THE REPUBLIC OF UGANDA

REPORT OF NATIONAL AIDS SPENDING ASSESSMENT STUDY

October 2018

Financial Years 2014/15, 2015/16 and 2016/17 and Institutionalization of HIV and AIDS Resource Tracking in Uganda

Uganda AIDS Commission

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REPORT OF NATIONAL AIDS SPENDING ASSESSMENT STUDY FOR FINANCIAL YEARS 2014/15, 2015/16 AND 2016/17 AND INSTITUTIONALIZATION OF HIV AND AIDS RESOURCE TRACKING IN UGANDA

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FOREWORD

The global outlook for HIV & AIDS funding shows a declining trend over the next foreseeable years as more competing priorities emerge. The resource envelop for HIV and AIDS response from the public sector, multilateral and bilateral partners and the private sector has been dwindling in the face of increasing demand for HIV and AIDS prevention, treatment and care, interventions. This calls for critical examination of the sustainability, efficiency and effectiveness of resource utilization in the national HIV and AIDS response. It is against this backdrop that this second NASA study was commissioned to track the resources and utilization of resources deployed in the HIV and AIDS response in Uganda in the recent past covering the financial years 2014/15, 2015/16 and 2016/17.

This NASA study has brought to light some of the salient issues in the national HIV and AIDS responds regarding sustainability, decision centers, interventions mix and beneficiaries population in the national HIV and AIDS response. This NASA report is envisaged to inform policy, planning and budgeting at different levels in the HIV and AIDS multi-sectoral response. Policy makers, planners and other actors in the response are urged to use the findings of this study to advocate for sustainable financing in the response. Emphasis needs to be put on domestic resource mobilization and scaling up of behavioral change communication in combination with test and treat interventions as game changers in achieving the goal of ending AIDS as a national health threat by 2030.

It is my sincere hope that the findings of this study will trigger actions at both policy and operational levels in directing resources appropriately in the National HIV and AIDS Response so that our common aspiration of ending AIDS as a national health threat by 2030 becomes a reality.

It is therefore my honor and privilege to forward this report of the second NASA study and I call upon all stakeholders to use the findings in this report to inform advocacy and decisions in financing HIV and AIDS response in Uganda.

Dr. Eddie Mukooyo Sefuluya

CHAIRMAN

ACKNOWLEDGEMENTS

Uganda AIDS Commission (UAC) in collaboration with Makerere School of Public Health undertook the second National AIDS Spending Assessment (NASA) study which covered the financial years 2014/15, 2015/16 and 2016/17. This is a report of the NASA study which was undertaken between January and July 2018. We are proud of this milestone for which I would like to thank all our stakeholders for making it happen. My special thanks goes to Irish Aid for providing the much needed financial support; UNAIDS and UNDP for providing technical assistance and quality assurance for this study.

UAC is greatly indebted to the members of the NASA Technical Working Group (TWG), who provided invaluable input at various stages of NASA; Joshua Karume, an international consultant, who provided technical assistance and whose attention to detail and international exposure in NASA studies contributed immensely to the success of this study; Rosette Khiga, a local consultant, whose vital input of local expertise was very timely. Were it not for their dedication and priceless input, the whole exercise would not have yield fruits.

I would like also to acknowledge the NASA Core team for their commitment, perseverance and teamwork needed to birth this document. Specific appreciation goes to Mr. Trouble Chikoko for his oversight role as a representative of UNAIDS and the team of investigators from Makerere School of Public Health headed by the Dean, of School of Public Health, Prof. Rhoda Wanyenze and Prof. David Serwadda, not forgetting Professor Elizeus Rutebemberwa, the principal investigator in the study.

Last but not least our gratitude goes to various stakeholders for their willingness to provide data that was used for the NASA. Specifically, we acknowledge the financial support from Irish Aid without which this study would not have been possible. We acknowledge the consistent technical and financial support from UNAIDS and participation of AIDS Development Partners (ADPs); NGOs/CSOs/FBOs/International Foundations; districts and health facilities (including private-not-for-profit hospitals); and Ministries, Departments and Agencies that provided information and participated at the NASA Validation Workshops.

We look forward to using the findings of this study to inform the National HIV and AIDS policy to guide future planning and resource mobilization.

Dr. Nelson Musoba

DIRECTOR GENERAL

Executive Summary

Uganda has been affected by the HIV and AIDS epidemic since 1980's. The HIV prevalence is still high at 6.2% (UPHIA 2017). A lot of efforts have been put in the response to reduce the HIV/AIDS prevalence from the previous higher levels, but more resources are still needed to achieve the 2030 targets of having HIV and AIDS as no longer a public health threat. This needs concerted funding, planning and coordination of efforts from different stakeholders.

This National AIDS Spending Assessment (NASA) applied the Joint United Nations Programme on HIV and AIDS (UNAIDS) internationally developed resource tracking methodology that set out to inform stakeholders about the funders of HIV and AIDS activities, the amount of resources available, how much was spent on HIV activities, decision makers involved in the allocation of HIV resources, HIV activities funded, implementers of such activities and the populations who benefited from the HIV goods and services provided. The resource tracking methodology followed the money from the source up to the beneficiaries receiving goods and services. Findings from this study will be used for resource mobilization, planning, resource allocation and management of the national HIV response. Another benefit expected of this NASA was to assess whether the implementation of HIV activities is aligned to the HIV and AIDS National Strategic Plan for the country.

This is the second NASA conducted in Uganda after the first one which happened in 2012 that considered financial years 2008/09 and 2009/10. This second NASA was conducted in 2018 and considered financial years 2014/15, 2015/16 and 2016/17. The methodology applied in the first NASA was slightly different from the approach used in the second NASA. While data collection was done from all perspectives i.e. from sources, agents and providers of services and triangulation done from different stakeholders to avoid double counting in the first NASA, this second NASA majorly collected data from the national level (sources of funds) and from a few providers with triangulation done to avoid double counting. Where a source mentioned a provider as recipient of their funds and we had all details from the source, the data from the provider was excluded to avoid double counting.

In the first NASA, funding from all sectors such as public, private and external was considered. For instance, a proportion of business entities were sampled and the data was extrapolated to cover all business entities. Out of pocket expenditure was calculated using expert opinion on per capita in-patient and outpatient department utilization. Attribution factor index for HIV and AIDS spending was estimated as well as cost factors. Since these estimations used secondary data, certain spending e.g. on nutrition, psychosocial support and burial costs were excluded.

Data was collected using hard copies of the questionnaire or in excel formats used by funders and the data coded to the NASA categorization. The second step involved data entry into the Data Processing (DP) sheets for processing, coding and cleaning before it was

transferred to the Resource Tracking Tool (RTT) system, integrated and analyzed. The RTT could give some analysis on a yearly basis but for comparison of findings across the three years, data was exported into excel from which all the graphs and tables for the 3 years were generated.

The preliminary findings presented in this report are mainly from the public sector, external funds and sampled Private Not For Profit organizations. This study did not include Private For Profit businesses, workplace programmes and out of pocket expenditures. A separate comprehensive study for the Private for Profit and out of pocket expenditures will be conducted.

Total Spending on HIV and AIDS in Uganda

Results from the data availed, revealed that Uganda spent UGX 1.210 trillion (USD 433.5 million) on HIV/AIDS in 2014/15. The spending dramatically increased by 53.8% to UGX 2.269 trillion (USD 666.8 million) in 2015/16 and increased by 3.7% from 2015/16 to 2016/17 to UGX 2.411 trillion (USD 691.8 million). Since a big proportion of the spending came from external funding and is also used for procurement of supplies that are paid for in foreign currency, the value in USD gives a more realistic change across the three financial years as it cancels the apparent increase attributed to a rise in the exchange rate.

Source of funding for HIV and AIDS in Uganda (2014/15-2016/17)

Of the total HIV/AIDS expenditure, public sources contributed 9.4% (USD40.6 million) in 2014/15 which declined by 24.5% as a proportion of total spending in that year to USD 30.7 million in 2015/16 and rose again in 2016/17 by 33.5% to USD 40.9 million. The Private Not For Profit sector decreased from USD 4.9 million in 2014/15 to USD 1.9 million (2015/16) a decrease of 60.9% and then rose again to USD 2.6 million (2016/17), an increase of 35.9%.

External sources contributed 89.5% (USD 388.0 million) of total HIV and AIDS expenditure in Uganda in 2014/15. External aid rose by 63.5% between 2014/15 and 2015/16, from USD 388.0 million to USD634.2 million and in 2016/17, it increased slightly by 2.2 % to USD 648.0 million.

Compared to the previous NASA there has generally been increased funding for HIV and AIDS activities. However, the increase in funding was from external funding which increased from USD 398.8 million in 2008/09 to USD 648.0 million in 2016/17. Public funding instead reduced from USD 65.6 million in 2008/09 to USD 40.9 million in 2016/17. This is mainly attributed to a higher conversion rate of Shillings to the US Dollar in 2016/17 than in 2008/9.

It is important to note that the largest portion of external sources for HIV and AIDS funding comes from Government of the United States of America (USG) through U.S. President's Emergency Plan for AIDS Relief (PEPFAR), contributing 99.8% on average of the total bilateral funds, over the three-year period.

Spending according to the AIDS Spending Categories

Care and treatment got the highest HIV/AIDS spending proportions across all the 3 years. It was the highest at 54.3% in 2014/15, 40.8% in 2015/16 and 39.6% in 2016/17. However, in absolute terms, the funding for treatment increased from UGX 656.7 billion in 2014/15 to UGX 926.5 billion in 2015/16 and UGX 955.0 billion in 2016/17. This is followed by systems strengthening at 18.5% in 2014/15, to 27.7% in 2015/16 and 21.3% in 2016/17. Prevention activities took a smaller proportion from 18.9% in 2014/15 to 12.2% in 2015/16 and 13.6% in 2016/17. The biggest increase across the years occurred in human resources which rose from 2.1% in 2014/15 to 12.9% in 2015/16 and still rose to 17.4% in 2016/17. The proportion spent on prevention activities is less than expected. Prevention needs emphasis if new infections are to be reduced.

Compared to the first NASA of 2008/09 and 2009/10, both NASAs show that Care and treatment takes the biggest share with the first NASA putting it at 50.8% in 2008/09 and 51.1% in 2009/10. Both NASAs put prevention in third place, after system strengthening, the proportion of prevention has moved from 18.6% in 2008/09 and 18.2% in 2009/10 to 18.9% in 2014/15, 12.2% in 2015/16 and 13.6% in 2016/17. Overall, there is a reduction in proportion spent on prevention activities.

Beneficiary populations

The people living with HIV and AIDS (PLHIV) had the highest HIV expenditure and this increased over the years. In 2014/15, the proportion was 57.9% increasing to 59.0% in 2015/16 and to 70.9% in 2016/17. This was followed by funding to the non-targeted populations and the general population. The proportion of funding to the most at-risk populations (MARPs) was very low. In 2014/15, it was 0.7% lowering to 0.6% in 2015/16 and remained at 0.6% in 2016/17. Compared to the previous NASA, the profile for beneficiaries of HIV and AIDS funding has remained similar.

Institutionalization of the National AIDS Spending Assessment activity

The stakeholder meetings held strongly recommended the institutionalization of the HIV and AIDS resource tracking under the Uganda AIDS Commission (UAC). Nascent steps were taken to generate the mapping of HIV and AIDS partners which information in subsequent NASAs would support data collection. Trainings were also conducted for the mid-western and mid-northern regions which indicated a disparity of implementing institutions across districts. Such data reflecting local conditions is crucial for planning and assessing equity issues within the HIV and AIDS response.

Conclusion and recommendations

The NASA for three consecutive financial years has given an estimate of how much funding came from government and external partners and given a trend on how funding for various activities has been over the three years. What comes out clearly is that funding has been increasing over the three years 2014/15, 2015/16 and 2016/17. This NASA has demonstrated that the significant increase in the actual expenditure is primarily due increased funding from bilateral and multilateral partners, which implies that Uganda's

HIV and AIDS response is still majorly funded by development partners. It is important to note that prevention activities took less than 20% of the funding during the 3 years in study. Apart from care and treatment which also doubles as a preventative measure, other prevention activities which would reduce HIV and AIDS incidence were in third place across all the 3 years.

Government needs to take up an increased role in the HIV and AIDs response by allocating additional funds to its HIV and AIDS response rather than depend heavily on external funding.

In addition, Government of Uganda needs to own the HIV and AIDS response and make programmatic decision on how the available HIV and AIDs resource envelop should be allocated and implemented according to the disease burden, patterns of the epidemic and likely impact.

It is imperative to institutionalize routine HIV and AIDS expenditure tracking systems and build institutional capacity of various actors in order for better planning and management of the HIV and AIDS epidemic. As part of institutionalization of HIV and AIDS resource tracking, the Ministry of Finance Planning and Economic Development in collaboration with UAC needs to create a vote output for HIV and AIDS mainstreaming to track HIV and AIDS budget allocation and expenditure in all Ministries, Departments and Agencies (MDAs) and Local Government. UAC should develop and disseminate policy guidelines for HIV and AIDS resource tracking as part of the HIV and AIDS mainstreaming guidelines across all sectors.

ACRONYMS

ACORD	Agency for Cooperation and Research in Development
ADPs	AIDS Development Partners
AGHA	Action Group for Health, Human Rights and HIV and AIDS
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders on HIV and AIDS in Africa
AMREF	African Medical and Research Foundation
ANECCA	African Network for Care of Children Affected by HIV and AIDS
ART	Anti-Retroviral Therapy
ARV	Anti-Retrovirals
ASC	AIDS Spending Categories
AVSI	International Volunteers Service Association
BP	Beneficiary Population
CAO	Chief Administrative Officer
CBO	Community Based Organisation
CDC	Centres for Diseases Control and Prevention
CEHURD	Center for Health Human Rights and Development
CHAI	Clinton Health Access Initiative
CHAU	Community Health Alliance Uganda
CSO	Civil Society Organisation
DHO	District Health officer
DP	Data Processing
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FA	Financing Agents
FS	Financing Sources
GLRA	German Leprosy Relief Association
GoU	Government Of Uganda
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System

ICWEA	International Community Of Women Living With HIV in Eastern Africa
IDI	Infectious Diseases Institute
IOM	International Organization for Migration
IRCU	Inter-Religious Council of Uganda
JCRC	Joint Clinical Research Center
JMS	Joint Medical Stores
M&E	Monitoring and Evaluation
MDAS	Ministries Departments and Agencies
MakSPH	Makerere University School of Public Health
MARPs	Most at Risk Populations
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MSH	Management Sciences for Health
NACWOLA	National Community of Women Living with HIV and AIDS
NAFOPHANU	National Forum of People with HIV and AIDS Networks in Uganda
NADIC	National AIDS Documentation and Information
NASA	National AIDS Spending Assessment
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NMS	National Medical Stores
NSP	National Strategic Plan
NUDIPU	National Union of Disabled Persons in Uganda
OAFLA	Organization of African First Ladies against HIV and AIDS
OOPE	Out of Pocket Expenditure
OVC	Orphans and Vulnerable Children
PACE	Programme for Accessible Health, Communication and Education
PEPFAR	President's Emergency Plan for AIDS Relief
PF	Production Factors
PITC	Provider initiated counselling and testing
PLHIV	People Living With HIV and AIDS

PMTCT	Prevention of Mother to Child Transmission
PNFP	Private-Non-For-Profit
PREFA	Protecting Families Against HIV and AIDS
PS	Providers of Services
RAHU	Reach A Hand Uganda
RACA	Rakai Counsellors Association
RTS	Resource Tracking system
RTT	Resource Tracking Tool
TASO	The AIDS Support Organization
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UGX	Uganda shillings
UMSC	Uganda Muslim Supreme Council
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNASO	Uganda Network of AIDS Service Organizations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
UPHIA	Uganda Population base HIV Impact Assessment
USAID	United States Agency for International Development
USD	United states dollar
USG	Unites states government
UWESO	Uganda Women's Efforts to Support Orphans
WB	World Bank
WFP	World Food Programme

CHAPTER 1:

BACKGROUND AND INTRODUCTION

1.1 Background

Uganda is among the countries that have demonstrated remarkable success in the fight against HIV AND AIDS by achieving a dramatic reduction in the adult HIV prevalence rate from 19% in 1991 to 6.5% in the early 2000s, largely due to committed and sustained political leadership, early intervention, a strong focus on prevention, and a multi-sectoral approach (Okware, 2001).

Despite the above achievement, there was a resurgence of HIV infections which led to a rise in HIV prevalence to 7.3% in 2011 (UAIS 2011), mainly attributed to complacency.

Results from the Uganda Population base HIV Impact Assessment (UPHIA) that was conducted from August 2016 to March 2017 indicated that the HIV prevalence among adults aged 15 – 49 years was 6% and 15-64years was 6.2% (females 7.6% and males 4.7%)[1] compared to 7.3% (females 8.2% and males 6.1%) in 2011. The reduction in HIV prevalence over the period is mainly attributed to a combination of factors namely multi-sectoral approach, test and treat policy, targeted interventions, increased funding, political commitments among others. At a prevalence rate of 6.2% (2017) and the number of PLHIV in Uganda stood at 1.3m, meaning HIV still remains a burden which requires sustainable financing to check the epidemic.

Since the HIV epidemic started in Uganda, there has been concerted financial support from development partners, national and private sources to curb the epidemic [2]. However, one notable challenge is lack of proper mechanisms and capacity for tracking of resources used for the HIV and AIDS interventions [3]. As a result, it has been very difficult to ascertain the total amount of resources available for HIV and AIDS and how such funding has translated into implementation of HIV and AIDS related activities in Uganda.

In 2001, the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) urged countries to invest in a monitoring and evaluation system of the HIV response [4]. This entails the institutionalization of a monitoring system that would enable the implementers collect financial and health service delivery data on the HIV response on a regular basis. Countries have had different successes and challenges as they implemented the system.

The Joint United Nations Programme on HIV and AIDS (UNAIDS) together with other partners have supported countries to track their expenditures on HIV and AIDS. Many African countries have conducted National AIDS Spending Assessments (NASA) studies namely Nigeria, Zambia, Namibia, Mozambique, Namibia, Liberia, Ethiopia, Kenya in Africa and Philippines, Indonesia and Papua New Guinea, outside Africa. Uganda conducted the first NASA in 2012 for the financial years 2008/09 and 2009/10. This is the second NASA conducted to provide information on HIV and AIDS expenditure in Uganda for the financial years 2014/15, 2015/16 and 2016/17.

1.2 Introduction

This NASA study was undertaken to measure and track resources of the national response to HIV from the funding sources to the beneficiaries of the HIV programmes. The NASA study generated information for policymakers to determine whether funds were spent as planned or as intended in line with the National AIDS Strategic Plan priorities. The NASA attempted to answer the following questions: who paid for and who decided to purchase HIV and AIDS goods and services? (Financing Sources & Financing Agents); who benefited from HIV and AIDS services (Beneficiary Populations); who provided the HIV and AIDS services (Providers); what HIV and AIDS services were provided (AIDS Spending Categories); and what were the resource costs/inputs used (Production factors).

Information got through NASA has been used in various ways in other countries. It has been used for improved allocation of funds into those sections of the population where HIV and AIDS is high especially in non-generalized HIV epidemics in Eastern Europe [5, 6]. Even in those countries with a generalized epidemic, information at national and supra national level can be used to ascertain the alignment of expenditure to evidence in the response to HIV and AIDS [7]. Resource tracking can demonstrate the funding sources and spending on different interventions and populations [8, 9].

Although NASA has been conducted at national level to track resources supporting the national responses, it can also be targeted to specific areas within a country when decisions on area-specific response are needed. NASA methodologies have been used for specific areas like counties in China [10]. This helps to not only assess the HIV response at national and supra-national levels but even for specific areas within a country especially when there is a special need like an exceptionally high HIV prevalence region compared to other areas.

Countries have been increasing their contributions to the HIV epidemic differently [11]. Some countries like Zimbabwe have started a specific levy on domestic taxes to support the HIV response [12]. As donors change their priorities in funding patterns, countries affected with HIV and AIDS need to get innovative ways to finance their HIV and AIDS activities [13]. Planning for new ways of spending in HIV and AIDS will benefit tremendously from resource tracking that uses good quality data, that is comprehensive and whose information is transmitted in a timely manner.

Resource tracking has been practised over time through National Health Accounts (NHA) but also for specific programs like reproductive health [14, 15] and vaccines [16]. Resource tracking is important for effective planning, budgeting, reporting, and policy-making. Having a resource tracking system (RTS) helps to identify the amount of resources coming from different sources, how they are spent, and who actually benefits from the services. By having an RTS over time, changes in the financial inflows and expenditure patterns are followed. Sometimes, novel requirements tap into the existing resources and stifle the capacity of organizations to respond effectively. Analysis of resources coming into the organization and their utilization helps to identify challenges and provides the much needed information that would be used to address them.

However, in low and middle-income countries with scarce resources, there is a big contribution from the households and the private sector. Resource tracking in reproductive health over time has underscored the importance of tracking private sector resources [14]. An analysis of the NHA for the HIV and AIDS related expenditure in five African countries (Kenya, Rwanda, Malawi, Tanzania

and Zambia) between 2002 and 2006 indicated a reduction in private sector expenditure except for Tanzania. This situation called for a re-alignment of commitments from each player especially considering the long term sustainability of the HIV response [17]. Apart from South Africa whose health systems are functioning properly and contributing significantly to the health needs of the public, most other African countries still depend largely on private funds. Many RTS across Africa are conducted with very little private sector information because of the difficulty in getting this information although private business, insurances, PNFP and household funds are significant contributions in funding health services.

In NASA, data transmission is circular. While there is transmission of data from the lower levels upwards to the highest level through a reporting mechanism, there is also a corresponding feedback loop coming from the highest level to the lowest level where data is collected. The feedback mechanism is very important if the data quality is to improve [16]. The process of information flow across the different levels should be fast and effective. Like any system, there is need for continuous quality improvement and this is enhanced if there is an effective and efficient feedback mechanism.

Government plays an important role in the health services delivery to its population. Much of the support that comes from developmental partners is provided to the government either as budget support or for specific programs of government. It is therefore critical that when an RTS is being designed and executed, there is strong government support if quality financial data is to be expected [18]. In areas where resource tracking has been implemented, weak government financial and health information systems have been the main challenges [19]. Strong emphasis therefore needs to be put on the collaboration with and effective support from the government institutions both at central and local level.

In Uganda the first NASA whose report came out in 2012 assessed the HIV and AIDS resources for the financial years 2008/9 – 2009/10 and recommended among others, institutionalizing of the resource tracking for the HIV and AIDS response [3].

1.3 Rationale for an HIV and AIDS Spending Assessment

Funding for HIV and AIDS programs in Uganda has greatly increased over the years, however, there have been competing global and national priorities for the scarce resources. In addition, the current prevalent and incident rates seem to still pose a threat to the Ugandan population. There is therefore need to track the amount of funds invested in HIV and AIDS response and also to evaluate how these resources have translated to programmatic interventions and to beneficiary groups. HIV and AIDS programs and interventions take a huge bulk of resources of the Health sector and the national budget, however, tracking of resources for HIV and AIDS in Uganda is still a major challenge and yet it is key in informing current and future planning for the HIV and AIDS response.

In addition, there has been a gap of HIV and AIDS financing information since 2012 when the last NASA was conducted. The data was old and stakeholders could not use outdated data to plan effectively for the response. It was important to conduct a second and more recent NASA to inform future planning and decision making for HIV/AIDS.

It is against this background that UNAIDS and UAC, deemed it fit to commission the second NASA.

1.4 Objectives

The specific objectives for this second NASA were:

1. To generate data on HIV and AIDS resources in Uganda for the financial years 2014/2015, 2015/16, 2016/17
2. To develop the HIV and AIDS data base of financial resources, financing agents and service providers as part of the National AIDS Documentation and Information (NADIC) activities
3. To prepare a report of expenditure trends that will contribute to the development of the Investment Case and inform possible re-prioritization.
4. To build in country capacity to undertake regular and targeted HIV and AIDS resource tracking in the process of institutionalization to inform planning and resource allocation

CHAPTER 2:

NASA SCOPE AND METHODOLOGY

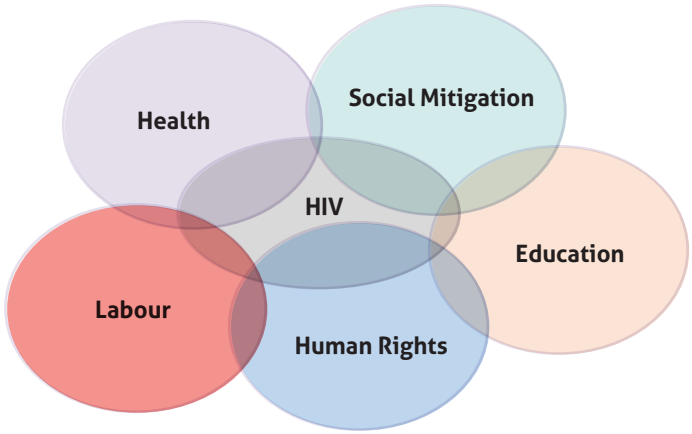
2.1 Scope of the NASA

This NASA focused on HIV and AIDS expenditure for financial years 2014/15, 2015/2016 and 2016/2017. The analysis aimed at tracking expenditure across the six vectors of the NASA. Through answering the following questions;

- Who paid and who purchased HIV and AIDS services during the period under review? (Financing Sources & Financing Agents) – Actual spending (not commitments/budgets)
- Who provided the services? (Providers)
- What was provided? (AIDS Spending Categories/activities)
- Who benefited? (Beneficiary Populations)
- What was bought? (Production factors).

However, production factors were excluded due to lack of disaggregated data from most of the data sources. Sources of funds included: public, external and private not for Profit. Private for profit and out-of-pocket expenditure (OOPE) were excluded for further investigation in future. Expenditure was collected in Uganda Shillings (UGX) as a base currency and where data was in foreign currency, average annual exchange rates were applied. Data was collected from major players that contribute to the HIV response in Uganda. The sectors beyond health that were considered include social mitigation like supporting orphans and vulnerable children (OVC), education, human rights, and labour. Data from Ministries, Departments and Agencies (MDAs) was collected through reports to Ministry of Finance, Ministry of Health, Ministry of Defence and also using the aggregate figures from the NHA as illustrated in the figure below.

Figure 1: Sectors of HIV and AIDS expenditure tracking



2.2 Study area

Data was collected at national and district levels. At national level, data was collected from providers of funds while at district level, data was collected from providers of HIV and AIDS services. A total of 20 districts which had been included in the first NASA were again sampled. The districts were Kampala, Luwero, Mubende, Masaka, Rakai, Mbarara, Rukungi, Kasese, Hoima, Mukono, Jinja, Busia, Mbale, Kapchorwa, Kotido, Soroti, Apac, Arua, Koboko and Gulu. The district data for Private Not for Profit organisations was included in the analysis except for those organizations whose data had been obtained at national level.

2.3 Study population

A composite list of international, national and district/community-based organizations was generated from different sources. Lists of implementing partners were obtained from UAC, district focal persons and implementing partners. The list included International and national NGOs, district-based NGOs and CBOs in each selected district. In addition to this list, snowballing was used to include organizations not previously identified. Organizations were identified through mapping and from data that was obtained at the district level who stated certain organisations as their sources of funds and/or financing agents. These organizations were then included onto the list for NASA.

2.4 Preparatory phase

2.4.1 Training of the Core Team and Technical Working Group (TWG) Members

Members of the Core Task Team and TWG received a three-day training. The objectives of the training were three-fold: to gain in-depth understanding of the NASA methodology and principles; to empower the NASA Core Task Team and TWG to provide effective supervision; and to develop a tentative plan for this NASA (NASA II) phase 1 implementation. Participants were drawn from UAC, Makerere University School of Public Health (MakSPH), Ministry of Gender Labour and Social Development, Uganda Bureau of Statistics (UBOS), UNAIDS, United Nations International Children's Emergency Fund (UNICEF), National Forum of People Living with HIV & AIDS Networks in Uganda (NAFOPHANU), Ministry of Local Government, Ministry of Health, Centres for Disease Control and Prevention (CDC), United States Agency for International Development (USAID), Ministry of Finance, Planning and Economic Development, USAID funded Monitoring and Evaluation of Emergency Plan Progress (MEEPP) project implemented by Social & Scientific Systems (SSS), Inc., MakSPH-Monitoring and Evaluation Technical Support (METS) program, Irish Aid and United Nations Population Fund (UNFPA).

2.4.2 Sensitization of the Districts Leaders

There was an engagement between districts leaders, Core Team and TWG. The objectives were: to sensitize the Chief Administrative Officers (CAOs) about the upcoming NASA, and get their buy-in, active participation and support to the NASA activities. CAOs were tasked to identify 2 technical staff designated as NASA district focal persons to be trained to collect data over the years or for institutionalization purposes. CAOs were given a criterion for selecting district data collectors. The designated staff were technical persons employed by the district, conversant and knowledgeable with HIV and AIDS concepts, and able to interpret data/statistics and to take on more tasks.

2.4.3 Training of District Focal Persons

Three-day training for district focal persons was conducted. The training involved theoretical and practical exercises, plenary discussions, and field excursions. The objective of the training was to build capacity for the district focal persons on the HIV and AIDS resource tracking in Uganda, orientation on NASA and its importance, UNAIDS data collection tools and the NASA data collection process. The training covered the NASA methodology, classifications and definitions, and institutionalization of the HIV and AIDS resource tracking in Uganda. Participants were taken to the field to pilot the NASA tools.

2.4.4 Benchmarking NASA in Ghana

Members of the TWG went to Ghana to benchmark on how Ghana has been conducting annual NASAs. The objectives were: to examine Ghana's approach of conducting NASA; guiding principles, successes, lessons learnt and challenges; to understudy the processes of administering and monitoring of the AIDS spending; to understudy the involvement of different key stakeholders at all levels; and to evaluate how the Government of Ghana uses routine NASA reports to support policy, programming and evidence-based decision making.

2.4.5 Training of the UAC and MakSPH Teams in Geneva – Switzerland

The UAC and MakSPH teams attended a training in Geneva conducted by UNAIDS on the implementation and institutionalization of NASA. The objectives of the training were: to provide updated guidance on the conceptual framework focusing on the standard principles, methods and tools; to review, discuss and assess country experiences; and to plan and inform the next steps of an in-depth HIV resource tracking exercise at the national level. The training covered the overview of the HIV resource tracking initiative, country progress in resource tracking, the NASA framework, NASA classifications, data collection, health information management systems, provider level costing, international data collection, mapping for the HIV resource tracking and institutionalization of NASA.

2.4.6 Stakeholder Workshops

There was a stakeholders' engagement workshop for the sources of HIV funding. The objectives of the stakeholder engagement were to orient donors/sources of HIV and AIDS funding about the NASA concept, data collection tools and the importance for NASA in Uganda as well as to understand the role of key HIV&AIDS players in the NASA and validate timelines for NASA data collection.

There was also a workshop for the agents and providers. The objectives of the stakeholders' workshop were: to orient the participants about the NASA concept and importance of NASA in Uganda; understand the role of key HIV and AIDS players in the NASA; familiarize with data collection tools; appreciate timelines for NASA data collection; buy-in and support the NASA by allowing access to financial data in their organizations.

2.4.7 Training of Data Collection Teams

Two trainings were conducted for the data collectors. The first one was done at the beginning where teams for upcountry data collection as well as one team for Kampala were trained. The second

training was for additional teams for Kampala data collection as one team was found to be inadequate considering the number of organizations where data was to be collected in Kampala. In each of the trainings, data collectors were trained for five days. The training included piloting of the NASA data collection tools and the data collectors reported back their experiences of piloting the tools.

2.5 Data collection

2.5.1 Data variables

Data were collected on funding sources, financing agents, providers of services, HIV and AIDS activities and beneficiary population. Data collection was aimed at capturing all financial transactions and spending related to HIV and AIDS interventions. In addition to HIV and AIDS funding, income and expenditure data, qualitative data was collected on processes and challenges in releasing and accessing HIV and AIDS funds by sources/agents and providers respectively. Data collection for Kampala stretched from February 2018 to August 2018 while data collection in the districts was from March 2018 to May 2018.

2.5.2 Data Collection Tools

The UNAIDS NASA data collection tools were used to collect qualitative and quantitative data, using close-ended question for funding/HIV expenditure and open-ended qualitative questions to collect funding mechanisms, challenges and absorptive capacity. Data was collected using both soft and hard copies of the tools. However, some big organizations, provided expenditure reports that data collectors populated in NASA format.

2.5.3 Data Collection Approaches

NASA data was collected through face-to-face interviews and extensive review of expenditure records. HIV and AIDS actual expenditure data was obtained from quarterly, bi-annual and annual expenditure reports as well as audited accounts of participating organizations. Both top-down and bottom-up approaches were employed during data collection. The top-down approach involved collecting data from sources while the bottom-up approach involved collecting data from the providers. Whenever a complete data set would be provided by the financing source, all the data from the agents and providers indicating funding received from that source would be excluded to ensure that there is no double counting from the source and provider perspectives. This is how data triangulation was achieved.

2.6 Data management and analysis

2.6.1 Data Management

Data from the districts were collected by the data collectors and cross checked by the team leader for completeness. The data were field edited, verified to ensure completeness and stored securely. It was handed over to the central supervisors in hard copy.

Data captured were entered into Data Processing (DP) sheets. The DP sheet is an excel-based spreadsheet that translates raw data into a NASA format that is ready to be entered into the Resource

Tracking Tool (RTT) for analysis. Its format follows the six vectors of the NASA methodology namely; sources of funds, financing agents, providers of HIV services, AIDS spending categories/activities, beneficiary population (and their numbers) and production factors.

Data processing was done by a team of four data collectors who had taken part in data collection. The data entry team was trained in data processing for five days. During data processing, data were cleaned and verified, and any missing, incomplete or contradictory data were identified and corrected. It is during this process that the team (investigators, consultants and data processing team) agreed on assumptions and coding according to NASA classifications. Data processing also involved changing all funds into Uganda shillings based on average exchange rates for each currency for each year. All DP sheets were reviewed by the investigators and consultants for completeness and quality before approving them for entry into RTT.

2.6.2 Data Entry

The same team that entered data into DP sheets was trained in data entry into RTT under supervision of the investigators and consultants. Further cleaning was done in the NASA RTT before analysis was done. Data entry into the RTT was conducted at the NADIC section at UAC offices.

2.6.3 Overview of data collected

The table below shows the number of organizations which provided data.

Table 1: Organizations that provided data

District	Public	Private	International	Total
Apac	1	7	0	8
Arua	5	6	0	11
Busia	1	12	0	13
Gulu	2	8	0	10
Hoima	2	6	0	8
Jinja	4	4	0	8
Kampala	10	32	12	54
Kapchorwa	2	11	1	14
Kasese	1	18	2	21
Koboko	1	3	2	6
Kotido	1	7	0	8
Luwero	1	12	0	13
Masaka	5	17	0	22
Mbale	3	15	0	18
Mbarara	8	4	0	12
Mubende	5	15	0	20

Mukono	5	15	0	20
Rakai	3	6	0	9
Rukungiri	4	15	0	19
Soroti	4	12	0	16
Total	68	225	17	310

There were organizations visited that did not give data and are not included in the table. Secondly, the column for public organizations shows small numbers because most of the government facilities under the districts do not receive cash. They only receive supplies and salaries. In most cases, the District Health Office (DHO) would be visited first and would give all the data. Ultimately, all government expenditure was captured from Ministries at the central level. The 11 international organizations in Kampala include all the major sources of funds (bilateral and multilateral) for the HIV and AIDS response. They provided total expenditure for all of their recipients within the country. Some of the organizations which were visited and did not provide data indicated that they could not provide the data unless they received prior clearance from the funders. Some organizations indicated that they were no longer providing support in HIV and AIDS services. Other organizations that provided funds in 2014/15 or 2015/16 had phased out and their offices closed.

2.6.4 Data Analysis

Aggregation of quantitative data and analysis were undertaken in the RTT. Additional analysis was conducted in Excel using data extracted from RTT. Qualitative data was summarized based on the key thematic areas; 1) funding mechanisms, 2) decision making, 3) reporting mechanisms, 4) challenges in accessing funds and 5) recommendations to address challenges.

2.7 Quality Control

a. Data collectors and their supervisors were trained for one week on the NASA process and practical sessions on filling of the questionnaire by using test cases. The adapted tools were pilot tested to ensure robustness of the methods and ensure tools collected the desired data. Data collected was cross-checked by the team leader for completeness.

b. Pilot testing was done for all the trained data collectors.

c. All teams worked in Kampala under close supervision before being sent upcountry.

d. There was regular supervision by the TWG members and UNAIDS through submission of reports and face-to-face meetings.

e. Quality control by the international consultant who supported the data collection process, the data processing, the data entry processes and the report writing. He ensured the quality and completeness of the data being collected by the team, identified gaps and addressed the challenges.

f. A national consultant was recruited to support the final stages of data entry and analysis as well as report writing.

g. A validation workshop was conducted with stakeholders to; (1) share preliminary findings, (2) for organizations that provided data to confirm that the data represented what was provided, and (3) to get stakeholders' input into the report.

2.8 Assumptions

The following key assumptions were made

a. When the Financing Source or Financing Agent was not able to give the detailed data on specific transfers to the different providers, we estimated based on the percentage of funds split between the activities as their contribution towards their recipients and vice-versa.

b. In cases where funds were pooled from various sources and it was impossible to link the sources to specific activities, it was assumed that the amount attributable to the funding source for each activity was proportional to their contribution on the total pool.

c. All the pool funding mechanisms, like the Civil Society Fund, were considered as sources and given a specific code FS.03.99.

d. For standardisation only, the Bank of Uganda annual average exchange rate shown in table 2 below was applied to all currency conversions since all figures are presented in Uganda Shillings.

Table 2: Average Exchange Rates for the Financial Years

Currency	2014/2015 (UGX)	2015/2016 (UGX)	2016/2017 (UGX)
1 USD	2,790	3,402	3,486
1 Euro	3,541	3,824	3,998
1 Pound	4,789	4,925.5	4,613

a. Program management costs of lower level service providers were split proportionally between their core activities. The overhead cost for big service providers were coded under Program management because it was very difficult to proportionally distribute the cost across the AIDS Spending Categories (ASCs).

b. Where any agent spent some funds on administering funds - these were captured in a separate DP sheet where the agent was also the provider of services (PS) and the ASC 04.02 for the amount spent on administration.

c. Where details were not available on the beneficiaries of programme spending, the most obvious based on the ASC was selected. For example,

   i. The spending of UAC on programme administration was assumed to benefit the general population.

   ii. The administration costs of other organisations were assumed to be non-targeted.

iii. Community mobilisation and educational programmes targeted the general population.

iv. All activities done for World AIDS day were considered under Advocacy and the beneficiary population was assumed to be general population.

v. The M&E activities were assumed to be non- targeted interventions.

vi. For the training received by health worker (trained health workers, village health teams, Peers Educators, opinion leaders) the beneficiary population were the population that receives services that heath workers were trained on, mostly PLHIV

vii. When prevention of mother to child transmission (PMTCT) is not broken down by age then it was considered to benefit both the mother and the child and in this case the beneficiary population was children to be born to HIV positive mothers.

d. US Government provided their total expenditure for the three financial years. Specific activities could not be linked to the providers. We lumped up all their providers together under a particular code PS.99 named PEPFAR's providers during the analysis.

e. All PEPFAR funded provider data were assumed to be captured in the data provided by PEPFAR country office therefore any PEPFAR funding data obtained from providers was excluded.

f. The National Medical Stores (NMS) provided data for the supplies to all the government facilities countrywide. The NMS is mandated by government to supply all the drugs to all the government facilities country wide. All the data on drugs and supplies collected from government facilities from the districts was excluded from the analysis.

g. For non-financial goods (health and non-health commodities), an average unit cost was determined through discussions with the persons involved in service delivery. However, when all the facilities receiving PEPFAR funding and government funding were removed, the non-financial goods especially drugs and supplies drastically reduced.

h. Public spending on systems strengthening was estimated at 40% of the figure spent on HIV and other sexually transmitted diseases following a discussion between the NASA team and a team in Ministry of Health who conducted the NHA 2014/15 and 2015/16. The proportion for 2016/17 was estimated to have increased by the same proportion as 2014/15 to 2015/16.

2.9 Limitations of the Study

a. Generally HIV and AIDS hidden costs for integrated programs from all sectors were hard to estimate. For instance the spending in defending human rights. As a result, this NASA might have some under estimation on the overall HIV spending in the country.

b. While TB is the most common opportunistic infection among PLHIV, TB spending under NHA was outside the HIV sub-account under the NHA. TB funding estimates were not included in this survey

c. Although the private-for-profit sector such as health insurance companies contribute an estimated 5% to the HIV and AIDS expenditure and OOPE to the HIV and AIDS expenditure contributes 95% of the private expenditure on health (NHA 2014/15-2015/16), they are not included in this report. Attempts are being made to collect these data in the near future to get the overall resource envelop to HIV and AIDS in Uganda.

d. The expenditure data of some organizations was not broken down up to production factors or specific target population, thus production factors were excluded from the survey

e. Per capita expenditure could not be estimated at this time because there was still need to collect the private for profit and OOPE which would need to be included in the numerator.

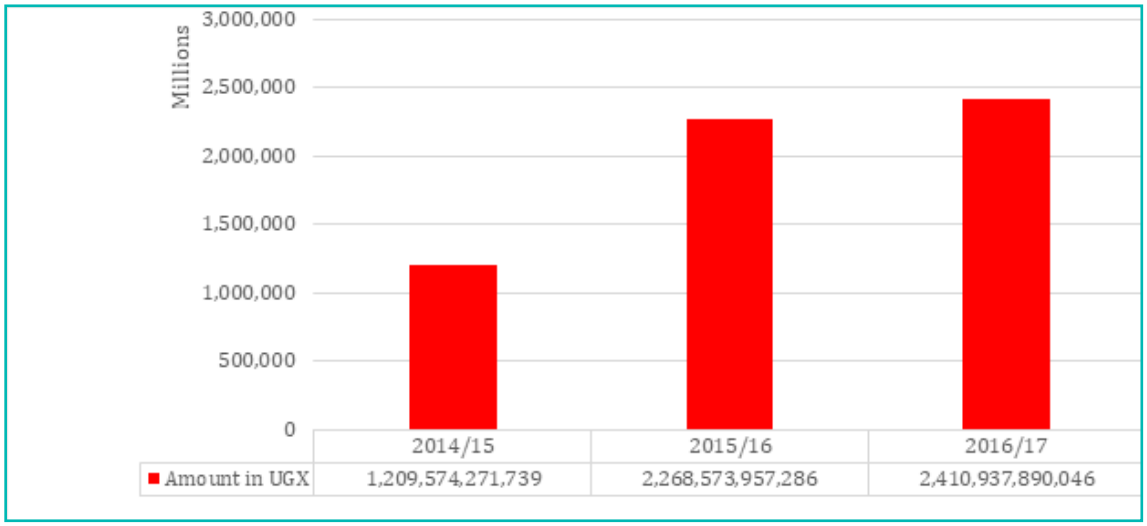
CHAPTER 3:

FINDINGS

3.1 Total expenditure on HIV and AIDS

The findings of the NASA reveal that the total expenditure on HIV and AIDS related activities in Uganda was UGX 1.210 trillion (USD 433.5 million) in Financial Year 2014/15, UGX 2.269 trillion (USD 666.8 million) in Financial Year 2015/16, and UGX 2.411 trillion (USD 691.6 million) in Financial Year 2016/17. Figure 2 shows the trend of expenditure on HIV and AIDS during the financial years 2014/15, 2015/16 and 2016/17.

Figure 2: Total Spending on HIV and AIDS in Uganda 2014/15, 2015/16 & 2016/17



There was a dramatic increase in the total amount of funds spent on HIV and AIDS related activities from financial year 2014/15 to financial year 2015/16 and a steady increase between financial Year 2015/16 and financial Year 2016/17.

The 88% increase in the funding and expenditure on the HIV and AIDS response between 2014/15 and 2015/16 in UGX is mainly attributed to a sharp increase in bilateral and multilateral funding as well as the high difference in the exchange rates.

3.2 Sources of funding for HIV and AIDS

The main funders for HIV and AIDS in Uganda are external sources accounting for an average of about 92.8% across the three years under study, followed by public sources at an average of 6.63% and finally Private Not For Profit at 0.60% as illustrated in Table 3 below. This NASA did not capture the

private for profit sector sources of funds for HIV, which would include businesses, household and individual spending (OOPE). Table 2 below demonstrates that the national response is mostly donor driven with much of the funds coming from external sources.

Table 3: Sources of funding from 2014/15 to 2016/17

HIV sources	2014/15 (UGX)	2014/15 %	2015/16 (UGX)	2015/16 %	2016/17 (UGX)	2016/17 %
Public	113,337,109,262	9.37	104,354,402,035	4.60	142,727,523,091	5.92
External	1,082,448,015,779	89.49	2,157,640,690,775	95.11	2,259,048,802,973	93.70
Private Not For Profit	13,789,146,698	1.14	6,578,864,476	0.29	9,161,563,982	0.38

Public sources contributed 9% (UGX 113.31 billion/USD 40.6 million) of total HIV expenditure in 2014/15 and declined by 24% (in USD terms to avoid exchange variation) to (UGX 104.35 billion/ USD 30.7 million) in 2015/16. In 2016/17 the public fund rose by 34% in USD terms to (UGX 142.77 billion/USD 41.0 million). External sources contributed 90% (UGX 1.082 trillion/USD 387.9 million) of total HIV and AIDS expenditure in Uganda in 2014/15. It rose by 64% in USD terms between 2014/15 and 2015/16, from (UGX 1.082 trillion/USD 387.9 million) to (UGX 2.158 trillion/USD 634.2 million) and in 2016/17, the external funds increased slightly by 2.2 % in USD terms to (UGX 2.260 trillion/USD 648.2 million).

The table below shows the funding from external sources and the public sector compared with the 2008/09 and 2009/10 NASA.

Table 4: External and Public HIV and AIDS spending 2008/09, 2009/10, 2014/15, 2015/16 and 2016/17

Year	2008/09	2009/10	2014/15	2015/16	2016/17
External (millions of USD)	398.8	390.1	388.0	634.2	648.0
Public (millions of USD)	65.6	60.0	40.6	30.7	41.0

Compared to the first NASA, external funding increased from USD 398.8 million in 2008/09 to USD 648.0 million in 2016/17. Public funding however reduced from USD 65.6 million in 2008/09 to USD 41.0 million in 2016/17.

External Funding on HIV and AIDS in Uganda

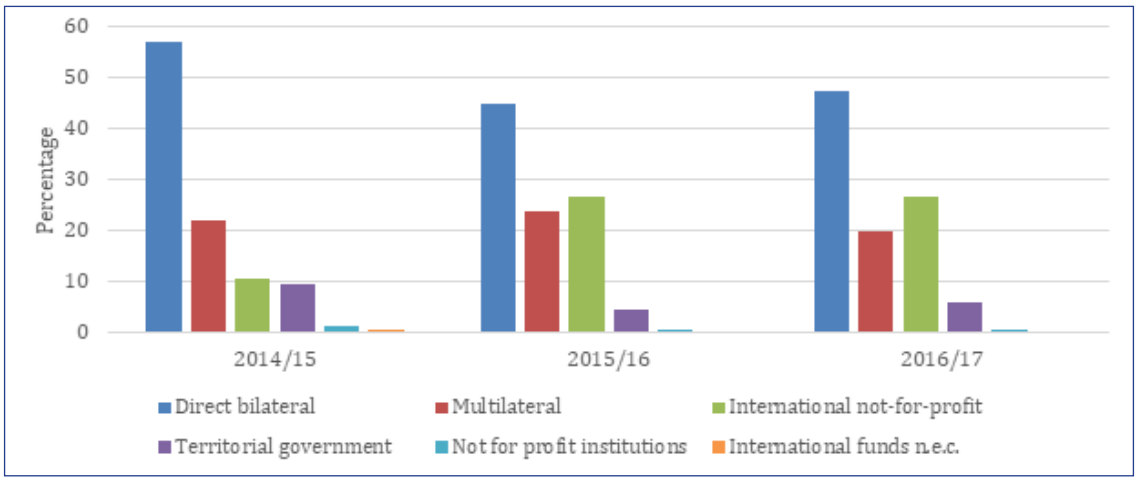
In 2014/15, the bilateral contributions had the biggest proportion of the total external funding. The bilateral contributions were 57.11% of the total HIV spending followed by multilateral agencies at 21.96% and, the external not for profit organizations at 10.41% as shown in the table below.

Table 5: External Funding on HIV and AIDS in Uganda (UGX, 2014/15 – 2016/17)

FY	2014/15		2015/16		2016/17	
	UGX	%	UGX	%	UGX	%
Direct bilateral	690,787,866,590	57.11	1,015,186,845,885	44.75	1,137,721,590,313	47.19
Multi lateral	265,622,510,074	21.96	538,559,457,460	23.74	478,571,171,174	19.85
International not for profit	125,916,681,688	10.41	603,894,387,430	26.62	642,514,947,697	26.65

The bilateral contributions increased from UGX 691.0 billion in 2014/15 to UGX 1.015 trillion in 2015/16 and to UGX 1.138 trillion in 2016/17. The second biggest contributor in external funding was international not for profit organisations which rose from UGX 125.9 million in 2014/15 to UGX 603.9 million in 2015/16 and to UGX 642.5 million in 2016/17.

Figure 3: Comparison of sources of HIV and AIDS funds from 2014/15 – 2016/17 by percentage.



The proportion of direct bilateral contributions decreased from 57.1% in 2014/15 to 44.8% in 2015/16 but increased again to 47.2% in 2016/17. The multilateral organizations increased from 22.0% in 2014/15 to 23.7% in 2015/16 but declined to 19.9% in 2016/17. The other big contributor was the international not for profit organizations and foundations at 10.4% in 2014/15 and 26.6% in 2015/16 and slightly increased to 26.7% in 2016/17

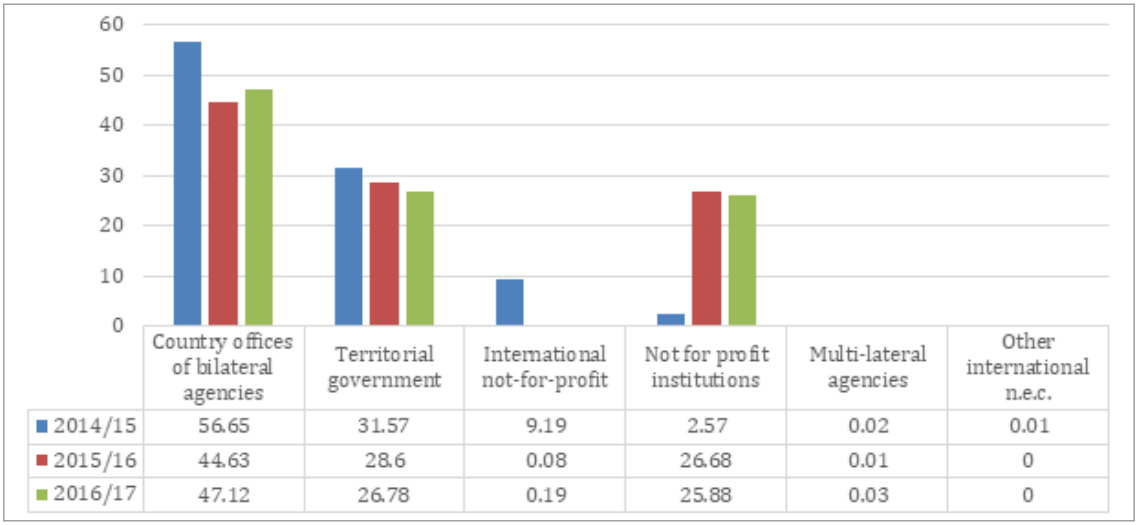
Overall, results reveal the HIV and AIDS response in Uganda is heavily funded by external sources. This has a negative implication in a sense that if donors withdrew or reduced their contributions, Uganda would face a big challenge on sustaining its HIV response.

3.3 Financial agents

In the financing of the HIV and AIDS interventions, financial agents are entities that pool financial resources to finance service provision programmes and also make programmatic decisions about

implementation of HIV and AIDS interventions. The figure below shows the proportions that different institutions made decisions on.

Figure 4: Financial agents for HIV and AIDS expenditure 2014/15 – 2016/17



	Country offices of bilateral agencies	Territorial government	International not-for-profit	Not for profit institutions	Multi-lateral agencies	Other international n.e.c.
2014/15	56.65	31.57	9.19	2.57	0.02	0.01
2015/16	44.63	28.6	0.08	26.68	0.01	0
2016/17	47.12	26.78	0.19	25.88	0.03	0

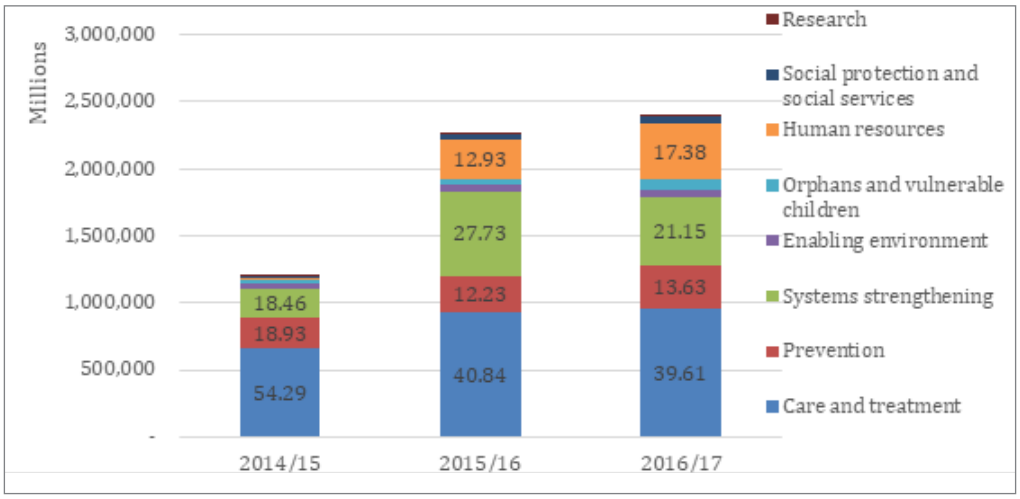
In the three years 2014/15, 2015/16 and 2016/17, the country offices of bilateral agencies managed the highest proportion of HIV and AIDS funds. As presented in figure 4 above, their percentage shares as total of HIV funds were 56.65%, 44.63 %and 47.12% in 2014/15, 2015/16 & 2016/17 respectively. These were followed by Government of Uganda financing agents whose percentages as a total of HIV and AIDS funds were 31.57%, 28.60% and 26.78% in FYs 2014, 2015 and 2016 respectively. This shows that bilateral financial agents took leadership and more ownership in programmatic decisions than the government of Uganda on implementation of HIV and AIDS interventions. This poses a challenge also in the sense that if Uganda cannot take the lead in decisions making on how its HIV response should be implemented, then it will never fulfill its objectives and align its response according to HIV/AIDS National strategic plan

The biggest change in management of how finances are spent was within the not for profit institutions whose control rose from 2.57% in 2014/15 to 26.68% in 2015/16. This also happened with the loss of control from international not for profit institutions and foundations whose control fell from 9.19% to 0.08% from FY 2014/15 to 2015/16.

3.4 HIV spending Activities in Uganda (2014/15, 2015/16, 2016/17)

This section presents how total HIV/AIDS spending was implemented across the eight HIV and AIDS spending categories. The eight HIV and AIDS thematic areas include; Prevention, Care & treatment, OVC, Programme management and Administration, Human resources, Social protection and social services, enabling environment and HIV and AIDS related research. These broad categories are further disaggregated into more specific activities/interventions.

Figure 5: HIV and AIDS activities undertaken in Uganda – all sources (UGX, 2014/15 – 2016/17)



As shown in figure 5 above, most of the HIV and AIDS funds were spent on care and treatment activities across the years.

Care and treatment which included ART, home-based care, Lab services, PITC and Nutrition figured more prominently as a priority program taking 50% of total HIV and AIDS funds in 2014/15, in proportional terms it decreased to 41% and to 40% in 2015/16 and 2016/17 respectively. This is followed by system strengthening and program coordination consuming 18% in 2014/15, 28% in 2015/16 and 21% in 2016/17. In proportional terms, the Human resource share increased drastically from 2% of the total in 2014/15, to 13% in 2015/16, and again to 17% in 2016/17. In contrast, the expenditure on a range of prevention activities decreased from 19% of the total in 2014/15 to 12% in 2015/16 and slightly increased to 14% of the total spending in 2016/17. However, there was increase in the absolute amounts spent in all years under assessment. There was relatively low spending on OVC support which took approximately 2% on average of the total spending over the three-year period. The remaining categories were social protection, enabling environment and HIV-related research, receiving together only 4.4% on average over the three years.

An analysis was done on how funding from different financial sources are spent according to specific interventions. The funding sources are categorized as external funds, public funds and private funds.

3.5 Comparison of how different financial sources provided funds for specific AIDS spending categories interventions

Across the years, different sources put funding to different activities in varying proportions across the years 2014/15 to 2016/17. This is shown in the table below.

Table 6: Spending activities per source of funds in Uganda (UGX, 2014/15-2016/17)

	2014			2015			2016		
Sources of fund in Uganda (% proportion of the total spent in 2014/15 - 2016/18	Public	Private	International	Public	Private	International	Public	Private	International
Prevention		37%	21%		15%	13%		9%	15%
Care and treatment	49%	8%	56%	35%	0%	42%	46%	2%	40%
OVC		1%	3%		0%	2%		1%	3%
Programme management	51%	18%	15%	65%	37%	26%	54%	28%	19%
Human resources		4%	2%		5%	14%		7%	19%
Social protection and services		4%	1%		0%	2%		0%	2%
Enabling environment		28%	2%		43%	2%		53%	2%

The table above shows that the government of Uganda mainly funded care and treatment and programme management across the 3 years. Care and treatment took 49%, 35% and 46% of total public funds in 2014/15, 2015/16 and 2016/17 respectively while programme management took 51%, 65% and 54% as a proportion of total public funds in 2014/15, 2015/16 and 2016/17 respectively.

Similarly, a big proportion of external fund also went into care and treatment and programme management across the three years. As a percentage of total external HIV spending, care and treatment took 56%, 42% and 40% in 2014/15, 2015/16 and 2016/17 respectively while programme management took 15%, 26% and 19% respectively. Prevention activities take third place as total share of external funds at 21%,13% and 15% for the years 2014/15, 2015/16 and 2016/17 respectively

The pattern was slightly different for Private Not For Profit sources whose major funding went into prevention but the proportions reduced significantly across the three years. For instance, as a percentage of total Not For private funds, prevention took 37% in 2014/15 and this reduced to 15% and 9% in the years 2015/16 and 2016/17 respectively.

According to the 2017 UPHIA report, national HIV prevalence among adults had declined from 7.3% in 2011 to 6.0% in 2016. These declines were attributed to a decreasing number of new infections in the recent years due to the impact of intensified treatment services in the country.

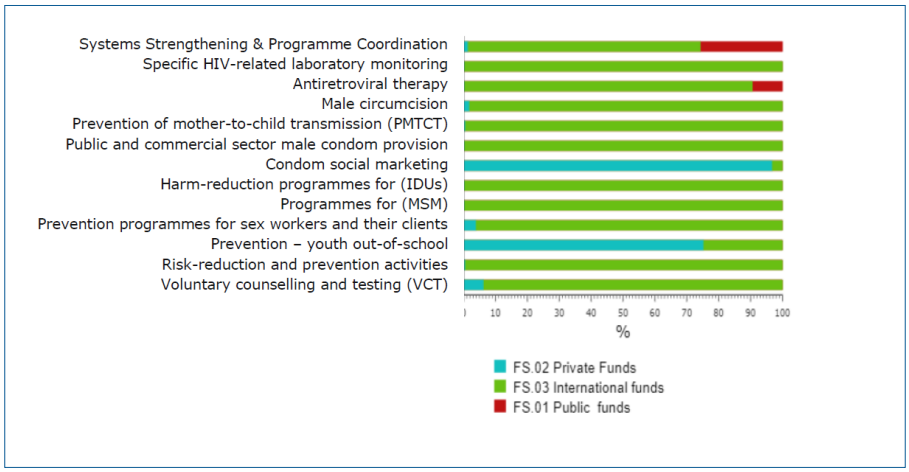
While care and treatment has played a big role in reduction of prevalence and incident rates among the adult population in the recent years, according to the UPHIA 2017, it is imperative to reprioritize allocation to prevention measures especially among the young age groups 20-24 years and 25-29 years. UPHIA 2017 report identified existing gaps in the HIV programmes and specific populations that need special focus.

For instance, HIV and AIDS prevalence among those aged 15-19 years was 1.1% (1.8% in girls and 0.5% in boys), this increased to 3.3% among those aged 20-24 years (5.1% in young women and 1.3% in young men). It then increased again to 6.3% among those aged 25-29(8.5% in women and 3.5% in men). This suggests new infections remain an issue in especially younger females and these continuing infection rates necessitate innovative interventions to prevent new infections in young people (UPHIA report, 2017)

3.6 Sources of funds for specific interventions by financial years 2014/15, 2015/16 and 2016/17

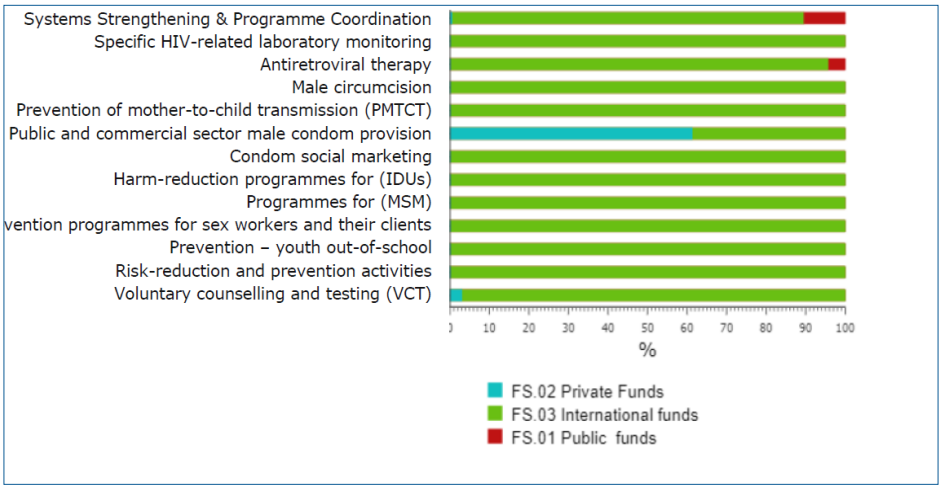
For the FY 2014/15, it should be noted that public funds contributed a big proportion to the systems strengthening and programme coordination as well as ART. Private not for profit funds were mainly spent on condom social marketing and prevention programmes among youth who are out of school as illustrated in the figure below.

Figure 6: Sources of funds for specific interventions in FY 2014/15



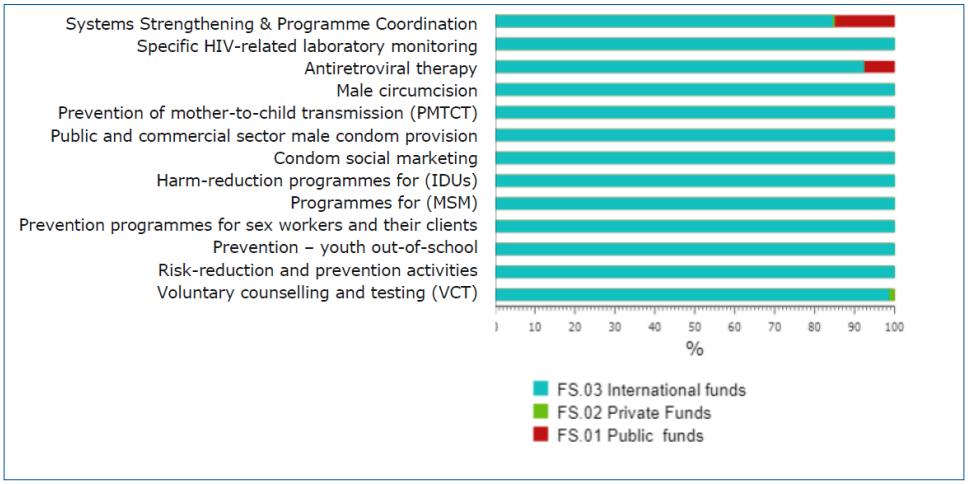
During the FY 2014/15, the bulk of the interventions were supported by external funds, except for condom social marketing and prevention for youth out of school where private funds contributed over 90% and about 75% respectively. The private funds also contributed about 6%, 4%, 2.5% and 1.5% towards HIV counseling and testing (HCT), prevention programmes for sex workers and their clients and male circumcision, system strengthening and programme coordination respectively. Public funds supported about 30% of system strengthening and programme coordination, and 10% of ART interventions.

Figure 7: Sources of funds for specific interventions in FY 2015/16



During the FY 2015/16 most interventions were supported by external funds apart from public and commercial sector male condom provision activities which were supported by private funds supported at 60%. The government of Uganda supported about 10% and 5% of systems strengthening and antiretroviral therapy respectively.

Figure 8: Sources of funds for specific interventions in FY 2016/17



Results further revealed that during the FY 2016/17, Uganda relied heavily on external funds to finance the bulk of it's HIV and AIDS response with the exceptional of public funds contributing about 20% of system strengthening and programme coordination and about 8% of ART interventions. The private sector contributed about 1% of the HCT intervention funds.

Again, as discussed in the sections above, over-reliance on external funds to finance a country's HIV and AIDS response is not sustainable and might have negative implications on the Ugandan population because should the external sources change their funding priorities or withdraw funding completely a large number of PLHIV on ART will be greatly affected. This calls for the government to foresee such situation and plan accordingly to avert any possible adverse consequences that might arise in future.

3.6.1 Breakdown of Spending on HIV and AIDS Prevention activities in Uganda (UGX' 2014/15 – 2016/17)

This section presents the proportion of funding to prevention interventions over the three years as percentage of the total spending in prevention. Overall, the proportion of funding to prevention decreased as percentage of the total from a high of 18.93% in 2014/15 to 12.23% in 2015/16 and13.64% in 2016/17. However, even within the prevention activities, there were variations across the years. The reduction in the funding proportion for prevention intervention is not a welcome trend. Prevention is generaly regarded as more cost effective intervention in HIV and AIDS epidemic disease control compared to other interventions.

Less commitment in allocating a fair share of scarce resources to HIV andAIDS prevention activities could explain the recent increases in the infection rates among the young adults 20-29 years of age.

Therefore there is need for government to invest more funds into prevention interventions to curb the high HIV incident rates especially among adolecent girls and young women.

The proportions of the expenditure on key prevention activities as a percentage of the total expenditure on prevention is given in the table below.

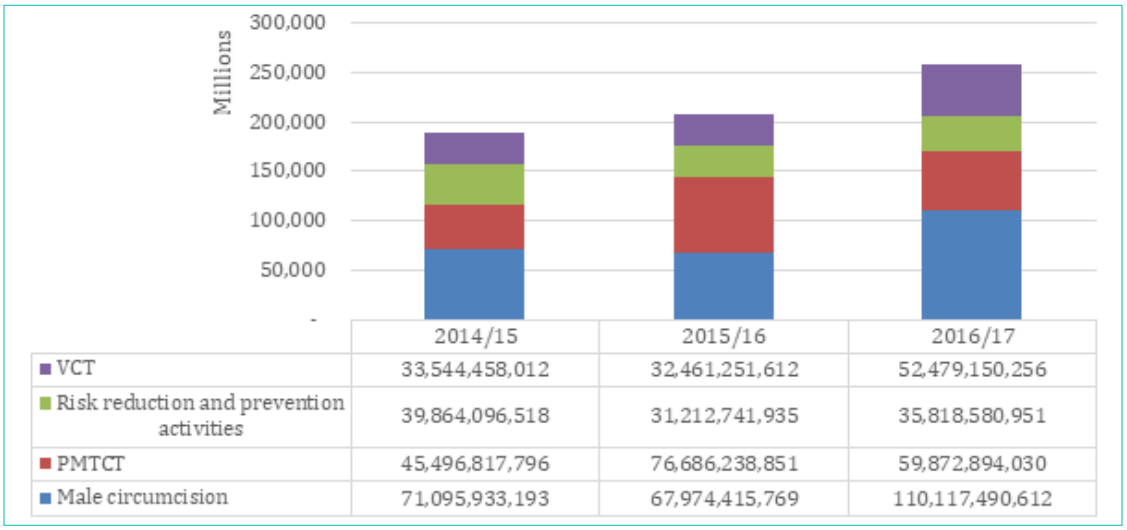
Table 7: Proportions of main prevention activities 2014/15 – 2016/17

Prevention activities	2014/15	2015/16	2016/17
Male circumcision	31.05%	24.50%	33.51%
PMTCT	19.87%	27.64%	18.22%
Risk reduction and other sexual prevention activities	17.41%	11.25%	10.90%
HCT	14.65%	11.70%	15.97%
Others	17.78%	24.91%	21.40%

During FY 2014/15, the activity that took the highest funding was male circumcision (31.05%), followed by PMTCT (19.87%). Risk reduction and other sexual prevention activities for vulnerable and accessible populations took the third position with 17.41% and HCT came fourth with 14.65%. The four interventions took a combined 83% of the funds to prevention activities in 2014/15, 75% in 2015/16 and 79% in 2016/17.

An analysis was made to explore the funding to key prevention interventions over the three years in absolute UGX funding.

Figure 9: Expenditure on key prevention interventions 2014/15 – 2016/17



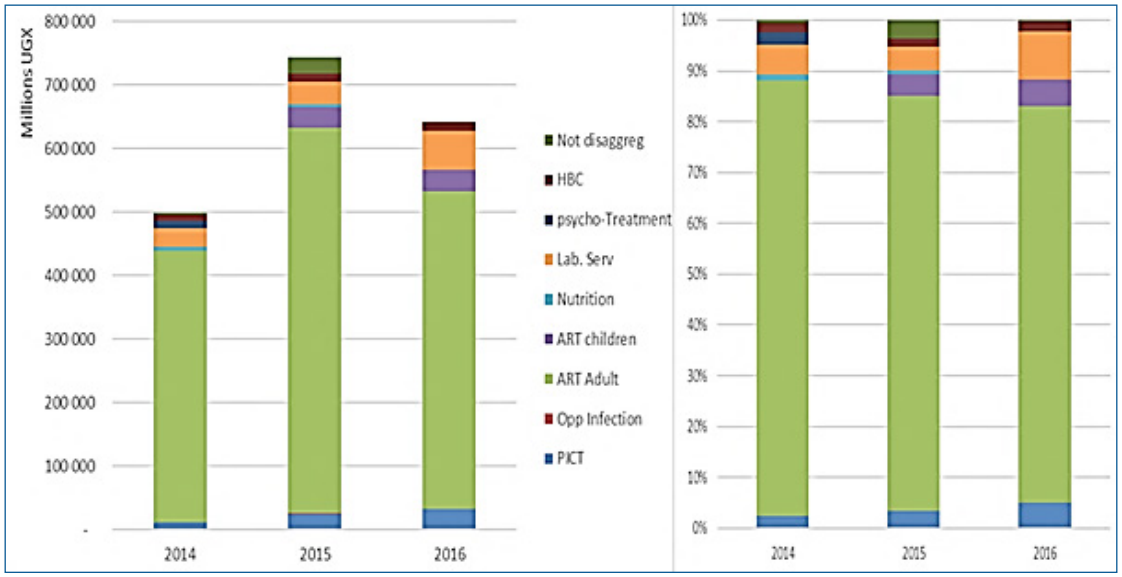
	2014/15	2015/16	2016/17
VCT	33,544,458,012	32,461,251,612	52,479,150,256
Risk reduction and prevention activities	39,864,096,518	31,212,741,935	35,818,580,951
PMTCT	45,496,817,796	76,686,238,851	59,872,894,030
Male circumcision	71,095,933,193	67,974,415,769	110,117,490,612

It was found that the funding for four interventions of HCT, PMTCT and male circumcision increased over time. However, prevention activities aimed at prevention of transmission among PLHIV reduced from UGX 39.9 billion in 2014/15 to UGX 31.2 billion and again rose slightly to UGX 35.8 billion but still below the 2014/15 amount.

3.6.2 Breakdown of Spending on HIV and AIDS Treatment Activities in Uganda (UGX' 2014/15 – 2016/17)

The HIV and AIDS treatment activities were assessed over the three years. The results are given in the figure below.

Figure 10: HIV and AIDS treatment activities 2014/15 – 2016/17



The highest percentage of HIV and AIDs spending among the care and treatment category went to Adult ART in all the three financial years 2014/15 to 2016/17. Lab services and children ART came second and third respectively and these activities increased steadily across the three years. Other activities such as psycho-social support and nutrition took small amounts.

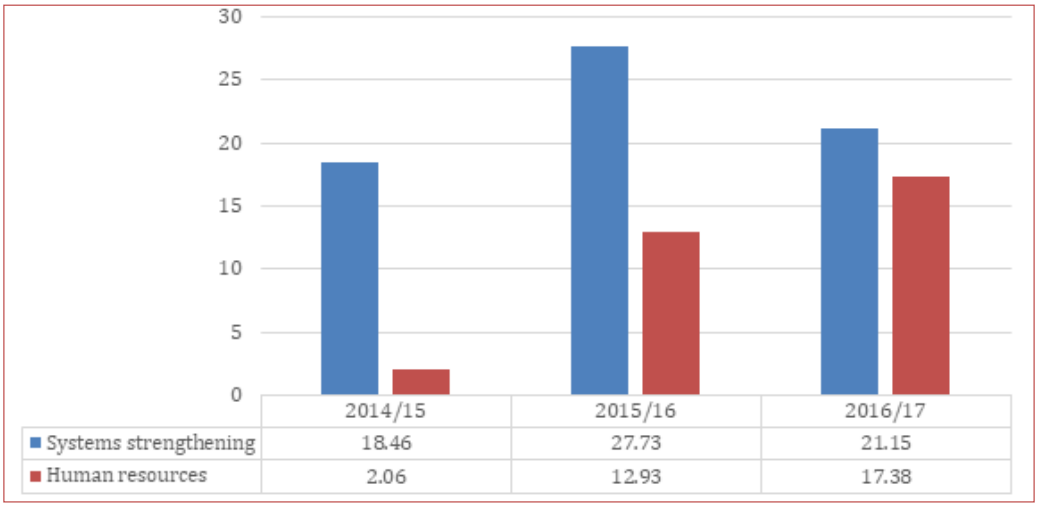
Expenditure on ARVs took the highest proportion of expenditure from 87.72% in 2014/15 to 87.86% in 2015/16 and 86.06% in 2016/17.

ART is an important intervention in supressing HIV viral load and thus preventing transmission of HIV to others. However, prevention interventions also need to be funded adequately to avert any new HIV infections, especially from PLHIV who are not on ART, and keep the young population free from the epidemic.

3.6.3 Spending on Systems Strengthening & Programme Coordination and Human resources in 2014/15-2016/17

An analysis was done for the systems strengthening and human resources. This is presented in the figure below.

Figure 11: Systems strengthening / programme coordination and human resources expenditure 2014/15 – 2016/17



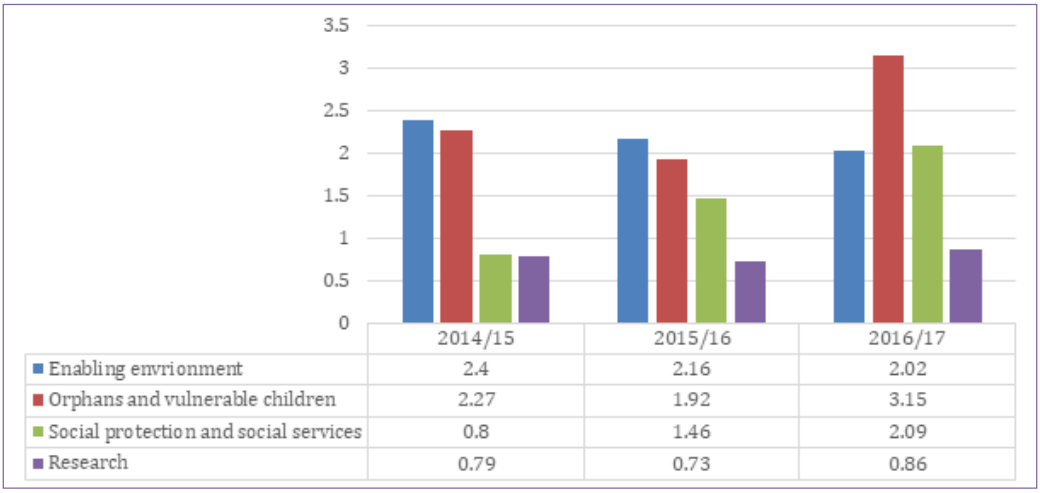
	2014/15	2015/16	2016/17
Systems strengthening	18.46	27.73	21.15
Human resources	2.06	12.93	17.38

The proportion of expenditure on systems strengthening and programme coordination as percentage of the total expenditure varied between 18.46% in 2014/15 to 27.73% in 2015/16 and again went down to 21.15% in 2016/17. In contrast, the proportion going to human resources increased dramatically from 2.06% in 2014/15 to 12.93% in 2015/16 and then to 17.38% in 2016/17. Although the numbers are still small, there is a noticeable focus on human resources over the three years under study. Whereas the relative importance of systems strengthening in the HIV and AIDS response has gained prominence, spending more than 25% of the funding on this activity may suffocate other interventions. It may be helpful to balance the programme coordination with the funding that ultimately caters for services that clients in the facilities receive. Human resources are critical for the HIV and AIDS response and continued funding in system strengthening would sustain investments in health which heavily depend on an effective workforce.

3.6.4 Spending on Mitigation activities in 2014/15-2016/17

Other HIV/AIDS thematic areas such as OVC, Social Protection, research and enabling environment are presented below in figure 12.

Figure 12: Expenditure on mitigation efforts from 2014/15 – 2016/17



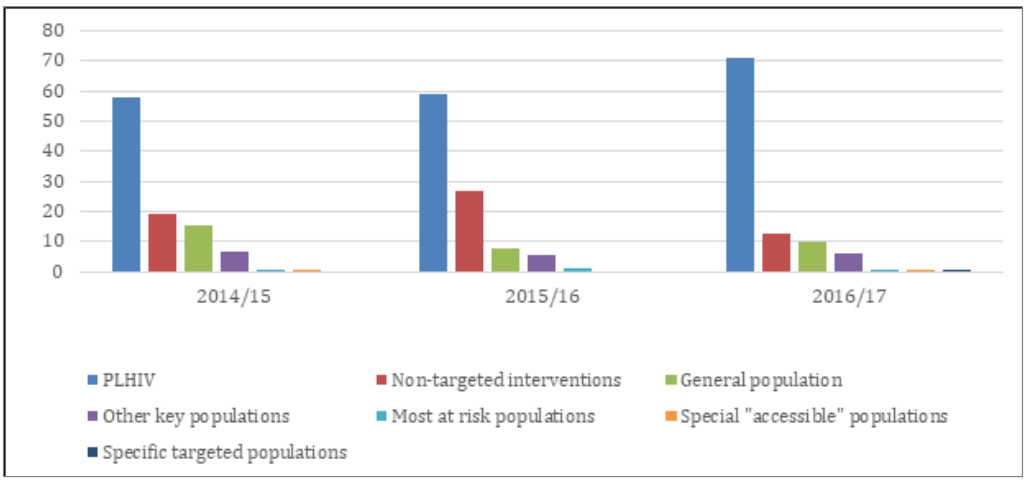
	2014/15	2015/16	2016/17
Enabling envrionment	2.4	2.16	2.02
Orphans and vulnerable children	2.27	1.92	3.15
Social protection and social services	0.8	1.46	2.09
Research	0.79	0.73	0.86

The proportion of funding spent on the ensuring an enabling environment, OVC and research did not change much across the three years. For social protection, there was an increase from 0.8% in 2014/15 to 1.46% in 2015/16 and then to 2.09% in 2016/17. Added together, the four mitigating activities did not even reach 9% of the total expenditure in any of the three years. HIV and AIDS has an impact on all sectors of society, the response needs to also take into account the context in which these interventions are implemented. Beyond treating those infected, there is a multitude of orphans who need support. To improve both treatment and prevention interventions, research needs to be sustained so that more effective and efficient mechanisms are identified and later incorporated into the response.

3.7 Beneficiary population

An analysis was made on how the HIV and AIDS spending benefitted different populations. This is presented in the figure below.

Figure 13: Proportion of funds spent on different beneficiary populations



Across the years, the highest proportion of the expenditure went to PLHIV (57.94% in 2014/15, 58.96% in 2015/16 and 70.86% in 2016/17) followed by non-targeted interventions (19.30% in 2014/15, 26.81% in 2015/16 and 12.76% in 2016/17) and then the general population (15.46% in 2014/15, 7.57% in 2015/16 and 9.94% in 2016/17). "Other key populations" took the fourth position at (6.57% in 2014/15, 5.49% in 2015/16 and 5.78% in 2016/17). Most At Risk Populations (MARPs) got less than 1% except in 2015/16 when they received 1.16%. The proportion being spent on PLHIV kept increasing over the years with the amount spent on other population segments showing a mixed picture. This could be reflecting the change to the test and treat policy that put a lot of people on ART irrespective of their immune status. As the PLHIV live longer and new infections keep bringing in new people into the system for treatment, the expenditure on PLHIV will keep going higher. It is important to treat PLHIV to live longer and at the same time preventing those on treatment from transmitting the disease to others but it is even more important to prevent infection among HIV negative persons. Government needs to increase funding to those activities that reduce new HIV infections.

One of the key populations to target and allocate more funding to, would be the MARPs who are currently getting very little funding and yet evidence shows they are more likely to transmit HIV.

3.8 The U.S Government (USG) funding for HIV and AIDS in Uganda

The U.S. government through PEPFAR remains the biggest contributor to the HIV and AIDS response annually in Uganda. Given the magnitude of their contribution, this section looks specifically at PEPFAR spending in three consecutive years. PEPFAR spent USD245 million in 2014/15, increasing by 21% to USD 297 million the following year, and continued to increase by 10% reaching USD 325 million in 2016/17. The funds were spent through its various agencies, partners and sub-partners thus totalling to USD 867 million over the three years period. Figure 5 below shows the activities on which the PEPFAR funds were spent in Uganda for each of the three years.

Figure 14: USG spending on HIV and Aids in Uganda (USD 2014/15 – 2016/17)

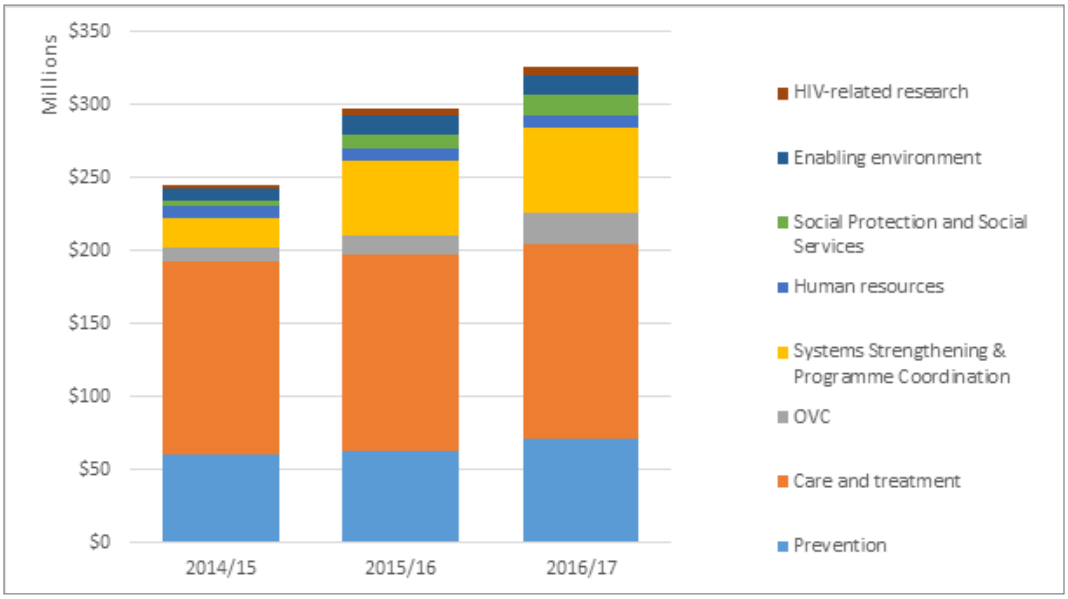
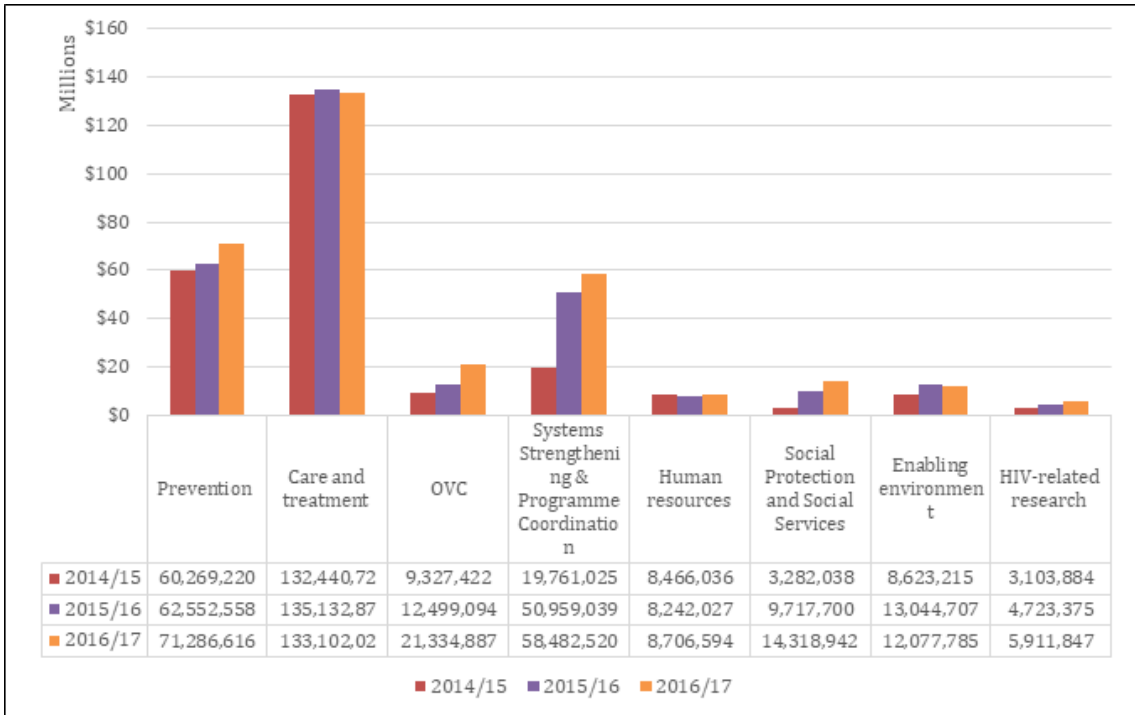


Figure above indicates that care and treatment took up the largest single share of expenditure in each year, 54% in 2014/15, 46% and 41% in 2015/16 and 2016/17 respectively. The second major spending activities were prevention, in 2014/15 it took a share of expenditure of 25%, 21% in 2015/16 and 22% in 2016/17. Followed by systems strengthening and programme coordination costs consuming 8% in 2014/15, 17% in 2015/16 and 18% in 2016/17 of total PEPFAR funds. It is important to note that while the commitment towards care and treatment and prevention is decreasing, funding of program coordination is increasing across the years.

Comparison across the years shows that the absolute amount of funds dedicated to most of the ASCs kept increasing as shown in the figure below.

Figure 15: Comparison of expenditure across the different ASCs

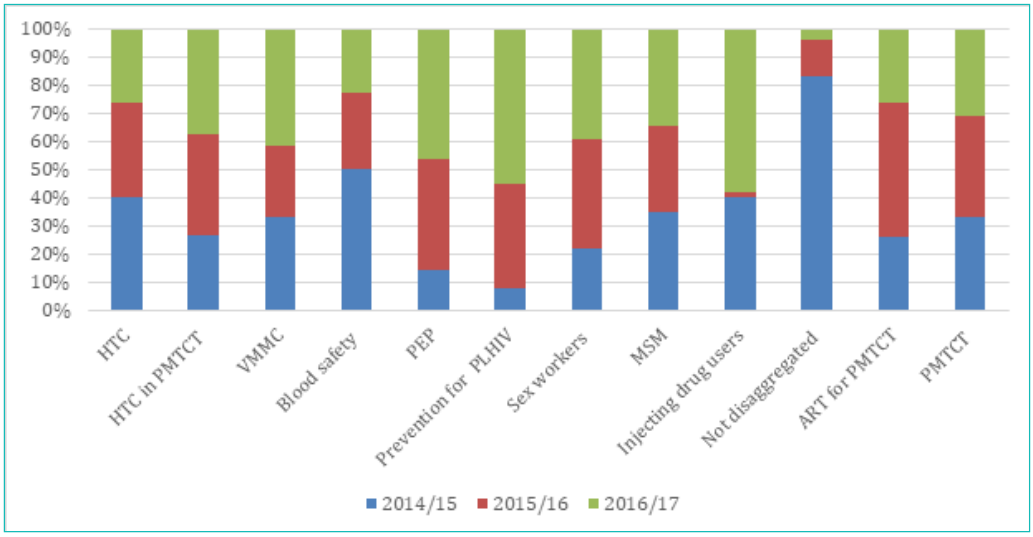


	Prevention	Care and treatment	OVC	Systems Strengthening & Programme Coordination	Human resources	Social Protection and Social Services	Enabling environment	HIV-related research
2014/15	60,269,220	132,440,72	9,327,422	19,761,025	8,466,036	3,282,038	8,623,215	3,103,884
2015/16	62,552,558	135,132,87	12,499,094	50,959,039	8,242,027	9,717,700	13,044,707	4,723,375
2016/17	71,286,616	133,102,02	21,334,887	58,482,520	8,706,594	14,318,942	12,077,785	5,911,847

As can be seen from figure 15, the amounts for prevention, OVC, systems strengthening, social protections and social services as well as HIV related research increased continuously over the three years. Care and treatment took the biggest percentage and its values were stable as well as that allocated to human resources.

The distribution of funding within each of the ASCs increased across the years. The proportions within prevention are shown in the figure below.

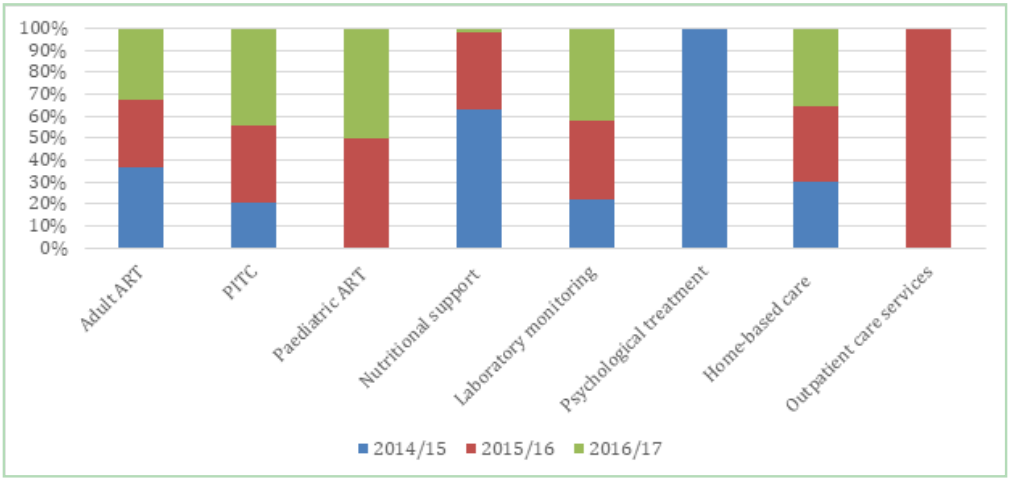
Figure 16: Expenditure within prevention activities across 2014/15 – 2016/17



As can be seen from the figure above, Harm-reduction programmes for injecting drug users (IDUs) received small amounts of funding in 2015/16 relative to the years of 2014/15 and 2016/17. Prevention of HIV transmission aimed at PLHIV received more funding in 2016/17 relative to the previous two years. Prevention activities not disaggregated by intervention had got a lot of funding in 2014/15 but this reduced significantly in the following two years.

Variations were also observed within care and treatment as indicated in the figure below.

Figure 17: Expenditure within Care and treatment activities across 2014/15 – 2016/17

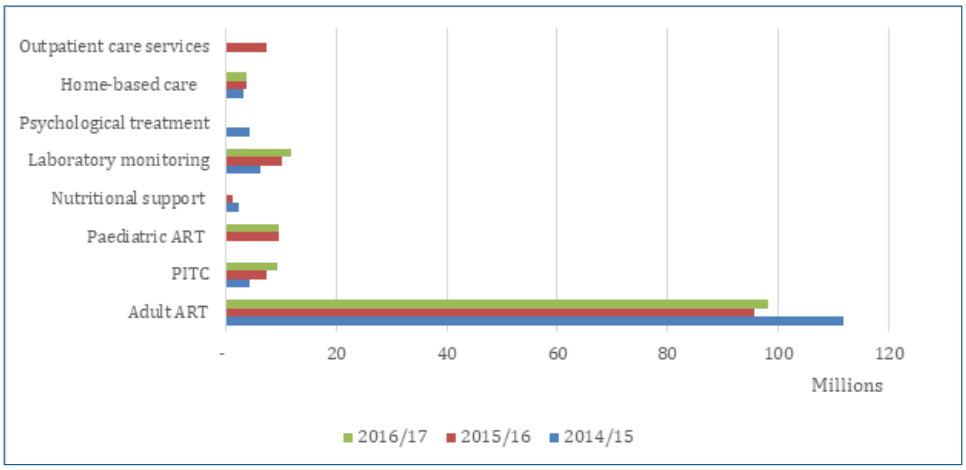


It can be seen that funding for Psychosocial support services was only given in 2014/15 and not for other years while funding for Outpatient care services not disaggregated by intervention was only given in 2014/15 and not for the other years under study. Whereas there was no funding for paediatric antiretroviral therapy not disaggregated by line of treatment in 2014/15, the following

years received funding almost in similar amounts. The amounts for Provider- initiated testing and counselling (PITC) increased over time from 2014/15 to 2016/17.

When the activities are compared across each other, the funding comes out as shown below.

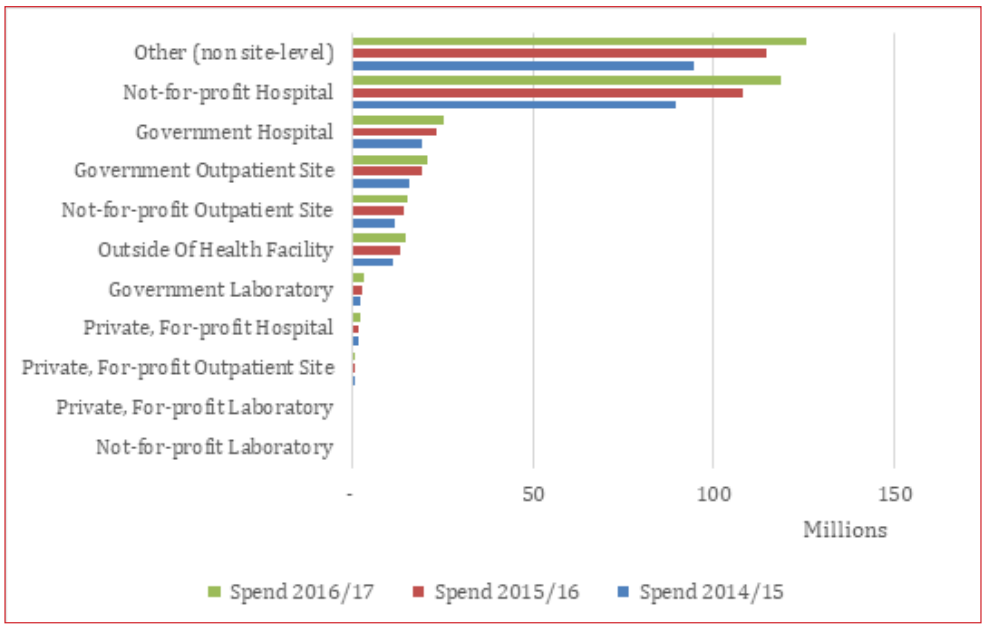
Figure 18: Amount of funding for each activity across 2014/15 – 2016/17



It can be seen from the figure about that most of the funding went to Adult antiretroviral therapy not disaggregated by line of treatment. The rest of the activities within care and treatment received relatively small amounts.

In terms of providers, USG funding was channeled across different types of providers and with various amounts as indicated in the figure below.

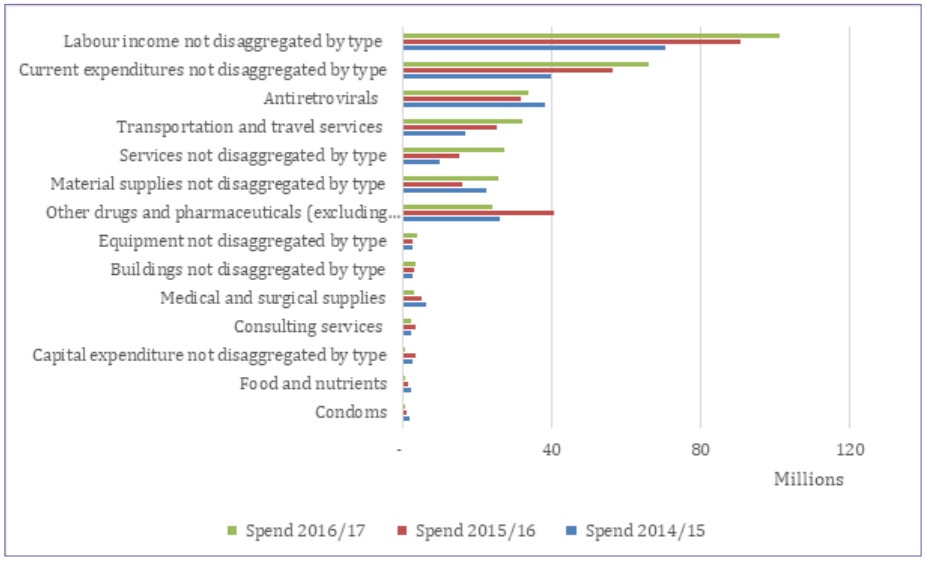
Figure 19: Providers through whom funding from USG was channeled



The biggest funding went to not for profit hospitals and other non-site level providers. Other providers included the government hospitals, government outpatient sites, not for profit outpatient sites and outside of health facility sites.

Analysis was also done for the production factors where USG funding goes. This is indicated in the figure below.

Figure 20: Production factors of USG funding 2014/15 – 2016/17



As can be seen from figure 20 above, big amounts of funding went to labour income not disaggregated by type and current expenditures not disaggregated by type. Significant amounts were to pharmaceuticals, ARVs, materials supplies, transportation and travel services and services not disaggregated by type.

3.9 Institutionalization of the NASA

The preparatory activities done in the beginning of the NASA exercise such as benchmarking in Ghana, training in Geneva and working with the districts were aimed at institutionalizing the NASA so that the data can be collected regularly from the districts and forwarded to NADIC at UAC for compilation and analysis.

In addition to the 20 districts where the data collection took place and where the HIV focal persons came for training, two regions namely the mid-western region and the mid northern region sent the Chief Finance Officer and the HIV focal persons for training so that they could facilitate the organizations in their districts to generate the data. At the writing of the report, this is still work in progress. However, what was clear was the big variations across districts in terms of numbers and size of organizations operating in each district. Some districts had very few partners while others had many partners. This highlights possible inequity in the HIV and AIDS response and hence needs to be addressed by government. Secondly, such information collected on regular basis would help the UAC and its partners to plan regularly and prioritize areas which need more support.

CHAPTER 4:

KEY ISSUES, CONCLUSIONS AND RECOMMENDATIONS

4.1 Key issues

a. External sources contribute the biggest portion of the funds used in the HIV and AIDS response in Uganda. With the data that we have now, external funds account for between 89% - 95% of HIV funding across all the 3 years under study. The biggest contribution was direct bilateral funding followed by international not for profit organizations and multilateral agencies.

b. Country offices of bilateral agencies control the biggest amount of money for HIV and AIDS in terms of deciding where the funding should go. This ranged from 56.7% in 2014/15 to 44.6% in 2015/16 and 47.1% in 2016/17.

c. The biggest beneficiary populations are PLHIV followed by non-targeted populations and then the general population. The proportion of PLHIV was 57.9% in 2014/15, 59.0% in 2015/16 and 70.9% in 2016/17.

d. Although the percentage of the expenditure on MARPs was still less than 1% of the total HIV and AIDS expenditure in each of the three years, it kept increasing from UGX 7.9 billion in 2014/15, to UGX 13.0 billion in 2015/16 and then to UGX 14.1 billion in 2016/17.

e. Expenditure of HIV Counselling and Testing as a proportion of funding to prevention activities increased modestly. It was 14.7% in 2014/15. It decreased to 11.7% in 2015/16 and increased again in 2016/17 to 16.0%.

f. Expenditure on ART was highest in terms of percentage of total funding. It was 87.7% in 2014/15, 87.9% in 2015/16 and 86.1% in 2016/17.

g. External funding for HIV/AIDS has increased by 62% from USD 398.8 million in 2008/09 to USD 648.0 million in 2016/17. However, public funding from available data has decreased by 53% from a high of USD 65.6 million in 2008/09 to a low of USD 30.7 million in 2015/16 which again rose up by 34% to USD 41.0 million in 2016/17.

h. Mapping HIV and AIDS organizations reveals variations in terms of number of organizations across districts.

4.2 Conclusions

a. Uganda is still heavily dependent on Development Partners for funding HIV and AIDS interventions.

b. The biggest portion of HIV and AIDS funding is decided upon by the country offices of bilateral agencies. The central government decides on a less amount of money.

c. The biggest amount of money for HIV and AIDS activities goes to the PLHIV as beneficiaries.

d. The proportion of funding to MARPs is still small in proportion to other interventions for HIV and AIDS although it has been increasing over time.

e. HIV counselling and testing takes a small proportion of funding which has been hovering between 11 – 16% of the funding going to prevention activities.

f. Care and Treatment consumes the largest proportion of HIV spending in Uganda.

g. From the available data, funding for HIV and AIDS activities from the Uganda government has decreased while that from external funding has increased.

h. Variation in HIV and AIDS support across districts brings variation in intensity of response and can create pockets of inadequate response as well as issues of equity.

4.3 Recommendations

a. Government of Uganda should ensure that it allocates more funding to finance its HIV and AIDS response. Too much reliance on external funding is not sustainable and might have negative implication on its population if good measures are not taken to address this problem.

b. The government needs to work with all the stakeholders in the HIV and AIDS response to ensure that as much as possible the decisions on the funding levels and implementation for HIV activities are made by public institutions.

c. Government together with external partners need to allocate more funds towards prevention activities. With high new HIV infections among the young people especially young women aged 20-29 years, it is very crucial that innovative prevention measures are put in place to curb the high HIV incident rates.

d. We recommend that the allocation going to MARPs be increased to a fair share because this group could potentially contribute to more HIV transmissions.

e. HIV counselling and Testing being the entry point to treatment needs to be prioritized by the various financing sources as this is key to achieving the 90 90 90 targets.

f. ARVs take a big proportion of the funding. These are lifesaving drugs. Government needs to put into place a mechanism in which such drugs could still be accessed beyond the time of external funding.

g. Government funding has been reducing contrary to what it should be. The government needs to urgently increase its funding to the HIV and AIDS response as ultimately, it will have to shoulder the responsibility when external funding reduces.

h. Institutionalization of NASA in the UAC needs to be supported by all the stakeholders in the HIV and AIDS response as this will in addition to give regular expenditure information give variations across the district and inform where more support should be directed. The Government should create a Vote output for HIV and AIDS mainstreaming to track all expenditure on HIV and AIDS in all MDAs. UAC should develop and disseminate resource tracking guidelines as part of the HIV and AIDS mainstreaming guidelines.

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APPENDICES

Appendix 1: Organizations that provided data for the NASA

District	Organizations
1. Apac	1. Acenlworo Child & Family Program 2. AIDS Information Center (AIC) Apac 3. Apac District Forum for PLHA 4. DHO's Office 5. Ibuje Child Development Center 6. Ikwera Community project 7. Local Church Pro-Active Response to HIV and AIDS (LOCPRA) 8. Reproductive Health Uganda (RHU) Apac
2. Arua	1. Adumi HC IV 2. Arua Diocese 3. Arua Referral Regional Hospital 4. Assumpta HC III 5. Ediofe HC III 6. Kuluva Hospital 7. NACWOLA 8. Oli River HC IV 9. Police HC III 10. Rhema Hospital 11. Rural Initiative for Community Empowerment (RICE)
3. Busia	1. Busia HC IV 2. Busia Town Child Development Centre 3. Busime Rural Development Association 4. Businywa Child Development Centre 5. Buteba Child Development Centre 6. CYRA Uganda 7. Dabani Hospital 8. Foundation for Christ Ministry 9. Friends of Christ revival ministries 10. Masafu Hospital 11. Nabulola Community Health Initiative 12. World Vision 13. Youth Environmental Services

4. Gulu	1. Awach HC IV 2. Comboni Samaritans of Gulu 3. Gulu District Local Government 4. Gulu Independent Hospital 5. Gulu Regional Referral Hospital 6. Gwendiya Village Health Team 7. Lacor Hospital 8. Partners for Community Health and Development Organisation (PACHE-DO) 9. St. Mary's Hospital Lacor 10. Youth Alive Uganda
5. Hoima	1. Azur Christian Health Centre IV 2. Echo Green 3. ECO Uganda 4. Hoima Central Police Station HC III 5. Hoima district Local Government 6. Hoima Regional Referral Hospital 7. Meeting Point Hoima 8. Uganda Red Cross Society
6. Jinja	1. DHO's Office 2. Budondo HC IV 3. Children AIDS Funds, Uganda 4. Jinja Area Communities Federation 5. Mothers 2 Mothers 6. Mpumudde HC IV 7. Restless Development 8. Wakuluba HC IV

7. Kampala	1. Ministry of Health 2. Ministry of Finance, Planning and Economic Development 3. Uganda Peoples Defence Forces 4. Electoral Commission 5. Uganda AIDS Commission 6. National Medical Stores (NMS) 7. Ministry of Trade and Industry 8. Ministry of Tourism Wildlife and Antiquities 9. Inspectorate of Government 10. Uganda Tuberculosis and Leprosy program 11. Action Group for Health Human Rights and HIV and AIDS Uganda (AGHA-U) 12. Action on Disability& Development (ADD) International 13. African Medical and Research Foundation (AMREF) Uganda 14. AIDS Health Care Foundation - Uganda Cares 15. Baylor College Children's Foundation 16. Compassion International In Uganda 17. Delloitte and Touche 18. HEPS Uganda 19. Holy Cross Orthodox Hospital 20. Infectious Diseases Institute (IDI) 21. Kisenyi Teenage center 22. Kitebi Teenage Center 23. Komamboga Youth Center 24. Makerere Women Development Association 25. Mamas Club 26. Martyr's Family Clinic and Maternity Home Gaba 27. Most At Risk Populations -MARPI 28. National Forum for People Living with HIV&AIDS in Uganda (NAFOPHA-NU) 29. PREFA- Protecting families against HIV/ AIDS 30. Reach a hand Uganda 31. Reach Out Mbuya Parish AIDS Initiative 32. The AIDS Support Organization-TASO 33. Uganda Health Marketing Group - UHMG

	34. Uganda National AIDS Support Organizations-UNASO 35. UGANET- Uganda Networks of People living with HIV and AIDS 36. Voluntary Action for Development (VAD) 37. Voluntary Action for Development(VAD) 38. ADD International 39. Zaam Clinic and Maternity Clinic 40. Agency for Cooperation and Research in Development (ACORD) 41. United States of America / PEPFAR 42. AVSI Foundation 43. Global Fund to Fight Aids, Tuberculosis And Malaria 44. Clinton Health AIDS Initiative (CHAI) 45. International Organization of Migration (IOM) 46. Irish Aid 47. UNAIDS-Joint United Nations Programme on HIV and AIDS 48. UNDP-United Nations Development Programme 49. UNESCO-United Nations Education, Scientific and Cultural Organization 50. UNFPA-United Nations Population Fund 51. Elizabeth Glaser Pediatric AIDS Foundation 52. Germany Leprosy 53. UNICEF-United National International Children's Educational Fund 54. World Health Organization
8. Kapchorwa	1. Bugimwota Child Development Centre 2. DHO's Office 3. Evangelicals of the Body of Christ Ministries 4. Kapchorwa Child Development Centre 5. Kapchorwa Civil Society Organization Alliance (KACSOA) 6. Kapchorwa District Hospital 7. Kapchorwa Forum for People Living with HIV (KAFOPHA) 8. Kapchorwa Integrated Community Mobilization Program (KICOMPE) 9. Kapchorwa Network of AIDS Service Organisation 10. Kutung Child Development Centre 11. Registered Trustees of Hope Africa International 12. Sebei Diocese Community Development and Empowerment 13. Sunrise Child Initiative Uganda 14. Uganda Red Cross Society

9. Kasese	1. Action for Community Development (ACODEV) 2. Allied PLHIV 3. Bishop Masereka Christian Foundation 4. Bwera Hospital 5. Bwera People Living with HIV and AIDS Organisation 6. DHO's Office 7. Karusandara HIV and AIDS Group 8. Kasanga PHC 9. Kasese Community Health and Education Foundation 10. Kasese District Forum of PHA Networks (KADFPHAN) 11. Kasese District Forum of PLHIV 12. Katwe Kabatooro PLHIV 13. Medicines' San Frontieres (MSF) 14. NACWOLA 15. Nakasinga West HIV and AIDS United Group 16. National Community of Women Living with HIV (NACWOLA) 17. National Youth Organization for Development 18. National Youth Organization for Development (NAYODE) 19. Nyakasinga West HIV and AIDS United Group 20. Save the Children 21. Young and Powerful Initiative (YAPI)
10. Koboko	1. Federation of Communities Infected and Affected with HIV and AIDS Koboko (FECHA-K) 2. Infectious Disease Institute (IDI) 3. Koboko Civil Society Network (KOCISONET) 4. Koboko District 5. Partners in Community Transformation (PICOT) 6. Youth and Women Community Development Organisation
11. Kotido	1. CUAMM 2. DHO's Office 3. KDDO/COU H/C III Diocesan Development Services- North Karamoja 4. Help Child Karamoja 5. Kotido Positive Living Association (KOPLA) 6. Losilang HC II under Caritas Mgt 7. Nakere Rural Women Activists 8. Uganda Red Cross Society

12. Luwero	1. Bishop Asili Ceaser Hospital 2. Bukuma Organisation for People Living with HIV and AIDS (PLWHA) 3. Greater Health Organisation-Mukuma 4. Kagala Liason Group 5. Kalagala People Living with HIV and AIDS Group 6. Kasana Luweero Diocese 7. Luweero Local Government (DHO's Office) 8. Luwero District Forum for People Living with HIV and AIDS(PLHA) 9. Makulubita Assika Obulamu 10. Nyimbwa Multi-Purpose Organization of PLWHA(NYIMUPHAS) 11. Reach out Mbuya (Kasaala) 12. Team Community Development Organisation 13. Uganda Cares
13. Masaka	1. AIDS Healthcare Foundation (AHF)-Uganda Cares 2. Armoured Brigade HC III 3. Buddu Social Development Association (BUSODA) 4. CHEDRA 5. Child Restoration Outreach (CRO) 6. FOHO 7. Human Rights Defenders Masaka (HURIDEM) 8. Kitovu Mobile Hospital 9. Kiyumba HC IV 10. Masaka Association Disabled Persons Living with HIV&AIDS (MADIPHA) 11. Masaka Diocese (Caritas MADDO) 12. Masaka District Local Government (DHO's Office) 13. Masaka District Union of Persons with Disabilities (MADIPU) 14. Masaka Police HC III 15. Masaka Prison HC III 16. MIFUMI 17. Nkobazambogo Youth Group 18. River of Life Church 19. SAVO 20. The AIDS Support Organisation (TASO) 21. Uganda Women's Effort to save Orphans (UWESO) 22. UNBOUND

14. Mbale	1. ACET(U) Mbale Office 2. Ahmadiyya Health Centre III 3. Aids Care Education and Training (ACET –Uganda) 4. AIDS Information Centre (AIC) 5. Bufumbo HC IV 6. Busiu HC IV 7. DHO's Office 8. Hope Foundation for Development 9. Hunger Project Busoba 10. IUIU Medical Centre 11. Joy Hospice 12. Mbale Area Federation of Communities (MAFOC) 13. Mt. Elgon Hospital 14. Namatala HC IV 15. Poverty Alleviation and Community development foundation 16. Programme for Accessible Health Communication and Education (PACE) 17. The Hunger Project Uganda 18. Uganda Red Cross Society Mbale
15. Mbarara	1. DHO's Office 2. Mbarara Regional Referral Hospital 3. Mayanja Memorial Hospital 4. Bwizibwera HC IV 5. Kakoba HC IV 6. Kinoni HC IV 7. Rubindi HC III 8. Kagongi HC III 9. Biharwe HC III 10. AIDS Information Centre 11. Elizabeth Glazer Paediatric AIDS Foundation 12. Reproductive Health Uganda

16. Mubende	1. Children and Wives of Disabled Soldiers Association (CAWODISA) 2. DHO's Office Mubende 3. ELMA Project Mild May Uganda 4. Kasambya HC III 5. Kasana Child Development Centre 6. Kasenyi St. Thomas Child Development Centre 7. Kibalinga HC III 8. KIDO KISS 9. Kiganda HC IV 10. Mild May Uganda 11. Monitoring and Evaluation Technical Support (METS) 12. Mubende Development Network (MUDNet) 13. Mubende District Network of AIDS Service Organizations (MUNASO). 14. Mubende Hospital 15. Nabingoola HC III 16. Nation Forum for People Living with HIV in Uganda (NAFOPHANU) 17. Nurture Africa 18. Programme for Accessible Health Communication and Education (PACE) 19. SORAK-Strategic Organisation for Real Action 20. World Vision
17. Rakai	1. World Vision 2. Rakai Counselors Association (RACA) 3. Rakai Health Sciences Program (RHSP) 4. Rakai Aids Initiative Network (RAIN) 5. AHF/Uganda Cares 6. Community Initiative for the Prevention of HIV and AIDS (CIPA) 7. Lwanagwa HC III 8. Kyalulangira HC III 9. Kiziba HC III

18. Rukungiri	1. Agape Nyakibale 2. Azur Christian Health Centre 3. Bugangari Child Development Centre 4. District Health Officer's Office 5. Kakinga Child Development Centre 6. Karoli Lwanga Hospital Kyakibale 7. Kebisoni HC IV 8. Kiganda Child Development Centre 9. Kinyansano Child Development Centre 10. Kisizi HC III 11. Kisiizi Hospital 12. Kyamakanda Child Development Centre 13. Lubirizi Child Development Centre 14. North Kigezi HC IV 15. Nyakibale Hospital 16. Nyakisoroza Child Development Centre 17. RUDINET 18. Rukungiri HC IV 19. Rwerere Child Development Centre
19. Soroti	1. AIDS Information Centre 2. AMACET 3. Asuret HC III 4. Charity Women Association (CHAWOA) 5. DHO's Office Soroti 6. Gweri HC III 7. Health Needs 8. Kamuda HC III 9. Princess Diana Memorial HC IV 10. Soroti HC III 11. Soroti Referral Hospital 12. SORUDO 13. TASO Soroti Regional Project 14. TESO Safe Motherhood 15. Tiriri HC IV 16. Uganda Cares

Appendix 2: NASA technical Working Group and core teams

Technical Working Group / National Task Team for NASA

SN	Name	Institution
	Dr. Nelson Musoba	UAC
	Mr. Trouble Chikoko	UNAIDS
	Mr. Quinto Rwotoyera	UAC
	Ms. Sarah Khanakwa	UAC
	Mr. Charles Otai	UAC
	Dr. Elizeus Rutebemberwa	MakSPH
	Dr. Sebastian Olikira Baine	MakSPH
	Mr. Samuel Etajak	MakSPH
	Ms. Sharon Kwagala	MoLG
	Mr. Robert Mac Gregor	CHAI
	Dr. Pande Stephen	MoH/ACP
	Dr. Juliet Tumwikire	SITES
	Dr. Peter Wakooba	UAC
	Mr. Eugene Oola	UAC
	Ms. Juliana Namutundu	Mak SPH
	Ms. Tusaasirwa Ruth Muguta	MoGLSD
	Ms. Shamim Nanteza	MoFPED
	Mr. Stephen Baryahirwa	UBOS
	Mr. Simon Ndizeye	UNFPA
	Mr. Mulira Herberts	MAK SPH - METS
	Dr. Nobert Mubiru	USAID
	Dr. Flora Banage	CDC
	Dr. Steve Okokwu	UNICEF
	Mr. Peter Oumo	Irish Aid
	Mr. Ezrah Rwakinanga	
	Mr. Issa Gumonye	
	Mr. John Sseggujja	

NASA Core team

SN	Name	Institution
1	Dr. Nelson Musoba	UAC
2	Mr. Trouble Chikoko	UNAIDS
3	Mr. Quinto Rwotoyera	UAC
4	Ms. Sarah Khanakwa	UAC
5	Mr. Charles Otai	UAC
6	Dr. Elizeus Rutebemberwa	MakSPH
7	Dr. Sebastian Olikira Baine	MakSPH
8	Ms. Juliana Namutundu	MakSPH
9	Mr. Samuel Etajak	MakSPH

Appendix 3: Data collection and entry teams

Kampala Data collection Team	
1.	Resty Nakayima
2.	Lestine Bitakwitse
3.	Jovine Azazoa Etima
4.	Mugisha Kwiringira
5.	Solomon Tsebeni Wafula
6.	Jacquelyn Ijokoreng
7.	Carol Kamya
8.	Grace Kabasinguzi
9.	Sarah Auma Sempebwa
10.	Lawrence Tindyebwa
11.	Benedict Muhwezi
12.	Edna Agaba Mubiru
13.	John Ssegujja
14.	Vicky Kyobutungi

Districts Data collection Team	
1.	Robert Ssentongo
2.	Robinah Komuhendo
3.	Susan Mutesi
4.	Nyakol Ronald
5.	John Bosco Oribakiriho
6.	Turyarugayo Martin
7.	Nathan Isabirye
8.	Nakazzi Doreen
9.	Mayanja Samuel Mubiru
10	Wanula Judith Clara
11.	Tenywa Ronald
12.	Kusasira Pritchard
13.	Moses Tayanga A
14.	Jennipher Kataike

Data entry team
Mr. Mugisha Kwiringira
Ms. Resty Nakayima
Ms. Robina Komuhendo
Mr. Robert Ssentongo

Appendix 4: Participants for the Financing Sources Workshop

1) Uganda AIDS Commission (UAC)
2) Ministry of Finance, Planning and Economic Development (MoFPED)
3) United Nations Educational, Scientific and Cultural Organization (UNESCO)
4) Irish AID,
5) World Health Organization (WHO),
6) CCM Secretariat,
7) UNAIDS,
8) International Organization for Migration (IOM)
9) Makerere University School of Public Health (MakSPH).

Appendix 5: Participants for stakeholder workshop for agents and providers

SN.	Participants
1)	Uganda AIDS Commission (UAC)
2)	AVSI Foundation
3)	Rakai Counsellors Association (RACA)
4)	Infectious Disease Institute (IDI)
5)	Joint Medical Stores (JMS)
6)	AMICAAL-U
7)	PACE
8)	RAHU
9)	AMREF
10)	CEHURD
11)	AIC
12)	NUDIPU
13)	OAFLA
14)	Inter Aid Uganda
15)	AHF Uganda Cares
16)	EGPAF
17)	Mild may Uganda,
18)	USAID SITES
19)	Baylor Uganda
20)	ANECCA
21)	UNASO
22)	PATH
23)	JCRC
24)	Buganda Kingdom
25)	PREFA
26)	MARPI
27)	Mama's Club
28)	MGLSD
29)	DELOITTE
30)	CHAI
31)	CIPLAQUL
32)	M2M
33)	Compassion International Uganda,
34)	Uganda Red Cross Society
35)	HEPS UG,
36)	CHAU,
37)	NACWOLA,
38)	ICWEA,
39)	SDA Uganda Union
40)	Ministry of Health
41)	FHI 360-CHC
42)	MSH
43)	TASO
44)	Reach Hand Uganda
45)	NAFOPHANU
46)	GLRA
47)	IRCU
48)	MARPS Network
49)	UMSC
50)	CHCI
51)	AGHA Uganda
52)	UWESO
53)	Makerere University School of Public Health.

Appendix 6: Key NASA definitions and terminologies

FUNDING SOURCES refer to where the money comes from. The main categories of Funding Sources are: Public (Ministry of Finance, Planning and Economic Development, parastatals, etc), Private (Households, Corporations, private firms, NGOs, etc) and International (Multilateral, Bilateral, NGOs, Foundations, Global health initiatives, etc). Financing sources (FS) are entities that provide money to financing agents.

FINANCING AGENTS refer to organisation which manage, organise and collects the funds. In other words, these are organisations which have the power and control over how funds are allocated and used. Therefore, these entities make programmatic decisions on the use of the resources they receive from the *Financing Sources*. There are financing agents in the public, private and donor sub-sectors. In Uganda, they include Ministry of Health and other line ministries, districts, urban authorities, NGOs, Civil society organisations, bilateral and multilateral organisations, etc. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent)

SERVICE PROVIDERS (PS); refer to the end users of health care funds, entities that actually provide/ deliver the health service. These help us answer the question: where did the funds go? The provider is responsible for the final product but can either sub-contract services or personnel or the delivery of the product or buy the inputs necessary for producing it itself. In the NASA classifications, service providers are categorized as (a) Government-which are government owned and managed (b) Non-government organisations, including the not-for-profit providers (c) Private-for-profit (d) Bilateral and Multilateral entities, and (e) rest-of-the world providers. Providers (PS) are entities that engage in the production, provision, and delivery of HIV services.

AIDS SPENDING CATEGORIES: Accordingly, AIDS spending classification is a functional classification that includes the categories of prevention, care and treatment, and other health and non-health services related to HIV. After review and evaluation of past response strategies to HIV, the programmes and budget lines have been structured into eight classes of spending categories: (1) Prevention, (2) Care and treatment, (3) Orphans and vulnerable children, (4) Programme management and administration, (5) Human resources, (6) Social protections and social services, (7) Enabling environment, and (8) Research. These are briefly defined below.

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

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

Orphans and vulnerable children: An orphan is defined as a child aged less than 18 who has lost one or both parents. In the NASA context, all expenditures to substitute for the parents taking care of their children because they have died from HIV; expenditures incurred in providing social mitigation

to all double orphans and half or single orphans need to be included. In this context, vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them. The resource tracking team should take into consideration that in sub-Saharan Africa the services to all orphans living below the nationally defined poverty line are considered as AIDS-related. This category refers to 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 or single orphans (children who have lost one parent).

Programme and administrative expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and facility upgrading through purchases of laboratory equipment and telecommunications. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole.

Human resources: This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. The HIV 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 from what is currently available in the health sector. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories. For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions—*ASC.01 Prevention* and *ASC.02 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.04 (Programme Management).

Social protections and social services: Social protection usually refers to functions of government or nongovernmental organizations relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by requirements such as sickness, old age, disability, unemployment, social exclusion, etc. Social protection comprises personal social services and social security. It includes expenditures on services and transfers provided not only to individual people but also to households, in addition to expenditures on services provided on a collective basis.

Enabling environment: Advocacy in the field of HIV includes a full set of services that generate an increased and wider range of support of the key principles and essential actions to promote HIV prevention and reduce stigma and discrimination. It also includes the promotion of the scaling-up of national, regional HIV programmes by national governments with key partners, such as bilateral and multilateral donors, civil society, and the private sector. Human rights programmes cover all the activities and resources invested for the protection of human rights, legislative aspects of a broad number of areas of social life, such as employment and discrimination, education, liberty, association, movement, expression, privacy, legal counselling and services, efforts to overcome discrimination and improve accessibility to social and health services.

HIV-related research (excluding operations research): is defined as the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well-being. This category excludes operations research on health systems aimed to improve health outcomes, including project or programme evaluation, which should be coded under ASC.04.04 (i.e. programme management and administration).

Other key definitions Targeted/intended beneficiary populations

These are populations specifically designed for to benefit from given interventions and or activities. They include the following;

People living with HIV: Regardless of a diagnosis/medical diagnosis of AIDS, the beneficiary of the intervention/activity should be living with HIV.

Most at Risk Populations-(MARPs); these are grouped based on the behavior they engage in that predisposes them to acquisition of the AIDs virus as compared to other groups. Such groups are more susceptible to having high rates of sexual partner exchange, to practice unprotected sex with multiple partners, or to use non-sterile drug injecting instruments which are in most cases shared. All these activities expose such populations to the risk of exposure to HIV. The groupings under MARPS include sex workers (SW), their clients, injecting drug users (IDUs), fishermen, and men who have sex with men (MSM).

Other key populations; these include groups that cannot be underestimated both in terms of the epidemic's dynamics, vulnerability and the response.

Specific "accessible" populations; Includes populations in organized settings making them easily accessible as children in school, women attending reproductive health clinics, university students, military, factory employees.

General population; Includes interventions aimed at the general population wholly and not any key accessible groupings. Such interventions could include a TV or radio campaign of communication for social and behaviour change. The populations include; General adult population aged older than 24 years, children aged under 15 years, youth aged 15 to 24 years.

Non-targeted interventions; these are indirect expenditures through interventions to no explicitly selected or targeted populations.

Specific targeted populations not elsewhere classified (n.e.c); these are classified as the key and targeted populations included in none of the above groupings.

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