Botswana National AIDS Coordinating Agency (NACA)
Joint United Nations Program on AIDS (UNAIDS)

BOTSWANA

NATIONAL AIDS SPENDING ASSESSMENT

2009/10, 2010/11, 2011/12

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

Contents

Abbreviations

ACHAP	African Comprehensive HIV/AIDS Partnerships
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioural Change Communication
BWP	Botswana pula
CDC	US Centres for Disease Control and Prevention
CHBC	Community Home Based Care
CSO	Civil Society Organisation
DoD	United States Department of Defence
EU	European Union
GoB	Government of Botswana
HAART	Highly Active Antiretroviral Therapy
MARPS	Most at risk populations
MFDP	Ministry of Finance and Development Planning
MLG	Ministry of Local Government
MOH	Ministry of Health
NACA	National AIDS Coordinating Agency
NGO	Non-governmental Organisation
NIH	National Insurance for Health
NOP	National Operational Plan
NSF	National Strategic Framework
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of Mother to Child
SIDA	Swedish International Development Cooperation Agency
USAID	Unites States Agency for International Development
VCT	Voluntary Counselling and Testing

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Executive Summary

Introduction

The Botswana National AIDS Spending Assessment 2009/10, 2010/11 and 2011/12 covers a period over which global financial resources for HIV and AIDS were beginning to dwindle. The 2010 UNAIDS *Report on the Global AIDS Epidemic* notes that globally a total of US$ 15.9 billion was available for the AIDS response in 2009; US$ 10 billion short of what was needed in 2010. In addition, international assistance did not increase for the first time from 2008, with donor governments' actual disbursements for the AIDS response in 2009 standing at US$ 7.6 billion in 2009, a slight decrease from the US$ 7.7 billion made available in 2008.

The financial resources shortfall threatens the gains that have been made in stemming the tide of the HIV epidemic. This is more so for Africa, were two-thirds of all AIDS expenditures come from external sources. Sub-Saharan Africa, with 68% of the estimated 34 million people living with HIV would be the region to suffer the most from decrease in global financial resources.

Botswana with close to 70% of its HIV and AIDS funding coming from local public resources look to have a more sustainable national response to HIV and AIDS than most of the African countries.

NASA Findings

Sources of Funding

The findings of the NASA study are that in 2009/10, 2010/11 and 2011/12, a total of P7,581billion (US$1,107billion) was spent on HIV and AIDS in Botswana, split between the financial years as follows:
2009/10: P2,272 billion (US$331million)
2010/11: P2,544 billion (US$377million)
2011/12: P2,765 billion (US$399million)

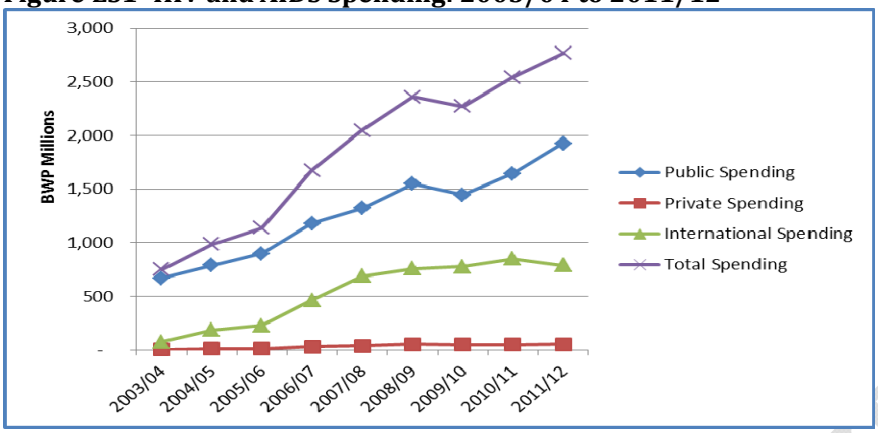
Over the three year period, 66% of HIV and AIDS spending were from the public resources. The international/external funding sources contributed 32% of the spending, while reported local private funding was 2%, partly because of the poor response to the study by the business sector.

Table ES 1 – Funding Sources 2009/10 -20011/12

	2009/10	2010/11	2011/12	Totals
Public Funds	1,444,541,069	1,645,062,601	1,924,301,941	5,013,905,611
Private Funds	50,672,274	50,222,953	53,628,047	154,523,274
External Funds	776,845,641	848,617,907	787,546,719	2,413,010,267
Totals	**2,272,058,984**	**2,543,903,461**	**2,765,476,707**	**7,581,439,152**

The trend over a nine year period from 2003/04 to 2011/12 show that the government of Botswana is increasingly funding more of the national response. This is illustrated in the graph below.

Figure ES1- HIV and AIDS Spending: 2003/04 to 2011/12



HIV and AIDS Spending Activities

Over the three year period under study, 56% (P4.217 billion) of HIV and AIDS spending in Botswana was on treatment and care of people living with HIV and AIDS. Estimated spending on hospitals and clinics patient care attributable to HIV and AIDS makes up most of the figure at P2,756 billion. Treatment and care also includes spending on ARV drugs and laboratory reagents for HIV monitoring. Spending on Orphan Care constitutes 16% (1.198 billion). Spending on prevention makes up 14% (P1.034bn). Programme management and administration, which includes monitoring and evaluation activities, accounts for 10% (P776million) of the overall spending. The remaining 5% was spent on training, Human rights and HIV and AIDS related research activities.

Table ES 2 - HIV and AIDS Spending Activities 2009/10 to 2011/12

	2009/10 BWP Millions	2010/11 BWP Millions	2011/12 BWP Millions	Totals BWP Millions
Prevention	396	381	257	1,034
Treatment	1,232	1,330	1,655	4,217
Orphans and vulnerable children (OVC)	382	419	397	1,198
Programme mgmt. & admin	235	258	283	776
Human resources (training)	9	84	59	151
Human & Legal Rights Activities	3	2	5	9
HIV/ AIDS Research	16	70	109	196
Grand Total	**2,272**	**2,544**	**2,765**	**7,581**

Public funds were mainly spent on care and treatment of people living with HIV and AIDS. In 2011/12, 72% of public spending on HIV and AIDS was on care and treatment, followed by Orphan care at 20% and prevention at 6%.

The International/external funds were spent mainly on programme management, prevention and treatment and care. While 98% of private funding was spend on treatment and care.

Spending by Beneficial Populations

With spending on HIV and AIDS being mostly on treatment and care, beneficiaries of HIV and AIDS spending in Botswana are mainly people living with HIV and AIDS, consuming 60% of the spending in 2011/12. In the same year, orphans and key vulnerable

populations benefited from 16% of the spending, 14% was spent on non-targeted interventions and 7% was spent for the benefit of the general population

Conclusion and Recommendations

- The government of Botswana is increasing funding most of the HIV and AIDS activities. With Botswana's economy heavily dependent on mining, poor performance of the sector would impact heavily on the availability of financial resources to fund HIV and AIDS interventions. There is thus a need to develop innovative ways to increase domestic private sector and external sources of funding. However, with generally dwindling international funding sources, there is also need to improve value for money through focusing on cost effective interventions in a more efficient manner (avoiding unnecessary spending).
- Over the period of the study, the trend reflected a decrease in funding for prevention. While the NASA data does not communicate the prioritisation nor comprehensiveness and effectiveness of the prevention interventions, it is worth recommending that Botswana continue to ensure that prevention is adequately funded.
- Like in the previous NASA studies, the estimation of spending at the hospitals and clinics attributable to HIV/AIDS was a challenge and will remain so for future NASA exercises. The basis used to allocate the patient care costs to HIV/AIDS should be the weighted ratio of HIV/AIDS patients to the overall number of patients seeking treatment. There is thus a need for a regular study of patients using hospitals and clinics services in order to be best able to determine the burden of HIV and AIDS on the hospitals and the clinics.
- There is hardly any spending on the most at risk populations. The suggestion from the NASA data is that these population groups are not being prioritised. The national response needs to identify and adequately resource interventions for these population groups
- The NASA remains a three yearly exercise in Botswana. Thus the information is not generated timely for decision makers. Botswana needs to institutionalise the NASA so that spending can be reported annually.

1. Introduction and Background

1.1. Global HIV and AIDS Status and Financing

According to the UNAIDS World AIDS Day Report 2011, at the end of 2010, an estimated 34 million people were living with HIV worldwide, up 17% from 2001. Sub-Saharan Africa remains the region most heavily affected by HIV, with about 68% of all people living with HIV residing in the region. The region only has 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, although there was a notable decline in the regional rate of new infections. The estimated 22.9 million people living with HIV in Sub-Saharan Africa, is up from the 2009 estimate of 22,5 million which included 2,3 million children.

The increase in people living with HIV could be partly due to a decrease in AIDS-related deaths in the region. There were 1.2 million deaths due to AIDS in 2010 compared to 1.3 million in 2009. These deaths have created an increasing number of orphans. About 16.6 million children are orphaned by AIDS worldwide, of which almost 90% live in sub-Saharan Africa.[1]

Overall, new infections are also decreasing worldwide. In 2009, new HIV infections were estimated at 2,6 million people compared with 3,1 million in 1999. HIV incidence has fallen by more than 25% between 2001 and 2009, in 22 countries in Sub-Saharan Africa. However, the majority of infections still occur is Sub-Saharan Africa where an estimated 1.8million people where infected in 2009.

Though successes are being made in slowing the tide of the epidemic, a lot still remains to be done. This means a lot more resources still need to be mobilised globally to fight the disease. However, funding for HIV and AIDS remains a global challenge and has become more so with the current economic crisis that began in 2008. Of the estimated 15 million people living with HIV in low- and middle-income countries (mostly sub-Saharan Africa) who needed treatment in 2011, 5.2 million had access. There is thus a huge financing gap amidst decreasing global financial resources.

With the disease burden mainly affecting low and middle income countries, international assistance is crucial to sustaining the AIDS response. According to UNAIDS, of the 132 countries reporting HIV spending in 2009 by funding source, 70 countries (53%) mostly from sub-Saharan Africa rely on international funds to finance 50% or more of HIV spending. And for the majority of the low- and middle-income countries, increasing domestic investment priority to the optimum levels is not even sufficient to meet the needs of the AIDS response.

In Africa, two-thirds of all AIDS expenditures come from external sources[2], making the sustainability of HIV and AIDS financing an ever present challenge. Donor fatigue and the current global economic crisis that began in 2008 have combined to slow down funding for HIV and AIDS. The UNAIDS *Report on the global AIDS epidemic* notes that globally a total of US$ 15.9 billion was available for the AIDS response in 2009; US$ 10 billion short of what was needed in 2010. In addition, international assistance did not increase for the first time from 2008, with donor governments' actual disbursements for the AIDS response in 2009 standing at US$ 7.6 billion in 2009, a slight decrease from the US$ 7.7 billion made available in 2008.

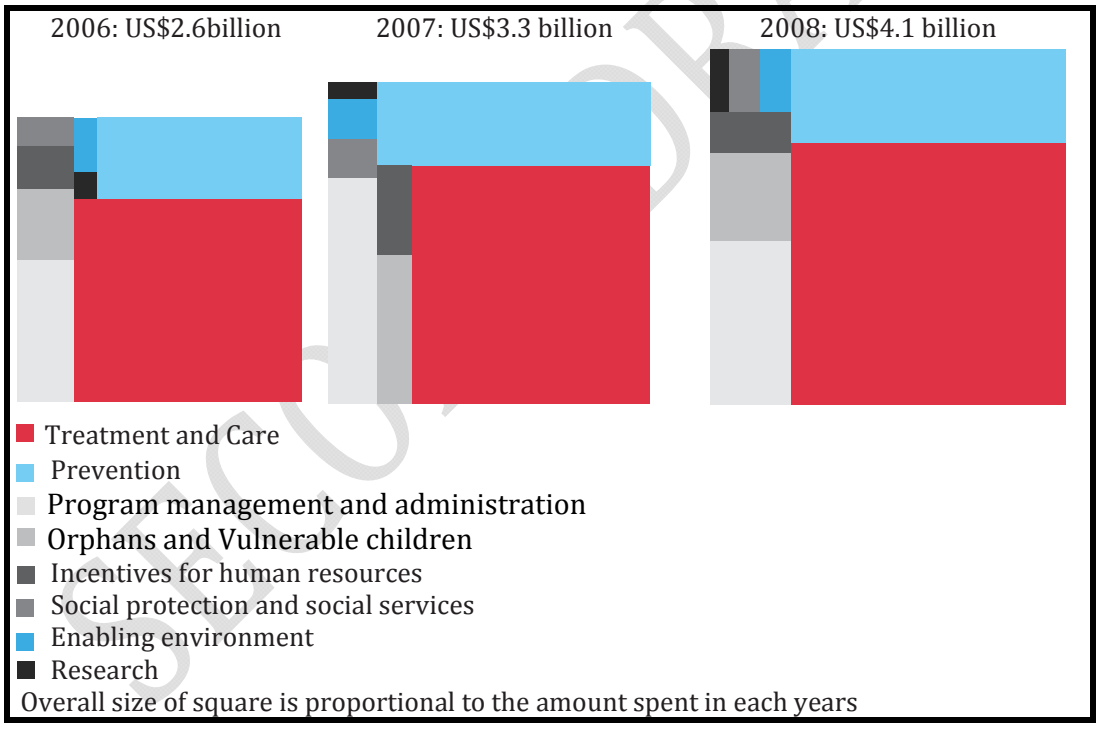
[1] www.avert.org/hiv-aids-africa.htm
[2] AIDS dependency Crisis, Sourcing African Solutions – UNAIDS

The Global Fund called off its next round of new funding proposals in 2011, due to financial constraints resulting from failure of donors to meet their commitments. The fear is that the current funding decline may result in an increase in new infections, due both to downturns in effective prevention programming and a stagnation or decline in treatment access.

1.2. Global Spending Patterns

Per the UNAIDS, globally, between 2006 and 2008, treatment and care programmes received 56% and HIV prevention programmes received 20% of the total resources available[3] Treatment in many countries is funded equally between domestic and international funds, while prevention programs are mainly funded through international sources. Figure 1.1 below taken from the UNAIDS Global AIDS Report for 2010 shows the programmatic spending in 43 low and middle income countries between 2006 and 2008.

Fig 1.1: HIV and AIDS Spending in 43 Low and Middle Income Countries 2006-2008



Source: UNAIDS Report on the Global Aids Epidemic – 2010 (page 149)

[3] UNAIDS Report On The Global Aids Epidemic - 2010

1.3. HIV and AIDS in Botswana

Botswana is a landlocked semi-arid country covering an area of 582,000 square kilometres, divided into 16 administrative and 29 health districts.

The population of Botswana is estimated to be 2,024,787 million people (2011)[4]. Of these 51% are women and 49% are men. Young people under the age of 25 years constitute 54% (women 27.4% and men 26.4%). Between 1991 and 2001, the population grew at an average annual rate of 2.4%. However from 2001 through 2009, the population growth rate has declined to 1.9% due to HIV and AIDS5 and other factors such as increased opportunities for employment for women, declining fertility rate, increased literacy rates, and access to better health care. Life expectancy at birth has decreased from 65.3 years in 1991 to 54.4 years (60 years for women and 48.8 years for men) in 2006 as a result of HIV and AIDS6.

Botswana is one the countries that are most affected by the HIV and AIDS pandemic. It has one of the highest prevalence and incidence rates in Southern Africa, the region which is the epicentre of HIV and AIDS. The Botswana AIDS Impact Survey III (BAIS III), 2008, estimates the national AIDS prevalence rate at 17.6% compared with 17,1% in the BAIS II, 2004. HIV incidence is estimated at 2.89%. The high prevalence rate is a consequence of the successful ART program which has over 95% of people eligible for treatment receiving the lifesaving ARV drugs. The prevalence among females is estimates at 20.4% and males at 14.2%. HIV incidence is also higher for woman at 3,5% with males at 2,3%

Botswana was one of the first countries in Africa to provide free ART to its citizens using public funds in 2002. As per the MoH's HAART Patient Update Summary, at end of March 2010, there were 145 167 patients on HAART, while at end of March 2011, there were 164 559 and at end of March 2012, 184,058 patients. The 2012 patients figure amounts to 96,6% of the people in need of ART. Of the March 2012 patients, **153,312** patients were on treatment in the public sector, of which 62.1% were females. Children aged less than 13 years accounted for 5.5% (8,424) of the public sector patients. A further **16,074** patients were treated by the private sector under the Government's Out-sourcing Program. Another **14,672** patients were being treated in the private sector of the country by the Medical Aid Schemes and Work-place Programs[7]. As at March 2012, a cumulative total of **19,851** patients had died while on HAART since the inception of the ARV program in 2002.

As at 31 March 2010 there were 45,816 orphans registered with the Department of Social Services and receiving material and education support from the government. This figure was 42, 069 in March 2011 and 41,324 as at 31 December 2011.

The prevention of mother to transmission is one of the most successful in Africa. Access to mother to child prevention (PMTCT) is about 97%[8]

[4] CSO
[5] MFDP, 2009, National Development Plan 10, April 2009 to March 2016. pg. 13, 14
[6] Ibid (1)
[7] HAART Patient Update Summary March 2012 – MOH Department of AIDS Prevention and Care
[8] The Botswana National Strategic Framework for HIV and AIDS 2012-2016

1.4. Macro-economic Environment

Botswana's Gross Domestic Product (GDP) at 1993/94 prices stood at P27,464billion in 2011, growing at an average rate of just over 3% between 2006 and 2011[9]. Mining contributes approximately 30% of the GDP. The average GDP growth rate between 2006 and 2011 was dragged down by the negative growth of -4,8% in 2009 as a result of the global economic crisis that hit hard on Botswana's mining sector, the main contributor to GDP. Since then GDP grew at a rate of 7% in 2010 and 5,7% in 2011.

Botswana has one of the highest GDP per capita in Africa. According to the World Bank, Botswana's GDP per capita at nominal prices was at $8,680 between 2006 and 2011 compared to $8,070 for the biggest African economy, South Africa[10].

However despite the seemingly good economic indicators, unemployment is high and increasing. The unemployment rate is at 17,8 per the Botswana Core Welfare Survey 2009/10, released in December 2011, compared to 17.5% in the 2005/06 Labour Force Survey. Youths between the ages of 14 and 25 are the most affected.

Per the Botswana Core Welfare Indicators (Poverty) Survey 2009/10, the number of individuals falling below the poverty datum line fell to 20.7% from 30.6% in 2005/06. In the same survey, the national estimates of persons living below the internationally comparable measure of$1.25 per day fell from 23.4% to 6.5% over the same period. This is attributable to sustained economic growth and some government sponsored social welfare programmes.

1.5. Health, HIV and AIDS Financing in Botswana

The results of the National Health Accounts (NHA) 2007/08 to 2009/10 show that as a percentage of total government spending, over the three year period, an average of 17,7% was spent by government of Botswana on health. This is above the Abuja declaration of 15%[11]. The NHA also show that Botswana has one of Southern Africa's highest per capita spending on health second only in Southern Africa to South Africa. The per capita health spending in 2009/10 stood at $444.66.[12]

The direct government allocation to HIV and AIDS through NACA for the years 2009/10 to 2011/12 averages 2% of government expenditure[13] at approximately BWP900million each year ($129million). The actual HIV and AIDS spending by the government attributable to HIV and AIDS is far more than that as a large portion of Ministry of Health spending is also indirectly attributable to HIV and AIDS.

Overall, the government of Botswana funds most of the national response to HIV and AIDS. There is some international funding support for HIV prevention and treatment programs, mainly from PEPFAR funds, ACHAP (a public private sector initiative between the government of Botswana, MSD/Merck Company Foundation and the Bill and Melinda Gates Foundation), the World Bank, EU, SIDA and the UN agencies. There are also a number of other international foundations and trusts that have been funding the

[9] CSO, 2011
[10] http://data.worldbank.org/indicator/NY.GDP.PCAP.CD
[11] In April 2001, heads of sates of the African Union meeting in Abuja, Nigeria, pledged and set a target of 15% of their annual budgets to improve the health sector.
[12] National Health Accounts 2007/08, 2008/09, 2009/10 – Ministry of Health Botswana
[13] Author's calculations

civil society, like Stephen Lewis Foundation, Olive Leaf Foundation, OSI, OSISA, Human Sciences Research Council (HRSC), ARASA, Welcome Trust, Planet AID, Oak Foundation, International Development Research Centre, Social & Scientific Systems, Planet AID, Coca Cola and Shell. The domestic private sector is not well documented, but through contributions to the medical aids and wellness programs, some organisations fund ART access for their employees.

2. The Botswana National Strategic Framework for HIV and AIDS 2010-2016 1Introduction

To guide stakeholders and ensure a coordinated approach of the national response to HIV and AIDS, Botswana has developed the Second NSF 2010-2016. The document outlines the National priorities for the response between 2010 and 2016. It lays out responsibilities for the various stakeholders involved in implementing HIV and AIDS activities.

2.1. The Goal and Priority Areas of the NSF 2010-16

The goal of the strategic framework is 'Prevention of New HIV Infection by 2016'. It focuses on four priority areas:
Priority Area 1: Prevention of New Infections
Priority Area 2: Systems Strengthening
Priority Area 3: Strategic Information management
Priority Area 4: Scaling up Treatment, care and support

2.2. NSF Priorities, Objectives and Outcomes 2010-16

Table 2.1 below outlines the four NSF II priorities, the associated objectives and the anticipated outcome results. The NSF II has ranked the four priorities in order of their perceived importance. However, the priority areas are seen as complementary as the effective implementation of one priority area will contribute to the attainment of the other areas.

Table 2. 1: NSF priorities, objectives and outcomes

Priority areas		Objectives	Outcomes
1	Prevention of New Infections	i. Reduction of the incidence of sexual transmission of HIV among females and males aged 10-49 years ii. Increased access to health care services for HIV prevention	i. Increased proportion of females and males aged 10-49 years practising safer sexual behaviours ii. Improved utilisation of health care services for prevention
2	Systems Strengthening	i. Strengthened community and health systems capacity for universal access to quality, comprehensive and sustainable HIV and AIDS services ii. Effective and efficient coordination of the response, including meaningful harmonisation and alignment of stakeholders support to the national response at all levels iii. Strengthened and sustained political leadership and commitment on HIV and AIDS at all levels iv. Improved ethical and legal	i. Communities empowered to effectively respond to HIV and AIDS ii. Improved access to quality HIV and AIDS services iii. Partners aligned to national priorities and held accountable iv. National response adequately resourced v. Ethical and legal environment for HIV and AIDS improved

Priority areas		Objectives	Outcomes
		environment to support the national response,	
3	Strategic Information Management	i. Strengthened information management system of the national response to enhance information sharing and utilisation	i. Increased availability of quality, comprehensive and harmonised information on the response to the epidemic ii. Improved utilisation of information by partners for policy development, advocacy, and programming iii. Improved basic and operational research, monitoring and evaluation of the HIV and AIDS response
4	Scaling Up Treatment Care and Support	i. Increased access to HIV and AIDS comprehensive quality treatment, care and support services	i. Improved access to comprehensive quality treatment, care and support services

Source: National Operational Plan for HIV and AIDS 2012-2016

With the emphasis on prevention, the NSF 2010-16 notes the successes of clinical prevention like PMTCT, where access is about 97% and the ART services that are unequalled in Africa.

The NSF states the following regarding prevention activities:

- That the mid - term review of the NSFI (NACA, 2007) identified the need to focus on prevention of new HIV infections as a key priority
- That general consensus is that prevention efforts overall are under-funded and there is insufficient targeting of prevention efforts due to the gap in the identification of specific groups and their unique profiles.

2.3. National Operational Plan for HIV and AIDS 2012-2016

The National Strategic framework has been operationalized for its last four years of implementation through the National Operational Plan 2012-16. The resources needed to implement the operational plan have been estimated at P9.7billion over a four year period at an average of P2.4billion per year. Treatment, care and support accounts for 89% of the resources needed to implement the operational plan. The Orphan Care program makes up 64% of treatment, care and support and 57% of the overall estimated cost of implementing the NOP. ART is 26% of the overall cost of the NOP and CHBC is at 6%.

Table 2. 2 : Resource Needs per the NOP 2012-16

	2012/13 Pula Millions	2013/14 Pula Millions	2014/15 Pula Millions	2015/16 Pula Millions	Total Cost Pula Millions
Priority 1: Prevention of New HIV Infections	256	257	212	201	926
Priority 2: Systems Strengthening	11	20	11	15	56

Priority 3: Strategic Information Management	35	15	8	41	99
Priority 4: Treatment, Care and Support	2,125	2,179	2,198	2,155	8,657
Grand-Total (All 4 Priority Areas)	**2,427**	**2,471**	**2,428**	**2,412**	**9,738**

3. Scope and Objectives of the NASA in Botswana

3.1. Introduction

The National AIDS Spending Assessment (NASA) is undertaken to provide an estimate of spending on HIV and AIDS for the national response. NASA provides estimates of: what has been spent on HIV and AIDS; who has provided the funding; who managed the funding on behalf of the financiers; which service provider spent the money; and which population benefited from the spending. NASA can provide the base data for determining whether or not funds are being spent in line with the national strategic plans as intended, and whether or not there is equitable distribution of resources between the beneficial populations.

While the information provided is mainly financial and does not therefore provide information on the effective use of available resources, the data so collected can be compared with the resource needs to determine funding gaps. It can also be used in resource mobilisation and advocacy in order to scale up the response to HIV and AIDS. A further analysis of the spending against reported available funding can be made to determine funding bottlenecks and absorptive capacities.

3.2. Aim of the Botswana NASA 2009/10-2011/12

The overall aim of the study was to provide information on the financial flows and expenditures related to the national response to HIV and AIDS in Botswana, for the years 2009/10 to 2011/12. This study does not in any way attempt to examine the quality of services provided nor the output and impact of the spending.

3.3. Scope of NASA

This is Botswana's third National AIDS spending assessment and follows upon the second NASA which covered the periods 2005/06 to 2008/09 and the first NASA covering the period 2002/03 to 2004/05.

The NASA 2009/10 to 2011/12 was intended to provide estimates of HIV and AIDS spending from the following sources:

- Domestic Public funds
- Domestic Private sector funds, excluding out of pockets funding.
- International funds (development partners, international private organisations and foundations)

3.4. The objectives of this NASA

The objectives of the NASA 2009/10-2011/12 were to:

- Undertake an assessment of what was actually spent in Botswana between 2009/10 and 2011/12.
- Provide financial data the Global AIDS Response Progress Report indicator 6 for the years 2009/10, 2010/11 and 2011/12.
- Identify the flow of expenditure by source, functions, providers of services and targeted populations.
- Prepare a report on the HIV and AIDS financing in Botswana in order to inform decision makers.
- To make recommendations for a strategy for the institutionalisation of NASA in regular monitoring and evaluation of the national response to HIV and AIDS.

4. Methodology and Assumptions

4.1. Preparatory Work

The process began on the 29th of February 2012 with a stakeholder's inception meeting. The Research assistants underwent training on the NASA methodology and software from the 29th of February to the 2nd of March 2012.

4.2. Permission Letters

Formal letters requesting permission to access data were sent to the principals of HIV and AIDS stakeholder organisations including the permanent secretaries of government ministries.

4.3. Data Collection

Data collections took place from the 8th of March to 30 June 2012.

a) Database of all Stakeholders

The NACA database of all stakeholders involved in HIV and AIDS interventions in the country formed the basis upon which requests were made for spending data. In addition, information provided by some of the international funding agencies yielded other stakeholders missing from the NACA data base. The previous NASA was also used as a source of information on the stakeholders involved in HIV and AIDS interventions in Botswana.

b) Development of Questionnaires

The UNAIDS NASA format for the questionnaires was adjusted to suit the Botswana situation. The research assistants were trained in their use, with the assistance of the Centre for Economic Governance and AIDS in Africa (CEGAA), and they were correctly applied by the research assistants during the data collection process.

c) The Approach to Data Collection

Data collection process used two approaches namely "top down" and "bottom up". Top down approach involved collecting data from the main sources of funding and their agents. Bottom up approach involved collecting detailed data from the service providers and linking this back to the source of funding through the agent. The information was then triangulated to verify and avoid double counting.

d) Sources of Data

Primary financial data was collected from NACA, all other relevant government departments, all development partners and international donor agencies and the major NGOs. The primary sources of data provided expenditure which they directly incurred in Botswana and disbursements to other organisations. The disbursements were followed down through the chain to the point of consumption at the service provider level. The service provider is the level at which actual spending on activities and the beneficiaries are reported. However, in some cases the detailed expenditure records of the service providers could be obtained from the primary sources of data, and these were used for inclusion in the NASA (e.g. expenditure of small NGO's funded by ACHAP were captured using the ACHAP records).

Summarised below in table 3.1 is the response rate of organisations sampled for data collection, which shows an overall response rate of 75%. It is difficult to know, however, in value terms, how much is missing from the NASA, as some of the spending data for the organisations that did not respond was obtained from their

financing sources. With data having been obtained from the main sources of HIV and AIDS funding in Botswana, the author of this report estimates that in value terms more than 90% of HIV and AIDS spending was captured. Appendix 4 shows the response rate data in more detail; with organisations/institution names and the status of data collection for each year of the study.

Table 3. 1 : Botswana NASA 2009/10 to 2011/12 Response Rate

Target Group	Number Targeted	Number Responded	Response Rate (%)
Government Ministries and Departments	12	12	100%
Development partners	13	10	77%
CSOs/NGOs/FBOs	40	33	83%
Private business sector and Parastetals	19	8	42%
Total	84	63	75%

e) Districts Visits

Site visits were intended to provide more detailed expenditure information from the service providers at the district level as well as provide insight into the funding mechanism and implementation challenges.

9 Districts were selected based on population size and HIV prevalence statistics. These were:

- Gaborone
- Central district
- Selibe Phikwe
- Francistown
- Maun
- Ghanzi
- Kgalagadi
- Jwaneng
- Kweneng

Every effort was made to access information from the following offices:

- District AIDS coordinator's office
- District Health Teams (DHT)
- Social and Community Development (S&CD) units:
- Economic Planning and Treasury departments
- Matrons and Chief Medical Officers
- Program coordinators for PMTCT, CHBC and ARV programmes
- Development partners, NGOs/CSOs

4.4. Data Processing

The data collected was first captured in Excel sheets for cleaning, making calculations and estimates. In the excel sheets, the data was verified, checked and balanced before being transferred to the NASA Resource Tracking Software (RTS). The NASA RTS has been developed to facilitate the data processing for NASA into matrices of different classification axes. The NASA RTS outputs were exported to Excel software to produce summary tables, and graphs for analysis. That information from the NASA RTS is presented and discussed in this report.

4.5. Assumptions and Estimations

a) Differing financial years

Although different organisations have different financial years to each other and in respect to the Government fiscal year, they were all assumed to be aligned to the Government financial year, when summing up data for the NASA. This same approach was used for the previous NASAs.

b) ARV Drugs/Medicine Consumption

The objective of the NASA is to report drugs consumed at the health facility level. With no actual consumption available from the health facilities, actual spending on ARV drugs has been reported in the NASA.

c) Patient Care

HIV and AIDS related spending on hospitals and clinics patient care was arrived at by applying the percentage of morbidity estimated to be due to HIV and AIDS, to the expenditure from the Ministry of Health, Department of Clinical Services and from the Ministry of Local Government on health clinics (for years in which public health was managed by the ministry).

As per the previous NASA, 40% of hospital and clinics expenditure was assumed to be attributable to HIV and AIDS related illnesses. The 40% used for the NASA 2006-2008 was agreed on by all the stakeholders and key experts. Although it could be argued that due to the high ART coverage rates, the utilisation of hospital and general clinic services for HIV and AIDS related illnesses has reduced in recent years, without any other detailed study done on hospital utilisation, the same basis of estimating HIV spending has been maintained.

d) Laboratory Reagents

NASA is supposed to report on consumption of reagents by the laboratories. What has been reported, however, is the actual spending on these reagents by the Ministry of Health, obtained from National Health Laboratory.

e) Pooled Funds

Where the information provided did not enable the splitting of expenditure between various donor organisations funding an entity, spending on the identified HIV and AIDS activities was assumed to be proportional to each funding source's contribution to the total funds received.

f) **Foreign Currency Exchange Rates**

Where the expenditure collected was in US$, the average rate of exchange for the financial year of the organisation concerned was used to convert the amounts to Botswana Pula. The rates of exchange were obtained from the Bank of Botswana Financial Statistics Reports[14]. Refer to Appendix 1 for the exchange rates table.

4.6. Limitations of the Collected Data

a) Despite the efforts made to collect data from all organisations, some organisations did not respond. These were left out of the NASA, except where their information could be obtained from a secondary data source. The response from the private business sector was particularly poor and hence the reported spending by these

[14] www.bankofbotswana.bw

entities is very low. The response rate for the business sector was only 42 %(Refer to table 3.1).

b) Patient care expenditure constitutes the single largest value contribution to the overall expenditure. The determination of the figure is based on a ratio/percentage that is difficult to determine and has some subjectivity.

c) Some organisations provided sets of financial statements with expenses summed up based on the nature of expenditure, not according to the projects implemented or sources of funding. Splitting the expenses between the projects and donors was then based on the assumption that projects incurred expenses in direct proportion to their funding, which is not always the case.

4.7. Challenges Faced

4.7.1. Data Collection and Analysis Related Challenges

1. Slow/ no access to key players' data - Some stakeholders were slow in providing the information required for NASA. In the extreme cases, some stakeholders did not give access to the information required. All these called for prolonged negotiations in order to access the information. Appendix 4 shows which organisations provided information and those that did not.
2. Some organisations, especially CBOs, had problems unveiling their expenditures on accounts that their sponsors must know. This delayed the process of data collection.
3. Organisations have different financial reporting formats that are different from the NASA classifications. It thus took time to customise the data for the NASA categories.
4. Some organisations carry out activities that are difficult to classify per the NASA spending categories, especially programmes cutting across different spending categories. In some instances organisations did not provide enough information to enable classification of their activities, calling for judgements to be made by the data analysis team on appropriate classification.

4.7.2. NASA Classification Related Challenges

1. Where there are multiple intermediary agents, it can be difficult to ascertain which one acts as the primary agent. Financing agents are defined as the organisations through which financiers of HIV and AIDS interventions channel their funds to finance service provision programmes. They are the entities that make the programmatic decisions. When data is collected using the bottom up approach, service providers have to indicate their source of funds. In many cases, they identify an intermediary organisation as the source. When collecting data from these intermediary organisations they also identify their sources (which might again be intermediaries) and also identify organisations that they support with these funds. Organisations have to be linked through the chain until the actual source is identified. There may be confusion in determining of the intermediary organisations, is the financing agent (i.e. which organisation is responsible for the programming decision). Such an example is the PEPFAR funds earmarked for the government of Botswana and programmatically managed by the local CDC program office (BOTUSA) and NACA. Is the program decision made by NACA or BOTUSA?

   For all PEPFAR funding, financing agents are assumed to be the respective US government agents (CDC, USAID, DoD or NIH) except funds channelled through the government of Botswana, in which case NACA is assumed to be the agent.

5. NASA Findings

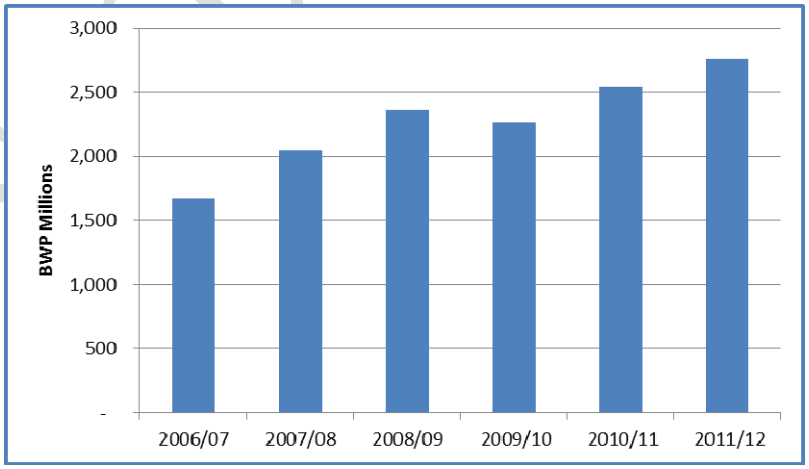
5.1. Total Spending HIV and Spending 2009/10 to 2011/12

According to the NASA findings, the total HIV and AIDS spending in Botswana from 2009/10 to 2011/12 was P7,581billion (US$1,070billion[15]) split between the years as follows:
2009/10: P2,272 billion (US$331million).
2010/11: P2,544 billion (US$377million), an increase of 12% in nominal pula terms from 2009/10.
2011/12: P2,765 billion (US$399million), an increase of 9% in nominal pula terms from 2010/11.
This represents an annual average increase over the period of 11% in nominal pula terms.

Compared to the previous NASA, covering the years 2006/07 to 2008/09, overall HIV and AIDS spending (for the period 2009/10 to 2011/12) increased by 25% in nominal pula terms from the total amount spent then of P6,082 billion[16](US$969billion). The 2006/07 to 2008/09 spending was split as follows:
2006/07: P1,676 billion (US$287 million)
2007/08: P2,047 billion (US$334 million)
2008/09: P2,359 billion (US$348 million)

Year and year, HIV and AIDS spending has increased steadily over the six year period from 2006/07 to 2011/12. Except for the slight dip in spending in 2009/10, there is a gradual increase in spending year on year, at an annual average nominal rate of 11%. Table 5.1 below shows the overall trends in HIV and AIDS spending in Botswana from 2006/07 to 2011/12.

Figure 5.1: Botswana's Total HIV and AIDS Spending (BWP millions) 2006/07-2011/12



[15] Converted using the average rate of exchange for each of the NASA financial years. The rates were obtained from the Bank of Botswana website. Refer to Appendix 1
[16] Botswana NASA 2006 - 2008

5.2. Financing Sources

Spending on HIV and AIDS interventions in Botswana is mainly from domestic public funds. In this report, domestic public funds refer to central government funds (spending from government revenues), the World Bank reimbursable loan and the government's contribution to the public medical aid scheme. Public funds financed approximately 66% of the HIV and AIDS spending over the three year period of the study (2009/10 – 2011/12). External or international sources financed approximately 32% of spending, with PEPFAR and ACHAP (a public private sector initiative between the government of Botswana, MSD/Merck Company Foundation and the Bill and Melinda Gates Foundation) making up the major part of the contribution. There is low spending reported from the private funding sources, at 2%). This is mainly due to the poor response to the NASA study by the private business sector, and also that this NASA did not seek to measure the out of pocket expenses directly paid by individuals. Table 5.2 illustrate the splitting of HIV and AIDS spending per each broad funding source category.

Table 5. 1: Funding Sources in Broad Categories 2009/10 to 2011/12

	2009/10	2010/11	2011/12	Totals
	BWP	BWP	BWP	BWP
Public Funds	1,444,541,069	1,645,062,601	1,924,301,941	5,013,905,611
Private Funds	50,672,274	50,222,953	53,628,047	154,523,274
External Funds	776,845,641	848,617,907	787,546,719	2,413,010,267
Totals	**2,272,058,984**	**2,543,903,461**	**2,765,476,707**	**7,581,439,152**

Figure 5.1 incorporates the results of the previous NASA study to show spending on HIV and AIDS from 2006/07 to 2011/12. Read together with figure 5.2, it shows that public spending has increased gradually over the six year period from P1, 181billion in 2006/07 to P1, 924 billion in 2011/12, having gone down slightly in 2009/10. Over that same period, external sources of funding increased from P465million in 2006/07 to a peak of P849million in 2010/11 before declining slightly to P788million in 2011/12. Though the response from the private business sector was poor, reported private spending increased from P29million in 2006/07 to P54million in 2011/12. Private sources of spending are mainly medical aid contributions by the private sector employers, and employees of both the private sector and the government. The government's contribution to medical aid is reflected under public sources of funding. The increase in external or international spending as a proportion of overall HIV and AIDS spending, which peaks in 2010/11, began from 2003/04 with the coming on board of PEPFAR. PEPFAR's funding has gradually increased over that period, although it is now showing a decline from 2011/12. The other international funding sources over that period were ACHAP and Forum Syd. These sources of international financing have since began to cut down funding, hence the upward trend of government spending as a proportion of overall HIV and AIDS spending in 2011/12.

Figure 5.3 is an illustrative comparison of funding proportions from 2003/04 to 2011/12. As a proportion of overall HIV and AIDS spending, government spending decreased from 70% in 2003/04 to 64% in 2009/10. It is beginning to rise again to compensate the gradually declining international funds. As at 2011/12 it stood at 70% of overall spending.

Figure 5.2: HIV and AIDS Spending by Source (BWP millions) 2006/07 to 2011/12

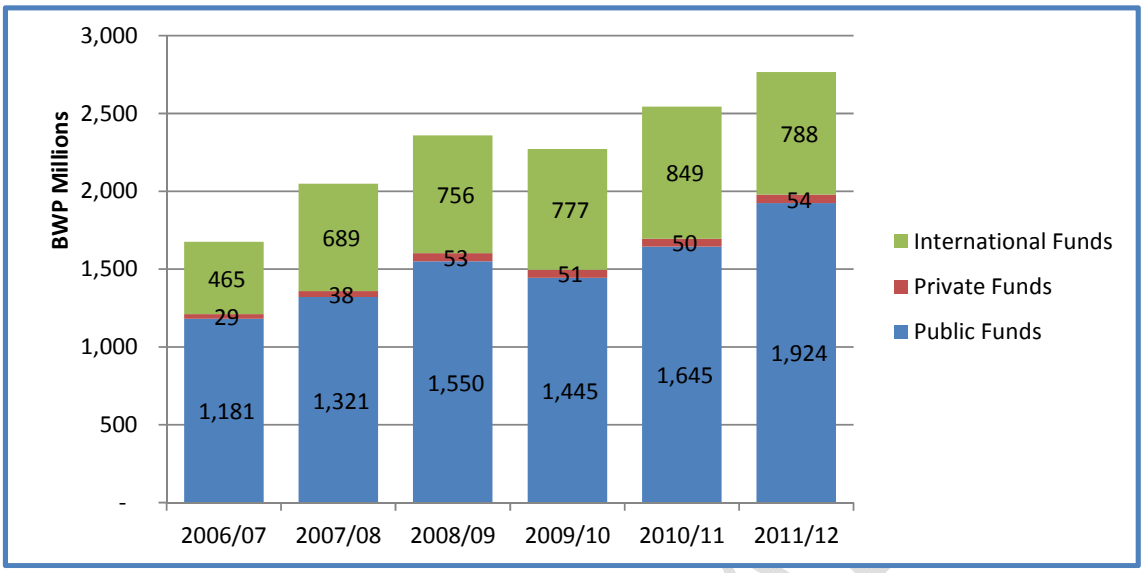


Figure 5.3 Spending Proportions on HIV by Source (%) 2006/07 to 2011/12

Figure 5.4 Funding Sources HIV Spending Comparisons (BWP mill) 2003/04 to 2011/12

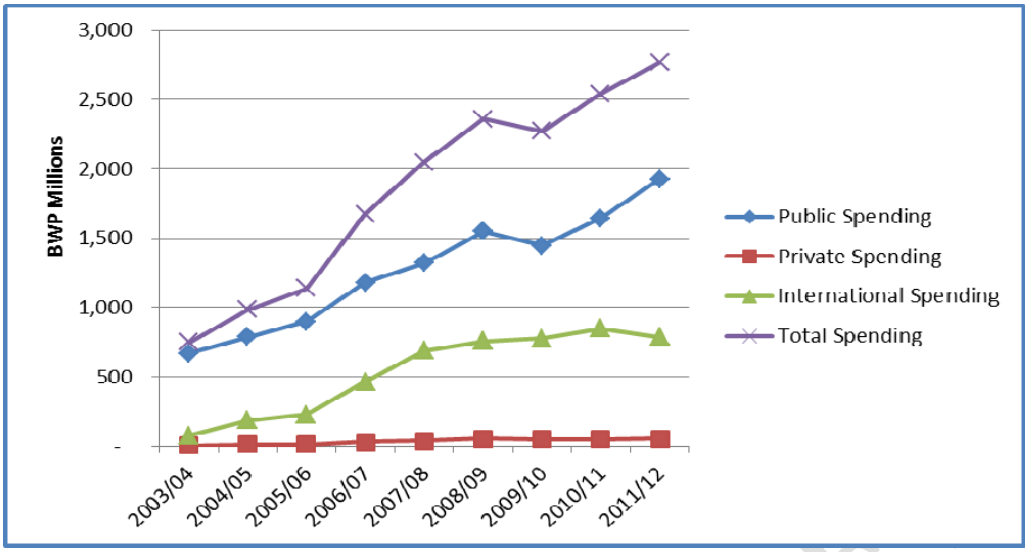


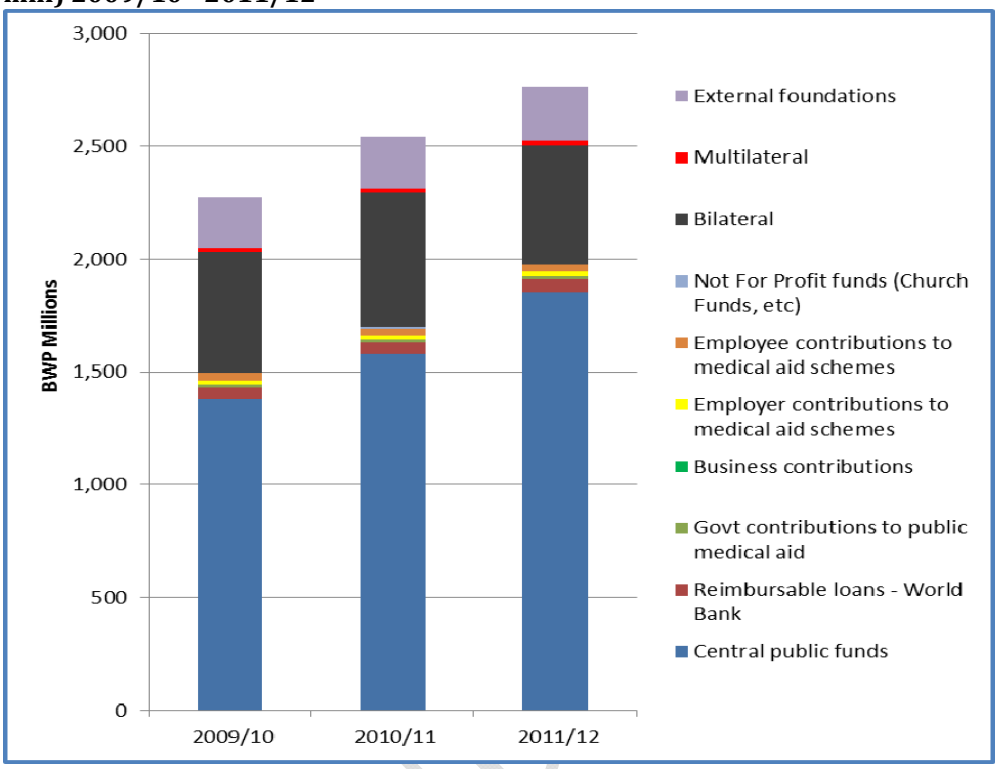
Table 5.2 and Figure 5.5 provide a slightly more detailed split of the funding sources. Public funds have been split into government (funded from government revenues), reimbursable loans, local and other public funds (government contributions to public medical aid). Private funds have been split into direct business contributions, private sector employer contributions to medical aid and employee (private and government workers) contributions to medical aid and also non-profit making institutions. International funding has been split into bilateral, multilateral and external foundations. From government revenues, P4,816 billion was spent on HIV and AIDS interventions in the three years 2009/10 – 2011/12, representing 64% of the overall HIV and AIDS spending. A total of P154 million was spent from the World Bank loan (2% of overall spending). Bilateral agencies (mainly PEPFAR) contributed 22% of the overall spending (P1,662 billion). External Foundations made up 9% of the overall spending, with ACHAP contributing most of the spending. Multilateral spending represents UN agencies (excluding the World Bank loan) and made up 1% of the total.

Table 5. 2 : Disaggregated HIV Funding Sources (BWP mill) 2009/10 to 2011/12

Sources	2009/10 BWP Millions	2010/11 BWP Millions	2011/12 BWP Millions	Totals BWP Millions
Central public funds	1,380.87	1,580.06	1,855.45	4,816.38
Reimbursable loans - World Bank	49.47	50.80	54.27	154.54
Other public funds (Gvt. contributions to Medical AIDS)	14.20	14.20	14.58	42.98
Business contributions	0.57	0.57	0.78	1.92
Employer contributions to medical aid schemes	17.70	17.48	18.97	54.15
Employee contributions to medical aid schemes	31.90	31.58	33.30	96.77
Not For Profit funds (Church Funds, etc.)	0.50	0.59	0.59	1.68
Bilateral	536.42	600.82	525.09	1,662.34
Multilateral	18.54	15.80	20.89	55.23
External foundations	221.88	232.00	241.56	695.44

Totals	**2,272.06**	**2,543.90**	**2,765.48**	**7,581.44**

Figure 5.5: Disaggregated Funding Sources for HIV Spending in Botswana (BWP mill) 2009/10 - 2011/12



5.3. Agents of Funding for HIV and AIDS Activities in Botswana

Financing agents are the organisations through which financiers of HIV and AIDS interventions channel their funds to finance service provision programmes. They are the entities that make the programmatic decisions. Financing agents can be broadly classified as public, private and external. Public agents include all government entities and parastatals (including public medical aid schemes). Private agents include local non-profit CSOs/NGOs, private medical schemes and local profit making private business organisation. External agents include country offices of bilateral agencies, multilateral agents, international non-profit organisations and foundations and international profit making organisations.

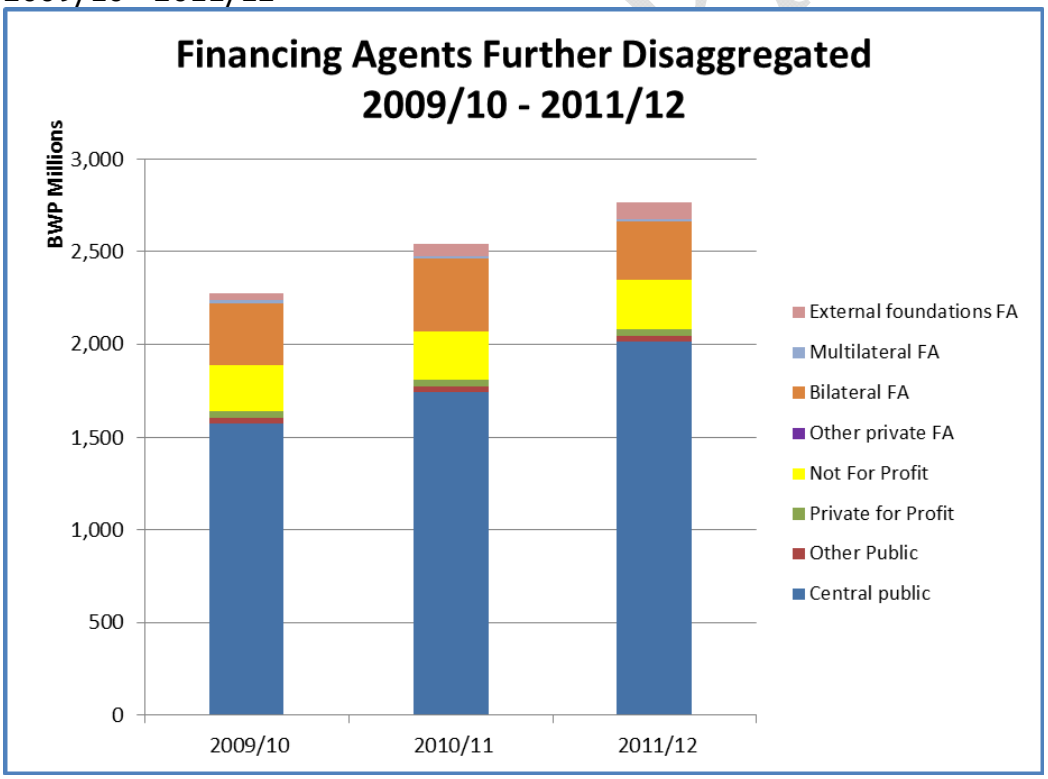
Table 5.3 below shows the spending per the broad categories of financing agents during the period of the NASA study. As per the findings, between 2009/10 and 2011/12, 71% of spending on HIV and AIDS in Botswana was managed by the public agents. This is in line with the fact that the main source of HIV and AIDS financing was public funds. In addition, a significant amount of external funding, especially from PEPFAR is managed by NACA. This implies that most of the decisions on what HIV and AIDS activities are implemented in Botswana are made locally by public entities and would thus be expected to be in line with national priorities. External agents managed 17% of funds. The private sector agents managed 12%.

Table 5. 3: Financing Agents for HIV Spending in Botswana (BWP) 2009/10 – 2011/12

	Total Public FA BWP	Total private FA BWP	Total External FA BWP	Totals BWP
2009/10	1,604,522,756	280,699,443	386,836,785	2,272,058,984
2010/11	1,768,874,329	298,644,219	476,384,913	2,543,90,461
2011/12	2,042,865,759	303,490,376	419,120,572	2,765,476,707
Totals	**5,416,262,844**	**882,834,038**	**1,282,342,270**	**7,581,439,152**

Figure 5.6 below shows the financing agents further disaggregated. When disaggregated further, the findings show that central government agents managed 70% of the funds, country offices of bilateral agents managed 14%, and local non-profit institutions managed 10% while external foundations managed approximately 3%. The rest of the funds were managed by parastatals, local private businesses and multilateral agents. Over 52% of the funds reported as managed by government entities were spent on public hospitals and clinics.

Figure 5.6 Financing Agents for HIV Spending Further Disaggregated (BWP) 2009/10 – 2011/12



5.4. HIV and AIDS Spending Activities in Botswana

5.4.1. Breakdown of HIV and AIDS Spending

Over the three year period under study, 56% (P4,217 billion) of HIV and AIDS spending was on treatment and care of people living with HIV and AIDS. Spending on hospitals

and clinics patient care attributable to HIV and AIDS made up 65% of this figure at P2,756 billion. Treatment and care also includes spending on ARV drugs and laboratory reagents for HIV monitoring, which came to 26% (P1,095 billion) of treatment and care spending. Spending on Orphan Care (OVC) constitutes 16% (P1.198 billion). As reported in the National Situational Analysis on OVC in Botswana (2008), 96,4% of support to OVC is from the Government of Botswana and mainly in the form of food[17]. Spending on prevention made up 14% of total HIV and AIDS spending (P1.034bn). Programme management and administration, which includes monitoring and evaluation activities, accounted for 10% (P776million) of the overall spending. The remaining 5% was spent on training, Human rights and HIV and AIDS research activities. Refer to table 5.4 and Figure 5.7 below.

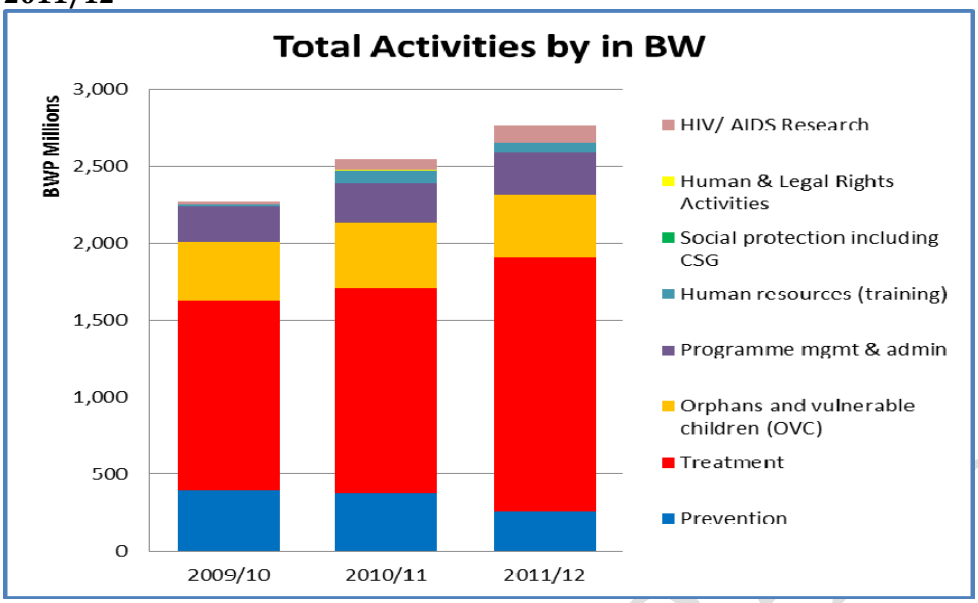
Globally, between 2006 and 2008, treatment and care programmes received 56% and HIV prevention programmes received 20% of the total resources available[18], which might indicate that Botswana's proportion on prevention is lower than average. Of concern is the fact that the prevention spending proportion dropped from 17% in 2009/11 to 9% in 2011/12. However, it is important to note that Botswana's prevention spending has been understated with regards to the PMTCT component. There is no available split for the ARV drugs between ART and PMTCT. Hence some of the ARV drugs which have all been included under treatment were actually used on the PMTCT program. The country's treatment proportion seems to be in line with the global spending proportions.

Table 5. 4 : Spending per AIDS Spending Categories - 2009/10 – 2011/12

	2009/10 BWP Millions	2010/11 BWP Millions	2011/12 BWP Millions	Totals BWP Millions
Prevention	396	381	257	1,034
Treatment	1,232	1,330	1,655	4,217
Orphans and vulnerable children (OVC)	382	419	397	1,198
Programme mgmt. & admin	235	258	283	776
Human resources (training)	9	84	59	151
Human & Legal Rights Activities	3	2	5	9
HIV/ AIDS Research	16	70	109	196
Grand Total	**2,272**	**2,544**	**2,765**	**7,581**

[17] National Situational Analysis on Orphans and Vulnerable Children in Botswana – Ministry of Local Government Department of Social Services (June 2008)
[18] UNAIDS report on the global aids epidemic | 2010

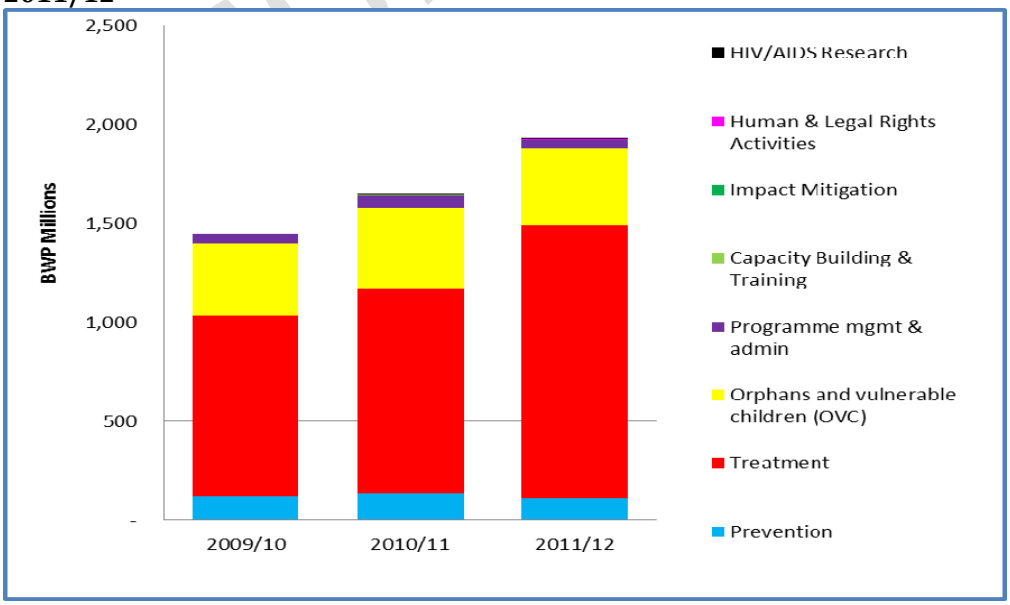
Figure 5.7: Spending per AIDS Spending Categories (BWP mill) 2009/10 – 2011/12



5.4.2. Financing Sources' Spending Priorities

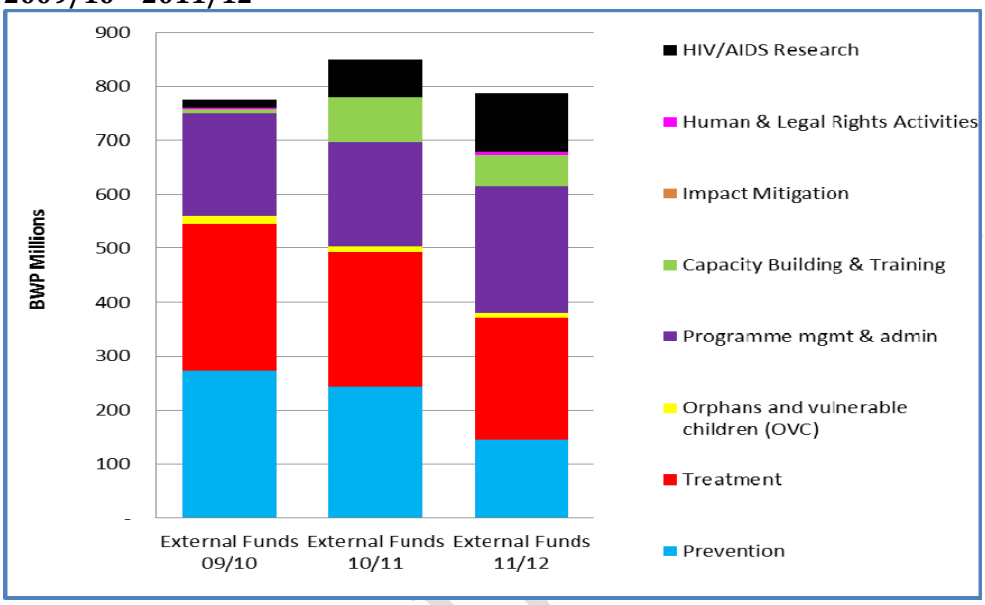
Public funds were mainly spent on care and treatment of people living with HIV and AIDS. In 2011/12, 72% of public spending on HIV and AIDS was on care and treatment (which is not only for ART but also includes the general hospital and clinic estimated spending), followed by OVC care at 20% and prevention 6%. Figure 5.8 illustrates the public spending proportions on HIV and AIDS over the three year period of the NASA study. Of concern is the reducing amount of public funding for prevention.

Figure 5.8: Public Funds HIV Spending Priorities (BWP millions), 2009/10-2011/12



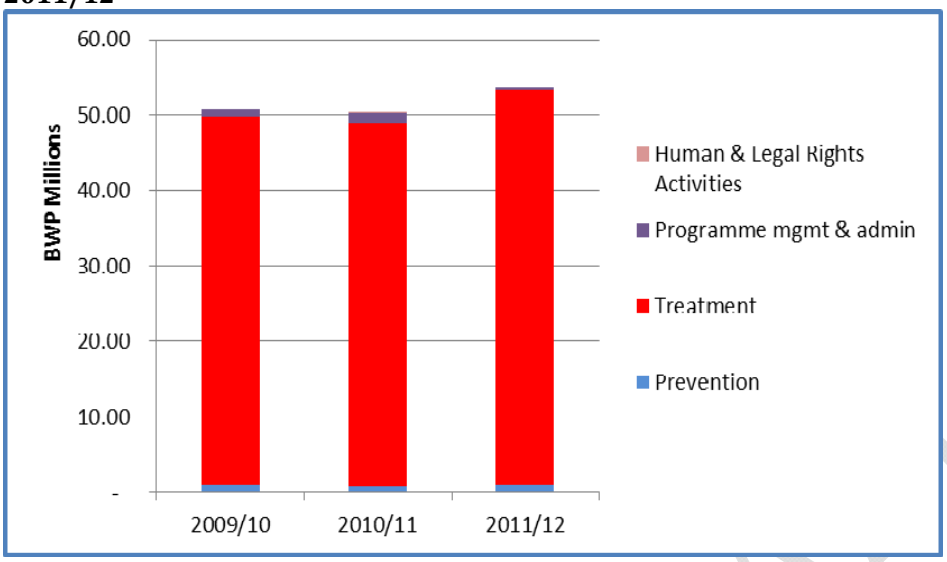
In 2011/12, the International/external funds were spent mainly on programme management (30%), treatment and care (28%) and prevention (18%). The trends show an increasing proportional spending on programme management, capacity building and HIV and AIDS research from 2009/10 to 2011/12, with decreasing proportional spending on care and treatment and prevention. Figure 5.9 illustrates the international/external spending patterns over the three year period of the NASA.

Figure 5.9: International/External Funds Spending Priorities (BWP millions), 2009/10 – 2011/12



Private funding, made up mainly of private sector employer medical aid contributions and employees contributions for both private sector and government, was spent largely on treatment (average of 97% over the three years) prevention (average of 2% over three years. Figure 5.10 illustrates spending from local private sources of funding.

Figure 5.10: Private Funding Spending Priorities (BWP millions), 2009/10-2011/12



5.4.3. Breakdown of HIV Prevention Spending in Botswana

Prevention spending decreased by 35% from P396million in 2009/10 to P257 in 2011/12. This is a worrying trend in view of the national response's prioritisation of prevention. There was decreased funding for prevention activities from both the government and international funding sources. The NASA found that 20% of prevention spending over the three year period was on various community mobilisation initiatives. Prevention programmes targeting the youth accounted for 19%, while prevention of mother to child (PMTCT) and voluntary counselling and testing each accounted for 15% of the spending. The PMTCT figure does not include any drugs as these cannot be split from the overall ARV drugs included under ART treatment. Prevention activities not disaggregated by intervention refer to those prevention activities that cannot be easily split according to the NASA activity categories. These activities accounted for 12% of all the prevention spending, over the three year period. They included some spending on the most at risk populations like sex workers and men who have sex with men. Male circumcision spending has grown from 2,5% of spending in 2009/10 to 12% in 2011/12, as a result of the scale-up of the Ministry of Health's male circumcision program. A total of 19,579 circumcisions were conducted during the period from April 2011 to March 2012, with 6,376 of these between January and March 2012[19]. Refer to Table 5.5 and figure 5.11 below.

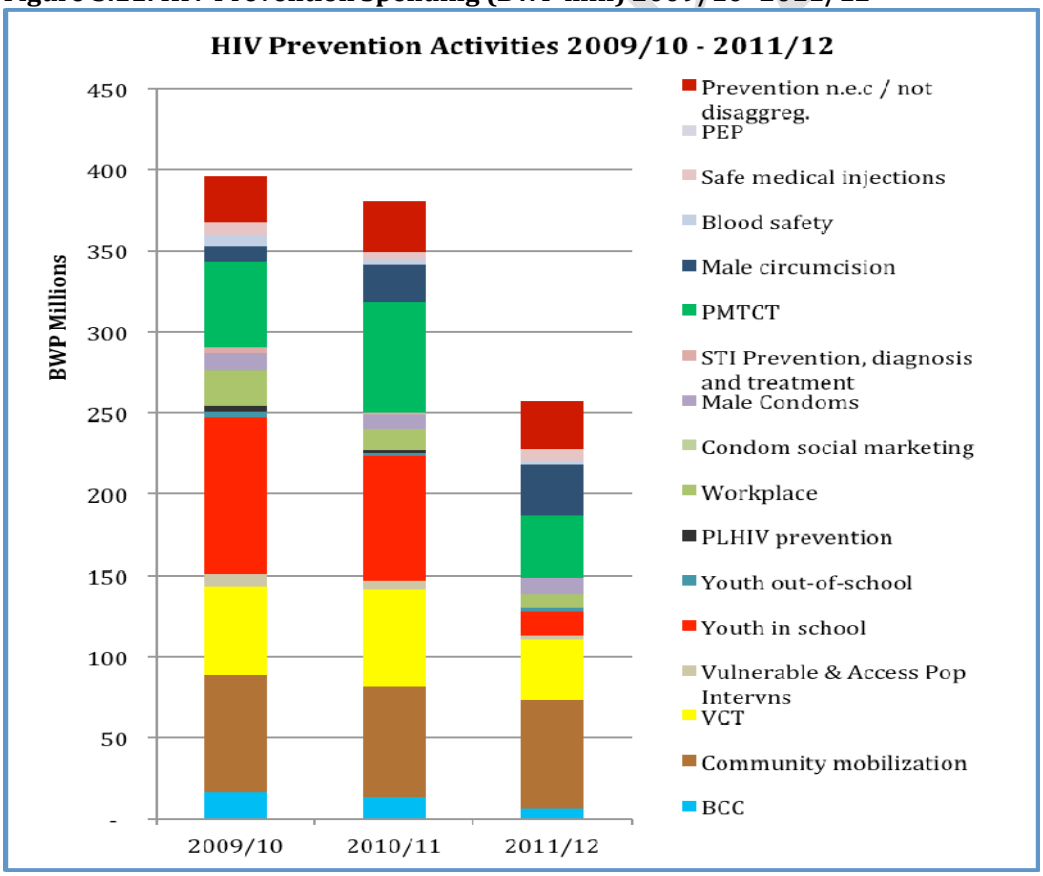
Table 5. 5 : HIV Prevention Spending Breakdown (BWP), 2009/10-2011/12

	2009/10 BWP	2010/11 BWP	2011/12 BWP
BCC	15,910,548	12,935,560	6,669,563
Community mobilization	72,606,325	68,773,668	66,635,303
VCT	54,433,105	59,839,097	36,779,840
Vulnerable & Access Pop Interventions	8,304,052	5,088,504	2,600,374
Youth in school	96,041,912	76,576,283	15,528,424

[19] MOH 4th Quarter Report 2011-12

	2009/10 BWP	2010/11 BWP	2011/12 BWP
Youth out-of-school	3,699,388	2,118,118	1,551,216
PLHIV prevention	3,402,379	1,737,229	-
Workplace	21,807,810	13,239,531	8,547,282
Condom social marketing	-	8,619	-
Male Condoms	11,120,201	8,728,937	10,064,553
STI Prevention, diagnosis and treatment	3,189,202	815,922	411,814
PMTCT	52,487,465	68,026,059	37,993,403
Male circumcision	9,747,662	23,166,922	31,707,533
Blood safety	7,376,050	3,628,238	2,534,597
Safe medical injections	7,039,251	4,169,843	6,113,730
PEP	-	32,332	517,240
Prevention n.e.c / not disaggreg.	28,923,926	31,925,388	29,843,917
Prevention total	**396,089,276**	**380,810,250**	**257,498,789**

Figure 5.11: HIV Prevention Spending (BWP mill) 2009/10- 2011/12



5.4.4. Breakdown of Spending on Treatment and Care in Botswana

Total spending on treatment and care increased by 32% from P1,232 billion in 2009/10 to P1,655 billion in 2011/12. This increase is mainly as a result of increase in inpatient and outpatient care combined spending from P748million in 2009/10 to P1,159 billion in 2010/11, an increase of 55% over the three year period. The inpatient and outpatient care of people living with HIV and AIDS account for 65% (P2,756 billion) of treatment and care spending over the three year period and was estimated at 40% of total public hospitals and clinics spend.

As at the end of March 2012, an estimated 190,525 people living with HIV were in need of treatment (CD cell count of 250 cells/mm^3 or less) of which 184,058 (96,6%) were receiving HAART[20]. The numbers of people needing treatment and those receiving it have grown significantly over the years, as Botswana nears universal access to treatment. As at December 2010, 170,617 were in need of HAART of which 161,219 (95,4%) were receiving treatment. As at end of February 2010, 150,122 people were on HAART, representing 91,7% of the projected number of people in need of treatment. Spending on treatment has thus increased accordingly.

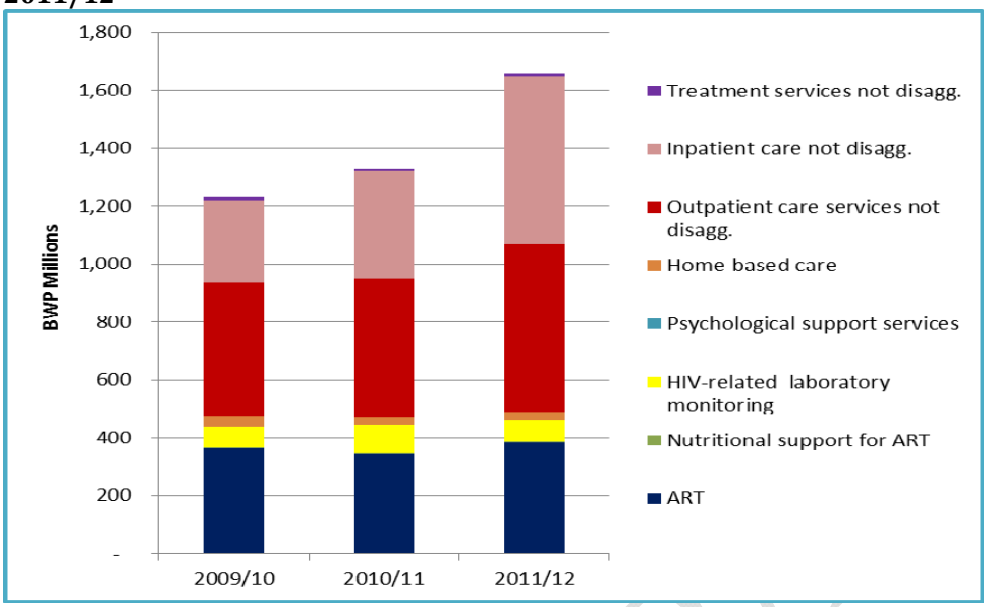
All the other components of treatment and care have remained fairly constant over the three year period of the NASA. ART spending (including HIV laboratory monitoring) accounts for 32%. It is important to note that ART spending only includes the ARV drugs and laboratory reagents. The cost of health personnel and related infrastructure support has not been included as they are difficult to estimate. However, since the inpatient and outpatient care spending was estimated based on expenditure of hospitals and clinics, it should include a share of ART personnel and infrastructure support. The drug component of the ART figure also includes drugs used for PMTCT as no splitting of the drugs between the two interventions was available. Tables 5.6 show the breakdown of treatment and care while Figure 5.7 illustrates the same information graphically.

Table 5. 6 :Treatment Spending Breakdown (BWP) 2009/10 – 2011/12

	2009/10 BWP Millions	2010/11 BWP Millions	2011/12 BWP Millions	Total BWP Millions
ART	364.65	345.99	384.22	1,094.86
Nutritional support for ART	1.34	1.48	0.45	3.27
HIV-related laboratory monitoring	71.14	96.25	75.35	242.74
Psychological support services	1.22	0.95	0.58	2.75
Home-based care	32.48	26.04	27.79	86.32
Outpatient care services not disagg.	464.38	479.52	579.71	1,523.61
Inpatient care not disagg.	283.34	369.34	579.71	1,232.40
Treatment services not disagg.	13.59	10.21	7.48	31.27
Treatment and Care Total	**1,232**	**1,330**	**1,655**	**4,217**

[20] Department of HIV and AIDS Prevention and Care, HIV Information Management Unit (March 2012)

Figure 5.12: HIV and AIDS Treatment Spending (BWP mill) 2009/10 to 2011/12



5.4.5. Spending on Orphans and Vulnerable Children in Botswana

The data available for the NASA does not disaggregate the OVC care spending into home/family support, education, health care or psychological support. However, most of the spending is on material support (food and clothing) and the source of that spending is the government of Botswana. P382million was spent in 2009/10, P419million in 2010/11 and P397million in 2011/12. The programme had a very high absorptive capacity, with most of the councils reporting spending more money than was made available by NACA. The reported expenditure did not include the administration expenses for the programme, which are incurred at ministerial level. These are reported in the Ministry of Local government recurrent expenses and have not been accounted for in this NASA.

5.4.6. Programme Management and Administration

Programme management and administration expenditure is defined as expenditure that occurs outside the point of health care or service delivery. They cover spending on services such as management of AIDS programmes, monitoring and evaluation, advocacy and facility upgrading through purchase of laboratory equipment and telecommunications.[21] Included in this category in the Botswana NASA are mainly the programme management costs of the local offices of bilateral agencies and NACA. In 2009/10 P235million was spent on programme management in total, P258million 2010/11 and P283million in 2011/12. The table below breakdown the programme management expenditure for 2009/10 to 2011/12

[21] National AIDS Spending Assessment (NASA) Classifications and Definitions - UNAIDS

Table 5. 7 : Programme Management and Administration Spending (BWP) 2009/10 to 2011/12

	2009/10 BWP Millions	2010/11 BWP Millions	2011/12 BWP Millions	Totals BWP Millions	%
Planning, coord. & management	47.82	70.33	73.98	192.13	24.8%
Admin & transaction costs	90.54	91.63	101.48	283.64	36.6%
M&E	4.47	13.11	10.98	28.56	3.7%
Operations research	0.76	0.07	-	0.83	0.1%
Serological-surveillance	4.85	2.75	5.54	13.15	1.7%
HIV drug-resistance surveillance	0.30	0.06	0.29	0.64	0.1%
Drug supply systems	-	2.32	0.14	2.46	0.3%
Information technology	0.25	0.13	-	0.37	0.0%
Upgrading/ construction of infrastructure	16.56	15.05	3.97	35.58	4.6%
Prog.Mgmt. not disagg.	69.44	61.78	48.77	179.99	23.2%
Prog.Mgmt. n.e.c	-	1.19	37.38	38.57	5.0%
TOTAL	**234.98**	**258.41**	**282.53**	**775.92**	**100.0%**

5.4.7. Spending on HIV and AIDS Related Research (excluding operations research)

In total P195 million was spent on HIV and AIDS related research of which 60% was on clinical research and 34% on epidemiological research. The low overall spending in 2009/10 is a result of the organisation that reported most of the research spending not providing data for 2009/10.

Table 5. 8 :HIV and AIDS related Research Spending Breakdown (2009/10-2011/12)

	2009/10 BWP	**2010/11** BWP	**2011/12** BWP	**Total** BWP
Clinical research	11,968,939	52,877,542	52,271,013	117,117,494
Epidemiological research	3,500,000	10,500,000	52,500,000	66,500,000
Behavioural research	552,730	2,580,753	282,980	3,416,463
HIV and AIDS-related research activities not disaggregated by type	194,463	4,254,645	3,473,872	7,922,980
HIV and AIDS-related research activities n.e.c.	-	-	847,560	847,560
	16,216,132	**70,212,940**	**109,375,425**	**195,804,497**

5.4.8. Spending by Service Providers

Service providers are the entities that engage directly in the production, provision and delivery of services. They can be broadly classified into three categories of; public, private and external/international providers. Public providers are the government entities and parastatals. Private providers include local non-profit organisations or NGOs and profit making organisations. International or external service providers include bilateral and multilateral agencies and other international organisations.

Public entities (mainly government hospitals and clinics) spent 74% of the total amount over the three year period, followed by private sector providers who spent 21% and international providers who spent 5%.

Table 5. 9 : Spending on HIV and AIDS per Service Providers (BWP) 2009/10-2011/12

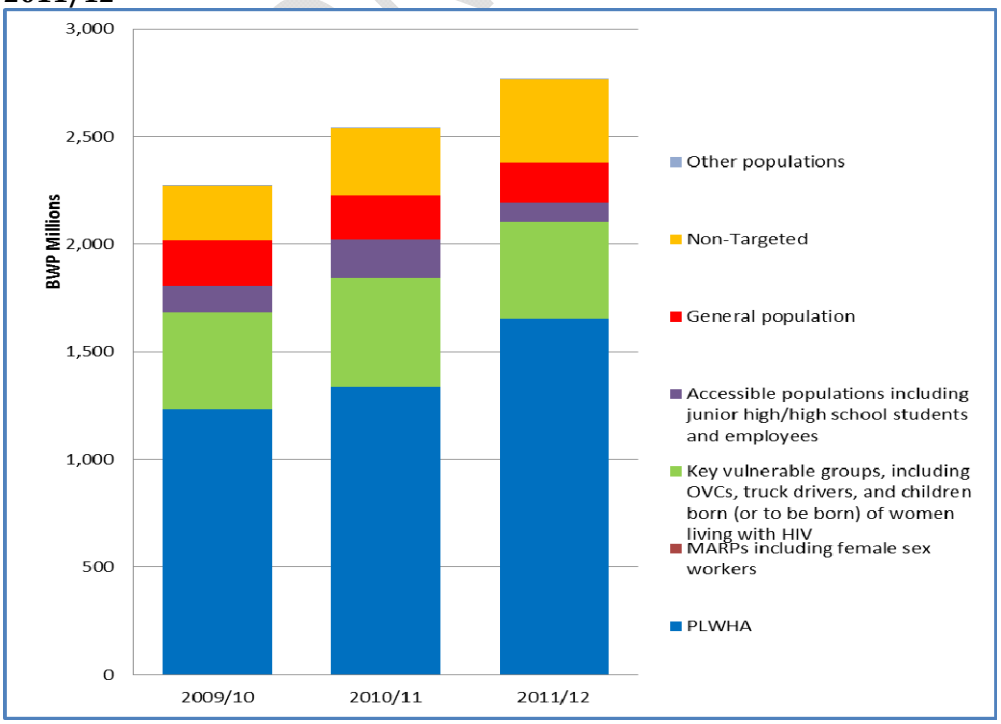
	2009/10 Pula	2010/11 Pula	2011/12 Pula	Total Pula
Public Providers	1,638,954,787	1,811,719,723	2,014,698,842	5,465,373,352
Private Providers	448,583,435	549,309,185	543,640,799	1,541,533,419
International/External providers	105,019,870	106,690,909	112,784,814	324,495,593
	2,192,558,092	2,467,719,817	2,671,124,455	7,331,402,364

5.4.9. Spending by Beneficiary populations

With Botswana's spending on HIV and AIDS being mostly on treatment and care, the main beneficiaries of HIV and AIDS spending were people living with HIV and AIDS, consuming 60% of the money in 2011/12. In the same year, orphans and key vulnerable populations benefited from 16% of the spending, 14% was spent on non-targeted interventions and 7% was spent for the benefit of the general population. Non-targeted interventions are those that do not directly benefit any population group, like program management and administration and research. Figure 5.13 below shows the spending proportions for each of the years 2009/10 to 2011/12.

Appendices 2a to 2c , show in more detail, the spending according to the beneficial populations for each of the years 2009/10 to 2011/12.

Figure 5.13: HIV Spending by Beneficiary Population (BWP mill) 2009/10 – 2011/12



5.4.10. Comparison of Spending to the National Strategic Framework 2010 – 2016

The Second Botswana National Strategic Framework (NSF) 2010-2016 was not costed for its early years of implementation. What is costed is the operationalized Botswana National Operational Plan (NOP) for HIV and AIDS 2012-2016. Thus, there are no resource needs estimates for the NSF period following within the current NASA which can be compared to the actual HIV and AIDS spending.

An attempt was made to compare the current spending priorities per the NASA against the NOP spending priorities. A challenge in carrying out that comparison was that the spending needs per the NOP were estimated according to four (4) priority arrears, which are not in line with the NASA spending categories. Thus some activities costed in one NOP priority area might cut across a number of NASA spending categories. An example is orphan care, which has its own separate spending category in the NASA but is included under priority area 4; treatment, care and support in the NOP. Also some of the NASA spending activities, like hospital and clinics patient care and HIV and AIDS related research are not included in the activities for the NOP 2012-2016.

Thus, for an effective comparison to be made the following was done to the NASA figures:

- Spending on hospital and clinics patient care was removed
- Orphan care was added with treatment and care
- The NASA spending categories of programme management and administration, Human resources and Human and legal rights activities were added together for comparison with NOP priority areas 2 and 3 (systems strengthening and strategic information management)

Table 5.10 below shows the adjusted NASA figure (after deducting patient care) per NOP classifications and table 5.11 is taken from the NOP 2012-16

The adjusted NASA figures per table 5.10 shows that 21% was spent on prevention between 2009/10 and 2011/12, 55% was spent on treatment, care and support , 19% on systems strengthening and strategic information management and 4% on HIV and AIDS related research which is not in the NOP. This is against the NOP 2012-2016 estimated resource needs proportion of 10% on prevention, 88% on treatment, care and support and 2% on systems strengthening and strategic information management. The high estimated resource needs for treatment, care and support in the NOP is a result of the high estimate for Orphan Care which makes up 64% of the estimated resources needed for treatment, care and support.

Comparison of NASA with the NOP also shows that the country spent more money per year on prevention, systems strengthening and strategic information management than the estimated future needs for these interventions. This suggests that prevention could be currently absorbing more financial resources than needed, maybe through implementation of high cost but less effective interventions than envisaged in the NOP.

Table 5. 10 : Adjusted NASA 2009/10-2011/12 (Without Patient Care) PER NOP Priority Areas

NOP Priority Areas	2009/10 Millions	2010/11 BWP	2011/12 BWP	Totals BWP
	396.09	Millions	Millions	Millions
Priority 1: Prevention of New HIV Infections	246.02	380.81	257.50	1,034
Priority 2 and 3: Systems Strengthening & Strategic Information Management	866.01	344.06	346.16	936
Priority 4: Treatment, Care and Support	16.22	899.95	893.02	2,659
HIV/AIDS Research	**1,524**	70.21	109.38	196
GRAND TOTAL (All 4 Priority Areas)				

Table 5. 11 : HIV and AIDS Resource Needs Estimates 2012/13 to 2015/16

	2012/13 BWP Millions	2013/14 BWP Millions	2014/15 BWP Millions	2015/16 BWP Millions	Total Cost Pula Millions
Priority 1: Prevention of New HIV Infections	256	257	212	201	926
Priority 2: Systems Strengthening	11	20	11	15	56
Priority 3: Strategic Information Management	35	15	8	41	99
Priority 4: Treatment, Care and Support	2,125	2,179	2,198	2,155	8,657
Grand-Total (All 4 Priority Areas)	**2,427**	**2,471**	**2,428**	**2,412**	**9,738**

Source: National Operational Plan for HIV and AIDS 2012-2016

6. HIV Funding Processes, Reporting Requirements and Financial Systems in Botswana

6.1. Public Sector Funding Channels

NACA coordinates all HIV activities funded using public funds. At the beginning of each financial year, Government ministries through their Planning Units submits project memorandum (proposals) to NACA requesting funding. NACA reviews the proposals and then submits them to the Office of the President for onward forwarding to the Ministry of Finance and Development Planning (MFDP). MFDP either approves, adjust or reject the memorandum. NACA then accesses the approved funds from the MFDP, through the Office of the President and transfers these to the implementing ministries in line with approved project memorandum. NACA reports to the MFDP through the Office of the President on funds disbursed and project implementation.

NACA also coordinates all funding from international sources or development partners that are channelled through the government. The principal recipient is the Ministry of Finance and Development Planning (MFDP). These funds follow the government procedures except that no project proposals are sent to MFDP but only request for warrants.

District level Funding
Irrespective of the source of funding, programs undertaken at the district level are routed through the Ministry of Local Government (MLG) from NACA. There are two channels that districts use to access these funds.

- District councils – NACA gives finance warrants to the MLG. The MLG pays over the money to the districts that then use their accounting system to procure supplies and services.
- District AIDS Coordinating offices (DACs) – NACA gives finance warrants to the MLG. Only letters of authority are issued to the districts by the MLG. The districts then make their payments through the GABS system (centralised government accounting system).

These district funds are for programs like PMTCT, OVC care, Isoniazid preventive therapy (IPT) activities and Community Home Based care (CHBC).

Public Entities Accounting Systems
All entities receiving funds for HIV and AIDS have to maintain a separate ledger for each program. In this way spending on each program/activity can be monitored. With all public ministries implementing workplace wellness programs funded through NACA, all ministries therefore receive some HIV/AIDS funding that have to be accounted for in the NASA.

At ministerial level, letters of authority are issued to the implementing units or departments and payment is done through the Government Accounting and Budgeting System GABS. Spending is controlled by program coordinators who also have the program reporting responsibilities.

At the Districts level, treasury officers have to maintain separate computerised ledgers for each program. However in some districts, program funds are mixed up in one ledger, making it difficult for program managers to access the funds and monitor spending on the program for which they in charge.

Public Health Care Activities Funding Processes

In Botswana healthcare is delivered through a decentralised system with primary health care being the pillar of the delivery system. Botswana has an extensive network of health facilities (hospitals, clinics, health posts, mobile stops) clustered in twenty four (24) health districts[22]. The health services are under the management of the Ministry of Health (MOH) which oversees all the hospitals (referral, districts and primary) and the Ministry of Local Government (MLG), which is in charge of clinics, health posts and mobile stops.

- **Public Hospital Funding Activities and Processes**

  The funding for the core activities of hospitals is by the government, through the Ministry of Health. All drugs are purchased centrally, through the Central Medical Stores (CMS), which is part of Ministry of Health. Laboratory reagents are procured through the National Health Laboratory (NHL), which is a department of the Ministry of Health. Donors such as ACHAP have in the past also provided some financial support, in particular, funding IDCCs and Resources centres.

  Hospitals services can broadly be classified into inpatient and outpatient care and treatment. Chapter 2 explains in detail how treatment relating to HIV and AIDS has been arrived at for inclusion in the NASA.

  Hospitals produce monthly reports of patient numbers and drugs and annually produce a report of activities for submission to the MOH. They do not produce financial report, as the financials are consolidated and produced at the Ministry level. They do maintain some form of ledgers for their direct running expenses.

  Up to the beginning of the financial year 2010/11, primary health care (clinics) was funded by the government through the MLG. They have since been integrated into the Ministry of Health's department of clinical services and funded and operated like the hospitals.

  Hospitals and clinics order all drugs/medicine from Central Medical Stores (CMS).

6.2. NGO Funding Processes

The NGOs operating in Botswana are Not for Profit institutions receiving funding from a wide spectrum of donors like USAID, PEPFAR (through CDC, USAID and DoD), ACHAP, EU, Forum Syd, governments of Netherland and Canada, Global Fund and the Government of Botswana.

NGOs normally go through the process of tendering for international donor funds once program announcements are made by the donor organisations. They thus receive direct funding from donors for their programs. Donors have various ways of transferring funds to the NGOs. Disbursements can be either monthly or quarterly based on the cash flow projections. The NGOs working with sub-grantees (other NGOs or community organisations) have to work with these sub-grantees in ensuring they produce information in the format that can be easily consolidated for donor reporting.

Donor organisations request progress reports at various intervals. These reports can be quarterly or annual and consist of both narrative and financial reports. Reporting requirements vary between donor organisations.

[22] Botswana Health Statistics Report 2005 – Central Statistics Office.

NGOs receiving funding from the government have to submit proposals which go through the government funding approval procedures noted above.

Challenges faced by NGOs

A long standing challenge remains the fact that many NGOs have poor management capacity, especially financial. Although clear reporting guidelines are provided, many NGOs cannot report accurately and timely on their expenditure. Since many donors are reluctant to pay salaries, NGOs are forced to employ persons of limited skills. Efforts to build capacity in financial systems are undermined by the high rate of staff turn-over. The problem of high staff-turnover is not limited to the NGO sector, but is also prevalent in the public sector. With each donor having its own financial report format and cycle, this calls for versatile financial management skills which are usually lacking in most of the organisations. A heavy burden is then placed on the limited financial management resources available, leading to late reporting and poor quality reports, causing delays in disbursements which ultimately affect the delivery of the projects and the absorption of the available funds.

Many NGOs struggle to fund their administrative functions as donors are only interested in funding those functions that directly impact their programs. This also affects the quality of administration staff that organizations can afford.

Funding from the government in particular takes time to be made available to the NGOs, as the process of approving funding is slow. This frustrates the efforts of the organizations in delivering service.

Spending rules vary between donor organizations and funds also come in with restrictions on the extent to which expenses can be realigned.

6.3. External Sources of Funding – Development Partners in Botswana

The key development partners (DPs) for HIV and AIDS activities in Botswana are PEPFAR, ACHAP and Global Fund. The UN Agencies also make differing contributions, primarily in providing technical support. Other smaller donors include Forum Syd, SIDA, DFID, government of the Netherlands and others.

Development Partners Funding Channels

The Ministry of Finance and Development Planning (MFDP) is the principal recipient for all donor funds granted for the implementation of HIV/AIDS programmes in the public sector. These grants may be transferred to the Government of Botswana (GoB) as an advance before programme implementation or as a reimbursement to the Botswana Government after programme implementation. NACA accesses all these funds and disburses the money to implementers (mainly MOH and MLG) according to their budgets, work plans and other agreed procedures. In return, NACA on behalf of the government of Botswana is expected to report back to donors in the form of periodic financial and narrative progress reports on funds disbursed and programme implementation. The reporting format may differ from one donor to another. All the donor funded projects are implemented in accordance with the signed Memoranda of Agreements between the donor and the MFDP (on behalf of the GoB), the project document and the annual work plans.

Development Partners reporting requirements

Each DP requires different reporting formats and styles, and regular expenditure reports which must be submitted before further transfers will be made. These differing

requirements place great burden on the recipients, in some cases, requiring specific financial officers just to attend to that DP's funds. Overall, the reporting data regarding donor fund expenditure are better than those for public expenditure.

Bottlenecks and Challenges in the DP Financing Systems
It was noted that the reporting requirements can delay requests for funding, which may hinder project implementation. Delays in transfers can cause projects receiving the funds late in the implementation cycle, which either leads to under-spending or 'dumping' where the recipients try to spend funds quickly, resulting in inefficient spending or that spending may not be according to the project proposal.

Challenges of the DP Data
Though recipients of DP funds have to report regularly, the records from the DPs tend to show only commitments and transfers. These usually do not equate to actual expenditure by either the recipient public services providers or the NGOs. This results in an *overestimation* of the actual spending in the country, *from the perspective of the DP,* who may argue that they have contributed more than the NASA reports.

6.4. UN Agencies Funding Processes

The UN agencies are in the main not implementing agencies but operate in Botswana through their implementing partners. Their partners are primarily government ministries and departments, and a few NGOs.

UN Funding Channels
UNAIDS, UNICEF, UNDP, UNFPA and WHO work closely with the government in determining their strategic plans and areas of prioritisation, so as to fit with the country priorities. Based on agreed programs and work plans, relevant government departments make requisitions to UN agencies who then disburse the funds, usually on a quarterly basis.

In addition, government departments also request more direct payments for specific services or goods, such as workshops, meetings, technical assistants, etc., where the UN agency or WHO will pay directly to the service providers. This avoids the bureaucracy of the government systems.

UN Recipient Reporting Requirements
The recipient department is required to submit quarterly expenditure reports directly to the UN agency, and copied to MLG or MoH and MFDP, before additional tranches will be processed. In addition, annual reports are required indicating the achievements and difficulties, as well as ensuring that progress is aligned to the strategic plan.

Quarterly review meetings are also held to monitor progress, as well as a final annual review meeting. Efforts are made to ensure sustainability of projects, and integration between government departments.

Bottlenecks and Challenges in the UN Financing Systems
The process of disbursement from UN agencies can take some time, since the cheque must be issued to the Government of Botswana, it goes first to the Ministry of Finance and Development Planning (MFDP), then copied to the relevant Ministry so that the ministry can request the funds.

Another key challenge is the different financial years of government (March to February) and the UN agencies (January to December). This means that as the UN is

closing accounts and slowing down, the government is going into their third quarter and usually the busiest in terms of expenditure and implementation. This often reflects as under-spending of the UN commitments in their end-of-year reports, because the bulk of expenditure will happen in the final quarter of government's year (i.e. the first quarter of the next calendar year).

7. RECOMMENDATIONS AND CONCLUSION

7.1. Recommendations

This chapter presents recommendations which flows from the findings made during the NASA process.

7.1.1. Sustainability of HIV and AIDS Funding

The government of Botswana is increasing funding most of the HIV and AIDS response. With Botswana's economy heavily dependent on mining, any poor performance of the sector would impact heavily on the availability of financial resources to fund HIV and AIDS programs. There is thus a need to develop innovative ways to increase domestic private sector and external sources of funding. However, with generally dwindling international funding sources, there is also need to improve value for money through focusing on cost effective interventions in a more efficient manner (avoiding unnecessary spending).

7.1.2. HIV Spending Priorities

As per the NSF 2010-16, prevention of HIV infection is a priority. NASA cannot measure the effectiveness of the prevention interventions as it is an expenditure report. Also, just by looking at the proportion of funds spent on the various interventions does not necessarily communicate the actual prioritisation of interventions.

However, the results of the NASA show a reduction in spending on prevention activities between 2009/10 and 2011/12 by both the government and the international donors. Going forward it is important for Botswana to ensure that the prevention activities are adequately resourced.

7.1.3. Improved financial information systems

There is the need to improve the financial information system in terms of the quality and accuracy of HIV/AIDS expenditure data. In some institutions, retrieval of the required information was difficult. Non-retrieval of some information led to some of the institutions providing incomplete information, while slow retrieval of information delayed the data collection phase.

7.1.4. Spending on most at risk populations

Spending on the most at risk populations (MARPs) such as for commercial sex workers (CSWs) and men who have sex with men (MSM) was hardly reported. The NASA findings suggest that less priority is being given to interventions targeting these most at risk populations. There is a need to look at the adequacy of interventions and funding for these populations.

7.1.5. Institutionalisation of NASA

The Botswana NASA reports have covered three financial years each. The usefulness of any information for decision making purposes is based on its timely production. Thus for policy and decision makers to make appropriate use of the NASA findings, it ideally should be undertaken regularly (annually). This is possible if NASA is institutionalised within the Monitoring and Evaluation (M&E) framework. Reporting of NASA information can be integrated with the existing mechanism within the M&E framework. However, these processes require standardization of expenditure reporting from all the various organizations.

NACA can design simple forms that implementers can use to make returns on a quarterly basis, together with other quarterly M&E indicators. This can be done through the adaptation of the UNAIDS designed forms used for the current NASA. In addition NACA could designate a specific office for the purpose of regular collection and analysis of the data.

7.1.6. Statistics for HIV patients' utilisation of hospital and clinic services

Like in the previous NASA studies, the estimation of spending at the hospitals and clinics attributable to HIV/AIDS was a challenge and will remain so for future NASA exercises. The basis used to allocate the patient care costs to HIV/AIDS is the ratio of HIV/AIDS patients to the overall number of patients seeking treatment. With the health statistics reports only reporting the disease diagnosis and leaving out HIV co – infections, there is need for a regular study of patients using hospitals and clinics services because of complications relating to HIV/AIDS. This will provide a better basis for the allocation of patient care spending.

7.1.7. Unit Costs of Services

In general there is need to develop and maintain a data base of the unit costs for the various HIV/AIDS activities implemented in the country. This would require a regular study and compilation of the various unit costs. The unit costs would help not only with the NASA estimations but with costing of strategic and operational plans and also for making international comparisons.

7.2. Conclusion

As the burden of financing HIV and AIDS continues to grow, Botswana spent P7,581 billion between 2009/10 and 2011/12. Year on year, spending on HIV and AIDS grew by 12% from P2,272 billion in 2009/10 to P2,544 billion in 2010/11 and by a further 9% to P2,765 billion in 2011/12. Overall the government of Botswana spent P5,014 billion, international funding sources P2,413 billion and the private business sector P155 million). The government of Botswana is increasingly funding most of the HIV and AIDS interventions in the country with close to 70% (P1,924 billion)of spending on HIV and AIDS in 2011/12 coming from central government resources. In the same year, international or external sources funded 28% (P788 million) and the domestic private sector funded 2% (P54 million).

Most of the money was spent on treatment and care at P4,217 billion, followed by orphan care at P1,198 billion, and prevention at P1, 034billion, program management and administration at P776million. The rest of the money was spent on human resources, human and legal rights and HIV and AIDS related research (P356 million).

The sustainability of the HIV and AIDS funding is dependent on the ability of the country to raise more funds from the domestic private sector and external sources of funding while also improving value for money through focusing on cost effective interventions and implementing activities in a more efficient manner

The current and previous NASA exercises undertaken for Botswana has highlighted the need for the institutionalisation of the NASA process. This would allow information to be collected on a more regular basis, making it timely available, for analysis and decision making.

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APPENDICES

Appendix 1: Exchange Rates

USD Exchange Rates for Conversion of Foreign Currency Denominated Expenditure

EXCHANGE RATES: US DOLLAR PER PULA - AVERAGES		EXCHANGE RATES: PULA PER US DOLLAR - AVERAGES
Period	US dollar	Pula
Jan 1 to Dec 31, 2009	0.1405	7.1174
Jan 1 to Dec 31, 2010	0.1473	6.7889
Jan 1 to Dec 31, 2011	0.1467	6.8166
Oct 1, 2008 - Sept 30, 2009	0.1384	7.2254
Oct 1, 2009 - Sept 30, 2010	0.1470	6.8027
Oct 1, 2010 - Sept 30, 2011	0.1496	6.6845
July 1, 2008 - June 30, 2009	0.1338	7.4738
July 1, 2009 - June 30, 2010	0.1469	6.8074
July 1, 2010 - June 30, 2011	0.1505	6.6445
April 1, 2009 - Mar 31, 2010	0.1457	6.8634
April 1, 2010 - Mar 31, 2011	0.1481	6.7522
April 1, 2011 - Mar 31, 2012	0.1444	6.9252

Source: Bank of Botswana

Appendix 2a: HIV Spending Activities by Beneficiary Populations 2009/10

Activities	PLWHA	MARPs	OVCs & Vuln. Pops	Accessible Pops.	General Pop.	Non-targeted	Specific targeted populations not elsewhere classified (n.e.c.)	Totals
Prevention	5,015,617	-	64,918,896	118,148,490	207,340,033	-	666,240	396,089,276
Treatment & Care	1,227,112,763	-	1,615,440	-	3,418,739	-	-	1,232,146,942
OVC Support	-	-	381,582,302	-	-	-	-	381,582,302
Programme Mgmt	298,931	-	101,179	11,614	108,886	234,457,536	-	234,978,146
Human Resource	-	-	60,707	7,276,799	-	987,355	215,489	8,540,350
Social protection	-	-	-	-	-	-	-	-
Enabling Environmt	12,307	-	549,072	-	334,030	1,434,560	175,877	2,505,846
Research	-	-	-	552,730	1,809,229	13,854,173	-	16,216,132
Totals	**1,232,439,618**	**-**	**448,827,596**	**125,989,633**	**213,010,917**	**250,733,624**	**1,057,606**	**2,272,058,994**

Appendix 2b: HIV Spending Activities by Beneficiary Populations 2010/11

Activities	PLWHA	MARPs	OVC & Vuln.Pops	Access. Pops.	General Pop.	Non-Targeted	Specific targeted populations not elsewhere classified (n.e.c.)	Totals
Prevention	1,887,476	10,864	82,065,025	94,500,493	199,538,464	-	2,807,928	378,002,322
Treatment & Care	1,324,871,861	-	3,961,038	-	947,791	-	-	1,329,780,690
OVC Support	-	-	419,038,444	-	-	-	-	419,038,444
Programme Mgmt	525,683	-	112,575	-	1,851,948	255,923,919	-	258,414,125
Human Resource Dvpt.	157,236	-	-	83,121,891	-	320,559	179,036	83,599,686
Social protection	-	-	-	-	-	-	-	-
Enabling Environmt	7,560	57,729	900,000	-	145,196	732,753	25,055	1,843,238
Research	12,188,287	-	-	472,594	-	57,552,059	-	70,212,940
Totals	**1,339,638,103**	**68,593**	**506,077,082**	**178,094,978**	**202,483,399**	**314,529,290**	**3,012,019**	**2,543,903,464**

Appendix 2c: HIV Spending Activities by Beneficiary Populations 2011/12

Activities	PLWHA	MARPs	OVC & Vuln.Pops	Access. Pops.	General Pop.	Non-Targeted	Specific targeted populations not elsewhere classified (n.e.c.)	Totals
Prevention	275,106	-	51,411,351	31,321,562	173,719,368	-	771,402	256,727,387
Treatment & Care	1,654,119,727	-	585,326	-	577,585	-	-	1,655,282,638
OVC Support	788,755	-	396,371,516	-	-	-	-	397,160,271
Programme Mgmt.	463,959	-	56,749	-	5,362,891	276,643,990	-	282,527,589
Human Resource Dvpt.	85,373	-	249,533	57,895,542	47,055	254,039	37,573	58,531,542
Social protection	-	-	-	-	-	-	-	-
Enabling Environmt	177,662	68,289	780,000	-	3,404,259	608,198	24,475	5,038,408
Research	-	21,577	-	-	713,972	108,639,876	-	109,375,425
Totals	1,655,910,582	89,866	449,454,475	89,217,104	183,825,130	386,146,103	833,450	**2,765,476,710**

Appendix 3a: Botswana AIDS Spending Categories and Sources of Funding 2009/10

Currency : BWP Millions

	Public funds				Private Funds	International funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.01 Prevention												
ASC.01.01 Communication for social and behavioural change	3.98	0.42	-	4.39	0.01	6.96	2.80	1.75	-	-	11.51	15.91
ASC.01.02 Community mobilization	10.15	12.28	-	22.44	0.57	39.73	5.19	3.58	-	1.11	49.60	72.61
ASC.01.03 Voluntary counselling and testing (VCT)	17.29	-	-	17.29	-	36.19	-	0.96	-	-	37.14	54.43
ASC.01.04 Risk-reduction for vulnerable and accessible populations	8.30	-	-	8.30	-	-	-	-	-	-	-	8.30
ASC.01.05 Prevention – youth in school	0.49	0.29	-	0.78	0.30	90.53	-	4.43	-	-	94.96	96.04
ASC.01.06 Prevention – youth out-of-school	-	-	-	-	-	-	-	3.70	-	-	3.70	3.70
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)	-	-	-	-	-	3.40	-	-	-	-	3.40	3.40
ASC.01.11 Prevention programmes in the workplace	16.16	0.24	-	16.39	-	5.41	-	-	-	-	5.41	21.81
ASC.01.13 Public and commercial sector male condom provision	-	1.57	-	1.57	-	9.15	0.40	-	-	-	9.55	11.12
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	-	-	-	-	-	3.19	-	-	-	-	3.19	3.19
ASC.01.17 Prevention of mother-to-child transmission (PMTCT)	29.36	9.68	-	39.03	-	11.35	0.90	1.20	-	-	13.45	52.49
ASC.01.18 Male circumcision	-	-	-	-	-	9.37	-	0.38	-	-	9.75	9.75

	Public funds				Private Funds	International funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.01.19 Blood safety	-	-	-	-	-	7.17	-	0.21	-	-	7.38	7.38
ASC.01.20 Safe medical injections	-	-	-	-	-	7.04	-	-	-	-	7.04	7.04
ASC.01.98 Prevention activities not disaggregated by intervention	12.14	-	-	12.14	-	14.96	1.82	-	-	-	16.78	28.92
ASC.01 Prevention Total	97.87	24.47	-	122.34	0.87	244.44	11.12	16.21	-	1.11	272.88	396.09
	-	-	-	-	-	-	-	-	-	-	-	-
ASC.02 Care and treatment												
ASC.02.01 Outpatient care												
ASC.02.01.03 Antiretroviral therapy	41.20	20.94	11.75	73.89	43.31	87.27	-	160.18	-	-	247.45	364.65
ASC.02.01.04 Nutritional support associated to ARV therapy	-	-	-	-	-	1.34	-	-	-	-	1.34	1.34
ASC.02.01.05 Specific HIV-related laboratory monitoring	55.29	-	2.44	57.73	5.45	7.96	-	-	-	-	7.96	71.14
ASC.02.01.07 Psychological treatment and support services	1.22	-	-	1.22	-	-	-	-	-	-	-	1.22
ASC.02.01.09 Home-based care	29.62	-	-	29.62	0.20	2.66	-	-	-	-	2.66	32.48
ASC.02.01.98 Outpatient care services not disaggregated by intervention	464.38	-	-	464.38	-	-	-	-	-	-	-	464.38
ASC.02.02 Inpatient care												
ASC.02.02.98 Inpatient care services not disaggregated by intervention	283.34	-	-	283.34	-	-	-	-	-	-	-	283.34

	Public funds				Private Funds	International funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.02.98 Care and treatment services not disaggregated by intervention	-	-	-	-	-	11.39	-	-	-	-	11.39	11.39
ASC.02.99 Care and treatment services n.e.c.	-	-	-	-	-	2.19	-	-	-	-	2.19	2.19
ASC.02 Care and treatment Total	875.05	20.94	14.20	910.19	48.97	112.81	-	160.18	-	-	272.99	1,232.15
ASC.03 Orphans and vulnerable children (OVC)												
ASC.03.03 OVC Family/home support	0.03	-	-	0.03	-	0.37	-	-	0.05	-	0.43	0.46
ASC.03.04 OVC Community support	-	-	-	-	-	-	-	2.60	-	-	2.60	2.60
ASC.03.06 OVC Institutional care	-	-	-	-	-	-	1.89	-	-	-	1.89	1.89
ASC.03.98 OVC Services not disaggregated by intervention	366.54	-	-	366.54	-	9.89	0.12	0.09	-	-	10.10	376.64
ASC.03.99 OVC services n.e.c.	0.00	-	-	0.00	-	-	-	-	-	-	-	0.00
ASC.03 Orphans and vulnerable children (OVC) Total	366.57	-	-	366.57	-	10.26	2.01	2.69	0.05	-	15.02	381.58
ASC.04 Programme management and administration												
ASC.04.01 Planning, coordination and programme management	16.49	4.01	-	20.49	-	21.42	4.20	1.70	-	-	27.32	47.82
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds Total	18.99	-	-	18.99	-	70.58	-	-	-	0.97	71.55	90.54

	Public funds				Private Funds	International funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.04.03 Monitoring and evaluation	-	-	-	-	0.83	3.58	-	0.06	-	-	3.64	4.47
ASC.04.04 Operations research	-	-	-	-	-	-	0.76	-	-	-	0.76	0.76
ASC.04.05 Serological-surveillance (serosurveillance)	4.62	-	-	4.62	-	0.23	-	-	-	-	0.23	4.85
ASC.04.06 HIV drug-resistance surveillance	-	-	-	-	-	-	-	0.30	-	-	0.30	0.30
ASC.04.08 Information technology	0.15	-	-	0.15	-	-	0.10	-	-	-	0.10	0.25
ASC.04.10 Upgrading and construction of infrastructure	0.00	-	-	0.00	-	14.73	-	1.83	-	-	16.56	16.56
ASC.04.98 Programme management and administration not disaggregated by type	0.52	-	-	0.52	-	35.89	-	33.02	-	-	68.91	69.44
ASC.04 Programme management and administration Total	40.76	4.01	-	44.77	0.83	146.43	5.06	36.91	-	0.97	189.38	234.98
ASC.05 Human resources												
ASC.05.03 Training	0.63	-	-	0.63	-	7.57	0.34	-	-	-	7.92	8.54
ASC.05 Human resources Total	0.63	-	-	0.63	-	7.57	0.34	-	-	-	7.92	8.54
ASC.07 Enabling environment												
ASC.07.01 Advocacy	-	-	-	-	-	0.21	-	0.15	-	-	0.36	0.36
ASC.07.02 Human rights programmes	-	-	-	-	-	1.13	-	0.23	-	-	1.35	1.35
ASC.07.03 AIDS-specific institutional development	-	-	-	-	-	0.71	-	0.09	-	-	0.79	0.79

	Public funds				Private Funds	International funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.07 Enabling environment Total	-	-	-	-	-	2.04	-	0.46	-	-	2.51	2.51
ASC.08 HIV and AIDS-related research (excluding operations research)												
ASC.08.02 Clinical research	-	-	-	-	-	8.80	-	3.17	-	-	11.97	11.97
ASC.08.03 Epidemiological research	-	-	-	-	-	3.50	-	-	-	-	3.50	3.50
ASC.08.04 Social science research	-	-	-	-	-	0.55	-	-	-	-	0.55	0.55
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	-	0.06	-	0.06	-	0.01	-	0.13	-	-	0.14	0.19
ASC.08 HIV and AIDS-related research (excluding operations research) Total	-	0.06	-	0.06	-	12.86	-	3.30	-	-	16.16	16.22
Grand Total	1,380.87	49.47	14.20	1,444.54	50.67	536.42	18.54	219.74	0.05	2.08	776.85	2,272.06

Appendix 3b: Botswana AIDS Spending Categories and Sources of Funding 2010/11

Currency: BWP Millions

	Public funds					Private Funds	International Funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.01 Prevention													
ASC.01.01 Communication for social and behavioural change	2.20	0.60	-	-	2.80	-	7.61	2.39	0.13	-	-	10.14	12.94
ASC.01.02 Community mobilization Total	11.03	19.39	-	0.11	30.53	0.55	31.60	2.52	3.58	-	-	37.69	68.77
ASC.01.03 Voluntary counselling and testing (VCT)	16.59	-	-	-	16.59	-	43.25	-	-	-	-	43.25	59.84
ASC.01.04 Risk-reduction for vulnerable and accessible populations	1.20	3.89	-	-	5.09	-	-	-	-	-	-	-	5.09
ASC.01.05 Prevention – youth in school	0.02	4.49	-	-	4.52	0.27	69.11	-	2.68	-	-	71.79	76.58
ASC.01.06 Prevention – youth out-of-school	0.01	-	-	-	0.01	-	-	-	2.11	-	-	2.11	2.12
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV (PLHIV)	-	-	-	-	-	-	1.74	-	-	-	-	1.74	1.74
ASC.01.11 Prevention programmes in the workplace	6.57	1.66	-	-	8.23	-	5.01	-	-	-	-	5.01	13.24
ASC.01.12 Condom social marketing	0.01	-	-	-	0.01	-	-	-	-	-	-	-	0.01
ASC.01.13 Public and commercial sector male condom provision	-	-	-	-	-	-	8.73	-	-	-	-	8.73	8.73
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	-	-	-	-	-	-	0.82	-	-	-	-	0.82	0.82
ASC.01.17 Prevention of mother-to-child transmission (PMTCT) Total	58.39	-	-	-	58.39	-	8.96	0.68	-	-	-	9.64	68.03
ASC.01.18 Male circumcision	2.08	-	-	-	2.08	-	16.75	-	4.33	-	-	21.08	23.17

	Public funds					Private Funds	International Funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.01.19 Blood safety	-	-	-	-	-	-	3.63	-	-	-	-	3.63	3.63
ASC.01.20 Safe medical injections	-	-	-	-	-	-	4.17	-	-	-	-	4.17	4.17
ASC.01.22 Post-exposure prophylaxis (PEP)	-	0.03	-	-	0.03	-	-	-	-	-	-	-	0.03
ASC.01.98 Prevention activities not disaggregated by intervention	8.31	0.31	-	-	8.62	-	23.03	0.27	-	-	-	23.30	31.93
ASC.01 Prevention Total	106.41	30.38	-	0.11	136.90	0.82	224.40	5.86	12.83	-	-	243.09	380.81
ASC.02 Care and treatment													
ASC.02.01 Outpatient care													
ASC.02.01.03 Antiretroviral therapy	82.15	-	10.98	-	93.13	41.47	46.67	-	164.71	-	-	211.38	345.99
ASC.02.01.04 Nutritional support associated to ARV therapy	-	-	-	-	-	-	1.48	-	-	-	-	1.48	1.48
ASC.02.01.05 Specific HIV-related laboratory monitoring	62.34	-	3.12	-	65.46	6.44	24.35	-	-	-	-	24.35	96.25
ASC.02.01.07 Psychological treatment and support services	0.95	-	-	-	0.95	-	-	-	-	-	-	-	0.95
ASC.02.01.09 Home-based care	22.68	-	-	-	22.68	0.30	3.06	-	-	-	-	3.06	26.04
ASC.02.01.98 Outpatient care services not disaggregated by intervention	479.52	-	-	-	479.52	-	-	-	-	-	-	-	479.52
	-	-	-	-	-	-	-	-	-	-	-	-	-
ASC.02.02 Inpatient care	-	-	-	-	-	-	-	-	-	-	-	-	369.34
ASC.02.98 Care and treatment services not disaggregated by intervention	369.34	-	-	-	369.34	-	-	-	-	-	-	-	-

	Public funds					Private Funds	International Funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.02.98 Care and treatment services not disaggregated by intervention	-	-	-	-	-	-	10.11	-	-	-	-	10.11	10.11
ASC.02.99 Care and treatment services n.e.c.	-	-	-	-	-	-	0.10	-	-	-	-	0.10	0.10
ASC.02 Care and treatment Total	1,016.99	-	14.10	-	1,031.08	48.21	85.78	-	164.71	-	-	250.48	1,329.78
ASC.03 Orphans and vulnerable children (OVC)													
ASC.03.03 OVC Family/home support	0.01	-	-	-	0.01	-	0.03	0.28	-	0.05	-	0.36	0.37
ASC.03.04 OVC Community support	-	-	-	-	-	-	-	-	1.56	-	-	1.56	1.56
ASC.03.06 OVC Institutional care	-	-	-	-	-	-	-	0.95	-	-	-	0.95	0.95
ASC.03.98 OVC Services not disaggregated by intervention	408.96	-	-	-	408.96	-	6.75	0.10	0.34	-	-	7.20	416.16
ASC.03 Orphans and vulnerable children (OVC) Total	408.97	-	-	-	408.97	-	6.78	1.34	1.90	0.05	-	10.07	419.04
ASC.04 Programme management and administration													
ASC.04.01 Planning, coordination and programme management	16.48	17.56	-	-	34.04	-	17.53	5.35	13.41	-	-	36.29	70.33
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	19.35	-	-	-	19.35	-	71.71	-	-	-	0.57	72.27	91.63
ASC.04.03 Monitoring and evaluation	0.02	-	-	-	0.02	1.14	6.12	0.13	5.56	0.15	-	11.95	13.11
ASC.04.04 Operations research	-	-	-	-	-	-	-	0.07	-	-	-	0.07	0.07

	Public funds					Private Funds	International Funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.04.05 Serological-surveillance (serosurveillance)	0.46	-	-	-	0.46	-	2.29	-	-	-	-	2.29	2.75
ASC.04.06 HIV drug-resistance surveillance	-	-	-	-	-	-	-	-	0.06	-	-	0.06	0.06
ASC.04.07 Drug supply systems	-	1.73	-	-	1.73	-	-	0.59	-	-	-	0.59	2.32
ASC.04.08 Information technology	-	-	-	-	-	-	-	0.13	-	-	-	0.13	0.13
ASC.04.10 Upgrading and construction of infrastructure	9.03	-	-	-	9.03	-	6.01	-	-	-	-	6.01	15.05
ASC.04.98 Programme management and administration not disaggregated by type	-	0.13	-	-	0.13	-	43.57	-	18.09	-	-	61.65	61.78
ASC.04.99 Programme management and administration n.e.c	-	-	-	-	-	-	0.47	0.72	-	-	-	1.19	1.19
ASC.04 Programme management and administration Total	45.35	19.42	-	-	64.77	1.14	147.69	6.99	37.11	0.15	0.57	192.50	258.41
ASC.05 Human resources													
ASC.05.03 Training	0.11	1.00	-	-	1.11	-	75.39	0.77	6.20	0.31	-	82.67	83.78
ASC.05 Human resources Total	0.11	1.00	-	-	1.11	-	75.39	0.77	6.20	0.31	-	82.67	83.78
ASC.07 Enabling environment													
ASC.07.01 Advocacy	-	-	-	-	-	-	0.19	-	0.04	-	-	0.23	0.23
ASC.07.02 Human rights programmes	0.90	-	-	-	0.90	-	0.09	-	0.08	-	-	0.17	1.07
ASC.07.03 AIDS-specific institutional development	-	-	-	-	-	-	0.44	-	0.08	-	-	0.52	0.52

	Public funds					Private Funds	International Funds						Grand Total
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions	Multilateral Agencies	International not-for-profit organizations and foundations	International for profit organizations	International funds n.e.c.	International funds Total	
ASC.07.05 Programmes to reduce Gender Based Violence	0.00	-	-	-	0.00	0.05	-	-	-	-	-	-	0.05
ASC.07 Enabling environment Total	0.90	-	-	-	0.90	0.05	0.73	-	0.19	-	-	0.91	1.87
ASC.08 HIV and AIDS-related research (excluding operations research)													
ASC.08.02 Clinical research	-	-	-	-	-	-	44.43	0.85	6.24	1.36	-	52.88	52.88
ASC.08.03 Epidemiological research	-	-	-	-	-	-	10.50	-	-	-	-	10.50	10.50
ASC.08.04 Social science research	-	-	-	-	-	-	2.58	-	-	-	-	2.58	2.58
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	1.32	-	-	-	1.32	-	2.55	-	0.39	-	-	2.93	4.25
ASC.08 HIV and AIDS-related research (excluding operations research) Total	1.32	-	-	-	1.32	-	60.06	0.85	6.63	1.36	-	68.89	70.21
Grand Total	1,580.06	50.80	14.10	0.11	1,645.06	50.22	600.82	15.80	229.57	1.86	0.57	848.62	2,543.90

Appendix 3c: Botswana AIDS Spending Categories and Sources of Funding 2011/12

Currency: BWP Millions

	Public funds					Private Funds	International Fund					
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions Total	Multilateral Agencies (ii) Total	International not-for-profit organizations and foundations Total	International for profit organizations	International funds Total	Grand Total
ASC.01 Prevention												
ASC.01.01 Communication for social and behavioural change	1.52	0.12	-	-	1.64	0.02	3.43	1.56	0.02	-	5.02	6.67
ASC.01.02 Community mobilization	9.14	32.86	-	0.25	42.26	0.08	20.11	2.09	1.89	0.21	24.30	66.64
ASC.01.03 Voluntary counselling and testing (VCT)	8.10	-	-	-	8.10	-	28.68	-	-	-	28.68	36.78
ASC.01.04 Risk-reduction for vulnerable and accessible populations	0.41	2.19	-	-	2.60	-	-	-	-	-	-	2.60
ASC.01.05 Prevention – youth in school	-	6.36	-	-	6.36	0.31	7.33	-	1.53	-	8.86	15.53
ASC.01.06 Prevention – youth out-of-school	-	-	-	-	-	0.03	-	-	1.53	-	1.53	1.55
ASC.01.11 Prevention programmes in the workplace	4.42	1.11	-	-	5.53	0.43	2.59	-	-	-	2.59	8.55
ASC.01.13 Public and commercial sector male condom provision	-	-	-	-	-	-	10.06	-	-	-	10.06	10.06
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	-	-	-	-	-	-	0.41	-	-	-	0.41	0.41
ASC.01.17 Prevention of mother-to-child transmission (PMTCT)	35.25	-	-	-	35.25	-	2.74	-	-	-	2.74	37.99
ASC.01.18 Male circumcision	2.99	-	-	-	2.99	-	12.88	-	15.84	-	28.72	31.71
ASC.01.19 Blood safety	-	-	-	-	-	-	2.53	-	-	-	2.53	2.53
ASC.01.20 Safe medical injections	-	-	-	-	-	-	6.11	-	-	-	6.11	6.11
ASC.01.22 Post-exposure prophylaxis (PEP)												

	Public funds					Private Funds	International Fund					
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions Total	Multilateral Agencies (ii) Total	International not-for-profit organizations and foundations Total	International for profit organizations	International funds Total	Grand Total
	-	0.52	-	-	0.52	-	-	-	-	-	-	0.52
ASC.01.98 Prevention activities not disaggregated by intervention	-	5.74	-	-	5.74	-	23.28	0.82	-	-	24.10	29.84
ASC.01 Prevention Total	61.83	48.91	-	0.25	110.99	0.86	120.17	4.47	20.81	0.21	145.65	257.50
ASC.02 Care and treatment												
ASC.02.01 Outpatient care												
ASC.02.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment Total	-	-	-	-	-	-	-	-	0.67	-	0.67	0.67
ASC.02.01.03 Antiretroviral therapy	118.69	-	10.99	-	129.68	45.04	46.92	-	162.57	-	209.50	384.22
ASC.02.01.04 Nutritional support associated to ARV therapy	-	-	-	-	-	-	0.15	0.30	-	-	0.45	0.45
ASC.02.01.05 Specific HIV-related laboratory monitoring	59.70	-	3.34	-	63.04	7.23	5.08	-	-	-	5.08	75.35
ASC.02.01.07 Psychological treatment and support services	0.58	-	-	-	0.58	-	-	-	-	-	-	0.58
ASC.02.01.09 Home-based care	23.51	-	-	-	23.51	0.24	4.05	-	-	-	4.05	27.79
ASC.02.01.98 Outpatient care services not disaggregated by intervention	579.71	-	-	-	579.71	-	-	-	-	-	-	579.71
ASC.02.02 Inpatient care	-	-	-	-	-	-	-	-	-	-	-	-
ASC.02.02.98 Inpatient care services not disaggregated by intervention	579.71	-	-	-	579.71	-	-	-	-	-	-	579.71
ASC.02.98 Care and treatment services not disaggregated by intervention	-	-	-	-	-	-	6.59	0.21	-	-	6.81	6.81
ASC.02 Care and treatment Total	1,361.90	-	14.33	-	1,376.23	52.50	62.80	0.51	163.24	-	226.55	1,655.28

	Public funds					Private Funds	International Fund					
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions Total	Multilateral Agencies (ii) Total	International not-for-profit organizations and foundations Total	International for profit organizations	International funds Total	Grand Total
ASC.03 Orphans and vulnerable children (OVC)												
ASC.03.01 OVC Education	-	-	-	-	-	-	0.53	-	-	-	0.53	0.53
ASC.03.03 OVC Family/home support	-	-	-	-	-	-	0.18	-	-	-	0.18	0.18
ASC.03.04 OVC Community support	-	-	-	-	-	-	-	-	0.42	-	0.42	0.42
ASC.03.06 OVC Institutional care	-	-	-	-	-	-	-	0.79	-	-	0.79	0.79
ASC.03.98 OVC Services not disaggregated by intervention	389.56	-	-	-	389.56	-	5.68	-	-	-	5.68	395.24
ASC.03 Orphans and vulnerable children (OVC) Total	389.56	-	-	-	389.56	-	6.39	0.79	0.42	-	7.60	397.16
ASC.04 Programme management and administration												
ASC.04.01 Planning, coordination and programme management	19.58	5.22	-	-	24.80	-	22.92	12.84	13.41	-	49.17	73.98
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	20.74	-	-	-	20.74	0.27	80.24	0.23	-	-	80.47	101.48
ASC.04.03 Monitoring and evaluation	-	-	-	-	-	-	4.77	0.09	5.96	0.15	10.98	10.98
ASC.04.05 Serological-surveillance (serosurveillance)	0.39	-	-	-	0.39	-	5.15	-	-	-	5.15	5.54
ASC.04.06 HIV drug-resistance surveillance	-	-	-	-	-	-	-	-	0.29	-	0.29	0.29
ASC.04.07 Drug supply systems	-	0.14	-	-	0.14	-	-	-	-	-	-	0.14
ASC.04.10 Upgrading and construction of infrastructure	0.62	-	-	-	0.62	-	3.35	-	-	-	3.35	3.97

	Public funds					Private Funds	International Fund					
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions Total	Multilateral Agencies (ii) Total	International not-for-profit organizations and foundations Total	International for profit organizations	International funds Total	Grand Total
ASC.04.98 Programme management and administration not disaggregated by type	-	-	-	-	-	-	25.03	-	23.74	-	48.77	48.77
ASC.04.99 Programme management and administration n.e.c	-	-	-	-	-	-	37.38	-	-	-	37.38	37.38
ASC.04 Programme management and administration Total	41.33	5.36	-	-	46.69	0.27	178.85	13.16	43.40	0.15	235.57	282.53
ASC.05 Human resources												
ASC.05.03 Training	-	-	-	-	-	-	53.84	0.70	2.89	1.14	58.57	58.57
ASC.05 Human resources Total	-	-	-	-	-	-	53.84	0.70	2.89	1.14	58.57	58.57
ASC.07 Enabling environment												
ASC.07.01 Advocacy	-	-	-	-	-	-	0.34	-	3.03	-	3.37	3.37
ASC.07.02 Human rights programmes	0.78	-	-	-	0.78	-	0.49	0.16	0.11	-	0.75	1.53
ASC.07.03 AIDS-specific institutional development	-	-	-	-	-	-	-	-	0.16	-	0.16	0.16
ASC.07 Enabling environment Total	0.78	-	-	-	0.78	-	0.83	0.16	3.30	-	4.28	5.06
ASC.08 HIV and AIDS-related research (excluding operations research)												
ASC.08.02 Clinical research	-	-	-	-	-	-	46.61	-	3.75	1.91	52.27	52.27
ASC.08.03 Epidemiological research	-	-	-	-	-	-	52.50	-	-	-	52.50	52.50
ASC.08.04 Social science research	-	-	-	-	-	-	-	0.26	0.02	-	0.28	0.28

	Public funds					Private Funds	International Fund					
AIDS Spending Categories	Central government revenue	Reimbursable loans	Employer's compulsory contributions to social security	Other public funds n.e.c.	Public funds Total	Private Funds Total	Direct bilateral contributions Total	Multilateral Agencies (ii) Total	International not-for-profit organizations and foundations Total	International for profit organizations	International funds Total	Grand Total
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	0.05	-	-	-	0.05	-	3.10	-	0.32	-	3.42	3.47
ASC.08.99 HIV and AIDS-related research activities n.e.c.	-	-	-	-	-	-	-	0.85	-	-	0.85	0.85
ASC.08 HIV and AIDS-related research (excluding operations research) Total	0.05	-	-	-	0.05	-	102.21	1.11	4.09	1.91	109.33	109.38
Grand Total	1,855.45	54.27	14.33	0.25	1,924.30	53.63	525.09	20.89	238.15	3.41	787.55	2,765.48

Appendix 4: Organisations' Response to Data Request

Note: Checked boxes reflect that data was collected.

		2009/10	2010/11	2011/12
	Government Ministries and Departments			
1	National AIDS Coordinating Agency (NACA)	☒	☒	☒
2	Botswana Bureau of Standards (BOBS)	☒	☒	☒
3	Botswana Defence Force (BDF)	☒	☒	☒
4	Botswana Police services	☒	☒	☒
5	Botswana Prison Services	☒	☒	☒
6	Department of Youth	☒	☒	☒
7	Ministry of Labour and Home Affairs	☒	☒	☒
8	Ministry of Local Government	☒	☒	☒
9	Ministry of Education and Skills Development	☒	☒	☒
10	Ministry of Finance and Development Planning	☒	☒	☒
11	Ministry of Health	☒	☒	☒
12	Women's Affairs Department	☒	☒	☒
	Development partners			
1	Centers for Disease Control and Prevention (CDC)	☒	☒	☒
2	ACHAP	☒	☒	☒
3	Forum Syd Botswana	☒	☒	☒
4	International Labour Organisation (ILO)	☐	☐	☐
5	KNCV	☐	☐	☐
6	UNAIDS	☒	☒	☒
7	UNDP	☒	☒	☒
8	UNHCR	☒	☒	☒
9	UNICEF	☒	☒	☒
10	UNFPA	☒	☒	☒
11	USAID	☒	☒	☒
12	WHO	☒	☒	☒
	CSOs/NGOs/FBOs			
1	BOFWA	☒	☒	☒
2	Academy for Educational Development	☒	☒	☒
3	Baylor Children's Clinical Centre of Excellence	☒	☒	☒
4	BNYC	☐	☐	☐
5	BOCAIP	☒	☒	☒
6	BOCONGO	☐	☐	☐
7	BONASO	☐	☐	☐
8	BONELA	☒	☒	☒
9	BONEPWA	☒	☒	☒
10	Botswana Council of Churches	☐	☐	☐
11	Botswana Harvard Aids Institute partnership	☐	☒	☒
12	Botswana Open Baptist Church	☒	☒	☒

13	Botswana Red Cross Society	☒	☒	☒
14	Botswana Retired Nurses Society(BORNUS)	☒	☒	☒
15	Centre for Youth of Hope (CEYOHO)	☒	☒	☒
16	Family Health International	☒	☒	☒
17	Hope worldwide Botswana	☒	☒	☒
18	House of Hope Trust	☒	☒	☒
19	Humana people to people	☒	☒	☒
20	I-TECH	☒	☒	☒
21	Jhpiego (Affiliate of John Hopkins University)	☐	☐	☐
22	JSI	☒	☒	☒
23	Makgabaneng	☒	☒	☒
24	Marang Child Care Trust	☒	☒	☒
25	Masiela trust fund	☒	☒	☒
26	NASTAD	☒	☒	☒
27	Otse Community Home Based Care Society	☒	☒	☒
28	Pathfinders International Botswana	☐	☐	☐
29	PEACE CORPS	☒	☒	☒
30	Population services international	☒	☒	☒
31	Project Concern International	☒	☒	☒
32	RTI	☐	☐	☐
33	SCMS	☒	☒	☒
34	SOS Children's Village	☒	☒	☒
35	Tebelopele Voluntary Counselling and Testing Centres	☒	☒	☒
36	The Light and Courage Centre	☒	☒	☒
37	Tirisanyo Catholic commission	☒	☒	☒
38	UPENN	☒	☒	☒
39	URC	☒	☒	☒
40	YOHO	☒	☒	☒
	Private business sector and Parastetals			
1	Associated Fund Administrators (AFA)	☒	☒	☒
2	Barclays Bank	☐	☐	☐
3	BBCA	☐	☐	☐
4	BCL	☐	☐	☐
5	BOMAID	☒	☒	☒
6	Botswana National Productivity Centre	☒	☒	☒
7	BPC	☐	☐	☐
8	BPOMAS	☒	☒	☒
9	BTC	☐	☐	☐
10	Debswana	☐	☐	☐
11	FNB	☐	☐	☐
12	Kgalagadi Breweries	☐	☐	☐
13	Pula Medical AID	☒	☒	☒
14	Standard Chartered Bank	☒	☒	☒
15	Tati Nickel Mining Company	☐	☐	☐

16	University of Botswana	☒	☒	☒
17	WUC	☐	☐	☐
18	YWCA	☒	☒	☒