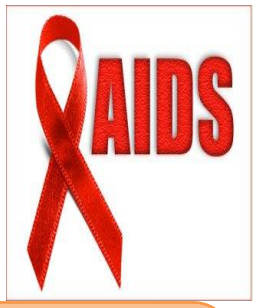
ISLAMIC REPUBLIC OF IRAN

National AIDS Spending Assessment (NASA)



Financial Resources Flow in National Response to HIV/AIDS: 2012

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The Major Counterpart:

- Ministry of Health and Medical Education
- Ministry of Cooperatives, Labor and Social Welfare (Welfare Organization)
- Ministry of Education
- Universities of Medical Sciences and health services
- International Country Office (UNDP, UNAIDS, UNICEF, WHO, UNFPA, UNODC and …)
- Iran Prisons Organization
- Iranian Blood Transfusion Organization
- Iran Broadcasting Organization
- Tehran Municipality
- Drug Control Headquarter

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TABLE OF ABBREVIATION:

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
ART	Antiretroviral therapy
ASC	AIDS spending category
BP	Beneficiary Population
BTO	Blood Transfusion Organization
EMRO	Eastern Mediterranean Regional office
FS	Financing Source
FA	Financing Agent
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
IDCH	Iran Drug Control Headquarter
IR Iran	Islamic republic of Iran
IDU	Injection drug user
MARP	Most-at-risk populations
M&E	Monitoring and Evaluation
MENA	Middle East and north of Africa
MCLSW	Ministry of Cooperative, Labor and Social Welfare
MoH	Ministry of Health
MoHME	Ministry of health and medical education
MSM	Men who have sex with other men
MU	Medical Universities
NASA	National AIDS Spending Assessment
n.e.c.	Not elsewhere classified
NGO	Nongovernmental organization
NHA	National health accounts
OI	Opportunistic infections
OOP	Out-of-pocket
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PF	Production Factor
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PS	Provider Service
STI	Sexually transmitted infection
SW	Sex workers
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS

UNDP United Nations Development Program
UNFPA United Nations Population Fund (United Nations Fund for Population Activities)
UNGASS United Nations General Assembly Special Session
UNICEF United Nations International Children's Emergency Fund
UNODC United Nations Office on Drugs and Crime
USD United States Dollars
VCT Voluntary Counseling and Testing

EXECUTIVE SUMMERY:

HIV and AIDS programs in IR Iran finance via three main sources: public, private and external (international). Financial resources are tracked by financing source whether it is public, private or international and among the different providers and beneficiaries (target groups).

In 2013 with the purpose of ensuring a coordinated and adequately resourced response, the Islamic Republic of Iran committed to undertaking a National AIDS Spending Assessment (NASA) to exhaustively track actual HIV-related spending from public, international and private sources for the financial annual period of 2012. This initiative is supported by a Global Fund support project; GFATM Round 8.

The NASA in the Islamic Republic of Iran will be conducted by a steering committee selected by the national counterparts with the support of an International NASA expert. In order to effectively implement the project, steering committee will assign a working group to directly lead the project. The working group and the International NASA consultant will be the national NASA task force.

The assessment focused on tracking national HIV expenditure for 2012. This project will be conducted through five stages**:** Project preparation and literature review, Data Collection, Data Processing, Data Analysis and Final Report.

Data collection covered spending funded from public, external and private sources (the last only partially). The data for 2012 were obtained from the primary sources of information. There were a number of limitations to this study. Key among them was the problem of missing HIV expenditure information.

It was also difficult to carry out a comparison of expenditure between NASA guideline and HIV/AIDS financing in Iran especially in AIDS spending categories and financing agents. In addition to there were some differences in coding and accounting method of financing organization and providers.

As NASA was implemented in IR Iran for the first time, there was no possibility of analyzing dynamics or trends in AIDS spending.

Finally we complete these five NASA matrices: Financial Source with AIDS Spending Categories (FS*ASC), Financial Agents with AIDS Spending Categories (FA*ASC), Service Providers with AIDS Spending Categories (PS*ASC),

Beneficiary Population with AIDS Spending Categories (BP*ASC) and Financial Agents with Service Providers (FA*PS).

Main findings

Iran spent a total of 1,676,898,000,000 IR Rial (US $ 129,650,000) on HIV and AIDS in 2012. It is near 0.37% of total health expenditure. Public funds constituted 57% of the total expenditure. Funds from external sources made up 8% of all HIV expenditure in 2012, while private sources of funding accounted for 35%. The NASA findings regarding providers of HIV services show that public organizations finance and provide the majority of these services in Iran.

An estimated 894,979,000,000 IR Rials (53.4% of total expenditure), 728,402,000,000 IR Rials (43.4% of total expenditure) was spent by public and private service providers in 2012 respectively. Multilateral providers was spent only 3.1%.

Analysis of data according to the NASA categories shows that the key spending priorities in 2012 have been prevention activities (81.1% of total expenditure); Care and Treatment (9.6% of total expenditure) and Program Management and Administrative Strengthening (5.8% of total expenditure). Another important key intervention area is human resources (1.9% of total expenditure). Other programmatic areas, including spending on Social Protection and social services, HIV-Related Research and OVC spending on creating an Enabling Environment, made up 1.6% in 2012.

Analysis beneficiary populations show that the most beneficiary population of HIV/AIDS services is MARP. 45.7% of total spent benefited the MARP and 16.9% other key population, 2.9 specific “accessible” population (people attending STI clinics, youth at school, etc.), 15% general population, 11.9% PLHIV, 7.1% non-targeted interventions.

Based on the NHA reporting, the OOP in health sector is high in Iran. The share of it in AIDS related services financing is 35%. But since the many service of HIV/AIDS are free of charge in Iran so that it was expected the value of it’s would be very low.

Conclusions and recommendations:

The data collection process for spending in health sector not institutionalized in Iran. It is recommended to design data gathering system for NHA and subaccount of it by its methodology and codes. It is clear designing for some subaccount such and AIDS should be done by its methodology.

There is a necessity to undertake a comprehensive assessment of out-of-pocket (OOP) expenditure on HIV. Based on the NHA reporting the OOP in health sector is high in Iran. This in AIDS related services is 35%. But since the many service of HIV/AIDS are free of charge in Iran so that it is recommended to provide additional explanation on OOP in reporting and presenting. For example OOP is high in few services such as IDU services. This is in order to innovating moral hazard.

In order to establish to what extent OOP constitutes a large or small portion of total AIDS expenditure, it is recommended that questions related to HIV spending are incorporated into existing household surveys.

An effective tool for the National AIDS Spending Assessment was introduced and a national mechanism for its implementation on a regular basis was developed. This will enable implementation and regular improvement of the monitoring of the national response to HIV, the tracking of the efficiency of HIV-related programs and activities, and will also serve as a basis for improving national strategic planning in the field of HIV/AIDS.

In order to reduction in financial relationship between the providers and beneficiaries, the OOP payment should be decreased as possible and these fund should be pooled in one fund. This can led to high efficiency and prevent the supply induced demand.

There are some basic services and some major financing agent and also some providers in Iran that they are not in NASA guideline. In order to coordination and homogenization in reporting of NASA it is recommended these services and agents added to NASA guideline.

Finally it is strongly recommended the results of this study would use in planning specially in strategic program and focus on some services that mentioned in key finding and conclusion.

CHAPTER I:

- ***Introduction***
- ***Overall development/economic context***
- ***Iran's HIV Epidemic at a Glance***
- ***Iran's HIV Response at a Glance***
- ***Objectives***

Introduction

HIV prevalence remains low in the general population of Iran, but HIV prevalence in people who inject drugs is around 15 per cent. Iran's HIV epidemic is therefore categorized as a concentrated epidemic. Effective measures have been put in place over the past decade to control the epidemic among injecting drug users; these harm reduction efforts have succeeded in slowing down the epidemic in this group. Nevertheless, injecting drug use remains the principal mode of transmission in Iran. It is therefore imperative to expand current harm reduction programmes in order to reach the goal of zero new infections due to injecting drug use.

Evidence has emerged in recent years of an increase in sexual transmission of HIV in Iran. For example, the proportion of reported cases attributed to sexual transmission has been steadily increasing, and there are also indications that high-risk sexual practices are increasing among young people. HIV prevalence among Vulnerable Women has also increased markedly in recent years, and has now reached 4 per cent approximately. Unprotected sex is also common among injecting drug users. In addition, the use of amphetamine-type stimulants has also increased in recent years, as have the high-risk sexual behaviors associated with their use. We thus need to scale up interventions aimed at reducing the prevalence of high-risk sexual behavior.

The number of women living with HIV has also been increasing in recent years. Even though the number of new infections among children remains thankfully low, we need significantly to expand our efforts in the area of PMTCT, if we are to prevent an emergent epidemic in this group.

In Iran, HIV transmission through contaminated blood and blood products has been fully controlled. To maintain the effectiveness of current measures, however, we need to reinforce them and incorporate new advances and technologies as they emerge.

Overall development/economic context

The Islamic Republic of Iran covers an area of 1.648,000,000 square kilometers and possesses 31 provinces and 402 districts. According to the 2011 General Population

and Household Census, the population of Iran is approximately 76.5,000,000 people. The Islamic Republic of Iran is a young country, with 32 per cent of the population under 20 years of age. The Total Fertility Rate in 2010 was reported at less than two, compared with 6.7 children per women in 1980. The government has therefore reviewed its population policy in order to mitigate the effects of this decline in population growth and increase the total fertility rate to between 2.0 and 2.5 children per woman. The urbanization rate has also grown consistently in recent years. At present more than 68 per cent of the population is urban. Internal migration and immigration are also common phenomena. According to the 2011 Census, more than 5,000,000 people had migrated during the five years preceding the census, and more than 1.45,000,000 Afghans, 51 thousand Iraqis and 17 thousand Pakistanis are currently living in Iran. Based on the same census, 18.9 per cent of men aged 25-49 and 18.7 per cent of women aged 25-49 are unmarried. The marriage rate in men and women aged 20-24 was 21.9 and 51.8 per cent, respectively.

The country economic situation has not been impervious to the global economic crisis, especially recent fluctuations in the oil market, which have slowed the country's economic growth in recent years. Iran economy grew by approximately 4 per cent in 2010 and the Ministry of Economic Affairs estimated Iran's gross domestic product in 2012 at some 484 billion US dollars. In 2010, oil and gas accounted for 9 per cent of gross domestic product, with agriculture accounting for 14 per cent, industry for 22 per cent, and services for the remaining 55 per cent. The Islamic Republic of Iran possesses the world's second largest reserves of natural gas, and the third largest of oil. The country has had to face the dual challenges of inflation and unemployment in recent years. The official unemployment rate was estimated in 2012 at 28.7 per cent. According to the 2011 Census, more 3.29,000,000 people in the country are jobless. It is reported elsewhere that the pool of job-seekers is increasingly by about 600,000 every year. The Statistical Centre of Iran has reported the unemployment rate in second quarter of 2011 was 12.3 per cent.

The Ministry of Health and Medical Education, in addition to providing healthcare at the primary, secondary and tertiary levels, is also responsible for training the medical and paramedical workforce. It is also responsible at national level for setting policy and strategies as well as the administration and funding of programmes. At provincial level, the medical universities are responsible for providing healthcare and training human resources. At district and village level, it is the district health networks, comprised of the district health centre, urban and rural health centers, health bases and health homes, and district hospitals, that fulfil this responsibility. The

current coverage rate for healthcare providers is 0.8 physicians, 0.5 midwives and 2.3 nurses per 1000 population.

Health's share of gross domestic product stood at around 6 per cent in 2010. Financial resources allocated to healthcare consist of a combination of out-of-pocket payment, government funds, and public taxes, healthcare insurance and individual donations. National Health Accounts reports estimate that the private sector invests in only 10 per cent of hospital beds but accounts for nearly 20 per cent of all healthcare expenditure.

The majority of development indicators have shown improvement over recent decades. Life expectancy at birth was 72 years in 2010, compared with 53.9 years in 1970-75, having thus increased about 33 per cent over 25-30 years. The net primary enrolment rate in 2009 was nearly 100 per cent, and the secondary enrolment rate grew from 66 per cent in 1995 to 84 per cent in 2009. As a result, the youth literacy rate has increased from 77 per cent in 1995 to more than 99 per cent in 2009, with the figure increasing even more remarkably in young girls. Nevertheless, the 2011 Census reports that 9.7,000,000 people over the age of 6 years are illiterate, with the majority of them over the age of forty.

The Islamic Republic of Iran is well poised the Millennium Development Goal on the elimination of gender inequality. The economic role of women in the Islamic Republic of Iran has increased in leaps and bounds in recent years, even though their rates of employment and labor force participation have remained constant.

Under-five mortality has declined steadily from 65 per 1000 in 1990 to 27 per 1000 in 2009, as has the maternal mortality ratio from 150 to 30 per 100,000 live births over the same period. Overall, the country health indicators place it above the average for the region, this being mostly due to the provision of comprehensive and effective primary healthcare, which reaches virtually all urban and rural areas of the country equally.

The Islamic Republic of Iran formulates its policies in accordance with the 5th Five-Year National Development Plan (2011-15), itself based on the Twenty-Year Outlook Document (2005-2025). The focus of the 5th Plan is market-oriented reforms and improving socio-economic indicators.

Iran’s HIV Epidemic at a Glance

The first case of HIV in Iran was reported in 1986. Between 1986 and 1995, the number of reported cases increased only very slowly. The first case of HIV transmission through injecting drug use (needle sharing) was reported in 1989, and the number of such cases increased by only 5-10 cases per year until 1995. In 1996, however, the IDU epidemic took off and the number of cases reported annually began to increase dramatically. Thus for the first time injecting drug use became the most common route of HIV transmission in the country and remains it to this day.

Although the number of reported cases attributed to sexual transmission increased from 50 cases in 2000 to three times that number in 2006, the proportion of reported cases attributed to sexual transmission remained steady at 5-8 per cent. The proportion increased thereafter such that in 2012 sexual transmission accounted for 33.6 per cent of all recorded cases. This marked increased in the number of recorded cases can be largely attributed to an increase in the number of service delivery points for women and thus the identification of a greater number of HIV-infected women.

According to data from the HIV case registry, the number of people known to be living with HIV in Iran was 27 888 as of March 2014, of whom 88.7 per cent were men and 11.3 per cent women. As of the same date, 5 813 people had been identified with advanced HIV illness/AIDS and 5 761 had died of AIDS-related causes. HIV infection is most prevalent in the 25-34 age groups, accounting for 45.8 per cent of all recorded cases. Of all the cases recorded since 1986 in the country, the most common route of transmission has been needle sharing among injecting drug users, accounting for 67.6 per cent of recorded cases, followed by sexual transmission (13.4 per cent of recorded cases), mother-to-child transmission (1.2 per cent of recorded cases), and transfusion of blood and blood products (0.9 per cent of recorded cases). In 16.9 per cent of cases, the route of transmission is not clear.

As in every other country, recorded cases only account for a fraction of the total HIV population. Based on the latest estimation and projection exercise conducted in 2011 using the UNAIDS model, Iran's HIV population is estimated to be 93 305 (61 778 men and 31 527 women). These numbers are projected to increase by 2015 to 144 690 (101 790 men and 42 900 women), representing a 35-per cent increase in five years.

Based on modelling studies conducted in 2011, people who inject drugs still account for the largest number of new cases, even though harm reduction programmes (free needle-syringe exchange and methadone maintenance treatment) have succeeded in reducing this population's share of the overall HIV population from 80 per cent in 2006 to 56 per cent in 2012. HIV prevalence among people who inject drugs averaged

15 per cent nationwide in 2010, which doesn't show marked change from the figure of 15.3 per cent reported in the 2008 national bio-behavioural survey. Notwithstanding, the large number of injecting and non-injecting drug users constitute a serious threat to the continued success of the aforementioned programme. According to the last rapid situation assessment of substance abuse, which was carried out in 2007, between 1.1 and 1.2,000,000 in Iran are suffer from drug dependency and the number of people who inject drugs is estimated at 230-255 thousand.

Modelling studies carried out in 2011 also show that sexual transmission is the second most common route of transmission. Twelve per cent of new infections occur in the sexual partners of people who inject drugs. In one bio-behavioural study, conducted in 2010 among the sexual partners of injecting drug users, the prevalence of HIV among the female sexual partners of injecting drug users was measured at 3.7 per cent. In fact, modelling studies show that sexual transmission is on the rise. It is also estimated that HIV prevalence is increasing among new population groups, such as the spouses of injecting drug users, and other groups at highest risk of sexual transmission. Increasing use of stimulants and synthetic psychoactive (amphetamine-type) substances is another threat and necessitates effective interventions to reduce high-risk sexual practices lest they fuel the epidemic further.

In spite of this, HIV prevalence in the general population remains low, as evidenced by the very low HIV prevalence reported through sentinel surveillance and other studies. This means the window of opportunity remains open.

Iran's HIV Response at a Glance

The 3rd National Strategic Plan (2010-14) was developed to respond to the HIV epidemic in Iran. This programme, the result of close, multi-scrotal collaboration between all the relevant stakeholder institutions and organizations, comprises 10 strategies and 41 strategic objectives, and has been endorsed by the Council of Ministers. The programme's strategies include information, education and communication; blood safety; voluntary counselling and testing; harm reduction; prevention of sexual transmission; management of sexually transmitted infections; treatment and care of people living with HIV and their families; support and empowerment; establishment of an epidemiologic surveillance system; and strengthening infrastructure.

Many of Iran's harm reduction programmes have been documented by the World Health Organization and UNAIDS as "role models" and "good practices" in the

Middle East and North Africa (Eastern Mediterranean) region, leading to the establishment of three knowledge hubs (WHO collaborative centers) in the country, in the areas of surveillance, harm reduction, and HIV treatment. Thus the knowledge and experience accrued by Iran can be shared with other countries. As of September 2012, free needle-syringes were being distributed by more than 559 service outlets. Research also shows that a significant proportion of injecting drug users obtains its needle-syringes from pharmacies. In the 2010 bio-behavioural survey of injecting drug users, 91.7 per cent of respondents reported using a fresh needle-syringe on their last injection. As of September 2012, the number of outlets providing methadone maintenance treatment (MMT) stood at 4 249, which had catered for close to half a million drug users in the year ending September 2012. This does not mean necessarily that all these people were receiving MMT throughout the reporting period, nor does it imply that all people under treatment actually were injecting drug users. Nevertheless, MMT coverage trends increased steadily between 2001 and 2011.

In the field of IEC, the Ministry of Health and Medical Education and its programme partners have developed and implemented comprehensive programmes targeting HIV at risk groups. In many instances, Iran has been a pioneer in this area in the MENA-EMRO region. The most important of these measures have been to create clusters of student (peer) educators, to develop HIV prevention packages for families, the production of dozens of educational pamphlets and films to promote HIV prevention among injecting drug users, prisoners, HIV at risk young people, and families. We have also set up a number of "Positive Clubs" as part of our measures to provide psychosocial support for people living with HIV and their families. In the same vein, we have also established a national Social Protection Task Force to address this component of the response. One of the Task Force's achievements has been successfully to negotiate free medical insurance for all PLHIV and their families. The Task Force and the Positive Clubs have also instituted efforts to reduce HIV-related stigma and discrimination.

HIV treatment and care services are provided in accordance with standard national guidelines, which are based on the guidelines proposed by the WHO and have been adapted to the epidemiologic profile of the country by the National Technical Committee for HIV Treatment & Care, which is composed of prominent experts and academics in this domain. These guidelines are routinely reviewed and revised every two years. An infectious diseases specialist is appointed as "focal point" for HIV treatment in every medical university in the country. The latest antiretroviral medication is available across the country and is dispensed free-of-charge to patients

in accordance with national guidelines through "Triangular Clinics", which are affiliated to the Public Health Department of the local medical university.

In Iran, voluntary counselling and testing services are principally delivered through the triangular clinics, also known as behavioural disorders counselling centres, and counselling posts. The State Welfare Organization and the State Prisons Organization are also major providers of VCT services across the country. The overwhelming majority of HIV testing conducted in the country is voluntary in nature and the client is informed of the results, although there are indications that the private sector conducts HIV tests without the knowledge or consent of patients. Triangular clinics and counselling posts are easily accessible to the entire population and all the services on offer are free of charge. In the 2010 national bio-behavioural survey of injecting drug users, twenty-five per cent of respondent IDUs had taken an HIV test during the 12 months preceding the survey and received their result.

OBJECTIVES

The project is aimed at implementing and institutionalizing HIV/AIDS Resource Tracking in the Islamic Republic of Iran based on the National AIDS Spending Assessment methodology (NASA) in order to provide information on the AIDS spending for the year 2012.

The specific objectives are:

- To identify total HIV and AIDS expenditure in 2012
- To ascertain the sources of funds used to finance national response in 2012
- To estimate the total and share of international funding on HIV and AIDS HIV and AIDS in Iran in 2012
- To obtain a description of the beneficiaries from HIV and AIDS services
- To investigate the distribution of funding by source and agent
- To describe the use of funds for HIV and AIDS based on AIDS Spending Categories (ASC).
- To identify HIV and AIDS related services providers
- To provide recommendation on the application of NASA to policy makers

CHAPTER II:

- **Methodology**
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- **Data Collection Methods**
- **Project Steps**
    - **Preparation Phase**
    - **Preparation of data collection tool**
    - **Data Collection**
    - **Data Processing**
    - **Data Analysis**
    - **Final Report**
-

Methodology

The methodology used in this research to study the AIDS spending groups is the so-called systematic method proposed by UNAIDS which is designed to specify the financial flow and national expenditures related to AIDS. This method is designed to clearly show the actual expenditures of the financial resources provided by the government, national and international organizations both in the area of health and separately but still related to health such as training and social welfare.

The output of this study indicates the country's responsiveness to AIDS, including care and treatment services to AIDS patients. The significance of monitoring what is spent in controlling HIV/AIDS roots in specifying the spending groups at country level and in relation to the national program of controlling AIDS. The so-called tool, "National AIDS Spending Assessment", monitors the amount of expenditures spent by different resources, and provides the decision makers with a comprehensive view on the distribution of resources in the main spending groups in the area of AIDS in terms of prevention, care and treatment, management, research and so on.

As it was stated, the "National AIDS Spending Assessment" or NASA is designed by UNAIDS and studies the flow of fund from financial resources to providers by monitoring all financial payments from resources to end users. This tool handles the financial system by relating financial resources to budget providing organizations and then budget providing organizations to service providers, in order to monitor the expenditures used in different activities and interventions.

NASA Categories of HIV/AIDS Expenditures

Financing Sources (abbreviated as FS for NASA purposes) are entities or pools that fund the purchase of provider services or other forms of mobilization by the financing agents. Examples include Ministry of Finance and donors. Financing agents (FA) are entities that pool financial resources collected from the various financing sources and transfer them to pay for or purchase HIV care, and other services or goods. Financing agents may pool resources that pay directly for resources they consume, such as

household out-of-pocket payments, or they may be entities that buy on behalf of specific beneficiaries, such as insurance firms on behalf of employer and household contributions or NGOs on behalf of donors.

Providers (PS) are entities or persons that engage directly in the production, provision, and delivery of services. Providers supply services and/or are responsible for a final product or the subcontracting of a complex process. A provider is usually accountable to the beneficiary for the delivery and the quality of service rendered. HIV and AIDS services are supplied in a wide range of settings outside the health industry and providers, for example, schools and social community centres, in addition to health centres and hospitals.

Production factors (PF) for NASA purposes, are inputs or budgetary items (akin to resource cost classifications used in the SHA and NHA) that can be divided into two major categories: 1) current expenditures and 2) capital expenditures. Examples include wages, supplies, and services.

AIDS spending categories (ASC) are the HIV/AIDS-related services and products rendered. Examples include mass media, curative care, and research.

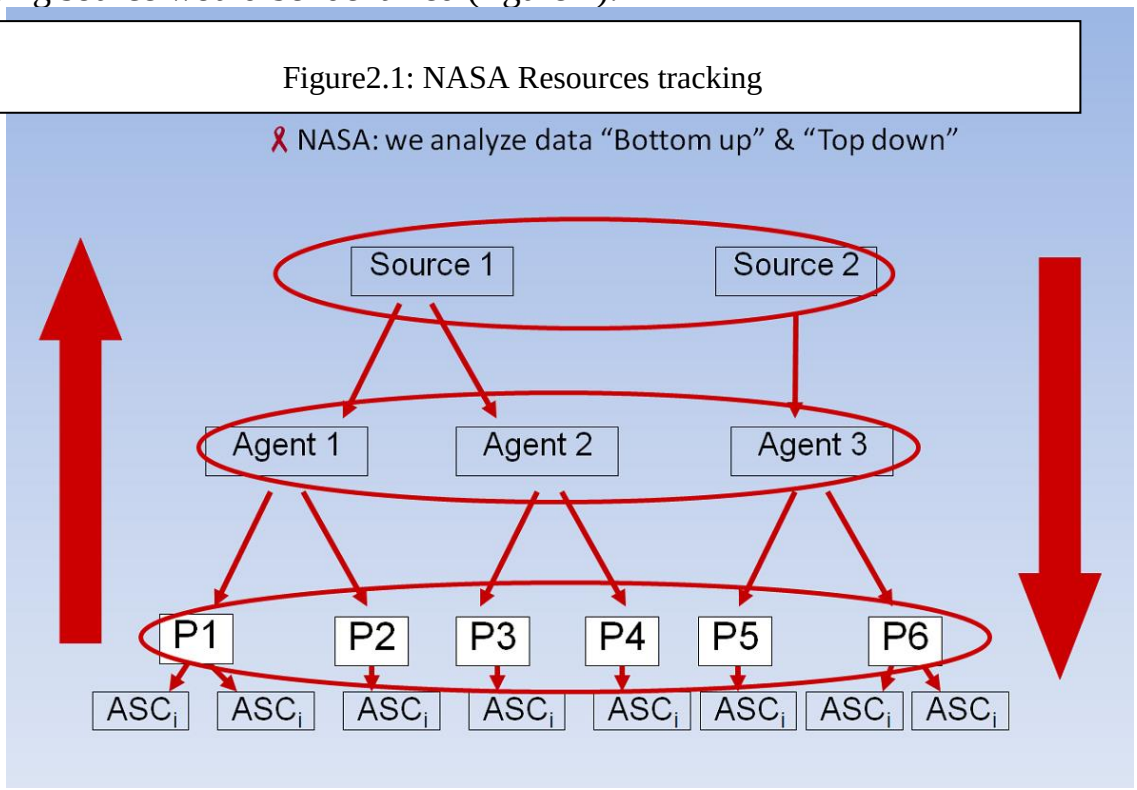
Beneficiaries (BP) are people who have benefited or have been served by spending on HIV/AIDS goods and services. The beneficiary population is not the intended target of funds, but rather the recipients of HIV/AIDS services and commodities. Beneficiary populations of interest to NASA are those most-at-risk populations such as sex workers, their clients, injecting drug users, and men who have sex with men.

Data collection method

NASA calculate AIDS expenditures irrespective of budget and credit by means of two approaches: Top down and bottom up, both of which track down the flow of fund via costing services, goods and instruments made available by service providers for implementation of the activities.
In top down approach the whole resources allocated to the financing agents from the main source are identified and tracked down. This will specify the service providers who have received the fund. Subsequent to identification of service providers and the allocated budget, the resources are tracked down to specify the kinds of services.

The next step includes identification of AIDS spending categories, service providers as well as the relevant expenditure. In the other words, the expenditure is tracked down from organizations that allocate budget to services providers and beneficiaries.
Bottom up approach acts vice versa. Firstly, the amount of services, beneficiaries and service providers are identified. Then the unit cost of services is estimated. Then expenditure is estimated for all services in one service provider. When the unit cost of services and as well as providers are calculated, the financing agent and the main financing source would be identified (figure 1).

Figure2.1: NASA Resources tracking



In order to data collection we use the bottom up approach. The expenditures are summed up from the lowest level and gradually reach the main source. In the first phase ASC are identified as per the relevant guidelines. Secondly the beneficiaries are specified and finally the service expenditure is estimated according to the accounting documents. After calculating the service expenditure, the total expenditure of each service provider is estimated and financing agents and resources are identified.
It is noteworthy that when we have no financial report we use the budgetary expenditure audit in order to an estimate of the actual volume of expenditures be obtained with the existing data as well as interview with key people and authorities. By using these methods, the estimated amount of actual expenditures is provided in this report.

Project steps:

Preparation phase:

Through coordination between AIDS Office and Centre for Disease Control of the Ministry of Health and in consultation with the representative of UNAIDS Office, the strategic committee of NASA was assigned to review the Program and implementing it. The committee comprised of managers and representations of national and international organizations active in the area of HIV/AIDS and/or those bodies offering services to HIV/AIDS patients.

In the meeting dated February 2013, held in the Ministry of Health, discussions were made about the objectives of the Program, method of data collection, analysis of the data, documentation method as well as the consequences, at the presence of the Deputy of Health of the Ministry.

It was approved in the same meeting that each organization assigns a representative to the working group established by the AIDS Office and Center for Disease Control for implementation of the Program and the representative would be later trained in a workshop on the modality of implementing the Program, including data collection method.

Preparation of data collection tools:

Data collection tools are the matrix that build up based on "National AIDS Spending Assessment" guideline with excel software. Following designing the tables, in order to making suitable tables, each cell was discussed in the focus group including the national experts on AIDS as well as finance and epidemiology. After entering variables in the excel tables, five tables were finalized.

1. Table of service providers and financing agents

Financing Agents (columns of table)

The first table is related to financing agents and services providers. In "National AIDS Spending Assessment (NASA): classification and definitions" that has been prepared by Joint United Nations Program on HIV/AIDS (UNAIDS) 2009, there are three main sections (one digit code 01): public, private and international sectors. Public sector is divided into five smaller sections (two digit code 01.01- 01.04 and 01.99) of territorial

government, public social security, government employee insurance programmes, Parastatal organizations and other public financing agents not elsewhere categorized.

Territorial government breaks up into three smaller sections (three digit code) i.e. Central or federal authorities, state/provincial/regional authorities and Local/municipal authorities. In the next phase these sections are divided into four digit codes to collect more precise data on the flow of fund. The section of central or federal authorities is divided into 11 four digit codes, State/provincial/regional authorities and Local/municipal authorities are categorized into 7 four digit codes and 6 four digit codes, respectively. Thus in this table public section includes 24, four digit codes and four, two digit codes (excluding the public sector). Each of these codes shows a financing agent n.e.c.

The second financing agent is the private sector (FA.02) that is categorized into seven smaller sections. Thus there are 7 two digit codes. The third financing agent is the international section including 5 subcategory of country offices of bilateral agencies managing external resources and fulfilling financing agent roles, multilateral agencies managing external resources, international non-profit-making organizations and foundations, international profit-making organizations and other international financing agents n.e.c (two digit codes of FA.03.01- FA.03.04 and FA.03.99). Then each of the financing agents is divided into smaller sections of main financing agents. This guideline consists of 89 international financing agents.

Overall, there are 124 columns in the table of financing agents, each representing an agent. But they are not all of them active in Iran. Out of 31 active financing agents in Iran that are selected by the focus group, 21 agents are active in the public sector, 3 agents in the private sector and 7 agents in the international sector. Thus the final table includes 31 columns of financing agents. Some of these agents were not introduced as a financial agent. Therefore when we decide to enter them as agents we build the new code for each on. This maybe led to the code of financial agent in this report differs from original NASA guideline.

Financing Agent				Central Authorities (FA.01.01.01)							
				Mistry of Health	Minstry Of Education	Ministry of Cooperatives, Labor and Social				Drug Control Headquart	State Welfare Organization
						Health Care Insurance	Social Insurance	Well Fare Services	Supportive		
Providers(PS)			NASA	1.01.01.01	01.01.01.02	1.1.1.3.1	1.1.1.3.2	1.1.1.3.3	1.1.1.3.4	1.01.01.04	1.01.01.05
Public sector providers	Governmental organizations PS.1	Hospitals	PS.01.01	21,478.3	0.0	1,137.0	450.0	0.0	0.0	0.0	0.0
		Ambulatory care	PS.01.02	208,705.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0
		Dental offices	PS.01.03	1,204.6	0.0	9.8	0.0	0.0	0.0	0.0	0.0
		Mental health and substance	PS.01.04	32,995.9	0.0	0.0	0.0	0.0	0.0	11,887.2	0.0
		Laboratory and imaging	PS.01.05	4,551.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Blood Bank	PS.01.06	2,635.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Pharmacies and providers of	PS.01.07	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Schools and training facilities	PS.01.08	1,269.7	3,200.0	0.0	0.0	0.0	0.0	0.0	0.0
		Orphanages	PS.01.09	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Research institutions	PS.01.10	1,455.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Supportive Organization	PS.01.11	46.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Positive Clubes	PS.01.12	10.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Government entities	PS.01.13	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Minstry of Health	PS.01.13.01	3,464.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
		Minstry of Education	PS.01.13.02	0.0	468.0	0.0	0.0	0.0	0.0	0.0	0.0
		Universities of Medical Science	PS.01.13.03	39,737.4	0.0	0.0	0.0	0.0	0.0	31.0	0.0

AIDS Service Providers (rows of the first table):

AIDS Service Providers that are a part of this table were identified according to the guideline that divides the service providers into 5 categories. The last 2 categories play a minor role in providing services. The first section includes public sector (PS.01) with two main sections of governmental organizations and parastatal organizations and one section related to other providers. Governmental organizations (PS.01.01) include 15 codes of main service providers. PS.01.01.10 is divided into 4 sub codes and PS.01.01.14 has 9 sub codes. Thus in the section of public organizations, 26 providers of AIDS Spending Categories are introduced. Parastatal organizations are the second public service providers with 14 providers. The code of PS.01.02.10 is divided into 4 sub providers.

The second main provider is the private sector (PS.02) that has three subcategories. The two main subcategories include non-profit providers (PS.02.01) and profit-making private sector providers including profit-making FBOs (PS.02.02) and the third section is related to other private sector providers (PS.02.99). Non-profit providers have two subcategories of non-profit non-faith-based providers including 16 providers and non-profit faith-based providers with 15 providers. There are also 16 service providers in profit-making private sector. Thus according to this guideline there are 47 service providers in the private sector. Out of these providers, 10 private service providers were selected by the focus group. They include laboratory and imaging facilities, harm

reduction centers, dental offices, schools and training facilities, pharmacies and providers of medical goods, ambulatory care, hospitals, orphanages, support facilities providers, clubs of HIV positive friends and other service providers.

The international service providers are divided into two main categories of bilateral agencies and multilateral agencies (PS.03). The other national and foreign providers are put in the section of other providers.

2. The table of ASC and service providers

This table combines ASC and service providers. The service providers were described above. Service providers and ASC are put in the columns and rows of the table, respectively. Each service provider is asked to categorize its services into 8 categories according to the following list.

Aids spending categories are broken down into 4-digit codes. But this table just includes 2 two-digit codes. Thus in total 47 AIDS spending categories in the country are divided into 8 main categories. Prevention with 21 services makes up the first category.

Care and treatment fall into the second category (ASC.02) and include 4 services. The third category is related to orphans and vulnerable children (OVC) and is comprised of 7 services. (ASC.03)

Category no. 4 is related to programme management and administration and includes the whole executive expenditure out of the area that health services are provided. The program expenditure consists of expenditure of AIDS services management plans, monitoring and evaluation (M&E), awareness raising, pre-service training and purchasing laboratory and telecommunications equipment. Due to lack of data, this category does not break down in to type of services (ASC.04).

Human Resources is the 5th category of AIDS Spending Categories. This category includes four services and the code of this category is ASC.05.

Social protection and social services (excluding OVC) is the sixth AIDS Spending category. It is comprised of 5 services as shown in the table. Enabling environment (ASC.07) is the 7^{th} service that is divided into 6 services.

The last category of services is related to the costs of research services (ASC.08) and has no subcategory. It includes the costs of production of knowledge that can be used to prevent diseases and promote, restore, maintain, protect and improve the

development and welfare of population. The costs of operational researches do not fall into this category.

Provider services(PS)		Public Sectors											
		Governmental agencies: PS.1											
		Hospitals	Ambulatory care	Dental offices	Mental health and substance abuse	Laboratory and imaging facilities	Blood Bank	Pharmacies and providers of medical	Schools and training facilities	Orphanages	Research institutions	Supportive Organization	Positive Clubes
Aids Spending Categories	NASA Code	PS.1.1	PS.1.2	PS.1.3	PS.1.4	PS.1.5	PS.1.6	PS.1.7	PS.1.8	PS.1.9	PS.1.10	PS.1.11	PS.1.12
Prevention	ASC.1	3,025	132,295	802	99,300	1,667	204,674	0	4,376	0	5	24	10
Education, Education and Communication for increasing awareness	ASC.1.1	213	9,853	186	634	25	0	0	663	0	5	14	10
Social Mobilization	ASC.1.2	5	2,069	0	84	0	0	0	13	0	0	10	0
Voluntary Counseling and Testing	ASC.1.3	١۴٠	٣۴٠٨٢١	.	٢،٢١٢	١،١۴٣	١،۶۴۵	.	٧	.	.	.	.
Risk-reduction for vulnerable and accessible population	ASC.1.4	66	12,727	252	54,215	331	54	0	0	0	0	0	0
Prevention-youth in School	ASC.1.5	0	884	0	0	0	0	0	3,560	0	0	0	0
Prevention-youth in out of School	ASC.1.6	0	76	0	10	0	0	0	60	0	0	0	0
Prevention of HIV transmission aimed at pepole living with HIV(PLHIV)	ASC.1.7	10	2,410	143	317	0	0	0	0	0	0	0	0
Prevention programmes for sex workers and their	ASC.1.8	0	12,887	23	8,098	0	0	0	0	0	0	0	0
Programmes for men who sex with men(MSM)	ASC.1.9	0	331	0	76	0	0	0	0	0	0	0	0
Harm-reduction programmes for injecting drug users.(IDUs)	ASC.1.10	0	2,877	63	31,500	81	0	0	5	0	0	0	0
Prevention programmes in workplace	ASC.1.11	293	499	30	57	20	70	0	10	0	0	0	0
Condom Social Markating	ASC.1.12	0	0	0	0	0	0	0	0	0	0	0	0
Public and commercial sector male condom provision	ASC.1.13	0	23,158	0	1,239	0	0	0	0	0	0	0	0
Public and commercial sector female condom provision	ASC.1.14	0	0	0	0	0	0	0	0	0	0	0	0
Prevention, diagnosis and treatment of Sexuality Transmitted Infection(STI)	ASC.1.15	168	16,824	0	263	0	0	0	58	0	0	0	0
Prevention of mother to child transmistion(PMTCT)	ASC.1.16	133	7,468	0	71	0	0	0	0	0	0	0	0
Blood Safety	ASC.1.17	0	81	0	0	0	191,235	0	0	0	0	0	0
Safe medical injection	ASC.1.18	1,232	2,448	40	443	17	0	0	0	0	0	0	0
Universal precautions	ASC.1.19	628	1,072	65	55	0	11,339	0	0	0	0	0	0
Post-exposure prophylaxis (PEP)	ASC.1.20	108	1,433	0	25	0	0	0	0	0	0	0	0
Prevention activities n.e.c	ASC.1.99	10	377	0	2	0	328	0	0	0	0	0	0
Care and Treatment	ASC.02	41,065	113,011	767	326	3,271	389	0	0	0	0	0	0

3. Table of beneficiaries of AIDS Spending Categories

This table shows the beneficiary population of services. Service providers and beneficiaries are put in the rows and the columns of the table, respectively. Beneficiaries are divided into 7 main categories. Each category in turn has its own subcategories. The first category (BP.01) is related to the people living with HIV/AIDS and is divided into 2 subcategories of people who are above or under the age of 15.

The second group includes Most-at-risk populations (BP.02) and is divided into 4 categories as per the attached table. The third category (other key populations) has the most subcategorizes and consists of the people who cannot be put in the previous category, but are at risk with HIV. This category is comprised of 14 subcategories. The 4th category is divided into 10 subcategories and includes people who are reachable such as students, health and medical personnel, military, university students etc. the 5th category includes the general public. The 6th category is related to the costs of services provided with no specific target group and mainly includes support systems. The last category covers those beneficiaries who had not been categorized before.

Beneficiary Populations		(PLHIV) BP.1		BP.2Most-at-risk populations(MARP)						
		Adult and young people (aged 15 and over) living with HIV	Children (aged under 15) living with HIV	Injecting drug users (IDU) and their sexual partners	Sex workers (SW) and their clients	Men who have sex with men (MSM)	Other Most at risk	Orphans and vulnerable children (OVC)	Children born or to be born of women living with HIV	Refugees (externally displaced)
Aids Spending Categories	NASA Code	BP.1.1	BP.1.2	BP.2.1	BP.2.2	BP.2.3	BP.2.99	BP.3.1	BP.3.2	BP.3.3
Prevention	ASC.1	28,124	409	715,956	37,294	2,551	9,364	2,438	6,212	2,366
Education, Education and Communication for increasing awareness	ASC.1.1	2,161	183	1,199	257	202	1,086	0	188	11
Social Mobilization	ASC.1.2	112	19	49	23	1	159	0	12	18
Voluntary Counseling and Testing	ASC.1.3	0	0	9,495	5,477	418	4,993	512	660	52
Risk-reduction for vulnerable and accessible population	ASC.1.4	353	0	596,003	5,612	31	2,182	1,879	1,013	1,791
Prevention-youth in School	ASC.1.5	0	0	0	0	0	0	0	0	2
Prevention-youth in out of School	ASC.1.6	0	0	0	0	0	0	3	2	2
Prevention of HIV transmission aimed at pepole living with HIV(PLHIV)	ASC.1.7	8,162	199	0	0	0	0	0	93	0
Prevention programmes for sex workers and their clients	ASC.1.8	0	0	0	24,293	0	0	0	0	0
Programmes for men who sex with men(MSM)	ASC.1.9	0	0	0	0	1,833	0	0	0	0
Harm-reduction programmes for injecting drug users(IDUs)	ASC.1.10	1,996	0	107,228	0	0	0	0	0	490
Prevention programmes in workplace	ASC.1.11	0	0	0	0	0	0	0	2	0
Condom Social Markating	ASC.1.12	0	0	0	0	0	0	0	0	0
Public and commercial sector male condom provision	ASC.1.13	879	0	760	488	0	0	0	0	0
Public and commercial sector female condom provision	ASC.1.14	0	0	0	0	0	0	0	0	0
Prevention, diagnosis and treatment of Sexuality Transmitted Infection(STI)	ASC.1.15	2,086	0	329	1,024	67	638	0	31	0
Prevention of mother to child transmistion(PMTCT)	ASC.1.16	7,001	0	0	0	0	0	0	4,160	0
Blood Safety	ASC.1.17	0	0	0	0	0	0	0	0	0

4. Table of financing agents and AIDS Sending Categories

Table 4 is related to financing agents and AIDS Sending Categories. The table shows those individuals or organizations that fund each AIDS Sending Category. It also depicts the organizations' field of activity.

Financing Agent		Public Sector FA.01													
		Territorial Goverment 0101													
		Central Authorities (FA.1.1.1)									Provencial Authorities .FA.01.01.02				
		Mistry of Health	Minstry Of Educatio n	Ministry of Cooperatives, Labor and Social Welfare				Drug Control Headquarte r	State Welfare Organizatio n	Iranian Blood Transfusion Organizatio	Univesity of Medical Science	Eduction Organisation at provencial level	State Welfare Organiztion at provecial level	Drug Control Headquarter at Provencial Level	
Aids Spending Categories(ASC)	NASA id			Health Care Insurance	Social Insurance	Well Fare Services	Supportive								
		1.1.1.1	1.1.1.2	1.1.1.3.1	1.1.1.3.2	1.1.1.3.3	1.1.1.3.4	1.1.1.4	1.1.1.5	1.1.1.6	1.1.2.1	1.1.2.2	1.1.2.3	1.1.2.4	1
Prevention	ASC.01	176465.92	3200	107.99	0.00	6300.00	23004.00	51201.17	4500.00	202428.00	0.00	0.00	0.00	0.00	
Education, Education and Communication for increasing	ASC.01.01	14978.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Social Mobilization	ASC.01.02	3556.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Voluntary Counseling and Testing	ASC.01.03	41956.43	0.00	0.00	0.00	0.00	0.00	55.00	0.00	0.00	0.00	0.00	0.00	0.00	
Risk-reduction for vulnerable and accessible population	ASC.01.04	16210.80	0.00	0.00	0.00	0.00	0.00	11887.17	0.00	0.00	0.00	0.00	0.00	0.00	
Prevention-youth in School	ASC.01.05	1728.25	3200.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Prevention-youth in out of School	ASC.01.06	174.31	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Prevention of HIV transmission aimed at pepole living with	ASC.01.07	3439.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Prevention programmes for sex workers and their clients	ASC.01.08	10735.00	0.00	0.00	0.00	600.00	2200.00	3850.00	400.00	0.00	0.00	0.00	0.00	0.00	
Programmes for men who sex with men(MSM)	ASC.01.09	182.72	0.00	0.00	0.00	250.00	500.00	800.00	100.00	0.00	0.00	0.00	0.00	0.00	
Harm-reduction programmes for injecting drug users(IDUs)	ASC.01.10	21689.42	0.00	0.00	0.00	5450.00	20304.00	34609.00	4000.00	0.00	0.00	0.00	0.00	0.00	
Prevention programmes in workplace	ASC.01.11	1177.95	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Condom Social Markating	ASC.01.12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Public and commercial sector male condom provision	ASC.01.13	26238.79	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Public and commercial sector	ASC.01.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

5. Table of financing sources and AIDS spending categories

Table 5 is related to financing sources and AIDS Spending Categories and shows the main financing source of AIDS as per each provided service. This table has three main categories of public, private and international sectors that are divided into subcategories. In total the table includes 17 financing sources. Following drawing up the tables, they were discussed in a meeting attended by finance and AIDS experts. Then tables were separately reviewed, modified and finalized.

financing source		Public Funds FS.01								Private FundsFS.		
		Territorial government funds FS.1.1				Social security funds FS.01.02			Other public funds n.e.c.			
Aids Spending Categories		Central government revenue	State/provincial government revenue	Local/municipal government revenue	(Reimburseable Loans)	Employer's compulsory contributions to social	Employee's compulsory contributions to social	Government transfers to social security		Profit-making institutions and corporations	Households' funds	Non-profit making institutions (other than social insurance
ASC	NASA	FS.1.1.1	FS.1.1.2	FS.1.1.3	FS.1.1.4	FS.01.02.01	FS.01.02.02	FS.01.02.03	FS.01.99	FS.02.01	FS.02.02	FS.02.03
Prevention	ASC.1	685694	129	3290	0	0	0	0	52	8	589221	459
Education, Education and Communication for increasing awareness	ASC.1.1	217578	129	3290	0	0	0	0	5	4	0	68
Social Mobilization	ASC.1.2	3606	0	0	0	0	0	0	0	5	0	55
Voluntary Counseling and Testing	ASC.1.3	42011	0	0	0	0	0	0	0	0	0	0
Risk-reduction for vulnerable and accessible population	ASC.1.4	41505	0	0	0	0	0	0	0	0	587640	50
Prevention-youth in School	ASC.1.5	4928	0	0	0	0	0	0	45	0	0	0
Prevention-youth in out of School	ASC.1.6	211	0	0	0	0	0	0	0	0	40	0
Prevention of HIV transmission aimed at pepole living with HIV/PLHIV	ASC.1.7	3440	0	0	0	0	0	0	0	0	50	63
Prevention programmes for sex workers and their clients	ASC.1.8	17785	0	0	0	0	0	0	0	0	0	193
Programmes for men who sex with men(MSM)	ASC.1.9	1833	0	0	0	0	0	0	0	0	0	0
Harm-reduction programmes for injecting drug users (IDUs)	ASC.1.10	88446	0	0	0	0	0	0	0	0	60	30
Prevention programmes in workplace	ASC.1.11	1178	0	0	0	0	0	0	0	0	50	0
Condom Social Markating	ASC.1.12	0	0	0	0	0	0	0	0	0	0	0

Data collection:

To collect data, the UNAIDS guideline was translated and localized to help finalizing the tables. The cases described in the tables were supported by samples and for those issues not covered by the guideline, the necessary instructions were given. The tables and the relevant guidelines were sent to the organizations and agencies for completion. This was aimed to brief the organizations' representatives prior to their participation in the training workshop. After the people who were responsible for managing data collection in their respective organizations were invited to take part in four training workshops. The participants were educated on the objectives of the program, method of data collection by means of devised tables/forms. The guidelines for filling up the tables/forms were also distributed among the participants. The filled out tables were collected from the organizations and relevant bodies. Meanwhile, members of the technical committee monitored the process of data collection in relevant organizations

(such as State Welfare Organization and State Prisons and Security and Corrective Measures Organization) and provided the necessary trainings to guarantee the highest precision. To avoid double counting, the organizations were required to enter those expenditures that were supported by accounting documents. The data source includes accounting documents, strategic programmes, the organizations' budgets, documents of fund allocation and reports.

Data Processing:

The data was categorized into four main categories by means of Excel tables as follows:

- Data relevant to Medical universities;
- Data relevant to International organizations;
- Data relevant to Ministry of Health and Medical Education;
- Data relevant to those bodies that cover specific services or groups (such as State Prisons and Security and Corrective Measures Organization, Ministry of Education, IRIB, …)

After data was compiled into particular group, data set was then entered into NASA MATRIX based on its classification as it is mentioned in NASA guideline, the data entry/processing is described as follows:

Then data compiled by particular groups was entered into NASA MATRIX based on its classification.

Meanwhile, the data collected from the medical universities was separately analyzed as per the guideline, budgets, reports and national data. The experts were contacted to resolve the problems and clarify the issues. In case of discrepancy between the expert's instructions and the guideline or facing problems, the data was sent back to the expert for more explanation. The returned data was reviewed for several times to ensure their accuracy and compliance with the guideline. Then the data entry was discussed to avoid inclusion of similar data. Moreover, the data of five Excel sheets as well as that of related universities were compared with each other. The medical universities' data was finalized and entered into a MATRIX drawn up for the whole country

Then the data of Ministry of Health and Medical Education as well as other national and international organizations was monitored and evaluated. The filled out tables were analyzed and feedback was given to the organizations. The tables were finalized after several referrals. A matrix file was devised for the whole organizations. Also a

separate file was designed for the expenditure of Ministry of Health and Medical Education as well as international organizations. Later four Excel files were prepared in the form of five MATRIX tables. The tables were analyzed once more to exclude the repetitive figures. They were then compiled in five tables of an Excel file.

During the process of data collection, foreign advisors were consulted to resolve ambiguities or advise on the issues not addressed by the guideline. The national tables were finalized after receiving the international advisor's comments.

Data Analysis:

The analysis firstly describes total national HIV and AIDS expenditure in 2012. Moreover it allows to establish the: (I) level and proportion of funding from different sources; (ii) which providers were receiving funds and from what sources; (iii) amount of funding allocated to services and functions related to HIV/AIDS.

One of the main analyses is about the key beneficiaries. This shows end user of HIV and AIDS services. Beneficiary table describes what group benefits from which services. On the other hand we can identify policy orientation in HIV and AIDS program base on expenditures on beneficiaries and AIDS spending categories.

In terms of the HIV and AIDS spending category, some approaches were utilized to anticipate possible difficulties on how to classify the widely range of various programs. It was firstly gathering more detail information by checking the spending one by one referring to NASA requirement. Then, interview key staff was done once necessary. Should the differences on interpreting the spending category was occurred, data collector may initiate a discussion with the key staff and confirmed the spending category into NASA format.

Final Report:

The preliminary draft was submitted to the CDC and final version of it is provided and submitted when comments of CDC and UN agency include in it.

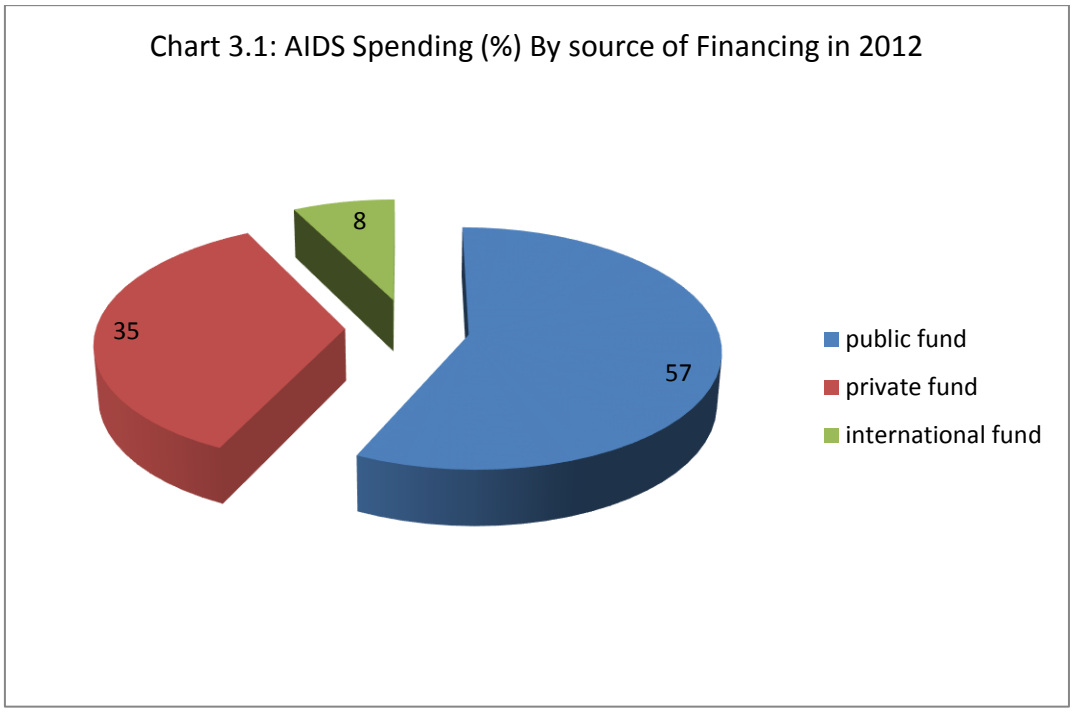
The report will facilitate the institutionalization and capacity building of the NASA for national as well as provincial level teams. Wide dissemination of the report would facilitate use for decision making and to promote national and international dialogue as well as commitment from the national and international community.

CHAPTER III:

- FINDINGS ON HIV AND AIDS SPENDING IN 2012
- EXPENDITURE BY SOURCE
- AIDS SPENDING CATEGORIES
- EXPENDITURE BY PROVIDERS
- EXPENDITURE BY BENEFICIEARIES

FINDINGS ON HIV AND AIDS SPENDING IN 2012:

Total expenditure on AIDS and HIV-related services, is 1,676,898,000,000 IR Rails regardless of its source in 1391. This spending includes all expenditure that is included in this area, according to NASA's Guide. According to the Iranian national health accounts total health expenditure in 2011 was equal to 401,786,080,000,000 Rial. It is estimated total health expenditure in 2012 exceeded the amount of 450 thousand billion Rial. So it is conclude that the expenditure of AIDS-related services in 2012 was about 0.37% of total health expenditure. Figure 3.1 shows the main sources of financing of AIDS in Iran on 2012. As the diagram shows, the main source of financing AIDS expenditure is public resources (57 %).



35% of AIDS spending is finance by private sector and out of pocket payment is the main sources of private sector (over 99%). International agencies finance 8% of Aids spending in Iran only on 2012.

The sources of international financing are multilateral agencies servicing earmarked grants and other international sources. Other sources, such as direct bilateral contributions and international profit and non-profit-making organizations and

foundations don't have role in financing of HIV services in Iran. Over %98 of international resources for AIDS spending in Iran is taken from multilateral agencies servicing earmarked grants.

In the public sector, more than 99% of fund finance via central government revenue. Other sectors such as municipalities, local government revenue and social security funds have little role in the financing of HIV-related services.

Table 3.1 shows the financing sources by AIDS spending categories in IR Rial and USD in 2012.

Table 3.1: AIDS spending categories by financing Sources (1USD is equal 12934 IR Rial)

financing source		public fund		Private fund		International fund		Total	
		(Milion IR Riral)	USD (1000)	(Milion IR Riral)	USD (1000)	(Milion IR Riral)	USD (1000)		
Aids Spending Categories (ASC)	NASA Code	FS.01		FS.02		FS.03		(Milion IR Riral)	(USD 1000)
Prevention	ASC.1	689191	53285	592578	45815	78419	6063	1360188	105164
Care and Treatment	ASC.02	156818	12124	1634	126	1695	131	160147	12382
Orphans and Vulnerable Children)	ASC.03	2834	219	44	3	0	0	2878	222
Programmes for management and administration	ASC.04	65783	5086	0	0	31634	2446	97417	7532
Human Resource	ASC.05	21148	1635	0	0	10580	818	31727	2453
Social protection and social services (excluding OVC)	ASC.06	15416	1192	437	34	17	1	15870	1227
Enabling environment	ASC.07	452	35	0	0	58	4	510	39
HIV-related research (excluding operations research)	ASC.08	4161	322	0	0	4001	309	8162	631
Total		**955802**	**73898**	**594692**	**45979**	**126404**	**9773**	**1676898**	**129650**

The contribution (%) of financing sources in the AIDS spending categories are shown in table 3.2. As a table declares the public fund is the main source of each category. In some categories such as orphan and vulnerable children, care and treatment and social protection and social services public contribution in financing is very high. The contribution of public and international fund in HIV related research is close.

Table 3.2: AIDS spending categories by financing Sources (%)

financing source		public fund	private fund	International fund	Total
Aids Spending Categories(ASC)	NASA Code	FS.01	FS.02	FS.03	
Prevention	ASC.01	50.7	43.6	5.8	100
Care and Treatment	ASC.02	97.9	1.0	1.1	100
Orphans and Vulnerable Children (OVC)	ASC.03	98.5	1.5	0.0	100
Program for management and administration	ASC.04	67.5	0.0	32.5	100
Human Resource	ASC.05	66.7	0.0	33.3	100
Social protection and social services (excluding OVC)	ASC.06	97.1	2.8	0.1	100
Enabling environment	ASC.07	88.7	0.0	11.4	100
HIV-related research (excluding operations research)	ASC.08	51.0	0.0	49.0	100
Total		57	35	8	100

Table 3.3 shows the share of AIDS categories from the financing sources. In the other word this table shows that how much of total fund in each source is spent in each category. Based on the results, the most share of fund is spent in the prevention services in all 3 sources. Enabling environment has the lowest share from total fund of all financing sources. Care and treatment has the second most share from public fund whereas is program for management and administration has the second most share from international fund.

Table 3.3: Financing sources by AIDS spending categories (%)

financing source		public fund	private fund	International fund
ASC Aids Spending Categories	NASA Code	FS.01	FS.02	FS.03
Prevention	ASC.1	72.1	99.6	62.0
Care and Treatment	ASC.02	16.4	0.3	1.3
Orphans and Vulnerable Children	ASC.03	0.3	0.0	0.0
Program for management and administration	ASC.04	6.9	0.0	25.0

Human Resource	ASC.05	2.2	0.0	8.4
Social protection and social services (excluding OVC)	ASC.06	1.6	0.1	0.0
Enabling environment	ASC.07	0.0	0.0	0.0
HIV-related research (excluding operations research)	ASC.08	0.4	0.0	3.2
Total		100	100	100

AIDS Spending Categories by Financing Agents

There are three main financing agents in AIDS spending: Public agent, private agent and international organizations. The share of financing agents and financing sources in AIDS spending are same in Iran approximately. The share of financing agents in real amount and percentage of them in 2012 is shown in table 3.4.

Table 3.4: Total AIDS spending by main financing agents in IR Rial and USD

financing agents	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
public sector	955,819	73,899.69	51,926.91	57
private sector	594,675	45,977.67	32,307.02	35
international organization	126,404	9,773.00	6,867.17	8
Total	1,676,898	129,650.37	91,101.10	100

Exchange Rate: 1USD is equal to 12934 IR Rial and Average Exchange Rate is equal to 18407 IR Rial

Based on the results public financing agent, private sector and international organizations finance the 57%, 35% and 8% of total AIDS spending in Iran in 2012 respectively. These are same for financing sources but there are very different financing agents in public sector (table 3.5).

In the international sector over the 98% of total fund are financed from multilateral agencies and 2% of it is financed from other sources. The difference between the amount for multilateral agencies sources and international organization as an agent is the other international sources.

Table3.5: Public financing agent on AIDS spending (Million IR Rial)

Financing Agents	Territorial Governments							other public authorities	Total
	MoH & MU*	IDCH**	MoCISW	BTO	Prisons Or	Broadcasting	Others		
Amounts	339,178	51,241	60,709	202,758	91,411	202,608	7,536	379	955,820
Percent (%)	35.49	5.36	6.35	21.21	9.56	21.2	0.79	0.04	100

* Ministry of Health and Medical Universities. ** Iran Drug Control Headquarter. *** Ministry of Cooperative, Labor and Social Welfare. **** Blood Transfusion Organization

Table 3.5 shows the total public fund on AIDS on IR Rial (Million) in 2012. Public fund consist of tow sector: governmental and nongovernmental. Governmental agents have the main role (955,441,000,000 IR Rial) in the financing of AIDS spending and public nongovernmental agents finance the 379,000,000 IR Rial of expenditure. Ministry of health and medical universities are the main financing agents in public sector and 35.49% of public fund are finances by these agents. Blood transfusion organization and broad casting are the second and third main financing agents.

Table3.6: Private financing agent on AIDS spending

Agent Financing		Private Sector FA.2 (Million IR Rial)		
		Out of Pocket Payment	Non Government Organization	Other Private Financing Agent
Aids Spending Categories(ASC)	NASA Code	2.01	2.02	2.99
Prevention	ASC.01	589,157	460	2,925
Care and Treatment	ASC.02	1,583	1	50
Orphans and Vulnerable Children	ASC.03	44	0	0
Program for management and administration	ASC.04	0	0	0
Human Resource	ASC.05	0	15	0
Social protection and social services (excluding OVC)	ASC.06	23	393	20
Enabling environment	ASC.07	0	5	0
HIV-related research (excluding operations research)	ASC.08	0	0	0
Total		590,807	874	2,995

There are 3 financing agent and source in the private sector: Households (Out of pocket payment), nongovernmental organization and other private financing agents. Out of 99% of private fund is financed by out of pocket. Analysis of private fund by AIDS spending categories show that over 99.6% of private fund is spent in prevention services and 99.7% of out of pocket payment is spent in prevention. The detail of this expenditure is explained in the AIDS spending by categories.

International fund by spending categories is shown in table 3.7. International agencies have spent 126,404,000,000 IR Rial in 2012. UNDP have had the most spending (91,270,000,000 IR Rial) on AIDS between the international agencies. On the other hand prevention activities have had the most expenditure between the AIDS spending categories. International agencies didn't any fund on orphan and vulnerable children services.

Agent Financing	International Purchasing Organization (million IR Rial)							Total
	FA.3.2. multilateral Agency							
	UNAIDS	UNICEF	UNDP/GF	WHO	UNFPA	UNODC	Other	

Aids Spending Categories(ASC)	NASA Code	03.02.01	03.02.02	03.02.03	03.02.04	03.02.05	03.02.06	03.02.99	
Prevention	ASC.01	7,803	2,482	59,388	1,213	2,826	2,407	2,302	78,421
Care and Treatment	ASC.02	389	0	1,190	107	9	0	0	1,695
Orphans and Vulnerable Children	ASC.03	0	0	0	0	0	0	0	0
Programs for management and administration	ASC.04	5,157	416	23,780	970	650	340	320	31,633
Human Resource	ASC.05	3,908	0	6,474	198	0	0	0	10,579
Social protection and social services (excluding OVC)	ASC.06	0	0	17	0	0	0	0	17
Enabling environment	ASC.07	0	0	58	0	0	0	0	58
HIV-related research (excluding operations research)	ASC.08	412	0	364	1,056	252	1,917	0	4,000
Total		17,669	2,898	91,270	3,544	3,737	4,664	2,622	126,404

Table3.7: International financing agent on AIDS spending

AIDS spending categories by service providers

Providers Services (PS) are entities that engage in the production, provision, and delivery of HIV services. Chart 3.2 shows the three major HIV and AIDS services providers: Public, private and international agencies.
Public provider is the major provider and provides and delivers the 56% of HIV services in Iran in 2012. Private providers and international agencies produce and deliver about 41% and 3% of HIV/AIDS services respectively.

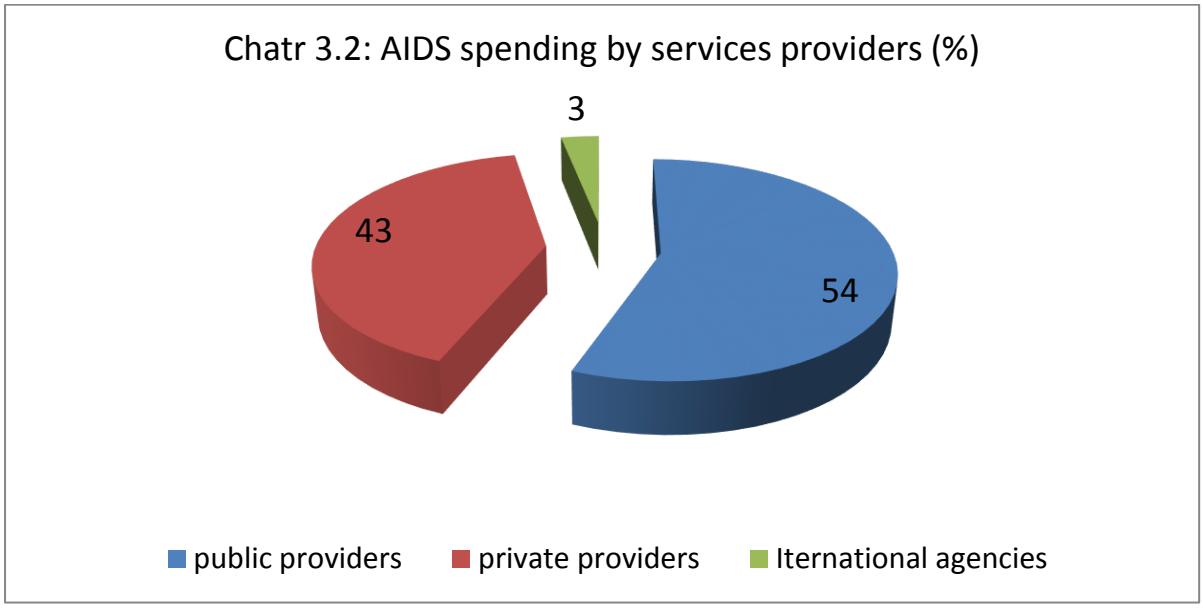


Table 3.8: Total expending by main service providers

AIDS Services Providers	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)
Public Providers	894,978	69,196	48,622
Private Providers	728,402	56,317	39,572
Bilateral and multilateral entities	51,290	3,966	2,786
Others	2,227	172	121
Total	1,676,898	129,650	91,101

Base on the results there are 15 main AIDS services providers in the public sector of Iran. Other service providers have little role in producing and provident of AIDS services. These providers are aggregated in the other providers' box. Harm reduction centers have provided the most services and have spent the 45.7% of total expenditure on AIDS in order to produce and deliver of services. Ambulatory care providers, blood bank and broadcasting provide the most services and located in the next rank.

Ambulatory care providers have provided the most services in the public sector. Other provider such as blood bank and broadcasting, governmental entities and harm reduction centers are the next providers that have provided the most services in the public sector. In this way, These 5 providers have provided the 92% of total public services.

There are several entities that categorized in the governmental entities. 4.7% of services have provided by these entities and the main entities were the Ministry of Health, Medical Universities and Ministry of Education.

Table 3.9: Total AIDS spending by service providers in detail

Provider entities	Hospitals	Ambulatory care	Dental offices	Harm Reduction Centers	Laboratory and imaging	Blood Bank	Pharmacies and providers of	Schools and training facilities
IR Rial (1000000)	46,901	278,681	1,642	765,557	5,129	205,393	50	4,472
USD (1000)	3,626	21,546	127	59,190	397	15,880	4	346
Average Exchange Rate (1000)	2,548	15,140	89	41,591	279	11,158	3	243
Percent (%)	2.8	16.6	0.1	45.7	0.3	12.2	0.0	0.3
Provider entities	Research institutions	Orphanages	Supportive Organization	Positive Clubes	Broadcastin	Other providers	Internation agencies	Governmental entities
IR Rial (1000000)	1,949	2,500	56	14,550	202,357	18,133	51,290	78,238
USD (1000)	151	193	4	1,125	15,645	1,402	3,966	6,049
Average Exchange Rate (1000)	106	136	3	790	10,993	985	2,786	4,250
Percent (%)	0.1	0.1	0.0	0.9	12.1	1.1	3.1	4.7

There are 10 active service provider centers in the private sector based on the results. Harm reduction centers and positive clubs have provided the over than 99% of the services which have been provided in the private sector. Other providers have provided the 1% of services only.

Table 3.10 shows the fund that allocated to the providers by the financing agents. As the table declares private providers finance the most of their fund from private sector. In the other word about 95% of private fund are absorbed by private providers. The main provider in the private sector is the harm reduction centers (addiction treatment centers).

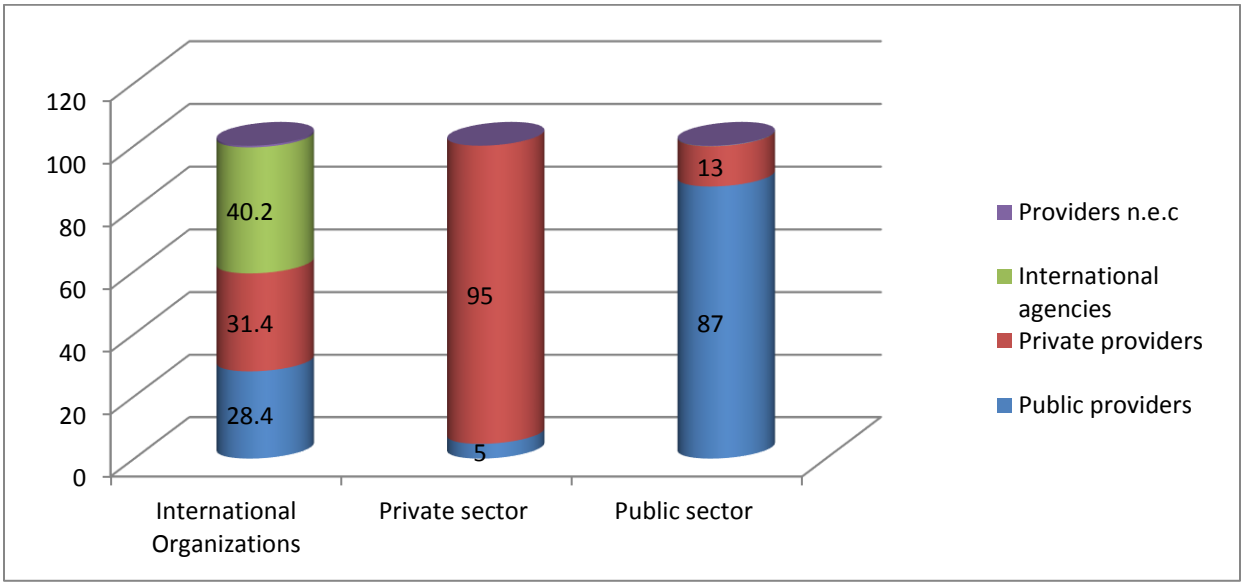
Table3.10: financing agents and service providers

FA*PS	Public sector (IR Rial 1000000)	Private sector (IR Rial 1000000)	International Organizations (IR Rial 1000000)
Public providers	831,541	28,066	35,371
Private providers	122,217	566,609	39,576
International agencies	527	0	50,763
Providers n.e.c	1,533	0	694

Since the more services are provided free of charge in the public sector so that a little share of private fund (less than 5%) allocated to the public sector.

All three groups of provider financed some their activities from international fund. Chart 3.3 shows the share of financing source by service providers

Chart 3.3: The share of financing source in financing of services providers

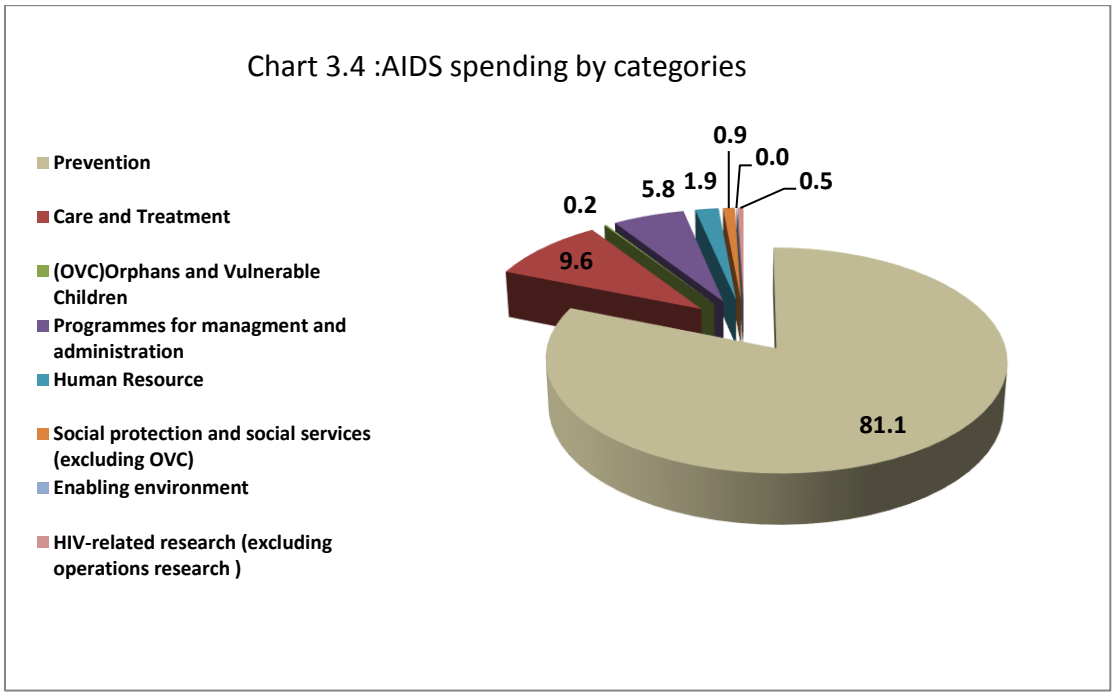


AIDS Spending by Categories:

The AIDS spending classification is a functional classification that includes the categories of prevention, care and treatment, orphans and vulnerable children, program management and administration, human resources, social protections and social services, enabling environment and research.

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

Based on results the share of prevention expenditure in 2012 is very high. 81% of total AIDS spending was allocated to prevention activities in 2012. Prevention has very various sub categories and prevention services providers have produce very wide category of services. Therefore it has had the most share of AIDS spending.



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

includes very wide subcategories in its interventions and activities. But due to lack detail of information we can distinct 2 digit codes (Outpatient care, Inpatient Care, Patient transport and emergency rescue and care and treatment services n.e.c) under the care and treatment only. Our results show that Iran has spent 9.6% of Total AIDS Spending (TAS) on care and treatment.

Based on NASA guideline, **program management and administration** expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole. Program management and administration was the third largest ASC in Iran in 2012 with 5.8%.

Table 3.11: AIDS expenditure by categories

ASC	IR Rial (1000000)	USD* (1000)	Average market USD Exchange Rate in 2012 (1000)	Percent
Prevention	1,360,190	105,164	73,895	81.1
Care and Treatment	160,147	12,382	8,700	9.6
Orphans and Vulnerable Children (OVC)	2,877	222	156	0.2
Programs for management and administration	97,417	7,532	5,292	5.8
Human Resource	31,727	2,453	1,724	1.9
Social protection and social services (excluding OVC)	15,870	1,227	862	0.9
Enabling environment	510	39	28	0.0
HIV-related research (excluding operations research)	8,161	631	443	0.5
Total	1,676,898	129,650	91,101	100.0

1USD= 12934 IR Rial. Average USD Exchange Rate (1000) = 18407 IR Rial

Human resources expenditures refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. Study results show that Iran has spent 1.9 of total AIDS spending in this category. The detail of spending on this category will be explained later.

Other ASCs such as Social protection and social services (0.9%), Orphans and Vulnerable Children (0.2%), HIV-related research (0.5%) and enabling environment (under 0.03) have very low share in the Iranian AIDS services package. In totally 1.6% of total AIDS expenditure has spent on these four categories. The share of enabling environment in AIDS services is almost zero.

Table 3.12 shows the AIDS spending categories by financing agents in real million IR Rial and percent. The most shares of AIDS spending in each three agents are allocated to the prevention activities. Private sector has allocated over the 99% of its fund to the prevention and international agencies have allocated the low share of its fund to prevention services between the financing agents. The most private fund is allocated to the IDU whereas international agencies don't very active in these services.

Table 3.12: AIDS spending categories by financing agents in IR Rial and USD

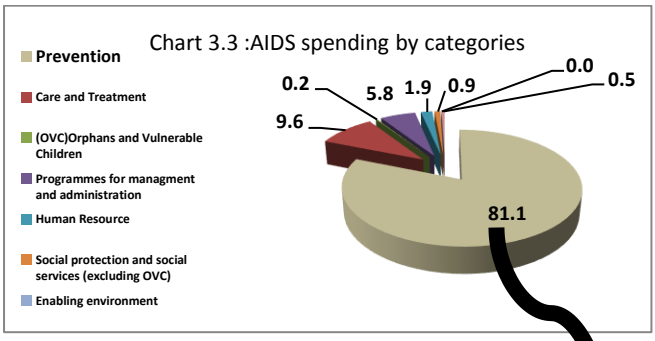
Financing Agents / ASC	Public Agents		Private sector		International Agencies	
	IR Rial (1000000)	(%)	IR Rial (1000000)	(%)	IR Rial (1000000)	(%)
Prevention	**689,226**	**72.1**	**592,542**	**99.6**	**78,421**	**62.0**
Care and Treatment	**156,818**	**16.4**	**1,634**	**0.3**	**1,695**	**1.3**
Orphans and Vulnerable Children	**2,834**	**0.3**	**44**	**0.0**	**0**	**0.0**
Programs for management and administration	**65,783**	**6.9**	**0**	**0.0**	**31,633**	**25.0**
Human Resource	**21,133**	**2.2**	**15**	**0.0**	**10,579**	**8.4**
Social protection and social services (excluding OVC)	**15,416**	**1.6**	**436**	**0.1**	**17**	**0.0**
Enabling environment	**448**	**0.0**	**5**	**0.0**	**58**	**0.0**
HIV-related research	**4,162**	**0.4**	**0**	**0.0**	**4,000**	**3.2**
Total	**955,820**	**100**	**594,676**	**100**	**126,404**	**100**

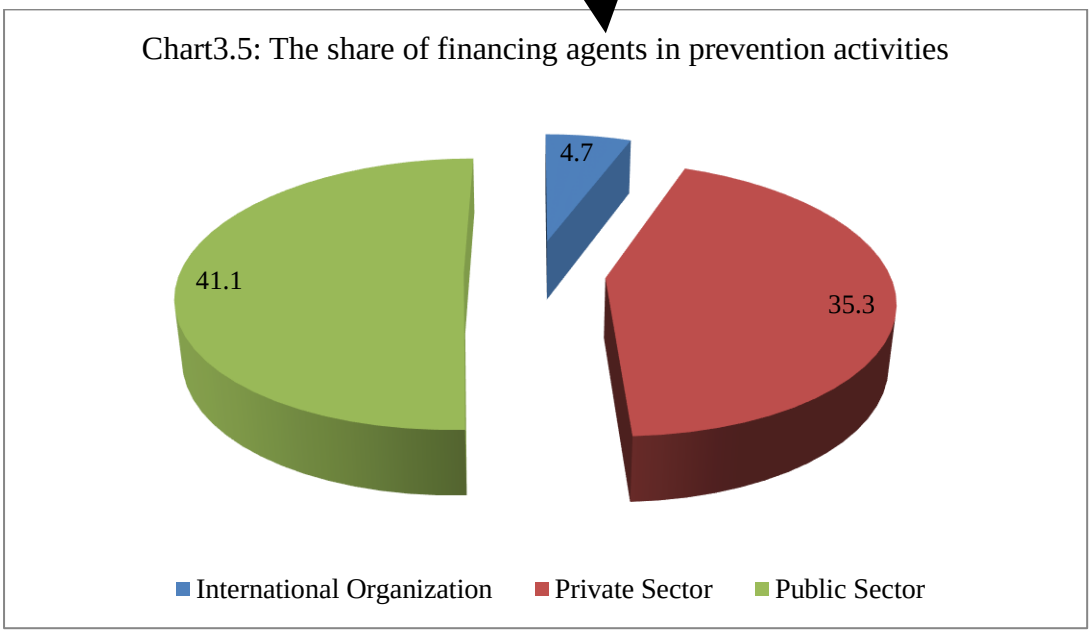
Care and treatment has the second most expenditure in public financing whereas program for management and administration is the second most category funded by international agencies. Based on the finding, enabling environment and orphans and vulnerable children activities have very little funded by each three financing agents.

National AIDS Spending by each categories:

Prevention:

Prevention services have very high share on Iran national Aids spending. The total share of it is over 81% in 2012. The 41.1% of this amount is financed by public financing agent, 35.3% and 4.7% of it is financed by private sector and international organizations respectively.





Prevention category contains very wide activities between the ASC. Among the 22 specific activities in the guideline, 18 specific activities and 2 nonspecific activities (ASC.01.98 and ASC.01.99) of prevention have funded in 2012. Some of them are produced and delivered in very wide range such as harm-reduction programs for injecting drug users (IDUs).

Table 3.13: Total AIDS expenditure on prevention services by its subcategories

Prevention subcategories	Total spending on prevention services

	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
Total	1,360,188	105,164	73,895	100.0
Education, Education and Communication for increasing awareness	220,157	17,022	11,961	16.2
Social Mobilization	4,055	313	220	0.3
Voluntary Counseling and Testing	9,639	745	524	0.7
Risk-reduction for vulnerable and accessible population	55,834	4,317	3,033	4.1
Prevention-youth in School	10,525	814	572	0.8
Prevention-youth in out of School	3,489	270	190	0.3
Prevention of HIV transmission aimed at people living with HIV(PLHIV)	10,513	813	571	0.8
Prevention programs for sex workers and their clients	35,739	2,763	1,942	2.6
Programs for men who sex with men(MSM)	2,578	199	140	0.2
Harm-reduction programs for injecting drug users.(IDUs)	719,371	55,619	39,081	52.9
Prevention programs in workplace	4,073	315	221	0.3
Public and commercial sector male condom provision	26,020	2,012	1,414	1.9
Prevention, diagnosis and treatment of Sexuality Transmitted Infection(STI)	20,889	1,615	1,135	1.5
Prevention of mother to child transmission(PMTCT)	13,375	1,034	727	1.0
Blood Safety	191,330	14,793	10,394	14.1
Safe medical injection	4,794	371	260	0.4
Universal precautions	13,205	1,021	717	1.0
Post-exposure prophylaxis (PEP)	1,807	140	98	0.1
Prevention activities not broken down by intervention	11,622	899	631	0.9
Prevention activities n.e.c	1,172	91	64	0.1

Table 3.13 shows the prevention activities that have financed and produced in 2012. Table shows real amount and the share of each activity in total prevention expenditure. Over the half of prevention expenditure is spend in one activity. Based on the results, near the 53% of prevention expenditure is spent on *harm reduction program for injecting drug users*. There are many wide activities such as VCT as part of programs for injecting drug users, condom social marketing and male and female condom provision, STI prevention and treatment, behavior change communication, sterile syringe and needle exchange, drug substitution treatment as part of programs for injecting drug users (IDUs) and two nonspecific activities that categorized under this code.
Education and communication for increasing awareness are activities have the second most expenditure in prevention subcategories. The high cost of education and communication via television is the main reason for high expenditure in this category.
On the other hand there are 9 activities in prevention subcategories such as prevention-youth in school and out of school, social mobilization, voluntary counseling and testing, prevention of HIV transmission aimed at People Living with HIV (PLHIV), programs for Men who Sex with Men (MSM), prevention programs in workplace, Post-Exposure Prophylaxis (PEP) and safe medical injections that they have very low share in prevention expenditure (in total 3.7%).

Table 3.14: Prevention subcategories expenditure by financing agents

Prevention subcategories	Public Sector	(%)	Private Sector	(%)	International Organization	(%)
Total	689,226	100	592,541	100	78,421	100
Education, Education and Communication for increasing awareness	216,427	31	83	0	3,648	5

Social Mobilization	3,603	1	64	0	388	0
Voluntary Counseling and Testing	9,392	1	0	0	248	0
Risk-reduction for vulnerable and accessible population	28,906	4	9,629	2	17,299	22
Prevention-youth in School	5,717	1	0	0	4,808	6
Prevention-youth in out of School	3,101	0	40	0	347	0
Prevention of HIV transmission aimed at people living with HIV(PLHIV)	5,066	1	453	0	4,994	6
Prevention programs for sex workers and their clients	29,131	4	193	0	6,416	8
Programs for men who sex with men(MSM)	2,578	0	0	0	0	0
Harm-reduction programs for injecting drug users.(IDUs)	127,733	19	568,055	96	23,583	30
Prevention programs in workplace	1,615	0	50	0	2,407	3
Public and commercial sector male condom provision	25,989	4	0	0	31	0
Prevention, diagnosis and treatment of Sexuality Transmitted Infection(STI)	6,824	1	13,084	2	980	1
Prevention of mother to child transmission(PMTCT)	9,650	1	266	0	3,459	4
Blood Safety	191,330	28	0	0	0	0
Safe medical injection	4,794	1	0	0	0	0
Universal precautions	13,185	2	20	0	0	0
Post-exposure prophylaxis (PEP)	1,807	0	0	0	0	0
Prevention activities not broken down by intervention	1,370	0	554	0	9,698	12
Prevention activities n.e.c	1,008	0	50	0	114	0

Prevention subcategories expenditure by their financing agents are shown in table 3.14 As table shows the *education and communication for increasing awareness* and *blood safety* are the two main activities which funded by public financing agents. Whereas blood safety activity are not funded by private and international organizations and the most fund is allocated to *harm-*

reduction programs for injecting drug users (IDUs). Risk-reduction for vulnerable and accessible population is the second most funded activity in the international financing agent.

Unlike other activities, the private sector is very active in *harm-reduction programs* and the most spending of it is financed by out of pocket payments. Therefore near the 96% of private fund are allocated to the IDUs.

Care and treatment:

Based on the results Iran has spent 9.6% of Total AIDS Spending on care and treatment. There are two main subcategories in the care and treatment activities: Outpatient care and inpatient care. 98% of total care and treatment expenditure are allocated to these activities. However there are many activities under the outpatient and inpatient services unfortunately there are not data for break down them in detail. The other activity has 0.6% and the two other non specific activities have 1.4% of total care and treatment expenditure.

Table 3.15: Total AIDS expenditure on care and treatment by its subcategories

Care and treatment subcategories	Total spending on care and treatment			
	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
Outpatient care	116,580	9,013.4	6,333.5	72.8
Inpatient Care	40,348	3,119.5	2,192.0	25.2
Patient transport and emergency rescue	887	68.6	48.2	0.6
Care and treatment services not broken down by intervention	2,319	179.3	126.0	1.4
Care and treatment services n.e.c.	14	1.1	0.7	0.0
Total	160,147	12,381.90	8,700.36	100

Orphans and Vulnerable Children (OVC):

Total expenditure on this category is only 0.2% of total AIDS spending. Table 3.16 shows the expenditure on the subcategories of OVC in IR Rial, USD and average exchange rate in 2012. OVC institutional care has the most expenditure (52%) between the 8 activities. Public fund are funded for OVC and International sources are not allocated to it.

Table 3.16: Total AIDS expenditure on OVC by its subcategories

Orphans and Vulnerable	Total spending on OVC

Children (OVC) subcategories	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
OVC Education	327	25.3	17.8	11.4
OVC Basic health care	358	27.7	19.4	12.4
OVC family/home support	220	17.0	11.9	7.6
OVC community support	218	16.9	11.8	7.6
OVC Social services and administrative costs	205	15.8	11.1	7.1
OVC Institutional care	1,500	116.0	81.5	52.1
Services for OVC not broken down by intervention	50	3.9	2.7	1.7
OVC Services n.e.c	0	0.0	0.0	0.0
Total	**2,878**	222.5	156.3	100

Program for management and administration and HIV- related research expenditure are nor broken down by types due to lack information. So that we do not have any information of those in detail. These two categories have the 6.3% of total AIDS spending in 2012.

Table 3.17: Total AIDS expenditure on human resources by its subcategories

Human Resources	Total spending on Human Resources			
	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
Monetary incentive for human resource	11,142	861.4	605.3	35.1
Formative education to build-up an HIV workforce	1,376	106.4	74.7	4.3
Training	7,066	546.3	383.9	22.3
Human resources not broken down by type	11,196	865.6	608.2	35.3
Human resource n.e.c	948	73.3	51.5	3.0
Total	31,727	2,453.0	1,723.6	100

Human Resources:

Human resources have the 1.9% of total AIDS expenditure in 2012. Table 3.17 shows the details of this expenditure by its subcategories. There are large amount of human resources spending (35%) that it is not broken down by type. Monetary incentive for human resources and training are the two main categories in human resource spending.

Social protection and social services

Social protection and social services and enabling environment in AIDS spending are not well considered. It is allocated only 0.9% of total AIDS spending to these services. Social protection through provision of social services is the main service in this category. It has 64% of total social protection expenditure and Social protection through in-kind benefits has the second most expenditure

Table 3.18: Total AIDS expenditure on social protection and social services by its subcategories

Social protection and social services (excluding OVC)	Total spending on social protection and social services			
	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
Social protection through monetary benefits	1,794	138.7	97.5	11.3
Social protection through in-kind benefits	3,626	280.4	197.0	22.9
Social protection through provision of social services	10,163	785.7	552.1	64.0
HIV-specific income generation projects	28	2.2	1.5	0.2
Social protection services and social services not broken down by type	221	17.1	12.0	1.4
Social protection services and social services n.e.c	38	2.9	2.1	0.2
Total	15,870	1,226.98	862.16	100

Enabling Environment:

There were 4 specific services and 2 nonspecific services in our data collection tool and in the table 3.19 also. But as the table shows the fund is spent in 2 subcategories of enabling environment. Of course the 11.4% of spending could not categorized by respondents and research team. Advocacy services are the main activity in the enabling environment activities and 86.5% of total enabling environment expenditure is spent in this activity. There are no expenditure on AIDS-specific institutional development, Human rights programs and Programs to reduce Gender Based Violence.

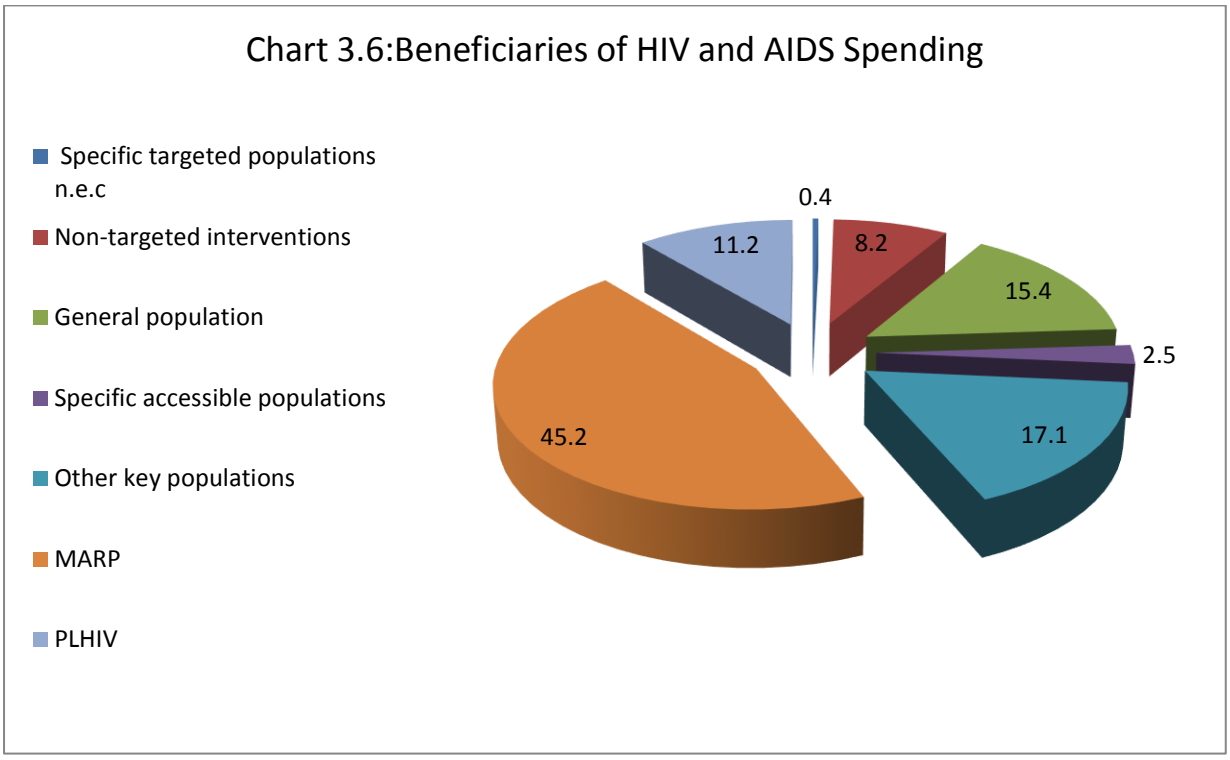
Table 3.19: Total AIDS expenditure on enabling environment by its subcategories

Enabling environment	Total spending on Enabling environment			
	IR Rial (1000000)	USD (1000)	Average Exchange Rate (1000)	(%)
Advocacy	441	34.1	24.0	86.5
Human rights programs	0	0.0	0.0	0.0
AIDS-specific institutional development	0	0.0	0.0	0.0
AIDS-specific programs focused on women	11	0.9	0.6	2.2
Programs to reduce Gender Based Violence	0	0.0	0.0	0.0
Enabling environment activities not broken down by type	0	0.0	0.0	0.0
Enabling environment n.e.c.	58.0	4.5	3.1	11.4
Total	510	39.4	27.7	100

Beneficiaries of HIV and AIDS Spending

There are six sub categories and one nonspecific category (specific targeted population not elsewhere classified (n.e.c.)) of beneficiary populations in the NASA model. Chart 3.6 and table 3.20 show the share and real amount spending per each category in IR Rial and USD in 2012. Based on the results the most beneficiary of AIDS spending in Iran is MARP. Iran spent 758,690,000,000 IR Rial (45.2

% of AIDS financial resources) on most at risk population. Other key populations and General population are the second and third most beneficiaries of Iran AIDS spending.



It is seem that PLHIV would be the most beneficiary population of HIV/AIDS services, but they are the forth beneficiary population in 2012. The most AIDS services that have used by PLHIV are care and treatment.

General population has benefited 257801,000,000 IR Rial of total AIDS spending (table3.20). The most share of this spending is prevention services.

Table 3.20 AIDS Spending by beneficiary population in 2012

Beneficiary Populations	PLHIV	MARP	Other key populations	Specific accessible populations	General population	Non-targeted interventions	Specific targeted populations n.e.c	Total
AIDS Spending (IR Rial 1000000)	187,046	758,690	287,509	41,672	257,801	137,460	6,719	1,676,898
USD (1000)	14.462	58.659	22.229	3.222	19.932	10.628	0.519	129.650
Average USD Exchange Rate (1000)	10.162	41.217	15.620	2.264	14.006	7.468	0.365	91.101
Percent	11.2	45.2	17.1	2.5	15.4	8.2	0.4	100.0

A further disaggregation of the data provides the various sub category groups of populations that have benefited from spending on HIV and AIDS programs in 2012 in the next tables and charts. Table 3.21 shows the AIDS services that population has benefit from them. Unlike other services,

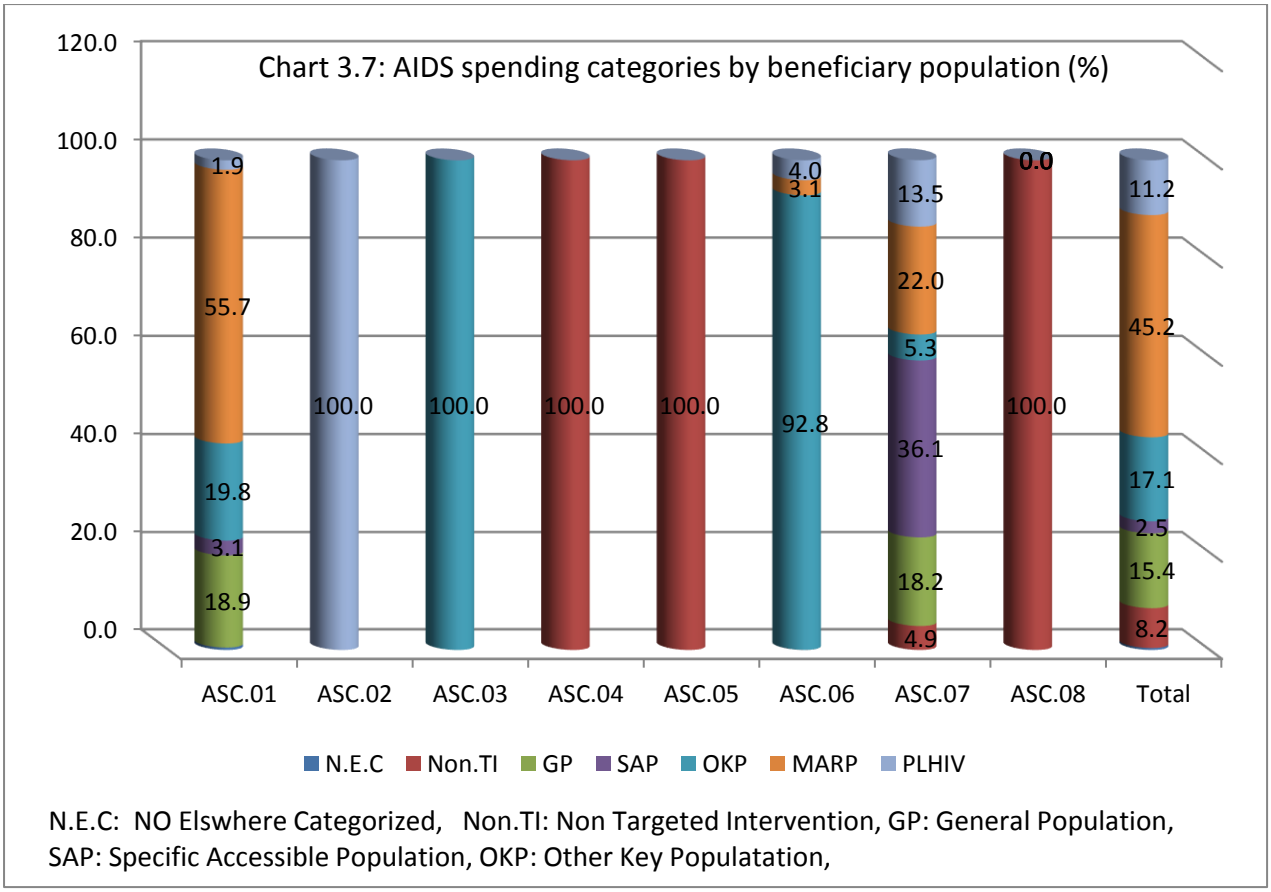
prevention services have been used by all population. Some other AIDS spending categories have been used by specific population such as care and treatment, OVC services, programs for management and administration and human resource.

Table 3.21 AIDS Spending categories by beneficiary population in 2012 (IR Million Rial)

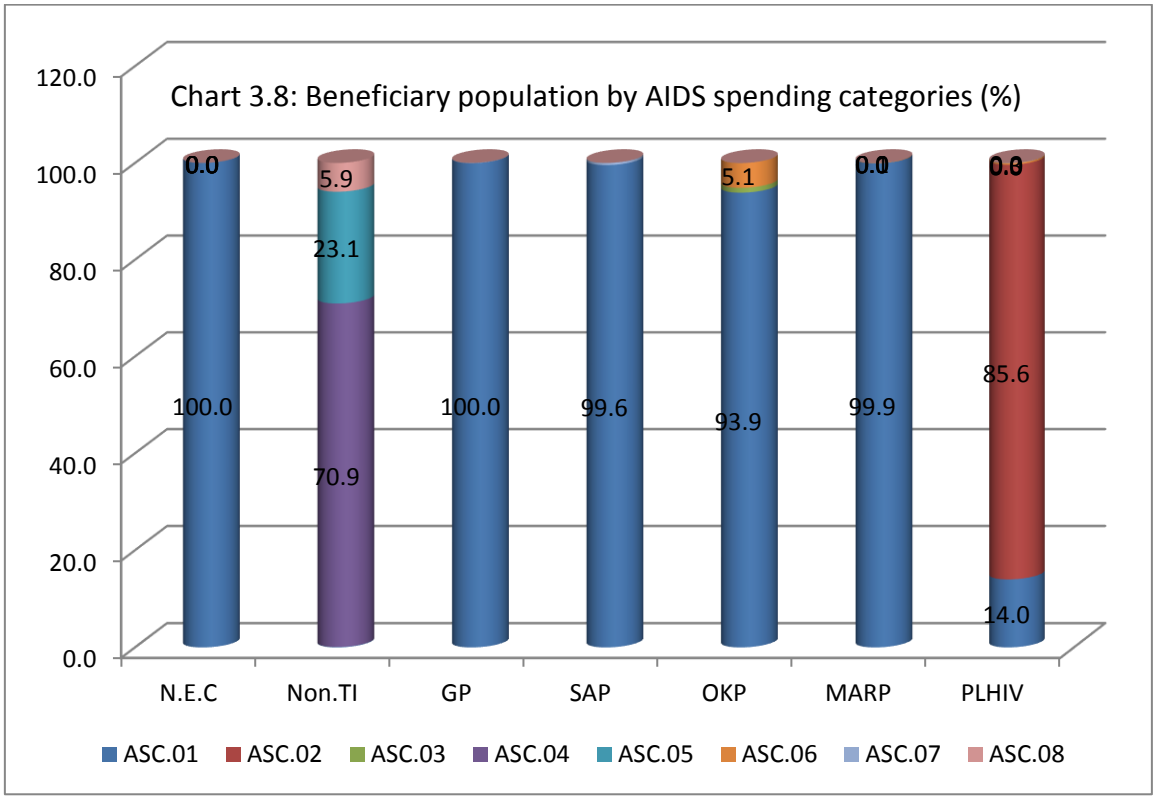
ASC*Beneficiary population	PLHIV	MARP	Other key population	Specific accessible population	General population	Non-targeted interventions	Specific targeted populations n.e.c	Total
Prevention	26,189	758,086	269,871	41,488	257,708	128	6,719	1,360,188
Care and Treatment	160,147	0	0	0	0	0	0	160,147
Orphans and Vulnerable Children	0	0	2,878	0	0	0	0	2,878
Programs for management and administration	0	0	0	0	0	97,416	0	97,416
Human Resource	0	0	0	0	0	31,727	0	31,727
Social protection and social services (excluding OVC)	641	493	14,733	0	0	2	0	15,870
Enabling environment	69	112	27	184	93	25	0	510
HIV-related research	0	0	0	0	0	8,162	0	8,162
Total	187,046	758,690	287,509	41,672	257,801	137,460	6,719	1,676,898

Chart 3.7 shows the beneficiary population of each AIDS services. Most at risk population have used the most AIDS services in totally. They use 55.7%, 22% and 31% of prevention, enabling environment and social protection and social services respectively. All services of care and treatment are used by people live with HIV (PLHIV). On the other hand orphan and vulnerable children services totally are used by other key population. There are 3 categories (program for management and administration, human resources and HIV related research) that they are produced and provided without any targeted population so they are categorized as non-targeted intervention.

Prevention services are used by: 18.9% by general population, 55.7% by MARP, 19.8 by other key population, 3.1% by specific accessible population, and 1.9% by PLHIV.



N.E.C: NO Elswhere Categorized, Non.TI: Non Targeted Intervention, GP: General Population, SAP: Specific Accessible Population, OKP: Other Key Populatation,



Total AIDS services that are used by specific population are shown in chart 3.8. In the other hand you can see broken down services that have used by specific population such as PLHIV. As an example broken down services that have used by PLHIV are: 85.6% care and treatment, 14% prevention, 3% social protection and social services and 1% other services. Near the 100% services that have used by other key population, specific accessible population, general population and specific population not elsewhere categorized is prevention.

CHAPTER IV:

Key finding and Conclusion

Recommendation

Limitations:

Key finding and conclusion:

Iran spent a total of 1,676,898,000,000 IR Rials (US $ 129,650,000) on HIV and AIDS in 2012. It is near 0.37% of total health expenditure. Public funds constituted 57% of the total expenditure.

Funds from external sources made up 8% of all HIV expenditure in 2012, while private sources of funding accounted for 35%. The NASA findings regarding providers of HIV services show that public organizations finance and provide the majority of these services in Iran.

An estimated 894,979,000,000 IR Rials (53.4% of total expenditure) was spent by public service providers in 2012. Private sector providers of HIV-related services include are totally for-profit organizations and was spent 728,402,000,000 IR Rials (43.4% of total expenditure). The results of NASA confirm the general trend that provision of targeted HIV prevention services to MARP (45.7% of total expenditure) has relied mostly on Private for -profit providers (NGOs) funded by private and public sector. Multilateral organizations are also involved in the provision of various HIV and AIDS services (3.1%).

A further disaggregation of data according to the NASA categories shows that the key spending priorities in 2012 have been prevention activities (81.1% of total expenditure); Care and Treatment (9.6% of total expenditure) and Program Management and Administrative Strengthening (5.8% of total expenditure). Another important key intervention area is Human resources (1.9% of total expenditure). Other programmatic areas, including spending on Social Protection and social services, HIV-Related Research and OVC spending on creating an Enabling Environment, made up 1.6% in 2012.

The results show that in 2012 HIV Prevention expenditure was 1,360,188,000,000 IR Rial (US $ 105,164,000) and was spent on the following eight activities: Harm reduction programmes for injecting drug users.(IDUs) (52.9%), Education and communication for increasing awareness (16.2%), blood safety (14.1%), risk reduction for vulnerable and accessible population (4.1%), prevention programmes for sex workers and their clients (2.6), public and commercial sector male condom provision (1.9%), prevention, diagnosis and treatment of Sexuality Transmitted Infection(STI) (1.5%) and Prevention of mother to child transmission (PMTCT) (1%). 5.7% was spent in the other activities.

Total expenditure on Care and Treatment in 2012 was 160,147,000,000 IR Rial (US $ 12,381,900) (9.6% of total expenditure). Over 72.8% of the total expenditure on Care and Treatment was spent on outpatient care. Inpatient care has had 25.2% and other spending categories have had 2% share of total expenditure on Care and Treatment in 2012.

A summary of OVC spending from the study shows that total spending in this area in 2012 was 327,000,000 IR Rial (US $ 25,300) (about 0.2% of total expenditure, entirely from public funding). The main spending on OVC was allocated to OVC institutional care (52.1%). Other basic spending are on: OVC basic health care (12.4% of total OVC expenditure), OVC education (11.4), Family/Home support (7.6%) and OVC community support (7.6%), OVC Social services and administrative costs (7.1%) and 1.7% of OVC expenditure are spent in other categories.

Resources for the national AIDS response have contributed to program management, planning and coordination, upgrading laboratory facilities, infrastructure and new equipment, serological surveillance, monitoring and evaluation and other activities within the area of program management and administrative strengthening. Total spending on this area was 97416,000,000 IR Rials (5.8% of total expenditure).

Spending on Human Resources made up 31,727,000,000 IR Rials (US $ 2,453,000 (1.9% of total expenditure)). Although 35.3% of total human resource expenditure is not broken down but in 2012 most of human resources amount went into monetary incentives for human resources (35.1% of total human resources expenditure), and training public health sector personnel (22.3%).

Total funding on social protection and social services (excluding OVC) was 15,870,000,000 IR Rials (US$ 1,226,980 (0.9% of total expenditure)), approximately entirely from public funding (97%). The main spending in this category is the social protection through provision of social services (64%).

Spending on Enabling Environment in 2012 made up 510,000,000 IR Rials (US $ 39,400 (0.03% of total expenditure). Most of this amount went into advocacy activity (86.5%), AIDS- specific programmes focused on women (2.2%) and the remaining is not broken down (11.4%).

Total spending on HIV-related research (excluding operations research) was 8,162,000,000 IR Rials (US$ 631,028 (over 0.5% of total expenditure, from international and public funding).

Analysis beneficiary populations show that the most beneficiary population of HIV/AIDS services is MARP. 45.7% of total spent benefited the MARP and 16.9% other key population, 2.9 specific “accessible” population (people attending STI clinics, youth at school, etc.), 15% general population, 11.9% PLHIV, 7.1% non- targeted interventions.

There are some key AIDS related services in the NASA guideline that they are not provide and deliver in Iran or provide at the very small scale such as social condom marketing, social services and social protection.

Based on the NHA reporting, the OOP in health sector is high in Iran. The share of it in AIDS related services financing is 35%. But since the many service of HIV/AIDS are free of charge in Iran so that it was expected the value of it's would be very low.

Key recommendations

The data collection process for spending in health sector not institutionalized in Iran. It is recommended to design data gathering system for NHA and subaccount of it by its methodology and codes. It is clear designing for some subaccount such and AIDS should be done by its methodology. Taking into consideration the structural features of Iran healthcare and social security system, namely, a great number of health and social organizations participating in the response to HIV, the process of data collection for NASA has to a large extent become possible thanks to the adoption of the NASA reporting form as official reporting procedure by the Ministry of Health and medical education. Especially susceptibility is developed by running the first round of NASA.

In order to obtain reliable estimates of HIV expenditure, there is a need to strengthen the capacity of sector ministries to track expenditure. This will enable effective financial monitoring and representation of all-round allocations by all ministries and departments participating in the response to HIV.

Resource mobilization is an important element for a scaled-up response to HIV. Given the gaps that exist between the current commitment and that needed to reach Universal Access on the one hand, and actual and required expenditure on the other, increased financial flows to support interventions are especially critical. The sectoral HIV plans play a very important role in resource mobilization, both domestically and internationally. It is therefore critical to establish the financial expenditure of the sectoral HIV plans and comprehensively link them to the overall national planning and budgetary process for resource allocation.

There is a necessity to undertake a comprehensive assessment of out-of-pocket (OOP) expenditure on HIV. Based on the NHA reporting the OOP in health sector is high in Iran. This in AIDS related services is 35%. But since the many service of HIV/AIDS are free of charge in Iran so that it is recommended to provide additional explanation on OOP in reporting and presenting. For example OOP is high in few services such as IDU services. This is in order to prevent moral hazard.

In order to establish to what extent OOP constitutes a large or small portion of total AIDS expenditure, it is recommended that questions related to HIV spending are incorporated into existing household surveys. This will enable the government to establish the proportion of households with excessive AIDS expenditure in Iran. To increase the quality and consistency of the data obtained at the country level, Iran is considering the possibility of introducing a system of national health accounts which will enable effective financial monitoring and promote the capacity development of the national system of monitoring and evaluation.

An effective tool for the National AIDS Spending Assessment was introduced and a national mechanism for its implementation on a regular basis was developed. This will enable implementation and regular improvement of the monitoring of the national response to HIV, the tracking of the efficiency of HIV-related programs and activities, and will also serve as a basis for improving national strategic planning in the field of HIV/AIDS.

In order to reduction in financial relationship between the providers and beneficiaries, the OOP payment should be decreased as possible and these fund should be pooled in one fund. This can led to high efficiency and prevent the supply induced demand.

There are some basic services and some major financing agent and also some providers in Iran that they are not in NASA guideline. In order to coordination and homogenization in reporting of NASA it is recommended these services and agents added to NASA guideline.

Additionally, the National AIDS Spending Assessment (NASA) provides a set of spending categories which can be used for monitoring and evaluation purposes. It is proposed that NAC institutionalize a process of tracking expenditures using NASA tools, not only for future UNGASS reporting but also for resource mobilization and advocacy purposes.

Finally it is strongly recommended the results of this study would use in planning specially in strategic program and focus on some services that mentioned in key finding and conclusion.

Limitations:

NASA tool has been successfully used for this study. Of course, some limitations are in place, but do not impact the overall picture of the findings. Some limitations we noted are:

1. Data for national level might still underestimate in terms of some missing information from the sectors. For example, sectors may classify the activity as non AIDS related but in reality related to AIDS program such as school program activities, prevention on drug abuse (including HIV-AIDS prevention), youth program etc.
2. There are some expenditure in some institution and agents such as scientific association that maybe related on HIV/AIDS. The study is not covered this expenditure.
3. This study has covered most of the major sources of fund for AIDS programs in Iran. However, some donors or NGOs who actually involved in AIDS activities may not covered in this study. This study has covered OOP payment get from service providers. It is maybe missed some OOP payment.
4. There are many unknown HIV people in the country. They use health and social services and may pay for these services but it is not covered in this study.