REPUBLIC OF MALAWI

NATIONAL AIDS SPENDING ASSESSMENT (NASA) REPORT

FY 2015/16, FY 2016/17, FY 2017/18 and FY 2018/19

The Malawi National AIDS Commission

August 2021

The Malawi National AIDS Commision
Providing Leadership and Coordinating the National Response to HIV and AIDS in Malawi

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NATIONAL AIDS SPENDING ASSESSMENT

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The Malawi National AIDS Commission

LILONGWE, MALAWI

August 2021

This National AIDS Spending Assessment was implemented by the National AIDS Commission through funding provided by UNAIDS and UNDP.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AGYW	Adolescent Girls and Young Women
ART	Anti-retroviral Therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BP	Beneficiary Population
DCT	Data Consolidation Tool
FAP	Financing Agent-Purchaser
FE	Funding Entity
FY	Financial year
GDP	Goss Domestic Product
GFATM	Global Fund for AIDS, Malaria and Tuberculosis
GAM	Global AIDS Monitoring
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HTC	HIV Testing and Counselling
MWK	Malawian Kwacha
MOH	Ministry of Health
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NHA	National Health Accounts
NSP	National Strategic Plan
PF	Production Factor
PEPFAR	Presidents Emergency Fund for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PrEP	Prevention of Mother to Child Transmission of HIV

PS	Provider of Service
REV	Revenue
RM	Resource Mapping
RTT	Resource Tracking Tool
SBCC	Social and Behaviour Change Communication resource mapping
SCH	Financing scheme
SDM	Service Delivery Modality
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	Joint United Nations Program on AIDS
USD	United States of America Dollar
USD	United States of America Dollar

Executive Summary

Background

Recent past ad hoc analysis has indicated that HIV funding in Malawi predominantly comes from Development Partners, with minimal financial resources coming from domestic sources. Future funding projections portray decreasing numbers of development partners funding the HIV response. The expected decrease in partner funding and the ever-increasing need for ART calls for a focus on HIV financing. Therefore, the Government of Malawi continues to address low domestic resource mobilisation to ensure increased resources for HIV services in the country. In an effort to inform financing of the response, tracking of funding that has been available for the response was commissioned by the Government through the National AIDS Commission. Tracking of financial flows within the HIV sector is facilitated by UNAIDS developed methodology called the National AIDS Spending Assessment. The tracking results inform financing policy by providing information on the role of various stakeholders in financing the response, how the financial resources fit within the overall national response, which groups are being targeted, which programmes are being prioritized, and the funding gaps evident.

The National AIDS Spending Assessment, in tracking resource flows and funding for the HIV response, also provides information needed for tracking the progress of the targets under the Declaration of Commitment on HIV/AIDS that were adopted by the United Nations General Assembly Special Sessions on HIV in 2001. The importance notwithstanding, the last National AIDS Spending Assessment in Malawi was conducted in 2011/12, covering expenditure for 2007/08 and 2008/09. As a result, ad hoc expenditure analyses have been conducted yearly for generating indicator 8.1 for Global AIDS Monitoring reporting.

Purpose and objectives

The primary objective was to collect data on HIV expenditures in Malawi for 2015/16 to 2018/19 using the National AIDS Spending Assessment methodology. Specific objectives were:

a) To implement a methodology for systematic monitoring of HIV financial flows at the national level using the NASA methodology in Malawi;
b) To adapt the NASA methodology, classification and tools to the Malawi context;
c) Build national-level capacity for systematic monitoring of HIV/AIDS financing flows using the NASA methodology, with a view to a yearly, fully-institutionalized NASA, but harmonized with resource mapping (RM) and national health accounts (NHA).
d) To conduct an HIV spending assessment focusing on public and development partner (external) resources and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities.
e) To collect (or estimate) the household/ individual out-of-pocket expenditure (OOPE) for HIV-related health services.
f) To identify and measure the flow of resources for HIV by the funding entity *(FE),* revenue *(REV),* financing scheme *(SCH),* financing agent-purchaser *(FAP)*, service

provider *(PS),* the service delivery modality *(SDM),* function/ intervention *(ASC)*, cost components (factors of production, *PF*) and beneficiary populations *(BP)*.

Methodology

The National AIDS Spending Assessment NASA for Malawi was implemented as part of a harmonized and fully integrated data collection process for the seventh round of Malawi's Health Sector Resource Mapping. The harmonization enabled data collection jointly in order to provide data for resource mapping, the National Health Accounts and the National AIDS Spending Assessment. A sample of 431 entities was selected for the harmonized data collection, encompassing the government, partners, and private sectors. Data collection was carried out between September 2020 and March 2021.

The RM data collected were verified and checked for errors before combined in a data set. Data for NASA requirements were cross-walked from this data set. The mapped HIV expenditure data were entered into Data Consolidation Tool for further processing. The data from DCT files were transferred to Resource Tracking Tool (RTT generation of summary tables and analysis according to the six dimensions of NASA.

Results

The total HIV expenditure from the main financing entities was MWK 154,276 million (USD 268 million) in 2015/16, MWK 234,230 million (USD 328 million) in 2016/17, MWK 219,570 million (USD 302 million) in 2017/18 and MWK 256,286 million (USD 352 million) in 2018/19. The results showed that there were three main specific financing sources, consisting of the Government of Malawi, the United States Government and the Global Fund for AIDS, Malaria and Tuberculosis. The three entities contributed 93 per cent of the total HIV expenditure in 2015/16, 94% per cent in 2016/17, 92 per cent in 2017/18 and 96 per cent in 2018/19.

The contribution to total HIV expenditure for the Government of Malawi was as follows: MWK 33,563 million (USD 58.32 million) in 2015/16, MWK 38,615 million (USD 54.04 million) in 2016/17, MWK 45,930 million (USD 63.09 million) in 2017/18 and MWK 45,343 million (USD 62.26 million) in 2018/19. In GFATM financing amounted to MWK 59,845 million (USD 103.99 million) in 2015/16, MWK 105,071 million (USD 147.03 million) in 2016/17, MWK 68,818 million (USD 94.52 million) in 2017/18, and MWK 106,350 million (USD 146.04 million) in 2018/19. Additionally, funding from the Government of the United States increased progressively from MWK 50,392 million (USD 87.57 million) in 2015/16 to MWK 77,392 million (USD 108.30 million) in 2016/17, MWK 87,323 million (USD 119.94 million) in 2017/18, and MWK 94,086 million (USD 129.20 million) in 2018/19.

Overall, international entities were the main sources of funding for HIV response in Malawi and contributed about 80 per cent of the total expenditure each year. The government contribution was at about 20 per cent overall, and it was mainly in terms of human resources for health. While these results underscore the importance of international sources, they also point to the problem of sustainable financing of HIV in Malawi.

Public sector entities, as financing agents, accounted for the highest percentage of expenditure, followed by international purchasing organisations. Furthermore, government entities were also the leading providers of HIV services in all the years, accounting for 68 per cent of total HIV expenditure in 2015/16, 65.3 per cent in 2016/17, 64.7 per cent in 2017/18 and 59.3 per cent in 2018/19. Service delivery modalities are the modes used by service providers to deliver HIV services to the beneficiary populations. The results showed that facility-based delivery modalities accounted for the highest share of expenditure at over 60 per cent each year, followed by non-applicable SDM at slightly above 21% and community-based Service delivery modalities at less than 10 per cent.

In terms of HIV services, care and treatment took the highest share of expenditure in each year, at about 61.1 per cent in 2015/16, 61 per cent in 2016/17, 51.3 per cent in 2017/18 and 61.5 per cent in 2018/19. Programme enablers and systems strengthening accounted for the second-largest share of total expenditure, 24 per cent in 2015/16, 20 per cent in 2016/17, 24 per cent in 2017/18 and 15 per cent in 2018/19. HIV testing and counselling took the third-largest share of expenditure, followed by HIV prevention. The United States Government and the Global Fund to Fight AIDS, Tuberculosis and Malaria were the main sources of funds for financing prevention activities. The Government of Malawi supported the prevention effort, contributing 8.1 per cent in 2015/16, 4.5 per cent in 2016/17, 4.4 per cent in 2017/18 and 4.2 per cent in 2018/19.

Care and treatment encompassed various interventions, including ART and opportunity infections prevention and treatment GFATM was the leading financing entity (54%), followed by the Government of Malawi (27%) and the United States Government (18%). The funding from the GFATM increased significantly between 2015/16 and 2016/17 but decreased between 2016/17 and 2017/18 and increased by a margin in 2018/19. The funding from United States Government increased steadily over the three years with a decrease in the last year. The Government of Malawi funding increased over the four years but was mainly indirect through human resources for health.

Sources of funds for HIV testing and counselling were mainly from the Government of the United States, followed by the Government of Malawi, mainly through staff expenditure, GFATM and other international sources.

In terms of programme support services called programme enablers, public systems strengthen took the largest share of spending on programme enablers, 21% in 2015/16, 30% in 2016/17, 29% in 2017/18 and 43% in 2018/19. Programme administration and management costs were the second main category (24% in 2015/16, 27% in 2016/17, 28% in 2017/18 and 22% in 2018/19). The sources of funds for this largest category were USG and GFATM. People living with HIV were the main beneficiaries taking 60 per cent of the expenditure in four years. The non-targeted intervention took the second largest (21%) of the expenditure

Recurrent expenditure took a huge percentage of over 94 per cent each year. Medical products and supplies consisting mainly of ARVs, laboratory reagents and materials, HIV tests

diagnostics as well non-medical supplies accounted for 47 per cent of total expenditure in 2015/16, 82 per cent in 2016/17, 66 per cent in 2017/18 and 79 per cent in 2018/19. The largest component of the medical supplies was ARVs which accounted for 26 per cent of total expenditure in 2015/16, 44 per cent in 2016/17, 32 per cent in 2017/18 and 61 per cent in 2018/19. Personnel as an input took a significant share of the total expenditure, 32 per cent in 2015/16 to 34 per cent in 2016/17, 40 per cent in 2017/18 and 45 per cent in 2018/19. Operational and programme management cost accounted for 8.7 per cent of the total expenditure in 2015/16, 15.3 per cent in 2016/17, 13.2 per cent in 2017/18 and 14.6 per cent in 2018/19.

The results have showed that total expenditure was more cost of most of interventions a in the Malawi national HIV strategic plan for the period. However, the expenditure on some key areas such as prevention, HTC , OVC and social protection was less than estimated costing the NSP 2015-2020.

Conclusions

The following conclusion can be drawn from the results:

a) The funding for the HIV response, the country, as flattened.
b) The funding relies heavily on two external sources, the GFATM and the Government of the United States.
c) There is a high risk of sustaining the funding of the HIV response because the bulk of the funding comes from external sources.
d) The contribution of the Government of Malawi is important, but it is mainly indirect through funding of human resources for health.
e) Low priority given to social enablers and social support programmes.
f) There was balanced prioritisation of expenditure across prevention and care and treatment, but generally, there were variances in estimated costs and actual expenditure.

Recommendations

1. In view of the stagnation in external funding and increase in need of care and treatment, it is essential for the Government of Malawi needs to urgently explore sustainable ways for financing the response. Increase government allocation from own domestically generated revenue will go a long way in reducing the sustainability problem.
2. However, there is an extent to which the Government can allocate additional funding given fiscal space constraints and funding needs for other sectors. Therefore, finding cost-effective, sustainable financing options is also imperative.
3. In addition to funding HRH, the Government should consider more direct funding for HIV interventions.
4. Need to relook at unit costs used NSPs to determine the reasons for variances in NSP costs and expenditure.

1 INTRODUCTION

1.1 National Development Context

Malawi is a landlocked south-east African country covering 118,500 square kilometres. It is bordered by Zambia, the United Republic of Tanzania and Mozambique, and has a 750-kilometre-long border with Lake Malawi. According to the Government of Malawi (2019), the total population in the 2018 Malawi population and housing was 17,563,749. The population is generally young, with 51 per cent under the age of 18 years. Additionally, the population growth is relatively high, with an annual growth rate of 2.9 per cent between 2008 and 2018. This population growth notwithstanding, the total fertility rate (TFR) has been falling. For instance, it was at 4.4 children per woman in 2015/16 compared to 6.7 in 1992.

Malawi is a low-income country with a per capita gross domestic product (GDP) of MWK 190,561 (USD 331.14[1]) in 2015, MWK 225,490 (USD 315.55) in 2016, MWK 258,834 (USD 355.52) in 2017, MWK 277,118 (USD 380.53) in 2018 and MWK 304,326 (USD 411.55) in 2019. The economic growth rate has been modest over the recent past. It grew at 2.8 per cent in 2015, 2.4 per cent in 2016, 4.0 per cent in 2017, 3.2 per cent in 2018 and 4.4 per cent in 2019. According to World Bank (2020), Malawi's economy has been heavily affected by COVID-19, with economic growth projected at 1.0 per cent in 2020, consequently reducing GDP per capita by 2.0 per cent in the year.

The country has made good progress in building its human capital in terms of knowledge, skills and health, with life expectancy at birth at 63.7 years in 2018 and self-reported literacy for the population aged 15 years and above at 83.0 for males and 68.8 for females. However, poverty and inequality remain stubbornly high, with a national poverty rate of 51.5 per cent in 2016 (World Bank, 2021b).

[1] World Bank.2021a. Retrieved from https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MW.

1.2 Country's HIV/AIDS Response and Policy Framework

The goal of the National Strategic Plan for HIV and AIDS (NSP 2015-2020) was to prevent the further spread of HIV infection, promote access to treatment for PLHIV and mitigate the health, social-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation. The NSP set an ambitious target of 90:90:90. This target entailed that by 2020, Malawi would have 90% of people living with HIV knowing their status, 90% of those known to be HIV positive initiated on treatment and 90% of patients on treatment would be retained in care and adhere to Antiretroviral Therapy (ART), so that their viral load is suppressed. The aspiration to attain this ambitious target would ensure that Malawi has an AIDS-free nation by 2030. The NSP 2015-2020 coincided with the period of NASA analysis.

HIV funding in Malawi predominantly comes from Development Partners, with minimal financial resources coming from domestic revenue collections and loans from multilateral agencies, among other sources. According to the 2018 Global AIDS Monitoring Report, approximately 97% of all funding in the reporting period originated from development partners. This, combined with the decline in resources and the ever-increasing number of ART patients, creates an environment in Malawi where investing for optimal results is the focus of HIV financing. The Government of Malawi is compelled to do more with less. Future funding projections depict decreasing numbers of development partners funding the response, particularly with the ending of the World Bank-funded Nutrition, HIV and AIDS Project, which was among the limited predominant sources of HIV and AIDS financing. In light of the prevailing declining funding towards health and HIV and AIDS, the Government of Malawi continues to address low domestic resource mobilization by exploring other financing modalities; and ensuring that critical social sectors such as health make up a significant proportion of the national budget.

1.3 Tracking the Expenditure on HIV/AIDS – Globally and in Malawi

The multisectoral nature of the national response to HIV and AIDS in Malawi entailed various actors from different sectors, including external sources. In efforts to support these aims, the Government commissioned a resource tracking exercise through the National AIDS

Commission to track financial flows from all the different sources down to the level of service utilization. It is imperative for those supporting the response to understand and know how their financial resources fit within the overall national response, which groups are being targeted, which programmes are being prioritized and the funding gaps evident.

Thus, the National AIDS Spending Assessment (NASA) is crucial in the country's resource tracking activities. It establishes the flow of financial resources going towards the national HIV response. In addition, NASA is relevant in tracking the progress of the targets under the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Sessions on HIV in 2001. The last NASA in Malawi was conducted in the 2011/12 Financial Year and covered fiscal years 2007/08 – 2008/09 with over 120 organizations participating in the exercise. However, the response rate from Government institutions was very limited, with non-inclusion of capital and human resource expenditure by the Government. Since then, ad hoc expenditure analyses have been conducted yearly for merely informing indicator 8.1 in Global AIDS Monitoring (GAM) reporting.

Therefore, it was expedient that Malawi conducted a comprehensive NASA to capture financial flows from external sources (donors and international organizations) and government, including human resource expenditure on HIV and AIDS.

1.4 Purpose and Objectives

The primary objective was to collect data on HIV expenditures in Malawi for financial years 2015/16 to 2018/19 using the National AIDS Spending Assessment methodology. Specific objectives were:

g) To implement a methodology for systematic monitoring of HIV financial flows at the national level using the NASA methodology in Malawi;
h) To adapt the NASA methodology, classification and tools to the Malawi context;
i) Build national-level capacity for systematic monitoring of HIV/AIDS financing flows using the NASA methodology, with a view to a yearly, fully-institutionalized NASA, but harmonised with resource mapping (RM) and national health accounts (NHA).

j) To conduct an HIV spending assessment focusing on public and development partner (external) resources and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities.

k) To collect (or estimate) the household/ individual out-of-pocket expenditure (OOPE) for HIV-related health services.

l) To identify and measure the flow of resources for HIV by the funding entity *(FE),* revenue *(REV),* financing scheme *(SCH),* financing agent-purchaser *(FAP)*, service provider *(PS),* the service delivery modality *(SDM),* function/ intervention *(ASC)*, cost components (factors of production, *PF*) and beneficiary populations *(BP)*.

1.5 Scope of The Assessment

This assessment focused on tracking national HIV expenditure for 2015/16, 2016/17, 2017/18, and 2018/19. Expenditure data on HIV activities included public (Government), domestic private sources, and international sources. Household out of pocket (OOP was excluded because of a lack of studies on population health expenditure and utilisation.

1.6 Study Limitations

There were a couple of limitations that were encountered in the development of the NASA report. First was the delay in the implementation of the NASA data collection due to COVID-19. While the study was anticipated to be completed in May 2020, the data collection was up to September 2020. Additionally, the data collection was mainly online due to COVID-19 and this approach too long to obtain most of the data. However, all the major players in the sector provided the data.

The data collection covered only one financial year, 2018/19, while the data for 2015/16, 2016/17 and 2017/18 were obtained from the Resource Mapping (RM) 6 exercise that had been completed in 2019. The RM 6 was focused on collecting budget data and expenditure data for resource tracking and for use by the National Health Accounts. The RM 6 data, while relevant and adequate for NASA purposes, were not granular enough for some intervention

classifications. This granularity problem necessitated the use of descriptions of activities in the RM 6 to align the activities to NASA classifications. The RM 6 data also seemed to have aggregated too much on the factors of production. The RM 7 NASA incorporated the NASA classifications. The RM 7 involved collecting expenditure data for the financial year 2018/19 for both NASA and NHA resource flow tracking.

The RM 6 data also understated expenditure for PEPFAR for 2015/16, 2016/17 and 2017/18. Therefore, additional data on HIV expenditure by the Government of the United States were obtained from the PEPFAR expenditure website.

The out-of-pocket was not included, although it was one of the objectives of the study. This exclusion was due to the lack of a recent survey on household expenditure on health services and the lack of expenditure studies on people living with HIV. The only available study was one conducted in 2011 that was too old to provide reliable estimations. This NASA did not have enough resources to conduct an expenditure survey on the households and individuals. The expenditure on HIV by the domestic private sector was also not included in the study by design. It was not part of the objectives of the study.

Lastly, the indirect expenditure on HIV by the government, through facility running costs, was not included due non-availability of the disaggregated data at the district level.

The limitations notwithstanding, the report accurately represents the financing of HIV activities in the country during the period under consideration.

2 METHODS AND DATA SOURCES

2.1 Integrated Process

Historically, RM, NHA and NASA have been conducted as parallel exercises; however, the previous round of RM was the first to integrate data collection with the NHA. The NASA was implemented as part of a harmonised and fully integrated data collection process for the seventh round of Malawi's Health Sector Resource Mapping, the National Health Accounts (NHA) and the National AIDS Spending Assessment (NASA). The RM, NHA and NASA differ in their specific objectives, but all serve to improve the understanding of the health sector's resources, which in turn can be used to strengthen aid coordination and channel resources towards the most cost-effective interventions as prioritized within the Essential Health Package (EHP).

NASA was integrated for the following reasons:

1. To reduce the time burden on submitting organizations and the MOH,
2. To enable cost savings through the use of the same data enumerators for both exercises,
3. To ensure the sustainability of the NASA process in the future - RM and NHA are both annual exercises for which capacity within the MOH has been developed. By integrating NASA into the routine processes of the MOH, there is greater assurance that the exercise can be conducted in the future by MOH/NAC officers.

Under the harmonized process, a single data collection tool was developed, and it integrated the requirements for RM, NHA and NASA. The tool was used to collect data from government entities, bilateral/multilateral partners, and NGOs.

2.2 Sampling

The study used the sample already used in the previous RM but with some additional organizations. A total of 431 were selected, encompassing the government sector, partners and the private sector. The sample ensured that almost all financing sources, financing agents and implementers were captured. However, the sample of 431 was for the needs for RM,

NHA and NASA and; therefore, not all the entities were engaged in HIV activities. The sample of entities that provided data for NASA was 94 in the RM 6 and 52 in the RM 7.

2.3 Data Collection Tool

An Excel-based data collection template was adapted from the previous RM-NHA round 6 and shared with all submitting organizations. The template captured expenditure data for FY 2018/19 and budgets for FY 2020/21 and FY 2021/2022. For each activity, the template included specific data elements to answer the key questions of the RM, NHA and NASA exercises. The data elements were broadly divided into six categories: (1) Financiers and Implementers; (2) Programs, Projects, and Activities; (3) HSSP II Alignment; (4) Geography; (5) In-Service Training Details, and (6) Currency and Budgeting. Furthermore, each of these data elements will be cross-walked to the corresponding categories within the NHA and NASA. The key elements captured in the data collection tool and the correspondence between exercises are outlined in Table 2.1.

Table 2.1: Data collection elements and correspondence between exercises

	Type	Data Element	Definition of Data Element	Illustrative Example
1	Financiers and Implementers	**Submitting Organization**	Organization that submitted budgeting information	Action Aid
		Financing Source	The organization or entity financing the activity	Global Fund
		Primary Implementing Agent	Primary organization or entity that is carrying out implementation	Action Aid
		Sub-Implementing Agent	Additional organization or entity carrying out the activity as a sub-grantee of the Primary Implementing Agent, if applicable	Southern African AIDS Trust
2	Programs, Projects, Activities	**Project Name**	Specific project that is supported by the activity	TB/HIV Epidemic Control
		Activity	Free-form text to describe the specific activity within the intervention	Comprehensive programs for people in prisons
		Programmatic Function*	Programmatic area, function, or disease supported by the activity	HIV Including Viral Hepatitis and other STIs
		Programmatic Intervention Level 1*	General intervention supported by the activity, dependent on the programmatic function	Prevention

	Type	Data Element	Definition of Data Element	Illustrative Example
		Programmatic Intervention Level 2*	Detailed intervention supported by the activity, dependent on the programmatic intervention level 1	Behaviour Change Communication for HIV
		EHP Intervention	Alignment to Malawi's Essential Health Package interventions	Community Health Promotion & Engagement
		Target Population*	Subpopulation targeted for HIV, TB, and malaria interventions only	People in prisons and other closed settings
3	HSSP II Alignment	**HSSP II Objective***	Classification of activities according to the relevant Health Sector Strategic Plan II (HSSP II) objectives	Human Resources for Health
		HSSP II Sub-Area*	Classification of activities according to the relevant Health Sector Strategic Plan II (HSSP II) sub-areas, dependent on the selection for HSSP II objective	Health worker training – in-service
4	Geography	**District**	Percentage of funding earmarked for specific district(s); if central level, can be specified as 100% central level	50% Mwanza, 50% Thyolo
5	In-Service Training Details**	**Type of Training***	Modality of the training, i.e., on the job (i.e., taking place at a health facility), offsite, or virtual/online	Offsite
		Health Worker Cadre Type*	The health worker cadre type targeted by the training, e.g., pharmacy, nursing, laboratory, etc.	Nursing
		Health Worker Cadre*	The specific health worker cadre targeted by the training, dependent on the selection for health worker cadre type	Nurse Officer
		# of Health Workers Targeted	Total number of health workers trained from July 2019 - June 2020.	50
		Activity Frequency	Frequency of the trainings, i.e., annually, biannually, quarterly, monthly, or other	Quarterly
		Monthly Implementation Plan	Tentative implementation timeline for the training, disaggregated by month, from July 2019 – June 2020	Implemented from March – May 2020
6	Currency and Budgeting	**Currency**	Currency of the submitting organization's budget	USD
		Fiscal Year Start Month	Fiscal year start month of the submitting organization	July
		Expenditures by Year	Expenditure amount per year for FY 2018/2019	USD 100,000 annually

	Type	Data Element	Definition of Data Element	Illustrative Example
		Budgets by Year	Budget amount per year for FY 2019/2020, FY 2020/2021 and FY 2021/2022	USD 150,000 annually

2.4 The NASA Classifications

The new NASA classifications are available for the NASA assignment in the country. In the new NASA classifications, there are three dimensions and nine vectors of capturing expenditure. The three dimensions are financing, provision and use. 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 funding entities or pools which are sources of financing HIV and AIDS interventions. Health care financing schemes (SCH) are the main financing arrangements through which people obtain health services and include direct payments by households for services and goods and third-party financing arrangements. Revenue (REV) embody the different financing types pooled into the various financing schemes. FAP are entities that mobilise financial resources from different financing sources (pools) and transfer them to pay for or 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 institutional entities that produce and provide health care goods and services, which benefit individuals or population groups. SDM are channels of service providers such as public health facilities, private health facilities and NGOs. These providers use inputs, called factors of production, such as human resources, materials, and utilities, to produce HIV and AIDS services.

There are two classes for capturing expenditure in the use dimension, entailing the services referred to as AIDS spending categories (ASC) and beneficiary populations (BP). 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. 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 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 include the Five Pillars for achieving less than 500 000 new infections by 2020.

2.5 Data Processing

The RM data collected were be verified and checked for errors before they were combined in a data set. Data for NASA requirements were cross-walked from this data set. The cross-walk was necessary before proceeding. Specifically, for the cross-walk, NASA data variables were introduced in the RM 6 and RM 7 data spreadsheets resulting in the direct mapping of the NASA to RM-NHA database. RM 6 covers 2015/16, 2016/17 and 2017/18 and 2018/19.

The first operation in the cross-walk was to link all the financing sources in the Resource Mapping RM 6 and RM 7 database to three NASA data elements, namely, Financing Entity (FE); Revenue (REV); and Financing Scheme (SCH). This step involved creating a sheet in which the said elements were linked and introducing formulas in the three NASA columns (FE, REV and SCH) so that in every transaction or row, the FE, REV and SCH columns could be read into the financing source and automatically determine their respective values.

The second operation was to link primary implementing agents and, where applicable, sub-implementing agents in the RM data to NASA's Financing Agent and Purchaser (FAP) and Providers of Services (PS) so that the columns of the two said NASA elements would be filled

automatically. During the rigorous cross-walk process, five NASA data elements were mapped as mentioned, and these included FE, REV, SCH, FAP and FE. The data elements that remained for mapping manually included: AIDS Spending Category (ASC); Service Delivery Mode (SDM); Beneficiary Population (BP); and Production Factor (PF).

2.6 Data Analysis

Once the data mapping was done, the data were entered into Data Consolidation Tool (DCT) for further processing. The data from DCT files were transferred to Resource Tracking Tool (RTT). The consultants undertook the analysis and generated summary, tables, graphics and analysis according to the six dimensions of NASA.

2.7 Quality Assurance

To ensure quality control of the data collection, the Local Consultant, with the support of the Ministry of Health RM team, supervised data collection. In addition, some of the research assistants that have been involved in similar assignments were assigned supervisory role. The Local Consultant and the MOH RM team checked the filled questionnaires on a daily basis, and where there were gaps, they were addressed promptly. The soft data forms were also shared with the International Consultant. The MOH RM team took some days to review and clean all the data before submitting data for NASA.

3 EXPENDITURE ANALYSIS RESULTS

3.1. Total Expenditure on HIV Activities

The trend in total HIV spending In Malawi is shown in Figure 3.1 and Table 3.1. The expenditure was from all the main sources of funding for the HIV and AIDS intervention in the country.

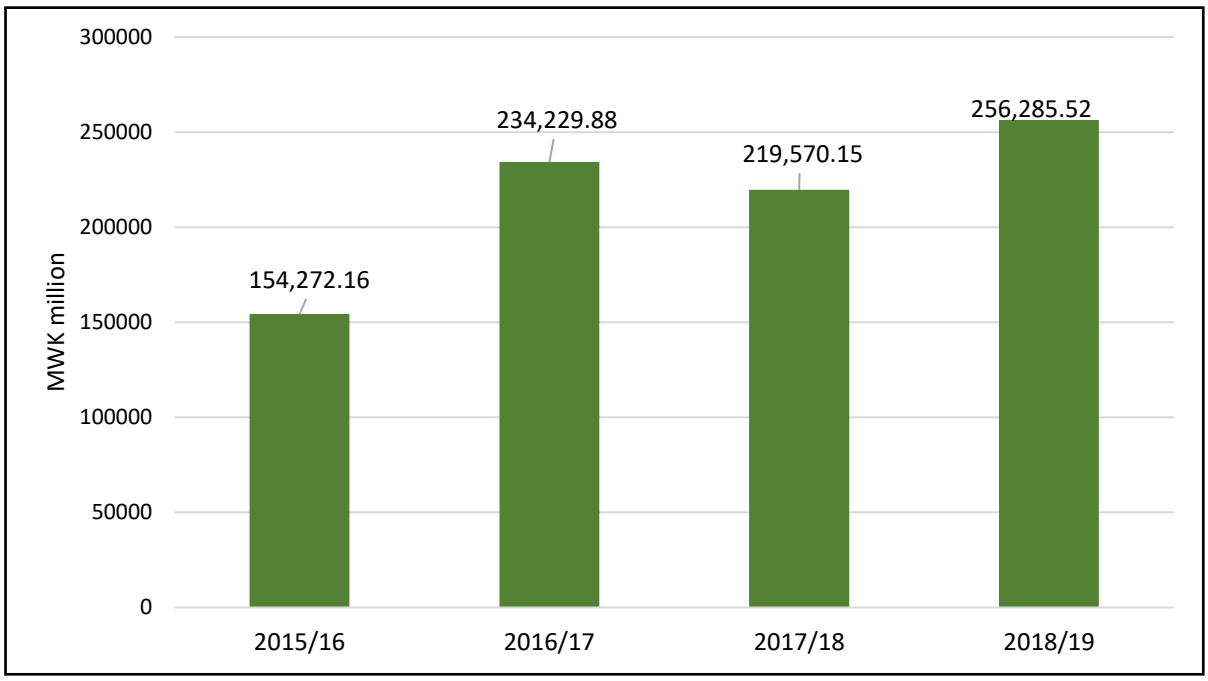


Figure 3.1: Total HIV expenditure

Table 3.1: Total HIV expenditure

Year	MWK million	USD million
2015/16	154,276.16	268.08
2016/17	234,229.88	327.78
2017/18	219,570.15	301.59
2018/19	256,285.52	351.92

Table 3.1 and Figure 3.1 shows that total expenditure from the main financing entities was MWK 154,276 million (USD 268 million)[2] in 2015/16, MWK 234,230 million (USD 328 million) in 2016/17, MWK 219,570 million (USD 302 million) in 2017/18 and MWK 256,286 million

2 Exchange rate of MWK 575.48 = USD 1 in 2015/16, MWK 714.61= USD 1 in 2016/17, MWK 728.04 = USD 1 in 2017/18 and MWK 728.25 = USD 1 in 2018/19. Source: United Nations.

(USD 352 million) in 2018/19. Although there was a marked increase in the total HIV expenditure between 2015/16 and 2016/17, the trend thereafter was almost plateauing or stagnant. The per capita HIV spending in the country is shown in Figure 3.2.

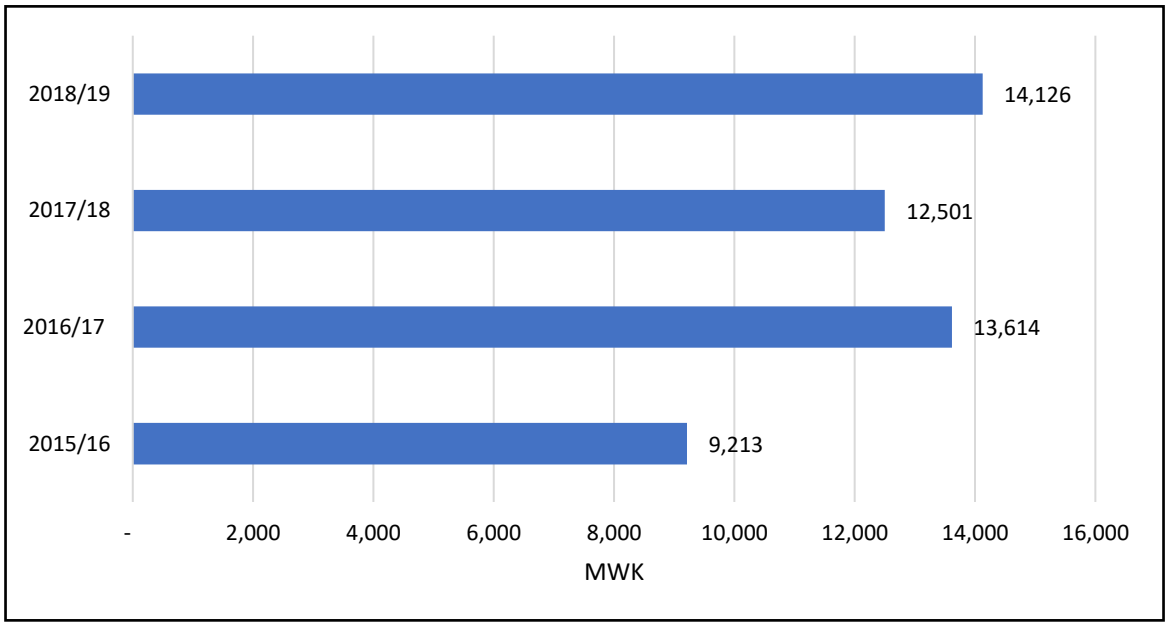


Figure 3.2: Trend in per capita HV expenditure

Figure 3.2 shows that per capita expenditure increased from MWK 9,213 (USD 16.01) in 2015/16 to MWK 13,614 (USD 19.05) in 2016/17 but declined to MWK 12,501 (USD 17.17) in 2017/18 and then increased to MWK 14,126 (USD 19.40) in 2018/19. The trend in per capita HIV expenditure mirrored the total expenditure trend, although the total population increased in the period under consideration.

3.2. HIV and AIDS Expenditure by Financing Entities

The main financing entities (FE) were sources of funds for HIV interventions implementation in Malawi. The total expenditure in absolute amount and percentages is presented in Table 3.2 and Table 3.3, respectively.

Table 3.2: HIV expenditure by financing entities (MWK million)

Financing Entity	2015/16	2016/17	2017/18	2018/19	Total
FE.01 Public Entities	33,564.99	38,618.30	45,956.02	45,342.69	163,481.99
FE.03 International Entities	120,707.18	195,611.58	173,614.13	210,942.83	700,875.72
Total	154,272.16	234,229.88	219,570.15	256,285.52	864,357.72

Table 3.3: HIV Expenditure by financing entities (%)

Financing Entity	2015/16	2016/17	2017/18	2018/19	Total
FE.01 Public Entities	21.76%	16.49%	20.93%	17.94%	18.91%
FE.03 International Entities	78.24%	83.51%	79.07%	82.31%	81.09%
Total	100%	100%	100%	100%	100%

Public sector entities consisting of the Government of Malawi contributed, to the total HIV expenditure, MWK 33,565 million (USD 58.33 million) in 2015/16. The contribution by the Government increased modestly to MWK 38,618 million (USD 54.04 million) in 2016/17 and further increased to MWK 45,956 million (USD 63.12 million) in 2017/18 but stagnated between 2017/18 and 2018/19 where it was MWK 45,343 million (USD 62.26 million) in 2018/19. The total contribution to the HIV expenditure from international entities or sources fluctuated over the period of the four years, being MWK 120,707 million (USD 209.75 million) in 2015/16, MWK 195,612 million (USD 273.73 million) in 2016/17, MWK 173,614 million (USD 238.47 million) in 2017/18, and MWK 210,942 million (USD 289.66 million) in 2018/19.

Table 3.3 shows that, over the period, international entities were the main sources of funding for HIV response in Malawi and contributed about 80 per cent of the total expenditure each year. While these results underscore the importance of international sources, they also point to the problem of sustainable financing of HIV in Malawi. The government contribution was at about 20 per cent overall, and it was mainly in terms of human resources for health. The detailed listing of expenditure by some specific financing entities is shown in Table 3.4.

Table 3.4: Expenditure by detailed financing entities (MWK million)

Financing Entity	2015/16		2016/17		2017/18		2018/19		Total	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%	MWK million	%
FE.01.01.01 Government of Malawi	33,564.99	21.8%	38,618.30	16.5%	45,956.02	20.9%	45,342.69	17.7%	163,482.00	18.9%
FE.03.01.05 Government of Canada	0.09	0.00%	-	0.00%	-	0.0%	19.76	0.0%	19.85	0.0%
FE.03.01.09 Government of Germany	49.49	0.03%	63.82	0.03%	89.52	0.0%	69.4	0.0%	272.23	0.0%
FE.03.01.12 Government of Ireland	17.62	0.01%	-	0.00%	-	0.0%	7.61	0.0%	25.23	0.0%
FE.03.01.13 Government of Italy							46.51	0.0%	46.51	0.0%
FE.03.01.14 Government of Japan			0.68	0.00%	4.11	0.0%		0.0%	4.78	0.0%
FE.03.01.17 Government of Netherlands			8.06	0.00%	63.32	0.0%		0.0%	71.38	0.0%
FE.03.01.19 Government of Norway	39.41	0.03%	0.02	0.00%	-	0.0%	0.48	0.0%	39.91	0.0%
FE.03.01.26 Government of Sweden	824.57	0.53%	779.94	0.33%	499.29	0.2%	68.07	0.0%	2,171.88	0.3%
FE.03.01.27 Government of Switzerland	7.35	0.00%	47.73	0.02%	44.66	0.0%		0.0%	99.74	0.0%
FE.03.01.29 Government of United Kingdom	8.2	0.01%	2.12	0.00%	-	0.0%	124.33	0.1%	134.66	0.0%
FE.03.01.30 Government of United States	50,391.99	32.66%	77,392.04	33.0%	87,323.26	39.8%	94,086.34	36.7%	309,193.62	35.8%
FE.03.02.05 International Organization for Migration (IOM)					4.64	0.0%			4.64	0.0%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	59,844.53	38.79%	105,071.28	44.9%	68,818.03	31.3%	106,350.11	41.5%	340,083.95	39.3%
FE.03.02.08 UNAIDS Secretariat	192.39	0.12%	111.18	0.1%	66.68	0.0%	72.43	0.0%	442.68	0.1%
FE.03.02.09 United Nations Children's Fund (UNICEF)	592.5	0.38%	1,025.89	0.4%	778.6	0.4%	133.09	0.1%	2,530.08	0.3%

FE.03.02.11 United Nations Development Programme (UNDP)	101.75	0.07%	30.54	0.0%	18.42	0.0%	83.99	0.0%	234.68	0.0%
FE.03.02.15 United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms							305.14	0.1%	305.14	0.0%
FE.03.02.17 United Nations Population Fund (UNFPA)	2.88	0.00%	3.57	0.0%	232.91	0.1%	113.91	0.0%	353.27	0.0%
FE.03.02.18 World Bank Group (WB)	3,241.98	2.10%	5,365.60	2.3%	3,508.88	1.6%		0.0%	12,116.47	1.4%
FE.03.02.20 World Health Organization (WHO)	121.43	0.08%	-	0.0%	14.52	0.0%	1.26	0.0%	137.21	0.0%
FE.03.02.99 Other Multilateral organizations n.e.c.	514.6	0.33%	2,013.99	0.9%	-	0.0%	1,569.15	0.6%	4,097.74	0.5%
FE.03.03. International NGOs and Foundation	4,678.06	0.03	3,558.22	1.5%	12,014.36	5.5%	7,891.26	3.1%	28,141.89	3.3%
Total	154,272.16	1.00	234,229.88	100.0%	219,570.15	100.0%	256,285.52	100.0%	864,357.72	100.0%

Table 3.4 provides evidence that there were three main specific financing entities in the assessment period, consisting of the Government of Malawi, the Government of the United States and the Global Fund for AIDS, Malaria and Tuberculosis (GFATM). The three entities contributed 93 per cent of the total HIV expenditure in 2015/16, 2016/17 (94%), 2017/18 (92%) and 2018/19 (95%).

In terms of the Government of Malawi fiscal year of 1st July to 30th June the following year, it is shown in Table 3.4 that expenditure from GFATM financing amounted to MWK 59,845 million (USD 103.90 million) in 2015/16, MWK 105,071 million (USD 147.01 million) in 2016/17, MWK 68,818 million (USD 94.97 million) in 2017/18, and MWK 106,350.11 million (USD 146.04 million) in 2018/19. Within the same Government of Malawi fiscal years, the expenditure from funding from the Government of the United States increased steadily through the four years, being MWK 50,392 million (USD 82.00 million) in 2015/16, MWK 77,392 million (USD 108.19 million) in 2016/17, MWK 87,323 million (USD 119.99 million) in 2017/18, and MWK 94,086 million (USD 128.87 million) in 2018/19. In the years 2015/16 and 2016/17, GFATM was the leading source of expenditure, while in the years 2017/18 and 2018/19, the Government of the United States overtook GFATM to become the leading funder of the HIV response in Malawi.

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 3.5). Internal transfers and grants reflected the type of revenue that the Government of Malawi disbursed to different Government ministries and entities in order to finance the HIV and AIDS interventions. These transfers were mainly derived from government general tax revenue. Direct bilateral financial transfers encompassed financing mainly from the Government of United States, while direct multilateral financial transfers constituted financing from GFATM, UN agencies and European Union. Other direct foreign transfers reflect funding from international NGOs and foundations transferring resources for the HIV response in the country.

Table 3.5 shows that, in the period of the four years, direct multilateral transfer was the leading type of revenue, followed by direct bilateral financial transfers and internal transfers and grants

Table 3.5: HIV expenditure by type of revenue

Revenue type	2015/16	2016/17	2017/18	2018/19	Grand Total	Per cent
	MWK million					
REV.01 Transfers from government domestic revenue including reimbursable loans (allocated to HIV purposes)	33,564.99	38,618.30	45,956.02	45,342.69	163,481.99	18.9%
REV.01.01 Internal transfers and grants	33,564.99	38,618.30	45,956.02	45,342.69	163,481.99	18.9%
REV.07 Direct foreign transfers	120,707.18	195,611.58	173,614.13	210,942.83	700,875.72	81.1%
REV.07.01.01 Direct bilateral financial transfers	51,338.73	78,294.41	88,024.16	94,555.59	312,212.88	37.4%
REV.07.01.02 Direct multilateral financial transfers	64,690.40	113,758.95	73,575.61	108,494.73	360,519.68	39.7%
REV.07.01.99 Direct foreign financial transfers n.e.c.	4,678.06	3,558.23	12,014.37	7,892.51	28,143.16	3.4%
Total	**154,272.16**	**234,229.88**	**219,570.15**	**227,351.20**	**835,423.40**	**100%**

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. The financing schemes from the different entities in Malawi during the period under consideration are shown in Table 3.6.

Table 3.6 shows government financing schemes dominated, accounted 61.35 per cent in the four years considered. However, the government financing schemes slightly varied when considered on a year by year's basis being 65 per cent in 2015/16, 63 per cent in 2016/17, 56 per cent in 2017/18 and 63 per cent in 2017/18. Not-for-profit organisation schemes were the other main categories being responsible for 35 per cent, 37per cent, 44 per cent, and 37 per cent of total HIV expenditure in 2015/16, 2016/17, 2017/18 and 2018/19, respectively.

Table 3.6: HIV expenditure by financing schemes

Financing Schemes	2015/16	2016/17	2017/18	2018/19	Grand Total	Per cent
	MWK million					
SCH.01 Government schemes and compulsory contributory health care schemes	99,952.80	147,819.54	121,895.21	160,634.51	530,302.06	61.35%
SCH.01.01 Government schemes	99,952.80	147,819.54	121,895.21	160,634.51	530,302.06	100.00%
SCH.01.01.01 Central government schemes	99,952.80	147,819.54	121,895.21	160,634.51	530,302.06	100.00%
SCH.02 Voluntary payment schemes	54,319.37	86,410.34	97,674.94	95,651.01	334,055.65	38.65%
SCH.02.02 Not-for-profit organisation schemes	54,319.37	86,410.34	97,674.94	95,651.01	334,055.65	38.65%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)	53,462.93	85,122.10	96,268.08	94,107.19	328,960.30	98.47%
SCH.02.02.02 Resident foreign agencies schemes	856.44	1,288.24	1,406.86	1,543.82	5,095.35	1.55%
Total	**154,272.16**	**234,229.88**	**219,570.15**	**256,285.52**	**864,357.72**	**100%**

3.5. Expenditure Breakdown by Financing Agents and Purchasers

Financing agents and purchasers refer to entities managing and using the funds for payment or purchase of health services, medical supplies and other HIV and AIDS-related activities. The financing agents and purchasers also decide the type of activity or product to fund or purchase. Figure 3.3 shows that Government institutions were the main channels of funds for the HIV response in the four years on average, accounting for 60 per cent of the total expenditure.

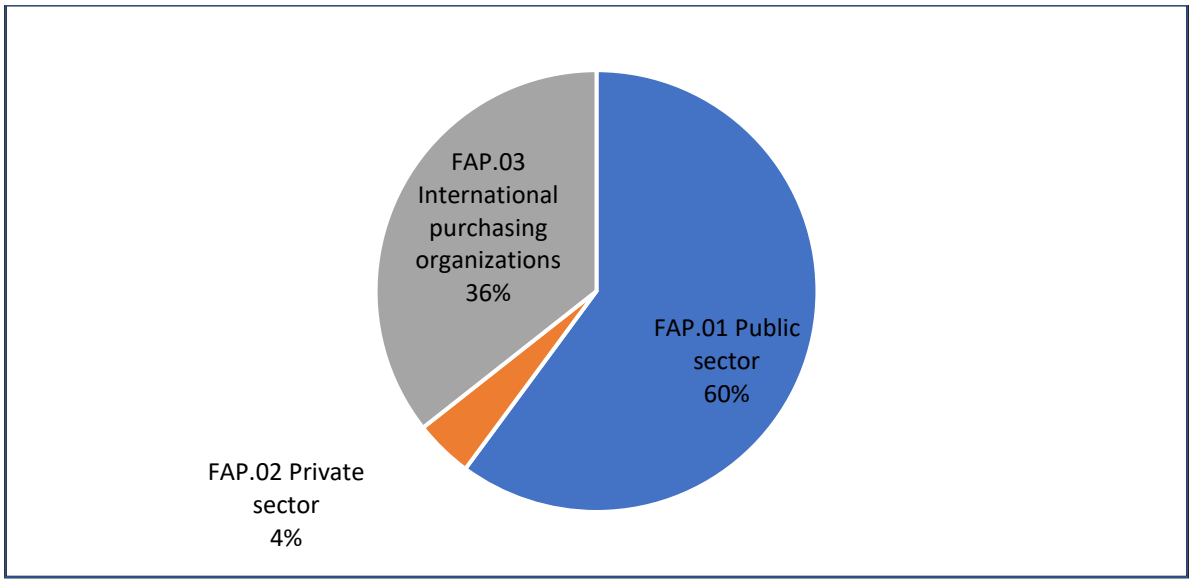
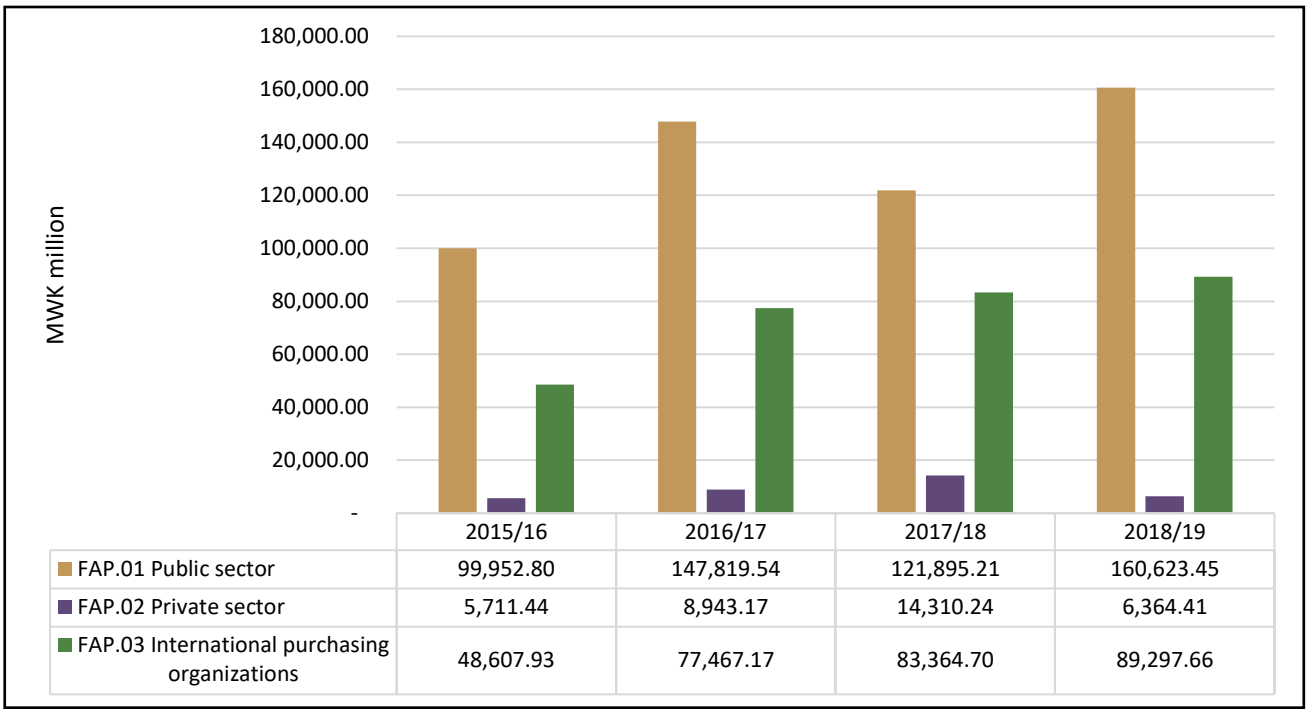


Figure 3.3: Distribution of expenditure by broad FAP

Furthermore, Figure 3.4 reveals that the amount of funding that went through the public sector, though highest in each year, fluctuated from year to year. A similar pattern was apparent for international purchasing organizations, which accounted for the second-highest amount of funds channelled through them. A more disaggregated expenditure by financing agents and purchasers is shown in Table 3.7, Table 3.8, Table 3.9 and Table 3.10 for 2015/16, 2016/17, 2017/18 and 2018/19, respectively.



	2015/16	2016/17	2017/18	2018/19
FAP.01 Public sector	99,952.80	147,819.54	121,895.21	160,623.45
FAP.02 Private sector	5,711.44	8,943.17	14,310.24	6,364.41
FAP.03 International purchasing organizations	48,607.93	77,467.17	83,364.70	89,297.66

Figure 3.4: Expenditure by broad FAP and year

Table 3.7: HIV expenditure by FAP 2015/16

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Percent
	MWK million									
FAP.01.01.01 Government of Malawi entities	33,370.30	-	1,183.45	3,281.21	59,209.63	-	-	-	97,044.58	62.905%
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	32,421.53	-	155.84	101.75	59,209.63	-	-	-	91,888.74	59.563%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	5.55	-	-	-	-	-	-	-	5.55	0.004%
FAP.01.01.01.10 National AIDS Commission	943.23	-	1,027.61	3,179.46	-	-	-	-	5,150.29	3.338%
FAP.01.01.02 State/provincial/regional authorities	-	-	-	143.87	-	-	-	-	143.87	0.093%
FAP.01.01.02.01 Ministry of Health (or equivalent state sector entity)	-	-	-	143.87	-	-	-	-	143.87	0.093%
FAP.01.01.03 Local/municipal authorities	194.68	-	-	-	-	-	-	-	194.68	0.126%
FAP.01.04 Parastatal organizations		-	2,211.57	0.15	-	357.94	-	-	2,569.66	1.666%
FAP.02.05 Not-for-profit institutions		54.96	4,630.25	273.83	0.08	752.32	-	-	5,711.44	3.702%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Percent
	MWK million									
(other than social insurance)										
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles		49.49	-	-	-	-	-	-	49.49	0.032 %
FAP.03.02 Multilateral agencies managing external resources		431.69	-	323.83	51.43	-	-	-	806.95	0.523 %
FAP.03.03 International not-for-profit organizations and foundations		410.60	30,879.74	822.98	583.40	2,836.19	30.49	1.42	35,564.82	23.053%
FAP.03.04 Projects within Universities		-	11,392.78	-	-	20.89	-	9.78	11,423.46	7.405 %
FAP.03.05 International for-profit organizations		-	94.20	-	-	669.01	-	-	763.21	0.495 %
Total	**33,564.99**	**946.74**	**50,391.99**	**4,845.86**	**59,844.53**	**4,636.36**	**30.49**	**11.21**	**154,272.16**	**100%**

Table 3.8: HIV expenditure by FAP 2016/17

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Percent
	MWK Million									
FAP.01.01.01 Government of Malawi entities	38,457.57	-	1,061.62	4,365.35	98,831.22	-	-	-	142,715.76	60.93 %
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	36,871.66	-	82.75	325.46	98,831.22	-	-	-	136,111.09	58.11 %
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	27.08	-	-	-	-	-	-	-	27.08	0.00%
FAP.01.01.01.10 National AIDS Commission	1,558.83	-	978.87	4,039.89	-	-	-	-	6,577.59	2.68%
FAP.01.01.03 Local/muni	160.72	-	-	-	-	-	-	-	160.72	0.07%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Percent
	MWK Million									
cipal authorities										
FAP.01.01.03.01 Department of Health (or equivalent local sector entity)	160.72	-	-	-	-	-	-	-	160.72	0.07%
FAP.01.04 Parastatal organizations		-	4,811.52	13.52	-	105.88	-	-	4,930.91	2.11%
FAP.01.99 Other public financing agents n.e.c.		-	-	12.15	-	-	-	-	12.15	0.01%
FAP.02.05 Not-for-profit institutions (other than social insurance)		2.15	3,073.97	605.56	-	185.40	82.38	-	3,949.46	1.69%
FAP.02.06 Corporations other than providers of health		-	4,993.71	-	-	-	-	-	4,993.71	2.13%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Percent
	MWK Million									
services (nonparastatal)										
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles		61.39	-	-	-	-	-	-	61.39	0.03%
FAP.03.02 Multilateral agencies managing external resources		259.47	-	681.61	284.58	1.20	-	-	1,226.85	0.52%
FAP.03.03 International not-for-profit organizations and foundations		579.37	36,251.02	3,009.49	5,955.48	3,153.09	11.37	5.30	48,965.12	20.90%
FAP.03.04 Projects within Universities		-	26,816.00	-	-	0.06	-	12.15	26,828.21	11.45%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Percent
	MWK Million									
FAP.03.05 International for-profit organizations		-	384.20	-	-	1.39	-	-	385.60	0.16%
Total	**38,618.30**	**902.37**	**77,392.04**	**8,687.67**	**105,071.28**	**3,447.02**	**93.75**	**17.45**	**234,229.88**	**100.00%**

Table 3.9: HIV expenditure by FAP 2017/18

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for-profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million									
FAP.01.01.01 Central or federal authorities	45,767.75	-	906.37	3,116.49	65,121.50	-	-	-	114,912.10	52.34%
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	41,322.71	-	652.70	22.64	65,121.50	-	-	-	107,119.55	48.79%
FAP.01.01.01.02 Ministry of Education	39.87	-	-	-	-	-	-	-	39.87	0.00%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for-profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million									
(or equivalent sector entity)										
FAP.01.01.01.10 National AIDS Commission	4,405.17	-	253.66	3,093.85	-	-	-	-	7,752.68	3.29%
FAP.01.01.03 Local/municipal authorities	175.17	-	-	-	-	-	-	-	175.17	0.08%
FAP.01.01.03.01 Department of Health (or equivalent local sector entity)	175.17	-	-	-	-	-	-	-	175.17	
FAP.01.04 Parastatal organizations	-	-	6,519.97	-	-	287.97	-	-	6,807.94	3.10%
FAP.02.05 Not-for-profit institutions (other than social insurance)	-	-	9,755.38	317.74	-	4,054.32	33.50	-	14,160.94	6.45%
FAP.02.06 Corporations other than providers of health services (nonparastatal)	-	-	128.87	-	-	20.44	-	-	149.31	0.07%
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles	-	89.52	-	-	-	-	-	-	89.52	0.04%
FAP.03.02 Multilateral agencies	-	67.43	-	993.40	189.23	67.28	-	-	1,317.34	0.60%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for-profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million									
managing external resources										
FAP.03.03 International not-for-profit organizations and foundations	13.10	543.95	41,100.49	310.67	3,507.30	6,440.02	41.07	-	51,956.61	23.66%
FAP.03.04 Projects within Universities		-	25,538.65	19.29	-	-	-	12.38	25,570.32	11.65%
FAP.03.05 International for-profit organizations		-	3,373.52	-	-	1,057.40	-	-	4,430.92	2.02%
Total	**45,956.02**	**700.90**	**87,323.26**	**4,757.58**	**68,818.03**	**11,927.43**	**74.56**	**12.38**	**219,570.15**	**100%**

Table 3.10: HIV expenditure by FAP 2018/19

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	Total	Per Cent
	MWK Million								
FAP.01.01.01 Central or federal authorities	45,306.66	-	215.23	150.81	105,349.86	298.65	-	151,321.21	59.04%
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	45,306.66	-	215.23	138.42	105,349.86	298.65	-	151,321.21	53.83%
FAP.01.01.01.03 Ministry of Social Development (or equivalent sector entity)	-	-	-	12.39	-	-	-	12.39	0.01%
FAP.01.01.03 Local/municipal authorities	27.53	-	-	-	-	-	-	27.53	0.01%
FAP.01.01.03.01 Department of Health (or equivalent local sector entity)	27.53	-	-	-	-	-	-	27.53	0.01%
FAP.01.04 Parastatal organizations	-	-	8,832.07	-	-	442.01	0.63	9,274.71	3.62%
FAP.02.05 Not-for-profit institutions (other than social insurance)	8.50	17.45	5,830.81	-	14.30	433.67	0.92	6,305.65	2.46%
FAP.02.06 Corporations other than providers of health services (nonparastatal)		-	-	-	-	-	53.24	53.24	0.02%
FAP.02.99 Other private financing agents n.e.c.		-	-	-	-	5.52	-	5.52	0.00%
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles		69.40	219.95	-	-	-	-	289.36	0.11%
FAP.03.02 Multilateral agencies managing external resources		68.07	-	1,186.40	-	-	-	1,254.47	0.49%
FAP.03.03 International not-for-profit organizations and foundations		181.24	54,074.86	889.02	985.95	6,617.36	38.32	62,786.74	24.50%

Financing Agents and Purchasers	FE.01 Public Entities	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	Total	Per Cent
	MWK Million								
FAP.03.04 Projects within Universities		-	23,813.94	52.75	-	-	-	23,866.69	9.31%
FAP.03.05 International for-profit organizations		-	1,099.46			0.95	-	1,100.41	0.43%
Total	**45,342.69**	**336.16**	**94,086.34**	**2,278.97**	**106,350.11**	**7,798.14**	**93.11**	**256,285.52**	**100%**

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 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. Figure 3.5 summarises the distribution of expenditure by the broad categories of providers of HIV services.

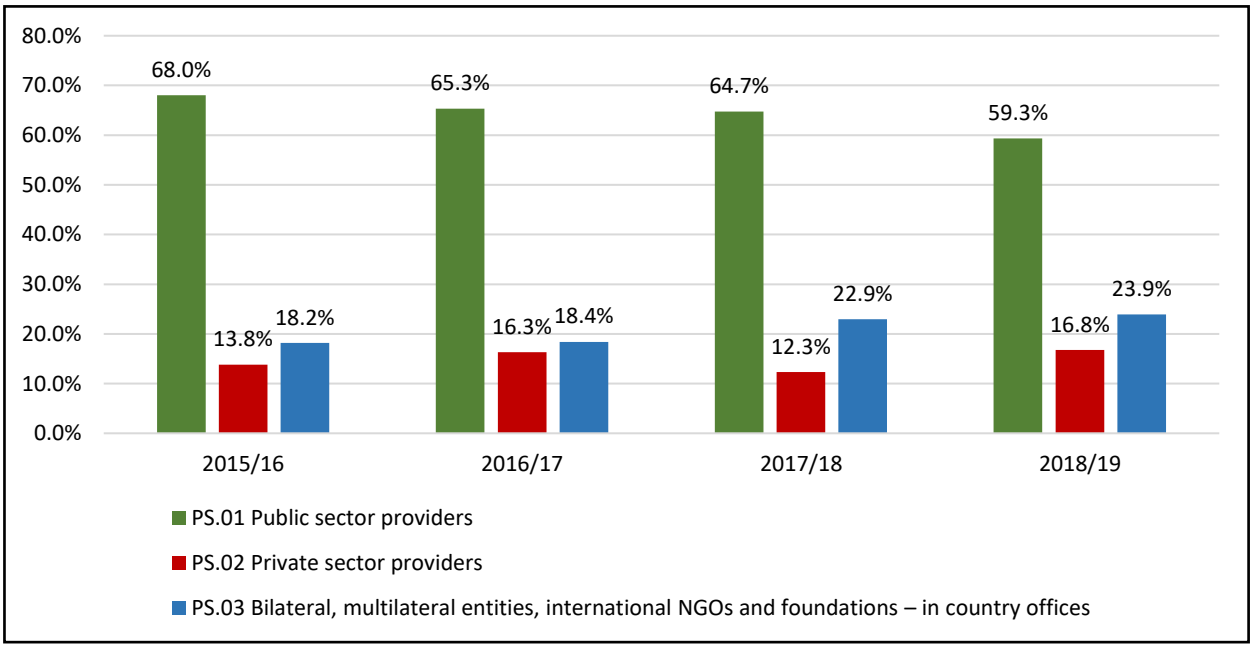


Figure 3.5: Percentage of expenditure by service providers

Figure 3.5 shows that government entities were the main providers of HIV services in all the years, given as 2015/16 (68%), 2016/17 (65.3%), 2017/18 (64.7%) and 2018/19 (59.3%). International entities, as shown, also played an important role in the provision of services in Malawi. Table 3.8, Table 3.9 and Table 3.10 provide a detailed picture of the main providers of HIV services during 2015/16, 2016/17, 2017/18 and 2018/19, respectively. The tables

indicate public health facilities is the largest provider of services and International NGOs and foundations, accounting for about 80 per cent of the total expenditure.

Table 3.11: HIV expenditure by service providers 2015/16

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Per cent
	MWK Million										
PS.01.01.01 Hospitals (public)	32,905.77	-	7.35	15,271.82	93.07	40,578.22	375.35	-	-	89,231.58	57.840%
PS.01.01.09.03 Higher education (public)	-	-	-	129.07	0.15	-	-	-	-	129.22	0.084%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	467.60	-	-	1,027.61	3,179.46	537.88	-	-	-	5,212.54	3.379%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	184.06	2.00	-	33.78	245.62	6,445.25	-	-	-	6,910.71	4.480%
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	5.55	-	-	-	-	-	-	-	-	5.55	0.004%
PS.01.02.09.03 Higher education (parastatal)	-	-	-	377.74	-	-	-	-	-	377.74	0.245%
PS.01.02.99 Parastatal organizations n.e.c.		-	-	2,110.62	-	-	933.42	-	-	3,044.04	1.973%

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Per cent
	MWK Million										
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)		-	47.61	8,688.44	83.51	425.93	95.79	-	-	9,341.27	6.055%
PS.02.01.02.01 Hospitals (private non-profit faith based)		-	-	-	190.32	10,164.09	11.42	-	-	10,365.83	6.719%
PS.02.01.02.13 Civil society organizations (private non-profit faith based)			-	-	-	0.08	85.45	-	-	85.52	0.055%
PS.02.02.01 Hospitals (profit-making private)			-	-	-	1,524.61	-	-	-	1,524.61	0.988%
PS.03.01 Bilateral agencies			49.49	-	-	-	-	-	-	49.49	0.032%
PS.03.02 Multilateral agencies			431.69	-	250.27	51.43	-	-	-	733.39	0.475%
PS.03.03 International NGOs and foundations			410.60	22,752.91	803.47	117.04	3,134.93	30.49	11.21	27,260.65	17.670%
Total	**33,562.99**	**2.00**	**946.74**	**50,391.99**	**4,845.86**	**59,844.53**	**4,636.36**	**30.49**	**11.21**	**154,272.16**	**100%**

Table 3.12: HIV expenditure by service providers 2016/17

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million										
PS.01.01.01 Hospitals (public)	38,400.85	-	2.43	23,952.05	990.54	66,880.73	238.53	-		130,465.14	55.700 %
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	47.94	-	-	978.87	4,038.59	128.94	-	-	-	5,194.33	2.218%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	139.32	3.11	-	23.28	325.46	12,193.15	-	-	-	12,684.32	5.415%
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	27.08	-	-	-	-	-	-	-	-	27.08	0.012%
PS.01.02.99 Parastatal organizations n.e.c.			-	4,524.51	13.52	-	44.96	-	-	4,582.98	1.957%
PS.01.99 Public sector providers n.e.c.			-	-	12.15	-	-	-	-	12.15	0.005%

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million										
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)			49.88	15,243.61	203.18	1,747.18	75.39	82.38	-	17,401.63	7.429%
PS.02.01.02.01 Hospitals (private non-profit faith based)			-	-	397.06	17,273.75	16.93	-	-	17,687.74	7.551%
PS.02.01.02.13 Civil society organizations (private non-profit faith based)			-	-	-	-	79.53	-	-	79.53	0.034%
PS.02.01.99 Other non-profit private sector providers n.e.c.			-	-	5.32	-	-	-	-	5.32	0.002%
PS.02.02.01 Hospitals (profit-making private)			-	-	-	2,591.06	-	-	-	2,591.06	1.106%
PS.02.99 Private sector providers n.e.c.			-	381.54	-	-	-	-	-	381.54	0.163%

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million										
PS.03.01 Bilateral agencies			61.39	-	-	-	-	-	-	61.39	0.026%
PS.03.02 Multilateral agencies			257.04	-	675.77	284.58	1.20	-	-	1,218.58	0.520%
PS.03.03 International NGOs and foundations			531.64	32,288.18	2,026.09	3,971.88	2,990.49	11.37	17.45	41,837.09	17.862 %
Total	**38,615.19**	**3.11**	**902.37**	**77,392.04**	**8,687.67**	**105,071.28**	**3,447.02**	**93.75**	**17.45**	**234,229.88**	**100%**

Table 3.13: HIV expenditure by service providers 2017/18

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for-profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million										
PS.01.01.01 Hospitals (public)	42,941.20	-	-	27,509.38	13.83	38,269.05	107.93	-	-	108,790.78	49.570%
PS.01.01.05 Blood banks (public)	-	-	-	-	-	56.35	-	-	-	56.35	0.026%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	2,861.15	-	-	870.40	3,093.85	76.18	-	-	-	6,901.58	3.143%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	88.12	12.58	-	15.58	22.64	16,341.83	-	-	-	16,531.34	7.506%
PS.01.01.13.03 Departments inside the Ministry of Education or equivalent	39.87	-	-	-	-	-	-	-	-	39.87	0.018%
PS.01.01.13.99 Government entities n.e.c.	-	-	-	3.82	-	-	-	-	-	3.82	0.002%

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for-profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million										
PS.01.02.99 Parastatal organizations n.e.c.	-	-	-	5,626.41	-	-	4,158.61	-	-	9,785.02	4.456 %
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	-	-	44.66	13,568.92	152.44	903.49	86.31	33.50	-	14,789.31	6.736 %
PS.02.01.02.01 Hospitals (private non-profit faith based)	-	-	-	255.45	165.30	8,962.42	10.80	-	-	9,393.96	4.278 %
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	-	-	-	1,279.51	-	-	76.78	-	-	1,356.29	0.618 %
PS.02.02.01 Hospitals (profit-making private)	-	-	-	-	-	1,415.67	-	-	-	1,415.67	0.645 %
PS.02.02.13 Consultancy firms (profit-making private)	-	-	-	-	-	-	20.44	-	-	20.44	0.009 %

Service Providers	FE.01.01.01 Government of Malawi	FE.01.99 Other public n.e.c.	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for-profit organizations	FE.03.99 Other International n.e.c.	Total	Per Cent
	MWK Million										
PS.02.99 Private sector providers n.e.c.		-	-	128.87	-	-	-	-	-	128.87	0.059 %
PS.03.01 Bilateral agencies		-	89.52	-	-	-	-	-	-	89.52	0.041 %
PS.03.02 Multilateral agencies		-	67.43	-	982.43	189.23	67.28	-	-	1,306.37	0.595 %
PS.03.03 International NGOs and foundations		13.10	499.29	38,064.93	327.10	2,603.82	7,399.29	41.07	12.38	48,960.97	22.29 9%
Total	**45,930.34**	**25.68**	**700.90**	**87,323.26**	**4,757.58**	**68,818.03**	**11,927.43**	**74.56**	**12.38**	**219,570.15**	**100%**

Table 3.14: HIV expenditure by service providers 2018/19

Service Providers	FE.01.01.01 Government of Malawi	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	Total	Per Cent
	MWK Million								
PS.01.01.01 Hospitals (public)	45,313.66	17.45	25,944.51	893.23	67,513.41	788.85	1.55	140,472.66	54.811%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	-	-	208.44	-	-	-	-	208.44	0.081%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	20.53	8.03	3.74	157.32	8,898.27	53.11	-	9,141.00	3.567%
PS.01.01.13.04 Departments inside the Ministry of Social Development or equivalent	-	-	-	66.69	-	-	-	66.69	0.026%
PS.01.01.13.98 Government entities not disaggregated	-	-	-	58.84	-	-	-	58.84	0.023%
PS.01.01.13.99 Government entities n.e.c.	-	-	1.29	-	-	-	-	1.29	0.001%
PS.01.02.09.99 Parastatal schools and training facilities n.e.c.	-	-	557.96	-	-	-	-	557.96	0.218%
PS.01.02.99 Parastatal	-	124.33	1,463.46	-	-	-	-	1,587.79	0.620%

Service Providers	FE.01.01.01 Government of Malawi	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	Total	Per Cent
	MWK Million								
organizations n.e.c.									
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	8.50	74.18	12,147.56	72.43	514.77	395.11	53.24	13,265.79	5.176%
PS.02.01.02.01 Hospitals (private non-profit faith based)	-	0.48	88.85	-	23,147.46	153.50	-	23,390.28	9.127%
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	-	-	465.92	-	-	-	-	465.92	0.182%
PS.02.02.01 Hospitals (profit-making private)					5,786.66			5,786.86	2.258%
PS.02.02.99 Profit-making private sector providers n.e.c.	-	-	-	-	61.00	-	-	61.00	0.024%
PS.03.01 Bilateral agencies	-	69.40	219.95	-	-	-	-	289.36	0.113%
PS.03.02 Multilateral agencies	-	33.68	-	1,030.46	-	-	-	1,064.14	0.415%
PS.03.03 International NGOs and foundations		8.61	52,984.66	-	428.34	6,407.56	38.32	59,867.48	23.360%

Service Providers	FE.01.01.01 Government of Malawi	FE.03.01 Governments providing bilateral aid	FE.03.01.30 Government of United States	FE.03.02 Multilateral Organizations	FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	FE.03.03 International not-for-profit organizations and foundations	FE.03.04 International for profit organizations	Total	Per Cent
	MWK Million								
Total	45,342.69	336.16	94,086.34	2,278.97	106,350.11	7,798.14	93.11	256,285.52	100%

3.7. Expenditure by Service Delivery Modalities

Service delivery modalities (SDM) are the modes used by service providers to deliver HIV services to the beneficiary populations. Table 3.15 shows the amount of HIV expenditure disaggregated by specific SDM, while Table 3.16 indicates the corresponding percentages of the expenditure by the SDM. The tables indicate the facility-based delivery modalities took the highest amount of expenditure, accounting for over 60 per cent in each year, followed by non-applicable SDM at slightly above 20% and community-based SDM responsible for less than 10 per cent.

Table 3.15: HIV expenditure by SDM (MWK million)

Service delivery modality	2015/16	2016/17	2017/18	2018/19	Total
SDM.01 Facility-based service modalities	102,448.41	158,501.91	134,255.57	177,946.33	573,152.22
SDM.01.01 Facility-based: Outpatient	102,448.41	156,937.50	133,381.64	177,292.44	570,059.99
SDM.01.03 Directly observed treatment (DOT)	-	1,564.42	873.93	653.89	3,092.23
SDM.02 Home and community based service modalities	7,329.98	16,639.53	15,159.59	19,035.44	58,164.54
SDM.02.01 Community-based: center	3,148.76	1,509.59	761.93	4,866.24	10,286.51
SDM.02.04 Community-based: mobile unit	-	-	-	12.86	12.86
SDM.02.05 Community-based: outreach	175.45	609.28	973.44	8,237.62	9,995.79
SDM.02.06 Community-based: home-based (including door-to-door)	-	8.69	4.84	5.74	19.28
SDM.02.07 HIV self-testing	71.42	1,330.91	1,973.16	44.33	3,419.83
SDM.02.98 Home and community based not disaggregated	3,934.35	13,181.06	11,446.22	5,868.65	34,430.28
SDM.03 Non applicable (ASC which does not have a specific SDM)	37,654.10	47,198.57	53,850.58	39,094.26	177,797.51
SDM.98 Modalities not disaggregated	6,839.67	11,889.87	16,304.41	20,209.49	55,243.43
Total	**154,272.16**	**234,229.88**	**219,570.15**	**256,285.52**	**864,357.72**

Table 3.16: HIV expenditure by SDM (%)

SDM	2015/16	2016/17	2017/18	2018/19	Total
SDM.01 Facility-based service modalities	66.41%	67.67%	61.14%	69.43%	66.32%
SDM.01.01 Facility-based: Outpatient	100.00%	99.01%	99.35%	99.63%	65.97%
SDM.01.03 Directly observed treatment (DOT)	0.00%	0.99%	0.65%	0.37%	0.36%
SDM.02 Home and community based service modalities	4.75%	7.10%	6.90%	7.43%	6.74%
SDM.02.01 Community-based: center	2.04%	0.64%	0.35%	1.90%	1.19%
SDM.02.04 Community-based: mobile unit	0.00%	0.00%	0.00%	0.01%	0.00%
SDM.02.05 Community-based: outreach	0.11%	0.26%	0.44%	3.21%	1.16%
SDM.02.06 Community-based: home-based (including door-to-door)	0.00%	0.00%	0.00%	0.00%	0.00%
SDM.02.07 HIV self-testing	0.05%	0.57%	0.90%	0.02%	0.40%
SDM.02.98 Home and community based not disaggregated	2.55%	5.63%	5.21%	2.29%	3.99%
SDM.03 Non applicable (ASC which does not have a specific SDM)	24.41%	20.15%	24.53%	15.25%	20.54%
SDM.98 Modalities not disaggregated	4.43%	5.08%	7.43%	7.89%	6.40%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

3.8. Expenditure on AIDS Spending Categories

3.8.1 Expenditure by Broad AIDS Spending Categories

The AIDS spending categories capture interventions in which the expenditure was incurred. NASA has eight broad categories of intervention, and within the broad categories are specific HIV interventions. Tables 3.17, Table 3.18, Table 3.19, and Figure 3.6 provide analysis of expenditure by the eight broad categories. Care and treatment took the highest share of expenditure in each year, at about 61.1 per cent in 2015/16, 61 per cent in 2016/17, 51.3 per cent in 2017/18 and 61.5 per cent in 2018/19. In 2015/16, the expenditure on care and treatment was MWK 94,188 million (USD 163.7million) in 2015/16, 142,984 million (USD 200.09 million) in 2016/17 and 112,784 million (USD 154.91 million) in 2017/18 and MWK 157,619 million (USD 216.44 million) in 2018/19.

Table 3.17: HIV expenditure by broad ASC (MWK million)

Aids Spending Category	2015/16	2016/17	2017/18	2018/19	Total
ASC.01 Prevention	10,690.02	20,768.82	24,122.17	23,555.94	79,136.95
ASC.02 HIV testing and counselling (HTC)	10,694.01	19,835.97	24,329.84	31,010.64	85,870.47
ASC.03 HIV Care and Treatment Care	94,187.92	142,983.74	112,784.13	157,619.22	507,575.01
ASC.04 Social protection and economic support	1,046.12	3,495.83	4,483.42	3,954.94	12,980.31
ASC.05 Social Enablers	111.35	111.59	44.15	922.09	1,189.19
ASC.06 Programme enablers and systems strengthening	37,075.15	46,418.77	53,590.38	38,231.61	175,315.91
ASC.07 Development synergies	467.60	498.66	172.03	697.17	1,835.45
ASC.08 HIV-related research		116.51	44.02	293.91	454.43
Total	**154,272.16**	**234,229.88**	**219,570.15**	**256,285.52**	**864,357.72**

Table 3.18: HIV expenditure by broad ASC (USD million)

Aids Spending Category	2015/16	2016/17	2017/18	2018/19	Total
ASC.01 Prevention	18.58	29.06	33.13	32.35	113.12
ASC.02 HIV testing and counselling (HTC)	18.58	27.76	33.42	42.58	122.34
ASC.03 HIV Care and Treatment Care	163.67	200.09	154.91	216.44	735.11
ASC.04 Social protection and economic support	1.82	4.89	6.16	5.43	18.30
ASC.05 Social Enablers (excluding the efforts for KPs above)	0.19	0.16	0.06	1.27	1.68
ASC.06 Programme enablers and systems strengthening	64.43	64.96	73.61	52.50	255.49
ASC.07 Development synergies	0.81	0.70	0.24	0.96	2.70
ASC.08 HIV-related research (paid by earmarked HIV funds)	-	0.16	0.06	0.40	0.63
Total	**268.08**	**327.78**	**301.59**	**351.92**	**1,249.36**

Table 3.19: Percentage expenditure by broad ASC

Aids Spending Category	2015/16	2016/17	2017/18	2018/19	Total
ASC.01 Prevention	6.9%	8.8%	11.0%	9.2%	9.0%
ASC.02 HIV testing and counselling (HTC)	6.9%	8.5%	11.1%	12.1%	9.8%
ASC.03 HIV Care and Treatment Care	61.1%	61.0%	51.3%	61.5%	58.8%
ASC.04 Social protection and economic support	0.7%	1.5%	2.0%	1.5%	1.5%
ASC.05 Social Enablers (excluding the efforts for KPs above)	0.1%	0.0%	0.0%	0.4%	0.1%
ASC.06 Programme enablers and systems strengthening	24.0%	19.8%	24.4%	14.9%	20.5%
ASC.07 Development synergies	0.3%	0.2%	0.1%	0.3%	0.2%
ASC.08 HIV-related research (paid by earmarked HIV funds)	0.0%	0.0%	0.0%	0.1%	0.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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 24 per cent in 2015/16, 20 per cent in 2016/17, 24 per cent in 2017/18 and 15 per cent in 2018/19. HIV testing and counselling took the third-largest share of expenditure, followed by HIV prevention. Table 3.17 shows that the expenditure on prevention increased modestly and steadily for the first three years and then had a decline in the last year. On the other hand, the expenditure on HTC increased steadily over the four years. Figure 3.6 depicts the trends in the expenditure on the broad categories.

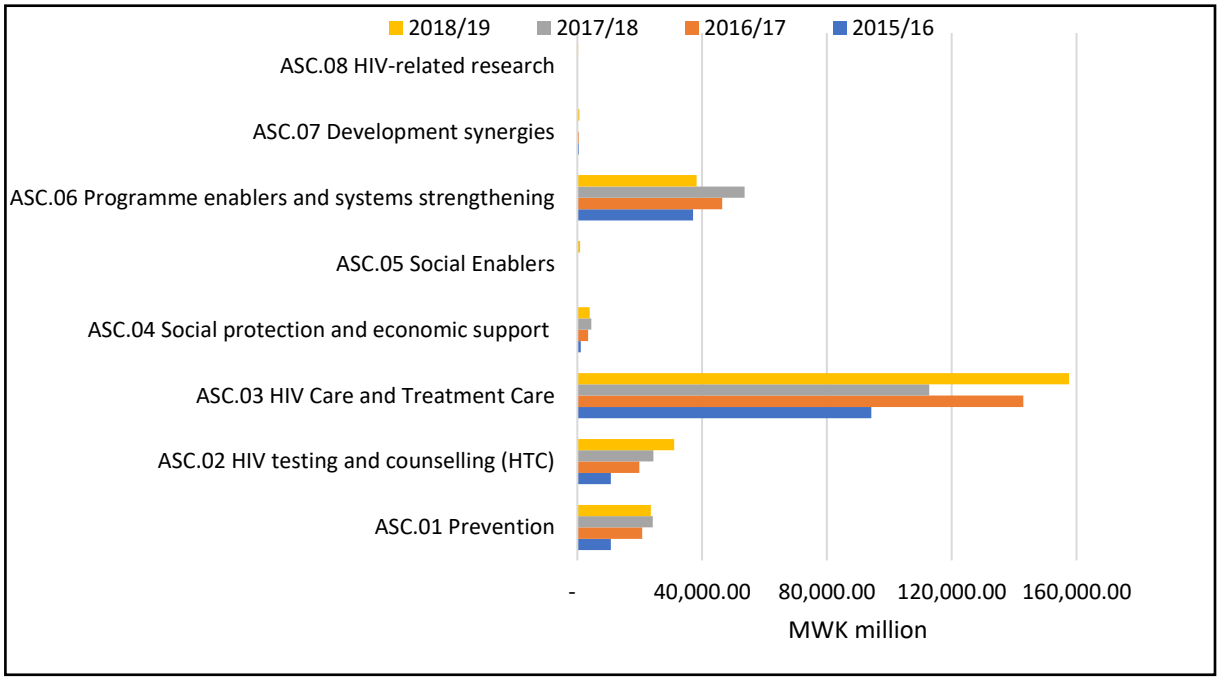


Figure 3.6: Trend in ASC expenditure

Unit expenditure of the specific beneficiary population in terms of prevention of mother to child transmission (PMTCT), HIV testing and counselling (HTS) and HIV care and treatment in each of the four years (Table 3.20).

Table 3.20: Unit expenditure per person per year

AIDS Spending Category	2015/16	2016/17	2017/18	2018/19
	Unit expenditure per person per year (MWK)			
ASC.01 Prevention-PMTCT	1,216.14	6,208.91	12,901.54	22,365.89
ASC.02 HIV testing and counselling (HTC)	3,601.71	5,417.36	5,478.99	6,982.77
ASC.03 HIV Care and Treatment Care	147,731.39	200,228.74	144,550.56	191,813.88

From Table 3.20 above, the unit expenditure to pregnant mothers and their unborn children was 1,216.14 MWK in 2015/16, 6,208.91 MWK in 2016/17, 12,901.54 MWK in 2017/18 and 22,366 MWK in 2018/19. The UEPPY for PMTCT increased over the four years. In the case of HTS, the unit expenditure per individual tested increased steadily over the four years from

3,601.71 MWK in 2015/16, 5,471.36 in 2016/17, 5,478.99 MWK in 2017/18 to 6,982.77 MWK in 2018/19.Table 3.20 also shows fluctuation on the UEPPY for individuals on care over the four period with 147,731.39 MWK in 2015/16 to an increase in 2016/17 to 200,228.74 MWK. This was followed by a decrease in 2017/18 with UEEPY being 144,550.56 MWK and then an increase to 191,813.88 MWK in 2018/19.

3.8.2 Expenditure on HIV Prevention

The expenditure composed prevention for the general population, prevention activities for key population (SW and MSM), PMTCT, and VMMC. Table 3.21 presents the results of expenditure on prevention by financing entities. The United States Government was the main source of funds for financing prevention activities, accounting for 49 per cent in 2015/16, 54 per cent in 2016/17, 58 per cent in 2017/18 and 68 per cent in 2018/19. The other main source was The Global Fund to Fight AIDS, Tuberculosis and Malaria, whose contribution was 23 per cent in 2015/16, 29 per cent in 2016/17, 27 per cent in 2017/18 and 21 per cent in 2018/19. The government of Malawi supported the prevention effort, contributing 8.1 per cent in 2015/16, 4.2 per cent in 2016/17, 4.2 per cent in 2017/18 and 4.3 per cent in 2018/19. Figure 3.7 provides additional analysis on how the different financing sources prioritise prevention each year. Furthermore, Table 3.22 shows the expenditure in terms of detailed prevention interventions.

Table 3.21: Expenditure by FE and year

	2015/16		2016/17		2017/18		2018/19	
Financing Entity	MWK million	%	MWK million	%	MWK million	%	MWK million	%
FE.01 Public Entities	865.43	8.1%	927.97	4.5%	1,070.90	4.4%	1,000.49	4.2%
FE.03.01.30 Government of United States	5,196.17	48.6%	11,094.48	53.4%	14,079.27	58.4 %	15,856.84	67.3%
FE.03.01 Governments providing bilateral aid (excluding USG)	212.12	2.0%	131.41	0.6%	63.32	0.3%	134.56	0.6%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	2,497.78	23.4%	6,070.63	29.2%	6,454.10	26.8 %	5,100.30	21.7%

Financing Entity	2015/16		2016/17		2017/18		2018/19	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%
FE.03.02 Multilateral Organizations	536.23	5.0%	1,613.22	7.8%	753.78	3.1%	-	0.0%
FE.03.03 International not-for-profit organizations and foundations	1,372.50	12.8%	918.96	4.4%	1,688.42	7.0%	1,463.76	6.2%
FE.03.04 International for profit organizations	-	0.0%	-	0.0%	-	0.0%	-	0.0%
FE.03.99 Other International n.e.c.	9.78	0.1%	12.15	0.1%	12.38	0.1%	-	0.0%
Total	**10,690.02**	**100%**	**20,768.82**	**100%**	**24,122.17**	**100 %**	**23,555.94**	**100%**

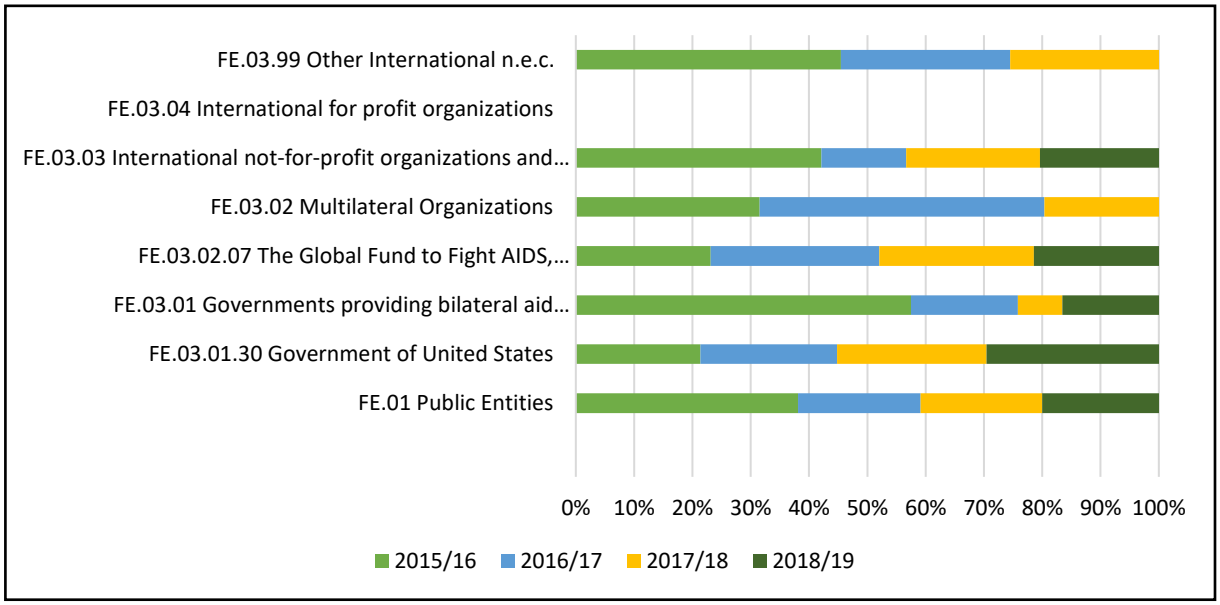


Figure 3.7: Prioritization of prevention by financing entities

Table 3.22: Expenditure on detailed prevention interventions (MWK million)

AIDS Spending Category	2015/16	2016/17	2017/18	2018/19	Total	Percent
ASC.01.01 Five Pillars of Prevention	5,506.99	11,410.37	16,225.35	16,988.04	50,130.74	63.30%
ASC.01.01.01 Prevention for adolescent girls and young women (AGYW) and their male partners in settings with high HIV prevalence	3,602.18	2,115.48	1,711.47	1,803.14	9,232.28	11.70%
ASC.01.01.02 Services for key populations	10.69	507.38	456.30	760.59	1,734.96	2.20%
ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above)	1,769.90	6,000.57	9,047.06	6,411.45	23,228.98	29.40%
ASC.01.01.04 Voluntary medical male circumcision (VMMC) for HIV prevention	120.66	2,784.94	5,008.92	7,895.11	15,809.63	20.20%
ASC.01.01.05 Pre-Exposure Prophylaxis (PrEP)	3.56	1.99	1.59	117.74	124.88	0.20%
ASC.01.02 Other Prevention activities	5,183.03	9,358.45	7,896.82	6,567.90	29,006.20	36.70%
ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT)	50.04	265.40	540.11	940.96	1,796.51	2.27%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	2,285.77	3,394.80	2,142.34	514.86	8,337.78	10.54%
ASC.01.02.03 Community mobilization for populations other than key populations	120.63	76.49	68.90	22.93	288.95	0.37%
ASC.01.02.04 Programmatic activities for vulnerable and accessible populations	7.31	7.71	5.80	-	20.82	0.03%
ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence)	159.71	3,539.48	1,794.21	-	5,493.40	6.94%
ASC.01.02.06 Prevention of HIV transmission aimed at people living with HIV and their partners (including sero-discordant couples)	748.23	808.49	904.63	1,032.85	3,494.20	4.42%
ASC.01.02.07 Prevention and wellness programmes in the workplace	7.15	8.36	14.44	-	29.94	0.04%
ASC.01.02.09 Post-exposure prophylaxis	0.29	0.36	0.36	8.32	9.33	0.01%
ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets	1,415.64	1,191.72	1,402.06	17.84	4,027.27	5.09%
ASC.01.02.98 Prevention activities not disaggregated	388.26	65.65	1,023.97	4,030.14	5,508.01	6.96%
Total	**10,690.02**	**20,768.82**	**24,122.17**	**23,555.94**	**79,136.95**	**100%**

Table 3.22 shows that prevention expenditure was dominated by the five pillars, which accounted for 63 per cent in the four years. Within the five pillars of prevention, public condoms distribution for the general population to prevent HIV took the largest share, being 29.4 per cent of the total expenditure on prevention in the four years. VMMC followed this at 20 per cent of prevention spending while prevention for adolescent girls and young women (AGYW) and their male partners took 11.7 per cent.

Figure 3.8 shows the relative contribution of the various financing entities for the five pillars. The US Government was the highest contributor at 58.41 per cent followed by the GFATM at 25.43 per cent and the least contributor was other international at 0.04 per cent.

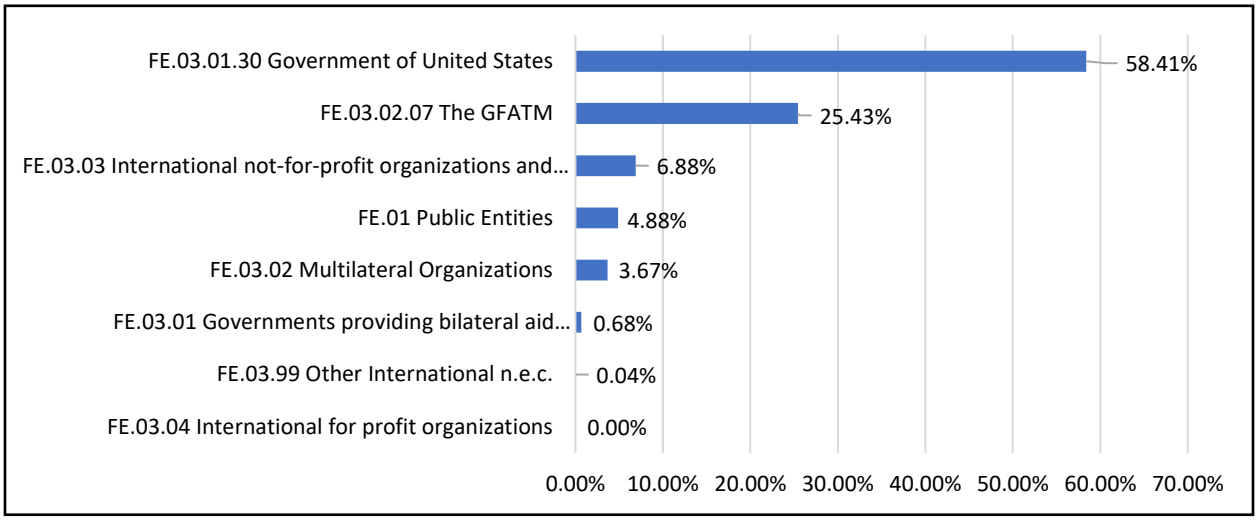


Figure 3.8: Expenditure on five pillars by financing entities

Apart from the five pillars, other prevention interventions jointly took 36.7 per cent of prevention spending. These interventions included social and behavioural communication for change (SBCC), (10.54%), prevention for children and youth (excluding AGYW) (6.9%), STI prevention and treatment programmes for populations other than the key population (5.09%), PMTCT (2.27%) and Prevention of HIV transmission aimed at people living with HIV and their partners (4.4%), among others.

3.8.3 Expenditure on Care and Treatment

Care and treatment encompassed various interventions, including ART and opportunity infections prevention and treatment. Figure 3.9 reveals that only four sources funded care and treatment in the country. GFATM was the leading financing entity (54%), followed by the Government of Malawi (27%), United States Government (18%) and international not-for-profit organisations and foundations (1%).

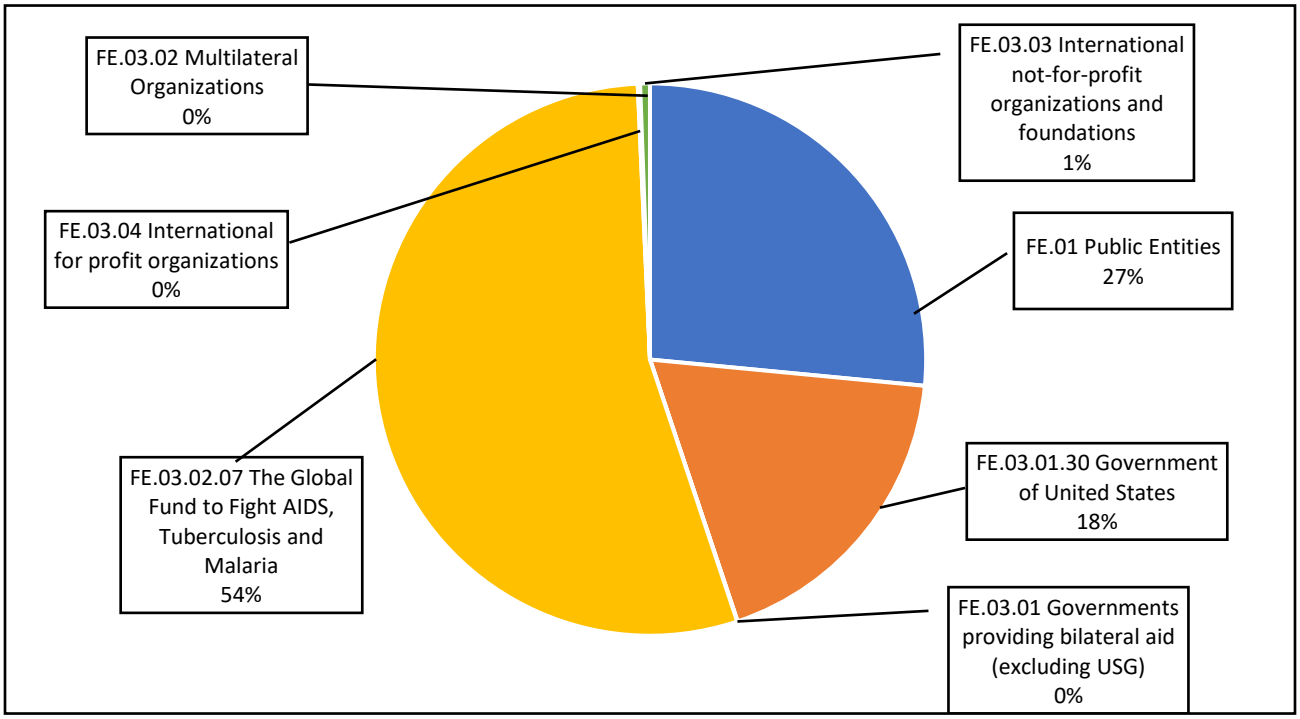


Figure 3.9: Expenditure on care and treatment by the financing entity

Table 3.23 shows that the expenditure from funding from the GFATM increased significantly between 2015/16 and 2016/17, but there was a sharp decrease between 2016/17 and 2017/18. The expenditure from this source recovered in 2018/19 to a higher level than what was achieved in 2016/17. The funding from United States Government increased steadily over the period of four years. The Government of Malawi funding, though, increased slowly on an annual basis and was in the form of indirect expenditure through human resources for health in the public health facilities.

Table 3.23: Trend in C&T expenditure by financing entity

	2015/16		2016/17		2017/18		2018/19	
Financing Entity	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**
FE.01 Public Entities	27,728.52	29.4%	32,513.52	22.7%	36,285.32	32.2%	38,075.75	24.2%
FE.03.01.30 Government of United States	15,244.74	16.2%	23,946.07	16.7%	27,879.49	24.6%	26,026.96	16.5%
FE.03.01 Governments providing bilateral aid (excluding USG)	7.35	0.0%	50.16	0.0%	44.66	0.0%	17.93	0.0%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	50,433.40	53.5%	86,283.22	60.3%	47,776.38	42.4%	91,565.00	58.2%
FE.03.02 Multilateral Organizations	96.21	0.1%	0.38	0.0%	122.88	0.1%	480.05	0.3%
FE.03.03 International not-for-profit organizations and foundations	677.71	0.7%	190.39	0.1%	675.40	0.6%	1,360.98	0.9%
FE.03.04 International for profit organizations		0.0%	-	0.0%	-	0.0%	1.55	0.0%
FE.03.99 Other International n.e.c.		0.0%		0.0%		0.0%	-	0.0%
Total	**94,187.92**	**100%**	**142,983.74**	**100%**	**112,784.13**	**100%**	**157,619.22**	**100%**

Table 3.24: Expenditure on care and treatment interventions per year

AIDS Spending Category	2015/16		2016/17		2017/18		2018/19	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%
ASC.03.01 Anti-retroviral therapy	66,340.88	70%	101,308.99	70.9%	81,975.05	72.7%	110,039.33	69.813%
ASC.03.01.01 ART for adults	16,478.41	17%	18,488.07	12.9%	20,961.46	18.6%	2,404.36	1.525%
ASC.03.01.02 ART for paediatrics	6,934.13	7%	7,262.36	5.1%	8,313.25	7.4%	4,181.46	2.653%
ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment)	6,073.52	6%	5,008.76	3.5%	5,519.65	4.9%	1,787.29	1.134%
ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	36,854.82	39%	70,550.30	49.3%	47,180.69	41.8%	101,666.22	64.501%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	392.93	0.4%	267.59	0.2%	273.61	0.2%	9,849.52	6.249%
ASC.03.03 Specific ART-related laboratory monitoring	12,157.59	12.9%	17,891.20	12.5%	23,906.94	21.2%	9,886.11	6.272%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	14,342.97	15.2%	20,620.36	14.4%	3,804.52	3.4%	426.10	0.270%
ASC.03.05 Psychological treatment and support service	-	0.0%	-	0.0%	-	0.0%	8.46	0.031%
ASC.03.06 Palliative care	344.07	0.4%	1,218.20	0.9%	396.75	0.4%	5.52	0.004%
ASC.03.98 Care and treatment services not disaggregated	609.48	0.6%	1,676.90	1.2%	2,427.27	2.2%	27,404.19	17.386%
Total	**94,187.92**	**100%**	**142,983.24**	**100%**	**112,784.13**	**100%**	**157,619.22**	**100%**

Table 3.24 shows that ART took the largest portion of the expenditure by 70 per cent in the four years, it was followed by specific ART-related lab monitoring at 13 per cent, prevention and treatment for PLHIV and KPs for co-infections and opportunistic infections at 8 per cent, care and treatment services not disaggregated at 6 per cent.

3.8.4 Expenditure on HIV Testing and Counselling (HTC)

Figure 3.10 shows that the sources of funds for HTC were more than in the case of care and treatment, and prevention. Still, the USG dominated that funding, followed by the Government of Malawi mainly through HRH, GFATM and other international sources.

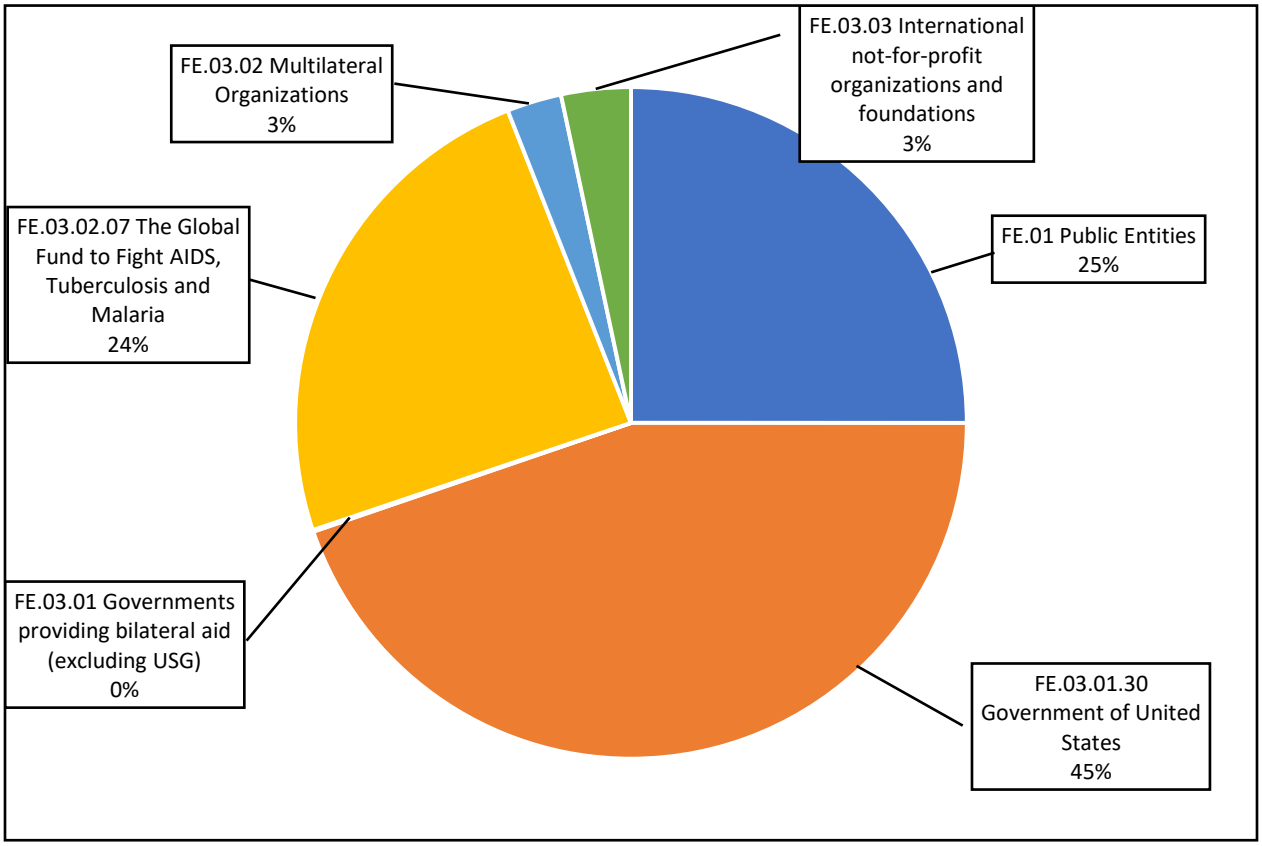


Figure 3.10: Expenditure on HTC by financing entities

Table 3.25: Expenditure on HTC by financing entity and year

	2015/16		2016/17		2017/18		2018/19	
Financing Entity	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**
FE.01 Public Entities	4,468.74	41.8%	5,081.95	25.6%	5,696.86	23.4%	6,255.86	20.2%
FE.03.01.30 Government of United States	3,582.71	33.5%	8,601.53	43.4%	11,600.32	47.7%	14,567.33	47.0%
FE.03.01 Governments providing bilateral aid (excluding USG)	39.14	0.4%	0.02	0.0%	-	0.0%	27.56	0.1%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	2,375.47	22.2%	4,504.46	22.7%	4,619.45	19.0%	9,304.51	30.0%
FE.03.02 Multilateral Organizations	7.41	0.1%	1,536.99	7.7%	170.76	0.7%	549.57	1.8%
FE.03.03 International not-for-profit organizations and foundations	220.54	2.1%	111.01	0.6%	2,242.46	9.2%	305.80	1.0%
Total	**10,694.01**	**100%**	**19,835.97**	**100%**	**24,329.84**	**100%**	**31,010.64**	**100%**

Table 3.26: Expenditure on HTC interventions by year

AIDS Spending Category	2015/16		2016/17		2017/18		2018/19	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%
ASC.02.01 HIV testing and counselling for sex workers	74.59	0.7%	168.92	0.9%	354.55	1.5%	176.33	0.6%
ASC.02.02 HIV testing and counselling for MSM	28.00	0.3%	42.28	0.2%	25.70	0.1%	289.40	0.9%
ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	1.74	0.0%	4.23	0.0%	26.34	0.1%	39.35	0.1%
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	3,241.49	30.3%	513.52	2.6%	21.51	0.1%	17.28	0.1%
ASC.02.07 Early infant (and paediatric??) diagnosis (EID) of HIV	62.22	0.6%	1.07	0.0%	18.50	0.1%	145.51	0.5%
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	48.76	0.5%	527.09	2.7%	1,145.56	4.7%	2,480.60	8.0%
ASC.02.09 Voluntary HIV testing and counselling for general population	6,842.99	64.0%	15,251.59	76.9%	20,524.87	84.4%	27,264.37	87.9%
ASC.02.10 Provider initiated testing and counselling (PITC)	394.22	3.7%	3,327.27	16.8%	2,212.45	9.1%	597.68	1.9%
ASC.02.12 Mandatory HIV testing (not VCT) (including premarital, job applications, visas etc.)		0.0%		0.0%	0.37	0.0%	0.13	0.0%
ASC.02.98 HIV testing and counselling activities not disaggregated		0.0%		0.0%		0.0%	0.93	0.0%
Total	**10,694.01**	**100%**	**19,835.97**	**100%**	**24,329.84**	**100%**	**31,011.57**	**100%**

3.8.5 Programme Enablers

The programme enablers are supportive undertaken to optimize the provision of HIV services to the beneficiary populations. The expenditure on this area of intervention is shown in Table 3.27 and Table 3.28. The United States Government funds accounted for more than 60 per cent of the expenditure in 2015/16, 2016/17, with a decline in 2017/18 having 54% then a significant increase in 2018/19 to 67%. The GFATM also contributed substantial amounts to the programme enablers. The Government of Malawi contribution was relatively small in all the years.

Table 3.28 shows that Public Systems Strengthening took the largest share of spending on programme enablers, being 21% in 2015/16, 30% in 2016/17, 29% in 2017/18 and 43% in 2018/19). Programme administration and management costs were the second main category (24% in 2015/16, 27% in 2016/17, 28% in 2017/18 and 22% in 2018/19). The sources of funds for this largest category were USG and GFATM. The other notable area of spending was Human resources for health (above-site programmes).

Table 3.27: Expenditure on programme enablers by financing entity

	2015/16		2016/17		2017/18		2018/19		Total	
Financing Entity	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**	**MWK million**	**%**
FE.01 Public Entities	500.30	1.3%	91.76	0.2%	2,890.37	5.4%	3,488.16	2.0%	3,488.16	2.0%
FE.03.01.30 Government of United States	25105.39	67.7%	29,809.52	64.2%	29,177.54	54.4%	117,725.31	67.2%	117,725.31	67.2%
FE.03.01 Governments providing bilateral aid (excluding USG)	685.60	1.8%	698.89	1.5%	592.92	1.1%	2,101.34	1.2%	2,101.34	1.2%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	4521.52	12.2%	8,208.66	17.7%	9,968.10	18.6%	22,987.60	13.1%	22,987.60	13.1%
FE.03.02 Multilateral Organizations	3991.63	10.8%	5,305.73	11.4%	3,608.45	6.7%	12,974.94	7.4%	12,974.94	7.4%
FE.03.03 International not-for-profit organizations and foundations	2238.79	6.0%	2,205.16	4.8%	7,278.43	13.6%	15,741.47	9.0%	15,741.47	9.0%
FE.03.04 International for profit organizations	30.49	0.1%	93.75	0.2%	74.56	0.1%	290.36	0.2%	290.36	0.2%
FE.03.99 Other International n.e.c.	1.42	0.0%	5.30	0.0%		0.0%	-	0.0%	6.73	0.0%
Total	**37,075.15**	**100%**	**46,418.77**	**100%**	**53,590.38**	**100%**	**175,309.18**	**100%**	**175,315.91**	**100%**

Table 3.28: Expenditure on programme enablers interventions by year

AIDS Spending Category	2015/16		2016/17		2017/18		2018/19		Total	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%	MWK million	%
ASC.06.01 Strategic planning, coordination and policy development	985.97	2.7%	1,406.40	3.0%	1,772.05	3.3%	773.12	2.0%	4,937.54	2.8%
ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes	120.98	0.3%	93.80	0.2%	13.99	0.0%	3.94	0.0%	232.72	0.1%
ASC.06.03 Programme administration and management costs (above service-delivery level)	8,910.73	24.0%	12,449.78	26.8%	14,847.94	27.7%	8,322.81	21.8%	44,531.26	25.4%
ASC.06.04 Strategic information	11,187.55	30.2%	5,345.01	11.5%	9,932.76	18.5%	8,612.86	22.5%	35,078.18	20.0%
ASC.06.05 Public Systems Strengthening	7,873.88	21.2%	13,682.34	29.5%	15,574.94	29.1%	16,470.02	43.1%	53,601.18	30.6%
ASC.06.06 Community system strengthening	144.99	0.4%	720.47	1.6%	279.86	0.5%	242.45	0.6%	1,387.76	0.8%
ASC.06.07 Human resources for health (above-site programmes)	7,851.04	21.2%	12,718.21	27.4%	8,626.57	16.1%	2,947.51	7.7%	32,143.34	18.3%
ASC.06.98 Programme enablers and systems strengthening not disagregated		0.0%	2.76	0.0%	2,542.26	4.7%	858.91	2.2%	3,403.93	1.9%
Total	**37,075.15**	**100%**	**46,418.77**	**100%**	**53,590.38**	**100%**	**38,231.61**	**100%**	**175,315.91**	**100%**

3.8.6 Social Enablers

Figure 3.11 shows that, over the four years, spending was concentrated on human rights programme, especially reducing discrimination and violence against women in the context of HIV, Human rights programmes. The funding came mainly from multilateral partners.

Table 3.29: expenditure on social enabler intervention

AIDS Spending Category	Total (MWK million)	Percent
ASC.05.01 Advocacy	125.19	10.5%
ASC.05.02 Human rights programmes	1064.00	89.5%
ASC.05.02.01 Stigma and discrimination reduction	26.62	2.2%
ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV	117.70	9.9%
ASC.05.02.04 Sensitization of lawmakers and law enforcement agents	2.37	0.2%
ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV	859.98	72.3%
ASC.05.02.98 Human rights programmes not disaggregated by type	57.32	4.8%
Total	**1189.19**	**100%**

Table 3.30: Expenditure on social enablers by financing entity

Financing Entity	2015/16		2016/17		2017/18		2018/19		Total	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%	MWK million	%
FE.03.01.30 Government of United States	0.29	0.3%	0.30	0.3%	0.29	0.7%	140.54	15.2%	141.42	11.9%
FE.03.01 Governments providing bilateral aid (excluding USG)	2.52	2.3%	21.89	19.6%	-	0.0%	28.87	3.1%	53.28	4.5%
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	16.36	14.7%	4.31	3.9%	-	0.0%	-	0.0%	20.67	1.7%
FE.03.02 Multilateral Organizations	92.19	82.8%	85.09	76.2%	43.87	99.3%	597.27	64.8%	818.41	68.8%
FE.03.03 International not-for-profit organizations and foundations	0.00	0.0%	-	0.0%	-	0.0%	155.42	16.9%	155.42	13.1%
Total	**111.35**	**100%**	**111.59**	**100%**	**44.15**	**100%**	**922.09**	**100%**	**1189.19**	**100%**

3.8.7 Beneficiary Populations

The Beneficiary Population (BP) analysis aims at estimating resources spent on a population as part of the service delivery process of programmatic intervention. Beneficiary population (BP) is a sub-set of the population that consumes HIV and AIDS-related goods and services. Figure 3.11 shows that, as expected, people living with HIV were the main beneficiaries taking 60 per cent of the expenditure in four years. Non-targeted intervention took the second largest (20%) of the expenditure.

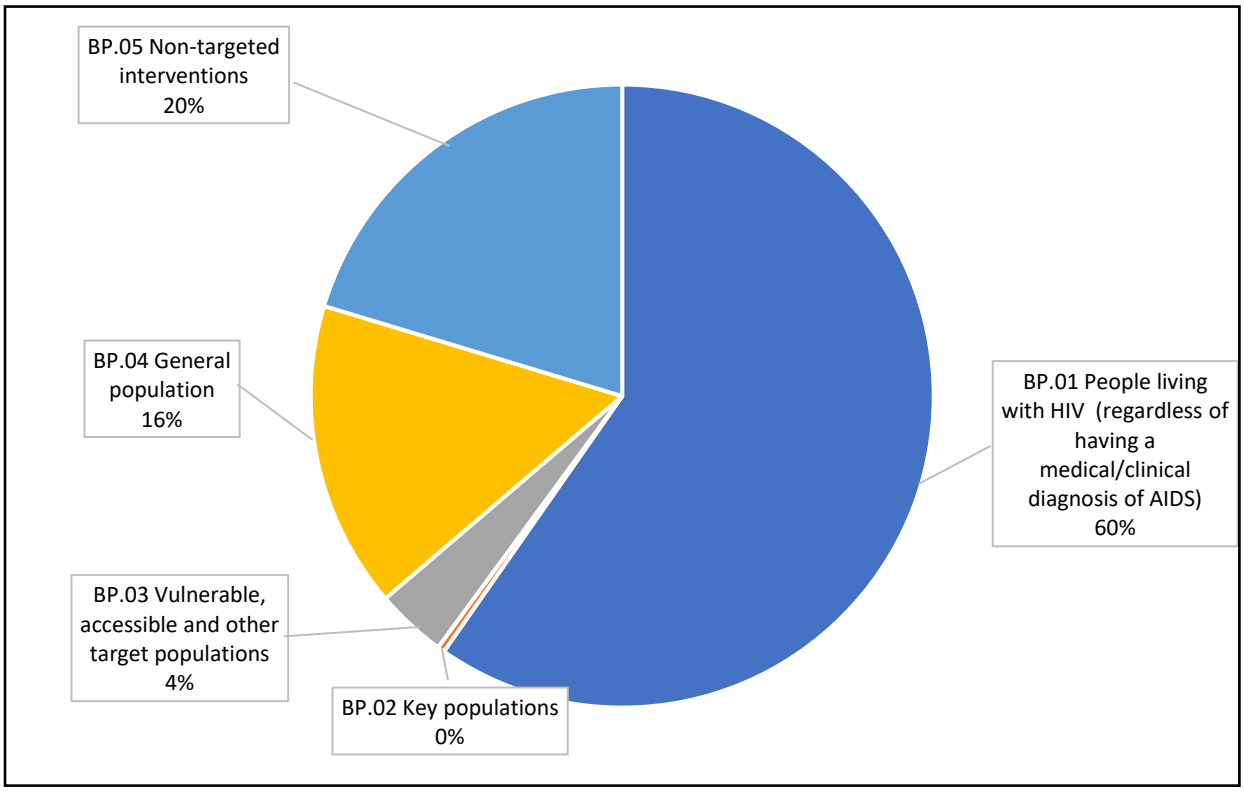


Figure 3.11: Expenditure by beneficiary population

3.8.8 Production Factors

The classification of production factors categorizes expenditures in terms of resources used for service provision in terms of wages, salaries, materials, and capital. As shown in Table 3.32, recurrent expenditure took a significant percentage of over 94 per cent each year. Capital expenditure accounted for less than 3 per cent. Medical products and supplies consisting mainly

of ARVs, laboratory reagents and materials, HIV tests diagnostics as well non-medical supplies accounted for 47 per cent of total expenditure in 2015/16, 82 per cent in 2016/17, 66 per cent in 2017/18 and 80% in 2018/19. The largest component of the medical supplies was ARVs which accounted for 26 per cent of total expenditure in 2015/16, 44 per cent in 2016/17, 32 per cent in 2017/18, 32 per cent in 2017/18 and 61% in 2018/19. Personnel as an input took a significant share of the total expenditure, 32 per cent in 2015/16 to 34 per cent in 2016/17, 40 per cent in 2017/18 and 45 per cent in 2018/19, showing an increase in the cost of personnel over the four years.

Operational and programme management cost, consisting of administrative and programme management, travel, rent and utilities, was the third-largest component. It accounted for 8.7 per cent of the total expenditure in 2015/16, 15.3 per cent in 2016/17, 13.2 per cent in 2017/18 and 14.6 per cent in 2018/19. Another notable factor of production was Laboratory reagents and materials – 2015/16 (8.8%), 2016/17 (18.6%), 2017/18 (2.3%) and 2018/19 (9%), with HIV testing reagents taking the larger share followed by Viral load test reagents. Training also took notable funding.

Table 3.31: Expenditure on production factors

Production Factor	2015/16		2016/17		2017/18		2018/19	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%
PF.01 Current direct and indirect expenditures	149,714.50	97%	227,935.57	97%	216,262.96	98.50%	241,406.08	94.20%
PF.01.01 Personnel costs	48,623.90	32%	52,373.96	34%	61,846.84	40.09%	69,627.62	45.13%
PF.01.01.01 Direct service providers	4,105.72	3%	8,648.62	6%	10,634.68	6.62%	20,562.83	13.33%
PF.01.01.02 Program management personnel costs	9,790.78	6%	3,746.32	2%	7,489.96	2.87%	3,328.92	2.16%
PF.01.01.98 Personnel not disaggregated	34,727.40	23%	39,979.01	26%	43,722.20	30.60%	45,735.87	29.65%
PF.01.02 Other operational and programme management current expenditures	13,493.73	9%	23,646.18	15%	20,404.98	13.23%	22,569.85	14.63%
PF.01.03 Medical products and supplies	72,261.88	47%	126,904.52	82%	102,033.85	66.14%	122,955.84	79.70%
PF.01.03.01 Pharmaceuticals	47,854.60	31%	77,390.80	50%	49,896.55	66.14%	97,837.33	63.41%
PF.01.03.01.01 Antiretrovirals	40,640.49	26%	68,073.18	44%	43,917.56	32.34%	93,742.22	60.76%
PF.01.03.01.02 Anti-tuberculosis drugs	1.15	0%	23.61	0%	8.95	28.45%	6.23	0.00%
PF.01.03.01.04 STI drugs	432.9	0%	273.4	0%	821.77	0.00%	-	0.00%
PF.01.03.01.06 Hepatitis treatment drugs	0.2	0%	0.25	0%	0.25	0.11%	-	0.00%
PF.01.03.01.07 OI other than TB drugs	6,312.25	4%	7,391.57	5%	3,455.33	0.00%	-	0.00%
PF.01.03.01.98 Pharmaceuticals not disaggregated	467.62	0%	1,628.79	1%	1,692.68	3.10%	4,088.88	2.65%
PF.01.03.02 Medical supplies	1,946.91	1%	8,119.79	5%	13,869.87	0.68%	6,385.37	4.14%
PF.01.03.02.01 Syringes and needles	-	0%	-	0%	0.45	8.99%	-	0.00%
PF.01.03.02.02 Condoms	1,769.90	1%	6,019.16	4%	9,153.66	0.00%	5,719.55	3.71%
PF.01.03.02.98 Medical supplies not disaggregated	177.01	0.12%	2,100.63	1%	4,715.76	6.67%	665.82	0.43%
PF.01.03.03 Laboratory reagents and materials	13,547.10	8.78%	28,626.16	19%	30,082.34	2.33%	14,478.32	9.39%
PF.01.03.03.01 HIV tests screening/diagnostics	2,952.99	1.91%	8,855.65	6%	12,611.12	19.50%	11,110.93	7.10%
PF.01.03.03.02 VL tests	5,603.15	3.63%	10,714.14	7%	14,826.12	6.03%	2,853.03	1.85%
PF.01.03.03.03 CD4 tests	2.88	0.00%	3.57	0%	137.23	7.30%	3.64	0.11%
PF.01.03.03.04 Diagnostic tests for STI (including rapid testing)	942.8	0.61%	703.02	0%	112.43	0.00%	29.86	0.02%
PF.01.03.03.05 Diagnostic tests for TB (including rapid testing)	-	0.00%	-	0%	1.62	0.48%	-	0.00%

Production Factor	2015/16		2016/17		2017/18		2018/19	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%
PF.01.03.03.06 Diagnostic tests for hepatitis (including rapid testing)	-	0.00%	-	0%	417.89	0.00%	-	0.00%
PF.01.03.03.98 Reagents and materials not disaggregated	4,045.28	2.62%	8,349.77	5%	1,975.93	0.00%	480.85	0.31%
PF.01.03.04 Non-medical supplies	6,658.18	4.32%	10,000.61	6%	5,972.95	5.69%	2,915.06	1.89%
PF.01.03.05 Office Supplies	2,206.50	1.43%	1,805.46	1%	1,439.85	3.87%	367.13	0.24%
PF.01.03.98 Medical products and supplies not disaggregated	48.59	0.03%	961.71	1%	772.3	0.93%	972.64	0.63%
PF.01.04 Contracted external services	1,975.49	1.28%	2,215.73	1%	11,906.92	0.50%	1,367.90	0.89%
PF.01.05 Transportation related to beneficiaries	-	0.00%	8.51	0%	-	0.00%	1,601.15	1.04%
PF.01.06 Housing/accommodation services for beneficiaries	2.3	0.00%	-	0%	-	0.00%	-	0.00%
PF.01.07 Financial support for beneficiaries	935.97	0.61%	3,179.43	2%	4,606.20	2.99%	1,213.61	0.79%
PF.01.08 Training- Training related per diems/transport/other costs	6,165.04	4.00%	6,618.39	4%	4,596.36	2.98%	16,178.96	10.49%
PF.01.09 Logistics of events, including catering services	3,487.66	2.26%	1,991.00	1%	646.65	0.42%	898.9	0.58%
PF.01.10 Indirect costs	234.95	0.15%	461.17	0%	129.8	0.08%	1,761.00	1.14%
PF.01.98 Current direct and indirect expenditures not disaggregated	2,533.57	1.64%	10,536.69	7%	10,091.34	6.54%	3,231.25	2.10%
PF.02 Capital expenditures	4,557.67	2.95%	6,294.31	3%	3,307.19	0.015062128	14,879.43	5.81%
PF.02.01 Building	1,021.53	0.66%	247.28	0%	430.99	0.20%	13,524.02	5.95%
PF.02.01.01 Laboratory and other infrastructure upgrading	34.53	0.02%	29.57	0%	187.72	0.09%	-	0.00%
PF.02.01.02 Construction and renovation	698.28	0.45%	217.71	0%	243.27	0.11%	13,504.34	5.94%
PF.02.01.98 Building not disaggregated	288.72	0.19%	-	0%	-	0.00%	19.68	0.01%
PF.02.02 Vehicles	292.22	0.19%	641.38	0%	359.42	0.16%	874.28	0.39%
PF.02.03 Other capital investment	3,243.92	2.10%	5,405.54	2%	2,505.68	1.14%	481.13	0.21%
PF.02.03.01 Information technology (hardware and software)	178.64	0.12%	147.81	0%	623.63	0.28%	41.72	0.02%

Production Factor	2015/16		2016/17		2017/18		2018/19	
	MWK million	%	MWK million	%	MWK million	%	MWK million	%
PF.02.03.02 Laboratory and other medical equipment	14.53	0.01%	775.8	0%	1,192.76	0.54%	365.57	0.16%
PF.02.03.03 Non medical equipment and furniture	3,050.53	1.98%	4,481.68	2%	689.29	0.31%	73.84	0.03%
PF.02.03.98 Other capital investment not disaggregated	0.22	0.00%	0.25	0%	-	0.00%	-	0.00%
PF.02.98 Capital expenditure not disaggregated	-	0.00%	0.11	0%	11.1	0.01%	-	0.00%
Total	**154,272**	**100%**	**234,230**	**100%**	**219,570**	**100%**	**256,286**	**100%**

3.9. Institutionalisation of NASA

The country has taken steps to institutionalize NASA. The steps undertaken are as follows:

(1) NASA is now harmonized in the Resource Mapping data collection process. The process is currently on its 7tth round. Resource Mapping is a Ministry of Health (MOH) activity that is carried regularly. It collects expenditure data for use by NHA as well as 2-year forward-looking budgets. The data collection for the health activities including HIV service =d (both health and non-health).

(2) The country team consisting of NAC and select MOH staff have been trained on NASA by UNAIDS. Additionally, the capacity of the local team, consisting of the local NASA consultant and research assistants, have participated in the collection of RM data.

(3) A tool for mapping RM data into NASA classifications for data processing was developed. A local team of four data entry clerks and the local consultant have ably used this tool.

(4) The NAC will need to only translate the data on the mapping tool into DCT and RTT. After which NASA report is written.

3.10. Comparison of NASA expenditure and NSP costs

A comparison of the NASA expenditure results and the estimated cost of the Malawi HIV-AIDS NSP 2015-2020 was made. Figure 3.12 shows the annual comparison.

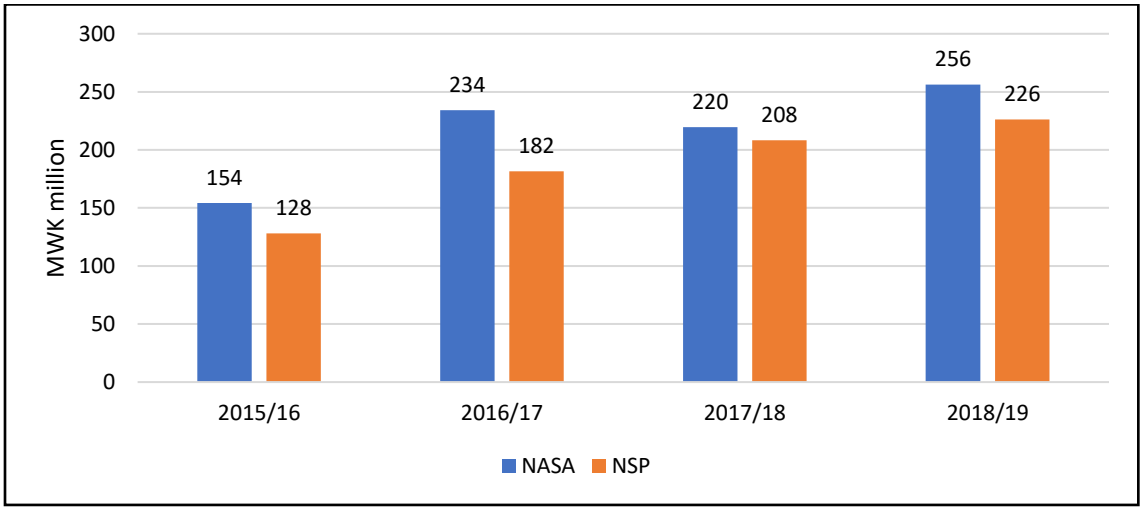


Figure 3.12: Comparison of total HIV expenditure and total NSP cost

Figure 3.12 shows that NASA's actual total expenditure was greater than the estimated total cost of all the interventions in the NSP in each of the years. Different factors might have explained the difference, but the reasons were not established, given the nature of NASA analysis which is mainly a financial analysis without follow up survey to establish observed trends. The comparison over the four years in terms of care and treatment interventions is shown in Figure 3.13.

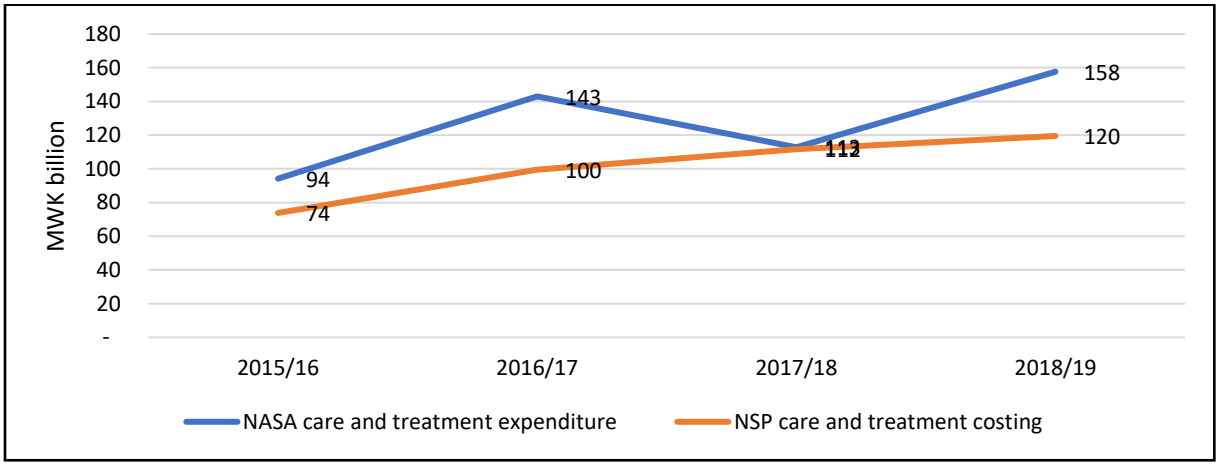
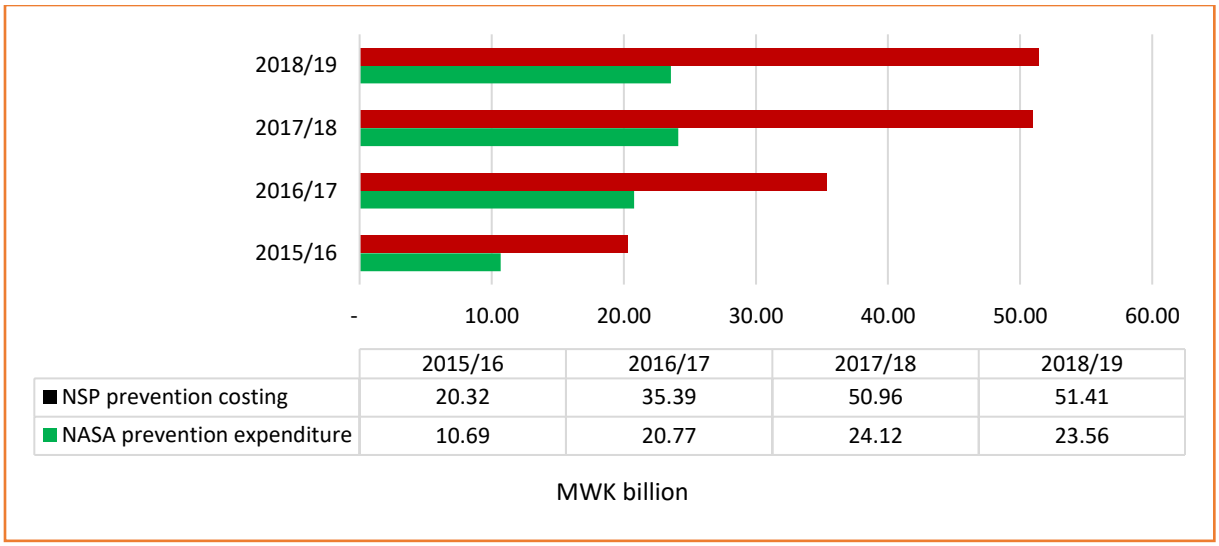


Figure 3.13: Comparison of expenditure and NSP cost on care and treatment

Although HIV expenditure on care and treatment was generally higher than the cost, the two were almost equal in 2017/18. The discrepancy was significant in the other three years, which warrants a closer look at the reasons, including the data inputs used in the NSP. The expenditure on HIV prevention was far less than projected costs, underscoring less prioritisation given to prevention in spending than expected cost in the NSP (see Figure 3.14). Similarly, the expenditure on HTC was more than the projected cost in the NSP, as shown in Figure 3.15 and expenditure on programme enablers and system strengthening was less than the NSP estimated cost in each year as presented in Table 3.23.



	2015/16	2016/17	2017/18	2018/19
NSP prevention costing	20.32	35.39	50.96	51.41
NASA prevention expenditure	10.69	20.77	24.12	23.56

Figure 3.14: Comparison of expenditure and total NSP cost on HIV prevention

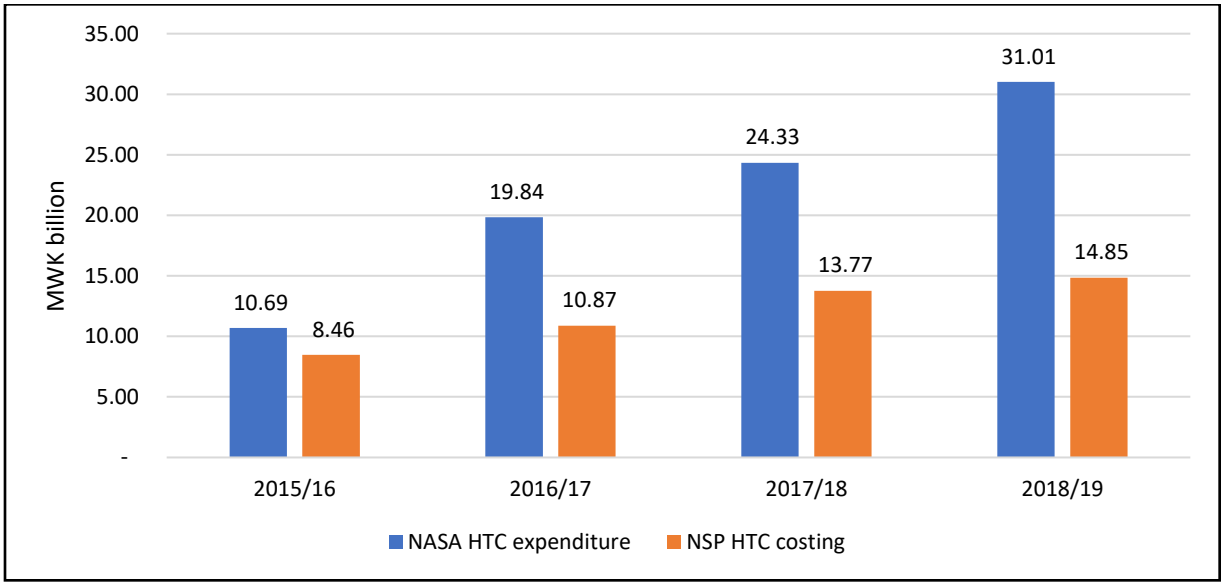


Figure 3.15: Comparison of expenditure and total NSP cost on HTC

Table 3.32: Expenditure and cost comparison on programme support

Year	NASA programme enablers and systems strengthening expenditure	NSP programme enablers and systems strengthening costing
2015/16	37.08	19.55
2016/17	46.42	28.13
2017/18	53.59	23.72
2018/19	38.23	31.75

Figure 3.16 shows that apart from 2015/16, expenditure on OVC and mitigation was higher than the projected cost in the NSP

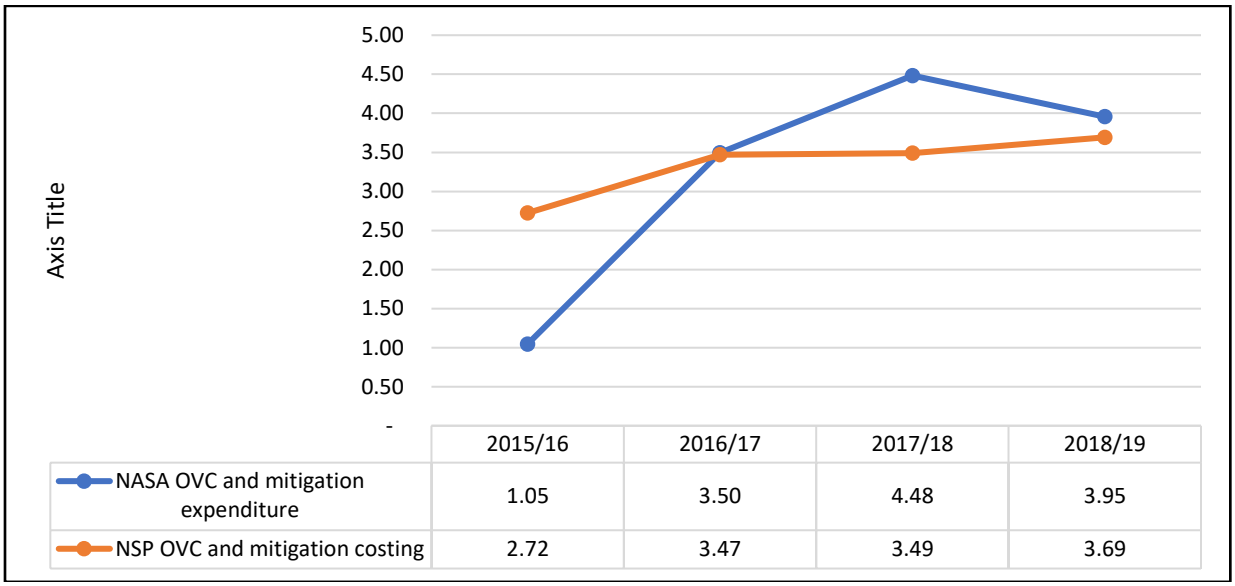


Figure 3.16: Comparison of HIV expenditure and NSP cost on OVC and other mitigations

4 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1. Summary

The National AIDS Spending Assessment NASA for Malawi was implemented as part of a harmonized and fully integrated data collection process for the seventh round of Malawi's Health Sector Resource Mapping. The new NASA classifications with three dimensions consisting of financing, provision and consumption and nine 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 data sources and were processed using Excel files and Resource Tracking Tool (RTT).

The results showed that funding for HIV has stagnated over a period of three years. There are only three main sources of funding the HIV response consisting of the Government of Malawi, the United States Government, and The Global Fund for AIDS, Tuberculosis and Malaria. The external sources are the main drivers of funding the HIV response. While public providers dominated service provision, international NGOs also play a significant role as financing agents and providers. Care and treatment dominate the expenditure, and as such, the funding benefits mainly people living with HIV.

The results have showed that total expenditure was more cost of most of interventions a in the Malawi national HIV strategic plan for the period. However, the expenditure on some key areas such as prevention, HTC , OVC and social protection was less than estimated costing the NSP 2015-2020.

4.2. Conclusions

The following conclusion can be drawn from the results:

g) The funding for the HIV response, the country, as flattened.

h) The funding relies heavily on two external sources, the GFATM and the Government of the United States.
i) There is a high risk of sustaining the funding of the HIV response because the bulk of the funding comes from external sources.
j) The contribution of the Government of Malawi is important, but it is mainly indirect through funding of human resources for health.
k) Low priority given to social enablers and social support programmes.
l) There was balanced prioritisation of expenditure across prevention and care and treatment but generally there were variances in estimated costs and actual expenditure.

4.3. Recommendations

5. In view of the stagnation in external funding and increase in need of care and treatment, it is essential for the Government of Malawi needs to urgently explore sustainable ways for financing the response. Increase government allocation from own domestically generated revenue will go a long way in reducing the sustainability problem.
6. However, there is an extent to which the Government can allocate additional funding given fiscal space constraints and funding needs for other sectors. Therefore, finding cost-effective, sustainable financing options is also imperative.
7. In addition to funding HRH, the Government should consider more direct funding for HIV interventions.
8. Need to relook at unit costs used NSPs to determine the reasons for variances in NSP costs and expenditure.

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