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Zimbabwe HIV & AIDS Subaccounts 2005

Prepared for
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Acronyms

ART	Antiretroviral therapy
ARV	Antiretroviral
CIMAS	Commercial and Industrial Medical AIDS Society
DfID	Department for International Development
EC	European Commission
FS	Financing sources
GoZ	Government of Zimbabwe
HC	Functions
HCR	Health related functions
HF	Financing Agents
HH	Household
HIMS	Health Information Management Systems
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HP	Providers
ICHF	International Classification for Health Accounts
IEC	Information, education and communication
MoH	Ministry of Health
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Nongovernmental organization
NHA	National Health Accounts
NHE	National HIV/AIDS Health Expenditures
OECD	Organization for Economic Co-operation and Development
OI	Opportunistic Infections
OOP	Out-of-pocket
OVC	Orphans and vulnerable children
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
R&D	Research and development
STI	Sexually transmitted infections
THAE	Total HIV/AIDS Expenditures
THE	Total HIV/AIDS Health Expenditure
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WB	World Bank
WHO	World Health Organization
ZACH	Zimbabwe Association of Church Related Hospitals

1. Background

With a sizeable adult prevalence rate of 20.1%¹, Zimbabwe is among the hardest hit countries in East, Central, and Southern Africa. Among the 1.4 million adults who are infected with the virus, close to 60 percent are women.² The disease is taking its toll on Zimbabweans – accounting in part for the reduction in life expectancy from 66 years in 1997³ to 33.9 years in 2002.⁴ Moreover, there is an estimated 0.98 million children who are orphaned due to AIDS.

Given the significant burden of HIV&AIDS on the country, the Government of Zimbabwe (GoZ) stepped up its efforts to combat the epidemic. In 2000, the Government established the National AIDS Council (NAC), comprised of government ministries, nongovernmental organizations (NGOs), faith-based groups, private sector and the media. The Council published a National Strategic Framework on HIV&AIDS that focuses largely on prevention in addition to care and support. Also, there are a large number of grassroots NGO efforts focusing on care and support to People Living with HIV&AIDS (PLWHA).

The health care system is currently in the process of being decentralized and is also expanding to include a growing private sector. In 2001, the government (including central and local) was the largest financier of health care funds, accounting for 50.5 percent of all spending, followed by households at 29 percent, employers 14 percent, and donors 5.4 percent.⁵ In contrast to other countries in the region, donors have played a minor role in health care financing in Zimbabwe.

However, with respect to HIV&AIDS, donors are playing a much greater role. Recently, a two-year Global Fund HIV&AIDS grant was approved. Given the influx of such donor funds, the Government of Zimbabwe is anxious to ensure that the use of these funds are properly tracked through the health care system, in line with its ongoing efforts to monitor private expenditures (in addition to public funds) in the health sector. One tool that can facilitate this tracking process, if conducted on a regular basis, is the National Health Accounts (NHA) HIV&AIDS subaccounts. Adapted from the widely-used National Health Accounts framework⁶ that tracks spending on overall health care, the subaccount offers a comprehensive expenditure review of national HIV&AIDS spending — public, private, and donor contributions — from their financing sources to their end uses.

The Government intends to use such data to inform its policy planning processes. Specifically, the GoZ hopes to use the data to facilitate the design of rational mechanisms for the allocation of HIV funds.

¹ UNAIDS. 2006. *2006 Report on the Global AIDS epidemic*. Joint United Nations Programme on HIV/AIDS (UNAIDS): Geneva, Switzerland.

² Zimbabwe National HIV/AIDS estimates 2005- Preliminary report.

³ USAID. 2002. *HIV/AIDS in Zimbabwe*. Prepared for USAID by Synergy Project.

⁴ UNDP. 2004. *Human Development Report 2004*. United Nations Development Programme (UNDP): New York, NY, USA.

⁵ Government of Zimbabwe. 2001. Draft National Health Accounts Report.

⁶ As described in the *Guide to Producing National Health Accounts in middle- and low-income countries*. (WB, WHO, USAID; 2003). Informally known as the *Producers' Guide* or *PG*.

2. Purpose

The purpose of the 2005 HIV&AIDS subaccounts was to gain a more comprehensive understanding of HIV&AIDS spending in Zimbabwe. Specifically, the subaccounts aimed to:

- Provide baseline data describing the pattern of spending prior to the surge of targeted donor funds for HIV&AIDS. This is critical for budgeting, and planning, of HIV&AIDS programs. If estimated for subsequent years, the subaccounts can serve as a useful monitoring and evaluation tool to determine if new funds are filling in existing financing gaps and strengthening current weaknesses in resource allocation.
- Provide information for advocacy and policy reforms that address HIV&AIDS more efficiently.
- Provide the technical and organizational capacity to conduct and institutionalize the NHA HIV&AIDS subaccounts using primary and secondary data.

3. Methodology

3.1. The Approach

The HIV&AIDS subaccounts activity was conducted within the institutionalization framework already adopted by the Government of Zimbabwe for the general health NHA effort (for which the government has conducted 3 estimations beginning with its first estimate for the 1999 fiscal year).

Like the general NHA, the data provided by the subaccounts aimed to be comprehensive, covering public, private and donor spending. The following key policy questions were addressed:

- How much money in total is spent on HIV&AIDS services?
- Who in the country pays for HIV&AIDS services? i.e. who are the ‘financing sources’ ?
- Who manages the allocation process of the funds? i.e. who are the ‘financing agents’ ?
- How are HIV&AIDS funds distributed—among providers and among services and products (referred to as ‘functions’ in NHA terminology) delivered?

In keeping with the institutionalization framework, the HIV&AIDS subaccounts was conducted as part of a broader NHA initiative that also examined overall expenditures on health care for the same time frame – the 2005 calendar year. In so doing, if a survey was commissioned to examine overall health expenses for the general NHA exercise, a module on HIV&AIDS would be added to help inform the subaccount tables. For the most part, the subaccounts relied on data sources similar to that needed for the general NHA - with the exception of the People Living with HIV&AIDS survey.

As per the norms of the NHA framework, the subaccounts produced at a minimum the standard series of two dimensional tables showing the flow of funds between -

- Financing Sources (FS) and Financing Agents (HF)
- Financing Agents (HF) and Providers (HP)
- Financing Agents (HF) and Functions (HC)
- Providers (HP) and Functions (HC)

3.2. Scope of the HIV&AIDS subaccounts

For purposes of the subaccount estimations, HIV&AIDS expenditures were defined as spending incurred on activities:

- That are primarily intended to have an impact on the health status of people living with HIV&AIDS (PLWHA) in a given period of time;
- That are intended to prevent the spread of HIV&AIDS which may target the population at large; and
- That are intended to mitigate the impact of HIV&AIDS.

This included the following:

- *Core health expenditures:* As adapted from the International Classification of Health Accounts (ICHA),⁷ core health expenditures on HIV&AIDS includes those primarily or entirely associated with HIV&AIDS health care such as services of curative care (treatment and care), rehabilitative health care services, Pharmaceuticals and non-durables, Prevention and Public health services, ancillary services to health care such as laboratory, general health administration.
- *Health-related expenditures:* Also adapted from ICHA, an HIV&AIDS-health related activity is one that overlaps with other fields of study such as education, overall “social” expenditure, and research and development. These include formal education and training, nutrition support, research and development, capital formation etc.
- *Non-health expenditures:* Activities whose principal purpose is not associated with health care, but aimed at mitigating the impact of HIV&AIDS on individuals and the population, such as care for orphans and vulnerable children, policy advocacy, etc.

Following from this definition, expenditure on the following activities were targeted for the Zimbabwe HIV&AIDS subaccount estimation. This list was developed based upon knowledge of existing HIV&AIDS services offered in the country for the year 2005:

HIV&AIDS core health expenditure:

- Treatment diagnostic services for HIV case management
 - Anti-retroviral treatment (ART) and monitoring
 - Opportunistic Infections (OI) treatment & monitoring
- Ancillary services to medical care (independent clinical laboratories)
- Medical goods dispensed to out patients (pharmaceuticals)
- Provision and administration of HIV&AIDS prevention and public health services (Prevention of Mother to Child Transmission (PMTCT), Voluntary Counseling and Testing (VCT), Behavior change, Youth programmes, Mass media, Condom promotion, Workplace programmes, Surveillance and other prevention services not specified by kind.
- General administration of HIV&AIDS services

⁷ ICHA is described in the *A System of Health Accounts*. (OECD, 2000). This forms the basis of NHA as described in the *Producers Guide*.

HIV&AIDS health related expenditures:

- Capital formation
- Education and training
- Research and development

HIV&AIDS Non-health expenditures:

- OVC Care and support activities
- PLWHA support
- Home Based Care

From the above, three possible “totals” can be computed as per NHA norms and also in keeping with the multisectoral approach to combating HIV&AIDS (that also involves non-health HIV&AIDS activities):

- Total HIV&AIDS Health Expenditure (**THE** for HIV&AIDS): Includes all the HIV&AIDS core health expenditures listed above as well as capital formation (as per the recommendations of the NHA Producers’ Guide).
- National HIV&AIDS Health Expenditures (**NHE** for HIV&AIDS): Includes all HIV&AIDS core health expenditures plus HIV&AIDS Health Related Expenditures listed above.
- Total HIV&AIDS Expenditures (**THAE**): Includes all HIV&AIDS core health expenditures, health related expenditures, and non-health expenditures.

This report principally refers to the THAE estimations.

3.3. Data sources

To estimate HIV&AIDS expenditures and their uses, the following data sources and methods were consulted (Table 1).

Table 1: Data Sources for HIV&AIDS Subaccounts

Entity	Type of data collected	Methods and data sources
Ministry of Health & Child Welfare	<ul style="list-style-type: none"> • Actual expenditures • Utilization figures • Inpatient days • Bed occupancy rates 	<ul style="list-style-type: none"> • Expenditure review of Budget books • HIMS review to identify utilization data for Opportunistic Infections • Survey of selected providers by type of facility and ownership • Key Informant Interviews
Other government Ministries and Departments including National AIDS Council (NAC)	<ul style="list-style-type: none"> • Actual expenditures 	<ul style="list-style-type: none"> • Expenditure review of Budget books • HIMS review to identify utilization data for Opportunistic Infections • Survey of selected providers by level of care and region • Key Informant Interviews
Donor	<ul style="list-style-type: none"> • Budgets • Disbursements • Actual Expenditures 	<ul style="list-style-type: none"> • National survey of all donors and international Non-governmental Organization/Foundation involved in funding HIV&AIDS services undertaken by UNAIDS/Zimbabwe Office

Entity	Type of data collected	Methods and data sources
NGOs	<ul style="list-style-type: none"> Budgets Disbursements Actual Expenditures 	<ul style="list-style-type: none"> National survey of all donors international NGOs/Foundations involved in funding HIV&AIDS services undertaken by UNAIDS/Zimbabwe Office
Firms and Corporations	<ul style="list-style-type: none"> Actual expenditures 	<ul style="list-style-type: none"> National survey of selected firms and corporations in for both general health and HIV&AIDS expenditures and financing and delivery
Private health insurance schemes	<ul style="list-style-type: none"> Actual expenditures 	<ul style="list-style-type: none"> Survey of all private health insurance firms involved in financing health care services including HIV&AIDS
Providers	<ul style="list-style-type: none"> Actual expenditures Utilization figures 	<ul style="list-style-type: none"> National sample survey of selected facilities by ownership: MoH&CW, Private not-for-profit, Private for-profit by level of care-health centre, district hospital, provincial hospital, central hospital, Traditional healers etc
People Living With HIV&AIDS (PLWHA)	<ul style="list-style-type: none"> Actual expenditures Utilization figures 	<ul style="list-style-type: none"> Special Survey targeting People Living With HIV&AIDS who have been confirmed HIV positive aged between 15 and above

Both the technical team and key HIV&AIDS stakeholders were involved in the identification of data sources and development of survey methodologies.

3.4. Primary data collection

Following a survey design workshop and a pre-testing, NHA surveys (that included questions on overall health care as well as HIV/AIDS) were conducted for the following institutional entities: donors, NGOs and implementing agencies, employers, insurance schemes, government entities, providers. In addition, for the HIV&AIDS subaccount specifically, a separate survey was conducted targeted PLWHA.

The surveys were conducted from April 2006 date to May 2006. The Table above shows the institutions surveyed and the type of data collected from these institutions.

3.4.1. Institutional surveys

The sampling of institutions aimed at being nationally representative, targeting all public, private for profit, Private not for profit entities. The selection procedure for institutions was as follows:

Stratified sampling

- Non Governmental Organizations
- Employers
- Providers
- Local Authorities excluding City Councils and municipalities where all selected.

Purposive selection or census

- All donors in Zimbabwe
- All Health Insurance firms
- Ministry of Health and Child Welfare;

- Other government ministries- undertook key informant interviews to identify ministries which are financing or providing health and / or HIV and AIDS services and goods.

Each survey was delivered in person by a NHA team member.

3.4.2. PLWHA survey

For the PLWHA survey, a set of survey administrator guidelines was developed⁸ and the enumerators for this instrument were health workers working in the sampled facilities providing HIV&AIDS services-ART, PMTCT or in associations. Ethical considerations regarding the interview process with PLWHA were reviewed (as per international norms) and documented in the PLWHA survey Guidelines.

The survey was based on a stratified sample of 809 patients drawn from 14 hospitals and one health center. The team began with a roster of the 78 facilities in Zimbabwe where ART was being delivered. From these, the team randomly selected 28 facilities. Thirteen of these (46%) refused to cooperate in the study, leaving 15 facilities that provided patient rosters. Approximately 50 patients were selected from each of these facilities. Because this design gave some patients a greater chance of selection than others, the team weighted the data to provide unbiased national estimates of spending

3.5. Data entry and analysis

All secondary and primary data collected were kept at the MOH&CW and UNAIDS (in particular for donors and Non Governmental Organizations). The following stages were carried out in order to ensure that the data collected were entered and analyzed correctly:

- Design of data entry screens for all institutions and PLWHA
- Enter institutional data using EXCEL
- Enter PLWHA data using SPSS

3.5.1. Data analysis for institutional spending

NHA Team members with experience in data entry were placed in charge of entering and cleaning the data collected. Once clean data sets were assembled, relevant information was entered in T-accounts of Financing Agents. The T-accounts assisted greatly in determining the sources of expenditures and in summarizing the expenditures by provider type and function prior to inserting them in the three dimensional HIV&AIDS Table-HFxHPxHC using the EXCEL program. Once the three dimensional HIV&AIDS Table-HFxHPxHC had balanced, the figures were then linked to other HIV&AIDS Tables: HFxHP; HFxHC and HPxHC.

It should be noted that the survey data provided estimates on ‘targeted’ or earmarked spending for HIV&AIDS by various institutions. However, this does not represent the total spending on HIV&AIDS by these institutions. This is because general resources available to non-market providers (contributed by various financing agents for all health services rendered by the provider) are also used

⁸ Adapted from the guideline document developed for the Rwanda 2002 HIV&AIDS subaccount estimation

to deliver HIV&AIDS care- such as the portion of a doctor nurse’s time spent attending to an HIV patient.⁹ To extract such non-targeted spending, an allocation factor was determined. In lieu of complex and sometimes costly studies (such as those that track time and motion), an allocation factor can be approximated and applied as a percentage of overall provider expenditures. The percentage used can be derived from a number of sources: 1) from HIV costing studies at hospitals and health centers, 2) from billing records for out-of-pocket payments of hospital discharges, and 3) from admission records and OP visits attributed to HIV concerns. Ideally, it is useful to obtain costing data to weigh against utilization rates to obtain the allocation factor. However, in Zimbabwe, it was difficult to obtain costing data and billing records. So some utilization data was used in the following manner to obtain non-targeted spending:

$$\frac{\text{Number of outpatient visits}_{\text{for HIV\&AIDS}} \text{ at a given provider}}{\text{Number of outpatient visits overall at a given provider}} \approx Y \% \text{ of overall OP expenditures that are used for HIV \&AIDS}$$

The total institutional expenditure estimate reported in the NHA tables refers to the addition of targeted and untargeted spending on HIV&AIDS.

3.5.2. Data analysis for PLWHA spending

As described earlier, health care facilities were the key point of entry to identifying PLWHA (for those who had tested positive) and providing their contact information.¹⁰ Of the 809 patients interviewed, 606 (75%) were receiving ART. Estimates of spending by patients on ART are based on these 606 interviews. Expenditures are calculated from two sets of questions. The first asks about outpatient visits during the four weeks preceding the interview. Since interviews were conducted in May 2006, these visits would have occurred in April and early May 2005. Up to three visits can be described in detail. For patients with more than three visits, we assumed that the excess visits had the same average spending levels as the three that were reported. About half (317) of the ART patients reported at least one outpatient visit during this period. Annualized outpatient spending is estimated as 13 times the mean spending for the four-week period (Zeros are included in the mean).

Respondents were asked to describe inpatient admissions for the past six-month period preceding the interview, that is, from November 2005 to April 2006. Ninety-seven of the ART patients reported at least one inpatient admission during this period. Annualized inpatient out-of-pocket spending is estimated as twice the mean for all ART respondents (including those with zero spending).

⁹ It should be noted that the full cost of intermediate inputs (including salaries, equipment, supplies) at private-for-profit providers is embedded within the price charged to patients or insurance schemes. Thus, non-targeted expenditures do not need to be estimated separately in these cases.

¹⁰ It should be noted, that effort was made to identify PLWHA from Associations of PLWHA, Voluntary Testing and Counseling Centres etc; however, this was not successful even after meetings with PLWHA and all stake holders in HIV/AIDS sector due to several factors such as stigma associated with HIV/AIDS and unavailability of the list of PLWHA from which a sample could be drawn, among others.

In order to arrive at the national estimated total expenditure by PLWHA, the following steps were followed:

1. PLWHA in stage 1&2 in 2005
Who were estimated to be around 1,025,397 in Zimbabwe in 2005 were subjected to the average general household out-of-pocket health expenditure per annum. This was on the assumption that the expenditures by PLWHA in stages 1&2 are similar to those of the general population
2. PLWHA in stage 3& 4 on ARVs in 2005
The average annualized expenditures per person living with HIV/AIDS obtained from the sample survey for both inpatient and out patient were multiplied by the estimated total of 24,000 PLWHA in 2005 to produce the national total expenditure for this group.
3. PLWHA in stage 3&4 Not on ARV in 2005
In 2005, it was estimated that there were 342,000 PLWHA who were in need of ARVs but due to several factors they were not put on ARVs. In order to estimate the expenditure for this group, the average expenditure per capita per annum for those in Stage 3&4 in the sample was extrapolated for this group in the same way as described in paragraph 2 above. This almost certainly overestimates total expenditures, because these patients were found on the patient rosters of hospitals and health centers. Patients who were not treated at such facilities probably had lower out-of-pocket expenditures, so the estimate based on this sample is biased when applied to them.

The total PLWHA expenditure estimate is a sum of spending from the above-mentioned groups.

3.6. Limitations of the study

3.6.1. Inflation related issues

During the period of study, inflation in Zimbabwe increased by over 1000%. This had significant implications for deflating the PLWHA reported expenditures from the year 2006 to 2005 as well as reporting donor and NGO reported expenditures in Zimbabwean dollars. The reasons for which are explained below:

- *Difficulty in identifying the correct index for deflating PLWHA expenditures.* The PLWHA study was undertaken in 2006 and since the focus of this study is 2005, the normal practice thus requires that the PLWHA figures be deflated to 2005. However, there is no reliable index for deflating these figures as the Health index for 2005 and 2006 appear to be too high and unrealistic. Any attempt to deflate the figures using these indices yielded results, which were too low, compared to what was the real situation in 2005 and as such, the NHA Team felt that such deflated figures were unrealistic. An attempt to use month-to-month inflation also yielded similar unrealistic results-very low figures. At this point, the NHA Team resolved that the 2006 PLWHA Out-of-pocket expenditures be deflated using the differences in the average exchange rates between 2005 and 2006 even though this index also faces many limitations in not capturing fully the multiple exchange rates which were available and used in Zimbabwe in 2005 by various groups (see next paragraph below). The indices for

deflation¹¹ used in this study which were as follows: US\$1=Z\$100,000 in 2005 and US\$1=Z\$190,903 in 2006 is thus the NHA Team's compromise. The interbank exchange rate as of July 1, 2005 was US\$1 = Z\$1,0176, approximately one tenth the amount used in these calculations. Consequently, amounts could differ by an order of magnitude depending on the rate assumptions.

- *Difficulty in identifying the appropriate exchange rate for conversion of US\$ to Zimbabwe dollars.* All donors expenditures were in US dollars, which according to the NHA practice requires that they be converted in Zimbabwe dollars prior to inserting them in the Tables. However, the results obtained depends on which rate one uses as there were four exchanges: 1) the official exchange rate 2) the bilateral and multilateral donors and international organizations negotiated exchange rate 3) the UN Agencies negotiated exchange rate; and 4) the parallel market exchange rate. Each rate implies a different purchasing power of the US \$. It was not possible to distinguish which donor used which rate. Consequently, after much discussion amongst the NHA Team, that included members from the donor community, it was decided that the official exchange rate be used, namely that 1 USD was equivalent to 100,000 Zimbabwe dollars in 2005. However, this may result in underestimating the true value of donor contributions as their US\$ were most likely able to purchase more Zimbabwean dollars (due to the use of various negotiated rates or parallel rates) than that specified in the official exchange report.

3.6.2. Lack of unit costs data

For the calculation of non-targeted spending by institutions at non-market providers, unit costs for specific services/interventions/diseases would have greatly assisted in estimating HIV&AIDS expenditures by developing ratios, which could then be, applied in general health expenditures of these providers. However, such data are not available in Zimbabwe. Consequently, the allocation factor derived was based on utilization data. However, this assumes that unit costs for all health services were the same and is a limitation of the estimate. Efforts to extract unit cost data from the health management information system for 2005 were not successful given and high levels of aggregation and weaknesses in reporting.

3.6.3. Sampling bias of PLWHA survey

As described above, the principal respondents of the PLWHA survey were individuals receiving ART. However, this represents only 24,000 of the 1,391,397 million adults who were estimated to be HIV positive in Zimbabwe in 2005. The reason for the bias was due to the lack of national rosters that would include (or other means for identifying) those who are positive (or do not know that they are positive) but in need of treatment as well as those who are in stage 1 &2 but may not have symptoms to warrant a change in utilization patterns at providers. This was identified as a critical issue and discussed amongst various stakeholders, including NAC members. To compensate for the bias in the survey sample, the national PLWHA estimate was produced by assuming the same expenditure pattern as the general population (from the general NHA household survey conducted in 2006) for the 1,025,397 million people who are diagnosed but not in need of ART. For those in need of ART and not receiving treatment, their out-of-pocket spending (for management of opportunistic infections)

¹¹ Deflation was done by dividing the 2005 exchange by the 2006 exchange rate multiplied by the estimated expenditure in 2006.

was the highest than those receiving ART, which is heavily subsidized. For this group estimated at 342,000, we estimated their expenditures using the average expenditures per capita per annum from the sample of those who were in stage 3&4 not yet on ARVs.

4. Findings of the HIV&AIDS Subaccounts

The findings of HIV&AIDS subaccounts are presented in four core Tables (shown in Appendix B). These tables illustrate the flow of funds between the principle dimensions of health accounts, namely sources of funding, the financing agents, providers, and functions related to HIV&AIDS spending. A summary of key statistics from the NHA subaccounts is shown in Table 2. Caution should be taken when interpreting the findings, particularly the U.S. dollar conversions, given the backdrop of inflation and use of multiple exchange rates in Zimbabwe.

Table 2 and Appendix B.1 show that total HIV&AIDS expenditure (THAE) in 2005 was around Z\$20.9 trillion, an equivalent of US\$209.4 million, which represents about US\$150.5 per capital per adult population living with HIV&AIDS. The largest contributors to this expenditure are donors at 49% of the total HIV&AIDS expenditures. This is similar to that found in other countries prior to the surge of external targeted funds for HIV&AIDS, which have undertaken similar studies such as Kenya, Malawi, Rwanda and Zambia.

Table 2: Summary of Key Findings of HIV&AIDS Subaccounts Study

General Indicators	2005
Total HIV&AIDS Expenditure (Z\$)	20,944,351,718,846
Total HIV&AIDS Health Expenditure	7,756,188,400,259
Total HIV&AIDS expenditure (at average US\$ exchange rate)	209,443,517
Total HIV&AIDS Expenditure Per adult population age 15 and above (Z\$)	15,052,750.38
Total HIV&AIDS Expenditure Per adult population age 15 and above (average US\$ exchange rate)	150.53
Financing Sources of HIV&AIDS Funds	
Public as a % of total HIV&AIDS expenditures	7%
Private as a % of total HIV&AIDS expenditures	43%
Donor as a % of total HIV&AIDS expenditures	49%
Household Spending	
Total HH spending as a % of total HIV&AIDS expenditures	40%
OOP spending as a % of total HIV&AIDS expenditures	40%
OOP spending per PLWHA (Z\$)	5,968,463.57
Out-of-pocket spending (at average US\$ exchange rate)	59.68
Financing Agents	
Public sector as a financing agent as a % of total HIV&AIDS expenditures	13%
Private sector as a financing agent as a % of total HIV&AIDS expenditures	57%
Rest of the World as a financing agent as a % of total HIV&AIDS expenditures	30%

General Indicators	2005
Providers	
Public provider spending as a % of total HIV&AIDS expenditures	19%
-Public hospital spending as a % of total HIV&AIDS expenditures	-18%
-Public health center spending as a % of total HIV&AIDS expenditures	-1%
Private provider spending as a % of total HIV&AIDS expenditures	27%
-Private hospital spending as a % of total HIV&AIDS expenditures	-23%
-Private health centres/dispensaries/clinic spending as a % of total HIV&AIDS expenditures	-4%
Provision of prevention and public health programs as a % of total HIV&AIDS expenditures	29%
Other Providers of HIV&AIDS services as a % of total HIV&AIDS expenditures	9%
Providers of Health Care Related services	1%
Providers of Non-Health Services	14%
Functions	
Curative Care as a % of total HIV&AIDS expenditures	54%
- Inpatient Curative (OIs Treatment)	11%
- Outpatient Curative (OIs Treatment)	43%
- ARV Treatment*	5%
Prevention and Public health programs as a % of total HIV&AIDS expenditures (PMTCT, VCT, IEC, STI prevention)	29%
Health Administration and Insurance as a % of total HIV&AIDS expenditures	0%
Other Health Functions as a % of total HIV&AIDS expenditures	1%
Health Related Functions as a % of total HIV&AIDS expenditures (education and training, and R&D)	1%
Non health expenditures as a % of total HIV&AIDS expenditures (OVC Support, PLWHA support, Home Based Care)	14%

Source: HIV&AIDS Subaccounts Tables in Annex B

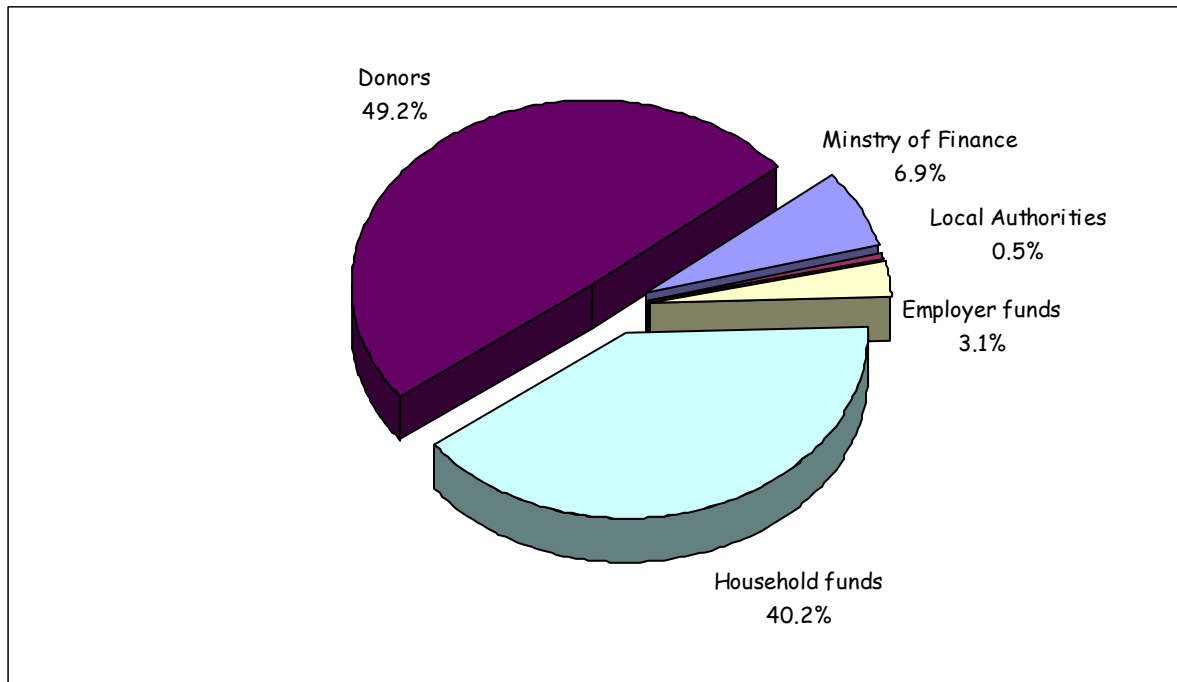
4.1. Flow from Financing sources to financing agents

4.1.1. Financiers of HIV&AIDS services in Zimbabwe

As noted earlier, donors were the major financing source of all HIV&AIDS spending (both health, health care related and non-health expenditures) contributing about 49% of the total HIV&AIDS. Households were the second major source of finance for HIV&AIDS and were responsible for 40% of total HIV&AIDS expenditures. The government came third with 7% contribution in total HIV&AIDS spending (for more details see Table 2 above and Appendix B.1). With the commencement of spending from the Global Fund resources in 2006, it is more likely that this picture has changed and there is need for continuous monitoring of the situation, particularly to assess the burden of financing on PLWHA. As can be seen from the subaccounts, PLWHA bore a significant share of financing for HIV&AIDS services in 2005 especially those in stage 3&4 not yet on ARVs (but in need of treatment). Such sizeable PLWHA expenditures (principally given out-of-pocket) needs to be examined further to determine whether or not they are 'catastrophic' in nature, possibly

substituting for other essential commodities for a household such as food, education etc in order to pay for health care services and goods.

Figure 1 Distribution of Total HIV&AIDS funds by Financing Source, 2005



Employers through their various initiatives (such as HIV&AIDS workplace programmes, contributions to insurance for their employees and dependents, provision of health care services and goods to HIV&AIDS patients in their on-site facilities, and reimbursements to employees who have incurred health care costs) contributed about 3% of total HIV&AIDS expenditures. This is significantly low, bearing in mind that Employers are hardest hit by HIV&AIDS, which is threatening to disrupt their productivity and hence the productivity of the whole economy. A study in Cote d’Ivoire found that a private electricity company which offered ARVs to employees made a saving of 4-5 times the cost of the programme, due to a fall in HIV&AIDS related absenteeism, fewer hospitalizations, a decrease in new AIDS cases, and reduced mortality.¹² Similarly, Zimbabwean employers may be well served to increase their spending on HIV&AIDS treatment, care and prevention so that absenteeism at workplaces is reduced and productivity is improved.

4.1.2. Financing sources and financing agents

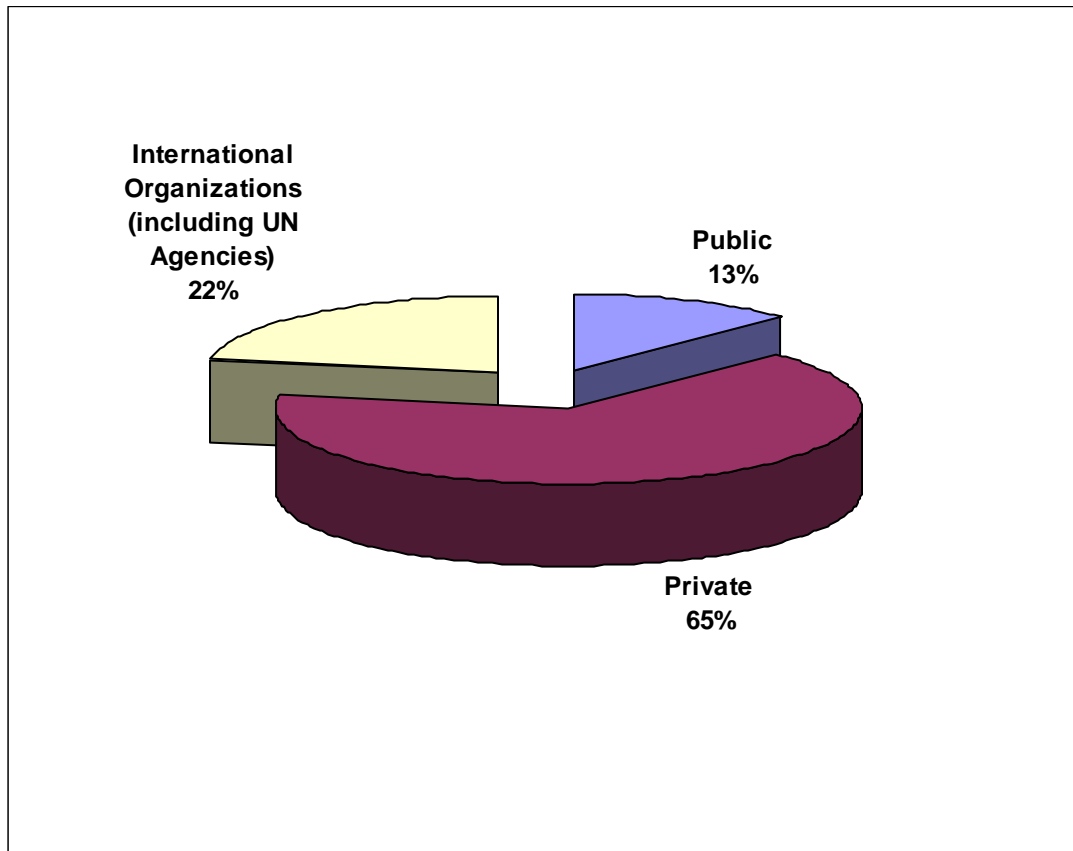
Transfers of funds are made initially between funding sources and financing agents. The latter receives the funds from HIV/AIDS financiers and allocates them to providers. In short, they have programmatic responsibilities- managing the allocation and utilization of funds.

The flow of funds from sources to agents can be seen in Appendix B.2. The major financing agent of HIV&AIDS was the private (65% of the total HIV&AIDS spending) sector, in particular direct

¹² “Antiretroviral Treatment can be cost saving for industry and lifesaving for workers: A case study from Cote d’Ivoire’s private sector” by Eholie, S., Nolan, M., Gaumon, A. et al (2003).

household out-of-pocket payments, which accounted for about 40 of the total HIV&AIDS expenditures in 2005. International Non Government Organizations including UN Agencies came second and managed about 22% of the total HIV&AIDS expenditures. The public sector including NAC managed only 13% of total HIV&AIDS expenditure (for more details see Figure 2 and Table 2 and Appendix B.2). Given the amount of funds passing directly to the provider as opposed to going through government entities, that traditionally played the stewardship/managerial role, it is critical that these efforts be coordinated so as to meet national goals in the fight against the epidemic.

Figure 2: Distribution of Total HIV&AIDS Expenditures by Financing Agents, 2005



As seen from Table 2 and Annex B.2, PLWHA through direct out-of-pocket payments to providers bear a greater burden of financing HIV&AIDS expenditure. Such high OOP spending is likely to have implications in dissuading the poor from utilizing health care services (WHO 2000)

Insurance coverage of opportunistic infections (OIs) and other HIV- related interventions was accounted for only 3 percent of total HIV/AIDS expenditures.

Table 3, shows how financing sources allocated their funds across various financing agents. From this table, it can be summarized that:

- About 30.4% of total donor HIV&AIDS expenditures were managed by international NGOs and UN Agencies
- About 28.2% of the donor HIV&AIDS expenditures passed through Local NGOs

- Only 8.9% of donor HIV&AIDS expenditures passed through the Ministry of Health and Child Welfare.
- About 79% of Ministry of Finance funds passed through the Ministry of Health& Child Welfare-this is through the funding of the annual budget for recurrent expenditures.

Table 3: Allocation of Total HIV&AIDS between Financing Sources and Financing Agents, 2005

	Donors	Ministry of Finance	Local Authority	Employer	Household
MOHCW	8.9%	79.4%			
NAC	1.5%	19.0%			
Other Ministries	0.1%	1.6%			
Local Authority			100.0%		
Private Insurance				68.6%	1.4%
Household Out-of-Pocket					98.6%
Private firms				31.4%	
Non Governmental Org.	28.2%				
Rest of the World	30.4%				
Financing agents of health related activities	2.7%				
Financing agents of non health activities	28.2%				
TOTAL	100%	100.0%	100.0%	100.0%	100.0%

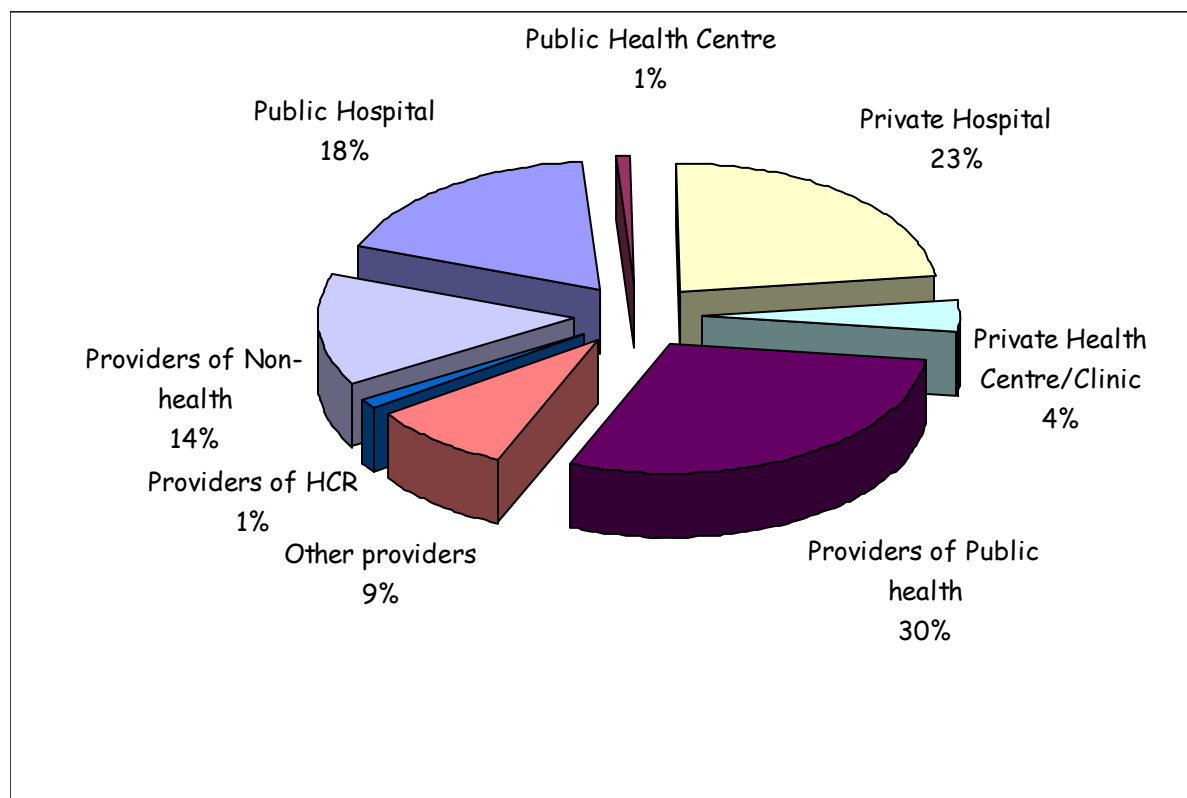
4.2. Flow from Financing Agents to Providers

4.2.1. Provider Expenditure

Providers of HIV&AIDS services provide core health care services, health related services such as education and training, and non-health services such as support to PLWHA, support to OVC, Home based care etc.

Figure 3, shows the provider breakdown of HIV&AIDS expenditures. Hospitals (both public and private) were the major recipients of HIV&AIDS funds, accounting for approximately 42% of the total HIV&AIDS resources. Within the hospital sector, private hospitals were the major spenders of total HIV&AIDS expenditures at 23% of the THAE. Public hospitals spent about 18% of the total HIV&AIDS expenditures. Providers of prevention and public health HIV&AIDS programmes were second, receiving about 29% of the total HIV&AIDS expenditures. While providers of non-health services were third at 14% of the total HIV&AIDS spending.

Figure 3: Distribution of Total HIV&AIDS Expenditures by provider type: 2005



A review of flow of funds between major financing agents and providers reveals that out of the total funds received by the Ministry of Health and Child Welfare, 45% was spent largely on the provision of prevention and public health programmes. Central hospitals and Provincial hospitals received about 29% and 10% of the THAE respectively (for more details see Appendix B.2)

Approximately 64% and 34% of total HIV&AIDS funds from donors and managed by local Non-Governmental Organizations, was spent on the provision of HIV&AIDS prevention and public health and on the delivery of non-health services respectively. UN Agencies and International Non-Governmental Organizations also spent their funds on the provision of prevention and public health programmes- to the tune of 38% of the THAE. About 27% of the funds managed by donors were passed on to various health facilities for provision of treatment of Opportunistic Infections and ART. Only 2% of the total HIV&AIDS funds were passed on to independent Laboratories for HIV&AIDS services (for more details see Appendix B.2).

A very different picture emerges when analysing PLWHA direct out-of-pocket payment distribution to providers. Approximately 48% of the total HIV&AIDS expenditures were spent directly by PLWHA at private hospitals for the management of OIs. About 23% and 10% of PLWHA funds were directly paid to central hospitals and Provincial hospitals for treatment of OIs respectively. A further 7% of PLWHA funds were paid directly to mission hospitals.

From this analysis, it can be concluded that majority of the funds from Ministry of Health and Child Welfare, Local NGOs, UN Agencies and international NGOs were mainly used for the provision of

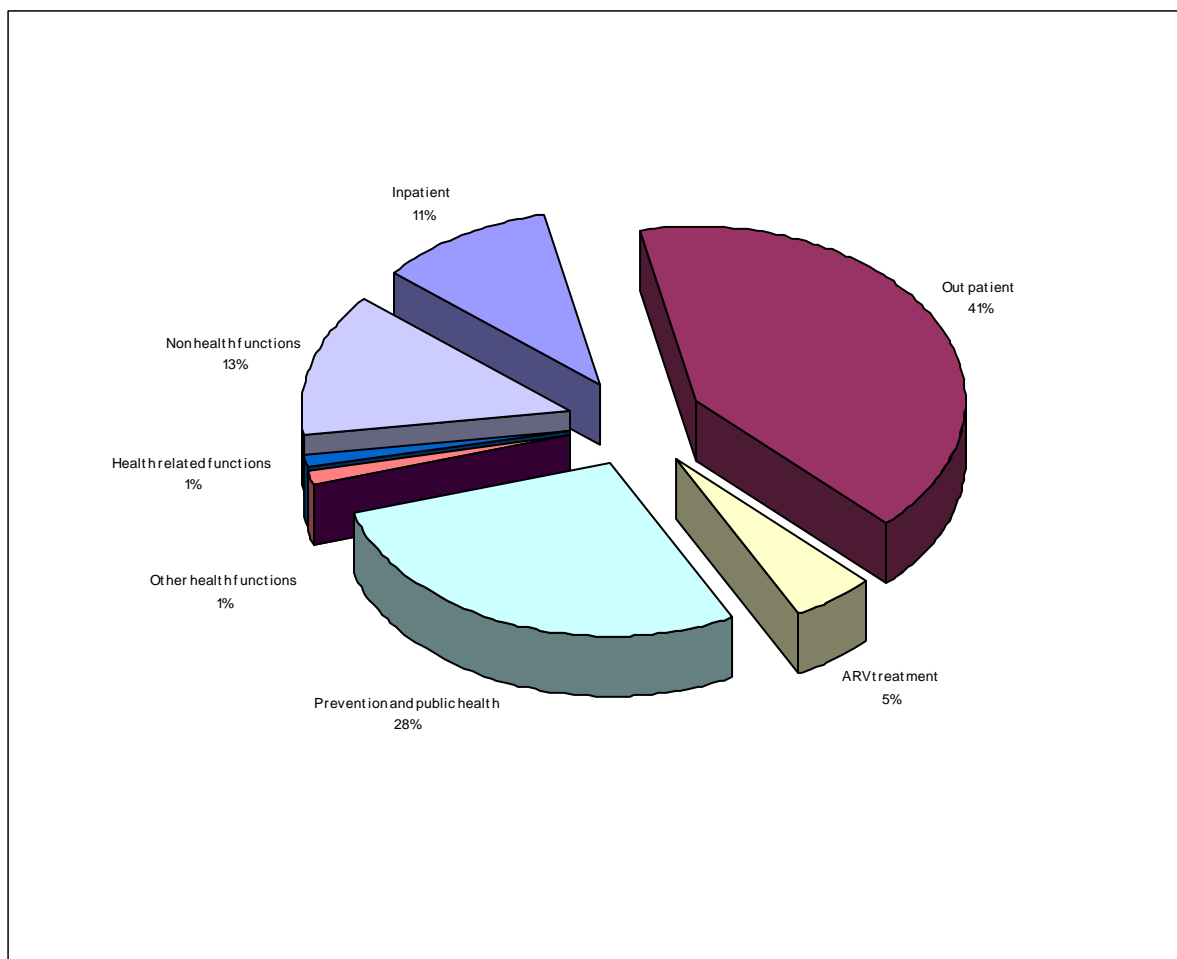
prevention and public health programmes for HIV&AIDS whereas PLWHA spending went directly to health facilities for treatment and care of OIs.

4.3. Flow from Financing Agents to Functions

A function is the term used to describe the actual service or good being provided. Examples of functions include: curative care (both inpatient and outpatient and for HIV&AIDS since there is no cure, this is equivalent to treatment and care of opportunistic infections and receiving ARVs among others), rehabilitative care, prevention and public health, and education and training (health related), care for OVCs (non-health), among others.

In 2005, the bulk of the HIV&AIDS funds were spent on treatment and care of OIs amounting to 54% of total HIV&AIDS expenditures. Provision of ARV consumed around 5% of the total HIV&AIDS expenditures and was mainly financed by Donors. Provision and administration of prevention and public health services for HIV&AIDS consumed around 29% of total HIV&AIDS spending (for more details see Figure 4, Table 2 and Appendix B.3).

Figure 4: Distribution of Total HIV&AIDS Expenditure by Function, 2005



An analysis of major financing agents for HIV&AIDS resource allocation and utilization by function shows that the Ministry of Health and Child Welfare spent most of its resources for HIV&AIDS on treatment and care of OIs (54% of the total HIV&AIDS expenditures, 48% and 6% for inpatient and out patients services respectively). About 45% of the funds for HIV&AIDS were spent on provision and administration of prevention and public health programmes (for more details see Appendix B.3).

With respect to local NGOs, about 64% of their total HIV&AIDS funds received from donors were spent on provision and administration of prevention and public health programmes for HIV&AIDS while the remainder was spent on non-health services, in particular OVC care and support, PLWHA support and home based care. As for the UN Agencies and international NGOs (Rest of the World), approximately 27% of their funds managed by themselves were spent on treatment and care of OIs and provision of ART. About 38% of the total HIV&AIDS funds directly managed by UN Agencies and international NGOs was spent on provision and administration of prevention and public health programmes while 6% and 27% of the funds managed by UN Agencies and international NGOs themselves were spent on health care related services (education and training and research) and non-health services (OVC support, PLWHA support and home-based care) respectively (for more details see Appendix B.3)

PLWHA through direct out-of-pocket payments to providers spent almost all their funds on treatment and care of OI (about 99%).

In summary, the Ministry of Health and Child Welfare (about 54% of the total HIV&AIDS funds) and PLWHA through direct out-of-pocket payments (99% of the total of the total HIV&AIDS funds) were principally responsible for paying for treatment and care of OIs. Donors, international NGOs and Local NGOs, on the other hand, were mainly responsible for the payment of provision and administration of prevention and public health programmes for HIV&AIDS and ART in 2005.

4.4. Flow from Providers to Functions

Appendix B.4 shows the flow of funds from providers to functions for HIV&AIDS expenditures. Public hospitals spent about 5% and 13% of the total HIV&AIDS funds on inpatient and outpatient respectively. In contrast, Private hospitals spent about 3% and 21% of the total HIV&AIDS funds on inpatient and outpatient services respectively. All other providers of health care services e.g. health centres, private clinics, traditional healers etc) for HIV&AIDS spent about 1% and 11% of the total HIV&AIDS funds on inpatient and outpatient services respectively. Providers of prevention and public health programmes spent 29% of the total HIV&AIDS funds. Providers of health care related activities such as education and training institutions and research institutions and providers of non-health services such as OVC support, PLWHA support etc spent about 1% and 14% of the total HIV&AIDS funds on health related activities and non-health activities respectively.

4.5. Flow from Financing Sources to Functions

Table 4 represents the distribution of financing sources by functions (for more details see Annex B.5). This table is obtained by combining the flows of funds between FSxHF and HF x HC. Alternately, this table is obtained by tracing the purpose of the funds transferred by the financing sources to each financing agent or tracing the purpose of funds managed by the financing source itself.

From the table it can be seen that the main financiers of services of curative care were PLWHA spending about 73% of the total expenditures on services of curative care and 39% of the total HIV&AIDS expenditures, seconded by Rest of the World at 12% of the total expenditures on services of curative care and Ministry of Finance came third at 10% of the total expenditures on services of curative care. As regards prevention and public health services, Rest of the World (external assistance) was the highest financier at 92% of the total prevention and public services expenditures and about 27% of total HIV&AIDS expenditures, seconded by Ministry of Finance at 5% of the total prevention and public services expenditures and Employers came third at 3% of the total prevention and public health expenditures.

Table 4 Distribution of Total HIV&AIDS Expenditures by Source of Finance and Function, 2005

Source of Finance	Function				
	Services of curative care	Prevention and public health services	Health Care Related Activities	Non-Health Care Activities	Other Activities
Ministry of Finance	10%	5%			4%
Local Authorities	1%	0%			
Employers	4%	3%			21%
Households	73%				46%
Rest of the World	12%	92%	100%	100%	29%
Total	100%	100%	100%	100%	100%

4.6. Financial flows mapped to UNGASS Funding matrix

The classification scheme used by the HIV/AIDS subaccounts, while faithful to the NHA framework, does allow for a cross-walk of the findings to other classification schema that may be useful for policy purposes. For example, in an effort to monitor the commitments made at the UN General Assembly Special Session on HIV, UNAIDS requests from each of its member countries the computation of a “national funding matrix.”¹³ A computation of this table using subaccount findings is presented in Annex B.6. It can be summaries as follows in Table 5.

¹³ UNAIDS, 2007. *Monitoring the Declaration of Commitment on HIV/AIDS; Guidelines on the Construction of Core Indicators 2008.*

Table 5: National Spending by UNAIDS AIDS Spending Categories

UNAIDS AIDS Spending Category	Percentage of Total HIV/AIDS expenditure
Prevention	28%
Care and Treatment	58%
Orphans and Vulnerable Children	10%
Program Management and Administration Strengthening	1%
Incentives for Human Resources	1%
Social Protection and Social Services excluding Orphans and Vulnerable Children	1%
Enabling Environment and Community Development	0%
Research excluding operations research	0%

5. Summary

The subaccounts show that total HIV&AIDS expenditures were Z\$20.9 trillion in 2005. Donors were the major financiers for all HIV&AIDS activities in Zimbabwe at 49%. PLWHA came second at 40% of the total HIV&AIDS expenditures. The Ministry of Finance was the third largest source of HIV&AIDS expenditures at 7% total HIV&AIDS expenditures.

In terms of the principal managers of HIV/AIDS funds (financing agents), the subaccounts finds that the Private sector, mainly PLWHA through direct out-of-pocket spending were the biggest managers/payers of providers, contributing to 40% of the total HIV&AIDS expenditures. UN Agencies and International NGOs were the second largest managers of HIV&AIDS handling about 15% of the total HIV&AIDS expenditures. Local NGOs came third handling about 14% of the total HIV&AIDS spending. Given the amount of funds passing directly to the provider as opposed to going through government entities (which manages only 13%, of THAE) that traditionally played the stewardship/managerial role, it is critical that HIV/AIDS efforts be coordinated so as to meet national goals in the fight against the epidemic.

At the provider level, the findings show that hospitals (public and private-both for profit and not for profit) were the major recipients of HIV&AIDS funds at 42% of the total HIV&AIDS expenditures. Further breakdown of the hospital expenditures shows that that private hospitals were the major recipients of HIV&AIDS funds (23% of the total HIV&AIDS expenditures) and public hospitals received about 18% of the total HIV&AIDS expenditures). Provision and administration of prevention and public health programmes for HIV&AIDS came second at 29% of the total HIV&AIDS expenditures. Providers of non-health expenditures were third at 13% of the total HIV&AIDS expenditures. All other providers of health care services for HIV&AIDS such as pharmacy, traditional healers etc were the fourth largest recipients of HIV&AIDS at 9% of the total HIV&AIDS expenditures.

At the functional level, the NHA subaccounts has revealed that approximately 54% of total HIV&AIDS expenditures were spent on services of curative care (treatment of OIs and provision of ART). Donors mainly financed ART. About 29% of the THAE was spent on provision and

administration of public health services. Health care related activities and non-health care activities consumed about 1% and 14% of the total HIV&AIDS expenditures respectively. Furthermore, PLWHA, through direct out-of-pocket payments to providers, were responsible for 73% of total expenditures on services of curative care. External Assistance was responsible for 92% of the total expenditures on provision and administration of prevention and public health services for HIV&AIDS. This therefore meant that PLWHA largely funded services of curative care while donors mainly funded provision and administration of prevention and public health services for HIV&AIDS.

In summary, the subaccounts show that

- Donors were the main financiers of HIV&AIDS spending in Zimbabwe (at 49% of THAE) in 2005 prior to the influx of targeted funds for HIV&AIDS.
- PLWHA contributed a significant share of HIV&AIDS resources (at 40% of THAE), more than the Government. This may have implications relating to catastrophic spending and should be investigated further.
- Funding was largely given to providers directly or managed by NGOs and donors, thus bypassing Government channels (which manages only 13% of the THAE at the financing agent level) which for the health sector have traditionally been the principal steward. While this may alleviate administrative burden for the Government, effort should be made to ensure that funds are spent in a coordinated fashion to achieve national goals in the fight against HIV&AIDS.
- Approximately 50% of funds were spent on treatment for opportunistic infections (financed primarily by PLWHA followed by the Government), with 5% for ART (financed primarily by donors). 29% was spent on prevention and public health programs (again heavily financed by donors) with the remainder spent on other health (1%), health-related (1%) and non-health HIV&AIDS activities (14%).

Annex A: References

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Appendix B: HIV and AIDS Subaccounts Tables, 2005

Appendix B.1: Financing Sources x Financing Agents (FS x FA)

	FS.1 Public Funds*		FS.2 Private Funds*		FS.3	Row Totals	As a % of THAE
	FS.1.1 Territorial government		FS.2.1 Employer Funds	FS.2.2 Household Funds	Rest of the World Funds		
	FS.1.1.1. General government	FS.1.1.2 Local Authorities					
42,990,081,483	FS.1.1.1.1. Ministry of Finance						
HF.1.1.1.1 Ministry of Health & Child Welfare	1,143,400,450,791				916,700,000,000	2,060,100,450,791	10%
HF.1.1.1.2 National AIDS Council	273,819,685,581				153,481,000,000	427,300,685,581	2%
HF.1.1.1.3 Other Ministries & Government Agencies	23,042,823,407				9,700,000,000	32,742,823,407	0%
HF.1.1.1.4 Local Authorities		111,743,099,893				111,743,099,893	1%
HF.2.2 Private Insurance Scheme			452,520,803,885	121,246,026,683		573,766,830,568	3%
HF.2.3 Household Out of Pocket Payments				8,304,502,309,807		8,304,502,309,807	40%
H.F.2.4 Non-Governmental Organizations					2,907,353,000,000	2,907,353,000,000	14%
HF.2.5 Private Firms/Employers			207,203,172,912			207,203,172,912	1%
HF.3 Rest of the World					3,131,476,027,300	3,131,476,027,300	15%
HF. Not Specified by Kind							0%
Total HIV&AIDS Health Expenditure	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	7,118,710,027,300	17,756,188,400,259	85%
							0%
Financing agents of Health Care Related Activities					282,979,354,842	282,979,354,842	1%
National HIV&AIDS Health Expenditures	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	7,401,689,382,142	18,039,167,755,102	86%
							0%
Financing agents of Non-Health Expenditures					2,905,183,963,745	2,905,183,963,745	14%
							0%
Total HIV&AIDS Expenditures	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	10,306,873,345,887	20,944,351,718,846	100%
As a % of THAE	7%	1%	3%	40%	49%	100%	

Appendix B.2: Financing Agents (HF) x Provider (HP), 2005

Provider	HF.1 Public				HF.2 Private Sector				HF.3 Rest of the World	Row totals and total expenditure measures	As a % of THAE
	HF.1.1.1.1 Ministry of Health & Child Welfare	HF.1.1.1.2 National AIDS Council	HF.1.1.1.3 Other Ministries & Government Agencies	HF.1.1.1.4 Local Authorities	HF.2.2 Private Insurance Scheme	HF.2.3 Household OOP Payments	HF.2.4.1.2 NGOs	HF.2.5 Private Firms / Employers			
HP.1 Hospital	1,077,993,598,967	-	20,667,401,827	-	143,011,757,542	7,488,914,609,218	-	42,990,081,483	-	8,773,577,449,036	42%
HP.1.1 General Hospitals	1,077,993,598,967	-	20,667,401,827	-	143,011,757,542	7,488,914,609,218	-	42,990,081,483	-	8,773,577,449,036	42%
HP.1.1.1 Government general hospitals	967,296,536,273	-	20,667,401,827	-	6,400,046,097	2,868,712,632,857	-	-	-	3,863,076,617,054	18%
HP.1.1.1.1 Central Hospitals	599,631,767,187	-	15,948,816,935	-	6,400,046,097	1,935,891,998,543	-	-	-	2,557,872,628,762	12%
HP.1.1.1.2 Provincial Hospitals	196,781,116,016	-	4,718,584,892	-	-	853,705,890,533	-	-	-	1,055,205,591,442	5%
HP.1.1.1.3 District Hospitals	170,883,653,070	-	-	-	-	79,114,743,781	-	-	-	249,998,396,851	1%
HP.1.1.2 Private Not-for-profit hospitals (Mission)	110,697,062,693	-	-	-	125,751,281,767	617,834,506,318	-	-	-	854,282,850,778	4%
HP.1.1.3 Private For-profit hospitals	-	-	-	-	10,860,429,678	4,002,367,470,043	-	42,990,081,483	-	4,056,217,981,204	19%
HP.2 Nursing and residential care facilities	317,373,046	-	-	-	1,052,581,568	-	-	-	-	1,369,954,614	0%
HP.3 Providers of ambulatory health care	48,098,301,169	-	1,887,433,957	87,234,426,841	324,379,970,563	556,025,498,189	-	-	92,792,962,220	1,110,418,592,938	5%
HP.3.1 Offices of physicians	-	-	-	-	324,379,970,563	-	-	-	-	324,379,970,563	2%
HP.3.4.9.1 Health centres /clinics	36,459,251,533	-	1,887,433,957	87,234,426,841	-	518,164,323,638	-	-	-	643,745,435,968	3%
HP.3.5 Medical and diagnostic laboratories	11,639,049,637	-	-	-	-	-	-	-	92,792,962,220	104,432,011,856	0%
HP3.9.3 Traditional practitioners	-	-	-	-	-	37,861,174,551	-	-	-	37,861,174,551	0%
HP.4 Retail sale and other providers of medical goods	-	-	-	-	105,322,520,896	61,599,065,992	-	-	-	166,921,586,888	1%
HP.5 Provision and administration of public health programs	927,985,156,250	311,640,759,200	10,187,987,624	24,508,673,052	-	-	2,907,353,000,000	164,213,091,429	1,783,236,468,961	6,129,125,136,516	29%
HP.6 General health administration and insurance	5,706,021,359	-	-	-	-	-	-	-	-	5,706,021,359	0%
HP.6.1 General Administration of Health	5,706,021,359	-	-	-	-	-	-	-	-	5,706,021,359	0%
HP.6.4 Other (private) Insurance	-	-	-	-	-	-	-	-	-	-	0%
HP.6.9 All other providers of health administration	-	-	-	-	-	-	-	-	-	-	0%
HP.9 Rest of the world	-	22,650,913,562	-	-	-	197,943,812,926	-	-	-	220,594,726,488	1%
Provider not specified by kind	-	93,009,012,819	-	-	-	19,323,482	-	-	1,255,446,596,119	1,348,474,932,420	6%
Total HIV&AIDS Health Expenditure	2,060,100,450,791	427,300,685,581	32,742,823,407	111,743,099,893	573,766,830,568	8,304,502,309,807	2,907,353,000,000	207,203,172,912	3,412,829,336,255	17,756,188,400,259	85%
HP.8 Institutions providing health related services	-	1,626,045,887	-	-	-	-	-	-	281,353,308,955	282,979,354,842	1%
HP.8.1 Research Institutions	-	1,626,045,887	-	-	-	-	-	-	540,804,054	2,166,849,941	0%
HP.8.2 Education and training institutions	-	-	-	-	-	-	-	-	280,812,504,901	280,812,504,901	1%
Total National HIV&AIDS Health Expenditure	2,060,100,450,791	428,926,731,468	32,742,823,407	111,743,099,893	573,766,830,568	8,304,502,309,807	2,907,353,000,000	207,203,172,912	3,412,829,336,255	18,039,167,755,101	86%
HP Institutions providing Non-Health Services	-	-	-	-	-	-	1,662,506,379,176	-	1,242,677,584,569	2,905,183,963,745	14%
Institutions providing OVC Care and Support	-	-	-	-	-	-	1,035,113,776,345	-	1,114,908,982,897	2,150,022,759,242	10%
Institutions providing PLWHA Support	-	-	-	-	-	-	118,624,068,694	-	127,768,601,672	246,392,670,366	1%
Institutions providing Home Based Care	-	-	-	-	-	-	508,768,534,137	-	-	508,768,534,137	2%
Total HIV&AIDS Expenditure (THAE)	2,060,100,450,791	428,926,731,468	32,742,823,407	111,743,099,893	573,766,830,568	8,304,502,309,807	4,569,859,379,176	207,203,172,912	4,655,506,920,824	20,944,351,718,846	100%
As a % of THAE	10%	2%	0%	1%	3%	40%	22%	1%	22%	100%	

Appendix B.3: Financing Against HIV's Function (HC), 2005

Function	HIV-1 source					HIV-2 Private Sector					HIV-3	Rest of the World	Sum total and total expenditure resources	As % of TDRAC
	HF 1.1.1 Ministry of Health & Child Welfare	HF 1.1.2 National Council	HF 1.1.3 Other Ministries & Government Agencies	HF 1.1.4 Local Authorities	HF 2.2 Private Secretary Scheme	HF 2.3 Household/NGO Personnel	HF 2.4 NGOs	HF 2.5 Private Firms & Corporations (Employees)	HF 3	Rest of the World				
HIV-1 Treatment services	8,715,762,022.96	6,099,021,629	22,769,875.307	87,245,526.801	482,466,889.673	8,252,966,251.922		42,999,066,480		1,209,498,796,019		1,287,207,766,478	2%	
HF 1.1 Treatment services-via	88,165,254,752	12,556,635,761.30	12,556,635,761.30	46,628,174,134.00	462,236,261,675.30	78,766,966,762		95,761,218,517		1,209,498,796,019		1,287,207,766,478	2%	
HF 1.1.1 Outpatient services-via	124,454,648,424	6,409,021,249		36,214,023,703	8,207,686,697	7,437,112,273,02		7,091,842,560		1,278,448,796,119		1,366,897,476,238	2%	
HF 1.1.1.1 HIV Treatment	5,609,001,849									1,667,874,460		1,667,874,460	0%	
HIV-1 Ancillary services to medical care	11,626,000,627									92,782,962,230		104,408,962,856	0%	
HF 1.1.1.1 Clinical laboratory	11,626,000,627									92,782,962,230		104,408,962,856	0%	
HIV-1 Medical goods dependent on medicines					105,322,520,800							105,322,520,800	0%	
HF 1.1.1.1 Pharmaceuticals and other medicinal goods					105,322,520,800							105,322,520,800	0%	
HIV-1 Prevention and public health services	107,987,151,290	111,488,779,260	10,107,987,624	24,588,673,652		2,607,353,000,000		166,213,891,429,60		1,792,226,668,961		4,129,222,476,216	2%	
HF 1.2 Prevention of Communicable Diseases	107,987,151,290	111,488,779,260	10,107,987,624	24,588,673,652		2,607,353,000,000		166,213,891,429,60		1,792,226,668,961		4,129,222,476,216	2%	
HF 1.2.1 PMPTCT	228,010,751,241					493,948,742,883		402,552,586,229		1,178,766,868,240		1,776,766,868,240	0%	
HF 1.2.1.1 VCT	28,440,000,447					433,225,675,461		219,991,222,681		769,611,888,808		1,058,811,888,808	0%	
HF 1.2.1.2 Behaviour Change	1,275,112,200					497,661,213,190		1,918,644,693,664		1,307,866,228,514		1,307,866,228,514	0%	
HF 1.2.1.3 Youth programmes						101,616,239,303		1,039,791,766,617		312,689,861,369		312,689,861,369	0%	
HF 1.2.1.3.1 Men only						16,899,622,181		16,899,622,181		27,229,661,439		27,229,661,439	0%	
HF 1.2.1.3.2 Gender Programme						84,687,216,666		106,767,676,762		1,689,771,676,666		1,689,771,676,666	0%	
HF 1.2.1.3.3 Women programme						17,039,390,448		7,562,372,113		15,742,572,633		15,742,572,633	0%	
HF 1.2.1.3.4 Surveillance						121,787,479,114		74,691,831,664		196,387,891,678		196,387,891,678	0%	
HF 1.2.1.3.4.1 HIV-1 risk reduction and administration of pre-exposure prophylaxis (PrEP) to HIV-1 at-risk programme	402,574,688,116	201,488,756,753	6,915,875,564	24,588,673,652		38,181,721		164,213,891,429,60		48,611,294		1,284,866,926,209	0%	
HIV-1 Health administration and health systems	5,786,021,209											5,786,021,209	0%	
HF 1.1 General Government Administration of Health	5,786,021,209											5,786,021,209	0%	
HF 1.2.2 Health Administration and Health Systems - Other Private													0%	
HF 1.2.2.1 General Government	23,626,615,620											23,626,615,620	0%	
Total HIV-1 AIDS Health Expenditure	2,669,266,476,791	427,389,687,260	22,762,821,897	111,740,899,893	573,766,826,268	8,260,826,268,007		2,967,232,668,000	207,281,372,912	3,412,829,326,233		12,776,126,686,228	2%	
HIV-2 Health related functions		1,026,667,487								281,323,966,058		282,350,633,545	0%	
HF 2.2 Education and Training		1,026,667,487								281,323,966,058		282,350,633,545	0%	
HF 2.2.1 Research and Development		1,026,667,487								140,661,933,029		140,661,933,029	0%	
Total National HIV/AIDS Health Expenditure	2,669,266,476,791	428,416,354,747	22,762,821,897	111,740,899,893	573,766,826,268	8,260,826,268,007		2,967,232,668,000	207,281,372,912	3,412,829,326,233	18,699,167,731,063	12,776,126,686,228	2%	
Non-health functions										1,252,277,664,509		1,252,277,664,509	0%	
UNV, Car and Support										1,114,696,062,897		1,114,696,062,897	0%	
UNV/A Support										137,581,601,612		137,581,601,612	0%	
Non-health total										1,252,277,664,509		1,252,277,664,509	0%	
Total HIV/AIDS Expenditure	2,669,266,476,791	428,416,354,747	22,762,821,897	111,740,899,893	573,766,826,268	8,260,826,268,007		4,269,499,279,176	207,281,372,912	4,665,066,990,742	19,951,445,395,572	12,776,126,686,228	2%	
As a % of TDRAC	10%	2%	0%	0%	0%	40%		22%	2%	2%	2%	100%		

Appendix B.4-Provider (HP) x Function (HC), 2005

Function	HP1 Hospital						HP2 Nursing and residential care facilities	HP3 Providers of ambulatory health care							HP4 Retail sale and other providers of medical goods	HP5 Provision and administration of public health programs	HP6 General health administration and insurance		HP7 Rest of the world	Provider not specified by class	HP8 Institutions providing health related services	HP9 Institutions providing health services	Total function	As a % of THAE		
	HP1 Government owned hospital							HP3 Providers of ambulatory health care									HP6.1 General Administration of health	HP6.2 All other providers of health administration								
	HP1.1.1 General	HP1.1.2 Provincial	HP1.1.3 District Hospital	HP1.1.4 Private For-Profit	HP1.1.5 Private Not-for-profit hospital (Migrant)	HP1.1.6 Private For-profit hospital		HP3.1 Physician	HP3.2 Other health professionals	HP3.3 Health service organizations	HP3.4 Health service organizations	HP3.5 Health service organizations	HP3.6 Health service organizations	HP3.7 Health service organizations			HP3.8 Health service organizations	HP3.9 Health service organizations							HP3.10 Health service organizations	HP3.11 Health service organizations
	Hospitals	Hospitals	District Hospitals	Private-Not-for-profit hospitals (Other)	Not-for-profit hospital (Migrant)	Profit hospital																				
HC1 Services of curative care	2,957,872,628.762	1,695,265,991.442	249,998,998,891	0	854,282,898,779	4,696,217,981.204	1,369,894,614	324,979,978,963	184,452,811,894	445,745,439,968	37,861,274,931	164,921,398,488	6,129,125,136,316	5,796,822,399	0	238,994,726,488	1,348,474,932,429	0	17,798,488,486,293	11,207,362,736,678	84%					
HC1.1 Inpatient curative care	648,976,488,976	344,121,127,152	472,641,494,698	0	298,938,889,068	287,899,821,046	1,369,894,614	324,979,978,963	184,452,811,894	445,745,439,968	37,861,274,931	164,921,398,488	6,129,125,136,316	5,796,822,399	0	238,994,726,488	1,348,474,932,429	0	17,798,488,486,293	1,928,026,999,428	9%					
HC1.3 Out patient curative care	1,695,265,991.442	811,488,864,126	777,357,504,194	0	854,282,898,779	1,768,318,154,058	0	0	0	0	0	0	0	0	0	0	0	0	0	9,079,363,737,250	95%					
HC2 Services of rehabilitative care																				8	6%					
HC3 Hospital inpatient diagnostic and outpatient																				166,921,398,488	1%					
HC4 Ancillary services to medical care																				194,452,811,894	0%					
HC5 Health related education																				194,452,811,894	0%					
HC6 Prevention and public health services																				6,129,125,136,316	20%					
HC6.1 PMVT																				1,176,704,508,262	0%					
HC6.2 VCT																				787,011,108,888	0%					
HC6.3 Behaviour Change																				1,687,869,218,214	0%					
HC6.4 Youth programmes																				312,697,089,198	0%					
HC6.5 Mass media																				21,120,968,492	0%					
HC6.6 Condom Promotion																				1,626,772,966,464	0%					
HC6.7 Workplace education																				19,744,279,514	0%					
HC6.8 Surveillance																				186,257,059,078	0%					
HC6.9 Sub. AD prevention and administration of pre-exposure public health HIV/AIDS programs sub																				1,296,660,998,022	0%					
HC7 Health administration and health insurance																				5,796,822,399	0%					
HC7.1 General Government Administration of Health Services																				5,796,822,399	0%					
HC8.1 Capital formation																				21,699,915,342	0%					
Total HIV/AIDS Health expenditure	2,697,872,628.762	1,695,265,991.442	249,998,998,891	0	854,282,898,779	4,696,217,981.204	1,369,894,614	324,979,978,963	184,452,811,894	445,745,439,968	37,861,274,931	164,921,398,488	6,129,125,136,316	5,796,822,399	0	238,994,726,488	1,348,474,932,429	0	17,798,488,486,293	22,689,915,642	0%					
HC8 Health related functions																				281,979,194,844	1%					
HC8.1 Health related functions																				281,979,194,844	1%					
HC8.2 Education and Training																				281,979,194,844	1%					
HC8.3 Research and Development																				281,979,194,844	1%					
Non-HIV/AIDS expenditure	2,697,872,628.762	1,695,265,991.442	249,998,998,891	0	854,282,898,779	4,696,217,981.204	1,369,894,614	324,979,978,963	184,452,811,894	445,745,439,968	37,861,274,931	164,921,398,488	6,129,125,136,316	5,796,822,399	0	238,994,726,488	1,348,474,932,429	0	17,798,488,486,293	10,099,387,705,250	91%					
SWA Support from Special Case																				2,697,872,628.762	0%					
SWA Support from Special Case																				2,697,872,628.762	0%					
Total HIV/AIDS expenditure as a % of THAE	2,697,872,628.762	1,695,265,991.442	249,998,998,891	0	854,282,898,779	4,696,217,981.204	1,369,894,614	324,979,978,963	184,452,811,894	445,745,439,968	37,861,274,931	164,921,398,488	6,129,125,136,316	5,796,822,399	0	238,994,726,488	1,348,474,932,429	0	17,798,488,486,293	20,948,361,748,844	0.00%					

Appendix B.5: Distribution of financing sources by Function (FSxHC), 2005

Function	Financing Sources					Total	As a % of THAE
	Ministry of Finance	Local Authorities	Employers	Households	Rest of the World		
HC.1 Services of curative care	1,137,325,059,329	87,234,426,841	412,444,682,717	8,242,903,243,815	1,348,455,608,938	11,228,363,021,640	54%
HC.1.1 Inpatient treatment of OI	1,004,470,390,495	49,018,374,138	144,522,677,583	785,790,986,783	-	1,983,802,428,999	9%
HC.1.3 Outpatient Treatment of OI	132,854,668,834	38,216,052,703	267,922,005,134	7,457,112,257,032	1,348,455,608,938	9,244,560,592,641	44%
HC.1.3.1 ART Treatment					1,057,137,264,221	1,057,137,264,221	5%
HC.4 Ancillary services to medical care	11,639,049,637				92,792,962,220	104,432,011,857	0%
HC.4.1 Clinical Laboratory	11,639,049,637				92,792,962,220	104,432,011,857	0%
HC.5 Medical goods dispensed to outpatients			83,066,202,651	182,845,092,675		265,911,295,326	1%
HC.5.1 Pharmaceuticals and other non durable goods			83,066,202,651	182,845,092,675		265,911,295,326	1%
HC.6 Prevention and public health	285,592,829,454	24,508,673,052	164,213,091,429		5,654,810,542,580	6,129,125,136,516	29%
HC.6.3 Prevention of communicable diseases	285,592,829,454	24,508,673,052	164,213,091,429		5,654,810,542,580	6,129,125,136,516	29%
HC.6.3.1 PMTCT					1,178,704,508,287	1,178,704,508,287	6%
HC.6.3.2 VCT					682,851,098,353	682,851,098,353	3%
HC.6.3.3 Behaviour Change					367,860,218,514	1,367,860,218,514	7%
HC.6.3.4 Youth programmes					12,693,083,380	312,693,083,380	1%
HC.6.3.5 Mass media					27,120,061,419	27,120,061,419	0%
HC.6.3.6 Condom Promotion					1,026,772,961,456	1,026,772,961,456	5%
HC.6.3.7 Workplace programmes					19,744,279,553	19,744,279,553	0%
HC.6.3.8 Surveillance					196,357,993,078	196,357,993,078	1%
HC.6.3.nsk Prevention and public health services nsk					842,706,338,540	842,706,338,540	4%
HC.7 General Health Administration&Insurance	5,706,021,359					5,706,021,359	0%
HC.7.1 General Government Administration of Health	5,706,021,359						0%
HC.R.1 Capital Formation					22,650,913,562	22,650,913,562	0%
Total HIV&AIDS Health Expenditures	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	7,118,710,027,300	17,756,188,400,260.00	85%
HC.R Health care related functions					282,979,354,842	282,979,354,842	1%
HC.R.2 Education and training					280,812,504,901	280,812,504,901	1%
HC.R.3 Research and Development					2,166,849,941	2,166,849,941	0%
National HIV&AIDS Expenditures	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	7,401,689,382,142	18,039,167,755,102	86%
Non health functions					2,905,183,963,745	2,905,183,963,745	14%
OVC Care and Support					2,150,022,759,242	2,150,022,759,242	10%
PLWHA Support					246,392,670,366	246,392,670,366	1%
Home Based Care					508,768,534,137	508,768,534,137	2%
Total HV&AIDS Expenditures (THAE)	1,440,262,959,779	111,743,099,893	659,723,976,797	8,425,748,336,490	10,306,873,345,887	20,944,351,718,847	100%
<i>As a % of THAE</i>	7%	1%	3%	40%	49%	100%	

Appendix B6: Financing sources by UNAIDS AIDS Spending Categories

YEAR 2005

Calendar Year: Yes No

Fiscal Year: _____ (specify beginning/end)

Average Exchar1USD=Z\$100,000

AIDS Spending Categories	Financing Sources									
	TOTAL <small>(Local Currency)</small>	Public Sources				International Sources	Private Sources <small>(optional for UNGASS reporting)</small>			
		Public	Sub-Total	Central / National	Sub- National	International Sub-Total	Private	Sub-Total	Corporations	Consumer / Out-of-pocket
TOTAL (Local Currency)	20,944,351,718,846	1,552,006,059,672	1,440,262,959,779	111,743,099,893	10,306,873,345,887	9,085,472,313,287	659,723,976,797	8,425,748,336,490	100%	
1. Prevention (sub-total)	5,932,767,143,437	310,101,502,506	285,592,829,454	24,508,673,052	5,458,452,549,502	164,213,091,429	164,213,091,429	-	28%	
1.1 Mass media	27,120,061,419	-	-	-	27,120,061,419	-	-	-	0%	
1.2 Community mobilization	367,860,218,514	-	-	-	367,860,218,514	-	-	-	2%	
1.3 Voluntary counselling and testing	682,851,098,353	-	-	-	682,851,098,353	-	-	-	3%	
1.5 Youth in school	12,693,083,380	-	-	-	12,693,083,380	-	-	-	0%	
1.11 Workplace activities	19,744,279,553	-	-	-	19,744,279,553	-	-	-	0%	
1.13 Public and commercial sector condom provision	1,026,772,961,456	-	-	-	1,026,772,961,456	-	-	-	5%	
1.17 Prevention of mother-to-child transmission	1,178,704,508,287	-	-	-	1,178,704,508,287	-	-	-	6%	
1.99 Others / Not-elsewhere classified	2,142,706,338,540	-	-	-	2,142,706,338,540	-	-	-	10%	
2. Care and Treatment (sub-total)	12,107,474,862,960	1,236,198,535,807	1,148,964,108,966	87,234,426,841	1,950,017,105,295	8,921,259,221,858	495,510,885,368	8,425,748,336,490	58%	
2.4 Antiretroviral therapy	1,057,137,264,221	-	-	-	1,057,137,264,221	-	-	-	5%	
2.6 Specific HIV laboratory monitoring	104,432,011,857	11,639,049,637	11,639,049,637	-	92,792,962,220	-	-	-	0%	
2.10 Home-based care	508,768,534,137	-	-	-	508,768,534,137	-	-	-	2%	
2.11 Additional/informal providers	-	-	-	-	-	-	-	37,861,174,551	0%	
2.12 Inpatient care	1,053,488,764,633	1,053,488,764,633	1,004,470,390,495	49,018,374,138	-	-	144,522,677,583	785,790,986,783	5%	
2.13 Opportunistic infection (OI) treatment	462,389,066,254	171,070,721,537	132,854,668,834	38,216,052,703	291,316,344,717	-	350,988,207,785	7,602,096,175,150	2%	
2.99 Others / Not-elsewhere classified	-	-	-	-	-	-	-	-	0%	
3. Orphans and Vulnerable Children * (sub-total)	2,150,022,759,242	-	-	-	2,150,022,759,242	-	-	-	10%	
4. Program Management and Administration Strengthening (sub-total)	224,714,927,999	5,706,021,359	5,706,021,359	-	219,008,906,640	-	-	-	1%	
4.1 Programme management	5,706,021,359	5,706,021,359	5,706,021,359	-	-	-	-	-	0%	
4.5 Sero-surveillance	196,357,993,078	-	-	-	196,357,993,078	-	-	-	1%	
4.10 Upgrading laboratory infrastructure	22,650,913,562	-	-	-	22,650,913,562	-	-	-	0%	
5. Incentives for Human Resources ** (sub-total)	280,812,504,901	-	-	-	280,812,504,901	-	-	-	1%	
5.5 Training	280,812,504,901	-	-	-	280,812,504,901	-	-	-	1%	
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	246,392,670,366	-	-	-	246,392,670,366	-	-	-	1%	
7. Enabling Environment and Community Development (sub-total)	-	-	-	-	-	-	-	-	0%	
8. Research excluding operations research which is included under (sub-total)	2,166,849,941	-	-	-	2,166,849,941	-	-	-	0%	
8.4 Social science research	2,166,849,941	-	-	-	2,166,849,941	-	-	-	0%	
	100%	7%	7%	1%	49%	43%	3%	40%		

* The term vulnerable children in this context refers to children whose parent is too ill to take care of them but do not qualify for social support as orphan.

** The item on Incentives for Human Resources needs to be disaggregated from the costs for service delivery of the other activities, e.g. in the in- and out-patient service provision. Efforts need to be made to avoid double counting.