The Kingdom of Eswatini

The National AIDS Spending Assessment (NASA)

Financial Years 2016/17, 2017/18 and 2018/19

October 2020

UNAIDS

NERCHA

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Abbreviations

AGYW	Adolescent girls and young women
AIDS	Acquired Immune Deficiency Syndrome
ASC	AIDS Spending Category
ART	Antiretroviral therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BP	Beneficiary Population
CANGO	Coordinating Assembly of Non-Governmental Organisations
COP	Country Operational Plan
CSO	Central Statistical Office
DCT	Data Consolidation Tool
DPMO	Deputy Prime Minister's Office
DSD	Differentiated service delivery
EA	Expenditure analysis (PEPFAR data)
AR	Expenditure Report (PEPFAR data)
EU	European Union
FE	Financing Entity
FAP	Financing agent - Purchaser
GAM	Global AIDS Monitor (formerly GARPR)
GDP	Gross Domestic Product
GDI	Gross domestic income
GF	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
HSS	Health systems strengthening
MEPD	Ministry of Economic Planning and Development
MOE	Ministry of Education
MOH	Ministry of Health
MOF	Ministry of Finance
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NERCHA	National Emergency Response Council on HIV and AIDS
NDP	National Development Plan
NMS	National Medical Stores
NGO	Non-governmental organisation
NHA	National Health Accounts
NSF	National Strategic Framework
OOP	Out-of-pocket payments
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PF	Production factor
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PEP	Post-Exposure Prophylaxis
PrEP	Pre-exposure prophylaxis
PF	Production factor
PS	Provider of services
REV	Financing revenues
RTT	Resource Tracking Tool (NASA)
SBC	Social behaviour change
SDM	Service delivery modality

SHA	System of Health Accounts
SCH	Financing schemes
SHMS	Swaziland HIV Incidence Measurement Survey
SNAP	Eswatini National AIDS Programme
SPES	Social protection and economic support
STI	Sexually Transmitted Infection
SWABCHA	Swaziland Business Coalition on HIV and AIDS
SZL	Emalangeni (Eswatini currency)
TB	Tuberculosis
TFR	Total Fertility rate
TWG	Technical working group
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly on HIV/AIDS
USD	United States dollar
USG	United States government
VMMC	Voluntary medical male circumcision
WB	World Bank
WHO	World Health Organisation

Foreword

The National Emergency Response Council on HIV and AIDS (NERCHA) with the support of UNAIDS conducted the fourth round of the National AIDS Spending Assessment (NASA). This report outlines a systematic methodology to track the flow of resources from source to beneficiary populations. Its resource tracking algorithm is designed using the same categories in the global health resource needs estimation model and globally accepted accounting procedures for National Accounts (NA), PEPFAR HIV Expenditure Analysis (EA), National AIDS Accounts (NAA), National Health Accounts (NHA), and AIDS Budget Analysis.

The information from the undertaking informs resource mobilization and allocation plans and enables the country to meet its obligations of reporting on progress made in response to GAM and other declarations. All partners that have carried out HIV related activities as a funder or implementing agency provided data on their expenditures. For purposes of triangulation, the data was collected at three levels: funding source, funding agent and service provider. The main aim of the NASA is to undertake a comprehensive analysis of actual expenditure for the HIV and AIDS activities in both health and non-health settings. The report therefore tells us who the funders for the national response are and the levels of expenditure in each of the HIV and AIDS programmatic classifications as determined by UNAIDS.

This report demonstrates the commitment of the Government of the Kingdom of Eswatini, the private sector, international and development partners in providing resources for coordinating and implementing the national response to a disease, which is HIV and AIDS. Noted in this report is the proportion of financial contribution by government, which has been increasing and basically signals the placing of health as one of the top priorities of government's programme. This is also demonstrated by the political will displayed by the country's leadership to control the spread of HIV. Worth mentioning is the contribution of the private sector, which indicates the willingness of the business community to join forces in assisting government to respond to a situation that has been proven to have adverse effects on the economy.

It is upon these auspices that all multisectoral HIV response stakeholders at all levels and spheres utilize this report as a yardstick to inform their planning and resource allocation for interventions or services implemented.

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NERCHA extends appreciation to all the stakeholders and key informants who provided information for the study.

Our appreciation goes to the consultants, Teresa Guthrie and Joshua Karume in leading and ensuring that this task is achieved. Special thanks go to the local consultant – Henry Ginindza and the team of data collectors for the dedication and commitment shown as they executed their tasks.

This assessment would not have been a success without the full weight of the steering committee headed by NERCHA Director Financial Services.

Lastly appreciation goes to the NERCHA team that facilitated and coordinated the whole process: Bheka Mziyako (Team lead – NASA), Bongani Dube (Assistant Team lead – NASA), Regional M&E Officers: Wandile Dlamini, Slungile Mhlanga, Njabuliso Dlamini and Gcina Kunene.

Executive Summary

The Kingdom of Eswatini continues to show commitment in the fight against HIV pandemic. Over the past decade, the country's HIV and AIDS response has formulated strategies to maximise resources for implementing technically effective interventions for combination prevention, social protection and comprehensive HIV treatment for all people living with HIV (PLHIV). According to the most recent UNAIDS HIV estimates (2019), 98% of PLHIV knew their status, 96% were on treatment and 92% were virally suppressed.

The Kingdom of Eswatini is in the process of strengthening the management of the national response to HIV and AIDS. The country's national HIV and AIDS strategic Framework (2018-2023) highlights the need to put in motion mechanisms to mobilise and realign resources to priorities that best serve the HIV response and to undertake regular tracking of expenditure. It is for this reason that the country undertook the third National AIDS Spending Assessment (NASA) covering the years 2016/17-2018/19, under the leadership of the National Emergency Response Council on HIV and AIDS (NERCHA) with the technical support from UNAIDS. The previous assessments covered 2007/08-2009/10 and 2010/11-2012/13. The NASA seeked to ascertain the flows of funds used to finance national responses to the HIV epidemic.

The exercise has been conducted in guidance by the NASA which outlines the classification to produce national AIDS spending assessments to track resources of national HIV and AIDS responses. The guide also ensures the allocation and consumption of services without duplication The NASA framework estimates the financing flows and expenditures from their origin (i.e. the financing entity, the funding agent and the service provider) to their final destination (i.e. the interventions, their production factors and the beneficiaries of the goods and services) in all sectors involved in the implementation of HIV programmes.

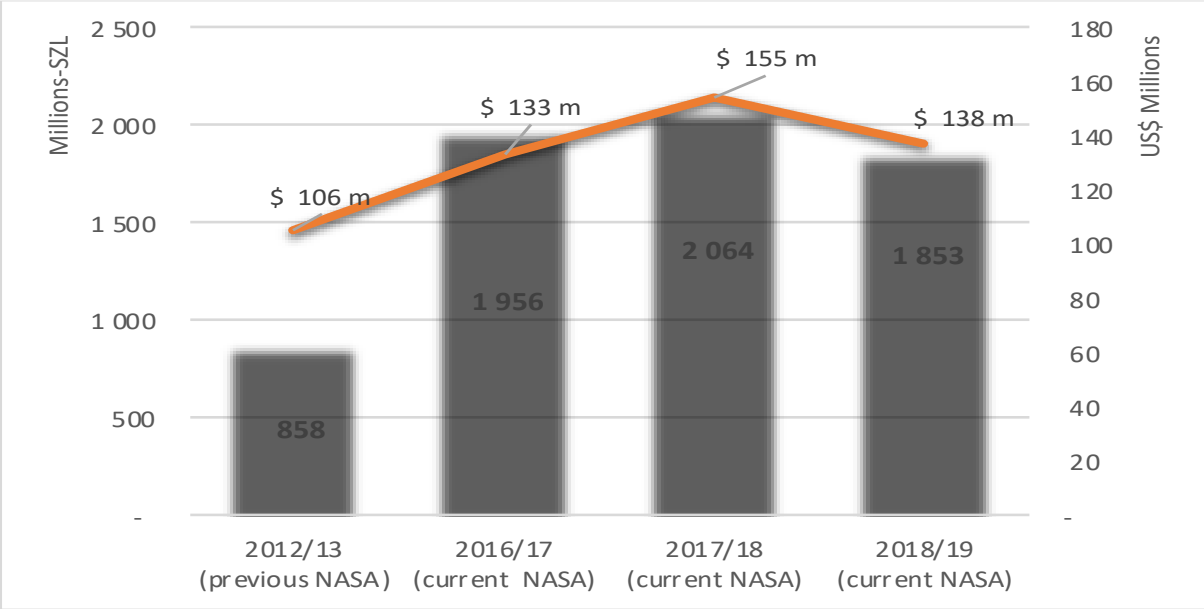
and the assessment used primary data collection techniques for 99% of expenditure data and only 1% was based on the National Health Accounts estimation of MOH shared costs attributable to HIV. The assessment has answered the following questions:

- How do the HIV funds flow in Eswatini?
- Who pays for HIV services in Eswatini? Who pools funds? What funding schemes are used?
- Which financing schemes and funding agents/providers are purchasing the HIV services?
- Who are the providers of HIV services in Eswatini?
- What HIV services are being provided, and what is being spent on them? What are their service delivery models?
- Which services are vulnerable to external shocks if international funding (entities and/or schemes) reduce?
- Who are the beneficiaries of HIV spending in Eswatini?
- What are the key cost drivers, the production factors, of the HIV spending in Eswatini?

Additionally, the study has explored issues of sustainability, allocative and technical efficiencies – *in as far as the data allowed, without having conducted full efficiency analyses.*

The results shows that the total expenditure for HIV in Eswatini in the fiscal year 2016/17 was SZL 1.96 billion (US$ 133 million[1]), increasing by 6% to SZL 2.1 billion (US$ 154.8 million) in 2017/18. In 2018/19 the amount decreased by 10% to SZL 1.85 billion (US$ 137.6 million). The decline in 2018/19 is partly explained by a 12% reduction in PEPFAR expenditures in 2018/19, as well as a 19% reduction in the Global Fund spending. HIV funding increased by 32% per year (on average) between 2012/13 and 2016/17.

Trends in HIV spending in Eswatini (2012/13 – 2018/19)



Note: The figures presented above for 2016/17 to 2018/19 were collected through the current NASA process, and represent actual expenditures reported by the respondents. Only 0.9% were provided by the National Health Accounts teams as estimates of the MOH indirect HIV spending. NASA collected **all other MOH direct HIV spending** (please refer to the assumptions section for details and exchange rates applied), as well as all other sources of funding for HIV.

The Government's commitment and leadership in the fight against HIV have been evidenced in their increasing commitment of public revenue to the HIV response (reaching 40% by 2018/19), via central government funding schemes, thereby improving sustainability and ensuring alignment to the NSF priorities. From the previous NASA (2012/13), the annual average rate of increase in public contributions, in Emalangeni (SZL) terms, over the four years (2012/13 - 2016/17) has been an impressive 20%, *average annually*. Over this NASA study period, the public commitment increased by 12% between 2016/17 and 2017/18. However, in 2018/19, due to stagnated economic growth, the public commitment to HIV grew by only 1% in SZL terms, but also noting that the international contributions between 2017/18 and 2018/19 declined by 17% in SZL (18% in USD). Importantly, Eswatini's proportional public contribution to all treatment and care interventions reached 52% by 2018/19, and 60% towards ART specifically. In terms of prevention spending, only 23% came from public resources in 2018/19, and these were primarily for interventions for children and youth, while the international funding entities were funding the Five Pillar prevention interventions.

[1] Exchange rates for SZL: 1USD = 14.7 in 2016/17, 13.3 in 2017/18, 13.5 in 2018/19.

Between 2017/18 and 2018/19, international funding for HIV in Eswatini declined by 18% in USD terms which was even less than their contributions in 2016/17,. further decline would force the Government to increase its HIV allocations, mobilize domestic resources and explore alternative funding options. Unfortunately, the poor economic climate added to the COVID-19 demands on the public budget will make this challenging.

The private sector's contribution to HIV made up only 0.7% of the total HIV spending in 2018/19, and further opportunities to leverage resources from this sector could be explored. Additionally, extra efforts will be required to improve their response rate to future NASAs, in order to better track their contributions.

The two key funding schemes for HIV in Eswatini in 2018/19 were government schemes (48%) and resident foreign agencies schemes (42%), and decreasing amounts going through non-resident foreign agency schemes (only 6% in 2018/19). Importantly the funding through government schemes increased in proportional terms over the three years, thus improving sustainability and national direction of the response. The government should consider measures to continue to increase the funding flowing through government schemes, in addition to increasing public revenue funding.

Additionally, the NASA results highlight the public sector's key role as financing agent and purchaser (FAP) of HIV services in the country. FAPs are entities which mobilize financial resources collected from different financing sources and transfer them to pay for, or purchase, health care or other services or goods. They are therefore important in ensuring efforts are aligned to the national priorities outlined in the NSF. It is notable, therefore, that 48% of all HIV funding went through public agent-purchasers (in 2018/19), which implies important leadership and ownership by the government. Only 4% went through private FAPs, and the 48% through international FAPs (mostly for PEPFAR funds).

Regarding the focus of spending over the three years, it was found that the amount spent on care and treatment increased by 27% in 2017/18 and then again slightly by 3% but continued to take a greater share of the total HIV envelop, reaching 36% by 2018/19. The spending on HIV testing services almost doubled between 2017/18 and 2018/19, from 3% to 6% of total HIV funding. Prevention spending increased by 12% and then 3% in 2018/19, with increasing shares going to the Five Pillars of Prevention at 32%, 32% and 41% in 2016/17, 2017/18 and 2018/19 respectively, with 10% of all prevention spending on AGYW, 2% for interventions for key populations, 13% for condoms, 15% for VMMC and 5% towards PrEP in the outer year. The remaining 59% prevention spending went to other (non-five-pillar) prevention interventions, such as 28% for children and youth interventions (not specifically for AGYW), community mobilization (11%), and 6% was for prevention not disaggregated.

Regarding providers of HIV services, this NASA found that in 2018/19 just under half (47%) of the HIV funds were channeled to public service providers, 18% went to non-profit organisations (civil society organisations, including some PEPFAR sub-recipients), 1% to private (for-profit) providers, 3% to international NGOs (INGOs), 1% to multilateral entities, and the remaining 30% went to the other PEPFAR implementing partners (IPs) and their sub-recipients (SRs)/ service providers.

Of all the HIV spending in Eswatini in 2018/19, 38% benefitted PLHIV (directly benefiting from the large share of spending on treatment and care), 23% went towards vulnerable and priority populations

(including OVCs, youth in school), *1% for key populations*[2] and 13% towards the general population. Finally, there were 25% of funds that went towards non-targeted interventions – which tend to be those at national levels, mostly the programme enablers and system strengthening, which are necessary to strengthen the entire system and benefit all.

The examination of the production factors (cost components) found that of all the funds from public entities in 2018/19, less than 8% was spent on personnel (*probably with some underestimation of civil servants' salaries engaged in HIV activities),* while 29% of international funding went to salaries. Just over half of the public funds (52%) went to medical good and pharmaceuticals (mostly ARVs), while 22% of international funds went to these. A third of public funds went to the financial support of beneficiaries (through the cash grants), and only 2% for operational costs (again, probably an underestimation due to being embedded in the general health budget). There were 13% of international funds reported for operational costs, while 33% of international funds were not disaggregated recurrent costs by production factor in 2018/19 (partly due to the new PEPFAR ER categorization).

In conclusion, the Kingdom of Eswatini has made great progress in its commitment of domestic revenue to the HIV response, and also in terms of the funds flowing through central government financing schemes, ensuring greater government direction and management of funds as well as improving sustainability, particularly for the ART programme..

[2] Note that here, we report that 3% of *all spending* (which can include all interventions), while earlier we indicated 1% of *only prevention* spending went to KP prevention interventions.

1. Introduction and background

Global commitment has been made to achieve the Fast-Track target to end AIDS by 2030 (UNAIDS, 2020). To facilitate this, Target 8 states: *"Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers"*.

In order to measure progress towards this target, and ultimately to achieve universal access to HIV prevention, care and treatment, and support services, each country must be able to timeously identify the use of financial resources allocated to HIV/AIDS response. Thus, in line with the UNGASS Declaration of Commitment on HIV/AIDS, UNAIDS in collaboration with governments, has developed a system to estimate the resource flows and levels of spending for the response to HIV at the country level through the implementation of National Aids Spending Assessment (NASA).

The NASA methodology/model provides strategic information on the effective allocation of financial resources and their use in the different focus areas of the national response. The NASA framework estimates the financing flows and expenditures from their origin (i.e. the financing entity, the funding agent and the service provider) to their final destination (i.e. the interventions, their production factors and the beneficiaries of the goods and services) in all sectors involved in the implementation of HIV programmes.

The Kingdom of Eswatini had carried out two rounds of NASA, the first in 2011 covered the period 2007/08 to 2009/10, and the second NASA was conducted in 2015 for the period 2010/11 - 2012/13. Both assessments were conducted under the leadership of the National Emergency Response Council on HIV and AIDS (NERCHA) with the technical support from UNAIDS.

This third NASA report covers the public financial years 2016/17, 2017/18, and 2018/19. The report aims to provide a description of the public, international, and private funding entities (excluding out-of-pocket payments) for HIV in Eswatini. In addition, the data presented here could trigger further analysis on issues such as equity, efficiency, absorptive capacity, allocative efficiency, and sustainability.

1.1. Eswatini country context

Landlocked between Mozambique and the East of South Africa, Eswatini is the second smallest country in Africa with 17,364 km² of landmass, divided into four administrative regions: Hhohho, Lubombo, Manzini, and Shiselweni. Each of the four regions is, in turn, divided into smaller tinkhundla (an inkhundla is an administrative subdivision smaller than a district but larger than an umphakatsi (or "chiefdom"). The 2017 Population Census Preliminary result estimated the population of Eswatini at 1.1 million comprising 48.6% males and 51.4% females (Central Statistical Office (CSO), 2017). The demographic portion of children aged 0-14 year was 35.5 %, followed by the adult group 25-54 years at 34% while adolescents and young people aged 15-24 years were 20.7% (CSO, 2017). The population density in Eswatini was 63 per km^2 in 2017, with 29.6% of the population being urban based (339,434 people) and the median age was 21.7 years in 2017, with 56 % of the population is below 25 years old (CSO, 2017).

Table 1: Eswatini demographic, socio-economic and health indicators

Indicator	Value and year		Indicator	Value and year
Population	1,093,238 (2017)		**Life expectancy**	57.7 years (2017)
Population growth (annual)	1.8% (2017)		**Total Fertility Rate (TFR)**	2.69 (2017)
GDP per capita	US$ 3,224.39 (2017)		**Health expenditure**	5.9% of GDP (2016)
GDI (PPP) per capita	$8,520 (2017)		**HIV-adult prevalence rate**	27.6% (2019)
GNI	$11.65 billion (2017)		**People living with HIV**	200 000 (2019)
GDP growth	2.0% (2017)		**Annual new HIV infections**	4500 (2019)
Public Finance deficit	E699. 5 million (2018)		**Annual AIDS deaths**	2300 (2019)
Human Development Index (HDI) value	0.588 (2017)		**Antenatal Coverage**	98% (WHO, 2018)
Population below the poverty line	58.9%		**% of children under 18 who are orphans**	23%
Sources: Swaziland Population and Housing Census (2017), Swaziland Household Income and Expenditure Survey, National Budget Estimates Book (2018), Eswatini Central Statistical Office (2018), World Bank (2017 & 2018), (SHIMS2 2016-2017), UNAIDS HIV estimates (Spectrum, 2019)				

1.2. Eswatini's economic situation

Eswatini is ranked 112/190 in the World Bank's Doing Business ranking and the country suffers a high level of poverty (58.9% in 2017) with a Gini Coefficient of 54.6 (2016) owing to significant income inequalities and an unemployment rate of 41.7% (World Bank, 2017).

The Central Bank of Eswatini (CBE) has projected that the economy will slow to 1.4 % in 2019 from 2.4% in 2018, mainly due to deteriorating fiscal space. According to the Central Statistics Office (CSO), the GDP is estimated to have grown from 2.0% in 2017 to 2.4% in 2018. This growth was attributed to positive development in the primary and tertiary sectors but was expected to decelerate to 0.4% in the course of 2019 and 2020 (MEPD, 2018). The impact of the Coronavirus (COVID-19) pandemic could unfortunately reduce projected economic growth further.

Prior to COVID-19, Eswatini was already experiencing a period of macroeconomic instability. The Ministry of Economic Planning and Development (MEPD) has noted that the economic condition deteriorated due to recurrent and prolonged drought and sharp decline in Southern African Customs Union (SACU) receipts. Rising government spending, lower sugar prices, lower customs revenues collected under SACU, and the accumulation of domestic arrears have widened the fiscal deficit, public debt has increased and international reserves have declined (MOEPD, 2017 & IMF, 2019).

In 2019, the policy of fiscal tightening was pursued in the country's development plan defined until 2022, giving priority to infrastructural development, agricultural production, and economic diversification while reducing poverty. Eswatini is promoting a comprehensive industrial policy to support diversification, develop local entrepreneurs, and promote industrialization across the country. In this context, the government has implemented initiatives to develop and promote Swazi indigenous entrepreneurship, particularly in small and medium-sized enterprises. However, the persistent challenges include climate vulnerability (drought), lack of technological preparedness, and dependence on neighbouring South Africa (AFDB, 2018).

Regarding health sector financing in Eswatini, the most recent National Health Accounts report for 2017/18 found that public revenues funded 51% of the total health spending, development partners contributed 25%, businesses 11% and out of pocket payments made up 12% of the total (MOH, 2019: NHA report).

1.3. HIV situation in Eswatini

The HIV epidemic in Eswatini was traditionally generalized but current evidence has shown that the epidemic has shifted to higher micro-epidemics with certain groups being disproportionately affected. HIV prevalence is estimated at 27.02% among adults aged 15-49 years, higher in females at 35.61% compared to males at 18.02% (UNAIDS estimates, 2020). New HIV infections are estimated at 4 500, of which 1 500 occurred among adolescents and young women aged 15-24 years (UNAIDS estimates, 2020). AIDS-related deaths are estimated at 2 300, of which 1300 were among females and 1 000 among males (UNAIDS estimates, 2020). HIV prevalence among sex workers was estimated at 60.5%, men who have sex with men (MSM) at 12.6% while adolescent girls and young women (AGYW) at 16,7% in 2015 (UNAIDS 'AIDSinfo', 2019).

The Kingdom of Eswatini continues to show commitment in the fight against HIV pandemic. Over the past decade, the government has pursued efforts to scale up HIV treatment and prevention programs, with a national target to end AIDS as a public health threat by 2022 (NSP 2019-2023). 9 The National Strategic Framework on HIV and AIDS 201-2023 (NSF) has formulated strategies to maximise resources for implementing technically effective interventions for combination prevention, and comprehensive HIV treatment for all people living with HIV (PLHIV).

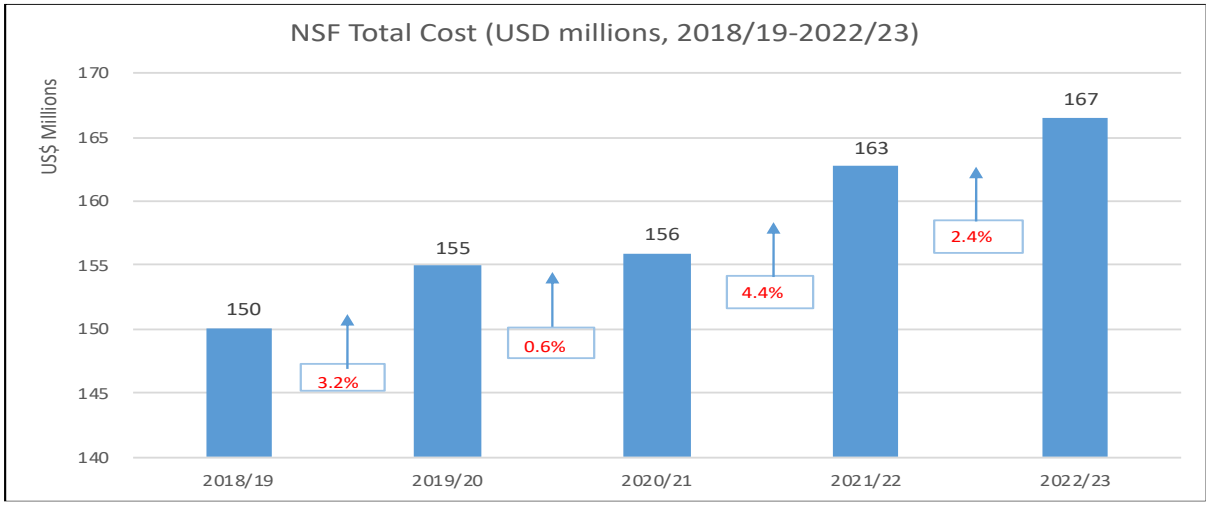
Eswatini has accelerated the implementation plan of the Test and Treat policy, so that all people living with HIV (PLHIV) are to be treated with Antiretroviral Therapy (ART) regardless of CD4 count, clinical stage, age or population. According to the most recent UNAIDS HIV estimates (2019), 98% of PLHIV knew their status, 96% were on treatment and 92% were virally suppressed.

The NSF (2018-2023) described HIV as one of the greatest threats to socio-economic development in the Kingdom and marks a change in the approach of managing the national response to evidence and results-based multisectoral and decentralised planning. To achieve the goal to end AIDS by 2022, the NSF has set the following targets:

1. Reduction of HIV incidence among persons aged 15-49 years by 85%.
2. Reduction of HIV incidence among persons aged 15-24 years by 85%.
3. Reduction of new HIV infections among infants aged 0-1 year to less than 0.05%.
4. Reduction of AIDS deaths by 50%.

The resources need to fund the full NSF were estimated and are shown in Figure 1 below.

Figure 1: Estimated resources needed for the NSF interventions and targets



Source: NERCHA, 2018. NSF (2018-23).

The previous NASA found that Eswatini government was the largest contributor of funding for Eswatini's HIV response with 42% share of the total spending in 2012/13, followed by the President's Emergency Plan for AIDS Relief (PEPFAR) with 40%, and then the Global Fund to Fight AIDS, Malaria, and Tuberculosis (GF) with 6%.

2. The National AIDS Spending Assessment in Eswatini

2.1. The rationale for an HIV spending assessment

The Kingdom of Eswatini is in the process of strengthening the management of the national response on HIV and AIDS. One of the requirements of the national HIV and AIDS Framework (2018-2023) is to put in motion a mechanism to mobilise and realign resources to priorities that best serve the HIV response and also track them.

The NASA framework produces. The NASA provides information that will guide the country authorities' decision-making, determine the level of expenditure incurred in each program area, to measure the potential financing gap, and to improve future allocative decisions and mobilize for additional resources in an evidence-based planning process. NASA results will inform the processes of developing key national strategies such as the Sustainability Plans, Allocative or Productive Efficiency analyses, to monitor the implementation of the National Multisectoral Strategic Framework (NSF) 2018-2023 and the country's Global Fund funding request. The NASA data also allows for further examination of aspects of equity, efficiency, absorptive capacity, and allocative efficiency, and are critical to inform the sustainability discourse.

2.2. Objectives of the NASA in Eswatini

The overall goal of this NASA is to contribute to the strengthening of comprehensive tracking of actual spending (from all funding entities) on the national response to HIV and AIDS in Eswatini, for the financial years 2016/17, 2017/18 and 2018/19, applying the new NASA (2020) framework.

Specific objectives of the assessment are:

1. To implement the new NASA 2020 methodology for systematic monitoring of HIV financial flows at the national and regional levels in Eswatini.
2. To use the new NASA 2020 classifications and the UNAIDS data collection tool (DCT), and to adapt the NASA tools to the Eswatini context only if necessary.
3. Build national-level capacity for systematic monitoring of HIV financing flows using the NASA methodology, with a view to a yearly, fully institutionalized NASA.
4. To conduct an HIV spending assessment focusing on public and development partner (international) resources and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities *but excluding out-of-pocket expenditure*.
5. To identify and measure the flow of resources for HIV applying the latest NASA 2020 vectors and classifications, including:
    a. funding entity *(FE),*
    b. revenue *(REV),*
    c. financing scheme *(SCH),*
    d. financing agent-purchaser *(FAP)*,
    e. the service provider *(PS),*
    f. the service delivery modality *(SDM),* function/ intervention *(ASC)*,
    g. cost components (factors of production, *PF*) and,
    h. beneficiary populations *(BP)*.
6. To prepare a report of expenditure trends that will inform the development of Sustainability Plans, mid-term review of the National Multisectoral Strategic Framework 2018-2023, the Global Fund funding request and to generate the financial matrix for the Global AIDS Monitor (GAM).

We believe that all these objectives have been fully realized, except that building national-level capacity to undertake NASA more routinely may require additional support, and various recommendations have been made for institutionalizing NASA.

2.3. NASA methodology and scope

The National AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV. The tool tracks actual expenditure (public, private, and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV.

The NASA methodology seeks to provide answers to seven key questions:

- Who pays for HIV services in Eswatini? Who pools funds? What funding schemes are used?

- Who purchases the HIV services?
- What mechanism (insurance) allows payment?
- Who are the providers of HIV services in Eswatini?
- What HIV services are being provided, and what is being spent on these? What are the service delivery models?
- Who are the beneficiaries of HIV spending in Eswatini?
- What are the key cost drivers, the production factors, of the HIV spending in Eswatini?

To answer these questions, the NASA methodology reconstructs all the financial transactions related to the national response to HIV. In the NASA2020 framework, the financial flows and expenditures related to the national response to HIV are grouped into three dimensions: finance, provision, and consumption/utilisation. Each of these dimensions is broken down into several vectors, a total of nine. The classification of the three dimensions and nine vectors constitutes the framework of the NASA 2020 and each of the nine vectors answers the above questions:

❖ **FINANCING**

1. **Financing entities (sources) (FE)** refers to economic units providing the resources to the schemes (used by the agents).
2. **Financing revenues (REV)** are mechanisms to provide resources to financing schemes (used by the agents).
3. **Financing schemes (SCH)** are modalities through which the population access the services.
4. **Financing agents & purchasers (FAP)** are economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities).

❖ **PROVISION OF HIV SERVICES**

5. Providers of services (PS) are entities that engage in the production, provision, and delivery of HIV services.
6. Production factors (PF) are inputs/resources (labour, capital, natural resources, "know-how," and entrepreneurial resources) used for the production of ASC.

❖ **USE**

7. AIDS spending categories (ASC) are HIV-related interventions and activities.
8. Beneficiary segments of the population (BP) are populations intended to benefit from specific activities (eg. key population groups such as men who have sex with men, injecting drug users, etc.)
9. Service delivery modality (SDM) – a new variable in NASA 2020 which indicates the modality of the service provided.

The following parameters defined the scope of this third NASA in Eswatini:

- ✓ Public financial years: 2016/17; 2017/18 and 2018/19.
- ✓ HIV interventions (excluding TB and STIs expenditures).
- ✓ Due to time and resource constraints the NASA steering committee decided to exclude the out-of-pocket payments (OOPs) from this current NASA.
- ✓ Funding entities to be included: public, international, private (businesses and non-profit).
- ✓ Level of the assessment: National.

- ✓ The database and report currency will be Emalangeni (SZL). Key tables will also be converted United States dollars (USD) in the appendices, applying each year's annual average weighted exchange rate from the Bank of Eswatini.
- ✓ All nine NASA vectors were captured, as far as available data allowed.

2.4. NASA teams

This NASA was conducted under the leadership of a steering committee led by NERCHA with support from UNAIDS. The committee was responsible for providing leadership and policy guidance and oversight of the process and results. The assessment was also conducted through a technical committee, with representation from government, civil society, private sector and development partners, who have played active parts in designing the NASA and providing technical advice. These included NERCHA, Ministry of Health, Ministry of Finance, Ministry of Economic Planning and Development, Clinton Health Access Initiative (CHAI), Coordinating Assembly of Non-Governmental Organizations (CANGO), Swaziland Business Coalition on HIV and AIDS, and UNAIDS.

Consultancy and field staff

Several advocacy and sensitization meetings were held with partners to facilitate the process. The NASA teams obtained all necessary permissions from the national authorities to access relevant data and conduct the assessment. The letter of support for the mission is presented in Appendix 4.

2.5. Operational NASA dimensions, vectors and definitions

In the NASA2020 framework, the financial flows and expenditures related to the national response to HIV are grouped into three dimensions: finance, provision, and consumption/utilisation. Each of these dimensions is broken down into several vectors, a total of nine. The classification of the three dimensions and nine vectors constitutes the framework of the NASA2020 system as follows:

2.6. NASA study design

The study design was a quantitative survey of the funding entities, funding agents/purchasers and service providers of HIV services in Eswatini. NASA implementation occurred in the following phases:

1. Planning, Mapping of Actors
2. Training of the local consultant and data collectors
3. Sampling and Data Collection
4. Quality Control and data validation
5. Data Analysis, Validation of Findings and Report Writing

2.7. Study population

A composite list of international, national and community-based organisations was generated from NERCHA. See annex X…The study was intended to include all funding entities for HIV, including:

- Public (all), international (all), private (not-for-profit and for-profit, noting that the response from for-profit sector was very weak)
- National and provincial levels: The four administrative regions were included in the sample for primary data collection, the spending of all four regions were captured through the central levels and headquarters.
- Providers of HIV services in Eswatini – including public facilities; UN agencies, NGOs (local and international).

For each of these organisations/departments, the Directors, Programme Managers, Finance Directors, and Finance Officers were interviewed.

Note that this study did not interview persons living with HIV (PLHIV) since individual or household spending on HIV was not included in the scope of the study. The collection of out-of-pocket spending (OOPs) normally requires a large household survey, with cost and time implications that were beyond the scope of this NASA.

2.8. Sampling approach

To facilitate the sampling process, the national NASA technical committee led by developed the register of all the stakeholders involved in HIV/AIDS to provide the sampling frame from which the majority of funding entities, funding agents/purchaser and key providers were selected for inclusion. The list of partners/stakeholders comprises all public, private-not-for-profit institutions, for-profit institutions (faith and non-faith-based organisations) as well as civil society or non-governmental organisations. In addition, the list of organisations was expanded through the snowballing approach during fieldwork.

Partners with the largest portfolio of services and expenditure were prioritized to ensure that at least 85% of all the HIV expenditure in the country was captured, while also ensuring the selection of smaller but important service providers (who may have been the only providers of specific services such as those for the key populations).

Additionally, the Swaziland Business Coalition on HIV and AIDS (SWABCHA) provided the list of private for-profit organisations providing HIV services in the Kingdom and PEPFAR also shared their list of Implementing Partners.

2.9. Data collection

Primary data were collected through a nationwide participation, and all organisations in the mapping list were approached for their expenditure data. The majority of data were collected from the institutions' main offices in Mbabane but included all their expenditure from all regions. Data

collection initially occurred over the period 15 July to 30 August 2019 but due to non-responses and unsatisfactory data, the second round of data collected was extended to 15 November 2019.

The NASA primary data was collected through face-to-face interviews as well as self-administered questionnaires, and the respondents' expenditure records were also obtained as part of the primary source for NASA. Data collectors assisted the respondents to complete the NASA forms. The assessment also used the secondary data through a desk review of key financial reports/documents, sources of funds, policies, annual programme reports, the National Multisectoral HIV and AIDS Strategic Framework (2018-2023), previous expenditure analysis reports, National Health Accounts, Estimates documents and audited reports.

HIV actual expenditure data was obtained from quarterly, bi-annual and annual expenditure reports as well as audited accounts of participating organisations. Top-down and bottom-up approaches were employed during data collection. The top-down approach involved collecting data from funding entities and funding agents while the bottom-up approach involved collecting data from the service providers. The data from the three levels were triangulated by comparing and consolidating them into one transaction, to avoid double counting. Thus, when a complete transaction was captured, all the data from the funding agents and providers indicating the same funding received from that source would be excluded to ensure that there is no double-counting from the source and provider perspectives.

PEPFAR provided their expenditure analysis (EA) and expenditure reporting (ER) data, and their IPs e did not need to be contacted. Where an organisation received funding other than PEPFAR, they were asked to only report their non-USG resources to avoid double counting. EA and ER data at the service provider level were not verified, but this was the data publicly available on the PEPFAR website and have therefore been validated by the PEPFAR agencies.

NASA data collection tools, developed by UNAIDS, were used to collect quantitative data, using close-ended questions for HIV expenditure data. Alongside with the traditional NASA forms, a new template had been designed specifically for the Eswatini NASA (Appendix 5). Data was collected using both soft and hard copies of the tools. However, PEPFAR and Global Fund among others, provided electronic expenditure reports that data collectors and consultants converted into the NASA format.

Ten data collectors and a local consultant were contracted by NERCHA and were trained in the NASA 2020 methodology, in the use of the NASA tools, as well as general interviewing and research skills.

2.10. Data capturing and processing

Data were first captured in the hard copies of the tools. The raw data were then entered into Excel spreadsheets and were translated into the format required to be captured in the Data Consolidation Tool (DCT). The data were entered into DCT by the international consultant. The DCT is an excel-based spreadsheet that follows the nine vectors of the NASA methodology. The DCT translates raw data into the NASA format, it serves to organize, clean, and verify the completeness of data, any missing, incomplete, or contradictory data were identified and addressed. The NASA principle of capturing only completed transactions and the processing of the data first in Excel sheets also assisted the team in undertaking triangulation, ensuring complete transactions, and reduced the chances of double counting.

2.11. Data Analysis

The data from DCT were imported into the NASA Resource Tool (RTT). The RTT software is a tool that allows the user to create the NASA set of matrixes, linking all the NASA vectors to the HIV spending amounts entered into the system. The use of RTT was exceptional in aggregating and analyzing the data, in creating funding flow diagrams, and it also generates the full dataset in excel spreadsheets that were used to create graphical displays and tables.

2.12. Quality Control

a) Data collectors and supervisors were trained for four days. The training aimed to provide the trainees with a strong theoretical understanding of the NASA2020 principles, methods and classifications, with practical sessions on filling of the tools using test cases.

b) Data collected were cross-checked daily by the international consultant managing the project (who was in-country and in the field) for completeness and accuracy.

c) There was regular supervision by the NASA technical committee and NERCHA through face-to-face meetings and debriefing.

d) Weekly briefing and review meetings were held by the consultancy team, and the NASA technical committee. Discussions about the data challenges, gaps, inaccuracies, coding issues helped the team to deal with any technical challenges, with the identification of possible solutions.

e) Constant quality control was undertaken by the international consultant who led the in-country data collection and capturing process, as well as the data processing and analysis.

f) The additional international NASA expert undertook another level of data checking of all captured data through a review of the RTT outputs. The expert ensured the quality and completeness of the data entered by the team, that each transaction had all the vectors labelled correctly, identified gaps, and requested corrective actions to be taken during the validation phase.

g) In addition, the RTT control board indicated where there were discrepancies that needed to be adjusted/ fixed. These were all corrected.

h) Data validation was done in two stages for accuracy and consistency. The initial stage was by the NASA technical committee to ensure the accuracy of the financial data as submitted by the various institutions. The second stage of the validation was by the individual institutions that provided large HIV expenditure datasets (MOH, NERCHA, PEPFAR and GF). The NASA findings were sent to the programme and finance focal persons in the institutions for confirmation. A final set of RTT outputs was generated after including their comments to produce tables and graphs for the final report.

2.13. Overview of the data collected gaps and quality of data sources

Data was collected using both top-down and bottom-up approaches, from the public and private sectors. The data was triangulated to recreate the full transaction, ensuring that the correct amount

actually spent by service providers, per intervention, were correctly captured, to avoid double counting. The captured HIV spending data includes:

1. The bulk (over 95%) of government HIV funding, especially:
    - ✓ Ministry of Health (MOH) **direct HIV spending**: ARVs, laboratories, test kits, condoms, and the HIV programme – from expenditure records.
    - ✓ MOH indirect, or shared, costs incurred in delivering HIV services: provided by the National Health Accounts report (see assumptions below) – only this small portion (5%) of the MOH HIV expenditure were provided from the NHA – ***all the other data are actual expenditures according to NASA principles.*** However, the low spending on capital might be because public investments in health facilities or infrastructure in the health sector were not labelled as HIV specifically and the NHA did not allocate any to HIV.
    - ✓ Social security grants: 100% of the Education Fund for Orphaned & Disadvantaged Children was captured in this NASA, and 27% of the Aging Person grant (applying the assumption of national HIV prevalence) as suggested by NERCHA.
    - ✓ Other ministries' HIV spending, where labelled as such, were captured.
2. International development partners: all PEPFAR, GF, UN agencies, and some smaller donors (bilateral and foundations). We believe we have captured 95% or more of international funding for HIV.
3. Private sector: mining, railways, construction, banking, medical insurance (SWAZIMED's data for all HIV spending were included: employer and employee contributions). Response rate was low, but we are not sure how much more was missed – no one knows if any other companies had HIV activities that we did not capture.

Table 2: Data collection status

Respondents	Data collected	Target	Coverage %
International	26	33	79%
Public ministries	13	20	65% (but given MOH primary HIV role, 95% of public spending was captured)
NGOs	22	26	85%
Companies	7	12	58%
Total	**68**	**91**	**75% response rate = around 95% of total HIV expenditure (estimated)**

Although Table 2 above shows a 75% positive response rate from the entire list of contacted institutions, it is important to note that data were successfully collected from the top four actors (Government, PEPFAR, GF and UN agencies), which together account for over 90% of all HIV spending in Eswatini. A good response rate (85%) was also achieved with the NGO sector, as well as all the NGOs who received PEPFAR funding were automatically covered in the PEPFAR data provided. The weakest sector's data were those of business sector where only 58% of the target organisations provided their data, despite several attempts to collect these data. The size of the 'missing' private funding is not

known, but it was felt that it may not represent a large amount (usually private sector contributions are less than 2% of SADC countries' total funding envelopes[3]).

The 65% of the public response rate was due to some ministries (including Ministry of Defence, Police, and Correctional Services) that did not provide their data, but which represent a very small contribution toward HIV response, according to NERCHA who know of all the public HIV activities. It is difficult to quantify the size of these ministries' HIV spending that are missing from this assessment, but given MOH's primary HIV role, we believe that the bulk of public spending has been captured through MOH, the Central Medical Store, and Swaziland National Reference Laboratory (NRL), as well as the estimated MOH shared, indirect, costs for delivering HIV services (provided by the NHA).

Overall, we believe the assessment has been successful in obtaining 90-95% of public and international sources, and captured the majority of NGOs' activities, and so, despite the weak private sector response**,** this NASA report presents around 95% of all HIV spending in Eswatini, while acknowledging that the exact size of what is missing from the private sector and other ministries is not known.

The bulk of the type of data collected (99%) was from expenditure reports, while only 1% was based on the NHA estimations from budget documents. The sources of data for the transactions were certified from primary source (94%), adapted from primary source (5%) and only 1% based on estimation – which were similar for the ASC and BP data source. For the PF data, 51% was certified from primary source, 48% were adapted from primary source and 1% from estimation (Table 3 below). These imply sound and valid data were collected for this NASA.

Table 3: NASA data types

Eswatini NASA data	2016/17	2017/18	2018/19
Overall type of NASA data:			
Expense reports	99%	99%	99%
SHA estimation (MOH shared costs)	1%	1%	1%
Transaction source type:			
Primary source certificate	95%	95%	95%
Adaption of primary source	4%	4%	4%
SHA estimation (MOH shared costs)	1%	1%	1%
ASC source type:			
Primary source certificate	96%	97%	96%
Adaption of primary source	3%	3%	3%
SHA estimation (MOH shared costs)	1%	1%	1%
BP source type:			
Primary source certificate	99%	99%	99%
Adaption of primary source	0.031%	0.000%	0.002%
SHA estimation (MOH shared costs)	1%	1%	1%
PF source type:			
Primary source certificate	10%	38%	65%
Adaption of primary source	89%	62%	34%
SHA estimation (MOH shared costs)	1%	1%	1%

[3] Audits of ART delivery in some countries have found only 1% are funded by private funding entities. Other NASA reports from East and Southern African countries consistently find extremely low private sector contributions – 2% or less, unless there is a strong private insurance sector, such as in South Africa, where their contributions could make up to 10-15%, depending on the insurance coverage of the population.

2.14. Assumptions and estimations

Overall, the NASA principle of capturing actual expenditure was adhered to for the majority (99%) of the data. However, there were a few cases where some assumptions had to be applied, as follows:

a) The MOH indirect shared spending (such as salaries, overheads, etc.) that support the delivery of HIV services, but were not specifically labelled as HIV, were estimated by the NHA team for 2017/18, applying distribution keys to apportion the MOH spending between diseases, between levels of care and between interventions. The assumptions behind the distribution keys were not provided. Since the NASA team had collected all MOH's direct HIV expenditure (ARVs, other meds, labs, commodities, blood bank, HIV programme etc.), we only used the share of MOH's salaries and other recurrent factors of provision that had been attributed to HIV by the NHA in 2017/18. This was calculated as 1.02% of the total MOH budget in that year. This same percentage was then applied to the MOH budgets for the other two NASA years 2016/17 and 2018/19. These **indirect** HIV costs (Table 4) were then added to the direct HIV costs that the NASA collected (Table 5), as shown in Table 6 below.

Note that the estimated portion from NHA only represents 5% of the total MOH spending on HIV, while the NASA process collected the other 95% of actual MOH direct HIV expenditure (Table 5), and the estimated portion forms less than 1% of the total HIV spending presented here.

Table 4: NHA estimated MOH shared (indirect/ embedded/ shared) costs) of salaries and other materials for HIV service delivery

NHA: central revenue funds for MOH indirect HIV spending (SZL)	2016/17 est.	2017/18 from NHA	2018/19 est.
MOH HIV-related salaries	12 604 810	12 013 580	12 310 647
Materials and services	3 999 025	3 811 450	3 905 698
Othe inputs ND.	1 281 656	1 221 540	1 251 746
Est. MOH indirect HIV spending (SZL)	**17 885 491**	**17 046 570**	**17 468 091**
Est. MOH indirect HIV spending (US$)	**$ 1 216 291**	**$ 1 278 870**	**$ 1 296 480**

Note: These figures were provided by the NHA team from their HIV disease spending (excluding the MOH direct HIV spending which NASA collected, shown in Table 5 below).

For purposes of creating the financial transaction in the NASA database for this figure provided by SHA, the FE, REV, SCH and FAP were captured as central Government. The PS was assumed to have been public clinics and the SDM was indicated as facility based. For the ASC, we used the code ASC.03.99 for treatment and care since we could not attribute it to specific interventions (and so as not to mix it with any other spending), and PLHIV were selected as the BP. For the PF, the SHA team had indicated the split between salaries, materials and other not disaggregated. The appropriate PF code was chosen for each of these.

This approach to estimating the MOH shared, indirect HIV costs may be different to the one taken in the rapid expenditure mapping for the NSF (2018-2023), which found a slightly larger portion of public funding for HIV but for which the assumptions applied could not be determined, in order to compare and triangulate, or to replicate, here.

Table 5: MOH direct HIV expenditure, collected through NASA process

NASA: MOH direct HIV Spending (SZL)	2016/17	2017/18	2018/19
HIV/AIDS program	10 749 707	10 439 474	10 834 478
BLOOD BANK	22 800 647	32 619 290	36 938 801
LABS	40 085 860	51 212 016	48 415 783
Central Medical Stores	8 155 943	8 328 318	9 651 944
ARV Therapy Programme	238 602 605	203 283 659	205 676 135
Capital investments	10 000 000	5 000 000	
MOH direct HIV total (SZL)	**330 394 761**	**310 882 757**	**311 517 141**
MOH direct HIV spending (US$)	**$ 22 468 284**	**$ 23 323 087**	**$ 23 120 780**

Note: The NASA figure for ARV procurement in 2017/18 is different to what the NHA reported because the ARVs were distributed in 2017/18, but only paid for by the government in 2018/19. Since NASA applies accrual-based accounting (when consumed) versus a cash-based approach (when paid for), the cost of the ARVs was captured in the 2017/18 financial year in this NASA report (while the NHA did not capture it in their 2017/18 estimate).

Table 6: Total MOH HIV spending: direct (from NASA) plus indirect (from NHA)

MOH total HIV spending (SZL)	2016/17	2017/18	2018/19	% of total MOH HIV spend
Est. MOH indirect HIV spending (SZL)	17 885 491	17 046 570	17 468 091	5%
MOH direct HIV total (SZL)	330 394 761	310 882 757	311 517 141	95%
Total MOH HIV spending (SLZ)	**348 280 252**	**327 929 327**	**328 985 232**	**100%**
Total MOH HIV spending (US$)	**$ 23 684 575**	**$ 24 601 957**	**$ 24 417 261**	
% of MOH total budget for HIV	20%	20%	19%	

Note: although the MOH spending on HIV increased in SZL-terms, when converted to US dollars, it appears to have decreased due to the weakening of the local currency vis-à-vis the US dollar.

It is possible that this NASA has underestimated the share of MOH overhead spending which could be attributed to HIV, but it was decided by the TWG that relying on the NHA estimates was the best option. Additionally, NASA included extensive efforts to obtain all development partners' expenditure data, while the rapid mapping for the NSF may have only captured the large entities (PEPFAR and Global Fund), in which case the public proportional contribution would have been reduced.

b) The Deputy Prime Minister's Office (DPMO) grant to elderly persons is aimed at supporting older persons as care givers to the sick and orphans. The **DPM office has advised to use HIV prevalence rate (27%) to inform the allocation of resource for HIV in Eswatini.**

c) PEPFAR's data from their expenditure analysis (EA) and expenditure reports (ER) were de-identified and so their implementing partners (IPs) and sub-recipients (SRs) were not named. Therefore, all the USG funds had to be lumped under one service provider category (PS.2.99) because they could not be identified as public, NGO, university, etc. Throughout the analysis, these are labelled as PEPFAR IPs and SRs, or were possible, assumed to be clinics where their activities were ART, VMMC and PMTCT.

d) Because the PEPFAR EA and ER data included all their IPs' spending, if any additional data were collected from any of the PEPFAR IPs or service providers (for USG funds), these were excluded in the analysis to avoid double counting. **Respondents were requested to only report their non-PEPFAR funding to the NASA researchers.**

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

   i. Programme enablers and systems strengthening services of all organisations were assumed to be non-targeted interventions.

   ii. For the training received by health workers (trained health workers, Peers Educators, opinion leaders) the beneficiary population was the population that receives the services that health workers were trained on, mostly PLHIV.

   iii. Prevention of mother to child transmission (PMTCT) was assumed to benefit children to be born to HIV positive mothers. The spending on the ARVs for the mother was captured under ART and was attributed to ART patients (which could not be disaggregated by sex).

f) The National Medical Stores (NMS) provided all data for all the drugs and other health/non-health commodities that the NMS provided to all the government facilities countrywide. Therefore, any ARV data also collected from government facilities were excluded from the analysis, so as to avoid double counting.

g) The annual average weighted exchange rate from the Central Bank of Eswatini were used for currency conversions, as follows:

Table 7: Average USD:SZL Exchange rates for the financial years

Currency	2016 SZL	2017 SZL	2018 SZL
1 US $	14.70494	13.3294	13.47347

Source: Central Bank of Eswatini.

2.15. Limitations of the Study

Some limitations of the study should be noted:

a) Generally, HIV costs for integrated and/or wellness programs from public sector other than health were difficult to identify since they did not have separate expenditures labeled as HIV-related. These costs are therefore underestimated but are likely to be a very small proportion of the entire response.

b) TB expenditures were not included in this survey.

c) The private-for-profit sector's contribution was under-reported due to poor response, despite several attempts to collect these data. This may indicate that they did not have any HIV spending to report. As explained in the overview of data section, typically, the private sector's response has been found to be less than 2% in other East and Southern African countries (except where there is a strong private health insurance). We captured Swazimed HIV expenditure, and therefore, it can be assumed that in Eswatini, any other private sector's contribution to total HIV envelop was relatively small and does not compromise this completeness of the assessment.

d) Out-of-pocket payments (OOPs) were not collected as they were not in the scope of the project (due to time and cost constraints). Though most HIV services in Eswatini are rendered free to the beneficiaries, the collection of OOPs may be important for future NASAs but would

require additional resources and time to collect accurately through a large-scale household survey.

e) This NASA could not collect expenditure per region. While some respondents could report their expenditure by sub-national level, the latest PEFPAR expenditure data no longer has the sub-national identifier. It would be beneficial for all partners to report their spending by sub-national level for more nuanced assessment of HIV spending, in relation to provincial need.

2.16. Variance between this NASA and the NSF rapid resource mapping

For the development of the NSF (2018-2022), a rapid resource mapping had been undertaken and indicated that the public contributions had increased to 48% of the total envelop for HIV in 2016/17 (NSF, 2018:64, Table 25). Unfortunately, the sources of these data and assumptions applied were not available to allow for comparison with the NASA findings presented in this report. This current NASA – in addition to collecting all the public **direct HIV** spending – also relied on the National Health Accounts estimate of the proportion that was the Ministry of Health's **indirect HIV** spending (the share of their overheads etc. that support the delivery of HIV services), which may have been different to (less than) the previous estimates of these 'embedded' costs. **In addition, this NASA took extra efforts to obtain all development partner's contributions, which therefore increased their proportional contribution (compared to the rapid mapping done for the NSF).**

3. NASA Findings

This section first provides a high-level perspective on the total HIV spending envelope in Eswatini and the funding flows between funding entities (FE), by funding schemes (SCH), from revenues of funding (REV). Thereafter, more detailed breakdowns are provided of the spending by funding agents and purchasers (FAPs), activities (AIDS spending categories, ASC), service delivery modalities (SDM), providers of services (PS), beneficiaries (BP), and production factors (PF). The first sub-section describes the financing systems for HIV in Eswatini.

3.1. HIV Funding Flows in Eswatini

One important aim of NASA is to provide a clear and transparent picture of HIV financing systems, including information that is relevant to health policy about the structure and flows of funds. "Health financing systems mobilise and allocate money, within the health system, to meet the current health needs of the population (individual and collective), with a view to expected future needs. Individuals may have access to care by means of direct payment for services and goods or through third-party financing arrangements, such as with a National Health Service, social insurance or voluntary insurance" (WHO, 2011). To describe the financing systems, NASA uses three vectors: Funding Scheme, Financing Revenue and Funding Entity, defined as follows:

- **Financing schemes** are the main "building blocks" of the functional structure of a country's health financing system: the main types of financing arrangements through which health services are paid for and obtained by people.
- **Financing revenues** of the financing schemes: the approach used to identify, classify and measure the mix of revenue sources for each financing scheme (for example, social security contributions used to fund the purchases by social security schemes and grants to sustain the non-profit organisation schemes).
- **Funding entities** of health care financing systems that may play the role of providers of revenues for financing schemes (such as governments, households and corporations). (WHO, 2011).

The HIV funding architecture in Eswatini is characterized by three main funding flows:

i. The central government funding entity provides transfers from domestic revenue flowing through central government schemes,
ii. International entities provide revenue from foreign direct transfers flowing through voluntary resident foreign agency schemes, and;
iii. International entities provide revenue from foreign direct transfers flowing through central government schemes (these were mainly funding from the Global Fund).

In addition to these three main financing schemes, a smaller portion of international entities' revenue from direct foreign transfers flows through non-resident foreign agency schemes, while a small amount of direct foreign transfers went through resident not-for-profit organisations (NGO) schemes. Voluntary insurance schemes were funded by voluntary prepayments from households and employers, but very small portions of the total funding were channeled through social insurance contribution schemes. Figure 2 shows these flows graphically.

Table 8: Financing Entities providing resources to Financial Schemes (SZL, 2018/19)

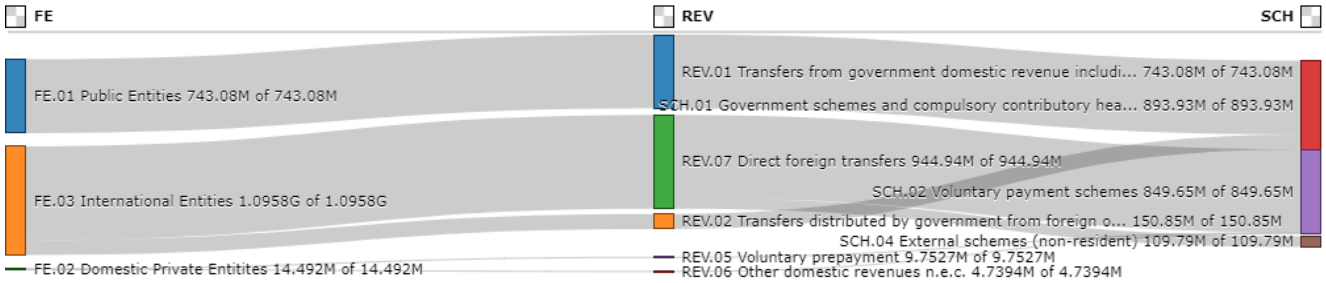
	Funding Entity			
Scheme	**FE.01 Public Entitie**	**FE.02 Domestic Pr**	**FE.03 Internationa**	**Grand Total**
SCH.01 Government schemes and compulsory contributory health care schemes	**743 075 808**		**150 851 856**	**893 927 664**
SCH.01.01 Government schemes	**743 075 808**		**150 851 856**	**893 927 664**
SCH.01.01.01 Central government schemes	716 990 530		150 851 856	867 842 385
SCH.01.01.98 Government schemes not dissagregated	26 085 278			26 085 278
SCH.02 Voluntary payment schemes		**13 913 546**	**806 969 332**	**820 882 878**
SCH.02.01 Voluntary insurance schemes		**9 752 664**		**9 752 664**
SCH.02.01.01 Primary/substitutory health insurance schemes		9 752 664		9 752 664
SCH.02.02 Not-for-profit organisation schemes			**806 969 332**	**806 969 332**
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.02.02.02)			29 023 681	29 023 681
SCH.02.02.02 Resident foreign agencies schemes			777 945 651	777 945 651
SCH.02.03 For-profit enterprise schemes		**4 160 881**		**4 160 881**
SCH.02.03.01 Enterprises (except health care providers) schemes		3 092 798		3 092 798
SCH.02.03.98 For-profit enterprise schemes not dissagregated		1 068 083		1 068 083
SCH.03 Household out-of-pocket payment		**578 545**		**578 545**
SCH.03.01 Out-of-pocket excluding cost-sharing		**578 545**		**578 545**
SCH.04 International schemes (non-resident)			**147 446 682**	**147 446 682**
SCH.04.02 Voluntary schemes (non-resident)			**147 446 682**	**147 446 682**
SCH.04.02.02 Other schemes (non-resident)			147 446 682	147 446 682
Total	**743 075 808**	**14 492 091**	**1 105 267 870**	**1 862 835 769**

Important for sustainability considerations is the fact that 40% of all the HIV spending in Eswatini in 2018/19 came from public funding entities, 44% were via transfers from government's domestic revenue, and **48% of all funding flowed through central government schemes in 2018/19**. This shows good dependence upon government revenue schemes, which improves the sustainability of the country's response. Additionally, 44% of HIV funding came through *resident* foreign agency schemes and 6% through *non-resident* foreign schemes. This implies the government has the larger responsibility in providing the revenue and in managing the funding for HIV, while still facing some risk due to the large portion (59%) originating from international funding entities, which may face external shocks which could affect their HIV commitments, such as the COVID-19 pandemic.

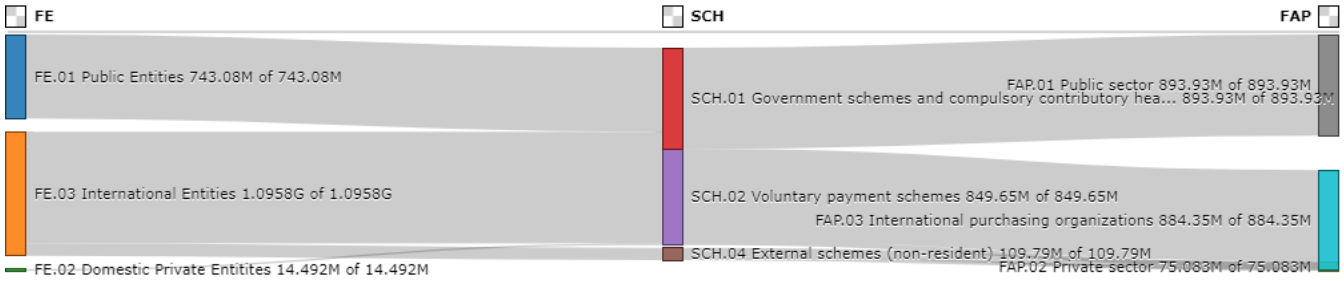
It is also important to consider which financing schemes are funding which funding agents and purchasers, which HIV activities and which beneficiaries – these are explored in greater depth under each of the relevant sections below.

Figure 2: Funding flows and amounts of funding for HIV in Eswatini

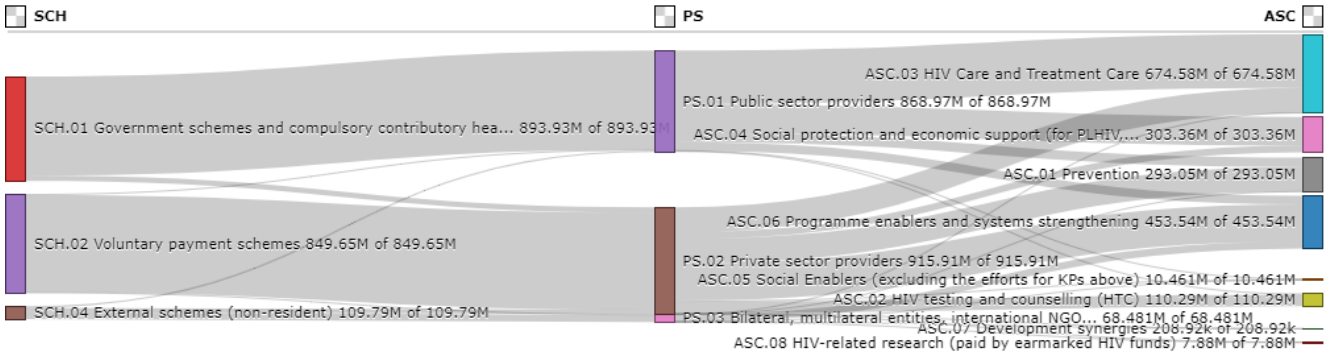
a) Funding entities to revenues to schemes: which funding entities are funding which financing schemes?



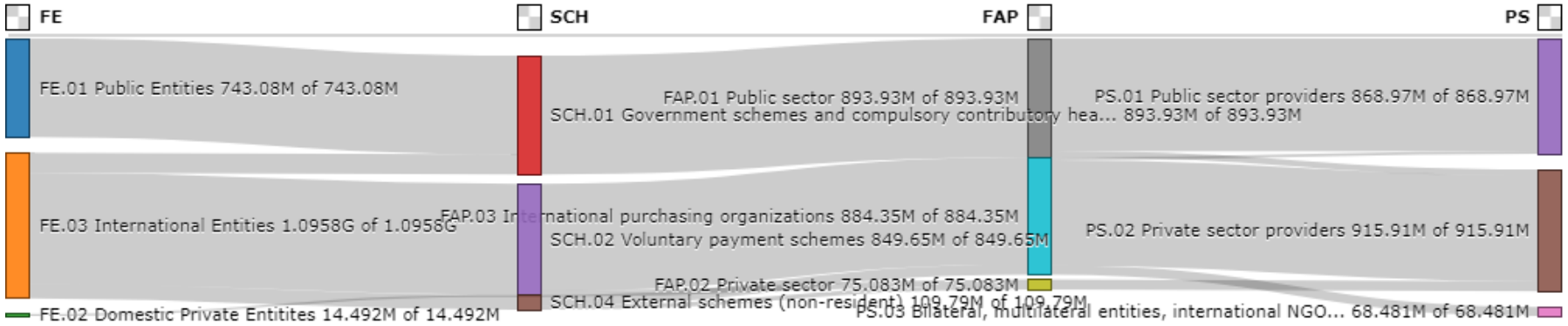
b) Funding entity to scheme to agent & purchasers



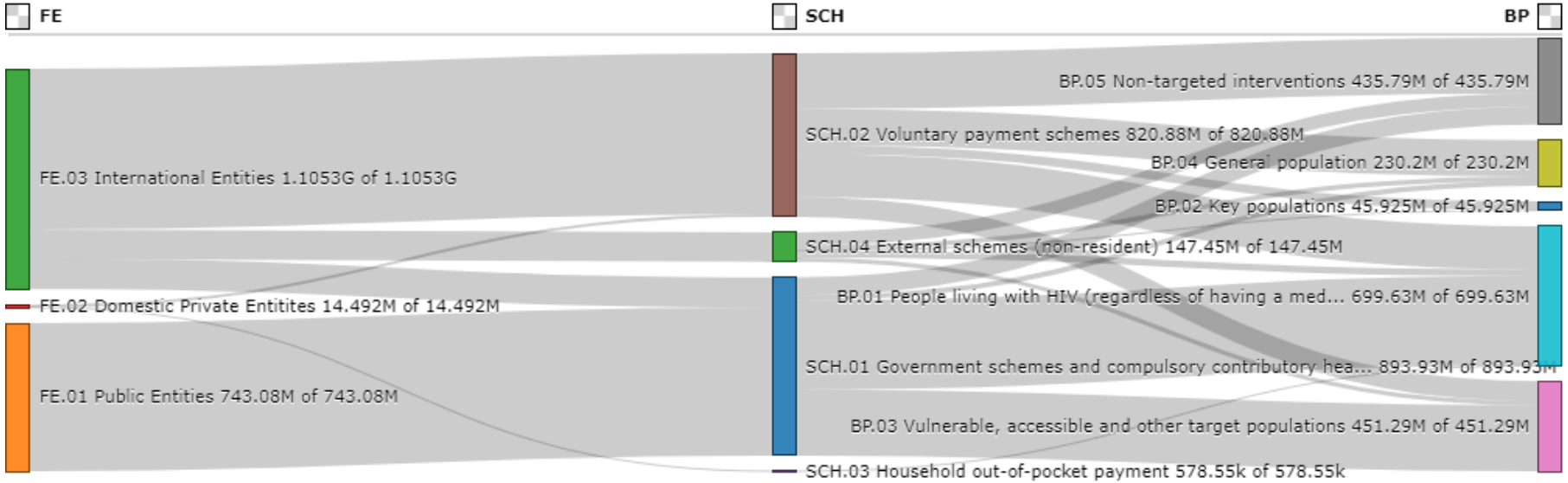
c) Funding scheme to providers to activities



e) Funding flows from financing entities to schemes to funding agents & purchasers to service providers



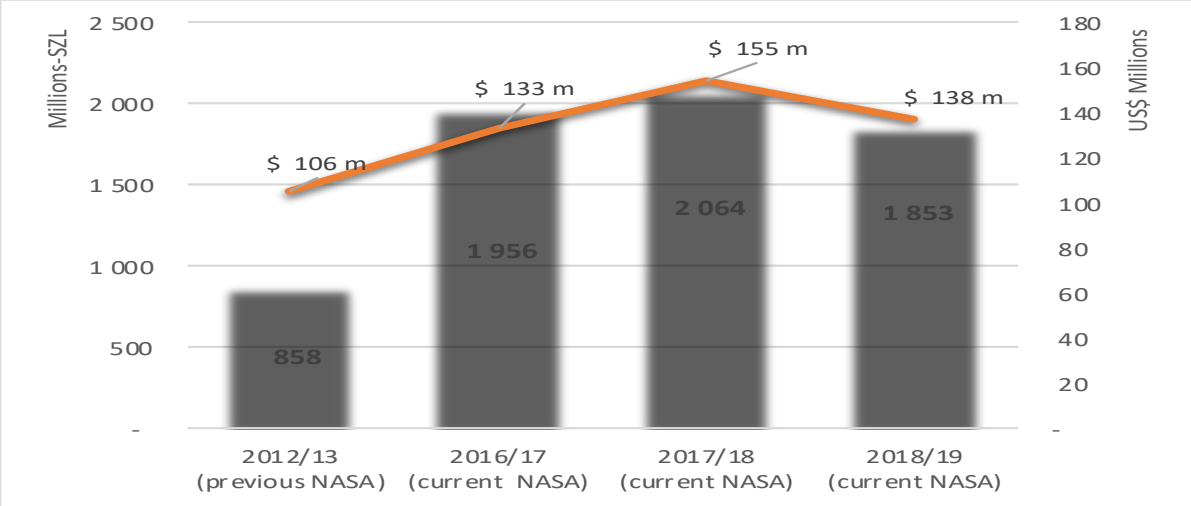
f) Which funding entities and schemes are funding services for which beneficiary group?



3.2. Total HIV/AIDS Spending in Eswatini (2016/17 – 2018/19)

The total expenditure for HIV in Eswatini in the fiscal year 2016/17 was SZL 1.96 billion (US$ 133 million[4]), increasing by 6% to SZL 2.1 billion (US$ 154.8 million) in 2017/18. In 2018/19 the amount decreased by 10% to SZL 1.85 billion (US$ 137.6 million) (Figure 3). The decline in 2018/19 is partly explained by a 12% reduction in PEPFAR expenditures in 2018/19[5], as well as a 19% reduction in the Global Fund spending. The previous NASA finding for 2012/13 is included in Figure 3 below to show trends in HIV funding between 2012/2013 and 2016/2017. HIV funding increased by 32% per year (on average) between 2012/13 and 2016/17.

Figure 3: Trends in HIV spending in Eswatini (2012/13 – 2018/19)



Note: The figures presented above for 2016/17 to 2018/19 were collected through the current NASA process, and represent actual expenditures reported by the respondents. Only 0.9% were provided by the National Health Accounts teams as estimates of the MOH indirect HIV spending. NASA collected **all other MOH direct HIV spending** (please refer to the assumptions section for details and exchange rates applied), as well as all other sources of funding for HIV.

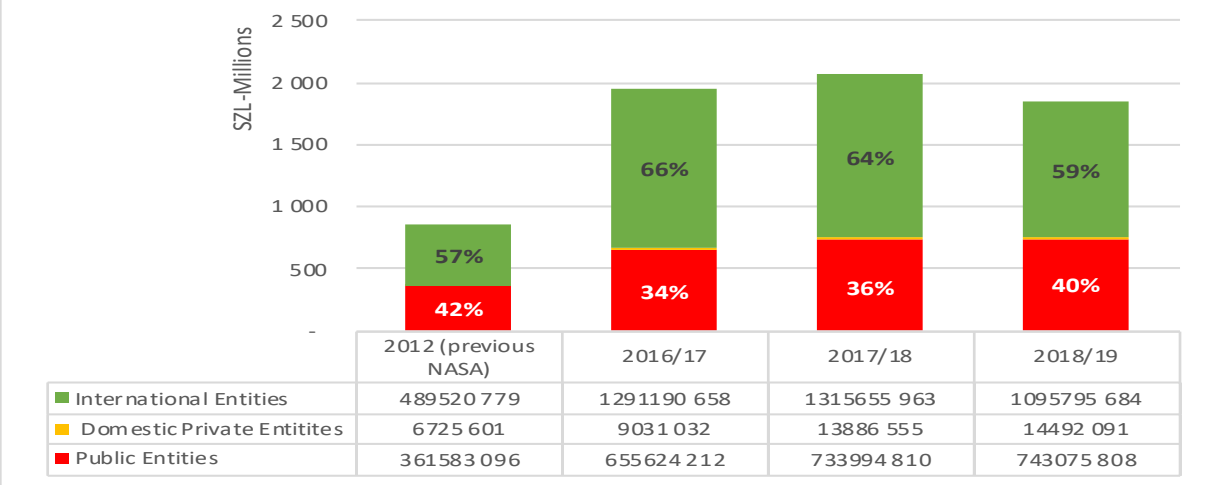
3.3. Funding Entities for the HIV response in Eswatini (2016/17 – 2018/19)

In 2016/17, Figure 4 shows that international funding entities were the largest contributor to HIV funding, with 66% of the total funding, followed by the public sector which contributed 34% while the private funding entities contributed less than 1%. In nominal terms, international sources contributed approximately SZL 1.29 billion in 2016/17 which increased slightly by 2% to SZL 1.3 billion in 2017/18, but then decreased by 17% to SZL 1.1 billion in 2018/19. The international funding proportional contribution declined from 66% in 2016/17 to 59% in 2018/19, while the public contribution increased to reach 40% of the total HIV funding by 2018/19. The public funds' nominal amount increased by 12% from SZL 656 million in 2016/17 to SZL 734 million in 2017/18, and then a 1% increase to reach SZL 743 million in 2018/19. Please refer to the methods section for an explanation of the variation between this NASA and the rapid resource mapping done for the NSF.

[4] Exchange rates for SZL: 1USD = 14.7 in 2016/17, 13.3 in 2017/18, 13.5 in 2018/19.

[5] PEPFAR expenditure analysis (EA) report for 2017/18 reported US$ 65.8 million expenditure, while PEPFAR expenditure report (ER) for 2018/19 reported US$ 57.7 million. See details in subsequent sections and appendices.

Figure 4: Total spending on HIV in Eswatini by funding entity (2016/17- 2018/19)



Note: only a small portion of the public funds (5% of MOH HIV spending = 1% of total HIV spending) was provided by the NHA estimates for the shared MOH overhead costs attributed to HIV. The rest of the data (99% of all the HIV spending) over the NASA assessment period are based on the NASA primary collection of actual HIV expenditure data, which have been triangulated according to the NASA approach.

Table 9: Total Spending on HIV in Eswatini by funding entity (2016/17-2018/19)

SZL	Public Entities	Domestic Private Entitites	International Entities	HIV Total in SZL
2012 (previous NASA)	361 583 096	6 725 601	489 520 779	857 829 476
2016/17	655 624 212	9 031 032	1 291 190 658	1 955 845 903
2017/18	733 994 810	13 886 555	1 315 655 963	2 063 537 328
2018/19	743 075 808	14 492 091	1 095 795 684	1 853 363 583

US$	Public Entities	Domestic Private Entitites	International Entities	HIV Total in US$
2016/17	44 585 303	614 150	87 806 591	133 006 044
2017/18	55 065 855	1 041 799	98 703 315	154 810 969
2018/19	55 151 034	1 075 602	81 329 879	137 556 515

Looking in more detail into the international funding sources, Table 10 shows the funding from bilateral entities, multilateral entities and international NGOs (INGOs) and foundations.

Table 10: International Funding Entities (SZL, 2016/17-2018/19, SZL, US$)

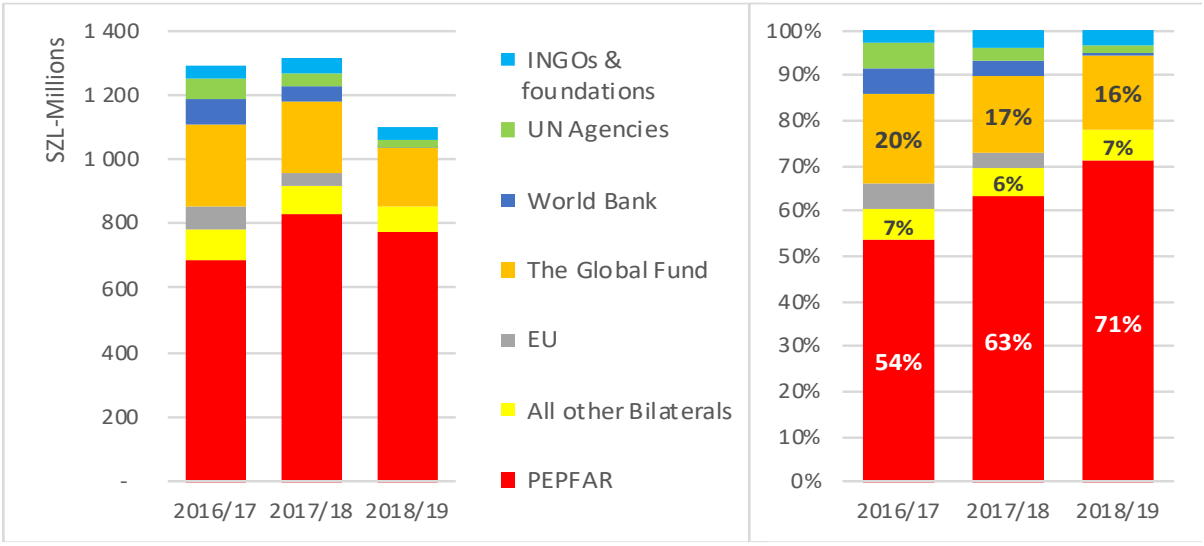
SZL	Bilateral funding entities	Multilateral funding entities	INGOs & foundations enties	Total from International Entities
2016	778 570 770	473 114 366	39 505 522	1 291 190 658
2017	913 832 073	347 818 068	54 005 822	1 315 655 963
2018	854 220 224	207 454 223	34 121 237	1 095 795 684
% in 2018/19	78%	19%	3%	100%

US$	Bilateral funding entities	Multilateral funding entities	INGOs & foundations enties	Total from International Entities
2016	$ 52 946 205	$ 32 173 839	$ 2 686 548	$ 87 806 591
2017	$ 68 557 630	$ 26 094 053	$ 4 051 632	$ 98 703 315
2018	$ 63 400 165	$ 15 397 238	$ 2 532 476	$ 81 329 879

Bilateral funding entities

The funding from all bilateral organisations made up the largest portion of the internationally sourced HIV funding, totaling 40%, 44%, 46% of **total HIV** funding in 2016/17, 2017/18 and 2018/19 respectively. The bilateral funding increased by 17% from SZL 779 million in 2016/17 to SZL 914 million in 2017/18, but then declined by 7% to SZL 854 million in 2018/19, driven mainly by the reduction in the Government of the United States of America's (USG) funding. The USG funding, through PEPFAR, went from SZL 691 million (US$ 46.97m) in 2016/17 (Figure 5), to SZL 830 million (US$ 62.2m) in 2017/18 and SZL 778 million (US$ 57.7m) in 2018/19, making up 42% of **total HIV funding** in the latter year. Other bilateral funding entities included the Governments of Switzerland, the Netherlands and the United Kingdom and others, and together they accounted for 7%, 6% and 7% of the total international funding in 2016/17, 2017/18 and 2018/19 respectively.

*Figure 5: International funding entities in Eswatini (SZLm, **% of international funds**, 2016/17 - 2018/19)*



Multilateral funding entities

Multilateral funding entities contributed 37%, 26% and 19% of total HIV funding in 2016/17, 2017/18 and 2018/19 respectively. The Global Fund (GF) was the largest contributor of multilateral funding, contributing SZL 255 million (US$ 17.3m) in 2016/17, SZL 222 million (US$ 16.6m) in 2017/18 and SZL 180 million (US$ 13.4m) in 2018/19 (the latter year being the first year of a new GF grant). World Bank

(WB), European Union (EU) and United Nations (UN) agencies each contributed around 5% of total international funding in 2016/17. However, WB and EU projects phased-out and their contributions had ceased by 2018/19. UN Agencies contributions declined from SZL 68.6 million (US$ 4.7m) to SZL 22.6m (US$ 1.7m) in 2018/19.

International not-for-profit organizations (INGOs) and foundations

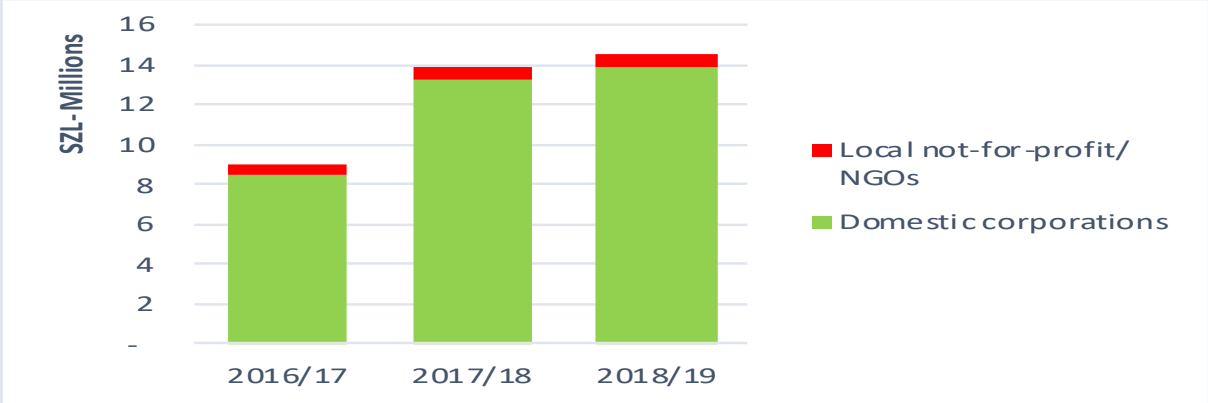
There were a few INGOs and foundations funding various HIV activities in Eswatini. These made relatively small contributions, but together contributed consistently around 4% of all HIV funding. The INGOs included International HIV/AIDS Alliance, International Red Cross Society, the Open Society Institute and a few others.

Details on all the international funding entities, particularly PEPFAR and GF, are presented in the appendices (Tables A29 & A30).

Private funding entities

Private sector funding was less than 1% of the total spending for HIV in all three years of the NASA study. The funding from private entities increased by 54% from SZL 9 million (US$ 614 thousand) in 2016/17 and to SZL 13.9 million (US$ 1m) in 2017/18, and further increased by 4% to SZL 14.5 million (US$ 1.1m) in 2018/19. Figure 6 below shows that most of private funding was from domestic corporations, while small amounts came from domestic not-for-profit institutions (NGOs).

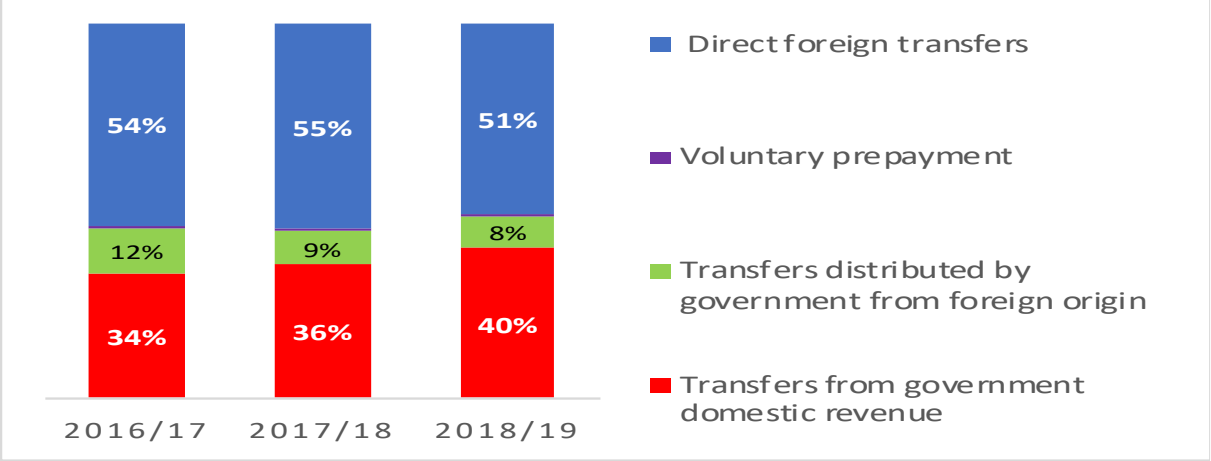
Figure 6: HIV and AIDS spending from private funding entities (2016/17-2018/19)



3.4. Revenues of financing for HIV in Eswatini

Revenues are the institutional economic units providing funding to financing schemes. Direct foreign transfers contributions were 61%, 60% and 56% of total HIV funding in 2016/17, 2017/18 and 2018/19 respectively. Importantly, the transfers from government domestic revenue increased from 38% in 2016/17 to 39% in 2017/18 and 44% in 2018/19. Revenues of financing schemes from social insurance, voluntary prepayments provided less than 1% in all three years.

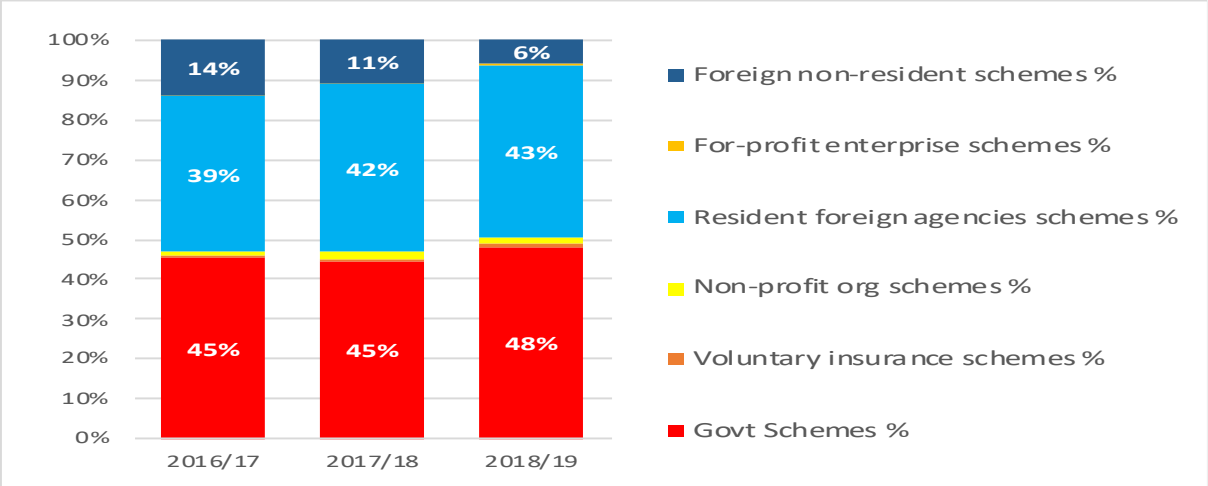
Figure 7: Revenue sources for HIV funding in Eswatini (%, 2016/7-2018/19)



3.5. Financing schemes of HIV funding in Eswatini

Financing schemes are structural components of health care financing systems. They are the types of financing arrangements through which people obtain health services (Figure 8, Table 11). The government schemes increased from 45% of the total HIV financing in 2016/17 and 2017/18 to 48% in 2018/19. The share of expenditure channeled through **resident** foreign agencies schemes also increased over the three years, from 39% in 2016/17 to 42% in 2017/18 and 43% in 2018/19. The total share of HIV funding channeled through **non-resident** foreign schemes decreased from 14% in 2016/17 to 11% in 2017/18 and again to 6% in 2018/19. Swazimed voluntary payment scheme made up a small proportion of less than 0.5% in each of the 3 financial years. Please refer to the previous section on funding flows to consider the relationships between the financing vectors.

Figure 8: Financing schemes of HIV funding in Eswatini (%, 2016/17 – 2018/19)



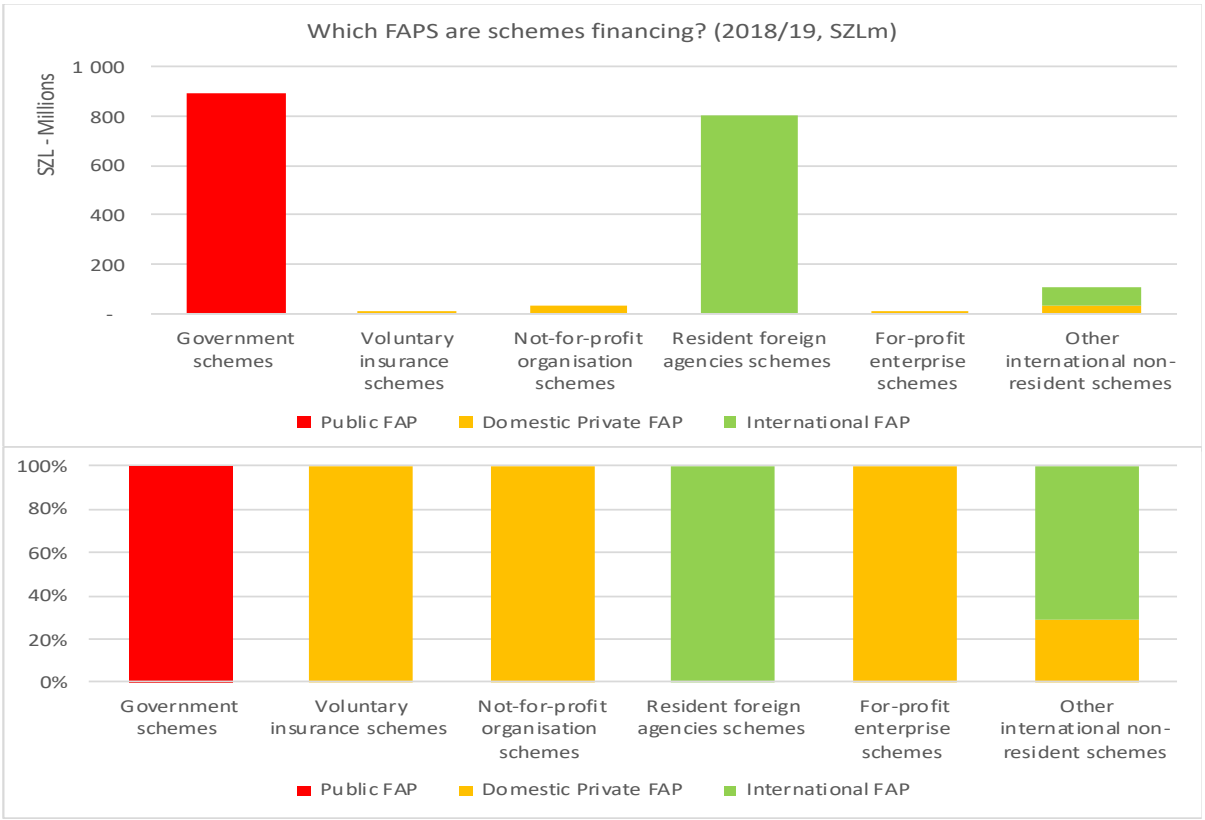
In 2018/19, funding from government entities flowed entirely via government schemes, while domestic private funding went primarily (67%) through voluntary insurance schemes and 29% through for-profit enterprises schemes (Table 11). Funding from international entities flowed mostly (74%) through resident foreign agencies' schemes, 14% through government schemes, 10% through non-resident foreign agencies' schemes, and only 3% via not-for-profit resident organization schemes.

Table 11: Which financing entities are funding which schemes? (2018/19)

2018/19 (SZL)	FINANCING ENTITY				
FINANCING SCHEME	**Public Entities**	**Domestic Private Entities**	**International Entities**	**Total (SZL)**	**SCH % in 2018/19**
Government schemes	743 075 808		150 851 856	893 927 664	48%
Voluntary insurance schemes		9 752 664		9 752 664	1%
Not-for-profit organisation schemes		578 545	29 023 681	29 602 226	2%
Resident foreign agencies schemes			806 132 723	806 132 723	43%
For-profit enterprise schemes		4 160 881		4 160 881	0%
Other international non-resident schemes			109 787 425	109 787 425	6%
Total	**743 075 808**	**14 492 091**	**1 095 795 684**	**1 853 363 583**	**100%**

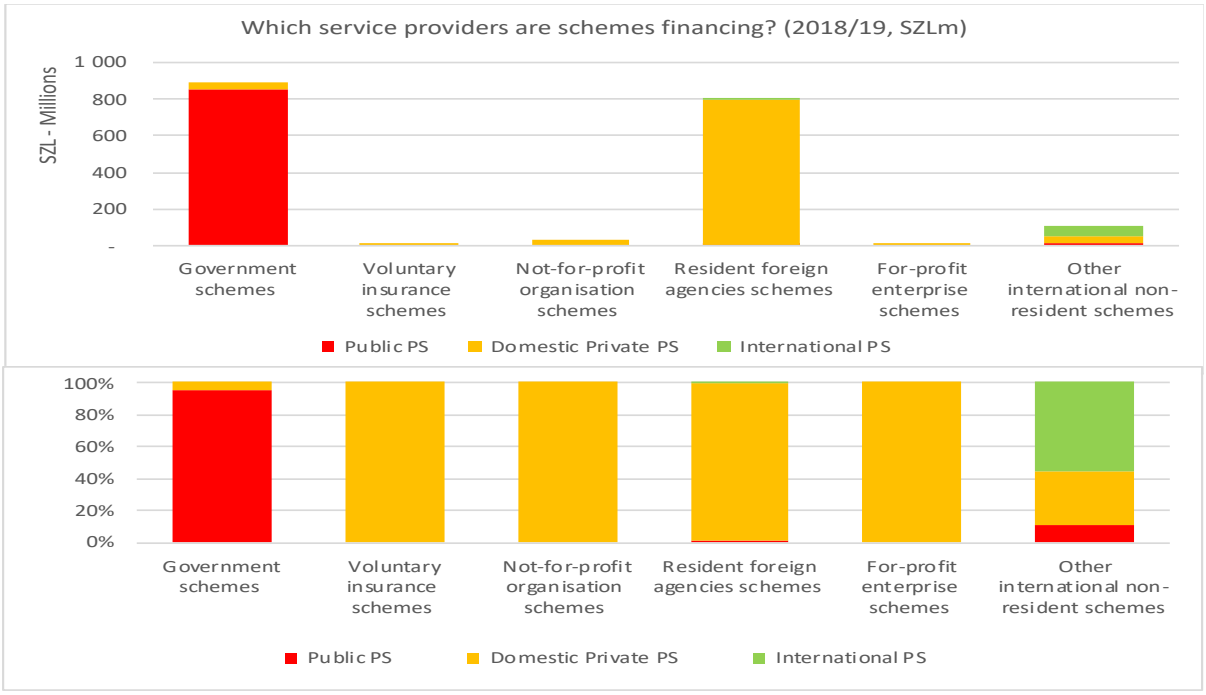
In considering the ownership and sustainability of the HIV response, it is important for policy makers to understand which financing schemes are funding which financing agent-purchasers (FAPs), since the latter determine the programmatic choices and therefore influence the prioritisation of efforts. In 2018/19 the government schemes (48% of all HIV funding) were funding only (100%) public FAPs (Figure 9), the resident foreign agency schemes were funding 100% international FAPs, and the for-profit enterprise schemes were funding 100% domestic private FAPs. Almost a third (29%) of the non-resident foreign schemes were funding domestic private (mostly non-profit) FAPs, while 71% went to international FAPs. The scheme therefore is an important determinant in the FAP selection, and across all the combinations, the largest was government schemes funding public FAPs, improving the public ownership and sustainability of the HIV response. Nevertheless, the next largest portion (41%) were funds via resident foreign agency schemes going to international FAPs.

Figure 9: Which financing schemes were funding which agents & purchasers? (2018/19)



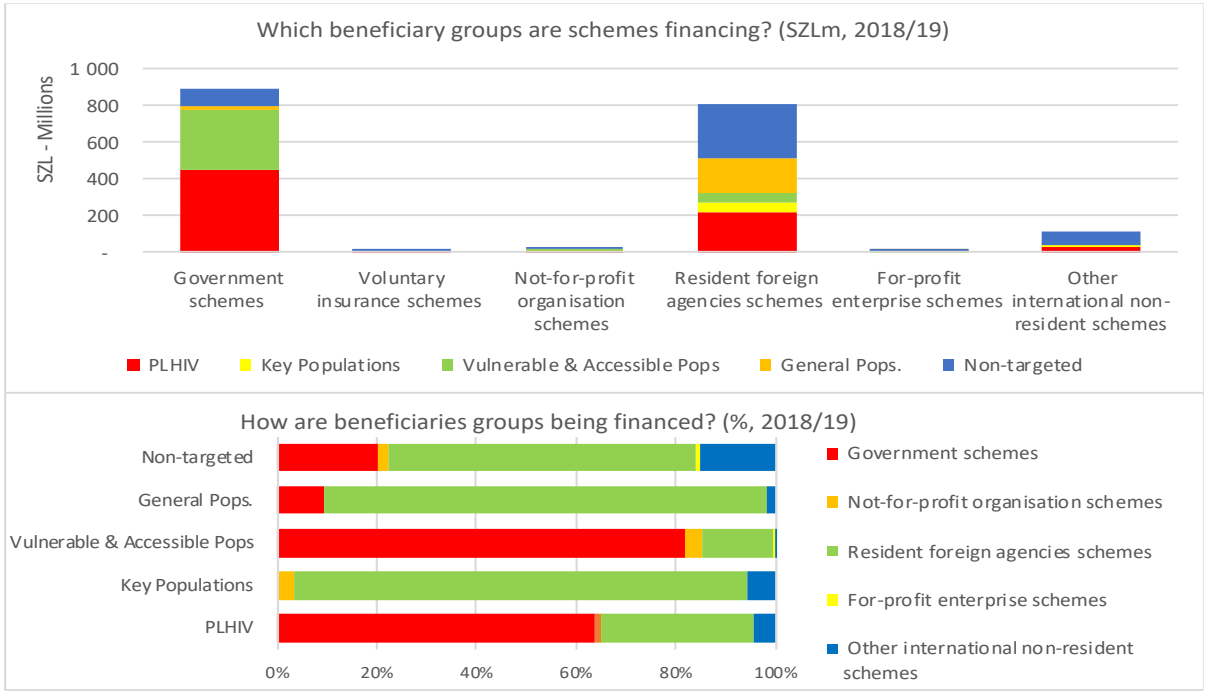
Similar patterns are seen in the schemes financing of service providers (Figure 10).

Figure 10: Which financing schemes are funding which HIV service providers?



It is also important to consider which beneficiary groups are being funded via which financing schemes. Figure 11 indicates that in 2018/19, there was a mix of beneficiaries being financed by the two main schemes, except that key populations received no funding via government schemes, which were focused more on PLHIV and vulnerable and accessible populations. The lower figure presents the same data in a different format, so as to reflect the contributions of the schemes to each beneficiary group.

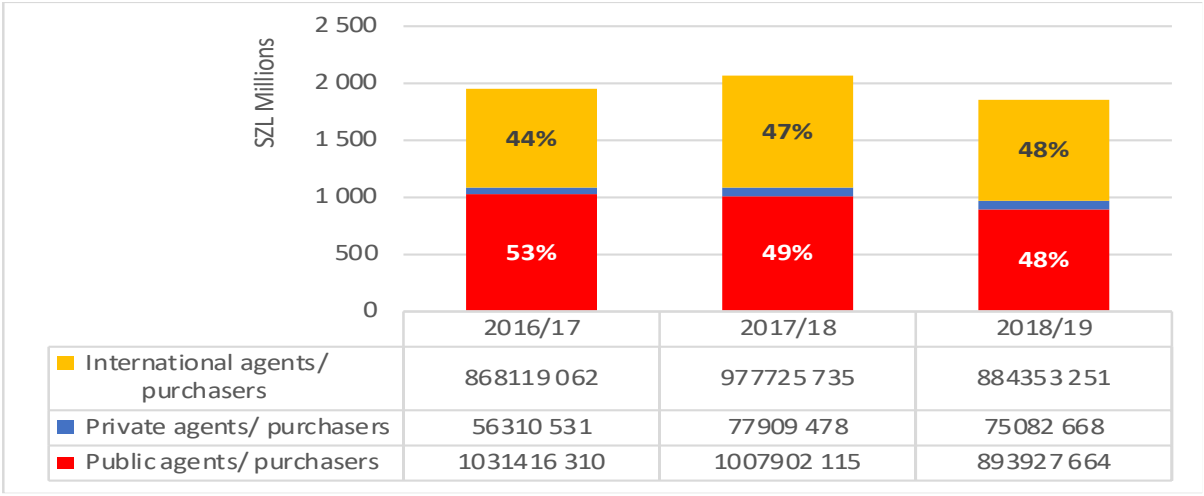
Figure 11: Which financing schemes are funding which beneficiary groups?



3.6. Financing agent-purchasers of HIV services in Eswatini

Financing agent-purchasers (FAPs) are entities that manage and distribute funds, purchase HIV services and goods, and determine the interventions to be purchased, hence they influence the direction of the national response. In 2018/19, HIV funds were managed equally between international agents and public agents (Figure 12). The large proportion of international funds were from USG and were therefore managed by PEPFAR country agencies - hence these were labelled as 'international' FAP. Most of the GF funds (84% in 2018/19) went through NERCHA, which was labelled as a public FAP.

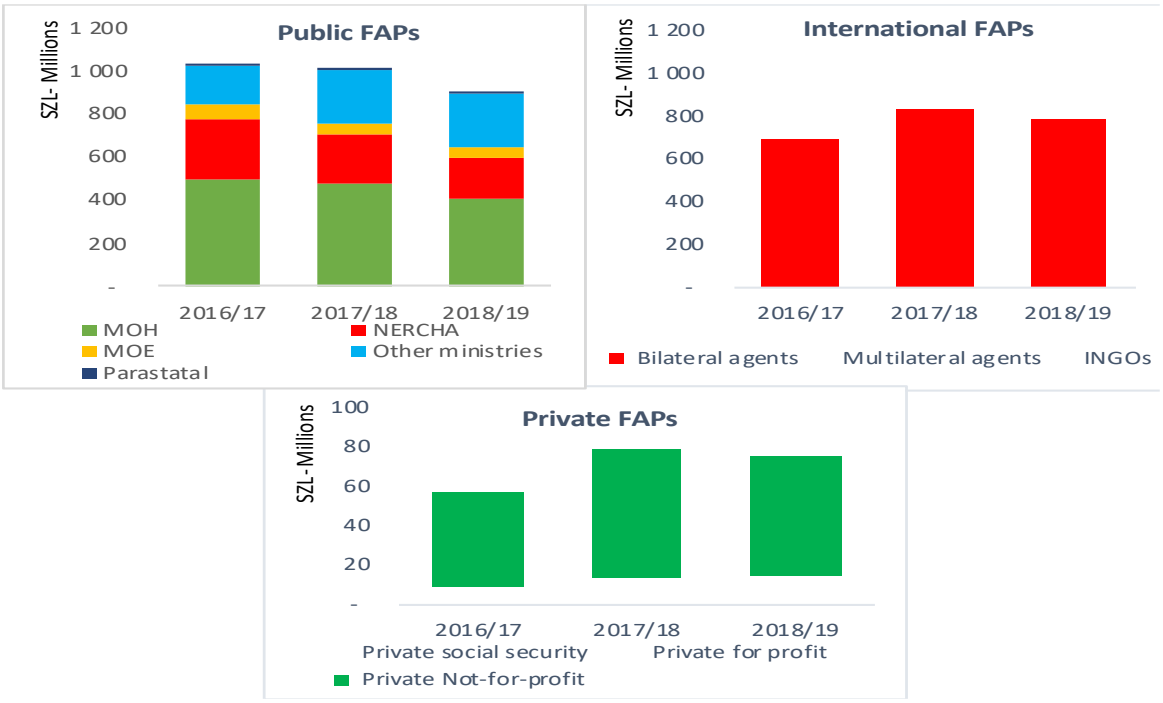
Figure 12: Funding agents and purchasers for HIV in Eswatini (2016/17-2018/19)



	2016/17	2017/18	2018/19
International agents/ purchasers	868119 062	977725 735	884353 251
Private agents/ purchasers	56310 531	77909 478	75082 668
Public agents/ purchasers	1031416 310	1007902 115	893927 664

The public sector FAPs included MOH, Ministry of Education (MOE), the Deputy Prime Minister Office (DPMO), NERCHA and other ministries (Figure 11).

Figure 13: HIV Financing agent-purchasers in Eswatini, further disaggregated (2016/17-2018/19)



The international FAPs, including PEPFAR, UN agencies and international NGOs, managed 44% of 2016/17 funds, 47% of 2017/18, and 48% of 2018/19 funds. About 3% of the funds in 2016/17 and 4% in 2017/18 and 2018/19 were managed by the private entities, which included insurance companies and domestic NGOs (including the GF grant managed by CANGO).

Table 12: Funding Agents/Purchasers are funding which providers of services? (SZL, 2016/17-2018/19)

AGENT-PURCHASER	HIV SERVICE PROVIDERS					
2016/17 (SZL)	**Public providers**	**Private providers (FP & NP)**	**International providers**	**PEPFAR IPs & SRs**	**Total 2016/17 (SZL)**	**% FAP share 2016/17**
Public agent/purchaser	995 862 187	35 554 123			1 031 416 310	53%
Private agent/purchaser		56 310 531			56 310 531	3%
International agent/purchaser	28 658 574	218 880 538	109 541 000	511 038 949	868 119 062	44%
Totals	**1 024 520 761**	**310 745 192**	**109 541 000**	**511 038 949**	**1 955 845 903**	
% PS share in 2016/17	52%	16%	6%	26%		
2017/18 (SZL)	**Public providers**	**Private providers (FP & NP)**	**International providers**	**PEPFAR IPs & SRs**	**Total 2017/18 (SZL)**	**% FAP share 2017/18**
Public agent/purchaser	971 479 780	36 422 335			1 007 902 115	49%
Private agent/purchaser		77 909 478			77 909 478	4%
International agent/purchaser	18 058 009	299 452 403	94 677 553	565 537 770	977 725 735	47%
Totals	**989 537 789**	**413 784 216**	**94 677 553**	**565 537 770**	**2 063 537 328**	
% PS share in 2017/18	48%	20%	5%	27%		
2018/19 (SZL)	**Public providers**	**Private providers (FP & NP)**	**International providers**	**PEPFAR IPs & SRs**	**Total 2018/19 (SZL)**	**% FAP share 2018/19**
Public agent/purchaser	848 114 002	45 813 661			893 927 664	48%
Private agent/purchaser		75 082 668			75 082 668	4%
International agent/purchaser	20 854 434	231 973 829	68 480 739	563 044 249	884 353 251	48%
Totals	**868 968 437**	**352 870 158**	**68 480 739**	**563 044 249**	**1 853 363 583**	
% PS share in 2018/19	47%	19%	4%	30%		

Table 12 above indicates that the public FAPs were mostly paying public service providers with smaller amounts going to private non-profit providers, while the majority of funding (59%) being managed by international FAPs went to the PEPFAR implementing partners and their sub-recipients, 31% to private not-for-profit providers, 8% to international providers (where they deliver services themselves in-country, and only 2% went to public service providers. Further breakdown of funding agents and purchasers are provided in the appendices (Tables A14 & A15).

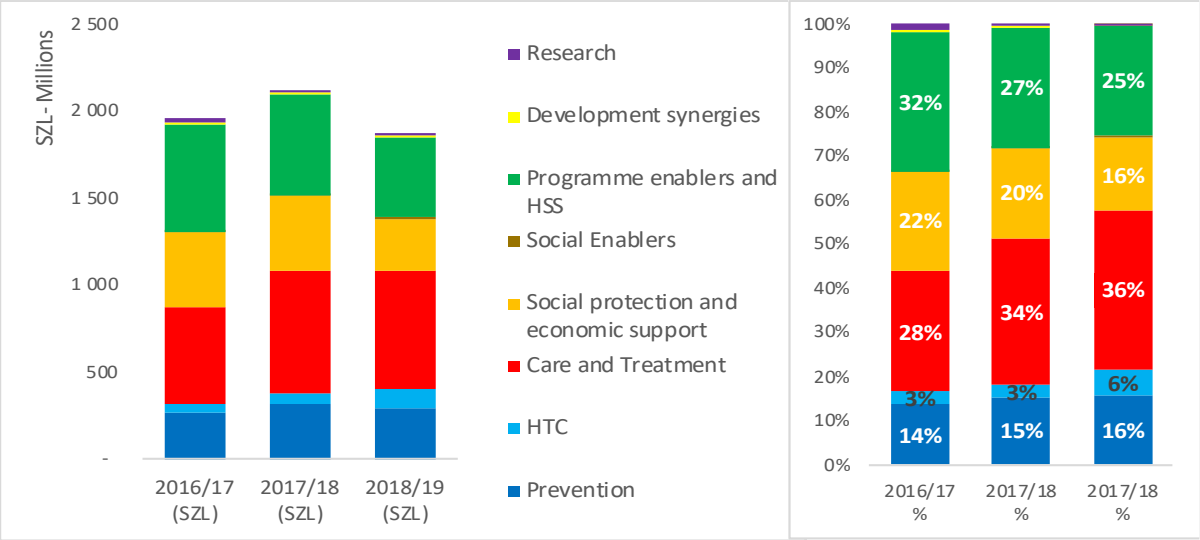
3.7. HIV spending by programme area and intervention

The NASA AIDS Spending Categories (ASCs) provide detailed disaggregation of the activities upon which HIV funds were spent, and these can be easily matched to the National Strategic HIV Framework (NSF) priority areas. However, the degree of disaggregation is dependent upon the degree of detail in the expenditure data provided by the respondents. The activities are first presented within their broader programme areas, as shown in Figure 14 both nominally and proportionally, followed by the disaggregation by interventions for each programmatic area. It is important to note that in the new NASA 2020 ASC classifications, all HIV testing and counselling (HTC) has been separated into a new programme area. Previously, voluntary counselling and testing (VCT) was under the prevention area, while provider-initiated testing and counselling (PITC) was under the treatment area. In the new NASA 2020 framework, all forms of HTC are now combined into programme area two, for HTC alone.

The largest expenditure in the two outer years was for HIV care and treatment category, accounting for 32% (SZL 653 million) in 2017/18, and 36% (SZL 675 million) in 2018/19 (increased from 26% (SZL 514 million in 2016/17). In 2016/17, the largest share of spending (36%) went towards programme

enablers and systems strengthening which then declined to 31% and 24% in 2017/18 and 2018/19 respectively. The third largest, but declining, expenditure was for social protection and economic support accounting for 21% (SZL 414 million), 20% (SZL 407 million) and 16% (SZL 303 million) over the three years, mostly driven by the Ministry of Education's (MOE) school feeding programme and the Deputy Prime Minister Office (DPMO) education fund for orphans and vulnerable children (OVC) and cash grants for elderly persons. The reduction (-23%) in PEPFAR's funding specifically for OVC contributed to the drop in social protection spending (possibly due to their new ER categories).

Figure 14: HIV spending by programme area (2016/17-2018/19)



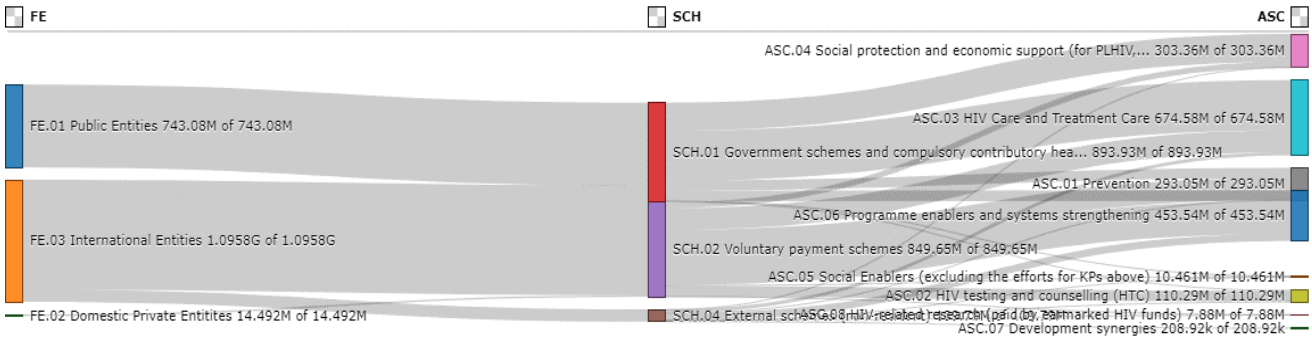
HIV prevention spending increased by 12% between 2016/17 and 2017/18, from SZL 254 million to SZL 284 million, and further increased by 3% to SZL 293 million in 2018/2019. Additionally, efforts in HTC ramped up from SZL 60 million in 2017/18 to SZL 110 million in 2018/19 (Table 13).

Table 13: HIV spending in Eswatini by programmatic area (SLZ, %, 2016/17-2018/19)

HIV Programme Area	2016/17 (SZL)	2017/18 (SZL)	2018/19 (SZL)	2016/17 %	2017/18 %	2017/18 %
Prevention	254 403 351	283 916 102	293 050 061	13%	14%	16%
HTC	37 068 339	60 019 273	110 294 863	2%	3%	6%
Care and Treatment	514 324 363	653 022 233	674 577 580	26%	32%	36%
Social protection and economic support	413 668 482	407 188 777	303 355 366	21%	20%	16%
Social Enablers	2 526 738	2 286 416	10 461 278	0.1%	0.1%	0.6%
Programme enablers and HSS	700 673 016	640 357 043	453 535 550	36%	31%	24%
Development synergies	1 986 797	8 487 087	208 916	0.1%	0.4%	0.0%
Research	31 194 817	8 260 398	7 879 970	1.6%	0.4%	0.4%
Total	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

The section below presents a deeper analysis of which programme areas are being funded by which funding entities, so as to identify those programmes which, being more dependent on international sources, might be more vulnerable to their changing priorities and possibly more at risk of being unsustainable if international funds decline. Figure 15 gives a visual representation of these funding flows and their relative contributions.

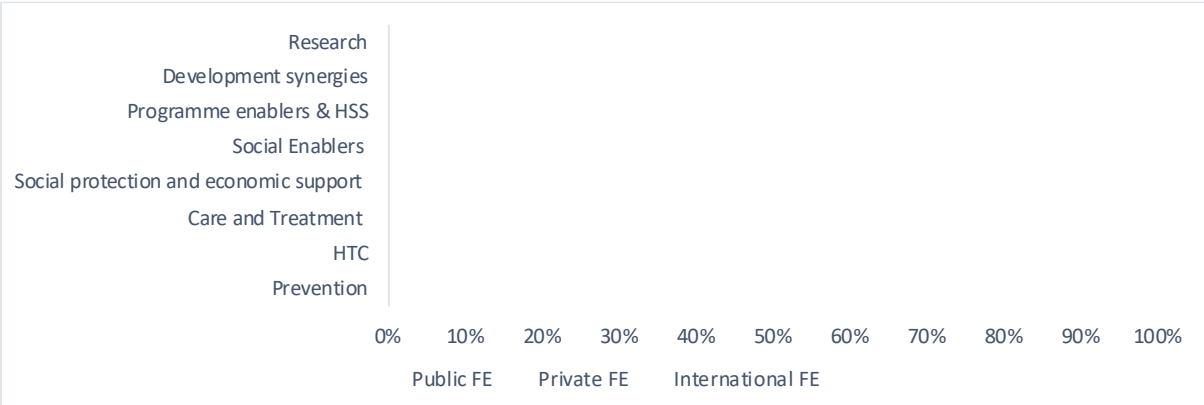
Figure 15: Which programme areas are being funded by which Funding Entities and through which Funding Schemes? (2018/19)



In 2018/19, public financing entities contributed the largest share (82%) to social protection and economic support, which was driven by the MOE's spending on school feeding and the DPMO's cash grants payment to ageing persons – representing their commitment to mitigating the impact of HIV on children (Figure 16). About 52% of HIV care and treatment was funded by public financing entities. International financing entities contributed 46% to HIV treatment and care interventions and the private sector contributed 1%. The future sustainability of HIV treatment and care is enhanced with the larger portion of funds coming from the government revenue.

Figure 16 shows that 77% of prevention activities were internationally funded and the remaining 23% were funded by the government in 2018/19, which may present a risk for the sustainability of HIV prevention efforts. International funding entities contributed 82%, private 3%, and public 15% to social enablers (advocacy and human right programmes). About 91% of HTC was funded by international funding entities, with 9% from the government. All the development synergies and HIV-related research were fully funded by international partners, which may present a potential sustainability challenge for these specific activities in future.

Figure 16: Financing entities proportional contributions to programmatic areas – sustainability measure? (%, 2018/19)

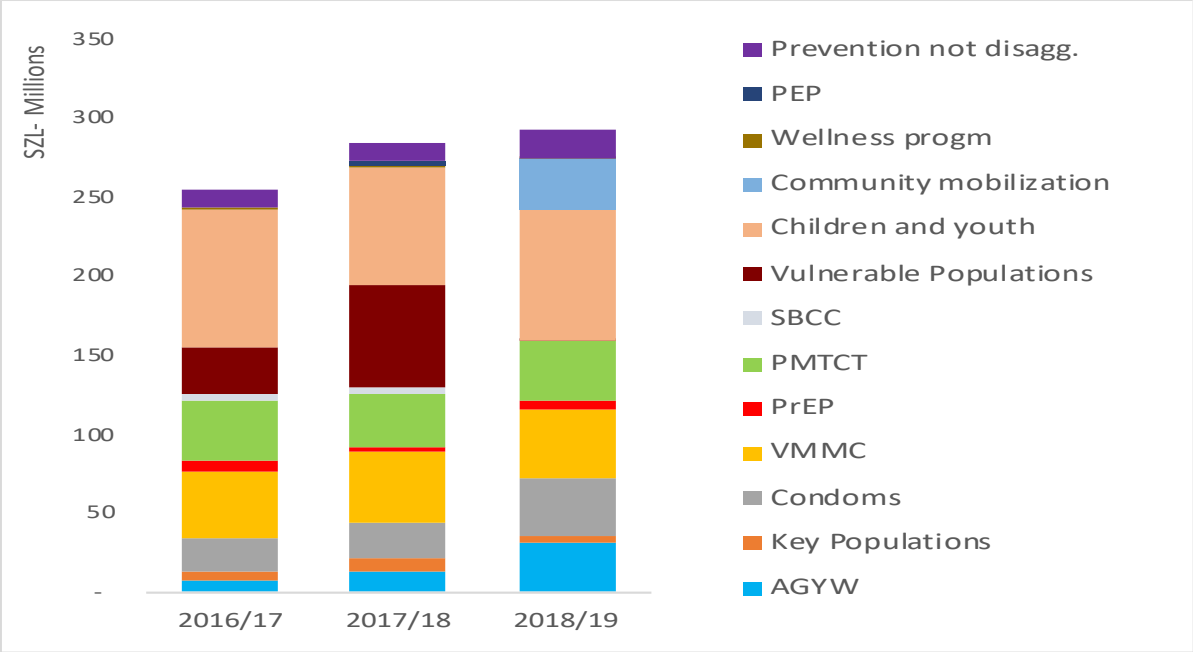


The detailed matrices (FExASC) are provided in the appendices (Tables A17 & A18). The following sub-sections explore the funding for specific interventions within each programmatic area in more detail, after which the service delivery modalities of all interventions are presented.

Prevention activities

The largest HIV prevention expenditure in all three years was for interventions aimed at children and youth, with SZL 87.8 million (35% of prevention spending) in 2016/17, SZL 75.3 million (27%) in 2017/18, and SZL 82.9 million (28%) in 2018/19. It was followed by VMMC which accounted for 17% of prevention spending in 2016/17 (SZL 42.3 million), which increased slightly to SZL 45.4 million (16%) in 2017/18, and then declined to SZL 43.8 million in 2018/19 (15% of prevention spending). As section 5 shows, there were 17, 884 VMMC performed in 2016/17, and this declined to 14,316 in 2018/19.

Figure 17: Total HIV prevention spending by intervention (2016/17-2018/19)



Note: 100% of the prevention expenditure data were collected through the NASA primary data collection process. These prevention figures do not include any estimation from the NHA dataset.

The spending on condoms declined from SZL 22.3 million in 2016/17 to SZL 21.7 million in 2017/18 but increased again to SZL 36.7 million in 2018/19 (13% of prevention spending). As shown in Section 5, the country distributed around 15 million units in 2016/17, 23 million units in 2017/18 and another 23 million units in 2018/19. The average number of condoms distributed were around 22 million units per annum, which equates to approximately SZL 1.32 (US$ 0.10) per condom distributed.

In 2018/19, PMTCT spending accounted for 15% of all HIV prevention spending, AGYW 10% (increasing from the previous two years as projects scaled-up), and PrEP for only 2%. There was 6% for prevention which was not disaggregated by intervention type. Thereafter, all the other prevention activities received around 1% or less of all the prevention funding. See the appendices (Table A19) for detailed figures.

Table 14 and Figure 18 show that the spending on the 5 pillars of HIV prevention increased by 11% between 2016/17 and 2017/18, and further increased by 33% to reach SZL 121.5 million in 2018/19, showing an important and growing commitment to focus on high impact prevention interventions.

Table 14: Spending on the pillars of prevention vs other preventions activities (2016/17-2018/19)

Prevention (SZL)	2016/17	2017/18	2018/19	2016/17 (%)	2017/18 (%)	2018/19 (%)
Five Pillars of Prevention	82 531 803	91 354 034	121 504 475	32%	32%	41%
Other Prevention	171 871 548	192 562 068	171 545 586	68%	68%	59%
Total Prevention	**254 403 351**	**283 916 102**	**293 050 061**	100%	100%	100%

Figure 18: Spending on the 5 pillars of prevention in Eswatini (%, 2016/17-2018/19)

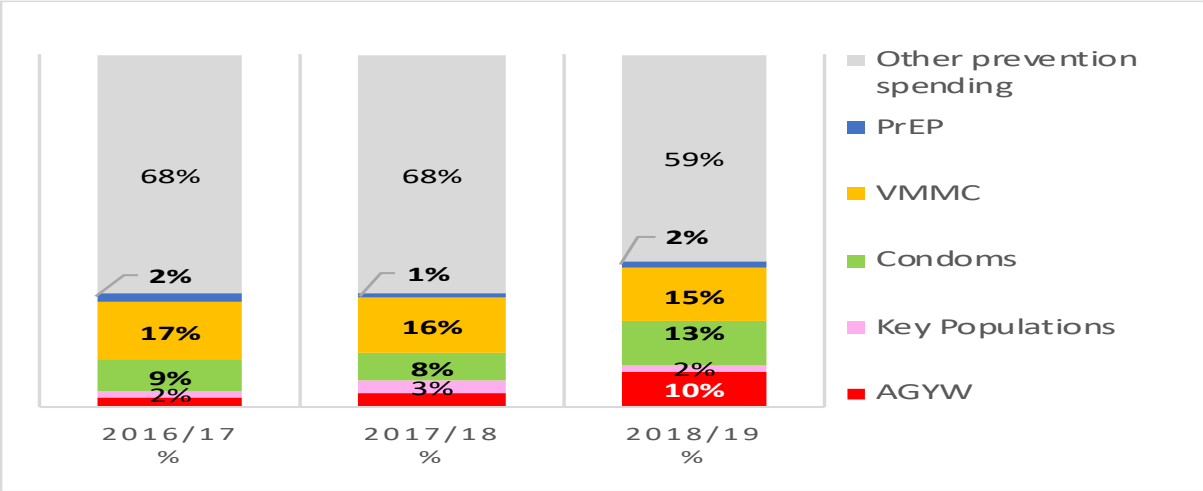
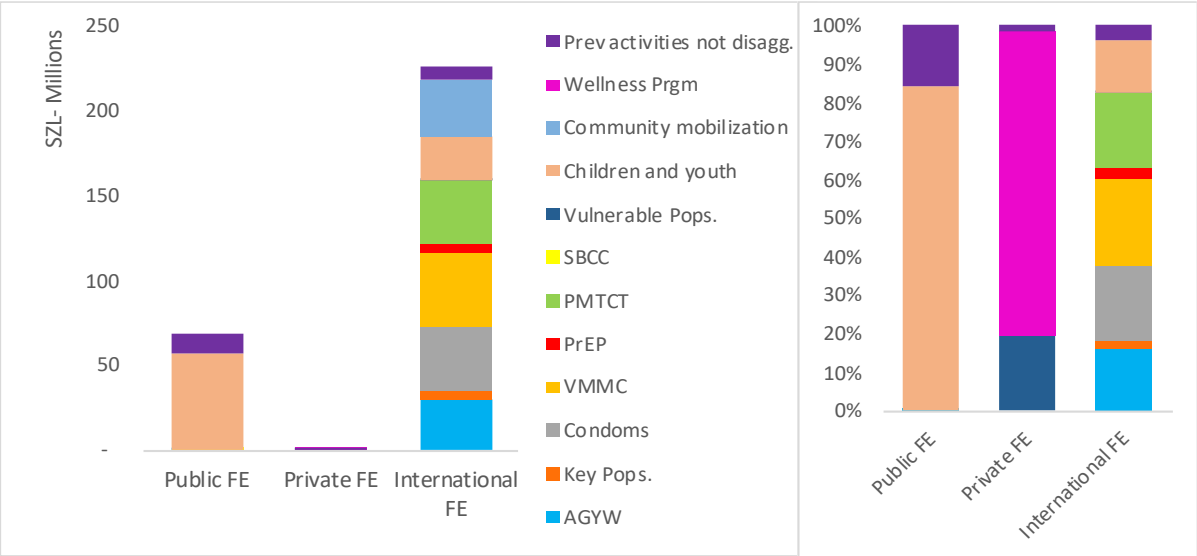


Figure 19 below shows which funding entities were financing the HIV prevention activities. Almost all HIV prevention activities were funded by international funding, except for those with children and youth which the government funding (84%) focused on. International funding entities funded a range of prevention activities, particularly the 5 Pillars of Prevention, with 20% *of their prevention spending* going towards VMMC in 2018/19, 14% for AGYW, 16% for condoms, 16% for PMTCT, 12% for children and youth, and 2% for key population interventions. A small portion (3%) of international prevention funding could not be disaggregated by intervention – compared to 16% of public prevention funding. The small private prevention funding, less than 1% of prevention spending (SZL 509 thousand) went mostly to wellness programmes in the workplace.

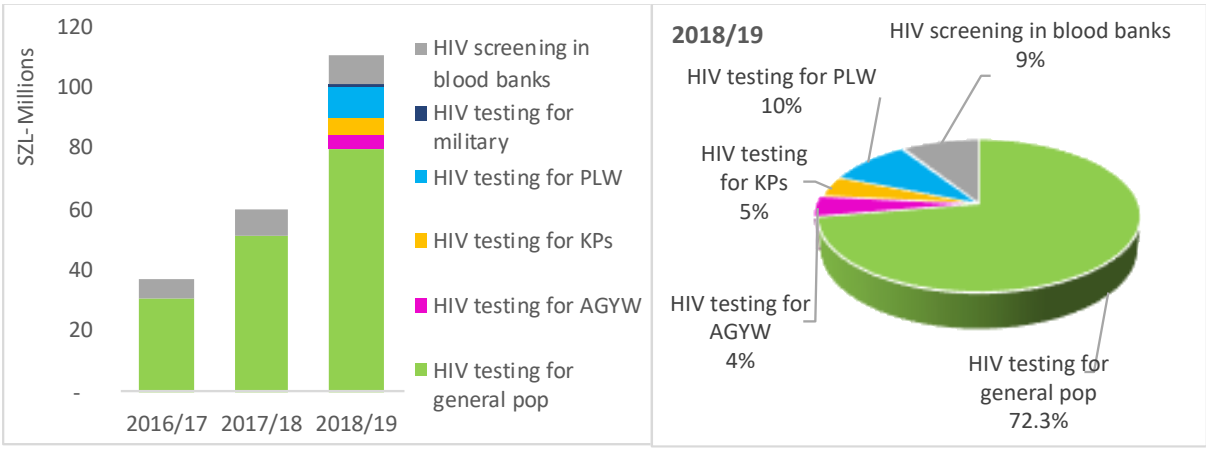
Figure 19: HIV prevention spending by funding entity (2018/19)



HIV Testing and counselling

Figure 20 shows that spending on HTC increased from SZL 37 million in 2016/17, to SZL 60 million in 2017/18, and almost doubled to reach SZL 110 million in 2018/19, mostly due to the increased PEPFAR funding allocated to HTC. The bulk (72%) of the HTC spending in 2018/19 went to testing of the general population, while 9% was for screening in the blood banks, 10% for pregnant and lactating women (PLW), 5% for key populations and 4% for AGYW. The HTC interventions were completely funded by international partners.

Figure 20: HTC spending by intervention (2016/17 - 2018/19)



Treatment and care activities

The spending on all treatment and care activities increased by 27% from SZL 514 million in 2016/17 to SZL 653 million in 2017/18, and then by only 3% in 2018/19, to reach SZL 675 million (Table 15, Figure 21). Of all this treatment and care spending, the expenditure on ART took the largest portion (60%) of SZL 310 million and SZL 391 million in 2016/17 and 2017/18 respectively, and SZL 456 million in 2018/19 (the jump in the outer year being due to improved coding of the PEPFAR ER data). Thereafter, spending on laboratory monitoring took 13%, 12% and 27% respectively. The not disaggregated care and treatment spending (primarily due to the old PEPFAR EA codes of FBCTS and CBCTS[6] which could not be disaggregated into specific activities) increased from 14% in 2016/17 to 20% in 2017/18, but then disappears in 2018/19 with the new PEPFAR ER coding (HIV clinical services and HIV drugs). It is important to note that there was an additional 3% in each year which reflects the estimated MOH shared costs (personnel and other recurrent) spent in the provision of HIV treatment services – provided by the National Health Accounts estimates (refer to Assumptions section).

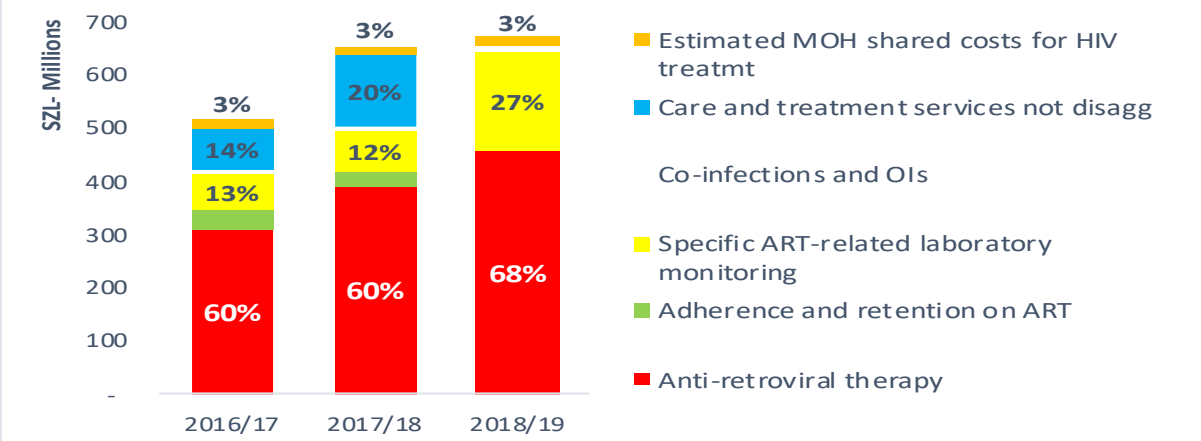
[6] FBCTS = facility-based care and treatment services. CBCTS = community-based care and treatment services. These included ART and other C&T services, which could not be disaggregated.

Table 15: HIV treatment & care spending by intervention (2016/17-2018/19)

Treatment and Care (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Anti-retroviral therapy	310 303 109	391 430 224	455 506 916	60%	60%	68%
Adherence and retention on ART	33 699 385	23 915 990	3 157 804	7%	4%	0%
Specific ART-related laboratory monitoring	69 398 689	80 343 799	183 622 760	13%	12%	27%
Co-infections and OIs	9 726 002	7 428 808	13 695 999	2%	1%	2%
Care and treatment services not disagg	73 311 686	132 856 842	1 126 010	14%	20%	0%
Estimated MOH shared costs for HIV treatmt	17 885 491	17 046 570	17 468 091	3%	3%	3%
Total treatment and care spend	**514 324 363**	**653 022 233**	**674 577 580**	**100%**	**100%**	**100%**

Note: the PEPFAR 2018 ER code for HIV clinical services may have included some adherence support activities, which could not be differentiated from the ART spending.

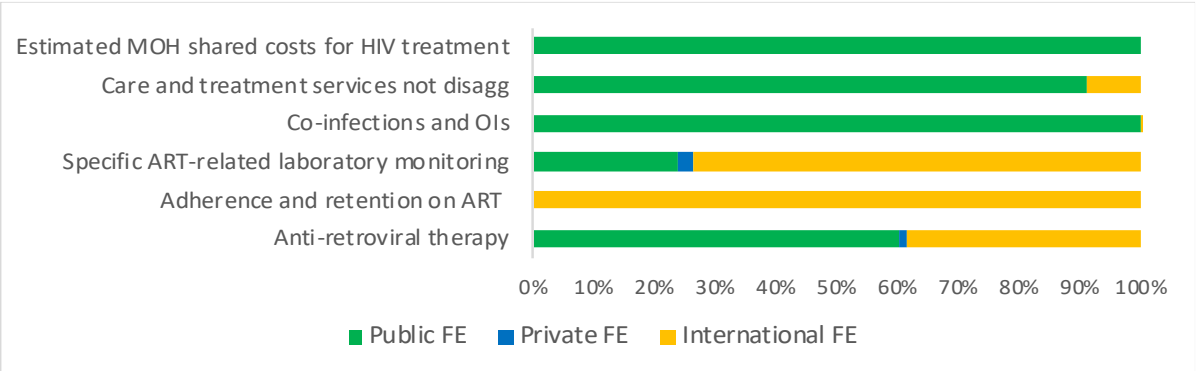
Figure 21: HIV treatment & care spending by intervention (2016/17-2018/19)



Note: Of this treatment and care data, 97% came from the NASA primary expenditure data collection process, while only 3% was provided by the NHA as the estimation of the MOH indirect, shared HIV costs. The ART spending specifically was 100% collected through the NASA primary data collection process and included the costs of ARVs which were consumed in 2018/19 but only paid for in 2019/20 (as per the NASA accrual accounting principle).

Figure 22 indicates that in 2018/19 public funds contributed the largest share (60%) to the ART programme, which is important for future sustainability, while international funds fully funded adherence and retention supportive activities, as well as contributing 74% to laboratory monitoring. About 24% of laboratory monitoring came from public entities and 2% from private sources.

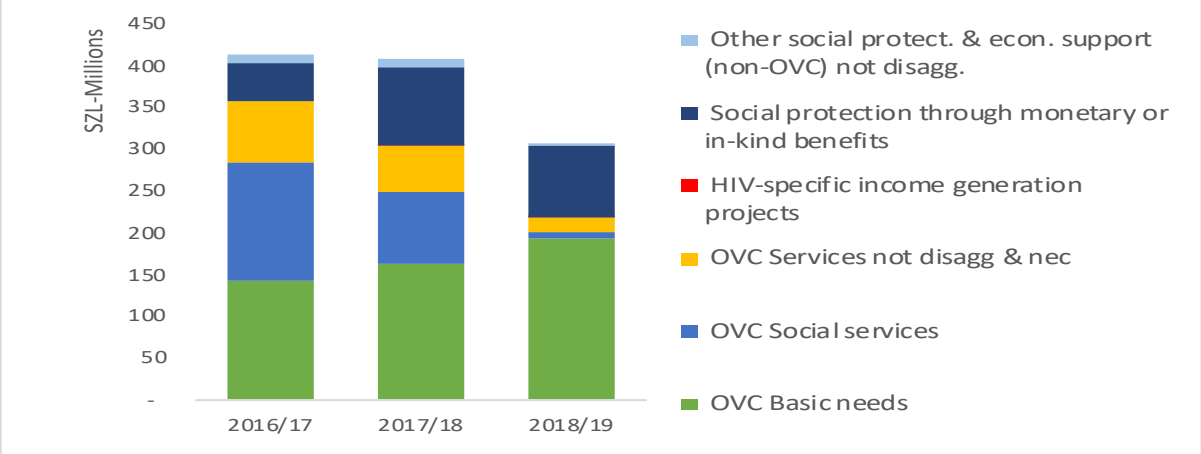
Figure 22: Proportional contributions to treatment and care activities by funding entities (%, 2018/19)



Social protection and economic support spending

Social protection and economic support (SPES) funding declined from SZL 414 million in 2016/17 to SZL 407 million in 2017/18, and further to SZL 303 million in 2018/19 – the majority of which, in all years, was for OVC support. The Government contribution made up 82% of all SPES spending in 2018/19, of which 64% was for OVC basic needs through the MOE school feeding programme, and 34% was for the grant for OVC education support and the ageing person financial support (through the Deputy Prime Minister's Office). The remaining 18% from international funding entities in 2018/19 also went mostly (99%) to OVC needs.

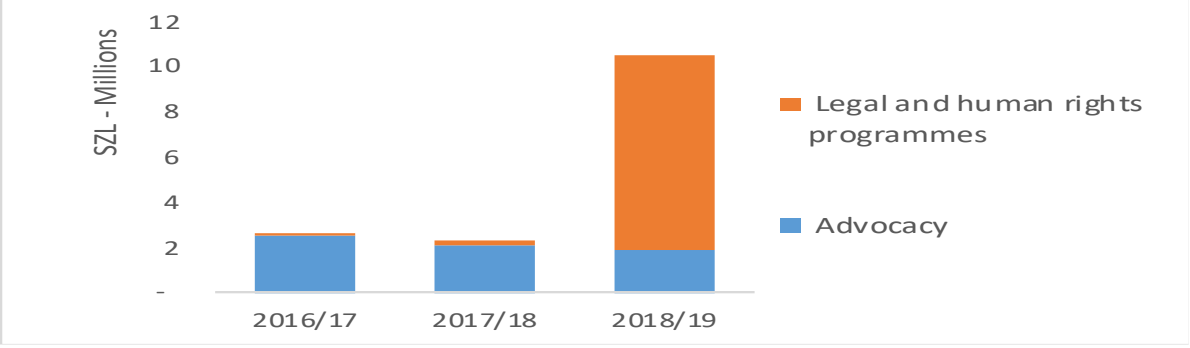
Figure 23: Social protection and economic support spending in Eswatini (2016/17-2018/19)



Social Enablers spending in Eswatini

The spending on social enablers overall was very low, with only SZL 2.5 million in 2016/17, SZL 2.3 million in 2017/18, and then increased to SZL 10.5 million in 2018/19. This increase was due to PEPFAR's financial support to legal, human rights and protection (according to the new ER category). Advocacy interventions expended SZL 2.5 million in 2016/17 and decreased gradually to SZL 1.9 million in 2018/19, while the amount going to human rights interventions increased significantly from SZL 210 thousand in 2017/18 to SZL 8.5 million in 2018/19. Human rights interventions accounted for 82% of the total spending on Social Enablers in 2018/19, and were entirely funded by international funding entities, while the largest proportion (81%) of advocacy spending was from public sources – mostly for the World AIDS Day activities which were described as being for advocacy intentions.

Figure 24: Social Enablers spending in Eswatini (2016/17-2018/19)

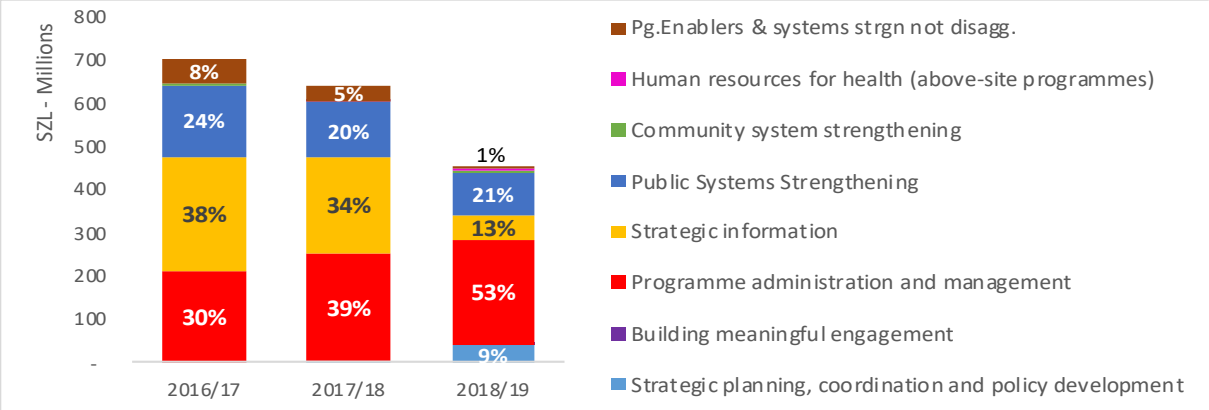


Programme enablers and systems strengthening spending

Total spending on programme enablers and system strengthening took a significant share of the total HIV spending in Eswatini: 36% (SZL 701 million) and 31% (640 million) in 2016/17 and 2017/18 respectively, and then declined in nominal and proportional amounts to 24% (SZL 454 million) of total HIV spending. In the latter year, the largest proportion 53% (SZL 242 million) was for programme administration and management activities, followed by public systems strengthening with 21% (SZL 96.7 million) and then strategic information at 13% (SZL 57.8 million). The reduction in the 'not disaggregated' category in 2018/19 was likely due to the improved categorization in the new PEPFAR ER format.

International funding entities provided the bulk of resources for programme enablers and systems strengthening (85%), totaling over SZL 387 million in 2018/19, while public entities contributed SZL 62.6 million (14%). The public spending on programme management and administration made up 7% of the total public spending on HIV in 2018/19, and international funding enetiteis contribution to the same made up 17% of the total international entities' funding for HIV. Refer to the appendices (Table A24) for the details.

Figure 25: Programme enablers and systems strengthening spending (2016/17-2018/19)



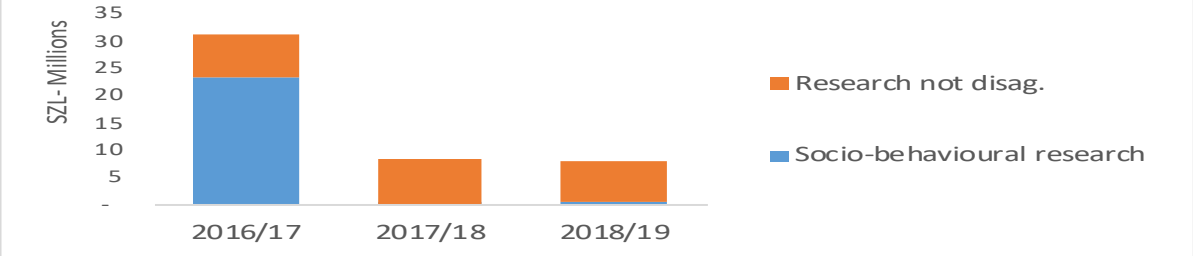
Development synergies spending

Spending on development synergies was extremely low, with only SZL 2 million in 2016/17, jumping to SZL 8.5 million in 2017/18 and then decreased to SZL 208 thousand in 2018/19. Almost all (98%) of this funding went towards the reduction of gender-based violence, while 2% was reportedly for formative education for the HIV workforce (this does not include service-specific training that would have been captured under the services for which they were being trained).

HIV-related research spending

In 2016/2017, spending on HIV-related research was SZL 31.2 million (1.6% of total HIV spending). In the subsequent years, spending on research decreased to SZL 8.3 million and SZL 7.9 million in 2017/18 and 2018/19 respectively (Figure 26). The higher research spending in 2016/2017 was for the Swaziland HIV Incidence Measurement Survey (SHIMS) conducted in 2016/17. It is important to note that other PEPFAR spending on HIV–related research might have been labelled as Strategic Information that could not be disaggregated, and hence research spending might be under-represented here.

Figure 26: HIV-related research spending in Eswatini (2016/17-2018/19)



Note: Research spending in 2016/2017 was higher due to the SHIMS.

3.8. HIV Service Delivery Modalities in Eswatini

The NASA 2020 framework has included the new Service Delivery Modality (SDM) vector, to identify the different ways that HIV services are being delivered. The data can provide the opportunity to analyse the efficiency of programmes according to their mode of delivery – *provided all the expenditure are labelled correctly and comprehensively.*

In order to achieve the NSP ambitious targets, the MOH, through the Eswatini National AIDS Programme (ENAP), has been implementing differentiated service delivery (DSD) models. Differentiated service delivery is a patient-centred approach whereby services are adapted to address both the needs of clients whilst simultaneously reducing the burden on the health system (Kambale et al, 2019). DSD models can include models of HIV testing, ART initiation and ART delivery for both stable and unstable clients and amongst different subpopulations (MOH, 2018).

By 2018/19, the facility-based interventions accounted for 44% of the total HIV spending, followed by the 'not applicable' category for services which did not have a specific delivery model (such as all the programme enablers, systems strengthening and other above site activities). Thereafter home- and community-based services made up 22% (which had declined over the period from 26% in 2016/17) and which included mainly HTC, social protection and economic support, and other community-based prevention activities (Figure 27).

Figure 27: HIV Service Delivery Model in Eswatini (%, 2016/17-2018/19)

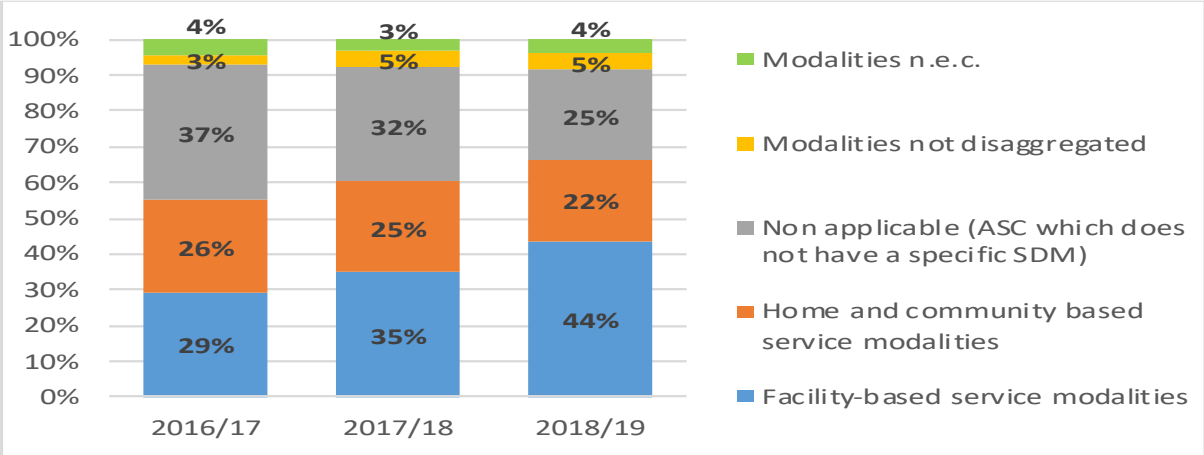
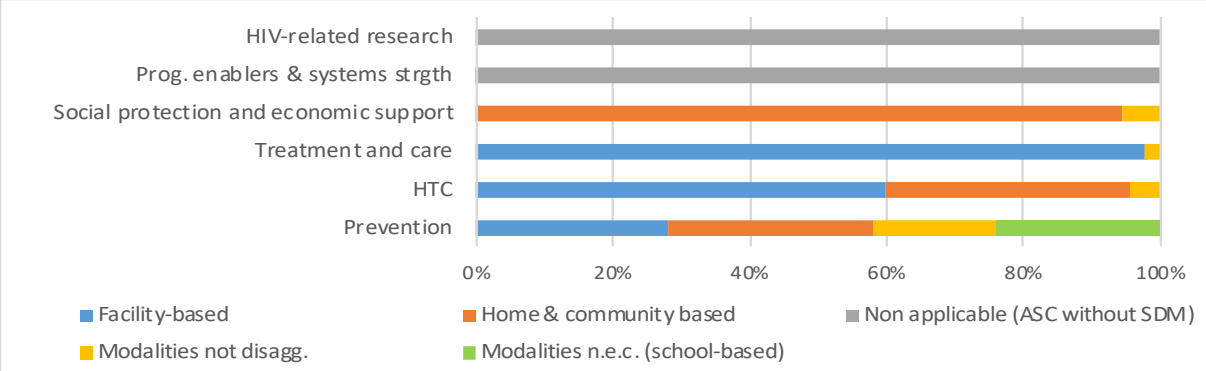


Figure 28 shows the proportional spending by service delivery modality per programme area in 2018/19. Almost all (98%) of the treatment and care services were delivered in facility-based modalities, while HTC was 60% facility-based, 36% home- or community-based and 4% was not

disaggregated. Spending on prevention were 30% for home- or community-based activities, 28% were facility-based, and 18% not disaggregated. Social protection and economic support (almost entirely for OVCs) were 94% home- and community-based interventions. As explained, for programme enablers and research, the SDM classification is not applicable.

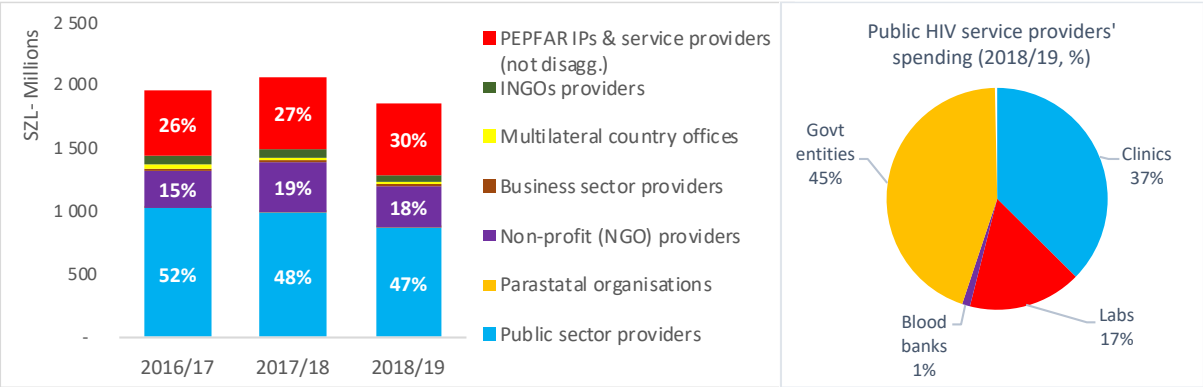
Figure 28: Service delivery modalities for HIV programme areas in Eswatini (%, 2018/19)



3.9. HIV provider of services (PS)

Figure 29 shows the distribution of HIV expenditures by the service provider category. The public sector providers provided around half of the HIV goods and services in all three years, but gradually declining; from SZL 1 billion in 2016/2017 to SZL 989 million and SZL 868 million in 2017/18 and 2018/2019 respectively. Local NGOs played an important role in service delivery, with expenditure of SZL 230 million, SZL 400 million and SZL 337 million in 2016/17, 2017/18 and 2018/2019 respectively – which included some of the PEPFAR sub-recipients and implementing partners. Those that could not be disaggregated (due to de-identified data) represented 26% (SZL 511 million) of the total HIV spending in 2016/17, 27% (SZL 566 million) in 2017/18, and 30% (SZL 563 million) in 2018/19. Other international agencies (multilaterals and INGOs) spent (themselves) 6%, 5% and 4% in each of the study years.

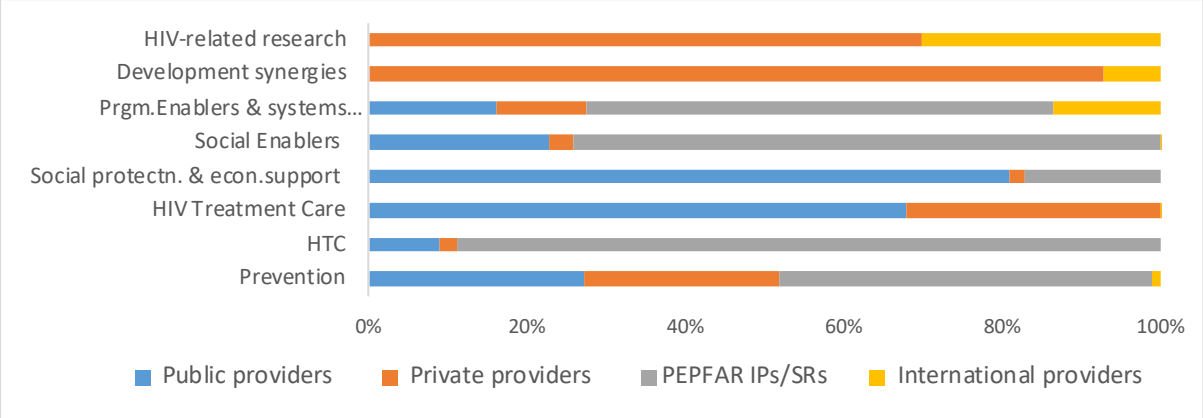
Figure 29: Providers of HIV services in Eswatini (2016/17-2018/19)



Note: PEPFAR expenditure data were provided without the service providers' details, hence they could not be broken down into types for the NASA categorization – they are therefore lumped together in the analysis (as PEPFAR implementing partners and service providers). Those providing treatment services were assumed to be facility-based private non-for-profit.

Figure 30 shows which programmatic areas are being delivered by which service provider type, in 2018/19. Further details of activities of Global Fund principal recipients are provided in the appendices (Table A30).

Figure 30: Service providers spending per programmatic area (%,2018/19)

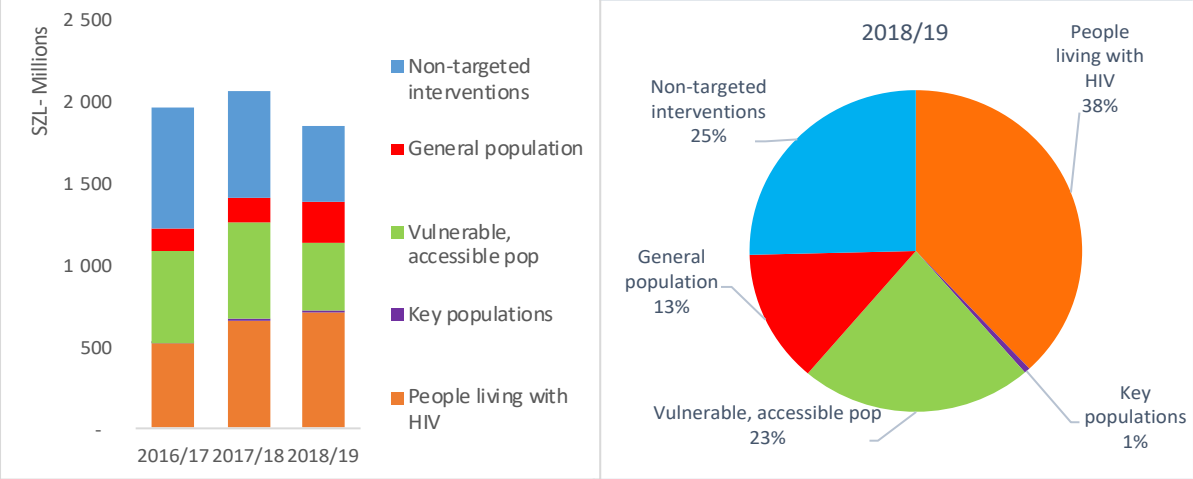


3.10. Beneficiaries of HIV spending

The main beneficiaries of HIV spending during the assessment period were people living with HIV (PLHIV) accounting for 26% (SZL 514 million) in 2016/17, which increased to 32% (SZL 654 million) in 2017/18 and then to SZL 705 million (38%) in 2018/19. This pattern of expenditures for PLHIV is consistent with the proportional spending on care and treatment which directly benefits PLHIV.

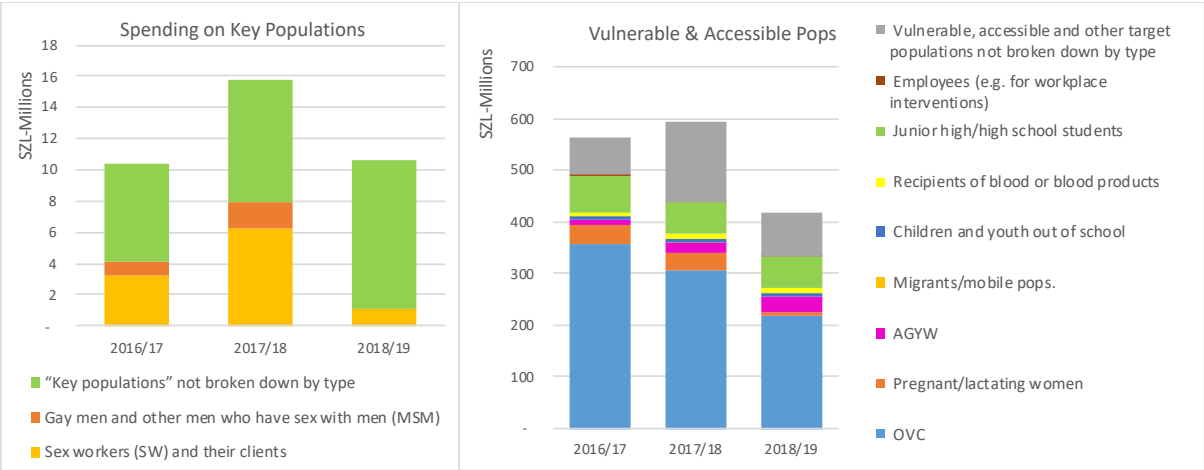
The second largest group of beneficiaries were vulnerable and accessible populations, which received 29% in 2016/17 and 2017/18, but then decreased in both nominal and proportional terms to 23% (SZL 419 million) in 2018/19. Within this category of vulnerable populations, the largest share (52%) went to OVC in 2018/19, followed by junior/high school student with 15%, AGYW 7% and all the other vulnerable and accessible groups combined accounted for 11% (Figure 32).

Figure 31: Beneficiaries of HIV spending in Eswatini (%, 2016/17-2018/19)



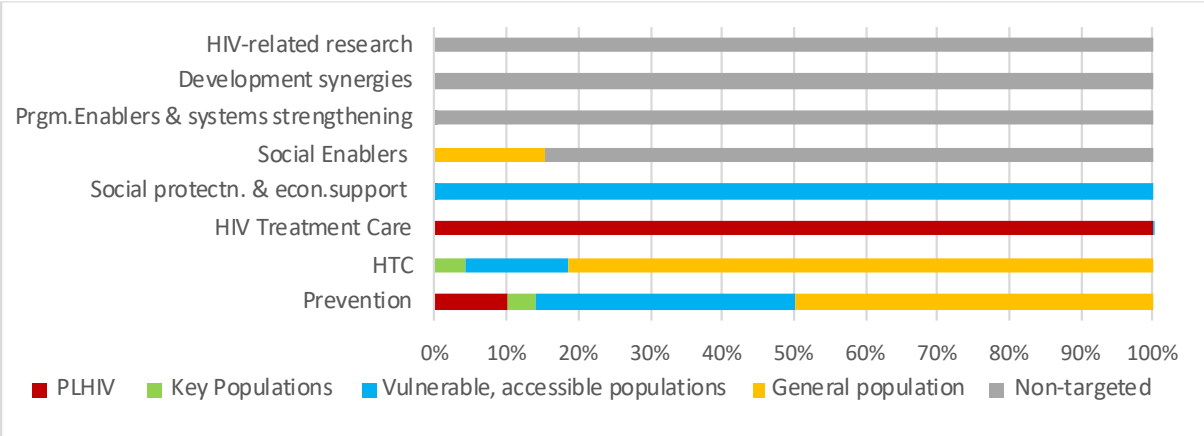
The general population who largely benefit from the prevention activities absorbed 12% of spending in 2018/19. Key populations benefitted from the least amount of spending (1% in all years). It should be noted that the key population category could not be further disaggregated in 2018/19, where 89% of key population spending was labelled not disaggregated because the new PEPFAR ER data in Eswatini did not provide the sub-beneficiary groups within 'key populations'. Non-targeted interventions accounted for 25% (SZL 470 million) in 2018/19, which reflects the large proportion of the HIV resource envelop spent on programme enablers and systems strengthening.

Figure 32: Spending on key populations and vulnerable/ accessible populations (2016/17-2018/19)



Regarding which programme areas are benefitting which groups, Figure 33 shows that the treatment and care services spending benefitted PLHIV in 2018/19, while HTC was primarily for the general population, vulnerable or priority populations and some for key populations. Prevention spending benefitted mostly the general population, then vulnerable and accessible populations, some key populations and PLHIV. All of the spending programme enablers, development synergies, HIV-related research and most of the social enablers were not targeted towards any particular beneficiary group.

Figure 33: Beneficiaries per programme area (%, 2017/18)



3.11. Production Factors of HIV/AIDS Spending

The production factor vector captures HIV expenditure according to the standard economic classification of resources (budgetary items/cost categories) used for the production of goods and services, such as salaries, medicines, goods, overheads, vehicles, and so on. This classification includes two major categories, the current expenditures and capital investments.

The current spending on HIV services made up 93%, 98% and 99% in 2016/17, 2017/18 and 2018/19 respectively (Table 16). The low spending on capital might be because public investments in health facilities or infrastructure in the health sector were not labelled as HIV-related. Alternatively, it implies that HIV services have mostly passed their set-up periods when such capital investment would have been needed.

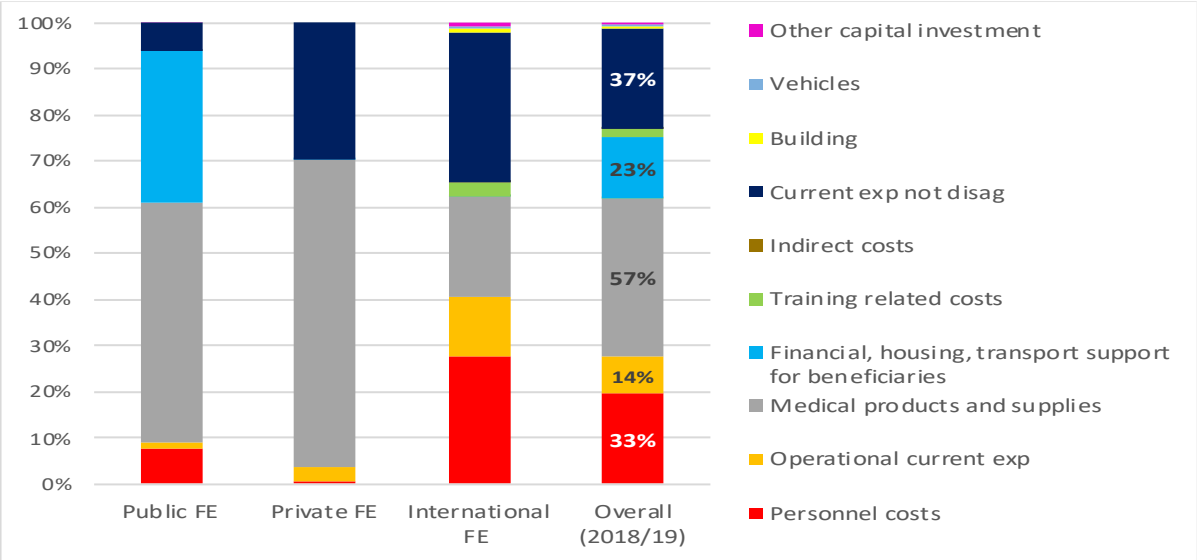
Table 16: Current and capital expenditure on HIV/AIDS (2016/17 – 2018/19)

Production factors	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Current direct and indirect expend.	1 826 045 407	2 020 513 425	1 831 087 839	93%	98%	99%
Capital expenditures	129 800 496	43 023 903	22 275 745	7%	2%	1%
Total	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

In 2018/19, medical products and supplies (including ARVs) accounted for 57% of all HIV spending, followed by personnel (33%), while the financial and other support to beneficiaries (including the grants) were at 23%. The 'not disaggregated current' expenditure accounted for 35%.

Figure 34 shows the production factor breakdown by funding entity, and most of the 'current not disaggregated' expenditure were international funding entities', forming 33% of their funds, while 22% of international funds went to medical products and supply, and 28% for personnel costs (of international entities' funding). Just over half of the public spending (52%) was allocated to medical products and supplies - principally for ARVs, and 33% spent on financial support to beneficiaries which included the elderly grant and OVC financial support. Public entities funding spent only 8% on personnel costs and with 6% on 'current not disaggregated' production factors. As noted in the assumptions section, we used the estimate provided by the SHA report for the small MOH shared (indirect) costs for HIV service delivery in facilities, and this may have been an underestimation of public personnel costs but the SHA assumptions were not available for interrogation or improvement.

Figure 34: Production factors of HIV spending by funding entities (%, 2018/19)



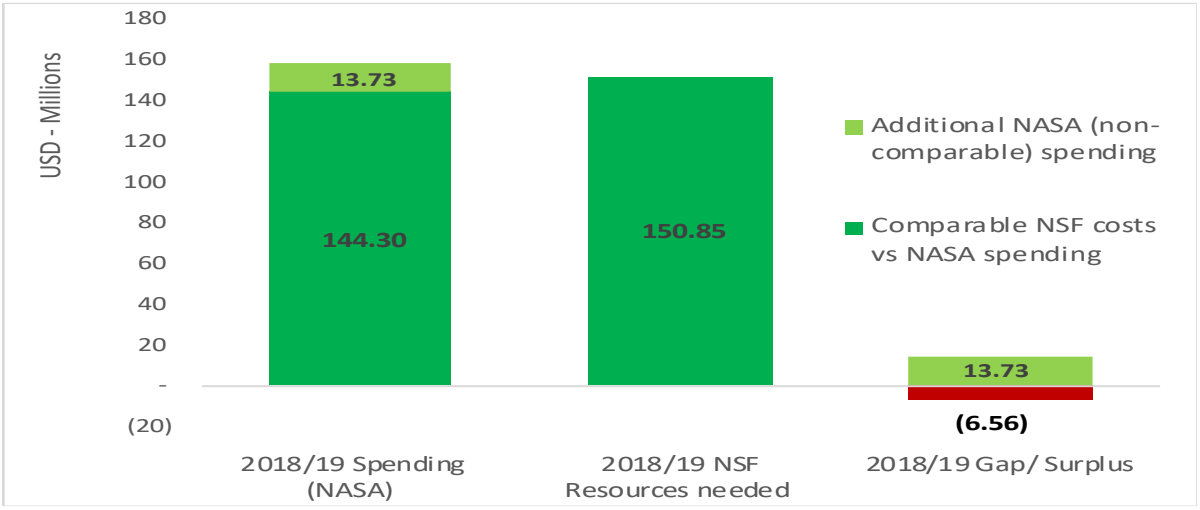
Of the spending on medical products and supplies in 2018/19, ARVs accounted for 53% (SZL 334 million) in 2018/19, condoms 5% (SZL 31 million), laboratory reagents 3% (SZL 16 million) and non-medical supplies took 19% (SZL 119 million). Refer to the appendices (Tables A21 and A22) for further details.

4. Comparison of Spending and Estimated Costs of the NSF – Adequacy of Funding and Allocative Efficiencies?

This section provides a comparison between the total NSF resources needed (as estimated for the year 2018/19) and actual spending in 2018/19 from this NASA - in order to explore the allocative efficiency of the response (whether there has been alignment of spending with the NSF priorities) and the adequacy of funding, to identify the programmes that experienced funding gaps.

Figure 35 compares those interventions for which both estimated costs and expenditure data were available and comparable for the year 2018/19, and a smaller amount of spending (US$ 14 million, SZL 185 million) which could not be directly matched to the costed NSF interventions. Spending categories which could not be matched included: HIV-research, community systems strengthening, opportunistic infection prevention and treatment, and interventions for children and youth other than for AGYW specifically. Excluding these additional expenditures, the spending closely matched the estimated resources needed, with only a possible small financing gap of around SZL 88 million (US$ 6.6 million) in 2018/19. There appears to have been adequate funding for the HIV response in Eswatini in 2018/19.

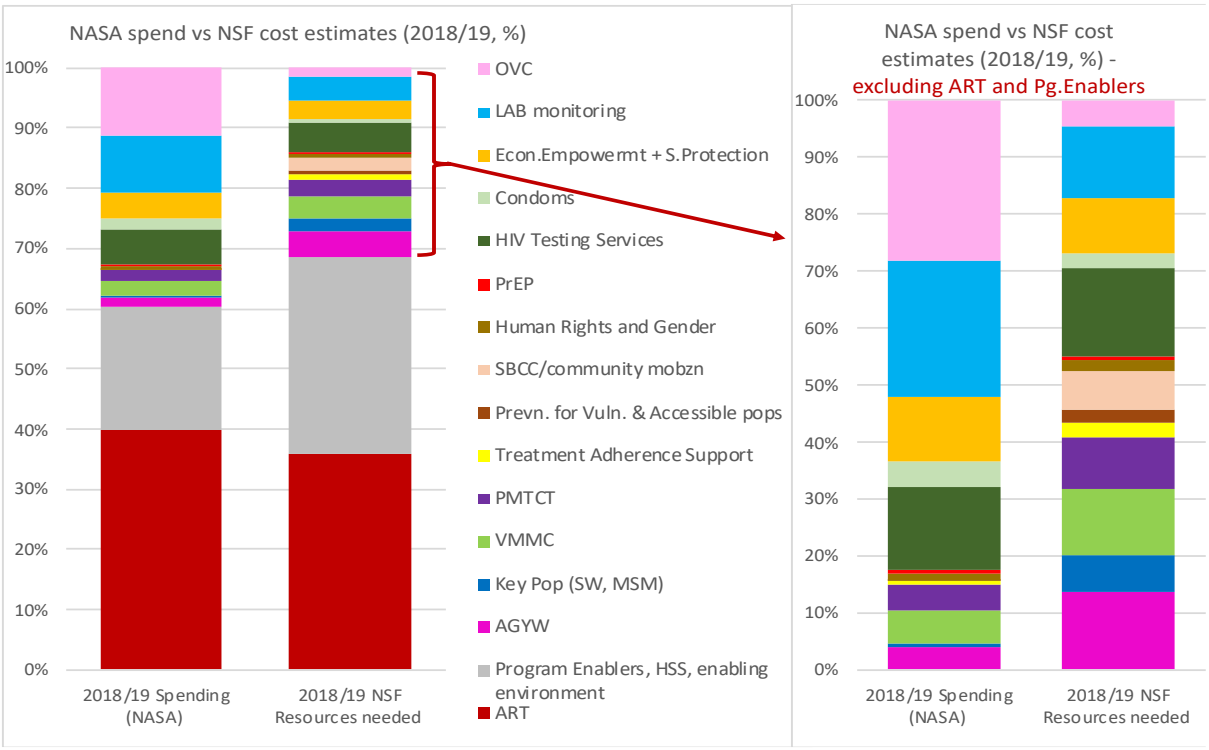
Figure 35: Comparing total NSF resources needed with spending (US$m, 2018/19)



When considering the *proportional* composition of spending in Eswatini versus the anticipated proportional needed resources for the NSF – as an *indication of prioritization* - Figure 36 (left side) shows that ART appears to have been adequately prioritised in spending[7], while programme enablers may have been under prioritized. Removing these two from the comparison (ART and programme enablers and systems strengthening since they are difficult to compare), the right-hand figure shows that spending appears to have over-priortised OVC support and laboratory monitoring, while spending on AGYW and key populations may have been under-prioritised. The remaining interventions' *proportional* spending was somewhat in line with the NSF cost estimates, which could imply that some allocative efficiencies were achieved in 2018/19.

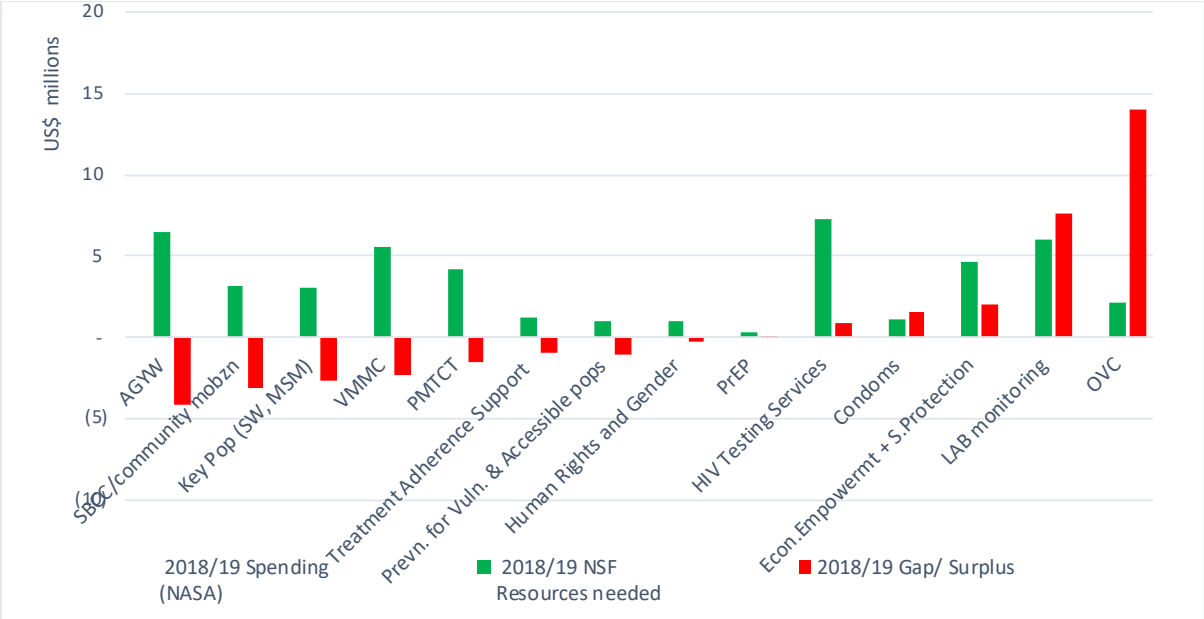
[7] NSF costed targeted number of people on ART for 2018/19 was around 196 000, while the actual number of people on ART by December 2018 was 177 156.

Figure 36: Proportional NSF spending versus need (%, 2018/19)



In terms of adequacy of funding and potential funding gaps, Figure 37 examines in further detail the specific NSF interventions (excluding ART and programme enablers) and shows spending per intervention, their needed resources and the calculated funding gap (left side of the figure) or surplus (right side).

*Figure 37: NASA spending versus NSF costs per intervention (**excluding ART & Pg.Enablers**) (US$m, 2018/19)*



In 2018/19, AGYW, key population interventions, VMMC, key populations and PMTCT may have experienced funding shortfalls in 2018/19. The observed gap for adherence and support may have

been because any spending on these activities were captured under ART (due to non-disaggregated categories), and indeed, the country achieved 97% viral suppression amongst people on treatment.

Laboratory monitoring and OVC support may have experienced a surplus of funding when compared to estimated resources needed in 2018/19. However, NASA captured the Education Fund and school feeding programme for OVC, which may not have been included in the cost estimates. For most other interventions, the spending is very much in line with the estimated resources needed in 2018/19 – which implies good allocative efficiency and adequacy of commitments for those NSF priorities.

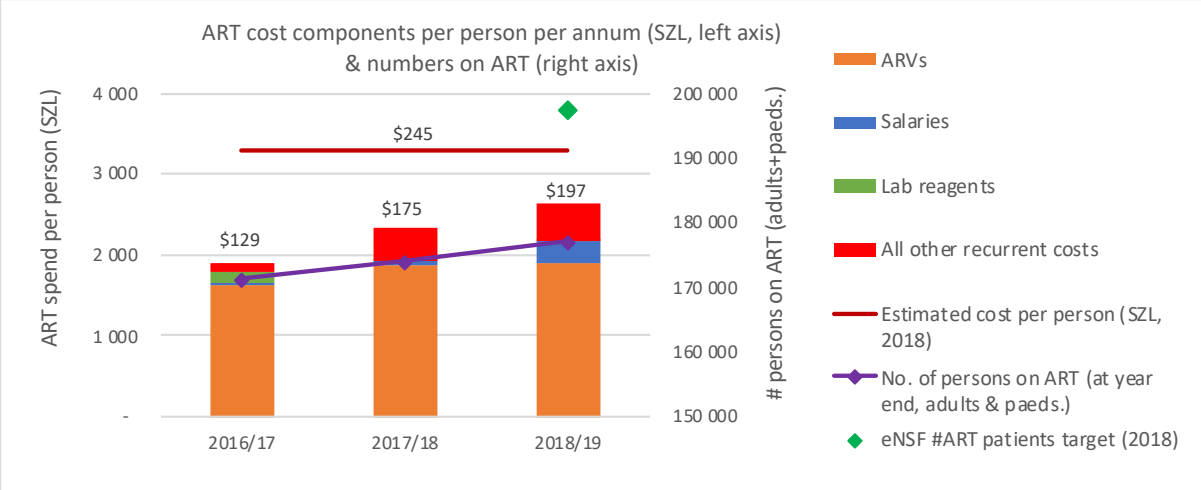
5. Efficiency of HIV Spending in Eswatini – Outputs versus Inputs

This section examines the annual spending on specific HIV interventions (ART, VMMC, HTC and condoms) with their annual outputs or performance indicators and presents the calculated unit of expenditure per person reached. This provides some indication of possible in-/efficiencies being realized in these interventions, trends in unit/spend and compares these with the anticipated unit cost[8] used in the NSF costing (in 2018/19). Furthermore, the section compares programme performance against NSF targets for 2018/19.

5.1. Eswatini spending per person on antiretroviral treatment

Figure 38 shows the trend in ART spending per person over the three-year period, increasing from SZL 1,900 (US$ 129) per person treated to SZL 2,300 (US$ 175) in 2017/18, and reaching SZL 2,650 (US$ 197). Over the period, the number of people on ART steadily increased from 171 thousand in 2016/17 to 177 thousand in 2018/19. The unit/spend was slightly lower than the estimated unit cost applied in the NSF costing of SZL 3,302 (US$ 245) per person in 2018/19 (averaged across all regimens). This might indicate technical efficiencies were achieved, one of which could have been the introduction of dolutegravir formulations.

Figure 38: Eswatini spending per person on ART per annum, and numbers on treatment



Note: The above figure does not include all the laboratory monitoring spending.

[8] It is important to note that unit costs usually include all possible ingredients/ cost components / shared costs etc., while the unit/spend, collected through the NASA, may have missed certain expenses that were not have been fully labeled to the intervention – such as public salaries, and therefore the unit/spend is usually slightly lower than the unit/cost.

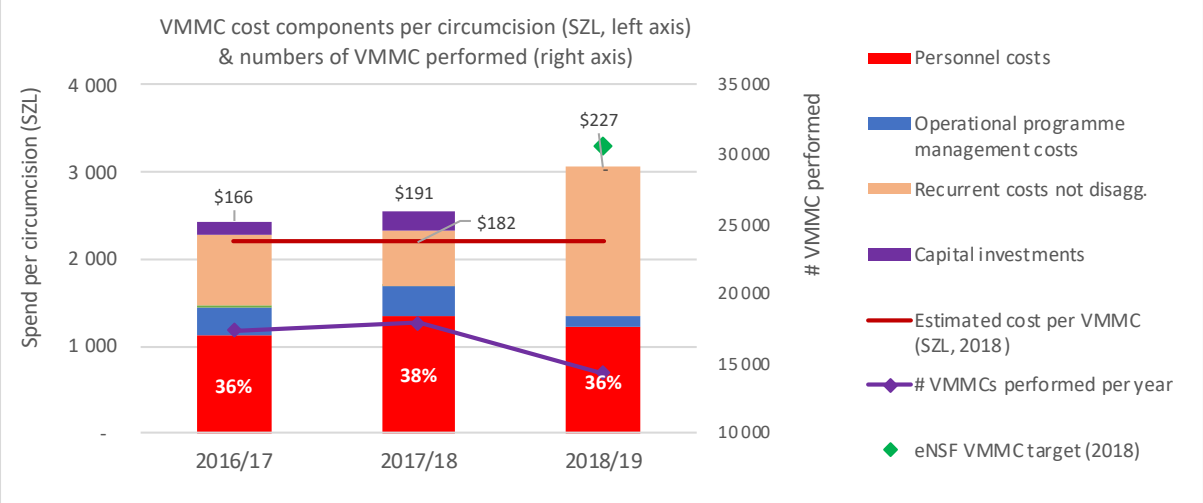
At the same time, Figure 38 shows the cost components of the ART unit of expenditure and that ARVs were clearly the cost driver, illustrating that potential savings will be primarily through reducing prices of ARVs, particularly of second-line regimens. It could also indicate that salaries and other recurrent expenditure, as well as laboratory expenditure, were not fully attributed to the ART programme, hence the lower unit/spend compared to the estimated unit cost.

5.2. Voluntary medical male circumcision

Examining the unit of expenditure on each circumcision, Figure 39 shows a slight increase from SZL 2,400 (US$ 166) in 2016/17 to SZL 2,500 (US$ 191) in 2017/18, and then a larger increase to SZL 3,000 (US$ 227) per circumcision. Fewer circumcisions were performed in 2018/19 and this may have undermined any potential economies of scale. The achieved numbers of circumcisions (14,3116) were just under half of the targeted number of around 30 thousand for 2018/19. This could cause greater operational costs for fewer circumcisions, thereby pushing up the unit/spend – possibly implying some inefficiencies (possibly illustrated by the large increase in recurrent costs not disaggregated in 2018/19). The estimated unit cost per circumcision applied in the NSF resource estimation was SLZ 2,200 (US$182), lower than the unit spend in all three years.

The main cost driver for VMMC in all three years were salaries, followed by operational and programme management costs in 2016/17 and 2017/18. Capital investments occurred only in 2016/17 and 2017/18.

Figure 39: Eswatini spending per VMMC performed (SZL) and outputs

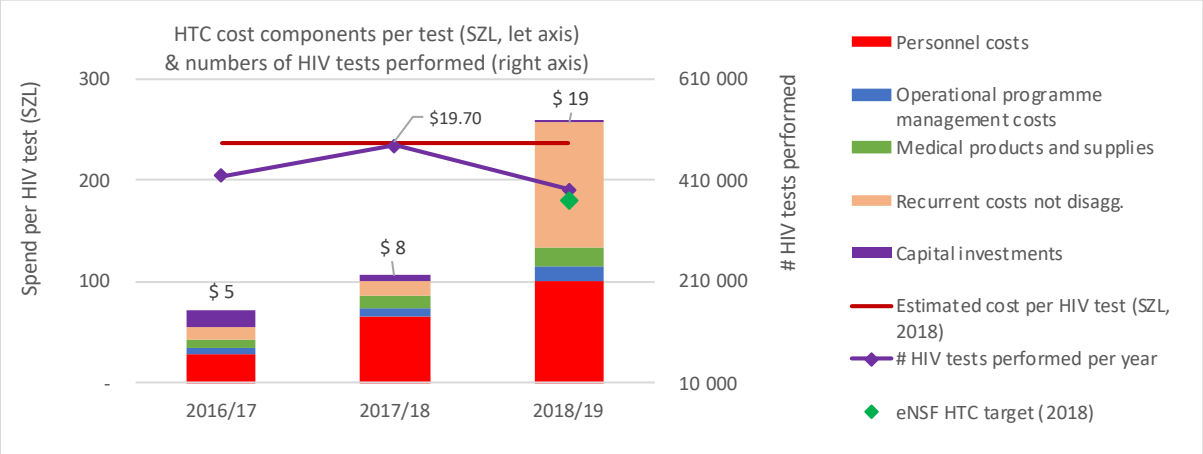


Note: 2018/19 labelling changed due to new PEPFAR ER categories, which may have caused the large portion of 'recurrent not disaggregated' in that year.

5.3. HIV testing and counselling

The unit spend per HIV test conducted (averaged across all delivery modalities), as shown in Figure 40, almost tripled between 2017/18 and 2018/19 – from SZL 106 (US$ 8) to SZL 256 (US$ 19) – driven by a large portion of 'recurrent not disaggregated'. The salary component of the unit/spend increased from SZL 28 in 2016/2017 to SZL 66 in 2017/2018 and reached SZL 101 in 2018/2019. Despite these increases, the unit spend per HIV test was close to the estimated cost per HIV test in the NSF costing, of SZL 237 (US$ 19.70) per test, and the NSF target for 2018/19 was reached in terms of numbers of tests conducted. This may imply that the programme performed as had been expected.

Figure 40: Eswatini spending per HIV test (SZL) and outputs

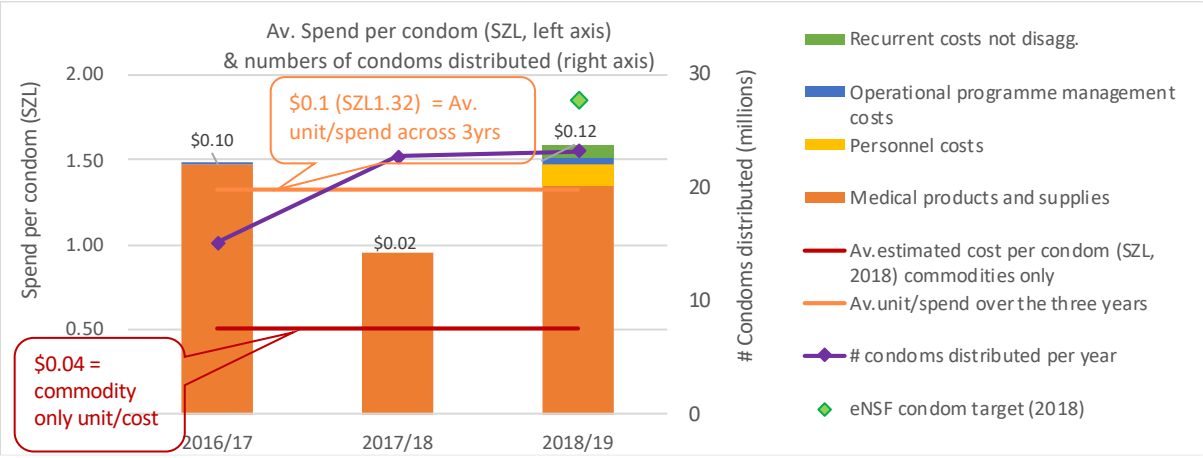


Note: 2018/19 labelling changed due to new PEPFAR ER categories, which may have caused the large portion of 'recurrent not disaggregated' in that year.

5.4. Condom programme spending

The spending per condom distributed (averaged across male and female condoms) appears to have declined in 2017/18, but then increased again to SZL 1.58 (US$ 0.12) per condom distributed (Figure 41). This fluctuation may have been due to bulk purchasing in 2016/17, with some stock only distributed in 2017/18 – this could not be verified. When taking the total condom spending over the three years and dividing by the total number distributed over the period, the average cost per condom was SZL 1.32 (US$ 0.10) – which is the average weighted distribution cost across the male and female condoms and may have included lubricant costs. This unit/spent is therefore higher than the unit/cost used for the NSF costing which only include the commodity price, at SZL 0.50 (US$ 0.04) per condom. The number of condoms distributed in 2018/19 were over 20 million, while the NSF target was around 27.7 million – this slight under-achievement may have caused the higher-than-estimated cost per unit.

Figure 41: Spending per condom distributed



6. Summary, Recommendations and Conclusion

This National AIDS Spending Assessment has applied the new NASA 2020 framework and used primary data collection techniques for 99% of expenditure data and only 1% was based on the National Health Accounts estimation of MOH shared costs attributable to HIV. The assessment has answered the following questions:

- Who pays for HIV services in Eswatini? Who pools funds? What funding schemes are used?
- Which financing schemes and funding agents/providers are purchasing the HIV services?
- Who are the providers of HIV services in Eswatini?
- What HIV services are being provided, and what is being spent on them? What are their service delivery models?
- Which services are vulnerable to external shocks if international funding (entities and/or schemes) reduce?
- Who are the beneficiaries of HIV spending in Eswatini?
- What are the key cost drivers, the production factors, of the HIV spending in Eswatini?

Additionally, the study has explored issues of sustainability, allocative and technical efficiencies – *in as far as the data allowed, without having conducted full efficiency analyses* –for consideration by all stakeholders. The key findings and ensuing recommendations are summarized below, followed by suggestions for institutionalizing NASA.

6.1. Key findings and recommendations

The Kingdom of Eswatini has demonstrated commitment and leadership in the fight against HIV, and their National Strategic Framework on HIV and AIDS 2018-2023 (NSF) has guided efforts to optimize resources for implementing technically effective interventions for combination prevention, as well as treatment for all people living with HIV (PLHIV). This has been evidenced in their increasing commitment of public revenue to the HIV response (reaching 40% by 2018/19), via central government funding schemes, thereby improving sustainability and ensuring alignment to the NSF priorities. From the previous NASA (2012/13), the annual average rate of increase in public contributions, in Emalangeni (SZL) terms, over the four years (2012/13 - 2016/17) has been an impressive 20%, *average annually*[9]. Over this NASA study period, the public commitment increased by 12% between 2016/17 and 2017/18. However, in 2018/19, due to stagnated economic growth, the public commitment to HIV grew by only 1% in SZL terms, but also noting that the international contributions between 2017/18 and 2018/19 declined by 17% in SZL (18% in USD). Importantly, Eswatini's proportional public contribution to all treatment and care interventions reached 52% by 2018/19, and 60% towards ART specifically. It is also likely that the public salaries contribution was underestimated (the shared MOH personnel costs provided by the National Health Accounts assessment appeared low). In terms of prevention spending, only 23% came from public resources in 2018/19, and these were primarily for interventions for children and youth, while the international

[9] This increase may have been partially due to including the public spending on the school feeding and a portion of the pensioners' grant (as explained in the assumptions section).

funding entities were funding the Five Pillar prevention interventions. The Government may need to consider increasing their contributions to highly impactful, five pillars of HIV prevention interventions.

Although off a small base, the private sector's contribution to HIV increased by 54% between 2016/17 and 2017/18, and then again by 4% in 2018/19. The private contribution made up only 0.7% of the total HIV spending in 2018/19, and further opportunities to leverage resources from this sector could be explored. Additionally, extra efforts will be required to improve their response rate to future NASAs, in order to better track their contributions.

As seen, between 2017/18 and 2018/19, international funding for HIV in Eswatini declined by 18% in USD terms – to even less than their contributions in 2016/17, and if it continues to decline further, the Government will need to increase their HIV allocations, mobilize domestic resources and explore alternative funding options. Unfortunately, the poor economic climate added to the COVID-19 demands on the public budget will make this challenging.

The two key funding schemes for HIV in Eswatini in 2018/19 were government schemes (48%) and resident foreign agencies schemes (42%), and decreasing amounts going through non-resident foreign agency schemes (only 6% in 2018/19). Importantly the funding through government schemes increased in proportional terms over the three years, thus improving sustainability and national direction of the response. The government should consider measures to continue to increase the funding flowing through government schemes, in addition to increasing public revenue funding.

Regarding the focus of spending over the three years, it was found that the amount spent on care and treatment increased by 27% in 2017/18 and then again slightly by 3% but continued to take a greater share of the total HIV envelop (reaching 36% by 2018/19). The spending on HIV testing services almost doubled between 2017/18 and 2018/19, from 3% to 6% of total HIV funding. These reflect great commitment by all stakeholders to reach the 90-90-90 targets.

Prevention spending increased by 12% and then 3% in 2018/19, with increasing shares going to the Five Pillars of Prevention: 32%, 32% and 41% in 2016/17, 2017/18 and 2018/19 respectively, with 10% of all prevention spending went to AGYW, only 2% for interventions for key populations, 13% for condoms, 15% for VMMC and 5% towards PrEP. The remaining 59% prevention spending went other (non-five-pillar) prevention interventions, such as 28% for children and youth interventions (not specifically for AGYW), community mobilization (11%), and 6% was for prevention not disaggregated. The Five Pillar prevention interventions were primarily funded by international sources, making them particularly vulnerable to changes in external funding, and underlining the need for increased public allocations to these key interventions.

Other interventions mostly funded by international partners were development synergies and HIV-related research (spending on both were very low). Of the spending on programme enablers and systems strengthening, the 13% that came from public entities (in 2018/19) went mostly towards programme administration and management (*forming only 7% of all public HIV funds*), while other systems strengthening (strategic information, strategic planning, community and public systems strengthening, and development of human resources for health) were all funded by international entities. Of all the international entities' HIV funding, 17% went to programme administration and management. Overall, there was very low spending on the social enablers and development synergies, and which might require increased prioritization in the future.

These NASA results highlights the public sector's important role as financing agent and purchaser (FAP) of HIV services in the country. FAPs are entities which mobilize financial resources collected from different financing sources and transfer them to pay for, or purchase, health care or other services or goods. They are therefore important in ensuring efforts are aligned to the national priorities outlined in the NSF. It is notable, therefore, that 48% of all HIV funding went through public agent-purchasers (in 2018/19), which implies important leadership and ownership by the government. Only 4% went through private FAPs, and the 48% through international FAPs (mostly for PEPFAR funds).

Regarding providers of HIV services, this NASA found that in 2018/19 just under half (47%) of the HIV funds were channeled to public service providers, 18% went to non-profit organisations (civil society organisations, including some PEPFAR sub-recipients), 1% to private (for-profit) providers, 3% to international NGOs (INGOs), 1% to multilateral entities, and the remaining 30% went to the other PEPFAR implementing partners (IPs) and their sub-recipients (SRs)/ service providers. Since the PEFAR expenditure data was de-identified, it was not possible to ascertain the types of these IPs and SRs for all PEPFAR expenditures.

Of all the HIV spending in Eswatini in 2018/19, 38% benefitted PLHIV (directly benefiting from the large share of spending on treatment and care), 23% went towards vulnerable and accessing populations (including OVCs, youth in school), only *1% for key populations*[10] and 13% towards the general population. The Government may need to realign funds towards key populations, if they remain a key mode of transmission in Eswatini. Finally, there were 25% of funds that went towards non-targeted interventions – which tend to be those at national levels, mostly the programme enablers and system strengthening, which are necessary to strengthen the entire system and benefit all.

The examination of the production factors found that of all the funds from public entities in 2018/19, less than 8% was spent on personnel (*probably with some underestimation of civil servants' salaries engaged in HIV activities),* while 29% of international funding went to salaries. Just over half of the public funds (52%) went to medical good and pharmaceuticals (mostly ARVs), while 22% of international funds went to these. A third of public funds went to the financial support of beneficiaries (through the cash grants), and only 2% for operational costs (again, probably an underestimation due to being embedded in the general health budget). There were 13% of international funds reported for operational costs, while 33% of international funds were not disaggregated recurrent costs by production factor in 2018/19 (partly due to the new PEPFAR ER categorization).

Comparing the total expenditure in 2018/19 with the estimated resources needed to achieve the NSF targets in that year found a very small possible shortfall. There was some spending for interventions which were not costed in the NSF (such as research, opportunistic infections prevention and treatment, and the school feeding programme for children and youth). The detailed financial gap analysis showed possible funding shortfalls for interventions for AGYW, key populations and other vulnerable populations, as well as for VMMC, PMTCT and treatment adherence support. Apart from these variations in nominal amounts per intervention (most of which can be explained), the proportional comparison of spending against NSF resources needed indicated good alignment of

[10] Note that here, we report that 3% of *all spending* (which can include all interventions), while earlier we indicated 1% of *only prevention* spending went to KP prevention interventions.

efforts with the NSF priorities, and that some measure of allocative efficiency has been achieved in the Eswatini HIV response.

Regarding technical efficiencies – noting that indepth programme evaluations were not conducted – the comparison of the unit of expenditure for certain interventions, and their cost components, with their anticipated unit/costs (as used in the NSF costing) provided some indication of areas where technical efficiencies have been made, such as for the ART and HTC programmes. The VMMC programme did not achieve the NSF targets for 2018/19 and may not have realized optimal efficiency. As such, greater efforts could focus on VMMC demand creation, while exploring potential cost savings in the personnel and operational cost components.

6.2. Recommendations for improving and institutionalizing NASA

Based on the experience of conducting this NASA in Eswatini, as well as previous resource tracking exercises, the following recommendations suggest steps to institutionalize NASA:

- NERCHA could increase awareness and understanding of NASA and its value-add, by optimising its utility, so as to improve the co-operation of respondents.
- NERCHA should develop a robust and comprehensive HIV database of funding entities, funding agent-purchasers and service providers. Mapping the HIV response (and keeping the database updated) is a necessity for NASA institutionalization.
- NERCHA to coordinate an effective and efficient tracking of HIV spending from funding entities to providers of services in Eswatini. The mechanisms should routinely and systematically collect information for NASA, from all respondents who would be aware of NASA requirements and therefore include the preparation of their data in their annual plans.
- Public sector, NGOs and private sector could strengthen their financial information management systems and code their HIV spending by activity and by province.
- The Government could create a Vote output for public HIV mainstreaming spending in all ministries, which would enhance their expenditure reporting against the budget vote.
- There is also need to encourage (or enforce) the private-for-profit sector's reporting of HIV expenditure, and to mobilize additional support from this sector.
- An online portal that allows for the uploading of expenditure records, in excel or other formats, would reduce the reporting burden on respondents. NERCHA could provide a relatively simple, and user-friendly, reporting template, with resource tracking guidelines. This will reduce the time taken for data preparation and collection, improving its accuracy and timeliness.
- UNAIDS to continue to develop the capacity of in-country stakeholders and experts in the NASA methodology so as to undertake regular resource tracking. An effective capacity building plan to train local teams, especially NERCHA officials (National and District levels) could be introduced, which will make it possible to implement and improve the monitoring of the response and improve national strategic planning to achieve epidemic control.

6.3. Conclusion

In conclusion, the Kingdom of Eswatini has made great progress in its commitment of domestic revenue to the HIV response, and also in terms of the funds flowing through central government financing schemes, ensuring greater government direction and management of funds as well as improving sustainability, particularly for the ART programme. Given the global, regional and local impact of COVID, Eswatini might face reducing external aid for HIV as well as tightening public fiscal space – hence maintaining the important gains made in the HIV response and epidemic control will require further domestic resource mobilization, as well as strategic allocation and more efficient utilization of available funding. Innovative financing mechanisms and additional sources of domestic funding, including the private sector, need to be secured for the entire health system within a national health financing strategy, and for HIV financing to be aligned to the national strategy and priorities.

References

African Development Bank (AFDB) (2018). Eswatini Economic Outlook. https://www.afdb.org/en/knowledge/statistics (accessed March 2020).

Central Bank of Eswatini (2019). Annual Economic Review Report 2018/19. Mbabane. Eswatini

Central Statistical Office (2017). Population and Housing Census, Preliminary Results. Mbabane, Eswatini 2017.

Eswatini Central Statistical Office (2018). 2016/2017 Eswatini Household Income and Expenditure Survey (EHIES). Mbabane, Eswatini.

International Monetary Fund, IMF Staff Completes 2019 Article IV Mission to Eswatini Press release 2019. https://www.imf.org/en/News/Articles/2019/11/04/pr19391-eswatini-imf-staff-completes-2019-article-iv-mission-to-eswatini. (Accessed March 2020)

Joint United Nations Programme on HIV and AIDS (2018). Eswatini HIV Estimates and Projections Report.

Government of the Kingdom of Eswatini. Swaziland HIV Incidence Measurement Survey 2 (SHIMS2) 2016-2017. Final Report. Mbabane: Government of the Kingdom of Eswatini; April 2019

Ministry of Economic Planning and Development, Eswatini, (2018). External Assistance to Eswatini, 2017/18. Aid Coordination and Management Section. Mbabane, Kingdom of Eswatini.

National Emergency Response Council on HIV and AIDS (NERCHA) (2018). The National Multisectoral HIV and AIDS Framework (eNSF) 2018 – 2023. Mbabane, Eswatini

US President's Emergency Plan for AIDs Relief (PEPFAR) (2019). Zambia Country Operational Plan (COP) 2019 Strategic Direction

UNAIDS (2018). 'AIDSinfo' Eswatini Overview. www.unaids.org/en/regionscountries/countries/swaziland (accessed March 2020).

UNAIDS (2020). Fast Track Commitments to End AIDS by 2030. Available:

https://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf

World Bank (2018). Swaziland Overview. https://www.worldbank.org/en/country/eswatini/overview. (accessed March 2019).

World Bank (2019). GINI index (World Bank estimate) – Eswatini. https://data.worldbank.org/indicator/SI.POV.GINI?locations=SZ

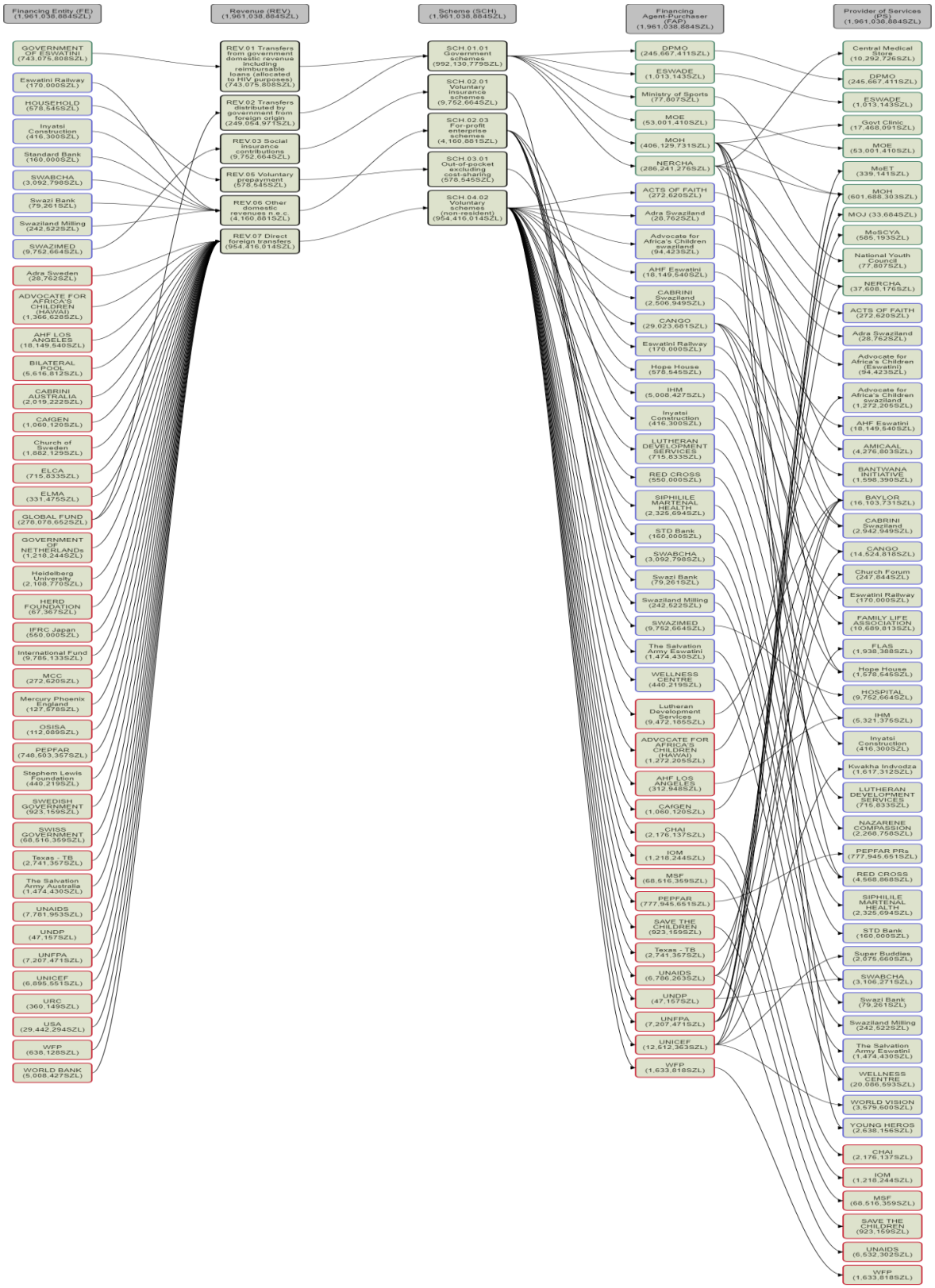
World Health Organisation [WHO]. (2018). Summary of the country profile for HIV and AIDS treatments. Downloaded from http://www.who.int/

https://www.worldbank.org/en/country/eswatini/overview

World Health Organisation [WHO]. (2011). System of Health Accounts: Classifications.

Appendices

Appendix 1: Funding flows between actors in the HIV response in Eswatini



Appendix 2: NASA tables

Table A1: Total HIV spending in Eswatini by funding entity (SZL and %, 2016/17-2018/19)

Funding Entity	2016/17 (SZL)	2016/17 % Share	2017/18 (SZL)	2017/18 % Share	2018/19 (SZL)	2018/19 % Share
Public	655 624 212	34%	733 994 810	36%	743 075 808	40%
Private	9 031 032	0.5%	13 886 555	0.7%	14 492 091	0.8%
International	1 291 190 658	66%	1 315 655 963	64%	1 095 795 684	59%
Total	**1 955 845 903**	**100%**	**2 063 537 328**	**100%**	**1 853 363 583**	**100%**

Table A2: International HIV funding entities (US$, 2017/17-2018/19)

All international funding entities	2016/17	2017/18	2018/19
PEPFAR	46 977 051	62 243 421	57 739 072
Other Bilaterals	5 969 154	6 314 209	5 661 094
EU	5 063 442	3 396 346	-
The Global Fund	17 325 578	16 633 484	13 350 350
World Bank	5 120 406	3 650 511	371 725
UN Agencies	4 664 413	2 413 713	1 675 163
INGOs & foundations	2 686 548	4 051 632	2 532 476
Total International HIV funds (US$)	**87 806 591**	**98 703 315**	**81 329 879**

Table A3: Bilateral HIV funding entities (US$, 2017/17-2018/19)

All bilateral funding entities	2016/17	2017/18	2018/19
Netherlands	12 289	222 539	90 418
Sweden	26 324	151 370	68 517
Switzerland	5 289 906	5 136 935	5 085 279
United Kingdom	37 220	-	-
United States (PEPFAR)	46 977 051	62 243 421	57 739 072
Other government(s) /other bilats.	603 416	803 365	416 879
Total Bilateral funds (US$)	52 946 205	68 557 630	63 400 165

Table A4: UN Agency HIV funding entities (US$, 2017/17-2018/19)

UN Agency Entities	2016/17	2017/18	2018/19
UNAIDS	690 219	669 171	503 676
UNICEF	874 864	648 790	511 787
UNDP	1 579 113	10 200	3 500
UNFPA	565 393	519 805	534 938
WFP	954 823	517 130	121 262
WHO	-	48 617	-
Total UN Agencies (US$)	**4 664 413**	**2 413 713**	**1 675 163**

Table A5: International NGOs and Foundations funding entities for HIV (US$, 2017/17-2018/19)

INGOs/ Foundations Entities	2016/17	2017/18	2018/19
International HIV/AIDS Alliance	1 142 826	1 092 271	-
EGPAF	41 382	985 690	-
Red Cross	2 813	36 613	40 821
OSI / OSF	-	-	8 319
Other INGOs / Foundations	1 499 526	1 937 058	2 483 336
Total INGOs/ Foundations (US$)	**2 686 548**	**4 051 632**	**2 532 476**

Table A6: Revenues for HIV funding in Eswatini (SZL, US$, 2016/17-2018/19)

REVENUE (SZL)	Transfers from government domestic revenue	Transfers distributed by government from foreign origin	Voluntary prepayment	Other domestic revenues	Direct foreign transfers	Total SZL
2016/17	655 624 212	233 267 991	5 467 045	3 563 987	1 057 922 667	1 955 845 903
2017/18	733 994 810	187 611 305	8 844 595	5 041 960	1 128 044 658	2 063 537 328
2018/19	743 075 808	150 851 856	9 752 664	4 739 427	944 943 829	1 853 363 583
						-
REVENUE (US$)	**Transfers from government domestic revenue**	**Transfers distributed by government from foreign origin**	**Voluntary prepayment**	**Other domestic revenues**	**Direct foreign transfers**	**Total US$**
2016/17	$ 44 585 303	$ 15 863 240	$ 371 783	$ 242 367	$ 71 943 351	$ 133 006 044
2017/18	$ 55 065 855	$ 14 075 000	$ 663 540	$ 378 259	$ 84 628 315	$ 154 810 969
2018/19	$ 55 151 034	$ 11 196 214	$ 723 842	$ 351 760	$ 70 133 665	$ 137 556 515

Table A7: Financing schemes for HIV in Eswatini (SZL, 2016/17-2018/19)

SCHEME (SZL)	Government schemes	Voluntary insurance schemes	Not-for-profit organisation schemes	Resident foreign agencies schemes	For-profit enterprise schemes	Foreign non-resident schemes	Total (SZL)
2016/17	889 485 310	5 467 045	22 050 910	768 232 508	3 016 672	267 593 458	1 955 845 903
2017/18	921 606 115	8 844 595	34 681 863	871 901 128	4 463 148	222 040 479	2 063 537 328
2018/19	893 927 664	9 752 664	29 602 226	806 132 723	4 160 881	109 787 425	1 853 363 583

Table A8: Financing schemes x financing entities in Eswatini (SZL, 2018/19)

2018/19 (SZL)	FINANCING ENTITY				
FINANCING SCHEME	**Public Entities**	**Domestic Private Entities**	**International Entities**	**Total (SZL)**	**SCH % in 2018/19**
Government schemes	743 075 808		150 851 856	893 927 664	48%
Voluntary insurance schemes		9 752 664		9 752 664	1%
Not-for-profit organisation schemes		578 545	29 023 681	29 602 226	2%
Resident foreign agencies schemes			806 132 723	806 132 723	43%
For-profit enterprise schemes		4 160 881		4 160 881	0%
Other international non-resident schemes			109 787 425	109 787 425	6%
Total	**743 075 808**	**14 492 091**	**1 095 795 684**	**1 853 363 583**	**100%**

Table A9: Financing schemes x financing agent/purchasers in Eswatini (SZL, 2018/19)

2018/29 (SZL)	FINANCING AGENT/PURCHASER			
FINANCING SCHEME	**Public FAP**	**Domestic Private**	**International FAP**	**Total (SZL)**
Government schemes	893 927 664			893 927 664
Voluntary insurance schemes		9 752 664		9 752 664
Not-for-profit organisation schemes		29 602 226		29 602 226
Resident foreign agencies schemes			806 132 723	806 132 723
For-profit enterprise schemes		4 160 881		4 160 881
Other international non-resident schemes		31 566 896	78 220 528	109 787 425
Total	**893 927 664**	**75 082 668**	**884 353 251**	**1 853 363 583**

Table A10: Financing schemes x HIV service providers in Eswatini (SZL, 2018/19)

2018/19 (SZL)	SERVICE PROVIDERS			
FINANCING SCHEME	**Public PS**	**Domestic Private PS**	**International PS**	**Total (SZL)**
Government schemes	848 114 002	45 813 661		893 927 664
Voluntary insurance schemes		9 752 664		9 752 664
Not-for-profit organisation schemes		29 602 226		29 602 226
Resident foreign agencies schemes	8 370 873	789 631 448	8 130 401	806 132 723
For-profit enterprise schemes		4 160 881		4 160 881
Other international non-resident schem	12 483 561	36 953 526	60 350 338	109 787 425
Total	**868 968 437**	**915 914 407**	**68 480 739**	**1 853 363 583**

Table A11: Financing schemes x beneficiary groups in Eswatini (SZL, 2018/19)

2018/19 (SZL)	BENEFICIARY GROUP					
FINANCING SCHEME	**PLHIV**	**Key Populations**	**Vulnerable & Accessible Pops**	**General Pops.**	**Non-targeted**	**Total (SZL)**
Government schemes	448 975 354		330 269 550	20 436 746	94 246 014	893 927 664
Voluntary insurance schemes	9 350 342				402 322	9 752 664
Not-for-profit organisation schemes	1 588 782	1 966 051	14 963 032		11 084 362	29 602 226
Resident foreign agencies schemes	215 479 870	5 460 056	72 518 906	223 466 568	289 207 323	806 132 723
For-profit enterprise schemes			502 661	262 900	3 395 320	4 160 881
Other international non-resident schem	29 784 094	3 145 032	1 118 077	3 805 469	71 934 753	109 787 425
Total	**705 178 442**	**10 571 139**	**419 372 225**	**247 971 683**	**470 270 094**	**1 853 363 583**

Table 12: Financing schemes x Funding Entities in Eswatini (SZL, 2018/19)

	Funding Entity			
Scheme	**FE.01 Public Entities**	**FE.02 Domestic Private Entitites**	**FE.03 International Entities**	**Grand Total**
SCH.01 Government schemes and compulsory contributory health care schemes	**743 075 808**		**150 851 856**	**893 927 664**
SCH.01.01 Government schemes	**743 075 808**		**150 851 856**	**893 927 664**
SCH.01.01.01 Central government schemes	716 990 530		150 851 856	867 842 385
SCH.01.01.98 Government schemes not dissagregated	26 085 278			26 085 278
SCH.02 Voluntary payment schemes		**13 913 546**	**806 969 332**	**820 882 878**
SCH.02.01 Voluntary insurance schemes		**9 752 664**		**9 752 664**
SCH.02.01.01 Primary/substitutory health insurance schemes		9 752 664		9 752 664
SCH.02.02 Not-for-profit organisation schemes			**806 969 332**	**806 969 332**
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.02.02.02)			29 023 681	29 023 681
SCH.02.02.02 Resident foreign agencies schemes			777 945 651	777 945 651
SCH.02.03 For-profit enterprise schemes		**4 160 881**		**4 160 881**
SCH.02.03.01 Enterprises (except health care providers) schemes		3 092 798		3 092 798
SCH.02.03.98 For-profit enterprise schemes not dissagregated		1 068 083		1 068 083
SCH.03 Household out-of-pocket payment		**578 545**		**578 545**
SCH.03.01 Out-of-pocket excluding cost-sharing		**578 545**		**578 545**
SCH.04 International schemes (non-resident)			**147 446 682**	**147 446 682**
SCH.04.02 Voluntary schemes (non-resident)			**147 446 682**	**147 446 682**
SCH.04.02.02 Other schemes (non-resident)			147 446 682	147 446 682
Total	**743 075 808**	**14 492 091**	**1 105 267 870**	**1 862 835 769**

Table A13: Financing agent-purchasers of HIV services in Eswatini (SZL and US$, 2016/17-2018/19)

FAP (SZL)	Public agents/ purchasers	Private agents/ purchasers	International FAPs	Total SZL
2016/17	1 031 416 310	56 310 531	868 119 062	1 955 845 903
2017/18	1 007 902 115	77 909 478	977 725 735	2 063 537 328
2018/19	893 927 664	75 082 668	884 353 251	1 853 363 583

FAP (US$)	Public agents/ purchasers	Private agents/ purchasers	International FAPs	Total US$
2016/17	$ 70 140 804	$ 3 829 361	$ 59 035 879	$ 133 006 044
2017/18	$ 75 614 965	$ 5 844 935	$ 73 351 069	$ 154 810 969
2018/19	$ 66 347 249	$ 5 572 630	$ 65 636 636	$ 137 556 515

Table A14: HIV Funding entities and their agents/purchasers (SZL, 2016/17-2018/19)

FUNDING ENTITY	FUNDING AGENT / PURCHASER				
2016/17 (SZL)	**Public FAP**	**Private FAP**	**International FAP**	**Total**	**% FE share**
Public funding entity	655 624 212			655 624 212	34%
Private funding entity		9 031 032		9 031 032	0%
International funding entity	375 792 098	47 279 499	868 119 062	1 291 190 658	66%
Total	**1 031 416 310**	**56 310 531**	**868 119 062**	**1 955 845 903**	
% FAP share	53%	3%	44%		

2017/18 (SZL)	**Public FAP**	**Private FAP**	**International FAP**	**Total**	**% FE share**
Public funding entity	733 994 810			733 994 810	36%
Private funding entity		13 886 555		13 886 555	1%
International funding entity	273 907 305	64 022 922	977 725 735	1 315 655 963	64%
Total	**1 007 902 115**	**77 909 478**	**977 725 735**	**2 063 537 328**	
% FAP share	49%	4%	47%		

2018/19 (SZL)	**Public FAP**	**Private FAP**	**International FAP**	**Total**	**% FE share**
Public funding entity	743 075 808			743 075 808	40%
Private funding entity		14 492 091		14 492 091	1%
International funding entity	150 851 856	60 590 578	884 353 251	1 095 795 684	59%
Total	**893 927 664**	**75 082 668**	**884 353 251**	**1 853 363 583**	
% FAP share	48%	4%	48%		

Table A15: HIV Funding agents/purchasers and their service provider types (SZL, 2016/17-2018/19)

AGENT-PURCHASER	HIV SERVICE PROVIDERS					
2016/17 (SZL)	**Public providers**	**Private providers (FP & NP)**	**International providers**	**PEPFAR IPs & SRs**	**Total 2016/17 (SZL)**	**% FAP share 2016/17**
Public agent/purchaser	995 862 187	35 554 123			1 031 416 310	53%
Private agent/purchaser		56 310 531			56 310 531	3%
International agent/purchaser	28 658 574	218 880 538	109 541 000	511 038 949	868 119 062	44%
Totals	**1 024 520 761**	**310 745 192**	**109 541 000**	**511 038 949**	**1 955 845 903**	
% PS share in 2016/17	52%	16%	6%	26%		

2017/18 (SZL)	**Public providers**	**Private providers (FP & NP)**	**International providers**	**PEPFAR IPs & SRs**	**Total 2017/18 (SZL)**	**% FAP share 2017/18**
Public agent/purchaser	971 479 780	36 422 335			1 007 902 115	49%
Private agent/purchaser		77 909 478			77 909 478	4%
International agent/purchaser	18 058 009	299 452 403	94 677 553	565 537 770	977 725 735	47%
Totals	**989 537 789**	**413 784 216**	**94 677 553**	**565 537 770**	**2 063 537 328**	
% PS share in 2017/18	48%	20%	5%	27%		

2018/19 (SZL)	**Public providers**	**Private providers (FP & NP)**	**International providers**	**PEPFAR IPs & SRs**	**Total 2018/19 (SZL)**	**% FAP share 2018/19**
Public agent/purchaser	848 114 002	45 813 661			893 927 664	48%
Private agent/purchaser		75 082 668			75 082 668	4%
International agent/purchaser	20 854 434	231 973 829	68 480 739	563 044 249	884 353 251	48%
Totals	**868 968 437**	**352 870 158**	**68 480 739**	**563 044 249**	**1 853 363 583**	
% PS share in 2018/19	47%	19%	4%	30%		

Table A16: HIV spending by programmatic areas (SZL, 2016/17-2018/19)

HIV Programme Area	2016/17 (SZL)	2017/18 (SZL)	2018/19 (SZL)	2016/17 %	2017/18 %	2017/18 %
Prevention	254 403 351	283 916 102	293 050 061	13%	14%	16%
HTC	37 068 339	60 019 273	110 294 863	2%	3%	6%
Care and Treatment	514 324 363	653 022 233	674 577 580	26%	32%	36%
Social protection and economic support	413 668 482	407 188 777	303 355 366	21%	20%	16%
Social Enablers	2 526 738	2 286 416	10 461 278	0.1%	0.1%	0.6%
Programme enablers and HSS	700 673 016	640 357 043	453 535 550	36%	31%	24%
Development synergies	1 986 797	8 487 087	208 916	0.1%	0.4%	0.0%
Research	31 194 817	8 260 398	7 879 970	1.6%	0.4%	0.4%
Total	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

Table A17: Funding sources for the HIV programmatic areas (SZL, %, 2018/19)

2018/19 (SZL)	Public FE	Private FE	International FE	Total (SZL)	ASC %	Public FE%	Private FE%	Internat. FE%
Prevention	67 932 563	509 261	224 608 237	293 050 061	16%	23%	0%	77%
HTC	9 973 476	200 000	100 121 386	110 294 863	6%	9%	0%	91%
Care and Treatment	351 079 380	9 928 888	313 569 313	674 577 580	36%	52%	1%	46%
Social protection % econ. support	249 947 654	-	53 407 713	303 355 366	16%	82%	0%	18%
Social Enablers	1 558 388	298 822	8 604 068	10 461 278	1%	15%	3%	82%
Programme enablers & HSS	62 584 347	3 555 120	387 396 083	453 535 550	24%	14%	1%	85%
Development synergies	-	-	208 916	208 916	0%	0%	0%	100%
Research	-	-	7 879 970	7 879 970	0%	0%	0%	100%
Total	**743 075 808**	**14 492 091**	**1 095 795 684**	**1 853 363 583**	**100%**			
Funding Entity % share	40%	1%	59%	100%				

Table A18: Funding sources for the HIV programmatic areas (US$, 2018/19)

2018/19 (US$)	Public FE	Private FE	International FE	Total (US$)
Prevention	5 041 950	37 797	16 670 408	21 750 155
HTC	740 231	14 844	7 431 002	8 186 077
Care and Treatment	26 057 087	736 921	23 273 092	50 067 101
Social protection and econo	18 551 097	-	3 963 917	22 515 014
Social Enablers	115 663	22 179	638 593	776 435
Programme enablers & HSS	4 645 006	263 861	28 752 510	33 661 377
Development synergies	-	-	15 506	15 506
Research	-	-	584 851	584 851
Total	**55 151 034**	**1 075 602**	**81 329 879**	**137 556 515**

Table A19: HIV prevention spending (SZL, %, 2016/17-2018/19)

Prevention (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
AGYW	7 540 029	12 255 016	30 408 030	3%	4%	10%
Key Populations	4 547 584	9 547 568	4 871 712	2%	3%	2%
Condoms	22 248 911	21 650 099	36 714 398	9%	8%	13%
VMMC	42 308 114	45 546 337	43 810 908	17%	16%	15%
PrEP	5 887 165	2 355 014	5 699 427	2%	1%	2%
PMTCT	37 753 309	34 147 309	37 049 058	15%	12%	13%
SBCC	4 910 588	4 551 706	4 400	2%	2%	0%
Community mobilization	-	-	32 715 427	0%	0%	11%
Vulnerable Populations	29 622 215	63 330 538	241 583	12%	22%	0%
Children and youth	87 771 712	75 300 243	82 892 855	35%	27%	28%
Wellness progm	653 778	856 087	402 661	0%	0%	0%
PEP	-	3 856 822	-	0%	1%	0%
Prevention not disagg.	11 159 946	10 519 363	18 239 603	4%	4%	6%
Total prevention spend (SZL)	**254 403 351**	**283 916 102**	**293 050 061**	**100%**	**100%**	**100%**

Five Pillars of Prevention	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
AGYW	7 540 029	12 255 016	30 408 030	3%	4%	10%
Key Populations	4 547 584	9 547 568	4 871 712	2%	3%	2%
Condoms	22 248 911	21 650 099	36 714 398	9%	8%	13%
VMMC	42 308 114	45 546 337	43 810 908	17%	16%	15%
PrEP	5 887 165	2 355 014	5 699 427	2%	1%	2%
Total spend on 5 pillars (SZL)	**82 531 803**	**91 354 034**	**121 504 475**	32%	32%	41%

Table A20: HIV testing and counselling (SZL, 2016/17-2018/19)

HTC (SZL)	2016/17	2017/18	2018/19
HIV testing for general pop	30 229 708	50 796 481	79 689 313
HIV testing for AGYW			4 829 929
HIV testing for KPs			4 835 884
HIV testing for PLW			10 716 892
HIV testing for military			249 367
HIV screening in blood banks	6 838 631	9 222 792	9 973 476
Total HIV testing spend	**37 068 339**	**60 019 273**	**110 294 863**

Table A21a: HIV care and treatment spending (SZL, %, 2016/17-2018/19)

Care and Treatment (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Anti-retroviral therapy	310 303 109	391 430 224	455 506 916	60%	60%	68%
Adherence and retention on ART	33 699 385	23 915 990	3 157 804	7%	4%	0%
Specific ART-related laboratory monitoring	69 398 689	80 343 799	183 622 760	13%	12%	27%
Co-infections and OIs	9 726 002	7 428 808	13 695 999	2%	1%	2%
Care and treatment services not disagg	73 311 686	132 856 842	1 126 010	14%	20%	0%
Estimated MOH shared costs for HIV treatmt	17 885 491	17 046 570	17 468 091	3%	3%	3%
Total treatment and care spend	**514 324 363**	**653 022 233**	**674 577 580**	**100%**	**100%**	**100%**

Table A21b: HIV care and treatment spending by Funding Entity (SZL, %, 2018/19)

Care and treatment (SZL, 2018/19)	Public FE	Private FE	International FE	Total (SZL)	Public FE%	Private FE%	Intern. FE%
Anti-retroviral therapy	274 881 468	5 515 888	175 109 559	455 506 916	60%	1%	38%
Adherence and retention on ART	-	-	3 157 804	3 157 804	0%	0%	100%
Specific ART-related laboratory monitoring	44 010 943	4 412 999	135 198 818	183 622 760	24%	2%	74%
Co-infections and OIs	13 691 202	-	4 797	13 695 999	100%	0%	0%
Care and treatment services not disagg	1 027 675	-	98 334	1 126 010	91%	0%	9%
Estimated MOH shared costs for HIV treatment	17 468 091			17 468 091	100%	0%	0%
Total	**351 079 380**	**9 928 888**	**313 569 313**	**674 577 580**			

Table A22: HIV social protection and economic support spending (SZL, %, 2016/17-2018/19)

Social protection and economic support (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
OVC Basic needs	141 604 270	161 898 363	193 562 937	34%	40%	64%
OVC Social services	141 931 000	86 662 145	7 459 331	34%	21%	2%
OVC Services not disagg & nec	74 124 647	56 118 910	16 220 426	18%	14%	5%
HIV-specific income generation projects	-	7 625	13 300	0%	0%	0%
Social protection through monetary or in-kind benefits	44 170 685	93 201 255	85 751 542	11%	23%	28%
Other social protect. & econ. support (non-OVC) not disagg.	11 837 879	9 300 480	347 831	3%	2%	0%
Total S.Protection & OVC spend	**413 668 482**	**407 188 777**	**303 355 366**	**100%**	**100%**	**100%**

Table A23: HIV social enablers spending (SZL, %, 2016/17-2018/19)

Social Enablers (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Advocacy	2 489 976	2 076 018	1 914 450	99%	91%	18%
Legal and human rights programmes	36 762	210 399	8 546 828	1%	9%	82%
Total	**2 526 738**	**2 286 416**	**10 461 278**	**100%**	**100%**	**100%**

Table A24: HIV programme enablers and systems strengthening spending (SZL, %, 2016/17-2018/19)

Programme enablers and systems strengthening (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Strategic planning, coordination and policy development	478 650	3 798 894	42 045 076	0%	1%	9%
Building meaningful engagement	-	-	76 842	0%	0%	0%
Programme administration and management	211 111 149	249 097 652	241 961 260	30%	39%	53%
Strategic information	265 865 786	220 745 183	57 750 930	38%	34%	13%
Public Systems Strengthening	165 882 437	129 124 238	96 715 959	24%	20%	21%
Community system strengthening	4 610 080	4 186 140	4 262 270	1%	1%	1%
Human resources for health (above-site programmes)	-	407 536	4 697 943	0%	0%	1%
Pg.Enablers & systems strgn not disagg.	52 724 913	32 997 400	6 025 269	8%	5%	1%
Total P.Enablers spend	**700 673 016**	**640 357 043**	**453 535 550**	**100%**	**100%**	**100%**

Table A25: HIV development synergies spending (SZL, %, 2016/17-2018/19)

Development synergies (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Formative education to build-up an HIV workforce & training	247 738	-	-	12%	0%	0%
Reducing gender based violence	1 739 059	8 487 087	208 916	88%	100%	100%
Total Dev.Synergies spend	**1 986 797**	**8 487 087**	**208 916**	**100%**	**100%**	**100%**

Table A26: HIV research spending (SZL, 2016/17-2018/19)

Research (SZL)	2016/17	2017/18	2018/19
Socio-behavioural research	23 184 000	106 635	209 337
Research not disag.	8 010 817	8 153 762	7 670 632
Total HIV research spend	**31 194 817**	**8 260 398**	**7 879 970**

Table A27: HIV service providers' spending (SZL, %, 2016/17-2018/19)

Service Providers (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Public sector providers	1 023 578 465	988 671 378	867 955 294	52%	48%	47%
Parastatal organisations	942 296	866 411	1 013 143	0%	0%	0%
Non-profit (NGO) providers	299 847 136	399 783 080	337 378 068	15%	19%	18%
Business sector providers	10 898 056	14 001 136	15 492 091	1%	1%	1%
Multilateral country offices	31 025 516	18 864 725	9 348 646	2%	1%	1%
INGOs providers	78 515 484	75 812 829	59 132 094	4%	4%	3%
PEPFAR IPs & service providers (not disagg.)	511 038 949	565 537 770	563 044 249	26%	27%	30%
Total	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

Table A28: Spending per HIV programme area by provider type (SZL, %, 2018/19)

2018/19	HIV SERVICE PROVIDERS			
Programme area (SZL)	**Public providers**	**Private providers**	**PEPFAR IPs/SRs**	**International providers**
Prevention	79 906 144	72 311 524	137 592 554	3 239 840
HTC	9 973 476	2 476 980	97 844 407	-
HIV Treatment Care	458 794 309	214 806 527	-	976 744
Social protectn. & econ.support	245 667 411	5 721 051	51 966 904	-
Social Enablers	2 605 214	343 930	8 513 145	12 131
Prgm.Enablers & systems strengthening	73 035 025	51 508 112	267 127 239	61 865 173
Development synergies	-	194 066	-	14 850
HIV-related research	-	5 507 969	-	2 372 001
Total	**869 981 580**	**352 870 158**	**563 044 249**	**68 480 739**

Table A29: HIV spending by service delivery modality (SZL, %, 2016/17-2018/19)

Service Delivery Modality (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Facility-based service modalities	569 018 029	719 515 448	808 770 797	29%	35%	44%
Home and community based service modalities	517 153 558	524 500 399	415 477 667	26%	25%	22%
Non applicable (ASC which does not have a specific SDM)	732 757 166	655 254 083	470 270 094	37%	32%	25%
Modalities not disaggregated	55 578 916	94 810 226	88 300 537	3%	5%	5%
Modalities n.e.c.	81 338 234	69 457 172	70 544 488	4%	3%	4%
Total SDM spend	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

Table A30: HIV programme area spending by service delivery modality (SZL, 2018/19)

Programme Area by SDM (SZL, 2018/19)	Facility-based	Home & community based	Non applicable (ASC without SDM)	Modalities not disagg.	Modalities n.e.c. (school-based)	Total (SZL)
Prevention	82 649 275	87 732 116	-	52 124 182	70 544 488	293 050 061
HTC	65 984 022	39 431 396	-	4 879 444		110 294 863
Treatment and care	659 936 568	170 471	-	14 470 541		674 577 580
Social protection & econ. suppor	-	286 528 996	-	16 826 370		303 355 366
Prog. enablers & systems strgth	200 931	-	453 334 618	-		453 535 550
HIV-related research	-	-	7 879 970	-		7 879 970
Total SDM spend	**808 770 797**	**415 477 667**	**470 270 094**	**88 300 537**	**70 544 488**	**1 853 363 583**

Table A31: HIV spending by beneficiary populations (SZL, %, 2016/17-2018/19)

Beneficiary population (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
People living with HIV	514 373 837	653 740 303	705 178 442	26%	32%	38%
Key populations	10 434 749	15 759 403	10 571 139	1%	1%	1%
Vulnerable, accessible pop	564 628 547	594 918 893	419 372 225	29%	29%	23%
General population	133 731 372	151 647 634	247 971 683	7%	7%	13%
Non-targeted interventions	732 677 396	647 471 094	470 270 094	37%	31%	25%
Total Beneficiary spend	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

Table A31: HIV spending on key and vulnerable/accessible populations (SZL, 2016/17-2018/19)

Key populations (SZL)	2016/17	2017/18	2018/19
Sex workers (SW) and their clients	3 189 591	6 239 785	1 127 972
Gay men and other men who have sex with men (MSM)	971 590	1 711 257	-
"Key populations" not broken down by type	6 273 569	7 808 361	9 443 167
Total key population spend	**10 434 749**	**15 759 403**	**10 571 139**
Vulnerable/ accessible pops (SZL)	**2016/17**	**2017/18**	**2018/19**
OVC	357 659 917	304 679 418	217 242 693
Pregnant/lactating women	37 696 443	34 142 533	6 950 597
AGYW	7 540 029	19 889 389	30 408 030
Migrants/mobile pops.	-	181 074	-
Children and youth out of school	7 364 064	9 251 084	7 140 682
Recipients of blood or blood products	6 838 631	9 222 792	9 973 476
Junior high/high school students	73 082 785	60 206 088	61 201 300
Employees (e.g. for workplace interventions)	653 778	856 087	402 661
Vulnerable, accessible and other target populations not broken down by type	73 792 900	156 490 428	86 052 785
Total vulnerable/accessible pop spend	**564 628 547**	**594 918 893**	**419 372 225**

Table A32: HIV spending by production factor (SZL, %, 2016/17-2018/19)

Production factor (SZL)	2016/17	2017/18	2018/19	2016/17 %	2017/18 %	2018/19 %
Personnel costs	267 669 344	347 691 852	361 972 891	14%	17%	20%
Operational current exp	80 272 740	82 189 407	153 344 065	4%	4%	8%
Medical products and supplies	563 000 690	617 022 137	629 251 727	29%	30%	34%
Contracted International services	563 400	4 017 661	79 308	0%	0%	0%
Financial, housing, transport suppo	327 730 273	341 425 942	247 016 363	17%	17%	13%
Training related costs	49 115 736	41 411 675	32 322 569	3%	2%	2%
Logistics of events	1 024 412	141 612	927 174	0%	0%	0%
Indirect costs	1 084 830	570 532	61 100	0%	0%	0%
Current exp not disag	535 583 981	586 042 606	406 112 642	27%	28%	22%
Building	19 586 381	12 200 739	9 697 755	1%	1%	1%
Vehicles	17 240 983	8 428 870	470 736	1%	0%	0%
Other capital investment	91 085 076	20 595 332	12 107 253	5%	1%	1%
Capital exp not disagg.	1 888 057	1 798 962	-	0%	0%	0%
Total	**1 955 845 903**	**2 063 537 328**	**1 853 363 583**	**100%**	**100%**	**100%**

Table A33: HIV funding entities' spending by production factor (SZL, %, 2018/19)

	FUNDING ENTITY						
Production factor (SZL, 2018/19)	**Public FE**	**Private FE**	**International FE**	**Total (SZL)**	**Public FE %**	**Private FE %**	**Internatn. FE %**
Personnel costs	57 702 941	123 600	304 146 350		8%	1%	28%
Operational current exp	11 429 916	432 700	141 481 449	153 344 065	2%	3%	13%
Medical products and supplies	383 668 823	9 616 803	235 966 101	629 251 727	52%	66%	22%
Contracted International services	-	-	79 308	79 308	0%	0%	0%
Financial, housing, transport support for beneficiaries	245 667 411	2 800	1 346 152	247 016 363	33%	0%	0%
Training related costs	-	-	32 322 569	32 322 569	0%	0%	3%
Logistics of events	77 807	-	849 366	927 174	0%	0%	0%
Indirect costs	-	-	61 100	61 100	0%	0%	0%
Current exp not disag	44 301 557	4 316 188	357 494 897	406 112 642	6%	30%	33%
Building	-	-	9 697 755	9 697 755	0%	0%	1%
Vehicles	-	-	470 736	470 736	0%	0%	0%
Other capital investment	227 351	-	11 879 902	12 107 253	0%	0%	1%
Total	**743 075 808**	**14 492 091**	**1 095 795 684**	**1 853 363 583**			

Table A34: PEPFAR spending by activity (US$, 2016/17-2018/19) – refer to app 6 for crosswalk details

PEPFAR HIV activities in Eswatini (US$, 2016/17-2018/19) (EA'16, EA'17, ER'18), plus extra condoms $			
PEPFAR HIV activities (US$)	**2016/17**	**2017/18**	**2018/19**
Prevention for Adolescent girls	$ -	$ -	$ 1 302 145
Services for key populations	$ 275 996	$ 596 037	$ 131 940
Condoms	$ 1 435 977	$ 1 580 163	$ 2 589 851
VMMC	$ 2 600 195	$ 2 795 082	$ 2 953 233
PrEP	$ -	$ 11 348	$ 273 305
PMTCT	$ 1 801 302	$ 2 067 296	$ 2 231 619
Community mobilizn / norms change (non-targeted)	$ -	$ -	$ 2 428 137
Program activities for vul & acces pop	$ 1 935 455	$ 4 547 875	$ -
PEP	$ -	$ 289 347	$ -
Prevention activities not disaggregated	$ -	$ -	$ 533 499
HTC for general and key populations	$ 1 990 750	$ 3 711 383	$ 7 262 005
HIV screening in blood banks	$ 46 410	$ 31 178	$ -
ART not disagg	$ 2 403 091	$ 4 655 474	$ 11 132 529
Specific ART-related lab monitoring	$ 460 476	$ 470 419	$ 2 585 819
Care and treatment services not disag	$ 4 912 702	$ 9 792 134	$ -
OVC services not disagg	$ 4 568 016	$ 3 952 205	$ 3 856 980
Human Right programmes (policy reform)	$ -	$ -	$ 631 845
Strategic planning, coordination and policy development	$ -	$ -	$ 2 856 762
Programme administration and management costs	$ 9 179 684	$ 12 303 886	$ 11 374 945
Strategic information	$ 8 374 271	$ 9 738 155	$ 3 201 771
Public Systems Strengthening (labs, PSC)	$ 3 576 777	$ 3 328 701	$ 1 663 820
Human resources for health (above-site programmes)	$ -	$ -	$ 348 681
Pgm.enablers & Sys.Stgnthg not disagg.	$ 3 415 949	$ 2 372 738	$ 380 186
Total PEPFAR spend	**$ 46 977 051**	**$ 62 243 421**	**$ 57 739 072**

Note these total are slightly higher than EA and ER totals bec PEPFAR office provided additional amounts of condom spending which were added

Table A35: Global Fund spending by activity (SZL, US$, 2016/17-2018/19)

Global Fund HIV activities (SZL)	2016/17	2017/18	2018/19	Total (SZL)
Prevention for AGYW	7 540 029	6 698 276	11 107 562	25 345 867
Prevention for key pops.	489 081	1 602 752	1 966 051	4 057 884
VMMC	4 072 403	8 289 571	4 020 612	16 382 586
PMTCT	5 776 849	6 095 440	6 024 458	17 896 746
Vulnerable & accessible pops preve	223 361	1 472 660	141 583	1 837 603
Prevention for children and youth	11 304 509	21 759 732	14 963 032	48 027 273
ART	23 166 041	53 387 441	9 819 741	86 373 223
Adherence and retention on ART	1 192 252	1 524 470	1 010 236	3 726 958
Specific ART-related laboratory mor	8 698 483	7 294 575	87 875 302	103 868 360
Programme admin & mgmt costs (a	14 825 864	15 239 139	20 472 350	50 537 353
Strategic information	139 056 534	85 720 175	11 678 614	236 455 322
Public system strengthening	37 100 256	12 630 126	9 880 623	59 611 005
Community system strengthening	1 325 926	-	915 374	2 241 300
Total	**254 771 586**	**221 714 356**	**179 875 537**	**656 361 479**

Global Fund HIV activities (US$)	2016/17	2017/18	2018/19	Total (US$)
Prevention for AGYW	$ 512 755	$ 502 519	$ 824 402	$ 1 839 676
Prevention for key pops.	$ 33 260	$ 120 242	$ 145 920	$ 299 422
VMMC	$ 276 941	$ 621 901	$ 298 410	$ 1 197 252
PMTCT	$ 392 851	$ 457 293	$ 447 135	$ 1 297 279
Vulnerable & accessible pops preve	$ 15 190	$ 110 482	$ 10 508	$ 136 180
Prevention for children and youth	$ 768 756	$ 1 632 462	$ 1 110 555	$ 3 511 773
ART	$ 1 575 392	$ 4 005 240	$ 728 820	$ 6 309 452
Adherence and retention on ART	$ 81 078	$ 114 369	$ 74 980	$ 270 427
Specific ART-related laboratory mor	$ 591 535	$ 547 255	$ 6 522 099	$ 7 660 888
Programme admin & mgmt costs (a	$ 1 008 223	$ 1 143 273	$ 1 519 456	$ 3 670 952
Strategic information	$ 9 456 450	$ 6 430 910	$ 866 786	$ 16 754 146
Public system strengthening	$ 2 522 979	$ 947 539	$ 733 339	$ 4 203 857
Community system strengthening	$ 90 169	$ -	$ 67 939	$ 158 108
Total	**$ 17 325 578**	**$ 16 633 484**	**$ 13 350 350**	**$ 47 309 411**

Figure A36: Global Fund spending by activity (SZL, 2016/17-2018/19)

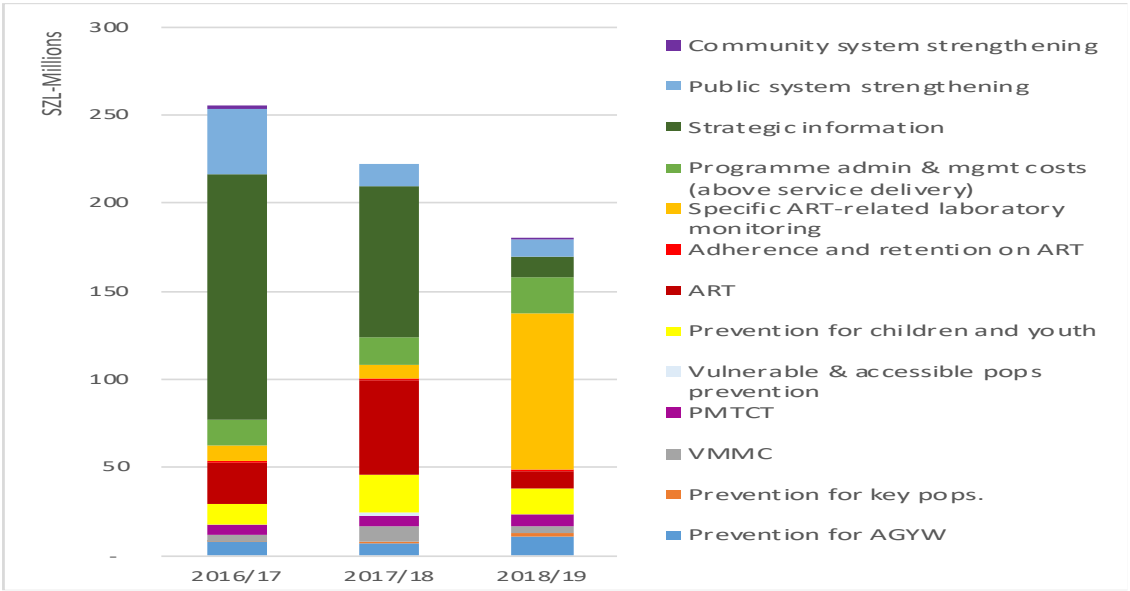
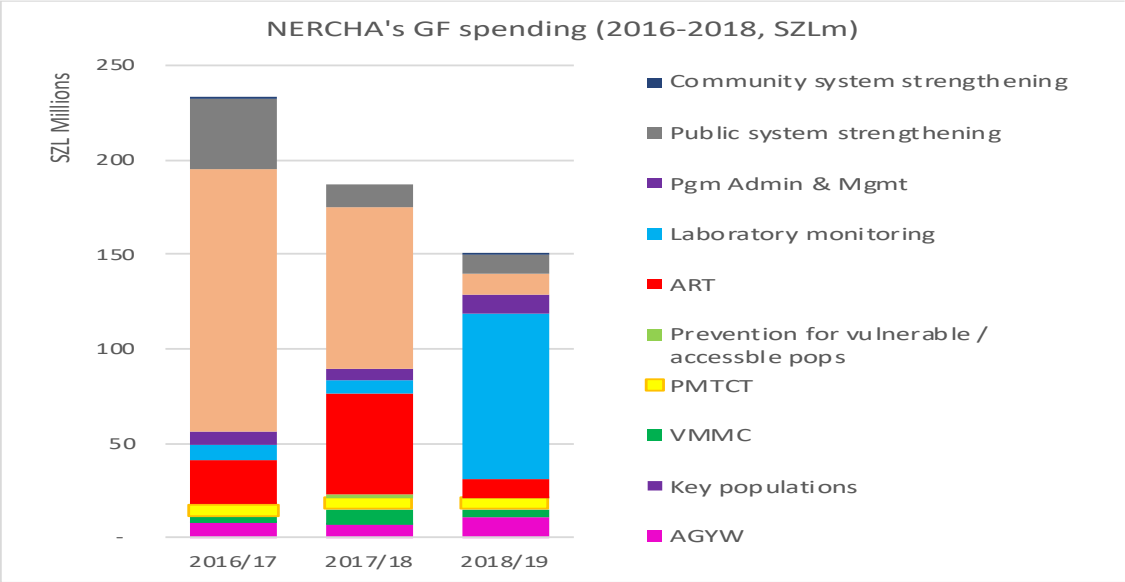


Table A37: Global Fund spending by PR (SZL, 2018/19)

GF activities (SZL, 2018/19)	NERCHA	CANGO	Total GF 2018/19
Five Pillars of Prevention	15 128 174	1 966 051	17 094 225
Other Prevention activities	6 166 040	14 963 032	21 129 073
Anti-retroviral therapy	9 819 741	-	9 819 741
Adherence and retention on ART	-	1 010 236	1 010 236
Specific ART-related laboratory monitoring	87 875 302	-	87 875 302
Programme admin and manag	9 387 987	11 084 362	20 472 350
Strategic information	11 678 614	-	11 678 614
Public Systems Strengthening	9 880 623	-	9 880 623
Community systems strengthening	915 374	-	915 374
Total GF spend (SZL)	**150 851 856**	**29 023 681**	**179 875 537**

Figure A38: NERCHA's Global Fund spending by activity (SZL, 2016/17-2018/19)



Appendix 3: Organizations that provided data for the NASA

Entities and organisations	Location
International Entities	
UNESCO	Mbabane, Ministry of Education
IOM	Mbabane
UNFPA	Mbabane UN Building
UNICEF	Mbabane UN Building
WHO	Mbabane UN Building
WFP	Mbabane UN Building
UNDP	Mbabane UN Building
UNAIDS	Mbabane UN Building
GFATM	Mbabane NERCHA/ CANGO
CHAI	Mbabane
USG (PEPFAR, USAID, CDC)	Ezulwini, USA Embassy House
SAfAIDS	Manzini, Liqhaga building 4th F
MSF	Mbabane
EGPAF/ AIDS FREE	Mbabane
FHI 360	Mbabane
CHAPS	Mbabane
AHF	Manzini
ICAP	Mbabane
IHM	Mbabane
URC	Mbabane
PSI	Mbabane
Public (Government Ministries)	
Ministry of Health	Mbabane
Ministry of Tourism	Mbabane
DPM's Office	Mbabane
Ministry of Economic Planning and Development	Mbabane
Ministry of Education & Training	Mbabane
Ministry of Youth, Sports & Culture	Mbabane
Central Medical Stores	Matsapha
Not-for-profit organisations	
Bantwana	Manzini
Baylor	Mbabane
CHAPS	Mbabane
Compassionate Swaziland	Mbabane
Cabrini Ministries	Lubombo, St Philips
Community Health Evangelism (CHE)	
Nazarene Compassionate Ministry	Manzini
Save the Children	Mbabane
ADRA	Sidvokodvo
MSF	Mbabane
Eswade	
World Vision	Mbabane
Hope House	Manzini
Joyful Hearts	Manzini

Acts of Faith	
Advocate for Africa	
Tambuti	
SWAPOL	Manzini
Positive Women Together in Action	Manzini
SWABCHA	Matsapha
AMICAALL Swaziland	Manzini, Lamvelase Building
Hand in Hand Swaziland	Mbabane
Cheshire Homes of Swaziland	Matsapha
SWAGAA	Manzini
CANGO	Mbabane
Salvation Army	Mbabane
Lutheran Development Services (LDS)	Mbabane
Young Heroes	Mbabane, NERCHA
Good Shepherd Hospital	Siteki
Kudvumisa Foundation (CHIPS)	Vuvulane
Tambuti	
FLAS	Manzini,
Baphalali Red Cross Swaziland	Mbabane
Business sector	
SwaziMed	Mbabane
Inyatsi Construction	Manzini, Inyatsi House
Eswatini railway	Matsapha
Standard Bank	
Swaziland Bank	
Swaziland Milling	Manzini

Appendix 4: Authorization letter for data collection

3rd July 2013

HIV Stakeholder
(NAME OF ORGANISATION)

Dear XXX

Re: Request to review funding and expenditure data to support for the National AIDS Spending Assessment (NASA) 2019

The National Emergency Response Council on HIV and AIDS (NERCHA) with the support of UNAIDS is conducting the fourth round of the National AIDS Spending Assessment (NASA). This is a systematic methodology to track the flow of resources from source to beneficiary populations. Its resource tracking algorithm is designed using the same categories in the global health resource needs estimation model and globally accepted accounting procedures for National Accounts (NA), PAPFAR HIV Expenditure Analysis (EA), National AIDS Accounts (NAA), National Health Accounts (NHA), and AIDS Budget Analysis. The information from the study will inform resource mobilization and allocation plans. This will be a fourth installment since the country has previously conducted NASAs in 2007, 2011, and 2014.

The methodology requires that all partners that have carried out HIV related activities as a funder or implementing agency provide data on their expenditures. For purposes of triangulation, the data is collected at three levels; funding source, funding agent and service provider. Please note that the NASA is not a financial audit.

NERCHA recognizes that your organization is key partner in the HIV response in Eswatini and invites your participation in the assessment. The participation would take the form of providing data on the amounts of resources received and expended during FY2017/2018 and FY2018/2019. The exercise will be conducted over the next two months (July and August) with the report expected to be finalized in September 2019.

A team of researchers will be visiting organizations during the period 15 July to 16 August 2019 to access relevant data. Organizations are urged to make available their financial records for the period and cooperate with the researchers in making this important exercise successful. All NASA Researchers will present to organizations a letter of accreditation from NERCHA.

For further details on the NASA please contact Mr. Bongani Dube at 2406 5120 or through email at bongani.dube@nercha.org.sz .

Your usual cooperation is highly appreciated, and we look forward to your response.

Kind Regards,

Mr. Khanya Mabuza
Executive Director

Appendix 5: Abbreviated data collection template used for some respondents

NASA	Region		Currency:
Year: 2018	Financing Entity (FE)		
	Financing Agent-Purchaser (FAP)		
	Provider (PS)		
	Total Amount spent	0	
ASC 1			
Service Delivery Model			**Amount spent:**
Beneficiary (BP) 1 (number reached & type of BP)	# reached	Type of beneficiary	
Beneficiary (BP) 2 (number reached & type of BP)	# reached	Type of beneficiary	
Total spent BP			-
Production Factor 1			
Production Factor 2			
Production Factor 3			
Production Factor 4			
Production Factor 5			
Total Spent PF			-

Appendix 6: Cross-Walk of the PEPFAR Categories to the NASA Categories

(NOTE DIFFERENT CROSSWALKS FOR THEIR EA AND ER DATASETS).

Appendix 6a. PEPFAR 2018 ER Program & sub-program crosswalk to NASA ASC and SDM

ER Prog&Subpgm CONCAT	NASA ASC	Check BEN variables	SDM assumed
C&T HIV Clinical Services	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT		SDM.01.01 Facility-based: Outpatient
C&T HIV Drugs	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT		SDM.01.01 Facility-based: Outpatient
C&T HIV Laboratory Services	ASC.03.03 Specific ART-related laboratory monitoring		SDM.01.01 Facility-based: Outpatient
C&T Not Disaggregated	ASC.03.98 Care and treatment services not disaggregated		SDM.01.01 Facility-based: Outpatient
HTS Community-based testing	ASC.02.09 Voluntary HIV testing and counselling for general population	Unless for specific KP bens	SDM.02.98 Home and community based not disaggregated
HTS Facility-based testing	ASC.02.09 Voluntary HIV testing and counselling for general population	Unless for specific KP bens	SDM.01.01 Facility-based: Outpatient
HTS Not Disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated		SDM.98 Modalities not disaggregated
PREV Comm. mobilization, behavi	ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	Unless for specific KP bens	SDM.98 Modalities not disaggregated
PREV Condom & Lubricant Prograr	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	Unless for specific KP bens	SDM.98 Modalities not disaggregated
PREV Not Disaggregated	ASC.01.02.98 Prevention activities not disaggregated		SDM.98 Modalities not disaggregated
PREV PrEP	ASC.01.01.05.98 PrEP not disaggregated by key population	Unless for specific KP bens	SDM.98 Modalities not disaggregated
PREV VMMC	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated		SDM.98 Modalities not disaggregated
SE Case Management	ASC.04.99 Social protection activities n.e.c	Unless for OVC	SDM.98 Modalities not disaggregated
SE Economic strengthening	ASC.04.02.03 HIV-specific income generation projects		SDM.98 Modalities not disaggregated
SE Education assistance	ASC.04.01.01 OVC Basic needs (health, education, housing)	Unless for AGYW	SDM.98 Modalities not disaggregated
SE Legal, human rights & protecti	ASC.05.02.02 HIV-related legal services		SDM.98 Modalities not disaggregated
SE Not Disaggregated	ASC.04.98 Social protection activities not disaggregated		SDM.98 Modalities not disaggregated
SE Psychosocial support	ASC.03.05 Psychological treatment and support service		SDM.98 Modalities not disaggregated
ASP HMIS, surveillance, & researc	ASC.06.04.98 Strategic information not disaggregated by type		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Human resources for health	ASC.06.07.01 Capacity building for health workers, excluding those at community level		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Institutional prevention	ASC.02.11 HIV screening in blood banks		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Laboratory systems strengthe	ASC.06.05.02 Laboratory system strengthening		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Laws, regulations & policy en	ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Not Disaggregated	ASC.06.98 Programme enablers and systems strengthening not disagregated		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Policy, planning, coordination	ASC.06.03 Programme administration and management costs (above service-delivery level)		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Procurement & supply chain r	ASC.06.05.01 Procurement and supply chain		SDM.03 Non applicable (ASC which does not have a specific SDM)
ASP Public financial management	ASC.06.05.04 Financial and accounting systems strengthening		SDM.03 Non applicable (ASC which does not have a specific SDM)
PM Program Management	ASC.06.03 Programme administration and management costs (above service-delivery level)		SDM.03 Non applicable (ASC which does not have a specific SDM)

Appendix 6b: PEPFAR 2018 ER Beneficiary crosswalk to NASA BP

PEPFAR BenCONCAT	NASA BP	Check the PgArea
FM Not disaggregated	BP.04.01.02 Female adult population	UNLESS ASC treatment> BP.01.98 People living with HIV not broken
KP Not disaggregated	BP.02.98 "Key populations" not broken down by type	
NonT Adults	BP.04.01.98 General adult population (aged older than 24) not broken down by gender	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
NonT Children	BP.04.02.98 Children (aged under 15) not broken down by gender	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
NonT Not disaggregated	BP.05 Non-targeted interventions	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
OVC Not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)	
PBFW Not disaggregated	BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their	
FM Young women & adolescent females	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence	
PRIPOP Military & other uniformed services	BP.03.21 Military	
PRIPOP Not disaggregated	BP.03.99 Other vulnerable, accessible and other target populations n.e.c.	
KP Men having sex with men	BP.02.03 Gay men and other men who have sex with men (MSM)	
NonT Young people & adolescents	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender	
OVC Orphans & vulnerable children	BP.03.01 Orphans and vulnerable children (OVC)	
KP People who inject drugs	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners	
KP Sex workers	BP.02.02.98 Sex workers, not broken down by gender, and their clients	
M Not disaggregated	BP.04.01.01 Male adult population	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
M Young men & adolescent males	BP.04.03.01 Young men	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
M Adult men	BP.04.01.01 Male adult population	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
M Boys	BP.04.02.01 Boys	UNLESS ASC treatment> BP.01.98 People living with HIV not broken down by age or gender
All ASP systems strengthening activities	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	

Appendix 6c: PEPFAR 2018 ER Object and sub-object class crosswalk to NASA PF

PEPFAR ER Obj CONCAT	NASA PF	Check PGArea for HIVdrugs
Supplies Other supplies	PF.01.03.04.98 Non-medical supplies not disaggregated	
Training Training	PF.01.08 Training- Training related per diems/transport/other costs	
Contractual Other contracts	PF.01.02.99 Other current costs n.e.c.	
Fringe Benefits Fringe Benefits	PF.01.01.01.02 Fringe Benefits - Direct service providers	Unless Above service-delivery > PF.01.01.02.99 Program management
Personnel Salaries- other staff	PF.01.01.01.01 Labor costs - Direct service providers	
Subrecipient Subrecipient	PF.01.02.98 Other current costs not disaggregated	
Travel Domestic travel	PF.01.02.03 Travel expenditure	
Travel International travel	PF.01.02.03 Travel expenditure	
Construction Construction	PF.02.01.02 Construction and renovation	
Equipment Non-health equipment	PF.02.03.03 Non medical equipment and furniture	
Other Other	PF.01.99 Current direct and indirect expenditures n.e.c.	
Contractual Contracted interventions	PF.01.99 Current direct and indirect expenditures n.e.c.	
Supplies Health- non pharmaceutical	PF.01.03.02.98 Medical supplies not disaggregated	
Personnel Salaries- health care workers	PF.01.01.01.01 Labor costs - Direct service providers	
Equipment Health equipment	PF.02.03.02 Laboratory and other medical equipment	
Supplies Pharmaceutical	PF.01.03.01.98 Pharmaceuticals not disaggregated	UNLESS HIVdrugs > PF.01.03.01.01 Antiretrovirals
Other Financial Support for beneficiaries	PF.01.07 Financial support for beneficiaries	
Contractual Contracted health care workers	PF.01.01.01.01 Labor costs - Direct service providers	
Indirect charges Indirect charges	PF.01.99 Current direct and indirect expenditures n.e.c.	