SOUTHERN AFRICAN NASA FINDINGS SYNTHESIS – CROSS COUNTRY COMPARISONS

Teresa Guthrie, Centre for Economic Governance and AIDS in Africa

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This brief report seeks to present the key findings from the countries in the ESA region that have undertaken National AIDS Spending Assessments (NASA)[1], which are Botswana, Zambia, Swaziland, Lesotho and Mozambique. As a comparator, the results from the Ghana NASA are shown in some graphs, representing a response to an HIV-epidemic with different characteristics to the ESA region. Acknowledgements to the country NASA teams for the use of their data.

Although the findings are now a few years old, they still present interesting and useful data and comparisons, which continue to be relevant for resource allocation decisions and policy reviews. Most of the countries had data for 2006, so this was used as the comparator year for the graphs below, excepting Botswana (2005 data) and Lesotho (2007 data). All the countries are currently underway with the institutionalization of resource tracking in their countries. In addition, Zimbabwe and Kenya have almost completed their first phase of NASA.

Background Data on Countries under Review

Among the countries that have undertaken a NASA in the ESA region, Swaziland and Lesotho are classified as lower middle-income countries, the remaining are low-income countries. The table below presents some of their key development indicators.

	HIV Adult Prevalence (%, 2006)	Population (2006)	GDP per capita PPP US$ (2007)	Human Dev. Index (2007)	THE per capita (NHA data) (PPP US$, 2005/06)
Botswana	24.1	1,639,833	$12,744	0.664	$635
Zambia	17.0	11,798,678	$1,273	0.453	$62
Mozambique	12.5	20,200,000	$739	0.366	$56
Lesotho	23.2	1,800,000	$1,440	0.496	$143
Swaziland	26.0	960,000	$4,705	0.542	$353
Ghana	3.4	23,279,350	$1,247	0.533	$100

THE = total health expenditure (public and external sources).

[1] For a full description of NASA please refer to the UNAIDS Notebook: http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp

Sources: UNAIDS website 2009, Human Development Report 2007, WHO website-NHA data 2006.

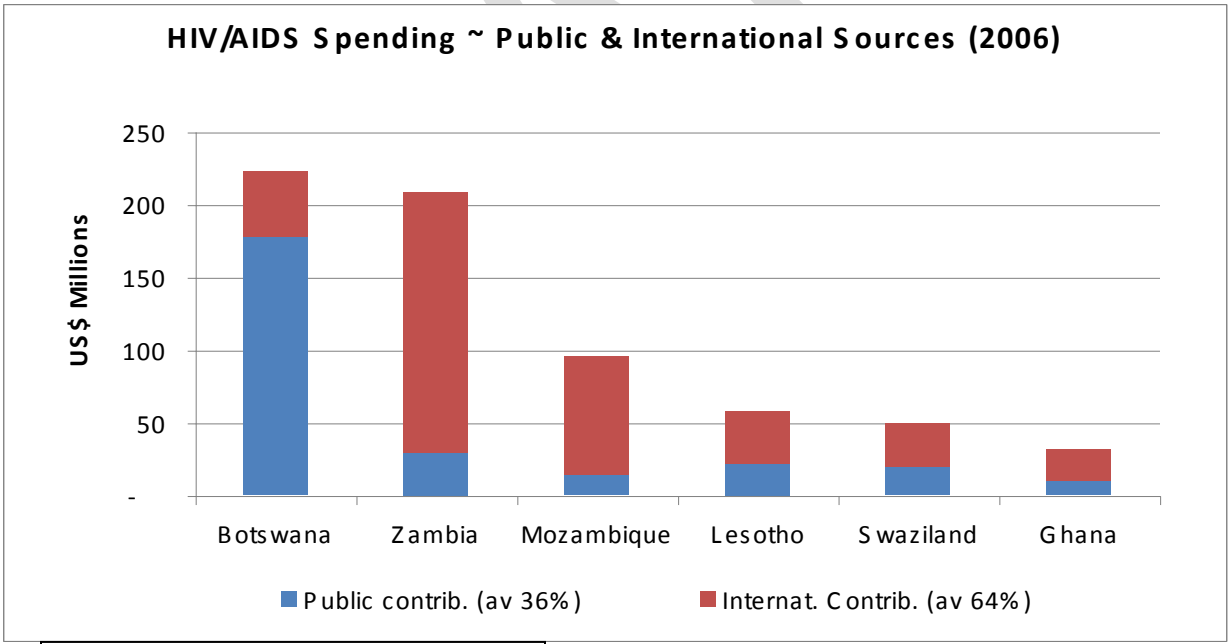
Note the large variations in the estimated health spending per capita, and bear these in mind when examining their HIV/AIDS per capita spending, although the figures below are **all** spending on HIV/AIDS, not only for health-interventions, so they are not directly comparable.

Summary of Key NASA Findings

Sources of Financing for HIV/AIDS in ESA (2005 to 2007)

The NASA reports allow for an analysis of trends in HIV/AIDS spending over time. These show increasing funding from both public and external sources. It will be important to track over the next few years how the global economic crisis is affecting financing for HIV/AIDS, health and development more generally.

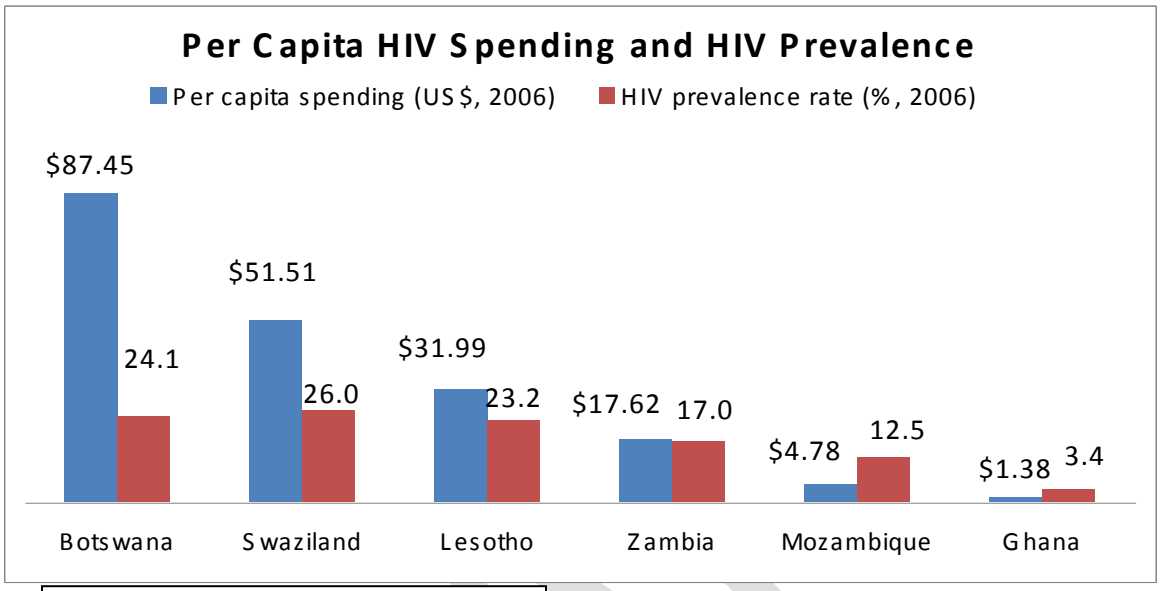
A cross-cutting look at spending in 2006 shows the heavy dependency upon external aid, excepting in Botswana, which undermines the long-term sustainability of the national HIV/AIDS response.



Botswana data for 2005, Lesotho for 2007.

Comparing the per capita HIV/AIDS spending per country with their HIV prevalence shows a wide range, with Botswana clearly the highest HIV/AIDS per capita spending ($87.45) in the region, HIV prevalence of 24% and with the highest GDP per capita of $ 12,744. On the

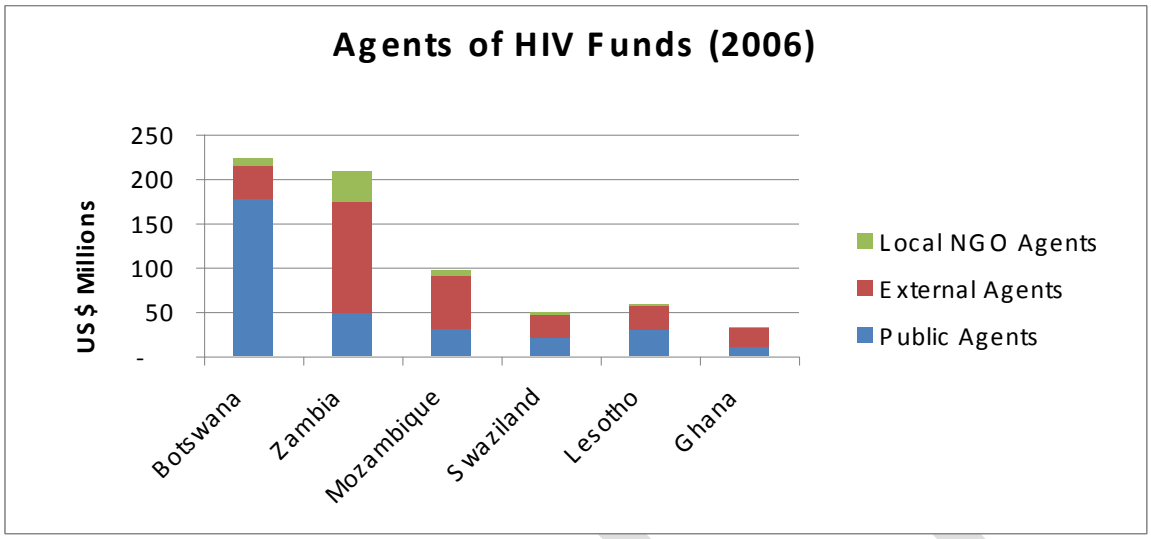
other hand, Mozambique spends US$ 4.78 on HIV/AIDS per capita, 12.5% prevalence rate and with a GDP per capita of $739. Ghana with a low prevalence had very low HIV per capita spending (US$ 1.38) in 2006.



Botswana data for 2005, Lesotho for 2007.

Spending on HIV/AIDS by Agent

The agent is the entity that receives and disburses funds, and determines how to spend the funds - which services are to be provided. In many cases it is the NAC which determines these, according to its National Strategic Plan/ Priorities. However, in other cases, it is the external funder which makes these decisions, and therefore they are the 'virtual' agent. For example, USG funds usually go through in-country offices (CDC, USAID) and these determine how the funds are to be spent by their recipients, therefore these external organizations are labeled as the agents. The table below shows the greater control that the Government of Botswana has because their response is primarily funded from local revenue. In comparison, the control of the Zambian response rests mainly with external agents, although they may attempt to align with government priorities, through collaboration with the NAC.



Botswana data for 2005, Lesotho for 2007.

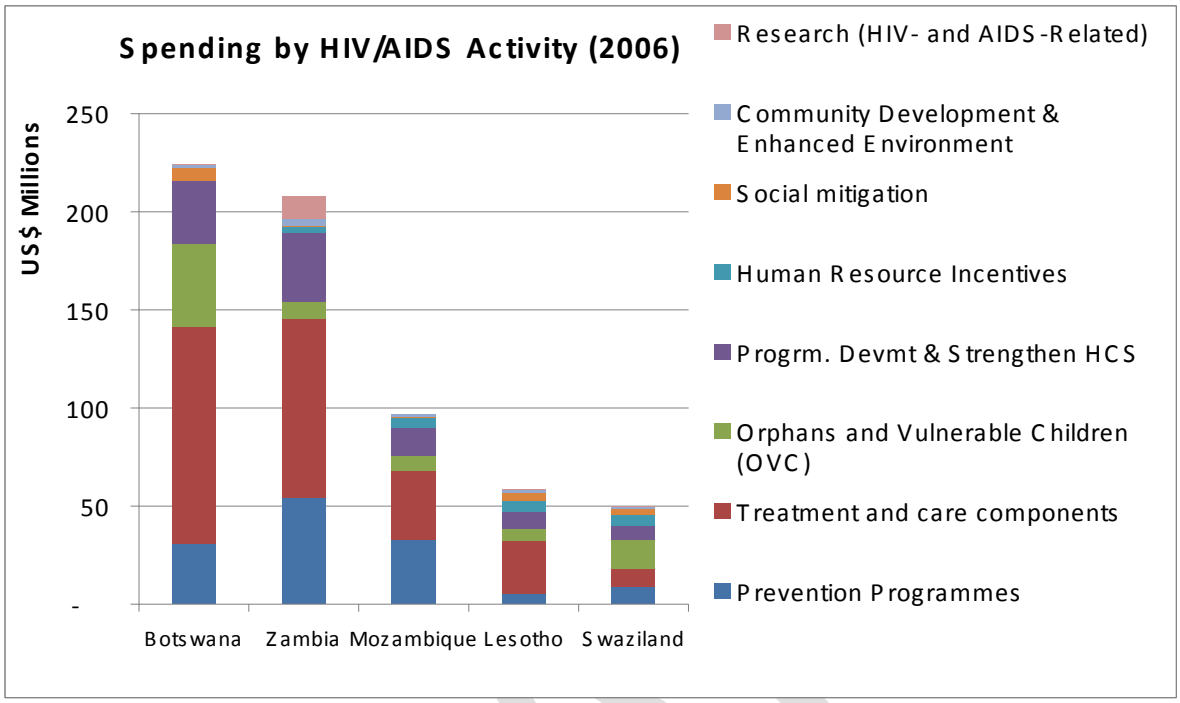
HV/AIDS Spending Activities

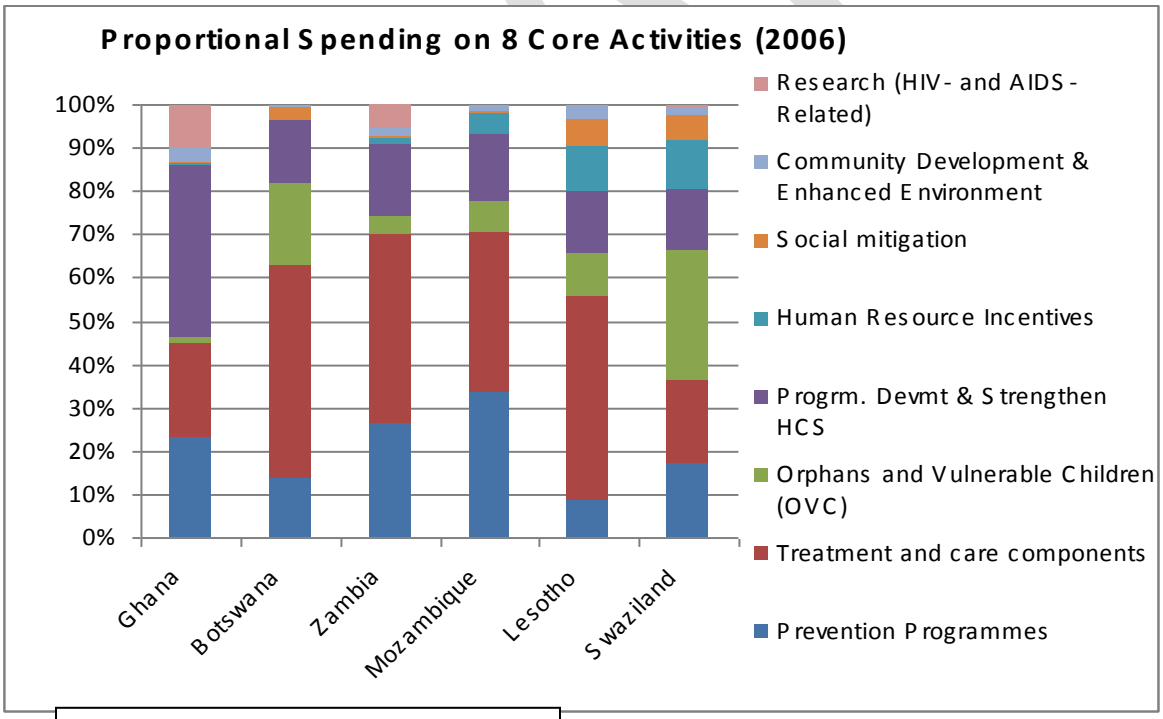
The NASA method allows for the capturing of every type of HIV/AIDS spending firstly in eight broad categories, and then each of these are separated into several sub-categories. Refer to the appendices which provide all the sub-categories and their definitions. The graphs below show the break down of spending in each of the countries by the 8 broad categories. It can be seen that treatment and care forms the largest proportion in most of the countries, especially Botswana and Lesotho. The treatment category includes ART as well as other treatment activities (in-patient and out-patient care, OI treatment, palliative care etc).

Prevention spending appears to be proportionally small in comparison to treatment, excepting in Swaziland. Obviously treatment per capita costs are higher and should not be directly compared with the cost effectiveness of prevention. Nevertheless, without adequate resource allocation to prevention, it will mean ever increasing numbers of people requiring treatment, leading to an unsustainable situation. Botswana has recently faced a reduction in public revenue due to the decreasing sale of diamonds, and therefore this will undermine their ability to cover the costs of their increasing treatment demands.

Note that human resource incentives below does not refer to the salary costs of persons involved in HIV/AIDS – those costs are captured under the activity that they deliver – rather

this category refers to additional allowances that might be given to attract people to work in the HIV/AIDS field. This is more common in the East European countries.





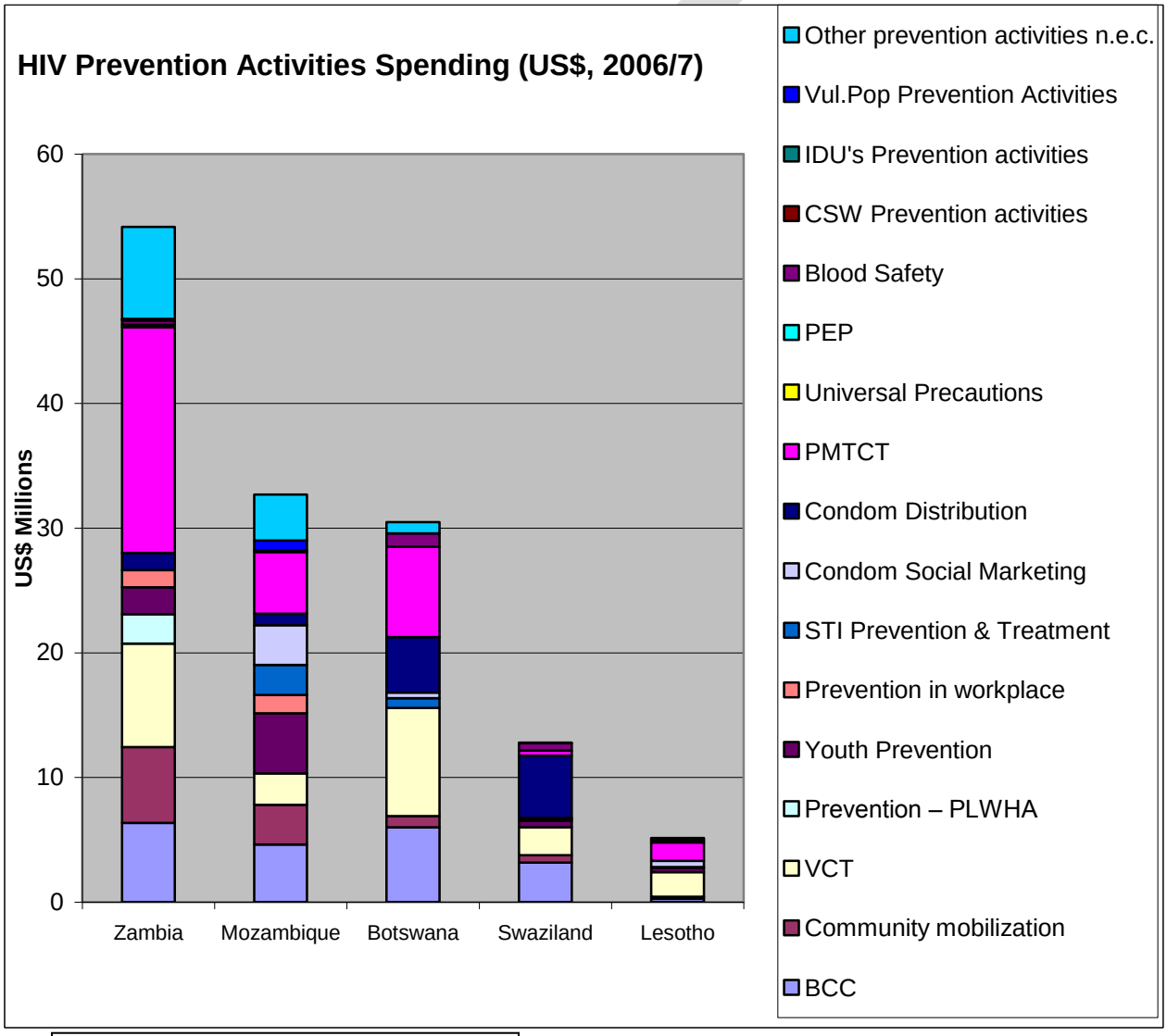
Botswana data for 2005, Lesotho for 2007.

Soci and research spending remain relatively small. Policy development, coordination, monitoring and evaluation, laboratory and health care

strengthening functions all fall under the programme development category, and forms an important component of spending, to varying degrees in the countries.

Details on HIV Prevention Spending

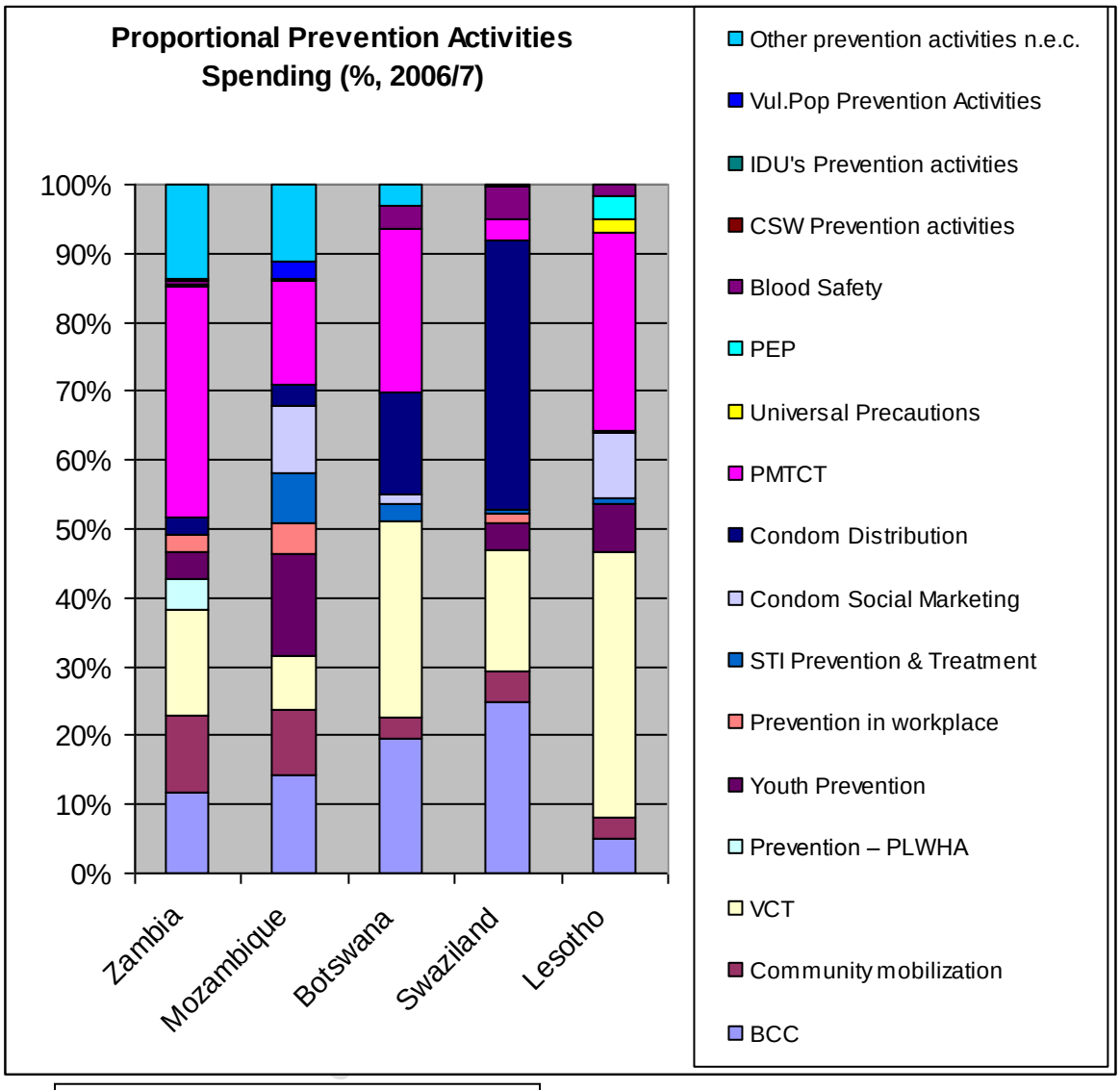
Within the Prevention category there are several sub-categories. An examination of the spending on these provides interesting insight into the preferred prevention activities, but with less evidence available on their effectiveness, it is difficult to ascertain the relative cost effectiveness of these interventions.



Botswana data for 2005, Lesotho for 2007.

BCC, VCT and PMTCT are the proportionally most funded prevention activities in all the countries (excepting PMTCT in Swaziland where perhaps it was not all captured or coded

correctly). Of concern are the relatively small amounts going to condom distribution, excepting in Swaziland. It appears that the spending on blood safety was not correctly captured as this is an expense that all ministries of health carry, and should be identified as HIV preventative spending. Community mobilization and youth spending, in-school and out-of-school, are also common prevention activities.

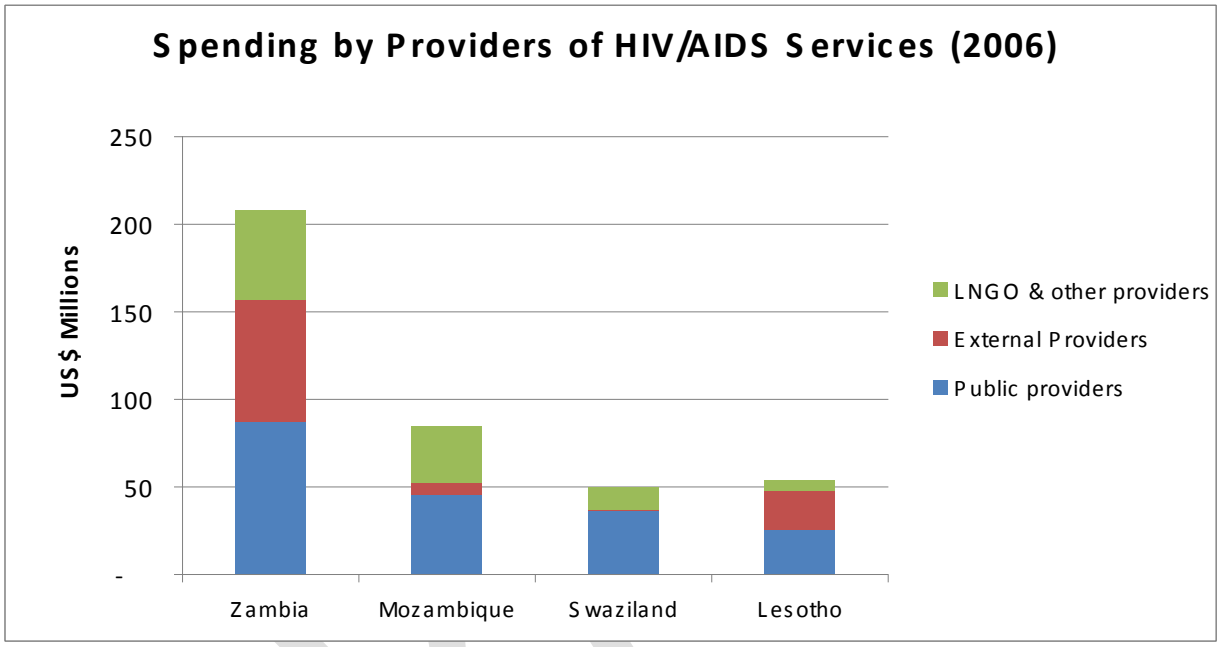


Botswana data for 2005, Lesotho for 2007.

In all these countries, the NASAs found very little spending on commercial sex workers, men who have sex with men, intravenous drug users, and other vulnerable populations. The Modes of Transmission studies in the ESA region are confirming that these are not the largest drivers of the epidemic, but rather multiple concurrent relationships, making married couples the most at risk.

Providers of HIV/AIDS Services

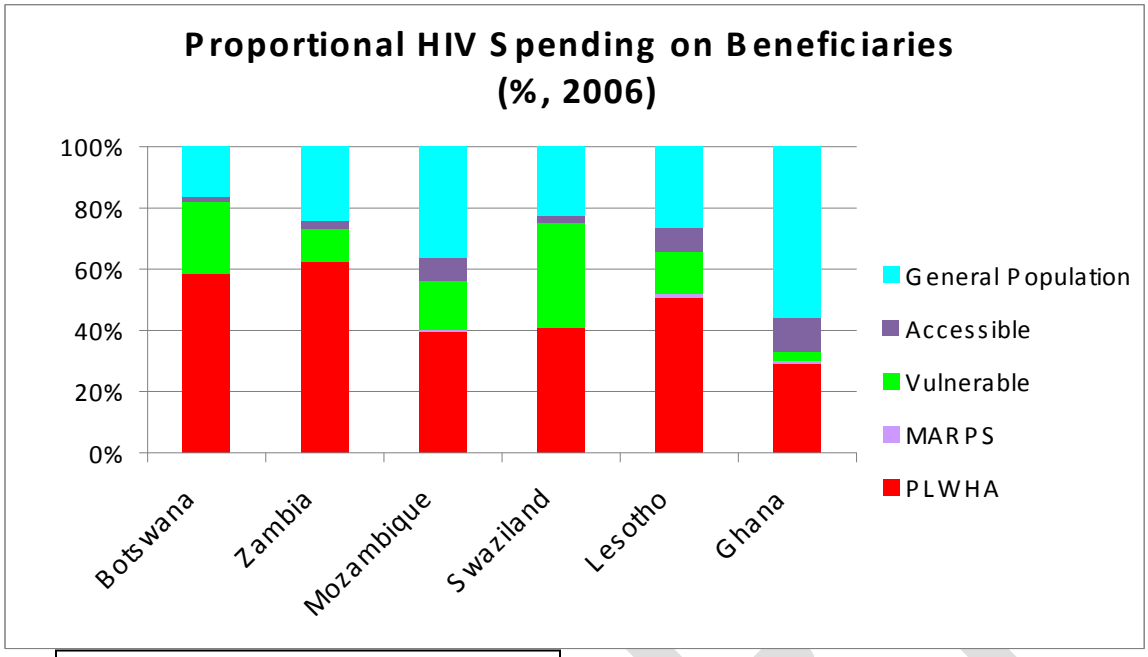
The NASA findings show that the majority of service providers remain public entities, with local NGOs playing an important role. In Zambia a large proportion are external providers – such as CDC, International NGOs, etc.



Lesotho data for 2007.

Beneficiaries of spending on HIV/AIDS

The NASA method tracks all HIV/AIDS spending down to the intended beneficiaries, presented broadly below in 5 categories: people living with HIV/AIDS; accessible populations (children in school, STI clinic attendees, etc); vulnerable populations (OVCs, truck drivers, refugees etc); most at risk (MARPS, which is according to UNAIDS definitions: commercial sex workers, men who have sex with men, intravenous drug users). Within each of these groups there are several sub-categories, by gender, age and specific groups, which allows for more detailed, nuanced analysis. The definition of MARPs, which was primarily generated within the context of the HIV epidemics in the Western world, may not be applicable in SSA where it has been shown by the Modes of Transmission studies that it is married couples who are most at risk.



Botswana data for 2005, Lesotho for 2007.

Because of the large component of spending on treatment, it can be seen that the beneficiaries of spending in the ESA countries are primarily PLWHA. In comparison, the spending in Ghana is mainly on preventive, behavioural change activities, which shows the beneficiaries as being mainly the general population. Spending on vulnerable groups tends to be for OVCs, and perhaps more attention is required for activities targeting accessible populations: youth in school, college and universities, people attending reproductive clinics, police and army forces, employees of all companies/ factories etc.

The spending in the ESA countries on the defined MARPS (CSWs, MSMs, IDUs) is almost non-existent. It would be difficult to attempt to track the spending that targets married couples, as there are very few programes that specifically target them, since they would tend to benefit from all the services provided.

Key Points and Recommendations

The NASAs have provided a standardized, comparable and internationally accepted approach to tracking of spending on all HIV/AIDS activities. The findings are of primary use within the country for all stakeholders in ensuring a harmonized and adequately funded national strategic response. In addition, they offer regional and international comparative data that can influence allocative decisions at the global and regional levels.

A few key points are highlighted in the above analysis, with regard to financing and spending priorities:

- In order to reduce the high dependency upon external aid, which undermines the long-term sustainability of the national HIV/AIDS response, innovative and sustainable financing options must be developed, that do not put additional burden on the poor, but which stimulate the private business contribution as well as taxing those goods and services which are price inelastic but do regressive on the poor.
- The per capita HIV/AIDS spending by country shows a wide range, and it is difficult to comment as to what is an average, or adequate amount to spend, or what might the minimum package of services per capita that must be provided cost.
- If harmonization and alignment of aid is to truly occur, then the function of agent, that of determining how external funds are spent, should be shifting more and more to the public entities. There is some evidence of this, but certainly greater effort is required, that is complimented with efforts to improve public financial management and accountability systems.
- Local NGOs and CBOs play an important role in implementing the response to HIV/AIDS, yet funding appears to be decreasing. They should continue to be supported, either through funds channeled through public agents, if efficient, or through direct funding mechanisms, which often allow for more flexibility to address the changing needs.
- More evidence is required on the cost effectiveness of prevention strategies so that spending on prevention might be most effectively increased.
- Creative prevention strategies that target those most at risk in SSA need to be designed and resourced.
- It is important that BCC, VCT and PMTCT continue to be well-funded, but of concern were the relatively small amounts going to condom distribution, which should be dramatically increased. The debate is whether the total spending on condoms should be attributed to HIV prevention, since that might not be intended purpose of their use, in which case only a portion of the spending should be claimed as HIV prevention. However, most NACs will argue that they distributed

the condoms with the intention of preventing HIV infection and therefore they would want all of that expenditure to accounted for as such.

- More attention is required for activities targeting accessible populations: youth in school, college and universities, people attending reproductive clinics, police and army forces, employees of all companies/ factories etc.
- The spending on social mitigation, community development, enabling environment and research could be increased, in order to ensure a multi-sectoral response that addresses all aspects of the epidemic.
- Policy development, coordination, monitoring and evaluation, laboratory and health system strengthening functions are important components in the response to HIV/AIDS and in overall health systems strengthening. More efficient use of resources in this regard is critical.

A few comments with regard to improved absorption of funds, financial information systems and accountability:

- The absorption of large amounts of funding could be improved by:
  - Reduced donor 'dumping' of funds at the end of the financial year,
  - Improved predictability of donor commitments, over longer periods, with options for draw-down credit,
  - Increased speed of disbursements, reduction of tedious systems, while also improving public accountability systems.
- Improve public financial reporting and information systems, and build the capacity of NACs for financial management.
- Routine resource tracking needs to be institutionalised into existing financial information and M&E systems.
- Harmonise all financial flows into one national system for reporting on commitments, disbursements & spending.
- Civil society needs to play greater role in monitoring public spending, through improved transparency and access to information, as well as through sharing their own spending activities.

For further information, contact:

Teresa Guthrie, Centre for Economic Governance and AIDS in Africa

teresa@cegaa.org