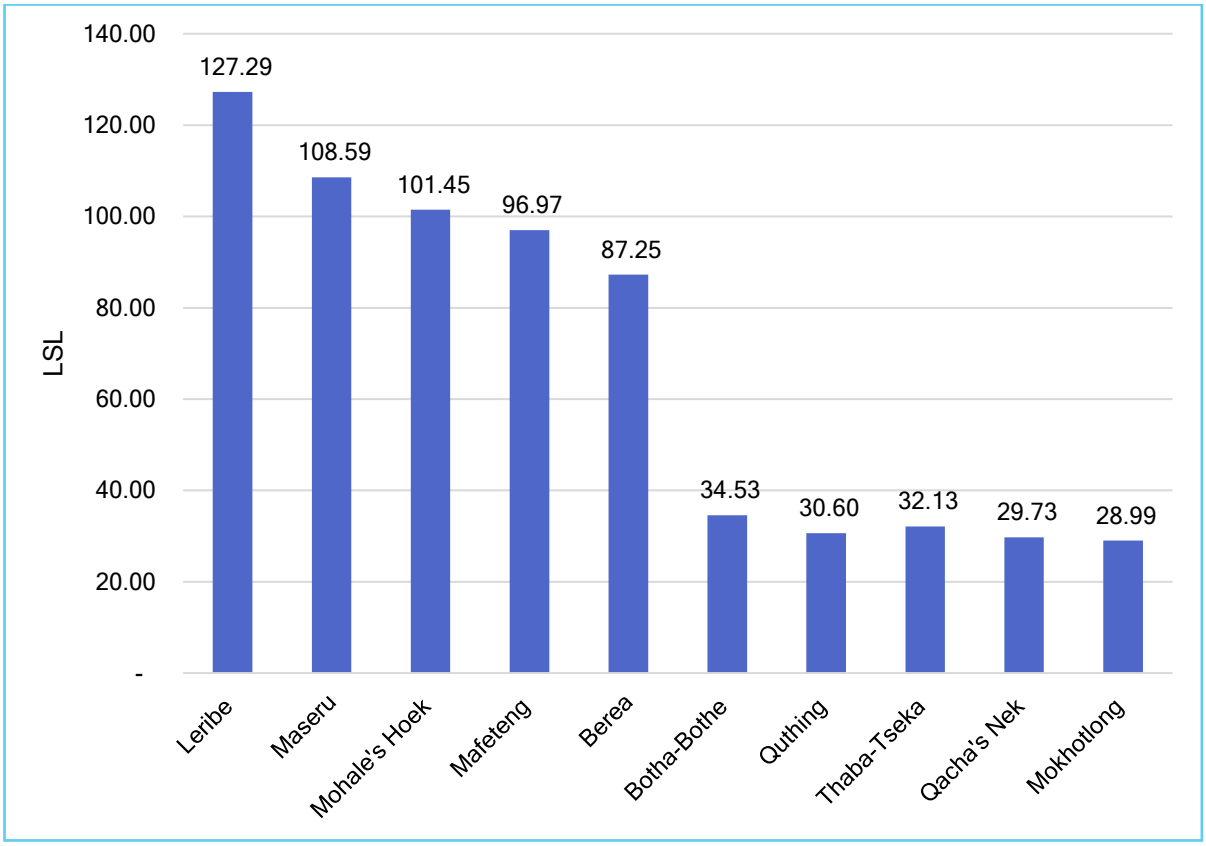
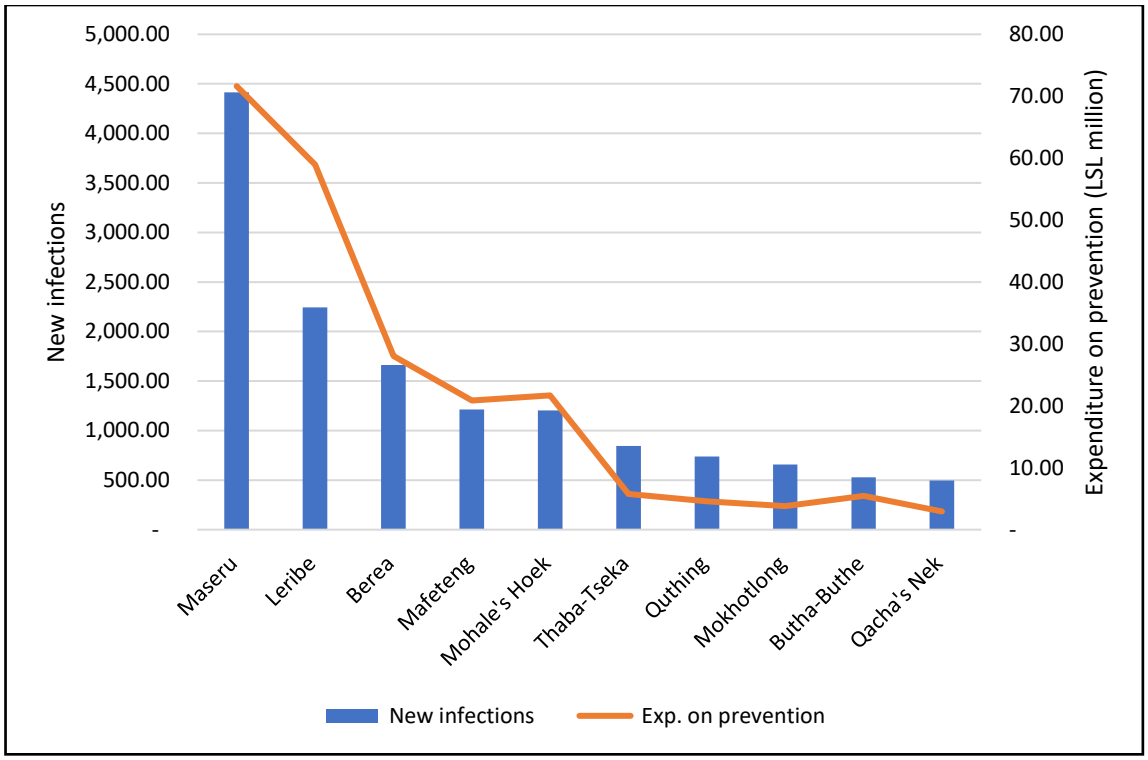


Figure 3.24 shows comparison of expenditure on prevention and new infections for the years 2017 and 2018. The expenditure on prevention was in favour of Leribe, Berea and Mafeteng.

Figure 3.24: Relation between prevention expenditure and HIV infections



Attempt was made to estimate the effect of prevention expenditure on new infections. A short panel data on new infections for two years 2017 and 2018 and prevention expenditure for 2016/17 and 2017/8 were used in the analysis. The results are shown in Table 3.18, where fixed effect model was adopted as appropriate based on some test.

Table 3.18: Fixed-effects regression results

Dependent variable: new HIV infections

Dependent Variable: INFECTIONS
Method: Panel Least Squares
Periods included: 2
Cross-sections included: 10
Total panel (balanced) observations: 20

Variable	Coefficient	Std. Error	t-Statistic	Prob.
EXP01	-6.193481	0.959513	-6.454820	0.0001
C	1538.734	24.94883	61.67559	0.0000

Effects Specification

Cross-section fixed (dummy variables)

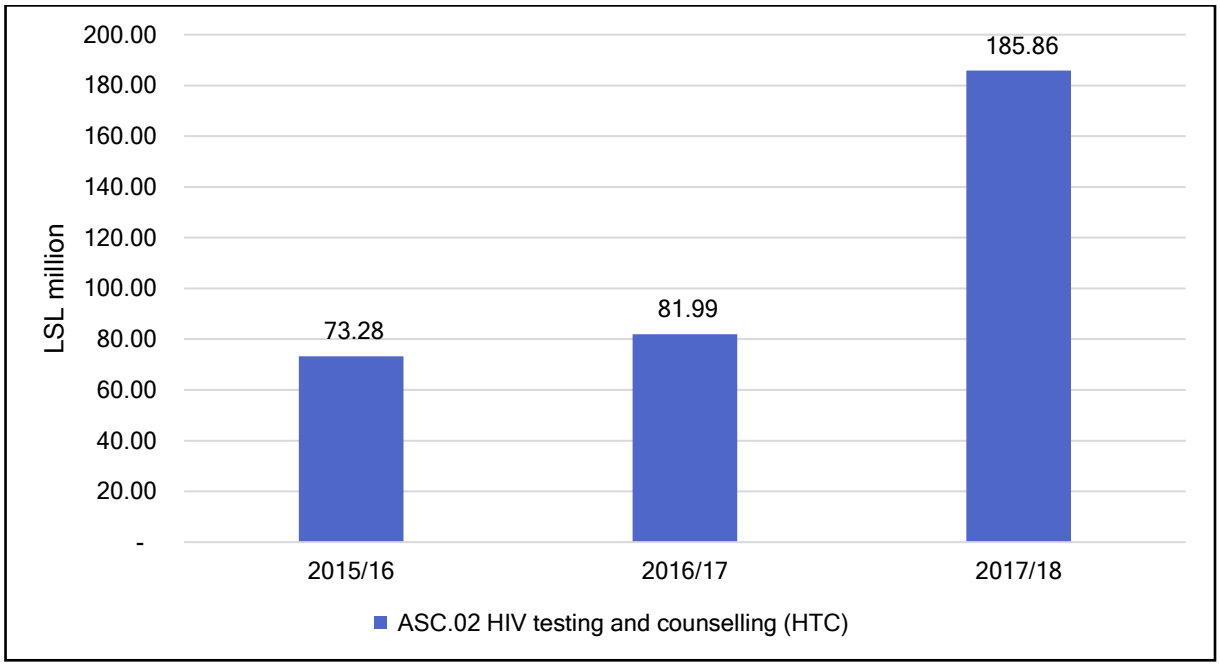
R-squared	0.998870
Adjusted R-squared	0.997614
S.E. of regression	56.89119
Sum squared resid	29129.47
Log likelihood	-101.2165
F-statistic	795.2527
Prob(F-statistic)	0.000000

The results show that prevention expenditure is associated with reduction in new infections. This is because the coefficient of expenditure on prevention is negative. This underscores that need to continue to prioritize HIV prevention as a way of bringing down new HIV infections.

3.10 Expenditure on HIV Testing

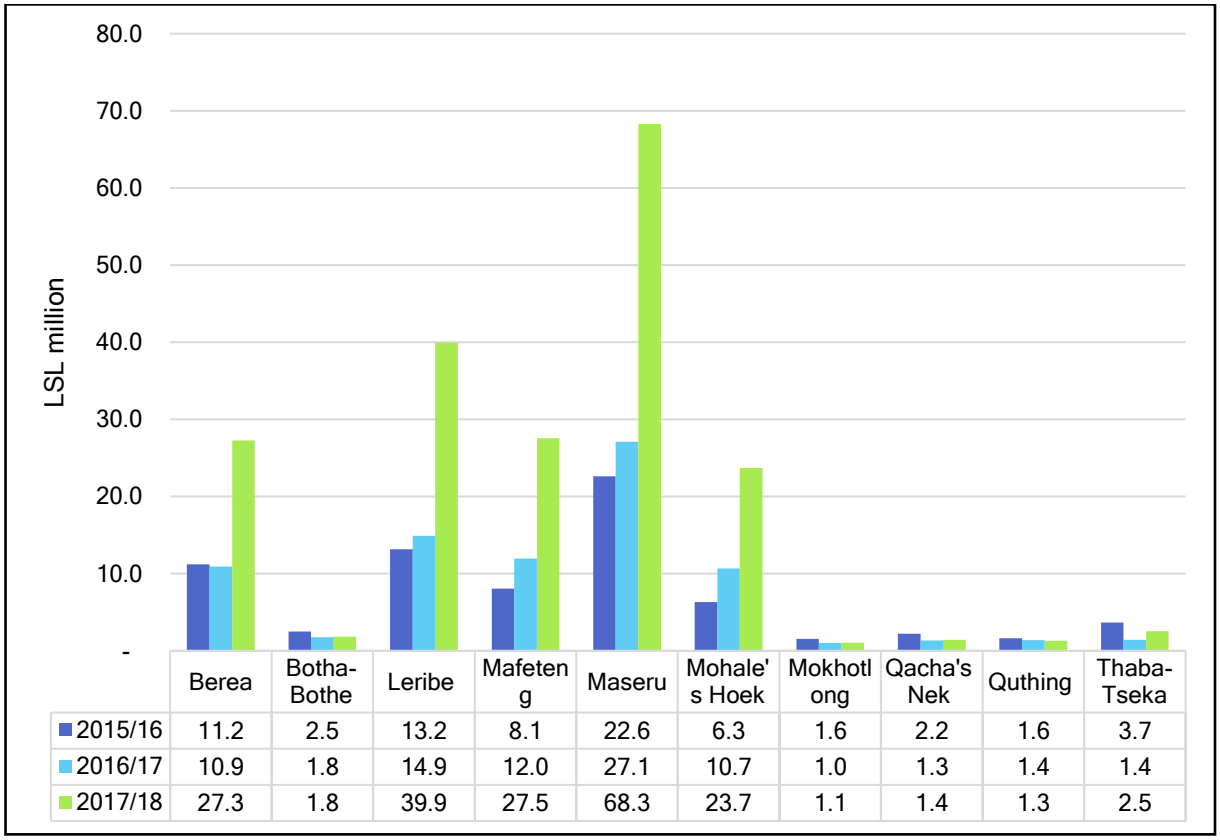
Figure 3.25 shows increasing trend in expenditure on HIV testing, but there was a sharp increase in expenditure in 2017/18. The total expenditure on HIV testing increased from LSL 71.28 million (US$ 6.45 million) in 2015/16 to LSL 72 million (US$ 6.66 million) in 2016/17 and LSL 170 (US$ 13.36 million). Likewise, the per capita testing was LSL 31 (US$ 3.21), LSL 36 (US$ 3.29), and LSL 84 (US$ 6.57), respectively, in 2015/16, 2016/17 and 2017/18.

Figure 3.4: Expenditure on HIV testing activities



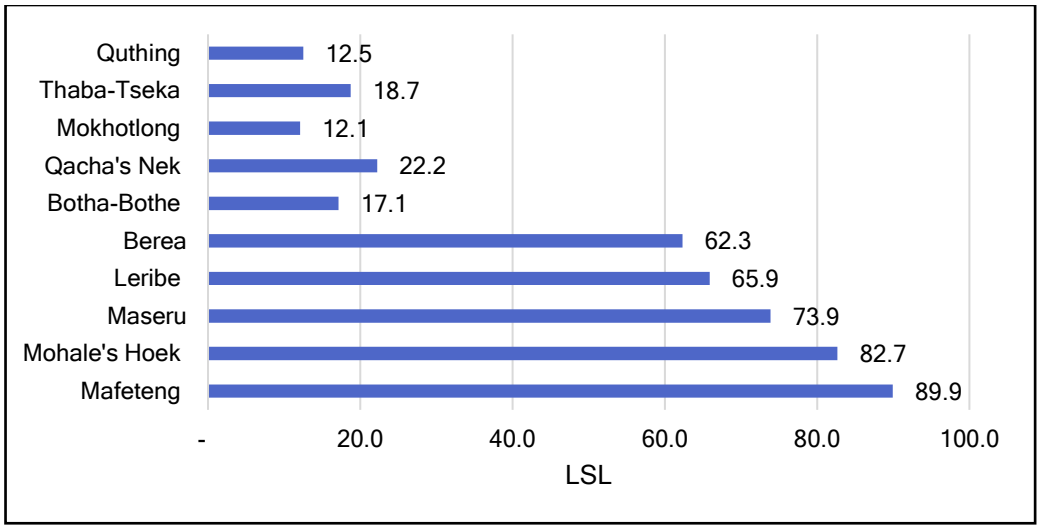
Further analysis was carried out to understand district prioritization of HIV testing financing. The picture is provided in Figure 3.26. Similar pattern is repeated with half of the districts taking bulk share of the expenditure. As was in the case of prevention, per capita expenditure reflected the trend in absolute figures (Figure 3.26).

Figure 3.26: Expenditure on HIV testing by district



	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
2015/16	11.2	2.5	13.2	8.1	22.6	6.3	1.6	2.2	1.6	3.7
2016/17	10.9	1.8	14.9	12.0	27.1	10.7	1.0	1.3	1.4	1.4
2017/18	27.3	1.8	39.9	27.5	68.3	23.7	1.1	1.4	1.3	2.5

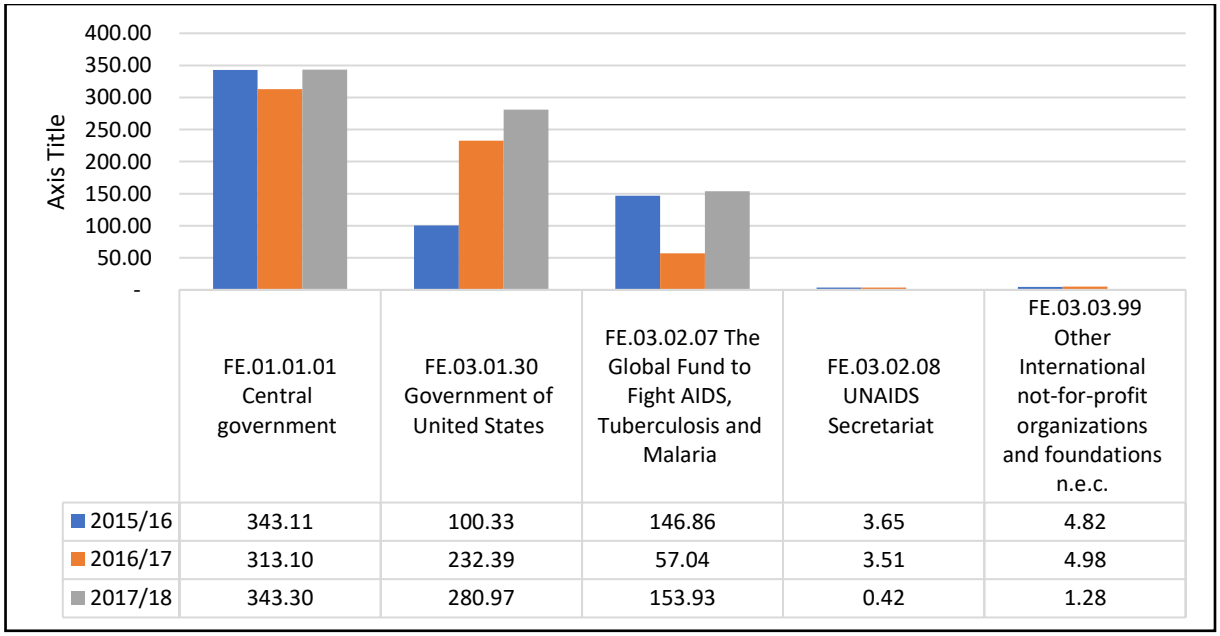
Figure 3.5: Per capita expenditure on HIV testing by district



3.11 Expenditure on Care and Treatment

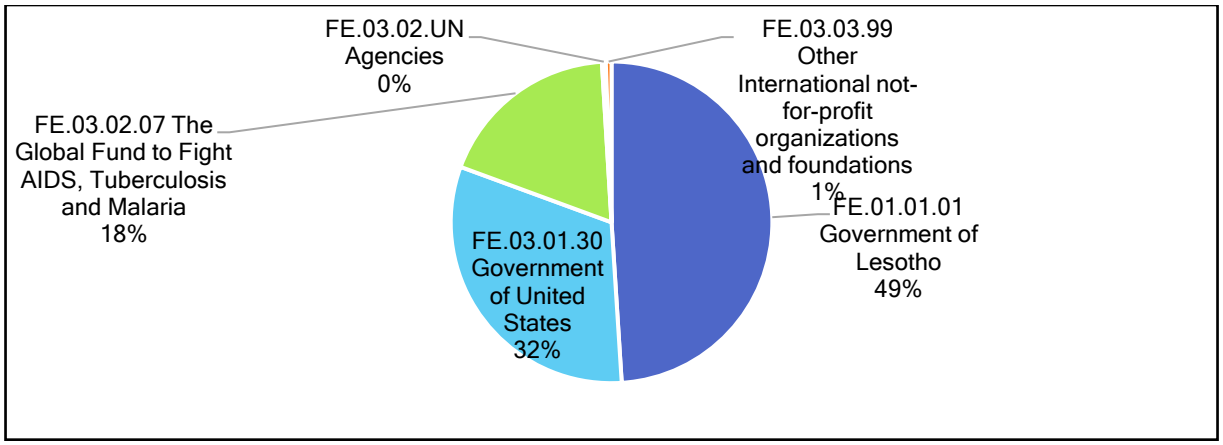
Care and treatment are the key priorities in the country, and this is reflected by resources allocation to the intervention. The financing entities and their contribution to care and treatment expenditure is shown in Figure 3.28 and Figure 3.29.

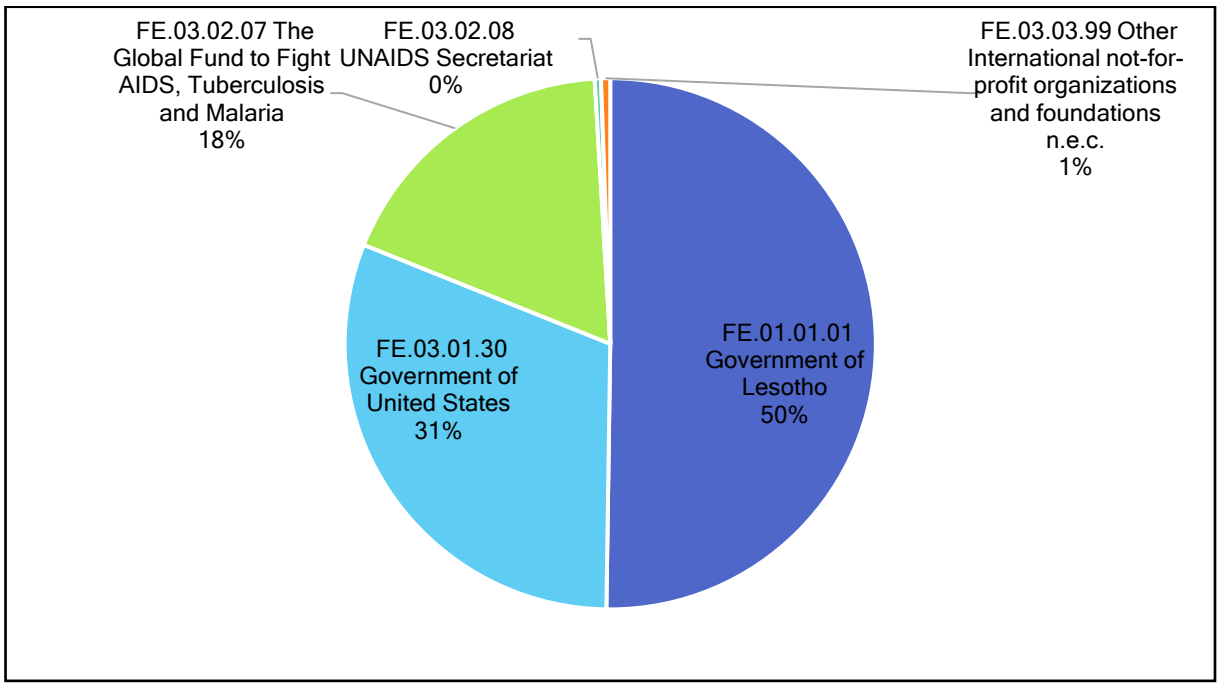
Figure 3.286: Expenditure on C&T by financing entity



	FE.01.01.01 Central government	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02.08 UNAIDS Secretariat	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.
2015/16	343.11	100.33	146.86	3.65	4.82
2016/17	313.10	232.39	57.04	3.51	4.98
2017/18	343.30	280.97	153.93	0.42	1.28

Figure 3.29: Three-year percentage contribution to expenditure on C&T by financing entity





Care and treatment were manly financed by three entities, consisting of Government of Lesotho, USG and GFATM. The Government share was significant due to its financing of ARVs and human resources for the provision of the care and treatment services. This notwithstanding, the amount expenditure from GoL declined lightly in 2016/17 then increase in 2017/18. The amount of expenditure from USG is shown in Figure 3.29 to have increased steadily over the three years. Table 3.19, Table 3.20 and Table 3.21 show distribution of expenditure on care and treatment by the specific interventions fo the years 2015/16. 2016/17 and 2017/18, respectively.

Table 3.19: Expenditure treatment and care (LSL million) – 2015/16

Intervention	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02. UN Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent of total
ASC.03.01 Anti-retroviral therapy	319.14	73.81	120.14	-	4.16	517.25	89.5%
ASC.03.01.01 ART for adults	295.95	65.81	114.44	-	-	476.20	82.4%
ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	295.95	65.81	114.44	-	-	476.20	82.4%
ASC.03.01.02 ART for paediatrics	23.19	8.00	5.71	-	4.16	41.05	7.1%
ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	23.19	8.00	5.71	-	4.16	41.05	7.1%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	-	-	-	3.65	-	3.65	0.6%
ASC.03.03 Specific ART-related laboratory monitoring	3.01	14.47	5.49	-	0.67	23.64	4.1%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	0.17	-	-	-	-	0.17	0.0%
ASC.03.04.03 Other OI prophylaxis (excluding TB and Hepatitis)	0.17	-	21.22	-	-	21.39	3.7%
ASC.03.98 Care and treatment services not disaggregated	-	12.05	-	-	-	12.05	2.1%
Total	**322.32**	**100.33**	**146.86**	**3.65**	**4.82**	**577.98**	**100.0%**

Intervention	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02. UN Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent of total
ASC.03.01 Anti-retroviral therapy	319.14	73.81	120.14	-	4.16	517.25	86.4%
ASC.03.01.01 ART for adults	295.95	65.81	114.44	-	-	476.2	79.5%
ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	295.95	65.81	114.44	-	-	476.2	79.5%
ASC.03.01.02 ART for paediatrics	23.19	8	5.71	-	4.16	41.05	6.9%
ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	23.19	8	5.71	-	4.16	41.05	6.9%
ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment)	20.79					20.79	3.5%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	-	-	-	3.65	-	3.65	0.6%
ASC.03.03 Specific ART-related laboratory monitoring	3.01	14.47	5.49	-	0.67	23.64	3.9%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	0.17	-	-	-	-	0.17	0.0%

ASC.03.04.03 Other OI prophylaxis (excluding TB and Hepatitis)	0.17	-	21.22	-	-	21.39	3.6%
ASC.03.98 Care and treatment services not disaggregated	-	12.05	-	-	-	12.05	2.0%

Table 3.21: Expenditure treatment and care (LSL million) – 2016/17

Intervention	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02. UN Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent of total
ASC.03.01 Anti-retroviral therapy	289.14	156.79	42.72	-	4.98	493.63	80.8%
ASC.03.01.01 ART for adults	272.63	142.84	40.58	-	-	456.05	74.6%
ASC.03.01.01. 98 Adult antiretroviral therapy not disaggregated by line of treatment	272.63	142.84	40.58	-	-	456.05	74.6%
ASC.03.01.02 ART for paediatrics	16.51	13.95	2.14	-	4.98	37.58	6.2%

ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	16.51	13.95	2.14	-	4.98	37.58	6.2%
ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment)	14.41					14.41	2.4%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	-	-	9.09	3.51	-	12.6	2.1%
ASC.03.03 Specific ART-related laboratory monitoring	9.38	45.55	4.72	-	-	59.66	9.8%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	0.17	-	0.51	-	-	0.68	0.1%
ASC.03.04.01 TB prevention, case finding, screening,	-	-	0.42	-	-	0.42	0.1%

diagnosis, treatment, and adherence for PLHIV and KPs							
ASC.03.04.01. 98 TB activities not disaggregated by type	-	-	0.42	-	-	0.42	0.1%
ASC.03.04.03 Other OI prophylaxis (excluding TB and Hepatitis)	0.17	-	-	-	-	0.17	0.0%
ASC.03.04.98 Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	0.17	-	0.09	-	-	0.26	0.0%
ASC.03.98 Care and treatment services not disaggregated	-	30.05	-	-	-	30.05	4.9%
Total	**313.09**	**232.39**	**57.04**	**3.51**	**4.98**	**611.01**	100.0%

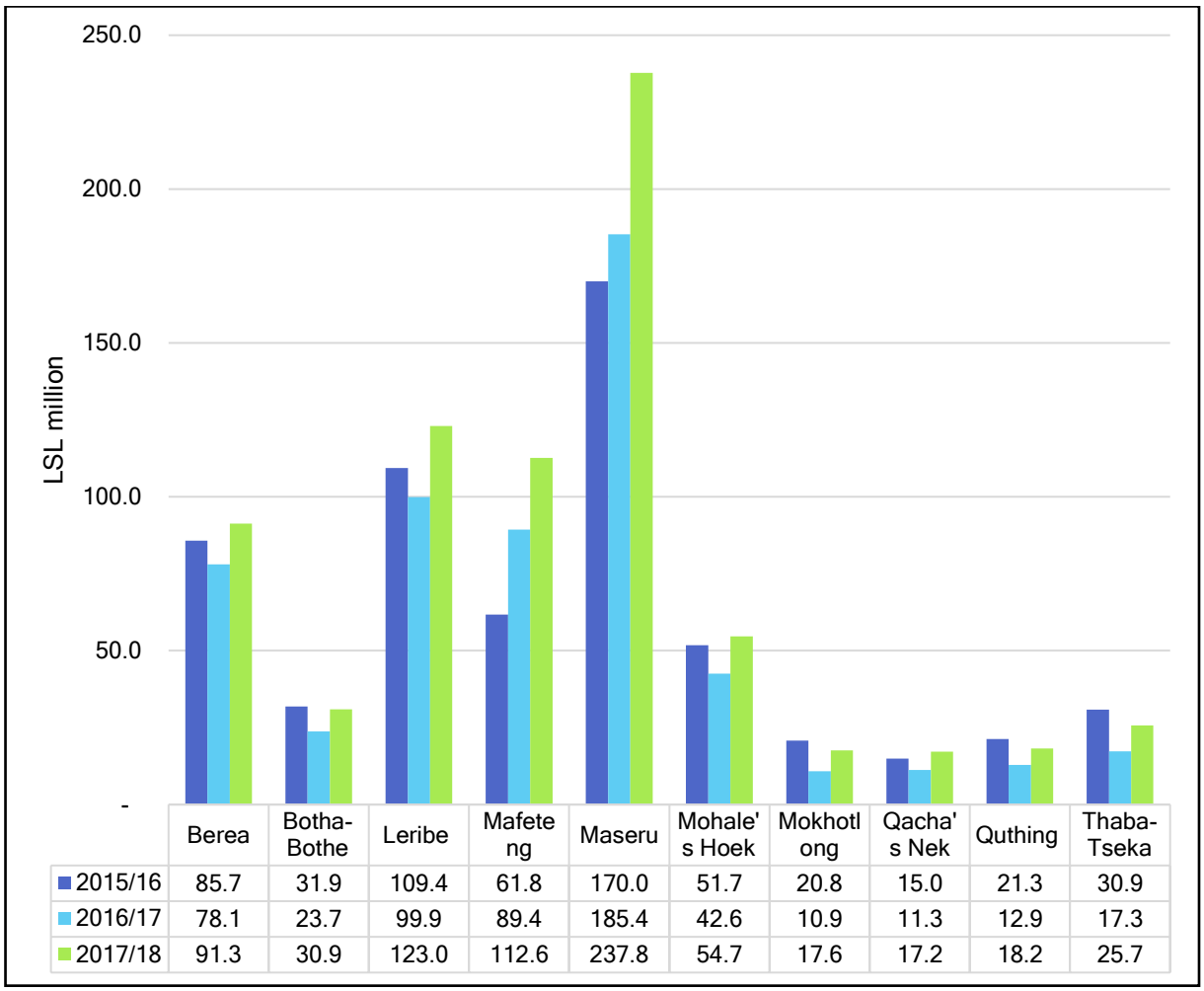
Table 3.22: Expenditure treatment and care (LSL million) – 2017/18

Intervention	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.02 UN Agencies	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent of total
ASC.03.01 Anti-retroviral therapy	315.68	196.55	139.42	-	1.28	558.31	71.6%
ASC.03.01.01 ART for adults	299.63	-	-	-	0.08	299.71	38.4%
ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	299.63	196.55	139.42	-	0.08	635.69	81.5%
ASC.03.01.02 ART for paediatrics	16.05	-	-	-	1.2	17.25	2.2%
ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	16.05	10.34	7.34	-	1.2	34.93	4.5%
ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment)	13.36	17.21	-	-	-	30.57	3.9%
ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by	-	-	-	0.42	-	0.42	0.1%

line of treatment nor for PMTCT							
ASC.03.03 Specific ART-related laboratory monitoring	14.09	55.08	-	-	-	69.17	8.9%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	0.17	-	7.16	-	-	7.33	0.9%
ASC.03.04.01 TB prevention, case finding, screening, disagnosis, treatment and adherence for PLHIV and KPs	-	-	3.82	-	-	3.82	0.5%
ASC.03.04.01.98 TB activities not disaggregated by type	-	-	3.82	-	-	3.82	0.5%
ASC.03.04.03 Other OI prophylaxis (excluding TB and Hepatitis)	0.17	-	-	-	-	0.17	0.0%
ASC.03.04.98 Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	-	-	3.34	-	-	3.34	0.4%
ASC.03.98 Care and treatment services not disaggregated	-	1.78	-	-	-	1.78	0.2%
Total	**343.30**	**280.97**	**153.93**	**0.42**	**1.28**	**779.90**	100.0%

The above tables show that ART accounted for bulk of the total expenditure on care and treatment in each of the years, being 89.5 percent in 2015/16, 82.7 percent in 2016/17 and 72,8 percent in 2017/18. Specific ART-related laboratory monitoring took the second position in terms of expenditure. Figure 3.30 depicts expenditure on care and treatment at the districts.

Figure 3.30: Expenditure on care and treatment by districts



	Berea	Botha-Bothe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
2015/16	85.7	31.9	109.4	61.8	170.0	51.7	20.8	15.0	21.3	30.9
2016/17	78.1	23.7	99.9	89.4	185.4	42.6	10.9	11.3	12.9	17.3
2017/18	91.3	30.9	123.0	112.6	237.8	54.7	17.6	17.2	18.2	25.7

Figure 3.30 shows consistent increase in expenditure on care in only Maseru and Mafeteng districts. Maseru, Leribe, Mafeteng and Berea took big share of the expenditure in all the three years. These districts also have the highest burden of HIV. A comparative analysis of the expenditure on care and treatment and number of people on ART was done as shown in Figure 3.31, Figure 3.32 and Figure 3.33, respectively, for the years 2015/16, 2016/17 and 2017/18. The results seemed to show some inconsistency between the two, suggesting difference in unit expenditure of reaching people on care and treatment in the different districts.

Figure 3.71: Expenditure on C&T and number on ART by district 2015/16

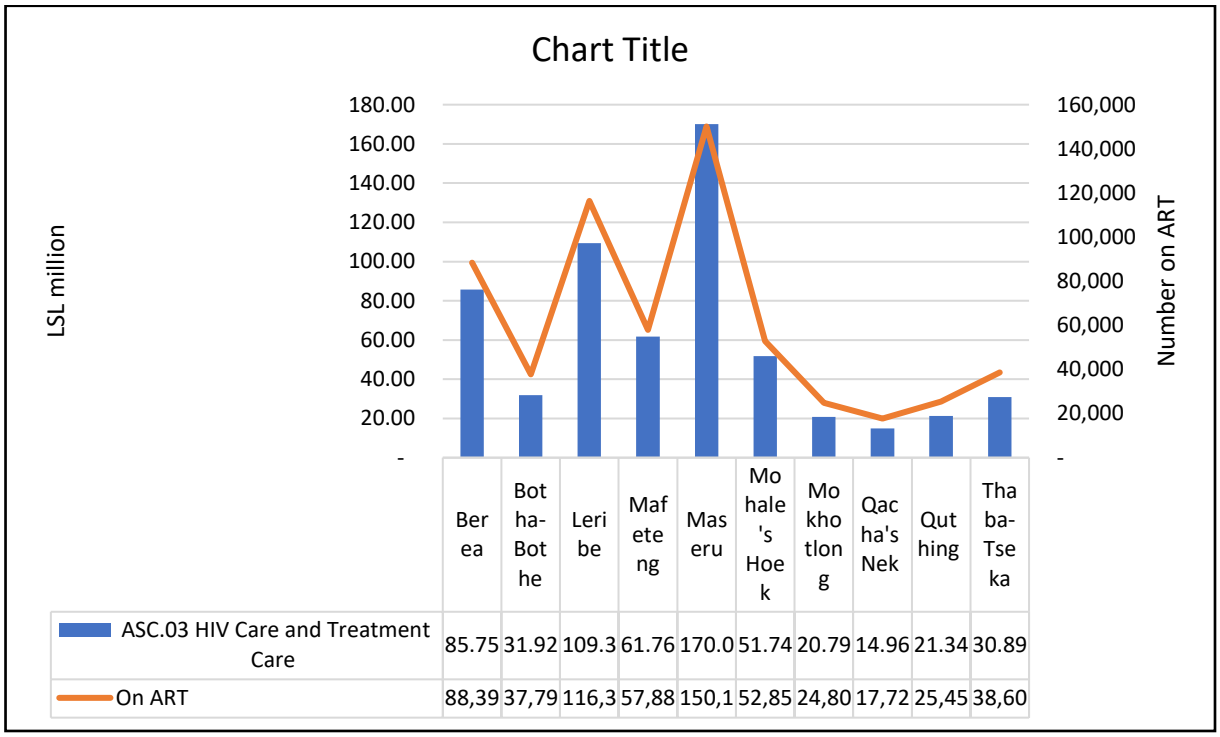


Figure 3.32: Expenditure on C&T and number on ART by district 2016/17

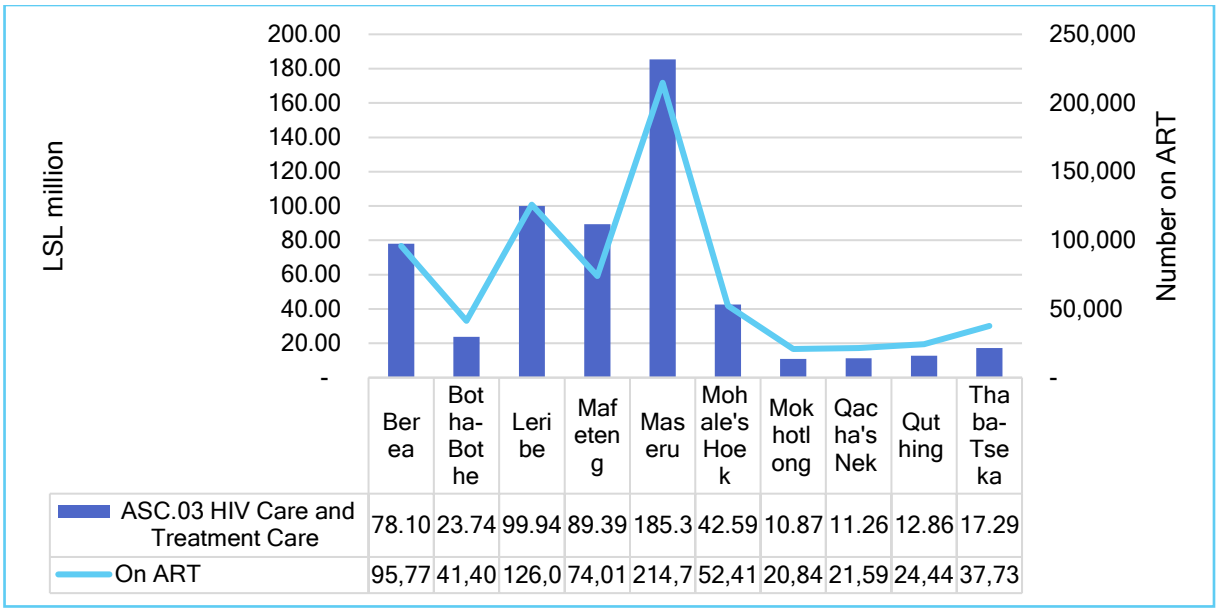


Figure 3.33: Expenditure on C&T and number on ART by district 2017/18

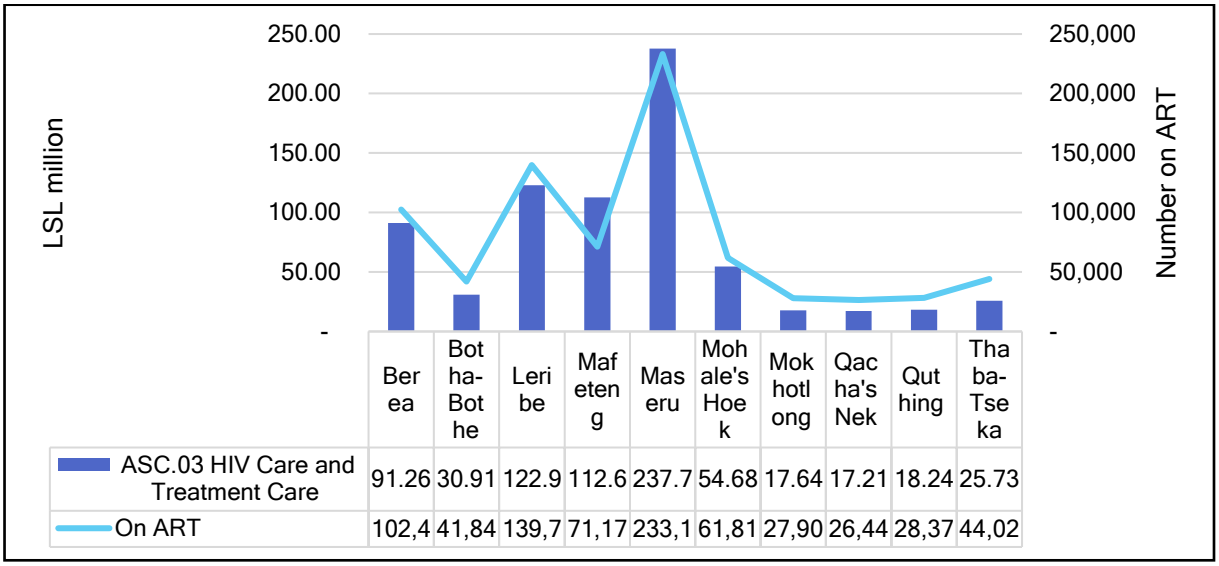
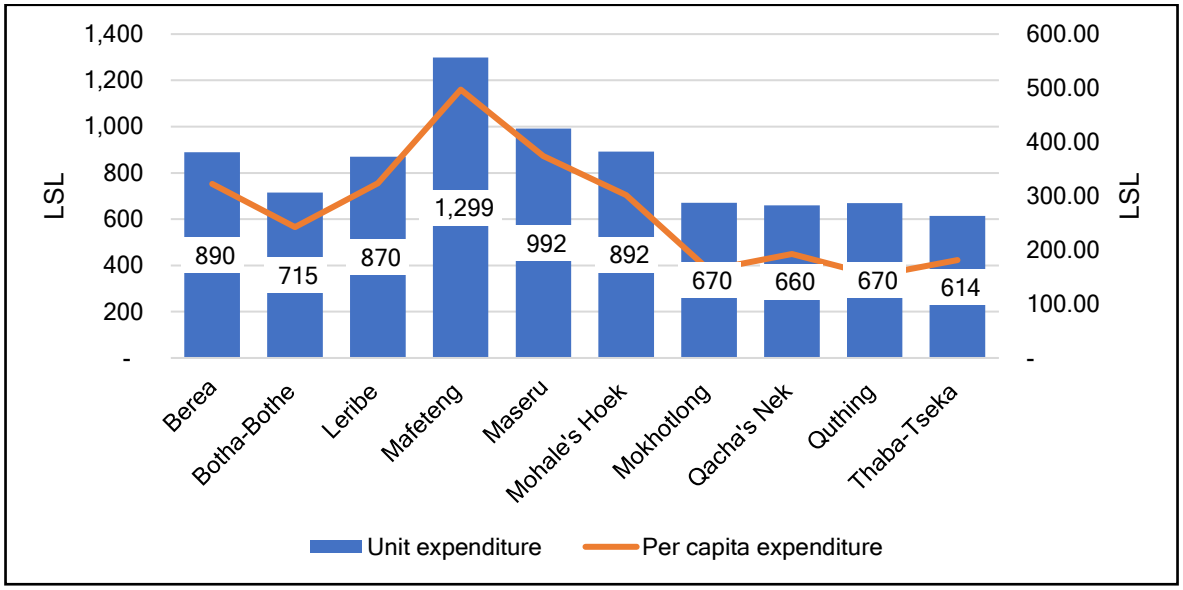


Figure 3.34 shows the comparison of the districts in terms of three-year average per capita expenditure and three-year average unit expenditure on care and treatment.

Figure 3.8: Average unit expenditure on C&T and per capita expenditure



As shown in Figure 3.34, the unit expenditure varied directly with per capita expenditure. However, in most districts there were variations between per capita expenditure and unit expenditure. It was only in Mokhotlong, Qacha's Nek, Quthing and Thaba-Tseka where the unit expenditure and per capita expenditure were almost equal. The results demonstrate differences in expenditure that may require explanations. This could be attributed to differences in efficiency and/or inefficiency among the different service providers. An attempt was made to estimate efficiency in provision of care and treatment services at the district level.

3.12 Efficiency Analysis

The differences in the expenditure across the districts necessitate some analysis on the efficiency of the districts in provision of care and treatment services. The care and treatment category of interventions was selected because of data availability. In literature, two broad approaches are available for estimating efficiency in service provision or production. These approaches are Data Envelopment Analysis (DEA) and stochastic Frontier Analysis (SFA). the DEA uses linear programming techniques in the estimation while SFA employs regression techniques. In the report, DEA was adopted because of small sample size of 10 districts.

In DEA, efficiency score or level of a district was measured relative to frontier constructed based on best performing districts. Therefore, the efficiency level obtained was relative meaning that it was in comparison with districts found to be efficient. In the analysis, two inputs consisted of human resources

and HIV expenditure on care and treatment were used while on output the number on ART treatment was used. The total human resources for health in district was proxied by the expenditure on personnel in the districts. The results as shown in Table 3.23.

Table 3.23: Efficiency levels for the districts - 2016/17 and 2017/18

District	Efficiency level	District position
Mokhotlong	100%	1
Qacha's Nek	91%	2
Berea	85%	3
Quthing	82%	4
Mohale's Hoek	73%	5
Thaba-Tseka	67%	6
Botha-Bothe	66%	7
Maseru	51%	8
Leribe	48%	9
Mafeteng	30%	10

The results in Table 3.23 show that Mokhotlong was rated the most efficient district in provision of ART services, followed by Qacha's Nek. These two districts were shown to have relatively low expenditure compared to other districts. Berea District is shown to be the third most efficient at 85 percent despite the fact that it was one of the districts with relatively large expenditure. The districts of Maseru, Leribe and mafeteng had the lowest efficiency level at 51 percent, 48 percent and 30 percent, respectively. Overall efficiency level for the country was 70 percent, which implies that the country can reduce resources for HIV by about 30 percent without affecting the level of ART service delivery. This resource-saving could be used to expend service delivery for HIV.

3.13 Expenditure On Social Protection And Economic Support

The expenditure i[under this broad area encompassed OVC and other safety nets to those infected and affected by HIV. As shown in Table 3.24, Table 3.25 and Table 3.26, respectively, for 2015/16. 2016/17 and 2017/18, there only three main sources of funding, consisting of the Government of Lesotho, the Government of the United States and International NGOs and foundations.

Table 3.24: Expenditure on social protection and economic (LSL million) - 2015/16

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.03 International not-for-profit organizations and foundations	Total
ASC.04.01 Social protection and economic support for OVC	0.29	12.91	6.31	19.50
ASC.04.01.01 OVC Basic needs (health, education, housing)	-	-	1.26	1.26
ASC.04.01.02 OVC Institutional and Community support	0.29	-	-	0.29
ASC.04.01.98 OVC Services not disaggregated by activity	-	12.91	5.05	17.95
ASC.04.02 Other social protection and economic support (non-OVC)	14.74	-	5.74	20.48
ASC.04.02.01 Social protection through monetary or in-kind benefits	14.74	-	-	14.74
ASC.04.02.98 Social protection services and social services not disaggregated by type	-	-	5.74	5.74
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	15.03	12.91	12.05	39.98

Table 3.25: Expenditure on social protection and economic (LSL million) - 2016/17

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total
ASC.04.01 Social protection and economic support for OVC	0.17	11.47	-	6.53	18.17
ASC.04.01.01 OVC Basic needs (health, education, housing)	-	-	-	1.31	1.31
ASC.04.01.02 OVC Institutional and Community support	0.17	-	-	-	0.17
ASC.04.01.98 OVC Services not disaggregated by activity	-	11.47	-	5.23	16.70
ASC.04.02 Other social protection and economic support (non-OVC)	5.70	-	3.52	35.68	44.90
ASC.04.02.01 Social protection through monetary or in-kind benefits	5.70	-	-	-	5.70
ASC.04.02.02 Social protection through provision of social services	-	-	3.52	-	3.52
ASC.04.02.98 Social protection	-	-	-	35.68	35.68

services and social services not disaggregated by type						
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	5.87	11.47	3.52	42.21	63.07	

Table 3.26: Expenditure on social protection and economic (LSL million) - 2017/18

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	**FE.03.02 UN Agencies**	FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	Total	Percent
ASC.04.01 Social protection and economic support for OVC	0.17	5.39	-	5.91	11.47	16.7%
ASC.04.01.02 OVC Institutional and	0.17	-	-	-	0.17	0.2%

Community support						
ASC.04.01.03 OVC Social Services (including financial benefits)	-	5.39	-	-	5.39	7.9%
ASC.04.01.98 OVC Services not disaggregated by activity	-	-	-	5.91	5.91	8.6%
ASC.04.02 Other social protection and economic support (non-OVC)	16.06	10.99	4.17	7.01	38.22	55.7%
ASC.04.02.01 Social protection through monetary or in-kind benefits	16.06	10.15	-	-	26.21	38.2%
ASC.04.02.02 Social protection through provision of social services	-	0.83	4.17	-	5.00	7.3%
ASC.04.02.98 Social protection services and social services not disaggregated by type	-	-	-	25.94	25.94	37.8%
ASC.04.98 Social protection activities	-	-	-	18.92	18.92	27.6%

not disaggregated						
ASC.04 Social protection and economic support (for PLHIV, their familes, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	16.22	16.38	4.17	31.84	68.61	100.0 %

3.13 Expenditure on Programme Enablers

The expenditure on this area of interventions is shown in Table 3.27, Table 3.28 and Table 3.29 for the years 2015/16, 2016.17 and 2017/18, respectively.

Table 3.27: Expenditure on programme enablers (LSL million) - 2015/16

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	Total	Percent
ASC.06.01 Strategic planning, coordination and policy development	6.17	-	-	0.21	6.38	2.8%
ASC.06.03 Programme administration and management costs (above service-delivery level)	-	121.07	10.29	0.95	132.31	58.3%
ASC.06.04 Strategic information	-	23.92	1.70	0.51	26.12	11.5%
ASC.06.04.04 Management information systems	-	-	1.70	0.14	1.84	0.8%
ASC.06.04.98 Strategic information not disaggregated by type	-	23.92	-	-	23.92	10.5%
ASC.06.04.99 Strategic information n.e.c.	-	-	-	0.37	0.37	0.2%
ASC.06.05 Public Systems Strengthenin	49.94	3.25	4.80	0.77	58.76	25.9%

ASC.06.05.01 Procurement and supply chain	-	-	4.35	-	4.35	1.9%
ASC.06.05.03 Institutional & organisational development (health, social, educational etc)	-	3.25	0.45	0.77	4.47	2.0%
ASC.06.05.98 Public system strengthening not disaggregated	49.94	-	-	-	49.94	22.0%
ASC.06.06 Community system strengthening	-	-	3.17	-	3.17	1.4%
ASC.06.06.02 Community worker education, training and support	-	-	1.00	-	1.00	0.4%
ASC.06.06.98 Community system strengthening not disaggregated	-	-	2.16	-	2.16	1.0%
ASC.06.07 Human resources for health (above-site programmes)	-	-	-	0.05	0.05	0.0%
ASC.06.07.01 Capacity building for health workers, excluding those at community level	-	-	-	0.05	0.05	0.0%
	56.11	148.23	19.96	2.49	226.78	100.0%

Table 3.28: Expenditure on programme enablers (LSL million) - 2016/17

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
ASC.06.01 Strategic planning, coordination and policy development	11.91	-	-	1.15	-	13.06	2.6%
ASC.06.03 Programme administration and management costs (above service-delivery level)	-	277.29	33.93	2.09	6.93	320.23	64.3%
ASC.06.04 Strategic information	-	38.05	7.76	1.52	-	47.33	9.5%
ASC.06.04.04 Management information systems	-	-	7.76	0.77	-	8.53	1.7%
ASC.06.04.98 Strategic information not	-	38.05	-	0.75	-	38.80	7.8%

disaggregated by type							
ASC.06.05 Public Systems Strengthenin	95.02	-	12.30	4.17	-	111.49	22.4%
ASC.06.05.01 Procurement and supply chain	-	-	5.73	-	-	5.73	1.1%
ASC.06.05.03 Institutional & organisational development (health, social, educational etc)	-	-	6.57	4.17	-	10.74	2.2%
ASC.06.05.98 Public system strengthening not disaggregated	95.02	-	-	-	-	95.02	19.1%
ASC.06.06 Community system strengthening	-	-	6.17	0.07	-	6.23	1.3%
ASC.06.06.02 Community worker education, training and support	-	-	0.47	0.07	-	0.54	0.1%

ASC.06.06.98 Community system strengthening not disaggregated	-	-	5.70	-	-	5.70	1.1%
ASC.06.07 Human resources for health (above-site programmes)	-	-	-	0.06	-	0.06	0.0%
ASC.06.07.01 Capacity building for health workers, excluding those at community level	-	-	-	0.06	-	0.06	0.0%
ASC.06 Programme enablers and systems strengthening	106.94	315.34	60.15	9.06	6.93	498.41	100.0%

Table 3.29: Expenditure on programme enablers (LSL million) - 2017/18

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	Total
ASC.06 Programme enablers and systems strengthening	13.39	19.54	-	1.00	33.93
ASC.06.01 Strategic planning, coordination and policy development	-	177.91	63.80	3.18	244.88
ASC.06.03 Programme administration and management costs (above service-delivery level)	-	9.42	3.84	0.75	14.00
ASC.06.04 Strategic information	-	-	-	0.08	0.08
ASC.06.04.01 Monitoring and evaluation	-	-	3.84	0.67	4.50
ASC.06.04.04 Management information systems	-	9.42	-	-	9.42
ASC.06.04.98 Strategic information not disaggregated by type	58.06	10.06	29.71	5.01	102.84
ASC.06.05 Public Systems Strengthenin	-	4.59	6.60	-	11.19
ASC.06.05.01 Procurement and supply chain	-	5.47	-	-	5.47
ASC.06.05.02 Laboratory system strengthening	-	-	22.95	5.01	27.96
ASC.06.05.03 Institutional & organisational development (health, social, educational etc)	58.06	-	0.16	-	58.22
ASC.06.05.98 Public system strengthening not disaggregated	-	-	9.52	-	9.52
ASC.06.06 Community system strengthening	-	-	0.36	-	0.36
ASC.06.06.02 Community worker education, training and support	-	-	9.16	-	9.16
ASC.06.06.98 Community system strengthening not disaggregated	-	-	-	-	-
ASC.06 Programme enablers and systems strengthening	71.45	216.93	106.86	9.94	405.18

The tables above show that programme planning, and policy development was the main category of the enablers being funded in the three years. It accounted for (see also Table 3.20)

3.14 Beneficiary Population

The analysis of the Beneficiary Population (BP) aims at estimating resources specifically spent on a population as part of the service delivery process of a programmatic intervention (UNAIDS, 2007). Beneficiary population (BP) is a sub-set of the population that consumes HIV and AIDS related goods and services. Details of the beneficiary populations and their percentage shares in total expenditure are given in Table 3.30 for 2015/16, Table 3.31 for 2016/17 and Table 3.32 for 2017/18. The results indicate that people living with HIV accounted for the largest share of the expenditure in all the three years.

Table 3.30: Expenditure by beneficiary population in 2015/16

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)	357.85	100.33	146.86	3.65	6.40	615.09	60.1%
BP.01.01 Adult and young people (aged 15 and over) living with HIV	319.76	71.49	139.52	-	-	530.77	51.9%
BP.01.01.03 Pregnant and breastfeeding women (and not on ART)	20.79	-	-	-	-	20.79	2.0%
BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender	298.97	71.49	139.52	-	-	509.98	49.8%
BP.01.02 Children (aged under 15) living with HIV	23.35	3.76	7.34	-	5.74	40.18	3.9%

BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender	23.35	3.76	7.34	-	5.74	40.18	3.9%
BP.01.98 People living with HIV not broken down by age or gender	14.74			3.65	0.67	19.06	1.9%
BP.02 Key populations	-	1.78	0.43	1.65	-	3.86	0.4%
BP.02.02 Sex workers (SW) and their clients	-	1.04	0.35	0.49	-	1.88	0.2%
BP.02.02.98 Sex workers, not broken down by gender, and their clients	-	1.04	0.35	0.49	-	1.88	0.2%
BP.02.03 Gay men and other men who have sex with men (MSM)	-	0.74	0.08	1.15	-	1.98	0.2%
BP.03 Vulnerable, accessible and other target populations	0.46	12.91	4.63	2.09	14.39	34.48	3.4%
BP.03.01 Orphans and vulnerable children (OVC)	0.29	12.91	-	-	12.05	25.24	2.5%
BP.03.02 Pregnant and breastfeeding HIV-positive women (not on	-	-	1.29	2.09	-	3.39	0.3%

ART) and their children to be born (un-determined HIV status) and new borns							
BP.03.12 Institutionalized children and youth	-	-	-	-	-	-	0.0%
BP.03.24 Employees (e.g. for workplace interventions)	0.18	-	-	-	-	0.18	0.0%
BP.03.98 Vulnerable, accessible and other target populations not broken down by type	-	-	3.34	-	2.34	5.68	0.6%
BP.04 General population	21.66	82.87	28.85	3.35	5.82	142.55	13.9%
BP.04.02 Children (aged under 15)	-	-	-	1.91	-	1.91	0.2%
BP.04.02.98 Children (aged under 15) not broken down by gender	-	-	-	1.91	-	1.91	0.2%
BP.04.03 Youth (aged 15 to 24)	8.50	36.42	-	-	-	44.93	4.4%
BP.04.03.01 Young men	8.50	36.42	-	-	-	44.93	4.4%
BP.04.98 General population not	13.16	46.44	28.85	1.44	5.82	95.72	9.4%

broken down by age or gender.							
BP.05 Non-targeted interventions	56.11	148.23	19.96	2.95	-	227.25	22.2%
Total	436.08	346.11	200.73	13.70	26.61	1,023.24	100.0%

Table 3.31: Expenditure by beneficiary population in 2016/17

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)	318.80	232.39	57.04	3.51	37.07	648.81	46.5%
BP.01.01 Adult and young	296.11	-	-	-	-	296.11	21.2%

people (aged 15 and over) living with HIV							
BP.01.01.03 Pregnant and breastfeeding women (and not on ART)	14.41	-	-	-	-	14.41	1.0%
BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender	281.70	220.77	54.19	-	-	556.66	39.9%
BP.01.02 Children (aged under 15) living with HIV	16.99	11.62	2.85	-	11.52	42.98	3.1%
BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender	16.99	11.62	2.85	-	11.52	42.98	3.1%
BP.01.98 People living with HIV not broken down by age or gender	5.70		57.04	3.51	25.55	91.81	6.6%
BP.02 Key populations	-	2.45	2.55	-	-	5.00	0.4%
BP.02.02 Sex workers (SW) and their clients	-	1.66	2.55	-	-	4.21	0.3%
BP.02.02.01 Female sex	-	-	0.92	-	-	0.92	0.1%

workers and their clients							
BP.02.02.03 Male sex workers (and their clients)	-	-	1.62	-	-	1.62	0.1%
BP.02.02.98 Sex workers, not broken down by gender, and their clients	-	1.66	0.01	-	-	1.67	0.1%
BP.02.03 Gay men and other men who have sex with men (MSM)	-	0.79	-	-	-	0.79	0.1%
BP.03 Vulnerable, accessible and other target populations	0.74	11.47	1.14	8.65	18.44	40.45	2.9%
BP.03.01 Orphans and vulnerable children (OVC)	0.17	11.47	-	-	6.53	18.17	1.3%
BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns	-	-	0.71	1.62	-	2.33	0.2%

BP.03.06 Migrants/mobile populations	-	-	-	7.04	-	7.04	0.5%
BP.03.17 Junior high/high school students	0.22	-	-	-	-	0.22	0.0%
BP.03.24 Employees (e.g. for workplace interventions)	0.35	-	-	-	-	0.35	0.0%
BP.03.98 Vulnerable, accessible and other target populations not broken down by type	-	-	0.43	-	11.91	12.34	0.9%
BP.04 General population	28.57	126.04	35.08	8.04	2.63	200.37	14.4%
BP.04.02 Children (aged under 15)	-	-	-	4.04	-	4.04	0.3%
BP.04.02.98 Children (aged under 15) not broken down by gender	-	-	-	4.04	-	4.04	0.3%
BP.04.03 Youth (aged 15 to 24)	11.29	46.93	-	-	-	58.21	4.2%
BP.04.03.01 Young men	11.29	46.93	-	-	-	58.21	4.2%
BP.04.98 General population not broken down	17.28	79.12	35.08	4.00	2.63	138.12	9.9%

by age or gender.							
BP.05 Non-targeted interventions	106.94	315.34	60.15	10.34	7.21	499.98	35.9%
Total	455.05	687.69	155.97	30.55	65.36	1,394.61	100.0%

Table 3.32: Expenditure by beneficiary population in 2017/18

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total
BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)	359.36	288.76	153.93	0.42	27.22	829.67
BP.01.01 Adult and young people (aged 15 and over) living with HIV	326.54	275.18	146.23	-	0.08	343.83
BP.01.01.03 Pregnant and breastfeeding women (and not on ART)	13.36	17.21	-	-	-	30.57

BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender	313.18	257.97	146.23	-	0.08	313.26
BP.01.02 Children (aged under 15) living with HIV	16.76	13.58	7.70	-	27.13	43.90
BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender	16.76	13.58	-	-	27.13	43.90
BP.01.98 People living with HIV not broken down by age or gender	16.06			0.42	-	441.95
BP.02 Key populations	-	39.11	5.85	4.17	-	49.13
BP.02.02 Sex workers (SW) and their clients	-	3.67	3.26	-	-	6.93
BP.02.02.01 Female sex workers and their clients	-	-	1.80	-	-	1.80
BP.02.02.98 Sex workers, not broken down by gender, and their clients	-	3.67	1.46	-	-	5.13
BP.02.03 Gay men and other men who have sex with men (MSM)	-	1.47	2.58	-	-	4.05
BP.02.98 “Key populations” not broken down by type	-	33.98	-	4.17	-	38.15
BP.03 Vulnerable, accessible and other target populations	3.30	19.18	48.79	5.48	20.40	97.15
BP.03.01 Orphans and vulnerable children (OVC)	0.17	5.88	-	-	5.91	11.96
BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns	-	-	23.15	1.31	-	24.45
BP.03.03 Adolescent girls and young women in countries with high HIV prevalence	-	13.04	-	-	-	13.04
BP.03.06 Migrants/mobile populations	-	-	-	4.17	-	4.17
BP.03.12 Institutionalized children and youth	-	-	8.84	-	-	8.84
BP.03.17 Junior high/high school students	0.22	-	-	-	-	0.22

BP.03.24 Employees (e.g. for workplace interventions)	2.91	-	-	-	-	2.91
BP.03.98 Vulnerable, accessible and other target populations not broken down by type	-	0.25	16.81	-	14.49	31.55
BP.04 General population	29.92	246.41	81.69	13.74	6.42	378.19
BP.04.02 Children (aged under 15)	-	-	-	5.54	1.85	7.38
BP.04.02.98 Children (aged under 15) not broken down by gender	-	-	-	5.54	1.85	7.38
BP.04.03 Youth (aged 15 to 24)	9.32	67.74	0.84	-	-	77.90
BP.04.03.01 Young men	9.32	67.74	0.84	-	-	77.90
BP.04.98 General population not broken down by age or gender.	20.60	178.68	80.86	8.21	4.58	292.91
BP.05 Non-targeted interventions	71.45	221.64	106.86	10.95	-	410.90
Total	464.03	815.11	397.12	34.75	54.04	1,765.05

3.15 Expenditure on Production Factors

The classification of production factors categorizes expenditures in terms of resources used for the production in terms wages, salaries, materials, and capital. Expenditure categorised in terms of factors of production is presented in Table 3.33, Table 3.34 and Table 3.35 for the years 2015/16, 2016/17 and 2017/18, respectively.

Table 3.33: Expenditure on inputs used in production (LSL million) 2015/16

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
PF.01 Current direct and indirect expenditures	384.21	309.74	200.73	13.29	25.92	933.90	91.3%
PF.01.01 Personnel costs	96.04	144.53	8.15	3.69	9.35	117.23	11.5%
PF.01.01.01 Direct service providers	91.58	87.38	-	1.20	0.22	1.42	0.1%
PF.01.01.01.01 Labor costs - Direct service providers	91.58	87.38	-	1.03	-	1.03	0.1%
PF.01.01.01.04 Consultants (external)	-		-	0.16	0.22	0.38	0.0%
PF.01.01.02 Program management personnel costs	4.46	57.15	-	0.84	-	5.30	0.5%
PF.01.01.02.01 Labor costs - Program management	-	52.93	-	0.84	-	0.84	0.1%
PF.01.01.02.98 Program management personnel not disaggregated	4.46	4.23	-	-	-	4.46	0.4%
PF.01.01.98 Personnel not disaggregated			8.15	1.65	9.13	110.51	10.8%
PF.01.02 Other operational and programme management current expenditures	17.42	27.33	7.41	2.43	7.68	62.26	6.1%

PF.01.02.01 Office rental costs	-	-	-	0.33	2.52	2.85	0.3%
PF.01.02.02 Office utilities costs (electricity, water, heating, etc.)	0.03	-	-	0.16	0.63	0.83	0.1%
PF.01.02.03 Travel expenditure	1.02	27.33	4.77	0.39	3.15	36.66	3.6%
PF.01.02.04 Administrative and programme management costs	16.37	-	2.64	1.54	1.37	21.93	2.1%
PF.01.03 Medical products and supplies	256.77	84.38	185.09	2.44	3.40	532.08	52.0%
PF.01.03.01 Pharmaceuticals	252.90	14.86	130.30	-	-	398.06	38.9%
PF.01.03.01.01 Antiretrovirals	252.73	-	120.14	-	-	372.87	36.4%
PF.01.03.01.07 OI other than TB drugs	0.17	-	-	-	-	0.17	0.0%
PF.01.03.01.98 Pharmaceuticals not disaggregated	-	14.86	10.15	-	-	25.02	2.4%
PF.01.03.02 Medical supplies	-	4.81	5.91	0.61	0.46	11.78	1.2%
PF.01.03.02.02 Condoms	-	-	1.59	0.61	-	2.20	0.2%
PF.01.03.02.98 Medical supplies not disaggregated	-	4.81	4.32	-	0.46	9.58	0.9%
PF.01.03.03 Laboratory reagents and materials	3.01	-	48.70	-	0.67	52.38	5.1%
PF.01.03.03.01 HIV tests screening/diagnostics	-	-	21.98	-	-	21.98	2.1%
PF.01.03.03.02 VL tests	0.23	-	-	-	-	0.23	0.0%
PF.01.03.03.03 CD4 tests	2.78	-	-	-	-	2.78	0.3%
PF.01.03.03.98 Reagents and materials not disaggregated	-	-	26.72	-	0.67	27.38	2.7%
PF.01.03.04 Non-medical supplies	0.86	64.66	0.19	1.79	2.28	69.78	6.8%
PF.01.03.04.01 Food and nutrients	-	-	-	1.69	-	1.69	0.2%
PF.01.03.04.02 Promotion and information materials	-	-	0.19	0.10	-	0.29	0.0%
PF.01.03.04.98 Non-medical supplies not disaggregated	0.86	64.66	-	-	2.28	67.80	6.6%
PF.01.03.05 Office Supplies	-	-	-	0.04	-	0.04	0.0%
PF.01.03.98 Medical products and supplies not disaggregated	-	0.04	-	-	-	0.04	0.0%

PF.01.04 Contracted external services	-	18.71	0.08	0.33	-	19.12	1.9%
PF.01.07 Financial support for beneficiaries	13.88	-	-	-	2.52	16.41	1.6%
PF.01.08 Training- Training related per diems/transport/other costs	0.01	34.80	-	3.54	1.89	40.25	3.9%
PF.01.09 Logistics of events, including catering services	0.08	-	-	0.64	1.07	1.79	0.2%
PF.01.98 Current direct and indirect expenditures not disaggregated	-		-	0.23	0.00	144.76	14.1%
PF.02 Capital expenditures	51.87	36.37	0.00	0.40	0.69	89.34	8.7%
PF.02.01 Building	51.87	10.38	-	-	0.35	62.60	6.1%
PF.02.01.01 Laboratory and other infrastructure upgrading	-	-	-	-	0.35	0.35	0.0%
PF.02.01.02 Construction and renovation	51.87	10.38	-	-	-	62.25	6.1%
PF.02.03 Other capital investment	-	25.99	0.00	0.40	0.34	26.74	2.6%
PF.02.03.01 Information technology (hardware and software)	-	-	-	0.30	-	0.30	0.0%
PF.02.03.02 Laboratory and other medical equipment	-	-	-	0.11	-	0.11	0.0%
PF.02.03.03 Non medical equipment and furniture	-	25.99	0.00	-	0.34	26.34	2.6%
Total	436.08	346.11	200.73	13.70	26.61	1,023.24	100.0%

Table 3.34: Expenditure on inputs used in production (LSL million) 2016/17

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
PF.01 Current direct and indirect expenditures	358.46	653.10	154.78	29.65	64.96	1,260.96	90.4%
PF.01.01 Personnel costs	120.69	-	22.50	10.52	34.19	187.89	13.5%
PF.01.01.01 Direct service providers	111.33	204.17	22.50	1.97	0.05	2.01	0.1%
PF.01.01.01.01 Labor costs - Direct service providers	111.33	197.73	-	1.90	-	1.90	0.1%
PF.01.01.01.04 Consultants (external)	-	6.44	-	0.06	0.05	0.11	0.0%
PF.01.01.02 Program management personnel costs	9.36	117.34	-	-	-	9.36	0.7%
PF.01.01.02.98 Program management personnel not disaggregated	9.36	117.34	-	-	-	9.36	0.7%
PF.01.01.98 Personnel not disaggregated				8.56	34.14	176.52	12.7%
PF.01.02 Other operational and programme management current expenditures	24.86	78.60	26.46	8.51	14.79	153.20	11.0%
PF.01.02.01 Office rental costs	-	-	-	2.39	-	2.39	0.2%
PF.01.02.02 Office utilities costs (electricity, water, heating, etc.)	0.05	-	-	0.13	0.62	0.80	0.1%
PF.01.02.03 Travel expenditure	0.76	78.60	14.17	0.64	6.93	101.10	7.2%

PF.01.02.04 Administrative and programme management costs	24.05	-	12.29	5.34	7.24	48.92	3.5%
PF.01.03 Medical products and supplies	206.75	140.82	105.33	4.29	4.40	461.59	33.1%
PF.01.03.01 Pharmaceuticals	197.15	83.33	44.59	-	-	325.08	23.3%
PF.01.03.01.01 Antiretrovirals	196.99	-	10.96	-	-	207.94	14.9%
PF.01.03.01.07 OI other than TB drugs	0.17	-	0.10	-	-	0.27	0.0%
PF.01.03.01.98 Pharmaceuticals not disaggregated	-	83.33	33.53	-	-	116.86	8.4%
PF.01.03.02 Medical supplies	-	0.85	10.17	3.43	0.00	14.45	1.0%
PF.01.03.02.02 Condoms	-	-	0.65	3.43	-	4.08	0.3%
PF.01.03.02.98 Medical supplies not disaggregated	-	0.85	9.51	-	0.00	10.37	0.7%
PF.01.03.03 Laboratory reagents and materials	9.38	-	39.48	-	-	48.86	3.5%
PF.01.03.03.01 HIV tests screening/diagnostics	-	-	2.99	-	-	2.99	0.2%
PF.01.03.03.03 CD4 tests	9.38	-	15.15	-	-	24.53	1.8%
PF.01.03.03.98 Reagents and materials not disaggregated	-	-	21.33	-	-	21.33	1.5%
PF.01.03.04 Non-medical supplies	0.22	56.64	11.09	0.64	4.39	72.98	5.2%
PF.01.03.04.01 Food and nutrients	-	-	9.09	0.21	-	9.30	0.7%
PF.01.03.04.02 Promotion and information materials	-	-	2.00	0.43	-	2.43	0.2%
PF.01.03.04.98 Non-medical supplies not disaggregated	0.22	56.64	-	-	4.39	61.25	4.4%
PF.01.03.05 Office Supplies	-	-	-	0.23	-	0.23	0.0%
PF.01.04 Contracted external services	0.30	25.86	0.48	0.07	-	26.71	1.9%
PF.01.07 Financial support for beneficiaries	5.49	-	0.02	-	1.31	6.82	0.5%

PF.01.08 Training- Training related per diems/transport/other costs	0.12	86.31	-	3.93	8.10	98.47	7.1%
PF.01.09 Logistics of events, including catering services	0.26	-	-	2.13	2.18	4.56	0.3%
PF.01.98 Current direct and indirect expenditures not disaggregated	-		-	0.20	-	321.71	23.1%
PF.02 Capital expenditures	96.58	34.59	1.19	0.90	0.40	133.65	9.6%
PF.02.01 Building	96.58	18.52	0.03	-	0.32	115.45	8.3%
PF.02.01.01 Laboratory and other infrastructure upgrading	-	-	-	-	0.32	0.32	0.0%
PF.02.01.02 Construction and renovation	96.58	18.52	-	-	-	115.10	8.3%
PF.02.01.98 Building not disaggregated	-	-	0.03	-	-	0.03	0.0%
PF.02.03 Other capital investment	-	16.07	0.84	0.90	0.07	17.88	1.3%
PF.02.03.01 Information technology (hardware and software)	-	-	0.27	0.90	-	1.16	0.1%
PF.02.03.02 Laboratory and other medical equipment	-	-	0.02	-	-	0.02	0.0%
PF.02.03.03 Non medical equipment and furniture	-	16.07	0.56	-	0.07	16.70	1.2%
PF.02.98 Capital expenditure not disaggregated	-	-	0.32	-	-	0.32	0.0%
Total	455.05	687.69	155.97	30.55	65.36	1,394.61	100.0%

Table 3.35: Expenditure on inputs used in production (LSL million) 2017/18

	FE.01.01.01 Government of Lesotho	FE.03.01.30 Government of United States	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	**FE.03.02 UN Agencies**	FE.03.03 International not-for-profit organizations and foundations	Total	Percent
PF.01 Current direct and indirect expenditures	404.34	794.65	367.27	34.10	54.03	1,654.39	93.7%
PF.01.01 Personnel costs	125.00	414.96	82.68	10.05	24.18	656.87	37.2%
PF.01.01.01 Direct service providers	114.56	209.27	82.68	2.68	-	409.19	23.2%
PF.01.01.01.01 Labor costs - Direct service providers	114.56	148.78	82.68	2.61	-	348.62	19.8%
PF.01.01.01.02 Fringe Benefits - Direct service providers	-	59.31	-	-	-	59.31	3.4%
PF.01.01.01.03 Performance based supplements, incentives	-	1.18	-	-	-	1.18	0.1%
PF.01.01.01.04 Consultants (external)	-	-	-	0.08	-	0.08	0.0%
PF.01.01.02 Program management personnel costs	10.45	181.54	-	-	-	191.99	10.9%

PF.01.01.02.01 Labor costs - Program management	-	151.85	-	-	-	151.85	8.6%
PF.01.01.02.02 Fringe Benefits - Program management	-	29.70	-	-	-	29.70	1.7%
PF.01.01.02.98 Program management personnel not disaggregated	10.45	-	-	-	-	10.45	0.6%
PF.01.01.98 Personnel not disaggregated		24.15		7.37	24.18	55.69	3.2%
PF.01.02 Other operational and programme management current expenditures	27.51	72.96	63.39	13.98	19.37	197.21	11.2%
PF.01.02.01 Office rental costs	-	-	-	5.77	-	5.77	0.3%
PF.01.02.02 Office utilities costs (electricity, water, heating, etc.)	0.03	-	-	0.39	3.10	3.53	0.2%
PF.01.02.03 Travel expenditure	1.01	59.11	37.61	0.80	4.31	102.84	5.8%
PF.01.02.04 Administrative and	26.47	13.85	25.79	7.01	11.95	85.07	4.8%

programme management costs							
PF.01.03 Medical products and supplies	233.24	60.98	185.78	3.16	0.10	483.26	27.4%
PF.01.03.01 Pharmaceuticals	218.46	-	116.49	-	0.08	335.03	19.0%
PF.01.03.01.01 Antiretrovirals	218.29	-	15.74	-	0.08	234.11	13.3%
PF.01.03.01.07 OI other than TB drugs	0.17	-	3.44	-	-	3.61	0.2%
PF.01.03.01.98 Pharmaceuticals not disaggregated	-	-	97.31	-	-	97.31	5.5%
PF.01.03.02 Medical supplies	-	45.07	46.55	2.96	0.02	94.59	5.4%
PF.01.03.02.02 Condoms	-	-	0.69	2.96	-	3.65	0.2%
PF.01.03.02.98 Medical supplies not disaggregated	-	45.07	45.86	-	0.02	90.95	5.2%
PF.01.03.03 Laboratory reagents and materials	14.09	-	19.48	-	0.00	33.57	1.9%
PF.01.03.03.01 HIV tests screening/diagnostics	-	-	10.50	-	0.00	10.50	0.6%
PF.01.03.03.03 CD4 tests	14.09	-	1.51	-	-	15.59	0.9%

PF.01.03.03.98 Reagents and materials not disaggregated	-	-	7.47	-	-	7.47	0.4%
PF.01.03.04 Non-medical supplies	0.70	15.80	3.26	-	-	19.75	1.1%
PF.01.03.04.02 Promotion and information materials	-	-	3.26	-	-	3.26	0.2%
PF.01.03.04.98 Non-medical supplies not disaggregated	0.70	14.50	-	-	-	15.20	0.9%
PF.01.03.04.99 Non-medical supplies n.e.c.	-	1.29	-	-	-	1.29	0.1%
PF.01.03.05 Office Supplies	-	-	-	0.20	-	0.20	0.0%
PF.01.03.98 Medical products and supplies not disaggregated	-	0.12	-	-	-	0.12	0.0%
PF.01.04 Contracted external services	2.86	66.01	24.26	0.05	-	93.18	5.3%
PF.01.05 Transportation related to beneficiaries	-	3.50	-	-	-	3.50	0.2%
PF.01.07 Financial support for beneficiaries	15.36	19.68	8.83	-	1.48	45.34	2.6%

PF.01.08 Training-Training related per diems/transport/other costs	0.21	18.68	-	5.09	5.17	29.15	1.7%
PF.01.09 Logistics of events, including catering services	0.15	0.05	-	1.46	3.73	5.39	0.3%
PF.01.10 Indirect costs	-	100.21	-	-	-	100.21	5.7%
PF.01.10.02 Indirect cost rate	-	100.21	-	-	-	100.21	5.7%
PF.01.98 Current direct and indirect expenditures not disaggregated	-	22.88	2.34	0.31	-	25.52	1.4%
PF.01.99 Current direct and indirect expenditures n.e.c.	-	14.75	-	-	-	14.75	0.8%
PF.02 Capital expenditures	59.69	20.46	29.85	0.65	0.01	110.66	6.3%
PF.02.01 Building	59.69	0.91	5.82	-	-	66.41	3.8%
PF.02.01.01 Laboratory and other infrastructure upgrading	-	0.18	-	-	-	0.18	0.0%
PF.02.01.02 Construction and renovation	59.69	0.73	-	-	-	60.42	3.4%

PF.02.01.98 Building not disaggregated	-	-	5.82	-	-	5.82	0.3%
PF.02.03 Other capital investment	-	19.55	19.73	0.65	0.01	39.95	2.3%
PF.02.03.01 Information technology (hardware and software)	-	-	0.12	0.65	-	0.78	0.0%
PF.02.03.02 Laboratory and other medical equipment	-	11.09	10.34	-	0.01	21.44	1.2%
PF.02.03.03 Non medical equipment and furniture	-	8.46	9.27	-	-	17.73	1.0%
PF.02.98 Capital expenditure not disaggregated	-	-	4.30	-	-	4.30	0.2%
Total	464.03	815.11	397.12	34.75	54.04	1,765.05	100.0%

The expenditure in the tables show that recurrent components took huge share being 92.5 percent in 2015/16, 91.8 percent in 2016/17 and 93.8 percent in 2017/18. Medical products and supplies consisting mainly of ARVs, laboratory reagents and materials, HIV tests diagnostics as well non-medical supplies took accounted for 48.5 percent total expenditure in 2015/16, 27.5 percent in 2016/17 and 27.5 in 2018/19. There was a decline in the absolute expenditure on the medical supplies between 2015/16 and 2016/17 and this was reversed in 2017/18. The largest component of the medical supplies was ARVs which accounted for 36.4 percent of total expenditure in 2015/16, 17.3 percent in 2016/17 and 19.1 percent in 2017/18.

Personnel as an input took significant share of the total expenditure, increasing from 25.7 percent in 2015/16 to 39.6 percent in 2016/17 and 37.2 percent in 2017/18. Although the percentage varied, the absolute expenditure on personnel increased steadily over the years. Operational and programme management cost consisting of administrative and programme management, travel, rent and utilities was the third component of the total expenditure accounting for 13.3 percent of the total expenditure in 2015/16,19.7 percent in 2016/17 and 11.1 percent in 2017/18. Other notable factor of production was training that accounted for 2.4 percent, 3.3 percent and 1.7 percent of total expenditure in 2015/16, 2016/17 and 2017/18, respectively. Additionally, financial support to the beneficiaries took 2.4 percent, 1.3 percent and 2.6 percent of total expenditure in 2015/16, 2016/17 and 2017/18, respectively.

3.16 HIV Spending and Projected Resource in Strategic Plan 2013 – 2016

The comparison was done for the financial year 2015/16 as this was the only year that was common to both NASA and the Strategic Plan. According to the Strategic Plan, total resource needs for the financial year 2015/16 was US$ 198 million. However, total expenditure from NASA for the year was US$ 105 million, this being only 53 percent of the resource needs according to the Strategic Plan. Figure shows comparison of the HIV expenditure and estimated resources for the different spending categories,

Figure 3.35: Resource needs and actual expenditure 2015/16

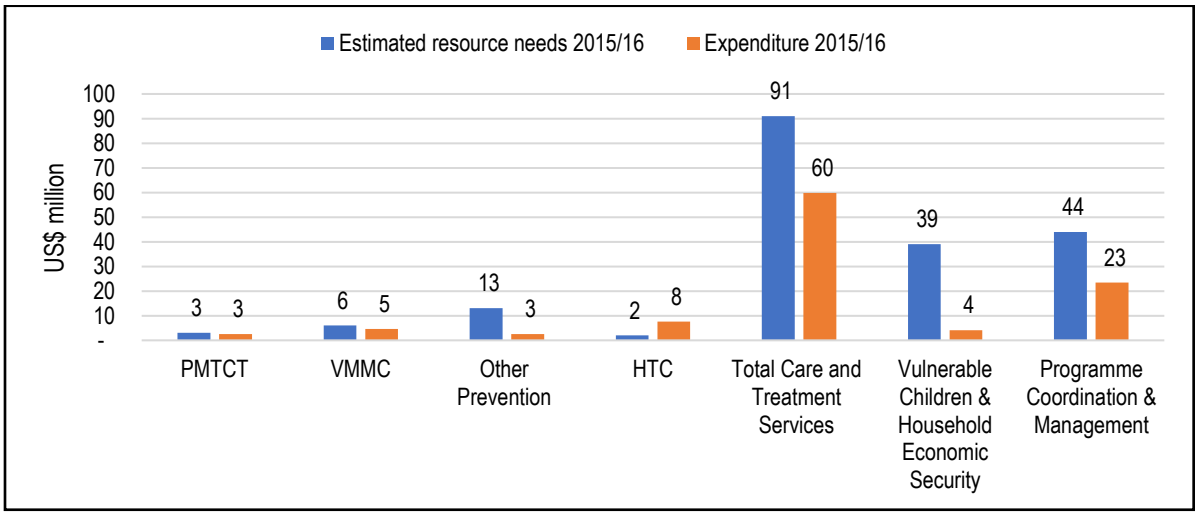


Figure 3.35 shows that all categories except HTC had expenditure falling short of the resources needs. While the had been estimated to cost US$ 2 million in 2015/16, actual expenditure was US$ 8 million. The expenditure on care and treatment was US$ 61 million which fell short of estimated resource requirements at US$ 91 million. It shown that OVC and safety nets for household was not given the priority it deserved as the expenditure was paltry US$ 4 million against the estimated resource needs of US$ 39 million.

4. SUMMARY, CONCLUSIONS AND IMPLICATIONS

4.1 Summary

Lesotho NASA 2019 was undertaken to find out the level of HIV spending in the country from the main sources of funding the HIV response. Three financing years, 2015/16, 2016/17 and 2017/18 were considered. The new NASA classifications framework was utilized where there were three dimensions consisting financing, provision and consumption and 9 vectors considered which entailed expenditure by financing entities, financing agents and purchasers, revenue streams, financing schemes, services providers, AIDS spending categories, production factors, service delivery mechanisms, and beneficiary population. Data were s collected from different sources and were processed using Excel files and Resource Tracking Tool (RTT).

The assessment results show that total expenditure on HIV and AIDS interventions in Lesotho increased steadily throughout the period of three years. There are only three main sources of funding the HIV response consisting Government of Lesotho, United States Government, and The Global Fund for AIDS, Tuberculosis and Malaria. The external sources contributed about 70 percent of the total expenditure. In this regards, international NGOs were the main financing agents. This notwithstanding, local government and faith-based health facilities dominated service provision. The results showed that interventions for care and treatment accounted for over 50 percent of the expenditure. This was followed by development enablers and interventions for prevention. As expected, the funding went to activities targeting at people living with HIV. Non-targeted intervention also took significant share of the expenditure followed by expenditure on activities for general population. Additionally, the results showed variations in expenditure across HIV interventions and also across the districts which may not augur well for optimized response nationally. The efficiency analysis showed that resource use efficiency can be increased, thus producing savings that ncan be harnessed to expand service provision.

4.2 Conclusions

The following conclusion can be drawn from the results:

- The resources for HIV response have been increasing, mainly attributes to PEPFAR programme.
- There is high risk of sustaining the funding of the HIV response because of bulk of the funding come from external sources.
- The contribution of the Government of Lesotho is critical and important. The fact the GoL finances about 80 percent of ARV as well providing human resources for service provision, themselves will reduce problem of financial sustainability of the response.
- There is inequality in funding the HIV response in the districts district with higher HIV burden had more than proportionate share of the expenditure than the districts with lower burden. This may suggest inequity in the financing.
- Children -related interventions are less prioritised. In terms of beneficiaries population, relatively minimal expenditure was realised for the children and youth.
- Low priority given to community system strengthening as compared to public system strengthening.

4.3 Key Recommendations

(i) Sustainability

The GoL should prioritize effort toward finding cost effective sustainable financing options for the response in the very neat future. Since the government is already funding the ARVs and human resources, improving sustainability may not require huge resources implications. It is recommended that government should continue to increase its contribution in order to ensure sustainability of the national response to HIV and AIDS.

(ii) Optimization of Response

A balance between funding prevention, and care and treatment need to be undertaken. The expenditure assessment seemed to point to underfunding of prevention interventions, specially targeted at key populations. The same applied to interventions for general population. However, it is noteworthy that the five pillars were shown to exhibit increasing expenditure over the three years.

(iii) Equity consideration

There is a strong need to improve equality allocation of funding to all the districts. However, there is need for analysis into the impact of a more equalized funding across the districts compared to concentrating funding on high burden districts.

(iv) Institutionalising Routine Expenditure Tracking

This is because data availability routine would assist the country to assess the performance of the response on regular basis. This is also a key component in monitoring whether funding is aligned to the priority interventions and if not aligned corrective measures can be put in place.

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