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VIET NAM NATIONAL AIDS SPENDING ASSESSMENT 2008-2010

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Viet Nam
National AIDS Spending Assessment
2008-2010

Hanoi, 2012

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List of Abbreviations

ADB	Asian Development Bank
AHF	AIDS Healthcare Foundation
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
ASC	AIDS spending categories
AusAID	Australian Agency for International Development
BCC	Behaviour change communication
BP	Beneficiary population
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention (United States Department of Health and Human Services)
CPMU	Central Project Management Unit(s)
CSO	Civil society organization
DFID	Department of International Development, UK
DOH	Provincial Department of Health
FA	Financing agent
FS	Financing source
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAARP	HIV/AIDS Asia Regional Program
HAPSAT	HIV/AIDS Program Sustainability Analysis Tool
HIV	Human immunodeficiency virus
IDU	Injecting drug user
M&E	Monitoring and evaluation
MdM	Médecins du Monde
MOH	Ministry of Health
MOLISA	Ministry of Labour, War Invalids and Social Affairs
MSM	Men who have sex with men
NHA	National Health Accounts
NTP	National Targeted Programme for HIV
OI	Opportunistic infection
OVC	Orphans and other vulnerable children
PAC	Provincial AIDS centre
PEPFAR	President's Emergency Plan for AIDS Relief
PF	Production factor
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PS	Provider of services
STI	Sexually transmitted infection(s)
FSW	Female sex worker(s)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
UNODC	United Nations Organization for Drugs and Crime
UNV	United Nations Volunteers
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VAAC	Viet Nam Administration of HIV/AIDS Control
VCT	Voluntary counselling and testing
WB	The World Bank
WHO	World Health Organization

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Foreword

In 2005, the Joint United Nations Program on HIV and AIDS (UNAIDS) developed the National AIDS Spending Assessment (NASA) based on previously elaborated HIV resource-tracking methods such as the USAID National Health Account HIV subaccount. The objective of this exercise was to make a tool available to national AIDS authorities at the country level to monitor HIV resources –not merely the health components of the response, but also education, social and protection services and other elements – in order to evaluate and quantify the multisectoral nature of national HIV responses.

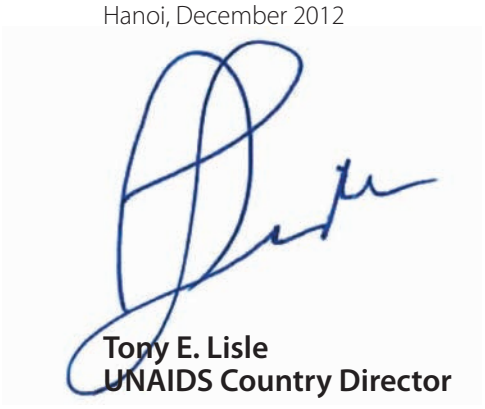
An accurate map of financial sources and the use made of funds is crucial for national AIDS responses, particularly where resources are decreasing and the effective allocation of resources is vital. Improving the efficiency of investments in HIV responses requires the identification of: financial sources and providers of HIV services; financial gaps and functional overlaps; and the total amount of resources devoted to particular HIV intervention areas. It is also important to track resources to ensure that local capacities to use HIV funding can be strengthened.

In 2010, the Viet Nam Administration for HIV/AIDS Control (VAAC) initiated the National AIDS Spending Assessment (NASA) exercise in Viet Nam, and asked the UNAIDS Office in Viet Nam to provide technical assistance in conducting a first NASA for the period 2008-2009. A second NASA was conducted in 2011 covering the year 2010. This initiative is in line with its efforts to: collect data on domestic and international HIV spending for the Viet Nam Country Progress Report; provide inputs to the National Health Account HIV subaccount process; and help inform the development of the next phase of the National HIV Strategy.

This report is a compiled analysis of these two NASA conducted in 2010 and 2011 in Viet Nam with technical support from UNAIDS Viet Nam. The first NASA captured AIDS expenditure by nearly all national and international funding sources in Viet Nam over the two-year period 2008 to 2009, while the second NASA captured this expenditure for 2010.

The report was prepared with the intention of providing to all partners a complete picture of AIDS spending in Viet Nam for the years 2008 to 2010. We hope that the report will serve as an important reference document for HIV-related planning and programming in Viet Nam.

Hanoi, December 2012



Tony E. Lisle
UNAIDS Country Director

Overview of Viet Nam AIDS expenditure 2008-2010

TOTAL EXPENDITURE:	**US$ 362,836,055**
AIDS expenditure by Funding Source (FS):	
Public:	US$ 52,067,028
International:	US$ 263,117,807
Private:	US$ 47,651,220
AIDS expenditure by Financing Agent (FA):	
Public:	US$ 175,481,779
International:	US$ 138,869,848
Private:	US$ 48,484,878
AIDS expenditure by Service Provider (PS):	
Public-sector providers:	US$ 222,298,115
Private-sector providers:	US$ 94,846,315
Bilateral and multilateral entities – in-country offices:	US$ 45,102,771
Providers not elsewhere classified:	US$ 589,304
AIDS expenditure by Programmatic Area:	
Prevention (approximately 32.4% of total expenditure)	
Total expenditure:	US$ 117,676,513
Main expenditure categories:	
• Communication for social and behaviour change	US$ 20,279,945
• Harm-reduction programmes for injecting drug users	US$ 18,725,591
• Blood safety	US$ 11,405,682
• Prevention programmes for sex workers and their clients	US$ 9,645,859
• Prevention of mother-to-child transmission	US$ 7,056,143
• Voluntary counselling and testing	US$ 8,469,683
• Risk-reduction for vulnerable and "accessible" populations	US$ 2,413,835
• Community mobilization	US$ 4,455,519
• Programmes for men who have sex with men	US$ 2,899,957
• Prevention activities not broken down by intervention	US$ 24,823,131
Care and treatment (approximately 27.5% of total expenditure)	
Total expenditure:	US$ 99,815,326
Main expenditure categories:	
• Outpatient care	US$ 73,760,833
• Inpatient care	US$ 9,520,329
• Non-disaggregated	US$ 16,633,198
OVC (1.1% of total expenditure)	
• Total expenditure:	US$ 4,098,717
Programme management and administration (approximately 28.8% of total expenditure)	
Total expenditure:	US$ 104,498,733
Main expenditure categories:	
• Planning, coordination and programme management	US$ 67,946,841
• Upgrading facilities and construction	US$ 12,665,845
• M&E	US$ 10,001,677
• Serological surveillance	US$ 2,229,903
Human resources (6.7% of total expenditure)	
Total expenditure:	US$ 24,295,371

Social protection and social services (less than 0.2% of total expenditure)	
Total expenditure:	US$ 857,256
Enabling environment (approximately 2.4% of total expenditure)	
Total expenditure:	US$ 8,539,453
HIV-related research (approximately 0.8% of total expenditure)	
Total expenditure:	US$ 3,055,136
AIDS expenditure by Beneficiary Population (BP):	
PLHIV:	US$ 108,918,227
Most-at-risk populations (MARP)[1]:	US$ 54,613,416
General population:	US$ 35,674,633
Specific "accessible" populations:	US$ 10,839,811
Other key populations:	US$ 18,624,419
Non-targeted interventions:	US$134,166,000
AIDS expenditure per capita:	
Annual per capita AIDS expenditure:	US$ 1.3
Annual AIDS expenditure per person living with HIV:	US$ 469

[1]. In the NASA terminology, "most at-risk population (MARP)" was used. It should be noted that the more recent terminology "key populations at higher risk" is now more often used to avoid the stigmatization of such populations.

Executive summary

This report is a compiled analysis of two National AIDS Spending Assessments (NASA) conducted in 2010 and 2011 in Viet Nam by a team of consultants hired by UNAIDS Vietnam, with the support from Viet Nam Administration of HIV/AIDS Control. The first NASA captured AIDS expenditure by nearly all national and international funding sources in Viet Nam over the two-year period 2008 to 2009, while the second NASA captured this expenditure for 2010. The two NASA track the resources of health services as well as social-mitigation, education, labour, justice and other sectors to embody the **multisectoral response** in Viet Nam. Through its findings, the NASA aim to inform and support the development of Viet Nam's new National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030.

Each assessment used the NASA methodology to systematically capture the flow of HIV-related financial resources from their origin to their ultimate beneficiary across various sources and service providers, and as delivered through a range of transactional mechanisms.

The NASA defines a transaction as consisting of the flow of financial resources from their origin with a financing source until their final administrative or programmatic expenditure in support of a beneficiary population, and it reconstructs each transaction along this continuum to ensure accounting accuracy and avoid double counting. The assessment produces double-entry tables to illustrate clearly the origin and destination of resources.

The NASA uses both top-down and bottom-up resource-tracking techniques to obtain and consolidate this information. The top-down approach tracks sources of HIV funding from donor reports, commitment reports and government budgets; conversely, bottom-up tracking captures HIV expenditure from service providers' expenditure records, facility-level records and governmental department expenditure accounts.

As part of each assessment, interviews were conducted with key national and international financing agents and implementing agencies based in Ha Noi and Ho Chi Minh City. In addition, expenditure data from provincial government budgets were obtained from 53 provincial AIDS centres (PAC) for 2008-2009 and 40 PAC for 2010. In total, 95 organizations contributed data and information to the 2008-2009 NASA and 71 provided data for the 2010 NASA.

Secondary financial data were used only where primary data were unavailable. The principal sources of secondary data used in the NASA include the results of the UNGASS survey of AIDS expenditure conducted by VAAC and UNAIDS, which tracks results through the end of 2009; expenditure on human resources in both the health and non-health sectors; and estimates of some public and household expenditure for which data were unavailable.

The key findings of the Viet Nam National AIDS Spending Assessments are as follows:

1. The volume of financial resources channelled to the national HIV response is substantial. In 2008-10, more than US$ 362 million were spent on HIV-related activities. During this period, the per capita annual AIDS expenditure was US$1.3 and US$ 469 were spent on each person living with HIV in Viet Nam. Between 2008 and 2010, total actual AIDS expenditure increased by 31%.
2. Viet Nam's HIV response is funded by public, private and international sources. Public sources, including central and provincial budgets, provided for 14% of national AIDS expenditure. A total of 90.7% of public funds for AIDS were transferred to the health sector.
3. International partners are the cornerstone of Viet Nam's HIV response, not only in providing financial resources but also as programme decision-makers and service providers. International partners provided around US$ 263 million (73% of national expenditure) for HIV-related activities in 2008-2010, and directly administered US$ 136 million (37% of national expenditure) during this period.
4. In 2008-2010, 79% of HIV-prevention expenditure and 56% of HIV care and treatment expenditure were covered by external funds.
5. The majority of expenditure from private sources between 2008 and 2010 consisted of out-of-pocket payments by PLHIV and their families. The contribution of the private sector and for-profit organizations to overall AIDS expenditure captured during this period was insignificant.
6. As the largest national AIDS financing agent, the Viet Nam Ministry of Health (MOH) plays a prominent role in determine how AIDS programmes are funded in the country. The MOH oversaw and managed US$ 128 million of AIDS funds (35% of national AIDS expenditure) between 2008 and 2010.

7. International non-profit organizations[1] are also crucial players in Viet Nam's HIV response. Between 2008 and 2010, they were responsible for allocating and administering 21.7% of total national AIDS expenditure.
8. During the assessment timeframe, public sector providers spent the majority (62%) of expenditure on HIV-related services; international and national non-profit organizations spent 26%; and external bilateral and multilateral agencies spent 12%.
9. The majority of AIDS expenditure in 2008-2010 was concentrated in three core areas: prevention (32.4% of total expenditure); care and treatment (27.5%); and programme management (28.8%). Human resource expenditure accounted for 6.7%. The remaining 4.6% was spent on the enabling environment (2.4%); OVC (1.1%); research (0.9%); and social protection and services (0.2%).
10. Between 2008 and 2010, PLHIV benefited from 30% of AIDS expenditure; 15% was directed towards most-at-risk populations (MARPs); 10% towards the general population; and 37% was expended on non-targeted interventions.
11. The majority (81%) of AIDS expenditure between 2008 and 2010 was current expenditure. Capital expenditure accounted for a minimal share of total expenditure.
12. The proportion of AIDS expenditure not disaggregated by type of expenditure remains relatively large, primarily due to insufficient detail available in the collected data. The limited capacity of current AIDS accounting systems impedes a production factor analysis.
13. Gender-disaggregated data on the beneficiaries was often not available.

Recommendations for future action

1. National AIDS spending assessments should be embedded as a routine exercise in Viet Nam to support strategic planning and analysis and to help guide the implementation of the national HIV response.
2. Spending assessments should also be conducted at the provincial level to allow for a more in-depth analysis of AIDS expenditure at the sub-national level and support strategic policy and programme planning.
3. Key experiences and lessons learned from the inaugural 2008-2010 Viet Nam NASA should be documented, analysed and incorporated, as appropriate, into future national AIDS spending assessments.
4. The NASA findings should be broadly disseminated among key national and international stakeholders to ensure their use.
5. Wherever possible, the NASA findings can be used as a good secondary source for costing and the estimation of unit costs in current intervention packages.
6. Cooperation with key international donors, including PEPFAR, to "crosswalk" their AIDS expenditure categories with those of NASA should be continued and strengthened to enhance the accuracy and utility of assessment results.

[2]. The NASA classifies both private for-profit and non-profit organizations as "nongovernmental organizations". For the purposes of this report, NASA terminology will be followed, and a distinction will be made between non-profit organizations (which are often called NGOs outside the NASA process) and for-profit organizations.

I. Introduction

1.1 The HIV epidemic in Viet Nam

The HIV epidemic in Viet Nam remains in a concentrated stage. There is evidence that it may have begun to stabilize over the last two years, with a decrease in HIV prevalence among most-at-risk populations, injecting drug users (IDUs)[3] and female sex workers (FSW) in some provinces, while prevalence trends remain stable or have increased in other provinces. According to 2011 sentinel surveillance, HIV prevalence among IDUs and FSW remains high, at 13.4% and 3% respectively; IBBS data indicate that prevalence among men who have sex with men (MSM) also remains high, at 16.7%. The distribution of HIV cases largely follows the distribution of these three populations, which are heavily concentrated in urban centres (though they are not absent in non-urban communities). Overall adult HIV prevalence (ages 15-49) remained at 0.45% in 2011[4]. It is estimated there will be up to 263,317 PLHIV by 2015[5].

As of 31 December 2011, HIV cases had been reported in all 63 provinces, 98% of districts and 77% of communes. The cumulative total since records began was 249,660 reported HIV cases, with 197,335 PLHIV still living and 52,325 AIDS-related deaths. The number of HIV cases reported to the Ministry of Health decreased rapidly between 2007 and 2009 and held steady at about 14,000 reports per year in 2010 and 2011. AIDS case reports and related mortality have also remained fairly steady since 2009. These case report numbers are consistent with declining HIV prevalence among most-at-risk populations.

People aged 20-39 years account for more than 80% of all reported cases[6]. A rise in reported cases of HIV-positive women, who now represent 31% of newly reported cases, reflects a probably slow but steady transmission of HIV to women by men engaging in highly risky behaviours[7].

1.2 The national response to HIV in Viet Nam

Viet Nam's recent achievements in the response include: (1) increased political commitment and leadership, which have resulted in positive developments in the response; (2) an increased focus on prevention, leading to progress towards increasing access to HIV services, notably harm-reduction services, and especially methadone maintenance therapy (MMT) for injecting drug users (IDUs); (3) the rapid expansion of antiretroviral therapy (ART) provision; and (4) greater participation of civil society in the national response, with strong community engagement[8].

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3. The NASA uses the term "injecting drug user" or IDU. It should be noted that the more recent terminology "people who inject drugs" or PWID, is now more often used in order to avoid stigmatization.
4. Preliminary Viet Nam HIV/AIDS Estimates and Projections 2011. Ministry of Health, National Technical Working Group on HIV Estimates and Projections, 2011.
5. Preliminary Viet Nam HIV/AIDS Estimates and Projections, 2011. Ministry of Health, National Technical Working Group on HIV Estimates and Projections, 2011.
6. HIV/AIDS Case Report and Implementation of HIV/AIDS Prevention and Control Programme in 2011. Planning for 2012. Ministry of Health, February 2012.
7. HIV/AIDS Case Report and Implementation of HIV/AIDS Prevention and Control Programme in 2011. Planning for 2012. Ministry of Health, February 2012.
8. For more detail, please see the Viet Nam AIDS Response Progress Report 2010-2011. National Committee for AIDS, Drugs and Prostitution Prevention and Control, 2012.

1.2.1 The institutional framework of the national HIV response

The HIV response in Viet Nam is coordinated by the National Committee for HIV, Drugs and Prostitution Prevention and Control. The Chairmanship of the Committee is held by a Deputy Prime Minister and leaders from each sector serve as Committee members. The Ministry of Health (MOH) is the National Committee focal point; the Viet Nam Administration of HIV/AIDS Control (VAAC), under the MOH, reports to the National Committee on national HIV issues and progress on behalf of the MOH. Other departments within the MOH, research institutions and central hospitals under direct MOH management lead in their respective areas of technical expertise. Viet Nam also has a unique project-management system, with five international donor-funded projects operating under direct MOH management through Central Project Management Units (CPMU). These projects are funded by the ADB, the Global Fund, the World Bank (from 2010, both the World Bank and DFID), CDC (LIFE-GAP) and the Australian HIV/AIDS Asia Regional Program (HAARP; also from 2010).

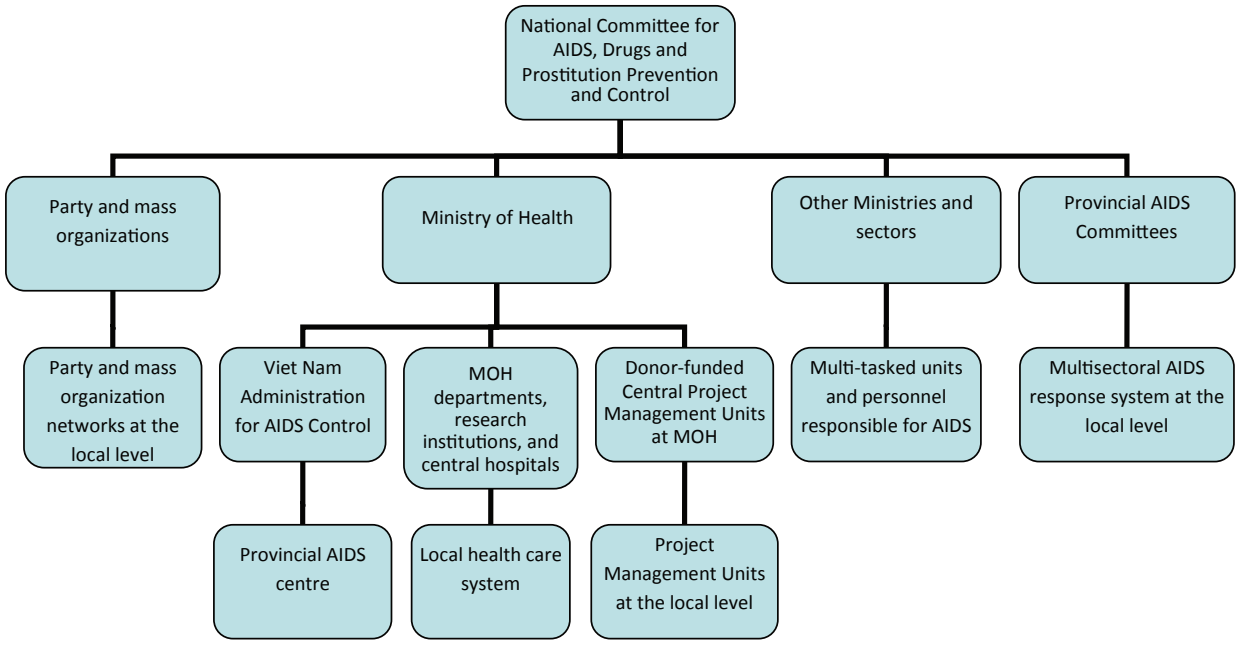
Other Ministries and sectors are involved in HIV prevention and control through multi-tasked units and personnel responsible for HIV, and typically have their own HIV-related policies and programmes in their specific areas of specific responsibility.

Provincial Committees for AIDS, Drugs and Prostitution Prevention and Control coordinate the multisectoral HIV response in each province. The Department of Health and the health facilities network play key roles in this system. The provincial AIDS centre (PAC), reporting to the Department of Health, is the specialised AIDS unit.

A myriad of service providers and institutions are engaged in the HIV response in Viet Nam, and their activities range from HIV prevention, care and treatment provision, to advocacy and involvement in policy-making, monitoring and evaluation and strategic information.

In addition, the HIV coordination system varies in some provinces. While the majority of provinces have established a PAC as the primary specialized health facility, in others, such as Ho Chi Minh City, the Provincial AIDS Committee directly coordinates and manages the multisectoral AIDS response.

Figure 1: Viet Nam's AIDS response system



Donor-funded projects and non-profit organizations also play important roles in Viet Nam's national HIV response. There are on-going efforts to coordinate these activities, as well as to harmonize the cost norms of donor-funded projects, non-profit organizations and public-sector actors. However, considerable work remains in this area.

1.2.2 National HIV policy

The 2006 Law on HIV Prevention and Control serves as the principal legislative document affirming the fundamental legal rights of PLHIV. According to the Law, along with other civil rights, PLHIV have the right to live in their community; to receive treatment and care; to receive education and training and have access to work; to keep their HIV status confidential (within certain limits); and to refuse diagnostic and treatment measures.

In recent years, the Government and National Assembly have also enacted, supplemented or amended numerous policies and legal documents, creating a stronger and more consistent legal framework for prevention and control activities. An Amendment of the Criminal Code in 2009 reclassified drug users as patients rather than criminals, thereby lowering the barriers they face in accessing HIV prevention, treatment, care and support services. Moreover, the Law on Health Insurance passed in 2008 recognized HIV as a health issue covered by health insurance. In 2010, harm-reduction approaches were bolstered by new legislation drafted to support the expansion of methadone maintenance therapy and the approval of a ***Programme of Action on Sex Work 2010-2015*** and a condom programme targeting tourism establishments. A variety of Decisions have also improved testing as well as treatment and care services. Programmes have been developed to raise PLHIV's awareness about their rights, with the establishment of legal aid clinics, a hotline, a training manual on HIV and the Law and efforts to make legal support services available.

In addition, the government demonstrated a clear prioritization of sustained support for orphans and vulnerable children. In 2009, the ***National Programme of Action on Children affected by HIV until 2010 with a vision to 2020***, which laid out specific objectives and directions for the national HIV response as it relates to children, was approved. A ***National Plan of Action for Children affected by HIV and AIDS, 2011-15*** was also drafted, while new or revised welfare programmes for children now include support for children affected by HIV.

During the NASA reporting period, the National Strategy on HIV prevention and control in Viet Nam to 2010 with a vision to 2020, which was approved in March 2004, served as the framework to guide all 18 Government Ministries and their Departments, 63 provincial authorities, civil society and international partners in their HIV-related activities. The strategy mandated that specific line ministries and their departments must be engaged in the HIV response, and emphasized the importance of a multisectoral and coordinated response to address the HIV epidemic, with specific attention paid to populations at higher risk of HIV infection.

The National Strategy had two goals and three main objectives:
(1) To reduce HIV prevalence among the general population to below 0.3% by 2010 with no further increase after 2010; and
(2) To reduce the adverse impacts of HIV on socio-economic development.

The main objectives under these goals were: (a) To control HIV transmission among most-at-risk populations and the general population by implementing comprehensive harm-reduction intervention measures; (b) to ensure the provision of care and appropriate treatment for PLHIV; and (c) to improve the management, monitoring, surveillance and evaluation systems of the HIV prevention and control programme.

Nine action programmes underpinned the implementation of the National Strategy:

1. Information, education and behaviour change communication on HIV;
2. HIV harm-reduction interventions and prevention of transmission;
3. Care and support for people living with HIV;
4. HIV surveillance and monitoring and evaluation;
5. Access to HIV treatment;
6. Prevention of mother-to-child transmission;
7. Management and treatment of sexually transmitted infections;
8. Blood transfusion safety; and
9. Enhancing capacity development and international cooperation.

National monitoring reports demonstrate that significant progress has been made towards the fulfilment of the Strategy's main objectives. Particularly notable achievements during the 2008-2010 period include:
(1) Increased political commitment and leadership, which have resulted in positive changes in the response;
(2) Improved collaboration between ministries, which has ensured a stronger multisectoral response and subsequent improvements in service delivery, most notably a rapid increase in the number of people who have access to HIV prevention, treatment, care and support services;
(3) An increased focus on prevention, leading to progress towards increasing access to HIV services, notably harm-reduction services, and especially the needle and syringe programme and methadone maintenance therapy for people who inject drugs;
(4) The rapid expansion of antiretroviral therapy provision; and
(5) The greater and more meaningful participation of civil society in the national response, with strong community engagement.

1.3 Objectives of national AIDS expenditure assessments (NASA)

The NASA will help to strengthen the national HIV response in Viet Nam by generating valuable information on the overall flow of national and international financial resources, their specific administrative and programmatic uses and the benefits they bring, particularly to most-at-risk populations. The data compiled through the NASA will also contribute to Viet Nam's having the best available financial data on which to make strategic policy and programmatic decisions related to its HIV epidemic.

Information from the NASA has been used to provide information for national reporting on AIDS spending, including Viet Nam's 2012 AIDS Response Progress Report (which used spending data covering the period 2009-2010). In this report, NASA data was used to report against an indicator measuring domestic and international AIDS spending by category and financial source. The NASA employs a systematic expenditure-tracking methodology that enables AIDS expenditure to be captured at various points along the transactional spectrum and to be measured with greater specificity.

The overall goals of the NASA are to:

1. Systematically monitor HIV financing flows at the national and regional/provincial levels;
2. Develop a strategy involving multisectoral and multi-level key partners to track AIDS expenditure in Viet Nam; and
3. Build national capacity for the systematic monitoring of HIV financing flows using NASA methodology.

Specific objectives are to:

- Develop a data-collection plan for the national level as well as for all regions and departments, including the identification of key stakeholders/entities among financing sources, financing agents and users/providers in the public and private sectors;
- Collect, validate and analyse financial data gathered at the national and regional/provincial levels; and
- Present and disseminate findings, including through the development of a complete set of NASA matrices.[9]

[9]. NASA Viet Nam Terms of Reference, 2010.

II.Methodology

2.1 The NASA approach

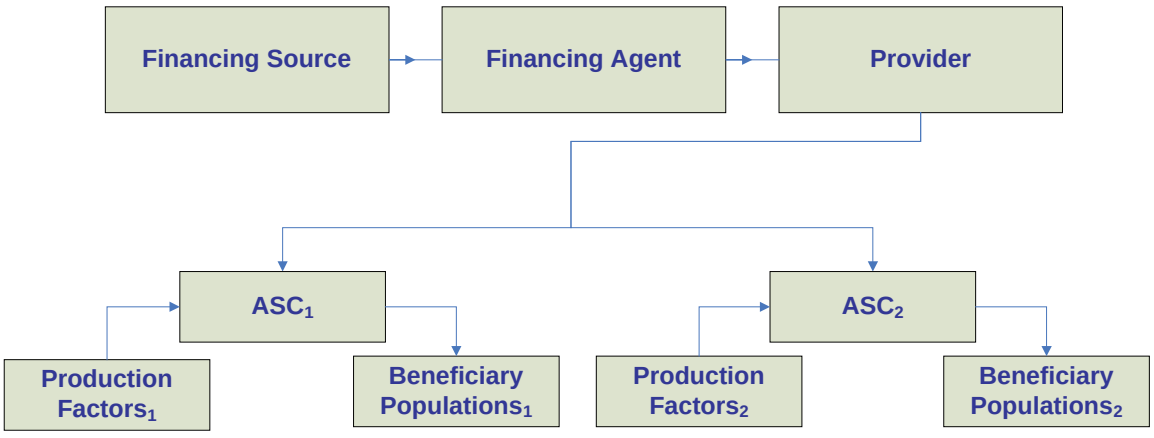
The National AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to support the national HIV response. The tool tracks actual expenditure (public, private and international) in both the health and non-health sectors (social mitigation, education, labour and justice) which comprise the national response to HIV[10].

The primary purpose of tracking HIV expenditure is to inform the most appropriate allocation of HIV-related financial resources and programmatic activities across the country. The NASA provides information that can contribute to a better understanding of a country's financial absorptive capacity, as well as of the equity, efficiency and effectiveness of the current HIV resource-allocation process.

In addition to establishing a continuous information system for HIV-related financing, the NASA facilitates a standardized reporting of indicators, monitoring progress towards achieving agreed targets under the *Declaration of Commitment* adopted by the 2001 United Nations General Assembly Special Session on HIV/AIDS (UNGASS)[11].

The NASA systematically captures the flow of financial resources from their origin to their ultimate beneficiary via various sources and service providers, and as delivered through a range of transactional mechanisms. The NASA defines a transaction as comprising the flow of financial resources from their initial transfer to an HIV service provider to their final administrative or programmatic expenditure in support of a beneficiary population (see Figure 2). The NASA uses both top-down and bottom-up resource-tracking techniques to obtain and consolidate expenditure information. The top-down approach tracks sources of HIV funding from donor reports, commitment reports and Government budgets; bottom-up tracking captures HIV expenditure from service providers' expenditure records, facility-level records and governmental department expenditure accounts.

Figure 2: Financial flow scheme



Where data are missing, internationally accepted costing techniques and standards are used to estimate past actual expenditure. Ingredient and step-down costing are used for direct and shared expenditure for HIV, while shared costs are allocated to the most appropriate utilization factor.

[10]. National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV financing flows and expenditure at country level. UNAIDS, 2006: draft; work in progress.
[11]. Declaration of Commitment. United National General Assembly Special Session on AIDS (UNGASS), 2001.

As part of its methodology, the NASA employs double-entry tables or matrices to illustrate clearly the origin and destination of financial resources. This helps to avoid the double-counting of HIV expenditure, as every transaction is reconstructed all the way from its original funding source to the recipient service provider or beneficiary population. This more rigorous method is superior to a simple addition of all expenditure by each partner that commits resources to HIV-related activities.

In order to be accurate and effective, the NASA requires that the study team have sufficient background information, a well-defined set of financial actors as information sources, a clear understanding of users' and informants' interests, and the support of an inter-institutional group to facilitate their access to information, participate in data analysis and contribute to data dissemination.

The NASA classification follows internationally accepted standard accounting methods and procedures, including the framework of the National Health Accounts (NHA) system. Tracked financial flows and AIDS expenditure are organized across three dimensions: financing; the provision of HIV services; and the use of HIV services. These classifications and categories comprise the framework of the NASA system (UNAIDS, 2009). The dimensions incorporate six categories[12]:

Financing

1. Financing agents (FA) (also known as purchaser agents) are entities that pool financial resources to finance service provision and make programmatic decisions regarding the type of activities and the specific service provider involved in actual service delivery.
2. Financing sources (FS) are entities that allocate funding to HIV in general and provide money to financing agents.

Provision of HIV services

3. Providers of services (PS) are entities that engage in the production, provision and delivery of HIV services.
4. Production factors/resource costs (PF) are inputs (labour, capital, natural resources, "know-how" and entrepreneurial resources).

Use

5. AIDS spending categories (ASC) are HIV-related interventions and activities.
6. Beneficiary populations (BP) are groups targeted with services, such as people living with HIV (PLHIV) or injecting drug users (IDUs).

2.2 The preparatory phase

Extensive preparations for the first NASA were undertaken well before its roll-out. To initiate the preparatory process, UNAIDS Viet Nam organised a one-week training course on the NASA methodology and its implementation approach for VAAC, UNAIDS personnel and the national consultants who would be involved in conducting the assessment.

Additional work carried out in advance of the assessment included the preparation of a concept note and a detailed road map to guide the NASA process. This was followed by a series of mapping exercises to identify the key stakeholders in the national HIV response, and particularly those that expend substantial HIV funds in Viet Nam. Wherever possible, the team sought to establish the principal resources flows from each financing source to its respective financing agents and service providers. The stakeholder mapping exercise resulted in a series of maps of actors, which helped to determine for which financial actors the NASA team would track AIDS expenditure.

[12]. For more detail please refer to the National AIDS Spending Assessment (NASA) Classification and Definition. UNAIDS, 2009.

The NASA data-collection form (see Appendix 2) was prepared based on the NASA Manual guidelines and incorporated technical input from NASA advisers and UNAIDS. The NASA team worked closely with the NHA team to ensure that the NASA results would be consistent with, and could readily be used for, the HIV subaccount of the NHA and the HIV/AIDS Program Sustainability Analysis Tool (HAPSAT).

Given the similarities in data needs and output between the NASA and the NHA, and the fact that these assessments (both being conducted for the first time) each provide HIV-related resource tracking in support of Viet Nam's development of the new National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030, UNAIDS Viet Nam and USAID (through the Health Systems 20/20 project) coordinated NASA and NHA data collection to avoid duplication of effort and reduce the burden placed on respondents (see Appendix 4 for a more detailed description of the collaboration between the NASA and the NHA.)

A NASA orientation workshop was jointly organized by VAAC and UNAIDS Viet Nam on 6 August 2010 for all key national and international partners in the HIV response, including Government officials, civil society organizations, UN representatives and bilateral agencies. Following the workshop, VAAC formally sent information and a request letter to all relevant ministries, institutions, donor agencies, international non-profit organizations and other stakeholders asking them to support the NASA process and provide data.

Under the leadership of VAAC, and with technical support from UNAIDS, a NASA task force was formed, comprising VAAC and UNAIDS staff to lead the assessment, two international consultants and five national consultants. The PEPFAR country office provided a staff member to support the task force in collecting data from PEPFAR implementing partners.

A clear division of labour was then established among the NASA team members, and a senior team member was assigned to lead each group responsible for the core components of data collection and processing.

The second NASA, conducted in late 2011, built upon the experiences of and lessons learnt from the first NASA, which was finalized in mid-2011. The main purpose of the second assessment was to provide data for Viet Nam's 2012 AIDS Response Progress Report, submitted in March 2012. The preparation phase was therefore shortened: a brief NASA orientation workshop with all the relevant partners that participated in the first NASA was jointly organized by VAAC and UNAIDS Viet Nam on 12 December 2011. The NASA team consisted of three staff from VAAC and UNAIDS and a national consultant who had participated in the first NASA. The NASA data-collection form (see Appendix 2) was prepared based on the NASA Manual guidelines and lessons learned from the previous NASA round[13]. It should be noted that data were only collected for five of the six vectors during this assessment (data on production factors were not collected). Data on AIDS spending categories (ASC) were collected and broken down to a two-digit level of detail for all seven major categories, while data on care and treatment were broken down to a three-digit level of detail.

2.3 Data collection

The first NASA collected AIDS expenditure data for 2008 and 2009. PEPFAR fiscal years 2008 (Oct 2007 – Sept 2008) and 2009 (Oct 2008 – Sept 2009) were used for the analysis of PEPFAR funds. For the remainder of the funds, calendar years were used to process the data. The second NASA collected AIDS expenditure data for 2010 and the PEPFAR fiscal year (Oct 2009 – Sept 2010) was applied to the relevant funds.

To ensure the most comprehensive possible scope, the NASA sought to collect AIDS expenditure data from all organizations involved in supporting the HIV response in Viet Nam, including the public sector, bilateral donors,

[13]. For more detail please see the "Guide to produce National AIDS Spending Assessment". UNAIDS, 2009.

multilateral institutions, international non-profit organizations and the private sector (see Table 1 for a breakdown of the organizations that contributed data to the NASA).

For each financing agent, interviews were conducted with their representatives in Ha Noi and Ho Chi Minh City. In addition, data on HIV expenditure from provincial budgets were collected from 53 and 40 provincial AIDS centres for 2008-2009 and 2010 respectively. AIDS expenditure by other public health institutions (e.g. national, regional, provincial and district hospitals; commune health centres; the pharmaceutical system) as well AIDS expenditure by the national health insurance system were not collected in the NASA.

Table 1: Type and number of organizations providing AIDS expenditure data

Type of respondent organization	NASA 2008-2009	NASA 2010
Public organization	70	44
Bilateral organization	7	9
Multilateral organization	9	7
International non-profit organization	7	10
International for-profit organization	2	1
Total	**95**	**71**

The data-collection process often required several visits to each relevant organization, including follow-up visits to clarify areas of confusion relating to the classification and recording of AIDS expenditure by category, or when inconsistencies were found in the data received. To the greatest extent possible, individual materials were collected from each funding source to improve understanding of the different types of intervention, implementation modalities and beneficiaries, project documents, annual reports, progress reports, annual work plans and budgets associated with the various funding entities. Information obtained through narrative reports, articles and websites also contributed to this process, as well as to that of assigning appropriate FS, FA and PS codes. The NASA data-collection process lasted approximately three months.

2.3.1 Data validation

The validation of the processed data was a critical step in the NASA exercise. Data validation was conducted throughout the assessment, with direct communication between the NASA team and each organization followed by validation meetings—first with the PEPFAR implementing partners, and later with all major HIV stakeholders in Viet Nam.

During the first NASA, two validation workshops were organized with PEPFAR. The initial validation workshop was held on 24 September 2010 and focused on the validation of NASA assumptions made regarding PEPFAR expenditure and the assignment of FA, PS, ASC and BP categories. The second workshop took place on 26 April 2011, and focused on validating the sub-analysis conducted of PEPFAR AIDS expenditure with PEPFAR implementing partners.

Following these validation efforts, the preliminary NASA results were presented to VAAC and key national and international partners during a workshop on the sustainability of the HIV response which was held in Ho Chi Minh City on 12 May 2011.
During the second NASA, the validation of spending figures was combined in a national validation workshop organized on 14 March prior to the submission of the Viet Nam 2012 AIDS Response Progress Report on 31 March.

2.3.2 Secondary data sources

As mentioned above, secondary data were only used where primary data were unavailable. The NASA used two types of secondary sources:

- The UNGASS survey of AIDS expenditure 2008-09 (reporting on UNGASS Indicator 1), which was conducted by VAAC in collaboration with UNAIDS and captured expenditure through the end of 2009. This source was used to fill in gaps in the data from several bilateral sources (e.g. Australia, Denmark, Ireland and the Netherlands) and with regard to public (provincial) budget expenditure; and
- Estimated out-of-pocket expenditure by PLHIV and their families provided by the USAID-supported Health Policy Initiative (HPI), which conducted a survey of such expenditure in 2010.

2.3.3 Estimations

- In addition to these secondary data sources, there are several estimates were made and used in this NASA based on the availability of raw data which can help to estimate the following expenditure
- Human resources: VAAC routine reporting data were used to estimate expenditure on human resources in both the health and non-health sectors – the latter including staff of Provincial AIDS Committees and those working on HIV within Departments of Labour, War Invalids and Social Affairs; Education and Training; Public Security; and Information and Communication. Human resources include full-time and part-time staff at the provincial, district and commune levels.
- Expenditure in the labour sector on AIDS-related services, including: support for children and adults living with HIV in public orphanages and social welfare centres; the payment of incentives to staff who care for AIDS patients; and the payment of basic health care support for detainees in rehabilitation centres. Information on this expenditure was based on monitoring data provided by the Ministry of Labour, War Invalids and Social Affairs collected during the first round of the NASA.
- Household expenditure on provider-initiated testing and counselling in different settings[14].
- Overhead expenditure by PACs: the average of the overheads expenditure reported by some PACs was used to estimate expenditure by the PACs that did not report against this requirement.

2.4 Data processing and analysis

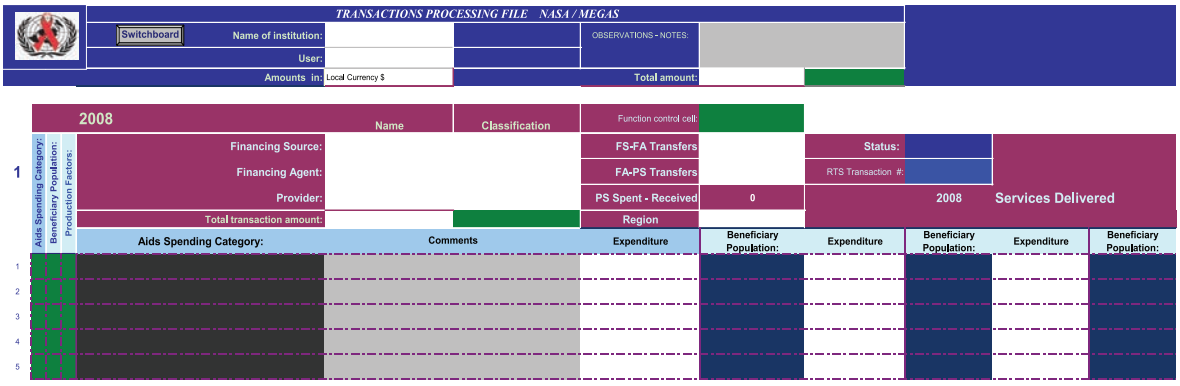
The data processing process consisted of five stages:

Stage 1: Upon receipt, all data were immediately checked for consistency, clarity and detail. If any data inconsistency was discovered, the submitting organization was contacted for clarification.

Stage 2: Once the data were deemed complete and consistent, NASA financial transactions were reconstructed using a pre-designed Excel spread sheet. This necessitated assigning a particular NASA classification to each expenditure item. This stage also entailed cleaning the data, as well as triangulating the three dimensions (source, provision and use) and six vectors (source, agent, service provider, AIDS spending category, production factor and beneficiary population) to ensure consistency.

[14]. HIV tests are performed as part of mandatory blood screening tests when people are administered to hospital for treatment.

Figure 3: Example of a NASA financial transaction spread sheet



Stage 3: Once the transactions were reconstructed and all the data triangulated, the data were entered into resource tracking software (RTS) specifically designed for NASA data analysis. Each transaction was entered separately with its identified financing source, financing agent, provider(s) of services, AIDS spending category, production factor and beneficiary population. The software performed various checks and automatically indicated if any data problems were present.

Stage 4: Given the large volume of data involved, the NASA team used Stata software to check and correct all data classifications and analysis. The use of Stata not only allowed the team to check for the overall consistency of the dataset, but also to identify errors for later correction in the RTS.

Stage 5: As the data checks and corrections in the RTS were not yet completed, Stata was used to generate the NASA tables and analysis.

General rules guiding data processing and analysis

When conducting the data processing and analysis, the NASA team followed a set of general rules to aid in the classification of HIV-related activities being undertaken by various organizations within specific AIDS expenditure and beneficiary population categories, and more specifically where data limitations or inconsistencies arose. These general rules included:

1. Most training activities were coded under ASC.05.03 (with assigned BP.06 ***Non-targeted interventions***), unless it was clear from the activity description that it was in-service training. In this case, it was classified as part of the relevant activity. Exceptions to this rule were made for training activities for a) peer educators (coded under ASC.01.02 ***Community mobilization*** for interventions targeting either PLHIV or most-at-risk populations), b) family members of PLHIV receiving home-based care (coded under ASC.02.01.09.02 ***Home-based non medical non-health care***) and c) teachers (coded under ASC.01.05 ***Prevention - youth in school***).
2. Activities related to policy development, legislative revision, strategic information and coordination, as well as conferences and experience sharing, were coded under ASC.04.01 ***Planning, coordination, and programme management***.
3. Due to an insufficient level of detail in the data collected, in many cases it was not possible to disaggregate activities such as BCC, VCT, STI and other services into separate ASCs according to the specific beneficiary population. In these cases, the codes ASC.01.01.98 ***Communication for social and behaviour change not broken down by type***, ASC.01.03 ***Voluntary counselling and testing*** and ASC.01.16 ***Prevention, diagnosis and treatment of sexually transmitted infections (STI)*** – typically used for service delivery to the general population – were assigned to the relevant activities. In these instances, the beneficiary population was coded as BP.02.98 "***Most-at-risk populations" not broken down by type***, BP.03.98 ***Other key populations not broken down by type*** or BP.04.98 ***Specific "accessible" populations not broken down by type***, depending on the type of activity.
4. In instances where coding problems arose, either due to miscoding in the self-administered data-collection forms or as a result of technical errors made during data input, the NASA team sought clarification from the organization from which the data originated.
5. In some cases, activities were not sufficiently defined or disaggregated to allow for the assignment of a specific ASC, which necessitated classifying them in a more general manner (e.g. ASC.01.99 ***Prevention activities not elsewhere***

classified). This approach sought to preserve the exhaustiveness of the overall expenditure tracking, but meant that a significant quantity of resources were difficult to analyse. In the absence of more detailed information, various informed assumptions were also used to disaggregate such activities into multiple categories and thereby assign them NASA codes.

6. Where expenditure totals appearing in the data-collection forms did not match detailed disaggregated data per provider or per activity implemented, the data were rechecked with the organization from which they originated.
7. Due to the complexity of the NASA methodology and its classification system, there were occasions when the financing sources and service providers identified by the submitting organization in the data-collection form did not correspond with NASA classifications and definitions. In these cases, the NASA team sought clarification from the source of the data and attempted to make an appropriate classification. For example, code PS.01.01.02 ***Ambulatory care*** was assigned to a wide range of organizations, including provincial preventive medicine centres, provincial AIDS centres, provincial communication and health education centres, population and reproductive health centres and VCT sites; PS.01.01.04 ***Mental health and substance abuse facilities*** was assigned to Centres for Treatment, Education and Social Labour (05/06 centres) for IDUs and FSW and methadone clinics; and PS.01.01.11 ***Foster homes/shelters*** was assigned to public social welfare centres.
8. The processing of expenditure data by production factor was a time- and labour-intensive undertaking. In many instances, the data collected were insufficiently detailed to allow for a clear identification of production factors. In these cases, the NASA team used code PF.01.98 ***Current expenditures not broken down by type*** or PF.02.98 ***Capital expenditure not broken down by type***. Where it was not possible to identify whether expenditure was current or capital, the code PF.98 ***Production factors not broken down by type*** was used.

2.5 Limitations and challenges

There were a number of limitations and challenges associated with conducting the NASA in Viet Nam. Firstly, as multiple financial flows each involve numerous intermediary partners prior to the actual expenditure of funds, it was often a challenge to reconstruct transactions correctly, and to avoid double-counting or data loss. Secondly, the wide variety of HIV service providers and their multifunctional scope of work added to the difficulty of identifying the primary role of each institution and assigning a PS code. Thirdly, there are significant variations in accounting systems, fiscal years and the classification of spending categories among national institutions and donor-supported projects, which created challenges for data synthesis and comparability. For example, the PEPFAR fiscal year starts on 1 October and ends on 30 September the following year, while the Government fiscal year follows the calendar year. Adjustments were therefore made where appropriate. Fourthly, it was often difficult to obtain financial expenditure information from private sources and direct health care providers. Finally, in cases where there was no other data available, budget information or reported financial expenditure was taken as actual expenditure. It was also sometimes necessary to estimate AIDS expenses for certain items based on secondary data and costing estimations. This may have resulted in overestimation/underestimation of actual expenditure.

III. HIV funding sources and mechanisms

3.1 Public funds

Public expenditure relies on two principal sources: central government revenues and provincial government revenues. Between 2008 and 2010, there were three main public funding channels for HIV: (1) the National Targeted Programme for HIV; (2) the annual budget allocation for HIV-related public organizations; and (3) the public investment programme.

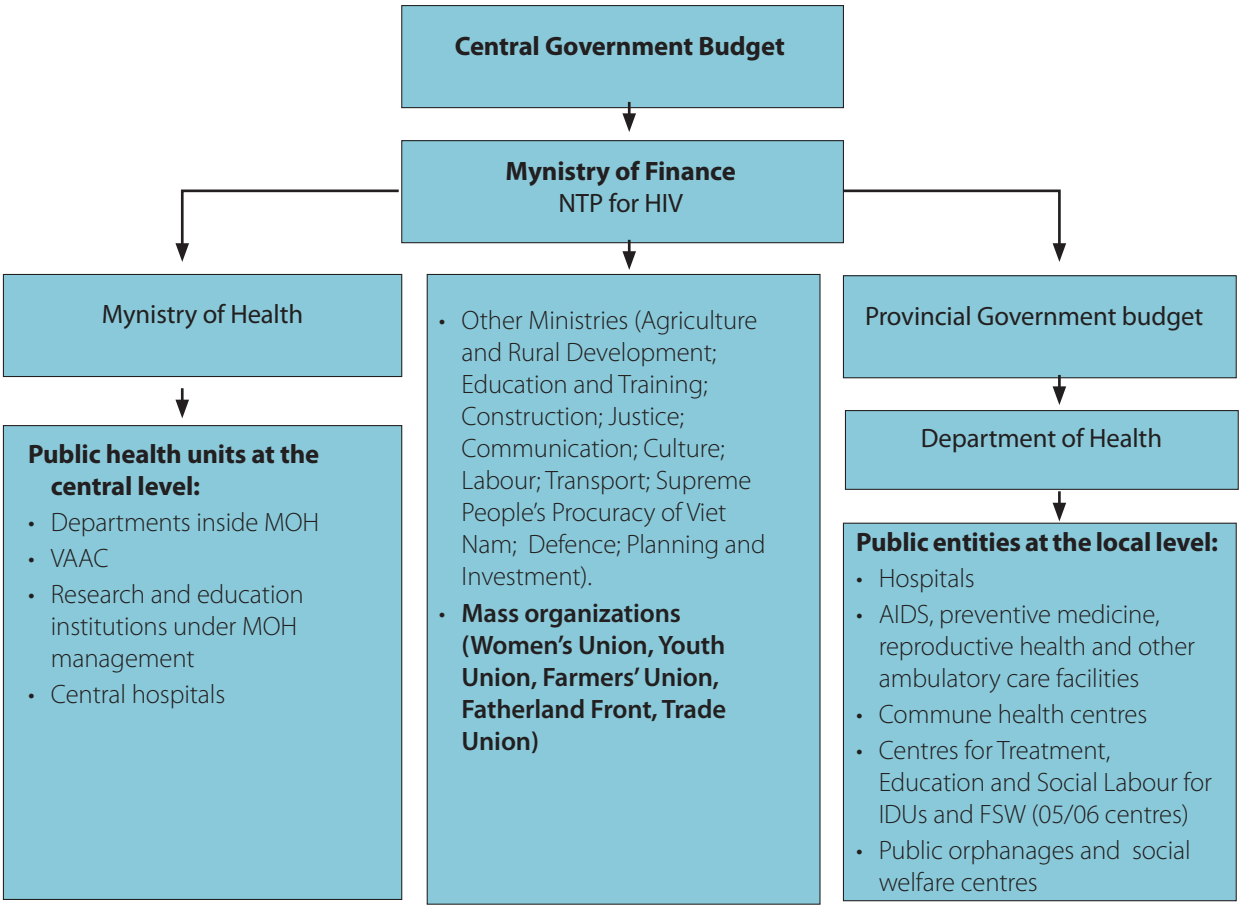
The National Targeted Programme for HIV

The National Targeted Programme for HIV (NTP) is a multisectoral framework for addressing the HIV epidemic coordinated by the Ministry of Health (MOH). The overall budget of the NTP through 2010 was approved in 2007 by Prime Ministerial Decision No. 108. The annual NTP budget is provided by the Ministry of Finance based on the MOH annual plan.

Central government revenues constitute the main source of funds for the NTP. Fund transfers for the NTP at the central level are made through the MOH account. The MOH transfers NTP funds to each relevant department, research institution and hospital under its management, as well as to other public entities outside the health sector, such as mass organizations and non-profit organizations, involved in the implementation of the NTP. The central government also transfers designated NTP funds to 63 Provincial People's Committees, which then allocate funds to designated implementers in their respective provinces.

Provincial authorities can contribute additional funds to NTP implementation at their discretion. As it was not possible to separate directly resourced provincial funds from those that originated from the central budget, the NASA team classified all NTP expenditure as central budget expenditure.

Figure 4: Funding flow - National Targeted Programme for HIV



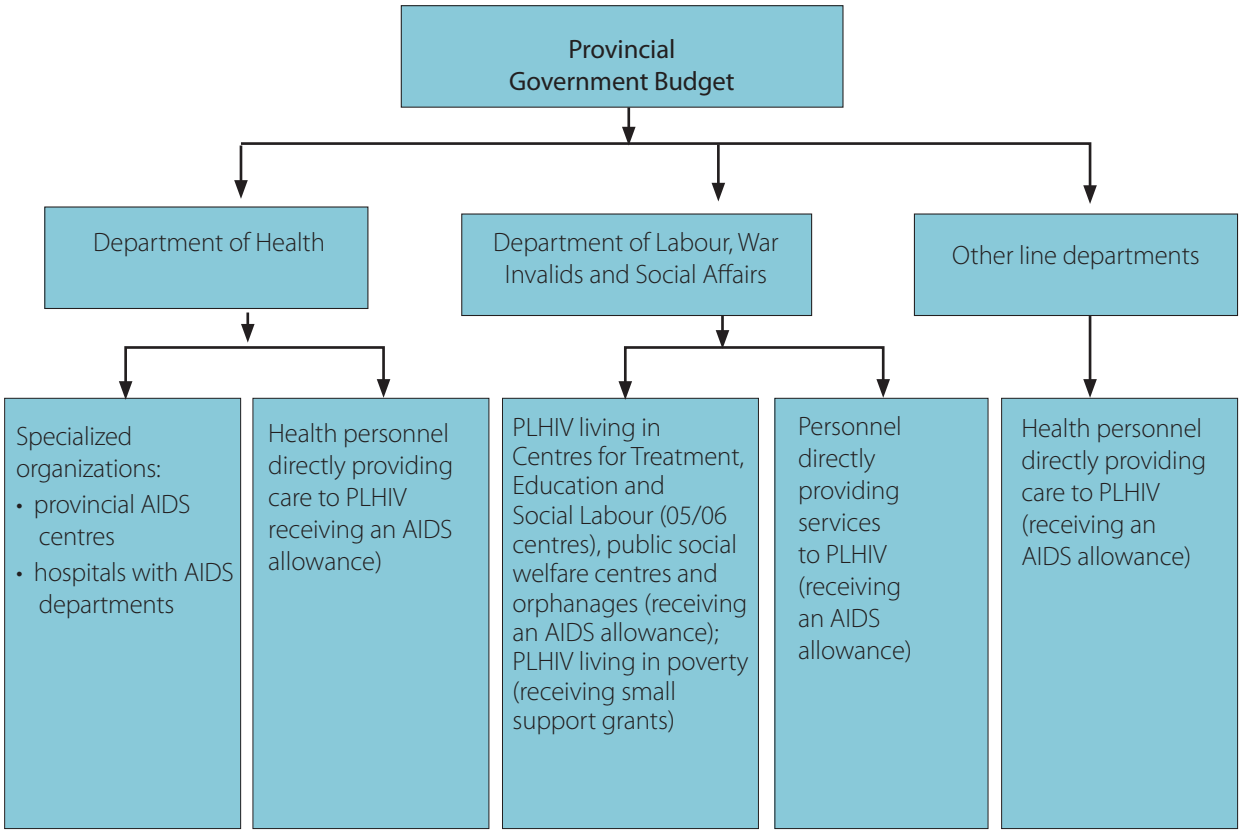
Annual budget allocation for HIV-related public organizations

In accordance with the 2002 Budget Law regulations, the central budget covers recurrent expenditure by public organizations at the central level, and the provincial budget covers the routine operations of public organizations at the provincial, district and commune levels.

At the central level, the MOH is responsible for the majority of HIV expenditure, which is primarily spent on the HIV-related policymaking, coordination and monitoring functions of the departments and institutions under MOH management. All other ministries and mass organizations have some HIV-related expenditure; however, these are normally covered by non-HIV budget lines (e.g. multi-tasked staff or workshops).

Annual provincial HIV budgets are typically distributed across several line departments, including health and labour. HIV funds are an integral part of annual budget allocation. Recipients of HIV funds in the health sector include facilities that provide specialized HIV services (e.g. AIDS departments in hospitals or provincial AIDS centres), and all health care workers who receive AIDS-specific allowances in accordance with health personnel policy. There are no HIV-specialized facilities in other sectors; however, significant funds are allocated for HIV in accordance with various HIV-related government policies and the personnel policies of each sector. The primary channels of annual HIV budget allocation are illustrated in Figure 5.

Figure 5: Provincial annual budget allocation for AIDS HIV



The Public Investment Programme

Some provinces have made significant capital investments in the construction and infrastructure of provincial AIDS centres through the Public Investment Programme. For the purposes of the NASA, all such investments are classified as expenditure under the provincial budget.

3.2 International funds

International grants accounted for the majority of HIV funds in Viet Nam during the period 2008-2010. Twenty eight (28) international donors financed HIV-related activities, including twelve (12) bilateral organizations, twelve (12) multilateral organizations and four (4) foundations.

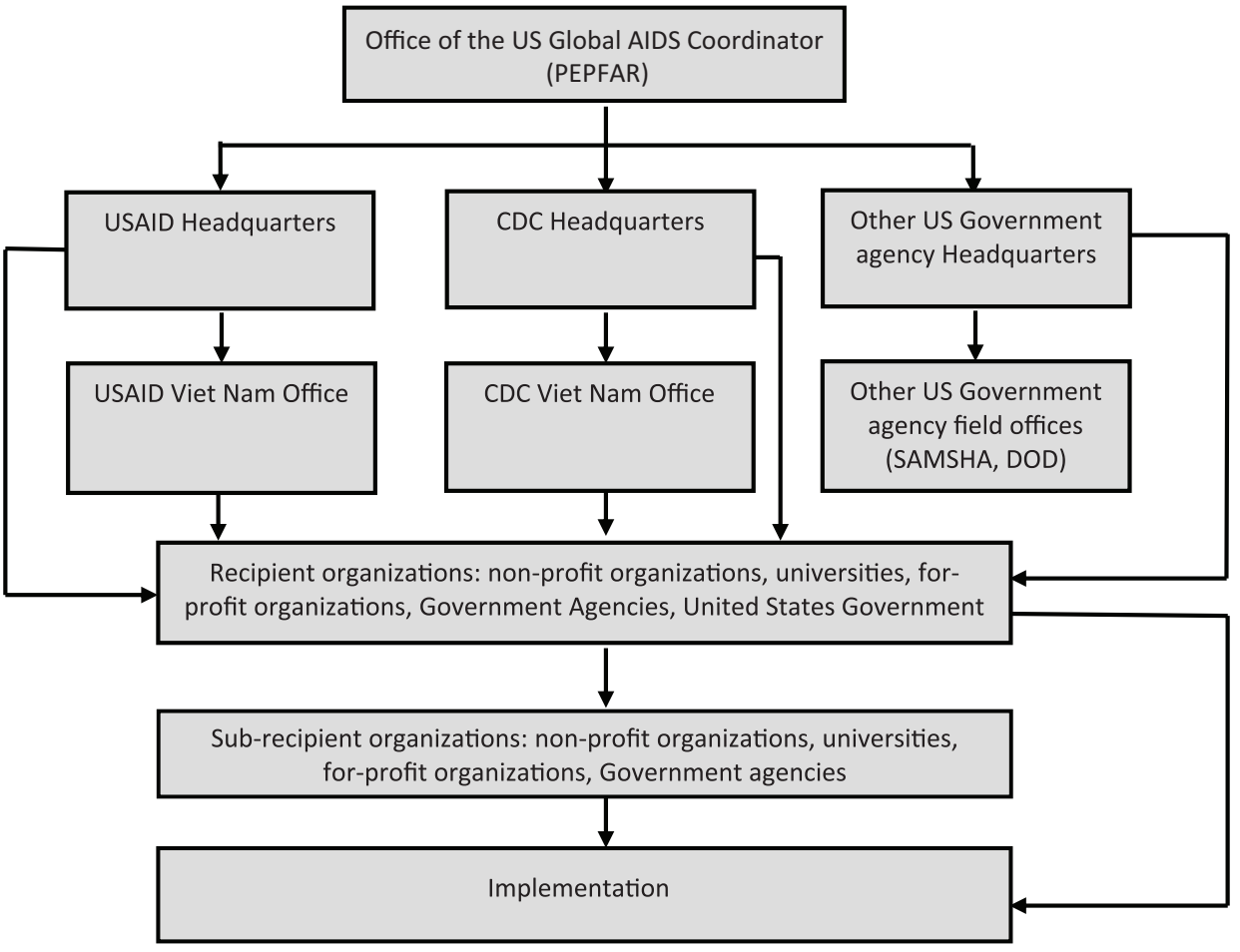
PEPFAR

As a PEPFAR focus country, Viet Nam receives significant United States (US) Government financial and in-kind resources to support its national HIV response. PEPFAR funds designated for Viet Nam are channelled from various US Government agencies to different types of recipient. PEPFAR funds are administered at two levels: the US-based headquarters and the Viet Nam field office. The NASA was only able to track funds flowing from the PEPFAR Viet Nam office to PEPFAR partners in Viet Nam, and therefore did not include those funds expended by the headquarters of US-based government agencies or PEPFAR implementing partners that do not reach Viet Nam.

As illustrated in Figure 6, the NASA captured funding flows from the four US Government agencies comprising PEPFAR: the US Agency for International Development (USAID), the US Centers for Disease Control and Prevention (CDC), the US Department of Defence (DoD) and the US Substance Abuse and Mental Health Services Administration (SAMSHA).

USAID and CDC are the principal US agencies supporting HIV-related activities in Viet Nam, and each channels funds to various types of recipient, including public entities, international and local non-profit organizations, for-profit organizations, UN agencies and other US Government agencies in Viet Nam. SAMSHA and DoD direct their (far smaller) budgets through other non-profit organizations and international universities.

Figure 6: Funding flow - PEPFAR



Other bilateral donors

Other bilateral HIV donors in Viet Nam include Australia, Canada, Denmark, France, Germany, Ireland, Japan, the Netherlands, Sweden and the United Kingdom. Most of their funds are transferred directly to Vietnamese Government agencies. Some small grants are also given to non-profit organizations and international universities.

The Asian Development Bank

Between 2008 and 2010, the Asian Development Bank (ADB) funded two HIV-related projects: HIV/AIDS Prevention among Youth and the Greater Mekong Subregion Regional Communicable Diseases Control Project. The first project was managed by the MOH Department of Population, and funding recipients included population facilities, other public entities and non-profit organizations that work with youth. The second project was a regional initiative supporting six provinces to undertake prevention activities, including HIV prevention.

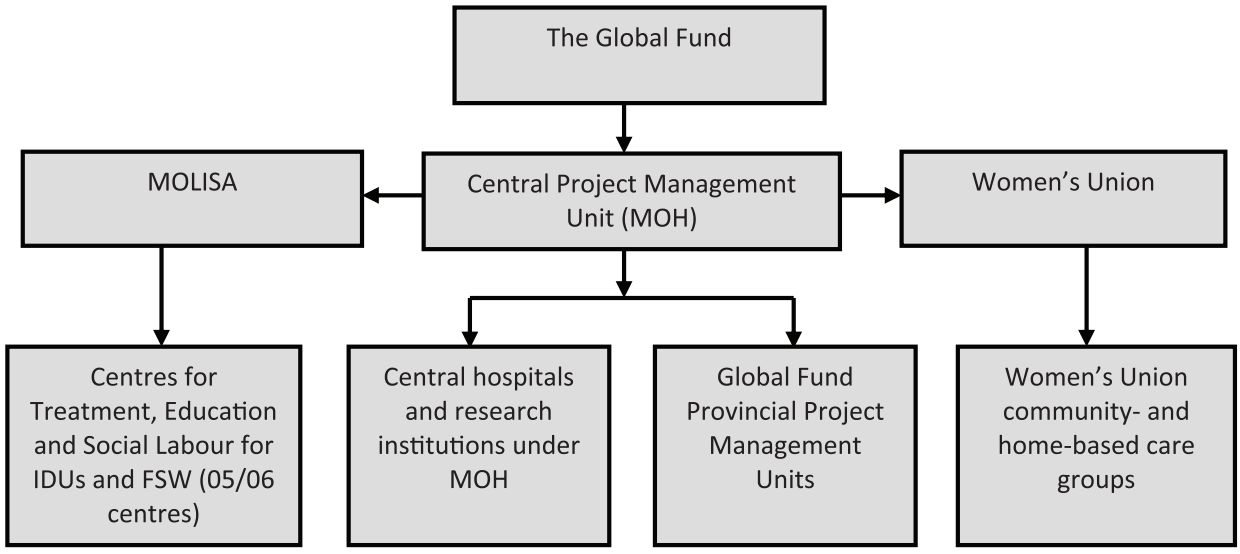
The World Bank

The World Bank project on HIV is managed by the MOH and covers 20 provinces. The World Bank Central Project Management Unit (CPMU), which is based at the MOH, receives funds from the World Bank and allocates them to 20 Provincial Project Management Units (PPMUs) for implementation. The World Bank CPMU also directly finances some HIV activities undertaken by MOH research institutions, several provincial preventive medicine centres, and Centres for Treatment, Education and Social Labour (05/06 centres) for IDUs and FSW. From 2010, project activities expanded to 32 provinces and received additional funds from the United Kingdom through the Department for International D evelopment (DFID).

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)

Between 2008 and 2010, Viet Nam received and spent Global Fund HIV grants under Round 6 (from 2008) and Round 8 (from 2010). The Global Fund project-management mechanism is based on the health system hierarchy (from central to provincial and lower levels) and uses existing human resources and infrastructure to carry out project activities. A Central Project Management Unit (CPMU), directly managed by VAAC (MOH), is the principal recipient of Global Fund HIV grants. The CPMU is also one of three sub-recipients managing these HIV grants, and channels funds to HIV activities within the health sector through Provincial Project Management Units (PPMU) and directly to national research institutes and hospitals. The other two sub-recipients are the Ministry of Labour, War Invalids and Social Affairs (MOLISA) and the Women's Union, both of which are centrally managed. MOLISA funds are spent on Centres for Treatment, Education and Social Labour for IDUs and FSW (05/06 centres), which are managed by the General Department for Social Evils Prevention. The Women's Union implementers are community-based and home-based care groups managed by local Women's Unions. Funds received from the Global Fund are transferred from the CPMU to PPMUs and sub-recipients on a quarterly basis.

Figure 7: Funding flow - The Global Fund



United Nations agencies

Key United Nations (UN) agencies involved in supporting Viet Nam's national HIV response include: UNAIDS, UNDP, UNESCO, UNFPA, UNICEF, UNODC, UN Women and the WHO. UN agencies do not use financial intermediaries for their funding. All UN funds are transferred directly to the implementers of HIV activities. Recipients of UN funds include public entities and Vietnamese non-profit and community-based organizations.

3.3 Private funds (including household expenditure)

The majority of private funds expended on HIV-related activities consist of household out-of-pocket payments. Such expenditure primarily comprises: (1) payments made for the care and treatment of PLHIV by themselves and their families; (2) direct outlays by individuals to screen their blood donations for HIV; and (3) private purchases of key commodities (e.g. condoms and clean needles).

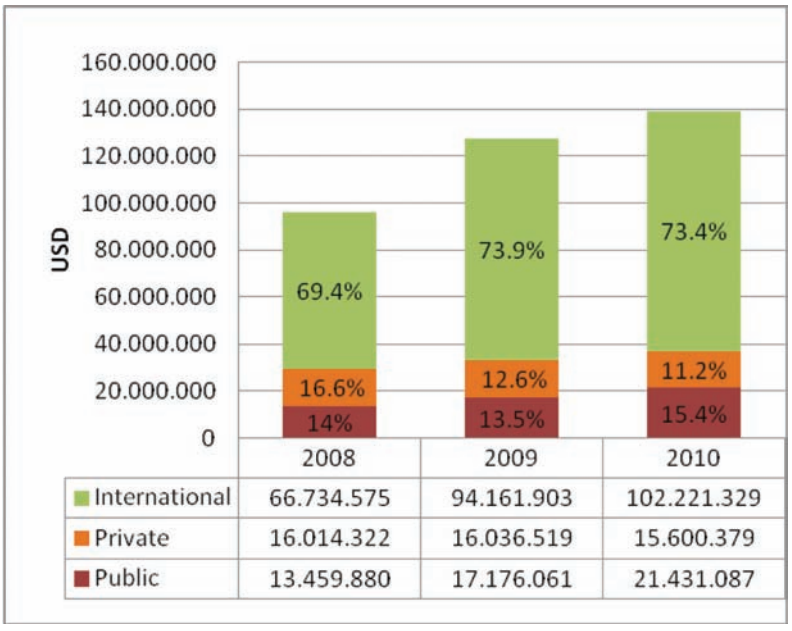
There is also some expenditure on HIV prevention by private businesses, such as the purchase of condoms by hotels and guesthouses for free distribution on their premises.

IV. Total AIDS expenditure 2008-2010

4.1 Overview of AIDS expenditure 2008-2010

Viet Nam spent a total of US$362,836,055 on the national response to HIV between 2008 and 2010. In 2008, over 96 million USD were spent on the HIV response; total AIDS expenditure in Viet Nam increased by 32% between 2008 and 2009 and 45% between 2008 and 2010.

Figure 8: Total national AIDS expenditure, 2008-2010



	2008	2009	2010
International	66.734.575	94.161.903	102.221.329
Private	16.014.322	16.036.519	15.600.379
Public	13.459.880	17.176.061	21.431.087

Per capita AIDS expenditure increased from US$0.79 in 2007 to US$1.13 in 2008, US$1.48 in 2009 and US$1.60 in 2010. Using the 2009 MOH medium estimate of the number of PLHIV in Viet Nam[15] , the NASA determined that AIDS expenditure per person living with HIV in the country increased from US$301 in 2007 to US$416 in 2008, US$520 in 2009 and US$607 in 2010.

[15]. Viet Nam HIV/AIDS Estimations and Projections 2007-2012. Ministry of Health.

Table 2: General statistics on national AIDS expenditure 2008-2010[16]

Indicators	2007	2008	2009	2010
Total AIDS expenditure, US$	66,280,815	96,208,777	127,374,483	139,252,795
Estimated number of PLHIV, medium scenario	220,422	231,422	242,557	254,000
AIDS expenditure as a percentage of GDP	0.09%	0.11%	0.13%	0.13%
Total AIDS expenditure as a percentage of overall health expenditure	1.5%	1.7%	No data	No data
AIDS public expenditure as a percentage of overall public expenditure on health	0.8%	1.3%	1.1%	No data
Per capita AIDS expenditure, US$	0.79	1.13	1.48	1.60
AIDS expenditure per person living with HIV, US$	301	416	520	607

4.2 AIDS expenditure by financing source

The NASA defines financing sources as "entities that provide money to financing agents". HIV-related activities in Viet Nam were supported by three major sources: public, private and international funds. The total funds provided by, and the proportional share of, each major financing source between 2008 and 2010 are illustrated in Table 3 and Figure 9.

Table 3: Summary of AIDS expenditure in Viet Nam by financing source, 2008-2010 (US$)

Source	2008	%	2009	%	2010	%	2008-2010	%
Public	13,459,880	14	17,176,061	13	21,431,087	15	52,067,028	14
Private	16,014,322	17	16,036,519	13	15,600,379	11	47,651,220	13
International	66,734,575	69	94,161,903	74	102,221,329	74	263,117,807	73
Total	**96,208,777**	**100**	**127,374,483**	**100**	**139,252,795**	**100**	**362,836,055**	**100**

[16]. Sources: Viet Nam HIV Estimates and Projections 2007-2012, Ministry of Health, 2009; National Health Account, Ministry of Health, 2010; Statistical Year Book, General Statistics Office, 2011; Government Budget Balance sheet 2007 and Government Budget Plan 2008 and 2009, Ministry of Finance, 2010. UNGASS survey, UNAIDS Viet Nam, 2010.

Figure 9: Contribution of major sources to total AIDS expenditure, 2008-2010

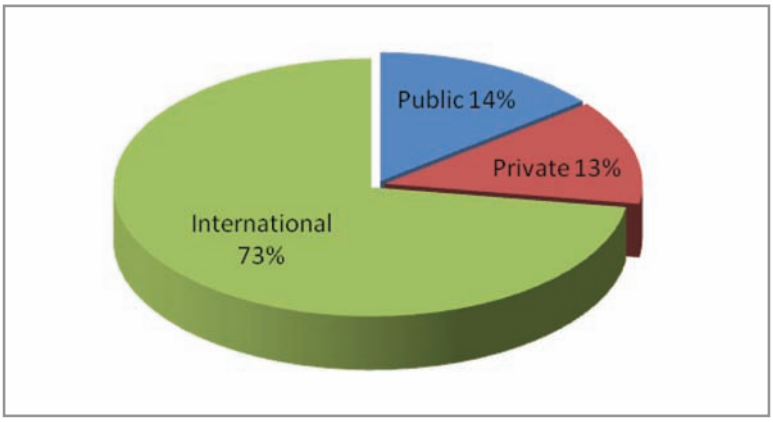


Table 4 presents a more detailed disaggregation of each financing source. As it demonstrates, externally provided funds grew substantially from 2008 to 2010, while domestic funds also increased but relatively slowly.

Table 4: Public, private and international AIDS expenditure in Viet Nam, 2008-2010 (US$)

Source	2008	2009	2010	Total 08-10
Public sources	**13,459,880**	**17,176,061**	**21,431,087**	**52,067,028**
Central government (including National Targeted Programme)	6,832,580	6,737,254	9,193,116	22,762,950
Provincial government	6,627,300	10,438,807	12,237,971	29,304,078
Private sources	**16,014,322**	**16,036,519**	**15,600,379**	**47,651,220**
For-profit organizations	82,581	144,812	No data	227,393
Households	15,931,741	15,891,707	15,600,379	47,423,827
International sources	**66,734,575**	**94,161,903**	**102,221,779**	**263,118,258**
Bilateral organizations	48,552,930	70,785,002	84,013,483	203,351,415
Multilateral organizations	17,849,999	22,975,231	17,512,495	58,337,726
International non-profit organizations	331,646	401,670	695,801	1,429,117
Total	**96,208,777**	**127,374,483**	**139,253,245**	**362,836,506**

Public financing sources

Public sources contributed 14.3% of total AIDS funds spent on AIDS between 2008 and 2010. There are two public sources of HIV funds: the central government budget, which primarily funds the National Targeted Programme for HIV, and the provincial government budget, which mainly funds the maintenance and operation of provincial AIDS authorities. The central government budget contributed 5-7% of national funds spent on AIDS between 2008 and 2010; the provincial government budget contributed 7-8% of national funds spent on AIDS during this period.

Table 5: Public AIDS expenditure by funding source, 2008-2010 (US$)

Public source	2008	%	2009	%	2010	%
Central government (including National Targeted Programme)	6,832,580	50.8	6,737,254	39.2	9,193,116	42.9
Provincial government	6,627,300	49.2	10,438,807	60.8	12,237,971	57.1
Total	**13,459,880**	**100**	**17,176,061**	**100**	**21,431,087**	**100**

International financing sources

International assistance contributes the majority of funds spent on AIDS in Viet Nam, accounting for 73% of total funds spent on AIDS between 2008 and 2010. About three-quarters of all international funds spent on AIDS were provided in the form of bilateral grants. Multilateral donors were responsible for the remaining externally provided funds spent on AIDS during this period. International non-profit organizations provided only 0.5% of total funds spent on AIDS between 2008 and 2010.

Table 6: Summary of AIDS expenditure by international source, 2008-2010 (US$)

International sources	2008	%	2009	%	2010	%
Bilateral organizations	48,552,930	72.8	70,785,002	75.2	84,013,483	82.2
Multilateral organizations	17,849,999	26.7	22,975,232	24.4	17,512,495	17.1
International non-profit organizations	331,646	0.5	401,670	0.4	695,801	0.7
Total	66,734,575	100	94,161,904	100	102,221,779	100

Figure 10: Disaggregation of international AIDS financing sources, 2008-2010

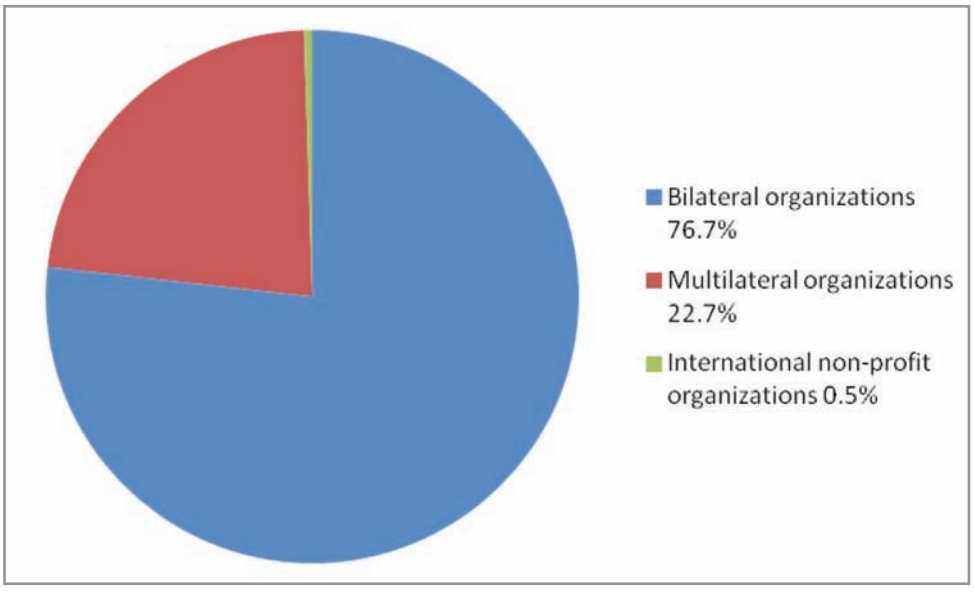


Table 7: AIDS expenditure by international financing source, 2008-2010 (US$)

Source	2008	2009	2010	Total 08-10
Total international sources	**66,734,575**	**94,161,904**	**102,221,779**	**263,118,258**
Bilateral organizations	**48,552,930**	**70,785,002**	**84,013,483**	**203,351,415**
Government of Australia	1,205,251	2,471,859	1,502,842	5,179,952
Government of Canada		137,207	300,000	437,207
Government of Denmark	954,800		4,176,787	5,131,587
Government of France	593,146	598,866	321,443	1,513,455
Government of the United Kingdom	4,470,027	2,256,690	7,534,127	14,260,844
Government of the United States (PEPFAR)	38,894,158	63,926,353	69,340,357	172,160,868
Government of Germany	596,419	158,084		754,503
Government of Ireland	304,091	398,397	117,000	819,488
Government of the Netherlands	581,876	385,379	502,195	1,469,450
Government of Sweden	953,162	448,912	159,897	1,561,971
Other Governments (Japan, Luxembourg, Norway)		3,255	58,835	62,090
Multilateral organizations	**17,849,999**	**22,975,232**	**17,512,495**	**58,337,726**
Asian Development Bank (ADB)	6,251,409	6,320,161	6,152,088	18,723,658
Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)	2,871,788	5,829,561	6,650,517	15,351,866
UN agencies	1,877,157	1,670,997	1,343,508	4,891,662
The World Bank	5,548,183	8,443,611	1,849,216	15,841,010
Other multilateral funds or development funds	1,301,462	710,902	1,517,166	3,529,530
International non-profit organizations	**331,646**	**401,670**	**695,801**	**1,429,117**
The Bill and Melinda Gates Foundation		46,697	20,887	67,584
Ford Foundation		14,880		14,880
Other international non-profit organizations	331,646	340,093	674,914	1,346,653

Private financing sources

Private sources contributed 14% of total funds spent on AIDS in Viet Nam between 2008 and 2010. Most private expenditure reported here consisted of household out-of-pocket payments that were captured by a 2010 Abt Associates/USAID Health Policy Initiative study.[17] The contribution of for-profit organizations to overall funds spent on AIDS during this period was insignificant.

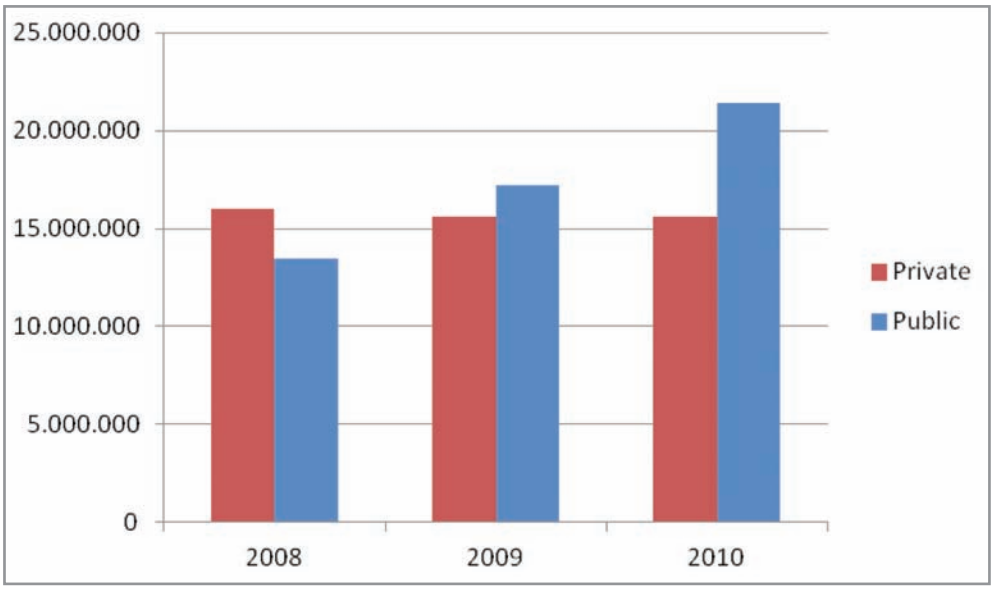
[17]. National Survey of People Living With HIV/AIDS in Viet Nam: Health Services Utilization and Out-of-Pocket Health Expenditure. Health Systems 20/20, 2010.

Table 8: Private financing sources for AIDS, 2008-2010 (US$)

Source	2008	2009	2010
Household funds	15,931,741	15,891,707	15,600,379
For-profit organizations	82,581	144,812	**No data**
Total	**16,014,322**	**16,036,519**	**15,600,379**

Figure 11 compares private and public AIDS expenditure between 2008 and 2010. In 2008, private expenditure exceeded public expenditure However, the gap between the two sources narrowed in 2009, and reversed in 2010: the ratio of private to public expenditure declining from 1.2:1 in 2008 to 1.1:1 in 2009 and 0.7:1 in 2010.

Figure 11: Private versus public expenditure on AIDS, 2008-2010



4.3 AIDS expenditure by financing agent

As defined by the NASA, financing agents (FA or purchaser agents) are intermediary entities that transfer resources from financing sources to service providers. Financing agents also determine the type of HIV services to be provided and the specific service provider involved in their delivery. The FA therefore plays a crucial role in determining the effectiveness of the national HIV response.

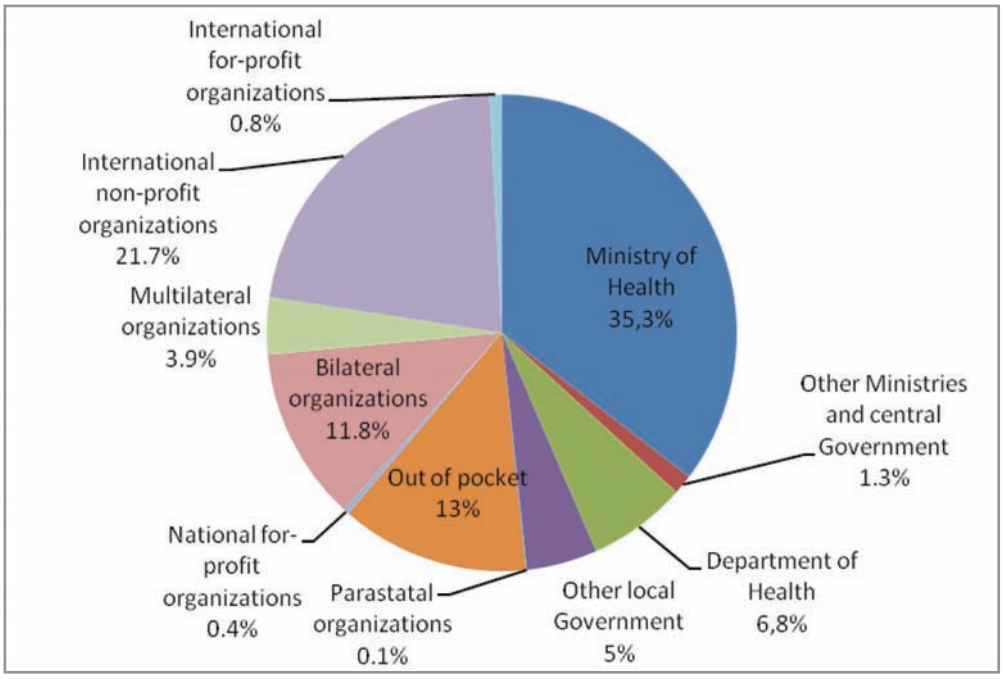
The main FAs engaged in Viet Nam's HIV response include the MOH and Departments of Health at the provincial level; other ministries and their sectoral departments; bilateral and multilateral agencies; international and national non-profit organizations; and households. While international for-profit organizations are involved, their role is fairly negligible.

Table 9: AIDS expenditure by major financing agent, 2008-2010 (US$)

Type of organization	2008	%	2009	%	2010	%
Public sector	**46,878,680**	**48.7**	**62,420,027**	**49.0**	**66,183,072**	**47.5**
Ministry of Health (MOH)	36,819,555		46,291,074		45,119,316	
Other Ministries and central Government	667,571		85,582		3,976,957	
Department of Health	5,221,097		8,962,341		10,436,162	
Other local departments and local Government	4,043,169		6,928,803		6,650,637	
Parastatal organizations	127,288		152,227			
Private sector	**15,879,654**	**16.5**	**15,818,315**	**12.4**	**16,786,909**	**12.1**
Out-of-pocket expenditure	15,764,930		15,600,377		15,600,379	
For-profit organizations	114,724		217,938		1,186,530	
International	**33,450,443**	**34.8**	**49,136,141**	**38.6**	**56,283,264**	**40.4**
Bilateral organizations	11,661,024		16,522,378		14,662,610	
Multilateral organizations	4,531,107		4,851,099		4,682,722	
International non-profit organizations	17,236,312		26,311,503		35,358,795	
International for-profit organizations	22,000		1,451,161		1,579,137	
Total	**96,208,777**	**100**	**127,374,483**	**100**	**139,253,245**	**100**

Figure 12 illustrates the proportional share of each major financing agent in terms of national AIDS expenditure. The MOH clearly plays the principal role in decision-making about HIV programme funding. The health sector – comprising the MOH and provincial Departments of Health – managed 42% of all HIV resources from 2008 to 2010.

Figure 12: Share of AIDS expenditure by financing agent, 2008-2010



4.4 AIDS expenditure by service provider

The NASA defines a service provider (PS) as any entity that engages in the production, provision and delivery of HIV services. In Viet Nam, there are three main groups of such providers: the public sector, the private sector, and in-country offices of bilateral and multilateral organizations.

The public sector covers public health facilities and institutions, including public hospitals and ambulatory care facilities such as: provincial AIDS centres, VCT sites, outpatient clinics located outside hospital environments, preventive health centres, health education centres and population centres. This sector also includes MOH departments and units, including health research institutions and HIV project management units as well as mental health and substance abuse facilities (such as methadone clinics and other drug-treatment facilities), as well as managerial units or focal points implementing HIV activities within other ministries. Other major public service providers include government entities such as the Ho Chi Minh City municipal AIDS Committee; parastatal organizations such as government associations and federations (e.g. the Women's Union and the Youth Union); and foster homes/shelters under the management of the Ministry of Labour, War Invalids and Social Affairs (e.g. public social welfare centres for homeless PLHIV and orphanages).

The private sector includes international and national non-profit organizations and other civil society organizations (CSOs); self-help and informal community-based organizations; faith-based organizations (FBOs); and for-profit organizations (including consulting firms, research institutions and private health care providers). Bilateral and multilateral organization in-country offices may provide management, technical assistance and advocacy, as well as undertake prevention activities.

The NASA data on AIDS expenditure by service provider for the period 2008-10 are presented in Table 10. The data show that MOH departments, public ambulatory care facilities and hospitals, civil society organizations and bilateral agencies were major service providers between 2008 and 2010. Expenditure on services provided by CSOs increased significantly in 2010.

Table 10: AIDS expenditure by service provider, 2008-2010 (US$)

Service providers		2008	2009	2010
PS.01 Public-sector providers		**62,281,186**	**83,034,250**	**76,982,679**
PS.01.01 Governmental organizations				
PS.01.01.01	Hospitals	16,036,019	22,240,373	10,728,041
PS.01.01.02	Ambulatory care	28,173,355	33,525,790	43,438,058
PS.01.01.04	Mental health and substance abuse facilities	1,604,221	2,278,144	1,573,863
PS.01.01.05	Laboratory and imaging facilities			78,879
PS.01.01.10	Schools and training facilities	316,478	544,279	692,064
PS.01.01.11	Foster homes/shelters	124,530	121,782	121,783
PS.01.01.13	Research institutions	837,010	2,194,080	2,874,105
PS.01.01.14.01	National AIDS Coordinating Authority			24,715
PS.01.01.14.02	Departments inside the Ministry of Health or equivalent	10,023,544	12,640,574	10,203,510
PS.01.01.14.03	Departments inside the Ministry of Education or equivalent	139,264	67,031	312,026
PS.01.01.14.05	Departments inside the Ministry of Defence or equivalent	3,075		
PS.01.01.14.07	Departments inside the Ministry of Labour or equivalent	112,082	1,725,703	180,146
PS.01.01.14.08	Departments inside the Ministry of Justice or equivalent	3,690	3,540	3,238
PS.01.01.99	Government organizations n.e.c.[18]	4,495,479	6,662,026	6,370,512
PS.01.02 Parastatal organizations		412,439	1,030,928	381,739
PS.02 Private-sector providers		**21,462,336**	**27,020,310**	**46,363,669**
PS.02.01.01 Non-profit non-faith-based providers		19,202,032	23,110,601	42,462,342
PS.02.01.01.14	Self-help and informal community- based organizations	5,464,261	5,454,931	5,430,128
PS.02.01.01.15	Civil society organizations	13,150,904	15,901,275	36,642,338
[Other PS.02.01.01]	[Other non-profit non-faith-based providers]	586,867	1,754,395	389,876
PS.02.01.02 Non-profit faith-based providers		725,656	900,761	436,052
PS.02.02 Profit-making private sector providers (including profit-making FBOs)		1,534,648	3,008,948	3,465,275
PS.03 Bilateral and multilateral entities – in-country offices		**12,170,603**	**17,025,271**	**15,906,897**
PS.03.01 Bilateral agencies		9,957,925	13,395,776	13,052,115
PS.03.02 Multilateral agencies		2,212,678	3,629,495	2,854,782
PS.99 Providers n.e.c.		**294,652**	**294,652**	
Total		**96,208,777**	**127,374,483**	**139,253,245**

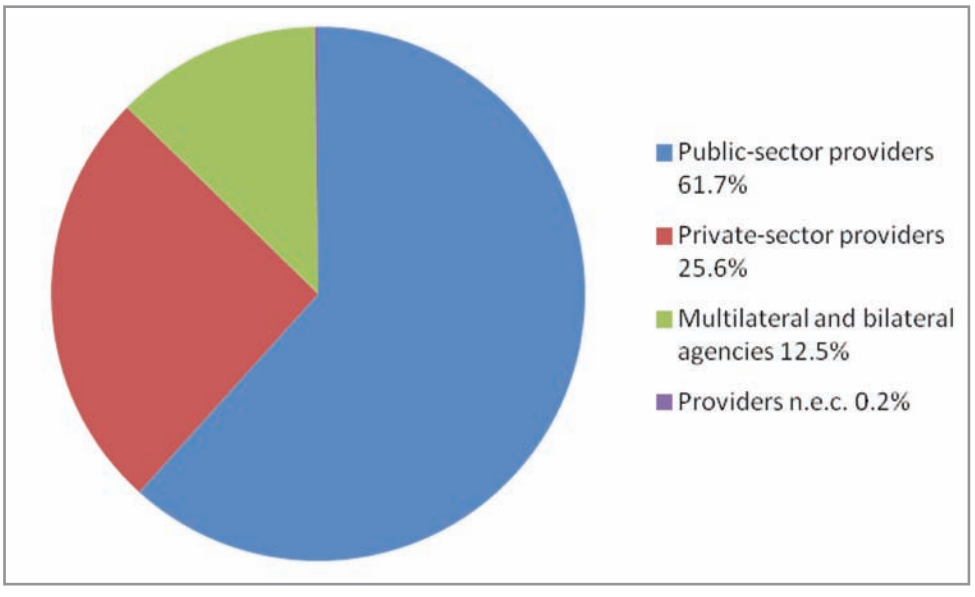
[18]. n.e.c. = not elsewhere classified

Table 11 summarizes the relative share of major service providers in terms of total AIDS expenditure. It shows that the public sector plays the primary role in the provision of HIV services. Between 2008 and 2010, 61% of HIV expenditure was undertaken by public entities.

Table 11: Summary of AIDS expenditure by major service provider, 2008-2010 (US$)

Service providers	2008	%	2009	%	2010	%
PS.01. Public-sector providers	**62,281,185**	**64.7**	**83,034,250**	**65.2**	**76,982,679**	**55.3**
PS.02. Private-sector providers	**21,462,336**	**22.3**	**27,020,310**	**21.2**	**46,363,669**	**33.3**
PS.02.01.01 Non-profit non-faith-based providers	19,202,032		23,110,601		42,462,342	
PS.02.01.02 Non-profit faith-based providers	725,656		900,761		436,052	
PS.02.02 Profit-making private sector providers	1,534,648		3,008,948		3,465,275	
PS.03 Bilateral and multilateral entities – in-country offices	**12,170,603**	**12.7**	**17,025,271**	**13.4**	**15,906,897**	**11.4**
PS.03.01 Bilateral agencies	9,957,925		13,395,776		13,052,115	
PS.03.02 Multilateral agencies	2,212,678		3,629,495		2,854,782	
PS.99 Providers n.e.c.	**294,652**	**0.3**	**294,652**	**0.2**		**0.0**
Total	**96,208,777**	**100**	**127,374,483**	**100**	**139,253,245**	**100**

Figure 13: Percentage share of key service providers in AIDS expenditure, 2008-2010



V. Flow of funds

The NASA allows for the tracking of funding flows from financing sources to financing agents and onward to service providers. This flow of funds is summarized in this section.

5.1 Flow of funds from financing sources to financing agents

Public sources

Public funds consist of central budget revenues and provincial budget revenues (Table 12). The majority of central-budget AIDS revenue (including the NTP on HIV and other budgeted expenditure) was channelled to the MOH or transferred directly from the Ministry of Finance to other Ministries and to provinces based on the annual work plan submitted by VAAC (MOH).
The majority of the provincial AIDS budget was channelled through the provincial health sector (Departments of Health); this provided 78.8%, 85.9% and 87.4% of all provincial HIV resources in 2008, 2009 and 2010 respectively. The remaining funds were channelled through other provincial sectoral departments.

Table 12: Disaggregation of public source AIDS expenditure by financing agent, 2008-2010 (US$)

Financing agent	2008	2009	2010	Total
Central budget				
Ministry of Health	6,832,580	6,711,254	8,842,402	22,386,236
Regional/provincial entities			350,714	350,714
Parastatal organizations		26,000		26,000
Central budget total	**6,832,580**	**6,737,254**	**9,193,116**	**22,762,950**
Provincial budget				
Departments of Health	5,221,097	8,962,341	10,694,196	24,877,634
Other sectoral departments	1,406,203	1,476,466	1,543,775	4,426,444
Provincial budget total	**6,627,300**	**10,438,807**	**12,237,971**	**29,304,078**
Total	**13,459,880**	**17,176,061**	**21,431,087**	**52,067,028**

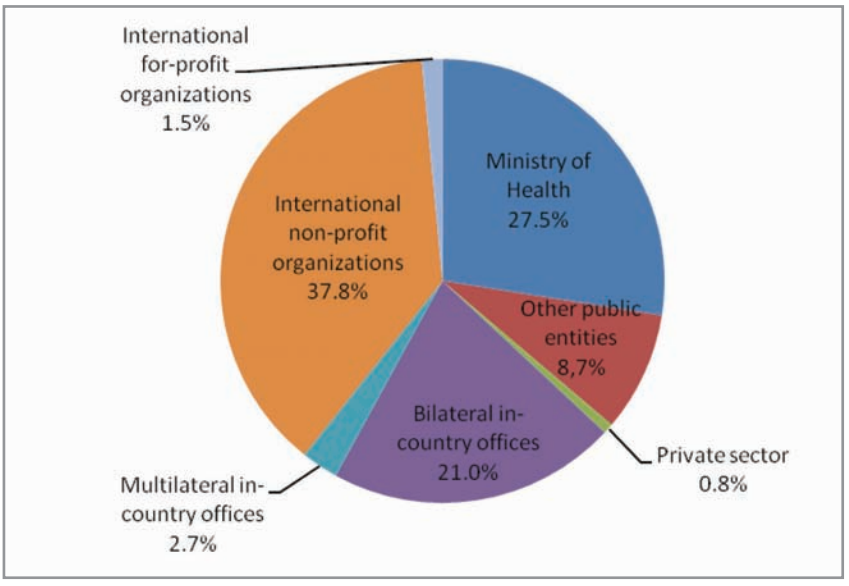
International sources

International funding sources not only include bilateral and multilateral donors, but also international non-profit organizations. However, as the NASA only captures AIDS expenditure for international non-profit organizations that are physically located in Viet Nam, for these entities the financing source and financing agent are one and the same. Therefore, in this section, we omit international non-profit organizations as FS, and focus solely on the flow of funds from bilateral and multilateral sources to their financing agents.
Bilateral funds for AIDS support HIV programmes managed by public sector entities, bilateral and multilateral agencies, international non-profit organizations and international for-profit organizations. Between 2008 and 2010, 27.5% of bilateral funds for AIDS were channelled to MOH AIDS-related programmes. Other public organizations received 8.7% of total funds for AIDS from bilateral sources. International non-profit organizations were the largest financing agents for bilateral donors, spending 37.8% of such funds on the implementation of HIV interventions. Bilateral agencies also expended 21% of the total funds on their own programmes. A modest amount was also channelled through non-profit private-sector financing agents, such as the Hanoi Association for Entrepreneur Women or public health associations.

Table 13: Disaggregation of bilateral AIDS expenditure by financing agent, 2008-2010 (US$)

Financing agents for bilateral sources	2008	2009	2010	% 2008-2010
Public sector				
Ministry of Health	15,541,346	19,003,720	21,367,059	27.5
Other public entities	3,431,826	5,664,145	8,631,013	8.7
Private sector	**114,724**	**217,938**	**1,186,530**	**0.8**
International financing agents				
Bilateral in-country offices	11,661,023	16,522,378	14,545,610	21.0
Multilateral in-country offices	1,158,500	2,420,602	1,947,053	2.7
International non-profit organizations	16,623,511	25,505,056	34,757,081	37.8
International for-profit organizations	22,000	1,451,161	1,579,137	1.5
Total	**48,552,930**	**70,785,000**	**84,013,483**	**100**

Figure 14: Disaggregation of bilateral AIDS expenditure by financing agent, 2008-2010 (US$)



Multilateral funding sources have two major types of financing agent: the MOH and multilateral organizations. The MOH spent 85.1% of multilateral funds, while 14.7% were used by multilateral organizations to finance their own HIV activities. A negligible percentage of funds were also transferred multilateral donors to international non-profit organizations and other ministries.

Table 14: Disaggregation of multilateral AIDS expenditure by financing agent, 2008-2010 (US$)

Financing agent	2008	2009	2010	% 2008-2010
Public				
Ministry of Health	14,445,628	20,576,101	14,651,821	85.1
Other ministries			28,892	0.1
International				
Multilateral organizations	3,372,608	2,383,800	2,831,782	14.7
International non-profit organizations	31,763	15,333		0.1
Total	**17,849,999**	**22,975,234**	**17,512,495**	**100**

Figure 15: Disaggregation of multilateral AIDS expenditure by financing agent, 2008-2010

5.2 Flow of funds from financing agents to service providers

The Ministry of Health as a financing agent

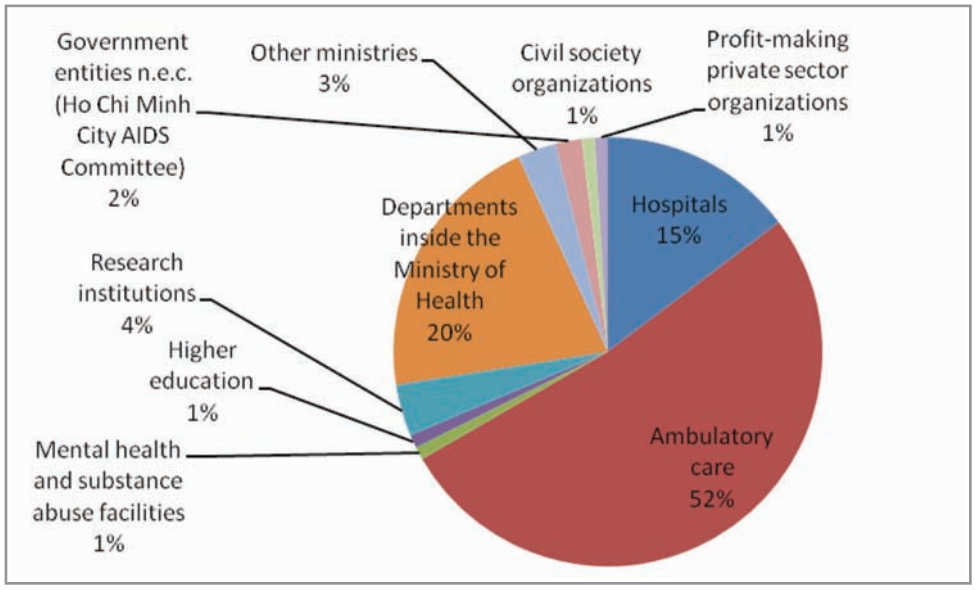
As a financing agent, the Ministry of Health (MOH) pools funds from the public sector and international donors to finance its HIV activities. The funds managed by the MOH increased by from US$36.8 million in 2008 to US$46.2 million in 2009 and US$45 million in 2010. Ninety-two per cent (92%) of all of the funds spent on AIDS managed by the MOH were channelled to three service providers: hospitals (15%); MOH departments (24%); and ambulatory care facilities (53%). Ambulatory care comprises all health services provided outside hospital settings, including through: outpatient clinics (OPC), voluntary counselling and testing (VCT) sites, behaviour change communication (BCC) centres, prevention of mother-to-child transmission (PMTCT) services, and public health and preventive health centres.

Table 15: Disaggregation of Ministry of Health AIDS expenditure by service provider, 2008-2010 (US$)

Service provider		2008	2009	2010	% 2008-2010[19]
Public-sector providers					
PS.01.01.01	Hospitals	7,525,836	10,848,764	1,129,445	**15**
PS.01.01.02	Ambulatory care	19,334,736	20,631,615	28,101,228	**53**
PS.01.01.04	Mental health and substance abuse facilities	171,581	820,101	202,380	**1**
PS.01.01.05	Laboratory and imaging facilities			78,879	**0**
PS.01.01.10.03	Higher education	308,024	517,738	680,861	**1**
PS.01.01.11	Foster homes/shelters	17,202			**0**
PS.01.01.13	Research institutions	699,043	1,351,245	2,686,900	**4**
PS.01.01.14.02	Departments inside the Ministry of Health	7,904,724	10,425,526	9,172,056	**21**
PS.01.01.14.03	Departments inside the Ministry of Education	18,451			**0**
PS.01.01.14.05	Departments inside the Ministry of Defence	3,075			**0**
PS.01.01.14.07	Departments inside the Ministry of Labour	54,568	270,452	60,193	**1**
PS.01.01.14.08	Departments inside the Ministry of Justice	3,690	3,540	3,238	**0**
PS.01.01.14.99	Government entities n.e.c. (Ho Chi Minh City AIDS Committee)	560,841	803,072	973,296	**2**
PS.01.01.99	Governmental organizations n.e.c.			7,017	**0**
PS.01.02	Parastatal organizations	167,255	241,473	28,605	**0**
Private-sector providers					
PS.02.01.01.15	Civil society organizations	50,528	377,549	991,512	**1**
PS.02.02	Profit-making private sector providers			846,653	**1**
Total		**36,819,554**	**46,291,075**	**44,962,263**	**100**

[19]. For the purposes of this table, percentages under 1% are marked as 0%.

Figure 16: Percentage share of service providers - Ministry of Health AIDS expenditure, 2008-2010



Provincial Departments of Health as financing agents

HIV funds managed by provincial Departments of Health (DOH) were mainly used to operate provincial AIDS centres (classified as ***PS.01.01.02 Ambulatory care***).

Table 16: Disaggregation of Department of Health AIDS expenditure by service provider, 2008-2010 (US$)

Service provider		2008	2009	2010	% 2008-2010
Public-sector providers					
PS.01.01.01	Hospitals		1,492,836	1,492,836	**15**
PS.01.01.02	Ambulatory care	5,175,368	7,419,985	8,786,287	**84**
PS.01.01.14.99	Government entities n.e.c. (Ho Chi Minh City AIDS Committee)	45,729	49,520	157,039	**1**
Total		**5,221,097**	**8,962,341**	**10,436,162**	**100**

Other public institutions as financing agents

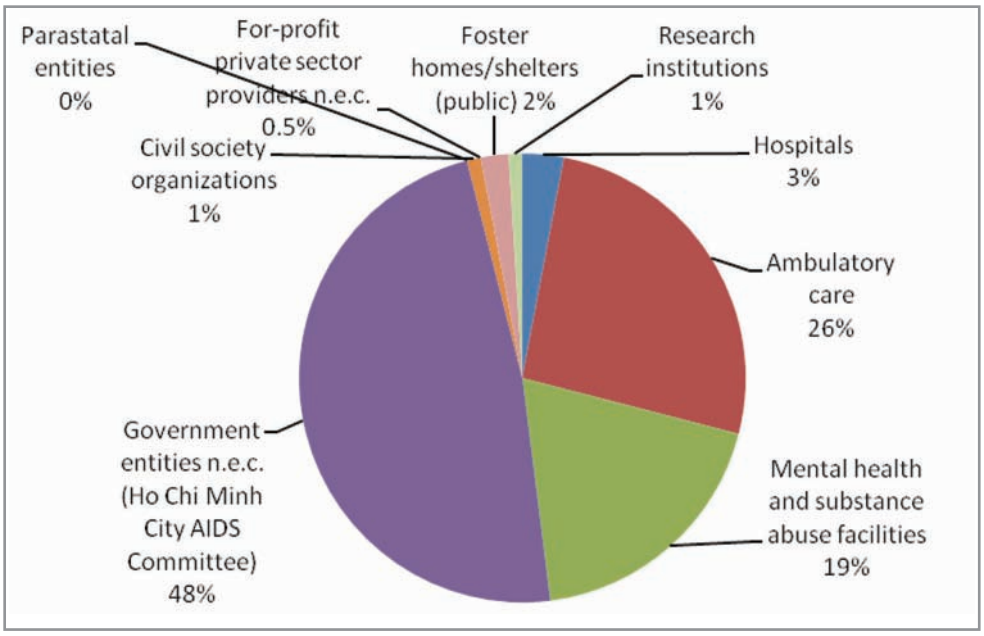
Non-health sector public financing agents include other Governmental agencies and ministries, the provincial departments of relevant sectors and parastatal organizations. The funds managed by these public financing agents increased from US$4.7 million in 2008 to US$7 million in 2009 and US$10 million in 2010.
Service providers receiving a significant portion of HIV funds from these public financing agents include the Ho Chi Minh City AIDS Committee (48%); health facilities (29%); and Centres for Treatment, Education and Social Labour (05/06 centres) for IDUs and FSW, classified as PS.01.01.04 (19%).

Table 17: Disaggregation of other public-institution AIDS expenditure by service provider, 2008-2010 (US$)

Service provider		2008	2009	2010	% 2008-2010[20]
Public-sector providers					
PS.01.01.01	Hospitals	409,395	295,659		**3**
PS.01.01.02	Ambulatory care	647,871	963,209	4,221,291	**26**
PS.01.01.04	Mental health and substance abuse facilities	1,404,669	1,443,007	1,371,483	**19**
PS.01.01.10.02	Secondary education	1,454	2,276		**0**
PS.01.01.10.03	Higher education	7,000			**0**
PS.01.01.11	Foster homes/shelters	97,767	121,782	121,783	**2**
PS.01.01.13	Research institutions	45,998	90,079		**1**
PS.01.01.14.07	Departments inside the Ministry of Labour	3,677	11,759		**0**
PS.01.01.14.99	Government entities n.e.c. (Ho Chi Minh City AIDS Committee)	2,002,245	3,991,198	4,894,655	**48**
PS.01.02	Parastatal organizations	74,895	45,147		**0**
Private-sector providers					
PS.02.01.01.11	Foster homes/shelters [non-profit non-faith-based]	15,769	18,382	18,382	**0**
PS.02.01.01.15	Civil society organizations	127,288	126,227		**1**
PS.02.02.99	Profit-making private-sector providers n.e.c.		31,887		**0**
Bilateral and multilateral entities – in-country offices					
PS.03.02	Multilateral agencies[21]		26,000		**0**
Total		**4,838,028**	**7,166,612**	**10,627,594**	**100**

[20]. For the purposes of this table, percentages under 1% are marked as 0%.
[21]. In this case, UNV benefits from Women's Union office space and administrative support.

Figure 17: Percentage share of key service providers – Other public institution AIDS expenditure, 2008-2010



Bilateral agencies as financing agents

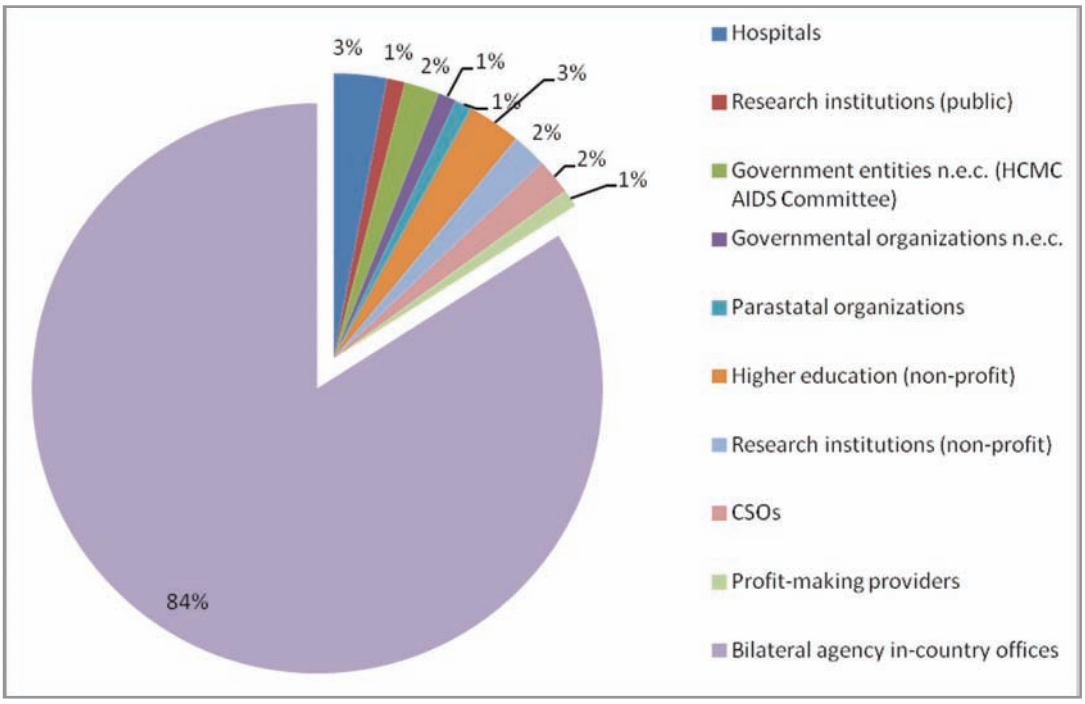
Where bilateral agency in-country offices acted as financing agents, 84% of total managed funds were used to finance HIV-related activities (primarily programme management and administration). The remaining 16% were channelled to public- and private-sector service providers.

Table 18: Disaggregation of bilateral agency AIDS expenditure by service provider, 2008-2010 (US$)

Service provider		2008	2009	2010	% 2008-2010[22]
Public-sector providers					
PS.01.01.01	Hospitals	566,957	536,294	207,417	**3**
PS.01.01.04	Mental health and substance abuse facilities	5,904			**0**
PS.01.01.13	Research institutions	91,969	205,937		**1**
PS.01.01.14.02	Departments inside the Ministry of Health	43,446	31,870	23,771	**0**
PS.01.01.14.99	Government entities n.e.c. (Ho Chi Minh City AIDS Committee)	730,493			**2**
PS.01.01.99	Governmental organizations n.e.c.		420,000		**1**
PS.01.02	Parastatal organizations	50,000	290,000		**1**
Private-sector providers					
PS.02.01.01.10.03	Higher education (non-profit non-faith-based)	180,000	602,500	371,109	**3**
PS.02.01.01.13	Research institutions (non-profit non-faith-based)		740,000		**2**
PS.02.01.01.14	Self-help and informal community-based organizations (non-profit non-faith-based)	34,329			**0**
PS.02.01.01.15	Civil society organizations (non-profit non-faith-based) (CSOs)			883,049	**2**
PS.02.02.13	Research institutions (profit-making)		300,000		**1**
PS.02.02.14	Consultancy firms (profit-making)			125,149	**0**
Bilateral and multilateral entities – in-country offices					
PS.03.01	Bilateral agencies	9,957,925	13,395,776	13,052,115	**84**
Total		**11,661,023**	**16,522,377**	**14,662,610**	**100**

[22]. For the purposes of this table, percentages under 1% are marked as 0%.

Figure 18: Percentage share of service providers – Bilateral financing agent AIDS expenditure, 2008-2010



Multilateral agencies as financing agent

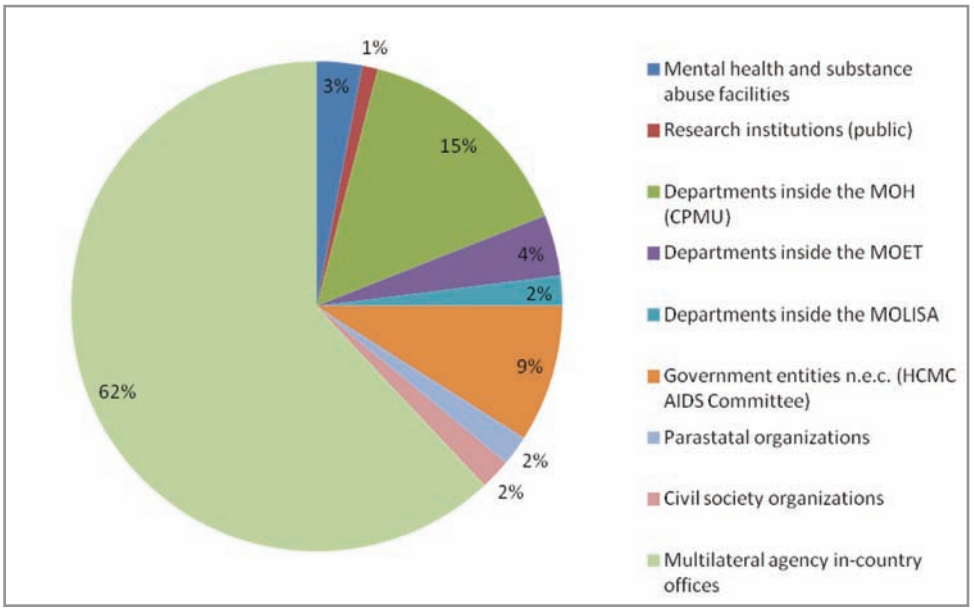
From 2008 to 2010, multilateral country offices acting as financing agents for their own funds channelled the majority (62%) of these funds to support their own HIV programme management and administration activities. Other service providers received significant transfers from multilateral agencies: Central Project Management Units managing multilateral funds; those coded as PS.01.01.14.02 (***Departments inside the Ministry of Health***, including VAAC), which received 15% of these funds; and the Ho Chi Minh City AIDS Committee (9%).

Table 19: Disaggregation of multilateral financing agent AIDS expenditure by service provider, 2008-2010 (US$)

Service provider		2008	2009	2010	% 2008-2010[23]
Public-sector providers					
PS.01.01.01	Hospitals		35,942		**0**
PS.01.01.04	Mental health and substance abuse facilities	146,557	186,913	142,214	**3**
PS.01.01.10.03	Higher education		24,265	11,203	**0**
PS.01.01.13	Research institutions		71,566	110,941	**1**
PS.01.01.14.02	Departments inside the Ministry of Health	992,726	638,993	516,049	**15**
PS.01.01.14.03	Departments inside the Ministry of Education	120,813	67,031	312,026	**4**
PS.01.01.14.07	Departments inside the Ministry of Labour	49,508	79,100	119,953	**2**
PS.01.01.14.99	Government entities n.e.c. (Ho Chi Minh City AIDS Committee)	929,897	38,475	325,372	**9**
All PS.01.02	Parastatal organizations	24,200	24,200	136,081	**2**
Private-sector providers					
PS.02.01.01.10.03	Higher education (non-profit non-faith-based)		3,291		**0**
PS.02.01.01.14	Self-help and informal community-based organizations (non-profit non-faith-based)		25,000	1,181	**0**
PS.02.01.01.15	Civil society organizations (non-profit non-faith-based)	54,729	52,829	152,920	**2**
Bilateral and multilateral entities – in-country offices					
PS.03.02	Multilateral agencies	2,212,678	3,603,494	2,854,782	**62**
Total		**4,531,108**	**4,851,099**	**4,682,722**	**100**

[23]. For the purposes of this table, percentages under 1% are marked as 0%.

Figure 19: Percentage share of service providers – Multilateral financing agent AIDS expenditure, 2008-2010



International non-profit organizations and foundations as financing agents

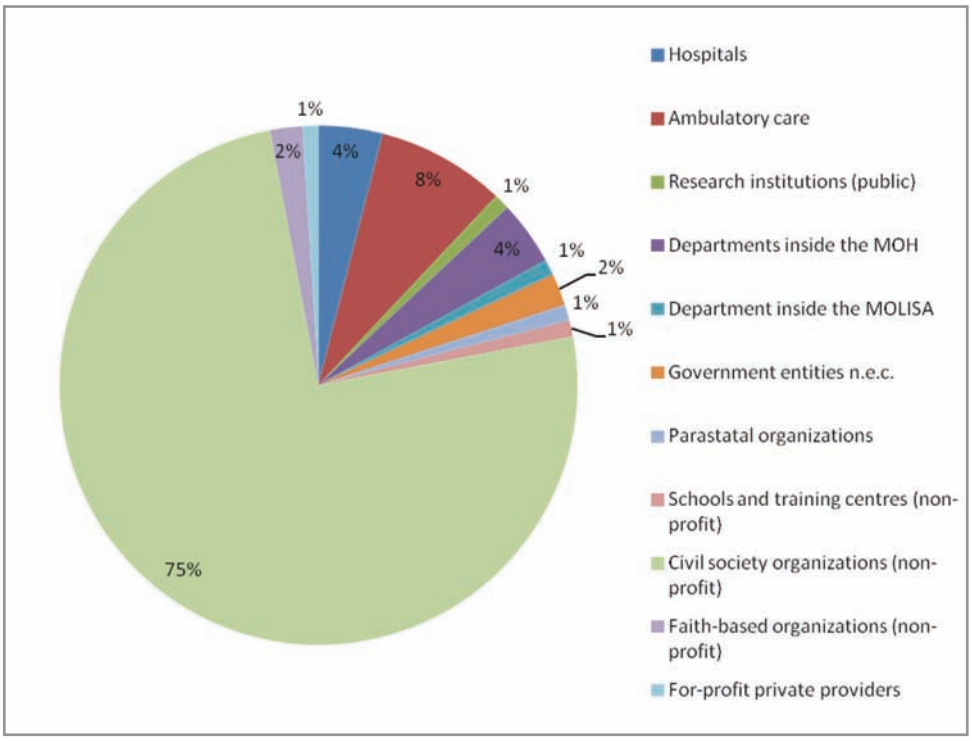
International non-profit organizations channelled 75% of the HIV funds they managed to international and national non-profit organizations providing services (specifically civil society organizations). Other service providers receiving a significant portion of funds from international non-profit financing agents included ambulatory care facilities (8% of all AIDS funds managed by international non-profit organizations), MOH departments (4%) and hospitals (4%).

Table 20: Disaggregation of international non-profit organization AIDS expenditure by service provider, 2008-2010 (US$)

Service provider		2008	2009	2010	% 2008-2010[24]
Public-sector providers					
PS.01.01.01	Hospitals	287,147	1,948,748	667,213	**4**
PS.01.01.02	Ambulatory care	1,201,955	2,657,202	2,187,038	**8**
PS.01.01.04	Mental health and substance abuse facilities	22,067	15,036	76,264	**0**
PS.01.01.11	Foster homes/shelters	9,561			**0**
PS.01.01.13	Research institutions		475,253		**1**
PS.01.01.14.02	Departments inside the Ministry of Health	1,082,648	1,544,185	334,595	**4**
PS.01.01.14.07	Departments inside the Ministry of Labour	4,329	1,080,579		**1**
PS.01.01.14.99	Government entities n.e.c. (Ho Chi Minh City AIDS Committee)	226,274	1,359,762	194,887	**2**
PS.01.02	Parastatal organizations	96,088	356,858		**1**
Private-sector providers					
PS.02.01.01.10	Schools and training facilities (non-profit non-faith-based)	390,713	380,849		**1**
PS.02.01.01.15	Civil society organizations (non-profit non-faith-based)	12,781,636	14,896,257	31,463,731	**75**
PS.02.01.02.14	Civil society organizations (non-profit faith-based)	705,656	566,621	435,067	**2**
PS.02.01.99	Other non-profit private sector providers	20,000	343,128		**0**
PS.02.02	Profit-making private sector providers	408,238	687,025		**1**
Total		**17,236,312**	**26,311,503**	**35,358,795**	**100**

[24]. For the purposes of this table, percentages under 1% are marked as 0%.

Figure 20: Percentage share of service providers – International non-profit organization AIDS expenditure, 2008-2010



VI. AIDS expenditure by programmatic area

The NASA also allows for the tracking of AIDS expenditure by programmatic area. The NASA categorizes such expenditure across eight core areas of HIV intervention: ASC.01 Prevention; ASC.02 Care and treatment; ASC.03 Orphaned and vulnerable children; ASC.04 Programme management and administration; ASC.05 Human resources; ASC.06 Social support and social services; ASC.07 Enabling environment; and ASC.08 HIV-related research.

As summarized in Table 21, expenditure in all programmatic areas increased significantly between 2008 and 2010. Prevention accounted for the highest proportion (32%) of total AIDS expenditure from 2008 to 2010, followed by programme management (30%) and care and treatment (26%). Expenditure on orphaned and vulnerable children (OVC) increased by the greatest percen6tage (63%) during this period.

Table 21: AIDS expenditure by key programmatic area, 2008-2010 (US$)

	AIDS spending category	2008	%	2009	%	2010	%	% 2008-2010
ASC.01	Prevention	31,913,528	33	40,811,053	31	44,951,932	33	**32.5**
ASC.02	Care and treatment	24,274,597	25	33,378,767	26	42,161,961	30	**27.5**
ASC.03	Orphaned and vulnerable children	872,092	1	1,425,733	1	1,800,891	1	**1.1**
ASC.04	Programme management and administration	28,980,635	30	38,745,169	31	36,772,929	26	**28.8**
ASC.05	Human resources	6,600,136	7	7,999,570	7	9,695,665	7	**6.7**
ASC.06	Social support and social services	286,045	0	361,244	0	209,967	0	**0.2**
ASC.07	Enabling environment	2,574,830	3	3,444,920	3	2,519,703	2	**2.4**
ASC.08	HIV-related research	706,914	1	1,208,027	1	1,140,197	1	**0.8**
	Total	**96,208,777**	**100**	**127,374,483**	**100**	**139,253,245**	**100**	**100**

[25]. For the purposes of this table, percentages under 1% are marked as 0%.

Figure 21: Percentage share of key programmatic areas in AIDS expenditure, 2008-2010

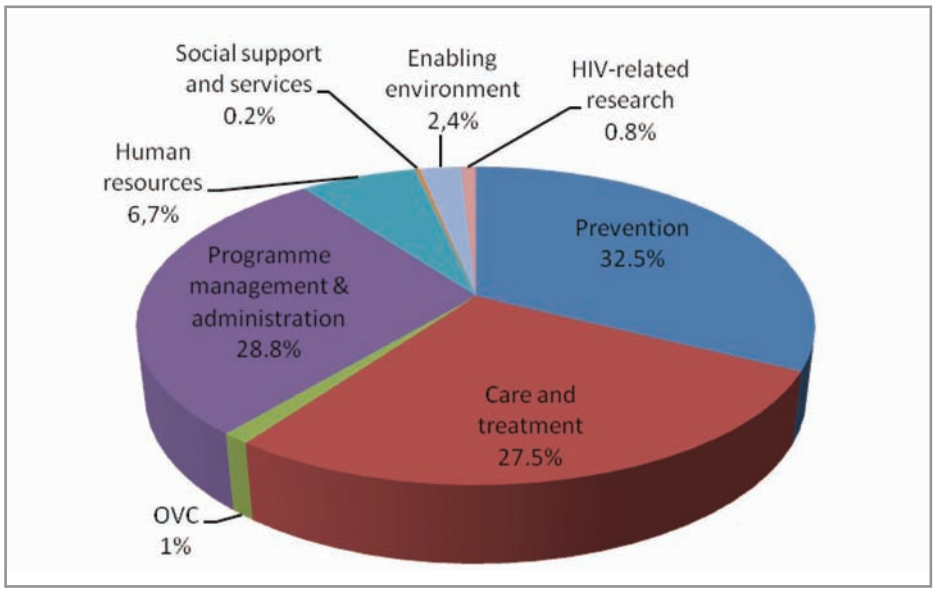
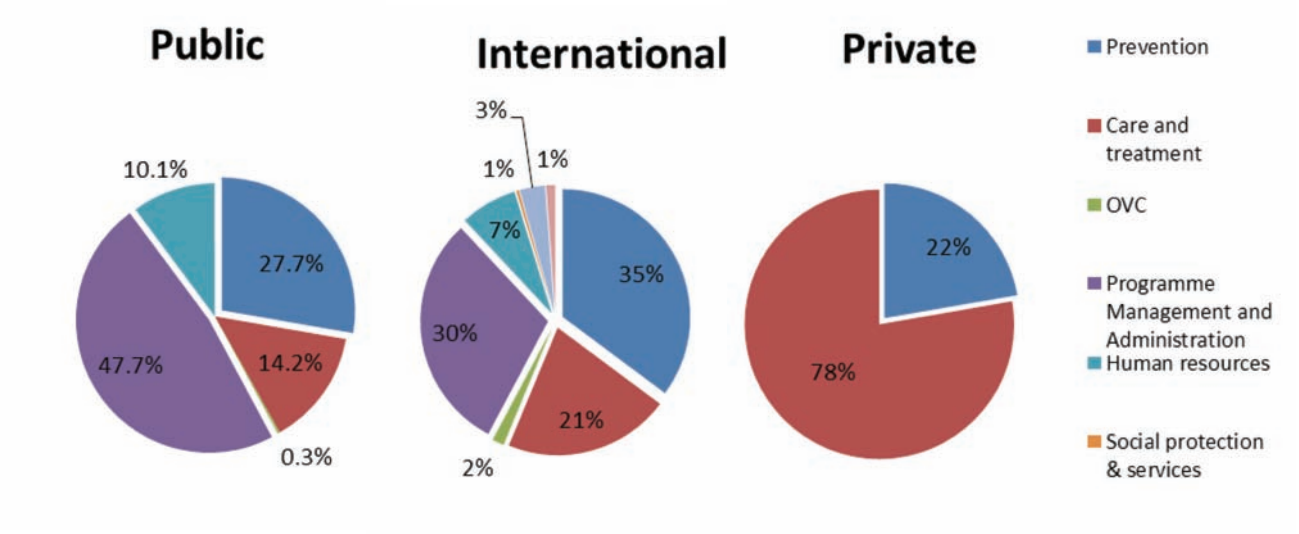


Table 22 disaggregates AIDS expenditure by key intervention area and major sources of funding. Public financing concentrated on programme management and administration (48% of expenditure) and prevention (28% of expenditure); private financing was mostly spent on care and treatment (78%); and international financing was principally channelled to prevention (35%), programme management and administration (30%) and care and treatment (21%). Figure 22 illustrates the percentage share of each key intervention area in terms of total expenditure by public, private and international financing sources.

Table 22: AIDS expenditure by key intervention area and financing source, 2008-2010 (US$)

	Public	International	Private
2008	**13,459,881**	**66,734,576**	**16,014,322**
Enabling environment		2,574,830	
Human resources	1,722,478	4,877,658	
OVC	50,618	819,827	1,648
Prevention	2,868,970	25,378,974	3,665,585
Programme management & administration	7,016,284	21,964,352	
Research	3,725	703,187	
Social protection & social services	3,875	282,170	
Care and treatment	1,793,931	10,133,578	12,347,089
2009	**17,176,061**	**94,161,904**	**16,036,518**
Enabling environment		3,444,920	
Human resources	1,778,481	6,221,088	
OVC	42,359	1,381,669	1,705
Prevention	4,149,705	32,973,625	3,687,724
Programme management & administration	8,400,077	30,345,093	
Research		1,208,027	
Social protection & social services		361,244	
Care and treatment	2,805,439	18,226,238	12,347,089
2010	**21,431,087**	**102,221,779**	**15,600,379**
Enabling environment	1,957	2,517,746	
Human resources	1,760,735	7,934,930	
OVC	49,127	1,751,764	
Prevention	7,426,742	34,271,902	3,253,288
Programme management & administration	9,407,939	27,364,990	
Research	10,822	1,129,375	
Social protection & social services	1,260	208,707	
Care and treatment	2,772,505	27,042,365	12,347,091
Total	**52,067,029**	**263,118,259**	**47,651,219**

Figure 22: Disaggregation of the AIDS expenditure of each financing source by key intervention area, 2008-2010



6.1 Prevention

Prevention is defined as a comprehensive set of activities or programmes designed to reduce risk behaviour. Results include a decrease in HIV infections among the population and improvements in quality and safety in health facilities with regard to therapies administered exclusively or in large part to HIV patients. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals[26] .

Expenditure on HIV prevention gradually increased from US$31.9 million in 2008 to US$40.8 million in 2009 and US$44.9 million in 2010. At the two-digit level, funds were spent on a total of 24 prevention categories, although 94% of HIV prevention expenditure was concentrated among 10 categories (see Table 24). These categories included: communication for social and behavioural change (17%); harm-reduction programmes for IDUs (15.9%); blood safety (10%); VCT (7%); PMTCT (6%) programmes for sex workers and their clients (8%); community mobilization (3.8%); programmes for MSM (2.5%); and risk-reduction programmes for vulnerable and accessible populations (2.1%). It is estimated that prevention activities not broken down by intervention received 21% of expenditure.

[26]. This definition is taken directly from the National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS, 2009.

Table 23: Expenditure on HIV prevention, 2008-2010 (US$)

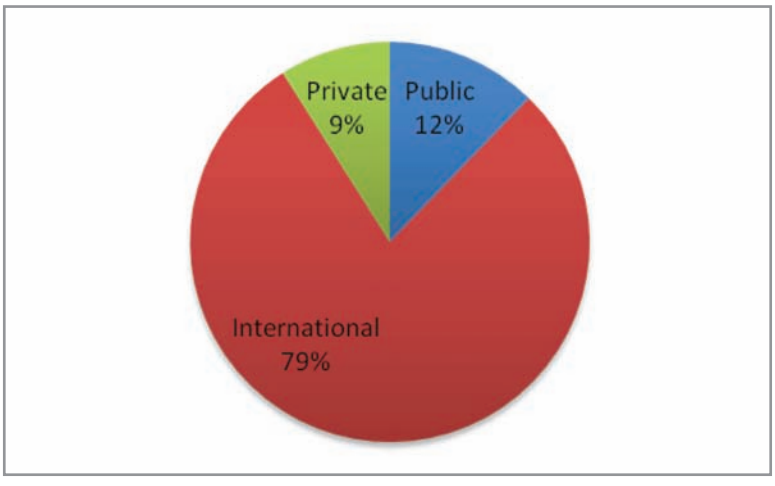
		2008	2009	2010
ASC.01	**Prevention (sub-total)**	**31,913,528**	**40,811,053**	**44,951,932**
ASC.01.01	Communication for social and behaviour change	6,861,283	7,423,982	5,994,680
ASC.01.02	Community mobilization	1,325,832	810,898	2,318,789
ASC.01.03	Voluntary counselling and testing (VCT)	1,308,824	2,483,879	4,676,980
ASC.01.04	Risk-reduction for vulnerable and accessible populations	1,083,168	1,202,466	128,202
ASC.01.05	Prevention - youth in school	316,088	153,497	99,102
ASC.01.06	Prevention - youth out of school	440,907	234,000	290,354
ASC.01.07	Prevention of HIV transmission aimed at people living with HIV	234,779	548,978	915,607
ASC.01.08	Prevention programmes for sex workers and their clients	3,021,373	3,917,357	2,707,129
ASC.01.09	Programmes for men who have sex with men	835,613	1,007,369	1,056,975
ASC.01.10	Harm-reduction programmes for injecting drug users	4,702,381	5,774,569	8,248,641
ASC.01.11	Prevention programmes in the workplace	264,410	246,234	1,309,879
ASC.01.12	Condom social marketing	2,153		604,922
ASC.01.13	Public and commercial sector male condom provision	46,973	204,681	59,544
ASC.01.14	Public and commercial sector female condom provision			810
ASC.01.15	Microbicides	18,328	23,599	7,062
ASC.01.16	Prevention, diagnosis and treatment of sexually transmitted infections	235,212	263,899	770,654
ASC.01.17	Prevention of mother-to-child transmission	1,673,181	2,402,482	2,980,480
ASC.01.18	Male circumcision			
ASC.01.19	Blood safety	4,316,317	3,965,649	3,123,716
ASC.01.20	Safe medical injections	35,848	61,727	11,700
ASC.01.21	Universal precautions	1,086	5,225	5,364
ASC.01.22	Post-exposure prophylaxis	308		3,212
ASC.01.98	Prevention activities not broken down by intervention	5,189,466	10,080,562	9,553,105
ASC.01.99	Prevention activities n.e.c.			85,025

Table 24: Expenditure on major prevention categories, 2008-2010 (US$)

Prevention expenditure categories		Total 2008-2010	% 2008-2010
ASC.01.98	Prevention activities not broken down by intervention	24,823,131	21.1
ASC.01.01	Communication for social and behaviour change	20,279,945	17.2
ASC.01.10	Harm-reduction programmes for injecting drug users	18,725,591	15.9
ASC.01.19	Blood safety	11,405,682	9.7
ASC.01.08	Prevention programmes for sex workers and their clients	9,645,859	8.2
ASC.01.03	Voluntary counselling and testing	8,469,683	7.2
ASC.01.17	Prevention of mother-to-child transmission	7,056,143	6.0
ASC.01.02	Community mobilization	4,455,519	3.8
ASC.01.09	Programmes for men who have sex with men	2,899,957	2.5
ASC.01.04	Risk-reduction for vulnerable and accessible populations	2,413,835	2.1
Proportion of expenditure on 10 biggest prevention categories/ total expenditure on prevention			**93.7**

International sources provided funds for 79% of prevention expenditure, public sources for 12% and private sources for 9%. See the 2008, 2009 and 2010 funding matrices (Appendix 6) for details of expenditure by public, private and international sources on HIV prevention activities.

Figure 23: Share of public, private and international sources in HIV prevention expenditure, 2008-2010



6.2 Care and treatment

Expenditure on care and treatment is all expenditure, purchases, transfers, and investment incurred to provide access to clinic-based, home-based or community-based activities for the care and treatment of HIV-positive adults and children

Expenditure on care and treatment also increased between 2008 and 2010, from US$24.3 million in 2008 to US$33.4 million in 2009 and US$42.2 million in 2010. Indeed, expenditure on ART more than doubled during this period, from US$6 million in 2008 to US$13 million in 2010.

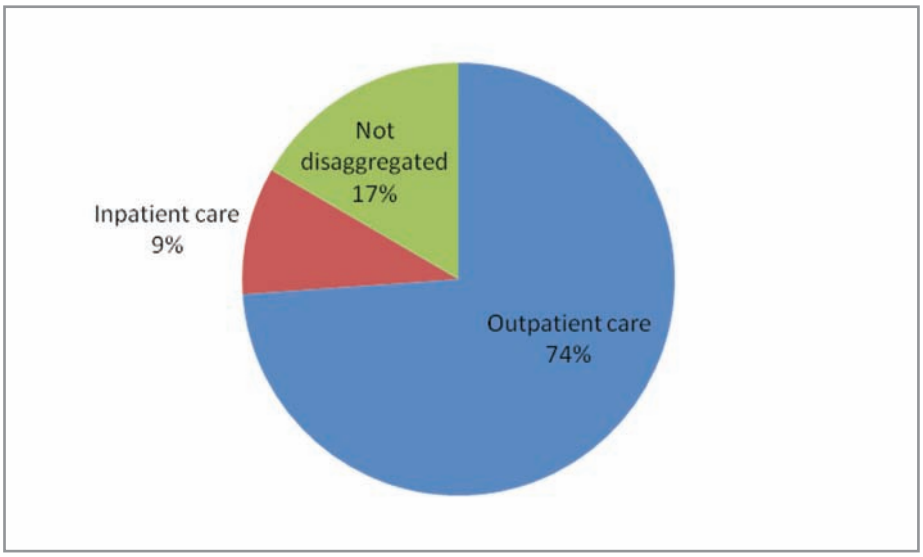
The following care and treatment activities attracted the majority of expenditure: ART for both adults and children (accounting for 27% of total care and treatment expenditure); home-based medical care (20%); outpatient prophylaxis and treatment for opportunistic infections (OI) (16%); and inpatient care (9%).

Table 25: Expenditure on care and treatment, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010
ASC.02	**Care and treatment (sub-total)**	**24,274,598**	**33,378,765**	**42,161,961**	
ASC.02.01	Outpatient care	18,262,106	22,950,855	32,547,870	**73.9**
ASC.02.01.01	Provider-initiated testing and counselling	96,071	255,291	282,383	**0.6**
ASC.02.01.02	Opportunistic infection (OI) outpatient prophylaxis and treatment	4,555,456	4,817,604	6,276,693	**15.7**
ASC.02.01.03	Antiretroviral therapy	6,172,042	8,118,648	12,942,285	**27.3**
ASC.02.01.04	Nutritional support associated with ARV therapy	3,321	21,361	193,573	**0.2**
ASC.02.01.05	Specific HIV-related laboratory monitoring	807,329	1,063,967	1,961,775	**3.8**
ASC.02.01.06	Dental programmes for PLHIV				**0.0**
ASC.02.01.07	Psychological treatment and support services	5,751	9,333	852,660	**0.9**
ASC.02.01.08	Outpatient palliative care	329,963	123,684	692,622	**1.1**
ASC.02.01.09	Home-based care	6,013,968	7,033,055	6,586,691	**19.7**
ASC.02.01.10	Traditional medicine and informal care and treatment services				**0.0**
ASC.02.01.98	Outpatient care services not broken down by intervention	278,204	1,507,912	2,756,133	**4.6**
ASC.02.01.99	Outpatient care services n.e.c.			3,055	**0.0**
ASC.02.02	Inpatient care	2,892,532	3,303,074	3,324,724	**9.5**
ASC.02.02.01	Inpatient treatment of opportunistic infections (OI)	62,188	244,165	505,979	**0.8**
ASC.02.02.02	Inpatient palliative care		233,249	3,352	**0.2**
ASC.02.02.98	Inpatient care services not broken down by intervention	2,829,133	2,825,660	2,815,393	**8.5**
ASC.02.02.99	Inpatient care services n.e.c.	492			**0.0**
ASC.02.03	Patient transport and emergency rescue	286			**0.0**
ASC.02.98	Care and treatment services not broken down by intervention	3,119,551	7,124,836	6,288,811	**16.6**
ASC.02.99	Care and treatment services n.e.c.	123		556	**0.0**

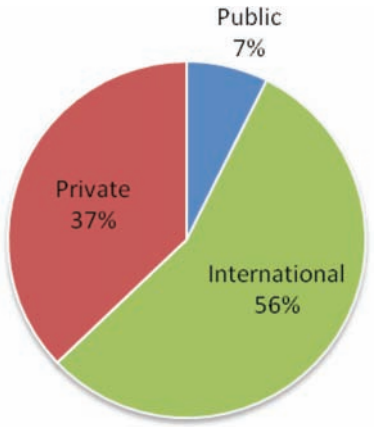
Figure 24 illustrates the distribution of care and treatment expenditure by two key groups of activity: outpatient care accounted for the majority of expenditure (74%), while inpatient care for patients with advanced HIV-related diseases accounted for 9% of total expenditure. Around 17% of care and treatment expenditure was not disaggregated.

Figure 24: Percentage share of care and treatment expenditure, 2008-2010



Disaggregating care and treatment expenditure by sources of funding revealed that 56% of care and treatment services between 2008 and 2010 were paid for by international sources; private sources (primarily out-of-pocket expenditure) accounted for 37%; and public sources (7%) covered the remainder.

Figure 25: Share of public, private and international sources in care and treatment expenditure, 2008-2010



International sources focused the majority of their care and treatment-related AIDS expenditure on several key areas: ART, home-based care and HIV-specific laboratory monitoring. All private funds for care and treatment were spent in three areas: home-based care, OI outpatient prophylaxis and treatment, and inpatient care services not broken down by intervention). Please see the 2008, 2009 and 2010 funding matrices (Appendix 6) for further detail.

6.3 Orphans and other vulnerable children (OVC)

An orphan is defined as a child aged under 18 who has lost one or both parents regardless of financial support (whether national AIDS programme-related or not). In the NASA context, all expenditure to substitute for the parents taking care of their children because they have died from HIV; expenditure incurred in providing social mitigation to all double orphans and half or single orphans need to be included. In this context, vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them[27].

OVC expenditure increased by 63% between 2008 and 2009, from US$0.87 million in 2008 to over US$1.4 million in 2009, and another 26% to US$1.8 million in 2010. As OVC services were often provided as part of a package of services, it was not possible for the NASA team to disaggregate a large portion of expenditure into two-digit sub-categories. In these three years, such expenditure increased by 16%. However, as a percentage of total OVC expenditure, spending on institutional care fell from 32% to 23% due to significant programmatic expansion in other categories. A total of 96% of OVC expenditure in 2008-09 was financed by international sources.

Table 26: Expenditure on OVC, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010
ASC.03	**OVC (sub-total)**	**872,092**	**1,425,733**	**1,800,891**	
ASC.03.01	OVC education	14,798	7,054	159,453	**4.4**
ASC.03.02	OVC basic health care	23,685	105,612	275,150	**9.9**
ASC.03.03	OVC family/home support	1,103	472	177,410	**4.4**
ASC.03.04	OVC community support	54,441	15,239	463,096	**13.0**
ASC.03.05	OVC social services and administrative costs		10,637	168,554	**4.4**
ASC.03.06	OVC institutional care	282,668	326,794	137,934	**18.2**
ASC.03.98	OVC services not broken down by intervention	436,485	959,925	419,294	**44.3**
ASC.03.99	OVC services n.e.c.	58,912			**1.4**

6.4 Programme management and administration

Programme expenditure is defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditure cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and facility upgrading through purchases of laboratory equipment and telecommunications. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole[28].

Expenditure on programme management and administration strengthening increased by 34% from nearly US$29 million in 2008 to US$38.7 million in 2009; in 2010, expenditure reduced slightly to US$36.7 million. Planning, coordination and programme management constituted the major expenditure category during this period, accounting for 63% of total expenditure in this area. Other significant categories included: monitoring and evaluation (accounting for 9% of total programme management expenditure); programme management and administration not broken down by type (8%);

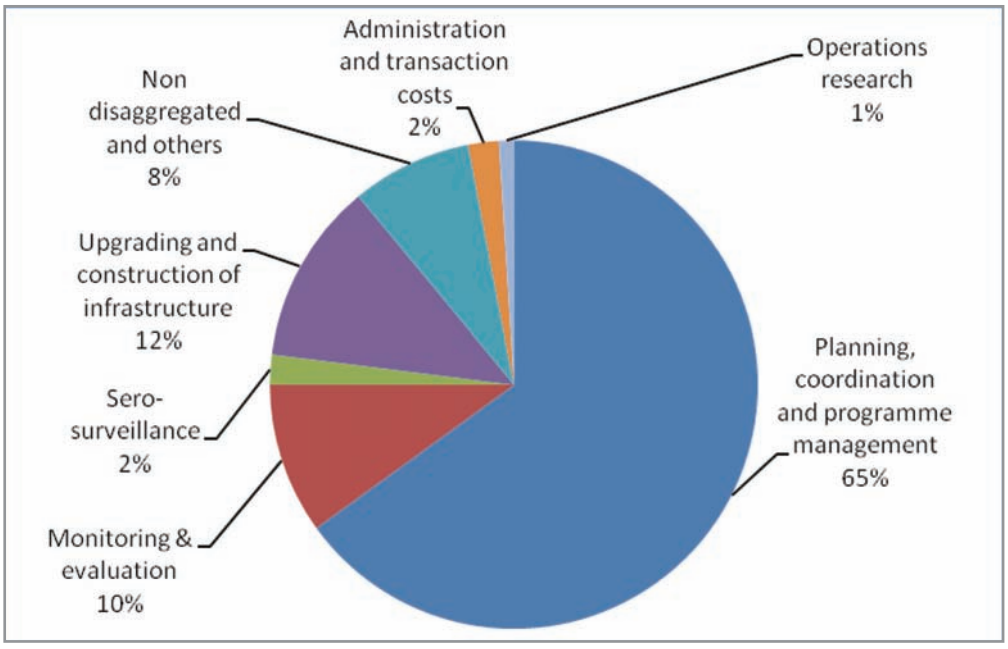
[27]. This definition is taken directly from the National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS, 2009.
[28]. This definition is taken directly from the National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS, 2009.

upgrading laboratory infrastructure and new equipment (6%); and upgrading and construction of infrastructure not broken down by intervention (5%). These categories together accounted for 91% of total expenditure on programme management and administration strengthening.

Table 27: Expenditure on HIV programme management and administration, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010
ASC.04	**Programme management and administration (sub-total)**	**28,980,635**	**38,745,169**	**36,772,929**	
ASC.04.01	Planning, coordination and programme management	19,214,666	23,282,571	25,449,604	**65.0**
ASC.04.02	Administration and transaction costs associated with managing and disbursing funds	612,457	770,079	796,587	**2.1**
ASC.04.03	Monitoring and evaluation	3,028,531	3,162,314	3,810,832	**9.6**
ASC.04.04	Operations research	118,400	610,901	26,302	**0.7**
ASC.04.05	Serological surveillance (serosurveillance)	350,847	1,534,961	344,095	**2.1**
ASC.04.06	HIV drug-resistance surveillance	1,292		8,833	**0.0**
ASC.04.07	Drug supply systems	669,025	591,286	533,119	**1.7**
ASC.04.08	Information technology	185,107	52,077	386,209	**0.6**
ASC.04.09	Patient tracking	13,117		30,034	**0.0**
ASC.04.10	Upgrading and construction of infrastructure	2,911,004	4,984,623	4,770,218	**12.1**
ASC.04.11	Mandatory HIV testing (not VCT)	24,503	3,068	88,666	**0.1**
ASC.04.98	Programme management and administration not broken down by type	1,747,546	3,700,278	499,357	**5.8**
ASC.04.99	Programme management and administration n.e.c.	104,140	53,011	29,073	**0.2**

Figure 26: Expenditure on programme management and administration, 2008-2010



Programme management expenditure was paid for by two financing sources, with international sources financing 77% of such expenditure, and the remainder (23%) supported by public sources.

6.5 Human resources

This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. The HIV workforce is not limited to the health system. Included in this category is the direct payment of wage benefits for health care workers[29].

Expenditure on human resources increased gradually by around 21% from US$6.6 million in 2008 to US$8 million in 2009, and by another 21% to US$9.7 million in 2010. Of this expenditure, 72.8% supported staff training; the vast majority of other expenditure in this area consisted of monetary incentive payments for staff (21.9%).

[29]. This definition is taken directly from the National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS, 2009.

Table 28: Expenditure on human resources, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010
ASC.05	**Human resources (sub-total)**	**6,600,136**	**7,999,570**	**9,695,665**	
ASC.05.01	Monetary incentives for human resources	1,309,477	1,378,058	2,628,445	**21.9**
ASC.05.02	Formative education to build up an AIDS workforce	9,841		896,787	**3.7**
ASC.05.03	Training	5,261,850	6,565,954	5,859,743	**72.8**
ASC.05.98	Human resources not broken down by type	18,968	55,558	172,097	**1.0**
ASC.05.99	Human resources n.e.c.			138,593	**0.6**

6.6 Social protection and social services

Social protection usually refers to functions of government or non-governmental organizations relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by requirements such as sickness, old age, disability, unemployment, social exclusion, etc. Social protection comprises personal social services and social security. It includes expenditure on services and transfers provided not only to individual people but also to households, in addition to expenditure on services provided on a collective basis[30].

It seems that expenditure on social protection and social services is not a significant category of spending. Expenditure increased from US$0.28 million in 2008 to US$0.36 million in 2009, but reduced again in 2010 to US$0.2 million. Spending in this area included income-generation for PLHIV as well as social protection services and social services not broken down by type.

Table 29: Expenditure on social protection and social services, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010
ASC.06	**Social protection and social services (sub-total)**	**286,045**	**361,244**	**209,967**	
ASC.06.01	Social protection through monetary benefits			432	**0.1**
ASC.06.02	Social protection through in-kind benefits			420	**0**
ASC.06.03	Social protection through provision of social services			19,921	**2.3**
ASC.06.04	HIV-specific income generation projects		233,371	140,601	**43.6**
ASC.06.98	Social protection services and social services not broken down by type	282,096	127,873	127	**47.8**
ASC.06.99	Social protection services and social services n.e.c.	3,949		48,466	**6.2**

[30]. This definition is taken directly from the National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS, 2009.

6.7 The enabling environment

The enabling environment covers advocacy to increase support for the response and to promote HIV prevention, the reduction of stigma and discrimination, the scaling-up of HIV programmes by national governments with key partners and the development of a strong HIV constituency among civil society, including people living with HIV. It also includes activities and resources invested in the protection of human rights and the legislative aspects of social life; investment in capacity building of nongovernmental organizations; programmes targeting women and girls, such as improved reproductive health activities, assistance for abused women and the protection of property and inheritance rights; and programmes to reduce gender-based violence, including policies and services that provide care for victims of sexual violence.

Expenditure on interventions to support the enabling environment increased by 34% from nearly US$2.6 million in 2008 to US$3.4 million in 2009, but decreased to US$2.5 million in 2010. The majority of this expenditure was directed towards advocacy and AIDS-specific institutional development, which respectively accounted for 60% and 29% of total expenditure between 2008 and 2010. These categories were solely financed by international sources.

Table 30: Expenditure to support the enabling environment, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010
ASC.07	**Enabling environment (sub-total)**	**2,574,830**	**3,444,920**	**2,519,703**	
ASC.07.01	Advocacy	1,160,594	1,884,347	2,080,247	**60.0**
ASC.07.02	Human rights programmes	41,536	147,628	93,925	**3.3**
ASC.07.03	AIDS-specific institutional development	1,021,171	1,181,837	286,921	**29.2**
ASC.07.04	AIDS-specific programmes focused on women	122,483	121,459	42,944	**3.4**
ASC.07.05	Programmes to reduce gender-based violence			1,212	**0.0**
ASC.07.98	Enabling environment not broken down by type	177,211	89,857	9,407	**3.2**
ASC.07.99	Enabling environment n.e.c.	51,835	19,792	5,047	**0.9**

6.8 HIV-related research

HIV-related research is defined as the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well-being. It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS. This category excludes operations research on health systems aimed to improve health outcomes, including project or programme evaluation.[31]. Expenditure on HIV-related research increased from US$0.71 million in 2008 to US$1.2 million in 2009 and reduced slightly to US$1.1 million in 2010. The research categories which received the most funding were clinical research (25% of total HIV-related research expenditure) and social science research (43%). HIV-related research was financed exclusively by international sources.

[31]. This definition is taken directly from the National AIDS Spending Assessment (NASA): Classification and Definitions. UNAIDS, 2009.

Table 31: Expenditure on HIV-related research, 2008-2010 (US$)

		2008	2009	2010	% 2008-2010[32]
ASC.08	**Research (sub-total)**	**706,912**	**1,208,027**	**1,140,197**	
ASC.08.01	Biomedical research		81,427	109,985	**6.3**
ASC.08.02	Clinical research	378,735	360,917	29,368	**25.2**
ASC.08.03	Epidemiological research	3,075		273,992	**9.1**
ASC.08.04	Social science research	119,701	529,747	662,153	**42.9**
ASC.08.05	Vaccine-related research				**0**
ASC.08.98	HIV-related research activities not broken down by type	205,401	205,936	43,580	**14.9**
ASC.08.99	HIV-related research activities n.e.c.		30,000	21,119	**1.6**

[32]. For the purposes of this table, percentages under 1% are marked as 0%.

VII. AIDS expenditure by beneficiary population

The NASA also allows for the classification of AIDS expenditure by beneficiary population. Table 32 itemizes annual AIDS expenditure by the six NASA beneficiary population categories: people living with HIV; most-at-risk populations; other key populations; specific "accessible" populations; the general population; and non-targeted interventions.

Between 2008 and 2010, 30% of AIDS expenditure benefited PLHIV. Expenditure on activities targeting most-at-risk populations (including IDUs, FSW and MSM) increased from 13% of total AIDS expenditure in 2008 to 17% of total AIDS expenditure in 2009 and reduced to 15% in 2010.

Other key populations – which includes OVC, children born or to be born to women living with HIV, recipients of blood or blood products, migrants/mobile populations, truck drivers/transport workers and commercial drivers, prisoners and other institutionalized persons, children and youth out of school, and partners of PLHIV – benefited from just over 5% of total AIDS expenditure between 2008 and 2010.

Specific "accessible" populations – which includes people attending STI clinics, factory employees, the military, the police and other uniformed services, students and health care workers – received just over 3% of total AIDS expenditure during this period. The general population benefited from 10% of total AIDS expenditure from 2008 to 2010.

Over 37% of total expenditure supported non-targeted activities, including training, programme management and administration, monitoring and evaluation and investment in infrastructure.

Table 32: AIDS expenditure by 6 categories of beneficiary population, 2008-2010 (US$)

Beneficiary population group		2008	%	2009	%	2010	%
BP.01	People living with HIV	26,628,661	28	35,694,752	28	46,594,814	33
BP.02	Most-at-risk populations	12,926,225	13	21,164,259	17	20,522,932	15
BP.03	Other key populations	5,365,753	6	6,471,014	5	6,787,652	5
BP.04	Specific "accessible" populations	4,450,925	5	2,841,871	2	3,547,015	3
BP.05	General population	9,460,271	10	11,023,664	9	15,190,698	11
BP.06	Non-targeted interventions	37,376,942	39	50,178,924	39	46,610,134	33
Total		**96,208,777**		**127,374,484**		**139,253,245**	

Figure 27: Disaggregation of AIDS expenditure by 6 categories of beneficiary population, 2008-2010

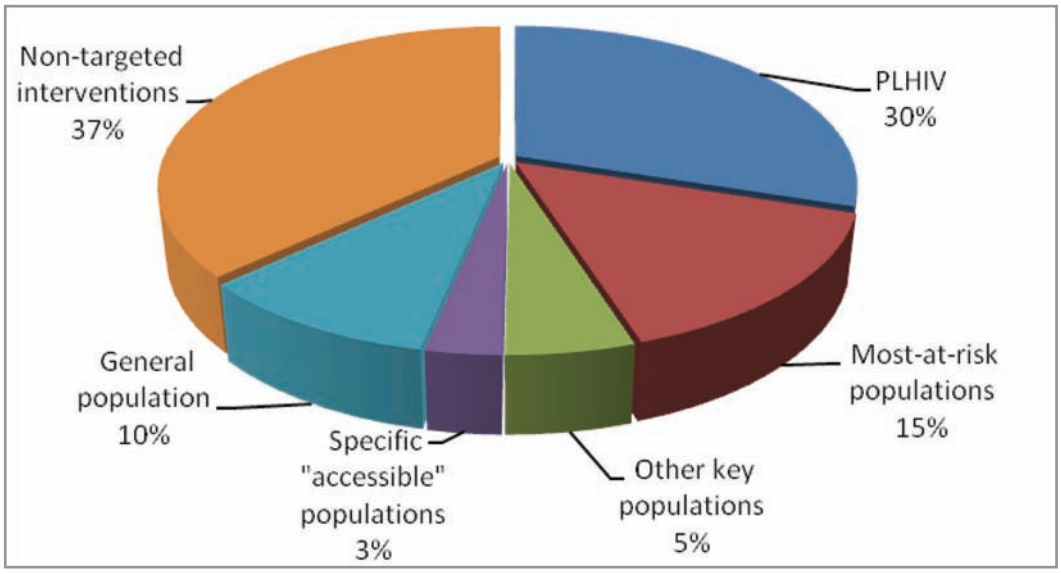


Table 33: AIDS expenditure by beneficiary population, 2008-2010 (US$)

	Beneficiary population	2008	2009	2010
BP.01.01.98	Adult and young people (aged 15 and over) living with HIV not broken down by gender	3,350,018	7,796,613	5,798,998
BP.01.02.98	Children (aged under 15) living with HIV not broken down by gender	1,509,119	2,679,265	1,688,306
BP.01.98	People living with HIV not broken down by age or gender	21,769,524	25,218,874	39,107,510
BP.02.01	Injecting drug users and their sexual partners	4,684,359	6,255,120	8,628,450
BP.02.02.01	Female sex workers and their clients	3,310,031	3,547,359	1,808,203
BP.02.02.03	Male non-transvestite sex workers (and their clients)	32,680		
BP.02.02.98	Sex workers, not broken down by gender, and their clients	266,220	552,917	1,143,073
BP.02.03	Men who have sex with men	798,874	971,818	1,067,814
BP.02.98	"Most-at-risk populations" not broken down by type	3,834,061	9,837,045	7,875,392
BP.03.01	Orphans and vulnerable children	576,837	1,199,393	1,980,997
BP.03.02	Children born or to be born of women living with HIV	1,639,808	2,215,826	2,967,383
BP.03.05	Migrants/mobile populations	33,535	48,437	51,622
BP.03.06	Indigenous groups	16,501	35,285	119,655
BP.03.07	Prisoners and other institutionalized persons	20,198	33,442	172,497

	Beneficiary population	2008	2009	2010
BP 03.08	Truck drivers/transport workers and commercial drivers		112,730	
BP.03.11	Children and youth out of school	1,415		33,864
BP.03.12	Institutionalized children and youth	1,454	2,363	
BP.03.14	Recipients of blood or blood products	2,717,633	2,495,410	1,434,777
BP.03.98	Other key populations not broken down by type	358,372	328,127	26,857
BP.04.01	People attending STI clinics	104,899	128,760	
BP.04.03	Junior high/high school students	42,253	25,000	92,192
BP.04.04	University students	199,435	146,466	
BP.04.05	Health care workers	36,155	61,727	
BP.04.06	Sailors	19,510		
BP.04.07	Military	253,075	180,000	150,000
BP.04.08	Police and other uniformed services (other than the military)		5,007	26,000
BP.04.10	Factory employees (e.g. for workplace interventions)	601,006	240,394	1,384,879
BP.04.98	Specific "accessible" populations not broken down by type	3,187,555	1,612,878	1,615,041
BP.04.99	Specific "accessible" populations n.e.c.	7,037	441,640	278,903
BP.05.01.02	Female adult population	330,087	472,974	9,144
BP.05.01.98	General adult population (aged older than 24) not broken down by gender	17,469	370,000	321,454
BP.05.02.98	Children (aged under 15) not broken down by gender	84,274	7,031	91,910
BP.05.03.98	Youth (aged 15 to 24) not broken down by gender	2,256,265	2,991,428	4,420,402
BP.05.98	General population not broken down by age or gender	6,772,176	7,182,230	10,347,788
BP.06	Non-targeted interventions	37,376,942	50,178,924	46,610,134
Total		**96,208,777**	**127,374,483**	**139,253,245**

VIII. AIDS expenditure by production facto

The NASA also allows for the classification of AIDS expenditure by production factor. The NASA defines production factors (or resource costs) as inputs used to provide AIDS-related services. Between 2008 and 2009, 83% of AIDS expenditure was current expenditure, capital expenditure accounted for only 5%, while 12% of expenditure is unclassified due to a lack of information. A detailed disaggregation of production factors is presented in Table 34.

The 2010 NASA was unable to capture this information due to time constraints and a lack of both completeness and availability of information.

Figure 28: Disaggregation of AIDS expenditure by type of expenditure, 2008-2009

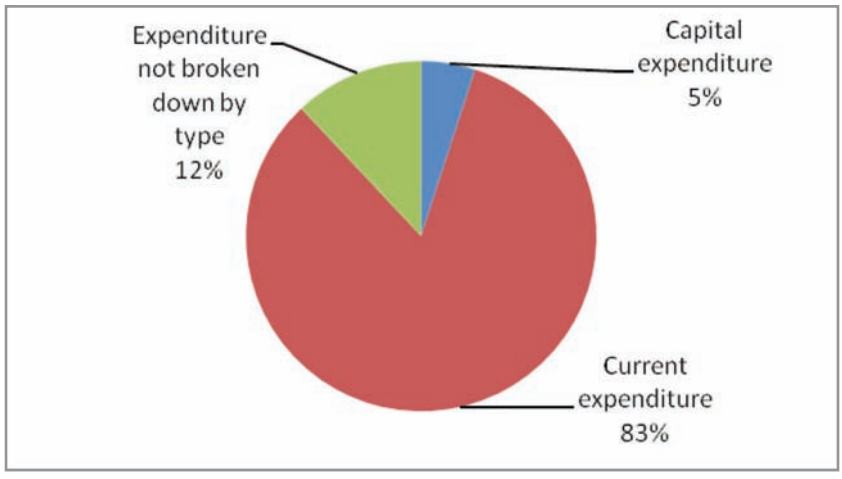


Table 34: Disaggregation of AIDS expenditure by production factor, 2008-2009 (US$)

Production factor		2008	2009	Total	%[33]
PF.01 Current expenditures		**80,961,943**	**101,096,159**	**182,058,102**	**81%**
PF.01.01.01	Wages	12,501,550	15,797,677	28,299,227	13%
PF.01.01.02	Social contributions	139,003	191,960	330,963	0%
PF.01.01.03	Non-wage labour income	208,745	109,872	318,617	0%
PF.01.01.98	Labour income not broken down by type	6,614	94,558	101,172	0%
PF.01.02.01.01	Antiretrovirals	1,451,351	1,719,885	3,171,236	1%
PF.01.02.01.02	Other drugs and pharmaceuticals (excluding antiretrovirals)	6,797,325	6,820,714	13,618,039	6%
PF.01.02.01.03	Medical and surgical supplies	977,305	1,491,694	2,468,999	1%
PF.01.02.01.04	Condoms	760,385	1,270,566	2,030,951	1%
PF.01.02.01.05	Reagents and materials	3,250,074	3,730,726	6,980,800	3%

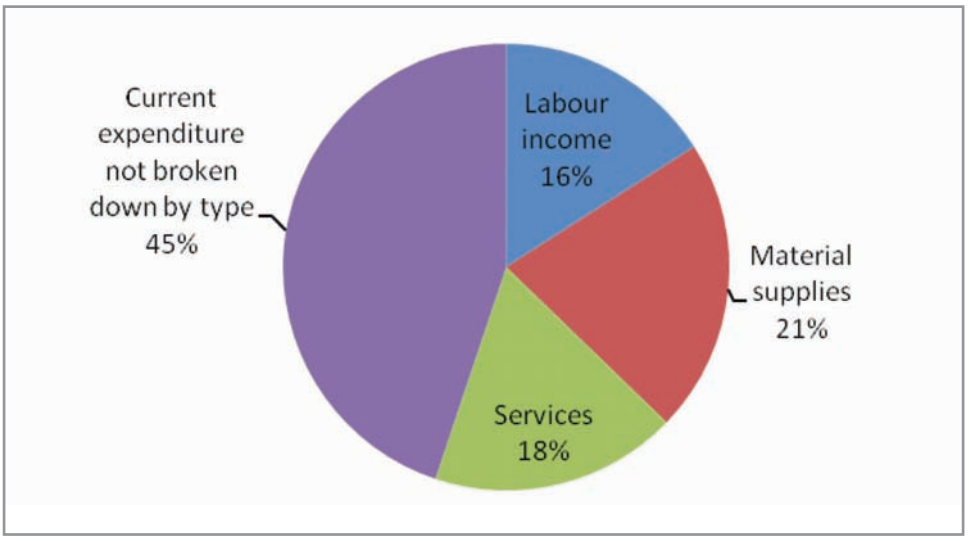
[33]. For the purposes of this table, percentages under 1% are marked as 0%.

Production factor		2008	2009	Total	%[33]
PF.01.02.01.06	Food and nutrients	116,594	189,517	306,111	0%
PF.01.02.01.07	Uniforms and school materials	41,957	68,348	110,305	0%
PF.01.02.01.98	Material supplies not broken down by type	4,398,779	5,621,157	10,019,936	4%
PF.01.02.01.99	Other material supplies n.e.c.	38,530	8,387	46,917	0%
PF.01.02.02.01	Administrative services	1,516,199	2,422,075	3,938,274	2%
PF.01.02.02.02	Maintenance and repair services	169,977	172,438	342,415	0%
PF.01.02.02.03	Publishers, motion picture, broadcasting and programming services	4,641,155	5,005,526	9,646,681	4%
PF.01.02.02.04	Consulting services	2,525,605	1,769,631	4,295,236	2%
PF.01.02.02.05	Transportation and travel services	1,544,528	1,865,923	3,410,451	2%
PF.01.02.02.06	Housing services	105,646	95,882	201,528	0%
PF.01.02.02.07	Logistics of events, including catering services	4,055,840	2,667,910	6,723,750	3%
PF.01.02.02.08	Financial intermediation services	7,334	2,960	10,294	0%
PF.01.02.02.98	Services not broken down by type	1,419,376	2,606,464	4,025,840	2%
PF.01.02.02.99	Services n.e.c.	6,780		6,780	0%
PF.01.98	Current expenditures not broken down by type	33,594,782	47,346,435	80,941,217	37%
PF.01.99	Current expenditures n.e.c.	686,509	25,854	712,363	0%
PF.02 Capital expenditures		**4,560,325**	**7,141,020**	**11,701,345**	**5%**
PF.02.01.01	Laboratory and other infrastructure upgrading	6,729	91,278	98,007	0%
PF.02.01.98	Buildings not broken down by type	1,135,481	1,264,847	2,400,328	1%
PF.02.02.01	Vehicles		27,505	27,505	0%
PF.02.02.02	Information technology (hardware and software)	131,356	154,529	285,885	0%
PF.02.02.03	Laboratory and other medical equipment	665,965	561,625	1,227,590	1%

Production factor		2008	2009	Total	%[33]
PF.02.02.98	Equipment not broken down by type	1,096,042	1,165,913	2,261,955	1%
PF.02.98	Capital expenditure not broken down by type	1,446,926	3,875,323	5,322,249	2%
PF.02.99	Capital expenditure n.e.c.	77,826		77,826	0%
PF.98	**Production factors not broken down by type**	**10,686,509**	**19,137,304**	**29,823,813**	**13%**
Total		**96,208,777**	**127,374,483**	**223,583,260**	

Figure 29, below, provides a detailed analysis of current AIDS expenditure by production factor. Between 2008 and 2009, current expenditure on HIV-related activities totalled US$182 million. Of this current expenditure, 16% was spent on labour income (such as wages and social contributions). Material supplies (such as antiretrovirals and other drugs, condoms and reagents) accounted for 21% of current expenditure, while services accounted for 18%. Due to a lack of information, 45% of current expenditure could not be disaggregated by type.

Figure 29: Disaggregation of current AIDS expenditure by production factor, 2008-2009



IX. Recommendations

The NASA is the first-ever study to capture comprehensive AIDS expenditure data related to the multisectoral national HIV response in Viet Nam, as well as to track the specific HIV services provided using these resources and the ultimate beneficiaries of these resources. The NASA data highlight the critical roles of various stakeholders in addressing the HIV epidemic in Viet Nam, the scope of their activities, the nature of their linkages and the broader impacts of their interventions. Gaining a greater understanding of these factors is an essential step towards informing and enabling the effective coordination and strategic planning of the national HIV response.

Based on the key findings from the NASA, this section highlights a series of recommendations for future action for consideration by national and international decision makers and HIV programme planners.

Recommendations for future action

1. National AIDS spending assessments should be embedded as a routine bi-annual exercise at the national level in Viet Nam to support strategic planning and analysis, to help guide the implementation of the national HIV response, and to provide inputs for the Country Progress report submitted to the United Nations.
2. Spending assessments also should be conducted at the provincial level to allow for a more in-depth analysis of AIDS expenditure at the sub-national level and support strategic policy and programme planning.
3. Key experiences and lessons learned from the inaugural 2008-2010 Viet Nam NASA should be documented, analysed and incorporated, as appropriate, into future national AIDS spending assessments.
4. The NASA findings should be broadly disseminated among key national and international stakeholders to ensure their use.
5. Wherever possible, the NASA findings can be used as a good secondary source for costing and the estimation of unit costs in current intervention packages.
6. Cooperation with key international donors, including PEPFAR, to "crosswalk" their AIDS expenditure categories with those of NASA should be continued and strengthened to enhance the accuracy and utility of future assessments.

X. Appendices

Appendix 1: References

1. *Circular No.1991/BYT-AIDS* dated 6/4/2010 to Deputy Prime Minister Truong Vinh Trong to report on the HIV/AIDS epidemic in 2009. Ministry of Health, 2010.
2. *Decision of the Prime Minister No.108/2007/QD-TTg* dated 17/7/2007 on the Approval of the National Target Programme on Preventing and Combating Some Social and Dangerous Diseases and HIV/AIDS in the period 2006-2010.
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5. *Economic and Public Health Survey of Institutional and Community Responses to Injecting Drug Use and HIV/AIDS in Viet Nam, 2005-07.* USAID and the Futures Group.
6. *Guide to produce National AIDS Spending Assessment.* UNAIDS, 2009.
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8. *National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV financing flows and expenditure at country level.* UNAIDS, 2006: draft; work in progress.
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10. NASA Viet Nam Terms of Reference, 2010.
11. *National Survey of People Living With HIV/AIDS in Viet Nam: Health Services Utilization and Out-of-Pocket Health Expenditure.* Health Systems 20/20, 2010.
12. *Preliminary Viet Nam HIV/AIDS Estimates and Projections 2011.* Ministry of Health, National Technical Working Group on HIV Estimates and Projections, 2011.
13. *Viet Nam AIDS Response Progress Report 2010-2011.* National Committee for AIDS, Drugs and Prostitution Prevention and Control, 2012.
14. *Viet Nam Country Progress Report 3/2010.* Government of Viet Nam, 2010.
15. *Viet Nam HIV/AIDS Estimations and Projections 2007-2012.* Ministry of Health, 2009.

Appendix 2: Data-collection form


National AIDS Spending Assessment (NASA) and National Health Accounts (NHA) Survey

Name of Organisation	
Acronym of Organisation	
Address of Organisation:	

Status of Organisation

Crosscheck the appropriate cell

Organisation	Public	NGO	Bilateral	Multilateral
National				
Provincial				
International				

Contact person in the organization

Full name: .....
Position: .....
Telephone (Office/ Mobile): .....
Email: .....
Address: .....

The reported information is used in an aggregate manner only. The use of the reported information is strictly confidential and the ethic and administrative responsibility is ensured by the NASA Taskforce

Year of report:	2008	2009	
Total Funds received by your organisation			
Funds Transferred to other organisations			
Funds Spent by your organisation			
TOTAL	-	-	
Currency reported:			(Select the currency on which figures are reported on each year. Please specify the name of the curre
The exchange rate used:			(Type the currency rate are used)

Funding for HIV/AIDS programs (This section is only for donor and government respondents*):**

Please indicate the total amount disbursed by year (past and anticipated) for HIV/AIDS programs, including the total as well as a breakdown by specific activities supported

	2010	2011	2012	2013	2014	
Total Funds						
Currency		-	-	-	-	(select the currency on which figures are

Funding by HIV/AIDS service category

Antiretroviral Therapy (ART)					
HIV Counselling and Testing (VCT)					
Prevention of Mother-to-Child Transmission (PMTCT)					
Care and Support - TB-HIV					
Care and Support - PRE-ART					
Care & Support - Non-ART					
Prevention					

Resources Used in 2008

In the survey below, we ask you to report on: **sources** of your 2008 HIV/AIDS funding as well as the **title** and **description** of each project or activity your organization implemented; n transferred project funding, if applicable; the actual **amount spent** on each project or activity; and the **beneficiary population(s)** reached, including the **number reached,** if possible. direct project costs that are spent in the country (e.g. clinic support, condom distribution, or in-country project office costs). Exclude indirect costs that support functions performed ou a home office abroad).

Financial resources used for specific activities

NOTE: (I) Use one line per Beneficiary Population for the same activity. (II) Use a different row to report on funds used and another row for funds transferred even if both

				Currency	
Financing source (Origin of the funds)	**Name of Project**	**Name of Activity**	**Description of Activity** (1-2 sentences)	**If funds are transffered to other organisation, please specify the name of the organization**	**Total Activity Amount** (Expenditures, not budgeted amounts)

PRODUCTION FACTORS in 2008

Production factors are inputs used to produce an intervention/project activity

NOTE: Insert row to add production factor as needed

	Description of the activity *(as reported in worksheet '2008 Resources Used')*							***Currency***
Production factors/inputs (list each item in one line) **See 'Production Factors List' tab*								
PF.01 Current expenditures								
PF.01.01 Labour income (compensation of employees and remuneration								
of owners)								
PF.01.01.01 Wages								
PF.01.01.02 Social contributions								
PF.01.01.03 Non-wage labour income								
PF.01.01.98 Labour income not broken down by type								
PF.01.01.99 Labour income n.e.c.								
PF.01.02 Supplies and services								
PF.01.02.01 Material supplies								
PF.01.02.01.01 Antiretrovirals								
PF.01.02.01.02 Other drugs and pharmaceuticals (excluding antiretrovirals)								
PF.01.02.01.03 Medical and surgical supplies								
PF.01.02.01.04 Condoms								
PF.01.02.01.05 Reagents and materials								
PF.01.02.01.06 Food and nutrients								
PF.01.02.01.07 Uniforms and school materials								
PF.01.02.01.98 Material supplies not broken down by type								
PF.01.02.01.99 Other material supplies n.e.c.								
PF.01.02.02 Services								
PF.01.02.02.01 Administrative services								
PF.01.02.02.02 Maintenance and repair services								
PF.01.02.02.03 Publisher, motion picture, broadcasting and programming services								
PF.01.02.02.04 Consulting services								
PF.01.02.02.05 Transportation and travel services								
PF.01.02.02.06 Housing services								
PF.01.02.02.07 Logistics of events, including catering services								
PF.01.02.02.08 Financial intermediation services								
PF.01.02.02.98 Services not broken down by type								
PF.01.02.02.99 Services n.e.c.								
PF.01.98 Current expenditures not broken down by type								
PF.01.99 Current expenditures n.e.c.								
PF.02 Capital expenditures								
PF.02.01 Buildings								
PF.02.01.01 Laboratory and other infrastructure upgrading								
PF.02.01.02 Construction of new health centres								
PF.02.01.98 Buildings not broken down by type								
PF.02.01.99 Buildings n.e.c.								
PF.02.02 Equipment								
PF.02.02.01 Vehicles								
PF.02.02.02 Information technology (hardware and software)								
PF.02.02.03 Laboratory and other medical equipment								
PF.02.02.98 Equipment not broken down by type								
PF.02.02.99 Equipment n.e.c.								
PF.02.98 Capital expenditure not broken down by type								
PF.02.99 Capital expenditure n.e.c.								
PF.98 Production factors not broken down by type								
Total	**0**	**0**	**0**	**0**				
Amount reported on the spreadsheet :								
"2008 Resources Used"	0	0	0	0	0	0	0	0
Control / Pending expenditures to classify in PF	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

List of production factors

CURRENT EXPENDITURES

Labour income (compensation of employees and remuneration of owners)

- Wages
- Social contributions
- Non-wage labour income
- Labour income not broken down by type
- Labour income not elsewhere classified

Supplies and services

Material supplies

- Antiretrovirals
- Other drugs and pharmaceuticals (excluding antiretrovirals)
- Medical and surgical supplies
- Condoms
- Reagents and materials
- Food and nutrients
- Uniforms and school materials
- Material supplies not broken down by type
- Other material supplies not elsewhere classified

Services

- Administrative services
- Maintenance and repair services
- Publisher, motion picture, broadcasting and programming services
- Consulting services
- Transportation and travel services
- Housing services
- Logistics of events, including catering services
- Financial intermediation services
- Services not broken down by type
- Services not elsewhere classified

Current expenditures not broken down by type

Current expenditures not elsewhere classified

CAPITAL EXPENDITURES

Buildings

- Laboratory and other infrastructure upgrading
- Construction of new health centres
- Buildings not broken down by type
- Buildings not elsewhere classified

Equipment

- Vehicles
- Information technology (hardware and software)
- Laboratory and other medical equipment
- Equipment not broken down by type
- Equipment not elsewhere classified

Capital expenditure not broken down by type

Capital expenditure not elsewhere classified

PRODUCTION FACTORS NOT BROKEN DOWN BY TYPE

List of Beneficiary Populations

People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)

- *Adult and young people (aged 15 and over) living with HIV*
  - Adult and young men (aged 15 and over) living with HIV
  - Adult and young women (aged 15 over) living with HIV
  - Adult and young people (aged 15 over) living with HIV not broken down by gender
- *Children (aged under 15) living with HIV*
  - Boys (aged under 15) living with HIV
  - Girls (aged under 15) living with HIV
  - Children (aged under 15) living with HIV not broken down by gender
- *People living with HIV not broken down by age or gender*

Most-at-risk populations

- *Injecting drug users (IDU) and their sexual partners*
- *Sex workers (SW) and their clients*
  - Female sex workers and their clients
  - Male transvestite sex workers (and their clients)
  - Male non-transvestite sex workers (and their clients)
  - Sex workers, not broken down by gender, and their clients
- *Men who have sex with men (MSM)*
- *Most-at-risk populations" not broken down by type*

Other key populations

- Orphans and vulnerable children (OVC)
- Children born or to be born of women living with HIV
- Refugees (externally displaced)
- Internally displaced populations (because of an emergency)
- Migrants/mobile populations
- Indigenous groups
- Prisoners and other institutionalized persons
- Truck drivers/transport workers and commercial drivers
- Children and youth living in the street
- Children and youth gang members
- Children and youth out of school
- Institutionalized children and youth
- Partners of people living with HIV
- Recipients of blood or blood products
- Other key populations not broken down by type
- Other key populations not elsewhere classified

Specific "accessible" populations

- People attending STI clinics
- Elementary school students
- Junior high/high school students
- University students
- Health care workers
- Sailors
- Military
- Police and other uniformed services (other than the military)
- Ex-combatants and other armed non-uniformed groups
- Factory employees (e.g. for workplace interventions)
- Specific "accessible " populations not broken down by type
- Specific "accessible " populations not elsewhere classified

General population

- General adult population (aged older than 24)
  - Male adult population
  - Female adult population
  - General adult population (aged older than 24) not broken down by gender
- Children (aged under 15)
  - Boys
  - Girls
  - Children (aged under 15) not broken down by gender

NASA dimension and categories:

Financing	
1. Financing agents (FA)	Entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent).
2. Financing sources (FS)	Entities that provide money to financing agents.
Provision of HIV services	
3. Providers (PS)	Entities that engage in the production, provision, and delivery of HIV services.
4. Production factors (PF)	Resources used for the production of ASC.
Use	
5. AIDS spending categories (ASC)	HIV-related interventions and activities.
6. Beneficiary segments of the population (BP)	Populations intended to benefit from specific activities.

NASA key AIDS spending categories:

ASC.01 Prevention: Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Results include a decrease in HIV infections among the population and improvements in quality and safety in health facilities with regard to therapies administered exclusively or in large part to HIV patients. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals.

ASC.02 Care and treatment refers to all expenditures, purchases, transfers and investment incurred to provide access to clinic-based, home-based or community-based activities for the treatment and care of HIV-positive adults and children.

ASC.03 Orphans and vulnerable children (OVC): An orphan is defined as a child aged under 18 who has lost one or both parents regardless of financial support (whether national AIDS programme-related or not). In the NASA context, all expenditures to substitute for the parents taking care of their children because they have died from HIV; expenditures incurred in providing social mitigation to all double orphans and half or single orphans need to be included. In this context, vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them.

ASC.04 Programme management and administration: Programme expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and facility upgrading through purchases of laboratory equipment and telecommunications. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole. It is important to note that when linking programme expenditure to people's access to treatment and prevention, only the share of investment that contributes to a HIV response and required to finance the services provided as part of the response to the HIV scourge be included.

ASC.05 Human resources: This category refers to services of the workforce through approaches for training, recruitment, retention, deployment and rewarding of quality performance of health care workers and managers for work in the HIV field. The HIV workforce is not limited to the health system. Included in this category is the direct payment of wage benefits for health care workers. These expenditures are aimed at ensuring the availability of human resources from what is currently available in the health sector. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories.

ASC.06 Social protection usually refers to functions of government or nongovernmental organizations relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by requirements such as sickness, old age, disability, unemployment, social exclusion etc. Social protection comprises personal social services and social security. It includes expenditures on services and transfers provided not only to individual people but also to households, in addition to expenditures on services provided on a collective basis.

ASC.07 Enabling environment: The enabling environment covers advocacy to increase support for the response and to promote HIV prevention, the reduction of stigma and discrimination, the scaling-up of HIV programmes by national governments with key partners and the development of a strong HIV constituency among civil society, including people living with HIV. It also includes activities and resources invested in the protection of human rights and the legislative aspects of social life; investment in capacity building of nongovernmental organizations; programmes targeting women and girls, such as improved reproductive health activities, assistance for abused women and the protection of property and inheritance rights; and programmes to reduce gender-based violence, including policies and services that provide care for victims of sexual violence.

ASC.08 HIV-related research (excluding operations research): HIV-related research is defined as the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well-being. It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS. Managers and administrators should be included when they spend at least 10% of their time supporting research activities. Researchers include postgraduate students but do not include technicians. Technicians and equivalent staff are people whose main tasks require technical knowledge and experience. They participate in R&D by performing scientific and technical tasks involving the application of concepts and operational methods, normally under the supervision of researchers. This category excludes operations research on health systems aimed to improve health outcomes, including project or programme evaluation, which should be coded under ASC.04.04.

Appendix 3: List of organizations providing data for the NASA

I	**Bilateral organizations**
	Australian Agency for International Development (AusAID)
	Canadian International Development Agency (CIDA)
	Danish International Development Agency (DANIDA)
	Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (ESTHER)
	Irish Aid
	Japan International Cooperation Agency (JICA)
	United Kingdom Department for International Development (DFID)
	United States Centers for Disease Control and Prevention (CDC)
	United States Agency for International Development (USAID)
	United States Department of Defense (DoD)
	United States President's Emergency Plan for AIDS Relief (PEPFAR)
	United States Substance Abuse and Mental Health Services Administration (SAMSHA)
	United States Supply Chain Management System (SCMS)
II	**Multilateral organizations**
	The Joint United Nations Programme on HIV/AIDS (UNAIDS)
	United Nations Development Programme (UNDP)
	United Nations Educational, Scientific and Cultural Organization (UNESCO)
	United Nations Population Fund (UNFPA)
	United Nations Children's Fund (UNICEF)
	United Nations Office on Drugs and Crime (UNODC)
	United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
	United Nations Volunteers (UNV)
	The World Health Organization (WHO)
III	**International non-profit organizations and foundations**
	AIDS Healthcare Foundation
	Beth Israel Deaconess Medical Center
	CARE International
	Clinton Health Access Initiative (CHAI)
	Chemonics
	Family Health International/FHI 360
	Harvard Medical School AIDS Initiative in Viet Nam (HAIVN)
	Management Sciences for Health (MSH)
	MEASURE
	Médecins du Monde Canada/France
	Medisch Comite Nederland Viet Nam (MCNV)
	Pact
	PATH USA
	Pathfinder Viet Nam
	PSI
	KNCV Foundation, Tuberculosis Control Assistance Programme
IV	**International for-profit organizations**
	Abt Associates

V	**Public organizations**
	Central Project Management Unit (CPMU) of the ADB Project on HIV/AIDS Prevention among Youth, Ministry of Health (MOH)
	CPMU of the Global Fund to Fight AIDS, Tuberculosis and Malaria Project on HIV/AIDS, MOH
	CPMU of the CDC LIFE-GAP Project, MOH
	CPMU of the HIV/AIDS Asia Regional Program (HAARP), MOH
	CPMU of the World Bank/DFID Project on HIV/AIDS, MOH
	Central Women's Union
	Central Youth Union
	Department for Student Affairs, Ministry of Education and Training
	General Department of Child Care and Protection, Ministry of Labour, War Invalids and Social Affairs (MOLISA)
	General Department of Social Evils Prevention, MOLISA
	General Department of Social Sponsorship, MOLISA
	General Statistics Office, MOLISA
	Ha Noi School of Public Health (HSPH), MOH
	Ho Chi Minh City Committee on AIDS Prevention
	Ho Chi Minh City Pasteur Institute
	National Institute of Dermatology and Venereology (NIDV), MOH
	National Institute of Haematology and Blood Transfusion (NIHBT), MOH
	National Institute of Hygiene and Epidemiology (NIHE), MOH
	National Institute of Infection and Tropical Diseases (NIITD), MOH
	Viet Nam Administration of HIV/AIDS Control (VAAC)
	Women, AIDS and Reproductive Health Centre, Viet Nam Women's Union
	Provincial AIDS centres (PAC)
	An Giang
	Ba Ria – Vung Tau
	Bac Giang
	Bac Lieu
	Bac Ninh
	Binh Duong
	Binh Phuoc
	Binh Thuan
	Ca Mau
	Can Tho
	Cao Bang
	Da Nang
	Dak Lak
	Dak Nong
	Dien Bien
	Dong Nai
	Dong Thap
	Gia Lai
	Ha Giang
	Ha Nam

	Ha Noi
	Ha Tinh
	Hai Duong
	Hai Phong
	Hau Giang
	Hung Yen
	Khanh Hoa
	Kien Giang
	Kon Tum
	Lai Chau
	Lam Dong
	Lang Son
	Lao Cai
	Long An
	Nghe An
	Ninh Binh
	Ninh Thuan
	Phu Tho
	Phu Yen
	Quang Binh
	Quang Nam
	Quang Ngai
	Quang Ninh
	Quang Tri
	Soc Trang
	Son La
	Tay Ninh
	Thai Binh
	Thai Nguyen
	Thanh Hoa
	Thua Thien Hue
	Tien Giang
	Tra Vinh
	Tuyen Quang
	Vinh Long
	Vinh Phuc
	Yen Bai

Appendix 4: NASA/National Health Account collaboration in Viet Nam

Introduction

Both UNAIDS Viet Nam and USAID (through the Health Systems 20/20 project, managed by Abt Associates) planned to support the development by VAAC of the new National Strategy on HIV/AIDS Prevention and Control to 2020, with a vision to 2030, by conducting HIV-sector resource tracking in Viet Nam for the fiscal year 2010, through the National AIDS Spending Assessment (NASA) and the National Health Account (NHA) HIV subaccount respectively.

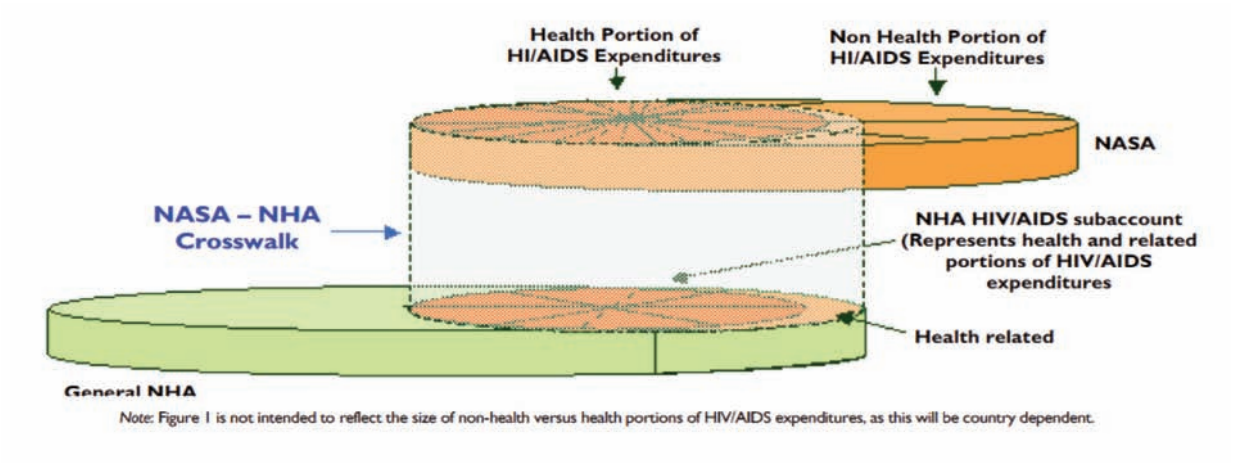
Because of the similarities in data needs and output, UNAIDS Viet Nam and Health Systems 20/20 decided to coordinate data collection in order to avoid the duplication of efforts and reduce the burden on respondents.

The following outlines the similarities and differences between the NASA and the NHA HIV subaccount analyses, and provides an overview of the joint NASA/NHA HIV subaccount exercise conducted in Viet Nam in 2010-2011.

A brief overview of overlaps and differences between the NASA and the NHA HIV subaccount

The primary distinction to be made (see Figure 30) is that while the NASA collects all HIV expenditure data to reflect a multisectoral response to HIV, the NHA HIV subaccount focuses on health and health-related expenditure and, depending on the local policy context, may distinguish between HIV-related and other health priorities (such as reproductive health). If the service or product on which the expenditure is made is non-health-related, the NHA will not collect this data. In addition, while the NASA counts the cost of all condoms, whether or not the primary reason for their use is HIV-related, the NHA will not count condoms distributed for family-planning reasons in the HIV subaccount. Equally, while the NASA will include all expenditure on PMTCT and the management and treatment of STIs, for policy reasons the NHA may exclude this expenditure where it is placed within a national reproductive health programme.

Figure 30: 'Crosswalk' between NASA and NHA



Source: Health Systems 20/20 Project, the Joint United Nations Programme for HIV/AIDS (UNAIDS), and the World Health Organization (WHO). June 2009. Linking NASA and NHA: Concepts and Mechanics. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

Reasons for conducting joint NASA/NHA data collection in Viet Nam

- **Coordination:** to align with the Paris Declaration on Aid Effectiveness and the UNAIDS "Three Ones" (key principles for the coordination of national AIDS responses).

- **Simplification:** to reduce the duplication of efforts and the burden on respondents (since donors, non-profit organizations and government institutions would respond to a single joint data-collection exercise rather than two independent surveys).

- **Impact:**
  - To bring together key government stakeholders (e.g. VAAC & MOH Finance & Planning) that have distinct but related policy challenges and information needs.
  - To link strategic discussions about HIV sector planning with overall health sector policy
  - To increase acceptance and use of results for policy (coordinated analysis and reporting allow for a single, consistent message – as opposed to the potential for conflicting results and reports if NASA and NHA are conducted independently).

- **Institutionalization:**
  - To integrate HIV-sector resource tracking into existing government mechanisms for the collection of data on and analysis of HIV health and non-health expenditure, thereby facilitating future routine, government-led exercises.
    - The Ministry of Health Finance and Planning Department regularly produces a general NHA estimation, and would like to incorporate the HIV subaccount into this process (an estimation of the NHA HIV subaccount was produced once, in 2006). If non-health HIV expenditure was added to the existing data-collection form and incorporated into its routine processes, the Finance and Planning Department could regularly produce the necessary data to estimate both the NASA and the HIV subaccount.
  - To generate practical guidance from the Viet Nam experience to inform joint NASA/NHA exercises in other countries:
    - Rwanda (2007-8, 2010) – NHA/NASA 'crosswalk tables' were applied to NHA estimation
    - Ethiopia (2009-2010) – Collaboration with UNAIDS in NHA estimation; NHA figures to be used to generate UNGASS tables
    - Namibia (2010) – Joint NHA/NASA data collection with UNAIDS
    - Democratic Republic of the Congo (2010) – Joint NHA/NASA data collection with UNAIDS and the PNMLS (National Multisectoral Programme against HIV/AIDS)
    - Viet Nam (2010-2011) – Joint NHA/NASA data collection; HIV subaccount developed using 'crosswalk'.

Process of linking the NASA and the NHA in Viet Nam

- **Logistical approach**
  - UNAIDS Viet Nam and Abt Associates (for the Health Systems 20/20 project) hired the same consultant to undertake the data collection and analysis for both the NASA and the NHA, so that a single person would understand and track the methodology and data collected for the two exercises.
  - This consultant provided both counterparts with regular updates on the timing, process and technical/logistical issues.
  - UNAIDS and Abt Associates attended joint stakeholder/technical meetings to increase opportunities for input and the joint development of strategies, approaches and assumptions.

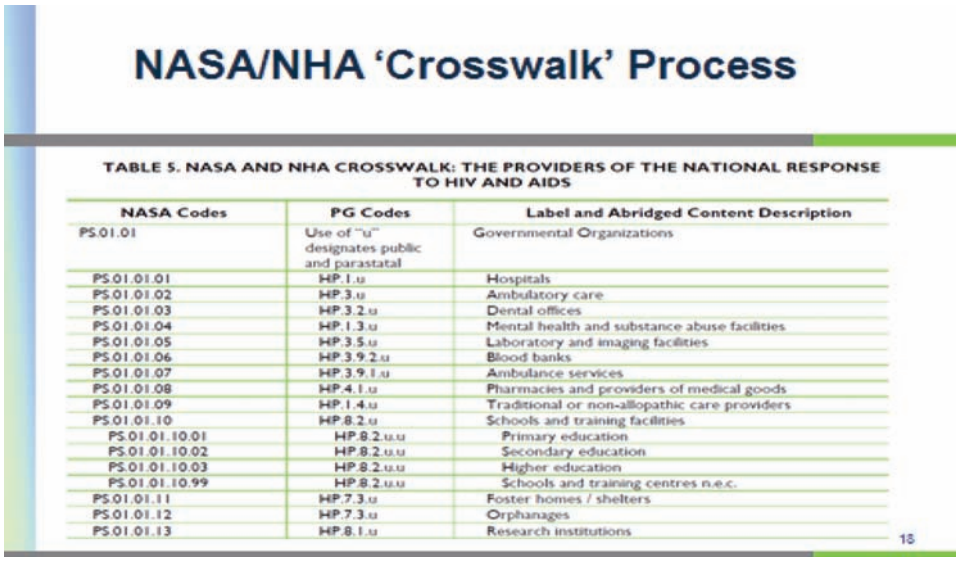
- **Technical approach**
  - A joint data-collection instrument, based on the NASA instrument (which typically collects more detailed expenditure information than the NHA survey) was developed, involving an exchange between the NASA and

- NHA technical teams to ensure the instrument was mutually agreeable.

  The data collection was conducted by the UNAIDS NASA team, including a joint NASA/NHA consultant. The NHA team provided technical input, including for the development of shared assumptions and the harmonization of the methodological approach (e.g. through the assignment of provider classifications, the
- identification of financing agents, etc.).
- The NASA data-collector training included presentations on the NASA/NHA links.
- The NASA data set was "crosswalked" to generate NHA tables (see Figure 31).

  The MOH Finance and Planning Department was closely involved in the process to ensure that the NHA HIV subaccount is consistent with the overall NHA. There are also plans to incorporate the HIV subaccount into the overall MOH NHA report.

Figure 31: Example of the 'crosswalk' of NASA/NHA categories



NASA/NHA 'Crosswalk' Process

TABLE 5. NASA AND NHA CROSSWALK: THE PROVIDERS OF THE NATIONAL RESPONSE TO HIV AND AIDS

NASA Codes	PG Codes	Label and Abridged Content Description
PS.01.01	Use of "u" designates public and parastatal	Governmental Organizations
PS.01.01.01	HP.1.u	Hospitals
PS.01.01.02	HP.3.u	Ambulatory care
PS.01.01.03	HP.3.2.u	Dental offices
PS.01.01.04	HP.1.3.u	Mental health and substance abuse facilities
PS.01.01.05	HP.3.5.u	Laboratory and imaging facilities
PS.01.01.06	HP.3.9.2.u	Blood banks
PS.01.01.07	HP.3.9.1.u	Ambulance services
PS.01.01.08	HP.4.1.u	Pharmacies and providers of medical goods
PS.01.01.09	HP.1.4.u	Traditional or non-allopathic care providers
PS.01.01.10	HP.8.2.u	Schools and training facilities
PS.01.01.10.01	HP.8.2.u.u	Primary education
PS.01.01.10.02	HP.8.2.u.u	Secondary education
PS.01.01.10.03	HP.8.2.u.u	Higher education
PS.01.01.10.99	HP.8.2.u.u	Schools and training centres n.e.c.
PS.01.01.11	HP.7.3.u	Foster homes / shelters
PS.01.01.12	HP.7.3.u	Orphanages
PS.01.01.13	HP.8.1.u	Research institutions

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Source: Health Systems 20/20 Project, the Joint United Nations Programme for HIV/AIDS (UNAIDS), and the World Health Organization (WHO). June 2009. Linking NASA and NHA: Concepts and Mechanics. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

- **Stakeholder approach**

  - Key stakeholders repeatedly received clear presentations on the objectives of NASA/NHA coordination.
  - Dissemination products were coordinated: separate reports were produced with a shared annex and coordinated methodology section. It has been suggested that a joint policy brief, focused on a specific issue, be produced.

Appendix 5: Key assumptions in data processing for different sources

NASA classification of National Targeted Programme for HIV (NTP) AIDS expenditure

Not all provinces reported on the NTP for the NASA. Data on the NTP covered 54 provinces in 2008, 41 provinces in 2009 and 33 provinces in 2010. The following provinces did not report on NTP spending in either year: Bac Kan, Ben Tre, Binh Dinh, Hai Duong, Hoa Binh, Nam Dinh, Thai Binh and Thanh Hoa.

The NTP in each province supports behaviour change communication (BCC) activities implemented by both health-related and non-health-related institutions. Depending on the type of service provider, BCC activities supported by the NTP were coded as ASC.01.01.01 ***Health-related communication for social and behaviour change***, ASC.01.01.02 ***Non-health-related communication for social and behaviour change*** or ASC.01.01.98 ***Communication for social and behaviour change not broken down by type***.

PAC and other public-institution monitoring and evaluation teams cover the surveillance of both HIV and STI programmes, as well as HIV programme monitoring. When the available information was insufficient to differentiate HIV surveillance and programme monitoring, the NASA team classified activities under code ASC.04.03 ***Monitoring and evaluation***.

It was also assumed that all ARV drugs provided through the NTP were consumed within the year of purchase. Therefore, ARV expenditure was disaggregated by treatment site in accordance with the number of patients treated in that time period.

NASA classification of PEPFAR AIDS expenditure

In tracking PEPFAR-supported AIDS expenditure, the NASA team reconstructed most financial transactions by collecting data from the implementing organizations that receive their funding from the United States (US) Government (represented by PEPFAR). Data from US Government agencies were obtained through direct interviews and from submitted data-collection forms.

Because, in this case, USAID is a provider of services, only direct USAID expenditure (e.g. office costs) was used to calculate its actual expenditure. For the purposes of the NASA, all additional USAID-supported expenditure data were obtained from USAID subcontractors (see below), and may have differed from data provided directly by USAID. In all cases, this expenditure was captured for the periods October 2007-September 2008 (for the NASA year 2008), October 2008-September 2009 (for the NASA year 2009) and October 2009-September 2010 (for the NASA year 2010).

CDC also provided budget allocations for October 2007-September 2008 (for the NASA year 2008), October 2008-September 2009 (for the NASA year 2009) and October 2009-September 2010 (for the NASA year 2010). In cases where actual expenditure data from CDC subcontractors were available (e.g. Ho Chi Minh City CDC, FHI 360, the CDC LIFE-GAP Project and the Pasteur Institute), these data were used in place of the CDC budget-allocation data, and presented in the column ***Spending amount provided by each partner from PEPFAR source***. PEPFAR-originating funds for which subcontracting organizations were FAs were presented in the ***Processed as FA*** column; funds for which these organizations were PS were presented in the ***Processed as PS*** column.

In 2008 and 2009, the data-collection form submitted by the United States Department of Defense (DoD) only contained enough detail to assign FS, FA and ASC codes to all listed activities. The relevant FA code was assigned to the organization from which the PS received its funds. To supplement this data, the report of the Center for Excellence (CoE), which manages grant transfers for the DoD, provided additional details about the actual PS for various activities. In 2010, the DoD itself provided sufficient information through the simplified NASA data-collection form.

For the following organizations, which reported receiving US Government support for a portion of their HIV activities, AIDS expenditure data were obtained from a combination of data-collection forms and primary reports or budget documents: Pact, FHI 360, PSI, Abt Associates, USAID, the CDC LIFE-GAP Project, the CDC Country Office, the US DoD/CoE, SCMS, SAMSHA, HAIVN, Chemonics, NIHE, UNAIDS, WHO, UNODC, the NIITD, and the General Statistics Office.

In addition, given that PEPFAR AIDS expenditure categories do not perfectly correspond with those used in the NASA, the NASA team used a PEPFAR-NASA "crosswalk" as well as general assumptions in order to classify PEPFAR expenditure under specific NASA-defined ASCs:

1. Expenditure on policy meetings and coordination is categorized as a non-targeted intervention under ASC.04.01.
2. Expenditure on monitoring is categorized as a non-targeted intervention under ASC.04.03.
3. Laboratory expenditure is categorized as ASC.04.10.01 ***Upgrading laboratory infrastructure and new laboratory equipment***.
4. Voluntary counselling and testing expenditure by the DoD is categorized as ASC.01.03 ***Voluntary counselling and testing*** [for the general population].

NASA classification of World Bank AIDS expenditure

For all World Bank-supported AIDS expenditure, the NASA classified the MOH as the FA and the PS were coded as defined by the Provider Coding Chart.

NASA classification of Global Fund AIDS expenditure

The first NASA (2008-2009) captured Global Fund AIDS expenditure under Round 6, as well as a small portion of expenditure under Round 1, which ended in March 2008. The second NASA (2010) captured Global Fund AIDS expenditure under Rounds 6 and 8 through a new funding mechanism (the "Single Stream of Funding"). The NASA received the budget execution documents for the Global Fund Central Project Management Unit in 2008, 2009 and 2010. The data were broken down by PS, which were coded as defined by the Provider Coding Chart. The MOH was identified as the FA. The Global Fund financial data contained details of funds as disbursed by Service Delivery Area (SDA), which enabled the NASA team to "crosswalk" Global Fund SDAs with NASA ASCs.

Global Fund support for ARV drugs did not begin in Viet Nam until the end of 2008. Following an MOH decision, in 2008 Global Fund-supported ART sites used PEPFAR ARV drugs in addition to Global Fund ARV drugs. Global Fund expenditure on ARV drugs was therefore funded by two financing sources: the Global Fund and PEPFAR. It was assumed that all ARV drugs purchased with Global Fund funds were used for treatment. The PEPFAR ARV drugs used at Global Fund-supported ART sites were costed based on the number of patients treated at these sites and the average per-patient costs for ARV drugs under each regimen (a, b, c, d), as provided by VAAC.

Appendix 6: National AIDS spending matrices 2008-2010

National AIDS spending matrix 2008

AIDS Spending Categories	Total AIDS spending	Public source			International sources				Private sources		
		Total national budget	Central budget	Local budget	Total international sources	Bilateral	Multilateral	Non-profit organisations	Total private funds	Profit-making institutions	Households' funds
Total spending, in $US	96,208,777	13,459,880	6,832,580	6,627,300	66,734,575	48,552,930	17,849,999	331,646	16,014,322	82,581	15,931,741
1. Prevention (sub-total)	31,913,528	2,868,970	2,526,902	342,068	25,378,974	14,399,969	10,977,249	1,756	3,665,585	82,581	3,583,003
1.01 Communication for social and behavioural change	6,861,283	1,584,691	1,504,955	79,736	5,276,592	1,135,827	4,140,766	-	-	-	-
1.02 Community mobilization	1,325,832	32,761	21,186	11,575	1,293,071	35,006	1,256,892	1,173	-		
1.03 Voluntary counselling and testing (VCT)	1,308,824	63,124	62,509	615	1,245,700	473,885	771,815	-	-		
1.04 Risk-reduction for vulnerable and accessible populations	1,083,168	18,880	18,880	-	1,064,288	881,954	182,334	-	-	-	-
1.05. Prevention - Youth in school	316,088	800	800		315,289	190,499	124,790	-	-		
1.06 Prevention - Youth out-of-school	440,907	1,415	1,415		439,492	-	439,492	-	-		
1.07 Prevention of HIV transmission aimed at people living with HIV	234,779	34,979	34,364	615	199,800	87,705	111,699	396	-	-	-
1.08 Prevention programmes for sex workers and their clients	3,021,373	1,046	1,046	-	2,834,519	2,555,440	279,079	-	185,808	61,936	123,872
1.09 Programmes for men who have sex with men	835,613	-	-	-	798,452	798,452	-	-	37,162	12,387	24,774
1.10 Harm-reduction programmes for injecting drug users	4,702,381	16,565	13,295	3,270	4,661,042	3,605,117	1,055,739	187	24,774	8,258	16,516
1.11 Prevention programmes in the workplace	264,410	7,688	7,073	615	256,722	-	256,722	-	-	-	-
1.12 Condom social marketing	2,153	2,153	2,153		-	-	-	-	-		
1.13 Public and commercial sector male condom provision	46,973	337	337		46,636	46,636	-	-	-		
1.14 Public and commercial sector female condom provision	-										
1.15 Microbicides	18,328	18,328	18,328		-	-	-	-	-		
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	235,212	123,319	114,291	9,028	111,894	40,546	71,347	-	-		
1.17 Prevention of mother-to-child transmission	1,673,181	137,093	125,777	11,317	1,536,088	510,176	1,025,912	-	-	-	-
1.18 Male Circumcision	-	-	-	-	-	-	-	-	-	-	-
1.19 Blood safety	4,316,317	446,747	420,214	26,533	800,000	800,000	-	-	3,069,570		3,069,570
1.20 Safe medical injections	35,848	35,638	35,023	615	210	210	-	-	-		
1.21 Universal precautions	1,086	1,086	1,086		-	-	-	-	-		
1.22 Post-exposure prophylaxis	308	308	308		-	-	-	-	-		
1.98 Prevention activities not disaggregated by intervention	5,189,465	342,015	143,866	198,149	4,499,180	3,238,517	1,260,663	-	348,271		348,271
1.99 Prevention activities not elsewhere classified	-										
2. Care and Treatment (sub-total)	24,274,597	1,793,931	1,203,192	590,738	10,133,578	8,829,135	1,275,305	29,138	12,347,089	-	12,347,089
2.01 Outpatient care	18,262,106	1,083,890	927,413	156,477	7,646,519	6,857,099	767,315	22,105	9,531,697	-	9,531,697
2.01.01 Provider- initiated testing and counselling	96,071	21,641	20,411	1,230	74,430	74,430	-	-	-		
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	4,555,456	158,415	75,434	82,980	295,276	74,231	213,020	8,026	4,101,766	-	4,101,766
2.01.03 Antiretroviral therapy	6,172,042	766,260	763,861	2,399	5,405,782	5,007,533	398,249	-	-	-	-
2.01.04 Nutritional support associated to ARV therapy	3,321	3,321	3,321		-	-	-	-	-		
2.01.05 Specific HIV-related laboratory monitoring	807,329	615	615		806,714	770,879	35,835	-	-		

2.01.06 Dental programmes for PLHIV											
2.01.07 Psychological treatment and support services	5,751	729	729		5,023	-	5,023	-	-		
2.01.08 Outpatient palliative care	329,963	93,790	23,921	69,868	236,174	231,842	-	4,332	-		
2.01.09 Home-based care	6,013,968	25,755	25,755	-	558,281	443,093	115,188	-	5,429,932	-	5,429,932
2.01.10 Traditional medicine and informal care and treatment services	-										
2.01.98 Outpatient care services not disaggregated by intervention	278,204	13,365	13,365		264,839	255,091	-	9,748	-		
2.01.99 Outpatient Care services not elsewhere classified	-										
2.02 In-patient care	2,892,531	32,690	32,197	492	44,450	37,418	-	7,032	2,815,392	-	2,815,392
2.02.01 Inpatient treatment of opportunistic infections (OI)	62,188	28,999	28,999		33,188	26,156	-	7,032	-		
2.02.02 Inpatient palliative care	719	308	308		412	412	-	-	-		
2.02.98 Inpatient care services not disaggregated by intervention	2,829,133	2,891	2,891		10,850	10,850	-	-	2,815,392		2,815,392
2.02.99 In-patient services not elsewhere classified	492	492		492	-	-	-	-	-		
2.03 Patient transport and emergency rescue	286	246	246		40	40	-	-	-		
2.98 Care and treatment services not disaggregated by intervention	3,119,551	676,982	243,213	433,769	2,442,569	1,934,579	507,990	-	-		
2.99 Care and treatment services not-elsewhere classified	123	123	123		-	-	-	-	-		
3. Orphans and Vulnerable Children (sub-total)	872,092	50,618	6,950	43,668	819,827	819,827	-	-	1,648	-	1,648
3.01 OVC Education	14,798	-			13,150	13,150	-	-	1,648		1,648
3.02 OVC Basic health care	23,685	185	185		23,501	23,501	-	-	-		
3.03 OVC Family/home support	1,103	308	308		795	795	-	-	-		
3.04 OVC Community support	54,441	6,458	6,458		47,983	47,983	-	-	-		
3.05 OVC Social services and Administrative costs	-										
3.06 OVC Institutional Care	282,668	43,668		43,668	239,000	239,000	-	-	-		
3.98 OVC services not disaggregated by intervention	436,485	-			436,485	436,485	-	-	-		
3.99 OVC services not-elsewhere classified	58,912	-			58,912	58,912	-	-	-		
4. Program Management and Administration Strengthening (sub-total)	28,980,635	7,016,284	2,620,348	4,395,936	21,964,352	18,071,786	3,838,992	53,574	-	-	-
4.01 Planning, coordination and programme management	19,214,666	3,826,386	647,491	3,178,895	15,388,280	13,375,940	1,980,581	31,759	-		
4.02 Administration and transaction costs associated with managing and disbursing funds	612,457	21,432	20,509	923	591,025	453,281	125,206	12,538	-		
4.03 Monitoring and evaluation	3,028,531	591,095	583,050	8,045	2,437,436	955,837	1,480,369	1,230	-		
4.04 Operations research	118,400	74,795	74,795		43,605	43,605	-	-	-		
4.05 Serological-surveillance (Serosurveillance)	350,847	349,018	332,363	16,655	1,829	1,829	-	-	-		
4.06 HIV drug-resistance surveillance	1,292	1,292	1,292		-	-	-	-	-		
4.07 Drug supply systems	669,025	40,357	40,357		628,668	628,668	-	-	-		
4.08 Information technology	185,107	5,901	4,920	980	179,207	72,291	103,939	2,977	-		
4.09 Patient tracking	13,117	12,904	11,674	1,230	213	213	-	-	-		
4.10 Upgrading and construction of infrastructure	2,911,004	1,700,586	601,989	1,098,597	1,210,419	1,056,452	148,896	5,070	-	-	-
4.11 Mandatory HIV testing (not VCT)	24,503	24,503	20,198	4,305	-	-	-	-	-		
4.98 Program Management and Administration Strengthening not disaggregated by type	1,747,546	264,551	178,245	86,306	1,482,995	1,482,995	-	-	-		
4.99 Program Management and Administration Strengthening not-elsewhere classified	104,140	103,465	103,465		675	675	-	-	-		
5. Human resources (sub-total)	6,600,136	1,722,478	469,432	1,253,045	4,877,658	3,608,811	1,211,036	57,812	-	-	-

5.01 Monetary incentives for human resources	1,309,477	1,257,863	17,486	1,240,377	51,615	-	-	51,615	-	-	-
5.02 Formative education to build-up an HIV workforce	9,841	9,841	9,841		-	-	-	-	-		
5.03 Training	5,261,850	435,806	423,138	12,668	4,826,044	3,608,811	1,211,036	6,197	-		
5.98 Incentives for Human Resources not specified by kind	18,968	18,968	18,968		-	-	-	-	-		
5.99 Incentives for Human Resources not elsewhere classified	-										
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	286,045	3,875	3,875	-	282,170	282,170	-	-	-	-	-
6.01 Social protection through monetary benefits											
6.02 Social protection through in-kind benefits											
6.03 Social protection through provision of social services											
6.04 HIV-specific income generation projects	282,096	0			282,096	282,096	-	-	-		
6.98 Social protection services and social services not disaggregated by type	3,949	3,875	3,875		74	74	-	-	-		
6.99 Social protection services and social services not elsewhere classified											
7. Enabling Environment (sub-total)	2,574,830	-	-	-	2,574,830	2,177,115	397,716	-	-	-	-
7.01 Advocacy	1,160,594	-			1,160,594	1,087,880	72,714	-	-		
7.02 Human rights programmes	41,536	-	-	-	41,536	25,458	16,078	-	-	-	-
7.03 AIDS-specific institutional development	1,021,171	-			1,021,171	1,016,371	4,800	-	-		
7.04 AIDS-specific programmes focused on women	122,483	-			122,483	32,483	90,000	-	-		
7.05 Programmes to reduce Gender Based Violence											
7.98 Enabling Environment and Community Development not disaggregated by type	177,211	-			177,211	13,885	163,326	-	-		
7.99 Enabling Environment and Community Development not elsewhere classified	51,836	-			51,836	1,038	50,798	-	-		
8. Research (sub-total)	706,912	3,725	1,880	1,845	703,187	364,118	149,701	189,368	-	-	-
8.01 Biomedical research											
8.02 Clinical research	378,735.2	-			378,735	189,368	-	189,368	-		
8.03 Epidemiological research	3,075.2	3,075.2	1,230	1,845	-	-	-	-	-		
8.04 Social science research	119,701.0	-	-	-	119,701.0	-	119,701.0	-	-	-	-
8.05 Vaccine-related research											
8.98 Research not disaggregated by type	205,400.7	650.1	650		204,751	174,751	30,000	-	-		
8.99 Research not elsewhere classified											

National AIDS spending matrix 2009

AIDS Spending Categories	Total AIDS spending	Public source			International sources				Private sources		
		Total national budget	Central budget	Local budget	Total international sources	Bilateral	Multilateral	Non-profit organisations	Total private funds	Profit-making institutions	Households' funds
Total spending, in $US	127,374,483	17,176,061	6,737,254	10,438,807	94,161,905	70,785,001	22,975,234	401,670	16,036,518	144,812	15,891,706
1. Prevention (sub-total)	40,811,053	4,149,704	2,605,963	1,543,742	32,973,625	20,277,348	12,693,917	2,361	3,687,724	144,812	3,542,911
1.01 Communication for social and behavioural change	7,423,982	1,662,671	1,562,237	100,434	5,761,311	907,220	4,854,091	-	-	-	-
1.02 Community mobilization	810,898	2,556	767	1,789	808,342	14,942	793,400	-	-	-	-
1.03 Voluntary counselling and testing (VCT)	2,483,879	71,809	71,809	-	2,412,070	1,178,967	1,233,103	-	-	-	-
1.04 Risk-reduction for vulnerable and accessible populations	1,202,466	560	560	-	1,201,906	731,944	469,961	-	-	-	-
1.05. Prevention - Youth in school	153,497	-	-	-	153,497	146,466	7,031	-	-	-	-
1.06 Prevention - Youth out-of-school	234,000	-	-	-	234,000	-	234,000	-	-	-	-
1.07 Prevention of HIV transmission aimed at people living with HIV	548,978	41,310	40,425	885	507,668	278,137	228,246	1,284	-	-	-
1.08 Prevention programmes for sex workers and their clients	3,917,357	-	-	-	3,591,529	2,760,675	830,854	-	325,827	108,609	217,218
1.09 Programmes for men who have sex with men	1,007,369	-	-	-	942,203	942,203	-	-	65,165	21,722	43,444
1.10 Harm-reduction programmes for injecting drug users	5,774,569	28,947	28,947	-	5,702,178	3,709,200	1,991,925	1,053	43,444	14,481	28,962
1.11 Prevention programmes in the workplace	246,234	5,841	5,841	-	240,394	148,964	91,430	-	-	-	-
1.12 Condom social marketing											
1.13 Public and commercial sector male condom provision	204,681	-	-	-	204,681	195,654	9,027	-	-	-	-
1.14 Public and commercial sector female condom provision											
1.15 Microbicides	23,599	23,599	23,599	-	-	-	-	-	-	-	-
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	263,899	111,504	105,030	6,474	152,395	8,033	144,339	24	-	-	-
1.17 Prevention of mother-to-child transmission	2,402,482	107,557	106,023	1,534	2,294,925	1,262,243	1,032,682	-	-	-	-
1.18 Male Circumcision											
1.19 Blood safety	3,965,649	316,633	308,963	7,670	744,000	744,000	-	-	2,905,017	-	2,905,017
1.20 Safe medical injections	61,727	20,317	20,317	-	41,410	41,410	-	-	-	-	-
1.21 Universal precautions	5,225	218	218	-	5,007	-	5,007	-	-	-	-
1.22 Post-exposure prophylaxis											
1.98 Prevention activities not disaggregated by intervention	10,080,561	1,756,181	331,226	1,424,956	7,976,110	7,207,288	768,822	-	348,271	-	348,271
1.99 Prevention activities not elsewhere classified											
2. Care and Treatment (sub-total)	33,378,767	2,805,439	1,150,242	1,655,197	18,226,238	15,535,820	2,664,970	25,448	12,347,089	-	12,347,089
2.01 Outpatient care	22,950,856	1,076,521	920,119	156,403	12,342,638	10,523,749	1,807,894	10,995	9,531,697	-	9,531,697
2.01.01 Provider- initiated testing and counselling	255,291	-	-	-	255,291	255,291	-	-	-	-	-
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	4,817,604	115,251	59,285	55,967	600,587	161,151	431,615	7,822	4,101,766	-	4,101,766
2.01.03 Antiretroviral therapy	8,118,648	804,481	802,322	2,159	7,314,168	6,301,176	1,012,991	-	-	-	-
2.01.04 Nutritional support associated to ARV therapy	21,361	-	-	-	21,361	-	21,361	-	-	-	-
2.01.05 Specific HIV-related laboratory monitoring	1,063,967	-	-	-	1,063,967	905,230	158,738	-	-	-	-
2.01.06 Dental programmes for PLHIV											
2.01.07 Psychological treatment and support services	9,333	-	-	-	9,333	-	9,333	-	-	-	-
2.01.08 Outpatient palliative care	123,684	115,274	16,997	98,277	8,410	7,319	-	1,090	-	-	-
2.01.09 Home-based care	7,033,055	17,987	17,987	-	1,585,136	1,421,193	163,943	-	5,429,932	-	5,429,932

2.01.10 Traditional medicine and informal care and treatment services											
2.01.98 Outpatient care services not disaggregated by intervention	1,507,912	23,528	23,528	-	1,484,384	1,472,388	9,913	2,083	-	-	-
2.01.99 Outpatient Care services not elsewhere classified											
2.02 In-patient care	3,303,074	26,024	26,024	-	461,658	447,205	-	14,453	2,815,392	-	2,815,392
2.02.01 Inpatient treatment of opportunistic infections (OI)	244,165	26,024	26,024	-	218,141	203,688	-	14,453	-	-	-
2.02.02 Inpatient palliative care	233,249	-	-	-	233,249	233,249	-	-	-	-	-
2.02.98 Inpatient care services not disaggregated by intervention	2,825,660	-	-	-	10,268	10,268	-	-	2,815,392	-	2,815,392
2.02.99 In-patient services not elsewhere classified											
2.03 Patient transport and emergency rescue											
2.98 Care and treatment services not disaggregated by intervention	7,124,836	1,702,894	204,099	1,498,795	5,421,942	4,564,866	857,076	-	-	-	-
2.99 Care and treatment services not-elsewhere classified											
3. Orphans and Vulnerable Children (sub-total)	1,425,733	42,359	472	41,887	1,381,669	1,381,669	-	-	1,705	-	1,705
3.01 OVC Education	7,054	-	-	-	5,350	5,350	-	-	1,705	-	1,705
3.02 OVC Basic health care	105,612	-	-	-	105,612	105,612	-	-	-	-	-
3.03 OVC Family/home support	472	472	472	-	-	-	-	-	-	-	-
3.04 OVC Community support	15,239	-	-	-	15,239	15,239	-	-	-	-	-
3.05 OVC Social services and Administrative costs	10,637	-	-	-	10,637	10,637	-	-	-	-	-
3.06 OVC Institutional Care	326,794	41,887	-	41,887	284,907	284,907	-	-	-	-	-
3.98 OVC services not disaggregated by intervention	959,925	-	-	-	959,925	959,925	-	-	-	-	-
3.99 OVC services not-elsewhere classified											
4. Program Management and Administration Strengthening (sub-total)	38,745,169	8,400,076	2,493,818	5,906,258	30,345,093	25,972,329	4,251,448	121,316	-	-	-
4.01 Planning, coordination and programme management	23,282,571	5,521,260	975,206	4,546,054	17,761,312	15,313,854	2,334,862	112,596	-	-	-
4.02 Administration and transaction costs associated with managing and disbursing funds	770,079	14,103	12,333	1,770	755,976	491,600	258,985	5,391	-	-	-
4.03 Monitoring and evaluation	3,162,314	560,092	554,865	5,228	2,602,222	1,101,189	1,499,296	1,736	-	-	-
4.04 Operations research	610,901	50,872	50,872	-	560,030	560,030	-	-	-	-	-
4.05 Serological-surveillance (Serosurveillance)	1,534,961	167,132	160,052	7,080	1,367,829	1,367,829	-	-	-	-	-
4.06 HIV drug-resistance surveillance											
4.07 Drug supply systems	591,286	-	-	-	591,286	591,286	-	-	-	-	-
4.08 Information technology	52,077	-	-	-	52,077	48,582	1,901	1,593	-	-	-
4.09 Patient tracking											
4.10 Upgrading and construction of infrastructure	4,984,623	1,814,970	564,138	1,250,832	3,169,653	3,013,249	156,403	-	-	-	-
4.11 Mandatory HIV testing (not VCT)	3,068	3,068	-	3,068	-	-	-	-	-	-	-
4.98 Program Management and Administration Strengthening not disaggregated by type	3,700,278	222,149	129,922	92,227	3,478,129	3,478,129	-	-	-	-	-
4.99 Program Management and Administration Strengthening not-elsewhere classified	53,012	46,431	46,431	-	6,581	6,581	-	-	-	-	-
5. Human resources (sub-total)	7,999,570	1,778,481	486,759	1,291,722	6,221,088	3,985,098	2,182,525	53,465	-	-	-
5.01 Monetary incentives for human resources	1,378,058	1,336,999	54,389	1,282,609	41,060	-	-	41,060	-	-	-
5.02 Formative education to build-up an HIV workforce											
5.03 Training	6,565,954	406,320	397,207	9,113	6,159,634	3,985,098	2,162,130	12,406	-	-	-
5.98 Incentives for Human Resources not specified by kind	55,558	35,162	35,162	-	20,395	-	20,395	-	-	-	-
5.99 Incentives for Human Resources not elsewhere classified											

6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	361,244	-	-	-	361,244	361,244	-	-	-	-	-
6.01 Social protection through monetary benefits											
6.02 Social protection through in-kind benefits											
6.03 Social protection through provision of social services											
6.04 HIV-specific income generation projects	233,371	-	-	-	233,371	233,371	-	-	-	-	-
6.98 Social protection services and social services not dis-aggregated by type	127,872	-	-	-	127,872	127,872	-	-	-	-	-
6.99 Social protection services and social services not elsewhere classified											
7. Enabling Environment (sub-total)	3,444,920	-	-	-	3,444,920	2,795,423	630,874	18,622	-	-	-
7.01 Advocacy	1,884,347	-	-	-	1,884,347	1,426,548	439,176	18,622	-	-	-
7.02 Human rights programmes	147,628	-	-	-	147,628	121,121	26,507	-	-	-	-
7.03 AIDS-specific institutional development	1,181,837	-	-	-	1,181,837	1,170,437	11,400	-	-	-	-
7.04 AIDS-specific programmes focused on women	121,459	-	-	-	121,459	28,259	93,200	-	-	-	-
7.05 Programmes to reduce Gender Based Violence											
7.98 Enabling Environment and Community Development not disaggregated by type	89,857	-	-	-	89,857	49,057	40,800	-	-	-	-
7.99 Enabling Environment and Community Development not elsewhere classified	19,791	-	-	-	19,791	-	19,791	-	-	-	-
8. Research (sub-total)	1,208,027	-	-	-	1,208,027	476,069	551,500	180,458	-	-	-
8.01 Biomedical research	81,427	-	-	-	81,427	81,427	-	-	-	-	-
8.02 Clinical research	360,917	-	-	-	360,917	180,458	-	180,458	-	-	-
8.03 Epidemiological research											
8.04 Social science research	529,747	-	-	-	529,747	8,247	521,500	-	-	-	-
8.05 Vaccine-related research											
8.98 Research not disaggregated by type	205,937	-	-	-	205,937	205,937	-	-	-	-	-
8.99 Research not elsewhere classified	30,000	-	-	-	30,000	-	30,000	-	-	-	-

National AIDS spending matrix 2010

AIDS Spending Categories	Total AIDS spending	Public source			International sources				Private sources	
		Total national budget	Central budget	Local budget	Total international sources	Bilateral	Multilateral	Non-profit organisations	Total private funds	Households' funds
Total spending, in $US	139,253,245	21,431,087	9,193,116	12,237,971	102,221,779	84,013,483	17,512,495	695,801	15,600,379	15,600,379
1. Prevention (sub-total)	44,951,932	7,426,742	6,000,792	1,425,950	34,271,902	26,988,044	7,281,641	2,217	3,253,288	3,253,288
1.01 Communication for social and behavioural change	5,994,680	1,685,738	1,609,281	76,457	4,308,942	1,195,027	3,113,915	-	-	-
1.02 Community mobilization	2,318,789	188,224	184,571	3,653	2,130,565	946,481	1,184,084	-	-	-
1.03 Voluntary counselling and testing (VCT)	4,676,980	109,325	109,325	-	4,567,655	3,338,907	1,228,748	-	-	-
1.04 Risk-reduction for vulnerable and accessible populations	128,202	35,180	35,180	-	93,022	93,022	-	-	-	-
1.05. Prevention - Youth in school	99,102	7,192	7,192	-	91,910	-	91,910	-	-	-
1.06 Prevention - Youth out-of-school	290,354	3,043	3,043	-	287,311	61,447	225,864		-	-
1.07 Prevention of HIV transmission aimed at people living with HIV	915,607	12,996	12,996	-	902,611	645,949	256,662	-	-	-
1.08 Prevention programmes for sex workers and their clients	2,707,129	20,156	20,156	-	2,686,973	2,683,546	3,427	-	-	-
1.09 Programmes for men who have sex with men	1,056,975	3,077	3,077	-	1,053,898	1,030,828	20,853	2,217	-	-
1.10 Harm-reduction programmes for injecting drug users	8,248,641	140,855	110,309	30,546	8,107,786	7,547,690	560,096	-	-	-
1.11 Prevention programmes in the workplace	1,309,879	17,553	1,685	15,868	1,292,326	1,163,326	129,000	-	-	-
1.12 Condom social marketing	604,922	7,887	7,887	-	597,035	566,332	30,703	-	-	-
1.13 Public and commercial sector male condom provision	59,544	29,116	18,575	10,541	30,428	-	30,428	-	-	-
1.14 Public and commercial sector female condom provision	810	810	810	-	-	-	-	-	-	-
1.15 Microbicides	7,062	1,430	1,430	-	5,632	-	5,632	-	-	-
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	770,654	106,032	106,032	-	664,622	600,772	63,850	-	-	-
1.17 Prevention of mother-to-child transmission	2,980,480	217,207	193,030	24,177	2,763,273	2,482,790	280,483	-	-	-
1.18 Male Circumcision										
1.19 Blood safety	3,123,716	208,699	208,699	-	10,000	10,000	-	-	2,905,017	2,905,017
1.20 Safe medical injections	11,700	2,700	2,700	-	9,000	9,000	-	-	-	-
1.21 Universal precautions	5,364	1,350	1,350	-	4,014	-	4,014	-	-	-
1.22 Post-exposure prophylaxis	3,212	3,212	3,212	-	-	-	-	-	-	-
1.98 Prevention activities not disaggregated by intervention	9,553,105	4,555,121	3,294,191	1,260,930	4,649,713	4,597,741	51,972	-	348,271	348,271
1.99 Prevention activities not elsewhere classified	85,025	69,839	66,061	3,778	15,186	15,186	-	-	-	-
2. Care and Treatment (sub-total)	42,161,961	2,772,505	1,038,253	1,734,252	27,042,365	24,194,479	2,303,224	544,662	12,347,091	12,347,091
2.01 Outpatient care	32,547,870	1,216,019	974,603	241,416	21,800,153	19,277,695	1,977,796	544,662	9,531,698	9,531,698
2.01.01 Provider- initiated testing and counselling	282,383	94,827	70,094	24,733	187,556	187,556	-	-	-	-
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	6,276,693	159,274	67,585	91,689	2,015,653	1,968,601	47,052	-	4,101,766	4,101,766
2.01.03 Antiretroviral therapy	12,942,285	754,317	747,516	6,801	12,187,968	10,387,898	1,287,849	512,221	-	-
2.01.04 Nutritional support associated to ARV therapy	193,573	8,598	2,175	6,423	184,975	124,328	60,647	-	-	-
2.01.05 Specific HIV-related laboratory monitoring	1,961,775	5,764	5,764	-	1,956,011	1,748,248	207,763	-	-	-
2.01.06 Dental programmes for PLHIV										

2.01.07 Psychological treatment and support services	852,660	13,736	13,736	-	838,924	838,924	-	-	-	-
2.01.08 Outpatient palliative care	692,622	103,191	4,914	98,277	589,431	589,431	-	-	-	-
2.01.09 Home-based care	6,586,691	15,193	1,700	13,493	1,141,566	992,990	148,576	-	5,429,932	5,429,932
2.01.10 Traditional medicine and informal care and treatment services										
2.01.98 Outpatient care services not disaggregated by intervention	2,756,133	58,064	58,064	-	2,698,069	2,439,719	225,909	32,441	-	-
2.01.99 Outpatient Care services not elsewhere classified	3,055	3,055	3,055	-	-	-	-	-	-	-
2.02 In-patient care	3,324,724	19,004	19,004	-	490,327	490,327	-	-	2,815,393	2,815,393
2.02.01 Inpatient treatment of opportunistic infections (OI)	505,979	15,652	15,652	-	490,327	490,327	-	-	-	-
2.02.02 Inpatient palliative care	3,352	3,352	3,352	-	-	-	-	-	-	-
2.02.98 Inpatient care services not disaggregated by intervention	2,815,393	-	-	-	-	-	-	-	2,815,393	2,815,393
2.02.99 In-patient services not elsewhere classified										
2.03 Patient transport and emergency rescue										
2.98 Care and treatment services not disaggregated by intervention	6,288,811	1,537,482	44,646	1,492,836	4,751,329	4,425,901	325,428	-	-	-
2.99 Care and treatment services not-elsewhere classified	556	-	-	-	556	556	-	-	-	-
3. Orphans and Vulnerable Children (sub-total)	1,800,891	49,127	7,239	41,888	1,751,764	1,639,413	112,351	-	-	-
3.01 OVC Education	159,453	138	138	-	159,315	159,315	-	-	-	-
3.02 OVC Basic health care	275,150	1,154	1,154	-	273,996	257,630	16,366	-	-	-
3.03 OVC Family/home support	177,410	4,064	4,064	-	173,346	158,346	15,000	-	-	-
3.04 OVC Community support	463,096	1,522	1,522	-	461,574	380,589	80,985	-	-	-
3.05 OVC Social services and Administrative costs	168,554	124	124	-	168,430	168,430	-	-	-	-
3.06 OVC Institutional Care	137,934	42,125	237	41,888	95,809	95,809	-	-	-	-
3.98 OVC services not disaggregated by intervention	419,294	-	-	-	419,294	419,294	-	-	-	-
3.99 OVC services not-elsewhere classified										
4. Program Management and Administration Strengthening (sub-total)	36,772,929	9,407,939	1,676,318	7,731,621	27,364,990	22,415,598	4,857,729	91,663	-	-
4.01 Planning, coordination and programme management	25,449,604	5,368,344	644,576	4,723,768	20,081,260	16,741,940	3,290,232	49,088	-	-
4.02 Administration and transaction costs associated with managing and disbursing funds	796,587	101,975	96,644	5,331	694,612	669,595	4,867	20,150	-	-
4.03 Monitoring and evaluation	3,810,832	363,874	352,422	11,452	3,446,958	2,601,112	827,876	17,970	-	-
4.04 Operations research	26,302	25,495	25,495	-	807	-	807	-	-	-
4.05 Serological-surveillance (Serosurveillance)	344,095	181,174	180,423	751	162,921	123,427	39,494	-	-	-
4.06 HIV drug-resistance surveillance	8,833	4,814	4,814	-	4,019	3,319	-	700	-	-
4.07 Drug supply systems	533,119	77,484	77,484	-	455,635	452,609	3,026	-	-	-
4.08 Information technology	386,209	27,480	1,894	25,586	358,729	352,717	2,286	3,726	-	-
4.09 Patient tracking	30,034	15,389	15,389	-	14,645	6,372	8,273	-	-	-
4.10 Upgrading and construction of infrastructure	4,770,218	3,092,058	134,088	2,957,970	1,678,160	1,053,941	624,190	29	-	-
4.11 Mandatory HIV testing (not VCT)	88,666	88,666	88,666	-	-	-	-	-	-	-
4.98 Program Management and Administration Strengthening not disaggregated by type	499,357	46,002	45,944	58	453,355	396,677	56,678	-	-	-
4.99 Program Management and Administration Strengthening not-elsewhere classified	29,073	15,184	8,479	6,705	13,889	13,889	-	-	-	-
5. Human resources (sub-total)	9,695,665	1,760,735	456,475	1,304,260	7,934,930	6,305,174	1,572,497	57,259	-	-
5.01 Monetary incentives for human resources	2,628,445	1,424,741	123,597	1,301,144	1,203,704	1,025,430	121,015	57,259	-	-
5.02 Formative education to build-up an HIV workforce	896,787	368	368	-	896,419	896,419	-	-	-	-

5.03 Training	5,859,743	284,730	282,786	1,944	5,575,013	4,123,531	1,451,482	-	-	-
5.98 Incentives for Human Resources not specified by kind	172,097	12,303	11,131	1,172	159,794	159,794	-	-	-	-
5.99 Incentives for Human Resources not elsewhere classified	138,593	38,593	38,593	-	100,000	100,000	-	-	-	-
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	209,967	1,260	1,260	-	208,707	160,241	48,466	-	-	-
6.01 Social protection through monetary benefits	432	432	432	-		-	-	-	-	-
6.02 Social protection through in-kind benefits	420	420	420	-	-	-	-	-	-	-
6.03 Social protection through provision of social services	19,921	281	281	-	19,640	19,640	-	-	-	-
6.04 HIV-specific income generation projects	140,601	-	-	-	140,601	140,601	-		-	-
6.98 Social protection services and social services not disaggregated by type	127	127	127	-	-	-	-	-	-	-
6.99 Social protection services and social services not elsewhere classified	48,466	-	-	-	48,466	-	48,466	-	-	-
7. Enabling Environment (sub-total)	2,519,703	1,957	1,957	-	2,517,746	1,535,409	982,337	-	-	-
7.01 Advocacy	2,080,247	570	570	-	2,079,677	1,203,768	875,909	-	-	-
7.02 Human rights programmes	93,925	174	174	-	93,751	90,756	2,995	-	-	-
7.03 AIDS-specific institutional development	286,921	154	154	-	286,767	220,626	66,141	-	-	-
7.04 AIDS-specific programmes focused on women	42,944	875	875	-	42,069	15,212	26,857	-	-	-
7.05 Programmes to reduce Gender Based Violence	1,212	184	184	-	1,028	-	1,028	-	-	-
7.98 Enabling Environment and Community Development not disaggregated by type	9,407	-	-	-	9,407	-	9,407	-	-	-
7.99 Enabling Environment and Community Development not elsewhere classified	5,047	-	-	-	5,047	5,047	-	-	-	-
8. Research (sub-total)	1,140,197	10,822	10,822	-	1,129,375	775,125	354,250	-	-	-
8.01 Biomedical research	109,985	-	-	-	109,985	109,985	-	-	-	-
8.02 Clinical research	29,368	-	-	-	29,368	17,921	11,447	-	-	-
8.03 Epidemiological research	273,992	9,548	9,548	-	264,444	264,444	-	-	-	-
8.04 Social science research	662,153	-	-	-	662,153	319,782	342,371	-	-	-
8.05 Vaccine-related research										
8.98 Research not disaggregated by type	43,580	-	-	-	43,580	43,148	432	-	-	-
8.99 Research not elsewhere classified	21,119	1,274	1,274	-	19,845	19,845	-	-	-	-

(Footnotes)

1 n.e.c. = not elsewhere classified

2 For the purposes of this table, percentages under 1% are marked as 0%.

3 For the purposes of this table, percentages under 1% are marked as 0%.

4 In this case, UNV benefits from Women's Union office space and administrative support.

5 For the purposes of this table, percentages under 1% are marked as 0%.

6 For the purposes of this table, percentages under 1% are marked as 0%.

7 For the purposes of this table, percentages under 1% are marked as 0%.

8 For the purposes of this table, percentages under 1% are marked as 0%.

9 For the purposes of this table, percentages under 1% are marked as 0%.