The Kingdom of Swaziland

National AIDS Spending Assessment (NASA)

For Financial years: 2010/11-2012/13

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CANGO	Coordination Assembly of Non-Governmental Organisations
CBO	Community Based Organizations
CHAI	Clinton Health Access Initiative
CSO	Central Statistical Office
DHS	Demographic and Health Survey
EU	European Union
FBO	Faith Based Organization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
INGO	International Non-Governmental Organization
NGO	Non-Governmental Organization
NERCHA	National Emergency Response Council on HIV and AIDS
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NASA	National AIDS Spending Assessment
RTS	Resource Tracking Software
RTT	Resource Tracking Tool
NGO	Non-Governmental Organization
NSF	National Strategic Framework
ENSF	Extended National Strategic Framework
OVC	Orphan and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	Presidents Emergency Programme for AIDS Relief
PLHIV	People Living With HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PSHACC	Public Sector HIV and AIDS Coordinating committee
SHACO	Swaziland HIV and AIDS Consortium
SHIMS	Swaziland HIV Incidence Measurement Survey
SNAP	Swaziland National AIDS Program
SZL	Swazi Lilangeni
UN	United Nations
UNAIDS	Joint United Nations Program on HIV AND AIDS
UNDP	United Nations Development Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nation Children's Fund
US$	United States Dollar
USG	United States Government
WFP	World Food Programme
WHO	World Health Organisation

Director's Foreword

The Government of the Kingdom of Swaziland and her development partners remain at the forefront in the efforts towards ending the AIDS Epidemic as a public health threat by 2022. As an effort to assist the country to monitor the invested resources in the multisectoral response to HIV and AIDS, NERCHA committed to undertaking a comprehensive assessment of HIV-related expenditure. This report is part of NERCHAs analytical work for evaluating and quantifying the multi-sectoral approach of the response, and also for identifying funding gaps and duplication of funding in the national response.

Given the many challenges that need to be overcome in providing HIV services, high levels of funding will be needed to move towards ending the AIDS epidemic as a public health threat by 2022. It is therefore imperative to have a clear knowledge of what is being spent on HIV and AIDS, to ascertain if the expenditures are targeted to the most cost-effective interventions and key priority areas. Knowledge of the total actual expenditure for the national response promotes greater transparency, efficiency, effectiveness and accountability to the Government, public, donors and beneficiaries.

This report therefore provides expenditure estimates of the overall HIV response in the country for the financial years 2010/11, 2011/12 and 2012/13 and will be of much value to all stakeholders for a better understanding of the financial flows and gaps in the national AIDS response. It also demonstrate the Commendable commitment from the government of Swaziland, private sector and the international partners for providing resources for the coordination and implementation of the national HIV and AIDS response.

It is my sincere hope that all stakeholders in the multisectoral HIV response from donor to service provider will use this report as a benchmark to inform their planning and resource allocation for all services or activities that are implemented

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National Executive Director
National Emergency Response Council on HIV and AIDS (NERCHA)

ACKNOWLEDGEMENTS

The Swaziland National AIDS Spending Assessment was commissioned by NERCHA in partnership with UNAIDS (Swaziland). The study was funded through the UNAIDS country office in Swaziland. NERCHA wishes to thank and appreciate the contributions and inputs of the members of the NASA Steering Committee (SC) given at various stages of the NASA exercise. NERCHA would also like to thank the various organizations that provided HIV and AIDS financial data, these organizations comprised public and private sectors, NGOs, Faith Based organizations and the civil society, bilateral and multilateral agencies and UN agencies

Further, NERCHA would like to thank all persons who contributed to the successful implementation and completion of the third comprehensive NASA in the Kingdom of Swaziland, especially the NASA Core Team members: Ms. Nokwazi Mathabela (NERCHA- M&E Manager), Mr. Nsindiso Dlamini (NERCHA- NASA Project Manager), Ms. Pepukai Chikukwa (UNAIDS-Strategic Information Adviser), Mr. Nuha Ceesay (UNAIDS-Investment and Efficiency Advisor), Ms. Thembisile Dlamini (UNAIDS-Community Mobilisation and Networking Advisor), Mr. Mduduzi Dlamini (PEPFAR- Deputy PEPFAR Coordinator-Swaziland) and Mr. Rob Kwon (CHAI- Health Financing Associate). Their tireless and tremendous efforts to this exercise are applauded. Also, we are appreciative of the efforts of some NERCHA staff members for guiding and participating in the NASA activities and processes

Finally, NERCHA would like to thank Dr. Urbanus Kioko Mutuku, the international consultant and Mr. Clinton Simelane, the local consultant and also the team of research assistants for conducting the Swaziland NASA survey in the country.

NERCHA in partnership with stakeholders will endeavor to institutionalize the NASA process so that reporting expenditures on HIV and AIDS becomes routine. The support of all partners and stakeholders is therefore critical in realizing the institutionalization and long term sustainability of the NASA. I therefore count on your continued support and commitment in this process and I know that I can always count on you to achieve this in Swaziland.

EXECUTIVE SUMMARY

The Government of Swaziland committed to the conduct of a full National AIDS Spending Assessment to track actual HIV and AIDS spending from public, international and private sources covering the periods 2010/11, 2011/12 and 2012/13. The financial data collected covered public, external and private spending on HIV and AIDS as well as funds channeled through government.

NASA is an international methodology for HIV and AIDS resource tracking and refers to the systematic, periodic, and exhaustive tracking of the actual spending by various HIV and AIDS stakeholders in the international, public and private sectors. The resource tracking methodology is aimed at following the money from the source up to the beneficiaries receiving goods and services NASA comprise specific boundaries around the transactions related to HIV and AIDS, functions that include eight programmatic areas: (1) prevention, (2) care and treatment, (3) orphans and vulnerable children (OVC), (4) Programme management and administration, (5) human resources, (6) Social protection and social services, (7) Enabling environment (8) HIV related research.

All sources of data were obtained from both primary and secondary sources. For primary data, a total of 92 organizations were sampled (17 external donors, 25 public institutions, 25 international NGOs and 35 FBO/CSO/NGOs) On the basis of information provided by funding sources and service providers, the study attempted to reconstruct overall spending on HIV and AIDS programmes in Swaziland. Funding come from three main sources: public, external (international) and private sources. Like many developing countries, the national response to HIV and AIDS in Swaziland is to a large extent sustained by external assistance secured from bilateral and multilateral organizations.

The objectives of the NASA are as follows:

- To track HIV and AIDS financing and expenditure by various stakeholders in the public, donor and private sub-sectors for the financial years 2010/11, 2011/12 and 2012/2013 respectively;

- To catalyse and facilitate actions which strengthen capacities to effectively track expenditures on HIV and AIDS, and synthesize this data into strategic information for decision-making

- To develop guidelines on how to institutionalize the function of routine financial monitoring utilizing tools adapted from the NASA methodology Special tracking of indirect or system-wide spending by government attributable to HIV and AIDS service provision

The findings of the NASA are summarized below;

Funding Levels – A total of SZL 2,705,290,131 (US$338,725,809) was spent on HIV and AIDS related activities in Swaziland in the financial years 2010/11, 2011/12 and 2012/13. Yearly expenditures range from SZL 854,175,027 (US$117,170,786) in 2010/11, SZL 993,285,628 (US$ 128,414,432) in 2011/12 to SZL857, 829,476 (US$ 96,007,776) in 2012/13. This represents an increase of 24% in 2010/11 from 2009/10, 16% in 2011/12 from 2010/11 but slightly declined by 14% from 2011/12 to 2012/13. However, in comparison with expenditure estimates for 2007/08-2009/10 NASA, the 2010/11-2012/13 registered higher totals of funding for the HIV and AIDS response.

Source of funds- In FY 2010/11 Public Sources contributed 57%; Private Sources 2% and International Sources 41%. However, there was some slight change in FY 2011/12 as the proportion of funding from International Sources is high (59%), and the largest

contribution of this funding comes from Bilateral Entities (49.9%) with United States of America contributing close to 49.7%. A similar pattern is maintained in the FY 2012/13.

The private funding at close to 1% in each of the FYs is insignificant, and is mostly from For-profit institutions and corporations, Not-for-profit institutions (other than social insurance and Private financing sources n.e.c). It should be noted that expenditure by households was not included in the estimation and as such, the contribution from private sources could have been understated. Public funds are mostly from central government.

Financing Agents - In 2010/11, 71% of the NASA funds were managed by the public sector Financing Agents (FAs), 2% by Private FAs and 27% by External FAs. A similar pattern is noted in the FY 2011/12 where Public FAs managed 60% of the total funds, 0.5% by the private sector and 39% by the External FAs. The proportion managed by the External FAs increased to 50% in the FY 2012/13 while Public Sector FAs managed almost a similar proportion. The proportion of funds managed by Private Sector FAs declined to 0.02%. The NASA further revealed that public FAs manage a higher proportion of funds for HIV and AIDS in Swaziland.

Providers of HIV/AIDS services – In 2010/11 over two thirds of the NASA funds in Swaziland were spent by Public Providers (67%), 57% in 2011/12 and 48% in 2012/13 respectively. The private sector spent about 12%, 43% and 49% of the funds in the FY 2010/11, 2011/12 and 2012/13 respectively while External Providers spent approximately 16% in 2010/11. In FYs 2011/12 and 2012/13, External Providers spent a negligible proportion of the funds (0.3% and 1% respectively). Based on the NASA estimates, it is evident that the bulk of the spending for the provision of HIV and AIDS services in Swaziland is therefore in the public sector. The largest proportion of spending amongst public sector are public hospitals, Ministry of Health Ministry of Education and NERCHA. The funds utilised by the Private Providers are mostly from International (especially bilateral entities) and Private Sources, and managed by External and Private FAs.

AIDS Spending Categories (ASCs) - The NASA estimates show that 18.4% of HIV and AIDS funding in Swaziland in the FY 2010/11 was spent on Prevention, 21.3% on Care and Treatment, 19% on OVCs, 27.7% on Programme Management, 6.5% on Human Resources, 5.9% on social protection and social services, 1% on enabling environment and less than 1% on HIV and AIDS related research. A similar pattern is discernible in FY 2011/12 with prevention taking 21.9%, care and treatment (33.7%) and OVC 23.8%).

Beneficiaries – The NASA has revealed an increased spending on the PLHIV, rising from 29.3% in FY 2010/11 to 45.4% in 2011/12 and 50% in 2012/13. This is understandable given the accelerated initiatives by the government to increase the number of people on treatment. About 32.6% of funding benefitted the general population in FY 2010/11, 15.2% in the FY 2011/12 and 12% in 2012/13. A combination of the three years reveals that 48% of the funding benefitted PLHIV followed by general population (23%), other key populations (15%), and specific accessible populations (6%) less than 1% was spent on most at risk populations.

NASA Estimates, affordability and sustainability

A close examination at the NASA results shows that the Public Sector is playing a significant role in funding and managing resources for HIV and AIDS in the country. The contribution from public funding over the three year period under consideration stood at 46% of total funding. The funding from External entities continued to play a significant role, in financing the national response. The main players, in terms of both financing and management of resources are the Public Sector and Bilateral entities. The private sector is playing a very minimal role – but it could be doing more if all funding from private sector including expenditure by households is included in the estimates. The public sector players (public and private) contribute about 47% of the resources (59% in 2010/11, 41% in 2011/12 and 43% in 2012/13; and manage more than half of the funds (73% in 2010/11, 60.5% in 2011/12 and 50% in 2012/13).

The scenario shown above has some policy implications for planning particularly with respect to sustainability of the response. Although funding from public sector sources has

seen significant improvement over the years, a larger proportion of funding still come from a few bilateral and multilateral entities. This is a major point of concern because if one entity withdraws for whatever reason it will lead to a major crisis.

A comparison of the NASA total estimates for FY 2010/11, 2011/12 and 2012/13 against the costed eNSF would have revealed whether the spending is in line with the identified priorities and whether there is more funding than is required for the implementation of eNSF. It was however not possible to examine these scenarios because the previous strategic framework had not been costed at the time of compiling this report.

Institutionalization of HIV/AIDS resource tracking

Based on lessons and findings of the third round of NASA, the role of various stakeholders in the national response is critical in aiding the process of the institutionalization of HIV and AIDS resource tracking in the country. It is therefore recommended that government and stakeholders consider developing and implementing a governance framework for HIV and AIDS resource tracking linking NASA production to the use of the data and its translation to support policy formulation and decision-making. It is further recommended that NERCHA strengthens internal capacity for the effective coordination and production of NASA; while key partners in the national response take the role of technical and policy dialogue.

It is also recommended that NERCHA take the lead, with support from the other players, in creating a central database of all HIV and AIDS stakeholders; in establishing an harmonized reporting formats and structures; and linking up with other government entities such as Central Statistics Office and MoH to routinely undertake surveys to provide information relevant to HIV and AIDS spending.

In conclusion, the NASA report provides comprehensive information on total HIV and AIDS financing and expenditure in the Kingdom of Swaziland as well as various classifications. Secondly, it provides information on the changing pattern of spending from

different sources for the national response; and thirdly, it provides recommendations on institutionalization of HIV and AIDS Resource Tracking in the country.

Recommendations-i) A key recommendation from this study is that the data generated by NASA should be used for policy formulation and decision-making including planning, resource mobilization, allocation, monitoring and evaluation of the HIV and AIDS response; The study further recommends that NASA to be institutionalized the including involvement of other government agencies to routinely collect HIV expenditure data and report periodically) It is also recommended that NERCHA and stakeholders undertake further analysis of the data to provide detailed information on key aspects such as geographical equity in HIV and AIDS spending, efficiency in the use of resources for HIV and AIDS, and comparison of the costed eNSF and the NASA data.

1 INTRODUCTION

1.1 Context for the assessment

Swaziland is a landlocked country in Southern Africa with a land surface area of about 17,364 square kilometres. It is divided into four administrative regions namely Hhohho, Manzini, Shiselweni, and Lubombo. It is further subdivided into 55 Tinkhundla (constituencies) and 360 chiefdoms and towns. The projected population of the country in 2015 is 1,119,3751 and 49% of whom are under the age 20. The total fertility rate was estimated at 3.8 births per 1000 women in 2007, representing a significant decline from 6.4 in 1986. Declining fertility levels, coupled with a rising rate of mortality, have contributed to the low annual rates of population growth.

Swaziland has made significant strides in the fight against HIV and AIDS despite being classified as one of the countries with the highest prevalence of 26% (SDHS, 2007) and incidence of 2.3% (SHIMS, 2011) Progress has been made in the area of PMTCT[NM2] and ART, with active participation of civil society in the HIV response..

The country relies on funding from external, public and private sources with 60%-70% of the funding coming from international sources (Swaziland NASA, 2011). Despite the increase in funding for the national response, there are still sustainability issues arising from dependency on external funds; challenges with regards to resource flow to implementing agencies; limited capacity of key stakeholders in the absorption of funds and the need to strengthen systems that would improve the accountability and reporting..

Prior to the implementation of the first (NASA) in 2007, there was no mechanism or system in place to track and direct HIV and AIDS funding. There was also very little information on how much money was spent on HIV and AIDS related activities and which groups were targeted and reached by these programmes. Resource tracking for HIV and AIDS has since gained prominence in Swaziland stemming from the need[NM3] to effectively and efficiently allocate resources to different interventions, according to the national priorities.

[1] Swaziland Population Projections (SPP), 2007-2030

In the face of the global recession in the past years and limited resources for funding HIV and AIDS related programmes, it has become prudent for the country to strengthen its monitoring and evaluation efforts to efficiently track funds and use the information for informed decision making. It was against this background that the country has decided to conduct another round of the NASA for the period 2010/2011, 2011/2012 and 2012/2013.

Analysis of the sources and financial flows of funding is critical due to the importance of effective allocation. Also, identifying the sources of finance and providers of HIV services, as well as the total amount of resources spent on HIV and AIDS improves the results of investments. It is also important to keep tracking resources, to ensure the strengthening of local capacities for effective use of additional funding within? HIV and AIDS programmes.

1.2 What is the NASA

NASA is a tool developed by UNAIDS to measure the entirety of resources included in a country's national HIV response. It was developed using the national health accounts framework and principles. NASA applies standard accounting methods to reconstruct all transactions in a given country, 'following the money' from the funding sources to agents and providers, and eventually to beneficiary populations. The NASA has been used to report progress on the 2001 Declaration of Commitment from the UN General Assembly Special Session on HIV/AIDS (UNGASS). It additionally supports countries in planning and monitoring their HIV activities. NASA analyses include levels and patterns of domestic HIV spending from public and international sources down to the recipient population. The tool tracks actual expenditure in both health and non-health sectors that comprises the national response to HIV and AIDS.

NASA uses both top-down and bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from donor reports, commitment reports, government budgets, whilst the bottom-up tracks expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts.

The need to track HIV expenditure stems from the fact that decisions regarding allocations for HIV and AIDS related activities must be based on the true effect of previous expenditure patterns on the profile of the epidemic in the various regions in the country. NASA is expected to provide information that will contribute to better understand a country's financial absorptive capacity, as well as issues of equity, efficiency and effectiveness of the resource allocation process. In addition to establishing a continuous information system of the financing of HIV and AIDS response, NASA facilitates standardized reporting of indicators monitoring progress towards the achievement of the targets of the Declaration of Commitments and the 2011 United Nations General Assembly Political Declaration on HIV and AIDS.. The feasibility of NASA relies on background information, identification of key players and potential sources of information, understanding users' and informants' interests, as well as the development of an inter-institutional group responsible for facilitating access to information, participating in the data analysis, and contributing to the data dissemination.

1.3 Objectives and purpose

The objective of the NASA is to conduct a systematic assessment of HIV and AIDS financial resource expenditures and actual absorption levels which are critical for improved resource planning. The specific objectives of the study are the following:

- To assess expenditures for HIV and AIDS from all international and public (domestic) sources of financing for the financial years 2010/11, 2011/~~12 and~~12 and 2012/2013 respectively
- To catalyze and facilitate actions which strengthen capacities to effectively track expenditures on HIV and AIDS, and synthesize this data into strategic information for decision-making
- To develop guidelines on how to institutionalize routine financial monitoring.

1.4 Scope of the assessment

The assessment focused on tracking national HIV expenditure for the financial years 2010/11, 2011/2012 and 2012/13 in the Kingdom of Swaziland. Data collection covered spending on HIV and AIDS funded from domestic, external and private sources.

1.5 Structure of the report

The report is organized into 6 chapters. The first chapter is the introduction of the report, objective and scope of NASA and background information about the Kingdom of Swaziland, the HIV and AIDS epidemic and the national response. Chapter two presents the context of the study particularly demographic and socioeconomic indicators while chapter three outlines the methodology and the process adopted by the NASA team in the Kingdom of Swaziland. It covers the approach to data collection, sources of data, data processing, analysis, challenges and limitations of the assessment. The fourth chapter presents the findings of the NASA and discussion of the NASA estimation while chapter five deals with policy implications for the NASA study findings including guidelines for institutionalisation of NASA. Finally, chapter six presents recommendations based on the findings.

2 OVERVIEW OF THE COUNTRY CONTEXT

Population: 1,419,623

Population growth (annual): 1.14% (2014 est.)

GDP per capita , US$ 3,034 (2013)

GNI per capita 2012, PPP (US$ 4840

GDP (PPP) per capita : $5,700 (2013 est.)

Human Development Index (HDI) value: 0.542Area: 17,364 sq km

Life expectancy: 50.54 years

Life expectancy: male: 51.04 years
female: 50.04 years (2014 est.)

Health expenditures: 8% of GDP (2011)

HIV-adult prevalence rate: 26.5% (2012 est)

HIV and AIDS-people living with HIV and AIDS: 212,900 (2012 est)

Population below poverty line: 69%

GDP: US $ 6.259 billion (2013 est);

GDP growth: 2.8(2013 est)

Total Fertility Rate: 3.4

Antenatal Coverage: 97%

%of children under 18 who are orphans: 23%

2.1 Kingdom of Swaziland: demographic and socioeconomic indicators

The Kingdom of Swaziland is located in Southern Africa bordered by South Africa and Mozambique and covers a land area of 17,364 Km2, with a population of 1.4 million inhabitants. Annual population growth is estimated at 1.14%. The 2007 census showed about 46% of the population is aged between 15-49 years and the male-female distribution is 45% -55%. The majority of the population resides in rural areas, with only about 23% residing in urban areas. The population is also relatively young, with about 69% under the age of 25. Close to 63% of the population lives below the poverty line, and about 29% lives below the extreme poverty line. The majority of the Swazis live on less than US$ 1.25 a day (purchasing power parity (PPP), equivalent) which is especially high for a middle-income country.

The country is divided into four administrative regions: Hhohho (where the capital city, Mbabane, and Government ministries are located), Manzini (which contains the largest industrial site in the country), Lubombo (where most of the agricultural plantations are located) and Shiselweni (the least developed region). The country is further subdivided into 55 constituencies (Tinkhundla) for political and administrative purposes. An Inkhundla operates as an administrative centre.

Swaziland is classified as a lower middle income country, despite 63 percent of the population living below the poverty line (Swaziland Income and Expenditure Survey, 2002). The 2005 United Nations Human Development Report

classified Swaziland among countries with low human development index. With economic growth being slightly higher than demographic growth (2.8 percent and 1.14 percent), the quality of life of the Swazis has improved over the period with GDP per capita reaching US$ 3,034 in 2013, a decline from US$ 3,047 in 2012.

2.2 HIV and AIDS situation analysis

The first HIV case was identified in 1986 and the first AIDS case in 1987 (UNAIDS Global Report 2012: AIDS info). Since then, the number of persons living with HIV and AIDS has increased rapidly throughout the population. The country has one of the highest HIV prevalence and incidence in the world estimated at 26.5% and 2.38% respectively among population aged 15–49 years (eNSF, 2014-2018). The SDHS of 2007 showed that women aged 15–49 have a higher prevalence than men (31% and 20% respectively). In both men and women, HIV prevalence increased steeply with age and peaked before age 40 (SHIMS, 2011). Peak HIV prevalence was lower for men (47%) than women (54%) and occurred at an older age (35-39 versus 30-34).

The prevalence is higher in women (38%), compared to men (23%). Recent data from SHIMS (2011) showed that the HIV epidemic is stabilizing but shifting to older populations. The SHIMS data further revealed significant reductions of 54% and 20% in prevalence among the18-~~24 year~~24-year age group among males and females, respectively. It shows that peak prevalence has shifted to older persons among women aged 30-34 from those aged 25-29 in 2006/7 and men aged 35-39 from 30-34 year olds' in 2006/7. HIV prevalence among female sex workers is very high (70%) and lower among men who have sex with other men (17%).

According to results of Spectrum HIV Estimates and Projection model (2013), HIV incidence for people aged 15-49 was 2.45 % in 2011 and 1.79% in 2013, and is projected to further decrease to 1.52% in 2015, and new infections among children at 18 months of age are estimated to be 11% of all exposed children in 2012 from 19.6% in 2009. Heterosexual sex remains the main mode of transmission of HIV in Swaziland, accounting for 94% of all new HIV infections (MOT, 2009). Risk factors include but are not limited

to, multiple and concurrent sexual partnerships, intergenerational and transactional sex, gender inequalities and gender based violence, low and inconsistent condom use and low uptake of male circumcision. ~~According to the preliminary report of the Swaziland HIV Estimates and Projections (2012), the annual incidence rate among 15-49 years is expected to reduce from 2.9% in 2011 to 1.9% in 2015~~[A4]

The latest statistics show that new HIV infections are declining and the HIV incidence rate among adults aged 18-49 is estimated at 2.38%, comprising of 1.7% and 3.1% amongst men and women, respectively (Swaziland Incidence Measurement Survey Study -SHIMS 2011). The SHIMS further indicates that the peak incidence of HIV infections is more pronounced among women aged 18-19, 20-24 and 30-34 and men aged 30-34 at close to 4% in these age groups.

2.3 National Response and AIDS funding in Swaziland

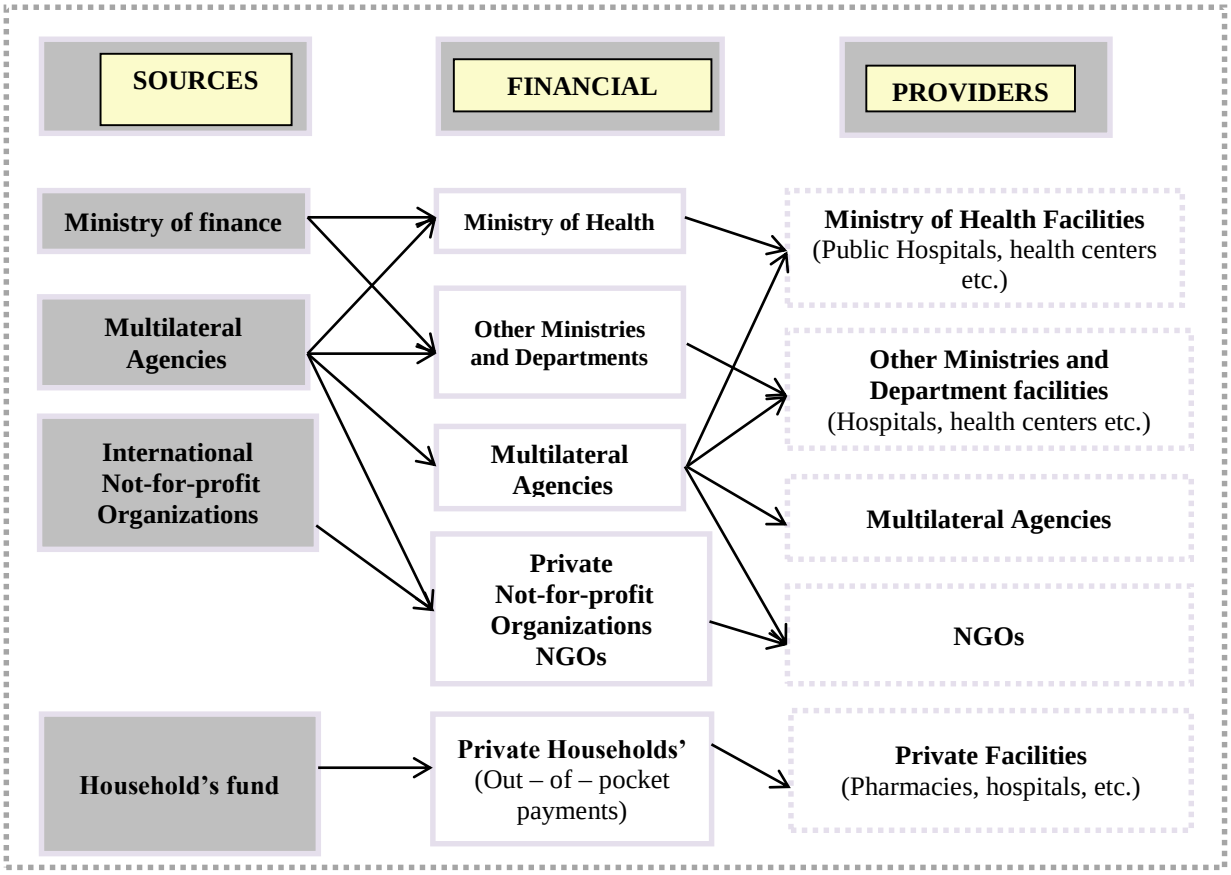
The country's response to HIV and AIDS dates back to 1987 through the Ministry of Health. The first HIV and AIDS plan (1987-1988) was developed by an AIDS Task Force which was later transformed into the Swaziland National AIDS Program (SNAP) and still remains the key planning and management arm for health sector HIV and AIDS services. Currently, the national response is led and coordinated by the National Emergency Response Council for HIV and AIDS (NERCHA) which was established in 2003 through an Act of Parliament, in part as a result of the global recognition of the multi-sectoral nature of HIV and AIDS and the call for one coordinating authority. It has overseen the development of three national HIV and AIDS strategic plans (2000 – 2005, 2006 – 2008 and 2009 – 2014) and a new Extended NSF covering the period 2014–2018). In addition, coordination has also been decentralized through the establishment of regional and community structures. The Public Sector response involves all public ministries and departments, directorates and units and is led by Public Sector HIV and AIDS Coordination Committee (PSHACC). Through PSHACC a public sector coordinating strategy has been developed and is being implemented.

The civil society organisations response is coordinated through the Swaziland HIV and AIDS Consortium (SHACO) an arm of the Coordinating Assembly of Non-Governmental Organisations (CANGO). CANGO includes civil society and private sector umbrella bodies that have been established to provide sector leadership in their respective areas. Private sector response is led by Swaziland Business Coalition on HIV and AIDS (SWABCHA). Development Partners are facilitated through the Donors' Forum and the Swaziland Partnership Forum. The national response is currently guided by the 2014-2018 National Strategic Framework (eNSF) with focus on the following priority areas: HIV Testing and Counselling, Social Behaviour Change, Condom Promotion and Distribution, Prevention of Mother to Child Transmission of HIV, Male Circumcision, Customised Interventions for Key Populations and the Vulnerable Groups, Pre Antiretroviral Therapy (Pre-ART), Antiretroviral Therapy, TB/HIV Co-Infection, Family Strengthening and Gender Based Violence

A number of policies have been put in place including the HIV prevention policy to support the national response. The government commitment to the national response has seen a significant increase in ART and PMTCT programmes. By December 2014, 100,138 of the 122,185, representing 82% people in need of treatment were receiving ART while 9,522 of the 11,307 HIV positive pregnant women (84%) were receiving PMTCT services (Swaziland Global AIDS Response Progress Reporting, 2014~~). The~~). The country's commitment to the response is reflected in the Extended National Strategic Framework (eNSF) (2014–2018), which focuses on high impact interventions and targets populations and regions where most of the infections are occurring. Out of the eNSF, the country further developed the Swaziland HIV Investment Case (SHIC) which identified five game changers (ART, PMTCT, MC, Prevention for young girls and TB/HIV co-~~infection) to~~infection) to help the country focus the key interventions areas of the that have the potential to Fast Track ending AIDS by 2030. The government has also shown its commitment to the national response through increased financing and procurement of all ARVs and TB drugs. Though HIV incidence has decreased since 2011, it is still relatively high and prevention remains a priority.

Available evidence shows that international sources continue to account for the largest source of funding for the national response with over 60 percent in 2010, up from 55 percent in 2009 while domestic funding remains at around 44 percent. This high level of internationally sourced funding suggests Swaziland's HIV response is currently unsustainable and reliant on continued international investments. Swaziland's HIV response is financially supported mostly by the Global Fund and PEPFAR.

Figure 1: HIV and AIDS Funding Flows in Swaziland



3 STUDY METHODOLOGY

3.1 NASA classifications

HIV spending is structured into eight categories of spending: (1) prevention; (2) treatment and care; (3) orphans and vulnerable children; (4) program management and administration; (5) human resources; (6) social protection; (7) enabling environment; and (8) research. NASA spending categories are also divided into a functional classification that includes health and non-health HIV services. The beneficiary populations (BPs) are classified under seven main categories with a number of sub-groups in each category to enable further disaggregating of the data collected. The BPs categories include: i) People living with HIV, ii) Most at risk populations, iii) Other key populations, iv) Specific "accessible" populations, v) General population, vi) Non-targeted interventions and vii) Specific targeted populations not elsewhere classified (n.e.c.).

This tracking of actual expenditures for HIV and AIDS in Swaziland used the NASA methodology, and captured the public and external sources of funds. This phase included the private contributions (from business, private health system, but excluded household and individual spending. The tracking also captured expenditure on productions factors although there were a number of gaps.

3.2 Preparatory phase

A one week preparatory and training of data collectors was undertaken in July 2014 in order to ascertain NERCHA ~~requirements, discuss~~requirements, discuss the nature and scope of the NASA study, reach a consensus on the terms of reference of the assessment, conduct training of the data collectors and participate in the sampling of organisations to be included in the NASA exercise. The preparatory phase also involved development of the interview schedules and adaptation of forms. The NASA team which consisted of an international and a national consultant assisted by the NERCHA Monitoring and Evaluation Officer and the NASA Core Team facilitated training sessions and assisted participants in ~~filling the~~filling the forms.

3.3 Sampling and Sources of Data

To facilitate the sampling process, a database of all the stakeholders involved in HIV and AIDS as sources, agents and providers, was developed using the Swaziland HIV and AIDS Programme Monitoring System (SHAPMoS) database and the HIV Stakeholders directory. The sampling frame included development partners, government ministries, NGOs (International and local), CSOs and the private sector organisations. For purposes of this study, all the main sources of funds (external and public), all agents of funds in Swaziland and all main service providers were included in the sampling frame. Specifically, major financing sources supporting HIV and AIDS were included in the study, consisting of United States Government (USG-President's Emergency Fund for AIDS Relief (PEPFAR); GFATM; and Government of Swaziland, Clinton Health Access Initiative (CHAI); MSF, and the United Nations. In addition to the financing sources, all financing agents were included in the study.

However, the main agents of the PEPFAR were not surveyed since the data on expenditure by USG was obtained directly from the source. For the purpose of the NASA estimates, all the government ministries were included in this study. A sample of NGO providers were surveyed to provide data on HIV and AIDS spending. The sampling frame for the NGOs was provided by NERCHA. In addition, all the major private sector organisations (approximately 25) were included in the study. In total they were 17 sources of funds, 25 Swazi government institutions, 25 international NGOs and 35 FBO/CSO/NGOs that were included in the study.

3.4 Obtaining Permissions and Access to Data

A press release through the office of the Prime minister was put out in the media as a means of launching the NASA and also requesting Institutions to avail the required data for the exercise. There were also letters introducing the NASA and the team of data collectors and requesting data from the stakeholders were sent out through the office of the Director for NERCHA to the various development partners, government ministries, NGOs, businesses

and bilateral and multilateral organizations.. In addition, NERCHA made follow up calls to the various stakeholders to book appointments for the first data collection visit.

3.5 Data collection

The assessment was undertaken through a desk review of key policy documents, programme documentation, review of expenditure analysis previously done by the Ministry of Health with technical assistance from CHAI, and institutional budgetary and expenditure reports for 2010/11, 2011/12 and 2012/13. Instructions on completing the AIDS spending reporting forms were adapted for Swaziland context and presented, alongside with NASA methodology and AIDS spending categories, during training workshop held at NERCHA.

The top-down approach which tracks sources of funds from donor reports, commitment reports, and government budgets was applied towards external funds and grants provided to Swaziland. The bottom-up approach, which tracks expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts was used on public sources of funding, and scaled up in the assessment to include the Ministry of Health, and other ministries and departments.

Financial monitoring of non-governmental organizations spending was carried out using both approaches. Non-governmental organizations perform preventive activities in response to the HIV epidemic only with the financial support of donors, mainly the GFATM and PEPFAR. Financial expenditures incurred using the funds of the main donor – GFATM – were tracked top-down using reports submitted by NGOs to the Grant Management Unit at NERCHA.

3.6 Data Entry into Excel Processing Files and into Resource Tracking Tool (RTT)

Initially, expenditure data collected was entered into NASA Excel processing forms,, verified and balanced. All information obtained was verified to ensure the validity of data from the records of the source, agents and providers, and also to avoid double counting. This ensured that each transaction was tracked from the source, financing agent, service

provider, uses of the funds (AIDS spending activity), beneficiaries of the funds and factors of production. Where the flow of the transaction was not complete, the Excel sheets highlighted the missing data and that enabled the data entry team to track and correct the error. This ensured that each transaction was complete and that only expenditures related to each source or financing agent are captured. The data from Excel files were transferred to Resource Tracking Tool (RTT) by a team of statisticians under the supervision of the international consultant. The RTT provides step-by-step guidance along the estimation process and makes it easier to monitor crosschecking among the different classification axes. The NASA RTT results databases were then exported to Excel to produce summary tables and graphs for analysis.

3.7 Validation of results

The NASA draft report was reviewed by the Core Team, and subsequently a national validation with representatives of all key HIV and AIDS stakeholders in Swaziland (with over 60 participants) was ~~conducted.The~~conducted. The comments and suggestions made were incorporated and a revised draft produced. In addition, there was a one key stakeholder discussion and validation of the findings before the final draft was finalized.

3.8 Quality assurance

To ensure quality control of the data collection, the NERCHA M&E Officer trained the data collection team on the NASA tools and ensured better understanding of their application. In addition, the NERCHA M&E Officer worked closely with the data collection teams during the entire period of data collection and data entry. The international consultant also provided back-stopping support to the data collection team to review the completed questionnaires on a daily basis and where there were gaps, verification and clarification was obtained from the respective organizations. The fi data collection forms were sent to the International Consultant for further verification.~~.~~

4 FINDINGS-NASA ESTIMATIONS

4.1 Total Expenditure on HIV andAIDS for 2010/11-2012/13

Total expenditure on HIV and AIDS (public, private and external) for 2010/11 ,2011/12 and 2012/13 amounted to SZL 2,705,290,131 (US$341,592,992.86). Individual years' expenditure is shown in the following table.

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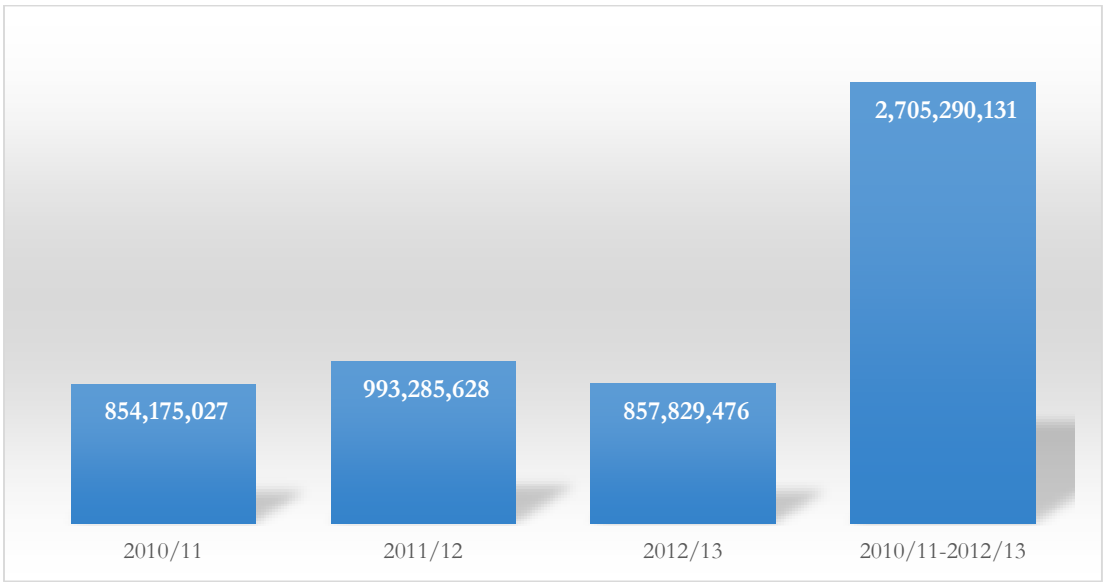
Figure 2: Total estimated HIV and AIDS spending, Swaziland NASA



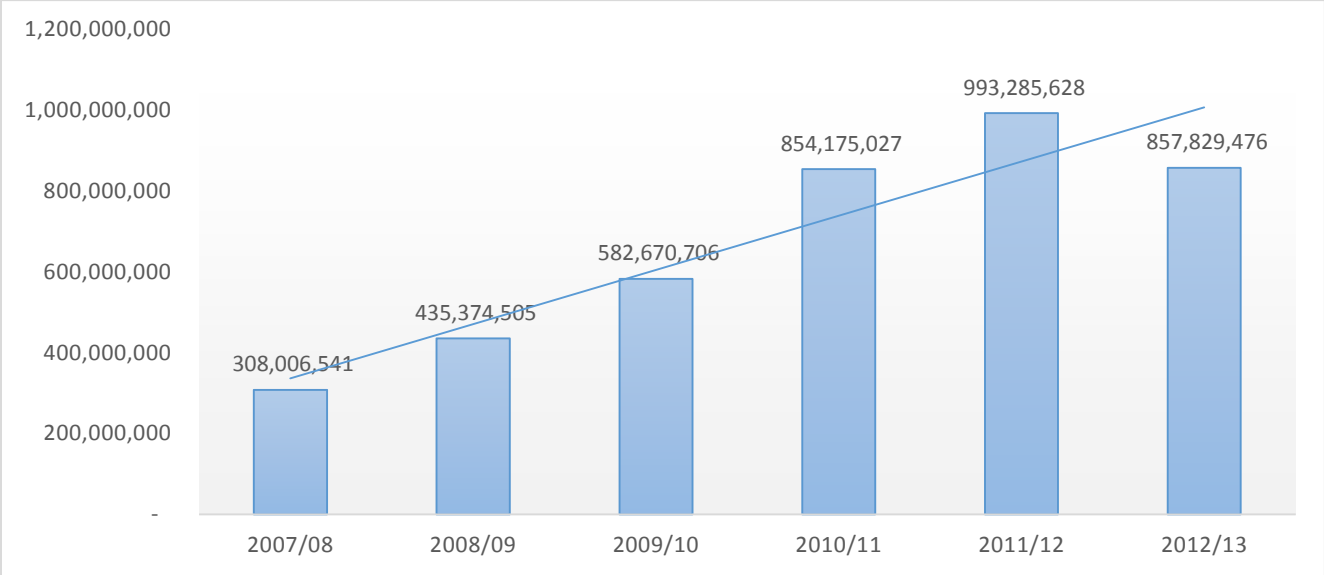
4.2 Trends in HIV and AIDS spending (2007/08-2012/13)

Figure 3 shows the trend in HIV and AIDS spending for the period 2007/08-2012/13, which depicts an increase in each successive year with the exception of the financial year 2012/13. Spending increased by 41% between 2007/08 and 2008/09 and by 34% between 2008/09 and 2009/10.

Between 2009/10 and 2010/11, spending increased by 47% while in 2010/11 and 2011/12 spending rose by 57%. However, in 2012/2013, spending declined by 14%, although in

absolute terms the amount was higher compared to spending in 2009/2010. The increasing pattern of spending shows commitment by the government and its pattern in the national response to the epidemic2.

Figure 3: Trends in HIV and AIDS spending (2007/08-2012/13)



4.3 Sources of finance

Sources of finance are the entities that provide money to financing agents to be pooled and disbursed. There are three main sources of HIV and AIDS funding in Swaziland, namely: public, international and private. The NASA results reveal that Swaziland's national response to HIV and AIDS is largely funded from international sources bar financial year 2010/11. Table 2 presents the total HIV and AIDS expenditure by sources of funds for 2010/11-2012/13 period. In 2010/11, public sources of funds accounted for 57% of the total HIV and AIDS expenditure while international sources of funds accounted for 41%. However, in the 2011/12 and 2012/13 financial years international sources of funds constituted the largest source of funding accounting for 59% , and 53% respectively of the

[2] AIDS spending has long been recognized, as an indicator of commitment, political will and support towards the HIV response

total HIV and AIDS expenditure in Swaziland. Public funding constituted the second largest source of funding accounting for 40% of total funds in 2011/12 and 46% in 2012/13.

Table 1: Total estimated HIV and AIDS spending by sources of funds (SZL)

	2010/11	2011/12	2012/13	2010/11-2012/13
Public funds	486,571,264	398,739,043	361,583,096	1,246,893,403
Private Funds	15,732,483	7,098,335	6,725,601	29,556,419
International funds	351,871,280	587,448,249	489,520,779	1,428,840,308
Total	**854,175,027**	**993,285,627**	**857,829,476**	**2,705,290,130**

Public funds decreased significantly by close to 18% in 2011/12 from the previous year and by a further 9% in 2012/13. The funding from private sources[3] has remained low relative to funding from the other sources and accounted for 2% in 2010/11, 1% in 2011/12 and 2012/13 respectively.

Overall, international sources accounted for 53% (SZL1, 428,840,308 equivalent to US$179,001,314) of the total expenditure while public sources accounted for 46% (SZL 1,246,893,403 equivalent to US$ 158,763,172) of the total expenditure. The relative contributions of the different sources are presented in Figure 4.

[3] Private sources of funding come from profit institutions and corporations, other private financing sources not classified and not-for-profit institutions excluding social insurance.

Figure 4: Share of total actual HIV and AIDS spending by source of funds (%)

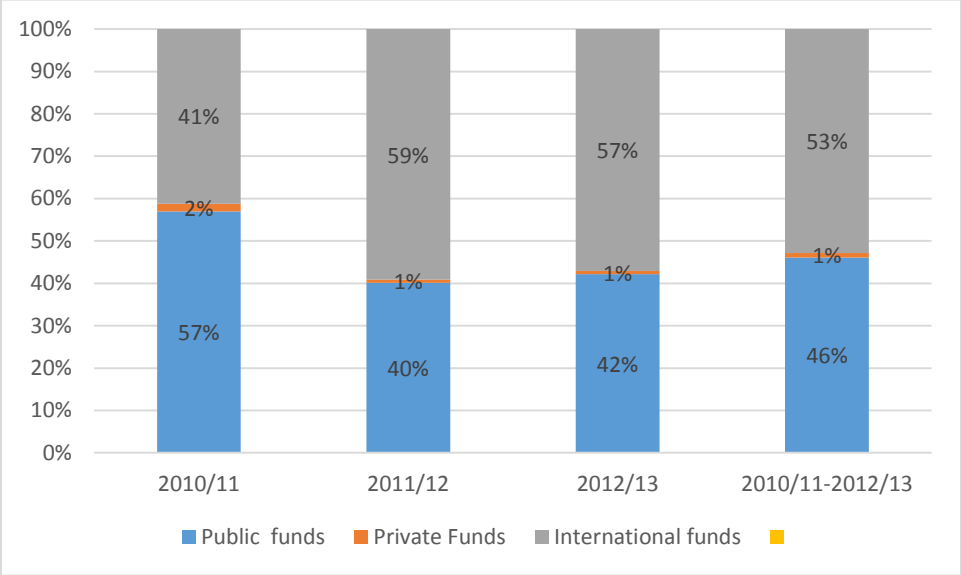


Table 3 shows the main blocks of funding sources over the three financial ~~yiears~~years in Emalangeni; while Table 4 shows the same in US Dollars.

Table 2: Estimated HIV and AIDS spending by main blocks of funding sources(SZL)

	2010	**2011**	**2012**	2010/11-2012/13
Public funds				
Central government funds	486,421,264	398,739,043	361,583,096	1,246,743,403
Other public funds n.e.c.	150,000			150,000
Sub-total	**486,571,264**	**398,739,043**	**361,583,096**	1,246,893,403
Private Funds				
For-profit institutions and corporations	1,393,064	1,026,031	1,751,192	4,170,287
Not-for-profit institutions (other than social insurance)	7,397,454	3,261,416	2,279,082	12,937,952
Private financing sources n.e.c.	6,941,965	2,810,888	2,695,327	12,448,180 [A5]
Sub-total	**15,732,483**	**7,098,335**	**6,725,601**	29,556,419
International funds				
Direct bilateral contributions	175,528,330	342,891,237	342,213,111	860,632,678
Multilateral Agencies (ii)	137,401,961	199,498,417	83,946,116	420,846,494

International not-for-profit organizations and foundations	33,630,354	45,033,661	59,671,600	138,335,615
International for profit organizations	3,475,520	24,935	1,265,798	4,766,253
International funds n.e.c.	1,835,115		2,424,154	4,259,269 [A6]
Sub-total	351,871,280	587,448,250	489,520,779	1,428,840,309
Total (SZL)	**854,175,027**	**993,285,628**	**857,829,476**	2,705,290,131.00

Table 3: Total estimated HIV and AIDS spending by main blocks of funding sources (US$)

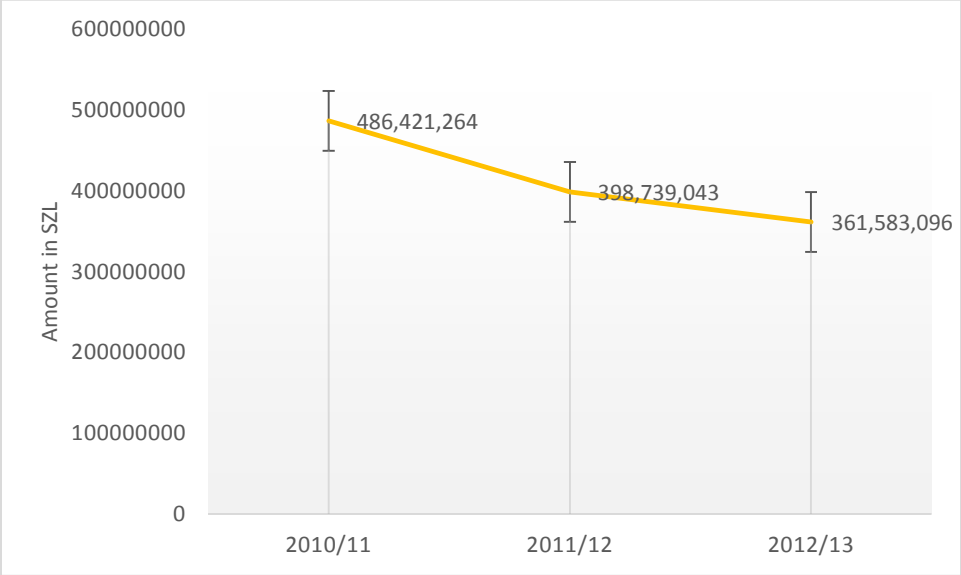
Public funds	**2010/11**	**2011/12**	**2012/13**	**2010/11-2012/13**
Central government funds	66,450,992	54,922,733	44,041,790.01	165,415,516
Other public funds n.e.c.	20,492	-	-	20,492
Sub-total	**66,471,484**	**54,922,733**	**44,041,790.01**	**165,436,007**
Private Funds				
For-profit institutions and corporations	190,309	141,327	213,299.88	544,936
Not-for-profit institutions (other than social insurance)	1,010,581	449,231	277,598.29	1,737,410
Private financing sources n.e.c.	948,356	387,175	328,298.05	1,663,829
Sub-total	**2,149,246**	**977,732**	**819,196.22**	**3,946,175**
International funds				
Direct bilateral contributions	23,979,280	47,230,198	41,682,473.93	112,891,952
Multilateral Agencies (ii)	18,770,760	27,479,121	10,224,861.88	56,474,742
International not-for-profit organizations and foundations	4,594,311	6,202,984	7,268,160.78	18,065,455
International for profit organizations	474,798	3,435	154,177.59	632,410
International funds n.e.c.	250,699	-	295,268.45	545,967
Sub-total	**48,069,847**	**80,915,737**	**59,624,942.63**	**188,610,527**
Total (US$)	**116,690,577**	**136,816,202**	**104,485,928.87**	**357,992,709**

4.4 Summary of HIV and AIDS spending by sources of funding

4.4.1 Public sources of funding

The contribution to the total spending on HIV and AIDS from public sources consisted mainly of revenue from the central government which amounted to SZL486,421,264, in 2010/11, SZL 398,739,043 in 2011/12 and SZL361,583,096 in 2012/13 of the total estimated amount spent on the response as summarised in Figure 5.

Figure 5: Public sources of funding 2010/11-2012/13[A7]



4.4.2 International sources of funding

The share of international sources of funding to the total HIV and AIDS spending in Swaziland is shown in Table 5. The majority of international financing for activities and programmes related to HIV and AIDS in 2010/11, 2011/12 and 2012/13 came from direct bilateral sources, which accounted for 49.9%, 58.4% and 69.9% respectively of the total amount spent.

Multilateral funds accounted for 39%, 34% and 17.1% of the international funding in 2010/11, 2011/12 and 2012/13 respectively. Among the multilateral agencies, the Global Fund is one of the main sources of funding for in the country accounting for 32.2%, 32.5% and 10.9% of the total source of funding in 2010/11, 2011/12 and 2012/13 respectively. In 2010/11, 9.6% of the funds were contributed by international not for. The share declined to 7.7% in 2011/12 but increased significantly to 12%. The share of multilateral funds of 39% in 2010/11 and 34% in 2012/13 was driven mainly by increases in the share of Global Funds (GFATM) in the overall funding resource. During the same period the share of International funds n.e.c remained relatively small at 0.5% in 2010/11 and 2012/13. The summary of spending from international sources is shown in appendix B.

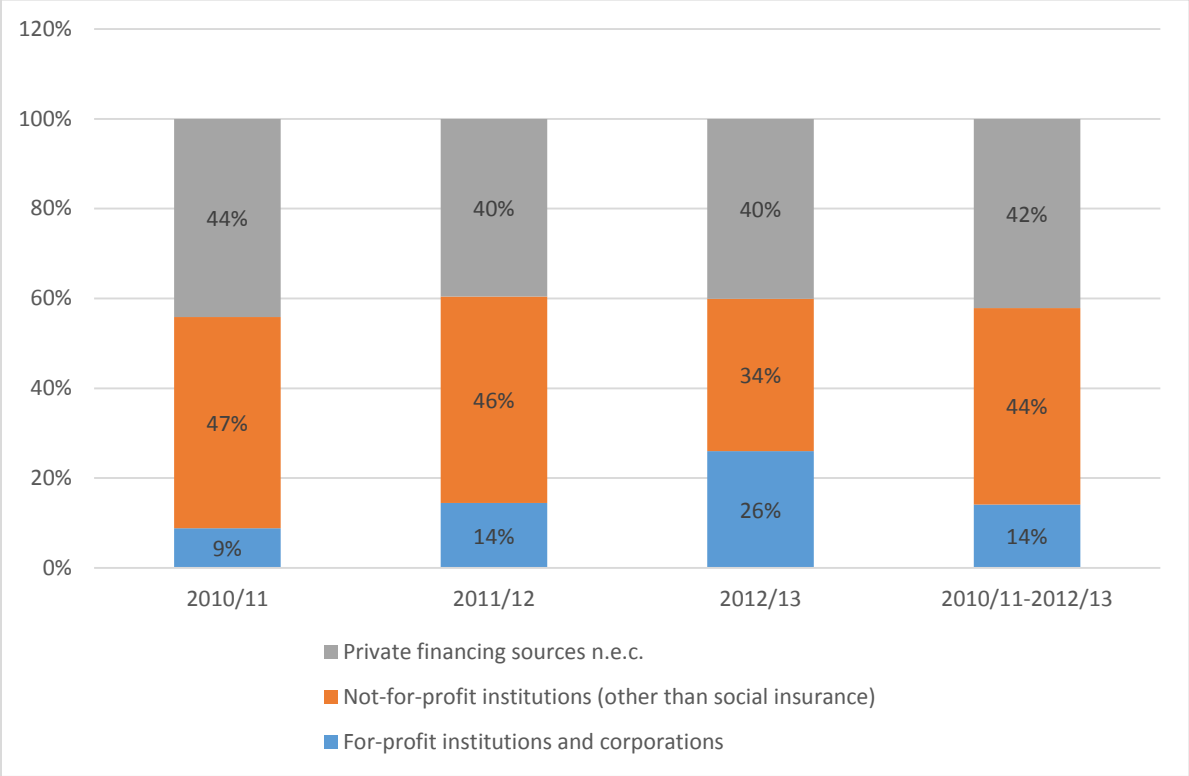
4.4.3 Private sources of funding

Within the private sources for 2010/11, 2011/12 and 2012/13, the major contributors were not-for-profit institutions (47%, 46% and 34%), while other private financing sources not classified accounted for the second largest share of HV and AIDS funding (44%) in 2010/11, 40% in 2011/12 and 40% in 2012/13. There was a decrease in the contribution from private sources in 2011/12 and 2012/13. Table 6 shows the proportional composition of private sources of funds for HIV/AIDS activities in 2010/11-2012/13.

Table 4: Summary of HIV and AIDS spending from private sources of funding (SZL)

	2010/11	2011/12	2012/13	2010/11-2012/13
For-profit institutions and corporations	1,393,064.00	1,026,031.00	1,751,192	4,170,287.00
Not-for-profit institutions (other than social insurance)	7,397,454.00	3,261,416.00	2,279,082	12,937,952.00
Private financing sources n.e.c.	6,941,964.00	2,810,888.00	2,695,327	12,448,179.00
Private Funds	**15,732,482.00**	**7,098,335.00**	**6,725,601**	**29,556,418.00**

Figure 6: Breakdown of HIV and AIDS spending from private sources (%)



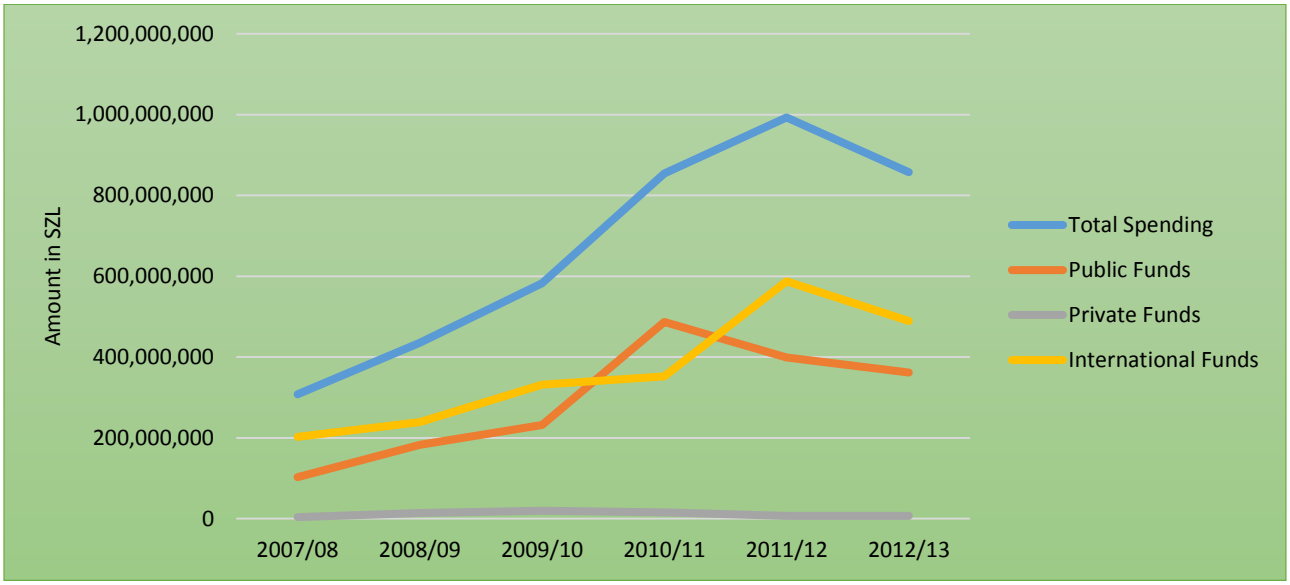
4.4.4 Trends in HIV and AIDS spending by source of funds

Table 7 and Figure 7 show that HIV and AIDS spending has been increasing from SZL308, 006,541 in 2007/08 to SZL993, 285,628 in 2011/12. Total expenditure however declined to SZL857, 829,476 in 2012/13. Expenditure by source reveals that public spending has been on the increase in each successive year except in 2011/12 and 2012/13 when there was a slight decrease in the share of public funds for HIV and AIDS. The high expenditure in 2010/11 may have been occasioned by increased government procurement of ARVs. Nevertheless, considering the expenditure in the previous years, especially the 2007/08-2009/10 period, public share to HIV and AIDS funding has remained relatively stable.

Table 5: Trends in HIV and AIDS spending (2007/08-2012/13) SZL

	2007/08-2009/10 NASA			2010/11-2012/13 NASA		
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Total Spending	**308,006,541**	**435,374,505**	**582,670,706**	**854,175,027**	**993,285,628**	**857,829,476**
Public Funds	102,612,949	182,905,780	231,521,283	486,571,264	398,739,043	361,583,096
Private Funds	3,255,027	13,926,289	19,385,536	15,732,482	7,098,335	6,725,601
International Funds	202,138,565	238,542,436	331,563,887	351,871,280	587,448,249	489,520,779

Figure 7: Trends in HIV and AIDS spending (2007/08-2012/13) (SZL)



4.5 Estimated HIV and AIDS Expenditure by Financing Sources and Financing Agents

. Financing agents refer to entities that manage and use the funds for payment or purchase of health services, medical supplies and other HIV and AIDS related activities. The financing agents also decide the type of activity or product to fund or purchase. In Swaziland, the main financing agents include government ministries and parastatals within government ministries, multilateral agencies managing external resources, country offices of bilateral agencies managing external resources, international NGOs, and international not-for-profit organizations.

As shown in Table 8, the main financing agents are public sector organizations, which accounted for over 60% of the total resources. International agents accounted for 39% while local private organizations managed around 1% of the total funds.

Table 6: Total HIV and AIDS expenditure by financing agent

	2010/11	2011/12	2012/13	2010/11-2012/12
Public sector	607,779,944 (71%)	599,169,962 (60%)	425,967,763 (50%)	1,632,917,669 (60%)
Private sector	12,978,532 (2%)	4,917,319 (0.5%)	200,500 (0.02%)	18,096,351 (1%)
International purchasing organizations	233,416,548 (27%)	389,198,346 (39%)	427,333,257 (50%)	1,049,948,151 (39%)
Total	**854,175,024 (100%)**	**993,285,627 (100%)**	**853,501,520 (100%)**	**2,700,962,171 (100%)**

Specifically, within the public sector, NERCHA managed the largest share (60 %) over the three year period under consideration, followed by Ministry of Health (32 %) while the Ministry of Education managed approximately 7%.

Table 7: Breakdown of total HIV and AIDS expenditure by public financing agents

Public sector	2010/11	%	2011/12	%	2012/13	%
Ministry of Health	174,307,413	28.7%	169,273,283	28%	175,807,386	41%
Ministry of Education	111,046,056	18.3%		0%		0%[A8]
Ministry of Defence		0.0%		0%	1,597,465	0%
Ministry of Finance)	70,000	0.0%	4,088,867	1%	4,174,206	1%
Ministry of Justice	1,996,840	0.3%		0%	1,518,652	0%
Other ministries	31,400	0.0%		0%		0%
NERCHA	317,482,351	52.2%	421,962,451	70%	232,188,463	55%
State/provincial/regional authorities	1,000	0.0%	34,918	0%	10,481,091	2%
Local/municipal authorities	2,584,884	0.4%	3,585,543	1%		0%
Parastatal organizations	260,000	0.0%	224,900	0%	200,500	0%
Total	**607,779,944**	**100.0%**	**599,169,962**	**100%**	**425,967,763**	**100%**

4.6 Providers of HIV and AIDS Services

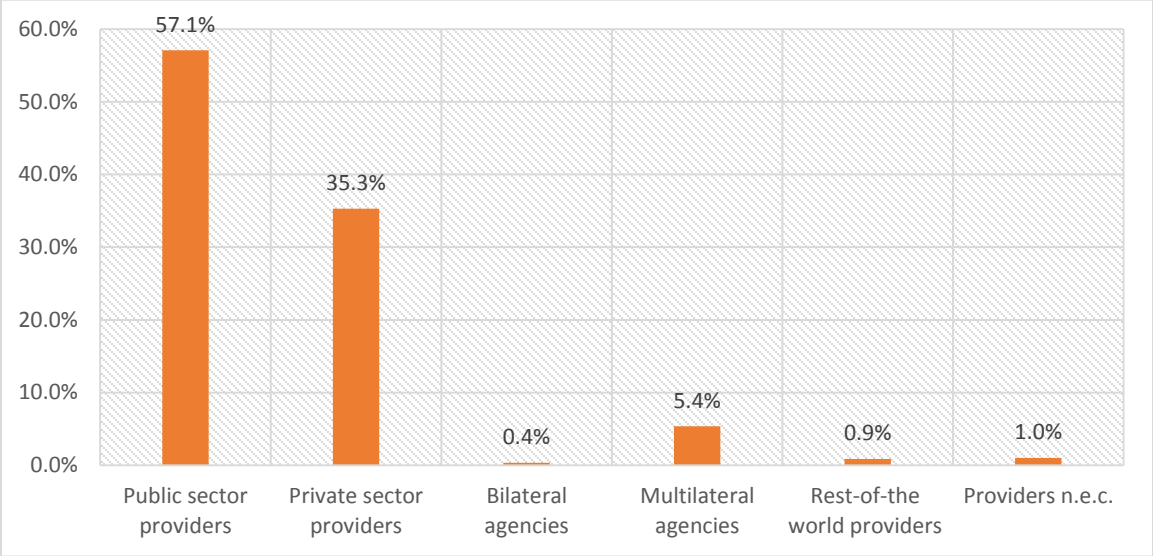
This section presents the analysis of providers of HIV and AIDS services. According to the NASA guidelines, Service Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. HIV and AIDS services are provided by a number of providers that include the government and other public entities, private for profit and non-profit organizations, corporate and non-corporate enterprises whose activity falls within the NASA boundaries regardless of formal or informal legal status. Table 10 and Figure 8 provide broad picture of the main providers of HIV and AIDS related providers of services.

Table 8: Summary expenditure by providers of services, (SZL)

Service providers	2010/11	%	2011/12	%	2012/13	%
Public sector providers	570,775,401	67%	563,255,316	57%	410,171,626	48%
Private sector providers	105,352,111	12%	425,492,222	43%	423,510,841	49%
Bilateral agencies	9,756,667	1%		0%		0%
Multilateral agencies	133,255,668	16%	2,883,366	0%	9,178,717	1%
Rest-of-the world providers	13,732,555	2%	1,654,723	0%	8,746,553	1%
Providers n.e.c.	21,302,622	2%		0%	6,221,739	1%
Total	**854,175,024**	**100%**	**993,285,627**	**100%**	**857,829,476**	**100%**

The public sector constitutes the largest provider of HIV and AIDS services, accounting for 67%, 57% and 48% of the expenditure in 2010/11, 2011/12 and 2012/13 respectively. Multilateral agencies spent 16%, 0.3% and 1% of the total amount in 2010/11, 2011/12 and 2012/13 respectively. Providers' not elsewhere classified (n.e.c.) also accounted for 2%, in 2010/11 and 1% in 2012/13. These providers were mainly international NGOs providing services directly in the country. The rest of the world providers spent 2%, 0.2% and 1% in 2010/11, 2011/12 and 2012/13 respectively. Private sector providers account for the second largest share of the expenditure accounting for 12%, 43% and 49% of the total HIV and AIDS expenditure in 2010/11, 2011/12 and 2012/13 respectively. It is evident from Figure 7 that private sector providers have increasingly assumed a leading role in the provision of HIV and AIDS services.

Figure 8: Percentages of expenditure by service providers



4.6.1 HIV and AIDS expenditure within the public sector providers

Table 11 reveals that NERCHA is the main provider of services from public funds channelled through public sector agents. NERCHA accounted for 22.6%, 6.5% and 8.5% for the FY 2010/2011, 2011/2012, and 2012/2013 respectively of the funds spent within the public sector providers. In 2010/11, government hospitals accounted for 26.8% of spending within the public sector providers, increased to 52.7% in 2011/12 and slightly decreased to 52.5% of the total funds spent within the public sector providers.

Table 9: HIV and AIDS expenditure within public sector providers (SZL)

Public sector providers	2010/11	%	2011/12	%	2012/13	%
Hospitals (Governmental)	152,992,453	26.8%	296,976,977	52.7%	214,948,695	52.4%
Laboratory and imaging facilities (Governmental)		0.0%	19,274,250	3.4%	4,886,597	1.2%
Blood banks (Governmental)		0.0%	13,513,539	2.4%		0.0%
Research institutions (Governmental)	769,500	0.1%		0.0%		0.0%
National AIDS commission (NERCHA)	129,006,045	22.6%	36,638,804	6.5%	34,921,915	8.5%
Departments inside the Ministry of Health or equivalent	44,019,974	7.7%	33,862,724	6.0%	4,639,072	1.1%
Departments inside the Ministry of Education	217,610,071	38.1%	151,915,333	27.0%	147,721,223	36.0% [A9]
Departments inside the Ministry of Social Development	10,503,226	1.8%	1,639,777	0.3%		0.0%
Departments inside the Ministry of Finance or equivalent		0.0%	20,800	0.0%		0.0%
Departments inside the Ministry of Justice or equivalent	1,996,840	0.3%		0.0%		0.0%
Government entities n.e.c.	8,845,278	1.5%	759,205	0.1%	749,659	0.2%
Governmental organizations n.e.c.	1,409,361	0.2%	8,345,000	1.5%		0.0% [A10]
Primary education (Parastatal)	430,418	0.1%		0.0%		0.0%
Public sector providers n.e.c.	3,192,235	0.6%	308,907	0.1%	2,304,465	0.6%
Total	570,775,401	100.0%	563,255,316	100.0%	410,171,626	100.0%

In the private sector, civil society organizations (Non-profit non faith-based) accounted for the largest share of the resources channelled through the private sector (SZL770, 185,806 equivalent to 80.7%). This was equivalent to US$94,433,949. Non-profit faith-based private sector providers spent SZL96, 816,073 (US$ 12,122,212) taking 10.1% of the total expenditure within the private sector.

Table 10: HIV and AIDS expenditure within private sector providers (SZL)

	2010/11	**2011/12**	**2012/13**	2010/11-2012/13	%
Hospitals (Non-profit non faith-based)	10,942,090			10,942,090	1.1%
Ambulatory care (Non-profit non faith-based)	2,758,798			2,758,798	0.3%
Schools and training facilities (Non-profit non faith-based)	439,630			439,630	0.0%
Research institutions (Non-profit non faith-based)	701,278			701,278	0.1%
Self-help and informal community-based organizations (Non-profit non faith-based)	1,628,886	416,064	1,225,554	3,270,504	0.3%
Civil society organizations (Non-profit non faith-based)	53,234,900	368,272,169	348,678,737	770,185,806	80.7%
Other non-profit non-faith-based providers n.e.c.	17,532,438	11,769,976	31,084,269	60,386,683	6.3%
Sub-total	87,238,020	380,458,209	380,988,560	848,684,789	89%
Non-profit faith-based providers	11,451,609	44,152,991	41,211,473	96,816,073	10.1%
Hospitals (Non-profit faith-based)	63,985	8,193,401	11,069,831	19,327,217	2.0%
Self-help and informal community-based organizations (Non-profit faith-based)	320,730	93,118	538,876	952,724	0.1%
Civil society organizations (Non-profit faith-based)	3,935,180	25,784,511	22,250,196	51,969,887	5.4%
Other non-profit faith-based private sector providers n.e.c.	7,131,714	10,081,961	7,352,570	24,566,245	2.6%
Sub-total	11,451,609	44,152,991	41,211,473	96,816,073	10.1%
Other non-profit private sector providers n.e.c.	5,677,488			5,677,488	0.6%
Workplace (For profit)	804,994	828,022	1,090,408	2,723,424	0.3%
For profit private sector providers n.e.c.	180,000	53,000	219,400	452,400	0.0%
Private sector providers n.e.c.			1,000	1,000	0.0%[A11]
Sub-total	6,662,482	881,022	1,310,808	8,854,312	0.9%
Grand total	**105,352,111**	**425,492,222**	**423,510,841**	**954,355,174**	**100.0%**

4.7 Detailed analysis of the HIV and AIDS core spending categories

This section presents the detailed analysis of HIV and AIDS core spending categories for the years 2010/11-2012/13. In each HIV and AIDS core spending category and the sub-categories are analyzed to show priorities of spending, by source of funds.

4.7.1 Key Spending Areas

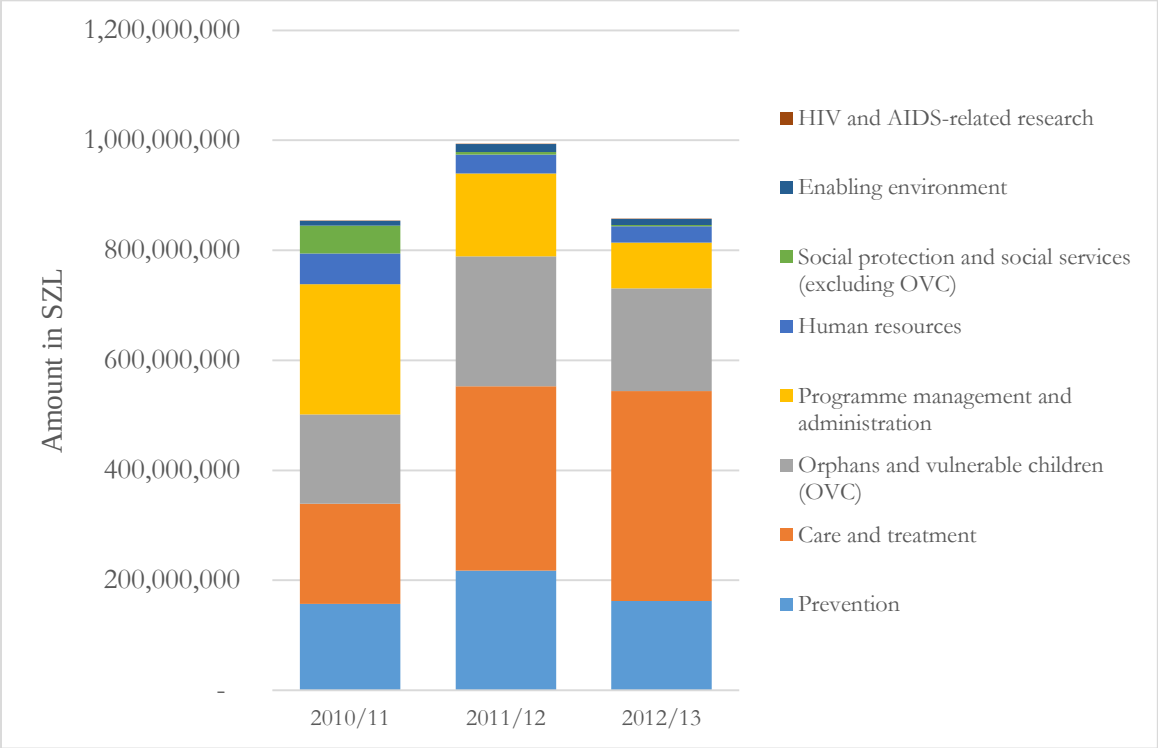
Table 13 and Figure 9 show the total HIV and AIDS spending on the key priority areas from 2010/11 to 2012/13. The largest spending went to care and treatment which accounted for 21.3% in 2010/11, 33.7% in 2011/12 and 44.5% in 2012/13. Spending on prevention accounted for 18.4% in 2010/11, 21.9% in 2011/12 and 19% in 2012/13 of the total HIV and AIDS spending. OVC spending accounted for 19%, 23.8% and 21.8% in 2010/11,

2011/12 and 2012/13 respectively. Spending on other key priority areas are summarized in Table 11.

Table 11**: Total Spending on Key Priorities**/Intervention areas**, 2010/2011 - 2012/2013 (SZL)**

Key priority areas	2010/11	%	2011/12	%	2012/13	%
Prevention	157,279,823	18.4 %	217,944,138	21.9 %	162,559,829	19.0 %
Care and treatment	182,291,523	21.3 %	334,877,677	33.7 %	381,545,035	44.5 %
Orphans and vulnerable children (OVC)	162,011,808	19.0 %	236,035,622	23.8 %	186,593,460	21.8 %
Programme management and administration	236,598,892	27.7 %	150,693,886	15.2 %	83,631,885	9.7%
Human resources	55,901,287	6.5%	34,619,055	3.5%	29,372,030	3.4%
Social protection and social services (excluding OVC)	50,552,343	5.9%	4,459,833	0.4%	2,083,300	0.2%
Enabling environment	8,709,696	1.0%	14,552,817	1.5%	11,181,321	1.3%
HIV and AIDS-related research	829,655	0.1%	102,600	0.0%	862,616	0.1%
Grand total	**854,175,027**	**100 %**	**993,285,628**	**100 %**	**857,829,476**	**100 %**

Figure 9: Total Expenditure Breakdowns by Intervention Areas, 2010/11-2012/13 (SZL)



4.7.2 Prevention activities

Prevention programmes involve a comprehensive set of activities or programmes designed to reduce risk behavior. The ultimate results of prevention programmes include a decrease in HIV infection among the population. Over the three year NASA period, a total of SZL 537,783,790 was spent on prevention activities. With a bulk of the expenditure on PMTCT, MC, Communication for social and behavioral change and VCT The following table depicts the amounts spent in each of the various prevention areas over the three financial years under review.

Table 12: Prevention spending activities, 2010/2011 – 2012/13 (SZL)

Key expenditure areas	2010/11	%	2011/12	%	2012/13	%
Communication for social and behavioural change	19,046,008	12.1%	21,836,420	10.0%	21,740,387	13.4%
Community mobilization	23,799,224	15.1%	12,853,183	5.9%	3,559,294	2.2%
Voluntary counselling and testing (VCT)	4,234,274	2.7%	15,683,265	7.2%	17,307,351	10.6%
Risk-reduction for vulnerable and accessible populations	**7,027,594**	**4.5%**	**5,243,069**	**2.4%**	**18,559,753**	**11.4%**
Prevention – youth in school	1,468,013	0.9%	190,962	0.1%	6,904,831	4.2%
Prevention – youth out-of-school	82,982	0.1%	38,815	0.0%	83,139	0.1%
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	875,261	0.6%	37,688,781	17.3%	11,963,380	7.4%
Prevention programmes in the workplace	331,280	0.2%	323,698	0.1%	723,115	0.4%
Condom social marketing	675,316	0.4%	155,435	0.1%	187,337	0.1%
Public and commercial sector male condom provision	1,260,254	0.8%	1,963,948	0.9%	2,066,551	1.3%
Public and commercial sector female condom provision	-		32,818	0.0%	154,143	0.1%
Prevention, diagnosis and treatment of sexually transmitted infections (STI)	941,373	0.6%	777,683	0.4%	732,858	0.5%
Prevention of mother-to-child transmission (PMTCT)	**20,572,480**	**13.1%**	**59,145,432**	**27.1%**	**32,623,280**	**20.1%**
Male circumcision	62,247,304	39.6%	25,555,791	11.7%	21,391,949	13.2%
Blood safety	1,542,659	1.0%	15,231,179	7.0%	6,845,994	4.2%
Safe medical injections	126,418	0.1%	132,296	0.1%	30,759	0.0%
Universal precautions	-		268,758	0.1%	1,239,825	0.8%
Post-exposure prophylaxis (PEP)	89,156	0.1%	72,180	0.0%	85,982	0.1%
Prevention activities not disaggregated by intervention	10,523,312	6.7%	19,113,621	8.8%	12,490,716	7.7%
Prevention activities n.e.c.	2,436,915	1.5%	1,636,804	0.8%	3,869,185	2.4%
Total	**157,279,823**	**100%**	**217,944,138**	**100%**	**162,559,829**	**100%**

4.7.3 Treatment and care spending activities

Table 15 shows the key areas of expenditures on treatment and care components. Care and treatment includes all expenditures, purchases, transfer and investment incurred to provide access to clinic and home-based activities for treatment and care of HIV- infected adults and children. The results reveal that the bulk of spending in all the three years was spent on care and treatment services not disaggregated by intervention-mainly for ARV therapy– both adult and paediatric ARVs

Table 13: Treatment and Care Spending Activities, 2010/11-2012/13 (SZL)

Key Areas of Expenditure	2010/11	%	2011/12	%	2012/13	%
Provider- initiated testing and counselling (PITC)	**63,624**	**0.03%**	**789,408**	**0.24%**	**17,490,094**	**4.58%**
OI outpatient treatment	**539,423**	**0.30%**	**-**		**-**	
Adult antiretroviral therapy	**393,730**	**0.22%**		**0.00%**	**467,047**	**0.12%**
First-line ART – adults		**0.00%**	**454,926**	**0.14%**		**0.00%**
Adult antiretroviral therapy not disaggregated by line of treatment	**-**		**1,123,878**	**0.34%**	**28,118,868**	**7.37%**
Paediatric antiretroviral therapy	**391,197**	**0.21%**	**-**		**-**	
Antiretroviral therapy not disaggregated neither by age nor by line of treatment	**36,229,394**	**19.87%**	**24,183,073**	**7.22%**	**-**	
Nutritional support associated to ARV therapy	**4,731,228**	**2.60%**	**4,225,138**	**1.26%**	**9,780,129**	**2.56%**
Specific HIV-related laboratory monitoring	**6,189,567**	**3.40%**	**13,122,229**	**3.92%**	**16,579,042**	**4.35%**
Dental programmes for PLHIV	**36,576**	**0.02%**	**55,242**	**0.02%**	**44,129**	**0.01%**
Psychological treatment and support services	**1,270,119**	**0.70%**	**242,734**	**0.07%**	**317,795**	**0.08%**
Outpatient palliative care	**2,154,872**	**1.18%**	**1,690,987**	**0.50%**	**2,127,363**	**0.56%**
Home-based medical care	**-**		**87,664**	**0.03%**	**180,461**	**0.05%**
Home-based non-medical/non-health care	**285,130**	**0.16%**	**506,179**	**0.15%**	**170,111**	**0.04%**
Home-based care not disaggregated by type	**6,379,742**	**3.50%**	**917,782**	**0.27%**	**997,248**	**0.26%**
Outpatient care services not disaggregated by intervention	**132,410**	**0.07%**	**746,670**	**0.22%**	**297,384**	**0.08%**
Outpatient care services n.e.c.	**5,446,078**	**2.99%**	**6,118,984**	**1.83%**	**8,787,029**	**2.30%**
Inpatient palliative care	**1,374,993**	**0.75%**	**1,168,125**	**0.35%**	**1,411,708**	**0.37%**
Inpatient care services not disaggregated by intervention	**214,581**	**0.12%**	**22,618**	**0.01%**	**7,980,430**	**2.09%**
Inpatient care services n.e.c.	**2,865,279**	**1.57%**	**3,142,299**	**0.94%**	**4,966,546**	**1.30%**
Patient transport and emergency rescue	**313,166**	**0.17%**	**-**		**-**	
Care and treatment services not disaggregated by intervention	**106,697,520**	**58.53%**	**179,736,023**	**53.67%**	**182,864,982**	**47.93%**
Care and treatment services n.e.c.	**6,582,894**	**3.61%**	**96,543,718**	**28.83%**	**98,964,669**	**25.94%**
Total	**182,291,523**	**100.00%**	**334,877,677**	**100.00%**	**381,545,035**	**100.00%**

Table 14: Care and treatment expenditure by spending category (2010/11-2012/13)

	Public	Private	International	Overall	Percent
Outpatient care					
Provider- initiated testing and counselling (PITC)	339,768	18,003,358	-	18,343,126	2.0%
OI outpatient treatment	-	539,423	-	539,423	0.1%
First-line ART – adults	-	1,315,703	-	1,315,703	0.1%
Adult antiretroviral therapy not disaggregated by line of treatment	23,249,857	5,992,889	-	29,242,746	3.3%
Paediatric antiretroviral therapy	-	-	391,197	391,197	0.0%
Antiretroviral therapy not disaggregated neither by age nor by line of treatment	47,661,584	7,356,052	5,394,831	60,412,467	6.7%
Nutritional support associated to ARV therapy	7,651,711	1,695,130	9,389,654	18,736,495	2.1%
Specific HIV-related laboratory monitoring	26,321,083	9,483,099	86,656	35,890,838	4.0%
Dental programmes for PLHIV	135,947	-	-	135,947	0.0%
Psychological treatment and support services	709,839	1,120,809	-	1,830,648	0.2%
Outpatient palliative care	1,385,319	4,587,903	-	5,973,222	0.7%
Home-based medical care	949	267,176	-	268,125	0.0%
Home-based non-medical/non-health care	5,000	956,420	-	961,420	0.1%
Home-based care not disaggregated by type	8,143,702	151,070	-	8,294,772	0.9%
Outpatient care services not disaggregated by intervention	135,430	1,041,034	-	1,176,464	0.1%
Outpatient care services n.e.c.	20,027,091	325,000	-	20,352,091	2.3%
Inpatient care					
Inpatient palliative care	-	3,954,826	-	3,954,826	0.4%
Inpatient care services not disaggregated by intervention	74,009	8,143,620	-	8,217,629	0.9%
Inpatient care services n.e.c.	10,974,124	-	-	10,974,124	1.2%
Patient transport and emergency rescue	-	313,166	-	313,166	0.0%
Care and treatment services not disaggregated by intervention	217,453,212	209,105,502	42,739,811	469,298,525	52.2%
Care and treatment services n.e.c.	676,777	195,347,766	6,066,738	202,091,281	22.5%
Total	**364,945,402**	**469,699,946**	**64,068,887**	**898,714,235**	**100.0%**

4.7.4 OVC Spending orphans and vulnerable children (OVC)

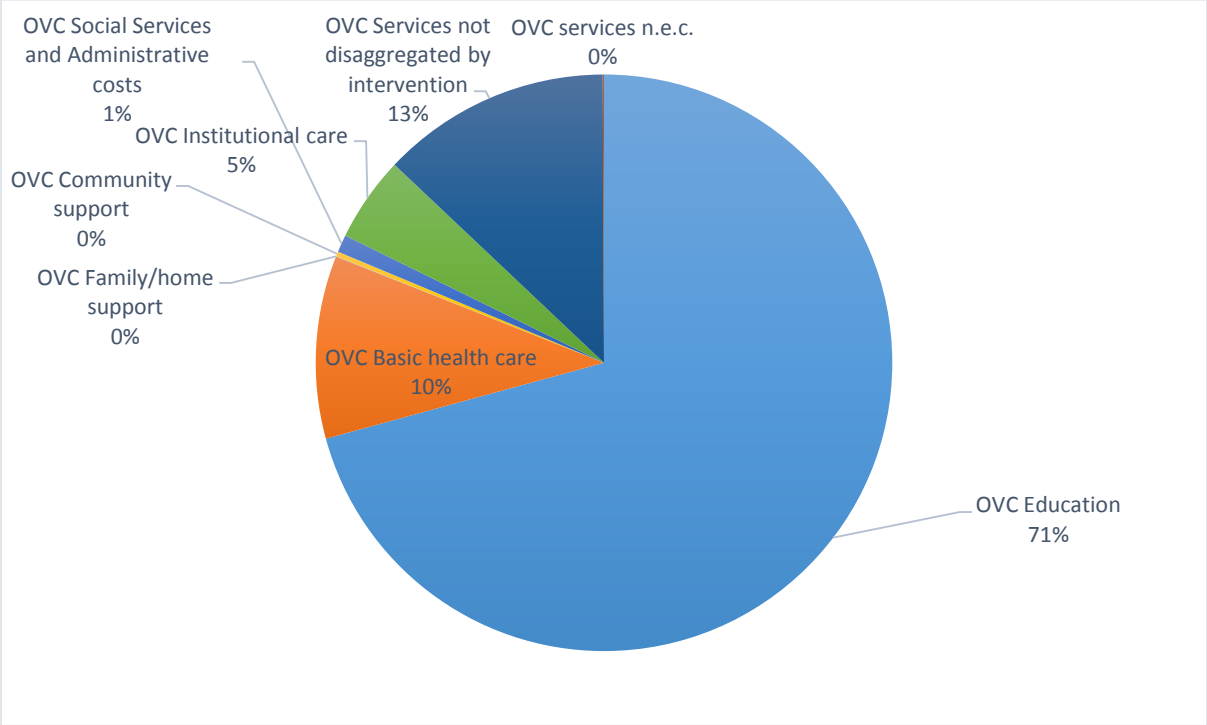
The OVC spending component included education, basic health care, family/home support, institutional care, and other services for OVC not classified in the previous activities. Results show that for the three years under consideration, OVC spending amounted to SZL 584,640,890. The following table shows expenditure per service provided under the OVC program.

Table 15: OVC programmes spending by source of fund (SZL)

OVC Spending Categories	2010/11	%	2011/12	%	2012/13	%
Education	128,154,663	**79.1**	144,540,426	**61.2**	140,997,214	**75.6**
Basic health care	1,960,595	**1.2**	43,325,128	**18.4**	14,605,338	**7.8**
Family/home support		**0.0**		**0.0**	162,281	**0.1**
Community support	773,479	**0.5**	629,359	**0.3**	146,937	**0.1**
Social Services and Administrative costs	2,045,994	**1.3**	3,460,510	**1.5**	231,110	**0.1**
Institutional care	10,281,061	**6.3**	11,504,920	**4.9**	6,139,961	**3.3**
Services not disaggregated by intervention	18,671,842	**11.5**	32,575,279	**13.8**	24,031,511	**12.**
services n.e.c.	124,174	**0.1**		**0.0**	279,108	**0.1**
Total	**162,011,808**	**100**	**236,035,622**	**100.0%**	**186,593,460**	**100.0%**

Overall, the expenditure was distributed into OVC education (79.1%), basic health care (1.2 %), institutional care (6.3 %) and other services not disaggregated by intervention (11.5%). The high contribution of public funds to OVC education shows there were deliberate efforts from the public funds source to support OVC education, reflecting the commitment in the National Multi-sectoral HIV and AIDS Strategic Plan to OVC education. Figure 3.7 shows the overall proportional OVC programmes spending over the three year period

Figure 10: Overall proportional OVC programmes spending 2010/11-2012/13



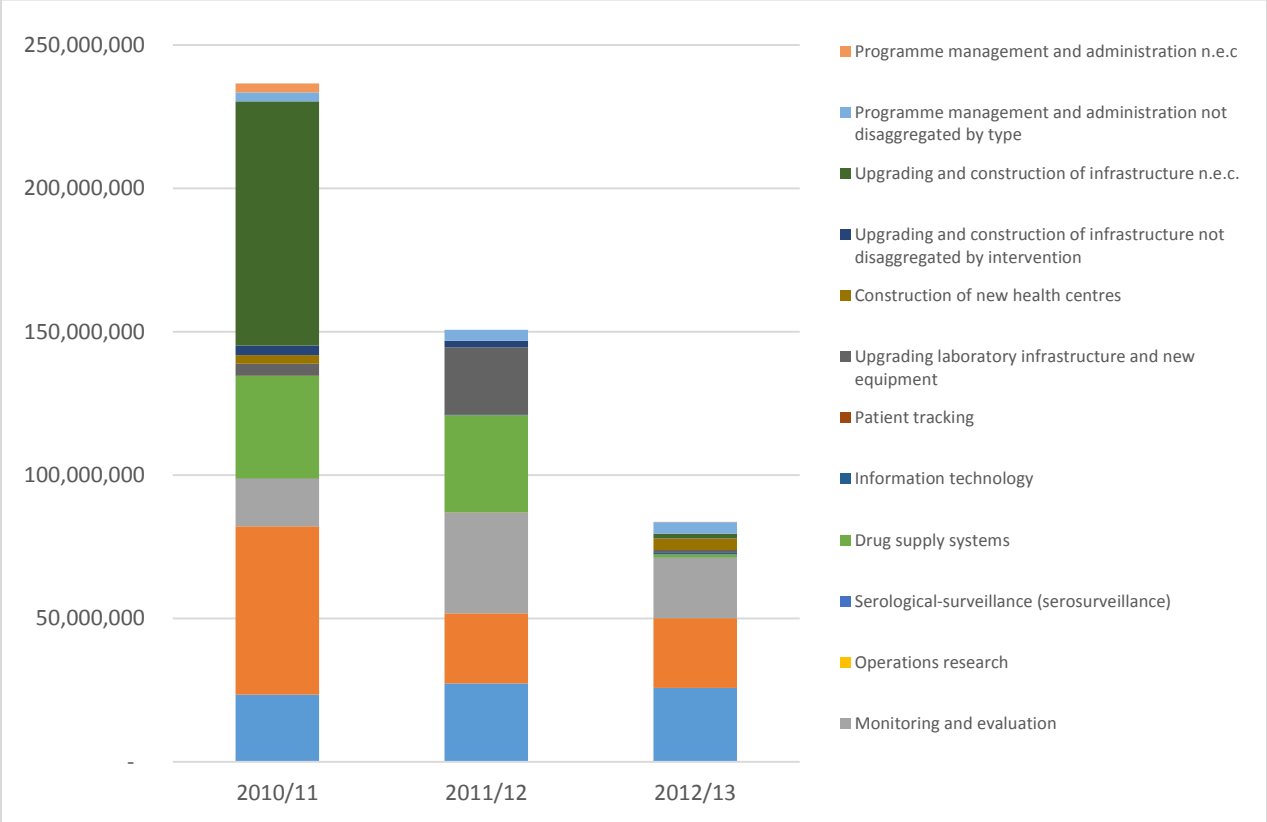
4.7.5 Programme Management and Administration Spending

These are expenses that are incurred at administrative level outside the point of health care delivery. The share of programme management and administration was 22.1% of the total spending. The table below shows the breakdown of expenditure for programme management spending activities.

Table 16: Programme Management Spending Activities, 2010/11-2012/13 (SZL)

Key Areas of Expenditure	2010/11	%	2011/12	%	2012/13	%
Planning, coordination and programme management	23,458,142	9.9%	27,394,340	18.2%	25,813,312	30.9%
Administration and transaction costs associated with managing and disbursing funds	58,745,945	24.8%	24,359,456	16.2%	24,334,275	29.1%
Monitoring and evaluation	16,671,321	7.0%	35,230,244	23.4%	21,000,450	25.1%
Operations research	52,003	0.0%	29,874	0.0%	26,472	0.0%
Serological-surveillance (serosurveillance)	11,195	0.0%	34,072	0.0%	12,567	0.0%
Drug supply systems	35,757,741	15.1%	33,844,995	22.5%	1,146,030	1.4%
Information technology	-		339,421	0.2%	510,905	0.6%
Patient tracking	26,693	0.0%	25,267	0.0%	33,375	0.0%
Upgrading laboratory infrastructure and new equipment	4,102,050	1.7%	23,292,407	15.5%	1,029,394	1.2%
Construction of new health centres	3,000,000	1.3%	-		4,029,992	4.8%
Upgrading and construction of infrastructure not disaggregated by intervention	3,417,399	1.4%	2,341,608	1.6%	32,365	0.0%
Upgrading and construction of infrastructure n.e.c.	85,070,712	36.0%	-		1,658,530	2.0%
Programme management and administration not disaggregated by type	3,195,904	1.4%	3,802,202	2.5%	3,959,674	4.7%
Programme management and administration n.e.c	3,089,787	1.3%	-		44,544	0.1%
Total	**236,598,892**	**100.0%**	**150,693,886**	**100.0%**	**83,631,885**	**100.0%**

Figure 11: Overall spending on programme management, 2010/11-2012/13



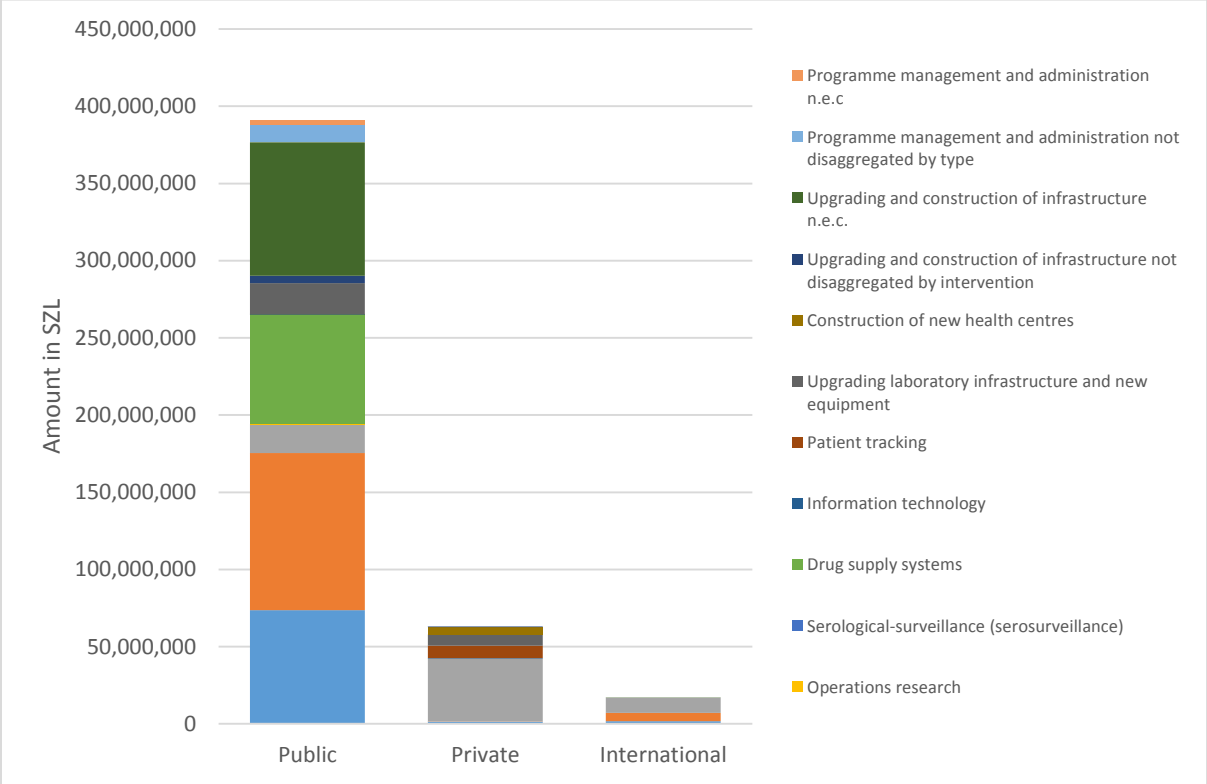
In terms of spending by source of funding, Table 19 shows that public sources of funds contributed the largest share to programme management and administration spending (SZL390,719,203 or US$53,376,940.30) over the three year period followed by private sources and international sources in that order which accounted for SZL63,096,195 (US$8,690,935.95) and SZL17,109,265 (US$2,083,954.32) respectively.

Table 17: Programme Management Spending Activities, 2010/11-2012/13 (SZL)

Key Areas of Expenditure	Public	%	Private	%	International	%
Planning, coordination and programme management	73,608,762	18.8%	1,259,375	2.0%	1,797,657	10.5%
Administration and transaction costs associated with managing and disbursing funds	101,814,695	26.1%	247,922	0.4%	5,377,059	31.4%
Monitoring and evaluation	18,662,550	4.8%	40,666,257	64.5%	9,756,667	57.0%
Operations research	108,349	0.0%	-		-	
Serological-surveillance (serosurveillance)	57,834	0.0%	-		-	
Drug supply systems	70,748,766	18.1%	-		-	
Information technology	370,117	0.1%	480,209	0.8%	-	
Patient tracking	85,335	0.0%	7,918,591	12.6%	-	
Upgrading laboratory infrastructure and new equipment	19,941,850	5.1%	7,379,951	11.7%	-	
Construction of new health centres	-		4,728,315	7.5%	-	
Upgrading and construction of infrastructure not disaggregated by intervention	4,795,692	1.2%	415,575	0.7%	-	
Upgrading and construction of infrastructure n.e.c.	86,433,142	22.1%	-		177,882	1.0%
Programme management and administration not disaggregated by type	10,957,780	2.8%	-		-	
Programme management and administration n.e.c	3,134,331	0.8%	-			0.0%
Total	**390,719,203**	100.0%	**63,096,195**	100.0%	**17,109,265**	100.0%

The results further show that the spending priorities between the public and international sources were slightly different. Public spending focused mainly on administration and transaction costs associated with managing and disbursing funds, upgrading and construction of infrastructure, and on drug supply system while international fund was channeled to planning and coordination and programme administration, monitoring and evaluation, and upgrading and construction of infrastructure. Notably, the spending on programme administration from the public source was higher than the contribution from the international fund source. Similarly, international sources of funding channeled more funds to monitoring and evaluation than the public sources. Figure 12 shows the actual spending, by source, on programme management and administration strengthening for years 2010/11-2012/13.

Figure 12: Programme Management Spending Activities, 2010/11-2012/13 (SZL)



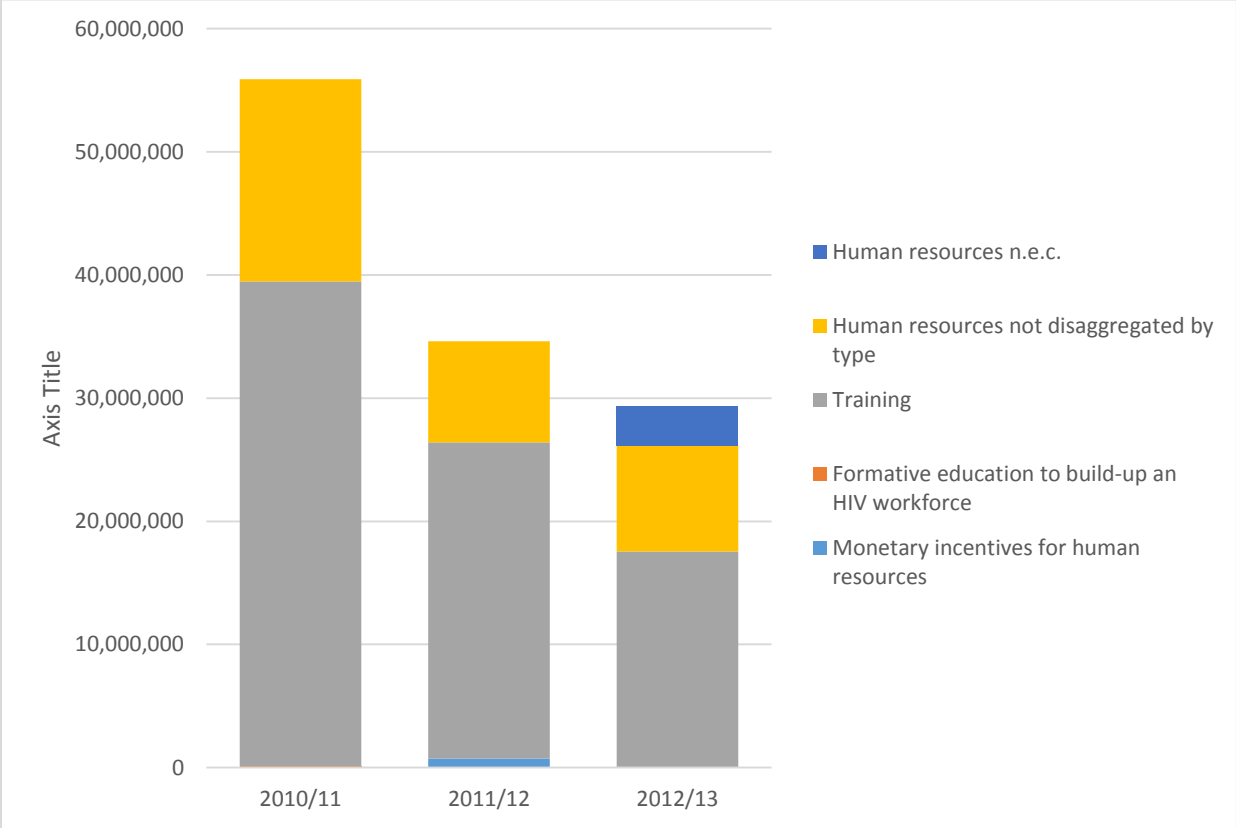
4.7.6 Human resources

The bulk expenditure for human resources amounted to SZL 119,892,372 over the three years under review. Most money under HR was spent on trainings (70.4% in 2010/11, 74.2% in 2011/12 and 59.8% in 2012/13). The table below shows the breakdon of expenditure under human reources for the NASA period.

Table 18:: Human resources spending activities, 2010/11-2012/13 (SZL)

Key Areas of Expenditure	2010/11	%	2011/12	%	2012/13	%
Monetary incentives for human resources	53,794	0.1%	728,025	2.1%	-	
Formative education to build-up an HIV workforce	64,336	0.1%	-		-	
Training	39,364,322	70.4%	25,682,738	74.2%	17,556,748	59.8%
Human resources not disaggregated by type	16,418,835	29.4%	8,208,292	23.7%	8,627,532	29.4%
Human resources n.e.c.	-				3,187,750	10.9%
Sub-Total	**55,901,287**	100.0%	**34,619,055**	100.0%	**29,372,030**	100.0%

Figure 13: Human Resource Spending Activities, 2010/11-2012/13 (SZL)



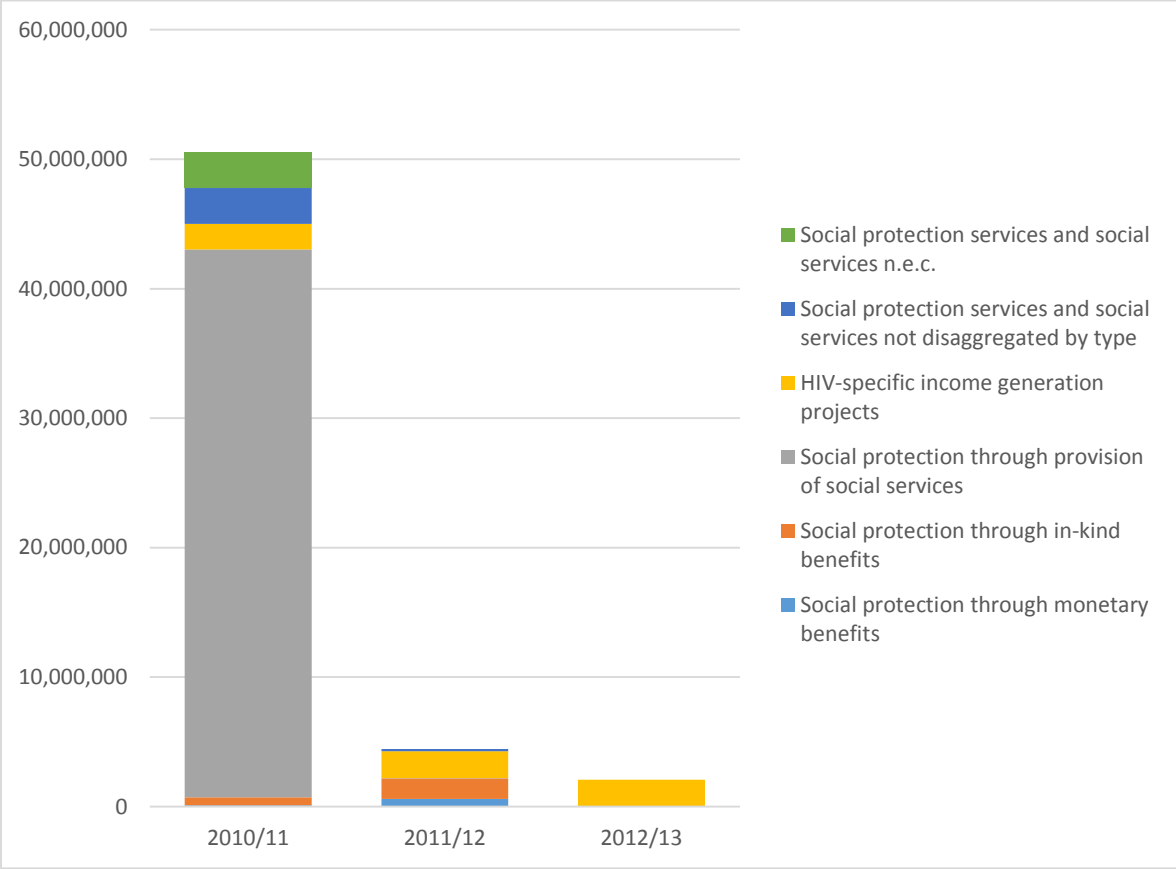
4.7.7 Social protection and social services (excluding OVC)

Spending on social protection and social services (excluding OVC) in 2010/11-2012/13 was financed exclusively from international sources of funding, as seen in the following table.

Table 19: Social protection and Social Services Activities, 2010/11-2012/13 (SZL)

Key Areas of Expenditure	2010/11	%	2011/12	%	2012/13	%
Social protection through monetary benefits	100,377	0.2%	590,534	13.2%	-	
Social protection through in-kind benefits	604,581	1.2%	1,593,552	35.7%	1,500	0.1%
Social protection through provision of social services	42,323,396	83.7%	20,893	0.5%	-	
HIV-specific income generation projects	1,970,000	3.9%	2,071,800	46.5%	2,081,800	99.9%
Social protection services and social services not disaggregated by type	2,779,224	5.5%	183,054	4.1%	-	
Social protection services and social services n.e.c.	2,774,765	5.5%	-		-	
Total	**50,552,343**	**100.0%**	**4,459,833**	**100.0%**	**2,083,300**	**100.0%**

Figure 14: Social protection and Social Services Activities, 2010/11-2012/13 (SZL)



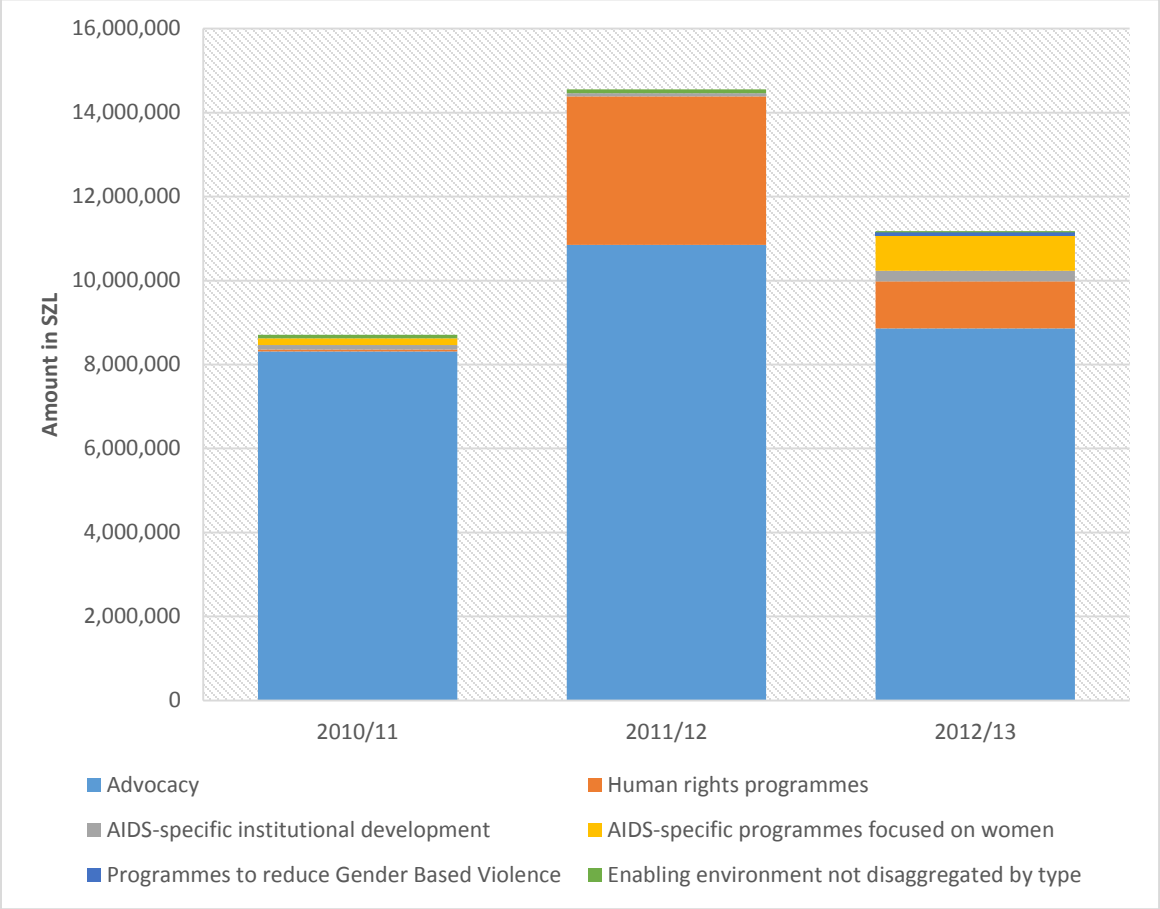
4.7.8 Enabling environment

In 2010/11, 2011/12 and 2012/13 total spending on enabling environment was SZL8,709,696 (US$1,189,849.18), SZL14,552,817 (US$2,004,520.25) and SZL11,181,321 (US$1,361,914.86) respectively. The main spending category under the enabling environment was advocacy throughout the 3 years with the least spending category being programmes to reduce gender based violence. The following table shows the breakdown in terms of expenditure by the different categories under enabling environment.

Table 20: Overview of spending on 'Enabling environment 2010/11-2012/13 (SZL)

Key Areas of Expenditure	2010/11	%	2011/12	%	2012/13	%
Advocacy	8,309,656	95.4%	10,849,266	74.6%	8,857,095	79.2%
Human rights programmes	47,075	0.5%	3,538,756	24.3%	1,122,628	10.0%
AIDS-specific institutional development	107,597	1.2%	72,475	0.5%	252,423	2.3%
AIDS-specific programmes focused on women	161,788	1.9%	-		835,800	7.5%
Programmes to reduce Gender Based Violence	-		-		78,968	0.7%
Enabling environment not disaggregated by type	83,580	1.0%	92,320	0.6%	34,407	0.3%
Total	**8,709,696**	**100.0%**	**14,552,817**	**100.0%**	**11,181,321**	**100.0%**

Figure 15: Enabling Environment Activities, 2010/11-2012/13 (SZL)



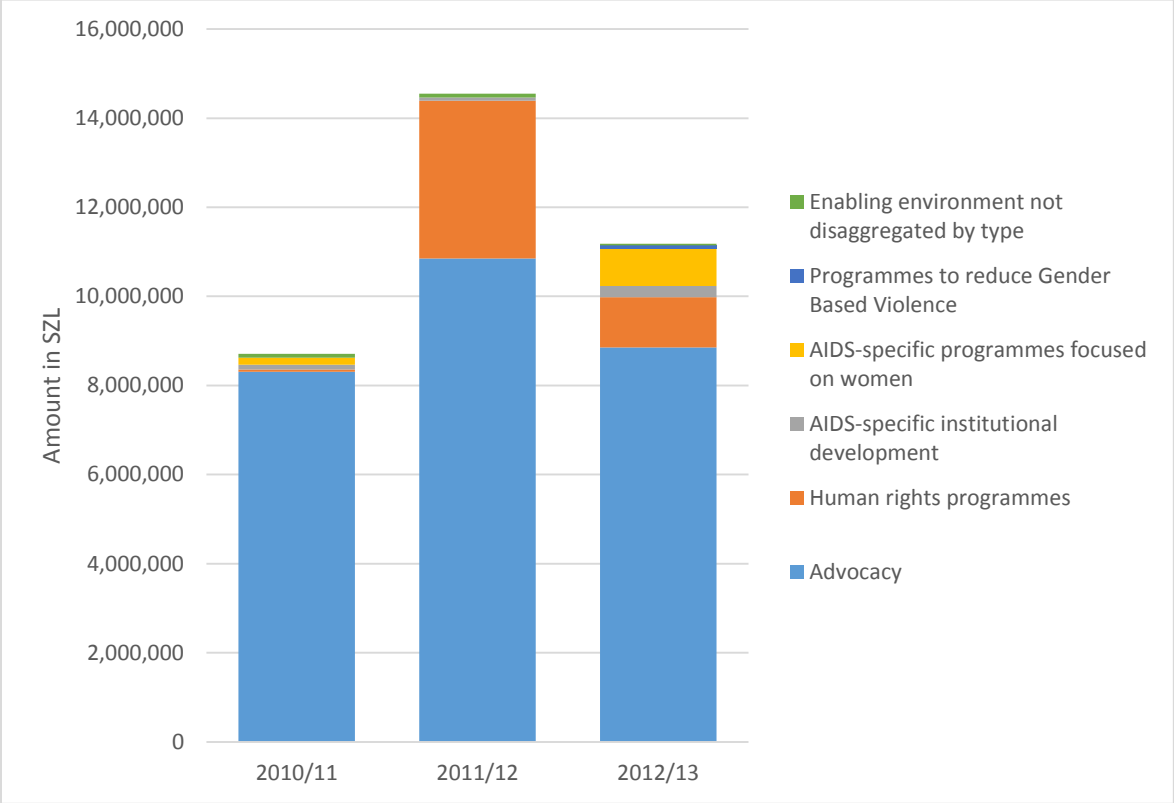
The table below shows expenditure by source of funds. Public spending on enabling environment in 2010/11, and 2012/13 was directed towards human rights programmes[4], whilst the private sector sources were spent largely on advocacy (93.5%) and AIDS-specific programmes focused on women (4.8%). International funds accounted for 96 % and 1% of total spending on enabling environment in 2010/11 and 2012/13 respectively

Table 21: Overview of spending on 'Enabling environment by source of funds (SZL)

Key Areas of Expenditure	Public	%	Private	%	International	%
Advocacy	356,106	6.8%	19,373,712	93.5%	8,286,199	97.8%
Human rights programmes	4,675,384	89.1%	-		33,075	0.4%
AIDS-specific institutional development	213,678	4.1%	68,347	0.3%	150,470	1.8%
AIDS-specific programmes focused on women	-		997,588	4.8%	-	
Programmes to reduce Gender Based Violence	-		78,968	0.4%	-	
Enabling environment not disaggregated by type	-		210,307	1.0%	-	
Total	**5,245,168**	**100.0%**	**20,728,922**	**100.0%**	**8,469,744**	**100.0%**

[4] The component of human rights category was largely capacity building in human rights

Figure 16: Enabling Environment, 2010/11-2012/13



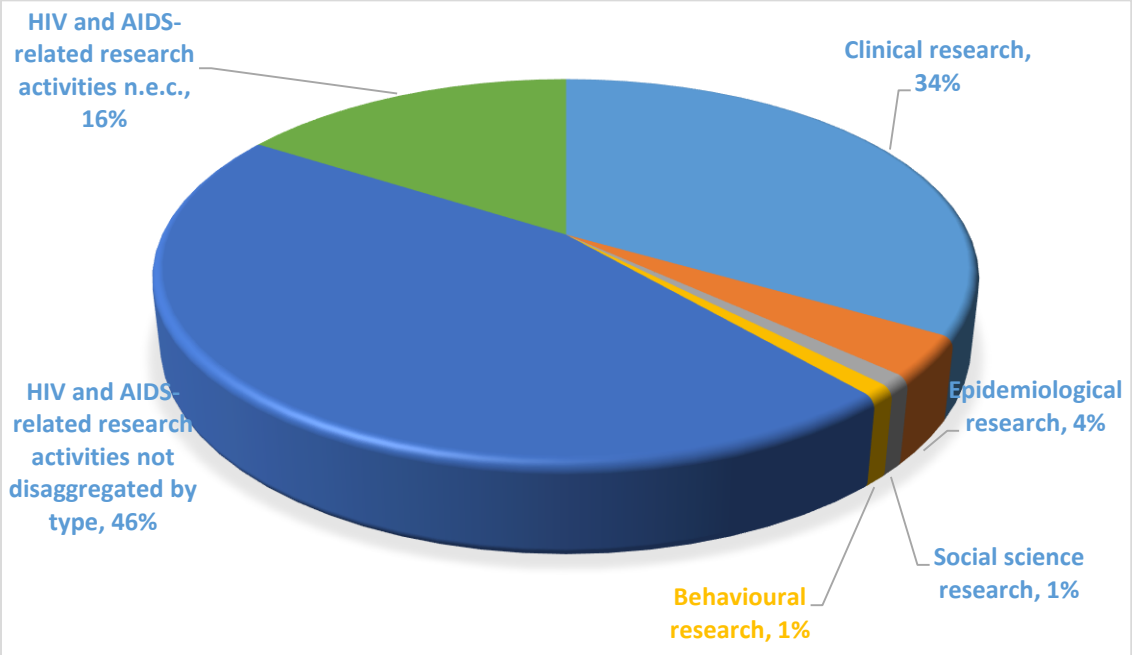
4.7.9 HIV-related research

Spending on 'HIV-related research' in 2010/11 and 2012/13 was financed exclusively from international sources of funding. Overall, HIV and AIDS related research activities not disaggregated by type accounted for 46% of total funding for this component while clinical research and epidemiological research accounted for 34% and 3% respectively.

Table 22: HIV-related research' expenditure by spending category, 2010/11-2012/13

Key activity areas	2010/11		2011/12		2012/13	
Clinical research	604,542	72.9%	-		-	
Epidemiological research	-		12,000	11.7%	50,375	5.8%
Social science research	-		-		16,773	1.9%
Behavioural research	-		-		16,773	1.9%
HIV and AIDS-related research activities not disaggregated by type	225,113	27.1%	90,600	88.3%	506,519	58.7%
HIV and AIDS-related research activities n.e.c.	-		-		288,949	33.5%
Sub-Total	**829,655**	100.0%	**102,600**	100.0%	**862,616**	100.0%

Figure 17: HIV-related research' expenditure, 2010/11-2012/13 (SZL[A12])



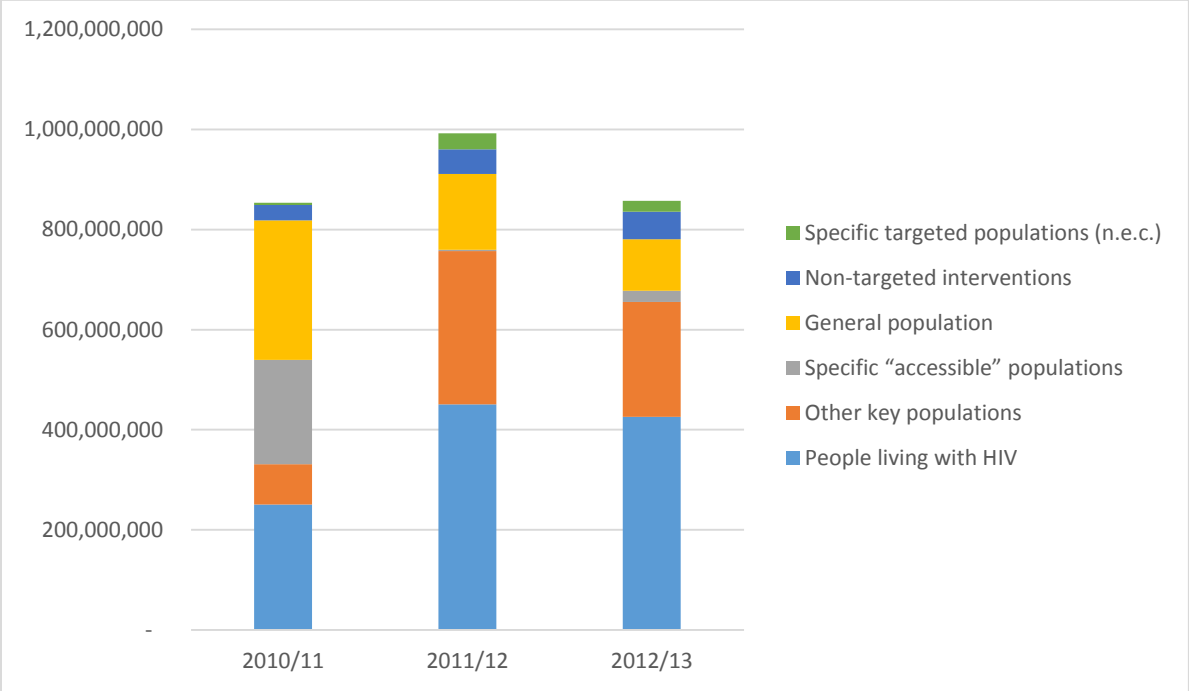
4.8 The beneficiaries of the spending activities

The analysis of the Beneficiary Population (BP) aims at estimating resources specifically spent on a population as part of the service delivery process of a programmatic intervention (UNAIDS, 2007). Beneficiary population (BP) is a sub-sect of the population that consumes HIV/AIDS related goods and services. Table 25 and Figure 18 represent expenditure results by the main beneficiary population of the HIV and AIDS expenditures and source of funds.

Table 23: HIV and AIDS spending by beneficiary population 2010/11-2012/13 (SZL)

Beneficiary Groups	**2010/11**	**%**	**2011/12**	%	**2012/13**	%
People living with HIV	250,443,167	29.3%	450,946,883	45.4%	425,556,744	50%
Other key populations	81,041,882	9.5%	306,209,400	30.8%	229,720,869	27%
Specific "accessible" populations	208,021,850	24.4%	2,416,529	0.2%	22,603,286	3%
General population	278,754,345	32.6%	151,387,805	15.2%	102,416,037	12%
Non-targeted interventions	30,939,931	3.6%	48,987,053	4.9%	54,972,030	6%
Specific targeted populations (n.e.c.)	4,155,507	0.5%	32,020,041	3.2%	21,974,721	3%
Total	**854,175,028**	**100.0%**	**993,285,628**	**100.0%**	**857,829,477**	**100%**

Figure 18: Spending by Beneficiary Group, 2010/11-2012/13 (SZL)



4.8.1 Estimated HIV and AIDS expenditure by beneficiary population

In order to highlight spending priorities of different HIV stakeholders (public, private and international) in Swaziland with different funding sources, the total expenditure is further broken down by beneficiary population and particular funding source. In 2010/11, funding from public sources to beneficiary population groups amounted to SZL 486,571,264 (US$ 66,745,029), while private sources and international sources spent SZL15, 732,483 (US$2,258,090) and SZL351, 849,029 (US$48,264,613) respectively. This represents 57%, 2% and 41% spending from public, private and international sources respectively in 2010/11.

In 2011/12 public funds accounted for SZL398, 739,043 (US$51,549,973) while private sources and spent international sources spent SZL7,098,335 (US$ 917,690.37) and SZL 587,448,250 (US$75,946,768) respectively on beneficiary population groups. Total spending from public funds in 2012/13 amounted to SZL 361,583,096 (US$40,468,170), private sources SZL 6,725,601 (US$ 752,725) and international sources SZL 489,520,780 (US$ 54,786,881).

Table 24: Spending by beneficiary population and source of funding, 2010/11 (SZL)

Beneficiary Groups	Public funds	Private Funds	International funds
People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)			
Adult and young women (15 years and over) living with HIV	1,625,763	-	192,628
Adult and young people (15 years and over) living with HIV not disaggregated by gender	-	1,997,439	983,469
Children (under 15 years) living with HIV	5,881,566	-	3,306,720
People living with HIV not disaggregated by age or gender	149,906,278	2,681,437	83,867,867
Sub-total	**157,413,607**	**4,678,876**	**88,350,684**
Most at risk populations			
Sex workers (SW) and their clients	-	-	
Female sex workers and their clients	-	-	320,000
Most at risk populations not disaggregated by type	498,346	-	-
Sub-total	**498,346**	**-**	**320,000**
Other key populations			

Orphans and vulnerable children (OVC)	27,419,967	650,602	27,914,185
Children born or to be born of women living with HIV	3,337,658	80,894	17,542,623
Prisoners and other institutionalized persons	1,996,840	-	-
Children and youth out of school	82,982	-	81,779
Partners of persons living with HIV	-	23,054	-
Recipients of blood or blood products	1,542,659	-	-
Other key populations not disaggregated by type	-	-	368,639
Sub-total	**34,380,106**	**754,550**	**45,907,226**
Specific "accessible" populations			
People attending STI clinics	-	-	22,252
Elementary school students	79,371,925	-	-
Junior high/high school students	114,091,004	50,359	2,594,632
University students	-	-	197,627
Health care workers	207,409	53,794	1,399,760
Factory employees (e.g. for workplace interventions)	21,650	214,416	258,726
Specific "accessible " populations not disaggregated by type	3,585,094	163,000	4,145,768
Specific "accessible " populations n.e.c.	-	121,341	1,523,093
Sub-total	**197,277,082**	**602,910**	**10,119,606**
General population			
General adult population (older than 24 years)			
Male adult population	2,080,024	-	-
General adult population (older than 24 years) not disaggregated by gender	48,664,578	2,445,450	90,779,265
Children (under 15 years)	-	-	5,780,682
Children (under 15 years) not disaggregated by gender	-	-	
Youth (age 15 to 24 years)		-	
Young men	2,080,024	-	205,729
Young females	-	-	423,869
Youth (age 15 to 24 years) not disaggregated by gender	-	-	3,136,495
General population not disaggregated by age or gender.	19,060,974	5,790,809	98,306,446
Sub-total	**71,885,600**	**8,236,259**	**198,632,486**
Non-targeted interventions	24,750,560	581,638	5,607,733
Specific targeted populations not elsewhere classified (n.e.c.)	365,963	878,250	2,911,294
Total	**486,571,264**	**15,732,483**	**351,849,029**

Table 25: Spending by beneficiary population and source of funding, 2011/12 (SZL)

Beneficiary Groups	Public funds	Private Funds	International funds
People living with HIV			
Adult and young women (15 years and over) living with HIV	-	-	272,800
Adult and young people (15 years and over) living with HIV not disaggregated by gender	-	588,705	3,657,925
Children (under 15 years) living with HIV	16,526	-	722,873
People living with HIV not disaggregated by age or gender	141,194,928	219,400	304,273,726
Sex workers (SW) and their clients	-	-	16,756
Most at risk populations not disaggregated by type	1,301,161	-	-
Sub-total	**142,512,615**	**808,105**	**308,944,080**
Other key populations	**157,931,243**	**1,777,814**	**146,500,343**
Orphans and vulnerable children (OVC)	148,598,564	1,743,030	82,983,685
Children born or to be born of women living with HIV	5,411,716	-	53,733,716
Prisoners and other institutionalized persons	1,597,472	-	-
Children and youth out of school	38,815	-	-
Partners of persons living with HIV	-	34,784	-
Recipients of blood or blood products	2,284,676	-	9,782,942
	157,931,243	1,777,814	146,500,343
Specific "accessible" populations			
Elementary school students	-	-	217,753
Junior high/high school students	190,962	-	-
Health care workers	152,296	-	248,758
Factory employees (e.g. for workplace interventions)	256,985	282,312	-
Specific "accessible " populations not disaggregated by type	168,143	-	349,192
Specific "accessible " populations n.e.c.	112,217	-	437,911
	880,603	282,312	1,253,614
General population			
Male adult population	1,480,722	-	-
Female adult population	181,282	-	-
General adult population (older than 24 years) not disaggregated by gender	641,787	-	23,678,601
Children (under 15 years)	-	-	372,769
Young men	1,480,722	-	456,731

Young females	-	-	637,490
Youth (age 15 to 24 years) not disaggregated by gender	3,303,845	3,026,018	319,155
General population not disaggregated by age or gender.	40,480,563	619,581	74,708,539
Sub-total	47,568,921	3,645,599	100,173,285
Non-targeted interventions	19,496,362	77,619	29,413,072
Specific targeted populations not elsewhere classified (n.e.c.)	30,349,299	506,886	1,163,856
Grand total	**398,739,043**	**7,098,335**	**587,448,250**

Table 26: Spending by beneficiary population and source of funding, 2012/13 (SZL)

Beneficiary Groups	Public funds	Private Funds	International funds
People living with HIV			
Adult and young men (15 years of age and over) living with HIV	-	-	685,833
Adult and young women (15 years and over) living with HIV	-	-	867,800
Adult and young people (15 years and over) living with HIV not disaggregated by gender	-	467,047	-
Girls (under 15 years) living with HIV	-	-	44,325
Children (under 15 years) living with HIV not disaggregated by gender	-	-	973,279
People living with HIV not disaggregated by age or gender	124,085,890	902,323	297,530,247
Sub-total	**124,085,890**	**1,369,370**	**300,101,484**
Most at risk populations			
Most at risk populations not disaggregated by type	585,790	-	-
Sub-total	585,790	-	-
Other key populations			
Orphans and vulnerable children (OVC)	140,884,215	1,836,398	45,174,323
Children born or to be born of women living with HIV	6,625,113	-	25,998,167
Prisoners and other institutionalized persons	1,597,465	-	-
Truck drivers/transport workers and commercial drivers	-	1,500	-
Children and youth out of school	32,018	-	101,361
Partners of persons living with HIV	-	43,096	-

Recipients of blood or blood products	1,959,397	-	4,886,597
Other key populations not disaggregated by type	-	-	581,219
Sub-total	**151,098,208**	**1,880,994**	**76,741,667**
Specific "accessible" populations			
Junior high/high school students	231,725	-	6,673,106
Health care workers	65,611	-	1,339,624
Police and other uniformed services (other than the military)	594,000	-	95,000
Factory employees (e.g. for workplace interventions)	3,125,607	797,665	20,000
Specific "accessible " populations not disaggregated by type	-	-	3,572,076
Specific "accessible " populations n.e.c.	-	-	6,088,872
Sub-total	**4,016,943**	**797,665**	**17,788,678**
General population			
General adult population (older than 24 years)			
Male adult population	1,546,951	-	-
Female adult population	27,020	-	-
General adult population (older than 24 years) not disaggregated by gender	809,596	-	1,274,190
Children (under 15 years)	-	-	4,786,546
Young men	2,687,380	-	1,377,319
Young females	1,140,430	-	269,142
Youth (age 15 to 24 years) not disaggregated by gender	223,126	1,534,361	4,917,272
General population not disaggregated by age or gender.	18,047,201	1,013,964	62,761,539
Sub-total	**24,481,704**	**2,548,325**	**75,386,008**
Non-targeted interventions	36,723,397	120,000	18,128,633
Specific targeted populations not elsewhere classified (n.e.c.)	20,591,164	9,247	1,374,310
Total	**361,583,096**	**6,725,601**	**489,520,780**

4.8.2 HIV/AIDS expenditure by production factors

According to UNAIDS (2009), NASA classification of production factors categorizes expenditures in terms of resources used for the production in terms of wages, salaries, materials, and capital. Expenditure categorised in terms of factors of production is presented in Table 30.

Table 27: Expenditure by factors of production 2010/11 – 2012/13 (SZL)

	2010/11	%	2011/12	%	2012/13	%
Current expenditures						
Wages	119,281,522	14.0%	179,638,744	18.1%	158,142,162	18.4%
Social contributions	1,331,512	0.2%	422,816	0.0%	405,422	0.0%
Labour income not disaggregated by type					101,347	0.01%
Labour income not disaggregated by type	23,861,877	2.8%	32,992,783	3.3%	23,165,398	2.7%
Sub-total	*144,474,911*	*16.9%*	*213,054,343*	*21.4%*	*181,814,329*	*21.2%*
Supplies and services						
Material supplies	233,085,082	27.3%	378,218,361	38.1%	231,746,584	27.0%
Antiretrovirals	40,486,007	4.7%	6,718,304	0.7%	5,259,881	0.6%
Other drugs and pharmaceuticals	11,837,703	1.4%	125,586,053	12.6%	42,592,015	5.0%
Medical and surgical supplies	24,994,210	2.9%	48,469,307	4.9%	1,718,231	0.2%
Condoms	1,083,445	0.1%	442,763	0.0%	435,824	0.1%
Reagents and materials	2,121,326	0.2%	1,612,807	0.2%	12,704,518	1.5%
Food and nutrients	25,149,249	2.9%	153,450,392	15.4%	7,322,643	0.9%
Uniforms and school materials	100,488,111	11.8%	426,221	0.0%	129,510,799	15.1%
Material supplies not disaggregated by type	21,688,368	2.5%	16,729,913	1.7%	24,728,297	2.9%
Other material supplies n.e.c.	5,236,663	0.6%	24,782,601	2.5%	7,474,376	0.9%
Sub-total-supplies	*233,085,082*	*27.3%*	*378,218,361*	*38.1%*	*231,746,584*	*27.0%*
Services	341,922,234	40.0%	349,702,979	35.2%	400,181,813	46.7%
Administrative services	93,986,167	11.0%	77,770,402	7.8%	77,170,523	9.0%
Maintenance and repair services	895,078	0.1%	824,175	0.1%	160,014	0.02%
Publisher-, motion picture-, broadcasting and programming services	1,535,866	0.2%	3,373,633	0.3%	1,728,268	0.2%
Consulting services	2,046,054	0.2%	2,681,459	0.3%	1,755,612	0.2%
Transportation and travel services	15,730,856	1.8%	20,129,395	2.0%	13,850,331	1.6%
Housing services	468,751	0.1%	21,688	0.0%	156,327	0.0%
Logistics of events, including catering services	3,080,313	0.4%	2,345,041	0.2%	2,395,440	0.3%
Financial intermediation services	2,520,437	0.3%	1,486,801	0.1%	2,247,598	0.3%
Services not disaggregated by type	158,847,458	18.6%	225,653,739	22.7%	285,981,650	33.3%
Services n.e.c.	62,811,254	7.4%	15,416,646	1.6%	14,736,050	1.7%
Sub-total-services	*341,922,234*	*40.0%*	*349,702,979*	*35.2%*	*400,181,813*	*46.7%*
Current expenditures not disaggregated by type	27,520,093	3.2%	41,788,204	4.2%	28,076,208	3.3%
Current expenditures n.e.c.	42,436	0.0%		0.0%	2,581	0.0%
Sub-total	*27,562,529*	*3.2%*	*41,788,204*	*4.2%*	*28,078,789*	*3.3%*
Total recurrent expenditure	**747,044,756**	**87.5%**	**982,763,887**	**98.9%**	**841,821,515**	**98.1%**
Capital expenditures	**102,465,694**	12.0%	**9,121,741**	0.9%	**12,474,479**	1.5%
Buildings	88,601,438	10.4%	890,833	0.1%	3,889,130	0.5%
Laboratory and other infrastructure upgrading	76,033,540	8.9%	162,562	0.0%		
Construction of new health centres	3,000,000	0.4%			3,159,480	0.4%
Buildings not disaggregated by type	628,579	0.1%	728,271	0.1%	726,339	0.1%
Buildings n.e.c.	8,939,319	1.0%		0.0%	3,311	0.0%
Sub-total	*88,601,438*	*10.4%*	*890,833*	*0.1%*	*3,889,130*	*0.5%*
Equipment	**10,236,109**	1.2%	**5,598,024**	0.6%	**6,320,989**	0.7%
Vehicles	3,486,240	0.4%	2,036,798	0.2%	3,193,066	0.4%
Information technology (hardware and software)	636,026	0.1%	483,609	0.0%	555,020	0.1%
Equipment not disaggregated by type[A13]		0.0%	148,615	0.0%	30,201	0.0%
Equipment not disaggregated by type[A14]	1,453,526	0.2%	2,929,002	0.3%	2,404,691	0.3%
Equipment n.e.c.	4,660,317	0.5%		0.0%	138,011	0.0%
Sub-total	*10,236,109*	*1.2%*	*5,598,024*	*0.6%*	*6,320,989*	*0.7%*

Capital expenditure not disaggregated by type	3,036,776	0.4%	2,632,884	0.3%	2,264,360	0.3%
Capital expenditure n.e.c.	591,371	0.1%		0.0%		0.0%
Production factors not disaggregated by type	4,664,576	0.5%	1,400,000	0.1%	3,533,483	0.4%
Sub-total	*8,292,723*	*1.0%*	*4,032,884*	*0.4%*	*5,797,843*	*0.7%*
Grand total	**854,175,026**	**100.0%**	**993,285,628**	**100.0%**	**857,829,477**	**100.0%**

5 INSTITUTIONALIZATION OF HIV AND AIDS RESOURCE TRACKING

The information provided by the NASA is very important for decision-making in the national response to HIV and AIDS. As such one of the tasks of the NASA team was to examine and suggest mechanisms for institutionalizing HIV and AIDS resource tracking in the country. This sub-section provides suggestions on the process for institutionalising NASA and draws upon:

- Lessons and findings of the round three NASA study;
- Understanding of the Swaziland's HIV and AIDS context including the stakeholders and structures; and
- Requirements for institutionalization as have been noted elsewhere for NASAs and similar resource tracking processes like National Health Accounts.

With the above background, this study recommends that some key areas need to be considered for continued and informative production of NASA in the country:

i. Need for the development and implementation of a governance framework linking NASA production to use of data and further analysis of the NASA data to provide detailed information on key aspects (e.g. equity in HIV and AIDS spending, efficiency analysis, comparing NASA data and costed eNSF etc) that are critical in supporting policy formulation and decision-making;
ii. Capacity Building – for production, dissemination and effective use of NASA data; and
iii. Governance for HIV and AIDS Resource Tracking

To guide the institutionalisation of NASA, NERCHA and other players should clearly define the responsibilities of NERCHA, bilateral and multilateral agencies and the private sector under the broad area of governance for HIV and AIDS resource tracking including:

- Coordination;
- Policy and technical issues; and
- Production of NASA.

5.1 Coordination for HIV and AIDS Resource Tracking

The NERCHA has the mandate for coordinating and planning the HIV and AIDS response in the country and it will be important for NERCHA to coordinate the NASA process. Specific roles could include:

1. Overseeing the creation of data repositories data on the types and identity of entities/ players in the HIV and AIDS response, and including financial and activity data [A15]
2. Overseeing the planning and budgeting of the NASA process;
3. Coordinating information gathering and the process of dissemination of data;

Specific activities to be undertaken by NERCHA in line with the specific roles would include:

a) Creation of a central database of all HIV and AIDS stakeholders

The lack of a central database with financial information (financial, activities, beneficiaries etc.) on all stakeholders in the HIV and AIDS response has been a big challenge for the three rounds of NASA that have been undertaken in the country. The third round of NASA experienced similar challenges that delayed the process and required gathering of the data from different sources. To improve efficiency of undertaking future NASA, it is highly recommended that such a database be created and updated on a regular basis by NERCHA. All the players should be able to provide the required information for inclusion in the database. This database will help in routine gathering of the required financial and other similar data including providing a sampling frame for subsequent NASAs.

b) Link into regular surveys done by the MOH, central statistical bureau, NHA etc.

Because of the multi-sectoral nature of HIV and AIDS and the need for information up to beneficiary level, substantial aspects of HIV and AIDS resource tracking require data that can only be collected in surveys. Given the cost of undertaking surveys is quite high, it is recommended that NERCHA and other players take advantage of routine data collection surveys undertaken by government agencies to provide some of the HIV and AIDS data required for a NASA exercise. For this to work, NERCHA need to work closely with the

entities and provide the necessary information to be collected or questions it would like to be answered in the surveys.

5.2 Policy and Technical Dialogue for HIV and AIDS Resource Tracking

NERCHA and other players need to strengthen existing structures for participation of the various players in Policy and Technical Dialogue for the national response. A multi-sectoral TWG could help in spearheading dialogue among stakeholders. One of the key responsibilities of the TWG is to ensure easy access to data, and to provide guidance on policy priorities and lead in exploring ways of using the data for decision-making.

5.3 Production of Data

As a coordinating agency, NERCHA should be responsible for the production of NASA data and dissemination of the same.

5.4 Capacity Building for HIV/AIDS Resource Tracking

A comprehensive approach is critical to build capacity for the complete cycle of data production, dissemination and use as opposed to one that focuses on particular aspects of the NASA cycle such as production of the NASA. This comprehensive approach to capacity building should be conducted at the individual and institutional levels. As a first step to capacity building, it will be necessary for NERCHA to undertake a capacity needs assessment, to aid the identification of critical gaps in the skills set at each stage of NASA implementation.

6 SUMMARY AND RECOMMENDATIONS

Since the advent of HIV, tracking and reporting financial expenditure has been a major challenge that many countries have been experiencing and Swaziland is no exception. In a bid to establish a system that would improve the inadequacies in financial expenditure tracking and reporting, the UNAIDS introduced the National AIDS Spending Assessment tracking tools to help countries generate data on investment in the national response. One of the major shortcomings of the NASA is that it is usually implemented as and when funds are available, countries deem it necessary to undertake the NASA, expensive, very demanding and stressful for implementing partners. In addition the objectives of the NASA are often confused and implementing partners see the NASA as another audit exercise and this misconception contributes significantly to the reluctance to willingly share accurate financial expenditure data. On the contrary the NASA is not an audit but an important element in shaping the landscape of the response.

The long term sustainability of the NASA is dependent on the implementers understanding the value of continuous tracking and monitoring of resources utilized in the response towards improving efficiencies. It is against this background that Swaziland deems it necessary to establish mechanisms in place to institutionalize the NASA and ensure its integration as part of the routine reporting obligations and requirements.

Swaziland has been conducting NASA since 2007 but not as routine financial tracking exercise. The need to continuously monitor financial expenditure data has become even more relevant today than ever before because of the changing landscape of the response focusing more on game changing interventions within the framework of the investment approach. In the institutionalization of the NASA and the long term sustainability the following are proposed for consideration:

6.1 The Principles of NASA:

The NASA should be first and foremost recognised as a resource-tracking framework for monitoring the annual flow of funds used to finance the response to HIV and AIDS in Swaziland and not an audit exercise. The basis for tracking financial expenditure is the eNSF which sets the landscape for harmonization and alignment of the response within the framework of the Three Ones principles. It is therefore imperative that the stakeholders appreciate the principles that the effectiveness of the response is equally measured against the resources utilized and how these resources are allocated against key priority areas. In line with the fulfilment of the eNSF requirement it should be obligatory for all implementing partners to submit their annual programmatic reports including financial expenditure data on the response and feedback consolidated and disseminated to stakeholders using the annual review or partnership forum platforms.

6.2 Establishing NASA Reporting Platform:

Under the current dispensation SHAPMOS is designed to collect both programmatic and financial data and reports from the implementing partners. However, the major shortcoming of SHAPMOS is that not all NASA categories are captured in the financial module and as such there is need to review the financial reporting template in alignment with the main NASA categories. There may be need to invest in equipment and infrastructure and subsequently migrate to real time electronic reporting. This requirement should be integrated with the current work on strengthening the HMIS with the view to standardising reporting and avoiding duplications. The National Coordinating structures should be responsible for managing the data collection and verification processes.

6.3 Capacity Building:

Although Swaziland over the years has accumulated a wealth of experience in conducting the NASA, there is a need to further strengthen capacity for long term sustainability. It is therefore pertinent that an initial investment be made to establish Focal Points at the national coordination levels and provide them with extensive training on NASA. In addition, a national core team should be identified and trained to develop the required expertise to support the future implementation of the NASA. The training should be further

supported by a mentoring programme to allow them to be exposed and participate as resource persons in other countries conducting NASA in the region within the framework of south-south Corporation.

Furthermore organizations involved in implementing HIV interventions should be trained on the NASA categories and reporting templates to enhance collaboration and acceptability in providing financial data in line with the NASA requirements. The creation of a critical mass of expertise who are well grounded on the NASA will eliminate the reliance on external technical support and in the long run result in the integration of the NASA in routine programme reporting.

6.4 High level advocacy:

The world has seen an unprecedented increase in funding [NM16]for HIV and AIDS programmes because of successful advocacy efforts that articulated the magnitude of the epidemic and its funding needs and Swaziland is no exception to this. While the increase in the level of funding is indeed a welcome development, what is perhaps equally critical is ensuring that the funds are invested in a way that delivers a well-coordinated and improved response that addresses key priority areas. In order to achieve this, policymakers, planners and funding agents require routine expenditure data to determine if funds are being spent in critical areas of need and in line with the eNSF. Furthermore, decision makers will better appreciate the allocation and use of funds, identify potential areas for resource mobilization, determine if a financing gap remains and see the level dependencies on either external or domestic resources. The decision makers will then be in a position to make strategic decisions on advocating for the availability and allocation of resources to key priority areas that will lead the country to ending AIDS in line with Vision 2022. (Linking the NASA with National Health Accounts, UNAIDS, June 2009)

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APPENDICES

Appendix A:

Table 27: List of organizations included in the sample

External Donors and lenders	Public (Government)	Int. NGOs	FBO/CSO/NGO
UNESCO	Min of Youth, Sports & Culture	Cabrini Ministries	UNISWA
ILO	Ministry of Health	TASC	Lusweti
Italian corporation	Ministry of Justice	PSI	Lutsango Lwaka Ngwane
CHAI	FINCORP	Save the Children	Lutheran Development Service
FAO	Correctional Services	ADRA	Young Heroes
UNODC	Swaziland National Housing Board	Red Cross	Scripture Union
UNFPA	Ministry of Tourism	ACAT	Sebenta
UNICEF	Min of Home Affairs	WLSA	Hospice at Home
USG (PEPFAR, USAID,CDC)	PSCHACC	ICAP	SWAAGA
WHO	Ministry of Economic Planning and Development	Elizabeth Glazer pediatric	COSPE
World Bank	Ministry of Education	Children's Cup	SWAPOL
WFP	Min of Agriculture	MSH	SACRO
GFATM	Audit	ESI	Swaziland Youth United Against HIV/AIDS
European Union	Min of Defense	AMICAALL	Gone Rural
UNDP	Treasury	Hand in Hand	SFTU
UNAIDS	Min of Natural Resources	Clinton Foundation	imphilo Isachubeka
	MTAD	FLAS	FUNDZA
	Min of Information, Communication and Technology	ICW	SHAPE
	Min of Housing & urban Devt	CARITAS Swaziland	Imbita Swaziland Women's Finance Trust
	Ministry of Finance	World Vision	Council of Swaziland Churches
	Min of Public Service	MSF	Membatsise Home Based Care

	DPM's Office	SOS	CARITAS
	Royal Swaziland Police	Action against hunger	Women Together
	SBIS	URC	CANGO
	NERCHA	Baylor	Church Forum
			FODSWA
			Khulisa umtfwana
			Salvation Army
			SASO
			SNYC
			SWANNEPHA
			THO
			Vusumnotfo
17	25	25	35

Appendix B

Table 28: Distribution of international sources of funds , 2010/11-2012/13.

	2010/11	%	2011/12	%	2012/13	%
International funds	**351,871,280**		**587,448,249**		**489,520,779**	
Direct bilateral contributions	**175,528,330**	**49.90%**	**342,891,237.00**	**58.40%**	**342,213,111**	**69.90%**
Government of Australia			520,000	0.10%		
Government of Belgium			25,346	0.00%		
Government of Germany			357,654	0.10%		
Government of Luxembourg	737,463	0.20%	369,914	0.10%		
Government of Norway			1,042,125	0.20%	1,241,812	0.30%
Government of Sweden					33,442	0.00%
Government of United Kingdom			1,318,316	0.20%	908,192	0.20%
Government of United States	174,790,867	49.70%	339,257,882	57.80%	340,029,665	69.50%
Multilateral Agencies (ii)	**137,401,962**	**39.00%**	**199,498,416**	**34.00%**	**83,946,115**	**17.10%**
European Commission	7,517,665	2.10%	229,473	0.00%	229,473	0.00%
FAO					560,000	0.10%
Regional Development Banks			31,766	0.00%		
GFATM	113,390,629	32.20%	190,839,596	32.50%	53,284,101	10.90%
UNAIDS Secretariat	220,897	0.10%	229,881	0.00%	431,605	0.10%
United Nations Children's Fund (UNICEF)	4,403,045	1.30%	162,482	0.00%	10,814,440	2.20%
UNDP	670,833	0.20%	249,628	0.00%	745,210	0.20%
UNESCO	826,864	0.20%	323,248	0.10%	667,140	0.10%
United Nations Population Fund (UNFPA)	6,901,374	2.00%	5,381,664	0.90%	7,830,375	1.60%
World Bank (WB)	1,651,195	0.50%	1,909,454	0.30%	2,438,196	0.50%
World Health Organization (WHO)	427,000	0.10%				
Multilateral funds or development funds n.e.c.	1,392,460	0.40%	141,224	0.00%	6,945,575	1.40%
International not-for-profit organizations and foundations	**33,630,353**	**9.60%**	**45,033,661**	**7.70%**	**59,671,601**	**12.20%**
International HIV and AIDS Alliance			395,542	0.10%	1,783,740	0.40%
Bill and Melinda Gates Foundation	189,462	0.10%				
Caritas International/Catholic Relief Services	350,000	0.10%				
Elizabeth Glaser Pediatric AIDS Foundation			281,429	0.00%	514,037	0.10%
Médecins sans Frontières	2,574,973	0.70%		0.00%		0.00%

PSI (Population Services International)	346,373	0.10%	445,961	0.10%	387,356	0.10%
United Nations Foundation					2,643,631	0.50%
World Vision	5,399,383	1.50%	10,004,961	1.70%	7,370,570	1.50%
International Planned Parenthood Federation	5,538,666	1.60%	6,343,474	1.10%	3,640,182	0.70%
Order of Malta					6,509,358	1.30%
Other International not-for-profit organizations and foundations n.e.c.	19,231,496	5.50%	27,559,294	4.70%	36,821,889	7.50%
International for profit organizations	**3,475,520**	**1.00%**	**24,935**	**0.00%**	**1,265,798**	**0.30%**
International funds n.e.c.	**1,835,115**	**0.50%**			**2,424,992**	**0.50%**

Table 29: Spending by beneficiary population 2010/11 – 2012/13 (SZL)

Beneficiary Groups	**2010/11**	**2011/12**	**2012/13**
People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)			
Adult and young men (15 years of age and over) living with HIV			685,833
Adult and young women (15 years and over) living with HIV	1,818,391	272,800	867,800
Adult and young people (15 years and over) living with HIV not disaggregated by gender	2,980,908	4,246,630	467,047
Girls (under 15 years) living with HIV			44,325
Children (under 15 years) living with HIV not disaggregated by gender	9,188,286	739,399	973,279
People living with HIV not disaggregated by age or gender	236,455,582	445,688,054	422,518,460
Sub-total	**250,443,167**	**450,946,883**	**425,556,744**
Most at risk populations			
Female sex workers and their clients	320,000	16,756	
Most at risk populations not disaggregated by type	498,346	1,301,161	585,790
Sub-total	**818,346**	**1,317,917**	**585,790**
Other key populations			
Orphans and vulnerable children (OVC)	55,984,754	233,325,279	187,894,936
Children born or to be born of women living with HIV	20,961,175	59,145,432	32,623,280
Prisoners and other institutionalized persons	1,996,840	1,597,472	1,597,465
Truck drivers/transport workers and commercial drivers			1,500
Children and youth out of school	164,761	38,815	133,379
Partners of persons living with HIV	23,054	34,784	43,096
Recipients of blood or blood products	1,542,659	12,067,618	6,845,994
Other key populations not disaggregated by type	368,639		581,219
Sub-total	**81,041,882**	**306,209,400**	**229,720,869**
Specific "accessible" populations			
People attending STI clinics	22,252		
Elementary school students	79,371,925	217,753	
Junior high/high school students	116,735,995	190,962	6,904,831
University students	197,627		

Health care workers	1,660,963	401,054	1,405,235
Police and other uniformed services (other than the military)			689,000
Factory employees (e.g. for workplace interventions)	494,792	539,297	3,943,272
Specific “accessible ” populations not disaggregated by type	7,893,862	517,335	3,572,076
specific “accessible ” populations n.e.c.	1,644,434	550,128	6,088,872
Sub-total	**208,021,850**	**2,416,529**	**22,603,286**
General population			
General adult population (older than 24 years)			
Male adult population	2,080,024	1,480,722	1,546,951
Female adult population		181,282	27,020
General adult population (older than 24 years) not disaggregated by gender	141,889,293	24,320,388	2,083,786
Children (under 15 years)	5,780,682	372,769	4,786,546
Young men	2,285,753	1,937,453	4,064,699
Young females	423,869	637,490	1,409,572
Youth (age 15 to 24 years) not disaggregated by gender	3,136,495	6,649,018	6,674,759
General population not disaggregated by age or gender.	123,158,229	115,808,683	81,822,704
Sub-total	**278,754,345**	**151,387,805**	**102,416,037**
Non-targeted interventions	**30,939,931**	**48,987,053**	**54,972,030**
Specific targeted populations not elsewhere classified (n.e.c.)	4,155,507	32,020,041	21,974,721
Grand total	**854,175,028**	**993,285,628**	**857,829,477**