Namibia National AIDS Spending Assessment (NASA)
2012/13 and 2013/14

MINISTRY OF HEALTH AND SOCIAL SERVICES
DIRECTORATE OF SPECIAL PROGRAMS

GOVERNMENT OF NAMIBIA

MOHSS and GLOBAL FUND

In association with

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CSO	Civil Society Organization
FY	Financial Year
GARPR	Global AIDS Response Progress Report
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIZ	German Society for International Cooperation
GRN	Government of the Republic of Namibia
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
IFSM	Integrated Financial Management System
IOM	International Organization for Migration
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoF	Ministry of Finance
MOHSS	Ministry of Health and Social Services
MTEF	Medium Term Expenditure Framework
N$	Namibian Dollar
n.e.c.	not elsewhere classified
NABCOA	National Business Coalition on AIDS
NAMAF	Namibia Association of Medical Aid Funds
NANASO	Namibia Network of AIDS Service Organisations
NASA	National AIDS Spending Assessment

NDHS	Namibia Demographic and Health Survey
NGO	Non Governmental Organization
NHA	National Health Account
NHIES	Namibia Household Income and Expenditure Survey
NIP	Namibia Institute of Pathology
NPC	National Public Commission
OOP	Out-of Pocket
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PSEMAS	Public Service Employees Medical Aid Scheme
RH	Reproductive health
SACU	Southern Africa Customs Union
STI	Sexually Transmitted Infection
TB	Tuberculosis
THE	Total Health Expenditure
TSF	Technical Support Facility
UN	United Nations
UNAIDS	The Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund

UNGASS	UN General Assembly Special Session on HIV and IDS
UNICEF	United Nations Children Education Fund
UNODC	United Nations Office on Drug Control
US$	United States Dollar
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

FORWARD

The Ministry of Health and Social Services (MOHSS) wishes to extend its sincere thanks, appreciation and gratitude to all Government Ministries and Departments, Development Partners, National and International Non- Government Organizations, Private Institutions and Stakeholders who contributed to the process of the National AIDS Spending Assessment (NASA) 2014.

The NASA exercise tracks HIV and AIDS expenditures for the financial years 2012/13 and 2013/14. It assesses the overall AIDS spending in the country by examining the flow of resources, expenditure by thematic and sub thematic categories, production factors and beneficiary population. The data collected gives us credible information on how Namibia is doing in terms of reaching the targets set out in the National strategic Framework (NSF) as well as achieving global and regional targets that Namibia is committed to. As part of the NSF, Namibia would like to see an increase in domestic National HIV and AIDS expenditure by the year 2015/16. This report gives us an indication on the progress made so far and it also provides us with recommendations on what we can do in order to improve our funding if we are to keep up with the trend of expenditure.

Acknowledging with thanks, the collaboration and cooperation from the stakeholders, the Ministry would like to express its appreciation for the highly valued information and trust that the cooperation continues.

Dr. Richard N. Kamwi, M.P

Minister of Health and Social Services

PREFACE

This report is a presentation of findings from Namibia's HIV/AIDS Resource and expenditure tracking exercise for the financial years 2012/13 and 2013/14 respectively. In its endeavor to institutionalize resource tracking in the health sector, the Ministry of Health and Social Services embarked on the exercise culminating in the production of this report.

The study leading to the report was conducted to provide a comprehensive assessment of all spending on HIV/AIDS in Namibia.

Additionally, an outcome of the study was to prepare and complete the National Funding Matrix to report on the Global AIDS Response Progress Reporting (GARPR) in 2013 and 2014. The GARPR is also a national commitment to the 2011 UN Political Declaration on HIV/AIDS.

The data collected and analyzed were derived from many sources comprising of government ministries, bilateral and multilateral organizations, nongovernmental organizations, and private institutions.

In view of the above, I most heartily express my utmost thanks and appreciation to all institutions for their contribution and support during the period of the exercise. Special recognition and commendation must be made of PEPFAR, the Global Fund PMU, GIZ and the UN for their cooperation and direct support through funding and technical assistance. I express profound gratitude also to UNAIDS for their unflinching financial and technical support to this worthy national undertaking

The study was conducted by a multidisciplinary team from the Ministry of Health and Social Services, Global Fund/DSP PMU, UNAIDS and a team comprising of an International consultant and two national consultants with supervisory oversight by the Resource mobilization Technical Advisory Committee of the National AIDS Executive Committee (NAEC).

As a result of this NASA report, we were privileged to be provided with vital expenditure information for national policymakers, donors, and other stakeholders to guide their strategic planning and dialogue to inform decision making.

Mr. Andrew Ndishishi

PERMANENT SECRETARY, MINISTRY OF HEALTH AND SOCILA SERVICES

1. Executive Summary

A National AIDS spending Assessment (NASA) was conducted in Namibia in the year 2014 by the Government of the Republic of Namibia through the Ministry of Health and Social Services with support from Global Fund and UNAIDS.

The overarching framework that guides the review of the HIV spending is the revised National Strategic Framework. The primary goal of the framework is to "facilitate strategies that curb the spread of the HIV and AIDS epidemic and mitigate social and economic impacts through a multi sectoral response", focusing on preventing the occurrence of new HIV infections in Namibia.

In collaboration with development partners, Namibia has made significant progress in the response to HIV and AIDS in the areas of prevention, treatment and care and OVC as evidenced by the reduction in prevalence from 17.8% in to 14.3% between the periods 2010/11 and 2013/14. Total funding expended for the HIV and AIDS response during the periods under review amounted to $201,060,024 for 2012/13 and $213,346,629 for 2013/14. The result from the NASA exercise shows an increase in the funds spent by 6% percent from 2012/2013 to 2013/2014.

Where the Resources came from.

Spending by **Government** was the highest in the two periods 2012/13 and 2013/14. In 2012/13 fiscal year spending by government was $111,050,386 and $136,620,606 in 2013/14 making up 55% and 64% respectively of total expenditures in both financial periods. This equates to an increase of 23% from the 2012/13 expenditure of $111,050,386 to 2013/14 expenditure of $136,620,606.

Bilateral spending for the fiscal year 2012/13 was $72,900,158 and in 2013/14 $59,334,193 making up 37% and 28% of total expenditures for both periods. Total bilateral spending comprised of funds from PEPFAR and GIZ. Total spending in 2012/13 was 72,900,158 (36%) while it was $59,334,190 (28%) in 2013/14. PEPFAR's portion of the total bilateral spending amounted to $71,394,683 (98%) in 2012/13 and $57,658,447 (97%) in 2013/14 while GIZ spent $1,505,475 (2%) and $1,675,746 (3%) in 2012/13 and 2013/14 respectively.

Multilateral sources comprising of UN Agencies and The Global Fund spent $14,160,067 in 2012/13 and $14,426,541 in 2013/14 making up 7% and 6.7% respectively of total HIV expenditure for both reporting periods. Of this total amount of multilateral spending, Global fund spent a total of $10, 495,196 (75%) to UN Agencies' spending of $3,664,901 (25%) in 2012/13 and in 2013/14 it was $11,978,348 (83%) to UN Agencies' $2,448,193 (17%).

Private Sources 'contribution captured in this exercise in 2012/13 and 2013/14 was $2,601,023 and $2,442,655 of the total HIV expenditures. By percentage, it was a little over 1% for both 2012/13 and 2013/14.

Who are the Beneficiaries?

There are six categories of Beneficiary Population, (PLHIV, Key Population, Other Key Population, Specific "Accessible" Population, and General Population and Non-Targeted Interventions).

PLHIV consists of all people living with HIV and AIDS regardless of having a medical/clinical diagnosis of AIDS. **Key Population** includes population groups such as Sex workers and their clients (SW), injecting drug users (IDUs), and men who have sex with men (MSM). **Other Key Population** include orphans and vulnerable children, children born or about to be born to HIV-positive mothers, refugees, internally displaced people and migrants. **Specific "Accessible" Population** include children in school, women attending reproductive health clinics, military personnel, and factory employees whilst **General Population** comprises interventions targeting the general population as a whole and not any particular accessible or key population. **Non-Targeted Intervention** refers to those expenditures that do not belong to an explicitly selected or targeted population.

From the analysis (see Table 21), it is shown that in the financial years 2012/13 and 2013/14, total amounts of $66,221,409 (33%) and $47,266,368 (22%) respectively were spent on **PLHIV**. This beneficiary group received the most of expenditures in 2012/1. In both financial periods, the **Key Population** benefitted the least at $960,808 (0.48%) in 2012/13 and $1,886,862 (1%) in 2013/14.

Other Key Populations benefitted to the tune of $42,750,384 (21%) in 2012/13and in 2013/14 amounted to $39,284,790 (18%). Expenditure on the **General Population** in 2012/13, totaled $25,699,816 (13%) and $34,971,871(16%) in 2013/14. Spending on **Non-Targeted Interventions** amounted to $21,856,853 (11%) and $26,957,787 respectively.

2. Background

2.1. Country Context

Namibia has a surface area of approximately 824,116 square kilometers. It is divided into 14 administrative regions. The population is estimated at 2,104,900 (2011)[1]. The country has the second lowest population density in the world (2.5 inhabitants per square kilometer). The population is spread unevenly across the country with the North-Central and North Eastern parts accounting for 60% of the population. Around 43% of the population is under the age of 15 year while Life expectancy has significantly improved to around 60 years of age (NDP4). Two thirds of the population lives in rural areas and engages in subsistence farming and livestock production.

The annual Gross Domestic Product (GDP) was estimated at $13.07 billion in 2012. The gross national income per capita of Namibia is $6,780 for 2012/13 whilst it was $7,240 for 2013/14. Namibia is classified by the World Bank as an upper Middle Income country with GNI per capita of $5,640 (Atlas Method). A review of the Human Development Index by UNDP in 2013 shows the Namibian index is 0.608 placing the country at number 128 out of 187 countries (2012)[2]. Namibia has one of the greatest income inequalities in the world, as evidenced by a Gini co-efficient of 0.6[3] with 37% unemployment[4].

The economy is both formal and informal, but is largely dependent on mining, fishery, large-scale farming and high-end tourism. This has given rise to a highly mobile population characterized by a system of circular labour migration to mines, ports, farms, urban areas and tourism nodes. Rural-urban migration is substantial and has resulted in growing informal settlements in cities, towns and smaller semi-urban localities. Internal mobility and socio-economic factors have tended to increase the likelihood of risky sexual behaviors and vulnerability to HIV infection[5].

2.2. HIV Prevalence Levels and Trends Magnitude

In 1986, the first case of HIV was reported in Namibia and the epidemic was estimated to have risen in the 1990s. Adult prevalence (15–49) climbed to about 22% in 2002 but dropped drastically in 2010 when a high level degree of intensity in combating the epidemic occurred. Namibia has a generalized and mature epidemic where HIV is transmitted primarily through heterosexual and mother-to-child transmission (MTCT).

For the period 2013/14, HIV prevalence amongst people aged 15 and above is estimated at 14.3% according to the Spectrum modeling.

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[1] National Planning Commission. Namibia 2011 Population and Housing Census Preliminary Results
[2] Human Development Report 2013
[3] World Bank 2012
[4] World Bank 2008 and NPC 2008
[5] Ibid
6 Spectrum Policy Modelling System, Version 4.392 (2011): Namibia model July 2011

People aged 15 and above totaling approximately 220,000 are currently estimated to be living with HIV. People living with HIV are projected to increase in 2016/17 to an estimated 227,000 and over 245,000 by 2019/20. The expected increase in the number of PLHIV will mainly be the outcome of reduced AIDS mortality due to improved and high coverage of ART. The Government has taken a decision to implement the new WHO 2013 Treatment Guidelines and will extend ART treatment to children below 15 years living with HIV including hepatitis B patients.

Amongst pregnant women attending Antenatal Clinics (ANC), The 2012 National HIV Sentinel Survey estimated 18% overall prevalence. It should however be noted that there is considerable variation between sites. Katima Mulilo (37.7%), Onandjokwe (25.7%), Oshikuku (24.7%), and Rundu (24.5%) were sites with the highest HIV prevalence rates while Windhoek Central Hospital (9.6%), Rehoboth (9.8%), Opuwo (9.8%), Gobabis (9.9%) and Okakarara (9.9%) recorded the lowest rates.

The highest HIV prevalence among women by age group was found to be high between the ages of 35 – 39 (34%) and women aged 30-34 years (30.8%). The HIV prevalence rate was lowest among women aged 15-19 years (5.4%) and women aged 20-24 years (10.9%)[6]. The reason for the prevalence rate being high among women in the age category 30-34 can be linked partially to the progressive increase in ART coverage. The high prevalence rates in the 30-34 age shows that pregnant women who were infected during their 20s are now living longer.

It is estimated that new HIV infections dropped from approximately 13,000 in 2012 to around 12,00 in 2013[7] and expected to drop further to below 5,500 by 2020. New female infections are estimated to remain above new male infections significantly during this period.

Additionally, it is anticipated that once the 2013 WHO ART Treatment and Prevention Guidelines are adopted, it is likely to have an effect on the progression of AIDS-related mortality. As a result of this, it is expected that the annual number of AIDS deaths amongst adults 15 and above which stood at about 5,500 at 2010 is expected to drop dramatically by 2017.

Approximately 250,000 children 18 years of age or younger are orphans or vulnerable children (OVC). Around 28% of these OVCs (69,000) have been estimated to be orphaned by AIDS by the end of the fiscal year 2013/14 **(MOHSS 2009, NDHS 2006/7).**

2.3. HIV and AIDS Funding

The National Government funding for HIV and AIDS relative to the National Health account contains HIV and AIDS as a sub-account. However, it is difficult to break down the sum total of the amounts of funds budgeted and those disbursed and spent directly to HIV and AIDS. In 2009/10

[6] MOHSS (2012) Report on the 2012 National HIV Sentinel Survey
April 2011 – March 2012, National AIDS and STI Control Programme. MOHSS, Windhoek.
[6] Spectrum Policy Modelling System, Version 4.69_500 (2013); Namibia Model September 2013
[6] MOHSS (2012) Report on the 2012 National HIV Sentinel Survey
[7] Spectrum Policy Modelling, UNAIDS 2014

government contributed 49.7% of total expenditure while in 2010/11contribution was 60.4%. However, current data shows that government funding for HIV and AIDS dropped to 55% in 2012/13 but increased substantially to 64% in 2013/14. This clearly demonstrates the commitment of government to HIV and AIDS response.

Comparatively, as a percentage of Government's spending, Namibia's HIV and AIDS budget is the second highest to South Africa amongst countries within the Southern African Customs Union. Funding for HIV and AIDS has come in substantive proportions from GFATM, PEPFAR and GIZ. PEPFAR is the primary source of external resource support for HIV programs in Namibia through its significant contribution to all major program areas. However, it must be noted that the contribution of PEPFAR declined by 29% from over $100 million in 2011/12 to $71 million in 2012/13. In the financial year 2013/14, there was a further decline in PEPFAR's contribution by 20% to $57 million.

This NASA process also highlights the fact that although funds have been made available annually, tracking how the funds are being used remained a challenge. Spending on health is now the leading priority area for donors, accounting for 79% of all donor disbursements in Namibia. Donor funding has been channeled through both government and civil society organizations. Funding equity remains a concern between HIV and AIDS related programmes and other mainstream health programmes.

The results from this exercise dictate the need for a more in-depth spending and cost benefit analysis that would enable the government and partners to invest in programmes that yield the highest impact. It would also ensure that data is available to inform future decisions on resource allocation and spending. The 2013 Mid Term Review of the AIDS response strongly suggest the development of an investment case for the Namibia AIDS response to address this issue.

3. Introduction

The 2014 NASA exercise is an initiative of the Government of the Republic of Namibia through the Directorate of Special Programs of the Ministry of Health and Social Services.

The exercise tracks HIV and AIDS expenditures for the financial years 2012/13 and 2013/14. The process assesses the overall AIDS spending in the country by examining the flow of resources (Sources of funds, Agents and Providers,), and expenditures by thematic and sub thematic categories, production factors and beneficiary population.

The objective of NASA is to track expenditures on both health and non-health components by using six variables (Financing Sources, Financing Agents, Functions or AIDS Spending Categories (ASC), Production Factors, Providers of Services and Intended Beneficiaries/Beneficiary Population).

The specific objectives of the 2014 NASA are:

1. To assess HIV and AIDS financing flows (National and International) and expenditures for eight ASCs through the collection of needed data and information from various categories of Stakeholders involved in the response to HIV and AIDS.
2. To complete a Funding Matrix for the 2014 GARPR and produce a report consisting of detailed analysis of the expenditure data collected.
3. To ensure that during the course of the exercise capacity is built, for the National Consultants working with the External Consultant, through the transfer of knowledge and skills on the NASA methodology. This will necessitate the building of an in-country capacity to undertake similar future exercises for Namibia without the need to solicit external consultancy.

Questions inherently addressed by the NASA are as follows:

i. What is actually disbursed and spent in each component of the HIV response? Are the expenditures going to priority HIV interventions?
ii. What is the allocation of AIDS spending in relation to the objectives and priority of the National Strategic Framework for HIV and AIDS 2010/11- 2015/16?
iii. Who are the major sources of HIV and AIDS funds in the country and where are the funds directed?
iv. Who are the main service providers and beneficiaries of these services?
v. Are sufficient resources invested to enhance capacity for scaling up human resources?
vi. Does international donor assistance contribute to enhance national capacity particularly in external and internal resource mobilization?

It is important to note that NASA is not a process that can provide information about whether or not specific interventions are cost-effective. This is not the purpose of the NASA and its tools cannot be utilized to generate such data. In addition, the NASA does not function as a tool for

audit and does not articulate whether or not funds were spent in line with agreed principles and procedures. However, if the process is done comprehensively, it can be used to highlight resource gaps for the AIDS response covering the period of review.

3.1. Process and Methodology

The process for the National AIDS Spending Assessment (NASA) commenced in February 2014. A core team based in the MOHSS was constituted to steer and conduct the preparation of the NASA exercise. The team comprised of professionals from the MOHSS and UNAIDS respectively to work along with an international consultants and two national consultants.

The core team ensured quality assurance throughout the entire NASA process. They also reviewed the NASA generic tools developed by UNAIDS and agreed to amend some portion to fit the Namibian country context in order to facilitate an easy and understandable method of data collection. By adapting the tool, it was possible to expand the NASA tools to include additional data or information where required or limit the collection of only those data and/or information required in particular instances.

The Stakeholders identified through a mapping exercise to participate in the NASA exercise were categorized as Sources, Agents and Providers wherein data collection tools were distributed to them. Initial briefing, follow-up visits to offices, telephone calls and email communication were made to keep stakeholders engaged. Capacity building was a key part of the entire process and commenced with a one day training workshop for programme and finance staff of stakeholders. The purpose was to acquaint them on the NASA objectives, processes, classifications and other details. The workshop was also followed by intermittent and periodic orientations of the participating organizations by the consultants.

The process was highly interactive with constant support from the Ministry of Health and Social Services and UNAIDS.

3.1.1. Data Processing and Quality Assurance

The primary sources of data and information were the Sources of fund and those who provided the goods and services (Agents/Providers). In many cases an organization performed in dual capacity as an Agent and a Provider. This includes the Ministry of Health and Social Services and UN Agencies. For most Civil Society organizations, who are by and large Providers of goods and services, their respective funding organization, provided the necessary data and information on their behalf. An example of this is PEPFAR who provided very substantial and detailed data on behalf of their implementing partners. However, it must be mentioned that a good number of the implementing partners were recipients of funds from more than one donor.

An unrelenting aspect of the exercise was ensuring the integrity and quality of all data collected. This was an integral concern of all those involved so as to avoid double counting, omissions, and errors in calculations and as far as possible, maximize data collection.

3.1.2. The Validation Process

Prior to preparation of the first draft of the NASA report, two consultative meetings were organized with the support of the MOHSS-HIV PMU and UNAIDS. The meetings provided a platform to inform stakeholders of preliminary findings and challenges of the process. It also served as a channel to engage them regarding their assessment of the process and findings.

As a result of the meetings, the views and recommendations of stakeholders provided a wider perspective of the process which impacted and helped shape this report. The meetings also facilitated the identification of gaps in the collection of data and the requisite leads and guidance to address those gaps.

The draft report also went through a series of reviews by the entire stakeholders who participated in the process.

3.2. Scope and limitations

The NASA exercise is based on data collection (qualitative and quantitative) from three groups of stakeholders: a) Sources, b) Agents and c) Providers. A source refers to the source of funds. For example, a donor such as PEPFAR or GFATM would be categorized as a source. Agents are those who serve as intermediaries or funding channels. Providers are those who provide the goods or services to the beneficiaries.

Most of the data contained in this NASA relied on the Source of funding as supplied by the Sources themselves. This meant that a top to bottom approach was used. The team of Consultants did not approach all of the Providers directly. As a result, some of private spending, household and out of pocket expenditures are also not captured for the periods under review.

Another limitation of this NASA exercise is the difference in fiscal year of different organizations. In some cases, data received had some overlap due to this limitation.

Given the diversity and complexity of private sector, concerted efforts were made to ensure inclusion of their data. Some of the hotels and banks have workplace programmes. Even some training institutions and allied groups may have some spending for HIV and AIDS; but access to such data remains a challenge and therefore limits optimal reporting on private sector investments in the national response.

Consumers and Out of Pocket Expenses (OOPE) are often related to opportunistic infections (OIs) and Home Based Care (HBC). In country contexts like that of Namibia, when some programme budget allocations are intended for management of OIs and HBC, it is very difficult to disaggregate OOPE. Given the level of current coverage of services, access and utilization as well as the tendency of clients to seek health services through private providers, a proper and acceptable method of estimating such expenses is necessary.

It is worth noting that some organizations have difficulties and are reluctant in reporting HR costs mainly of International Staff, partly because such expenditures are often directly handled by their

Headquarters without much involvement of Country Offices; in some cases, such costs could be much higher than the total of other programme related costs. Similarly, some expenditures such as capacity building, international trainings, seminars and visits are often incurred directly from the Sources outside the country. All such costs are beyond the boundary of this NASA to capture and analyze.

3.3. Assumptions and Clarifications

The NASA methodology allows for further disaggregation of the data to show expenditures by spending categories and to identify the categories of beneficiaries that receive funding. However, given the nature of data received a number of assumptions were made which were applied and helpful in ensuring the completeness of data, interpreting the findings and making recommendations.

3.3.1. Assumptions:

1. The problem of missing HIV expenditure information was more acute in respect to sectoral ministries. It was therefore difficult to draw a comprehensive conclusion on the HIV and AIDS financial flow to certain sectors. However, on the basis of information provided by the MoF and service providers, the exercise made attempts to reconstruct sectoral HIV and AIDS Spending.
2. In an instance where detailed expenditure records of providers were not available, the exercise assumed equal split of funds between the key programmes, unless instructed otherwise. Crude estimates were made of the proportion which could be considered HIV and AIDS expenditure, but these require further discussion and validation.
3. The MOHSS is classified as a financing source because it assigns the public and international resources to intended HIV use and not to any other alternative use. It is also classified as a HIV service provider.
4. PEPFAR provided expenditure data on its sub recipients. Although these data were also obtained from some of the recipient organizations, the assessment obtained a list of partners who received PEPFAR funding and managed to provide aggregate expenditure data for 2012/13 and 2013/14. In order to minimise the potential for double counting, the assessment utilised the aggregate expenditure data reported by PEPFAR.
5. Where the data on beneficiaries were not disaggregated and detailed enough, the bulk of it was assumed to be targeted to the general population. However for prevention programs such as mass media and HIV- Related Information and education with no specific target group, we assumed the general population as the key beneficiaries.
6. A few development partners had different financial reporting periods from that used by the government (April-March) e.g. PEPFAR (October-September). Effort was made to capture the actual expenditure according to the government's fiscal year. While it is recognized that this is not accurate, the magnitude of error is small and a likelihood to have some balancing between cases.
7. The end of year exchange rate of the US dollar to the Namibian dollar was used for each year of the study.

3.3.2. Clarifications:

1. A particular period must be chosen within which the expenditures covered in the report took place. For this resource tracking exercise, the Namibian fiscal or financial year (FY) was selected and specifically covered FY 2012/13 and FY 2013/14.
2. In monetary term, the value of the consumption of a good and service of interest is measured by Expenditure. Expenditures refer to realized spending.
3. Commitment - is promised to a recipient (e.g. Civil Society Organization) but not necessarily sent from the source (e.g. Donor).
4. Disbursements – a situation where funds are transferred to recipients from the source of funding but does not mean it is spent.
5. NASA tracks expenditures of goods and services covered in the specific fiscal years. Thus, goods donated but not distributed to the population during the fiscal periods under review, are not included in the report. This also applies to services to be rendered but not yet rendered.
6. NASA uses a method in which expenditures are only captured in the Fiscal year they were actually incurred rather than the period of commitments clarifying when beginning of the transaction was and the point of payment.
7.

The average exchange rates for both reporting periods are as follows:

I. 2012 – 9.254

II. 2013 – 10.7133

The above exchange rates are in respect to the United States dollars which is the currency used for this report. The exchange rate is based on the Central Bank average rate for each year. All Namibian dollar amounts contained in the data are converted to US dollar using these exchange rates, irrespective of the month in which the expenditure was incurred. It would be highly inefficient to try to analyze the data based on monthly or weekly exchange rates.

Secondly, where expenditures were not detailed in terms of production factor or beneficiary population, a percentage distribution was utilized. In most instances, data do have ASCs and beneficiary populations accurately defined. In the allocation of other costs, a proportional allocation is done to align with the ASC. For example, if a certain ASC carries 25% of total spending, the same percentage is applied to such when calculating wages.

According to the NASA Classifications manual, category (.98 and .99) is assigned where there is inadequate information for assigning a specific NASA classification for expenditure or beneficiary group. These codes have as narratives, “not disaggregated by type” and ”not elsewhere classified”.

4. Major findings

The 2014 NASA is assumed to have captured over 90% of spending in the country by development partners and the government. Efforts were made to capture a large proportion of private sector expenditures. It is highly probable that the outstanding expenditures of the private sector not captured include household out of pocket expenditures. The NASA exercise was able to answer most of the questions around the source of funds, the targeted interventions, the providers and beneficiaries of goods and services by categories and classification.

4.1. Data Sources

A total of 91 Agencies and Organizations (Government Ministries and Agencies, Development Partners and Private Sector, and Civil Societies), were earmarked for data collection. They included major funding sources available in the country, funding agents and providers with categories of domestic and international identities mostly located in Windhoek.

A total of 52 organizations were reported for. More than 30 organizations comprising of civil society organizations were reported for by their Sources of funding which included PEPFAR and GIZ. This meant that a top to bottom method was instituted curtailing any likelihood of double counting.

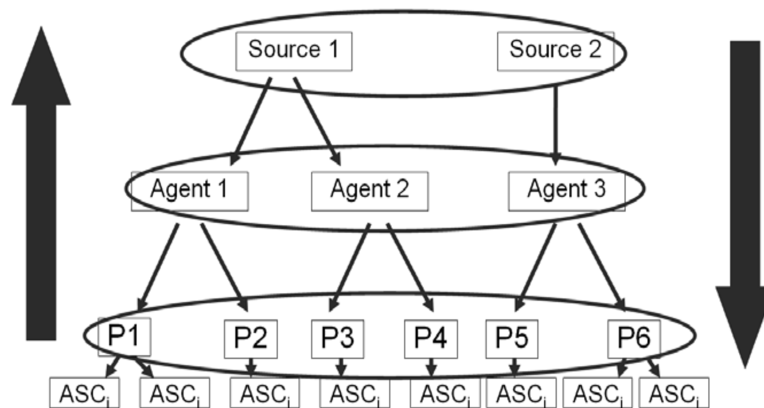

Figure 1 Fund Flow Chart – "Top to Bottom" – "Bottom to Top"

Table 1: NASA Respondents

Types organizations	*Number*	*%*
Central Government	6	12%
Bilateral Agencies	3	6%
Multilateral Agencies	8	15%
INGOs	10	19%
NGOs	21	40%
Private Sector	4	8%
Total	**52**	**100%**

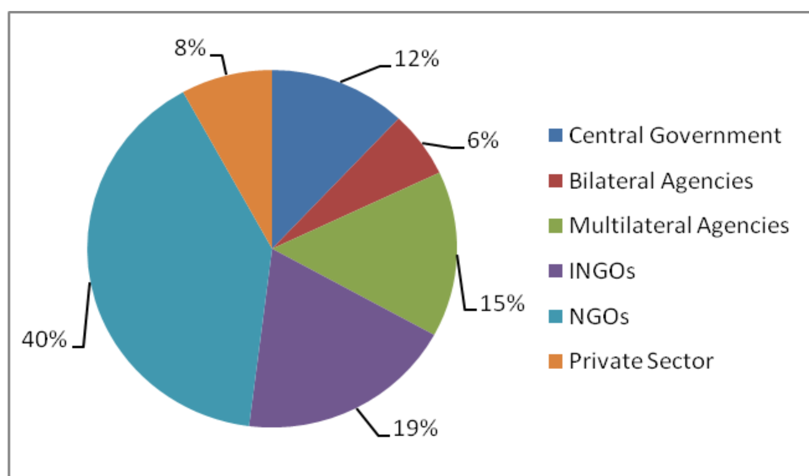

Figure 2: NASA Respondent by Percent 2012/13 and 2013/14

4.2. Data Sources Comparative Analysis 2009-2014

The assessment shows that total HIV and AIDS expenditures has fluctuated within the periods 2009 to 2014. The increment in total HIV and AIDS expenditures from 2009/10 to 2010/11 was 14.6%. In 2012/13, there was a decrease of approximately 28% of total expenditure while in the period 2013/14 there was an increment of 6% from the 2012/13 total HIV and AIDS expenditure of 20. See Table 3 below.

Table 2: HIV and AIDS Spending by Sources 2009 – 2014 (NASA 2009/10 – 2010/11)

Sources	2009/10	2010/11	2012/13	2013/14
Central Government	121,051,282	168,625,000	111,050,386	136,620,606
PEPFAR	87,320,513	92,375,000	71,394,683	57,658,447
Global Fund	26,192,308	9,319,444	10,495,166	11,978,348
GIZ	346,154	555,556	1,505,475	1,675,746
UN Agencies	8,346,154	7,847,222	3,664,901	2,448,193
Private Sector	230,769	319,444	2,601,023	2,442,655
Other International	-	-	348,390	522,634
Total	243,487,179	279,041,667	201,060,024	213,346,629

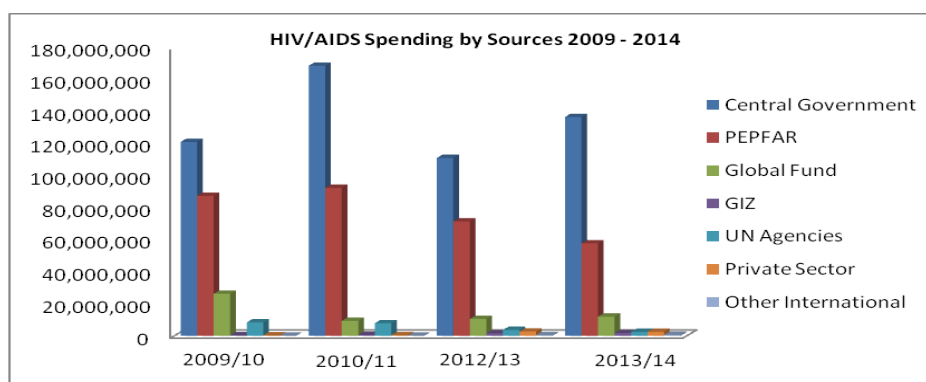

Figure 3: HIV and AIDS Spending by Sources 2009-2014

4.3. How Much Was Spent?

The total amount spent in Namibia was $201,060,024 in the period 2012/13 and $213,346,629 in the period 2013/14 respectively. Table 3 and Figure 4 below show disaggregation by sources.

Table 3: Expenditure by Source of Funding

SOURCES	2012 - 2013	%	2013 - 2014	%
Central Government	111,050,386	55%	136,620,606	64%
PEPFAR	71,394,683	36%	57,658,447	27%
Global Fund	10,495,166	5%	11,978,348	6%
GIZ	1,505,475	0.75%	1,675,746	0.76%
UN Agencies	3,664,901	2%	2,448,193	1%
Other International	348,390	0.25%	522,634	0.24%
Private	2,601,023	1%	2,442,655	1%
TOTAL	**201,060,024**	**100%**	**213,346,629**	**100%**

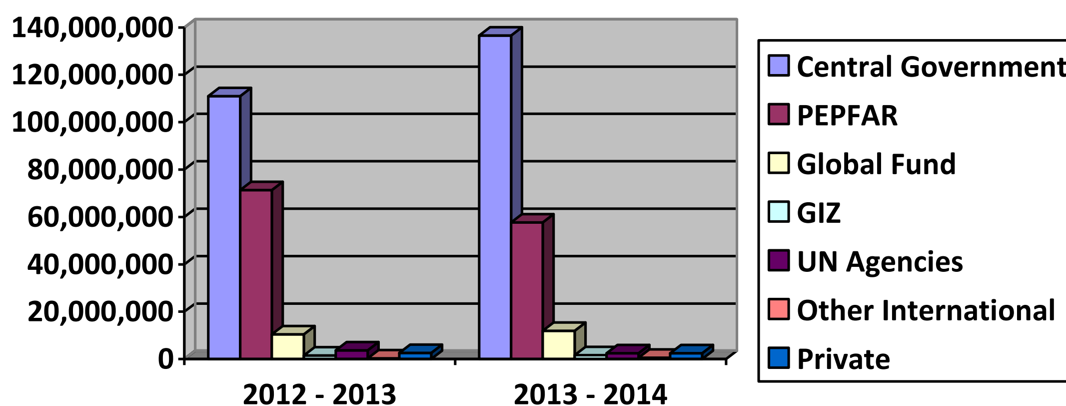

Figure 4: Source of funding – 2012/13 and 2013/14.

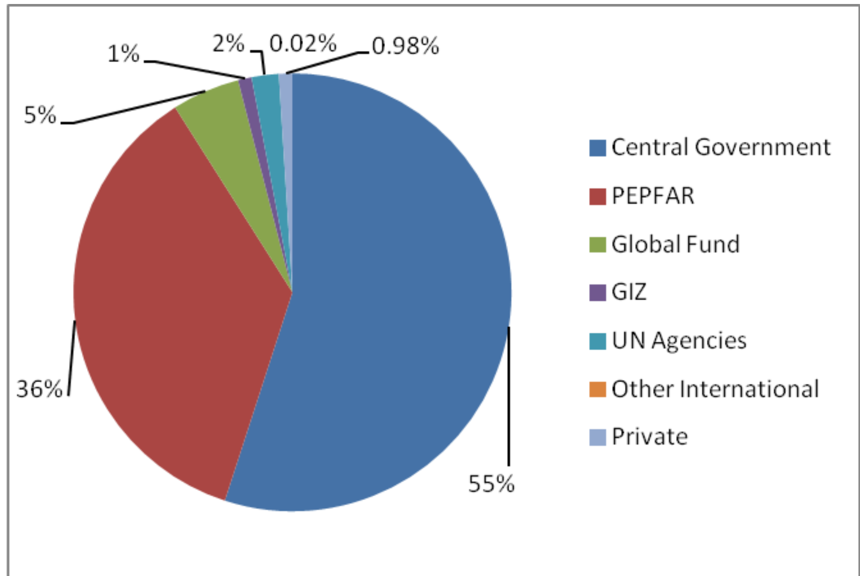

Figure 5: Source of funding by Percent 2012/13

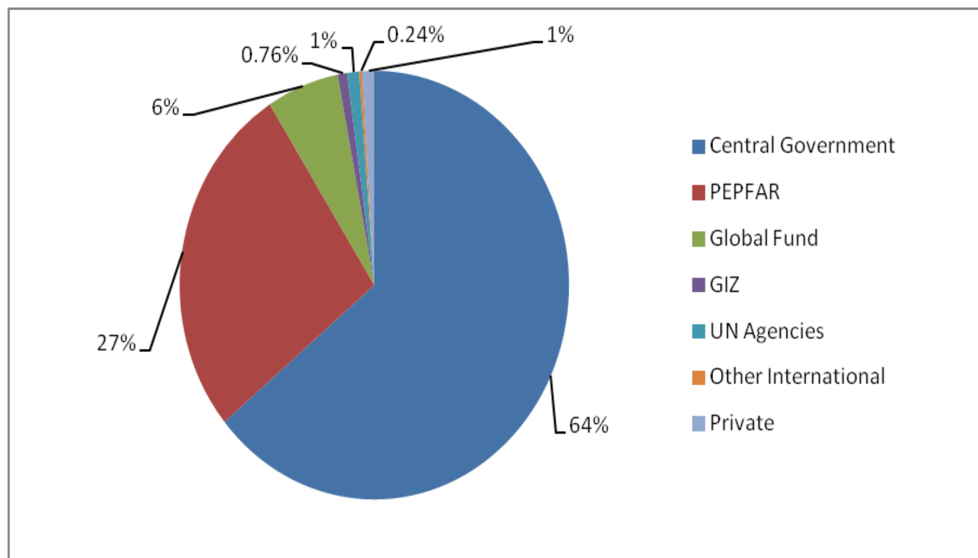

Figure 6: Source of funding by Percent 2013/14

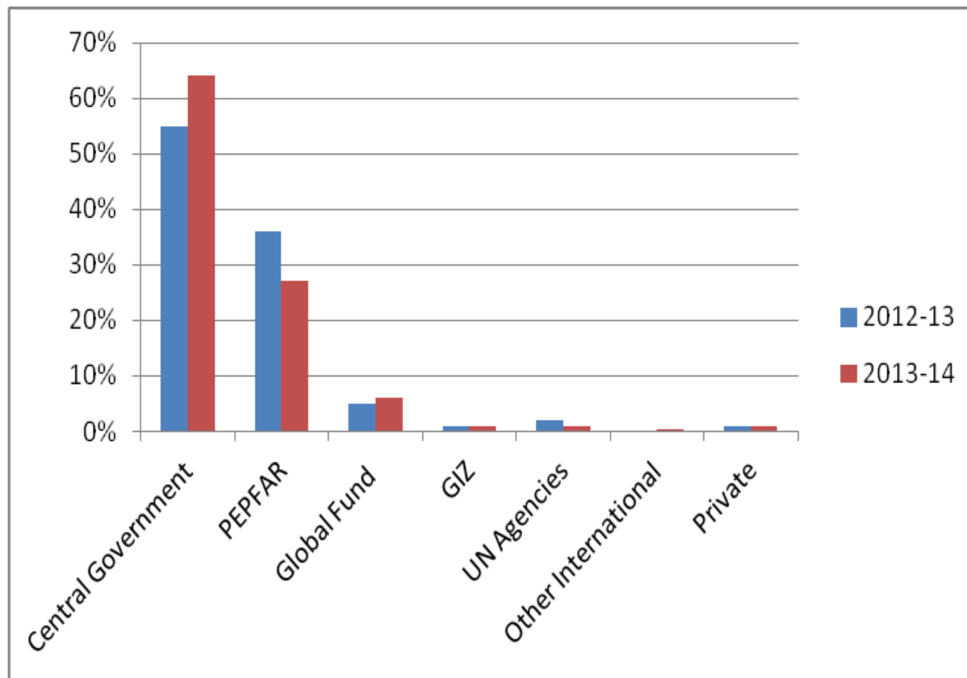

Figure 7: Source of funding by Percent 2012/13 and 2013/14

As shown in Table 4 and Figure 8 below, Private funds was 1% respectively for both reporting periods and may be attributed to several factors. For example, Out-of-Pocket Expenditure was not captured due to inadequate availability of data. However, a minimum amount of expenditures were accounted for from some reporting Private Organizations namely PSEMAS and Methealth.

Bilaterals and Multilaterals including INGOs who all constitute development partners are under the classification of International Sources of funding. In the course of both fiscal years 2012/13 and 2013/14, International spending was 44% and 35% respectively.

Table 4: Expenditure by Sources

SOURCE	2012/13	%	2013/14	%
Public Funds	111,050,386	55%	136,620,606	64%
International	87,408,615	44%	74,283,368	35%
Private	2,601,023	1%	2,442,655	1%
Total	**201,060,024**	100%	**213,346,629**	100%

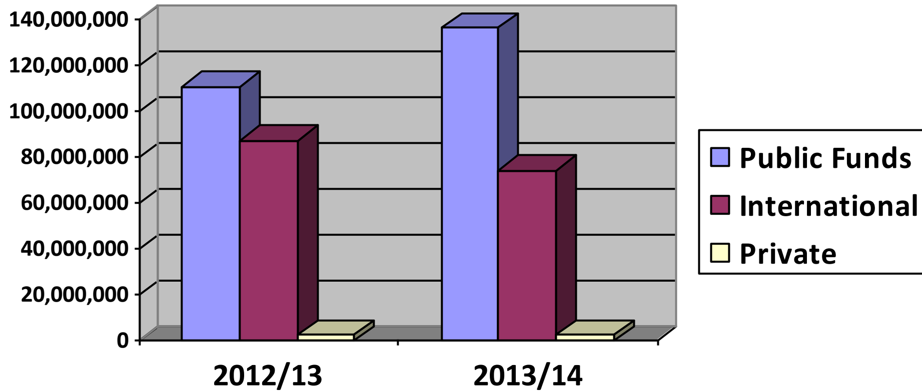

Figure 8: Financing Sources – 2012/13 and 2013/14

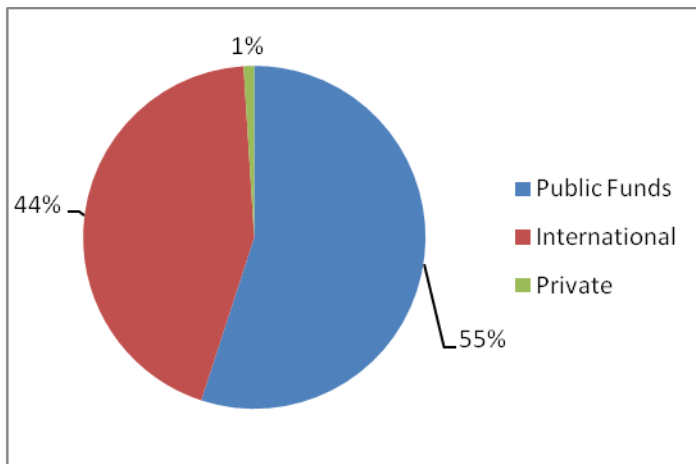

Figure 9: Financing Sources by Percent of Financing 2012/13

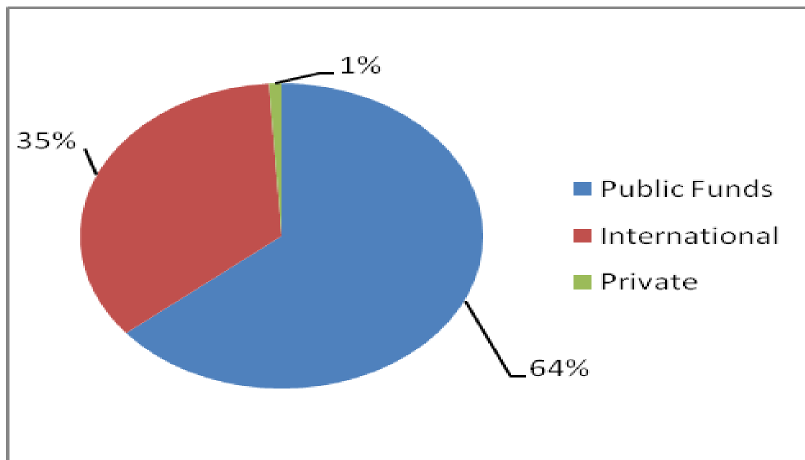

Figure 10: Financing Sources by Percent of Financing 2013/14

4.4. What Were Resources Spent On?

Of the total amount of $201,060,024 spent in the period 2012/13, the highest amount of $60,704,441 or 30% was spent on Care and Treatment and related activities, while the lowest amount of $1,656,656 or 1% was spent on Social Protection and Social Services excluding OVC.

Whereas in the period 2013/14, out of a total amount of $213,346,629 expended to the various major spending categories, the highest amount was spent on Human Resources $60,804,671 or 29% with the lowest amount being spent on Research, $1,545,164 or 0.4% of total 2013/14 spending. The decline in expenditures in Treatment and Care between 2012/13 and 2013/14 is due to the decrease of 60% in HIV and AIDS spending by PEPFAR mostly in the programme area of Treatment and Care. In 2012/13, PEPFAR's spending on Treatment and Care was $24,677,904 or 35% of a total spending of $71,394,683. In 2013/14, total spending by PEPFAR was down to $57,658,448 of which Treatment and Care amounted to $9,885,375 or 17% of the total spending.

Table 5: Spending By Categories of Major Service Delivery 2012/13

SPENDING CATEGORY	**2012/13**	**%**
Prevention	25,984,457	13%
Treatment and Care	60,704,441	30%
OVC	39,821,075	20%
System Strengthening and Programme Coordination	25,244,727	12%
Human Resources	40,436,276	20%
Social Protection and Social Services	1,656,656	1%
Enabling Environment	5,381,350	3%
Research	1,831,042	1%
TOTAL	**201,060,024**	**100%**

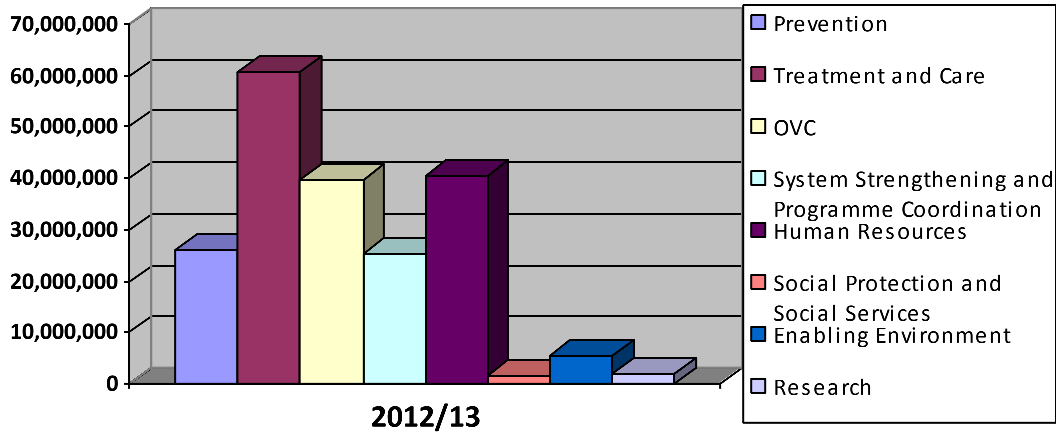

Figure 11: Spending by Categories 2012/13

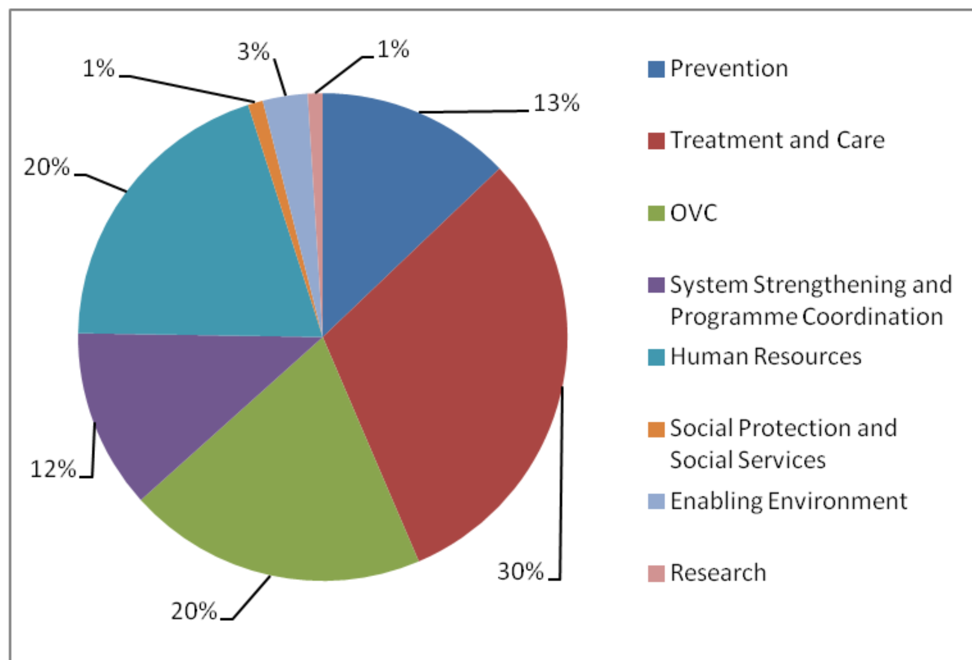

Figure 12: Major Spending Categories by Percent 2012/13

Table 6: Spending by Major Spending Categories – 2013/14

SPENDING CATEGORY	Amount 2013/14	%
Prevention	34,061,204	16%
Treatment and Care	38,291,448	18%
OVC	34,689,499	16%
System Strengthening and Programme Coordination	28,533,647	13%
Human Resources	60,804,671	29%
Social Protection and Social Services	3,303,525	1.60%
Enabling Environment	12,117,471	6%
Research	1,545,164	0.40%
TOTAL	**213,346,629**	**100%**

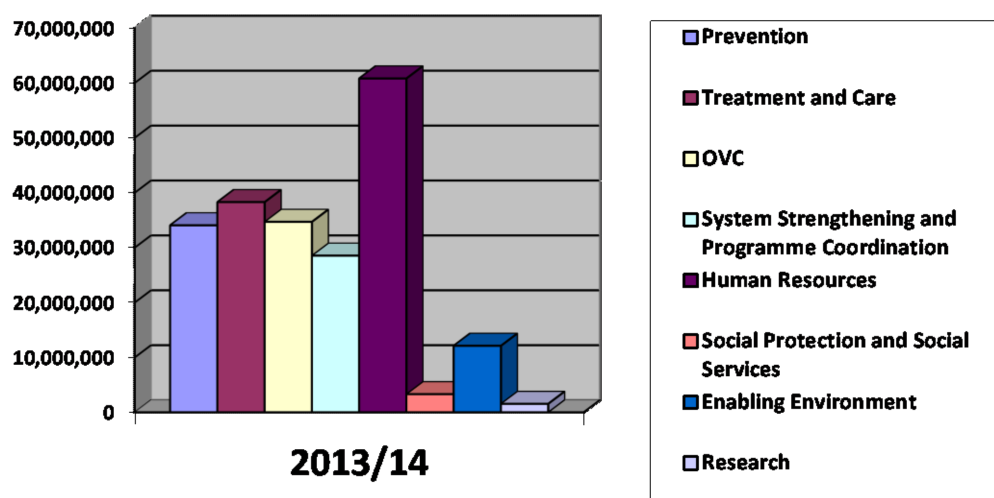

Figure 13: Spending by Major Spending Categories – 2013/14

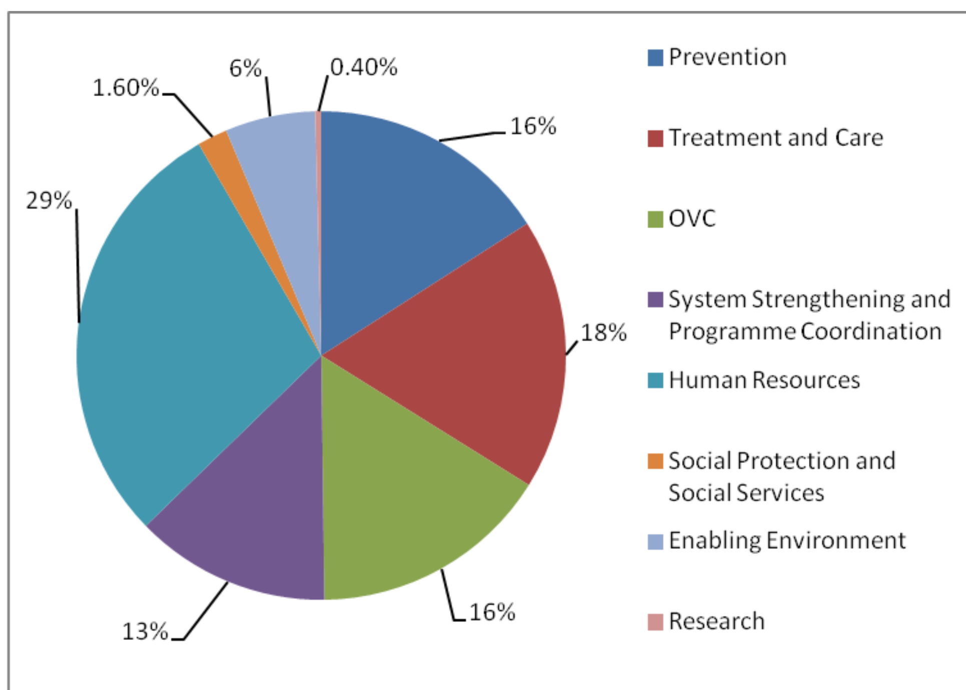

Figure 14: Major Spending Categories by Percent – 2013/14

Table 7: Percentage Distribution Of Expenditure in 2012/13 To 2013/14 By Programmes

Programmes	2012/13	2013/14
Prevention	13%	16%
Treatment and Care	30%	18%
OVC	20%	16%
System Strengthening and Programme Coordination	12%	13%
Human Resources	20%	29%
Social Protection and Social Services	1%	1.60%
Enabling Environment	3%	6%
Research	1%	0.40%
Total	**100%**	**100%**

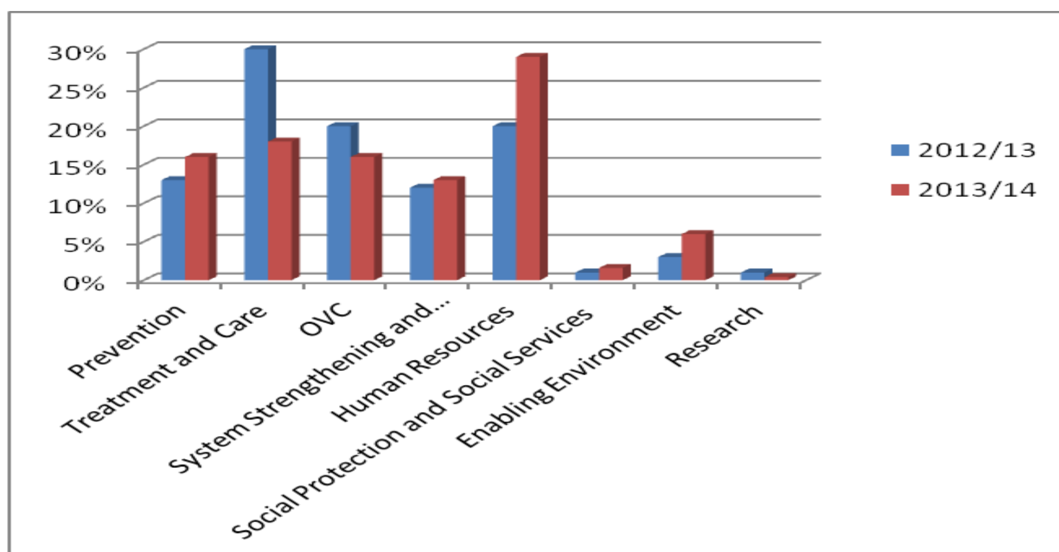

Figure 15: Major Spending Categories by Percent – 2012/13 to 2013/14

The following section highlights a detailed disaggregation of Expenditure by Agents and Service Providers by Key Programmes.

4.4.1. Prevention

Prevention spending rose by 31% in 2013/14 with expenditures of $25, 984,457 and 34,061,204 in 2012/13 and 2013/14 respectively.

Although spending for Prevention has increased by 31% from $25,984,457 (2012/13) to $34,061,204 (2013/14), there has been a relatively low spending on the Youth Population (Youth in School, Youth out of School and Male circumcision) among which new infections are on the increase according to the 2013 MTR. HIV prevalence amongst people aged 15 and above is estimated at 12.8% in 2013/14(2013 Spectrum modeling). Approximately 208,000 of people aged 15 and above were estimated to be living with HIV. The figure is projected to increase to over 227,000 by 2016/17, and to over 245,000 by 2019/20[8].

Overall, new HIV infections and AIDS related deaths are on the decline and estimates of total new infections suggests a drop from 11,878 in 2013 to around 11,057 in 2014. Annual AIDS related death is also estimated to have dropped from 6,585 in 2013 to 4,443 in 2014 **(2014 GARPR).**

[8] Spectrum Policy Modelling System, Version 4.69_500 (2013); Namibia Model September 2013

Table 8: Prevention Activities

PREVENTION ACTIVITIES	2012 - 2013	%	2013 - 2014	%
Communication For Social And Behavioral Change (BCC)	1,389,763	5%	909,481	3%
Community Social Mobilization	237,628	1%	228,012	1%
Voluntary Counseling And Testing (VCT)	9,438,230	37%	18,383,974	54%
Risk-Reduction And Prevention Activates For Vulnerable And Accessible Populations	7,148	0.03%	32,387	0.1%
Prevention - Youth In School	929,091	4%	739,890	2%
Prevention - Youth Out-Of-School	288,553	1%	356,615	1%
Prevention Of HIV Transmission Aimed At People Living With HIV	29,778	0.12%	582,360	2%
Prevention Programmes For Sex Workers And Their Clients	4,596	0.02%	1,026,718	3%
Programmes For Men Who Have Sex With Men	-	0%	319,143	1%
Harm-Reduction Programmes For Injecting Drug Users	-	0%	14,778	0.04%
Prevention Programmes In The Workplace	494,610	2%	175,566	0.5%
Condom Social Marketing	2,756,994	11%	2,906,556	8.5%
Public And Commercial Sector Female Condom Provision	243,899	1%	170,500	0.5%
Prevention Of Mother-To-Child Transmission	586,716	2%	951,012	3%
Male Circumcision	1,573,277	6%	642,409	2%
Blood Safety	685,937	3%	340,754	1%
Post-Exposure Prophylaxis	27,215	0.11%	38,734	0.1%
Pre-exposure prophylaxis (new category for GARPR 2014)	769,955	3%	319,292	1%
Prevention Activities Not Disaggregated By Intervention	6,298,280	24%	5,901,736	17%
Prevention Activities Not Elsewhere Classified	50,162	0.2%	21,287	0.06%
TOTAL PREVENTION ACTIVITIES	**25,811,832**	**100%**	**34,061,204**	**100%**

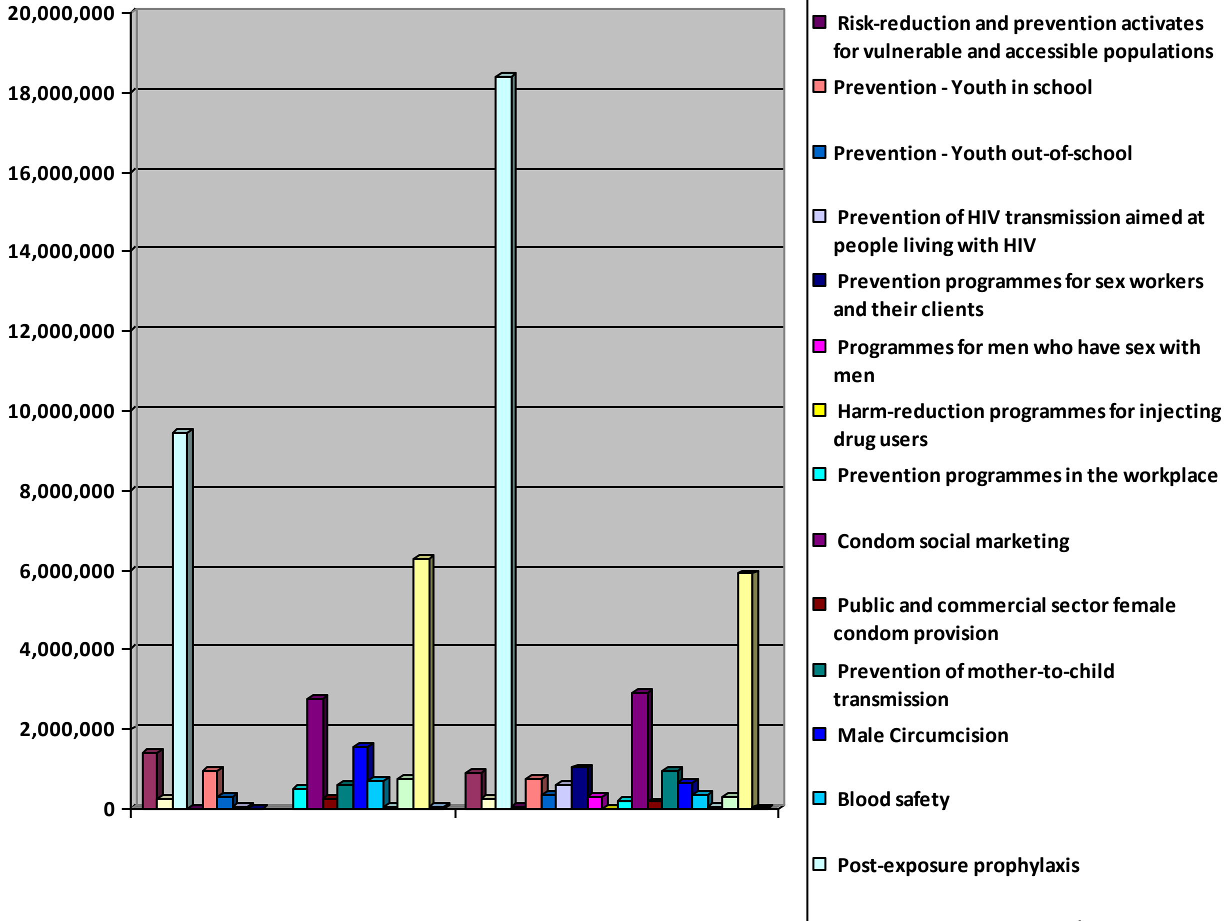

Figure 16: Prevention Activities 2012/13 and 2013/14

Prevention categories in term of expenditure ranking for 2012/13 and 2013/14 are shown below in Tables 9 and 10 respectively.

It should be noted that the amount stated for Prevention programmes in the workplace does not include those in the private sector. However, it is known that the private sector has these costs attached because insurers have screening/VCT as part of their packages. If these expenditures were quantified and included, the overall picture may have been different.

The report relied on the Work place expenditure data (Budget and Expenditure to date) provided by the Ministry of Finance for all Government Ministries and related agencies.

Table 9: Top 10 Prevention Spending Activities in 2012/13

Voluntary counseling and testing (VCT)	9,438,230	38%
Prevention activities not disaggregated by intervention	6,298,280	25%
Condom social marketing	2,756,994	11%
Male Circumcision	1,573,277	6%
Communication for social and behavioural change (BCC)	1,389,763	6%
Prevention - Youth in school	929,091	4%
Pre-exposure prophylaxis (new category for GARPR 2014)	769,955	3%
Blood safety	685,937	3%
Prevention of mother-to-child transmission	586,716	2%
Prevention programmes in the workplace	494,610	2%
TOTAL	**24,922,853**	100%

4.4.2. Treatment and Care

$60,877,066 was spent on Treatment and Care in the period 2012/13 and $38,291,448 in 2013/14. 75% and 76% respectively for each fiscal year were spent on ARVs, while Nutritional Support accounted for 11% and 6%. Home Base Care was 1% of total 2012/13 amount but increased by 8% in 2013/14 to 9%. $2,926,333 2012/13 and $1,431,370 2013/14 spending in this category were not classified in detail were grouped under ASC 2.98 (activities not disaggregated) and 2.99 (activities not elsewhere classified).

Table 10: Treatment and Care Activities

TREATMENT AND CARE ACTIVITIES	**2012 - 2013**	**%**	**2013 - 2014**	%
Provider- initiated testing and Counseling	1,328,764	2%	869,822	2.5%
Antiretroviral therapy	45,930,051	75%	29,247,514	76%
Nutritional support associated to ARV therapy	6,981,344	11.5%	2,339,624	6.1%
Specific HIV-related laboratory monitoring	231,363	0.5%	181,112	0.4%
Psychological treatment and support services	3,375,142	6%	719,384	2%
Home-based care	734,069	1%	3,502,622	9%
Outpatient care services not disaggregated by intervention	2,296,333	4%	691,201	2%
In-patient services not elsewhere classified	-	0%	30,516	0.08%
Care and treatment services not disaggregated by intervention	-	0%	709,653	1.85%
TOTAL TREATMENT AND CARE ACTIVITIES	**60,877,066**	**100%**	**38,291,448**	**100%**

Total expenditure on Treatment and Care has decreased drastically by 37% from $60,704,441 (2012/13) to $38,291,448 (2013/14). Most notable in the decrease are spending on ARTs from $45,930,051 (2012/13 to $29,247,514 (2013/14) a decline of 36%; spending on Nutritional Support from $6,981,344 (2012/13) to $2,339,624 (2013/14) a decline of 66%; Psychological Treatment and Support Services from $3,375,142 (2012/13) to $719,384 (2013/14) a decline of 79%.

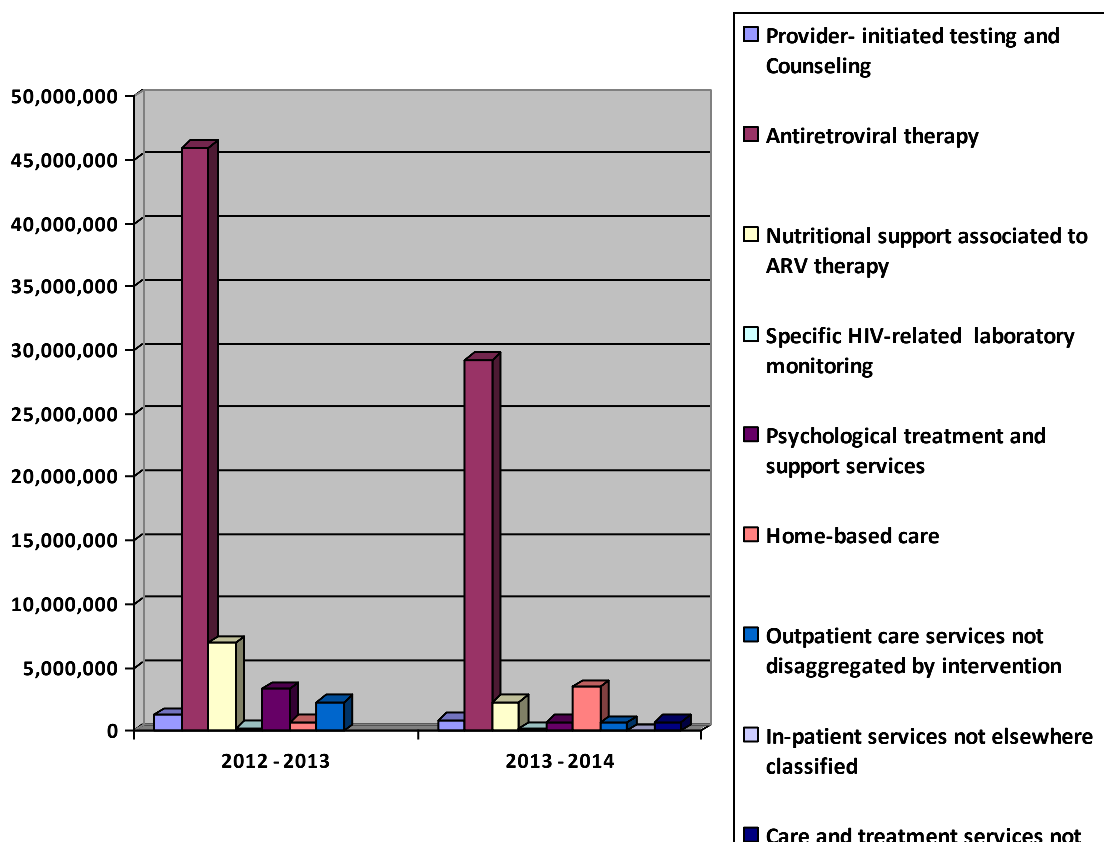

Figure 17: Treatment and Care Activities – 2012/13 and 2013/14.

4.4.3. Orphans and Vulnerable Children

Of the total spending in the country, OVC accounted for $39,821,075 or 20% of expenditures incurred in 2012/13 and reduced to 16% equaling $34,689,499 of 2013/14 expenditures. Within OVC related expenditure, Family/Home Support consumed the bulk of the resources amounting to 78% for each respective fiscal period. Education and Basic Health Care stood at 9.3% and 8.9% respectively.

Table 11: Orphans and Vulnerable Children

Orphans and Vulnerable Children	2012 - 2013	%	2013 - 2014	%
OVC Education	3,702,668	9.8%	1,088,711	3%
OVC Basic health care	3,547,406	9%	1,656,591	5%

OVC Family/home support	31,127,477	78%	27,183,370	78.6%
OVC Community support	38,550	0.1%	-	0%
OVC Social services and Administrative costs	-	0%	130,776	0.4%
OVC services not disaggregated by intervention	1,377,406	3%	4,630,051	13%
OVC services not-elsewhere classified	27,568	0.01%	-	0%
TOTAL OVC	**39,821,075**	**100%**	**34,689,499**	**100%**

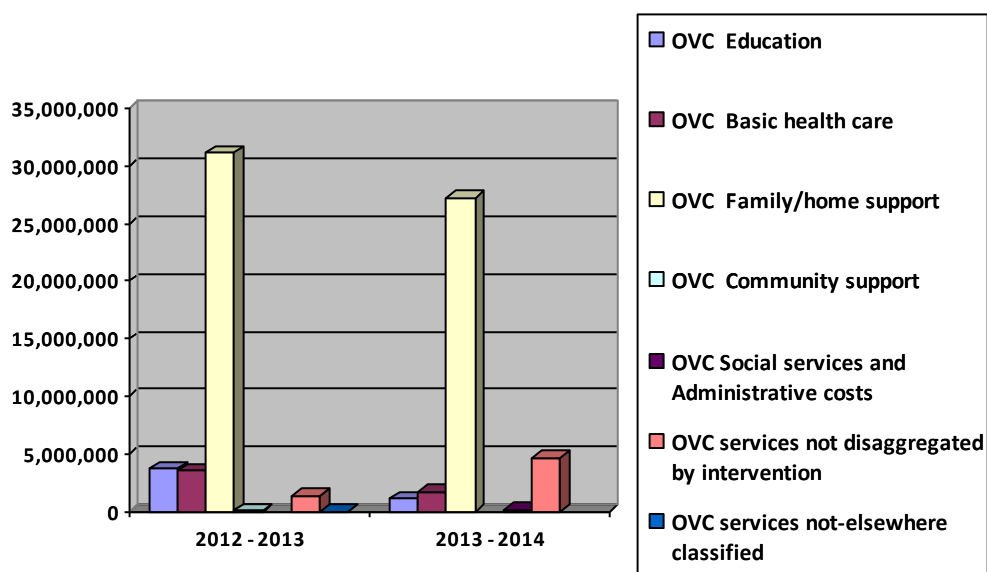

Figure 18: Breakdown of expenditure on OVC – 2012/13 and 2013/14.

4.4.4 System Strengthening and Program Coordination

System Strengthening and Programme Management consists of a wide variety of administrative activities related to the response to AIDS. As defined in the NASA classification, it is an essential component for effective and efficient delivery of goods and services.

In some instances, data received from various sources shows a pattern of lumping expenditures under this category. Concerted analytical effort was made to distinguish related expenses to the specific ASC and assign the appropriate NASA classification. In future NASA exercises, caution should be taken with regards to lumping figures together as solely administrative or overhead expenses of agent or provider.

Table 12: Systems Strengthening & Program Coordination

Systems Strengthening & Program Coordination	**2012 - 2013**	**%**	**2013 - 2014**	**%**
National planning, coordination and program management	9,006,297	36%	4,616,030	16%
Administration and transaction costs associated with managing and disbursing funds	7,107,367	28%	4,332,432	15%
Monitoring and evaluation	2,453,851	10%	1,893,513	7%
Operations research	863,939	3%	556,420	2%
Serological-surveillance (Serosurveillance)	2,348,465	9%	619,989	2.5%
HIV drug-resistance surveillance	47,574	0.5%	51,256	0.2%
Drug supply systems	532,215	2%	417,175	1.5%
Information technology	821,657	3%	11,804,973	41%
Upgrading and construction of infrastructure	409,461	2%	426,181	1.8%
Program Management and Administration Strengthening not disaggregated by type	759,616	3%	3,224,457	11%
Program Management and Administration Strengthening not-elsewhere classified	894,285	3.5%	591,321	2%
Total Systems Strengthening & Program Coordination	**25,244,727**	**100%**	**28,533,647**	**100%**

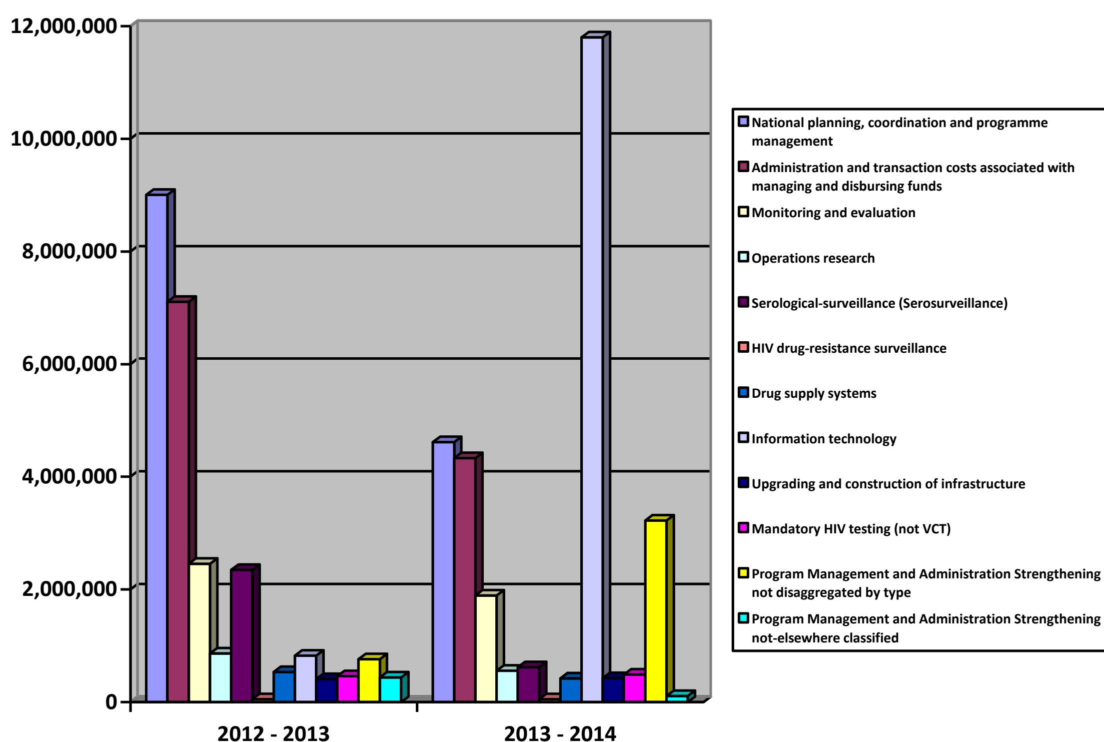

Figure 19: Systems Strengthening & Program Coordination – 2012/13 and 2013/14

4.4.5 Human Resources

Human capacity constraints cannot be overlooked. The 2013 MTR suggests that there is insufficient number of trained and well compensated staff for service delivery. This poses a major constraint to scaling up services. During the reporting period, spending on monetary incentives for human resources increased by 27% in 2013/14.

Table 13: Incentives for Human resources

Incentives for Human resources	**2012 - 2013**	**%**	**2013 - 2014**	**%**
Monetary incentives for human resources	33,263,257	82%	42,237,518	69%
Formative education to build-up an HIV workforce	393,201	1%	379,331	1%
Training	3,645,933	9%	1,876,258	3%
Incentives for Human Resources not specified by kind	3,133,885	8%	14,269,266	23%
Incentives for Human Resources not elsewhere classified	-	0%	2,042,298	4%
Incentives for Human resources Total	**40,436,276**	**100%**	**60,804,671**	**100%**

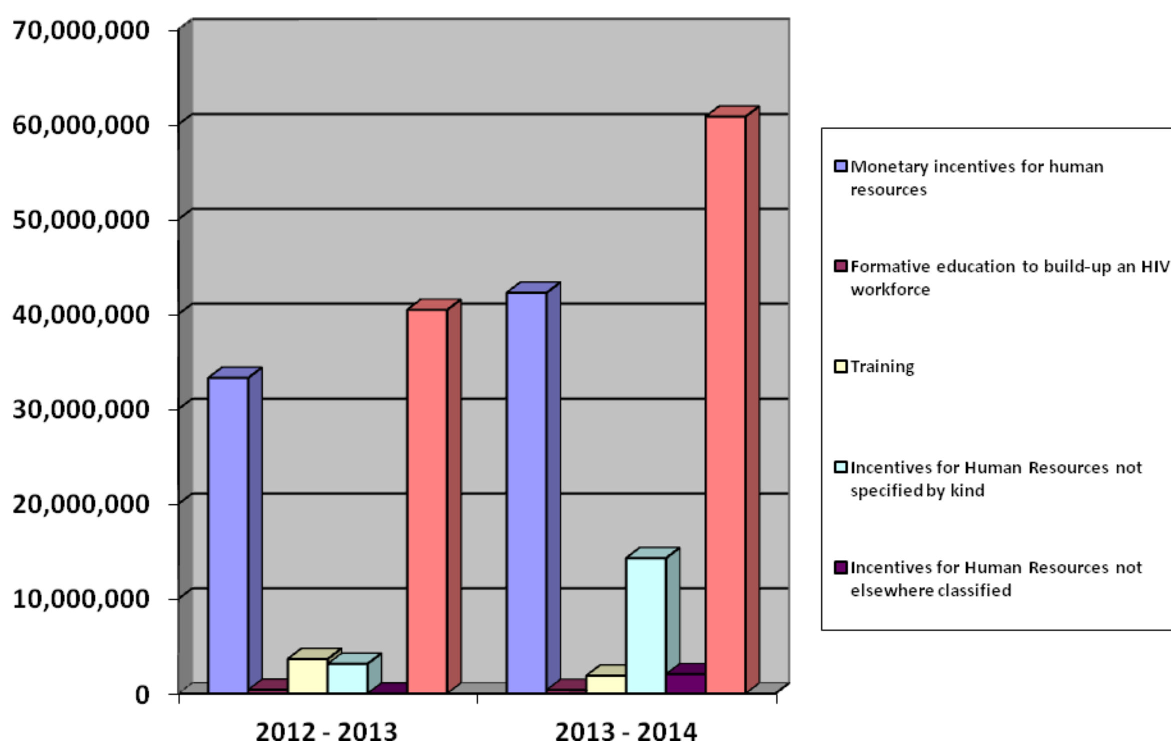

Figure 20: Breakdown of expenditures on Human resources 2012/13 and 2013/14

4.4.6 Social Services and Social Protection

Overall spending on Social Protection is relatively low at $1,656,656 and $3,303,525 making up 1% and 2% respectively for both reporting periods.

Table 14: Social Protection and Social Services excluding OVC

Social Protection and Social Services excluding OVC	2012 - 2013	%	2013 - 2014	%
Social protection through monetary benefits	111,951	7%	-	0%
Social protection through in-kind benefits	22,865	1%	240,617	7%
Social protection through provision of social services	540,289	33%	-	0%
HIV-specific income generation projects	871,209	53%	1,085,886	33%
Social protection services and social services not disaggregated by type	110,342	6%	1,977,022	60%
Social Protection and Social Services excluding OVC Total	**1,656,656**	**100%**	**3,303,525**	**100%**

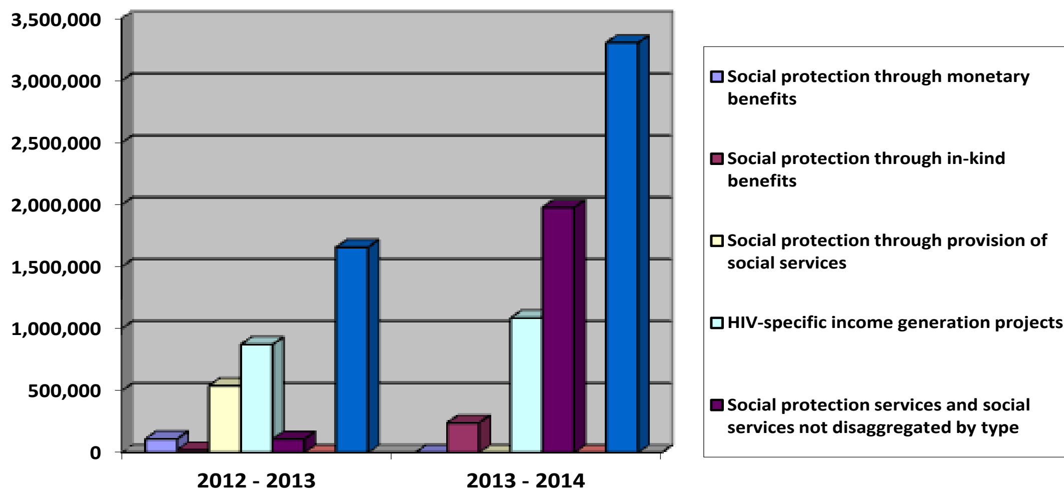

Figure 21: Expenditures on Social Protection and Social Services excluding OVC – 2012/13 and 2013/14

4.4.7 Enabling Environment and Community Development

Under this function, an increased and wider range of support is derived to include a full set of services from key principles. Also included are essential actions as well as policy development. Overall expenditures on Enabling Environment increased from 3% in 2012/13 to 6% in 2013/14 of total expenditures.

Table 15: Enabling Environment

Enabling Environment	2012 - 2013	%	2013 - 2014	%
Advocacy	89,643	1.7%	123,257	1%
Human rights programmes	69,399	1.3%	44,940	0.4%
AIDS-specific institutional development	3,966,164	73.7%	8,118,267	67%
AIDS-specific programmes focused on women	7,848	0.12%	55,795	0.6%
Enabling Environment and Community Development not disaggregated by type	1,237,140	23%	3,597,668	30%
Enabling Environment and Community Development not elsewhere classified	11,156	0.18%	177,544	1%
Enabling Environment Total	**5,381,350**	**100%**	**12,117,471**	**100%**

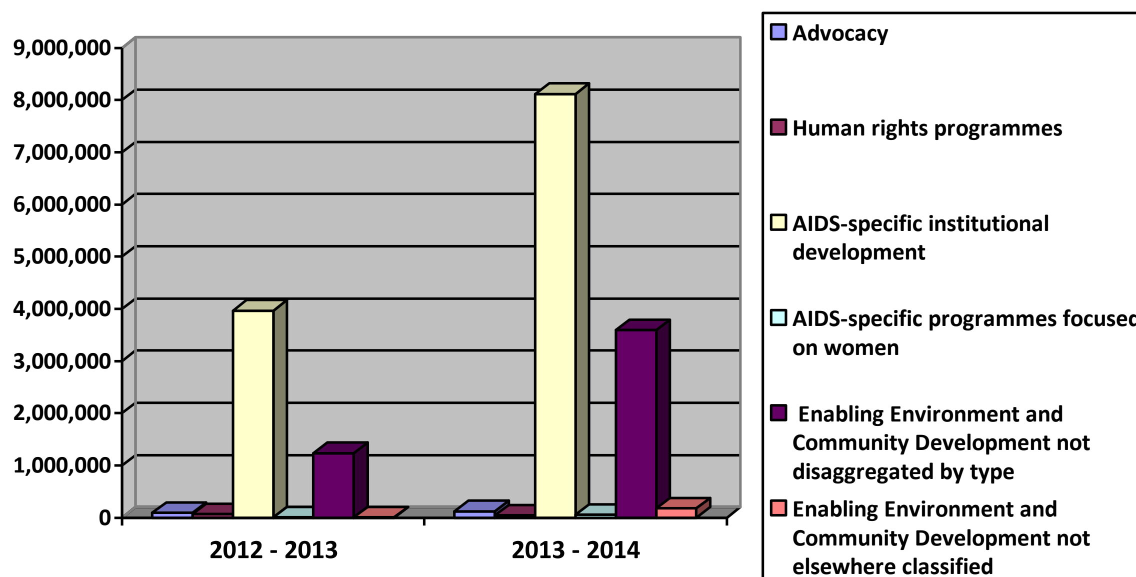

Figure 222: Expenditures on Enabling Environment 2012/13 and 2013/14

4.4.8 Research

Overall spending on Research activities made up 1% of total expenditure in 2012/13 and 0.4% in 2013/14.

Table 16: Research Activities

Research Activities	2012 - 2013	%	2013 – 2014	%
Epidemiological research	319,149	17%	571,429	37%
Research not disaggregated by type	1,511,893	83%	973,735	63%
Research Activities Total	**1,831,042**		**1,545,164**	**100%**

4.5. Government Spending

In 2012/13, Government's spending totaled $111,050,386 while in 2011/12 it was $168,625,000. In 2012/13, the highest spending program was Orphans and Vulnerable Children in the amount of $35,474,061 or 32% whilst in 2011/12 it was Treatment and Care amounting to 77,568 or 46% . The lowest program spending in 2012/13 was Enabling Environment at $319,149 or 0.3% whilst in 2011/12 the lowest spending were Social Protection and Social Services; Enabling Environment and Research amounting to $730,708 or 0.4% each respectively. In the period 2013/14, Government spending totaled $136,620,606.

The highest spending program was Human Resources in the amount of $57,775,234 or 42% with the lowest amount of $135,533 or 0.1% spent on Enabling Environment.

Table 17: Government Spending By Programmes

CATEGORIES	2012/13	2012/13	2013/14	2013/14
Prevention	6,403,222	6%	19,594,181	14%
Care and Treatment	30,770,350	28%	21,050,125	15%
Orphans & Vulnerable Children	35,474,061	32%	32,457,913	24%
Systems Strengthening	3,213,103	3%	3,059,169	3%
Human Resources	34,218,261	30%	57,775,234	42%
Social Protection	652,240	0.7%	1,977,022	1.5%
Enabling Environment	319,149	0.3%	135,533	0.1%
Research	-	0%	571,429	0.4%
TOTAL	**111,050,386**	**100%**	**136,620,606**	**100%**

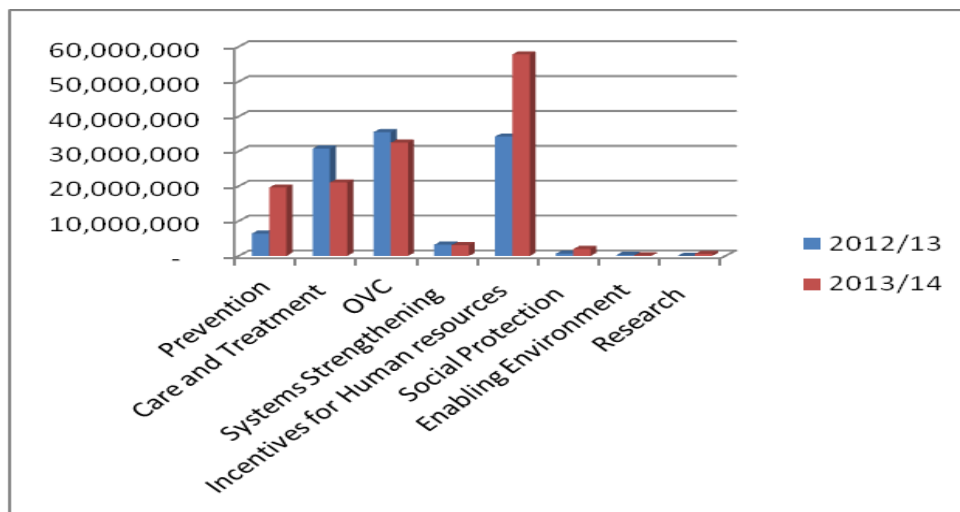

Figure 23: Government Spending By Programmes

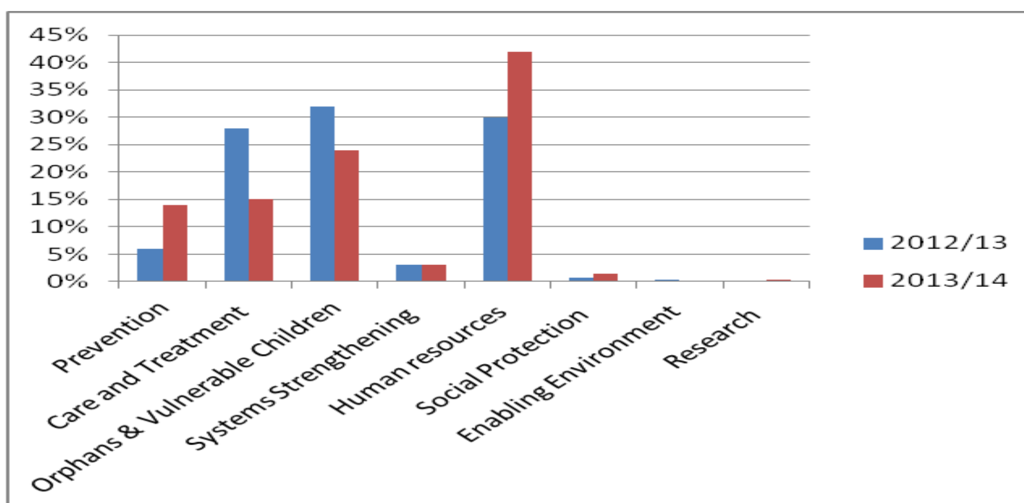

Figure 24: Government Spending By Programmes Expressed in %

4.6. Spending by Bilateral Institutions

Of the total spending in 2012/13, Bilaterals accounted for $72,900,158 or 37% whilst in 2013/14 spending reduced to $59,334,173 or 28% of total spending. PEPFAR's contribution to the Bilaterals spending is 98% and GIZ contributed the remaining 2%. Both of these Bilaterals have engaged above 30 different categories of Agents and Providers.

Table 18: Spending by Bilateral Institutions

Bilateral Source	2012/13	%	2013/14	%
PEPFAR	71,394,683.00	98%	57,658,447.00	97%
GIZ	1,505,475.00	2%	1,675,746.00	3%
Total	**72,900,158.00**	**100%**	**59,334,193.00**	**100%**

Care and Treatment, Prevention and System Strengthening and Programme Coordination were high on the spending priority areas of Bilateral Institutions as shown below in Table 19. In 2012/13, combined, they accounted for 87% of spending in total Bilateral spending in 2012/13. In 2013/14, in descending order it was System Strengthening and Programme Coordination, Enabling Environment and Prevention with a combined total of 71% of total spending.

Table 19: Bilateral Spending by Spending Categories

Spending Categories	2012 - 2013	%	2013 - 2014	%
Prevention	16,371,169	23%	10,858,230	18%
Care and Treatment	24,677,903	34%	9,885,375	17%
Orphans and Vulnerable Children	3,932,506	5%	1,998,537	3%
Systems Strengthening & Program Coordination	15,226,052	21%	19,852,064	34%
Incentives for Human resources	5,250,725	7%	2,837,957	5%
Social Protection and Social Services excluding OVC	894,074	1%	1,326,503	2%
Enabling Environment	5,035,836	7%	11,601,772	20%
Research	1,511,893	2%	973,735	2%
Total Bilateral Spending	**72,900,158**	**100%**	**59,334,173**	**100%**

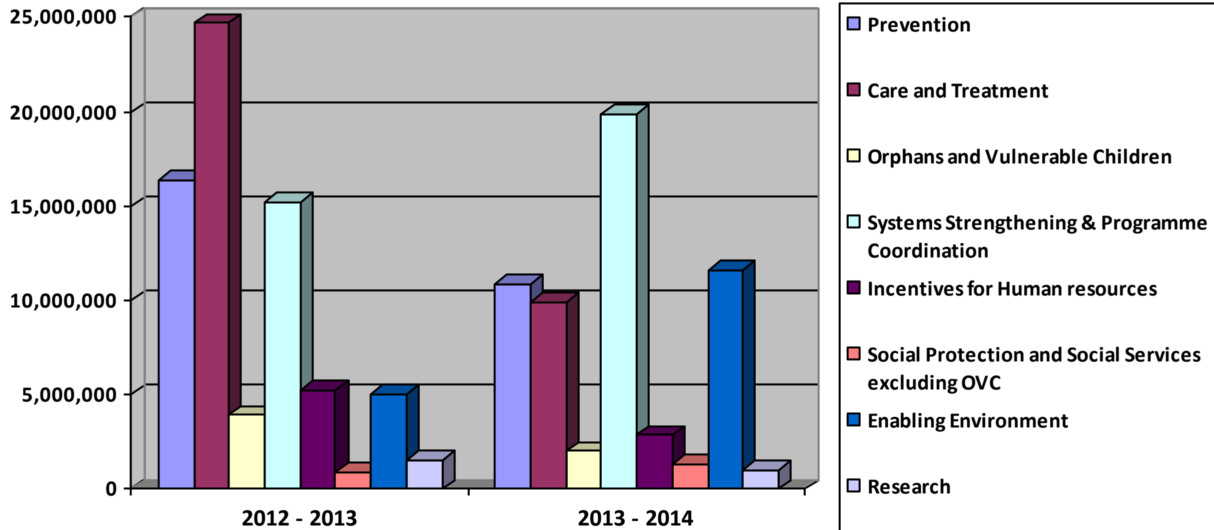

Figure 25: Bilateral Spending by Key Delivery Categories 2012/13 and 2013/14

4.7. Spending by Multilateral Institutions

Total financing by Multilateral Institutions to the AIDS response in the Country for the period 2012/13 was $14,160,067 making 7% of total HIV and AIDS spending whilst in 2013/14 it amounts to $14,426,536 or 6.8% of total HIV and AIDS spending. The total numbers of multilateral sources reported were 8 in each fiscal period of reporting.

Table 20: Spending by Multilateral Institutions

Multilateral Sources	2012/13	%	2013/14	%
Global Fund	10,495,166	74%	11,978,343	83%
IOM	80,000	0.5%	-	0%
UNAIDS	149,287	1%	322,749	2.2%
UNDP	359,292	3%	458,919	3.2%
UNESCO	33,259	0.2%	192,543	1.4%
UNFPA	1,985,256	14%	593,178	4%
UNICEF	771,588	5.3%	573,659	4%
UNODC	-	0%	132,998	1%
WHO	286,219	2%	174,147	1.2%
Grand Total	**14,160,067**	**100%**	**14,426,536**	**100%**

Expenditure by Multilateral institution was highest on Systems Strengthening and Coordination in both reporting period and accounting for 45% and 37% respectively.

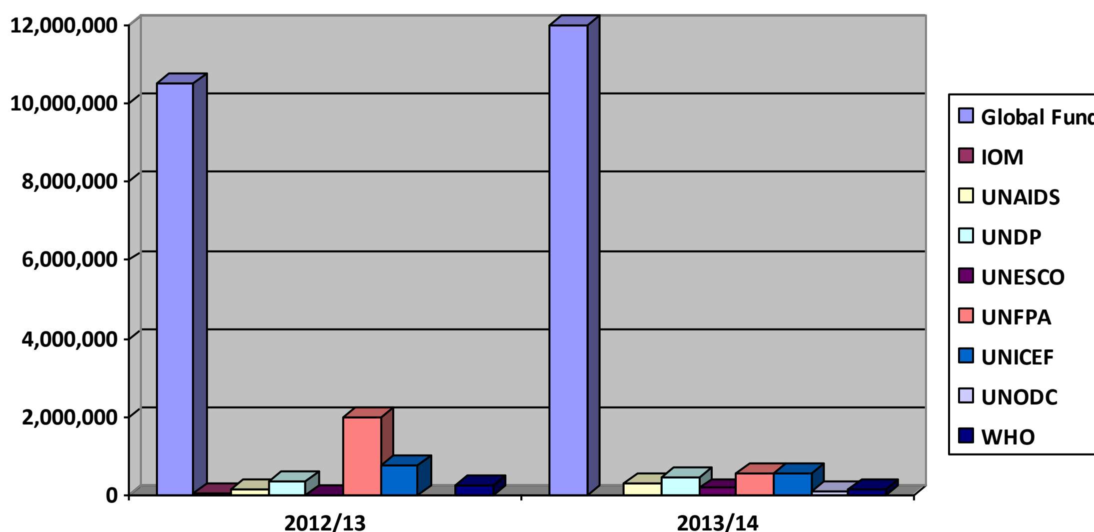

Figure 26: Expenditure Breakdown by Multilateral Institutions

Table 21: Multilateral Spending By ASC

ASC	2012/2013	%	2013/2014	%
Prevention	2,978,741	21%	2,896,520	20%
Care and Treatment	3,346,110	23.7%	5,440,452	38%
OVC	66,118	0.5%	233,044	1.5%
Systems Strengthening and Coordination	6,345,952	45%	5,284,874	37%
Incentives for Human resources	967,290	7%	191,480	1%
Social Services and Social Protection	110,342	0.8%	-	0%
Enabling Environment	345,514	2%	380,166	2.5%
Multilateral Spending by ASC Total	**14,160,067**	**100%**	**14,426,536**	**100%**

Table 22: UN Agencies Spending by Regions

REGIONS	2012/13	%	2013/14	%
Erongo	85,933	2.3%	20,550	0.8%
Hardap	83,201	2.1%	24,750	1%
Karas	67,393	2%	24,750	1%

Kavango	62,804	1.7%	20,000	0.8%
Khomas	709,772	19%	88,539	4%
National	1,302,075	36%	1,517,010	62%
Ohangwena	26,143	0.7%	15,000	0.6%
Omaheke	36,192	1.%	22,500	1%
Omusati	151,000	4%	68,000	3%
Oshana	183,129	5%	60,955	2%
Oshikoto	482,531	13.2%	252,000	10.3%
Otjozondjupa	474,728	13%	334,139	14%
Total	**3,664,901**	**100%**	**2,448,193.00**	**100%**

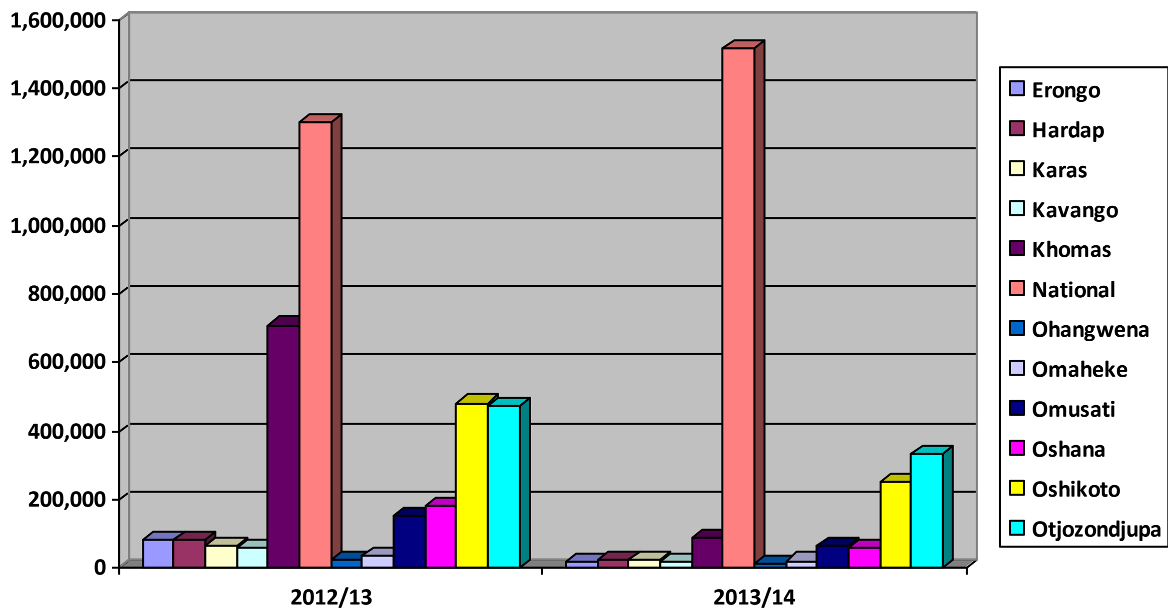

Figure 27: UN Agencies Spending by Regions 2012/13 and 2013/14

4.8 Beneficiary Populations

In the NASA methodology, Beneficiary Populations are categorized into 6 major functions namely PLHIV (people living with HIV and AIDS), Key Population (Sex Workers and their Clients, MSMs and IDUs), Other Key Population, (orphans and vulnerable children, children born or about to be born to HIV-positive mothers, refugees, internally displaced people and migrants), Specific "Accessible" Population (children in school, women attending reproductive health clinics, military personnel, and factory employees), General Population (interventions targeting the general population) and Non-Targeted Interventions (expenditures that do not belong to an explicitly selected or targeted population).

An analysis of the data collected disclosed that PLHIV benefitted the most in term of spending and accounted for 33% of total expenditure for 2012/13 but dropped by 29% in 2013/14. In 2013/14, Specific "accessible" Population was the highest in term of spending with an increase of 31%. The lowest in both periods was the Key population with 0.48% and 1% respectively.

Table 23: Spending By Major Beneficiary Population Category

CATEGORY	2012/13	%	2013/14	%
PEOPLE LIVING WITH HIV - (PLHIV)	66,221,409	33%	47,266,368	22%
KEY POPULATION	960,808	0.5%	1,886,862	1%
OTHER KEY POPULATION	42,750,384	21%	39,284,790	18%
SPECIFIC ACCESSIBLE POPULATION	43,570,754	21.7%	62,978,951	30%
GENERAL POPULATION	25,699,816	12.8%	34,971,871	16%
NON-TARGETED INTERVENTIONS	21,856,853	11%	26,957,787	13%
TOTAL	201,060,024	100%	213,346,629	100%

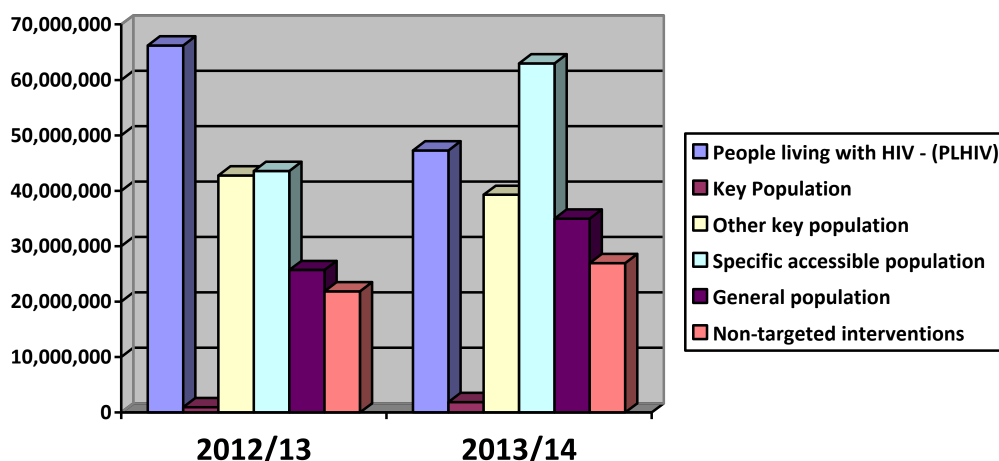

Figure 28: Spending By Major Beneficiary Population Category – 2012/13 and 2013/14

Table 24 below shows the detail of Beneficiary Population spending for the periods 2012/2013 and 2013/14 respectively.

Table 24: Beneficiary Population Spending By Sub-Category

Beneficiary Population by Subcategory	**2012/13**	**%**	**2013/14**	**%**
People living with HIV not broken down by age or gender	66,213,561	33%	47,210,573	22%
Adult and young women (aged 15 and over) living with HIV	7,848	0.004%	55,795	0.03%
Injecting Drug Users (IDU) and their Clients.	-	0%	14,778	0.007%
Male non - transvestite sex workers and their clients	-	0%	319,143	0.15%
Key Population not broken down by type	960,808	0.5%	1,552,941	1%
Orphans and vulnerable children	39,821,075	20%	34,689,499	16%
Children born or to be born of women living with HIV	586,716	0.3%	951,012	0.45%
Recipients of blood or blood product	685,937	0.3%	340,754	0.16%
Other key population not elsewhere classified (n.e.c.)	1,656,656	0.8%	3,303,525	2%
Children and Youth out of school	288,553	0.1%	356,615	0.17%
Health Care Workers	40,436,276	20%	60,804,671	29%
Accessible Populations not broken down by type	1,430,849	0.7%	947,843	0.44%
People attending STI clinics	1,415,076	0.7%	869,822	0.41%
Male adult population	1,745,902	0.9%	642,409	0.30%
Female Adult Population	243,899	0.1%	170,500	0.08%
General Population not broken down by age or gender	23,710,015	12%	34,158,962	16%
Non - Targeted Intervention	21,856,853	11%	26,957,787	13%
Beneficiary Population by Subcategory Total	**201,060,024**	**100%**	**213,346,629**	**100%**

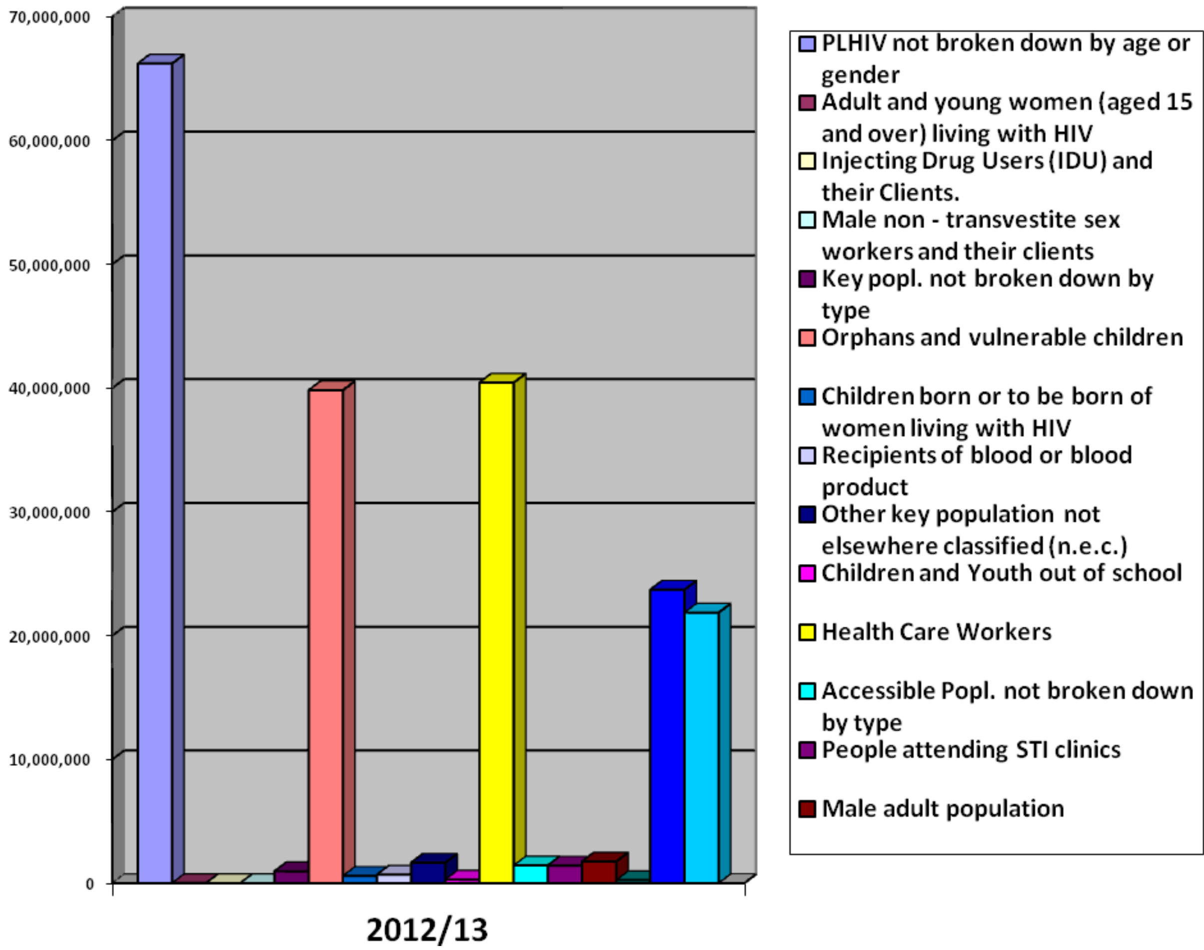

Figure 29: Beneficiary Population by Subcategory – 2012/13

5. Challenges

Major challenges were encountered during the process, but the most notable was in obtaining data. Some organizations did not participate in the data collection exercise and others who participated posed major delays due to late or incomplete data submission.

As a result, tracking the HIV and AIDS expenditures proved challenging and posed some limitations to the study. One major challenge was the unavailability of HIV expenditure data. Data limitations made it difficult to evaluate HIV expenditure in a number of areas including Public sector, Private sector, private household out-of-pocket expenditure on HIV and AIDS, organizational overheads, and production factors (capital and recurrent expenditure). In the private sector it was difficult to have access to senior respondents.

Another data related challenge was the delayed receipt of data from the relevant government bodies and private organizations. This was due largely to administrative/bureaucratic procedures in some of the institutions visited and non-response from some line ministries and private institutions even after official letters were sent.

Assignment of the appropriate NASA Classification to categories of expenditures was also a challenge as codes varied from one institution to another. Some financial data received from organizations could not adequately fit into the NASA classifications. Therefore repeated visits and consultations had to be undertaken to verify and classify the data appropriately. However, expenditure codes of PEPFAR's submission was an exception because their coding system and description was well aligned with the NASA codes thus necessitating the easy transfer of data into the NASA tool.

The categorization of stakeholders was also a challenge. Some stakeholders can be a source while being an agent at the same time. Likewise, some stakeholders are agents and providers at the same time; while a few of them fall into all three categories. This proves to be a major challenge with potential for double counting. All efforts were however made to ensure disaggregation of data appropriately.

6. Observations and Lessons Learned

i. Many stakeholders were familiar with the concept of NASA, but many did not factor the time or capacity required to participate fully or in a timely way.

ii. For many Organizations, filling in the NASA Data Collection Form in itself was an opportunity to align their own spending pattern according to the NASA classification.

7. Recommendations

In response to some of the challenges, lessons learned and observations, the following recommendations are being put forth:

I. Stakeholders involved in the AIDS response should align their budgetary frameworks and systems of expenditure tracking to the NASA ASCs.

II. It is recommended that a stronger lead role be played and instituted by government for the engagement and unconditional participation of all stakeholders in all future NASA exercises. Further, is the institutionalization of NASA as a part of the National M&E system through periodic and regular reporting from implementing partners. This would potentially strengthen national capacity in conducting NASA and the M&E system to track AIDS expenditures.

III. A further alignment of HIV spending to the National Strategic and Action Plans is recommended; as well as the engagement of multisectoral entities beyond health. The involvement of other non health sectors needs to be increased.

IV. NASA must be incorporated as an integral part of the M&E system, and to be seen as a process of continuous improvement such as any other component of the HIV M&E system. Also in the future, NASA should be integrated into the NHA. Such action would in the future minimize difficulties involved in AIDS spending assessment.

V. Regular NASA exercise should be undertaken to help determine resource needs and to help planning and allocation of resources. Key issues that would need to be considered are: (a) Increased advocacy on the relevance of recording AIDS expenditures in line with the NASA categories and (b) streamlining of financial disbursement and reporting mechanisms with the NASA methodology

VI. Strengthen HIV coordination mechanisms to have the requisite capacity for oversight responsibilities of sector ministries and agencies to track HIV and AIDS expenditures outside of health. This will ensure that sector spending on HIV and AIDS are monitored within a central financial monitoring mechanism.

VII. Alignment and harmonization of programme and financial systems amongst partners through joint planning and design, with consideration of a mini NASA undertaken as part of mid-term reviews and other review processes.

VIII. Capacity building for implementing partners on the NASA methodology should be considered periodically.

IX. Undertake a comprehensive assessment of OOP expenditures of HIV and AIDS should be considered. OOP expenditure tracking can be done separately or incorporated in future household surveys. This will enable the government to establish how households are coping with the burden of providing care.

X. As regards the underestimation of Private Sector and Household expenditures, it is recommended that this situation be addressed in the planned National Health Account that has been launched by the Ministry of Health.

XI. To ensure proper reporting on AIDS spending, there is a need for stakeholders to fully participate in data collection exercises. In addition, providers and implementers should advocate with their donors and agents to have streamlined reporting mechanisms that reduce the burden of reporting for ad-hoc or event-based exercises to a more systematic reporting across all spending assessment categories.

XII. **PREVENTION,TREATMENT and CARE**

It is recommended that:

a. Resources should be matched to the Prevention, Treatment and Care priorities of the revised National HIV Strategy in order to have an increased impact on incidence and deaths.
b. National budgetary allocations for HIV and AIDS programmes should reflect the priorities of the revised NSF 2013.
c. Government needs to innovatively identify sources of additional funding in the wake of diminishing funding from external sources.
d. To sustain the treatment coverage in Namibia, which stands at 84% for adult and 87% for children (2013 MTR), a more strategic investment is needed.

Evidently, while spending in Programmes over the periods under the 2013 MTR have started to yield some meaningful results, this momentum needs to be sustained.

XIII. **Proper Design and Targeting of the Interventions**

BP. 05 (non targeted population); ASC. 4.99 (…..programme intervention not classified); and PF.99 (current expenditure not disaggregated by type) are some of the non specific spending areas where further clarification is required so that analysis and interpretations are realistic. This also indicates the need for proper design and targeting of the interventions.

XIV. **Improved Financial Information Systems**

There is the need to improve the financial information system in terms of the quality and accuracy of HIV and AIDS expenditure data. In some institutions, retrieval of the required information was difficult. This led to some of the institutions providing incomplete information that is inadequate to assign proper NASA classification and code. Slow or late submission of information delayed the whole process.

ANNEX I: NASA Classification

As defined in National AIDS Spending Assessment (NASA) Classification taxonomy and Definitions; UNAIDS, 2009

In NASA, like other classification schemes, transactions are allocated to exactly one category without duplication or omission, that is, categories of the NASA classification are mutually exclusive and exhaustive. Mutually exclusive means that no transaction can be allocated to more than one category (there is no duplication). When categories are not mutually exclusive they

overestimate spending by double counting some transactions. Exhaustiveness means that each and every transaction can go into one category (there is no omission)

ASC: AIDS spending categories: Following categories under which spending are incurred. There are 8 main categories and many sub categories under each main category.

ASC.01 Prevention: Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals.

ASC.02 Treatment and Care: refers to all expenditures, purchases, transfers and investment incurred to provide access to clinic- and home- or community-based activities for the treatment and care of HIV-infected adults and children.

ASC.03 Orphans and Vulnerable Children (OVC): An orphan is defined as a child under the age of 18 years who has lost one or both parents regardless of financial support (AIDS programme-related or not). Vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them.

ASC.04 Strengthening of Programme Management and Administration: Programme expenditures are defined as expenses that are incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and facility upgrading through purchases of laboratory equipment and of telecommunications.

ASC.05 Incentives for the Recruitment and Retention of Human Resources– Human Capital: This category refers to services of the workforce through approaches for recruitment, retention, deployment and rewarding of quality performance of health care workers and managers for work in the HIV and AIDS field.

ASC.06 Social Protection and Social Services (excluding OVC): Social protection conventionally refers to functions of government relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by needs such as sickness, old age, disability, unemployment, social exclusion and so on.

ASC.07 Enabling Environment and Community Development: It includes a full set of services that generate an increased and wider range of support key principles and essential actions as well as policy development.

ASC.08 HIV and AIDS-Related Research (excluding operations research): It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes,

methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS.

ANNEX II: Definition of Abbreviation

BP: Beneficiaries Population Targeted or intended: The populations presented here are explicitly targeted or intended to benefit from specific activities. In pri nciple, the identification of the BPs is dictated by the intended use of the funds.

PS: Providers of Services. Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. Providers include government and other public entities, private for-profit and non-profit organizations, corporate and non-corporate enterprises and self-employed persons.

PF: Production Factors: Since the provider and production factors classifications are focused on the HIV and AIDS outputs, it is also desirable to analyse the inputs or production factors that create these outputs. In NASA the classification of production factors categorizes expenditures in terms of resources used for the production, i.e. wages, salaries, new buildings, renovations, etc. (budgetary items)

FA: Financing Agent: Entities which mobilize financial resources collected from different financing sources (pools) and transfer them to pay for or to purchase health care or other services or goods. These entities directly purchase from providers or steer in full, or as co-guarantors of payment, resources earmarked for the provision of commodities (services and/or goods) to satisfy a need.

FA: Financing Sources: Financing sources are entities or pools which *purchasers*, providers of financial intermediation services or paying agents, tap or use other forms of mobilization to fund the HIV and AIDS services.

ANNEX III: Data Collection Forms

Origin of the information: Select with an "X" the Source of the Information on the Provider	
A) Information given by the Provider.	
B) Information given by Other Institution than the Provider (i.e.: Agent or Financing Source)	
Institution:	
Person to Contact (Name and Title):	
Phone: E-mail:	

1. A Source is a Donor or an Origin of Financial and/or Non Financial Resources expected to be used in the implementation of activities.
2. An Agent is a proxy or one who acts for and on behalf of a Source and may also be a Provider
3. A Provider is a Person or Organization who receives Financial and/or Non Financial resources to implement Activities on behalf of or as required by a Source.
4. Information provided will be held in the strictest confidence, and will be rendered non-identifiable (information from all sources will be collated to provide a national view of resourcing and expenditure patterns) for provider in the Final National AIDS Spending Assessment Report.

Year(s)/Period(s) of the Expenditure Estimate:___________/_______________

Objectives of Data Collection from the Provider:

I. To Identify the Origin of the Funds spent by the Provider in the Year under Review.
II. To Identify in which NASA Functions/ Activities the Funds were spent.
III. To Identify the NASA Beneficiary Populations for each NASA Function/Activity.
IV. To identify the NASA Production Factors for each Function/ activity.

Indicate what Currency will be used throughout the form with an "X":	**Local Currency**	**US$ Exchange rate in Year of Assessment**	**Other (Specify):**

<table>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="4">Name of the Provider:</td></tr>
<tr><td colspan="4">1. Person to Contact (Name and Title):</td></tr>
<tr><td colspan="3">2. Address:</td><td>3. E-mail:</td></tr>
<tr><td colspan="2">4. Phone:</td><td colspan="2">5. Fax:</td></tr>
<tr><td rowspan="9">6. Institution: Select Category of Institution with an “X”.</td><td colspan="2">1. Central Government</td><td></td></tr>
<tr><td colspan="2">2. Regional Government</td><td></td></tr>
<tr><td colspan="2">3. Local Government</td><td></td></tr>
<tr><td colspan="2">4. Private-for-Profit National</td><td></td></tr>
<tr><td colspan="2">5. Private-for-Profit International</td><td></td></tr>
<tr><td colspan="2">6. National NGO/CBO/CSO</td><td></td></tr>
<tr><td colspan="2">7. International NGO/CSO</td><td></td></tr>
<tr><td colspan="2">8. Bilateral Agency</td><td></td></tr>
<tr><td colspan="2">9. Multilateral Agency</td><td></td></tr>
</table>

7. Destination of Funds:

7A. Origin of the Funds Received: List the Institution(s) that granted Fund(s) during the Year(s) under Study		
	Funds Received during the Year(s) under Review	
Origin of the Fund(s)/ Name of the Institution and Person to contact	Year:	Year:
7.1 Institution: Contact:		
7.2 Institution: Contact:		
7.3 Institution: Contact:		
7.4 Institution: Contact:		
7.5 Institution: Contact:		
TOTAL:		

7B. Origin of the Non Financial Resource(s) Received: List the Institution(s) that granted Non Financial Resource(s) during the Year(s) under Study.		
	Funds Received during the Year(s) under Review	
Origin of the Fund(s)/ Name of the Institution and Person to contact	Year:	Year:
7.1 Institution: Contact:		
7.2 Institution: Contact:		
7.3 Institution: Contact:		

7.4 Institution: Contact:		
7.5 Institution: Contact:		
TOTAL:		

8. Expenditure Funds received from "7A"

I. Identify and quantify the NASA Functions in which the funds were
II. Identify and quantify the NASA Beneficiary Population(s) of each F
III. Give the Actual Amount disbursed and Spent per Activity
IV. Give the Location (Geographic Region of Namibia) in which the Ac
V. Make Comments if necessary.

Function **(Code and Name)**	**Beneficiary Population** **(Code and Name)**	**Amount** **Spent**	**Geographic Region**	**Comments**

9. Expenditure Non Financial Resources received from “7B”
VI. Identify and quantify the NASA Functions in which the funds were spent. VII. Identify and quantify the NASA Beneficiary Population(s) of each Function. VIII. Give the Actual Amount disbursed and Spent per Activity IX. Give the Location (Geographic Region of Namibia) in which the Activities were carried out. X. Make Comments if necessary.

NAMIBIA NATIONAL AIDS SPENDING ASSESSMENT DATA COLLECTION – FORM # 1 (SOURCE/AGENT)

Year(s) of the Expenditure Estimate:__________________ and ______________________

Objectives of the Form:

I. To identify the origin of the Funds used or managed by Organization during the Year(s) under review.
II. To identify the Recipients of those Funds.

Indicate what Currency will be used throughout the form with an "X":	Local Currency	US$ Exchange rate in Year of Assessment	Other (specify):

Name of the Institution:

1. Financial Year: **(if not calendar year, please ask for quarterly expenditure reports)**

2. Person to Contact (Name and Title):

3. Address:	**4. E-mail:**

5. Phone:	**6. Fax:**

Type of Organization	Category	X
7. Type of Organization: Select category of Organization with an "X".	6.1 Central government	
	6.2 Regional government	
	6.3 Local government	
	6.4 Private-for-profit National	
	6.5 Private-for-profit International	
	6.6 National NGO/CBO	
	6.7 International NGO	
	6.8 Bilateral Agency	
	6.9 Multilateral Agency	

1. A Source is a Donor or an Origin of Financial and/or Non-Financial Resources expected to be used in the implementation of activities.
2. An Agent is a proxy or one who acts for and on behalf of a Source and may also be a Provider
3. A Provider is a Person or Organization who receives Financial and/or Non-Financial resources to implement Activities on behalf of or as required by a Source.

1. Destination of the funds:

I. List the Organization(s) to which Funds were transferred during the Year under review.

II. Quantify the Transferred Funds.

III. Quantify the Transferred Funds *reported as Spent.* If no information is available regarding the amount spent, state "No Data" in the cell.

7a. Funds Transferred: *List the Organizations to which your Agency transferred Funds during the Year ((s) under review.*

(Name of Organization and Contact Person)	***Funds Transferred***		***Funds Spent***		***Comments***
	Year:	***Year:***	***Year:***	***Year:***	
7.1 Organization: Contact:					
Organization: Contact:					
7.2 Organization: Contact:					
7.3 Organization: Contact:					
7.4 Organization: Contact:					
TOTAL					

7b. Non-Financial Resources: List the Organization (s) to which your Organization transferred Non-Financial Resources during the Year(s) under study.

(Name of Institution and Contact Person	Type of Goods Donated		Quantity Donated		Monetary Value in Year Assessment	
7.1 Institution:	Year:	Year:	Year:	Year:	Year:	Year:
Contact:						
7.2 Institution:						
Contact:						
7.3 Institution:						
Contact:						
7.4 Institution:						
Contact:						
7.5 Institution:						
Contact:						

1. Destination of the funds: **2. Expenditure of Funds received from “7A”** I. Identify and quantify the NASA Functions in which the funds were spent. II. Identify and quantify the NASA Beneficiary Population(s) of each Function. III. Give the Actual Amount disbursed and Spent per Activity IV. Give the Location (Geographic Region of Namibia) in which the Activities were carried out. V. Make Comments if necessary.

ASC (Code and Name)	Beneficiary Population (Code and Name)	Amount Spent	Geographic Region	Comments

1. Surveyor:	**Date:** / / 20__

ANNEX IV: MEMBERS - NASA CORE TEAM

No.	Full Names & Surnames	Designation	Organization	Tel. no	E-mail.
1.	Alexinah Muadinohamba	Acting Director	DSP/MoHSS/ HIV&AIDS	203 5033	muadinohambaa@nacop.net
2.	Anne-Marie Nitschke	Deputy Director	DSP/MoHSS/ENARC	203 2822	nitschkea@nacop.net
3.	Ambrosius K. Uakurama	CHPA	DSP/MoHSS/RMDC	203 2831	uakuramaa@nacop.net
4.	Mohamed Turay	M&E Advisor	DSP/MoHSS/RM&E, UNAIDS	204 6320	TurayM@unaids.org
5.	Anna Jonas	CHP	DSP/MoHSS/RM&E	203 2826	jonasa@nacop.net
6.	Anna Shifotoka	M&E	MoHSS/DSP/GF-PMU	296 5710	Anna.Shifotoka@globalfund.com.na
7.	Timotheus Angula	Accountant	DSP/MoHSS/RMDC	203 2289	angulat@nacop.net
8.	Lesley Usurua	CHPA	MoHSS, PP&HRD	203 2563	lusurua@mhss.gov.na or cusurua@yahoo.com
9.	L. Karises	Financial Advisor	Finance & Logistics/MoHSS	203 2158	lkarises@mhss.gov.na
10.	Laimi Amukwelele	Finance Manager	MoHSS/DSP/GF-PMU	296 5710	Laimi.Amukwelele@globalfund.com.na
11.	Michael De Klerk	M&E	DSP/MoHSS/RM&E	203 2438	deklerkm@NACOP.NET

ANNEX V: 2014 NASA Funding Matrix

Country:		NAMIBIA	
Reporting cycle:		FISCAL YEAR	
Data Measurement Tool		National AIDS Spending Assessment (NASA)	
Amounts reported in:		US DOLLARS	
Please indicate month and year (M/YYYY)	From:	Month	Year
		April	2012
	To:	March	2013
Name of Local Currency		NAMIBIAN DOLLAR	
Currency expressed in:		Millions (x 1,000,000)	
Average Exchange Rate for the year (local currency to USD)		9.255	

FUNDING MATRIX - 2012 - 2013

Financing Sources

2012 - 2013	TOTAL	Public Sources			International Sources						Private Sources (optional for UNGASS reporting)	
						Bilaterals		Multilaterals				
AIDS Spending Categories	US DOLLARS	Public Sub-Total	Central / National	All Other Public	International Sub-Total	PEPFAR	Other Bilaterals	UN Agencies	Global Fund	All Other International	Private Sub-Total	All Other Private
TOTAL US DOLLARS	201,060,024	111,050,386	102,099,987	8,631,250	87,408,615	71,394,683	1,505,475	3,664,901	10,495,166	348,390	2,601,023	2,601,023
1. Prevention (sub-total)	25,984,457	6,403,222	5,626,409	776,813	19,349,910	15,997,859	373,310	2,383,751	594,990	0	231,325	231,325
1.01 Communication for social and behavioural change (BCC)	1,389,763	0			1,389,763			1,125,160	264,603		0	
1.02 Community/social mobilization	237,628	0			237,628		38,741	198,887			0	
1.03 Voluntary counselling and testing (VCT)	9,438,230	2,509,350	1,905,162	604,188	6,928,880	6,823,848			105,032		0	
1.04 Risk-reduction and prevention activites for vulnerable and accessible populations	7,148	0			7,148		7,148				0	
1.05. Prevention - Youth in school	929,091	692,399	692,399		236,692			89,260	147,432		0	
1.06 Prevention - Youth out-of-school	288,553	0			288,553			288,553			0	
1.07 Prevention of HIV transmission aimed at people living with HIV	29,778	0			29,778			29,778			0	
1.08 Prevention programmes for sex	4,596	0			4,596			4,596			0	

workers and their clients												
1.11 Prevention programmes in the workplace	494,610	271,854	271,854		222,756		52,538	170,218			0	
1.12 Condom social marketing	2,756,994	2,756,994	2,756,994		0						0	
1.14 Public and commercial sector female condom provision	243,899	0			243,899			176,350	67,549		0	
1.17 Prevention of mother-to-child transmission	586,716	0			586,716	511,177		75,539			0	
1.18 Male Circumsicion	1,745,902	172,625		172,625	1,341,952	1,341,952					231,325	231,325
1.19 Blood safety	685,937	0			685,937	685,937					0	
1.22 Post-exposure prophylaxis	27,215	0			27,215	27,215					0	
1.23 Pre-exposure prophylaxis *(new category for GARPR 2014)*	769,955	0			769,955	769,955					0	
1.98 Prevention activities not disaggregated by intervention	6,298,280	0			6,298,280	5,837,775	274,883	175,248	10,374		0	
1.99 Prevention activities not elsewhere classified	50,162	0			50,162			50,162			0	
2. Care and Treatment (sub-total)	**60,704,441**	**30,770,350**	**22,915,913**	**7,854,437**	**28,024,013**	**24,677,903**	**0**	**0**	**3,346,110**	**0**	**1,910,078**	**1,910,078**
2.01 Outpatient care	59,927,629	29,993,538	**22,915,913**	**7,077,625**	28,024,013	**24,677,903**	**0**	**0**	**3,346,110**	**0**	1,910,078	**1,910,078**
2.01.01 Provider- initiated testing and counselling	1,328,764	0			1,328,764	1,328,764					0	
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	0	0			0						0	
2.01.03 Antiretroviral therapy	44,980,614	24,944,508	17,866,883	7,077,625	18,126,028	18,126,028					1,910,078	1,910,078
2.01.04 Nutritional support associated to ARV therapy	6,981,344	2,926,960	2,926,960		4,054,384	795,707			3,258,677		0	
2.01.05 Specific HIV-related laboratory monitoring	231,363	0			231,363	143,930			87,433		0	
2.01.07 Psychological treatment and support services	3,375,142	0			3,375,142	3,375,142					0	
2.01.09 Home-based care	734,069	0			734,069	734,069					0	
2.01.98 Outpatient care services not disaggregated by intervention	2,296,333	2,122,070	2,122,070		174,263	174,263					0	
2.02 In-patient care	86,312	86,312	**0**	**86,312**	0	**0**	**0**	**0**	**0**	**0**	0	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)		86,312		86,312	0						0	
2.98 Care and treatment services not disaggregated by intervention	690,500	690,500		**690,500**	0						0	
3. Orphans and Vulnerable Children (sub-total)	**39,821,075**	**35,474,061**	**35,474,061**	**0**	**4,347,014**	**3,932,506**	**0**	**27,568**	**38,550**	**348,390**	**0**	**0**

3.01 OVC Education	3,702,668	2,170,000	2,170,000		1,532,668	1,184,278				348,390	0	
3.02 OVC Basic health care	3,547,406	3,547,406	3,547,406		0						0	
3.03 OVC Family/home support	31,127,477	28,379,249	28,379,249		2,748,228	2,748,228					0	
3.04 OVC Community support	38,550	0			38,550				38,550		0	
3.98 OVC services not disaggregated by intervention	1,377,406	1,377,406	1,377,406		0						0	
3.99 OVC services not-elsewhere classified	27,568	0			27,568			27,568			0	
4. Systems Strengthening & Programme Coordination (sub-total) [*renamed from "Program Management and Administration Strengthening"*]	**25,244,727**	**3,213,103**	**3,213,103**	**0**	**21,572,004**	**15,044,478**	**181,574**	**854,652**	**5,491,300**	**0**	**459,620**	**459,620**
4.01 National planning, coordination and programme management	9,006,297	659,096	659,096		8,347,201	6,790,570		141,209	1,415,422		0	
4.02 Administration and transaction costs associated with managing and disbursing funds	7,107,367	0			7,107,367	3,819,695			3,287,672		0	
4.03 Monitoring and evaluation	2,453,851	79,910	79,910		2,373,941	1,943,863	8,702	206,428	214,948		0	
4.04 Operations research	863,939	0			863,939	863,939					0	
4.05 Serological-surveillance (Serosurveillance)	2,348,465	2,021,274	2,021,274		327,191	327,191					0	
4.06 HIV drug-resistance surveillance	47,574	0			47,574	36,355		11,219			0	
4.07 Drug supply systems	532,215	0			532,215	532,215					0	
4.08 Information technology	821,657	0			821,657	539,402		123,035	159,220		0	
4.09 Patient tracking	0	0			0						0	
4.10 Upgrading and construction of infrastructure	409,461	133,183	133,183		276,278	191,248			85,030		0	
4.11 Mandatory HIV Testing (Not VCT)	0	0			0						0	
4.98 Program Management and Administration Strengthening not disaggregated by type	759,616	319,640	319,640		439,976		172,872	236,542	30,562		0	
4.99 Program Management and Administration Strengthening not-elsewhere classified	434,665	0			434,665			136,219	298,446		0	
5. Incentives for Human resources (sub-total)	**40,436,276**	**34,218,261**	**34,218,261**	**0**	**6,218,015**	**4,504,136**	**746,589**	**79,170**	**888,120**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	33,263,257	32,516,668	32,516,668		746,589		746,589				0	
5.02 Formative education to build-up an HIV workforce	393,201	0			393,201	393,201					0	
5.03 Training	3,645,933	51,048	51,048		3,594,885	2,627,595		79,170	888,120		0	
5.98 Incentives for Human Resources not specified by kind	3,133,885	1,650,545	1,650,545		1,483,340	1,483,340					0	
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**1,656,656**	**652,240**	**652,240**	**0**	**1,004,416**	**894,074**	**0**	**0**	**110,342**	**0**	**0**	**0**
6.01 Social protection through monetary benefits	111,951	111,951	111,951		0						0	

6.02 Social protection through in-kind benefits	22,865	0			22,865	22,865					0	
6.03 Social protection through provision of social services	540,289	540,289	540,289		0						0	
6.04 HIV-specific income generation projects	871,209	0			871,209	871,209					0	
6.98 Social protection services and social services not disaggregated by type	110,342	0			110,342				110,342		0	
7. Enabling Environment (sub-total)	**5,381,350**	**0**	**0**	**0**	**5,381,350**	**4,831,834**	**204,002**	**319,760**	**25,754**	**0**	**0**	**0**
7.01 Advocacy	89,643	0			89,643		89,643				0	
7.02 Human rights programmes	69,399	0			69,399			69,399			0	
7.03 AIDS-specific institutional development	3,966,164	0			3,966,164	3,662,605	114,359	189,200			0	
7.04 AIDS-specific programmes focused on women	7,848	0			7,848			7,848			0	
7.98 Enabling Environment and Community Development not disaggregated by type	1,237,140	0			1,237,140	1,169,229		50,000	17,911		0	
7.99 Enabling Environment and Community Development not elsewhere classified	11,156	0			11,156			3,313	7,843		0	
8. Research (sub-total)	**1,831,042**	**319,149**	**0**	**0**	**1,511,893**	**1,511,893**	**0**	**0**	**0**	**0**	**0**	**0**
8.08 Social Science Research	319,149	319,149	319,149									
8.98 Research not disaggregated by type	1,511,893	0			1,511,893	1,511,893					0	

FUNDING MATRIX - 2013 - 2014

Country:	NAMIBIA		
Reporting cycle:	FISCAL YEAR		
Data Measurement Tool	National AIDS Spending Assessment (NASA)		
Amounts reported in:	US DOLLARS		
Please indicate month and year (M/YYYY)		Month	Year
	From:	April	2013
	To:	March	2014
Name of Local Currency	NAMIBIAN DOLLAR		
Currency expressed in:	Millions (x 1,000,000)		
Average Exchange Rate for the year (local currency to USD)	10.724		

Financing Source

2013 - 2014	TOTAL	Public Sources			International Sources	Bilaterals		Multilaterals			Private Sources (optional for UNGASS reporting)	
AIDS Spending Categories	US DOLLARS	Public Sub-Total	Central / National	All Other Public	International Sub-Total	PEPFAR	Other Bilaterals	UN Agencies	Global Fund	All Other International	Private Sub-Total	All Other Private
TOTAL US DOLLARS	**213,346,629**	**136,620,606**	**128,793,293**	**6,874,932**	**74,283,368**	**57,658,447**	**1,675,726**	**2,448,193**	**11,978,348**	**522,654**	**2,442,655**	**2,442,655**
1. Prevention (sub-total)	**34,061,204**	**19,594,181**	**19,070,390**	**523,791**	**14,277,404**	**10,393,909**	**464,321**	**1,338,505**	**1,558,015**	**522,654**	**189,619**	**189,619**
1.01 Communication for social and behavioural change (BCC)	909,481	**575,342**	575,342		334,139			334,139			0	
1.02 Community/social mobilization	228,012	0			228,012		91,805	136,207			0	
1.03 Voluntary counselling and testing (VCT)	18,383,974	15,264,847	14,767,103	497,744	3,119,127	2,319,629			302,834	496,664	0	
1.04 Risk-reduction and prevention activites for vulnerable and accessible populations	32,387	0			32,387		32,387				0	
1.05. Prevention - Youth in school	739,890	623,629	623,629		116,261		28,864	24,801	62,596		0	
1.06 Prevention - Youth out-of-school	356,615	313,320	313,320		43,295		43,295				0	
1.07 Prevention of HIV transmission aimed at people living with HIV	582,360	0			582,360	582,360					0	
1.08 Prevention programmes for sex workers and their clients	1,026,718	0			1,026,718	1,026,718					0	

1.09 Programmes for men who have sex with men	319,143	0			319,143	319,143					0	
1.10 Harm-reduction programmes for injecting drug users	14,778	0			14,778			14,778			0	
1.11 Prevention programmes in the workplace	175,566	0			175,566		95,683	79,883			0	
1.12 Condom social marketing	2,906,556	2,274,592	2,274,592		631,964				631,964		0	
1.13 Public and commercial sector male condom provision	0	0			0						0	
1.14 Public and commercial sector female condom provision	170,500	0			170,500			170,500			0	
1.17 Prevention of mother-to-child transmission	951,012	0			951,012	308,111		58,393	558,518	25,990	0	
1.18 Male Circumsicion	642,409	26,047	0	26,047	426,743	424,640			2,103		189,619	189,619
1.19 Blood safety	340,754	0			340,754	340,754					0	
1.22 Post-exposure prophylaxis	38,734	0			38,734	38,734					0	
1.23 Pre-exposure prophylaxis *(new category for GARPR 2014)*	319,292	0			319,292	319,292					0	
1.98 Prevention activities not disaggregated by intervention	5,901,736	516,404	516,404		5,385,332	4,714,528	172,287	498,517			0	
1.99 Prevention activities not elsewhere classified	21,287	0			21,287			21,287			0	
2. Care and Treatment (sub-total)	**38,291,448**	**21,050,125**	**14,698,984**	**6,351,141**	**15,325,827**	**9,885,375**	**0**	**57,756**	**5,382,696**	**0**	**1,915,496**	**1,915,496**
2.01 Outpatient care	35,623,095	20,327,784	**14,698,984**	**5,628,800**	15,295,311	**9,885,375**	**0**	**27,240**	**5,382,696**	**0**		**1,915,496**
2.01.01 Provider- initiated testing and counselling	857,134	0	0		857,134	857,134					0	
2.01.03 Antiretroviral therapy	29,247,514	18,410,525	12,781,725	5,628,800	8,921,493	4,391,161			4,530,332		1,915,496	1,915,496
2.01.04 Nutritional support associated to ARV therapy	2,339,624	1,917,259	1,917,259		422,365				422,365		0	
2.01.05 Specific HIV-related laboratory monitoring	181,112	0			181,112	181,112					0	
2.01.07 Psychological treatment and support services	719,384	0			719,384	692,144		27,240			0	
2.01.09 Home-based care	3,502,622	0			3,502,622	3,072,623			429,999		0	
2.01.98 Outpatient care services not disaggregated by intervention	691,201	0			691,201	691,201					0	
2.02 In-patient care	43,204	12,688	**0**	**12,688**	30,516	**0**	**0**	**30,516**	**0**	**0**	0	**0**
2.02.01 Inpatient treatment of opportunistic infections (OI)	12,688	12,688		12,688	0						0	
2.02.99 In-patient services not elsewhere classified	30,516	0			30,516			30,516			0	
2.98 Care and treatment services not disaggregated by intervention	709,653	709,653	**0**	**709,653**	0						0	
3. Orphans and Vulnerable Children (sub-total)	**34,689,499**	**32,457,913**	**32,457,913**	**0**	**2,231,586**	**1,998,537**	**0**	**130,776**	**102,273**	**0**	**0**	**0**
3.01 OVC Education	1,088,711	645,000	645,000		443,711	443,711					0	

3.02 OVC Basic health care	1,656,591	1,627,724	1,627,724		28,867	28,867					0	
3.03 OVC Family/home support	27,183,370	25,657,411	25,657,411		1,525,959	1,525,959					0	
3.05 OVC Social services and Administrative costs	130,776	0			130,776			130,776			0	
3.98 OVC services not disaggregated by intervention	4,630,051	4,527,778	4,527,778		102,273				102,273		0	
4. Systems Strengthening & Programme Coordination	**28,533,647**	**3,059,169**	**3,059,169**	**0**	**25,136,938**	**19,658,483**	**193,581**	**537,919**	**4,746,955**	**0**	**337,540**	**337,540**
4.01 National planning, coordination and programme management	4,616,030	1,087,321	1,087,321		3,528,709	2,919,230		118,480	490,999		0	
4.02 Administration and transaction costs associated with managing and disbursing funds	4,332,432	0			4,332,432	2,694,674			1,637,758		0	
4.03 Monitoring and evaluation	1,893,513	0			1,893,513	1,251,945	10,808	4,365	626,395		0	
4.04 Operations research	556,420	0			556,420	556,420					0	
4.05 Serological-surveillance (Serosurveillance)	619,889	380,952	380,952		238,937	238,937					0	
4.06 HIV drug-resistance surveillance	51,256	0			51,256	26,547		24,709			0	
4.07 Drug supply systems	417,175	0			417,175	417,175					0	
4.08 Information technology	11,804,973	126,296	126,296		11,678,677	11,163,716		4,388	510,573		0	
4.09 Patient tracking	0	0			0						0	
4.10 Upgrading and construction of infrastructure	426,181	0			426,181	389,839	9,325		27,017		0	
4.11 Mandatory HIV testing (not VCT)	0	0			0						0	
4.98 Program Management and Administration Strengthening not disaggregated by type	3,224,457	1,464,600	1,464,600		1,759,857		86,724	235,977	1,437,156		0	
4.99 Program Management and Administration Strengthening not-elsewhere classified	591,321	0			253781		86,724	150,000	17,057		337540	337,540
5. Incentives for Human resources (sub-total)	**60,804,671**	**57,775,234**	**57,775,234**	**0**	**3,029,437**	**2,150,810**	**687,147**	**19,703**	**171,777**	**0**	**0**	**0**
5.01 Monetary incentives for human resources	42,237,518	41,615,647	41,615,647		621,871		621,871				0	
5.02 Formative education to build-up an HIV workforce	379,331	0			379,331	379,331					0	
5.03 Training	1,876,258	310,685	310,685		1,565,573	1,374,093		19,703	171,777		0	
5.98 Incentives for Human Resources not specified by kind	14,269,266	13,871,880	13,871,880		397,386	397,386					0	
5.99 Incentives for Human Resources not elsewhere classified	2,042,298	1,977,022	1,977,022		65,276		65,276				0	
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**3,303,525**	**1,977,022**	**1,977,022**	**0**	**1,326,503**	**1,326,503**	**0**	**0**	**0**	**0**	**0**	**0**
6.02 Social protection through in-kind benefits	240,617	0			240,617	240,617					0	

6.04 HIV-specific income generation projects	1,085,886	0			1,085,886	1,085,886					0	
6.98 Social protection services and social services not disaggregated by type	1,977,022	1,977,022	1,977,022		0						0	
7. Enabling Environment (sub-total)	**12,117,471**	**135,533**	**135,533**	**0**	**11,981,938**	**11,271,095**	**330,677**	**363,534**	**16,632**	**0**	**0**	**0**
7.01 Advocacy	123,257	0			123,257		123,257				0	
7.02 Human rights programmes	44,940	0			44,940			44,940			0	
7.03 AIDS-specific institutional development	8,118,267	0			8,118,267	7,816,445	207,420	94,402			0	
7.04 AIDS-specific programmes focused on women	55,795	0			55,795			55,795			0	
7.98 Enabling Environment and Community Development not disaggregated by type	3,597,668	135,533	135,533		3,462,135	3,454,650			7,485		0	
7.99 Enabling Environment and Community Development n.e.c	177,544	0			177,544			168,397	9,147		0	
8. Research (sub-total)	**1,545,164**	**571,429**	**0**	**0**	**973,735**	**973,735**	**0**	**0**	**0**	**0**	**0**	**0**
8.04 Social science research	571,429	571,429	571,429		0						0	
8.98 Research not disaggregated by type	973,735	0			973,735	973,735					0	

REFERENCES

UNAIDS (2009), National AIDS Spending Assessment Resource Tracking System (User Guide), UNAIDS, 20, avenue Appia, CH-1211 Geneve 27 Suisse

UNAIDS (2009), National AIDS Spending Assessment (NASA) Classification taxonomy and Definitions, UNAIDS 20, avenue Appia, CH-1211 Geneve 27 Suisse

Namibia Health and HIV/AIDS Resource Tracking 2007/08 & 2008/09

National AIDS Spending Assessment (NASA) 2009/10 & 2010/11

National Planning Commission. Namibia 2011 Population and Housing Census Preliminary Results

Human Development Report 2013

Spectrum Policy Modelling System, Version 4.392 (2011): Namibia model July 2011

Spectrum Policy Modelling System, Version 4.69_500 (2013): Namibia model 11 October 2013

World Bank 2012

World Bank 2008 and NPC 2008

Promoting Pro-Poor Growth: Social Protection - © OECD 2009

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