07

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

*NASA Classifications for the measurement of HIV financing flows and expenditures*

PRE PUBLICATION

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UNAIDS
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**National AIDS Spending Assessment:** National AIDS Spending Assessment (NASA) Classification Tables
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The coordinators of this document welcome questions and comments, regarded as a valuable contribution to improve its contents. Feedback and suggestions may be addressed to: UNAIDS / Aids Financing & Economics Division / Resource Tracking, Needs & Costing Unit. email: *rtdata@unaids.org* or fax: +41 22 7914 798.

# Contents

# Acknowledgements

This abbreviated version of the *Notebook on methods, definitions and procedures for the measurement of HIV and AIDS financing flows and expenditures at country level* presents a short conceptual guidance and the classifications used describe the financial flows and expenditures related to HIV in low- and middle per capita income countries.

This guide, as well as the more detailed publication, represents the contribution of many people from different countries and organizations engaged and interested in the assessment and implementation of programs dealing with HIV, expressed in money terms.

The National AIDS Spending Assessment (NASA) is inspired from broader social accounting systems. Its methods are mainly based on principles sustaining the *System of Health Accounts* (SHA) and other approaches to meso- and macro-accounting, including *Government Finance Statistics* (GFS), *Social Protection Accounts, Household Income and Budgets* and the *System of National Accounts* (SNA). These principles are adapted to institutional constraints identified when tracking the projected needs and actual outlays in countries with middle- to low-per capita income.

The *Notebook* benefits from previous approaches to measuring expenditures for specific diseases, principally the National AIDS Accounts (NAA) conducted and developed by the Regional AIDS Initiative for Latin America and the Caribbean (SIDALAC) as well as the HIV/AIDS subaccounts supported by the USAID-funded Partners for Health Reform (PHR*plus*) project. The relevant methodological concepts are described in the more detailed *NASA Notebook*, which attempts to provide a high level of autonomy to implement NASA: these are also outlined in this shorter document.

This summarized guide harmonizes the multiple definitions related to HIV and AIDS programmes that are referred to in these manuals. It standardizes (in the statistical acceptance of that concept) the interventions or activities designed to combat the spread of the disease and to alleviate its social consequences. This innovation is principally captured in the AIDS Spending categories (ASC). The ASC classification was designed to measure all HIV programmes or activities conducted at country level that are part of the HIV response. That measure therefore is the main focus of the assessment. The effectiveness of the spending flows and how effectively funds are mobilized are key issues the society of nations has to address without prejudice for other issues, such as the productivity of the delivery institutions.

Furthermore, the use of the funds (classified by AIDS Spending Categories) is to be compared with the projected financial needs that low- and middle-per capita income countries need to fulfill as part of their ambition to raise the health status of their population on par with other development goals in the social and welfare, education, labour, etc. These constitute a desirable and holistic response to HIV and AIDS.

Like all accounting approaches, NASA relies on classifications. The proposals establishing the classifications have been discussed and approved by members of the UNAIDS Global Resource Tracking Consortium at its meeting held at UNAIDS headquarters in September 2005. Comments and suggestions on the draft *Notebook* have been received during many NASA workshops conducted during 2005 and 2006 in Geneva, Moscow, Cape-Town, Accra, Bangkok, Dakar, Jakarta, New Delhi, Gaborone, Guatemala City, Zanzibar, Chavannes de Bogis, Calabar and Maputo. Formal and informal

consultations of social scientists, statisticians and stakeholders in the global response to HIV have also contributed to greater precision in the terminology used and to clarifications of well-intended but somewhat abstruse concepts. The UNAIDS Global Consortium has taken stock of achievements and consolidated agreements at its meeting in September 2006.

Considerable coordination efforts have been made as part of the harmonization and alignment of the tools available at country level. For instance, there has been an alignment process between NASA and the HIV sub-accounts work developed by the World Health Organization and USAID-funded Health Systems 2020 (HS 20/20). Three documents are aspiring to become the guidelines for national teams who will be developing NASA in the future:

- this summary guide on concepts and presentation of classifications
- a crosswalk between National Health Sub-Accounts and NASA
- a detailed and more extensive *Notebook on methods, definitions and procedures for the measurement of HIV and AIDS financing flows and expenditures at country level.*

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# Foreword

Different departments in the UNAIDS Secretariat work together in building national and regional capacity for tracking financing flows and expenditures regarding interventions aimed at the HIV epidemic by providing a transparent methodology that is accessible to all and easy to implement. The AIDS Financing and Economics division of the Evidence, Monitoring and Policy department at UNAIDS headquarters supports the development of the National AIDS Spending Assessment (NASA) tool as parts of its policy mandate.

Central to this strategy is the production of a standard reference document – this summary guideline on the classification and basic definitions and the longer *Notebook that provides the overall framework* –, as well as the training and didactic materials helping in strengthening competence and capacity at regional and country levels. A third document will link NASA and NHA in order to ensure that the HIV-Health resource tracking is measured consistently by NASA(health components) as well as by the NHA HIV sub-accounts, which thus convert themselves in the same tool at disposal to the use of countries.

A Global Resource Tracking Consortium comprising the UNAIDS Secretariat and facilitators (experts working in the field as well as observers from countries providing external resources) has been set up to accelerate a consensus on a reliable resource flows' data collection method, on the evaluation of estimates and on projections collected disseminated or used by the international community. The Consortium is a forum to discuss data availability, the appropriateness of the assumptions made and a range of estimating methods used by resource trackers.

Workshops have helped (and are expected to continue helping) the training activities of UNAIDS, the World Bank, Regional Development Banks and other competent institutions' counterparts. As part of their daily activities in their national AIDS Coordinating Authority or cross-national data file, these actors maintain and expand a continuous information system tracking the use of financial resources earmarked to diminish the spread of the disease, to alleviate its impact, to reduce premature deaths and to support social mitigation.

Systemic tracking of HIV expenditure has become a matter of urgency with regard to the development and monitoring of national policies and to agencies providing assistance to the national HIV responses.

The budgetary process at work in all nations of the world, in compliance with requirements instilled by the International Monetary Fund (IMF), by the World Bank (WB), by the Regional Development Banks (AfDB, ADB, CDB, EBRD, IaDB, IsDB, etc), by the United Nations Development Program (UNDP), by the Global Fund for AIDS, Malaria, and Tb (GFATM), by other intergovernmental institutions, by several bilateral aid programs and through global schemes such as the High Indebted Poor Countries (HIPC) initiative, global objectives such as the Millennium Development Goals (MDG), require an integrated measurement of the cost of programs and of the financial response to societal challenges.

NASA is designed as a core-tracking tool for these monitoring and evaluation mandates without displacing or attempting to substitute the use of any other method or tool already in use.

Like other international manuals, NASA plays a role in compensating for real or potential gaps in the capacity of many nations to account for public policies, given the difficulty of internationally sponsored programmes of delivering a thorough evaluation of their programmes. Many abide by the UNAIDS "Three Ones" principle: *One agreed AIDS action framework*, that provides the basis for coordinating the work of all partners; *One national AIDS coordinating authority* with a broad-based multi-sectoral mandate; *One agreed country-level Monitoring and Evaluation System*.

Constructed as an instrument that monitors HIV services and interventions which change over time, NASA must deal with the challenges of measuring long-term effects, multi-sector responses and continuous inclusion of state-of-the-art actions in the national responses to AIDS. These extend beyond the boundaries of a disease monitored by health accounts: the recognition of the extreme demographic consequences and social risks. A necessary reference to investment in human capital, constitutes a key contribution of the assessment approach when it is compared with other instruments that deal with the cost of AIDS. The construction of NASA thus borrows here or there a leaf from *Social Protection Accounts* developed in higher per capita income countries, it interfaces with *Labour Market Accounts* and with *Public Expenditure Reviews*, it touches on a *Satellite Account* that would focus on *household income and spending*.

NASA can also be useful to document information about the supplementary nature or *additionality* of international financial assistance, whose strategic importance as a catalyst and as a promoter of action often exceeds its quantitative share in the mobilization of resources by society. As a primary tool to be used by each National AIDS Coordinating Authority, NASA is expected to provide recurrent information on a country's financial absorptive capacity, and basic information to start the analyses on structural bottlenecks, as well as on issues about the equity, the efficiency and the effectiveness of the resource allocation process. These are all essential aspects in a strategic information system aimed at supporting an expanded and effective response to HIV, as well as empowerment of the communities interested in an effective and prompt response.

There is no unique approach to accounting. Accountants face constraints in developing instruments, including timeliness, data collection costs, maintenance costs, accessibility to basic information on the intelligibility of the HIV response system. Each accounting approach is a unique combination of attributes and constraints, which this summary guide aims to make as clear as possible with regard to the issues involved. The following chapters and annexes are designed as independent segments that are part of the overall monitoring concept. Indeed, some users of this guide may be concerned only by specific aspects. A brief system description covering the construction of the NASA categories introduces the objective and the model on which this approach is based.

Classifications, definitions, matrices and models evolve over time. NASA has been designed as a tool to observe, to collect, to estimate, to organize information and to increase the intelligibility of the responses created by the spread of a virus. Behaviours have changed in the twenty-five years since society suddenly became aware of the catastrophic consequences of the spread of HIV and AIDS. The instruments have therefore designed to describe the environment and to quantify continuity and change in the responses generated by society. Much the same is observable for all economic and social activities.

NASA occupies a distinctive position on the Accounting and Statistics chessboard. Typically, accounts are constructs which track transactions at the level of units of financing, units of production or units of consumption, which intersect the flows observed in one dimension with those observed in another dimension, which reconstitute and cross-classify comprehensively and consistently all paths to understanding the behaviour at work.

As the epidemic is unique, as the mobilization to attempt its control and reversal is unique, as the vision to generate a reversal of the scourge is unique, so is the observation tool. So is the total sum of rules and constraints designed to track the flows affected to that containment and to assess the size of that effort. To sum up, the NASA tool sometimes has to address these characteristics in unique ways when dealing with AIDS, which is claimed to be exceptional.

# Abbreviations and acronyms

| | |
|---|---|
| ADB | Asian Development Bank |
| AfDB | African Development Bank |
| AIDS | Acquired Immune Deficiency Syndrome |
| ARV | Anti-retroviral drugs |
| ASC | AIDS Spending Category |
| ART | Anti-retroviral therapy |
| ATC | Anatomical Therapeutic Chemical classification |
| BCC | Behavioural Change Communication |
| CDB | Caribbean Development Bank |
| CIDA | Canadian International Development Agency |
| COFOG | Classification of the Functions of Government |
| COICOP | Classification of Individual Consumption by Purpose |
| COPNI | Classification of the Purposes of Non-Profit Institutions Serving Households |
| DAC | Development Assistance Committee (of the OECD) |
| DFID | Department for International Development (of the United Kingdom) |
| EBRD | European Bank for Reconstruction and Development |
| FA | Financing agents |
| FBO | Faith Based Organization |
| FS | Financing Sources / financing pools |
| GDP | Gross Domestic Product |
| GFS | Government Finance Statistics |
| GFTAM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GGE | General Government Expenditure |
| GTZ | Gesellschaft für Technische Zusammenarbeit (of Germany) |
| HIPC | Heavily Indebted Poor Countries |
| HIV | Human immunodeficiency virus |
| IADB | Inter-American Development Bank |
| ICD | International Classification of Disease (unless otherwise noted, 10th Revision) |
| ICHA | International Classification for Health Accounts |
| IDU | Injecting drug user |
| ILO | International Labour Organization |
| IMF | International Monetary Fund |
| IsDB | Islamic Development Bank |
| ISIC | International Standard Industrial Classification (unless otherwise noted, 3rd Rev.) |
| MARP | Most at Risk Populations |
| MDG | Millennium Development Goals |
| MSM | Men who have sex with men |
| NAA | National AIDS accounts |
| NAC | National AIDS Commission |
| NAP | National AIDS Programme |
| NASA | National AIDS Spending Assessment |
| n.e.c. | not elsewhere classified |
| NGO | Non-Governmental Organization |
| NHA | National Health Accounts |
| NPISH | Non Profit Institutions Serving Households |
| n.s.k. | not specified by kind |

| | |
|---|---|
| OECD | Organisation for Economic Cooperation and Development |
| OI | Opportunistic infection |
| OVC | Orphans and vulnerable children |
| PEP | Post-exposure prophylaxis |
| PF | Production factors / Resource costs in HIV and AIDS |
| PG | Producers Guide (*Guide to produce National Health Accounts*) |
| PHR*plus* | Partners for Health Reform *plus* |
| PLHA | Persons living with HIV |
| PMTCT | Prevention of mother to child transmission |
| PS | Provider (in the National response to HIV classification) |
| SIDA | Swedish International Development Cooperation Agency |
| SHA | System of Health Accounts |
| SIDALAC | Latin American and Caribbean monitoring of HIV and AIDS |
| SNA | System of National Accounts (unless otherwise noted 93 revision) |
| STI | Sexually transmitted infections |
| SW | Sex work, commercial sex, sale of sexual services, clients of- |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDOC | United Nations Office on Drugs and Crimes |
| UNGASS | United Nations General Assembly Special Session |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| UNOCHA | United Nations Office for the Coordination of Humanitarian Affairs |
| WB | World Bank |
| WFP | World Food Programme |
| WHO | World Health Organization |

# *1. Introduction*

1.1 This document condenses the essentials of the methodology and classification of a National AIDS Spending Assessment (NASA) framework. NASA is designed for tracking and measuring resources of the national responses to the HIV epidemic. These are further elaborated in the *NASA Notebook* (forthcoming).

1.2 NASA seeks to ascertain the source of funds used to finance national responses to the HIV epidemic. To achieve this objective, the resource tracking process follows the financial transactions from its source down to the final destination (i.e. the beneficiaries receiving goods and services).

1.3 NASA is not limited to tracking health expenditures for HIV. It also tracks non-health expenditures such as social mitigation, education, labour, justice and other sectors' expenditure related to HIV (multi-sectoral HIV response).

1.4 NASA aims to serve as an assessment and planning tool. It generates information useful for the decision-making process and for the design of policies aimed to reduce the HIV epidemic.

1.5 NASA combines bottom-up and top-down estimation procedures. Bottom-up estimation involves building up estimates from local unit data, whereas top-down estimation involves building down estimates from larger aggregates. To respond in a timely fashion to requests from planners and policy evaluators, NASA collates figures originating from a myriad of sources by standardizing their diversity as well as possible.

1.6 NASA facilitates a standardized reporting method of indicators that monitor progress towards achieving the targets of the Declaration of Commitment adopted by the United Nations General Assembly Special Sessions on HIV and AIDS (UNGASS I & II).[1]

1.7 Though not an all-in-one tool, NASA supports the UNAIDS "Three Ones" principle[2]. Delivering strategic information for the management of the National Response to HIV and AIDS by a single National AIDS Coordinating Authority that provides crucial input for the framework of action and is part of the construction of a single Monitoring and Evaluation framework.

1.8 As mentioned above, this document is limited to the basic structure of the methodology and to the introduction of its classifications. Classifications have proved in the past 25 centuries to be at the root of most scientific endeavours and of the progress of knowledge. This is why considerable effort has been made in framing and testing the NASA classifications, which are the purpose of this release (and the subject matter of workwhops

[1] [References of UNGASS I & II Declarations]

[2] The "Three Ones" principle for the coordination of national HIV and AIDS responses relates to *One agreed AIDS action framework*, that provides the basis for coordinating the work of all partners; *One national AIDS coordinating authority* with a broad-based multi-sectoral mandate: *One agreed AIDS country-level monitoring and evaluation system*.

designed to spread their use and to validate them further through usage). In addition, the classification tables features an "equivalency" column that lists the corresponding classifications used by the National Health Accounts (NHA) HIV/AIDS subaccounts. This is intended to facilitate the ability of health accountants to produce NASA tables and for NASA producers to export the estimates to NHA tables. Further description of how the two frameworks are linked is provided in a forthcoming document entitled "Linking NASA and NHA."

# 2. Conducting NASA: Organization and set-up, data collection, processing and reporting

## Three dimensions

2.1 In NASA, financial flows and expenditures related to the National Response to HIV and AIDS are organized according to three dimensions: finance, provision and consumption. These dimensions incorporate six categories:

Finance

1. Financing agents (FA) are entities that pool financial resources to finance programmes of provision of services

2. Financing sources[3] (FS) are entities that provide money to financing agents

Provision of HIV/AIDS services

3. Providers (PS) are entities that engage in the production, provision and delivery of HIV/AIDS services

4. Production factors / resource costs (PF) are inputs (labour, capital, natural resources, know how and entrepreneurial resources)

Use

5. Spending categories (ASC) are HIV/AIDS related interventions and activities

6. Beneficiary segments of population (BP), e.g., men who have sex with men, injecting drug users, etc..

2.2 The NASA methodology involves, however, a triangulation organized from different angles of vision, between spending and provision, spending and financing, provision and financing. At the minimum a cross-classification between spending categories and the origin of the funds mobilised. A cross-sectional mapping procedure of the resources and uses, the intake or receipts and uses or consumption of the three constitutive elements of a system:

- entities organising and ensuring the financing of that organisation

- a population group expressing a demand

- producers group responding in a systemis and systematic way the demand expressed by the population

[3] NASA focuses, by design, on the annual and direct burden of HIV and AIDS. An indirect measure and total cost require more information than what this guide lists, e.g. information about the educational attainment / achievements of HIV positive persons. The damage observed in premature loss of life observed in population pyramids can, for instance, not yet be fully assessed as death records do not collect information with relevant parameters such as educational attainment.

contributes to ensure a comprehensiveness of the assessment, as well as consistency, neutrality in respect of mode of financing and mode of production, and a minimization of the risks of double counting. Combing the diverse registries accessible in each country, the procedure also accelerates the accessibility to a synthesis by a triangulation process filling gaps and facilitating the imputation of lacunae in the distinct measurements of the system's constitutive elements.

## Conducting NASA

2.3 The procedure reported below constitutes an idealised and simplified approach. It has five steps: planning, data collection, data processing, data analysis and reporting.

### *Step 1: Planning*

2.4 During the planning step, the strategy, implementation and timetable are described. The sources and key informants are identified and selected. The methodological basis to produce NASA must be shared by the national teams.

2.5 Data can be obtained from public and private secondary (studies, reports, annual and periodical publications) and primary (household and specific surveys) sources. The data collection strategy is designed, the data collection forms are adapted, the initial analysis plan is formulated and the activities are programmed. The formats to record the progress reached as results are obtained.

2.6 The feasibility of NASA relies on background information, identification of key players and potential information sources, 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.

### *Step 2: Data Collection*

2.7 In the data collection phase, the progress level is recorded for each estimation component, and specific formats allow the generation of checklists to be filled by the supervisors during the data collection process. Quality control forms to cross-check the data collected are also used. The addresses and names of contact persons of collaborating entities are recorded. The information framework is completed, including demographic, epidemiological and economic data to help the estimation process. Detail should be recorded about the contact with institutions, the follow up on the data collection process, and the quality control of the gathered data.

2.8 NASA accountants are strongly urged to keep internal records about the actual steps of their exercise so as to improve the memory of the first exercise, facilitating a repeat thereafter, so as to develop shortcuts in subsequent exercises, so as to anticipate improvements in each vintage of NASA.

### *Step 3: Data Processing*

2.9 Collected data can be organized according to NASA matrices with assistance of the NASA-RTS software. The data inputs reconstruct each one of the transactions, allowing the data to be cross-checked, information gaps to be filled and inconsistencies or double counting to be removed. The main products of this step are double-entry tables describing HIV and AIDS financial flows in several combinations of entities.

2.10 The approach permits an easier input of data from different sources and contexts, and assists the national teams in the cross checking of the estimates. It also facilitates compliance with the consistency and comparability criteria /or attributes along time and across countries criteria, as it has a standardized categories structure, validated and refined by national experience.

2.11 When preparing a report on NASA transactions, accountants are required to indicate measurement conventions susceptible to affect the interpretation of the burden sustained or the incidence of financing scheme on the relative position of population segments

***Step 4 - Data Analysis***

2.12 When the financing and expenditures flows are completed and cross-checked, indicators may be calculated that relate HIV and AIDS expenditures with other figures, such as national health expenditure, population and the number of people living with HIV and AIDS.

2.13 Where the will of transparency prevails and statistical records permit, the monitoring of spending is accompanied by analyses of the beneficiaries, by analyses of the provision process and by analyses of the underlying financing flows

***Step 5 - Reporting***

2.14 A NASA report ideally includes matrices, summary tables, auxiliary tables and synthetic indicators which facilitate the situation analysis and exposition to selected audiences. The matrix system for reporting allows multiple combinations. The most frequent double entry tables to report results are:

1. FS x ASC — Financing Sources by AIDS Spending Category
2. FA x ASC — Financing Agents by AIDS Spending Category
3. PS x ASC — Providers by AIDS Spending Category
4. FA x PS — Financing Agents by Providers
5. PS x PF — Providers by Resources Costs
6. ASC x BP — AIDS Spending Category by Beneficiary Populations

2.15 When preparing a report on NASA transactions, accountants are required to indicate measurement conventions susceptible to affect the interpretation of the burden sustained or the incidence of financing scheme on the relative position of population segments

2.16 A NASA report can be used to analyse in a consistent, homogeneous and timely way nation's spending on

- repairing part of the damages the AIDS diagnostics causes to the health of individuals and its consequences on dependents

- containing the spread of the disease

- preventing its further expansion

information that can be used for decision-making purposes..

## Classifications

2.17 Classifications constitute the conduct through which NASA assesses first and foremost the expenditure on programs designed to implement the national response to HIV and AIDS. Beyond that target, NASA generates a first set of cross-sectional matrices designed to assess how that use of resources compares with the resources invested in provision and how expenditure on production factors or on providers coincides with the financial efforts of the nation. The classifications are thus a means to an end, an instrument to check the comprehensiveness, the consistency, the neutrality {in respect of financing and mode of delivery}, the plausibility of single dimensions. The cross-classifications inform rather on the coherence of the system and its axes.

2.18 In NASA, transactions are allocated to exactly one category without duplication or omission, that is, categories of the NASA classification are mutually exclusive and exhaustive. Mutually exclusive means that each transaction cannot be allocated into more than one category (there is no duplication). When categories are not mutually exclusive they overestimate spending by double counting some transactions. Exahustiveness means that each and every transaction can go into one category (there is no omission).

2.19 Where relevant and feasible, the classifications rely on international agreed sectoring, financing and production concepts and nomenclatures. Pertinent official statistics can thus readily be used and specific estimates collated, that respect the international standards easily integrated in a comparative framework.

2.20 The main classifications adopted are ISIC (the International Standard Industrial Classification 3rd Revision), COFOG (the Classification of the Functions of Government), COICOP (the Classification of Individual Consumption by Purpose), COPNI (the Classification of Non-Profit Institutions), CPC (the Central Product Classification), but also ICD (the International Classification of Diseases), ATC (the Anatomic Therapeutic Classification), ICHA (the International Classification of Health Accounts comprising principally two financial vectors, one fully operational, one partly described in the *Guide to Producing National health Accounts with special applications for low-income and middle-income countries* (WB, WHO, USAID, 2003); a provision vector, one fully operational, one partly described in the PG; and a final use vector which for NASA is specific, expressing the implementation of the national response to HIV and AIDS rather than conventional outputs). When deviations or differences from the standard references occur, they are noted.

# 3. Classifying the three dimensions that integrate NASA:

**Consumption / Final use** (AIDS Spending Categories and Beneficiaries)
**Production** (Providers and Production factors) and
**Financing** (Sources and Agents)

## Objective

3.1 This chapter is designed as a concise presentation of the classifications. The user desiring or needing a more analytical presentation or details on definitions is invited to turn to the *NASA Notebook* (forthcoming).

## Dimensions and Classifications

3.2 As mentioned in chapter 2, NASA methodology involves a triangulation around the three dimensions of Finance, Provision and Consumption in which *transactors* or agents move funds, transform them and dispose of the final product. A govenment budget *pays* for an activity or a household *purchases* from a provider an activity mobilizing *labour* and other *inputs*, including the use of capital equipment, material supplies whose outome is the consumption of the *goods* and *services* by *beneficiary* population segments.

3.3 The **triangulation** proposed between the dimensions of the policy: the consumption of commodities (ASC) –their provision (PF) and the channeling of funds (FA) to acquire the commodities, presents a computational advantage over other forms of analysis, notably a greater assurance at comprehensiveness, an assurance of consistency.

3.4 The classifications for the three dimensions and six categories (supplied in this chapter) constitute the skeleton of the NASA system. They structure in a triangular relationship information as to:

- "what the nation buys" [for most NASA compilers, this is their own country]
- "to which segments of the population the programs are directed?"
- "which activities supply the commodities (services or goods) consumed?"
- "what kind of resources have to be mobilized to achieve these targets?"
- "which agents mobilize the means to finance the national response to HIV and AIDS?"
- "how much the various entities contribute to that end?"

3.5 Each classification organizes and orders a specific part of the information. An accounting model increases the value of transparency, notably in verifying the interface between stakeholders (agents mobilizing financial or real resources and users) and of the system's transactions: intake / budget or funds captation / resources – mobilization / uses / consumption. .

3.6 The triangulation of the financial flows parallels the organization and ordering of physical data collated in relation to the HIV and AIDS epidemic, treatment and care, transmission avoidance, mitigation of the social effect. These indicators are collated

under United Nations auspices (see notably Appendix 6 of UNAIDS/07.12E/JC1318E *Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2008 reporting*).

3.7 The National Funding Matrix in the Core Indicators is constructed with the Aids Spending Categories (ASC) listed in table 3-1 below and with the Financing Sources (FS) listed in table 3-6. The identity between the core indicators and the NASA matrices is not coincidental. It expresses the will to verify the coherence of the programs implemented to combat HIV and AIDS or to mitigate their effects, and of the financial oversight accompanying them.

## *AIDS Spending Categories*

3.8 The principal classificatory principle is one of a functional, budgetary-like aggregation-disaggregation. The **organisation and ordering** of a myriad programmes, public - private as well as conducted by external agents, around a compact set of spending classes, is designed to facilitate an assessment of past response strategies to a major policy challenge and to project a plausible outcome of future spending patterns. After experimentation and after an evaluation of past response strategies to HIV exposure and AIDS diagnosis, and the ways to apprehend the vectors of those strategies, the programs and budget lines have been structured in eight spending classes or chapters of AIDS Spending Categories:

1. Prevention
2. Care and treatment
3. Orphans and vulnerable children
4. Program management and administration strengthening
5. Incentives for human resources
6. Social protections and social services
7. Enablement of environment and community programs
8. Research

3.9 At spending level (including subheadings, not counting the financing modes and the provision modes), 120 programs are identifiable. Definitions relating to the spending categories are in the Notebook. The main classes of financing agents – familiar to all stakeholders accountable for HIV and AIDS programs – constitute also the backbone of the financing sources classifications.

## Measurement

3.10 Blank cells confuse the users. When spending programs or “purchasing (paying)” agents are not present in a country reporting a NASA, the corresponding cells (in row and/or in columns) should be marked “0”. Cells for which an entry is expected but void of information should be indicated “n.a.” (not accessible / not available). Non-observed data and imputed data should likewise be documented. Multiple causes explaining these entries, the meta-data (sources and methods or table footnotes) are a more likely locus for that indication.

3.11 The classifications listed are very detailed, a larger breakdown than is typically accessible. Where records are well kept, they tend to be so at a fine level of breakdown. When details are accessible that are not listed, they can be reported identifying a category without entry; meta-data should explain what is not evident from the labels. When an ASC entry for which a desegregation considered desirable cannot be split, this should be reported as ".98" (not disaggregated, not specified by kind). When an estimate is unclassifiable due to data dearth and/or lack of specification in the classifications, it should be entered under ".99" (n.e.c. not elsewhere classified). When estimates are not accessible at the finest levels of detail (3 or more digits), an attempt should be made at the nest level of disaggregating. Categories ".98" do not violate the principle of mutually exclusiveness, since when tracking goods and services consumed, for each expenditure tracked, the data will be entered once, either disaggregated, or either not disaggregated by kind (".98").

3.12 As perceived, the national response to HIV and AIDS is financed by public programs, external assistance and private entities (philanthropic institutions, corporations and households). This response is largely carried out by public and by non-profit institution providers with a sizeable delivery of private practitioners in respect of treatment and care. The Financing and Provider classifications attempt to focus on these providers without, however, precluding the interventions of other agents. For use inside their national boundaries, accountants may skip rows or columns of financial intermediaries or provider subclasses that do not fit their situation; for international reporting, the codes proposed should preferably be used even when the sequence is not continuous in order to reduce the risk of errors when several countries' experience is being aggregated. That proposal also applies to detailed list of external financing agents in the tables 3-5 and 3-6 below.

3.13 The absolute measurement of spending on HIV and AIDS, proposed around the classifications listed below, is doubled up with a **relative measurement**: HIV and AIDS spending (ASC) against the total spending of the nation (proxied by the Gross Domestic Expenditure), against total public expenditure, against global social spending, against total expenditure on health and other meso-economic or social entities.

3.14 The majority of the countries associated to the pursuit of Millennium Development Goals (which, at the horizon of 2015, aims at a reversal of the incidence of AIDS) comply with the macro-economic (GDP and components), the public finance (GGE, general government expenditure), and the demographic denominators (total population) defined by the United Nations Statistics Division and by the International Monetary Fund notably. As most countries abide by the manuals to compile statistics and accounts produced by these institutions, the requisites of *relative* measurement of the HIV and AIDS – the denominators – need thus not be reproduced in this abridged manual.

3.15 The WHO has been releasing estimates of health financing and health spending since 2000. These provide a handy reference for one of the denominators sought (see *World Health Report. World Health Statistics* reprints the *relative* ratios, the website www.who-int/nha supplies absolute values in millions of National Currency Units) These institutions report data with a certain time lag after the end of the financial year (calendar year). The references cited are thus for the previous financial/fiscal year. When reporting NASA for the most recent year, it will often be necessary to access the denominators from national sources using definitions consistent with the international guidelines cited.

## National Health Accounts (NHA) and NASA Codes

3.16 When an AIDS Spending Assessment is conducted in the context of the National Health Accounts framework –which are a more recent accounting construct–, it is appropriate to note the corresponding NHA codes for entities or transactions which exert similar functions in the health system. While principally concerned with health-related HIV/AIDS activities, the data collection process used for the NHA HIV/AIDS subaccounts can be used to capture non-health data (as addendum items) so as to inform NASA. For example should a NGO survey be conducted for NHA purposes, questions may be added to ask respondents about their nonhealth HIV/AIDS spending (e.g. income support, legal services for PLWHA). In the following series of tables, the first column describes the NASA code and the second column lists the corresponding NHA code (except for Beneficiaries for which the selection criteria is specific to HIV and AIDS populations). The NHA codes are based on the *Guide to Produce National Health Accounts,* Geneva, WHO, 2003 (PG), which is based upon *A System of Health Accounts,* Paris, OECD, 2000 (SHA). The PG codes refer to those HIV/AIDS health activities/entities. Where a "**y**" follows a NHA code, this is intended as a placeholder for the creation of a new subcategory- the number of which is dependent on the national context. If there are two categories e.g. HC.6.3.**y** community mobilization. " and HC 6.3.**y** ABC," the "y" will be different for each category (as per NHA norms) and so "community mobilization" may be HC 6.3.**1** and "ABC" HC.6.3.**2**. Where a non-health activity/entity is listed under NASA, the second column will list the category as an "addendum" item.

3.17 In the real world, the health function and the programs of NASA overlap in respect of care. As the treatment of patients with HIV-related illness in most countries is only a small part of the health function, the reference to the PG code in the second column of the tables below should be understood as *part of the [code listed]*. For example, in the NASA table 3.5, the ASC.1.0.5 code of the NASA classification refers to HIV Prevention - Youth in school. The second column of the same table indicates that the latter code should be understood as part of the HS.6.2 code (ICHA-HC classification) that refers to school health servicesWhen such a breakdown exists in a country, the code may naturally be added. When a country's records permit to disaggregate further a spending category included in NASA, additional ventilations are advisable for domestic policy analysis purposes, as well as a possible pointer other countries may wish to emulate in subsequent NASA compilations.

3.18 Departures from the shared framework should be documented. This is designed mainly to facilitate a subsequent conduction of ad hoc studies with, however, a strong facet of continuity and/or recurrence. The interpretation of cross-country comparability gains also. Country-specific institutions gain to be spelled out. Part of the constituency for a NASA may not be familiar with the institutions embedded in a national response to HIV and AIDS, part is familiar. Different stakeholders may have a different understanding of their system's subtleties. Though NASA already results in a clarification of stances, in a better communication between stakeholders, the road is still uphill.

3.19 Large entities (e.g. a central government) should preferably be broken into specific statistical / budgetary units and specific extra-budgetary units. A proper implementation of NASA conduces to a thorough inventory of agents intervening in the national response and of their transactions.

## NASA Classifications

3.20 The classifications listed are designed to cover comprehensively and consistently the AIDS spending categories (ASC), the provision of services (PS) and the financing transactions (FA). No cross-national system matches exactly all national institutions and mechanisms developed to pursue shared goals. Additional classifications such as beneficiary populations (BP) can be used to organize expenditures data by demographic and specific characteristics of the beneficiary population.

3.21 The classifications are intended as a tool to organize the information accurately and in a neutral way. They do not dispense national statisticians from adapting the tool to the culture and environment of their nation, using the meta-data route (sources and methods, footnotes, other) to increase transparency, and to facilitate comparative use when and where needed.

3.22 All NASA spending categories (ASC) are part of the national economy. A ratio ASC to GDP is thus genuine as are ratios between NASA and partial representations of the economic and social system, principally the health system and the social protection system. The individual entries in the NASA classifications use the conventional definitions of the United Nations and specialized U.N. family institutions, augmenting the precision of these definitions or complementing them when required.

3.23 In table 3.1, italicized codes, and/or labels - abridged content descriptions indicate a supplementary breakdown or a new label of the original AIDS Spending Category label listed in the UNAIDS National funding matrix in *Guidelines on Construction of Core Indicators, 2008 Reporting* without change in the contents of the Table 3.1 entries.

| **Table 3.1 - AIDS Spending Categories [4]**<br>**PREVENTION, CARE, TREATMENT, SUPPORT AND SOCIAL MITIGATION** | | |
|---|---|---|
| **NASA code** | **PG code** | **Label and abridged content description** |
| **ASC.1** | **Sub-total** | **PREVENTION** |
| ASC.1.01 | HC.6.3.y +addendum | Communication for social and behavioural change (excluding similar activities within categories ASC.1.04, ASC.1.07 to ASC.1.11) |
| *ASC.1.01.1* | *HC.6.3.y* | *Health Communication for social and behavioural change: programmes targeting the health risks of HIV prevention campaigns* |
| *ASC.1.01. 2* | *Addendum* | *Non-health Communication for social and behavioural change: programmes targeting the non-health risks addressed in HIV prevention campaigns and any other mass media-related activities whose contents are not within the boundaries of health (as described in NHA), e.g. the social drivers of HIV infection* |
| *ASC.1.01.98* | *Addendum* | *Not-Disaggregated Communication for social and behavioral change: If it is not possible to disaggregate according to health or non-health contents* |
| ASC.1.02 | HC.6.3.y | Community mobilization |
| ASC.1.03 | HC.6.3.y | Voluntary counselling and testing excluding VCT services targeted to populations in ASC.1.04, ASC.1.07 to ASC.1.11 and ASC.1.17) |
| ASC.1.04 | HC.6.3.y | Risk-reduction for vulnerable and accessible populations[5] excluding those populations targeted by categories ASC 1.05-1.11 [6] |
| *ASC.1.04.1* | *HC.6.3.y.y* | *VCT as part of programmes for vulnerable and accessible populations* |
| *ASC.1.04.2* | *HC.6.3.y.y* | *Condom social marketing, public and commercial sector provision of condoms as* |

[4] ASC1-4, AC6-8 excludes monetary incentives for staff, which are explicitly included in ASC 5.
[5] Previously labelled: Programmes for vulnerable and special populations.

| | | |
|---|---|---|
| | | *part of programmes for vulnerable and accessible populations*[7] |
| *ASC.1.04.3* | *HC.6.3.y.y* | *STI prevention and treatment as part of programmes for vulnerable and accessible populations* |
| *ASC.1.04.4* | *HC.6.3.y.y* | *BCC/IEC as part of programmes for vulnerable and accessible populations* |
| *ASC.1.04.98* | *HC.6.3.y.y* | *Programmatic interventions for vulnerable and accessible population not disaggregated by type* |
| *ASC.1.04.99* | *HC.6.3.y.y* | *Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c.)* |
| ASC.1.05 | HC.6.2 | Prevention - Youth in school |
| ASC.1.06 | HC.6.3.y | Prevention - Youth out-of-school |
| ASC.1.07 | HC.6.3.y | Prevention of HIV transmission aimed at persons living with HIV (PLHA) |
| *ASC.1.07.1* | *HC.6.3.y.y* | *Counselling as part of programmes aimed at persons living with HIV (PLHA)* |
| *ASC.1.07.2* | *HC.6.3.y.y* | *Condom social marketing, public and commercial sector provision of condoms as part of programmes aimed at persons living with HIV (PLHA)*[8] |
| *ASC.1.07.3* | *HC.6.3.y.y* | *STI prevention and treatment as part of programmes aimed at persons living with HIV (PLHA)* |
| *ASC.1.07.4* | *HC.6.3.y.y* | *BCC/IEC as part of programmes aimed at persons living with HIV (PLHA)* |
| *ASC.1.07.98* | *HC.6.3.y.y* | *Programmatic interventions for vulnerable and accessible population not disaggregated by type* |
| *ASC.1.07.99* | *HC.6.3.y.y* | *Other programmatic interventions aimed at persons living with HIV (PLHA) not elsewhere classified (n.e.c.)* |
| ASC.1.08 | HC.6.3.y | Prevention programmes for sex workers and their clients. |

[7] Condom social marketing, public and commercial sector provision of condoms as part of programmes for vulnerable and accessible population includes all the program costs related to the condom promotion and provision, not only the cost of the fungibles.

[8] Condom social marketing, public and commercial sector provision of condoms as part of programmes for vulnerable and accessible population includes all the program costs related to the condom promotion and provision, not only the cost of the fungibles.

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|---|---|---|
| *ASC.1.08.1* | *HC.6.3.y.y* | *VCT as part of programmes for sex workers and their clients* |
| *ASC.1.08.2* | *HC.6.3.y.y* | *Condom social marketing, public and commercial sector provision of condoms as part of programmes for sex workers and their clients* |
| *ASC.1.08.3* | *HC.6.3.y.y* | *STI prevention and treatment as part of programmes for sex workers and their clients* |
| *ASC.1.08.4* | *HC.6.3.y.y* | *BCC/IEC as part of programmes for sex workers and their clients* |
| *ASC.1.08.98* | *HC.6.3.y.y* | *Programmatic interventions for sex workers and their clients not disaggregated by type* |
| *ASC.1.08.99* | *HC.6.3.y.y* | *Other programmatic interventions for sex workers and their clients not elsewhere classified (n.e.c.)* |
| ASC.1.09 | HC.6.3.y | Programmes for men who have sex with men (MSM) |
| *ASC.1.09.1* | *HC.6.3.y.y* | *VCT as part of programmes for men who have sex with men (MSM)* |
| *ASC.1.09.2* | *HC.6.3.y.y* | *Condom social marketing, public and commercial sector provision of condoms as part of programmes for men who have sex with men (MSM)* |
| *ASC.1.09.3* | *HC.6.3.y.y* | *STI prevention and treatment as part of programmes for men who have sex with men (MSM)* |
| *ASC.1.09.4* | *HC.6.3.y.y* | *BCC/IEC as part of programmes for men who have sex with men (MSM)* |
| *ASC.1.09.98* | *HC.6.3.y.y* | *Programmatic interventions for men who have sex with men (MSM) not disaggregated by type* |
| *ASC.1.09.99* | *HC.6.3.y.y* | *Other programmatic interventions for men who have sex with men (MSM) not elsewhere classified (n.e.c.)* |
| ASC.1.10 | HC.6.3.y | Harm-reduction programmes for injecting drug users (IDUs) |
| *ASC.1.10.1* | *HC.6.3.y.y* | *VCT as part of programmes for injecting drug users (IDUs)* |
| *ASC.1.10.2* | *HC.6.3.y.y* | *Condom social marketing, public and commercial sector provision of condoms as part of programmes for injecting drug users (IDUs)* |
| *ASC.1.10.3* | *HC.6.3.y.y* | *STI prevention and treatment as part of* |

| | | |
|---|---|---|
| | | *programmes for injecting drug users (IDUs)* |
| *ASC.1.10.4* | *HC.6.3.y.y* | *BCC/IEC as part of programmes for injecting drug users (IDUs)* |
| *ASC.1.10.98* | *HC.6.3.y.y* | *Programmatic interventions for injecting drug users (IDUs) not disaggregated by type* |
| *ASC.1.10.99* | *HC.6.3.y.y* | *Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.).* |
| ASC.1.11 | HC.6.3.y | Prevention programmes in the workplace |
| *ASC.1.11.1* | *HC.6.3.y.y* | *VCT as part of prevention programmes in the workplace* |
| *ASC.1.11.2* | *HC.6.3.y.y* | *Condom social marketing, public and commercial sector provision of condoms as part of prevention programmes in the workplace* |
| *ASC.1.11.3* | *HC.6.3.y.y* | *STI prevention and treatment as part of prevention programmes in the workplace* |
| *ASC.1.11.4* | *HC.6.3.y.y* | *BCC/IEC as part of prevention programmes in the workplace* |
| *ASC.1.11.98* | *HC.6.3.y.y* | *Prevention programmes in the workplace not disaggregated by type* |
| *ASC.1.11.99* | *HC.6.3.y.y* | *Prevention programmes in the workplace not elsewhere classified (n.e.c.).* |
| ASC.1.12 | HC.5.1.3.y | Condom social marketing excluding categories ASC 1.08-1.10 |
| ASC 1.13 | HC.5.1.3.y, HC.6.3y, HC.1.3.y | Public and commercial sector male condom provision excluding categories ASC 1.08-1.10 |
| ASC.1.14 | HC.5.1.3.y, HC.6.3y , HC.1.3.y | Public and commercial sector Female condom provision excluding categories ASC 1.08, 1.10 |
| ASC.1.15 | HC.5.1.1.y | Microbicides |
| ASC.1.16 | HC.6.3.y, HC.1.3.y | Prevention, diagnosis and treatment of sexually transmitted infections (STI) (Improving management of STI) excluding categories ASC 1.08-1.10 |
| ASC.1.17 | HC.1.1, yHC.1.3, y HC.6.3.y | Prevention of mother-to-child transmission (PMTCT) |
| *ASC.1.17.1* | *HC.6.3.y..y, HC.1.3..y.y , HC.1.1.y.y* | *Pregnant women counselling and testing in VCT programs* |
| *ASC.1.17.2* | *HC.6.3.2.y.y, HC.1.3.2.y.y* | *Antiretroviral prophylaxis for HIV-infected pregnant women and newborns* |

| | | |
|---|---|---|
| | *HC.1.1.2.y.y* | |
| *ASC.1.17.3* | *HC.6.3.y.y, - HC.1.3..y.y - HC.1.1.y.y* | *Safe infant feeding practices (including substitution of breast milk)* |
| *ASC.1.17.98* | *HC.6.3.y.nsk* | *PMTCT not-disaggregated by intervention* |
| *ASC.1.17.99* | *HC.6.3.y..y, HC.1.3..y.y , HC.1.1.y.y* | *PMTCT activities not elsewhere classified (n.e.c.)* |
| ASC.1.18 | HC.6.3.y | Blood safety |
| ASC.1.19 | HC.6.3.y | Post-exposure prophylaxis (PEP) |
| *ASC.1.19.1* | *HC.6.3.y.y* | *PEP in health care setting* |
| *ASC.1.19.2* | *HC.6.3.y.y* | *PEP after high risk exposure (violence or rape)* |
| *ASC.1.19.3* | *HC.6.3.y.y* | *PEP after unprotected sex* |
| *ASC.1.19.98* | *HC.6.3.y.nsk* | *Post-exposure prophylaxis not-disaggregated by intervention* |
| ASC.1.20 | HC.6.3.y | Safe medical injections |
| ASC.1.21 | Addendum | Male circumcision |
| ASC.1.22 | HC.6.3.y | Universal precautions (when the main or exclusive purpose to implement them is to limit HIV transmission) |
| ASC.1.99 | HC.6.3.y | Prevention activities not elsewhere classified (n.e.c.) |
| **ASC.2** | **Sub-total** | **CARE AND TREATMENT** |
| ASC.2.1 | HC.1.3 | Outpatient care |
| *ASC.2.1.01* | *HC.1.3.y, HC.1.1.y, HC.6.3.y* | *Provider initiated testing and counselling* |
| *ASC.2.1.02* | *HC.1.3.y* | *Opportunistic infection (OI) prophylaxis* |
| *ASC.2.1.03* | *HC.1.3.y HC.1.1.y HC.5.1.y* | *Anti-retroviral therapy* |
| ASC.2.1.03.1 | HC.1.3.y.y, HC.1.1 y.y, HC.5.1.y.y | Adult anti-retroviral therapy |
| - ASC. 2.1.03.1.1 | -HC.1.3..y.y.y | First line ART – Adults |

| | | |
|---|---|---|
| | -HC.1.1..y.y.y,<br>- HC.5.1..y.y.y | |
| - ASC. 2.1.03.1.2 | - HC.1.3.y.y.y<br>- HC.1.1..y.y.y.,<br>-HC.5.1.1..y.y.y | Second line ART – Adults |
| - ASC.2.1.03.1.3 | - HC.1.3..y.y.y,<br>- HC.1.1..y..y.y,<br>-HC.5.1.1..y.y.y | Adult multi-drug ART after 2nd line treatment fail |
| - ASC.2.1.03.1.98 | -HC.1.3..y.y.y,<br>-HC.1.1..y..y.y,<br>-HC.5.1.1.y.y.y | Adult antiretroviral therapy not-disaggregated by line of treatment |
| ASC.2.1.03.2 | HC.1.3.y.y,<br>HC.1.1.y.y,<br>HC.5.1.1.y.y | Paediatric Antiretroviral therapy |
| - ASC.2.1.03.2.1 | - HC.1.3y.y.y<br>-HC.1.1.y.y.y<br>- HC.5.1..y.y.y | First-line ART – Paediatric |
| - ASC.2.1.03.2.2 | - HC.1.3y.y.y,<br>- HC.1.1.y.y.y,<br>- HC.5.1..y.y.y | Second-line ART – Paediatric |
| - ASC.2.1.03.2.3 | - HC.1.3y.y.y,<br>- HC.1.1.y.y.y,<br>- HC.5.1..y.y.y | Paediatric multi-drug ART after 2nd line treatment fail |
| - ASC. 2.1.03.2.98 | - HC.1.3y.y.y<br>-HC.1.1.y.y.y<br>- HC.5.1..y.y.y | Paediatric antiretroviral therapy not-disaggregated by line of treatment |
| ASC.2.1.03.98 | HC.1.3.y.y,<br>HC.1.1.y.y<br>HC.5.1.y.y | Antiretroviral therapy not-disaggregated by age or line of treatment |
| *ASC.2.1.04* | *HC.6.3.y* | *Nutritional support associated to ARV therapy* |
| *ASC.2.1.05* | *HC.4.1.*<br>*HC.1.3.y -* | *Specific HIV-related laboratory monitoring* |

| | | |
|---|---|---|
| | *HC.1.1.y* | |
| *ASC.2.1.06* | *HC.6.3.y*[9] | *Dental programs for people living with HIV* |
| *ASC.2.1.07* | *HC.1.3.y* | *Psychological treatment and support services* |
| *ASC 2.1.08* | *HC.6.3.y, HC.1.3.y* | *Palliative care* |
| *ASC.2.1.09* | *HC.1.4+Addendum* | *Home-based care* |
| ASC.2.1.09.1 | HC.1.4 | Home-based medical care |
| ASC.2.1.09.2 | Addendum | Home-based non medical /non-health care |
| ASC.2.1.09.98 | Addendum | Home-based care not-disaggregated |
| *ASC.2.1.10* | *HP.3.3 x HC.1.3* | *Alternative and informal care and treatment services* |
| *ASC.2.1.99* | *HC.1.3,x* | *Outpatient care services not elsewhere classified (n.e.c.)* |
| ASC.2.2 | HC.1.1 | In-patient care |
| *ASC.2.2.1* | *HC.1.1.y* | *Opportunistic infections' (OI) treatment* |
| *ASC.2.2.99* | *HC.1..1.y* | *In-patient services not elsewhere classified (n.e.c.)* |
| ASC.2.3 | HC.4.3 [10] | Patient transport and emergency rescue |
| ASC.2.99 | HC.1 x | Care and treatment services not elsewhere classified (n.e.c.) |
| **ASC.3** | **Sub-total** | **ORPHANS AND VULNERABLE CHILDREN [11] (OVC)** |
| ASC.3.1 | Addendum | OVC Education |
| ASC.3.2 | HC.1.1<br>HC.1.3<br>HC.6.3 | OVC Basic health care [12] |

[9] For NHA purposes this category is considered as part of general health expenditures but not part of HIV/AIDS health expenditures. As such it would be included in the general NHA but excluded from the HIV/AIDS sub-account. For NASA purposes it is included in NASA when the dental care is provided within a program explicitly subsidized with HIV-allocated resources aimed exclusively at persons living with HIV who do not receive their care with usual practitioners because of discrimination or other similar causes.

[10] For NHA purposes, this refers to designated medical transport or reimbursed private transport. For more details on the definition, please refer to page 119 in the *System of Health Accounts.* (OECD, 2000).

[11] For NASA context, all expenditures to substitute for the parents taking care of their children because of them passing away because of HIV; expenditures incurred in providing social mitigation to all double orphans and half of single orphans need to be included. In this context, vulnerable children refer to those who are close to be orphans and who are not receiving support as orphans because at least one of their parents live and at the same time their parents are too ill to take care of them.

| | | |
|---|---|---|
| ASC.3.3 | Addendum | OVC Family / Home support |
| ASC.3.4 | Addendum | OVC Community support |
| ASC.3.5 | Addendum | OVC Administrative / Organization costs |
| ASC.3.6 | Addendum | OVC Institutional care |
| ASC.3.99 | Addendum | OVC services not elsewhere classified (n.e.c.) |
| **ASC.4** | **Sub-total** | **PROGRAMME MANAGEMENT AND ADMINISTRATION STRENGTHENING** |
| ASC.4.01 | HC.6.3.y +addendum (for nonhealth) | Planning, coordination and programme management |
| ASC.4.02 | Addendum | Programme Administration and Transaction costs associated with managing and disbursing funds |
| ASC.4.03 | HC.6.3.y | Monitoring and evaluation |
| ASC.4.04 | HC.6.3.y | Operations research |
| ASC.4.05 | HC.6.3.y | Serological-surveillance (Serosurveillance) |
| ASC.4.06 | HC.6.3.y | HIV drug-resistance surveillance |
| ASC.4.07 | HC.6.3.y | Drug supply systems |
| ASC.4.08 | HC.6.3.y | Information technology |
| ASC.4.09 | HC.6.3.y | Supervision of personnel and patient tracking |
| ASC.4.10 | HCR.1 | Upgrading and construction of infrastructure |
| *ASC.4.10.1* | *HCR.1.Y* | *Upgrading laboratory infrastructure and new equipment* |
| *ASC.4.10.2* | *HCR.1.Y* | *Construction of new health centres* |
| *ASC.4.10.99* | *HCR.1.Y* | *Upgrading and construction of infrastructure not elsewhere classified (n.e.c)* |
| ASC.4.99 | | Programme management- administration strengthening not elsewhere classified (n.e.c) |
| **ASC.5** | **Sub-total** | **HUMAN RESOURCES' RECRUITMENT AND RETENTION INCENTIVES - HUMAN CAPITAL** |
| ASC.5.1 | RC.1.1.y | Monetary incentives for physicians |

[12] The expenditures to be included under this code refer to those for any children that in principle should be provided by the parents; in their absence, social protection programs pay for their access to basic services. The health services here are not HIV specific. For NHA purposes these expenditures constitute part of the National Health Accounts but not part of the Health-HIV sub-accounts.

| | | |
|---|---|---|
| *ASC 5.1.1* | *RC.1.1.y.y* | *- for prevention* |
| *ASC 5.1.2* | *RC.1.1.y.y* | *- for care and treatment* |
| *ASC5.1.3* | *RC.1.1.y.y* | *- for program management and administration* |
| *ASC. 5.1.98* | *RC.1.1.y.y* | *- not disaggregated or not specified by kind (NSK)* |
| ASC.5.2 | RC.1.1.y | Monetary incentives for nurses |
| *ASC 5.2.1* | *RC.1.1.y.y* | *- for prevention* |
| *ASC 5.2.2* | *RC.1.1.y.y* | *- for care and treatment* |
| ASC5.2.3 | RC.1.1.y.y | - for program management and administration |
| ASC. 5.2.98 | RC.1.1.y.y | - not disaggregated or not specified by kind (NSK). |
| ASC.5.3 | RC.1.1. | Monetary incentives for other staff |
| *ASC 5.3.1* | *RC.1.1.y.y* | *- for prevention* |
| *ASC 5.3.2* | *RC.1.1.y.y* | *- for care and treatment* |
| *ASC5.5.3.3* | *RC.1.1.y.y* | *- for program management and administration* |
| *ASC. 5.3.98* | *RC.1.1.y.y* | *- not disaggregated or not specified by kind (NSK).* |
| ASC.5.4 | HCR.2.y | Formative education to build-up an HIV workforce |
| ASC.5.5 | HCR.2.y | Training |
| ASC.5.99 | RC.1.1.y.y | Incentives for human resources not elsewhere classified (n.e.c.) |
| **ASC.6** | **Sub-total** | **SOCIAL PROTECTION AND SOCIAL SERVICES (EXCLUDING OVC)** |
| ASC.6.1 | Addendum | Social protection through monetary benefits |
| ASC.6.2 | Addendum | Social protection through in-kind benefits |
| ASC.6.3 | Addendum | Social protection through provision of social services |
| ASC.6.4 | Addendum. | HIV-specific income generation projects |
| ASC.6.99 | Addendum | Social protection services and social services not elsewhere classified (n.e.c) |
| **ASC.7** | **Sub-total** | **ENABLING ENVIRONMENT AND COMMUNITY DEVELOPMENT** |
| ASC.7.1 | Addendum | Advocacy and strategic communication |
| ASC.7.2 | Addendum | Human rights |
| ASC 7.3 | HC.6.3.y | AIDS-specific Institutional Development |

| | | |
|---|---|---|
| ASC.7.4 | HC.6.3.y | AIDS-specific programmes focused on women |
| ASC.7.99 | Addendum | Enabling environment and community development not elsewhere classified (n.e.c) |
| **ASC.8** | **Sub-total** | **HIV AND AIDS-RELATED RESEARCH (EXCLUDING OPERATIONS RESEARCH )** |
| ASC.8.1 | HCR.3.y | Biomedical research |
| ASC.8.2 | HCR.3.y | Clinical research |
| ASC.8.3 | HCR.3.y | Epidemiological research |
| ASC.8.4 | Addendum | Social science research |
| ASC.8.5 | HCR.3.y | Behavioural research |
| ASC.8.6 | Addendum | Research in economics |
| ASC.8.7 | HCR.3.y | Vaccine-related research |
| ASC.8.99 | HC.R.3.y | - HIV and AIDS-related research activities not elsewhere classified (n.e.c.) |

## Table 3.2. - Targeted / Intended-Beneficiary populations (BP) [13]

| NASA code | Label and **abridged** content description |
|---|---|
| **BP.1** ***People living with HIV*** *(regardless of having a medical/clinical diagnosis of AIDS)* | |
| BP.1.1 | Adult and Young people (15 years of age and over) living with HIV |
| BP.1.1.1 | Adult and Young men (15 years of age and over) living with HIV |
| BP.1.1.2 | Adult and Young women (15 years and over) living with HIV |
| BP.1.1.98 | Adult and Young people (15 years and over) living with HIV not disaggregated by gender |

[13] The HIV expenditures here listed represent the populations which are explicitly targeted to benefit from specific activities. These are thus, applicable to programs and not to positive externalities or secondary benefits not originally intended by the execution of each program regardless of who eventually might benefits. When no there was not an explicit intention of directing the benefits to a specific population, the expenditures need to be labelled "not targeted". When the target population is not known, it needs to be recorded as non-targeted, since the objective is to explicitly identify the intended beneficiaries. Individuals might belong to more than one category, however, what needs to be classified is the expenditure according to the primary objective of the program depending on the implementation of such programs, e.g. point of the service delivery, type of provider of the services or specific outreach strategy.

| | |
|---|---|
| BP.1.2 | Children (under 15) living with HIV |
| BP.1.2.1 | Boys (under 15) living with HIV |
| BP.1.2.2 | Girls (under 15) living with HIV |
| BP.1.2.98 | Children (under 15) living with HIV not disaggregated by gender |
| BP.1.98 | People living with HIV not-disaggregated by age or gender |
| **BP.2 Most at risk populations** | |
| BP.2.1 | Injecting drug users (IDU) and their sexual partners |
| BP.2.2 | Sex workers (SW) and their clients |
| BP.2.2.1 | Female sex workers and their clients |
| BP.2.2.2 | Male transvestites sex workers (and their clients) |
| BP.2.2.3 | Male non-transvestites sex workers (and their clients) |
| BP.2.2.98 | Sex workers not disaggregated by gender and their clients |
| BP.2.3 | Men who have sex with men (MSM) |
| BP.2.99 | "Most at risk populations" not elsewhere classified (n.e.c.) |
| **BP.3 Other key populations** | |
| BP.3.01 | Orphans and vulnerable children (OVC) |
| BP.3.02 | Children born or to be born from women living with HIV |
| BP.3.03 | Refugees (externally displaced) |
| BP.3.04 | Internally displaced populations (because of an emergency) |
| BP.3.05 | Migrants / Mobile Populations |
| BP.3.06 | Indigenous groups |
| BP.3.07 | Prisoners and other institutionalized persons |
| BP.3.08 | Truck drivers / Transport workers and commercial drivers |
| BP.3.09 | Children and youth living in the street |
| BP.3.10 | Children and youth gang members |
| BP.3.11 | Children and youth out of the school |
| BP.3.12 | Institutionalized children and youth |
| BP.3.13 | Partners of persons living with HIV |
| BP.3.14 | Recipients of Blood or Blood product |
| BP.3.99 | "Other Key populations" not elsewhere classified (n.e.c.) |
| **BP.4 Specific "accessible" populations** | |
| BP.4.01 | People attending STI clinics |
| BP.4.02 | Children in school |
| BP.4.03 | Youth at school |
| BP.4.04 | University students |
| BP.4.05 | Health care workers |

| | |
|---|---|
| BP.4.06 | Sailors |
| BP.4.07 | Military |
| BP.4.08 | Police and other uniformed services (other than the military) |
| BP.4.09 | Ex-combatants and other armed non-uniformed groups |
| BP.4.10 | Factory Employees / Workers (e.g. for workplace interventions) |
| BP.4.99 | "Accessible populations" not elsewhere classified (n.e.c.) |
| **BP.5 General population** | |
| BP.5.1 | General Adult population (above 24) |
| BP.5.1.1 | Male adult population |
| BP.5.1.2 | Female adult population |
| BP.5.1.98 | General Adult population (above 24) not disaggregated by gender |
| BP.5.2 | Children (under 15) |
| BP.5.2.1 | Boys |
| BP.5.2.2 | Girls |
| BP.5.2.98 | Children (under 15) not disaggregated by gender |
| BP.5.3 | Youth (age 15 to 24) |
| BP.5.3.1 | Young men |
| BP.5.3.2 | Young females |
| BP.5.3.98 | Youth (age 15 to 24) not disaggregated by gender |
| BP.5.98 | General population not disaggregated by age or gender. |
| **BP.6 Non-targeted interventions.** | |
| **BP.99 Specific targeted populations not elsewhere classified (n.e.c.)** | |

**Table 3.3 - The Providers of the National Response to HIV & Aids**

| NASA codes | PG codes | Label and abridged content description |
|---|---|---|
| **PS.1** | | **Government Organizations** |
| **PS.1.1** | | **Public and Para-statal Providers** |
| **PS.1.1.01** | | **Hospitals** |
| **PS.1.1.02** | | **Ambulatory care** |
| **PS.1.1.03** | | **Dental offices** |
| **PS.1.1.04** | | **Mental health and substance abuse facilities** |
| **PS.1.1.05** | | **Laboratory and imaging facilities** |
| **PS.1.1.06** | | **Blood banks** |
| **PS.1.1.07** | | **Ambulance services** |
| **PS.1.1.08** | | **Pharmacies and providers of medical goods** |
| **PS.1.1.09** | | **Traditional or non allopathic care providers** |
| **PS.1.1.10** | | **Schools and training facilities** |
| PS.1.1.10.1 | | Primary education |
| PS.1.1.10.2 | | Secondary education |
| PS.1.1.10.3 | | Higher education |
| PS.1.1.10.99 | | Schools and Training centres not else where classified |
| **PS.1.1.11** | | **Foster homes / shelters** |
| **PS.1.1.12** | | **Orphanages** |
| **PS.1.1.13** | | **Research institutions** |
| **PS.1.1.14** | | **Government entities** |
| PS.1.1.14.1 | | National AIDS Commission (NACs) |
| PS.1.1.14.2 | | Departments inside the Ministry of Health (including. NAPs / NACPs) |
| PS.1.1.14.3 | | Departments inside the Ministry of Education |
| PS.1.1.14.4 | | Departments inside the Ministry of Social Development |
| PS.1.1.14.5 | | Departments inside the Ministry of Defense |
| PS.1.1.14.6 | | Departments inside the Ministry of Finance |
| PS.1.1.14.7 | | Departments inside the Ministry of Labour |
| PS.1.1.14.8 | | Departments inside the Ministry of Justice |
| PS.1.1.14.99 | | Entities inside other Ministries or Public Administration entities not elsewhere classified |
| **PS.1.1.99** | | **Public and Para-statal providers not elsewhere classified** |
| **PS.2** | | **Non-Governmental Organizations** |
| **PS.2.1** | | **Non-Profit Providers** |
| **PS.2.1.1** | | **Non-Profit Providers (except Faith Based Organizations)** |
| **PS.2.1.1.01** | | **Hospitals** |
| **PS.2.1.1.02** | | **Ambulatory care** |
| **PS.2.1.1.03** | | **Dental offices** |
| **PS.2.1.1.04** | | **Mental health and substance abuse facilities** |
| **PS.2.1.1.05** | | **Laboratory and imaging facilities** |
| **PS.2.1.1.06** | | **Blood banks** |
| **PS.2.1.1.07** | | **Ambulance services** |
| **PS.2.1.1.08** | | **Pharmacies and providers of medical goods** |

| | | |
|---|---|---|
| **PS.2.1.1.09** | | **Traditional or non allopathic care providers** |
| **PS.2.1.1.10** | | **Schools and training facilities** |
| PS.2.1.1.10.1 | | Primary education |
| PS.2.1.1.10.2 | | Secondary education |
| PS.2.1.1.10.3 | | Higher education |
| PS.2.1.1.10.99 | | Schools and Training centres not else where classified |
| **PS.2.1.1.11** | | **Foster homes / shelters** |
| **PS.2.1.1.12** | | **Orphanages** |
| **PS.2.1.1.13** | | **Research institutions** |
| **PS.2.1.1.14** | | **Consultancy Firms** |
| **PS.2.1.1.15** | | **Self Help Organizations** |
| **PS.2.1.1.16** | | **Community Based Organizations** |
| **PS.2.1.1.99** | | **Other Non-Profit providers not elsewhere classified** |
| **PS.2.1.2** | | **Faith Based Organizations non-profit** |
| **PS.2.1.2.01** | | **Hospitals** |
| **PS.2.1.2.02** | | **Ambulatory care** |
| **PS.2.1.2.03** | | **Dental offices** |
| **PS.2.1.2.04** | | **Mental health and substance abuse facilities** |
| **PS.2.1.2.05** | | **Laboratory and imaging facilities** |
| **PS.2.1.2.06** | | **Blood banks** |
| **PS.2.1.2.07** | | **Ambulance services** |
| **PS.2.1.2.08** | | **Pharmacies and providers of medical goods** |
| **PS.2.1.2.09** | | **Traditional or non allopathic care providers** |
| **PS.2.1.2.10** | | **Schools and training facilities** |
| PS.2.1.2.10.1 | | Primary education |
| PS.2.1.2.10.2 | | Secondary education |
| PS.2.1.2.10.3 | | Higher education |
| PS.2.1.2.10.99 | | Schools and Training centres not else where classified |
| **PS.2.1.2.11** | | **Foster homes / shelters** |
| **PS.2.1.2.12** | | **Orphanages** |
| **PS.2.1.2.99** | | **Other Non-Profit providers not elsewhere classified** |
| **PS.2.2** | | **For profit Private Providers (including for-profit FBO)** |
| **PS.2.2.01** | | **Hospitals** |
| **PS.2.2.02** | | **Ambulatory care** |
| **PS.2.2.03** | | **Dental offices** |
| **PS.2.2.04** | | **Mental health and substance abuse facilities** |
| **PS.2.2.05** | | **Laboratory and imaging facilities** |
| **PS.2.2.06** | | **Blood banks** |
| **PS.2.2.07** | | **Ambulance services** |
| **PS.2.2.08** | | **Pharmacies and providers of medical goods** |
| **PS.2.2.09** | | **Traditional or non allopathic care providers** |
| **PS.2.2.10** | | **Schools and training facilities** |
| PS.2.2.10.1 | | Primary education |
| PS.2.2.10.2 | | Secondary education |
| PS.2.2.10.3 | | Higher education |
| PS.2.2.10.99 | | Schools and Training centres not else where classified |
| **PS.2.2.11** | | **Foster homes / shelters** |
| **PS.2.2.12** | | **Orphanages** |
| **PS.2.2.13** | | **Research institutions** |
| **PS.2.2.14** | | **Consultancy Firms** |
| **PS.2.2.99** | | **Private providers not elsewhere classified** |

| | | |
|---|---|---|
| **PS.3** | **..** | **Bilateral and Multilateral entities – in country offices** |
| **PS.3.1** | **..** | **Bilateral Agencies** |
| **PS.3.2** | **..** | **Multilateral Agencies** |
| **PS.4** | **HP.10** | **Rest-of-the world providers (services received outside the country)** |
| **PS.99** | **HP.n.s.k** | **Providers not elsewhere classified** |

# Table 3-4. Resource Costing

## PRODUCTION FACTORS, CAPITAL AND HUMAN INVESTMENTS IN HIV AND AIDS

| NASA codes | PG codes [14] | Label and abridged content description |
|---|---|---|
| **PF.1** | **Sub-total** | **CURRENT EXPENDITURES** |
| **PF.1.1** | **RC.1.1** | **Labour income (Compensation of employees and remuneration of owners)** |
| PF.1.1.1 | RC.1.1.1 | Wages |
| PF.1.1.2 | RC.1.1.2 | Social contributions |
| PF.1.1.3 | RC 1.1.3 | Non-wage labour income |
| PF.1.1.98 | RC 1.1.n.s.k | Labour income not specified by kind (n.s.k) |
| **PF.1.2** | **RC.1.2** | **Supplies and services** |
| PF.1.2.1 | RC.1.2.1 | Material supplies |
| PF.1.2.1.1 | RC.1.2.1.1.y | Antiretrovirals |
| PF.1.2.1.2 | RC.1.2.1.1.y | Other drugs and pharmaceuticals (excluding antiretrovirals) |
| PF.1.2.1.3 | RC.1.2.1.2.y | Medical and surgical supplies |
| PF.1.2.1.4 | RC.1.2.1.2.y | Condoms |
| PF.1.2.1.5 | RC.1.2.1.2.y | Reagents and materials |
| PF.1.2.1.6 | RC.1.2.1.2.y | Food and nutrients |
| PF.1.2.1.7 | RC.1.2.1.2.y | Uniforms and school materials |
| PF.1.2.1.98 | RC.1.2.1.2.y | Material supplies not disaggregated by kind |
| PF.1.2.1.99 | RC.1.2.1.2.y | Other material supplies not elsewhere classified (n.e.c.) |
| PF.1.2.2 | RC.1.2.2 | Services |
| PF.1.2.2.1 | RC 1.2.2.y | Administrative services |
| PF.1.2.2.2 | RC 1.2.2.y | Maintenance and repair services |
| PF.1.2.2.3 | | Social and other administration services contracted |
| PF.1.2.2.3.1 | RC 1.2.2.y[15] | Basic health care packages purchased on behalf of key population at higher risk {e.g. OVC, ASC 3.2} |
| PF.1.2.2.3.2 | | Social protection, monetary benefits {mainly ASC 6.1} |
| PF.1.2.2.3.3 | | Educational support {e.g. ASC 3. 3, 5.4} |
| PF.1.2.2.3.4 | | Family / Home support (e.g., ASC 5.4) |
| PF.1.2.2.3.98 | | Social and other administration services contracted not disaggregated by kind |
| PF.1.2.2.3.99 | | Social and other administration services contracted not elsewhere classified (n.e.c.) |

[14] The PG codes listed in this column are for the health component only. They do not apply for nonhealth portion of these costs (for which some ISIC codes apply).
[15] Considered health but not part of HIV/AIDS health subaccounts.

| | | |
|---|---|---|
| PF.1.2.2.4 | RC 1.2.2.y | Publisher-, motion picture-, broadcasting and programming services |
| PF.1.2.2.5 | RC 1.2.2.y | Recurrent training in medical, paramedical, social care and related establishments |
| PF.1.2.2.6 | RC 1.2.2.y | Market research services |
| PF.1.2.2.7 | RC 1.2.2.y | Consulting services |
| PF.1.2.2.8 | RC 1.2.2.y | Transportation and travel services |
| PF.1.2.2.9 | | Housing services |
| PF.1.2.2.10 | | Catering (meals and drinks) services |
| PF.1.2.2.11 | RC.1.2.2.y | Transaction Costs/ Financial intermediation services |
| PF.1.2.2.98 | | Services not specified by kind (n.s.k.) |
| PF.1.2.2.99 | | Services not elsewhere classified (n.e.c.) |
| **PF.1.3** | **RC.1.3**[16] | **Consumption of fixed capital** |
| PF.1.3.1 | RC.1.3.y | Consumption of fixed capital in public establishments or entities |
| PF.1.3.2 | RC.1.3.y | Consumption of fixed capital in private establishments |
| PF.1.3.98 | RC.1.3.y | Consumption of fixed capital not-disaggregated by sector |
| **PF.1.98** | **RC.1** | **Current Expenditures not disaggregated by kind (n.s.k.)** |
| **PF.1.99** | **RC.1** | **Current Expenditures not elsewhere classified by kind (n.e.c.)** |
| **PF.2** | **RC.2** | **Capital investment, human capital and knowledge investment / Capital expenditure** |
| **PF.2.1** | **RC.2.1.y** | **Buildings** |
| PF.2.1.1 | RC.2.1 + R.C.2.2. | Laboratory and other infrastructure upgrading |
| PF.2.1.2 | RC.2.1 | Construction of new health centres |
| PF.2.1.99 | RC.2.y | Other buildings not elsewhere classified (n.e.c.) |
| **PF.2.2** | **RC.2.2** | **Equipment** |
| PF.2.2.1 | RC.2.2.1 | Vehicles |
| PF.2.2.2 | RC 2.2.2.y | Information technology (Hardware and Software) |
| PF.2.2.3 | RC 2.2.2.y | Laboratory and other medical equipments |
| PF.2.2.99 | RC 2.2.2.y | Other equipment not elsewhere classified (n.e.c.) |
| **PF.2.3** | | **Human capital** |
| PF.2.3.1 | Health related. Not classified under RC | Pre-service specialized medical, paramedical and technical education |
| **PF.2.98** | **RC 2.y** | **Capital expenditure not disaggregated by kind** |
| **PF.2.99** | **RC 2.y** | **Capital expenditure not elsewhere classified (n.e.c.)** |

[16] In the National Health Accounts, the codes RC 1.3 and RC. 1.2 are double counted. This will be addressed in the upcoming SHA revisions.

## Table 3-5 – Purchasing and Mobilisation

### FINANCING AGENTS IN THE NATIONAL RESPONSE TO HIV AND AIDS

| NASA code | PG code | Label and abridged content description |
|---|---|---|
| **FA 1** | **HF.1** | **Public Sector** |
| **FA 1.1** | **HF.1.1.** | **Territorial governments** |
| **FA 1.1.1** | **HF.1.1.1.** | **Central or Federal authorities** |
| FA 1.1.1.1 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Health |
| FA 1.1.1.2 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Education |
| FA 1.1.1.3 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Social Development |
| FA 1.1.1.4 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Defense |
| FA 1.1.1.5 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Finance |
| FA 1.1.1.6 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Labor |
| FA 1.1.1.7 | HF.1.1.1.y | Ministry (or equivalent sector entity) of Justice |
| FA 1.1.1.8 | HF.1.1.1.y | Other Ministries (or equivalent sector entities) |
| FA 1.1.1.9 | HF.1.1.1.y | Prime Minister‘s or President’s office |
| FA 1.1.1.10 | HF.1.1.1.y | National AIDS Commission |
| FA.1.1.1.99 | HF.1.1.1.y | Central or federal authorities’ entities not elsewhere classified (n.e.c.) |
| **FA.1.1.2** | **HF.1.1.2** | **State / provincial / regional authorities** |
| FA 1.1.2.1 | HF.1.1.2.1 | Ministry (or equivalent state sector entity) of Health |
| FA 1.1.2.2 | HF.1.1.2.2 | Ministry (or equivalent state sector entity) of Education |
| FA 1.1.2.3 | HF.1.1.2.3 | Ministry (or equivalent state sector entity) of Social Development |
| FA 1.1.2.4 | HF.1.1.2.4 | Other Ministries (or equivalent state sector entities) |
| FA 1.1.2.5 | HF.1.1.2.5 | Executive Office (or office of the head of the State/Province/Department) |
| FA 1.1.2.6 | HF.1.1.2.6 | State / Province / Department AIDS Commission |
| FA 1.1.2.99 | HF.1.1.1.y | State / provincial / regional entities not elsewhere classified (n.e.c.) |
| **FA.1.1.3** | **HF.1.1.3** | **Local / municipal authorities** |
| FA 1.1.3.1 | HF.1.1.3.y | Department (or equivalent local sector entity) of Health |
| FA 1.1.3.2 | HF.1.1.3.y | Deapartment (or equivalent local sector entity) of Education |
| FA 1.1.3.3 | HF.1.1.3.y | Department (or equivalent local sector entity) of Social Development |
| FA 1.1.3.4 | HF.1.1.3.y | Executive office (or office of the head of the local/municipal government) |
| FA 1.1.3.5 | HF.1.1.3.y | Local/municipal government AIDS commission |
| FA 1.1.3.99 | HF.1.1.3.y | Other local/municipal entities not elsewhere classified (n.e.c.) |

| | | |
|---|---|---|
| **FA 1.2** | **HF.1.2** | **Public Social Security** |
| **FA.1.3** | **HF.2.1.1** | **Government employee insurance programmes** |
| **FA.1.4** | **HF.2.5.1** | **Parastatal organisations** |
| **FA.1.99** | **HF.A.x** | **Other Public Financing Agents not elsewhere classified (n.e.c)** |
| **FA.2** | **HF.2** | **Private Sector** |
| **FA.2.1** | **H.2.1.** | **Private Social Security** |
| **FA 2.2** | **HF.2.1.2** | **Private employer insurance programmes** |
| **FA.2.3** | **HF.2.2** | **Private insurance entreprises [other than social insurance]** |
| **FA.2.4** | **HF.2.3** | **Private households' (out-of-pocket payments)** |
| **FA.2.5** | **HF.2.4** | **Not-for-profit institutions (other than social insurance)** |
| **FA.2.6** | **HF.2.5.2** | **Private non-parastatal organizations and corporations (other than health insurance)** |
| **FA.2.99** | **HFB.y** | **Other Private Financing Agents not elsewhere classified (n.e.c)** |
| **FA.3** | **HF.3** | **International Purchasing Organizations** |
| **FA.3.1** | **HF.3** | **Country offices of Bilateral Agencies managing external resources and fulfilling Financing Agent roles** |
| FA.3.1.01 | HF.3.y | Government of Australia |
| FA.3.1.02 | HF.3.y | Government of Austria |
| FA.3.1.03 | HF.3.y | Government of Belgium |
| FA.3.1.04 | HF.3.y | Government of Canada |
| FA.3.1.05 | HF.3.y | Government of Denmark |
| FA.3.1.06 | HF.3.y | Government of Finland |
| FA.3.1.07 | HF.3.y | Government of France |
| FA.3.1.08 | HF.3.y | Government of Germany |
| FA.3.1.09 | HF.3.y | Government of Greece |
| FA.3.1.10 | HF.3.y | Government of Ireland |
| FA.3.1.11 | HF.3.y | Government of Italy |
| FA.3.1.12 | HF.3.y | Government of Japan |
| FA.3.1.13 | HF.3.y | Government of Luxembourg |
| FA.3.1.14 | HF.3.y | Government of Netherlands |
| FA.3.1.15 | HF.3.y | Government of New Zealand |
| FA.3.1.16 | HF.3.y | Government of Norway |
| FA.3.1.17 | HF.3.y | Government of Portugal |
| FA.3.1.18 | HF.3.y | Government of Spain |
| FA.3.1.19 | HF.3.y | Government of Sweden |
| FA.3.1.20 | HF.3.y | Government of Switzerland |

| | | |
|---|---|---|
| FA.3.1.21 | HF.3.y | Government of United Kingdom |
| FA.3.1.22 | HF.3.y | Government of United States |
| FA.3.1.30 | HF.3.y | Government of People's Republic of China |
| FA.3.1.99 | HF.3.y | Other Government(s) of non-DAC countries / Other Bilateral Agencies not elsewhere classified (n.e.c.) |
| **FA.3.2** | **HF.3** | **Multilateral Agencies managing external resources** |
| FA.3.2.01 | HF.3.y | Commission of the European Communities |
| FA.3.2.02. | HF.3.y | International Labour Organization (ILO) |
| FA.3.2.03 | HF.3.y | Multilateral funds from the UN family of organisations not elsewhere listed |
| FA.3.2.04 | HF.3.y | Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.) |
| FA.3.2.05 | HF.3.y | "Principal recipients" of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) |
| FA.3.2.06 | HF.3.y | UNAIDS Secretariat |
| FA 3.2.07 | HF.3.y | United Nations Children's Fund (UNICEF) |
| FA 3.2.08 | HF.3.y | United Nations Development Programme (UNDP) |
| FA.3.2.09 | HF.3.y | United Nations Educational, Scientific and Cultural Organization (UNESCO) |
| FA 3.2.10 | HF.3.y | United Nations High Commissioner for Refugees (UNHCR) |
| FA 3.2.11 | HF.3.y | United Nations Office for Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms |
| FA 3.2.12 | | United Nations Office on Drugs and Crime (UNODC) |
| FA 3.2.13 | | United Nations Population Fund (UNFPA) |
| FA 3.2.14 | HF.3.y | World Bank (WB) |
| FA 3.2.15 | | World Food Programme (WFP) |
| FA 3.2.16 | | World Health Organization (WHO) |
| FA 3.2.99 | HF.3.y | Other Multilateral entities not elsewhere classified (n.e.c.) |
| **FA 3.3** | **HF.3** | **International not-for-profit organizations and foundations** |
| FA.3.3.01 | HF.3.y | International HIV/AIDS Alliance |
| FA.3.3.02 | HF.3.y | ActionAID |
| FA.3.3.03 | HF.3.y | Aga Khan Foundation |
| FA.3.3.04 | HF.3.y | Association François-Xavier Bagnoud |
| FA.3.3.05 | HF.3.y | Bernard van Leer Foundation |
| FA.3.3.06 | HF.3.y | Bill and Melinda Gates Foundation |
| FA.3.3.07 | HF.3.y | Bristol-Myers Squibb Foundation |
| FA.3.3.08 | HF.3.y | Care International |
| FA.3.3.09 | HF.3.y | Caritas Internationalis /Catholic Relief Services |

| | | |
|---|---|---|
| FA.3.3.10 | HF.3.y | Deutsche Stiftung Weltbevölkerung |
| FA.3.3.11 | HF.3.y | Diana Princess of Wales Memorial Fund |
| FA.3.3.12 | HF.3.y | Elizabeth Glaser Pediatric AIDS Foundation |
| FA.3.3.13 | HF.3.y | European Foundation Centre |
| FA.3.3.14 | HF.3.y | Family Health International |
| FA.3.3.15 | HF.3.y. | Foundation Mérieux |
| FA.3.3.16 | HF.3.y | Health Alliance International |
| FA.3.3.17 | HF.3.y | Helen K. and Arthur E. Johnson Foundation |
| FA.3.3.18 | HF.3.y | International Federation of Red Cross and Red Crescent Societies, and National Red Cross Societies |
| FA.3.3.19 | HF.3.y | King Baudouin Foundation |
| FA.3.3.20 | HF.3.y | Médecins sans Frontières |
| FA.3.3.21 | HF.3.y | Merck & Co., Inc |
| FA.3.3.22 | HF.3.y | Plan International |
| FA.3.3.23 | HF.3.y | PSI (Population Services International) |
| FA.3.3.24 | HF.3.y | SIDACTION (mainly Francophone countries) |
| FA.3.3.25 | HF.3.y | The Clinton Foundation |
| FA.3.3.26 | HF.3.y | The Ford Foundation |
| FA.3.3.27 | HF.3.y | The Henry J. Kaiser Family Foundation |
| FA.3.3.28 | HF.3.y | The Nuffield Trust |
| FA.3.3.29 | HF.3.y | The Open Society Institute / Soros Foundation |
| FA.3.3.30 | | The Rockefeller Foundation |
| FA.3.3.31 | | United Nations Foundation |
| FA.3.3.32 | HF.3.y | Wellcome Trust |
| FA.3.3.33 | HF.3.y | World Vision |
| FA.3.3.99 | HF.3.y | Other International not-for-profit organizations not elsewhere classified (n.e.c.) |
| **FA 3.4** | **HF.3** | **International for-profit organizations** |
| **FA 3.99** | **HF.3.y** | **Other International Financing Agents not elsewhere classified (n.e.c.)** |

**Notes:**
1.**Given that m**any *transactors* exert their activity through a variety of approaches, a transitory matrix – preparatory to the establishment of table 3.5 – may be advisable to cense all transactions, e.g.:

For public sector:

- outright purchases or payments of bills incurred by other agents (including of capital goods)
- subsidies lowering the cost of providing commodities
- monetary incentives paid to wage and salary paid producers

- capital transfers contributing to the acquisition of capital goods
- transfer payments to households (e.g. reimbursement of medical care outlays, social grants, means-tested benefits, etc.) *
- tax expenditure (reduction in individual income taxes or indirect taxes such as value added taxation resulting in higher user purchasing power) *

*reported as household funding replenishment in table 3-6

For private agents:

- outright purchases
- monetary incentives to selected providers

2. Though a genuine economic and social cost, only part of the financial intermediation costs (incurred by financing sources to secure purchasing or to replenish the funding pools) is accounted for. This is because, conventionally, the procurement cost of finance is considered to be a financial activity outside the treatment – care – prevention – social mitigation or other spending categories' boundaries. The costs of financial intermediation (interest payments on loans, mediation to position a purchaser on behalf of a financial source, etc.) prior to financing agent status is also not included. The information accessible enables reporting a wider range of transaction costs "below the line" under current accounting rules. This is advisable if only as an incentive to spare some of these costs in subsequent fiscal years.

| **Table 3.6 Burden-sharing classification (Financing Sources)** *SOURCES OF THE FUNDS* | | |
|---|---|---|
| **NASA code** | **PG code** | **Label and abridged content description** |
| **FS.1** | FS.1 | **Public Funds** |
| **FS 1.1** | FS.1.1 | **Territorial Government Funds** |
| **FS 1.1.1** | FS.1.1.1 | **Central Government Revenue** |
| **FS.1.1.2** | FS.1.1.2 | **State / Provincial Government Revenue** |
| **FS.1.1.3** | FS.1.1.3 | **Local / Municipal Government Revenue** |
| **FS.1.1.4** | | **Reimbursable loans** |
| **FS.1.2** | FS.2.3 - FS.1.1<br>FS.2.1- HF.1.2 | **Social security funds** [(i)] |
| FS.1.2.1 | | Employer compulsory contributions to Social Security |
| FS.1.2.2 | | Employee compulsory contributions to Social Security |
| FS.1.2.3 | | Government transfers to Social Security |
| **FS.1.99** | | **Other Public Funds not elsewhere classified (n.e.c.)** |
| **FS.2** | FS.2 | **PRIVATE FUNDS** |
| **FS.2.1** | FS.2.1 | **For-profit institutions – Corporate Funds** |
| **FS.2.2** | FS.2.2 | **Households' funds** |
| **FS.2.3** | FS.2.3 | **Not-for-profit institutions (other than social insurance)** |
| **FS.2.99** | | **Private Financing Sources not elsewhere classified (n.e.c.)** |
| **FS.3** | FS.3 | **International funds** |
| **FS. 3.1** | FS.3 | **Direct bilateral contributions** |
| FS.3.1.01 | | Government of Australia |
| FS.3.1.02 | | Government of Austria |
| FS.3.1.03 | | Government of Belgium |
| FS.3.1.04 | | Government of Canada |
| FS.3.1.05 | | Government of Denmark |
| FS.3.1.06 | | Government of Finland |
| FS.3.1.07 | | Government of France |
| FS.3.1.08 | | Government of Germany |
| FS.3.1.09 | | Government of Greece |
| FS.3.1.10 | | Government of Ireland |
| FS.3.1.11 | | Government of Italy |
| FS.3.1.12 | | Government of Japan |

| | | |
|---|---|---|
| FS.3.1.13 | | Government of Luxembourg |
| FS.3.1.14 | | Government of Netherlands |
| FS.3.1.15 | | Government of New Zealand |
| FS.3.1.16 | | Government of Norway |
| FS.3.1.17 | | Government of Portugal |
| FS.3.1.18 | | Government of Spain |
| FS.3.1.19 | | Government of Sweden |
| FS.3.1.20 | | Government of Switzerland |
| FS.3.1.21 | | Government of United Kingdom |
| FS.3.1.22 | | Government of United States |
| FS.3.1.23 | | Government of People's Republic of China |
| FS.3.1.99 | | Government of non-DAC countries/Bilateral Agencies n.e.c. |
| **FS.3.2** | FS.3 | **Multilateral Agencies contributions** [(ii)] |
| FS.3.2.01 | | Commission of the European Communities |
| FS.3.2.02. | | International Labour Organization (ILO) |
| FS.3.2.03 | | Multilateral funds from the UN family of organisations not elsewhere listed |
| FS.3.2.04 | | Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.) |
| FS.3.2.05 | | The Global Fund to Fight AIDS, Tuberculosis and Malaria |
| FS.3.2.06 | | UNAIDS Secretariat |
| FS.3.2.07 | | United Nations Children's Fund (UNICEF) |
| FS.3.2.08 | | United Nations Development Programme (UNDP) |
| FS.3.2.09 | | United Nations Educational, Scientific and Cultural Organization (UNESCO) |
| FS.3.2.10 | | United Nations High Commissioner for Refugees (UNHCR) |
| FS.3.2.11 | | United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms |
| FS.3.2.12 | | United Nations Office on Drugs and Crime (UNODC) |
| FS.3.2.13 | | United Nations Population Fund (UNFPA) |
| FS.3.2.14 | | World Bank (WB) |
| FS.3.2.15 | | World Food Programme (WFP) |
| FS.3.2.16 | | World Health Organization (WHO) |
| FS.3.2.99 | | Multilateral funds or development funds n.e.c. |
| **FS.3.3** | FS.3 | **International not-for-profit organizations and foundations** |
| FS.3.3.01 | | International HIV/AIDS Alliance |

| | | |
|---|---|---|
| FS.3.3.02 | | ActionAID |
| FS.3.3.03 | | Aga Khan Foundation |
| FS.3.3.04 | | Association François-Xavier Bagnoud |
| FS.3.3.05 | | Bernard van Leer Foundation |
| FS.3.3.06 | | Bill and Melinda Gates Foundation |
| FS.3.3.07 | | Bristol-Myers Squibb Foundation |
| FS.3.3.08 | | Care International |
| FS.3.3.09 | | Caritas Internationalis /Catholic Relief Services |
| FS.3.3.10 | | Deutsche Stiftung Weltbevölkerung |
| FS.3.3.11 | | Diana Princess of Wales Memorial Fund |
| FS.3.3.12 | | Elizabeth Glaser Pediatric AIDS Foundation |
| FS.3.3.13 | | European Foundation Centre |
| FS.3.3.14 | | Family Health International |
| FS.3.3.15 | | Foundation Mérieux |
| FS.3.3.16 | | Health Alliance International |
| FS.3.3.17 | | Helen K. and Arthur E. Johnson Foundation |
| FS.3.3.18 | | International Federation of Red Cross and Red Crescent Societies, and National Red Cross Societies |
| FS.3.3.19 | | King Baudouin Foundation |
| FS.3.3.20 | | Médecins sans Frontières |
| FS.3.3.21 | | Merck & Co., Inc |
| FS.3.3.22 | | Plan International |
| FS.3.3.23 | | PSI (Population Services International) |
| FS.3.3.24 | | SIDACTION (mainly Francophone countries) |
| FS.3.3.25 | | The Clinton Foundation |
| FS.3.3.26 | | The Ford Foundation |
| FS.3.3.27 | | The Henry J. Kaiser Family Foundation |
| FS.3.3.28 | | The Nuffield Trust |
| FS.3.3.29 | | The Open Society Institute / Soros Foundation |
| FS.3.3.30 | | The Rockefeller Foundation |
| FS.3.3.31 | | United Nations Foundation |
| FS.3.3.32 | | Wellcome Trust |
| FS.3.3.33 | | World Vision |
| FS.3.3.99 | | International not-for-profit organizations and foundations not elsewhere classified (n.e.c.) |
| **FS.3.4** | FS.3 | **International for profit organizations** |

(i): to prevent double counting, FS.2.1 and FS 2.2 should be estimated net of contributions to Social Security (when recorded under FS.1.2) as should territorial government (FS.1.1.1, FS.1.1.2, FS.1.1.3 in respect of transfers towards Social Security and employer contributions to Government Employee Health Insurance plans.

(ii): The multilateral funds obtain the bulk of their funds from the bilateral agencies (part from Foundations), The origin of the pools can mostly not be traced at the level of the recipient nation. When, .however, a multilateral agency operates a specific AIDS fund whose origin is readily identifiable, the metadata should preferably precise. E.g. the Asian Development Bank 2005 scheme is ascribable to Sweden, the International Federation of Red Cross and Red Crescent Societies involvement in Nepal, Sri Lanka, Vietnam and other Asian countries is traceable to the Organisation of Petroleum Exporting Countries International Development programme (OPIC).

Note: to prevent double counting, FS.2.1 and FS 2.2 should be estimated net of contributions to Social Security (when recorded under FS.1.2 and PFS.1.3) as should territorial government (FS.1.1.1, PFS.1.1.2, FS.1.1.3 in respect of transfers towards Social Security and employer contributions to Government Employee Health Insurance plans.

(1) The multilateral funds obtain the bulk of their funds from the bilateral agencies (part from Foundations), The origin of the pools can mostly not be traced at the level of the recipient nation. When, .however, a multilateral agency operates a specific AIDS fund whose origin is readily identifiable, the metadata should preferably precise. E.g. the Asian Development Bank 2005 scheme is ascribable to Sweden, the International Federation of Red Cross and Red Crescent Societies involvement in Nepal, Sri Lanka, Vietnam and other Asian countries is traceable to the Organisation of Petroleum Exporting Countries International Development programme (OPIC).

# 4. Epilogue

Since the time of Aristotle, classifications have represented the backbone of progress in sciences and knowledge, and remain the foundation of accounts. As listed here, they enable stakeholders in the national response to HIV and AIDS to establish the quantitative base of a thorough assessment of programmes designed to respond to the societal challenge, and to organize the provision and the financing of that policy.

Stakeholders at all levels should review the classifications carefully as to suitability of the latter in terms of their own specific situation (detailed definitions of the entries in the six tables will follow soon in the NASA *Notebook* – this information already exists, as NASA barrows from earlier UNAIDS evaluations and from the conventional United Nations family of classifications*).* The classification deliberately goes into greater detail to facilitate the work of those who will be collating numbers. It is not expected that all will complete it to such a degree. Once no further details are available, the next level up may be used. When finer programmes or precise financing sources can be identified, a further desegregation is allowed (with indication of the contents in the meta-data).

NASA estimates are part of the infrastructure of the Millennium Development Goal challenges. It is a perfectible instrument but actual hands-on use of it will show how good it really is. Therefore, the next stage is for many users to put it to the test.

# Annex 1. Defining AIDS Spending Categories and Beneficiaries of HIV-AIDS Programmes

AIDS expenditure refers to all public and private expenditure for activities related to the national response to the HIV and AIDS epidemic. The AIDS spending measures the output (which products and services are delivered) that is consumed or invested to reduce the impact of the epidemic. The AIDS spending classification is a functional classification that includes the categories of prevention, care and treatment, and health and non-health services related to HIV,

Beneficiary population refers to population who benefits from the activities and services of the national response to the epidemic. This population may (should) be looked at from several angles. The more common ones relate to attributes and include demographic, geographical, socioeconomic, health condition and vulnerability status. There is, however, a need to identify prevention interventions and monitoring - evaluation efforts among most-at-risk population segments.

To the extent that the products or the activities are straightforwardly described in the principal international classifications produced under United Nations' auspices: the Classification of Individual Consumption of Households, the Classification of the Non-Profit Institutions (COPNI), the Classification of the Functions of Government (COFOG), the International Standard Industrial Classification (ISIC), the standard international classifications serve as the beacon to define HIV and AIDS commodities.

The International Classification of Health Activities (ICHA), and the UNAIDS *Guidelines on Core Indicators for monitoring the Declaration of Commitment (UNGASS), on Surveillance and on Evaluation constitute some of the relevant references for these classifications*..

## *AIDS SPENDING CATEGORIES (ASC): definitions and descriptions*

### *ASC.1 Prevention.*

Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Results include a decrease in HIV infections among the population[17] and improvements in the quality and safety in health facilities in regard of therapies administered exclusively or in large part to HIV and AIDS patients. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age appropriate materials supporting programme goals.

[17] ***ABC.*** is a set of prevention strategies and activities (including training) to promote abstinence, delay sexual debut, fidelity and partner-reduction messages and related social and community norms. "ABC" activities include: (A) abstain from penetrative sexual intercourse (also used to indicate delay of sexual debut), is coded under ASC 1.05 ***(Prevention - Youth in school)*** and 1.06 (***Prevention - Youth out of school)***; (B) be faithful (reduce the number of partners or have sexual relations with only one partner). Community mobilization activities aimed at behavioural change and risk reduction is coded as ASC 1.2 **(*Community mobilization)***; and (C) (**Condom social marketing**) (use condoms consistently and correctly) which can be coded as ASC 1.12

***ASC.1.01 Communication for social and behavioral change:***. Programmes that focus on social change and social-pshychological determinants of individual change. A Communication for social and behavioral change campaign is general information addressing regions, states or countries. This entry includes, but is not limited to, brochures, pamphlets, handbooks, posters, newspaper or magazine articles, comic books, TV or radio shows or spots, songs, dramas or interactive theatre. This category excludes condom social marketing as a result of an activity coded under ASC 1.12 and any other informational services which are part of any of the spending categories described as prevention programmes (mother-to-child transmission prevention programme, to reduce stigmatization or to promote access to voluntary counselling and testing), and any other communication for social and behavioural change captured in prevention programs ASC.1.04, ASC.1.08 to ASC.1.10. Advocacy and strategic communication (ASC 7.1) constitutes the locus to report non-health communication for social behavioral change programmes. When joint programmes comprise *health risks avoidance* messages and *non-health risks avoidance* messages which can be separated, additional digits may be introduced (with indication of the pro-rating methodology adopted), e.g.

**ASC.1.01.1 Health Communication for social and behavioral change programmes targeting the health risks of HIV prevention campaigns.**[18]: campaigns with an explicit prevention purpose.

**ASC.1.01.2 Non-health Communication for social and behavioral change *programmes* targeting the non-health risks[19]:** addressed in HIV prevention campaigns and any other mass media-related activities whose contents are not within the boundaries of health (as described in NHA), and whose content is not captured under ASC.7.

**ASC.1.01.98 Not-Disaggregated Communication for social and behavioral change:** If it is not possible disaggregatd according to health or non-health contents

***ASC.1.02 Community mobilization***. Activities that create community commitment and involvement in achieving programme goals. This includes, but is not limited to: involvement of community groups (for example, people living with HIV) in programme planning and mobilization of community resources, peer education, support groups and self-representation. These activities are aimed at behavioral change and risk reduction.

***ASC.1.03 Voluntary counselling and testing.*** It is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV[20].Client-initiated confidential voluntary counselling and testing includes activities in which both HIV counselling and testing are consumed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection clinics). All HIV testing must be carried out

[18] The reference international guidelines do not split the activities underscoring these campaigns at the level of detail required to measure ASC.1.01.1 and ASC.1.01.2 but PHRplus which has estimated AIDS subaccounts indicates that, at operational level, this has been found possible.

[19] For example, non-health risk for drug users are prosecution and exposure to criminal activities.

[20] Voluntary Counselling and Testing (VCT), UNAIDS Technical Update, May 2000.

under conditions of the three Cs: counselling, confidentiality and informed consent. Testing to identify persons needing treatment is included in the Treatment and Care section and should be coded as provider-initiated testing. The cost of VCT includes the whole process of provision including the physician, counselor, laboratory and the post test counselling. Counselling and testing in the context of preventing mother-to-child transmission is coded under prevention of mother-to-child transmission (PMTCT). VCT services targeted to population in ASC.1.04 and in ASC1.07 to ASC.1.10. ASC.1.03 must be crossed with BP.5 General Population.

***ASC.1.04 Risk-reduction for vulnerable and accesible populations (Previously labelled Programmes for vulnerable and special populations).*** These populations include specific vulnerable groups such as indigenous groups, recruits, truck drivers, prisoners, migrants. Special attention should be given to those people in situations of conflict, i.e., refugee situation and internal displacement. It excludes MARP activities covered by categories ASC 1.08-ASC.1.10.

ASC.1.04.1 VCT as part of programmes for vulnerable and accessible population

ASC.1.04.2 Condom social marketing, public and commercial sector provision of condoms as part of programmes for vulnerable and accessible population

ASC.1.04.3 STI prevention and treatment as part of programmes for vulnerable and accessible population

ASC.1.04.4 BCC/IEC as part of programmes for vulnerable and accessible population: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.1.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type

ASC.1.04.99 Other programmatic interventions for vulnerable and accessible population not elsewhere classified (n.e.c.)

***ASC.1.05 Prevention - Youth in school***. Programmes that focus on young people enrolled in primary and secondary level schools (6–11 and 12–15). Prevention programmes in school include a full complement of tools to prevent HIV transmission. These comprise a comprehensive, appropriate, evidence- and skills-based sexual education; youth-friendly health services offering core interventions for the prevention of the transmission through unsafe drug injecting practices; and consistent access to male and female condoms. A critical element is the integration into school-based settings of life-skills-education programmes. Skills-based health education and interactive teaching methods have been shown to promote healthy lifestyles and to reduce risky behaviour. The life-skills-based HIV education in schools are a didactic and specific learning process for young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. (Teacher training – when measurement is required -- should be measured in accordance with the latest UNICEF guidelines.[21]) To track benefits, the accountant may wish to report expenditure on life-skills activities in both primary and secondary schools as a part of the education system

[21] UNICEF Guidelines can be found at http:/www.unicef.org/lifeskills/index_documents.html

spending (either independent or jointly with the health system). This programme should be coded and cross-classified with the specific beneficiary populations receiving the services, principally young people enrolled in primary and secondary level schools (6–11 and 12–15).

***ASC.1.06 Prevention - Youth out of school.*** Programmes that focus on young people between the ages of 6 and 15 out of school. Tools of these programmes are comprehensive, appropriate, evidence- and skills-based sexual education; youth friendly health services offering core interventions for the prevention of the transmission through unsafe drug injecting practices; and consistent access to male and female condoms.

***ASC.1.07 Prevention of HIV transmission aimed at persons living with HIV (PLHA)***. Programmes to reduce risky behaviours by infected people aimed to decrease the rate of infection in the population. The aim is to empower people living with HIV to avoid acquiring new sexually transmitted infections, delay HIV prevention and avoid passing their infections to others. This programmatic activity should be coded and cross-classified with the specific population segment receiving the services, i.e.: BP.1 People living with HIV. The programmatic interventions should be coded according to its characteristics as follows:

ASC.1.07.1 Counselling as part of prevention programmes of HIV transmission aimed at persons living with HIV (PLHA).

ASC.1.07.2 Condom social marketing, public and commercial sector provision of condoms as part of prevention programmes of HIV transmission aimed at persons living with HIV (PLHA).

ASC.1.07.3 STI prevention and treatment as part of prevention programmes of HIV transmission aimed at persons living with HIV (PLHA).

ASC.1.07.4 BCC/IEC as part of prevention programmes of HIV transmission aimed at persons living with HIV (PLHA): interventions aimed to promote risk reduction measures, including peer outreach.

ASC.1.07.98 Programmatic interventions for prevention programmes of HIV transmission aimed at persons living with HIV (PLHA) not disaggregated by type

ASC.1.07.99 Other programmatic interventions for prevention programmes of HIV transmission aimed at persons living with HIV (PLHA) not elsewhere classified (n.e.c.)

***ASC.1.08 Prevention programmes for sex workers and their clients*.** Programmes to promote risk-reduction measures including outreach (including peer), voluntary and confidential HIV counselling and testing, prevention of sexual transmission of HIV (including condoms and prevention and treatment of sexually transmitted infections) and consistent access to male and female condoms. This programmatic activity should be coded and cross-classified with the specific population segment receiving the services. This programmatic activity should be coded and crossed with the specific beneficiary populations receiving the services: BP.2.2 Sex workers (SW) and their clients. The programmatic interventions should be coded according to its characteristics as follows:

ASC.1.08.1 VCT as part of programmes for sex workers and their clients

ASC.1.08.2 Condom social marketing, public and commercial sector provision of condoms as part of programmes for sex workers and their clients

ASC.1.08.3 STI prevention and treatment as part of programmes for sex workers and their clients

ASC.1.08.4 BCC/IEC as part of programmes for sex workers and their clients: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.1.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type

ASC.1.08.99 Other programmatic interventions for sex workers and their clients not elsewhere classified (n.e.c.)

***ASC.1.09 Programmes for men who have sex with men (MSM)***. Programmes that focus on men who regularly or occasionally have sex with other men. These programmes include risk-reduction activities, outreach (including peer), voluntary and confidential HIV counselling and testing and prevention of sexual transmission of HIV (including condoms, prevention and treatment of sexually transmitted infections). Interpersonal communication (face-to-face) to reach MSM at risk; programmes developing and acquiring skills to negotiate safer behaviour, behavioural change and sustained engagement to prevent HIV infection. This programmatic activity should be coded and crossed with the specific beneficiary populations receiving the services: BP.2.3 Men who have sex with men (MSM). The programmatic interventions should be coded according to its characteristics as follows:

ASC.1.09.1 VCT as part of programmes for Men who have sex with men (MSM)

ASC.1.09.2 Condom social marketing, public and commercial sector provision of condoms as part of programmes for men who have sex with men (MSM)

ASC.1.09.3 STI prevention and treatment as part of programmes for men who have sex with men (MSM)

ASC.1.09.4 BCC/IEC as part of programmes for men who have sex with men (MSM): interventions aimed to promote risk reduction measures, including peer outreach.

ASC.1.09.98 Programmatic interventions for men who have sex with men (MSM) not disaggregated by type

ASC.1.09.99 Other programmatic interventions for Men who have sex with men (MSM) not elsewhere classified (n.e.c.)

***ASC.1.10 Harm-reduction programmes for injecting drug users (IDUs)***. Programmes that focus on reducing harm caused though drug use and reducing risk of spread. They include a set of treatment options such as substitution treatment and the implementation of harm-reduction measures (peer outreach, and sterile needle and syringe programmes), voluntary and confidential HIV counselling and testing and prevention of sexual transmission of HIV (including condoms and prevention and treatment of sexually transmitted infections). This programmatic activity should be coded and crossed with the specific beneficiary populations receiving the services: BP.2.1

Injecting (IDU) and other drug users and their sexual partners. The programmatic interventions should be coded according to its characteristics as follows:

ASC.1.10.1 VCT as part of programmes for injecting drug users (IDUs)

ASC.1.10.2 Condom social marketing, public and commercial sector provision of condoms as part of programmes for injecting drug users (IDUs)

ASC.1.10.3 STI prevention and treatment as part of programmes for injecting drug users (IDUs)

ASC.1.10.4 BCC/IEC as part of programmes for injecting drug users (IDUs): interventions aimed to promote risk reduction measures, including peer outreach.

ASC.1.10.98 Programmatic interventions for injecting drug users (IDUs) not disaggregated by type

ASC.1.10.99 Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.)

***ASC.1.11 Prevention programmes in the workplace*. Programmes that focus on reducing risk factors at the workplace.** These provide HIV prevention services for employees, their members, and the families of employees and members. This programmatic activity should be coded and crossed with the specific beneficiary populations receiving the services: i.e. Factory Employees / Workers. The programmatic interventions should be coded according to its characteristics as follows:

ASC.1.11.1 VCT as part of prevention programmes in the workplace

ASC.1.11.2 Condom social marketing, public and commercial sector provision of condoms as part of prevention programmes in the workplace

ASC.1.11.3 STI prevention and treatment as part of prevention programmes in the workplace

ASC.1.11.4 BCC/IEC as part of prevention programmes in the workplace: interventions aimed to promote risk reduction measures, including peer outreach.

ASC.1.11.98 Prevention programmes in the workplace not disaggregated by type

ASC.1.11.99 Prevention programmes in the workplace not elsewhere classified (n.e.c.)

***ASC.1.12 Condom social marketing*** refers to programmes that make condoms more accesible and acceptable. They include campaigns to promote the purchasing of condoms in private pharmacies and exclude procurement programmes. Condom social marketing activities conducted as part of program for a specific population (e.g.: MARPs) should not be coded in ASC.1.12 but on its correspondent ASC (ASC.1.04, ASC.1.07 to ASC.1.11). ASC.1.12 must be crossed with BP.5 General Population.

***ASC.1.13 Public and commercial sector male condom provision*** *refers to* procurement of condoms regardless of mode of distribution (cost-free, subsidized or commercially priced; accessibility to the general population or to specific groups). This includes the fungibles (condoms) and any other cost incurred on the distribution and provision. Nevertheless, not all the condoms distributed have an HIV prevention

component (some people use condoms exclusively for birth control purposes). There are different approaches to estimate the condom use HIV related expenditures. One recommended approach is to use country available demographic surveys or sexual behavioural surveys to find out the fraction of condoms attributable exclusively to birth control. This fraction or percentage should then be extracted from the total condoms estimated for ASC.1.13. Male condoms as part of specific programs for key populations and populations at higher risk, such as ASC1.04 and ASC1.08 to ASC.1.10 should not be coded in ASC.1.13, but on its correspondents programs.

***ASC.1.14*** ***Female condom*** **refers to** procurement of female condoms regardless of mode of distribution (cost-free, subsidized or commercially priced; accessibility to woman). The Female condoms distributed as part of a programmatic interventions to a specific accessible or most at risk population, should be coded on the specific programme, e.g.: Female condoms distributed to sex workers should be coded under ASC.1.08 Prevention programmes for sex workers and their clients.

***ASC.1.15*** ***Microbicides*** refers to procurement of conpounds that are applied inside the vagina or rectum to protect against STI. Once these will become available, the resource tracking system should identify investment in programmes making available microbicides that are proven safe and an effective complement to prevent at, at least, reduce new HIV infections.

***ASC.1.16*** ***Prevention, Diagnosis and treatment of Sexually Transmitted Infections (STI) (Improving management of STI) excluding categoreis ASC.1.04 and ASC.1.08-1.10.*** Prevention and care services, including diagnosis and treatment, related to sexually transmitted infections. From an HIV perspective, the treatment of STIs is coded as preventive (from a health system's perspective, this treatment is curative). The expenses for improved clinical management of STIs include medical consultations, tests and treatment for syphilis, gonorrhoea, herpes, candidiasis and trichomoniasis. The services targeted under this heading are programmes directed both to the general population or to specific population segments except those coded under ASC.1.04. This entry should be coded and cross-classified with the specific beneficiary populations receiving these services.

***ASC.1.17*** ***Prevention of mother-to-child transmission (PMCT)*** refers to services intended to avoid mother-to-child HIV transmission. These include counselling and testing for pregnant women, antiretroviral prophylaxis for HIV-infected pregnant women and newborns, counselling and support for safe infant feeding practices. PMTCT-plus ARV-treatments should be coded under antiretroviral therapy (treatment after delivery) ASC.2.1.03 When an HIV positive woman receives antiretroviral therapy before pregnancy is known and no change in the antiretroviral prescription occurs, the antiretroviral treatment should be included under "ARV therapy" ASC 2.4 Cultural sensitivity induces some countries to label the service 'parent-to-child transmission' to avoid stigmatizing pregnant women and to encourage male involvement in HIV prevention. Prevention of parent-to-child transmission then becomes PTCT. When adequate information is accessible, the position may be split , using another digit, between:

***ASC.1.17.1 Pregnant women counselling and testing in VCT programs***

***ASC.1.17.2 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns***

***ASC.1.17.3 Safe infant feeding practices (including substitution of breast milk)***

***ASC.1.17.98 PMTCT not-disaggregated by intervention***

***ASC.1.17.99 PMTCT activities not elsewhere classified (n.e.c.)***

***ASC.1.18 Blood safety.*** Blood safety expenditures and investment addressing activities supporting a nationally coordinated blood programme to prevent HIV transmission. Included are policies, infrastructure, equipment and supplies for testing activities and management to ensure a safe blood supply.

***ASC.1.19 Post-exposure prophylaxis (PEP).*** includes interventions and antiretroviral drugs after exposure to risk, which may be developed adding one digit as:

***ASC. 1.19.1 PEP in health care setting***

***ASC. 1.19.2 PEP after high-risk exposure (violence or rape)***

***ASC. 1.19.3 PEP after unprotected sex.***

***ASC. 1.19.98 Post-exposure prophylaxis not-disaggregated by intervention.***

***ASC.1.20 Safe medical injections.*** Medical transmission/injection safety targets the development of policies, training, waste-management systems, advocacy and other activities to promote (medical) injection safety. They include distribution/supply chain, cost and appropriate disposal of injection equipment and other related equipment and supplies. Only expenditure targeting the prevention of HIV transmission should be included.

***ASC.1.21Male Circumcision*** refer to the removal of the prepuce or foreskin covering the tip of the penis. It is important to identify an HIV prevention intention in the purpose of the male circumcision. Male circumcisions are performed in many countries as a usual practice and not related with a particular HIV programmatic intervention. When male circumcisions are part of country specific programmatic HIV prevention activities, the cost of these interventions should be captured here. Expenditures related to the promotion of Male Circumcision as part of an HIV preventive program, should also be accounted here.

***ASC.1.22 Universal precautions (when the main or exclusive purpose to implement them is to limit HIV transmission)*** refer to the use of gloves, masks and gowns by health care personnel to avoid HIV infection through contaminated blood. These are standard infection control practices to be used universally in healthcare settings to minimize the risk of exposure to pathogens, e.g. the use of gloves, barrier clothing, masks and goggles (when anticipating splatter) to prevent exposure to tissue, blood and body fluids. Expenditure data on universal precaution is driven by the number of hospital beds. Universal precautions are shared across the health system and are not AIDS-specific. Therefore, only a fraction of expenditures on universal precautions and safe medical injections should be included (95% based on an analysis of the burden of blood-borne communicable diseases—Hepatitis and HIV). Expenditures, within universal precautions,

are limited to those specifically aimed to prevent the HIV transmission in health care facilities. Expenditure on safety procedures in blood banks may not be divisible from the other costs incurred by that activity and are reported under ASC 1.18 blood safety

***ASC.1.99 Prevention activities not elsewhere classified (n.e.c.)*** includes all other preventive programmes, interventions and services which the country has recorded; considers relevant and is not listed above (e.g. male circumcision). The resource tracking team is likely to open subheadings to provide a comprehensive picture of the expenditure allocated to specific HIV transmission programmes. Preventive programmes directed to the general population or to specific group should be coded under ASC 1.16 Improving management of STI.

## *ASC.2 Care and Treatment*

***Care and treatment refers to a***ll expenditures, purchases, transfers and investment incurred to provide access to clinic- and home/community-based activities for the treatment and care of HIV-infected adults and children. The treatment and care component includes the following interventions and activities:

***ASC.2.1 Outpatient care refers to e***xpenses aimed at optimizing quality of life for HIV infected persons and their families. They refer to the continuum of care by means of antiretroviral therapy, symptom diagnosis and relief; nutritional support; psychological and spiritual support; clinical monitoring, related laboratory services and management of opportunistic infections (excluding TB) and other HIV- and AIDS-related complications; and culturally-appropriate end-of-life care. Outpatient care is composed by the following interventions and activities:

***ASC.2.1.01Provider initiated testing and counselling*** refers to the costing that takes place through voluntary counselling and testing (VCT) services. Under certain circumstances, when an individual is seeking medical care, HIV testing may be offered. This may be diagnostic—the patient presents symptoms that may be attributable to HIV or has an illness associated with HIV, such as tuberculosis—or this may be a routine offer to an asymptomatic person. For example, HIV testing may be offered as part of the clinical evaluation of patients with sexually transmitted infections and pregnant women. HIV testing may be offered to all patients where HIV is prevalent. The cost of diagnostic testing (provider-initiated testing including post-test counselling) is included as an initial test, followed by a confirmatory test if reactive. The cost of PIT includes the whole provision process: office, physician and laboratory. PIT excludes the testing under PMTC coded as ASC 1.17

***ASC.2.1.02 Opportunistic infections (OI) prophylaxi.s*** Prophylaxis for prevention of opportunistic infections (e.g., the cost of isoniazid to prevent TB and cotrimoxazole to protect against pathogens responsible for pneumonia, diarrhoea and their complications). Children born to women living with HIV receive 18 months of cotrimoxazole on a prophylactic basis..

***ASC.2.1.03 Antiretroviral therapy.*** The specific therapy includes a comprehensive group of recommended antiretroviral drugs, including the cost of supply logistics for either

adults or children[22]-[23]. The number of people being treated is based on country-specific evidence of current coverage. ART includes all modalities of ARV therapy. When an aggressive therapeutic course is received designed to suppress the viral replication and to slow the progress of the HIV disease, the therapy is labeled highly active antiretroviral therapy (HAART); the usual combination of three or more different drugs such as two nucleoside reverse transcriptase inhibitors and a protease inhibitor, two NRTIs and a non-nucleoside reverse transcriptase inhibitor or other combinations characterize this subclass, which has been shown to reduce the amount of the virus to a point where it becomes undetectable in a patient's blood. Where detailed information is collated, it may be broken down into:

***ASC.2.1.03.1 Adult antiretroviral therapy***

***ASC.2.1.03.1.1 First-line ART - Adults***

***ASC.2.1.03.1.2 Second line ART - Adults***

***ASC.2.1.03.1.3 Adult multi.drug ART after 2nd line treatment fail***

***ASC.2.1.03.1.98 Adult antiretroviral therapy not-disaggregated by line of treatment (n.d.)***

***ASC.2.1.03.2 Paediatric antiretroviral therapy***

***ASC.2.1.03.2.1 First-line ART - Paediatric***

***ASC.2.1.03.2.2 Second line ART - Paediatric***

***ASC.2.1.03.2.3 Paediatric multi-drug ART after 2nd line treatment fail***

***ASC.2.1.03.2.98 Paediatric antiretroviral therapy not-disaggregated by line of treatment (n.d.)***

Or as follows, when detailed information is missing:

***ASC.2.1.03.98 Antiretroviral therapy not-disaggregated by age or line of treatment.***

The term ART (antiretroviral therapy) can be used when it clearly refers to an antiretroviral combination of at least three drugs. The CD4 cell count is one indicator of HIV disease progression. A normal CD4 cell count ranges from about 600 to1,200 cells/mm$^3$; moderate immunosuppression in adults is associated with a CD4 cell count between 200 and 500 cells/mm$^3$, while severe immunodeficiency is associated with counts below 200 cells/mm$^3$. Current guidelines recommend treatment when the CD4 cell count falls below 350 cells/mm$^3$. An increasing number of AIDS patients are subject to a second-line treatment: the second preferred therapy is used after first-line treatment fails or if a person cannot tolerate first-line drugs. These subcategories have implications on the level of expenditure as the size of the population failing first line and requiring a more expensive second line combination increases. Thus, a population of patients with HIV infection may be classified as follows: (A) pre-ART, receiving care and prophylaxis, (B)

[22] http://www.who.int/hiv/pub/guidelines/WHO%20Adult%20ART%20Guidelines.pdf
[23] http://www.aids info.nih.gov/

first line ART, (C) second line ART, (C) failing second line, but still under antiretroviral treatment with a multi-drug regime called salvage or rescue therapy. Categories A is coded as 2.1.9 palliative care, B, C and D should be coded under its corresponding ASC 2.1.03 category..

ART should be delivered as part of a package of care interventions, including the provision of co-trimoxazole prophylaxis, the management of opportunistic infections and co-morbidities, nutritional support and palliative care. PMTCT-plus ARV-treatment activities should be coded under this code. Among children, other activities should be coded within programmes for orphans and vulnerable children (OVC) affected by HIV and AIDS. The expenditures associated with this activity should be accounted according to the specific beneficiary populations receiving the services such as women or children.

***ASC.2.1.04 Nutritional support associated to ARV therapy*** consists in clinical services that include food and nutritional supplements.

***ASC.2.1.05 Specific HIV-related laboratory monitoring*** includes laboratory expenditures for the delivery of CD4 cell count[24], viral load determination and testing for drug resistance aimed to monitor the biological response to antiretroviral therapy and to determine the disease progression for a person with HIV related disease. The viral load determines the amount of HIV RNA in a blood sample, reported as the number of HIV RNA copies per ml. of blood plasma. The VL provides information about the number of cells infected with HIV and is an important indicator of HIV progression and of the effectiveness of a treatment. The VL can be measured by different techniques, including branched chain DNA (bDNA) and reverse transcriptase-polymerase chain reaction (RT-PCR) assays. VL tests are usually done when an individual is diagnosed with HIV infection and at regular intervals after diagnosis. Resistance testing consists in a laboratory test to determine if an individual's HIV strain is resistant to any anti-HIV drugs and guide his/her clinical treatment. HIV drug resistance surveillance is aimed to the epidemiological monitoring of the prevalence and circulation of resistant viral strains among HIV infected specific populations. Thus providing with the number or proportion of HIV infected people in a given population whose HIV is resistant to particular anti-HIV drugs. The former activity for epidemiological purposes should be coded then under ASC.4.06. Other tests to monitor patients, e.g.: biochemistry and haematology tests should also be included as ASC.2.1.05.

***ASC.2.1.06 Dental programs for people living with HIV refer to*** odontological and related services performed on people living with HIV.

***ASC .2.1.07 Psychological treatment and support services***.

***ASC.2.1.08 Palliative care*** refers to attention that addresses pain and discomfort associated with HIV. All basic health care and support activities either clinic- or

[24] The CD4 cell count is a measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV/AIDS. A CD4 cell count is used by health care providers to determine when to begin, interrupt, or halt anti-HIV therapy; when to give preventive treatment for opportunistic infections; and to measure response to treatment. A normal CD4 cell count is between 500 and 1,400 cells/mm3 of blood, but an individual's CD4 count can vary. In HIV-infected individuals, a CD4 count at or below 200 cells/mm3 is considered an AIDS-defining condition.

home/community-based activities for HIV-infected adults and children and their families aimed at optimizing quality of life for HIV-infected persons and their families throughout the continuum of care by means of symptom diagnosis and relief; psychological and spiritual support; and culturally-appropriate end-of-life care. Clinic-based and home/community-based care and support activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV and AIDS should be coded under Orphans and Vulnerable Children and the antiretroviral treatment under antiretroviral therapy. Palliative care is a package of basic services provided to those people nearing death. Where records permit, a desegregation may be useful:

***ASC.2.1.09 Home based care*** *is external support for the AIDS chronically ill individuals and their families.*

***ASC.2.1.09.1 Home-based medical care:*** minor medical care, supplies for medical care except ARV (ASC.2.1.03) and nutritional support for ART (ASC.2.1.04).

***ASC.2.1.09.2 Home-based non medical non- health care*****:** food, companionship**.**

***ASC.2.1.09.98 Home-based care not-disaggregated***

***ASC.2.1.10 Alternative care and informal care and treatment services***. Alternative medicine represents any type of therapy that is not considered standard practice in a given culture. Includes traditional Chinese medicine, homeopathy, naturopathy, herbal medicine, and chiropractic methods. Complementary therapies are additional forms of treatment used as an adjunct to standard therapy, while alternative therapies are used instead of standard therapy. These services are usually delivered by alternative and informal providers and include specifically AIDS related activities.

***ASC.2.1.99 Other Outpatient Care services not elsewhere classified (n.e.c.)*** Includes all other outpatient interventions and activities that are not captured above in which the country is incurring and considers them as a relevant spending.

***ASC.2.2 In-patient care.*** All in-hospital care activities for HIV-infected adults and children aimed at the treatment of HIV related disease by means of diagnosis procedures, surgery, intensive care and overall hospital care. Hospital treatment for opportunistic infections should be coded as ASC 2.2.1. Though antiretroviral treatment usually is provided on an ambulatory basis, it should be coded under ASC 2.1.03, regardless of the setting in which is provided, ambulatory clinic or hospital.

***ASC.2.2.1 Opportunistic infections' (OI) treatment.*** The treatment of opportunistic infections (OI) refers to a package of medications, diagnoses and care episodes used for treatment of HIV-related diseases. OI are illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Persons living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in persons diagnosed with AIDS include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral and fungal infections. General TB treatment, prevention and related programming must be coded with expenditures directed for TB and not with HIV and AIDS funds to avoid double counting and overlap with other programmes' expenditures.

The total treatment cost of opportunistic infections is to be reported, not the AIDS treatment cost.

***ASC.2.2.99 In-patient care services not elsewhere classified (n.e.c.)*** Includes all other In-patient care interventions and activities that are not captured above in which the country is incurring and considers them as a relevant spending.

***ASC.2.3 Patient transport and emergency rescue:*** includes transport by ambulances and by all means of transport used for HIV and AIDs patients undergoing treatment and costs incurred for relatives travelling for the purpose to provide of company and assistance to these patients.

***ASC.2.99 Care and treatment services not elsewhere classified (n.e.c.)***. Includes all other care and treatment programmes, interventions and activities that are not captured above in which the country is incurring and considers them as a relevant spending. The resource tracking team will open subheadings to provide a comprehensive picture of all the expenditures allocated to the care and treatment directed to people living with HIV and AIDS patients and not listed above (e.g. some types of cancers). These services are directed to people living with HIV and AIDS patients and should be coded under ASC.2.99.

## *ASC.3 Orphans and Vulnerable Children (OVC).*

An orphan is defined as a child under the age of 18 who has lost one or both parents regardless of financial support (AIDS programme-related or not).

A Sub-Sahara African resource tracking lists the services to all orphans living below the nation-defined poverty line. Outside of Sub-Saharan Africa the resource tracking represent the AIDS contribution to general orphan programmes.

Children living below the poverty line who are dual orphans (children who have lost both parents), near orphans (children who will be orphaned in the following year) and half of those single orphans (children who have lost one parent).

To the extent that beneficiaries may be counted but benefits are not directly counted, these are measured as the counterpart of all expenses, transfers and related investments, including administrative costs incurred.

All services aimed at improving the lives of orphans and other vulnerable children and families affected by HIV and AIDS (other than the preventive services identified under ASC.1) should be retained. The “preventive health services for orphans and vulnerable children”, duly identified under ASC.1, should not be double-counted. Palliative care, including basic health care and support and TB/HIV prevention, management and treatment, as well as their related laboratory services and pharmaceuticals, when delivered within programmes for orphans and other vulnerable children affected by HIV and AIDS, should be coded in this class. Other health care associated with the continuum of HIV and AIDS illness, including HIV/TB services, when delivered outside a programme for orphans and other vulnerable children affected by HIV and AIDS, should be coded under the specific care programme. ART for children should be coded under ASC.2.1.03.2. The OVC component includes the following interventions and activities.

***ASC.3.1 OVC Education***. Primary school/Secondary school (school fees, uniforms, books and supplies, special fees/assessments)

***ASC.3.2 OVC Basic health-care*** (basic child care services such as immunizations, nutrition and routine health care, sexual and reproductive health services for older children). ART for children should be coded under ASC.2.1.03.2

***ASC.3.3 OVC Family / Home support*** (bed nets, clothes and shoes, blankets and bedding, food, income generation, child social assistance grants and other support).

***ASC.3.4 OVC Community support*** (identification of OVC in the community, outreach for street children, training and supporting full-time community workers, child care)

***ASC.3.5 OVC Administrative / Organization costs*** (e.g. birth certificates and other administrative and institutional arrangements necessary for implementing OVC care).

***ASC.3.6 OVC Institutional care***

***ASC. 3.99 OVC services for OVC not elsewhere classified (n.e.c).*** All other services addressing the needs and targeting specifically orphans and vulnerable children not listed above.

## *ASC.4 Programme management and administration strengthening*

Programme expenditures are defined as expenses that are incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, and facility upgrading through purchases of laboratory equipment and of telecommunications. Resource tracking includes the investment of training medical students and nurses in low-income countries. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole. It is important to note that, when linking programme expenditure to people's access to treatment and prevention, only the share of investment that contributes to an HIV and AIDS response and that is required to provide the services provided as part of the response to the HIV and AIDS scourge be included. The programme management component includes the following interventions and activities:

***ASC.4.01 Planning, coordination and programme management*** refers to expenditure incurred at administrative level outside the point of health care delivery, includes the dissemination of strategic information, of best practice - programme efficiency & effectiveness, planning/evaluation of prevention, care and treatment efforts; analysis and quality assurance of demographic and health data related to HIV and AIDS, the testing of implementation models even though these may be conducted in an delivery institution. Coordination activities, for instance in support to the Three Ones principle: Coordination of a single approved AIDS action framework and support to build/strengthen one National AIDS Coordinating Authority. Also included are expenditures related to the conduct of National AIDS Strategic planning and of Human Resource planning (e.g. district level). The resource tracking for human resources under programme costs are distinct from the disbursements of human resources as reported for personnel providing

prevention and treatment—ASC.1 and ASC.2—because those are offered as part of health care delivery services.

***ASC.4.02 Programme Administration and Transaction costs associated with managing and disbursing funds.*** Costs incurred to search and contract a financing agent which is incited to assume the purchasing function for a given ASC. This may be a multiple layer process, identified and monitored or external to the financing process proper. This item attempts to trace the costs of this procedure. This category captures a sometimes multi-layer process by which the designer or prime designer of an HIV/AIDS programme convenes to entrust the running of a programme to an agent. Overheads related to the management of funds should be captured here.

***ASC.4.03 Monitoring and evaluation***. Expenses related to ascertaining the direction and ultimate achievement of measurement of programme progress, the provision of feedback for accountability and quality, and implementation of targeted programmatic evaluation, the implementation and upgrading of information management systems (e.g. other monitoring and health management information systems), the evaluation of prevention, care and treatment efforts. Expenditures on M&E should include the salaries of the staff who implement monitor and evaluation programmes. Expenditures to conduct National Aids Spending Assessments (NASA) should be included under this code.

***ASC.4.04 Operations research.*** Investments and expenses incurred to perform applied operations research aimed at improving the management, delivery, and quality of health services. An operations researcher faced with a new problem is expected to determine which techniques are most appropriate given the nature of the system, the goals for improvement, and constraints on time and computing power.

***ASC.4.05 Serological-surveillance*** (Serosurveillance). Expenditure on registry, processing of information aimed to document the incidence and specific prevalence of the epidemic in the general population as well as specific populations. This entry also includes sentinel studies, mandatory reporting of cases and epidemiological analysis. Surveillance implies the ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. Collecting blood samples for the purpose of surveillance is called sero-surveillance. Built upon a country's existing data collection system, second generation HIV surveillance systems are designed to be adapted and modified to meet the specific needs of differing epidemics. For example, HIV surveillance in a country with a predominantly heterosexual epidemic will differ radically from surveillance in a country where HIV infection is mostly found among men who have sex with men (MSM) or injecting drug users (IDUs). Drug resistance surveillance is to be recorded under ASC.4.06. The surveillance programmes are aiming to improve the quality and diversity of information sources by developing and implementing standard and rigorous study protocols, using appropriate methods and tools.

***ASC.4.06 HIV drug-resistance surveillance*** includes the setting-up of sentinel sites, laboratory operations, materials and goods and the integration and support for activities of a National HIV-Drug Resistance Committee. Genotypic Assay (GART). HIV drug resistance surveillance is aimed to the epidemiological monitoring of the prevalence and to determine the circulation of resistant viral strains among HIV infected specific populations. Thus providing with the number or proportion of HIV infected people in a

given population whose HIV is resistant to particular anti-HIV drugs. Genotypic Antiretroviral Resistance Test (GART) determines if a particular strain of HIV has specific genetic mutations that are associated with drug resistance. The test analyzes a sample of the virus from an individual's blood to identify any genetic mutations that are associated with resistance to specific drugs. The Phenotypic Assay is different from a genotypic assay, which uses an indirect method, and determines by a direct experiment whether a particular strain of HIV is resistant to anti-HIV drugs.

***ASC.4.07 Drug supply systems*** includes the procurement, logistics, transportation and supply of antiretroviral and other essential drugs for the care of people with HIV infection. These expenditures are aimed to increase the capacity of logistics and drug supply systems, including staffing, development of administrative systems and upgrading of transportation infrastructure. These activities involve the support systems for pharmaceuticals, diagnostics, medical equipment, medical commodities and supplies to provide care and treatment of persons living with HIV and related infections. This includes the design, development and implementation of improved systems for forecasting, procurement, storage, distribution, and performance monitoring of HIV and AIDS pharmaceuticals, commodities and supplies. This category is limited to the actual purchase of pharmaceuticals, diagnostics, medical equipment, medical commodities and supplies needed to provide care and treatment of persons living with HIV and AIDS. This includes actual spending to improve ordering, purchasing, shipment and delivery of the full range of HIV- and AIDS-related pharmaceuticals, diagnostics and other medical commodities. Antiretroviral drugs purchased and delivered, must be coded under ASC 2.1.03 expenditures directed to antiretroviral therapy.

***ASC.4.08 Information technology.*** Implementation and upgrades of information systems, software and hardware integrated in information networks to manage clinical outcomes information.

***ASC.4.09 Supervision of personnel and patient tracking.*** The activities and resources to supervise personnel working on the field tracking patients and providing adherence support and treatment preparedness. These activities need to be accounted explicitly for HIV patients and special populations (e.g. IDUs). Salaries of human resources required to provide treatment and care services are covered to some extent in the expenditures to provide overall health services —ASC 2—programme costs (e.g. community health workers) and the human resource component 5.1, 5.2 and 5.3 (training and salaries for additional nurses and doctors).

***ASC.4.10 Upgrading and construction of infrastructure*** deals with investments, purchases and expenses that involve the construction, renovation, leasing, procurement (equipment, supplies, furniture, and vehicles), overhead and/or installation for the implementation of HIV and AIDS programmes. They include capital investments for building infrastructure that provide HIV and AIDS services. The programme investments include high fixed start-up costs (buying computers, e-mail connectivity, etc), specifically activities for the clinical monitoring and the purchase of new equipment. Development and strengthening of laboratory facilities to support HIV- and AIDS-related activities including purchase of equipment and commodities, provision of quality assurance, staff training and other technical assistance.

***ASC.4.10.1 Upgrading laboratory infrastructure and new equipment.***

***ASC.4.10.2 Construction of new health centres*** includes investment in new facilities to handle the prevention, treatment and care of people living with HIV and AIDS.

***ASC.4.10.99 Upgrading and construction of infrastructure not elsewhere classified (n.e.c.)***

***ASC.4.99 Programme management- administration strengthening activities not elsewhere classified (n.e.c).***

## *ASC.5 Human resources' recruitment and retention incentives - Human capital*

Services of the workforce through approaches for recruitment, retention, deployment and rewarding of quality performance of health care workers and managers to work in the HIV and AIDS field. The HIV and AIDS workforce is not limited to the health system. Included in this category is the direct payment of wage benefits for health care workers. These expenditures are aimed at ensuring the availability of human resources of what is currently available in the health sector. Thus they only aim at including the additional incentives for this purpose. The direct cost associated to human resources is included within the costs of each of the other spending categories.

For example, the human resources are accounted for within the unit costs of prevention and treatment interventions—ASC. 1 (Prevention) and ASC 2. (Care and treatment)—and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well— ASC. 4. (Programme Management).

Human resources are also included under the spending categories components (e.g. treatment management, community health workers linked to prevention activities, technical assistance). The incentives for human resources, currently covers mainly nurses and doctors; in a broader public health approach, the concept should also apply to monetary incentives to counsellors, clinical officers, adherence supporters and laboratory staff.

***ASC 5.1 Monetary incentives for physicians.*** Wage benefits for doctors at delivery service incorporated in the total remuneration package as a way of attracting and retaining human resources for health.

***ASC 5.2 Monetary incentives for nurses.*** Wage benefits for nurses at delivery service incorporated in the total remuneration package as a way of attracting and retaining human resources for health.

***ASC 5.3 Monetary incentives for other staff.*** Wage benefits for laboratory personnel, and other staff associated to HIV and AIDS delivery services. Strengthening the cadres of community health workers is covered as well. This should include the costs for health workers, social workers, especially nurse practitioners, clinical officers, and laboratory technicians.

***ASC 5.4*** ***Formative education to build-up of an AIDS workforce*** includes the provision of education for additional nurses and physicians that will be needed in the future. Activities to strengthen or expand pre-service education, such as curriculum development or faculty training, are also coded under this category.

***ASC 5.5*** ***Training***. Training sessions for all the appropriate senior professionals and health and non-health para-professionals include in-service training and continuing education delivered through a variety of modalities such as workshops, distance learning, on-the-job training, mentoring, etc. Support for building specific skill areas should also be included here, for example, strengthening interpersonal communication, improving laboratory skills, nutritional education for people living with HIV and their families.

***ASC5.99*** ***Other incentives for human resources not elsewhere classified (n.e.c.):*** *incentive programmes for human resources not included in above.*

### *ASC.6 Social protection and social services (excluding OVC)*

Social Protection conventionally refers to functions of government relating to the provision of cash-benefits and benefits-in-kind to categories of individuals defined by needs such as sickness, old age, disability, unemployment, social exclusion, and so on. Social Protection comprises personal social services and social security. Government outlays include expenditures on services and transfers provided not only to individual persons but also to households as well as expenditures on services provided on a collective basis. Because ASC monitors specifically programmes aimed at orphans and vulnerable children, when using public finance records by functions (the Classification of the Functions of Government, COFOG), care should be taken to separate social protection and social expenditure on orphans and children having lost one parent due to AIDS from the transfer payments and direct social outlays for these social purposes.

***ASC.6.1*** ***Social protection through monetary benefit*** includes social transfers such as “medical pensions”, early retirement and disability benefits for people living with HIV and AIDS, or family members.

***ASC.6.2*** ***Social protection through in–kind benefits*** refers to food security, food parcels, nutritional support, clothing, school fee rebates, books, transport and food vouchers, and support for HIV-positive persons.

***ASC.6.3*** ***Social protection through provision of social services*** refers to the development of activities aimed at social mitigation for people living with HIV and their families including funerary expenses, burial society fees, day-care services and transportation for patients.

***ASC.6.4*** ***HIV-specific income generation*** relates to projects and efforts to develop public work programmes, skills development, sheltered employment, livelihood, micro-credit and financing. Small grants for businesses activities for people living with HIV.

***ASC.6.99 Social protection services and social services not elsewhere classified (n.e.c.)*** Other direct economic support and social assistance to families affected by the HIV that comprises a social protection aspects.

### *ASC.7 Enabling environment and community development*

***ASC.7.1 Advocacy and strategic communication.*** Advocacy in HIV and AIDS includes a full set of services that generate an increased and wide range of support key principles and essential actions as well as the development of a communication strategy. It also includes the promotion of the scaling up of national, regional HIV and AIDS programmes by national governments with key partners, such as bilateral and multilateral donors, civil society and the private sector. Promotion and support of the development of a strong HIV constituency at the regional and country level, among civil society including: community groups; policy makers; opinion leaders; leaders of faith-based organizations; women's groups; youth leaders; people living with HIV and AIDS; to strengthen their capacity to advocate for effective HIV prevention, care and social support. Spending on all advocacy efforts to enhance the national response to HIV and AIDS. Strategic communication includes media reports, public pronouncements, national and regional declarations and conferences.

***ASC.7.2 Human rights.*** All the activities and resources invested for the protection of human rights, legislative aspects of employment and discrimination, legal counselling and services, efforts to overcome discrimination and improve accessibility to social and health services.

***ASC.7.3 AIDS-specific Institutional Development.*** Investment in nongovernmental organization capacity building (including faith-based organizations). Strengthening the ability of key local institution's to implement HIV and AIDS programmes efficiently with diminishing reliance, over time, on external technical assistance. This includes services that improve the financial management, human resource management, quality assurance, strategic planning, and leadership and coordination of partner organizations.

***ASC.7.4 AIDS-specific programmes focused on women.*** Programmes targeting women and girls, in addition to those explicitly included in the spending categories described above, for instance improved reproductive health activities, programmes to reduce violence against women, assistance and counselling addressing abused women and programmes to protect the property and inheritance rights of women and girls.

***ASC.7.99 Enabling environment and community development activities not elsewhere classified (n.e.c.):*** *environemental and community enablement programmes not specified, not included in above classes.*

## *ASC.8 HIV and AIDS-related research (excluding operations research)*

HIV- and AIDS-related research is defined as the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, improve the population's development and the people's well being. Researchers are professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS. Managers and administrators should be included when they spend at least 10% of their time supporting research activities. Researchers include postgraduate students but do not include technicians. Technicians and equivalent staff are persons whose main tasks require technical knowledge and experience. They participate in R&D by performing

scientific and technical tasks involving the application of concepts and operational methods, normally under the supervision of researchers. This category excludes operations research on health systems aimed to the improvement of health outcomes, including project or programme evaluation, which should be coded under ASC.4.04

Research, other than operations research, is not directly linked to the provision of services, and thus, it might be considered to be a satellite component of the expanded response to HIV and AIDS. Care is advised as to correctly classify research activities properly and not to include other activities frequently confused with research, such as population studies for epidemiological surveillance, monitoring and evaluation of the programmes, etc. The following activities are included when directly related to HIV and AIDS and the resource tracking activities within the NASA is considered optional.

***ASC.8. 1 Biomedical research***, which comprises the study of detection, cause, treatment and rehabilitation of persons with specific diseases or conditions, the design of methods, drugs and devices to address these health problems, and scientific investigations in such areas as cellular and molecular bases of disease, genetics and immunology.

***ASC.8.2 Clinical research***, which is based on the observation and treatment of patients or volunteers.

***ASC.8.3 Epidemiological research,*** which is concerned with the study and control of diseases and of exposures and other situations suspected of being harmful to health, care to exclude epidemiological surveillance is advised.

***ASC.8.4 Social science research***, which investigates the broad social aspects of HIV and AIDS.

***ASC.8.5 Behavioural research,*** which is associated with risk factors for ill health and disease with a view to promoting health and preventing disease, care to exclude epidemiological surveillance as well as evaluation of preventive interventions, is advised.

***ASC 8.6 Research in economics,*** *which* investigates a wide range of economic aspects of the HIV infection and the AIDS epidemic.

***ASC.8.7 Vaccine-related research.*** Specific activities aimed to support basic, laboratory, clinical and field related research for developing and testing an HIV vaccine.

***ASC.8.99 HIV and AIDS-related research activities not elsewhere classified (n.e.c.)***

## *TARGETED / INTENDED-BENEFICIARY POPULATIONs (BP): definitions and descriptions*

The Beneficiary Population aims at quantifying the resources specifically allocated to a population as part of the service delivery process of a programmatic intervention. The BP will be selected according the intention or target of the expenditure in such programmatic intervention. This represents an outcome linked to the resources spent, regardless of its effectiveness or effective coverage.

As a principle, the identification of the BPs is dictated by the intention of the use of the funds. For example, if members of the most at risk populations (MARP) are reached by

services aimed at the general population, the respective expenditure should be accounted for the latter, i.e. general population, and can not be attributed to any specific MARP population.

The NASA Beneficiary Populations classification is not intended to be used as a guideline to define populations by their characteristics that might make them be considered as those most at risk, key or priority populations[25]. It is intended to be a comprehensive list of diferent populations that are being considered as the intended beneficiary populations of HIV related services. Most of these categories follow different modes of delivery of services, unit-cost structures, etc. Additional populations might be targetted beneficiaries for HIV services; these could be coded with the ending two digits ".98".

***BP.1 People living with HIV*** (regardless of having a medical/clinical diagnosis of AIDS) This BP should be crossed with ASC which are conducted because the beneficiary of the activity is living with HIV .i.e.: ASC.2 Care and Treatment and ASC.1.07 Prevention of HIV transmission aimed at persons living with HIV. If the information is available, it can be crossed with the specific demographic group. E.g.: Boys receiving ART should be coded as ASC.1.03.2.x and crossed with BP.1.2.1 Boys (5-14). Whenever the information available does not allow splitting the expenditure by age and/or gender, the expenditure should be coded with the corresponding ending two digits ".98".

***BP.1.1 Adult and Young people (15 years of age and over) living with HIV***

***BP.1.1.1 Adult and Young men (15 years of age and over) living with HIV***

***BP.1.1.2 Adult and Young women (15 years and over) living with HIV***

***BP.1.1.98 Adult and Young people (15 years and over) living with HIV not disaggregated by gender***

***BP.1.2 Children (under 15) living with HIV***

***BP.1.2.1 Boys (under 15) living with HIV***

***BP.1.2.2 Girls (under 15) living with HIV***

***BP.1.2.98 Children (under 15) living with HIV not disaggregated by gender***

***BP.1.98 People living with HIV not-disaggregated by age or gender***

***BP.2 Most at risk populations*** can be grouped based on the behaviour they engage in that put them at greater risk for HIV infection. This, in turn, identifies those populations that should be a priority for monitoring and evaluation efforts of national and sub national programmes. These groupings of most-at-risk populations generally include the following: sex workers, their clients, injecting drug users, and men who have sex with men. These are populations more likely to have high rates of sexual partner exchange, to practice unprotected sex with multiple partners, or to use non-sterile drug injecting

[25] The concepts regarding the terms of "Most-At-Risk Populations and key populations at higher risk" are described in detail in: "A guide to monitoring and evaluating national HIV prevention programmes for Most-At-Risk Populations in low-level and concentrated epidemic settings; with applications for generalized epidemics" UNAIDS, 2007; and "Practical Guidelines for Intensifying HIV Prevention" UNAIDS, 2007. Available at: http://www.unaids.org.

equipment, all of which puts them at risk of exposure to HIV. Each MARP has a specific ASC, i.e. ASC.1.08 for SW, ASC.1.09 for MSM and ASC.1.10 for IDUs. For example, any intervention addressed to Sex Workers must be captured in ASC.1.08 and then crossed to the specific BP.2.2.x.

***BP.2.1 Injecting drug users (IDU) and their sexual partners***

***BP.2.2 Sex workers (SW) and their clients***

***BP.2.2.1 Female sex workers and their clients***

***BP.2.2.2 Male transvestites sex workers (and their clients)***

***BP.2.2.3 Male non-transvestites sex workers (and their clients)***

***BP.2.2.98 Sex workers not disaggregated by gender and their clients***

***BP.2.3 Men who have sex with men (MSM)***

***BP.2.99 "Most at risk populations" not elsewhere classified (n.e.c.)***

***BP.3 Other key populations*** includes populations such as orphans and vulnerable children, children born or to be born to HIV mothers, refugees, internally displaced, migrants, etc., considered as "key populations" for being key both for the epidemic's dynamics and key to the response.

***BP.3.01 Orphans and vulnerable children (OVC):*** An orphan is defined as a child under the age of 18 who has lost one or both parents regardless of financial support (AIDS programme-related or not). This BP must be crossed with its correspondent ASC under chapter ASC.3

***BP.3.02 Children born or to be born from women living with HIV:*** **(**must be crossed with ASC.1.17)

***BP.3.03 Refugees (externally displaced):*** Externally displaced populations (from outside the country borders) because of political or any other cause, seeking protection temporarily or permanently in the country. Must be crossed with ASC.1.04.x Risk Reduction for vulnerable and accessible populations.

***BP.3.04 Internally displaced populations (because of an emergency):*** People internally displaced because of an emergency, e.g.: earthquake, floods. Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.05 Migrants / Mobile Populations:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.06 Indigenous groups:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.07 Prisoners and other institutionalized persons:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.08 Truck drivers / Transport workers and commercial drivers:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.09 Children and youth living in the street:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.10 Children and youth gang members:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.11 Children and youth out of the school:*** Must be crossed with ASC.1.06 Prevention – Youth out-of-school.

***BP.3.12 Institutionalized children and youth:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.13 Partners of persons living with HIV:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.3.14 Recipients of Blood or Blood products***: Must be crossed with ASC.1.18 Blood Safety.

***BP.3.99 "Other Key populations" not elsewhere classified (n.e.c.):*** populations considered as "key population" at country level and not included in above classes. Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.4 Specific "accessible" populations*** include children in school, people attending STI clinics, children in school, women attending reproductive health clinics, military, factory employees, etc.

***BP.4.01 People attending STI clinics:*** Must be crossed with ASC.1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI).

***BP.4.02 Children in school:*** Must be crossed with ASC.1.05 Prevention – Youth in School. To be crossed with ASC.1.05 Prevention – Youth in School. (under 15 years old)

***BP.4.03 Youth at school:*** Must be crossed with ASC.1.05 Prevention – Youth in School. To be crossed with ASC.1.05 Prevention – Youth in School. (15 years old and more)

***BP.4.04 University students:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.4.05 Health care workers:*** Must be crossed with ASC.1.19.1 PEP in health care setting and/or ASC.1.22 Universal Precautions.

***BP.4.06 Sailors:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.4.07 Military:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.4.08 Police and other uniformed services (other than the military):*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.4.09 Ex-combatants and other armed non-uniformed groups:*** Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.4.10 Factory Employees / Workers (i.e. for workplace interventions):*** Must be crossed with ASC.1.11 (ASC.1.11.1, ASC.1.11.2, ASC.1.11.3, ASC.1.04.4, ASC.1.11.98 or ASC.1.11.99) Prevention programmes in the workplace.

***BP.4.99 "Accessible populations" not elsewhere classified (n.e.c.)*** populations considered as "accessible population" at country level and not included in above classes. Must be crossed with ASC.1.04 (ASC.1.04.1, ASC.1.04.2, ASC.1.04.3, ASC.1.04.4, ASC.1.04.98 or ASC.1.04.99) Risk Reduction for vulnerable and accessible populations.

***BP.5 General population*** it comprises interventions targeting the General population as a hole and not any particular accessible or key population. E.g.: a TV or Radio campaign of Communication for social and behavioural change, VCT.

***BP.6 Non-targeted*** *interventions: Expenditures not belonging to explicitly selected or targeted populations. Interventions not targeted to a specific population, or interventions benefiting a population on an indirect way, i.e.: ASC.4, ASC.5 and ASC.8 interventions should be crossed with BP.6.*

***BP.99 Specific targeted populations not elsewhere classified (n.e.c.)*****: targeted** populations not included in above classes.

# Annex 2 Tracking resources for the production and provision of HIV and AIDS services

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 supplied in a wide range of settings inside and outside the health industry. Providers include government and other public entities, private for-profit and non-profit organizations, corporate and non-corporate enterprises, self-employed persons whose activity falls within the NASA boundaries regardless of a formal or informal legal status.

Providers supply services and/or are responsible for a final product or the subcontracting of a complex process involving several units of production that may require the hiring of personnel and the acquisition of inputs, materials and services towards the final object sought. A provider is usually accountable to the beneficiary for the delivery and the

quality of the service rendered; the provision does not necessarily entail a positive or desirable outcome. All transactions between providers and beneficiaries are accountable.

A transaction between a financing agent and a provider of services is defined as the transfer of resources or purchasing of services. As part of that process, a financing agent acts on behalf of the final user and ensures the access to the services by financing and purchasing these services from the providers. The purchasing act entails a contractual arrangement, however informal this may be, that defines the service sought. The purchasing act may be related to a public policy, strategy, priority programme and intervention and the stewardship of the coordinating authority.

Accounting wise, transactions may be a cascade of purchasing acts. For example, a *National AIDS Coordinating Authority* (NAC) launches an Information & Communication campaign of awareness for the general population. To that end, it seeks collaboration from public providers and also contracts private providers. One component of the campaign may include the design, production, and exhibiting of posters. That *National AIDS Coordinating Authority* signs a collaboration agreement with the Information and Communication Department (I&C) at the Ministry of Education to design and produce posters. This institution, in turn, uses its own channels for the distribution of posters that are exhibited in public schools. The financing and purchasing agent is the NAC and the provider is the Ministry of Education through a so-called I &C establishment.

NASA includes traditional forms of medicine. Entries have been added for non-allopathic systems of medicine and for the dispensation of traditional or alternative medicines. These are important categories of providers in some regions. In South and East Asia, this category captures expenditures for hospitals of medical systems such as Ayurveda or traditional Chinese medicine, in Africa herbal and other forms of alternative medicine, not part of the allopathic tradition. The providers of all other services class should include the wide variety of informal and less-than-fully-qualified providers operating in many low-per capita income countries, regardless of whether these services are sanctioned by the legal system. When a category of provider does not exist in a country or when a decision has been made to exclude the services typically rendered by such providers, the categories listed need not be used. When a category of providers is somehow counted in the total but not shown separately, a second best is to include an "others" category. A new 1-digit category can be added to capture institutions that do not provide health care services but engage in other HIV and AIDS-relevant activities. A NASA guiding principle stipulates that all cells which logically need an entry be *populated* while abiding by another "plausibility" attribute.

Most providers listed in the classification hereafter supply services that address the demands and needs of the total population or of population segments that include groups other than persons with HIV or suffering from AIDS. A purpose of NASA is to capture the share of the activity that is related to a response to HIV and AIDS. This intent is pursued (and achieved) through sub-classifications in the main industrial and activity classifications or by a kind of pro-rating procedure which the accountants involved should carefully document.

NASA opts for a systematic distinction, unless not relevant / not applicable, between public (PS.1), private non-profit (PS.2), and private for profit (PS.3) providers. Public providers are territorial government-owned (central, regional, local) facilities, trust fund and extra-budgetary units (social security institutions, universities and autonomous government-owned establishments, public enterprise units whose social interventions are dissociated from their market operations). Private suppliers comprise non-profit and for-profit actors; below hospital level (PS.2.1 and PS.3.1), Private suppliers may be self-employed persons, nonetheless designated as "offices" regardless of size of their establishment. Bilateral and multilateral entities (PS.4) also play the role of providers of technical assistance, prevention activities, etc, Rest-of-the-world (PS.5) providers reflect a notional allocation of care obtained abroad by residents (in a few instances for which part of the records are accessible)

## *PROVIDERS OF SERVICES (PS): definitions and descriptions*

### *PS.1 Government Organizations*

#### *PS.1.1 Public and Para-statal Providers*.

**PS.1.1.01 Hospitals:** Public and Para-statal hospitals includes activities of short- or long-term hospitals, general or specialty medical and surgical and other human health institutions which have accommodation facilities and which engage in providing diagnostic and medical treatment to inpatients with any of a wide variety of medical conditions.

**PS.1.1.02 Ambulatory care:** Public and Para-statal establishments whose main function is the provision of medical nursing and other HIV and AIDS related attention on an out-patient basis. Included in this category are health centres and community health centres, whether specific or not for HIV and AIDS patients. Hospitals delivering ambulatory care, should be classified as hospitals, and crossed with the specific ASC outpatient activity delivered.

**PS.1.1.03 Dental offices:** Public and Para-statal offices of dental practitioners.

**PS.1.1.04 Mental health and substance abuse facilities:** Public and Para-statal psychiatric and substance abuse hospitals and rehabilitation centres.

**PS.1.1.05 Laboratory and imaging facilities:** Public and Para-statal establishments whose main function consists in carrying out diagnoses by means of biological analyses, clinical tests, radiology and other imaging devices.

**PS.1.1.06 Blood banks**: Public and Para-statal establishments whose main activity consists in collecting and screening blood and derivates.

**PS.1.1.07 Ambulance services:** Public and Para-statal supplier of transportation services by means of a vehicle adapted for the transport of patients.

**PS.1.1.08 Pharmacies and providers of medical goods:** Public and Para-statal suppliers of non durables (notably condoms), prosthetic and orthopaedic apparatuses, semi-durables, therapeutic appliances and other lasting equipment of personal use. Pharmacies inside hospitals or ambulatory centres should be coded as hospitals or ambulatory care.

The dispensation of herbal and other medicines consumed by AIDS sufferers, notably in Sub-Saharan Africa and in parts of Asia, may not take place in conventional retail outlets but carried out on open-air markets, which should not be coded as Pharmacies, but in the corresponding .99 category “others not else where classified”.

**PS.1.1.09 Traditional or non allopathic providers:** Public and Para-statal providers delivering traditional medicine. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

**PS.1.1.10 Schools and training facilities**: Public and Para-statal schools and training facilities comprise providers of schooling and other forms of transmission of knowledge and skills, including adult education, literacy programmes, military schools and academies, prison schools, etc, at any level or for any profession, oral or written as well as by radio and television or other means of communication, at their respective levels of enrolment. Training centers include all organizations whose main spending categories consists in staff training whenever HIV and AIDS is a specificity, e.g. clinical care, laboratory skills, counselling, human rights, advocacy and gender. According to the type of institution, it should be classidied as: PS.1.1.10.1.Primary education, PS.1.1.10.2 Secondary education, PS.1.1.10.3 Higher education or PS.1.1.10.99 Schools and training centres not elsewhere classified (n.e.c.).

**PS.1.1.11 Foster homes / shelters:** Public and Para-statal establishments providing temporary housing or sharing nurture for PLWHA.

**PS.1.1.12 Orphanages**: Public and Para-statal institutions whose main function consists in giving housing and care of orphans, foundlings, and abandoned children. Also called “group homes" or "children's homes”.

**PS.1.1.13 Research institutions:** Public and Para-statal organizations whose main function consists in generating new knowledge in matters of basic, applied, operational and administrative research that include programmes sustaining the response to HIV and AIDS. Three types of research are included: 1) basic research: experimental or theoretical work undertaken primarily to acquire new knowledge of the underlying foundations of phenomena and observable facts, without particular application or use in view, 2) applied research: original investigation undertaken in order to acquire new knowledge, directed primarily towards a specific practical aim or objective and 3) experimental development: systematic work, drawing on existing knowledge gained from research and/or practical experience, directed to producing new materials, products and devices, to installing new processes, systems and services, and to improving substantially those already produced or installed. Research and experimental development activities in this entry are subdivided into two categories: natural sciences and engineering; social sciences and the humanities.

**PS.1.1.14 Government entities:** Providers of good and services of the National HIV Response which are part of General Government, such as the National AIDS Coordinating Authority (National AIDS Commission and/or National AIDS Programme) and Departments inside different Ministries. These entities are mainly suppliers of promotion and prevention activities (including the interventions directed to their own personnel), as well as management, advocacy and regulation (mainly National AIDS

Commissions). The National AIDS programme, inside the Ministry of Health, should be coded as PS.1.1.14.2.

**PS.1.1.14.1 National AIDS Commission:** This item comprises all HIV related activities delivered by the National ASIDS Commission or equivalent entity. It does not comprise the activities delivered by other entities and for which the National AIDS Commission acts as an Agent exclusively.

**PS.1.1.14.2 Departments inside the Ministry of Health (including NAPs / NACPs):** This item comprises all HIV related activities delivered by Departments inside the Ministry of Health, except for the providers described under ASC.1.1.01 to ASC.1.1.13, which should captured in its correspondent ASC.1.1.01 to ASC.1.1.13.

**PS.1.1.14.3 Departments inside the Ministry of Education:** This item comprises all HIV related activities delivered by Departments inside the Ministry of Education, except for the providers described under ASC.1.1.01 to ASC.1.1.13, which should captured in its correspondent ASC.1.1.01 to ASC.1.1.13.

**PS.1.1.14.4 Departments inside the Ministry of Social Development:** This item comprises all HIV related activities delivered by Departments inside the Ministry of Social Development, except for the providers described under PS.1.1.01 to PS.1.1.13, which should captured in its correspondent PS.1.1.01 to PS.1.1.13.

**PS.1.1.14.5 Departments inside the Ministry of Defence:** This item comprises all HIV related activities delivered by Departments inside the Ministry of Defence, except for the providers described under PS.1.1.01 to PS.1.1.13, which should captured in its correspondent PS.1.1.01 to PS.1.1.13.

**PS.1.1.14.6 Departments inside the Ministry of Finance:** This item comprises all HIV related activities delivered by Departments inside the Ministry of Finance, except for the providers described under PS.1.1.01 to PS.1.1.13, which should captured in its correspondent PS.1.1.01 to PS.1.1.13.

**PS.1.1.14.7 Departments inside the Ministry of Labour:** This item comprises all HIV related activities delivered by Departments inside the Ministry of Labour, except for the providers described under PS.1.1.01 to PS.1.1.13, which should captured in its correspondent PS.1.1.01 to PS.1.1.13.

**PS.1.1.14.8 Departments inside the Ministry of Justice:** This item comprises all HIV related activities delivered by Departments inside the Ministry of Justice, except for the providers described under PS.1.1.01 to PS.1.1.13, which should captured in its correspondent PS.1.1.01 to PS.1.1.13.

**PS.1.1.14.99 Entities inside other Ministries or Public Administration entities not elsewhere classified (n.e.c.):** This item comprises all HIV related activities delivered by Entities inside other Ministries or Public Administration that are not captured in the previous definitions in PS.1.1.14, except for the providers described under PS.1.1.01 to PS.1.1.13, which should captured in its correspondent PS.1.1.01 to PS.1.1.13.

**PS.1.1.99 Providers not elsewhere classified (n.e.c.):** Public and Para-statal providers that are not contained in any of the previous definitions.

***PS.2 Non-Governmental Organizations:*** This item comprises Non-Governmental organizations providing good and services in the response to HIV. An NGO is an organization that is not part of the local or state or federal government. Even if the term NGO is usually interpreted as a synonym of non profit organization or of organizations that have primarily humanitarian or cooperative rather than commercial objectives, an NGO in its broadest sense, is one that is not directly part of the structure of government. In this sense, an NGO can either be a for profit or a non-profit organization.

***PS.2.1 Non-Profit Providers:*** This item comprises organizations providing good and services in the response to HIV that do not have profit-making purposes, Non-profit corporations, despite the name, can make a profit, but the profits must be used for the benefit of the organization or purpose the corporation was created for.

***PS.2.1.1 Non-Profit Providers (except Faith Based Organizations):*** This item comprises organizations providing good and services in the response to HIV that do not have profit-making purposes. Faith Based non-profit organizations, which should be coded as PS.2.1.2.

**PS.2.1.1.01 Hospitals:** Non-Profit short- or long-term hospitals, general or specialty medical and surgical and other human health institutions which have accommodation facilities and which engage in providing diagnostic and medical treatment to inpatients with any of a wide variety of medical conditions.

**PS.2.1.1.02 Ambulatory care:** Non-Profit establishments whose main function is the provision of medical nursing and other HIV and AIDS related attention on an out-patient basis. Included in this category are health centres and community health centres, whether specific or not for HIV and AIDS patients. Hospitals delivering ambulatory care, should be classified as hospitals, and crossed with the specific ASC outpatient activity delivered.

**PS.2.1.1.03 Dental offices:** Non-Profit offices of dental practitioners.

**PS.2.1.1.04 Mental health and substance abuse facilities:** Non-Profit psychiatric and substance abuse hospitals and rehabilitation centres.

**PS.2.1.1.05 Laboratory and imaging facilities:** Non-Profit establishments whose main function consists in carrying out diagnoses by means of biological analyses, clinical tests, radiology and other imaging devices.

**PS.2.1.1.06 Blood banks**: Non-Profit establishments whose main activity consists in collecting and screening blood and derivates.

**PS.2.1.1.07 Ambulance services:** Non-Profit supplier of transportation services by means of a vehicle adapted for the transport of patients.

**PS.2.1.1.08 Pharmacies and providers of medical goods:** Non-Profit suppliers of non durables (notably condoms), prosthetic and orthopaedic apparatuses, semi-durables, therapeutic appliances and other lasting equipment of personal use. Pharmacies inside hospitals or ambulatory centres should be coded as hospitals or ambulatory care. The

dispensation of herbal and other medicines consumed by AIDS sufferers, notably in Sub-Saharan Africa and in parts of Asia, may not take place in conventional retail outlets but carried out on open-air markets, which should not be coded as Pharmacies, but in the corresponding .99 category “others not else where classified”.

**PS.2.1.1.09 Traditional or non allopathic providers:** Non-Profit providers delivering traditional medicine. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

**PS.2.1.1.10 Schools and training facilities**: Non-Profit schools and training facilities comprise providers of schooling and other forms of transmission of knowledge and skills, including adult education, literacy programmes, military schools and academies, prison schools, etc, at any level or for any profession, oral or written as well as by radio and television or other means of communication, at their respective levels of enrolment. Training centers include all organizations whose main spending categories consists in staff training whenever HIV and AIDS is a specificity, e.g. clinical care, laboratory skills, counselling, human rights, advocacy and gender. According to the type of institution, it should be classidied as: PS.1.1.10.1.Primary education, PS.1.1.10.2 Secondary education, PS.1.1.10.3 Higher education or PS.1.1.10.99 Schools and training centres not elsewhere classified (n.e.c.).

**PS.2.1.1.11 Foster homes / shelters:** Non-Profit establishments providing temporary housing or sharing nurture for PLWHA.

**PS.2.1.1.12: Orphanages**: Non-Profit institutions whose main function consists in giving housing and care of orphans, foundlings, and abandoned children. Also called “group homes" or "children's homes”.

**PS.2.1.1.13: Research institutions:** Non-Profit organizations whose main function consists in generating new knowledge in matters of basic, applied, operational and administrative research that include programmes sustaining the response to HIV and AIDS. Three types of research are included: 1) basic research: experimental or theoretical work undertaken primarily to acquire new knowledge of the underlying foundations of phenomena and observable facts, without particular application or use in view, 2) applied research: original investigation undertaken in order to acquire new knowledge, directed primarily towards a specific practical aim or objective and 3) experimental development: systematic work, drawing on existing knowledge gained from research and/or practical experience, directed to producing new materials, products and devices, to installing new processes, systems and services, and to improving substantially those already produced or installed. Research and experimental development activities in this entry are subdivided into two categories: natural sciences and engineering; social sciences and the humanities.

**PS.2.1.1.14 Consultancy firms:** Non-Profit firm of experts providing professional advice or expertise to another organization for a fee.

**PS.2.1.1.15 Self Help Organizations:** Non-Profit organizations which provide an environment encouraging social interactions through group activities or individual

relationships especially for the purpose of rehabilitating or supporting patients, individuals dealing common health problems or risks.

**PS.2.1.1.16 Community Based Organizations:** Community-based organizations (CBOs) are informal organizations that provide various services towards the improvement of their living conditions.

**PS.2.1.1.99 Providers not elsewhere classified (n.e.c.):** Non-Profit providers that are not contained in the previous definitions.

***PS.2.1.2 Faith Based Organizations non-profit:*** This item comprises non-profit Faith Based Organizations providing good and services in the response to HIV. A faith-based organization is an organization, group, program or project that holds religious or worship services, or is affiliated with a religious denomination or house of worship. Faith-based non-profit organizations usually have a faith-based mission, but the services delivered may or may not have a faith-based content and they do not necessarily restrict participants to those who adhere to that particular faith.

**PS.2.1.2.01Hospitals:** Faith Based short- or long-term hospitals, general or specialty medical and surgical and other human health institutions which have accommodation facilities and which engage in providing diagnostic and medical treatment to inpatients with any of a wide variety of medical conditions.

**PS.2.1.2.02 Ambulatory care:** Faith Based establishments whose main function is the provision of medical nursing and other HIV and AIDS related attention on an out-patient basis. Included in this category are health centres and community health centres, whether specific or not for HIV and AIDS patients. Hospitals delivering ambulatory care, should be classified as hospitals, and crossed with the specific ASC outpatient activity delivered.

**PS.2.1.2.03 Dental offices:** Faith Based offices of dental practitioners.

**PS2.1.2.04 Mental health and substance abuse facilities:** Faith Based psychiatric and substance abuse hospitals and rehabilitation centres.

**PS.2.1.2.05 Laboratory and imaging facilities:** Faith Based establishments whose main function consists in carrying out diagnoses by means of biological analyses, clinical tests, radiology and other imaging devices.

**PS.2.1.2.06 Blood banks**: Faith Based establishments whose main activity consists in collecting and screening blood and derivates.

**PS.2.1.2.07 Ambulance services:** Faith Based supplier of transportation services by means of a vehicle adapted for the transport of patients.

**PS.2.1.2.08 Pharmacies and providers of medical goods:** Faith Based suppliers of non durables (notably condoms), prosthetic and orthopaedic apparatuses, semi-durables, therapeutic appliances and other lasting equipment of personal use. Pharmacies inside hospitals or ambulatory centres should be coded as hospitals or ambulatory care. The dispensation of herbal and other medicines consumed by AIDS sufferers, notably in Sub-Saharan Africa and in parts of Asia, may not take place in conventional retail outlets but

carried out on open-air markets, which should not be coded as Pharmacies, but in the corresponding .99 category "others not else where classified".

**PS.2.1.2.09 Traditional or non allopathic providers:** Faith Based providers delivering traditional medicine. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

**PS.2.1.2.10 Schools and training facilities**: Faith Based schools and training facilities comprise providers of schooling and other forms of transmission of knowledge and skills, including adult education, literacy programmes, military schools and academies, prison schools, etc, at any level or for any profession, oral or written as well as by radio and television or other means of communication, at their respective levels of enrolment. Training centers include all organizations whose main spending categories consists in staff training whenever HIV and AIDS is a specificity, e.g. clinical care, laboratory skills, counselling, human rights, advocacy and gender. According to the type of institution, it should be classified as: PS.1.1.10.1.Primary education, PS.1.1.10.2 Secondary education, PS.1.1.10.3 Higher education or PS.1.1.10.99 Schools and training centres not elsewhere classified (n.e.c.).

**PS.2.1.2.11 Foster homes / shelters:** Faith Based establishments providing temporary housing or sharing nurture for PLWHA.

**PS.2.1.2.12: Orphanages**: Faith Based institutions whose main function consists in giving housing and care of orphans, foundlings, and abandoned children. Also called "group homes" or "children's homes".

**PS.2.1.2.13: Research institutions** Faith Based organizations whose main function consists in generating new knowledge in matters of basic, applied, operational and administrative research that include programmes sustaining the response to HIV and AIDS. Three types of research are included: 1) basic research: experimental or theoretical work undertaken primarily to acquire new knowledge of the underlying foundations of phenomena and observable facts, without particular application or use in view, 2) applied research: original investigation undertaken in order to acquire new knowledge, directed primarily towards a specific practical aim or objective and 3) experimental development: systematic work, drawing on existing knowledge gained from research and/or practical experience, directed to producing new materials, products and devices, to installing new processes, systems and services, and to improving substantially those already produced or installed. Research and experimental development activities in this entry are subdivided into two categories: natural sciences and engineering; social sciences and the humanities.

***PS.2.2 For profit Private Providers (including for-profit FBO:*** This item comprises for profit organizations providing good and services in the response to HIV, including for profit Faith Based Organizations. A for-profit organization is an organization established or operated with the intention of making a profit.

**PS.2.2.01 Hospitals:** For profit Private short- or long-term hospitals, general or specialty medical and surgical and other human health institutions which have accommodation

facilities and which engage in providing diagnostic and medical treatment to inpatients with any of a wide variety of medical conditions.

**PS.2.2.02 Ambulatory care:** For profit Private establishments whose main function is the provision of medical nursing and other HIV and AIDS related attention on an out-patient basis. Included in this category are health centres and community health centres, whether specific or not for HIV and AIDS patients. Hospitals delivering ambulatory care, should be classified as hospitals, and crossed with the specific ASC outpatient activity delivered.

**PS.2.2.03 Dental offices:** For profit Private offices of dental practitioners.

**PS.2.3.04 Mental health and substance abuse facilities:** For profit Private psychiatric and substance abuse hospitals and rehabilitation centres.

**PS.2.2.05 Laboratory and imaging facilities:** For profit Private establishments whose main function consists in carrying out diagnoses by means of biological analyses, clinical tests, radiology and other imaging devices.

**PS.2.2.06 Blood banks**: For profit Private establishments whose main activity consists in collecting and screening blood and derivates.

**PS.2.2.07 Ambulance services:** For profit Private supplier of transportation services by means of a vehicle adapted for the transport of patients.

**PS.2.2.08 Pharmacies and providers of medical goods:** For profit Private suppliers of non durables (notably condoms), prosthetic and orthopaedic apparatuses, semi-durables, therapeutic appliances and other lasting equipment of personal use. Pharmacies inside hospitals or ambulatory centres should be coded as hospitals or ambulatory care. The dispensation of herbal and other medicines consumed by AIDS sufferers, notably in Sub-Saharan Africa and in parts of Asia, may not take place in conventional retail outlets but carried out on open-air markets, which should not be coded as Pharmacies, but in the corresponding .99 category “others not else where classified”.

**PS.2.2.09 Traditional or non allopathic providers:** For profit Private providers delivering traditional medicine. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

**PS.2.2.10 Schools and training facilities**: For profit Private schools and training facilities comprise providers of schooling and other forms of transmission of knowledge and skills, including adult education, literacy programmes, military schools and academies, prison schools, etc, at any level or for any profession, oral or written as well as by radio and television or other means of communication, at their respective levels of enrolment. Training centers include all organizations whose main spending categories consists in staff training whenever HIV and AIDS is a specificity, e.g. clinical care, laboratory skills, counselling, human rights, advocacy and gender. According to the type of institution, it should be classidied as: PS.1.1.10.1.Primary education, PS.1.1.10.2 Secondary education, PS.1.1.10.3 Higher education or PS.1.1.10.99 Schools and training centres not elsewhere classified (n.e.c.).

**PS.2.2.11 Foster homes / shelters:** For profit Private establishments providing temporary housing or sharing nurture for PLWHA.

**PS.2.2.12: Orphanages**: For profit Private institutions whose main function consists in giving housing and care of orphans, foundlings, and abandoned children. Also called “group homes" or "children's homes”.

**PS.2.2.13: Research institutions:** For profit Private organizations whose main function consists in generating new knowledge in matters of basic, applied, operational and administrative research that include programmes sustaining the response to HIV and AIDS. Three types of research are included: 1) basic research: experimental or theoretical work undertaken primarily to acquire new knowledge of the underlying foundations of phenomena and observable facts, without particular application or use in view, 2) applied research: original investigation undertaken in order to acquire new knowledge, directed primarily towards a specific practical aim or objective and 3) experimental development: systematic work, drawing on existing knowledge gained from research and/or practical experience, directed to producing new materials, products and devices, to installing new processes, systems and services, and to improving substantially those already produced or installed. Research and experimental development activities in this entry are subdivided into two categories: natural sciences and engineering; social sciences and the humanities.

**PS.2.2.14 Consultancy firms:** For profit Private firm of experts providing professional advice or expertise to another organization for a fee.

**PS.2.2.99 Providers not elsewhere classified (n.e.c.):** For profit Private Providers that are not contained in the previous definitions.

**PS.3 Bilateral and multilateral entities – in country offices:** Besides their main role as Financing Sources and/or Financing Agents, whenever they are directly involved in the production of good and services captured in the Aids Spending Categories (ASC), the in country Bilateral and Multilateral offices are also playing the role of providers, and they must be registered accordingly. Bilateral and multilateral agencies are suppliers of technical assistance, management, prevention and advocacy activities, among other significant interventions.

**PS.3.1 Bilateral Agencies:** Biltilateral in country offices providing goods and services in the response to HIV

**PS.3.2 Multilateral Agencies:** Multilateral in country offices providing goods and services in the response to HIV

**PS.5 Rest-of-the world providers:** Providers delivering goods and services to national residents. Example: people living with HIV visiting private physicians of a neighbouring country. Or blood samples sent abroad for CD4 or Viral Load testing. Whatever service is being provided abroad to national residents should be coded here. Sometimes a national laboratory can send blood samples abroad to be tested, but in this case the provider is still the national laboratory that is subcontracting services abroad (that will finally be production factors).

**PS.99 Providers not elsewhere classified (n.e.c.):** Providers that are not contained in the previous definitions.

## *PRODUCTION FACTORS (PF): definitions and descriptions*

Labour and capital are two factors that contribute to the creation of output. Labour represents the human contributions to the production and capital are goods used in the production of other goods. Since the provider and production factors classifications are focused on the HIV and AIDS outputs, it is desirable also to analyse the inputs or production factors that create these outputs. In NASA the classification of production factors categorizes expenditures on resources used for the production, i.e., wages, salaries, new buildings, renovations, etc (budgetary items) An analysis of resource spending can have many policy uses, including development of policies regarding payments for human resources, for investment, for expenditure on anti-retrovirals, and for other significant inputs.

> There are well-defined schemes to be used. The *International Monetary Fund* (IMF) *Government finance statistics* manual and the *System of Health Accounts* (SHA), for instance, use the same economic classification of expenditure. This summary guide uses comparable breakdowns that can be easily transferred to other reports. The resource cost classification captures expenditure according to the standard economic classification of resources used for the production of goods and services. The classification includes two major categories: (1) current expenditures and (2) capital expenditures. This classification includes breakdowns for each category and can be applied in most instances to the activities of providers. This classification has been also used in other accounting exercises as object of expenditure and budgetary items.

Mainly outside the Health Sector, accounting records might not be as specific as the NASA PF classification. For this reason, sub categories ".98" were added in every category of Production Factors (to assure comprehensiveness and to avoid forced distributions into categories when there is not enough information to disaggregate them into the third or fourth digit).

### *Classification of production factors*
### *(budgetary items or otherwise identified object of expenditure)*

***PF.1* Current expenditures:** Refers to the total value of the resources in cash or in kind, payable to a health provider or to a social amenity provider by a financing agent on behalf of the final consumer of health services or of social amenities in return for services performed (including the delivery of goods) during the year of the assessment.

**PF.1.1 Labour income** (***Compensation of employees and remuneration of owners)*.**

> **PF.1.1.1 Wages**: Includes all kinds of wages, salaries, and other forms of compensation, including extra payments of any nature, such as payments for

overtime or night work, bonuses, various allowances and annual holidays. In-kind payments include meals, drinks, travel, special clothing, transportation to and from work, car parking, day-care for children, and the value of interest forgone when loans are provided at nil—or reduced—interest rate. Also included are payments to recruit or retain workers (health or else) in providing HIV or AIDS services.

**PF.1.1.2 Social contributions**: Includes social contributions received by health or by social care personnel. Exceptions include employers' social contributions, in-kind payments of supplies and services required for work, and payments made to non-active workers.

**PF.1.1.3 Non-wage labour income**: Includes honoraria earned by self-employed providers of care and other services contributing to the *National Response to HIV and AIDS*, gratuities, and diverse forms of compensating services rendered different than those listed under PF.1.1.1. PF.1.1.2.

**PF.1.1.98 Labour income not specified by kind (n.s.k.):** Includes Labour income not captured in the previous definitions.

**PF.1.2 Supplies and services:** Supplies and services consist of all goods and subcontracted services used as inputs in production of HIV related activities. This category includes goods that are entirely used up when they are fed into the production process, during which they deteriorate or are lost, accidentally damaged or pilfered. Such goods include inexpensive durable goods, for example hand tools, and goods that are cheaper than machinery and equipment.

**PF.1.2.1 Material supplies:** One of the most important types of supplies is pharmaceuticals. For this reason, a subcategory is created specifically for antiretrovirals and other pharmaceuticals. Donations of materials and supplies should be treated to reflect real values, so the amounts recorded should be at market prices and net of subsidies minus indirect taxes. Market and non-market goods acquired to increase inventory stocks should not be included.

**PF.1.2.1.1 Antiretrovirals:** comprises all the different drugs effective against HIV. It includes all regimes of treatment.

**PF.1.2.1.2 Other drugs and pharmaceuticals (excluding antiretrovirals):** comprises all drugs used e.g. for treating Opportunistic infections or Sexually Transmitted Infections. It excludes Antiretrovirals, which are coded under PF.1.2.1.1.

**PF.1.2.1.3 Medical and surgical supplies:** comprise medical and surgical supplies. Medical and surgical supplies are disposable or reusable items that generally do not contain mechanical parts commonly found in medical equipment. Mostly used in offices, emergency rooms or surgical rooms.

**PF.1.2.1.4 Condoms:** comprises both female and male condoms.

**PF.1.2.1.5 Reagents and materials:** it comprise reagents used in tests such as CD4, Viral Load, Elisa test, biochemistry, haematology, etc. It

also comprises all other materials except for medical materials coded under PF.1.2.1.3.

**PF.1.2.1.6 Food and nutrients:** it comprises food or nutrients used for treatment purposes, prevention, or other, such as food served in workshops or training activities.

**PF.1.2.1.7 Uniforms and school materials:** it comprises uniforms and school materials. These are mostly related to OVC related ASC.

**PF.1.2.1.98 Material supplies not disaggregated by kind:** it comprises materials and supplies expenditures for which there is not enough information to disaggregate them into the fourth digit.

**PF.1.2.1.99 Other material supplies not elsewhere classified (n.e.c.):** it comprises any other materials and supplies not captured in the previous definitions.

**PF.1.2.2 Services:** The complexity of delivering services in response to HIV and AIDS involves a considerable amount of subcontracting of intermediate services and implemented by an external organisation. When this is the case, the expenditure on personnel, supplies, transportation are included together. Services conducted by employees are excluded as their wages are recorded under PF.1.1 and expenditures on supplies are under PF.1.2.1. Both intermediate and final services purchased are to be retained, including care and social services as well as services required for the periodic maintenance and repair of fixed assets, so that those assets can be used over the expected service lives without changing their performance. Services used as employees', compensation are excluded.

**PF.1.2.2.1 Administrative services:**

**PF.1.2.2.2 Maintenance and repair services:**

**PF.1.2.2.3 Social and other administration services contracted:**

**PS.1.2.2.3.1 Basic health care packages purchased on behalf of key population at higher risk {e.g. OVC, ASC 3.2}:**

**PS.1.2.2.3.2 Social protection, monetary benefits {mainly ASC 6.1}:**

**PS.1.2.2.3.3 Educational support {e.g. ASC 3. 3, 5.4}:**

**Family / Home support (e.g., ASC 5.4) :**

**PS.1.2.2.3.98 Social and other administration services contracted not disaggregated by kind:** it comprises social and other administration services contracted for which there is not enough information to disaggregate them into the fifth digit.

**PS.1.2.2.3.99 Social and other administration services contracted not elsewhere classified (n.e.c.):** it comprises Social and other administration services contracted not captured in the previous definitions.

**PF.1.2.2.4 Publishers, motion picture, broadcasting and programming services:** includes the publishing of books, brochures, leaflets, dictionaries, encyclopaedias, atlases, maps and charts; publishing of newspapers, journals and periodicals; directory and mailing list and other publishing, as well as software publishing..

**PF.1.2.2.5 Recurrent training in medical, paramedical, social care and related establishments:**

**PF.1.2.2.6 Market research services** include notably the AIDS Prevention programme purchase of advertising campaigns and placement of such advertising in periodicals, newspapers, radio and television, or other media as well as the design of display structures and sites.

**PF.1.2.2.7 Consulting services:**

**PF.1.2.2.8 Transportation and travel services:** it comprises services related with transportation and travel. E.g.: airplane tickets, car rental.

**PF.1.2.2.9 Housing services:**

**PF.1.2.2.10 Catering (meals and drinks) services:** it comprises food and beverage serving activities providing complete meals or drinks.

**PF.1.2.2.11 Transaction Costs / Financial intermediation services:**

**PF.1.2.2.98 Services not-specified by kind (n.s.k.):** it comprises services for which there is not enough information to disaggregate them into the fourth or fifth digit.

**PF.1.2.2.99 Services not elsewhere classified (n.e.c.):** it comprises any other services not captured in the previous definitions.

**PF.1.3 Consumption of fixed capital**: The consumption of fixed capital represents the reduction in the value of the fixed assets used in the production process during the accounting period, resulting from physical deterioration, normal obsolescence or damage, i.e., depreciation. It measures the decline in the usefulness of a fixed asset for purposes of production. Measurement is frequently an assumed regular rate of decline of their efficiency in production over time, based on an average service life of the asset. The only case when the depreciation is included within NASA is when there is a reposition fund created for the purpose of future capital investment with annual cash deposits in the amount of the annual depreciation discounted value, taking into account the time when the cost for reposition is to occur, i.e. when the actual financial expenditure is taking place. I NASA, the capital expenditure is recorded in the year it occurred as part of PF.2. Capital Expenditure (see below).

**PF.1.3.1 Consumption of fixed capital in public establishments or entitie:**

**PF.1.3.2 Consumption of fixed capital in private establishments:**

**PF.1.3.98 Consumption of fixed capital not-disaggregated by sector:**

**PF.1.98 Current expenditure not disaggregated by kind:** it comprises current expenditures for which there is not information available to disaggregate the expenditures into Labour income, supplies and services or consumption of fixed capital.

**PF.1.99 Current expenditure not elsewhere classified:** it comprises current expenditures not captured in above definitions.

**PF.2 Capital investment, human capital and knowledge investment / Capital expenditure.** Capital expenditure records the value of non-financial assets that are acquired, disposed of or have experienced a change in value during the period under study. The assets held by the health system include new acquisitions, and major renovation and maintenance of tangible and intangible assets that are used repeatedly or continuously in production processes of health care or of social amenities over periods of time longer than one year. The main categories of the classification features are buildings, capital equipment and capital transfers. These categories may include major renovation, reconstruction or enlargement of existing fixed assets, as these interventions can improve and extend the previously expected service life of the asset.

**PF.2.1 Buildings**

**PF.2.1.1 Laboratory and other infrastructure upgrading**

**PF.2.1.2 Construction of new health centres**

**PF.2.1.99 Other Buildings not elsewhere classified (n.e.c.)**

**PF.2.2 Equipment**

**PF.2.2.1 Vehicles**

**PF.2.2.2 Information technology (hardware and software)**

**PF.2.2.99 Other Equipment not elsewhere classified (n.e.c.)**

**PF.2.3 Human capital** refers to skills, technical knowledge, competencies and other attributes embodied in labour and used to produce goods and services. Human capital is acquired through working experience, training, and education, Human capital includes pre-service specialized medical, paramedical and technical education.

**PF.2.98 Capital expenditure not disaggregated by kind: i**t comprises capital expenditures for which there is not information available to disaggregate the expenditures into Buildings, Equipment or Human Capital.

**PF.2.99 Capital expenditure not elsewhere classified (n.e.c.):** it comprises capital expenditures not captured in above definitions.

# Annex 3. Tracking financing resources

## *CLASSIFICATION OF FINANCING AGENTS (FA): definitions and descriptions*

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

Financing agents may pool resources that pay directly for resources they consume (principally households) and may comprise entities that buy on behalf of specific beneficiaries (mainly intermediaries such as insurers or donors).

This classification is altogether cross-national and nation-specific. Each country organizes its national response to HIV and AIDS in manners consistent with its culture and its history. Whichever label, some institutions are ruled by government agents, some are ruled by private agents, some are partnerships and/or subject to considerable regulation affecting their financing and management.

NASA is constructed in respect of the sectoring rules adopted by the community of nations, principally the *System of National Accounts* (SNA93) and its supporting classifications.

The SNA93 is the United Nations reporting facility for total activity, total spending patterns and total financial flows. The United Nations Regional Economic Commissions in Africa (ECA), Asia and the Pacific (ESCAP), Europe (UNECE), Latin America (ECLA), Western Asia (ESCWA) have developed sizeable SNA implementation programmes in their respective areas. The International Monetary Fund (IMF), the World Bank (WB), the African Development Bank, (AfDB), the Asian Development Bank (ADB), the InterAmerican Development Bank (IDB), the Islamic development Bank, the European Bank for Reconstruction and Development (EBRD), the Caribbean Development Bank (CDB) and the Caribbean Community (CARICOM also actively promote the implementation of the SNA framework or components of the framework, such as Government Finance Statistics.

A NASA worksheet is very detailed, more detailed than the listing provided below. An agent deals with a number of budget lines, appropriation programmes and spending authorizations. These are often country specific and are not censed below. Ministries of Justice or equivalent entity have typically an AIDS budget line for prisoners, some have two or more, distinguishing between prevention and attention for adults incarcerated and youth in a civic rehabilitation centre.

As the statistical units may vary, a NASA compiler is urged at meta-data level and, whenever feasible, to further desegregate the agents list presented and extensions

respecting the standard classificatory principle. A guiding rule might be that programmes contributing at least 1 or 2 % of the measured financing of HIV and AIDS programmes constitute a relevant statistical unit.

Depending on constitutional, legislative or administrative arrangements, Ministries of Justice may be involved in the provision of programmes notably as administrators of prisons or responsible for the implementation of court decisions regarding, say, the compulsory licensing on public health grounds of antriretrovirals. Ministries of the Interior may deal with local authorities' affairs, with civil defence, with pilgrimages and with tourist inflows [some countries have a Ministry of Tourism]. A careful nation-specific inventory of administrations and institutions involved in spending and delivery programmes. The Ministry of Finance is frequently the single source of most budgets but other ministries may have the authority to raise some revenue. The Ministry of Finance is seldom the purchaser or front-line payer of the National Response to HIV and AIDS. In addition to the ministries listed, extrabudgetary entities abound, e.g. an autonomous purchasing agency of condoms, teaching hospitals, a blood bank. Where relevant, the detailed inventory conducted in each country leads to blow up entries shown above, specifically FA.1.4 social security and trust funds, and FA.1.6, parastatal entities. Accountability requires each NASA to be nation-specific in the identification of the financing pools (Financing Sources), of the purchasers or payers (Financing Agents) of the suppliers (Providers) as each Financing Function and each Production Function is somehow unique. The inputs mobilised, the PF factor costs, may vary in weight but tend to be more universal though varying in relative weight, the uses is what UNAIDS and Member States most want to compare.

Departing from the two sectors SNA guiding principle: public and private, NASA identifies a third Financing Agent group: the Rest-of-the-World, as a sizeable share of the response to HIV and AIDS is not only provided under bilateral or multilateral external assistance programmes but are also managed by external agents. To identify that contribution and to maintain a large degree of neutrality in the presentation of the national response to HIV and AIDS, NASA invites all accounts to separate domestically generated pools from externally generated pools regardless of whether the external funds are managed by resident or by non-resident agents. Though these interventions constitute a delegation of sovereign national authority, the actual allocation of funds resting in the hands of the intervening agency, the departure from the SNA rule is dictated by the policy intelligibility requirement of the NASA framework. Its introduction does not invalidate the model classificatory principle nor the aggregate spending / financing total. When compiling data, specific programmes may be identified as distinct statistical units using an additional digit.

The main financing agents are:

**FA.1** ***PUBLIC SECTOR***

**FA.1.1 Territorial governments:**

**FA.1.1.1 Central or Federal authorities**

**FA.1.1.1.1** Ministry (or equivalent sector entity) of Health

**FA.1.1.1.2** Ministry (or equivalent sector entity) of Education

**FA.1.1.1.3** Ministry (or equivalent sector entity) of Social Development

**FA.1.1.1.4** Ministry (or equivalent sector entity) of Defence

**FA.1.1.1.5** Ministry (or equivalent sector entity) of Finance

**FA.1.1.1.6** Ministry (or equivalent sector entity) of Labour

**FA.1.1.1.7** Ministry (or equivalent sector entity) of Justice

**FA.1.1.1.8** Other Ministries (or equivalent local sector entities)

**FA.1.1.1.9** Prime Minister‘s or President’s office

**FA.1.1.1.10** National AIDS Commission

**FA.1.1.1.99** Other central or federal authorities’ entities not elsewhere classified (n.e.c.)

**FA.1.1.2 State / provincial / regional authorities**

**FA.1.1.2.1** Ministry (or equivalent sector entity) of Health

**FA.1.1.2.2** Ministry (or equivalent sector entity) of Education

**FA.1.1.2.3** Ministry (or equivalent sector entity) of Social Development

**FA.1.1.2.4** Other Ministries (or equivalent local sector entities)

**FA.1.1.2.5** Executive Office (office of the head of the State/Province/Department)

**FA.1.1.2.6** State/Province/Department AIDS Commission

**FA.1.1.2.99** Other State/provincial/regional entities not elsewhere classified (n.e.c.)

**FA.1.1.3 Local / municipal authorities**

**FA.1.1.3.1** Department (or equivalent sector entity) of Health

**FA.1.1.3.2** Department (or equivalent sector entity) of Education

**FA.1.1.3.3** Department (or equivalent sector entity) of Social Development

**FA.1.1.3.4** Executive Office (or office of the head of the local/municipal government)

**FA.1.1.3.5** Local/municipal authority AIDS Commission

**FA.1.3.99** Other local/municipal entities not elsewhere classified (n.e.c.)

**FA.1.2 Public Social Security**

**FA.1.3 Government employee insurance programmes**

**FA.1.4 Parastatal organizations and extra-budgetary entities**

**FA.1.99 Other Public Financing Agents not elsewhere classified (n.e.c)**

**FA.2** ***PRIVATE SECTOR***

**FA.2.1 Private social security**

**FA.2.2 Private employer insurance programmes**

**FA.2.3 Private insurance enterprises [other than social insurance]**

**FA.2.4 Private households (out-of-pocket payments)**

**FA.2.5 Not-for-profit institutions (other than social insurance)**

**FA.2.6 Private non-parasatal organizations and corporations (other than health insurance)**

**FA.2.99 Other Private Financing Agent not elsewhere classified (n.e.c.)**

**FA.3** ***INTERNATIONAL PURCHASING ORGANIZATIONS***

**FA.3.1 Country offices of Bilateral Agencies managing external resources and fulfilling Financing Agent roles,** which manage the use of the resources from donor countries as earmarked grants (for example, USAID, GTZ, DfID, JICA)

**FA.3.1.01** Government of Australia

**FA.3.1.02** Government of Austria

**FA.3.1.03** Government of Belgium

**FA.3.1.04** Government of Canada

**FA.3.1.05** Government of Denmark

**FA.3.1.06** Government of Finland

**FA.3.1.07** Government of France

**FA.3.1.08** Government of Germany

**FA.3.1.09** Government of Greece

**FA.3.1.10** Government of Ireland

**FA.3.1.11** Government of Italy

**FA.3.1.12** Government of Japan

**FA.3.1.13** Government of Luxembourg

**FA.3.1.14** Government of Netherlands

**FA.3.1.15** Government of New Zealand

**FA.3.1.16** Government of Norway

**FA.3.1.17** Government of Portugal

**FA.3.1.18** Government of Spain

**FA.3.1.19** Government of Sweden

**FA.3.1.20** Government of Switzerland

**FA.3.1.21** Government of United Kingdom

**FA.3.1.22** Government of United States

FA.3.1.30 Government of People's Republic of China

**FA.3.1.99** Other Government(s) of non-DAC countries / Other Bilateral Agencies not elsewhere classified (n.e.c.)

**FA.3.2 Multilateral Agencies managing external resource**s that have been earmarked for the use in the recipient country by the donors

(The funds managed / disbursed by a multilateral agency supplied by another multilateral agency are to be reported under the agency managing the funds unless the source agent expressly contracts the disbursement agency to implement the funds according to its management rules).

**FA.3.2.01** Commission of the European Communities

**FA.3.2.02** International Labour Organization (ILO)

**FA.3.2.03** Multilateral funds from UN family of organizations not elsewhere listed

**FA.3.2.04** Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)

**FA.3.2.05** “Principal recipients” of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

**FA.3.2.06** UNAIDS Secretariat

**FA.3.2.07** United Nations Children's Fund (UNICEF)

**FA.3.2.08** United Nations Development Programme (UNDP)

**FA.3.2.09** United Nations Educational, Scientific and Cultural Organization (UNESCO)

**FA.3.2.10** United Nations High Commissioner for Refugees (UNHCR)

**FA.3.2.11** United Nations Office for Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms

**FA.3.2.12** United Nations Office on Drugs and Crime (UNODC)

**FA.3.2.13** United Nations Population Fund (UNFPA)

**FA.3.2.14** World Bank (WB)

**FA.3.2.15** World Food Programme (WFP)

**FA.3.2.16** World Health Organization (WHO)

**FA.3.2.99** Other Multilateral entities not elsewhere classified (n.e.c.)

### FA.3.3 International not-for profit organizations and foundations

**FA.3.3.01** International HIV/AIDS Alliance

**FA.3.3.02** ActionAID

**FA.3.3.03** Aga Khan Foundation

**FA.3.3.04** Association François-Xavier Bagnoud

**FA.3.3.05** Bernard van Leer Foundation

**FA.3.3.06** Bill and Melinda Gates Foundation

**FA.3.3.07** Bristol-Myers Squibb Foundation

**FA.3.3.08** Care International

**FA.3.3.09** Caritas Internationalis/Catholic Relief Services

**FA.3.3.10** Deutsche Stiftung Weltbevölkerung

**FA.3.3.11** Diana Princess of Wales Memorial Fund

**FA.3.3.12** Elizabeth Glaser Pediatric AIDS Foundation

**FA.3.3.13** European Foundation Centre

**FA.3.3.14** Family Health International

**FA.3.3.15** Foundation Mérieux

**FA.3.3.16** Health Alliance International

**FA.3.3.17** Helen K. and Arthur E. Johnson Foundation

**FA.3.3.18** International Federation of Red Cross and Red Crescent and National Red Cross Societies

**FA.3.3.19** King Baudouin Foundation

**FA.3.3.20** Médecins sans Frontières

**FA.3.3.21** Merck & Co., Inc

**FA.3.3.22** Plan International

**FA.3.3.23** PSI (Population Services International)

**FA.3.3.24** SIDACTION (mainly Francophone countries)

**FA.3.3.25** The Clinton Foundation

**FA.3.3.26** The Ford Foundation

**FA.3.3.27** The Henry J. Kaiser Family Foundation

**FA.3.3.28** The Nuffield Trust

**FA.3.3.29** The Open Society Institute / Soros Foundation

**FA.3.3.30** The Rockefeller Foundation

**FA.3.3.31** United Nations Foundation

**FA.3.3.32** Wellcome Trust

**FA.3.3.33** World Vision

**FA.3.3.99** Other International not-for-profit organizations and foundations not elsewhere classified (n.e.c.)

**FA.3.4 International for-profit organizations**

**FA.3.99 Other International Financing Agents not elsewhere classified (n.e.c.)**

The three financing schemes not familiar to most are Multi Donor Trust Funds (MDTF): funds looking for a purpose, Joint Programming Mechanism (JPM): A purpose looking for funds, and Coherence Funds: A funds to fill a gap to complement bilateral and joint resource mobilization.

## *CLASSIFICATION OF FINANCING SOURCES (FS): definitions and descriptions*

Financing sources are entities or pools which *purchasers*, provider of financial intermediation services or paying agents, tap or use other forms of mobilisation to fund the HIV and AIDS services.[26] An analysis of financing sources is of particular interest in countries where funding for the HIV and AIDS response is heavily dependent on international sources of financing or when there are few management entities.

The classification is compatible with existing schemes and with the SHA. It is designed to reflect some of the key policy interests in the *National Response to HIV and AIDS*, domestic funding and the donor-country relationship. The schedule attempts to distinguish between funds that are allocated by governments, donor funding, earmarked, and households. All government funds are further divided into general revenue of territorial governments.

The policy relevance criterion dictates in a single-disease/single-set of programmes to treat as the basic source the authority or agent which commits the funds. When the financing for HIV and AIDS activities are delivered directly from the Ministry of Finance

[26] A distinction between financial sources and financing agents has been implemented in the WHO-WB-USAID, *Guide to Producing National Health Accounts*, 2003. Previous resource tracking tools, like the National AIDS Accounts, did not separate the receipt or origin of funds from the spending function. It is analytically sounder in an approach inspired from the convention T-bookkeeping approaches in which receipts and outlays, assets and liabilities are posted on the opposite sides of the T to compile two categories dealing each with a function than a single one composite category embracing two distinct functions, like revenue pooling and purchasing. In countries facing financing bottlenecks, the strategic gains from the supplementary knowledge about the origin of the funds pooled by agents are considerable.

or the country's treasury, this would be the source because of the decision on the amount of the funding for HIV and AIDS. The recipient organization/agency/unit would of the amounts defined by the source are the financing agents inasmuch such entity can make the decision on the use of such funds by deciding the services and goods to be purchased with the available funds. For example, when there is a *National AIDS Coordinating Authority* in a given country which receives funds directly from the *National Treasury* and uses the funds for the activities (or functions) decided by the council itself (using any kind of procedure), the source is the *Ministry of Finance* and the financing agency would be the Council itself. Alternatively, when in the same country or in another, there is an HIV and AIDS programme within the Ministry of Health, the source is the Ministry of Health and the financing agent the programme inasmuch the former determines the amount for HIV and the latter the services or functions that form part of the HIV and AIDS activities. Likewise, the Ministries of Education, Social Development, etc., could be the source of the activities in their respective areas of competence.

All bodies of territorial governments, i.e. departments and establishments—central, state or local—that engage in a wide range of activities such as administration, defence, health, education and other social services, promotion of economic growth and welfare, and technological development.

**FS.1 PUBLIC FUNDS**

**FS.1.1 Territorial governments:**

**FS.1.1.1 Central Government Revenue**

**FS.1.1.2 State / provincial Government Revenue**

**FS.1.1.3 Local / municipal Government Revenue**

**FS.1.1.4 Reimbursable loans**, if reimbursable loans are public funds.

**Interest payments** accruing to loans made by different entities are not negligible. Interest is defined as payment on top of the amount of the principal borrowed that has to be paid to the creditor by the debtor over a given period of time without reducing the outstanding amount. Interest may be a predetermined sum of money or a percentage of the outstanding principal. Interest is added to the principal. When government units pay interest on debts on behalf of another unit, as the government incurring the debt as the primary obligor (debtor), the existing debt of another unit should be recorded as a subsidy (when the other unit is an enterprise), or transfer (if it is a government unit)

**FS.1.2 Public social security funds**

**FS.1.2.1 Employer compulsory contributions to Social Security**

**FS.1.2.2 Employee compulsory contributions to Social Security**

**FS.1.2.3 Government transfers to Social Security**

**FS.1.99 Other Public Financing Source not elsewhere classified (n.e.c.)**

## FS.2 PRIVATE FUNDS

**FS.2.1 For-profit institutions and Corporations**

**FS.2.2 Households' funds**

**FS.2.3 Not-for-profit institutions (other than social insurance)**

**FS.2.99 Private Financing Sources not elsewhere classified (n.e.c.)**

## FS.3 INTERNATIONAL FUNDS[27]

Resources originating from outside the country and executed in the current year. Bilateral and multilateral international grants as well as funds contributed by institutions and individuals outside the country are included to the extent that they are used in the current period.

**FS.3.1. Direct bilateral contributions**: Allocations as grant or non-reimbursable financial cooperation that high-income countries provide to recipient countries directly, e.g. budget support directly to the treasury of recipient countries. The contributions reported under this item concern government to government transfers and do not include contributions or grants made by the governments listed below to the multilateral agencies listed under FS.3.2 or to the non-resident suppliers of non-profit institutions listed under FA.2.5 unless a sole supplier of FA.2.4 The underlying principles are double-counting avoidance and distinction between origin of funds which may be a Rest-of-the-World agent and the purchasing agent or paying agent which are mostly resident agents. At transaction level – which is what the FS and the FA classifications measure – though there is a correspondence between the legal personality of the agents, there is no correspondence between the FS.3 weights (revenue received from abroad) and FA.3 weights (purchases and payments made to providers by external agents from bureaus they maintain in the country or, in the case of small recipient countries, in the Region).

**FS.3.1.01** Government of Australia

**FS.3.1.02** Government of Austria

**FS.3.1.03** Government of Belgium

**FS.3.1.04** Government of Canada

**FS.3.1.05** Government of Denmark

[27] Rest of the world

**FS.3.1.06** Government of Finland

**FS.3.1.07** Government of France

**FS.3.1.08** Government of Germany

**FS.3.1.09** Government of Greece

**FS.3.1.10** Government of Ireland

**FS.3.1.11** Government of Italy

**FS.3.1.12** Government of Japan

**FS.3.1.13** Government of Luxembourg

**FS.3.1.14** Government of Netherlands

**FS.3.1.15** Government of New Zealand

**FS.3.1.16** Government of Norway

**FS.3.1.17** Government of Portugal

**FS.3.1.18** Government of Spain

**FS.3.1.19** Government of Sweden

**FS.3.1.20** Government of Switzerland

**FS.3.1.21** Government of United Kingdom

**FS.3.1.22** Government of United States

FS.3.1.30 Government of People's Republic of China

**FS.3.1.99** Government(s) of non-DAC countries / Bilateral Agencies n.e.c.[28]

**FS.3.2. Multilateral Agencies contributions**. International Public or public/private organizations, institutions or Agencies which receive contributions from donor countries and from other sources, thus multilateral funding is a mechanism whereby assistance investments are pooled by different donors and granted in not necessarily one-to-one relationships between donor and recipient countries. This usually occurs via international agencies within the UN system, development banks. The Global Fund to Fight AIDS, Tuberculosis and Malaria is a private/public multilateral organization

**FS.3.2.01** Commission of the European Communities

**FS.3.2.02** International Labour Organization (ILO)

**FS.3.2.03** Multilateral funds from the United NationsUN family of organisations not listed above

[28] To be specified when filled.

**FS.3.2.04** Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)

**FS.3.2.05** The Global Fund to Fight AIDS, Tuberculosis and Malaria

**FS.3.2.06** UNAIDS Secretariat

**FS.3.2.07** United Nations Children's Fund (UNICEF)

**FS.3.2.08** United Nations Development Programme (UNDP)

**FS.3.2.09** United Nations Educational, Scientific and Cultural Organization (UNESCO)

**FS.3.2.10** Office of the United Nations High Commissioner for Refugees (UNHCR)

**FS.3.2.11** United Nations Office for Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms

**FS.3.2.12** United Nations Office on Drugs and Crime (UNODC)

**FS.3.2.13** United Nations Population Fund (UNFPA)

**FS.3.2.14** World Bank (WB)

**FS.3.2.15** World Food Programme (WFP)

**FS.3.2.16** World Health Organization (WHO)

**FS.3.1.99** Multilateral funds or development funds n.e.c.

**FS.3.3** International not-for-profit organizations and foundations: entities whose home base or headquarter is located outside of the country where the use of the funds as goods or services is provided/delivered. The 20 top charities in the early 2000s are listed below plus a category for those not included in this list. The relevance of each foundation will differ according to region and beneficiary country.

**FS.3.3.01** International HIV/AIDS Alliance

**FS.3.3.02** ActionAID

**FS.3.3.03** Aga Khan Foundation

**FS.3.3.04** Association François-Xavier Bagnoud

**FS.3.3.05** Bernard van Leer Foundation

**FS.3.3.06** Bill and Melinda Gates Foundation

**FS.3.3.07** Bristol-Myers Squibb Foundation

**FS.3.3.08** Care International

**FS.3.3.09** Caritas Internationalis/Catholic Relief Services

**FS.3.3.10** Deutsche Stiftung Weltbevölkerung

**FS.3.3.11** Diana Princess of Wales Memorial Fund

**FS.3.3.12** Elizabeth Glaser Pediatric AIDS Foundation

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**FS.3.3.19** King Baudouin Foundation

**FS.3.3.20** Médecins sans Frontières

**FS.3.3.21** Merck & Co., Inc

**FS.3.3.22** Plan International

**FS.3.3.23** PSI (Population Services International)

**FS.3.3.24** SIDACTION (mainly Francophone countries)

**FS.3.3.25** The Bill Clinton Foundation

**FS.3.3.26** The Ford Foundation

**FS.3.3.27** The Henry J. Kaiser Family Foundation

**FS.3.3.28** The Nuffield Trust

**FS.3.3.29** The Open Society Institute (Soros Foundation)

**FS.3.3.30** The Rockefeller Foundation

**FS.3.3.31** United Nations Foundation

**FS.3.3.32** Wellcome Trust

**FS.3.3.33** World Vision

**FS.3.3.99** International not-for-profit organizations and foundations not elsewhere classified (n.e.c.)

**FS.3.4 International for-profit organizations:** entities whose home base or headquarters is located outside of the country where the services or goods, are provided, including among others, multinational pharmaceutical and biotechnology companies.