MINISTRY OF HEALTH

IN COLLABORATION WITH

JOINT UNITED NATIONS PROGRAMME ON HIV & AIDS (UNAIDS)

Jamaica –National AIDS Spending Assessment

April 2009-March 2010

An Assessment of HIV and AIDS Financing Flows and Expenditure

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September 2012

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Acknowledgements

The National HIV & AIDS Programme together with the Joint United Nations Programme on HIV/AIDS express their gratitude to non-governmental, faith-based, government ministries, private sector, bilateral and multilateral agencies, and other stakeholders for their invaluable contribution towards the National AIDS Spending Assessment (NASA).

The professional disposition and engaging demeanour of the NASA Team who worked assiduously to capture and input the relevant data, contributed to the success of the NASA Jamaica. We are very pleased with the output of this assessment and hope that the information provided will continue to build capacity at the national and international level.

Acronyms

ASC	AIDS Spending Category
ARV	Anti-Retro Virals
CD4 Test	Test to determine T-cell count
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CIMA	Chartered Institute of Management Accountants
CSO	Civil Society Organization
GOJ	Government of Jamaica
ITECH	International Training and Education Centre on HIV
MARP	Most at Risk Populations
M&E	Monitoring and Evaluation
MSM	Men who have sex with men
NAPS	National AIDS Programme Secretariat
NASA	National AIDS Spending Assessment
NSP	National Strategic Plan
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAHO	Pan-American Health Organization
PCHA	Presidents Commission of HIV & AIDS
PEPFAR	US Presidents Emergency Plan for AIDS Relief
PLWH	People Living with HIV & AIDS
PMTCT	Prevention of Mother to Child Transmission Programme
SW	Sex Worker
TB	Tuberculosis
UA	Universal Access
UN	United Nations
UNGASS	United Nations General Assembly Special Sessions on HIV and AIDS
UNICEF	United Nations Children Fund
UNTG	United Nations Theme Group on HIV & AIDS
USAID	The United States Agency for International Development
VCT	Voluntary Counselling & Testing
WHO	World Health Organization

Document Guidance and Glossary

This section is aimed at assisting the reader in understanding the frequently used NASA terminologies which are used especially in results section.

- **Administrative Costs**- This is considered a production factor under NASA categorization. It speaks to cost related to coordination and administration of an HIV activity, especially as it relates to CSO activities
- **Logistics**- This is the catering, room rental and any other resource which goes into the coordination of an activity such as a workshop or an outreach intervention.
- **Not –identified**- This means that with respect to financial sources, financial agents and service providers there was not enough data provided to determine the name of the organization.
- **Not classified**- This means there was a lack of specification in the classifications so unclassifiable expenditure was defined as Not Elsewhere Classified, this is especially true for the inputs for production factors.
- **Vulnerable Population**- Vulnerable populations include youth, men who have sex with men (MSM), sex workers (SW) and drug users (DU). The data is often combined together in graphs to as a result of the low expenditure in comparison to other expenditure classifications also being displayed.
- **Guidance for Interpreting Graphs** - Missing bars or almost invisible bars indicate that there was either little or no expenditure by that organization or in that area per year in comparison to other expenditure classifications being displayed.

Executive Summary

The contents of this document reflect of the results of the National AIDS Spending Assessment for Jamaica for the fiscal years 2009/10- 2010/11. The results depict a very close approximation of what was actually spent on HIV and AIDS in the national response. The limitation of the results is dependent on the data which were collected for analysis. Therefore outcomes in this assessment are based on mainly mainstream and traditional government, international donor, as well as civil society organizations which are known to participate in the HIV and AIDS response in Jamaica. The results show almost no private sector expenditure. This however does not mean that there is no expenditure by this sector by the contrary as anecdotally, several private sector companies have sponsored HIV/AIDS interventions but the nature of the private response makes it challenging to gather this data.. As NASA, becomes more streamlined and common place as a reporting mechanism, it is hoped that it will be able to collect data from a wider cross-section of stakeholders, both traditional and non-traditional.

It is hoped that the results of this assessment will assist in the planning and execution of the Jamaican HIV response in years to come, especially, as funding shifts from HIV, which requires the country's response to be more self sustaining.

The National AIDS Spending Assessment (NASA) aims to look at six main areas of HIV and AIDS expenditure. They are:

- Who finances the AIDS response?
- Who manages the funds?
- Who provides the services?
- Which intervention was provided?
- Who benefits from the funds?
- What was bought to realize the intervention?

Further to this, NASA has eight AIDS Spending Categories (ASC). ASC are considered functional classifications which are based on the typical categories of HIV/AIDS interventions and

priorities. For the purpose of the Jamaica assessment, seven of these spending categories were investigated, two of which were combined with each other. For the purpose of the assessment Enabling Environment and Social Protection were combined as these interventions can be considered to fall under the same priority area in the Jamaica response as well as the fact that expenditure in each category was minimal. The ASCs assessed were:

- ASC.01 – Prevention
- ASC.02- Care and Treatment
- ASC.03- Orphans and Vulnerable Children
- ASC.04- Programme Management and Administration ASC.06-Social Protection and Social Service
- ASC.07- Enabling Environment
- ASC.08- Research

For the purposes of this study, expenditure on Human Resources and Prevention of Mother to Child Transmission (PMCT) were disaggregated from their AIDS spending categories. It was thought to be prudent to assess and analyze the human resource cost separately as it seeks to place a monetary value on the GOJs contribution to HIV, especially as sustainability has become extremely important in a world of declining international funding. Most Human Resource type activities are found in the ASC of Programme Management, which is where most administrative, planning and coordinating activities related to HIV programmes are recorded. Human Resource is also a cross cutting theme among all ASC, and is one of the main production factor inputs for HIV expenditure.

PMTCT was expanded from its ASC of Prevention, because in the first phase of NASA data collection there seemed to be little or no expenditure on this integral HIV activity. Further to this considering that this area is one of the main achievements of the Jamaican HIV Programme, the expenditure on this section is important and necessary if the gains made are to be sustained and maintained.

The NASA methodology involves several stages. These include data collection, data entry and data analysis and the final report. The Jamaican NASA was conducted in two phases. Phase 1 was conducted between October to November 2011. It was believed that the data received from the stakeholders was insufficient to make a valid approximation of expenditure. Therefore, another phase took place between April and June 2012..

The tables below represent a summary of the results of the assessment. They speak to the monies expended in total for both years as well as the main areas of expenditure under the AIDS spending categories.

Fact Sheets on Jamaica HIV & AIDS Expenditure for the period 2009 and 2010

Fact Sheet 1 Total HIV & AIDS Expenditure by Source for 2009/10-2010/11 Fiscal years[1]

HIV & AIDS Expenditure by Financial Source	JMD 2009/10	JMD 2010/11	USD 2009/10	USD 2010/11
Total Spending	1,452,421,525	1,395,186,486	16,912,221	16,245,767
Public:	299,413,802	349,193,472	3,486,421	4,066,063
Percent	20.65	25%	20.65	25%
International:	1,149,007,722.99	1,037,728,579.02	13,379,223.60	12,083,472.04
Percent	79%	75%	79%	75%
Private:	4,000,000	4,000,000	46,577	46,577
Percent	0.30%	0.30%	0.30%	0.30%

Fact Sheet 2 Total Expenditure by Classification by Service Providers

HIV & AIDS Expenditure by Service Providers		JMD 2009/10	JMD 2010/11
Public Provider	Health Sector	820,474,730.43	889,686,725.7
	Government Ministries	273,712,172.10	108,304,866.3
Bilateral and Multilateral International Agencies		65,407,370.93	24167204.12
Civil Society		287,736,537.03	337050637.3
Private		-	-
Research		970,666	10,644,827

[1] Exchange rate used is 85.88

Fact Sheet 3 Main Expenditure Areas in Prevention for 2009-2010 Fiscal years

HIV & AIDS Expenditure by Programme Areas		JMD 2009/10	JMD 2010/11				
Prevention		557,464,929	499,707,881				
Main Spending							
ASC Code	Spending Categories[2]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%
ASC.01.01.02 Non-health-related communication for social and behavioural change	Information, Education and Communications	411,398,543	73.8%	ASC.01.01.01 Health-related communication for social and behavioural change	Information, Education and Communications	202,691,722	40.5%
ASC.01.03 Voluntary counselling and testing (VCT)	VCT	26,435,219	4.7%	ASC.01.04 Risk Reduction for Vulnerable and Accesible Populations	Behaviour Change Communications	69,107,878	13.86%
ASC.01.09 Programmes for MSM	HIV Prevention for MSM	12,871,070	2.3%	ASC.01.05 Prevention – youth in school	Prevention Youth In School	58,295,336	11.66%
ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	Condom Social Marketing	12,575,409	2.2%	ASC.01.03 Voluntary counselling and testing (VCT)	VCT	52332661	10.4%

Fact Sheet 4 Main Expenditure Areas in Treatment and Care for 2009-2010 Fiscal years

		JMD 2009/10	JMD 2010/11				
Treatment Care and Support		541,507,773	502,322,368				
Main Spending							
ASC Codes	Treatment, Care and Support [1]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%
ASC.02.01.03.98 Antiretroviral therapy	Antiretroviral therapy (ARV)	195,267,785	36%	ASC.02.01.03.98 Antiretroviral therapy	Antiretroviral therapy (ARV)	234,199,407	46.6%
ASC.02.01.98 Outpatient care	Outpatient Care	227,744,219	42%	ASC.02.01.98 Outpatient care	Outpatient Care	215,100,123	42.8%

[2] The fact sheets capture the highest areas of expenditure by priority area rather than all the expenditure. The full details of the expenditure by the relevant category are captured in the appendices related to the Matrices.

services				services			
ASC.02.01.05 Specific HIV-related laboratory monitoring	Laboratory	97,228,593	17.9%	ASC.02.01.05 Specific HIV-related laboratory monitoring	Laboratory	22,498,261	4.4%

Fact Sheet 5 Main Expenditure Areas in Orphans & Vulnerable Children for 2009-2010 Fiscal years

		JMD 2009/10	JMD 2010/11				
Orphans and Vulnerable Children		2,528,500	2,544,000				
Main Spending							
Codes	OVC Spending Categories[1]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%
ASC 03.01	OVC Education	2,014,250	79.7%	ASC 03.01 ASC.03.04	OVC Education OVC Community Support	2,022,000 6,574,681	30%% 72%

Fact Sheet 6 Main Expenditure Areas in Programme Management for 2009-2010 Fiscal years

		JMD 2009/10	JMD 2010/11				
Programme Management and Administration		248,851,338	256,305,830				
Main Spending							
ASC Codes	Programme Management Spending Categories[1]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%
ASC.04.01 Planning, coordination and programme management	Programme Management	155,713,806	62.5%	ASC.04.01 Planning, coordination and programme management	Programme Management	157,411,632	61%
ASC.04.03 Monitoring and evaluation	M&E	33,942,739	13.6%	ASC.04.03 Monitoring and evaluation	M&E	40,406,547	15.7%

Fact Sheet 7 Main Expenditure Areas in Enabling Environment and Social Protection for 2009-2010 Fiscal years

		JMD 2009/10	JMD 2010/11				
Social Protection & Enabling Environment		98,915,928	96,657,467				
Main Spending							
Codes	Social Protection[1]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%

ASC.07.01	Advocacy	31,314,597	31.6%	ASC.07.01	Advocacy	52,434,206	54.2%
ASC.07.98	Enabling Environment	46,223,440	46.7%	ASC.07.98	Enabling Environment	13,65,4259	14.1%
ASC 06.04	Income Generation	5,606,857.86	5.6%	ASC 06.04	Income Generation	11,330,308	11.7%

Fact Sheet 8 Main Expenditure Areas in Research for 2009-2010 Fiscal years

		JMD 2009/10	JMD 2010/11				
Surveillance & Research Main Spending		3,153,057	3,915100				
Codes	Spending Categories[1]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%
ASC.08.04.01 Behavioural Research	Research	2,957,017	93.8%	ASC.08.03 Epidemiological Research	Research	1,717,600	43.8
				ASC.08.04.01 Behavioural Research	Research	2197500	56.1

Fact Sheet 9 Expenditure on Main Beneficiary Populations for 2009-2010 Fiscal years

Beneficiary Populations Main Spending							
Codes	Beneficiary Population[1]	JMD 2009/10	%	ASC Code	Spending Categories	JMD 2010/11	%
BP.01.98 People living with HIV	PLWHIV	670,855,607	46%	BP.01.98 People living with HIV	PLWHIV	675,616,601	48%
BP.05.98 General population	General Population	184,302,811	12%	BP.06 Non-targeted interventions	No Targeted eg Salaries	177,694,794	12.7%
BP.06 Non-targeted interventions	No Targeted eg Salaries	118,327,854	9.%	BP.05.01.98 General adult population	General Population	85,215,427	6.1%
BP.04.99.Low income accessible	Low income	76,913,200	5%	BP.02.03 Men who have sex with men (MSM)	MSM	108,877,384	7.8%
BP.02.03 Men who have sex with men (MSM)	MSM	88,258,694	6%	BP.05.03.98 Youth	Young People	48,737,095	3.4%

Fact Sheet 10 Expenditure on Human Resources by Main Funding Sources for 2009-2010 Fiscal years

Human Resource Costs		
Financial Source	2009/10 J$	2010/11 J$
Global Fund	77,257,885	169,457,906
GOJ / WB	89,856,552	108,243,022
Central Government	164,875,344	127,654,945
Total	331,989,781	405,355,873

Fact Sheet 11 Expenditure on PMTCT by Main Funding Sources for 2009-2010 Fiscal years

PMTCT Costs		
Financial Source	2009/10 J$	2010/11 J$
Global Fund	744,923	4,834,396
GOJ / WB	4,699,345	11,398,790
UNICEF	15,413,529	
Other International	17,303,530	
PEPFAR		21500
Total	38,161,328	16,254,659

Background

Jamaica's Socio-Economic Context

Jamaica is classified as an Upper Middle Income Country with a GDP of USD13.9b in 2010 an increase of 9.3% of USD12.6b from 2009. These figures have yet to recover from the GDP of USD14.1b experienced in 2008 prior to the global economic crisis.[3] Whilst the economy is generally improving the country still faces long term problems which may impact on the country's ability to meet the costs of providing care to HIV patients without donor support. The country has a significant debt-burden of a debt to GDP ratio of almost 130% and which has risen significantly from 2006 of 117%. As debt records the total stock of direct fixed term contractual obligations and liabilities there is a requirement on the government for fiscal discipline to maintain debt payments.[4]

In 2010 the country signed a Standby Arrangement with the IMF to support the country's economic reform and recover from mounting government debt, weak economic growth and the effects of the global economic crisis. Whilst the agreement will support economic development and place public sector finances on a sound footing the government will have limited ability for social and health spending as a result of a need to reign in public sector expenditure.[5]

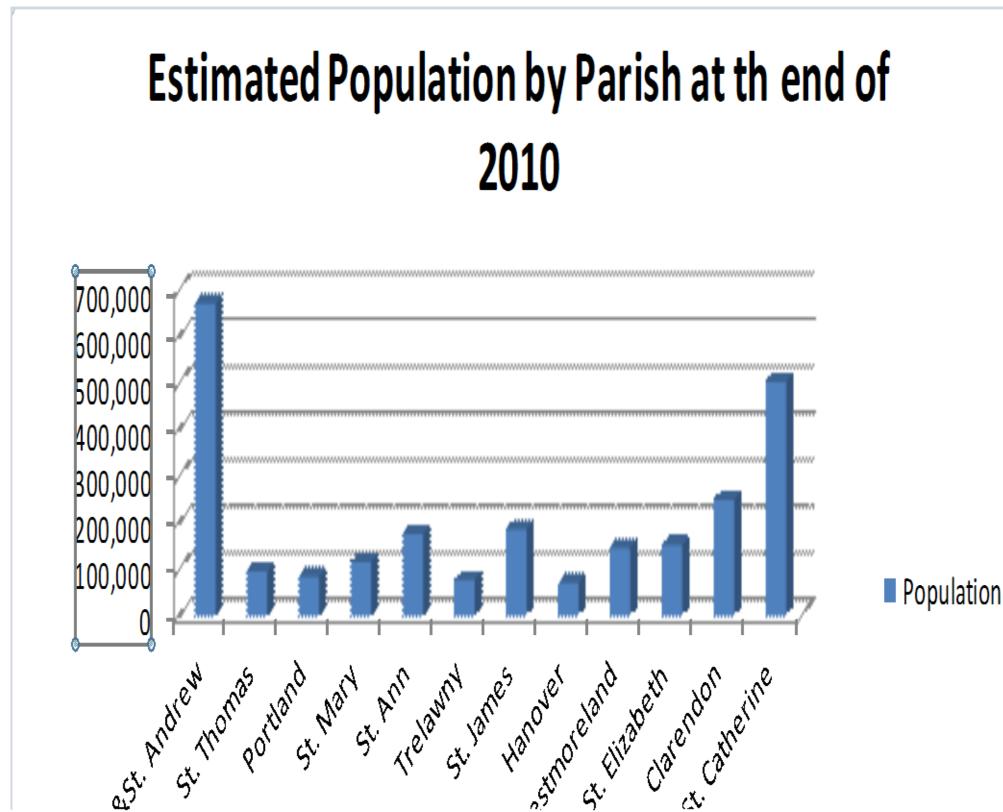
Tourism plays a major factor in the economic development of the country and accounts for 20% of the GDP followed by remittances which reduced to 15% of GDP in 2009. The percentage of the labour force currently unemployed is 14% and the poverty headcount is at 9.9% in 2007 although this represents an improvement from 19.1% in 2003. The literacy rates for adults over 15 are 86% and there is a 93.3% primary school enrolment rate which has remained relatively consistent since 1999. The infant mortality rate per 1,000 population is 23.3 in 2010 which slightly higher than 19.6 for other middle income countries.

[3] The World Bank
[4] US State Department
[5] International Monetary Fund, February 4, 2010.

Jamaica population and sex distribution, urban and rural[6].

At the end of 2010 it was estimated that the population of Jamaica was 2,705, 800 At the end of 2010, the female population was estimated to be 4% greater than male with approximately 1, 380, 000 females and 1, 325, 800 males. The largest age groups are between 10-14 and 15-19. This accounts for 527,636 persons or approximately 20% of the population.The majority of the persons live in the parishes of Kingston & St. Andrew, St. Catherine, Clarendon and Manchester. These four parishes account for approximately 60% of the population. St. James which is home to the country's second city has the fifth largest population in the island with 185, 344 person. The less developed and urbanized parishes such as St. Thomas, Portland and Trelawny smaller populations of less than 100, 000 persons each.

Chart 1 Estimated Population by Parish at the end of 2010



[6] Statistical Institute of Jamaica http://statinja.gov.jm/MidYearPopulationbyAgeandSex2008.aspx

HIV Epidemic

The trend of the HIV and AIDS epidemic in Jamaica is considered generalized, with a prevalence of 1.7%. This percentage represents approximately 32,000 persons of whom it is anticipated that 50% do not know their status. However there are concentrated epidemics in the most at risk populations (MARPs) with approximately 32% prevalence among MSM and 5% in the SW population. Although the prevalence amongst the MSM is reported at 32%, the majority of the HIV cases of the 27,272 reported from 1982 until the end of 2010 are through heterosexual contact. Four Percent (4%) of the cases transmission has been self reported as through bi-sexual male and another 3.5% through homosexual contact.[7]

There continues to be a decline in the number of HIV cases reported each year. In 2006 the largest number of HIV cases was reported at 2121[7]. Since then there has been a steady decrease in the numbers of reported HIV cases each year and which was also noted in the ante-natal clinics. The reduction in reported numbers of annual HIV cases is a possible indication that behaviour change programmes in Jamaica are having an impact and that the incidence is decreasing.[7] Further to this there has been a 50% decline in AIDS related deaths since the start of public universal access to ARVs until the end of 2010. There were 331 reported AIDS related deaths in 2010 compared to 665 in 2004. This decline can be attributed to increased access to ARV treatment as well as a general improvement in the healthcare system is it relates to HIV/AIDS such laboratory testing for CD count and PCR. [7]

At the end of the 2010 there were 711 men and 792 women reporting with advanced HIV. Although more men still carry the burden of HIV, there has been an increasing rate among women. Currently the male to female ratio of HIV is 1.35: 1[7].

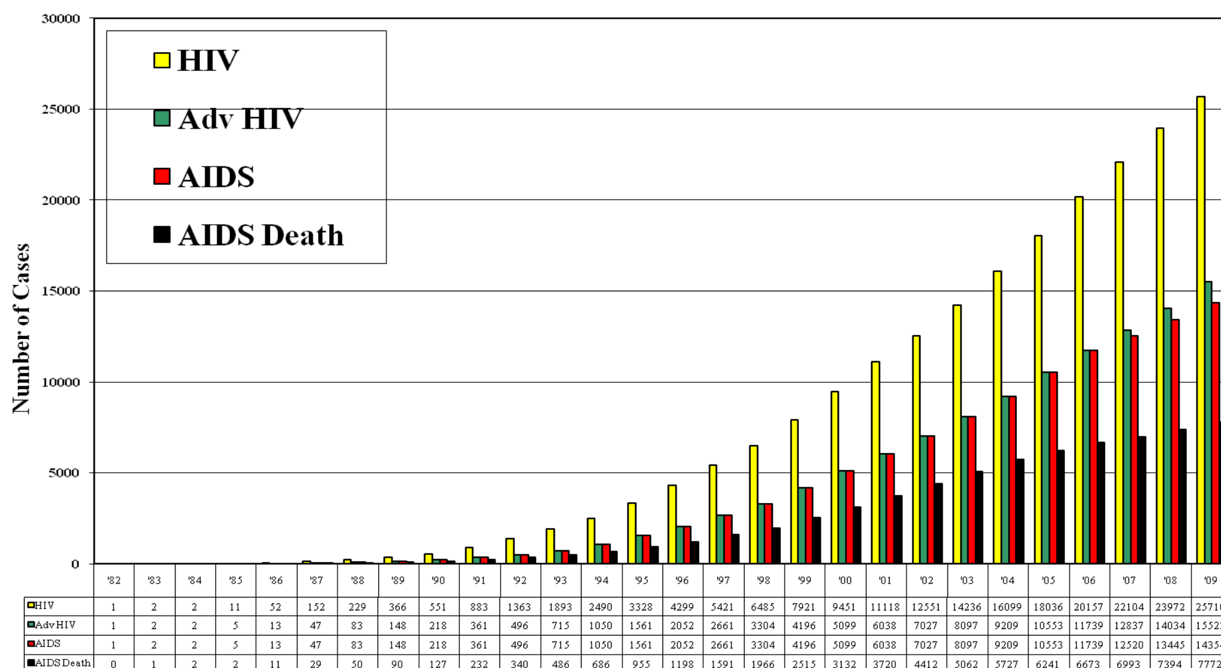
Kingston and Montego Bay, the two cities of Jamaica have the highest burden of HIV in the island with prevalence rates of 1494 and 1956 per 100,000 respectively. The parishes which constitute the tourism belt, St. Ann, Westmoreland and Hanover have the next highest

[7] AIDS Report 2010, National HIV/STI Programme, Ministry of Health, Kingston, Jamaica, Released on November 25, 2011

prevalence rates. There was an increase in the number of HIV/AIDS cases reported in Clarendon and Manchester, moving from 147 (combined) in 2009 to 214 in 2010[7].

Mother to child transmission has decreased significantly with the less than 5% of transmission rate. In 2010 only 19 children were born with HIV. Risk factors for HIV in Jamaica include multiple sex partners, STI history as well as sex with SW. Most at risk populations in Jamaica include MSM, SW, prisoners and homeless crack cocaine users[7].

Chart 2 Cumulative HIV Advance HIV AIDS Cases & AIDS Deaths 1982 – 2009[3]



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95
HIV	1	2	2	11	52	152	229	366	551	883	1363	1893	2490	3328
Adv HIV	1	2	2	5	13	47	83	148	218	361	496	715	1050	1561
AIDS	1	2	2	5	13	47	83	148	218	361	496	715	1050	1561
AIDS Death	0	1	2	2	11	29	50	90	127	232	340	486	686	955

	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09
HIV	4299	5421	6485	7921	9451	11118	12551	14236	16099	18036	20157	22104	23972	25710
Adv HIV	2052	2661	3304	4196	5099	6038	7027	8097	9209	10553	11739	12837	14034	15523
AIDS	2052	2661	3304	4196	5099	6038	7027	8097	9209	10553	11739	12520	13445	14354
AIDS Death	1198	1591	1966	2515	3132	3720	4412	5062	5727	6241	6673	6993	7394	7772

Jamaica's National Strategic Plan for HIV/AIDS spans the years 2007-2012. The plan has four main priority areas and has an accompanying M&E plan. The four main priority areas of the NSP 2007-2012 are: prevention, treatment and care, enabling environment and empowerment, and governance. All but one of these priority areas have strategic objectives which give focus to most at risk populations (MARPs). In Jamaica MARPs are considered, MSM, SW, Homeless Crack-cocaine users, Inmates and Out of school youth. Of the 35 sub-recipients of the NHP 85% have programmes geared towards youth, 7% towards MSM and 4% towards SW.

Sub-recipients under the NHP include government ministries, member based PLHIV , CSO, and private sector umbrella organizations, academic institutions and regional health authorities. Further to this, through the National AIDS Committee (NAC), the NHP facilitates a multi-sectoral response which includes faith based organizations as well Parish AIDS Associations which provide support and care for persons affected and infected on a parish level.

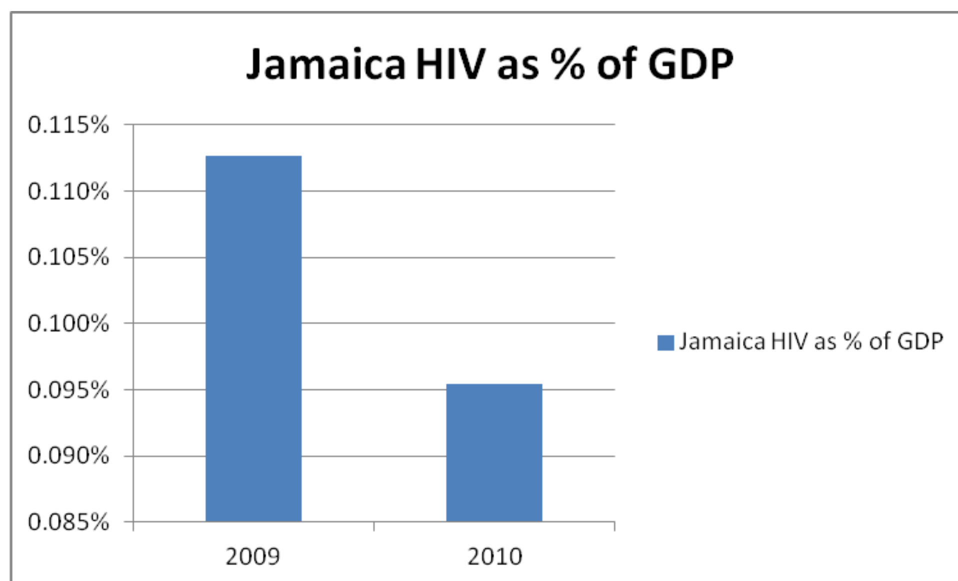
In 2010 several international NGOs such as World Learning and FHI 360 became stakeholders with respect to HIV prevention and programming targeting most at risk populations of MSM and SW. These organizations are funded by PEPFAR. Through PEPFAR there has been technical assistance in the areas of laboratory development, research, monitoring and evaluation and capacity building and training for health sector workers. Further to this there are a number of International Development Partners (IDP) such as various UNAIDS, UNICEF, UNFPA and other UN organizations that support HIV in Jamaica.

The majority of the National HIV Strategic Plan is funded by IDPs, such as the GOJ / WB (WB) and the Global Fund against AIDS Tuberculosis and Malaria (GFATM) and PEPFAR. There is a projected a 67.3 % shortfall in the funding for the NSP indicating the inability to effectively complete all activities due to insufficient funds. The NSP was budgeted at USD 201.2 million; however only USD 65.7 million is available[8]. Jamaica also finds itself in the interesting category of being an Upper Middle Income country is no longer eligible for loans. Additionally, at the end of 2011, Global Fund announced that it will not be disseminating any new grants and will only be strengthening existing programmes. This picture indicates that Jamaica needs to examine cost-effective measures to ensure the sustainability of its HIV programme.

HIV only accounts for JMD 1.2 billion of the MOH's JMD 31 billion budget; however it should be noted that there is an unknown contribution by GOJ as there has been no costing on the resources (including drugs for OIs), time and personnel dedicated to HIV through the public health system.

[8] Planning Institute of Jamaica 2009

Chart 3 Expenditure on HIV as % of GDP



HIV and AIDS Funding Source – Donors contribution to HIV and AIDS in Jamaica

Global Fund

The Global Fund Agreement aims to consolidate existing gains while scaling up to provide universal access (UA) to HIV Treatment, Care and Prevention Services with special emphasis on special vulnerable populations. It is part of a Round 7 Grant valued at USD39,991,051

Phase 1 started 15 November 2010, Phase 1 Ending 31 July 2010, Phase 2 Ending 31 July 2013. Under the agreement several priority areas should have activities implemented. The activities priority areas are:

- **Prevention-** Scale up of programmes targeting socially vulnerable, marginalised populations and MARP – PLWHA, MSM, CSW and clients, adolescents and youth, drug users and prison inmates. Adolescents 10-14 years, youth 15-24.

- **Treatment care and Support**- UA for all person in need – comprehensive care, intensify adherence counselling efforts, monitor and prevent resistance and improve standardised methods of tracking adherence. Target people in need of ARV, PLWHA
- **Enabling Environment**- Operationalize the national HIV policy and various other HIV policies and empower beneficiaries of these policies to understand their rights and seek redress. There should be participation from PLWHA and CSO sector to ensure implementation. Reducing S&D and affirming the rights of all Jamaicans. Target the NGO Sector

The Goal of the agreement is to reduce the transmission of new HIV infections and mitigate the impact of HIV. Several activities were sighted to be implemented for this goal to be achieved. The activities including the implementation of Health and Family Life Education (HFLE) Programmes in 1000 primary, secondary and independent schools, training civil society organizations in gender sensitive and low literacy BCC. Scale up rapid outreach testing in rural communities, increasing condom access among low income and high risk populations as well as scale up diagnostic services and to integrate and S&D reporting across all sectors. Under the agreement as well social protection programmes such as income generation small grants programmes to be improved in order to assist PLHIV.

The World Bank/Government of Jamaica

The World Bank's Second HIV & AIDS Project which is a loan valued at USD10m was signed in June 2008 and is projected to be closed out by November 30, 2012. The Project's aim is to assist in the National HIV Programmes i.e deepening of prevention interventions targeted at high risk groups and the general population; increase access to treatment, care and support services for the infected and affected; strengthen programme management and analysis to identify priorities for building the capacity of the health sector to respond to the HIV epidemic.

The activities under this agreement are in tandem with the priority areas outlined in the 2007-2012 NSP for HIV and AIDS in Jamaica.

Prevention -Strengthen MOH and RHA to deliver HIV related services for prevention through the health care system and to:

- Support behaviour change communications targeting at risk groups and the GP.
- Expand VCT to permit scaling up of treatment
- Improve management of STIs
- Promoting and providing condoms to increase use
- Improving blood safety services
- In addition there will be non-health care sector activities such as the scaling up of the Non-Health Line Ministries to prevention activities to make the response multi-sectoral by Supporting Non-Health Line Ministries work plans
- Co-financing staffing costs of the focal points
- Provision of TA and training.

There will also be support prevention activities by CSO and the private sector by offering TA and grants to demand driven projects targeting key populations at higher risk

- **Treatment, Care and Support**,- Support scale up of treatment, care and support by
- Improving the public laboratory system to enhance diagnostic capacity related to HIV and TB
- Strengthened capacity to manage OI, TB, ARV regimes through development and dissemination of technical guidelines and protocols
- Training of healthcare workers
- Provision of drugs, nutritional supplements and infant feeding formula
- **Institutional Capacity** -Strengthening for legislative reform, policy formulation, programme management and M&E.
- TA to legislative and policy framework – update of the public health act, advocating for further legislative and policy reform.
- Co-finance staff for technical and fiduciary function- PCU and RHA, M&E (Equipment , training in M&E)

- Strengthen M&E systems by supporting the development of M&E framework and operational plan and surveillance systems and conducting studies, surveys, surveillance on the General Population and special groups
- **Health Sector Development** – Improve management of bio-medical waste by:
- Improving waste mgmt facilities – equipment, waste disposal supplies, - proper segregation and procurement of waste services
- Creation of plans & systems to facilitate documentation of infectious waste
- TA training materials –post exposure prophylaxis.

USAID

The Assistance Agreement between USA and Jamaica for HIV Prevalence in Most at Risk Populations reduced and effects mitigated. The grant value is USD1,176,309 with the GOJ contribution of USD363,087. The intermediate results of this agreement include

- Sexual Transmission of HIV reduced
- Use of Strategic Information for evidence based policies and programs improved
- Stigma and Discrimination Reduced

The agreement started on September 30, 2009 is scheduled to be completed by September 30, 2014. The activities which are aligned to the desired outcomes are:

- **Sexual Transmission of HIV Reduced -** Through targeting the most at risk population groups through an enhanced CSO response. Strengthened capacity, sustainability to offer adequate programmes and service. JN+ and Jamaica AIDS Support for Life are a priority. Technical assistance to improve access to Global Fund Grants.
- **Use of Strategic Information for evidence based policies and programmes improved-** Increase availability and quality of HIV & AIDS Data to characterise the epidemic and support evidenced based decision making for improved programs, policies and health service. Activities will include designing population based behavioural surveys and strengthening M&E systems particularly around routine health information systems.

- **Stigma & Discrimination reduced-** S&D is pervasive and limit UA to preventative care and support. Activities include public dialogues on the amendment of the Occupational Health and Safety act to include HIV & AIDS workplace policies. TA to ensure that HIV & AIDS workplace polices are implemented in the private sector. TA to the Jamaica business council on HIV & AIDS. Work with the Ministry of Labour and Social Security HIV & AIDS Workplace Programme.

United Nations joint team on HIV/AIDS UNAIDS

UNAIDS is mandated to provide technical support to assist in the implementation of national AIDS programmes. UNAIDS has a close partnership with the Global Fund in several areas, including supporting the Fund's full grant cycle – from the development of AIDS grant proposals to programme implementation to monitoring and evaluation. UNAIDS assists the Country Coordinating Mechanisms (CCMs) as needed in developing AIDS proposals for consideration by the Global Fund. It also strengthens CCMs by ensuring the meaningful participation of civil society.

Purpose of NASA

Jamaica in its effort to monitor and evaluate the response to the AIDS pandemic and achieve the financing goals set out in the 2001 UNGASS Declaration, decided to track the flow of financial resources from funding source to actual expenditure. This data is used to measure national commitment and action, an important component of the UNGASS Declaration.

In that respect, UNAIDS together with the NHP supported the implementation of a National HIV/AIDS Spending Assessment (NASA), which is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV/AIDS in low- and middle-income countries. It describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease using the bottom-up and top-down approach. Financial resources are tracked by financing

source whether it is public, private or international and among the different providers and beneficiaries (target groups).

The main objective of resource tracking at the country level is to determine what is actually disbursed or spent in a country. The resource tracking process follows the money from its origin (i.e. source) down to the destination, the beneficiaries receiving goods and services. It offers an improved understanding of the current levels of spending as well as the main barriers for the optimal use of these financial resources.

The argument for conducting a NASA exercise in Jamaica is further strengthened as the third replenishment for the Global Fund came to an end in 2010 with only modest results. Donors committed only US$11.7m billion for the period 2011-2013 which corresponds to just over half of what is needed to by the Global Fund to protect gains, meet existing commitments and also to scale up its work according to the demand of developing countries responding to HIV & AIDS, TB and Malaria. Contributions from G8 countries make up the majority of the Global Fund resources, but it is recognized that, there is a need to mobilise new funding sources among the private sector as well as upper middle income countries. The funding shortfall partly reflects the effect of the global financial crisis[9]. As a result of insufficient resources to meet all commitments in May 2011 a new eligibility, counterpart financing and prioritization policy for all funding channels was adopted[10]. An eligibility criteria was determined in order to apply for funding from the Global Fund based on income level, disease burden, official development assistance recipient and recent funding history.

Additionally, in November 2011 the Global Fund cancelled round 11 of the funding proposals and the establishment of a transitional funding mechanism in order to provide for the continuation of funding for projects currently being funded by the Global Fund. In December to further counterpart financing and prioritization policies will be issued.

It is likely that going forward there will be increasing pressure placed on donor agencies as funding becomes harder to access. With the context of the situation with the Global Fund

[9] (The Lancet, Volume 376, Issue 9749, Page 1274, 16 October 2010)
[10] Eligibility, Counterpart Financing and Prioritization Information Note. The Global Fund July 2011.

together with a review of recent headlines making reference to donor funding the messages appear to be AIDS: When the Funding Fails; Drying up of HIV Funding, a ticking time bomb; Eurozones economic turmoil.[11]

It is in light of its HIV epidemic and socio-economic situation, its HIV funding stream, as well as, the global economic and funding climate, the NHP in Jamaica thought prudent to conduct as assessment of this nature.

[11] Devex, November and December 2011.

Introduction

The UNAIDS developed National AIDS Spending Assessment methodology faciliatates the development of a systematic description of the financial flows related to the consumption of HIV related goods and services. Their intent is to describe the national HIV system from an expenditure perspective and meet the increased expectations from analysts, policy makers and the general public alike for more sophisticated information that can be gained through the collection of HIV related expenditure data. HIV and AIDS spending accounts are increasingly expected to provide an input (along with other Key Performacne Indicators) to improve analytical tools that are used to monitor and assess health system performance. The aim of the accounting framework for HIV financing is to provide a clear and transparent picture of the key transactions (flows) and the structure of the financing system of countries. A comprehensive account for the flow of financing requires tools for monitoring the transactions for revenue-raising and resource-allocation, as well as the institutional entities involved. In Jamaica, the methodology used was based on the Guide to Produce National AIDS Spending Assessment, May 2009 which was produced by Joint UN Programme on HIV & AIDS, WHO and World Bank.

The aims of the Jamaican NASA consultation process were to implement as well as build country capacity in a methodology for systematic monitoring of HIV/AIDS financial flows at national and regional level using the National AIDS Spending Assessment methodology (NASA), as well as, to develop a strategy involving multi-sectoral and multi-level key partners to track HIV and AIDS spending in country.

The project is aimed at implementing and institutionalizing HIV/AIDS Resource Tracking in Jamaica based on the National AIDS Spending Assessment methodology (NASA). The overall objectives of the project are to implement a methodology for systematic monitoring of HIV/AIDS financial flows at national and regional level using the National AIDS Spending Assessment methodology (NASA). Another aim is the development of a strategy involving multi-

sectoral and multi-level key partners to track HIV and AIDS spending in Jamaica. Additionally, to build national level and regional capacity for systematic monitoring of HIV/AIDS financing flows using National AIDS Spending Assessment methodology (NASA).

The NASA methodology responds for a particular year to six different questions:

- Who finances the AIDS response?
- Who manages the funds?
- Who provides the services?
- Which intervention was provided?
- Who benefits from the funds?
- What was bought to realize the intervention?

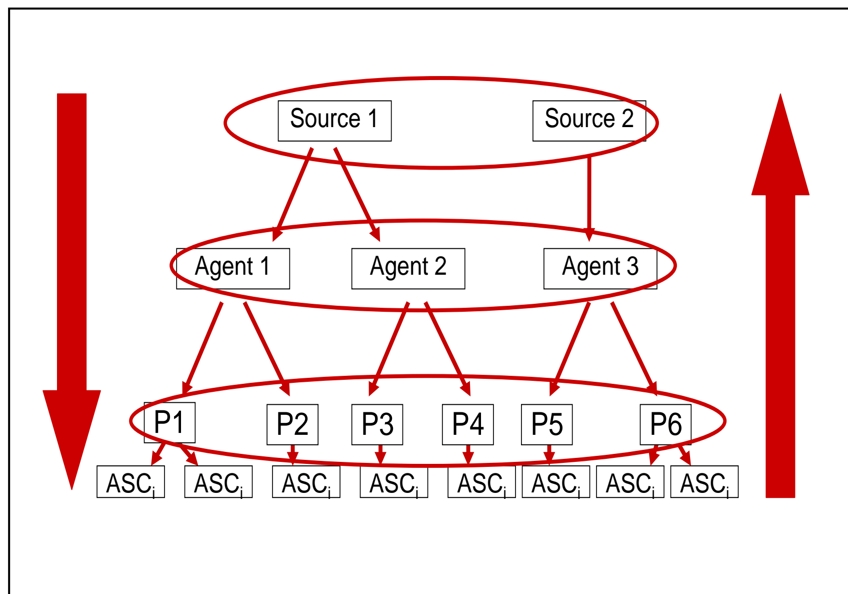
In order to answer these questions, the NASA methodology reconstructs all the financial transactions related to the national response to the HIV and AIDS epidemic. A transaction is a transfer of resources between different economic agents and follows the money through the financing sources, buyers and providers and the description of its factors of the production function.

The financial transactions are reconstructed by identifying three dimensions: financing, provision and use. Each dimension incorporates two vectors. Each of the six vectors answers the above questions:

- The financing sources (FS) are entities that available the funds to finance the HIV and AIDS services (e.g. PEPFAR, the Global Fund, Public sources, out of pocket expenditures).
- The financing agents (FA) are entities that mobilizes the resources to finance specific programmes and that take the decision on how they should be spent.
- The providers (PS) are entities that engage in the production, provision, and delivery of HIV and AIDS services. They carry out the different interventions.
- The production factors (PF) are the resources bought to produce the interventions (ex. wages, services, consumables, capital).
- The AIDS Spending Categories (ASC) are the activities and services provided as the multi-sectoral response to HIV and AIDS (e.g. prevention, care and treatment, OVC, social mitigation, research).
- The Beneficiary populations (BP) are the intended part of the population benefiting from a specific intervention (e.g. PLWH, most at risk populations, general population).

NASA, also, reconstructs all the transactions to report the actual spending, consumption and delivery made for HIV and AIDS in a selected year. Thus, NASA does not report budgets, stocks, commitments or disbursements. In order to establish the actual spending, NASA uses the "top-down" and "bottom-up" estimation of the resource flows, by costing the services and goods delivered by the providers for each of the activities, or functions, and then reconstructing the financial transactions from the sources, through the financing agents, and describing the use of the resources by disaggregating the production function components and the beneficiaries of such functions.

Figure 1 NASA Methodology, Bottom Up/Top Down Approaches



The assessments are based on the NASA classifications[12], which tend to be consistent with the strengthening of the coordination, alignment and harmonization processes in the context of the UNAIDS "Three Ones" principles[13]. These classifications were recently revised and published in the UNAIDS website.

[12] National AIDS Spending Assessment (NASA): Classification taxonomy and Definitions http://www.unaids.org/en/KnowledgeCentre/HIVData/Tracking/Nasa.asp

[13] UNAIDS. "The "Three Ones" in action: where we are and where we go from here". Joint United Nations Programme on HIV/AIDS. UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, World Bank, May 2005.

Methodology

There are three principle dimensions that are used to track resources and integrate these into the NASA methodology. For the first dimension of Financial Resources these are identified and mapped and separately identified by Financial Sources and Financial Agents. The data collected from these sectors is actual expenditure incurred rather than committed or budgeted figures. The second dimension relates to the tracking of resources by the Providers of Services and which also includes the Production Factors associated with HIV. As with Financial Resources the providers have to be identified and mapped and included in the study. The final dimension is related to the activity undertaken and the identification of targeted populations. Expenditure on activity is classified according to the NASA AIDS Spending Categories and in accordance with the definitions of Beneficiary Populations.

The Jamaica NASA Process involved several steps. These steps included:

- Sensitization
- Data Collection and Entry
- Data Analysis

Sensitization

This step involved several sensitization and capacity building workshops for stakeholders and key technical persons in the RHA, the NHP and UNAIDS. Stakeholders were given basic information on NASA, including the NASA codes and the purpose of conducting a NASA exercise. Technical stakeholders' skills were built in conducting NASA, NASA calculation and NASA coding for data entry. This capacity building was facilitated by an International expert on Health and HIV resource tracking Daniel Aran who conducted a number of technical assistance activities in June 2012.

Data Collection and Data Entry

Data collection was done in two phases, October to November 2011 and April to June 2012, as the first phase yielded a less than 44% and this was considered inadequate for a valid approximation of expenditure. However, by the end of phase II there was a response rate of 65%. When the government sector is taken into consideration there is a 78% response rate.

As stated in the introduction NASA seeks to answer six main questions:

a. Who finances the AIDS response?
b. Who manages the funds?
c. Who provides the services?
d. Which intervention was provided?
e. Who benefits from the funds?
f. What was bought to realize the intervention?

This information was collected by administering data collection tools to relevant stakeholders. The tools were disseminated via the internet to the various types of stakeholders. The stakeholders included financing sources, financing agents, and service providers, therefore data collection is validated and triangulated

In several instances the consultant had to have face to face meetings with stakeholders in order to assist in the completion of the data collection tool. The RHA, whose capacity were built in NASA data collection gathered data within the regions, especially as it related to human resources and treatment activities. This information was sent to the main NASA consultants who conducted the data entry and analysis.

There were two versions of the tools (see appendices iv), as data collection was conducted in two phases. Table 1 below shows the number of organizations from each sector which responded over the two phases

There is a seemingly low response from the government sector, however due to the nature of the response, all or most HIV government expenditure, notwithstanding the ministry, is done through the NHP through its Prevention or Enabling Environment components. To this end their expenditure data is captured in the NHP. From this perspective, there was close to 100% reporting on government ministries' HIV activities. When this assumption is applied the response rate for NASA moves from 65% to 78%.

The Ministry of Education and the Ministry of Labour can be considered anomalies to this assumption. MOE receives funding outside of the NHP from organizations such as the UN Theme Group like UNICEF, UNESCO and UNFPA. Additionally, future NASA's need to examine the GOJ contribution to staff from Ministry of Labour who implement HIV activity who are not funded by NHP.

For the purposes of this assessment, NHP was assigned three categories which were GF, GOJ/WB and USAID which are the main external financial sources which the NHP manages.

Table 1 NASA Respondents by Sector

Type of Organization	Targeted Amount	Number Respondents (1st phase)	Number Respondents (2nd phase)	Total Number Respondents
Civil Society	19	7	8	15
Government Ministries	12	12	-	12
National HIV Programme, Ministry of Health	3	3	-	3
Bi-lateral and Multi-lateral Agencies	19	8	3	11
Private Sector	2	1	1	2
Quasi-Government including RHA and UWI Health Centres	10	6	2	8
TOTALS	**65**	**28**	**17**	**51**

After the data was collected, a file was created for each respondent. NASA Coding was applied to all data collected, along with calculations to assist in appropriating funds to specific AIDS Spending Categories. The formulas applied to each respondent are to be found in appendix III.

Data Analysis

After the data entry had been completed, all data were entered into a data base. From this database matrices and pivot tables and charts were generated to give the results relating to spending categories, including financial agents, service providers and resources which HIV funds were expended on. The database will be submitted to the NHP while the matrices are attached this report. The analysis also ensured there was double counting of expenditure as it relates to financial source, funding agent or service provider.

The matrices which were analysed included:

1. Financing Sources (FS) x Financing Agents (FA) 2009
2. Financing Sources (FS) x AIDS Spending Categories (ASC) 2009
3. Financing Agents (FA) x AIDS Spending Categories (ASC) 2009
4. Financing Agents (FA) x Providers of Services (PS) 2009
5. Financing Agents (FA) x Beneficiary Populations (BP) 2009
6. AIDS Spending Categories (ASC) x Beneficiary Populations (BP) 2009
7. Providers of services (PS) x Production Factors (PF) 2009
8. Providers of services (PS) x AIDS Spending Categories (ASC) 2009
9. AIDS Spending Categories (ASC) x Production Factors (PF) 2009
10. Financing Sources (FS) x Financing Agents (FA) 2010
11. Financing Sources (FS) x AIDS Spending Categories (ASC) 2010
12. Financing Agents (FA) x AIDS Spending Categories (ASC) 2010
13. Financing Agents (FA) x Providers of Services (PS) 2010
14. Financing Agents (FA) x Beneficiary Populations (BP) 2010
15. AIDS Spending Categories (ASC) x Beneficiary Populations (BP) 2010
16. Providers of services (PS) x Production Factors (PF) 2010
17. Providers of services (PS) x AIDS Spending Categories (ASC) 2010

18. AIDS Spending Categories (ASC) x Production Factors (PF) 2010
19. The UNGASS Matrix / Indicator n°1 – Submitted in a separate excel file

Results- Expenditure Flows

In this section of the report the results of the NASA project will be described and will provide the estimates on the expenditure in relation to HIV and AIDS by Priority area and will answer the following six questions:

Who finances the AIDS response?

Analysis of the financial source, those entities that provide money to financing agents of interest, especially in the Jamaican context where there is a high dependence on international, donor and loan funding.

With regard to the World Bank Loan there was discussion on how this financial source should be classified in the NASA study as either donor funds or in effect Government of Jamaica funding. Whilst the WB loan is for a specific purpose i.e. HIV and AIDS rather than a loan for general budget support it could be classified as a distinct and separate financial source and which helps in developing the complete picture of all the financial sources. This in turn gives better information for strategic decision making. The GF, however classify loan funds as the governments contribution when it is allocated to the health sector or a specific disease programme such as HIV & AIDS. As a result of this distinction by the Global Funds the NASA report has classified the WB loan as GOJ funding source. As however, there are advantages to distinguish between funds sourced from general revenue and funds sourced from the WB loan especially for issues of sustainability the report identifies these two different funding sources but recognizes that they are in essence public funds.

Who manages the funds?

The financing agents are those institutions that make the programmatic decisions on the use of the funds. The agent receives the financial resources, at times from multiple sources and transfers these to providers to finance programs and activities.

Who provides the services?

The provider of services is contracted by the financing agent for a specific service and includes entities in the health sector, government, private sector and civil society organizations.

Which intervention was provided?

The NASA classification of AIDS spending categories includes spending on prevention, care and treatment and other health and non Health Services related to HIV. The classifications list also includes: orphans and vulnerable children, programme management, social protection and enabling environment and research.

Who benefits from the funds?

The beneficiary populations are those populations that are explicitly targeted from the activities that have been performed and are identified in accordance to the intention of the programmatic intervention.

What was bought to realize the intervention?

The production factors are simply the objects of expenditure that create the services that have been performed and include such items as wages, materials and services, medication, production costs and consumption of capital amongst others.

The results are split into several sections which answers the six questions for each AIDS Spending Category. The expenditure categories which were reported on for the Jamaica NASA are as follows:

1. General Overview of Expenditure

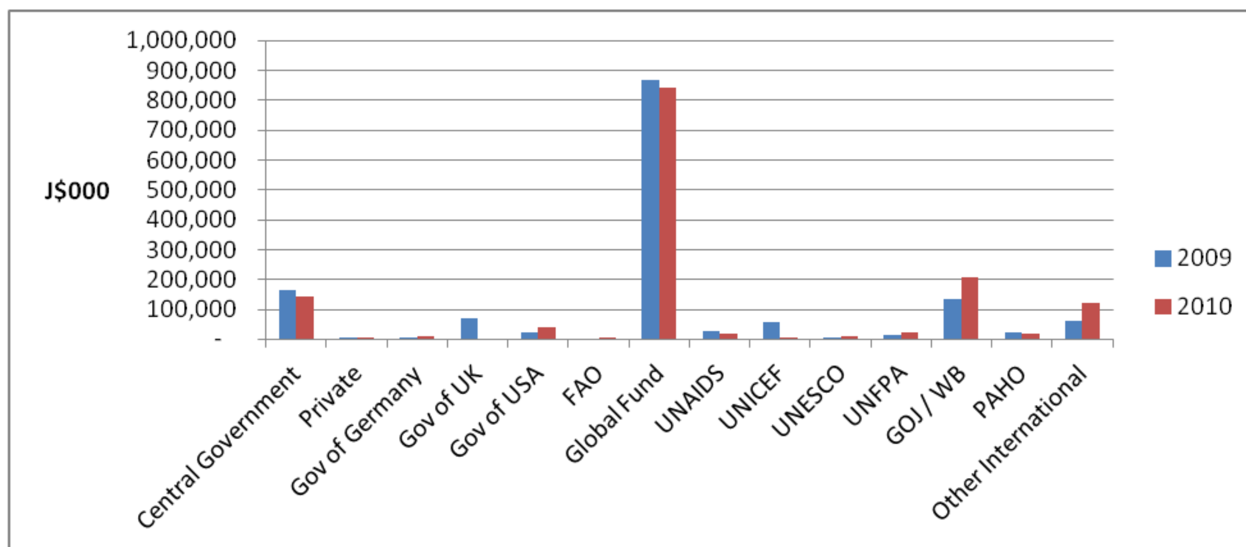
2. Prevention Expenditure
3. Treatment and Care Expenditure
4. Orphans and Vulnerable Children Expenditure
5. Programme Management Expenditure
6. Enabling Environment and Social Protection Expenditure
7. Research Expenditure
8. Human Resources Expenditure
9. Prevention from Mother to Child Transmission (PMTCT)

1. General Overview

1.1 Total Expenditure by Financial Source

The majority of HIV expenditure in both 2009/10 and 2010/11 fiscal years in Jamaica, by a financial source, were done by the Global Fund. GOJ was the next biggest spender when the monies from Central Government and World Bank Loans are taken into consideration. The expenditure by GF in both years was almost four times and three times that of GOJ for 2009/10 and 2011/10 respectively. This accounted for 79% and 75% of all HIV expenditure for 2009/10 and 2010/11 respectively. It should be noted that GF expenditure reduced from 79% in 2009/10 to 75% in 2010/10. The inverse was true for GOJ expenditure; there was an increase from 20.65% to 25% over the two fiscal years being investigated.

Chart 4 Total HIV& AIDS Expenditure by Financial Source

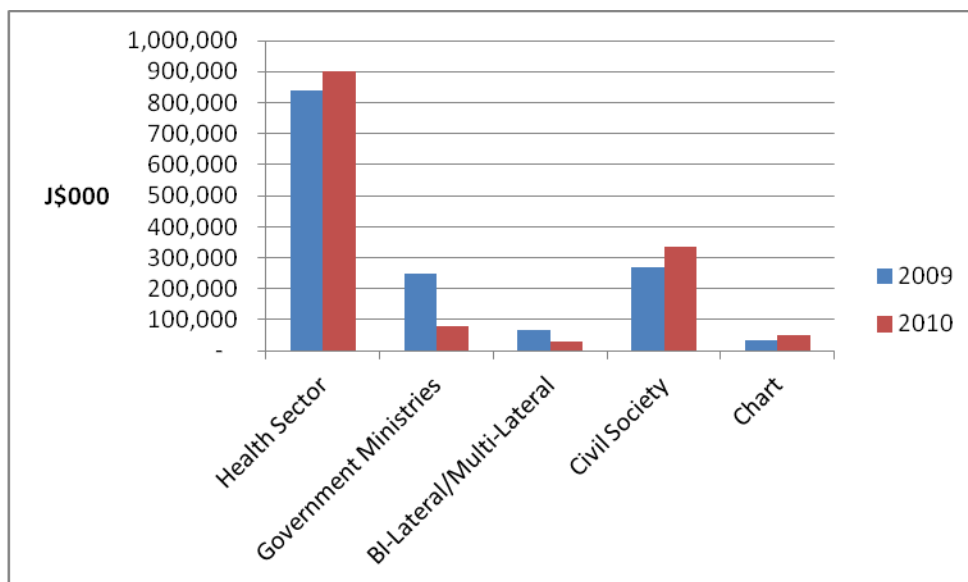


1.2 Total Expenditure by Sector

When expenditure by sector was examined, the health sector expended most money on HIV. This means they were the biggest spending service providers. This can be attributed to several facts, that the NHP is the project coordinating unit for the GF, operates out of the MOH as well as the fact that treatment and care of HIV such as patient care and the procurement and dispensing of ARVs would occur in the health sector and these resources are more costly

expenditure items. Civil Society who had the next highest level of expenditure compared to the health sector, expended 35% less in 2009 than civil the health sector and 37% less in 2010; however the actual dollar value of CSO expenditure increased from J$ 287,736,537.03 to J$337,050,637.03.

Chart 5 Total Expenditure by Sectors

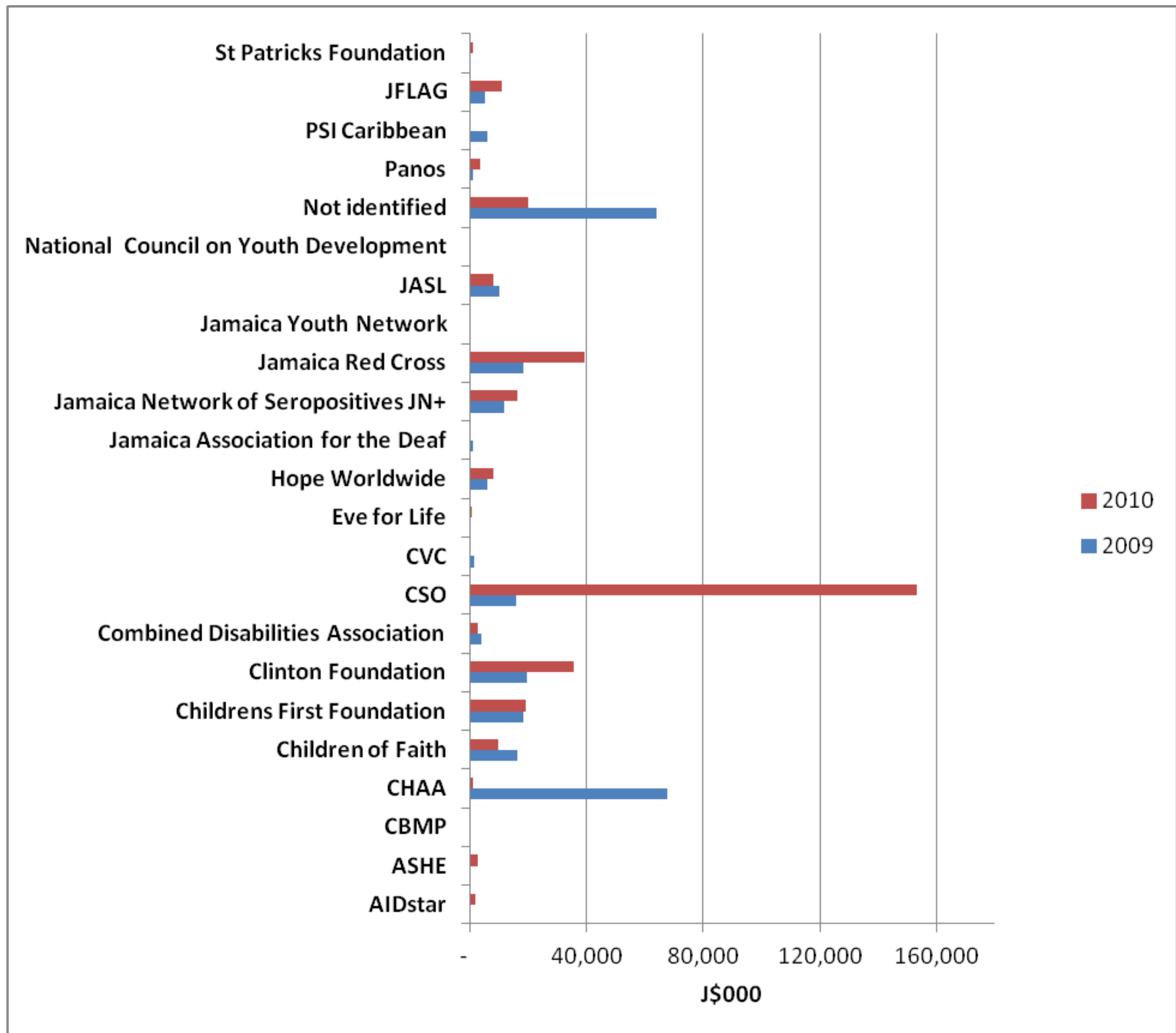


1.3 Total Expenditure by Civil Society Organizations

Civil Society organizations implement the volume of prevention activities and from seen in the previous section account for the second highest expenditure on HIV and AIDS in Jamaica behind the health sector. The graph below extrapolates and highlights which civil society organizations are expending the most in the response.

The Jamaica Red Cross was the highest spending CSO with expenditure of J$18Min 09/10 fiscal year. This expenditure was doubled in the following fiscal year to J$ 39M. The other big CSO spenders were Children's First approximately J$ 18M for both years, Clinton Foundation with J$ 19Min 09/10 fiscal year and JMD 35mil in 10/11 fiscal year. It must be noted that Caribbean HIV and AIDS Alliance (CHAA)spent J$ 67M in 2009, however this expenditure went down to only J$ 1M, which is quite significant. This decrease is in tandem with the closure of CHAA private sector prevention programme in Jamaica.

Chart 6 Total Expenditure by Civil Society Organizations

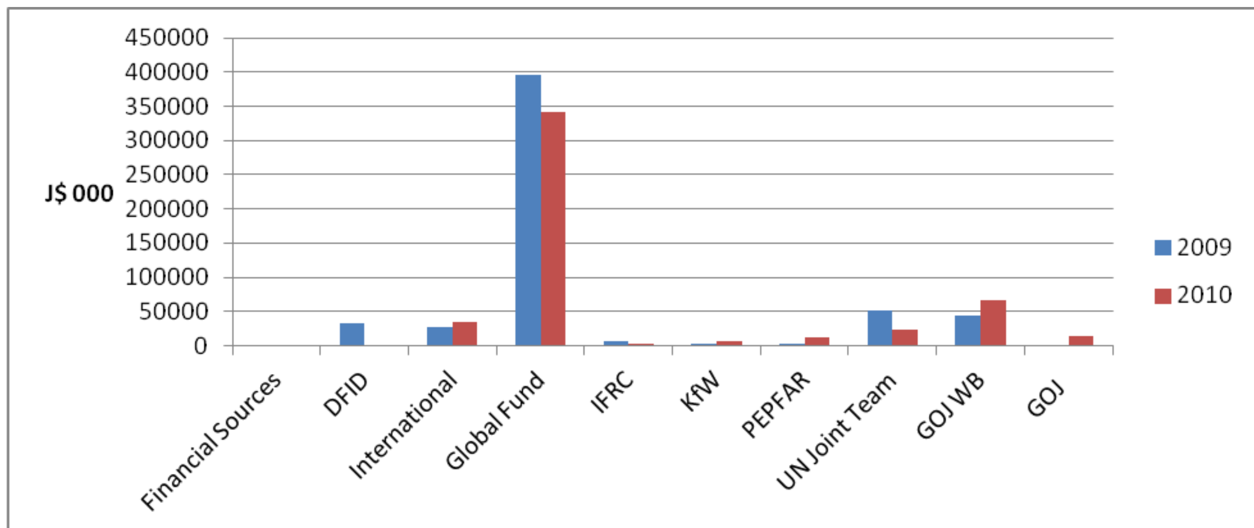


2.0 Prevention

2.1 Who Finances-Financial Sources

Total prevention expenditure for 2009 and 2010 respectively was J$557M and J$449M. Prevention had several financial sources, however, the main source was the GF who contributed on average for the two fiscal years in question approximately 70%. In 2009, 8% of prevention expenditure came from he GOJ/WB expenditure was reported at 8% of total prevention in 2009. In 2010 the GOJ burden which included the WB loan was 16% of total prevention expenditure. United Nation Theme Group which include UNAIDS, UNICEF, UNESCO, PAHO and UNFPA contributed a total of 9% in 2009 which reduced to 5% in 2010 fiscal year. Other funders include DFID which contributed 6% in 2009.

Chart 7 Prevention- Financial Sources Expenditure

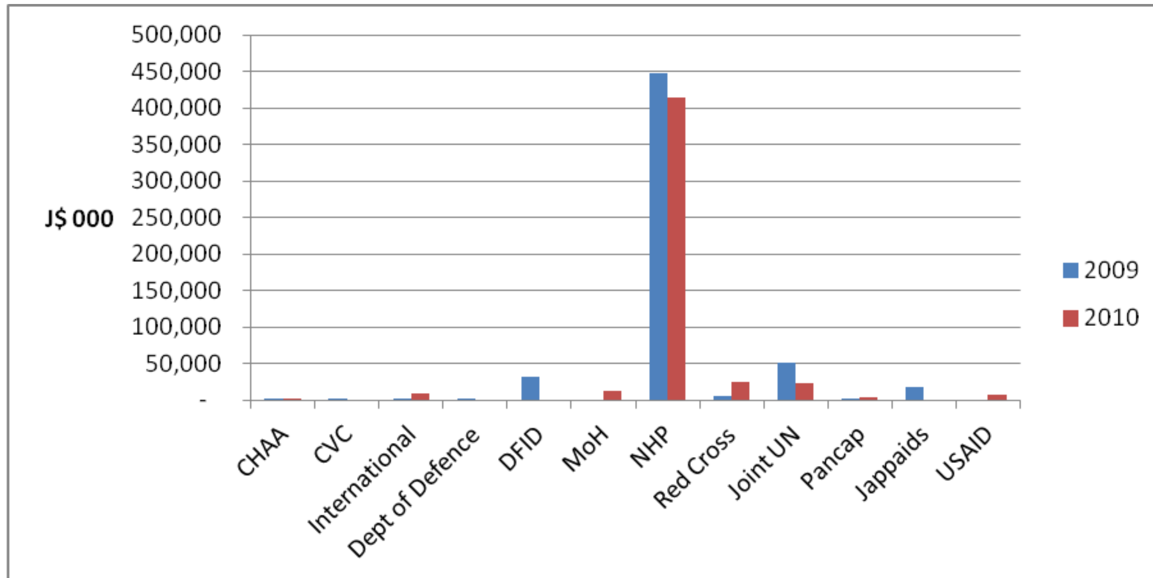


2.2 Who Manages the Funds- Financial Agent

With the exception of DFID in 2009 a significant majority of the funds are concentrated within the NHP and came from the Global Fund and the GOJ/WB. DFID provided J$31m in 2009. The NHP was the biggest financial agent, expending J$447million in 2009 and J$427million in 2010.

Actual expenditure on prevention by NHP reduced by J$20 million, the percentage spent actually increased from 80% in 2009 to 85% in 2010.

Chart 8 Prevention Financial Agents Expenditure



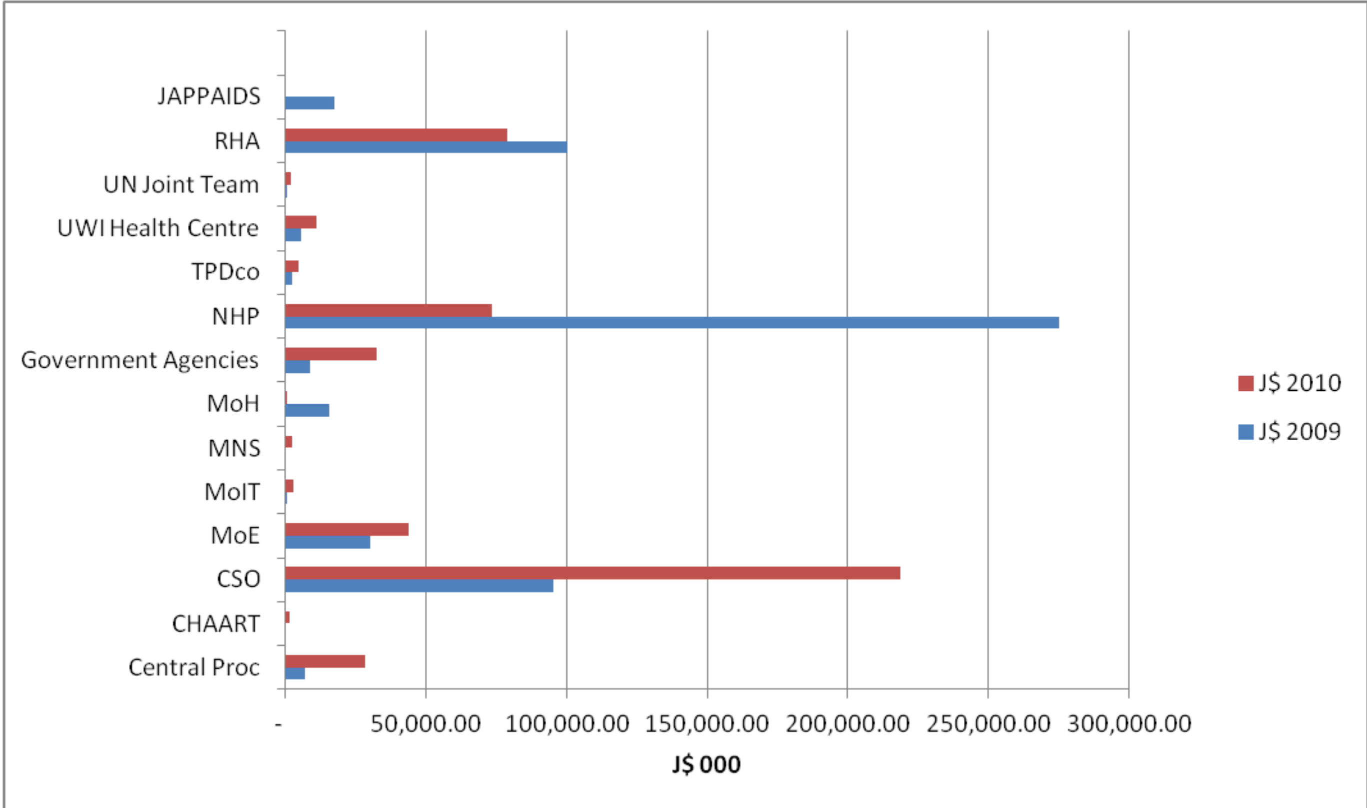
2.3 Who Provides the Services- Service Providers

Ascertaining data on individual service providers proved to be a challenge for the financial systems at the NHP. The summary financial reports for the GF and USAID do not as capture who provides the services, thus the importance of a high stakeholder response in order to triangulate and validate expenditure from all sectors. In these instances where the service provider was not clearly identified, NHP was ascribed the role of provider; subsequently there seems to be a high expenditure value for NHP in the role of service provider. It should also be noted that this figure which is seemingly the highest for service providers decreased in 2010/11 fiscal year to approximately J$73M, which is approximately three times less than the 2009 fiscal year figure of JMD 275mil.

Nevertheless, Civil Society remains a significant provider of services along with the RHAs. The Ministry of Education is the biggest government provider of prevention services outside of the

Health Ministry, primarily because of its Health and Family Life Education (HFLE) Programme. CSOs spent J$ 95M on prevention in 2009. There was an increase to J$ 218M in 2010. Expenditure by MOE also increased in 2010 from the 2009 figure from J$30M to J$43M. These increases in 2010 are in tandem, with the decrease in seeming expenditure by NHP.

Chart 9 Prevention- Service Providers Expenditure

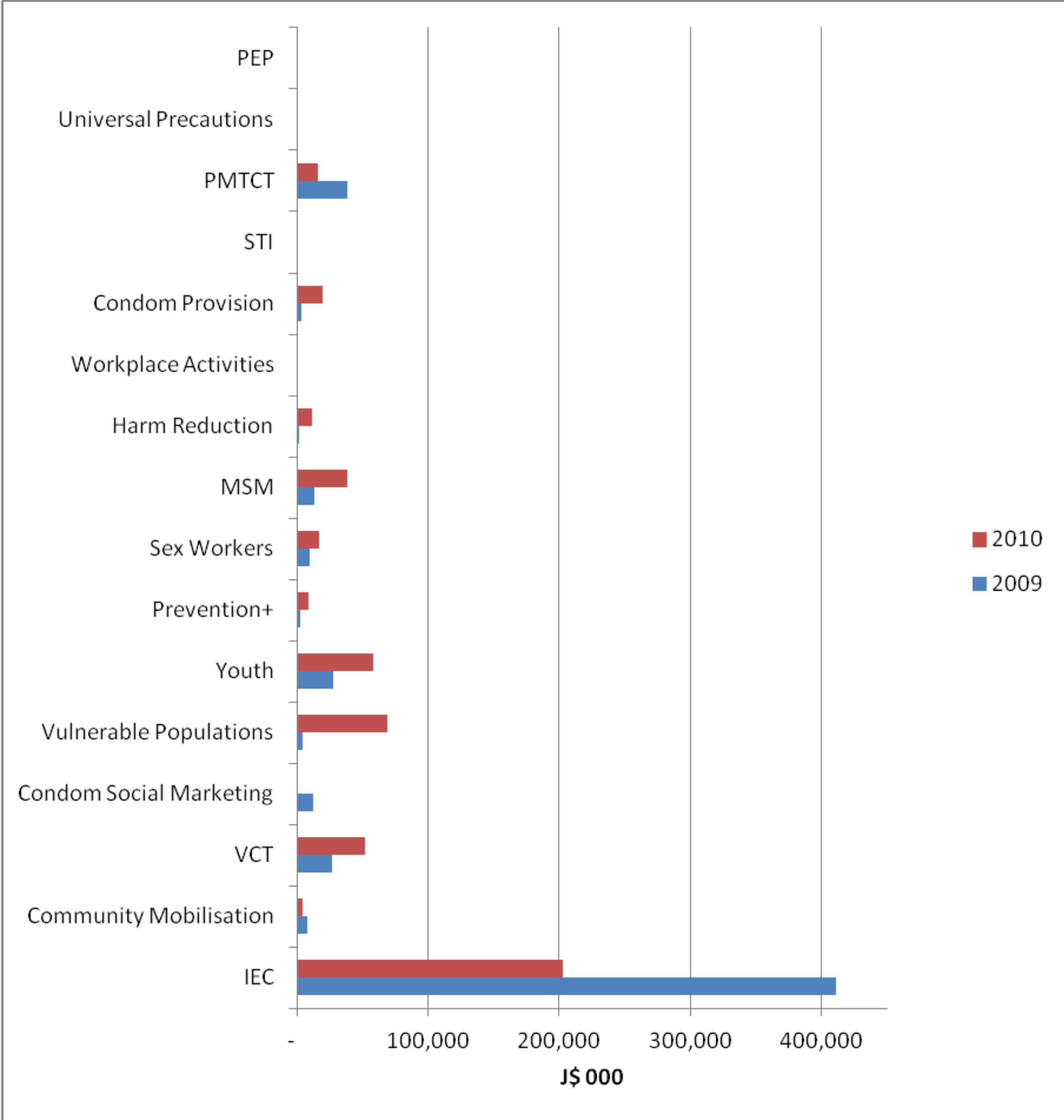


2.4 Which intervention was provided- Intervention Implemented

In 2009 the majority of the prevention expenditure was directed at information and educational material. Expenditure on IEC reduced by over half in 2010 from J$411M to J$202M as the focus moved to VCT where expenditure increased by 100% from J$26Mto J$52M. Expenditure related to vulnerable populations, youth as well as prevention programmes for

sex workers and drug users saw significant increases. Expenditure on MSM related prevention programmes increased by 200% moving from the 2009 value of J$12 M to J$38 M in 2010.

Chart 10 Prevention Intervention Implemented Expenditure

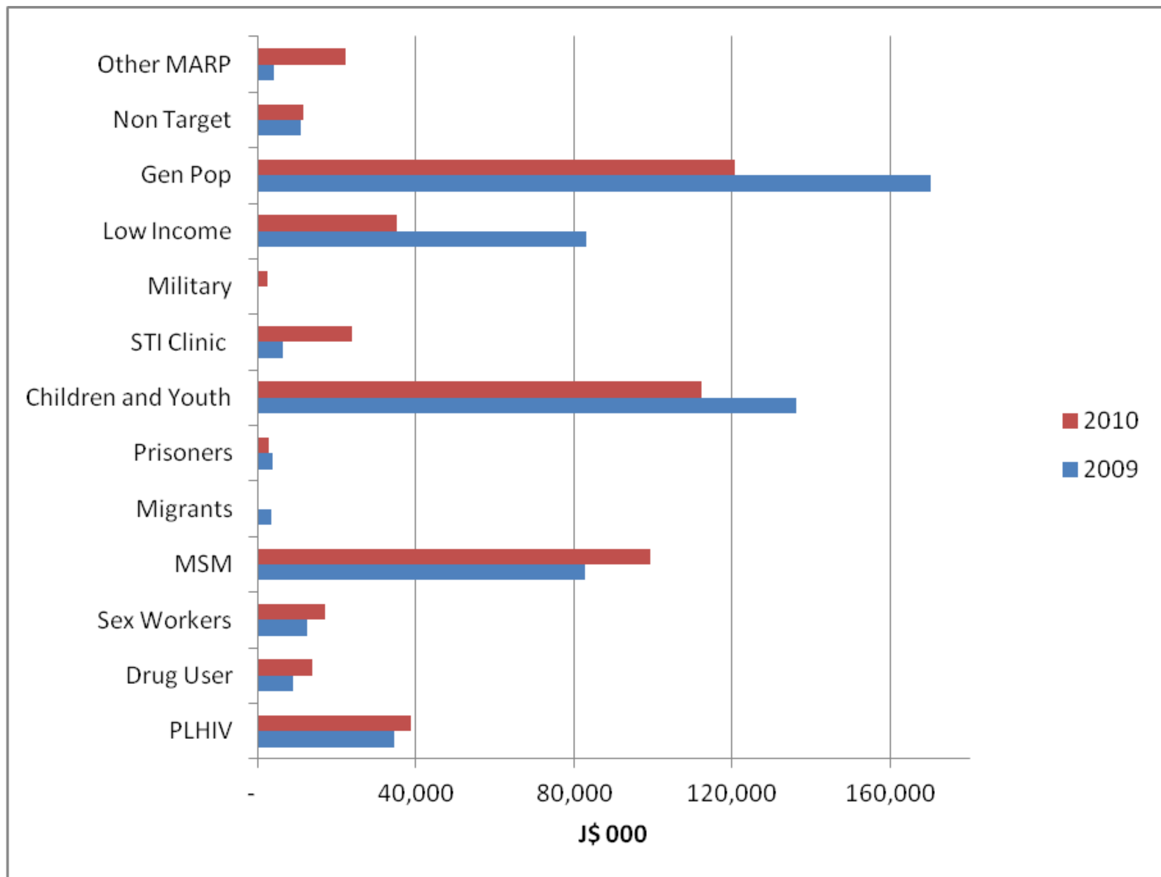


2.5 Who Benefits from the Funds- Beneficiary Population

Between 2009 and 2010 there was a movement away from targeting the general population which accounted for 30% of expenditure in 2009 but which had reduced to 24% in 2010. The

change in focus reflects an increase priority on prevention programmes for MSM which saw expenditure targeting MSM population increase from 15% to 20%. After the general population, the target population which the most money was spent on was children and youth with a J$136M in 2009 and 112 million 2010. This represents a percentage expenditure fall from 24% of all prevention monies in 2009 to 22% in 2010. Expenditure on PLHIV increased from 6% to 8%. There was an expenditure of 2 % on both Sex Workers and Drug Users which both increased to 3% in 2010. People attending STI clinics expenditure increased from 1% to 6% from 2009 to 2010. Much of the expenditure targeted towards the Global Fund category of Low Income Populations is targeted towards sex workers and expenditure in this priority declined from 14% in 2009 to 7% in 2010.

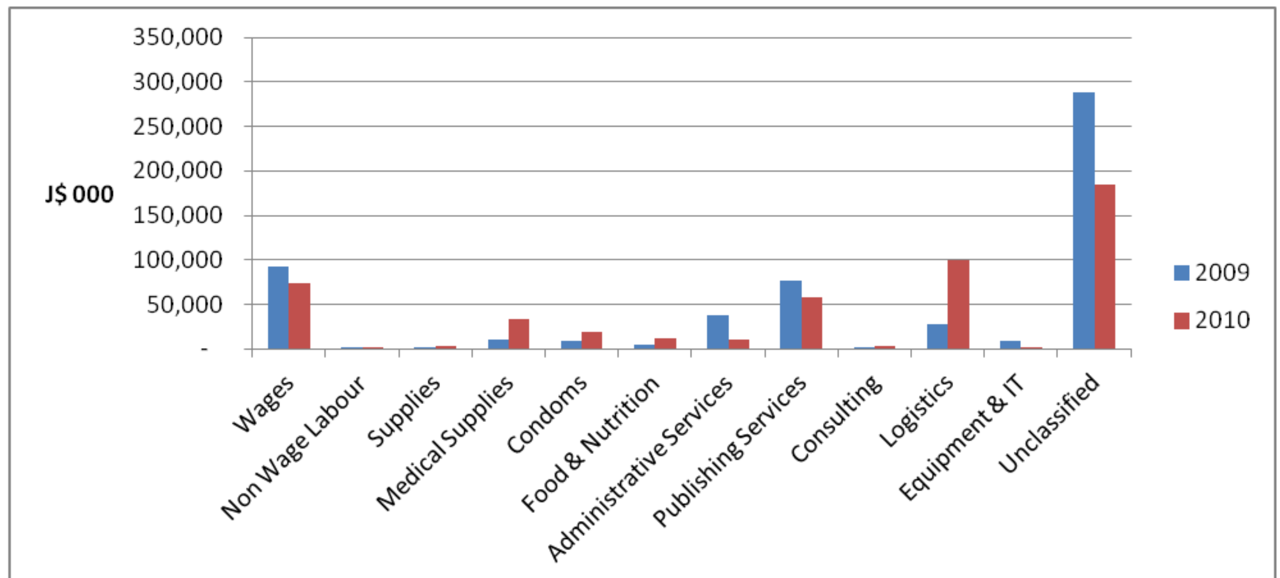
Chart 11 Prevention- Beneficiary Population Expenditure



2.6 What was bought to realize the intervention- Production Factors

The capturing of expenditure in relation to the NASA classification of Production Factors often produces challenges in reporting especially in the not for profit sector. The expenditure on wages was captured with a reasonable degree of certainty at the NHP as expenditure on this classification tended to have separate account codes in the summary financial reports. The resource which had the highest amount of expenditure in order to implement prevention activities was Human Resources. This represented 16% in 2009 and 14% in 2010. Publishing Services, which is the resource input for production IEC and mass media activities was next accounting for 13% in 2009 and 11% in 2010. Logistics which involves inputs such as venue and catering for prevention activities accounted for 19% of expenditure in 2010 which was a significant jump from 4% in 2009. It should be noted that the majority of the production factor expenditure for 2009 at 51% were categorized as “unclassified”. “Unclassified” means that from the data that was given the production factor could not be ascertained or placed in a NASA production factor (pf) category.

Chart 12 Prevention- Production Factors Expenditure

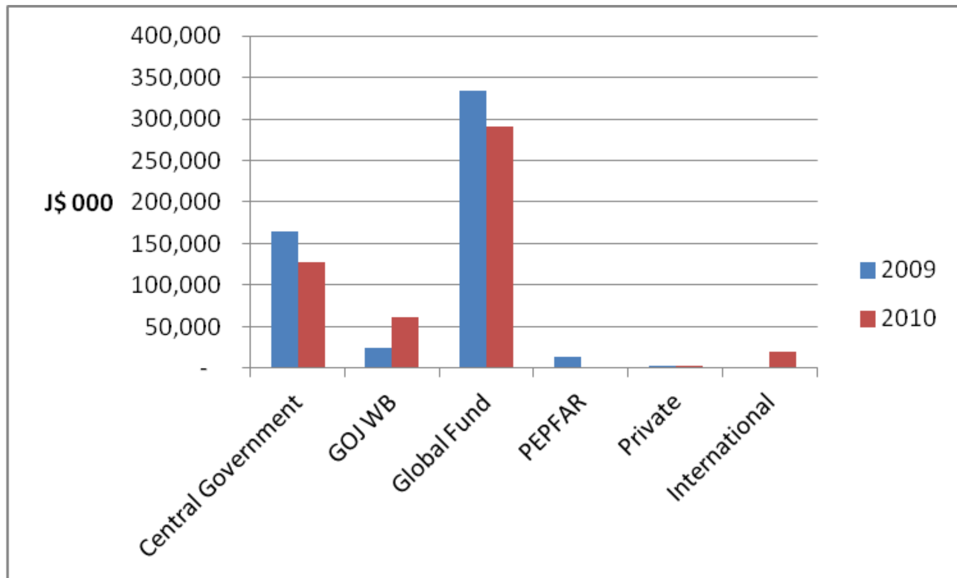


3. Treatment, Care & Support

3.1 Who finances the AIDS response-Financial Source

With regard to treatment there is a closer relationship in expenditure between that made by the Government of Jamaica (GOJ) and the Global Fund for both the fiscal periods. The GOJ provided a total of 35% of the funding in 2009 which was made up of 30% financed from general revenue and a further 5 % financed through the GOJ / WB as compared to 61% in respect to the Global Fund. In 2010 GOJ increased its share of the responsibility for treatment with expenditure rising to 38% of the funding although the share between general revenue and World Bank sources changed to 25% and 13%. Although GF remained the principle contributor to expenditure on treatment in 2010 their contribution dropped to 57% of the overall expenditure. Total expenditure on Treatment fell from J$541m in 2009 to J$502m in 2010.

Chart 13 Treatment-Financial Source Expenditure

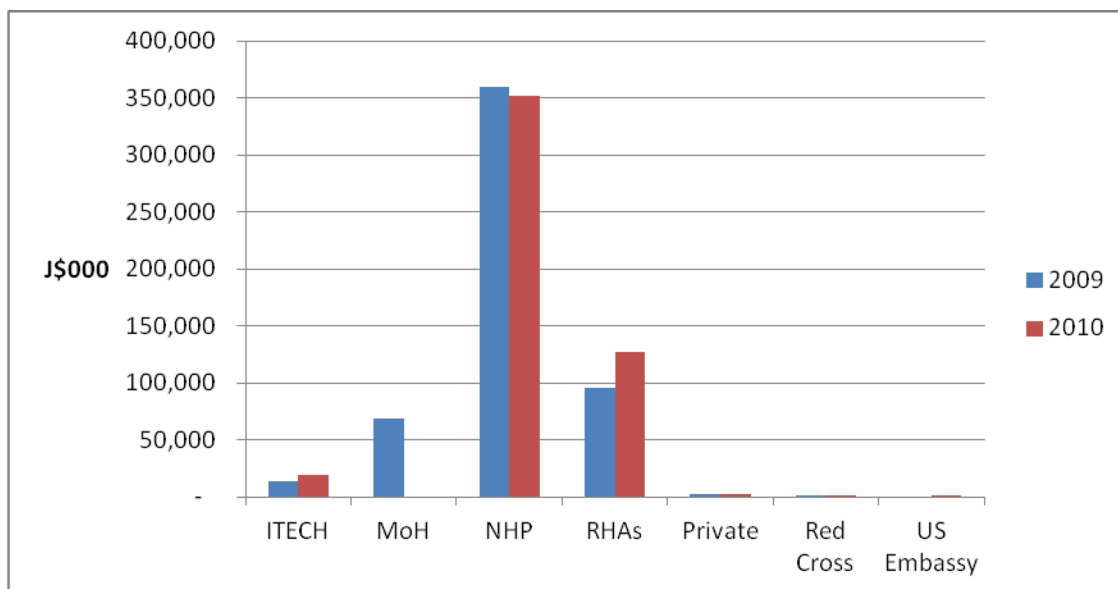


3.2 Who manages the funds- Financial Agent

The funds are principally managed through the NHP especially in relation to the donor funding from the Global Fund, World Bank and USAID, however the RHA also managed 24% of the funding in 2010, sourced from GOJ and donor agencies.

The amount expended by NHP as a financial agent for 2009 and 2010 fiscal years were J$ 359M and J$352Mil respectively, remaining pretty much constant for the two fiscal years. These figures highlight the fact that most of HIV coordination and expenditure on a national level in Jamaica is done through NHP.

Chart 14 Treatment- Financial Agents

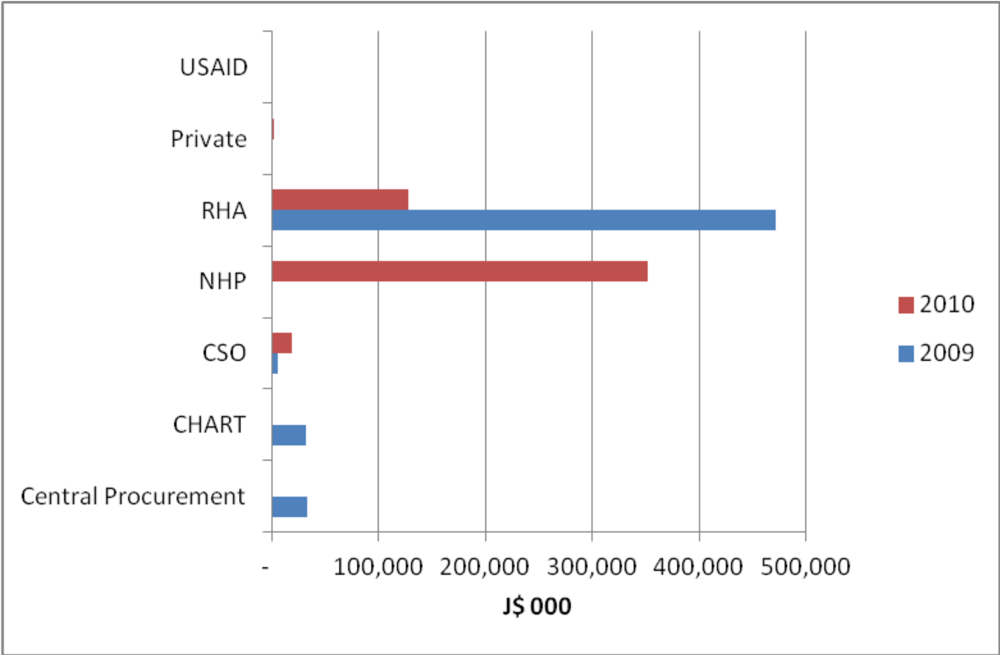


3.3 Who provides the services- Service Providers

As with expenditure on prevention capturing data on providers proved to have been a challenge for the financial systems at the NHP. The summary financial reports for the GF and USAID do not capture service providers. In these instances where the service provider was not clearly identified, NHP was ascribed the role of provider; subsequently there seems to be a high expenditure value for NHP in the role of service provider. However, data submitted by the RHA supplemented the data submitted by the NHP which is indicating that NHP only acted as a

service provider in 2010. The majority of treatment services are provided through the RHAs as it is in the regions where medical services are administered to persons living with HIV. This also includes the distribution of ARVs. RHAs expended J$471M in 2009 and J$127 M on as a provider of treatment services.

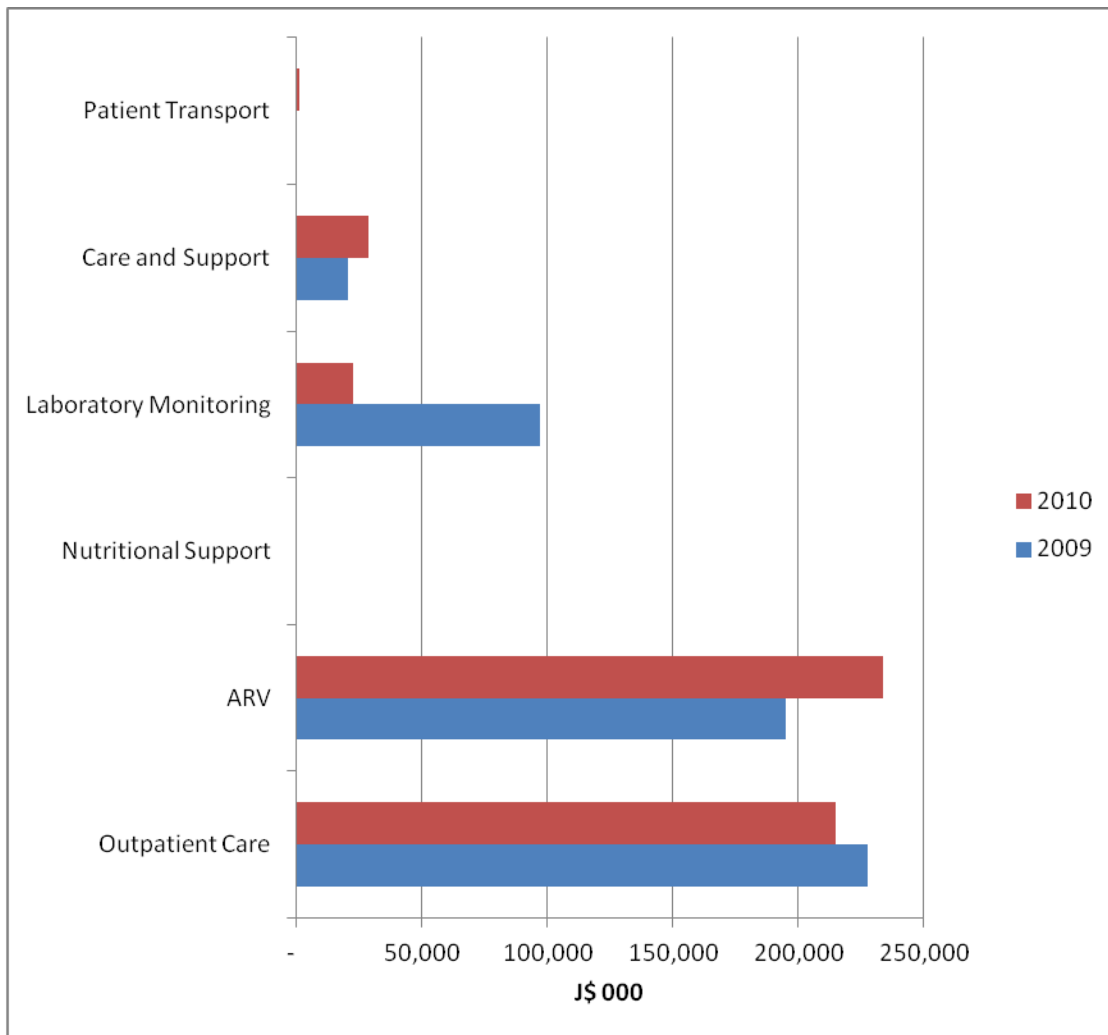
Chart 15 Treatment Service Providers Expenditure



3.4 Which intervention was provided- Treatment Intervention Implemented

The expenditure on outpatient care was approximately 13 million more than that of expenditure on ARV for the two year period. A significant portion of the expenditure on outpatient care is related to the Human Resource costs funded through the GOJ and which is discussed further in the following chapter. However, funding on outpatient care reduced from J$227M in 2009 to J$215M in 2010. Expenditure on ARV increased from J$195M in 2009 to J$234M in 2010. In future NASA studies it is recommended that further analysis is undertaken as to define the reasons for the increased expenditure in ARV to determine if this is as a result of increased demand, movements from 1st to second line medication or changes in prescribing patterns.

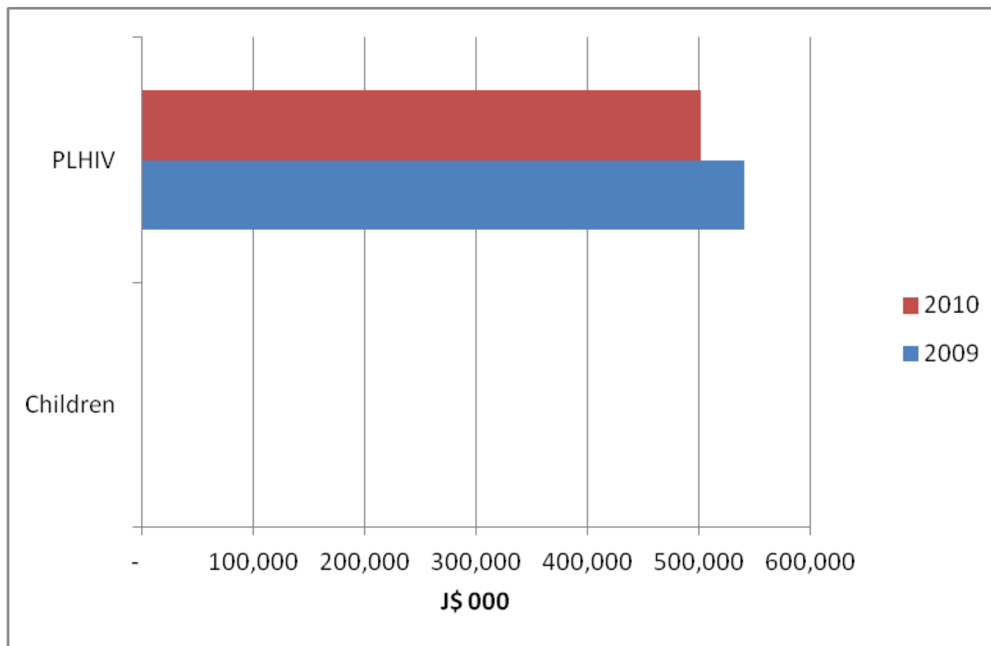
Chart 16 Treatment Intervention Provided Expenditure



3.5 Who benefits from the funds- Beneficiary Population

As can be expected with Treatment 100% of the programmes are targeted towards PLHIV although in 2010 some data was captured in respect to activities targeting children with HIV. There was an approximately J$40M decline in expenditure on the beneficiary population of PLHIV moving from J$540M in 2009 to J$ 501M in 2010. This shift is in tandem with expenditure changes from 2009 to 2010 for treatment interventions provided.

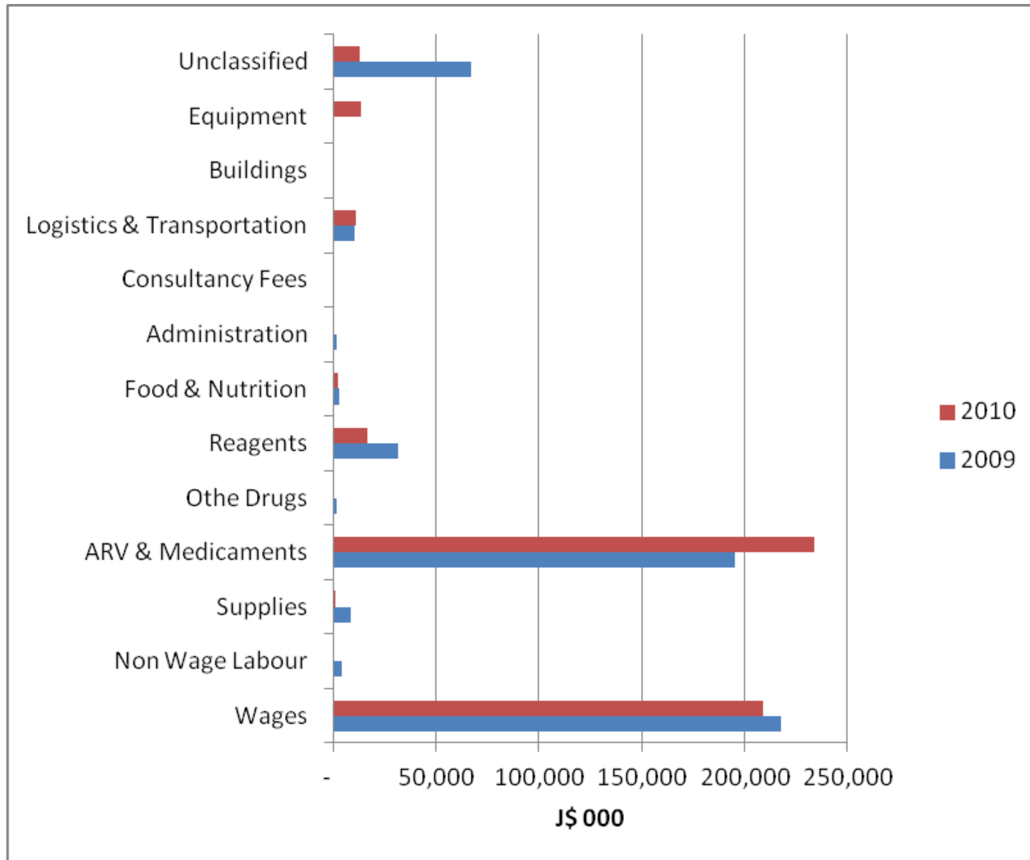
Chart 17 Treatment- Beneficiary Populations Expenditure



3.6 What was bought to realize the intervention- Production Factors

Conducting the NASA exercise on a longer term basis would begin to demonstrate patters in terms of a declining expenditure on Human Resources and an increase in expenditure related to ARV medication. In both years the expenditure on ARV medication exceeded the staffing costs associated with the care and treatment of PLHIV. Therefore there was a 38 million dollar increase on ARV expenditure in 2010 and a an 8 million dollar decline in expenditure on human resource cost for care and support moving from 217 million to 208 million.

Chart 18 Treatment- Production Factors Expenditure



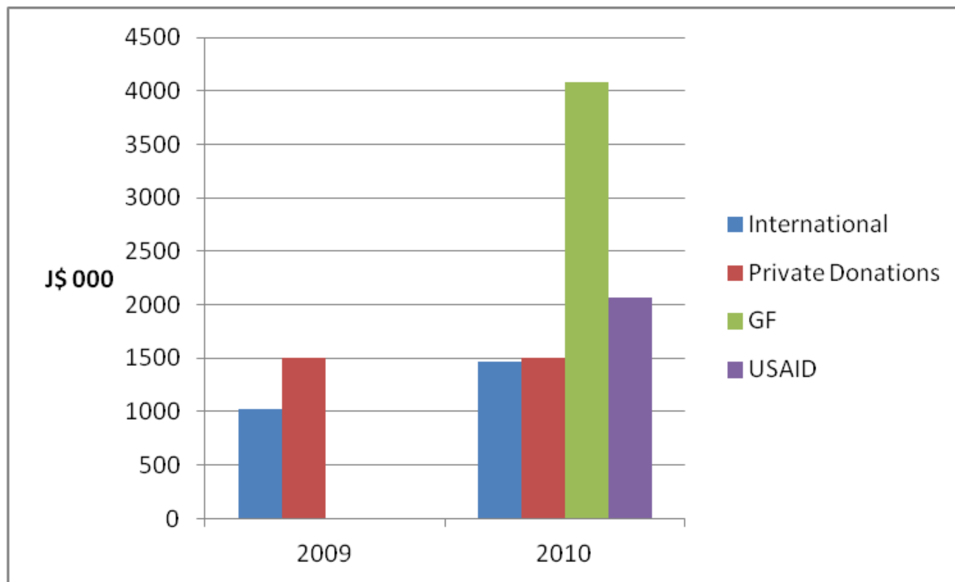
4. Orphans & Vulnerable Children

4.1 Who finances the AIDS response- Financial Source

Private sector, although limited data on expenditure and limited expenditure, was the most consistent contributor to the response of orphans and vulnerable children. The expenditure by private sector was approximately JMD 1.5mil each year. In 2009 this was approximately 50% of the expenditure on OVC. In 2010 there was expenditure from international funders, such as Food for the Poor apart from the traditional funding sources like the Global Fund, WB and UN Theme group. In 2010 contributions to OVC also came from the GF and USAID. In fact in 2010 GF monies was 44.8% of the expenditure on OVC. It should be noted there was an increase in expenditure of approximately 4 times between 2009 and 2010. Food for the Poor is one of the international organizations which funds OVC.

This seemingly minimal expenditure on OVC may be indicative of the fact that not many mainstream service providers or those who are involved in the national response provide OVC services. This however does not mean that resources are not being expended on OVC services. It is quite telling that the majority of private sector expenditure which was captured by the study was amongst OVC. The NHP should use this as an indicator that the private sector is involved in the response but possibly at the community level. Additionally, the issue of OVCs could possible used as a medium to engage the private sector in assisting in the HIV response nationally. Moreover, future NASA assessments should use this information to track other private sector expenditures.

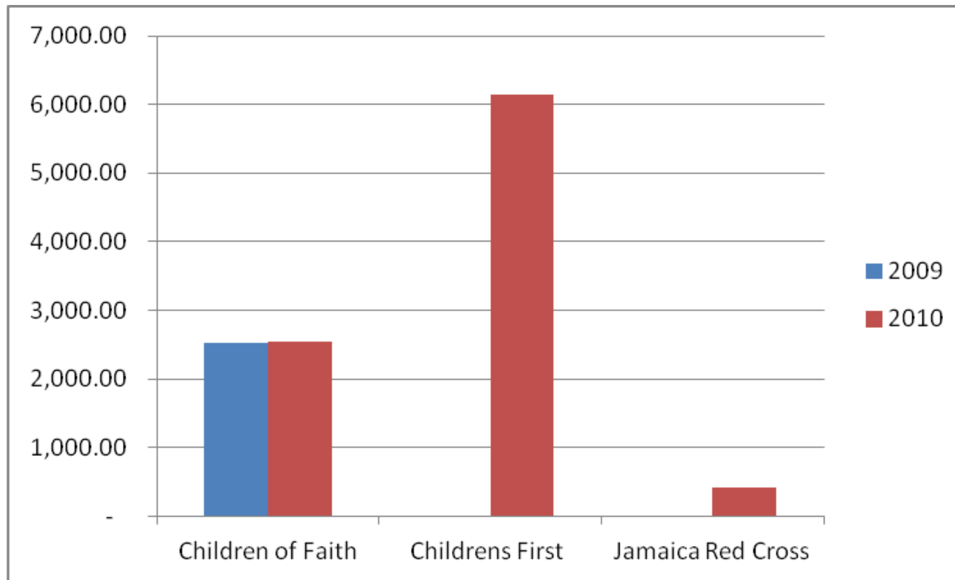
Chart 19 OVC- Financial Sources Expenditure



4.2 Who provides the services- Service Providers

Services were provided by only 3 civil society organizations, Red Cross, Children's First and Children of Faith. Provision of services being supplied through these CSOs includes education and basic health care. 2million each year was spent on OVC education while approximately 500,000 was spent on basic health care each year. Only, Children of Faith provided OVC services for both years being assessed.

Chart 20 OVC- Service Providers Expenditure

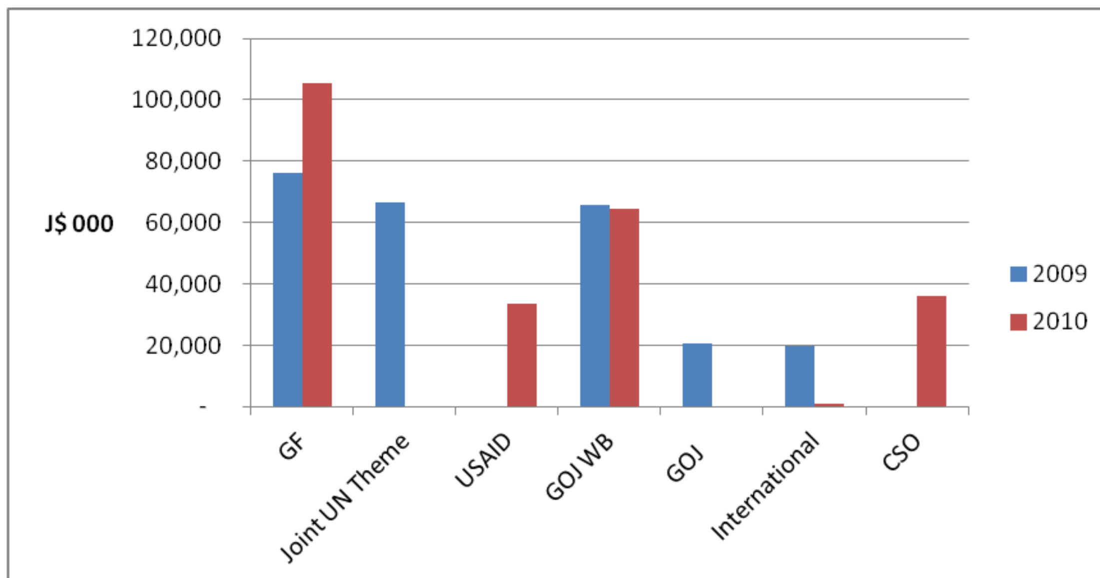


5. Programme Management and Administration

5.1 Who finances the AIDS response- Financial Source

The Global Fund and GOJ/WB are the main sources for finance for Programme Management and fund most, if not all the staff positions associated with the coordination of the national response together with the administration costs of disbursing the funds. The GF spent JMD 105mil on Programme Management while GOJ/WB spent JMD65mil in the 2010 fiscal year. Smaller contributions towards programme administration are made by organizations such as The Elton John Foundation which is a significant contributor to Programme Management Expenditure providing donor support to the Clinton Foundation to meet their operating costs. This is captured under International Organization.

Chart 21 Programme Management Financial Source Expenditure

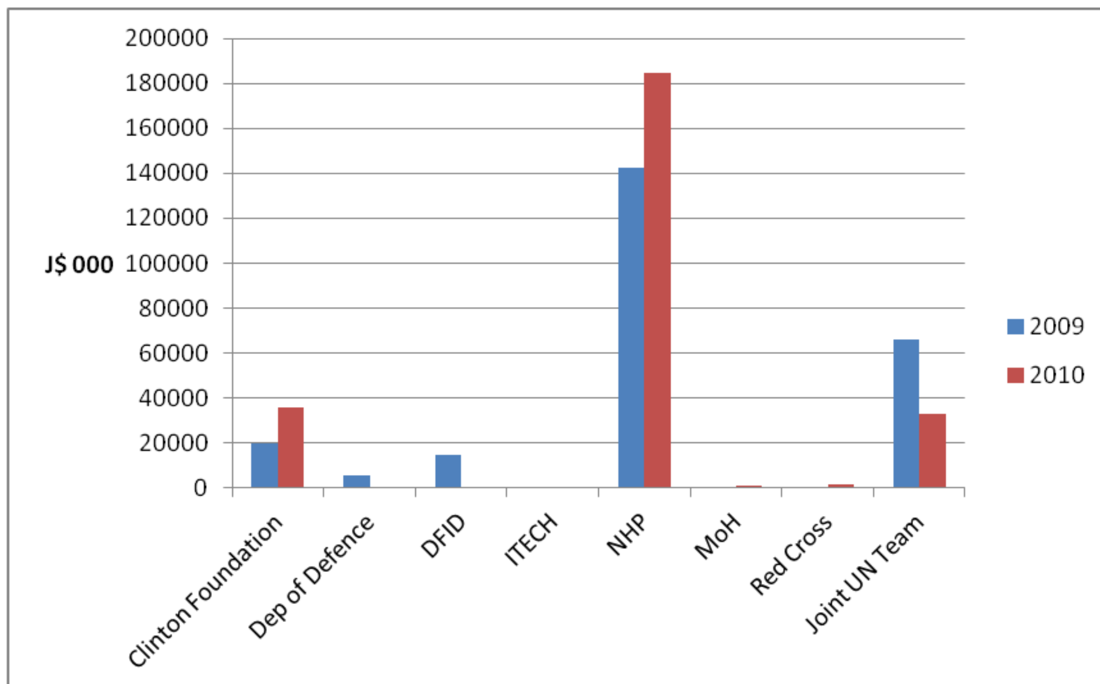


5.2 Who manages the funds? –Financial Agent

The NHP is the main agent for the coordination of programme management funds, managing expenditure of approximately J$142 million and J$184 million dollars respectively for 2009 and

2010. The Clinton Foundation and the UN Joint Team were the next major contributors to programme management with 35 million and 33 million respectively being spent in 2010. These figures signified a 50% increase for the Clinton Foundation from the previous year a 50% decrease for the UN Joint team from 2009. Much of the expenditure related to these organizations is directed at meeting Human Resource costs.

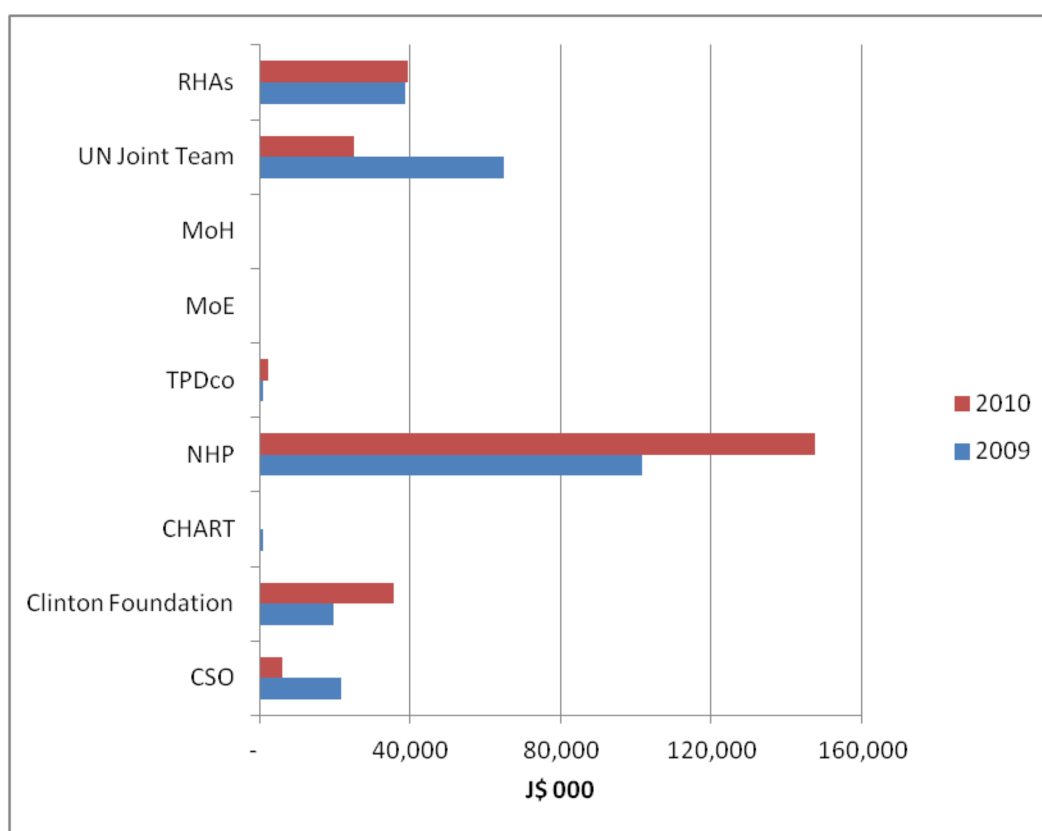
Chart 22 Programme Management- Financial Agent Expenditure



5.3 Who provides the services- Service Providers

As the services performed in respect to Programme Management relate to planning and coordination, Finance, M&E and reporting the main provider of services is the NHP. Expenditure on programme management in relation to CSO has reduced considerably between 2009 and 2010 from J$21M to J$6M which may indicate a reduction in capacity for that sector to meet the demands associated with coordinating and managing programme funds.

Chart 23 Programme management- Service Provider Expenditure

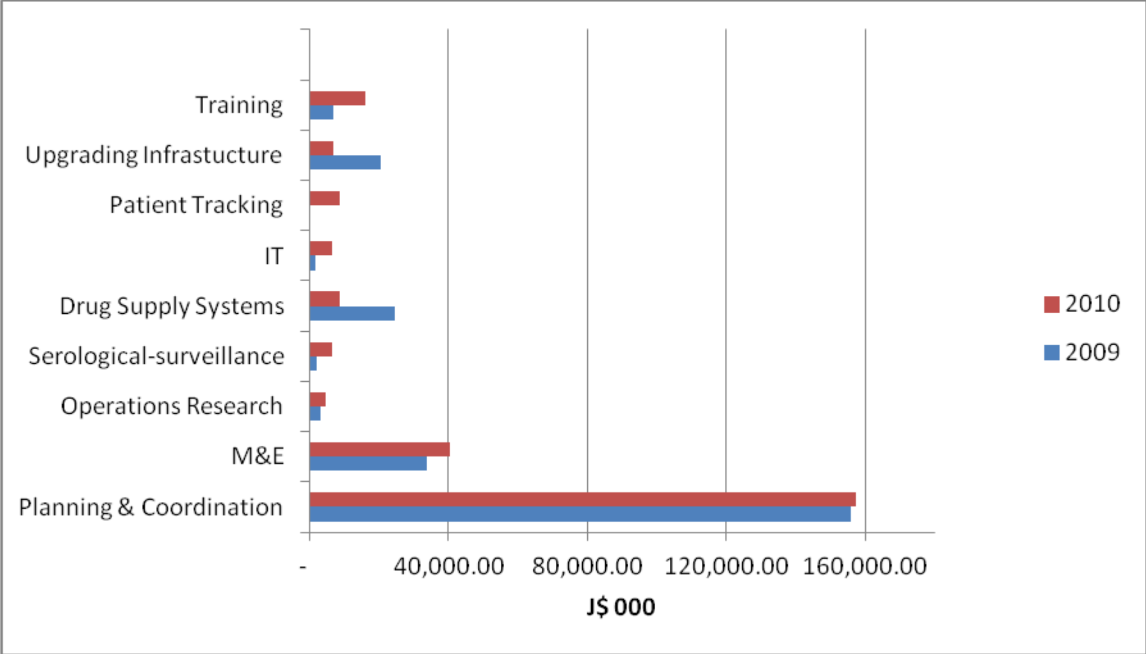


5.4 Which intervention was provided- Intervention Activity Implemented

The majority of the expenditure on Programme Management is spent on the activities of Planning & Coordination followed by Monitoring and Evaluation. These accounted for 62% and

16% respectively of the Programme Management Expenditure in 2010. In 2009 there was expenditure in relation to the upgrading of buildings and infrastructure and expenditure stronger on training almost tripled in 2010.

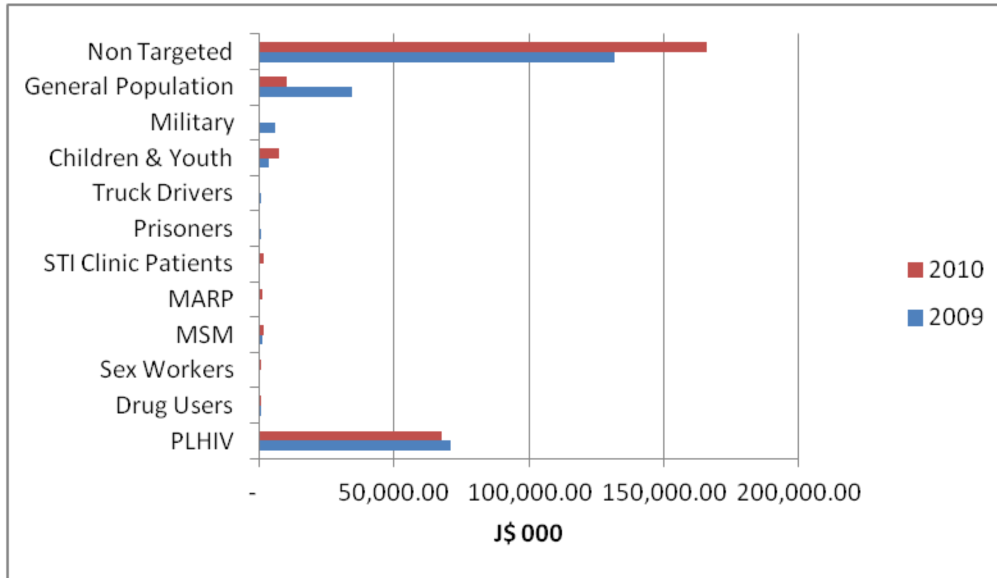
Chart 24 Programme Management- Intervention Implemented Expenditure



5.5 Who benefits from the funds- Beneficiary Population

The majority of the funding is not targeted, as most activities under the ASC of Progamme Management do not have direct beneficiaries and are undertaken to facilitate the coordination and monitoring of the entire response. There was approximately 28% and 26% respectively for 2009 and 2010 was expenditure targeting PLHIVs. Programmatic expenditure targeted at PLHIV included Planning & Coordination, Monitoring & Evaluation, Operations Research, Serological Surveillance, Patient Tracking and the upgrading of laboratory infrastructure and equipment.

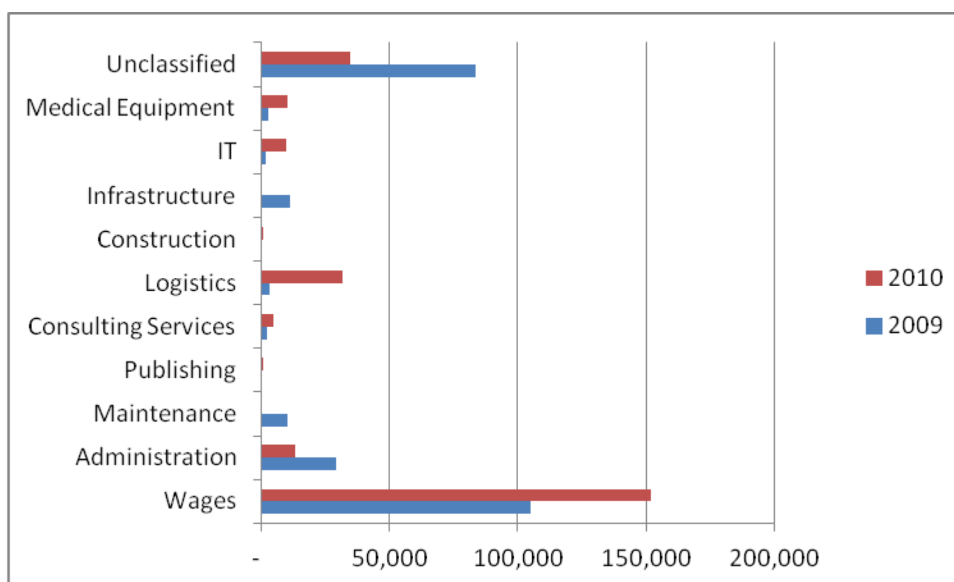
Chart 25 Programme Management-Beneficiary Population



5.6 What was bought to realize the intervention- Production Factors

The majority of the expenditure under Programme Management meets the Human Resource Costs associated with the Planning & Coordination of the National Response together with the management of the donor funding. Expenditure on wages increased from 42% in 2009 to 59% of overall Programme Management Expenditure in 2010. This represents an increase of approximately J$46M over the two year period, from J$105M in 2009 to J$151M in 2010. 33.5% of the expenditure for resources use to make programme management activities come to realization in 2009 was considered “unclassified”. Therefore from the data which was collected no resource cost was given.

Chart 26 Programme Management- Production Factor Expenditure



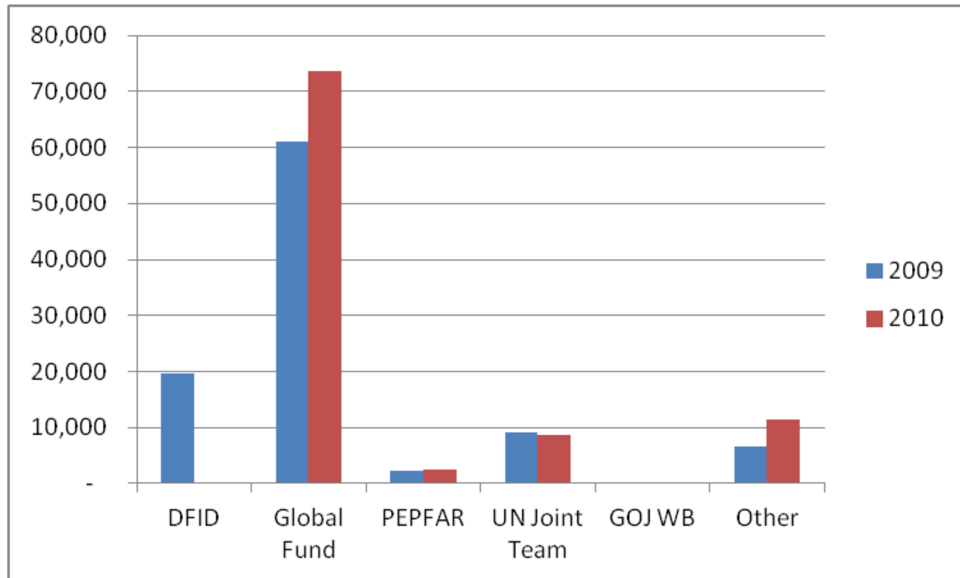
6. Social Protection and the Enabling Environment

6.1 Who finances the AIDS response- Financial Source

As with most of the AIDS Spending Categories, Social Protection and the Enabling Environment relied heavily on the GF for its expenditure. GF expenditure on social protection and the enabling environment was J$61M and J$73M respectively for 2009 and 2010. This represents 61% and 76% respectively of the total social protection and enabling environment expenditure. Other financial sources included DFID the UN Joint Team and other smaller International Organizations such as Astrea, MAC AIDS and AMFAR which had substantially less expenditure than GF. Expenditure for DFID was only recorded in 2009. The combination of the smaller non-traditional sources of funding accounted for 6% and 11% respectively for 2009 and 2010, signifying the only increase in expenditure apart from GF in 2010. With regard the management of the funds the NHP is the sole agent responsible for the management of Global Fund resources in respect to Social protection and the Enabling Environment. CSO's such as JFLAG

managed monies from the smaller international sources. Total spent on this category of activities was J$99M and J$96M respectively for 2009 and 2010

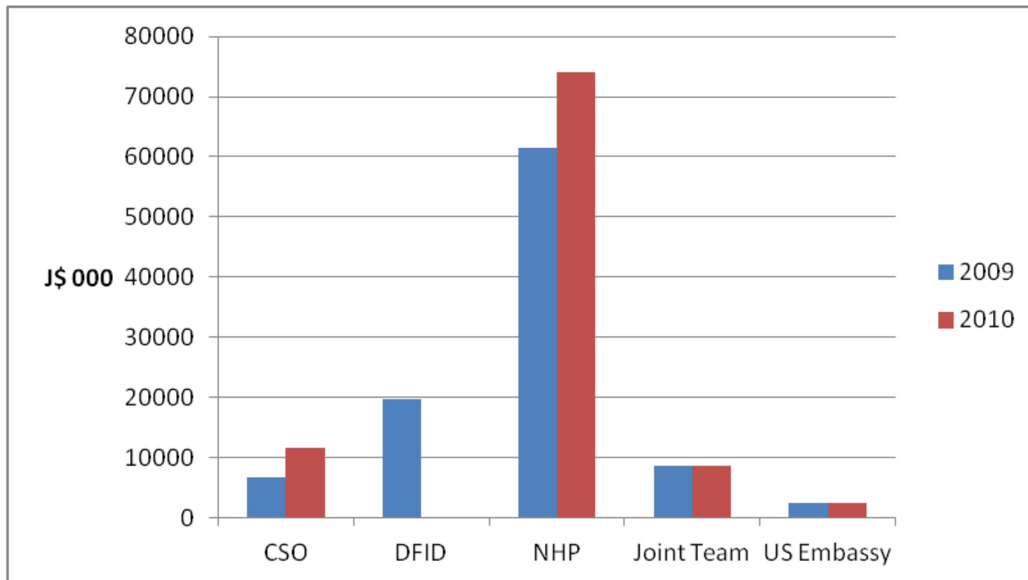
Chart 27 Social Protection and Enabling Environment Financial Source Expenditure



6.2 Who Manages the Funds- Financial Agent

With regard the management of the funds the NHP is the sole agent responsible for the management of Global Fund resources in respect to Social protection and the Enabling Environment. CSO's such as JFLAG managed monies from the smaller international sources. JFLAG was able to secure funding from outside the traditional pool to assist in their programme activities which are linked to social security and enabling environment, thus them a major player as a financial agent under this AIDS Spending Category spending J$11 M in 2010 which is an increase from the previous where expenditure was J$ 5M.

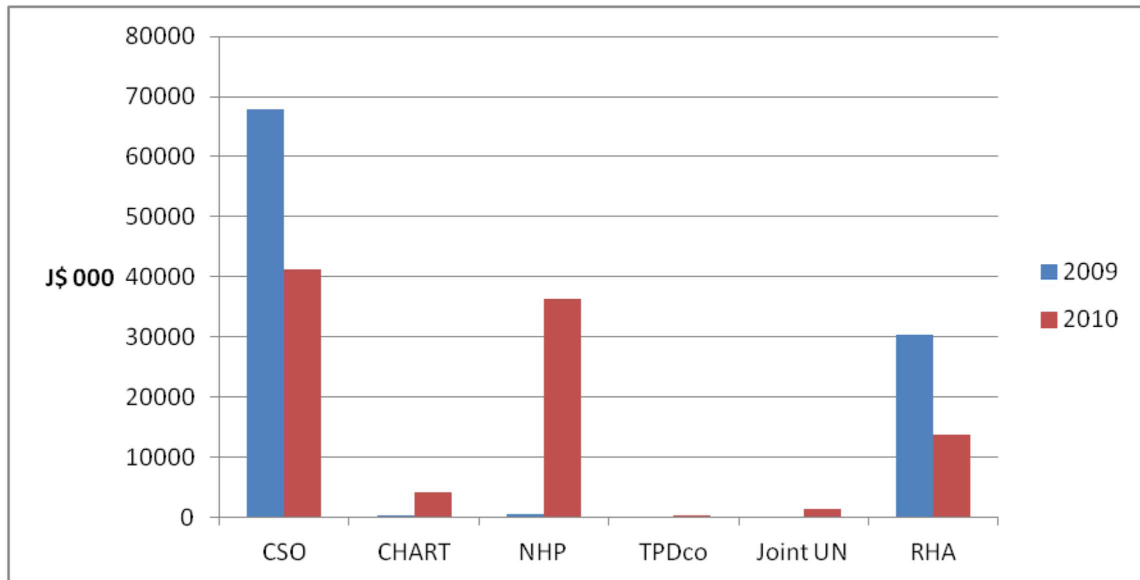
Chart 28 Social Security and Enabling Environment Financial Agent Expenditure



6.3 Who provides the services- Service Providers

As with expenditure on prevention and treatment capturing data on providers proved to be a challenge for the financial systems at the NHP in that overall this data was not recorded in the summary financial reports for neither the Global Fund nor USAID. In 2010, the NHP was listed as one of the major providers of social protection services with that said, CSOs were the major providers of social protection in both years accounting for 69% and 42% respectively for 2009 and 2010 social protection expenditure. RHA's were also involved in providing social protection and enabling environment services, with expenditure of J$36.4M and J$13M in respectively for 2009 and 2010. There was an unusual provider of services for the social protection and enabling environment, it was TPDCo who expended a miniscule amount of J$30,000 in 2010.

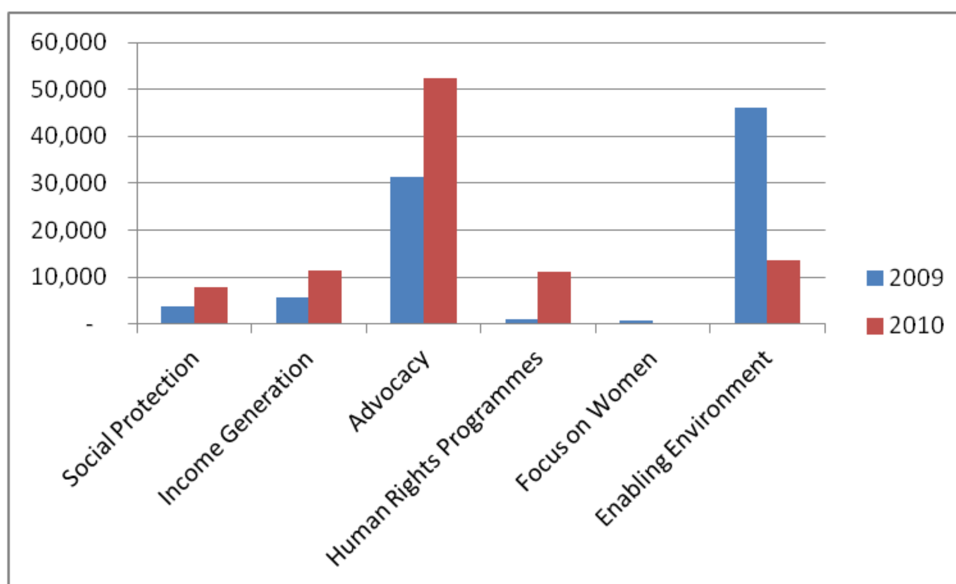
Chart 29 Social Services and Enabling Environment Service Providers Expenditure



6.4 Which intervention was provided – Intervention Activity Implemented

The intervention which most money was spent on was Advocacy. In 2010 J$52million was spent, an increase of from J$31million in 2009. This expenditure represents 54% of social protection and enabling environment in 2010. In 2009 there was a 46% expenditure on enabling the environment, this however seemed to have decreased significantly to only 14% in 2010. There was a slight increase in spending on income generation programmes from 3% to 8% of social protection expenditure from 2009 to 2010.

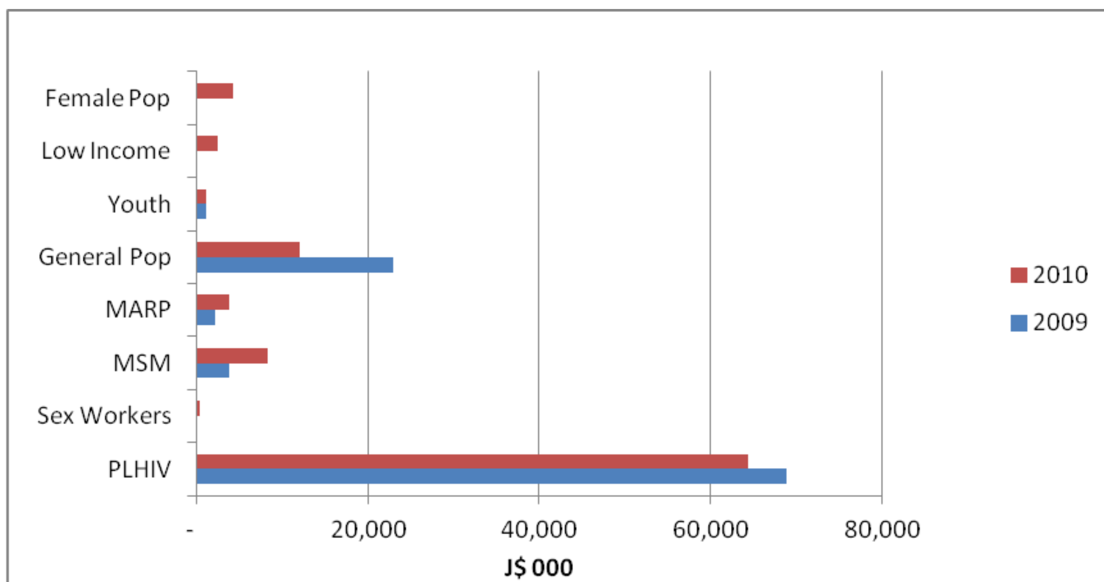
Chart 30 Social Protection and Enabling Environment- Intervention Implementation Expenditure



6.5 Who benefits from the funds- Beneficiary Population

As the main thrust of this priority area is the reduction in Stigma and Discrimination together with generating wider support for PLHIV the main beneficiary targeted is PLHIV with 69% of the expenditure in 2009 and 66% in 2010. Expenditure on the general population was J$22million and J$12million respectively for each year 2009 and 2010. This accounted for 23% and 12 % respectively of expenditure in this AIDS Spending Category.

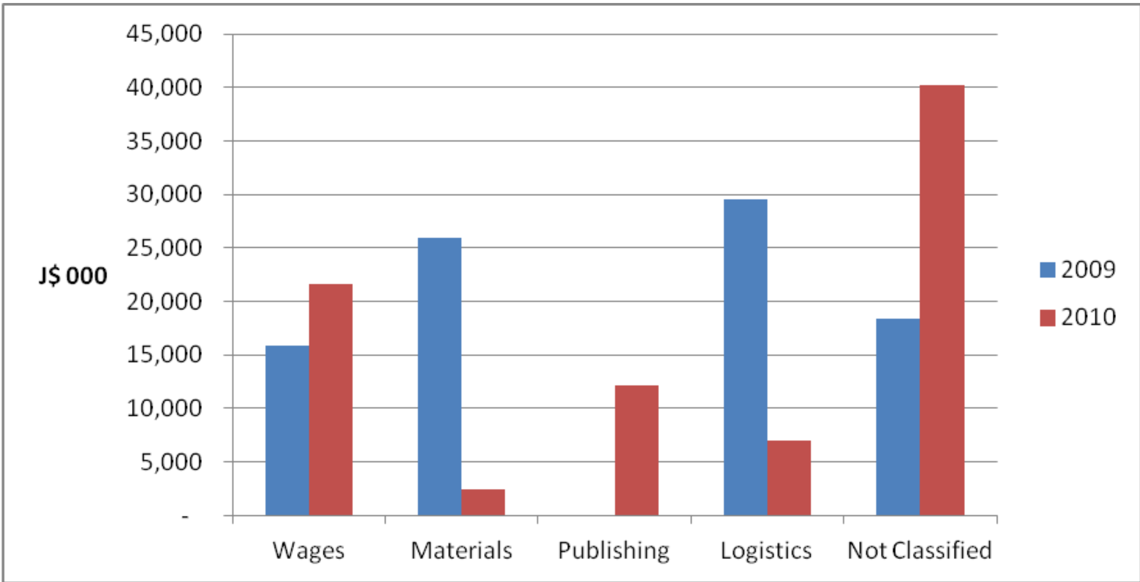
Chart 31 Social Services and Enabling Environment Beneficiary Population Expenditure



6.6 What was bought to realize the intervention- Production Factors

The majority of the production factors were not classified. This means from the data collected there was insufficient information on the production factors for them to be individually categorized. Expenditure on wages increased from J$15m in 2009 to J$21m in 2010. However in 2009, the highest spending disaggregated category for social services and the enabling environment was logistics, followed by materials and wages.

Chart 32 Social Services and Enabling Environment Production Factors Expenditure

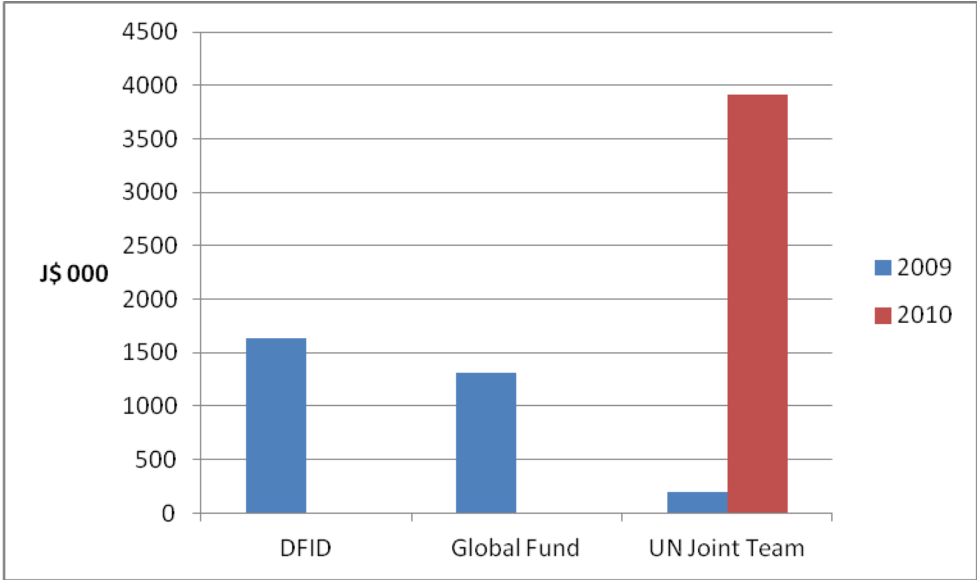


7. Research

7.1 Who finances the AIDS response- Financial Source

Reflecting a donor led approach to financing research had little consistency between the two financial periods. In 2009 DFID and the Global Fund were the main sources of funding with the UN Joint Team being the only financing source in 2010. Total expenditure on Research showed an incremental increase from 2009 to 2010. In 2009 expenditure was J$3.1mil while in 2010 it was J$3.9mil. The UN Agencies involved in research were UNFPA and UNAIDS.

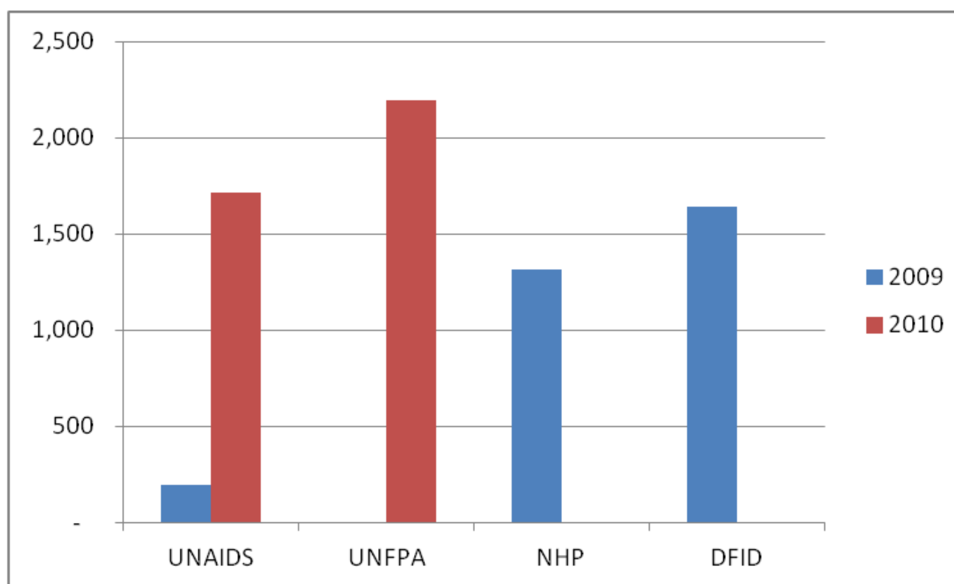
Chart 33 Research Financing Source Expenditure



7.2 Who manages the funds- Financial Agents

As with the table presented previously management of the funds is dependent upon whichever donor agency is funding the research project. Therefore management was done by DFID, UNAIDS and NHP in 2009 and in 2010 management was done by UNFPA and UNAIDS.

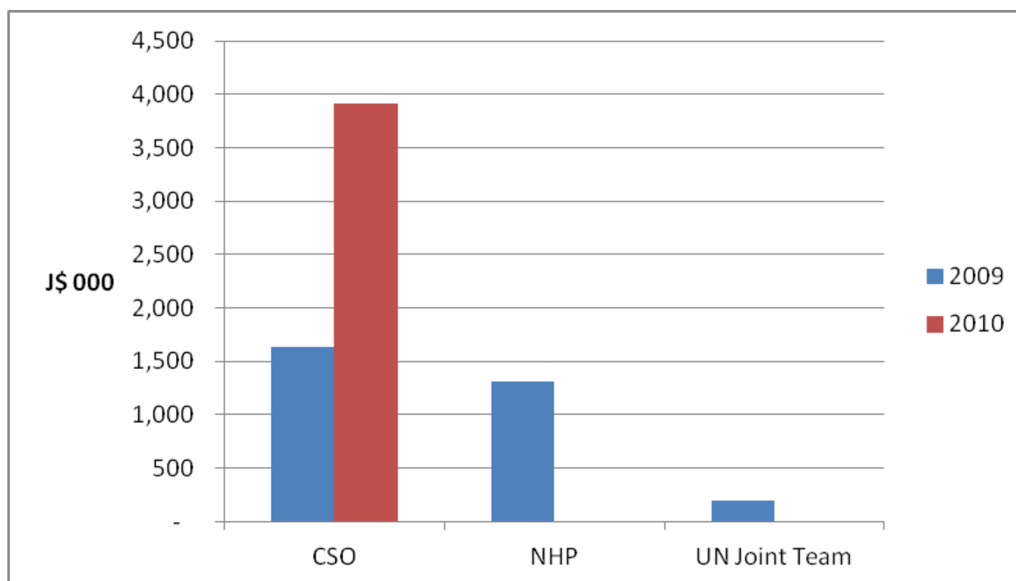
Chart 34 Research Financial Agent Expenditure



7.3 Who provides the services- Service Provider

There is some consistency with respect to the providers of the services for research which tends to be with civil society. The UN Joint team although a provider of financial resources is generally not a provider of services. With the NHP capturing data on providers proved to be a challenge for the financial systems in that overall this data was not captured in the summary financial reports for the Global Fund and USAID. CSO expended J$1.6M in 2009 on HIV related research. This figure increased by approximately 100% to J$3.9Mil in 2010 and accounted for the only research service providers for 2010.

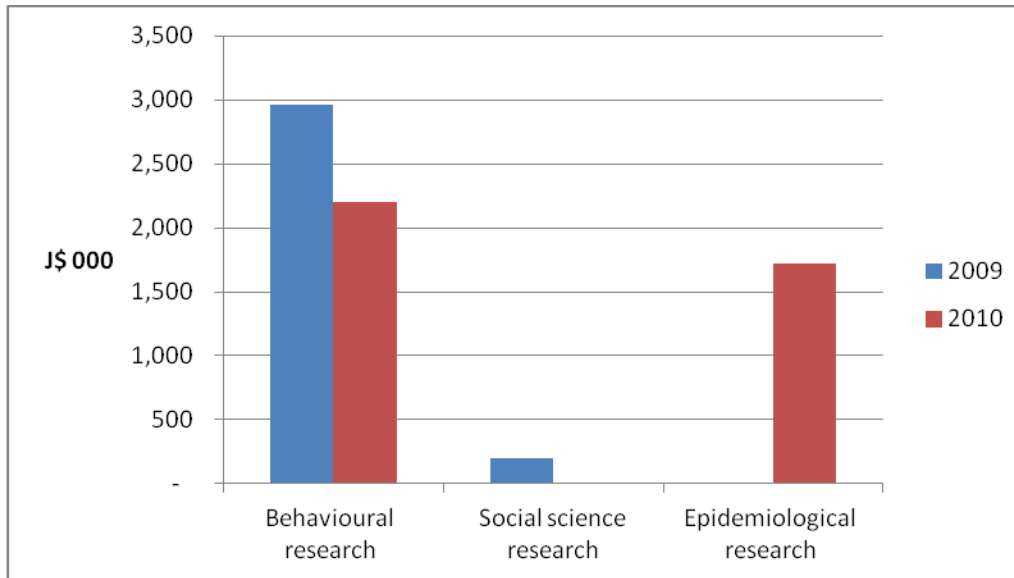
Chart 35 Research Service Provider Expenditure



7.4 Which intervention was provided- Intervention Implemented

The activities provided included the HIV estimates exercise that was funded by UNAIDS in 2010 as well as 2009 studies on the "Knowledge, Attitudes, Behaviours and Practices of Tourists, Hotel workers and Hotel Management" and a "Determination of the Barriers to Change in High Risk Behaviour among MSM". Behavioural research was also done among Sex Workers. Behavioural research accounted for approximately 90% of funds of research expenditure in 2009.

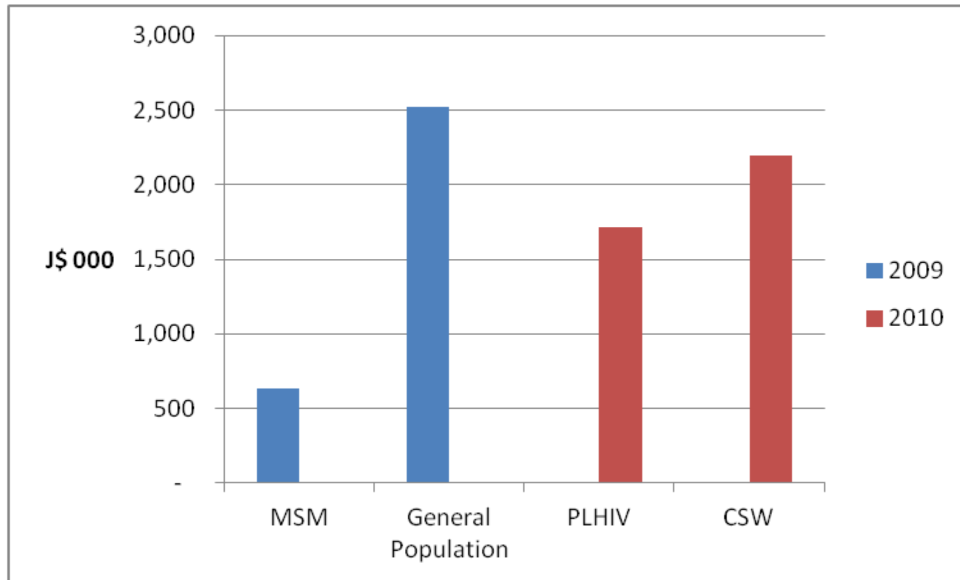
Chart 36 Research Intervention Implemented Expenditure



7.5 Who benefits from the funds- Beneficiary Population

In 2009, 80% of the J$3.1mil which was spent on research, targeted the general population and only 20% targeted the most at risk group of MSM. In 2010 there was no expenditure on the general population, however two groups which are considered high risk and vulnerable were the target population of research, these were PLHIV who accounted for 44% of the J$3.9mil expenditure on this category and CSWs whom 56% of the expenditure in this category targeted. The expenditure on MARPs in 2010 is a possibly indication that Jamaica is becoming cognizant of the fact that evidence based documentation is important in HIV programme implementation.

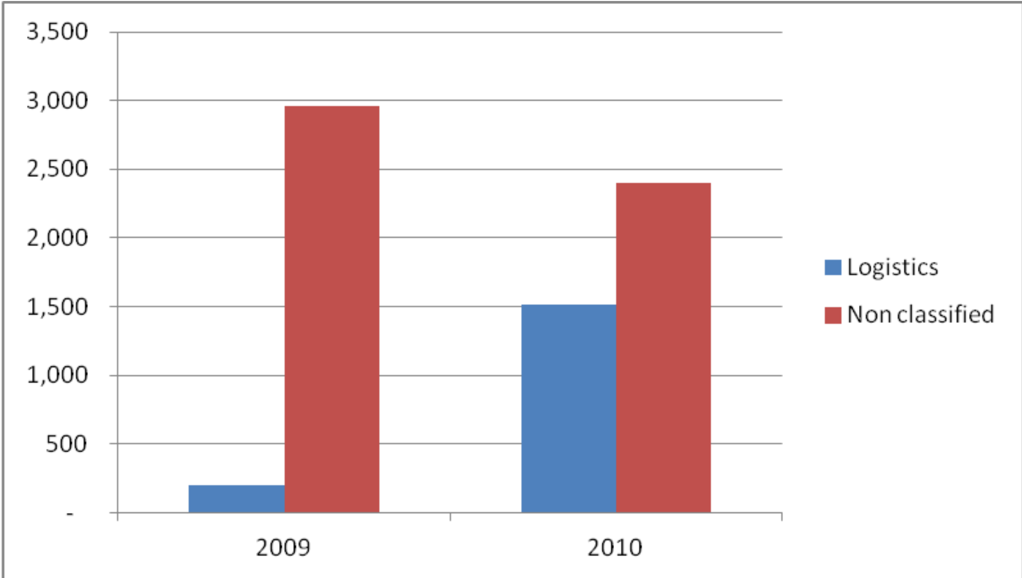
Chart 37 Research- Beneficiary Population Expenditure



7.6 What was bought to realize the intervention- Production Factors

The main expenditure on production factors were listed as “not classified” both in 2009 and 2010. This indicates that there was not enough information to disaggregate the individual resources. There, however was a decrease in this “not classified” category in 2010 and an increase of from J$196,000 in 2009 to J$1.15million for the logistics related to conducting research activities.

Chart 38 Research Production Factors Expenditure



8. Expenditure on Human Resource

In this section of the report an estimate is made of the hidden costs of responding to the HIV epidemic in terms of the expenditure that is made on human resources. As many of the staff who are treating HIV patients in the treatment sites are employed by and paid from central government sources of financing the identification on expenditure on human resources can be included within governments shared responsibility for meeting the needs of people living with HIV. To reiterate, these figures for HR are estimated and it is area for strengthening future NASA approaches.

There are two major sources of funding in respect human resources for the National HIV & AIDS response: there is direct funding from the donor agencies with the majority of the funding coming from the Global Fund and GOJ/WB for those staff who work either full time or part time in the care and treatment of PLHIV. Secondly, indirect funding from central government which meets the salaries and wages costs of medical and support staff and whom also have a major role to play in the treatment and care of PLHIV. The critical distinction between the two classifications is that direct funding on human resources can be identified as a distinct expenditure item that can be included in the NASA. With the indirect costs on human resources, the estimate has to be made using statistical or other data in the assignment of a portion of the total expenditure on human resources by the RHAs to that which could reasonably assumed to be activity related to HIV and AIDS. In other words, direct expenditure can be directly attributable to HIV, as is the case for the purchase of HIV related medication or if medical staff work for a dedicated HIV outpatient facility. Indirect expenditure on HIV is a component of service provision which cannot be easily or conveniently identified because is forms part of the everyday services being provided. A good example is a nurse caring for patients in a General Medical ward some of whom may have HIV.

It should also be noted that there also Human Resource cost as it relates to CSO's and their programmatic interventions. Some of this funding comes from the Global Fund while a smaller portion comes from UN organizations and other smaller international bodies who give assistance to CSO. CSO costs, because they tend to focus on HIV service provision in most cases

are classified as direct expenditure with costs being directly attributable to HIV. The challenge, as with all expenditure classifications is to split the expenditure between activities especially if the CSO are working on Prevention and also Advocacy activities for example. Also, in the case of International NGOs which work on sectors other than HIV, for example the Red Cross unless HR expenditure is specifically identified to HIV projects estimates of indirect expenditure have to be prepared. The methodology for this is to use a similar approach to that used with health care providers. However, in Jamaica most of the NGOs who reported information were able to identify direct HIV costs. The CSO expenditure has not been able to capture volunteer costs. Many CSO rely on volunteers to care for people with HIV and sensitise the general public at HIV related events. The contribution from volunteers to the national response is likely to be significant but the problem for costing this element can be captured in the saying 'Volunteers are not paid not because they are worthless but because they are priceless'[14] Challenges in determining these costs relate to both the financial and economic costs associated with volunteering. Voluntary financial costs raise questions such as, what unit cost to charge, and would it change depending on the service being provided? Economic questions related to volunteering concern the Opportunity costs of volunteering and whether volunteers crowd out public provision of services or vice versa. Although, at the outset of the project CSO indicated an interest in capturing information, at least on the hours performed by volunteers this information proved difficult and time consuming to capture.

[14] Author Unknown

Chart 39 Human Resources- Financial Sources Expenditure

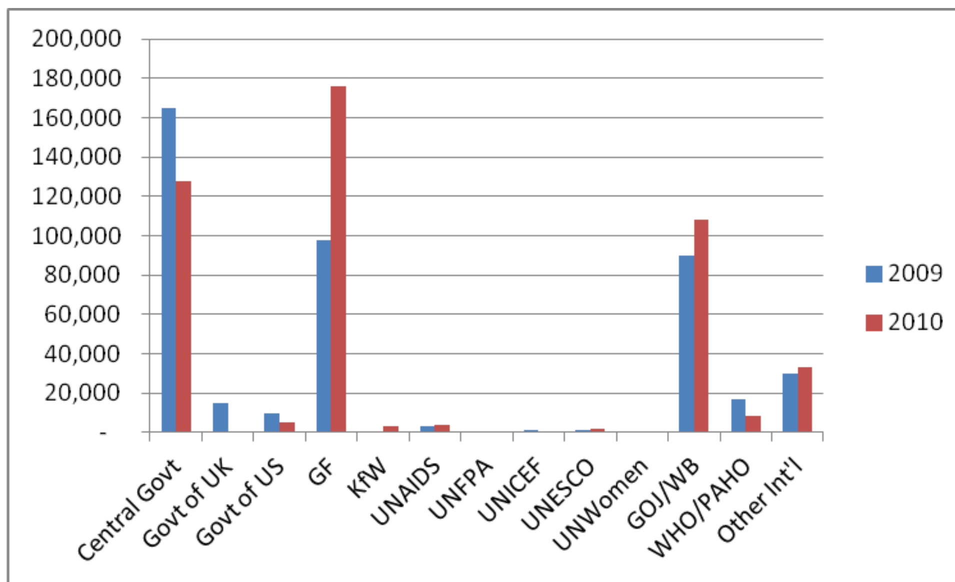
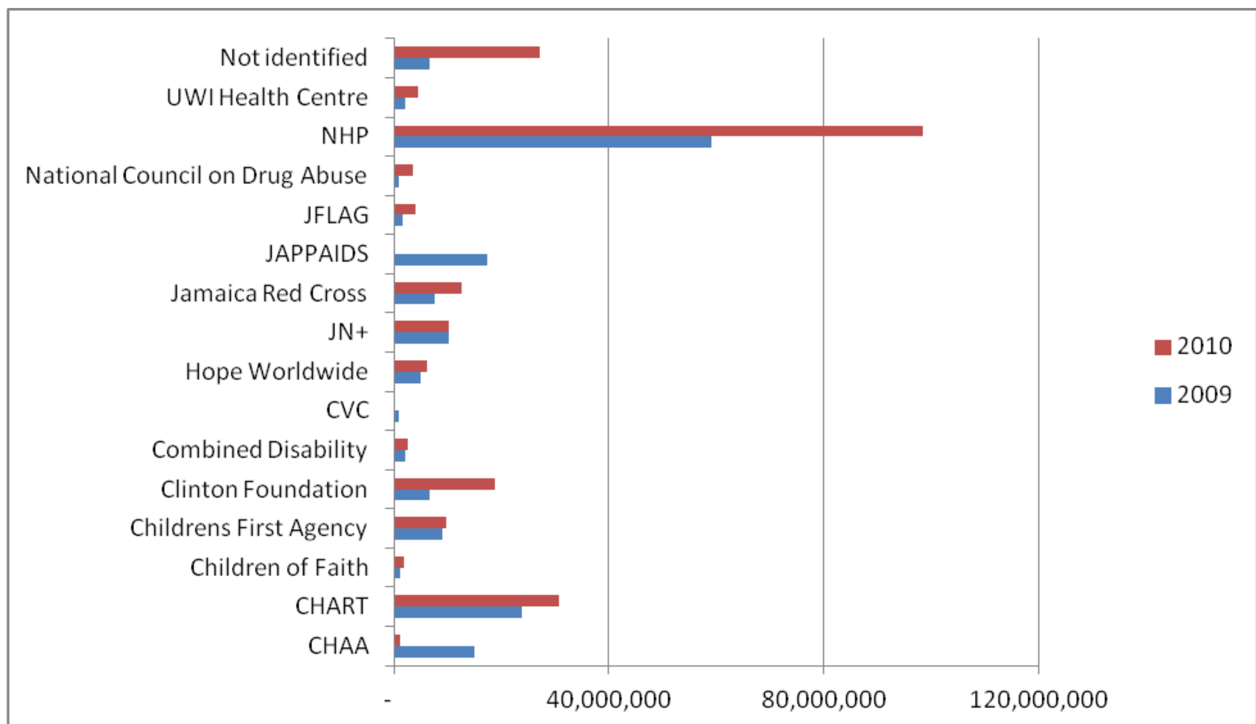


Chart 40 Civil Society Expenditure on Human Resources



8.1 Who finances AIDS response- Financial Source

Direct expenditure on human resources is J$77m in 2009/10 from the global fund and J$89m from the GOJ / WB. In 2010/11 the expenditure from the global fund on human resources was J$169m, an increase of 119% and from the GOJ / WB, increasing from the 2009 figure to J$108m or 21%. Expenditure from these two sources paid the staffing costs of the NHP and contributed to the staffing costs for the prevention, treatment and care functions associated with the RHAs.

With regard to the indirect expenditure on human resources a methodology had to be created to assign expenditure on human resources at the treatment sites based on overall HR expenditure per site related to the a HIV and AIDS activity.

Whilst there have been a number of related studies in this area in Jamaica there was no concrete methodology for assigning human resource costs to activity through the identification of a reasonable absorption factor. The studies that have been undertaken have included work by the Clinton foundation, KPMG and PAHO and which helped guide the approach used by the NASA team. The methodology used is described in more detail below but in short the approach is to try and determine the HR cost per outpatient visit or Inpatient stay and multiplied by the actual activity. Whilst, NASA is only evaluating the expenditure related to HIV a Health sector approach to analysing HR costs to activity can help determine the value of HR and the relationship between expenditure, activity and strategic planning. For example, if the strategic health plan for the country is to place more emphasis on Chronic Non-Communicable Disease then theoretically analysis of HR expenditure should reflect more time is being spent with this client group. If this is not the case, then it signals that there is something wrong with the strategic plan or that treatment services are not changing to reflect the strategic plan. There are a number of costing tools available, some have been developed by the WHO together with other agencies[15].

[15] Technical Review of the Costing Tools for the Health MDGs. WHO, UNICEF, World Bank, UNFPA, Government of Norway. http://www.who.int/pmnch/topics/economics/costoolsreviewpack.pdf

The estimate the HR costs in the HIV treatment sites, first the total cost had to be established, second an absorption factor had to be used and thirdly estimates of HR costs by HIV activity were calculated.

In the expenditure data submitted by NERHA, WRHA and SRHA information was given on the total expenditure on salaries and wages by treatment site. NERHA further split this information by category in terms of outpatient and paediatric services.

The information captured by the statistical unit of the Ministry of Health included the number of inpatient days by specialty and hospital, the mean length of stay, the total number of outpatient cases by hospital and specialty and the number of outpatient paediatric cases. In these reports the total activity of the health sector is presented however, there is no separate identification of inpatients presenting with HIV. Nevertheless, the data on outpatients was used to determine the absorption of total costs by HIV related activity. Costs were further disaggregated by region. In the report submitted by the monitoring and evaluation department in the NHP gave details on the 'summary of advanced HIV cases in Jamaica by parish' whereby the total curative cases in 2009 was 15,523 and in 2010 was 17,026. The data by parish was used to form the basis of the HIV related activity by region. The assumption was, for the purposes of estimating the HR HIV related expenditure by region was that those PLHIV identified by parish would visit the treatment site within their own parish. Data submitted by the Clinton Foundation indicated that on average there would be 12 outpatient visits per year.[16]

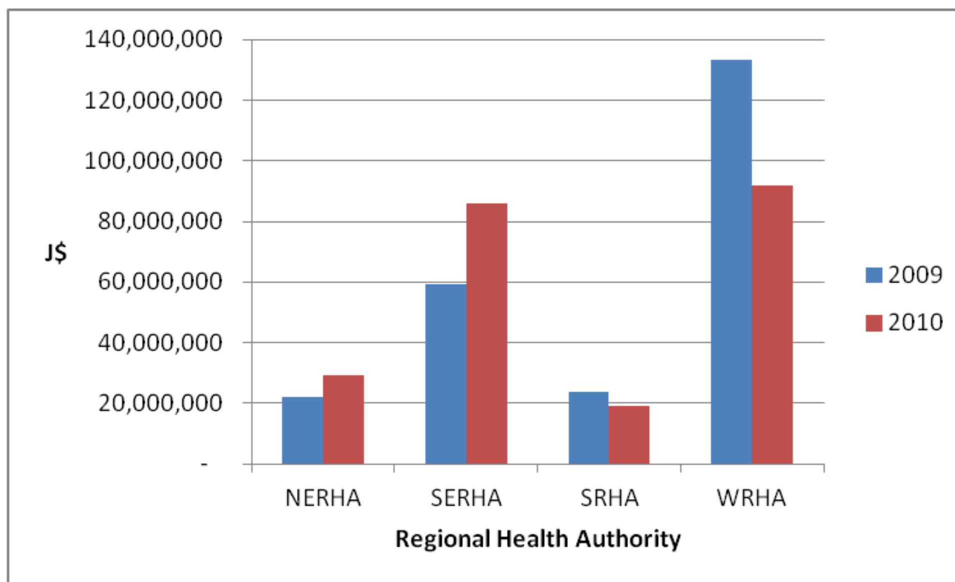
8.2 Who provides the service- Service Providers

Outlined below are the estimates for each RHA in terms of the expenditure on human resources related to HIV activity. More detailed data is presented in a series of tables outlined in appendix VII. There are a number of common assumptions made for each region and these are:

[16] Clinton Foundation (Preliminary Data) Health System Strengthening, Identifying the Bottlenecks and improving the delivery of healthcare services at treatment sites, CHAI Jamaica, June 2011

a. That in the absence of concrete information on HIV related activity a conservative approach will be adopted using the best information that is available.
b. That the HIV related out-patients data is included within the outpatient total cases information presented by the statistical unit of the ministry of health.
c. Secondly, that the PLHIV visit the treatment sites in the region in which they live.
d. Thirdly, that the PLHIV visit the treatment sites 12 times per year.

Chart 41 Human Resource Expenditure by RHA



For SERHA there was no separate expenditure on human resources submitted and therefore it was not possible to estimate a cost per outpatient visit. As a result an average cost per outpatient visit was used based on the estimated cost per outpatient identified at the three other RHAs; as such the estimated cost per outpatient visit at SERHA was J$528 in 2009 and J$604 in 2010. In 2009 there were 8,283 PLHIV within the boundaries of SERHA and 8952 in 2010 it was assumed that they visited the treatment site 12 times per annum resulting in 99k outpatient visits in 2009 and 107k outpatient visits in 2010. The total estimated expenditure on human resources was J$52m in 2009 and J$65m in 2010.

Total expenditure on human resources in relation to HIV by NERHA is J$3.1m in 2009 and J$3.9m in 2010. These figures are based on the total expenditure on human resources in 2009 of J$7.1m and J$8.5m in 2010. Total outpatient activity in 2009 was 49k cases of which 21k are assumed to be HIV related. Cost per outpatient visit is estimated to be J$143.

Total expenditure on human resources in relation to HIV by WRHA is J$24.5m in 2009 and J$39.5m in 2010 and which are based on the total expenditure on human resources in 2009 of J$68m and J$105m in 2010. Total outpatient activity in 2009 was 133k cases of which 47k are assumed to be HIV related and in 2010 there was 137k outpatient cases of which it is assumed that 51k were related to HIV. Cost per outpatient visit is estimated to be J$513 in 2009 and J$770 in 2010 which based on the number of patients seen equates to a total costs for Human Resources for HIV of J$24.5m for 2009 and J$39m in 2020.

For SRHA total expenditure on human resources in relation to HIV is J$165m in 2009 and J$19m in 2010 based on the total expenditure on human resources of J$74m for both years. Expenditure on Human Resource although giving the appearance of not changing between the two fiscal periods, is as a result of expenditure being submitted for only one fiscal year. As such, an assumption was made that these costs were reasonably reflective of HR costs for both years. Total outpatient activity in 2009 was 80k cases of which 17k are assumed to be HIV related and in 2010 there was 185k outpatient cases of which it is assumed that 22 were related to HIV. Cost per outpatient visit is estimated to be J$926 in 2009 and J$874 in 2010

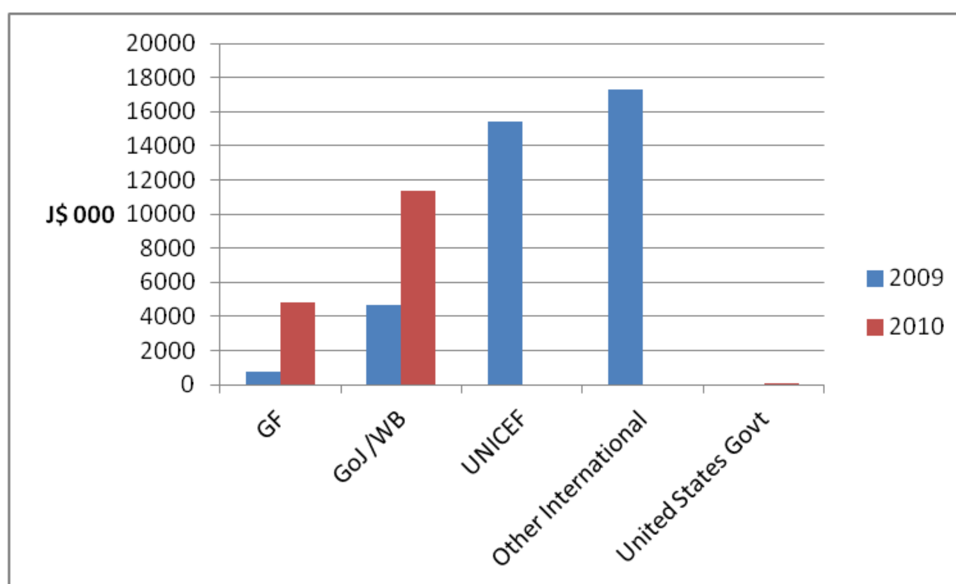
which was based on the number of patients seen and equates to a total costs for Human Resources for HIV of J$15.9m for 2009 and J$19m in 2010.

9. Prevention Mother to Child Transmission (PMTCT)

9.1 Who finances – Financial Source

The financing of PMTCT is quite inconsistent and fell by more than 50% from 2009 to 2010 which presents challenges to the consistent management of this component of the national response . In 2009 the 45% of the J$38M was expended by smaller international non –traditional sources such as the Fogarty International, National Institute of Health and the Elizabeth Glaser Foundation. This was closely followed by UNICEF with 40% of the expenditure. Unfortunately in 2010 funding from the smaller international organization and UNICEF was not sustained at fell away to 0%. 70% of PMTCT of the J$16m funding came from GOJ/WB in 2010.

Chart 42 PMTCT Financial Source Expenditure

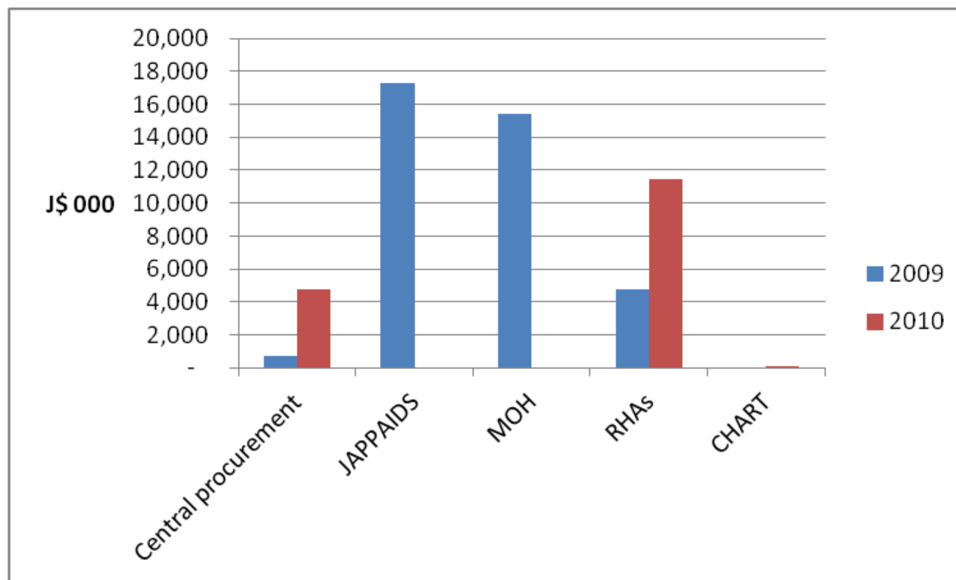


9.2 Who manages Funds- Financial Agent

In 2009, 45% of the PMTCT expenditure was managed by JAPPAIDS, whose sole purpose is focused on mother to child transmission. In 2010 both the RHAs and Central Government managed PMTCT activities and which accounted for 40% of the funding. The information presented in chart 43 demonstrates the transition of service provision from JAPPAIDS to the MoH and the RHA and further demonstrates the considerable drop in funding. As the data is capturing expenditure rather than service provision or service coverage it is not possible to indicate if there has been a change in the level of unmet need for

PMTCT services. However, it is recommended that expenditure on this priority together with relevant monitoring and evaluation indicators are reviewed regularly to monitor access and availability issues of PMTCT services.

Chart 43 PMTCT Financial Agent Expenditure[17]

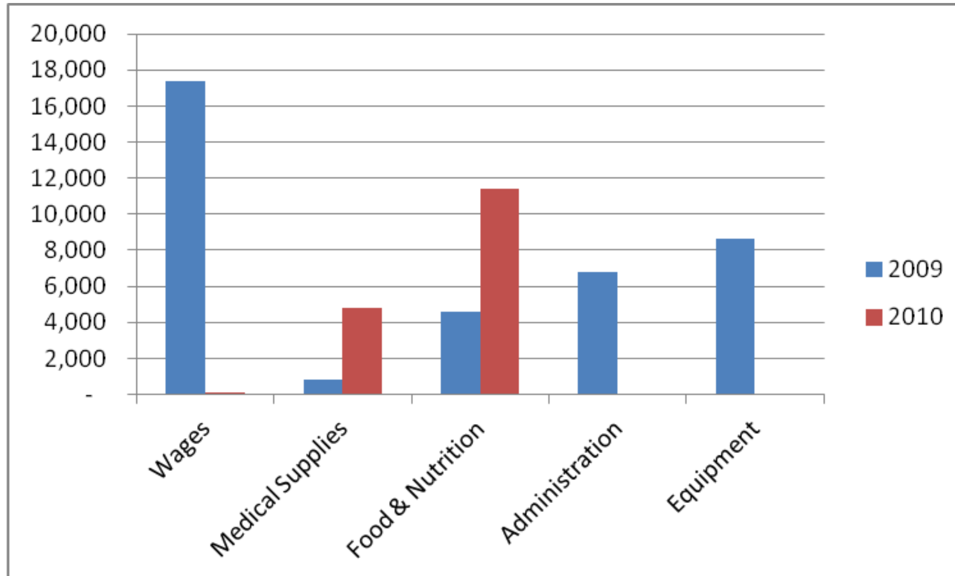


9.3 What resources were bought- Production Factors

The majority of expenditure on PMTCT was spent on Human Resources, 45% in 2009. However, in 2010 as the service provision transitioned to a different provider a very small portion of the data captured indicated that the expenditure was made on HR. Despite, the NASA project being run over two phases this data has not been able to be captured. Although, expenditure on HR expenditure has been included in the NASA the problem is that it has not been possible to disaggregate this to PMTCT. In the planning stages of subsequent NASAs greater consideration has to be given to capturing this data and methods of analysing donor related expenditure to the actual activities that are being performed whether this is through PMTCT, outpatient or inpatient care.

[17] CHART expenditure is relatively low so at J$316k in 2009. No expenditure is recorded in 2010.

Chart 44 PMTCT Production Factors Expenditures



Assumptions and Limitations

Assumptions

- The Ministry of Health (MoH)/Health Sector was considered as a financial agent, since they have the principal strategic and managerial authority with regards to public and donor funds. The Health sector is also classified as a service provider.
- The National HIV Programme (NHP) was classified separately to distinguish the external funding.
- The exchange rate of J$85.88 to US$1 is used throughout the study.
- Where the provider could not be identified the NASA classification of 'Provider not elsewhere classified' has been used.
- The assessment obtained data in relation to some organizations expenditure from the source of funding. In the final phase of the project the data was returned to the CSOs for verification.
- When data was not available or elements of data were missing a methodology for making estimations had to be applied that would link the known information to the NASA functions.
- The principle that was applied in these cases was to be as conservative as possible and tend, if possible to undervalue the real situation.

Limitations

- The NASA study attempts to link expenditure to activity through the AIDS Spending Classification. Most organisations in Jamaica do not practice any activity based budgeting or expenditure analysis. As such, expenditure data disaggregated to the activity level placed pressure on the organisations and key informants to generate the required data. In most cases budgeting and expenditure analysis prepared were at the production factor level i.e staffing costs, operating costs rather than link the expenditure to the cost drivers.
- USAID submitted data on their funding to civil societies in the AIDS spending categories associated with prevention, and care, treatment and support. However, the submission did not identify the individual providers or civil societies.

- Submission of data from the NHP on providers was often inadequate for the purposes of the study. Data from the Global Fund consisted of AIDS Spending Activities and the Resource Costs, however the data in terms of the Beneficiary Population and the Provider had to be estimated.
- Whilst information is included from the private sector the extent of consumption is limited to financial support from business identified by the CSOs. Out of pocket payments by patients and families in the care and support of PLWHA in terms of the extent of payments together with the providers utilised and services consumed are not available. This includes the provision of testing in the private sector for employment or insurance purposes or otherwise.
- As this was the first time the NASA study has been undertaken in Jamaica there was unfamiliarity with the methodology and the NASA classifications and definitions. Additionally data collection NASA proved to be challenging for several stakeholders due to the lack of familiarity with NASA terminology.
- There are a number of limitations with respect to the estimates for the human resource expenditure on HIV. The principle limitation is that an estimate has to be made in the first place and an absorption factor has to be determined as a result of expenditure data that is not automatically coded to activity. The following other limitations also apply:
- There are no estimates in relation to human resource costs and inpatients services. Although the Ministry of Health statistical units can produce data on the total in patient days by specialty, for example General Medicine or Orthopaedic and by hospital, there is no data available in respect to inpatient days by HIV status. Consequently, without further studies in this area it is not possible to estimate the number of in patients with HIV who are receiving care and treatment services and consequently, link the activity into a HR cost estimate.
- Secondly, the estimates themselves require a complex methodology to establish a cost per outpatient visit. For the project the estimate is based on actual human resource costs

divided by the total number of outpatient visits. Together with an assumption that PLHIV visit the treatment centre in the region where they live and that they visit the center 12 times per year.

Key Messages

The principle objectives of the NASA exercise were to implement a methodology for systematic monitoring of HIV/AIDS financial flows at national and regional level using the NASA methodology; develop a strategy involving multi-sectoral and multi-level key partners to track HIV and AIDS spending in Jamaica; and build national level and regional capacity for systematic monitoring of HIV/AIDS financing flows using National AIDS Spending Assessment methodology (NASA).

- The NASA project in Jamaica was able to achieve the multi-level and multi-sectoral participation of key stakeholders.
- The involvement of private sector needs to be increased, as well as sectors such as faith based organization.
- Several technical stakeholders from the NHP, RHA and UNAIDS became familiar with the NASA methodology of data entry, data verification, development of the database and reporting and as such, there was a successful development of national capacity. Secondly, staff at the Regional Health Authorities was identified, received additional training on the NASA methodology and were involved in the data collection stage for the NASA project so there was some limited development of capacity at the regional level.
- In country capacity still needs to be developed for data collection, triangulation and the construction of the databases and matrices.
- A sustained and institutionalized NASA will facilitate greater understanding of the information and this together with a policy of dissemination of the findings to stakeholder will encourage more active participation in the NASA process. . Continuing the NASA process will enable stakeholders to become familiar with the NASA methodology, begin to think more on how financial sources are linked to decisions on

provider contracting and how these decision subsequently affect the targeting of beneficiary populations.

Recommendations

- For civil society the majority of the funding that they currently receive is from international donors. Civil society will therefore need to examine their future role and how they can perform in the absence of a funding stream to support a multi-sectoral response for HIV. Civil society therefore needs to address the issues of sustainability and begin the process now to develop innovative and alternative sources of financing.

- With reduced funding and an increased emphasis on value for money and efficiency in the utilization of resources there is a stronger requirement for programmatic decisions to be based on evidence. The NASA study is indicating that only 0.2% of the overall HIV expenditure in both 2009 and 2010 was on research. There will need to be a greater emphasis on research in order to support programmatic decision-making and be more economical in the allocation of resources.

- NASA study should be used as a catalyst to begin National Health Accounts (NHA) in Jamaica. NASA will complement this study which examines expenditure on the wider health care system and illnesses.

Next Steps

1. There is a clear need for the National AIDS Spending Assessment project to continue and in the current economic climate the need to track resource flows and direct expenditure at those areas most in need becomes paramount.
2. This can only be achieved if users of the information see a clear link between financial data and using the information to better inform decision making for policy and programme decisions.
3. The immediate next will be:
    a. Disseminate the report to all stakeholders who are involved in the national response to HIV & AIDS and share the critical findings especially at the political level.
    b. Explain how the report can be used to facilitate decision making especially at the donor, governmental and civil society sectors.
    c. Cost the Jamaica National Strategic Plan and allocate indicative budgets to Priorities, Specific Objectives and Strategic Activities. There are a number of costing tools available, for example the Resource Needs Model (UNAIDS) and the HIV & AIDS Programme Sustainability Tool (USAID) together with technical support agencies familiar with their use who can be utilized to cost this element of the plan. Next steps would be begin a dialogue with UNAIDS, USAID and other agencies familiar with these tools, for example the Clinton Foundation to begin to move the process forward. If these tools and processes are linked to the National Health Accounts Model this could further strengthen activity based costing in the health sector and further improve overall financial information for decision making.

4. Institutionalize the NASA
    a. It is possible using the existing mechanism and structures that exist in Jamaica to institutionalize the NASA process. This involves several steps

i. Develop a core NASA team of about 3-5 persons, including the M&E focal points from the NHP and UNAIDS, as well as, RHA personnel and the local consultant.
ii. Edit or redesign, current stakeholder monthly reporting formats to capture data related to expenditure on activities and beneficiary populations
iii. Dedicate at least 6-8 weeks on the NASA process each year including data collection and data processing, if the team approach is to be used. The process will become more efficient if the reporting format is incorporated in monthly reports as well as the more NASA's are conducted.

b. Outlined in table 10 is an example work plan which sets the steps required to implement the NASA over 6mth period using the human resource pool that exists already.

Table 2 Implementation Schedule for a Sustainable NASA

NASA Process	Activity	Timeline						Notes
		Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	
Planning	Review NASA Manuals							Review the existing NASA manuals to obtain an understanding of the methodology and the dimensions
	Review NASA Report 2010							Review the report and review the findings, limitations, recommendations and methodology
	Review strengths and weakness in the current reporting system in the MOH							Review to determine where the data gaps are
	Determine the best methodology for the absorption factor							Find a method to know the expenditure by functions. WinSig is a relatively, simple method for allocating costs to Functions, i.e. Curative, Preventative, Diagnostic, Rehabilitative. There are other methods so review alternatives and select best method with consideration of complexity and accuracy.
	Determine the characteristics, identify and train Resource People in NASA methodology							Identify personnel in the health districts and main providers of who can assist in data collection and implementation of survey tools. This will also require a leader person and local implementation teams
	Design the guide to Data Collection Tools							The questionnaire that will be used to guide the data collection process with respect to the financial expenditure and absorption factor

NASA Process	Activity	Timeline						Notes
		Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	
Data Collection	Implement data collection Tools							The resource people implement the data collection tools in respect to the expenditure information and the data are required for the absorption factor
	Key Informant Interviews							Conduct key informant interviews that will determine the validity of the information collected
	Follow up with Key Informants for submission of data							Ideally the submission of data will be relatively quickly however there will need to be a provision for any late submissions
Data Processing	Prepare the transaction in the data collections tool							Used excel with pivot tables to produce the required information.
Data Analysis	Triangulate							Triangulate data and verify to make sure there is no double counting and similarly no data gaps
	Validate							A validation meeting with key informants is a critical component to ensure all the vanity of the data
Report	Prepare Draft Report Review Prepare Final Report							For the reporting stage prepare the draft to report submit this to management after the ministry of health for review and based on comments received prepare the final report
	Strategic Planning							The National Health accounts can now be used in the strategic planning process. With regard to the analysis stage of strategic planning the NASA can be used for allocation efficiency, in the planning phase selected interventions can be studied and in the assessment stage the NASA Data can be used to determine accountability

NASA Process	Activity	Timeline						Notes
		Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	
Planning	Review the Strengthen and Limitations of the Project							In order to prepare for the next NASA project review the elements of the project that went well and also those elements that require strengthening and make the requisite adjustments of the next NASA.

Appendices

Appendix I- References

1. MOH National HIV / STI Draft NHP Annual Report 2010
2. MOH National HIV / STI NHP Annual Report 2009
3. Evaluation of Human Resource and Organisation Needs of the National HIV/AIDS/STI Control and Prevention Programme. KPMG, 2009.
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Appendix II- NASA Classifications

ASC: AIDS spending categories: Following categories under which spending are incurred. There are 8 main categories and many sub categories under each main category.

ASC.01 Prevention: Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behavior. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age appropriate materials supporting programme goals.

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

ASC.03 Orphans and Vulnerable Children (OVC): An orphan is defined as a child under the age of 18 years who has lost one or both parents regardless of financial support (AIDS programme-related or not). 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 Strengthening of Programme Management and Administration: Programme expenditures are defined as expenses that are 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 of telecommunications.

ASC.05 Incentives for the Recruitment and Retention of Human Resources Human Capital: This category refers to services of the workforce through approaches for recruitment, retention,

deployment and rewarding of quality performance of health care workers and managers for work in the HIV and AIDS field.

ASC.06 Social Protection and Social Services (excluding OVC): Social protection conventionally refers to functions of government relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by needs such as sickness, old age, disability, unemployment, social exclusion and so on.

ASC.07 Enabling Environment and Community Development: It includes a full set of services that generate an increased and wider range of support key principles and essential actions as well as policy development. Nepal National AIDS Spending Assessment Report 2007 49

ASC.08 HIV and AIDS-Related Research (excluding operations research): 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.

2. BP: Beneficiaries Population Targeted or intended: The populations presented here are explicitly targeted or intended to benefit from specific activities. In principle, the identification of the BPs is dictated by the intended use of the funds.

3. PS: Providers of Services: Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. Providers include government and other public entities, private for-profit and non-profit organizations, corporate and non-corporate enterprises and self-employed persons.

4. PF: Production Factors: Since the provider and production factors classifications are focused on the HIV and AIDS outputs, it is also desirable to analyse the inputs or production factors that create these outputs. In NASA the classification of production factors categorizes expenditures

in terms of resources used for the production, i.e. wages, salaries, new buildings, renovations, etc. (budgetary items)

5. FA: Financing Agent: Entities which mobilize financial resources collected from different financing sources (pools) and transfer them to pay for or to purchase health care or other services or goods. These entities directly purchase from providers or steer in full, or as co-guarantors of payment, resources earmarked for the provision of commodities (services and/ or goods) to satisfy a need.

6. FA: Financing Sources: Financing sources are entities or pools which purchasers, providers of financial intermediation services or paying agents, tap or use other forms of mobilization to fund the HIV and AIDS services.

Appendix III - Methodology for Cost Allocation

The following section describes the methodology that was used to establish the allocation of apportioning costs in situations when there was a lack of information or when expenditure had to be allocated from one NASA dimension to another. In both cases often a suitable absorption factor had to be determined. As a reminder the NASA methodology enables expenditure to be allocated across the six dimensions of financial source, financial agent, provider, AIDS spending category, beneficiary population and resource cost. In most cases, it was unusual for data to be already allocated across the five dimensions. The NHP World Bank Financial Accounts being the one exception. As a result, the expenditure for each organisation had to be distributed using proxy variables as indicators of the likely distribution. In the majority of cases, all organizations that submitted data had information available on financial source, financial agent and provider. In most cases information was also available on the resource cost. The information that was missing in the majority of cases was related to AIDS Spending Category. Outlined below, the methodology that has been applied to allocate the expenditure by dimension for each organisation has been described.

1.0 Ministry of Health. National HIV & AIDS Programme.

There are three main financial sources that the NAP manages: these are the World Bank Loan, Global Fund and USAID Grants. Given the stringent fiduciary responsibilities that the Government of Jamaica has in respect to the loans and grants with the three international development agencies meant that the financial information provided was highly detailed. The methodology for allocating expenditure across the NASA dimension is described below.

1.1 World Bank

The data submitted under the WB project was highly detailed and included every single transaction from the accounting general ledger and included over 8,000 entries. Whilst this level of data could have caused problems in allocating the expenditure against the NASA dimension, each transaction was allocated a financial code which identified the provider, Beneficiary Population and this together with the account transaction resulted in very little need for any costs estimation or apportions exercises.

Dimension	Cost Allocation
Financial Source	All WB
Financial Agent	All NAP
Provider	Most indicated. Some providers were identified through cross checking the data submissions from providers of WB funds
AIDS Spending Category	In most cases the ASC was described in the activity descriptions for the GF grant. These descriptions were then compared to the descriptions for each ASC code in the NASA manual
Beneficiary Population	Indicated in the financial codes
Resource Cost	The TOR required data to be collected on HR. Salary data was available and additional details were provided and cross referenced to other entities data forms.

1.2 Global Fund.

Under the global fund project and expenditure was aggregated into the objectives and the activities under the grant of which there were 11 together with Empowerment and Governance and M&E. The Objectives are:

Objective 1: To improve access to gender sensitive, age appropriate HIV, Sexual reproductive Health
Objective 2: To increase gender sensitive prevention services for vulnerable populations, including sex workers, MSM, adolescents and youth, inmates, drug users, PLWHA and high risk persons at selected sites
Objective 4: Support Behaviour Change Interventions including condom promotion and dual
Objective 5: To create a supportive environment for safer sexual behaviour and stigma reduction using mass media
Objective 6: Treatment Care and Support
Objective 7: Improve the availability and quality of diagnostic and monitoring services for PLWHA of all ages
Objective 8:To provide Adherence Counseling and psychocial support to PLWHA
Ojective 9: Enabling Enviroment
Objective 10: To reduce discrimination in all sectors including Health
Objective 11: To advocate and facilitate programmes that protects human rights
EMPOWERMENT & GOVERNANCE (Admin)
MONITORING & EVALUATION

In terms of the availability of data by NASA dimension:

Dimension	Cost Allocation
Financial Source	All GF
Financial Agent	All NAP
Provider	Not all providers were indicated. By aggregating all expenditure to objective and activity meant that the detail on provider was missing. In most cases the description of the activity gave an indication of the provider for example: Conduct workshops for healthcare workers, under objective 6 or, train youth leaders under objective 10 and partners with NGO and the private sector under objective 2. The providers being RHAs, Ministry of Education and Civil Society The expenditure was then cross referenced against the data submission provided by the other providers of services i.e RHA, Ministry of Education and Civies using a top down and a bottom up approach linking the two entities through either the description given for beneficiary population of AIDS Spending Activity. As a result the database could begin to reflect the diversity of activities that are taking place but also avoid double counting expenditure.
AIDS Spending Category	In most cases the ASC was described in the activity descriptions for the GF grant. These descriptions were then compared to the descriptions for each ASC code in the NASA manual. One issue that arose in the verification meeting with the NHP was that the expenditure classified under Objective 2 of the GF grant Low Income Families is not recognized as an activity description by the Prevention Team. Instead, the prevention team classifies activity by the vulnerable populations that they are targeting including Sex workers and MSM. Following the verification meeting expenditure originally classified under low income was re-classified according to the project activities of the prevention team.
Beneficiary Population	Many activities are explitly targeted towards certain populations especially vulnerable populations. In many cases the BP was unclear especially with regard gender sensitive prevention. In many cases the targeting was determined through cross referencing against other provider data submissions.

Resource Cost	The TOR required data to be collected on HR which was only available for the PCU GF team. HR costs for the RHA and other entities was collected and cross referenced to other entities data forms.

1.3 USAID.

The level of detail provided under the USAID element of the NHP preented challenges to allocate the expenditure to the NASA dimensions. The data submitted only gave total expenditure by Objective and not be the sub-classifications of Goals or Activity. The Objectives included the following

OBJECTIVE 1:To Increase safer sex practices and improve attitudes and behaviours among vulnerable high-risk groups
OBJECTIVE 2: To Reduce HIV Transmission by delaying sexual initiation, promoting abstinence and increasing condom use among sexually active adolescents
OBJECTIVE 3: To reduce stigma and discrimination and improve the protection of the rights of selected vulnerable groups or most at risk populations (MARPs) through work with faith-based organisations (FBOs)
OBJECTIVE 4: Ministry of Labor and Social Services Activities –-Finalize and Disseminate the national HIV/AIDS Workplace Policy
OBJECTIVE 5: To Support the capacity building of stakeholders (PLWHA and CBOs) involved in HIV policy making, program design, implementation and M&E
OBJECTIVE 6: Support the Capacity Building at the MOH staff involved in HIV policy making, program design, implementation and M&E

In terms of the availability of data by NASA dimension:

Dimension	Cost Allocation
Financial Source	All USAID
Financial Agent	Through the data collection exercise it appeared that there are two USAID funding streams; via the NAP and directly through the US embassy.
Provider	No providers were indicated. The only way expenditure could be allocated to providers was when the providers submitted data sheets and these could be cross referenced to the USAID submission.
AIDS Spending Category	It was challenging to identify the ASC based on the submission. As with the providers fortunately the activity could be classified by the data sheets submitted by providers
Beneficiary Population	It was challenging to identify the ASC based on the submission. As with the providers fortunately the activity could be classified by the data sheets submitted by providers
Resource Cost	The TOR required data to be collected on HR. No data could be disaggregated on HR from the USAID submission and as such all expenditure was classified as PF.98 Production factors not disaggregated by type

2.0 Regional Health Authorities.

The RHAs are funded from a combination of funds supplied by Central Government via the Ministry of Health and the international development funds via the National HIV Programme. The allocation of costs is based on the following:

2.1 RHA Human Resource Costs.

A significant portion of the HR costs associated with treatment of the HIV response is funded by central government in the form of payment for salaries and wages at the RHAs. Many of these staff provide treatment, care, support and other services for people affected by HIV and AIDS. In order to reflect this expenditure a methodology had to be developed for apportioning costs to activity.

Dimension	Cost Allocation
Financial Source	Central Government
Financial Agent	Ministry of Health
Provider	The respective RHA – NERHA, SRHA, WRHA and SERHA
AIDS Spending Category	Outpatient Care. To establish the HR costs by activity included the following methodology. i. Each RHA provided the total treatment associated HR costs for each Parish – in the case of NERHA; Each hospital in the case of SRHA; each hospital for WRHA ii. Total out Patient activity was obtained from the MoH Statistical unit. iii. Dividing total HR costs by the number of outpatient visits gave a unit cost per outpatient visit. iv. Data was also supplied on the number of HIV patients by parish and using data supplied by the Clinton Foundation a conservative estimate was made on the number of HIV related out-patient visits per year i. e 12. v. The total HIV HR treatment costs are therefore the unit cost per out-patient * the estimated number of HIV related ou-patients. In-Patient Care. Whilst there was good data on inpatients, including total activity and average length of stay there was no HIV related in-patient activity. Therefore it was not possible to determine a suitable apportion rate for In-patient care.
Beneficiary Population	PLWHIV
Resource Cost	Salaries and Wages

Western Regional Health Authority, North Eastern Regional Health Authority, SRHA

Dimension	Cost Allocation
Financial Source	Three sources were identified of central government, GOJ/WB and Global Fund
Financial Agent	Where MoH for the Central Government funding and NHP for all others
Provider	Classified as WRHA
AIDS Spending Category	CG funding sources paid for staffing costs associated with treatment. WB/GOJ funding sources were directed towards prevention activities. GF funded prevention, treatment services and salary related expenditure.
Beneficiary Population	The expenditure was linked to work plan activities which in most cases permitted the BP to be identified.
Resource Cost	With the exception of HR costs it was difficult to determine the Resource costs. In these cases the costs were defined as : PF.98 Production factors not disaggregated by type

3. The Joint UN Theme Group on HIV

3.1 UNICEF –

Dimension	Cost Allocation
Financial Source	UNICEF
Financial Agent	UNICEF
Provider	For both fiscal periods the providers were the Ministry of Education, Ministry of Health and Civil Society. In the data submission the transfers to each provider were identified
AIDS Spending Category	There were several activities identified Prevention-youth in and out of school, Training, Community support and Programme management. In all cases there was a direct relationship between the expenditure and activity and no estimates or apportionaments were required.
Beneficiary Population	BP were Youth although there was, especially in relation to training a non targeted BP
Resource Cost	All costs were identified as Administrative services.

3.2 UNFPA

Dimension	Cost Allocation
Financial Source	UNFPA
Financial Agent	UNFPA
Provider	Most of the expenditure was done by NHP and other health agencies like National Family Planning, Ministry of Education and youth agencies and CSO. UNFPA also prov
AIDS Spending Category	Information collected in NASA tool helped identify beneficiary populations and AIDS Spending categories which included, advocacy, communication for behavior change and some programme manangement.
Beneficiary Population	BP were identified through data collection tools and assumed considering the population of the providers. These usually including, SWs, youth and other most at risk populations
Resource Cost	Most of the costs were for logistics to implement activities as well as consultancy fees and non-wage fees.

3.3 UNAIDS

Dimension	Cost Allocation
Financial Source	UNAIDS
Financial Agent	UNAIDS
Provider	The majority of expenditure was made by UNAIDS although some grants were given to CSO's. The expenditure by CSO had to be cross referenced against the UNAIDS data sheet to avoid any double counting.
AIDS Spending Category	Interviews with staff helped identify the ASC and BP
Beneficiary Population	BP were identified through interviews with staff
Resource Cost	These costs were split between HR associated with Programme Management and costs of running programmatic activities.

3.4 UNESCO.

All activities targeted young people in school and the main providers were the Ministry of Educations and the Jamaica Association of the Deaf. The data forms submitted by both these organisations were cross referenced against the UNESCO submission.

3.5 PAHO.

Dimension	Cost Allocation
Financial Source	PAHO
Financial Agent	PAHO
Provider	The service providers receiving funds from PAHO were not clearly defined therefore they are listed as Providers not disaggregated. It should be noted that PAHO's recipients include government and non-government organizations. It should be noted that PAHO disbursed funds according to the needs of recipients.
AIDS Spending Category	Interviews with staff helped identify the ASC and BP
Beneficiary Population	This was not clearly defined
Resource Cost	Resource cost were human resource for PAHO apart from consulting fees in 2010 for research, resource cost were not broken down

4. International Agencies

4.1 US State Department

Information presented detailed providers (Civil Society Organizations) and split the expenditure by ASC and BP. There was no information on resource costs and as such these were all coded as 'PF.98 Production factors not disaggregated by type'.

4.2 Clinton Foundation.

Funded by two separate international NGOs activities expenditure was identified to the activities in the Data submission. As a technical assistance organisation the majority of the expenditure was related to HR.

5. Out of Pocket Expenditure -Condoms

a. Expenditure on condoms for 2010 was estimated based on the CARISMA Total Condom Market Approach report.

Dimension	Cost Allocation
Financial Source	Out of Pocket
Financial Agent	Out of Pocket
Provider	Classified as Private Pharmacies
AIDS Spending Category	Public and commercial sector condom provision. The expenditure was determined by: Public Condom Provision: Unit Costs * Quantity (0.023 * 7.6m) Private Sector Provision: Unit Costs * Quantity (0.57 * 7.7m) LESS the expenditure already captured under the GF data sheete. The figures above were extrapolated from the report.
Beneficiary Population	No data so classified as general population
Resource Cost	No data on cost breakdown between selling and distribution and overhead costs so classified as 'condoms'

6. Civil Society

6.1 JN +

Organization is targets soley PLHIV both general HIV populace as well as targeted activities for women. There were several funding sources such as the Global Fund, UNFPA, and to a lesser extent FAO and CTAG. AIDS Spending categories were mainly Social Protection which involves income generation as well as enabling environment and advocacy.

6.2 Combined Disability Association.

With only one funding source identified by the organization the data submission was cross referenced against the GF data submission.

6.3 Jamaica Youth Advocacy Network.

The main activity was advocacy targeting young people. The activities were cross referenced against the data submission for GF and UNICEF

6.4 PSI.

The funding source was identified as PEPFAR through the Department of Defense. In 2010 the German Development bank funded activities with expenditure split 3 ways between the target groups of Youth, MSM and MSM. With regard resource costs HR costs were able to be separately identified.

6.5 Caribbean HIV/AIDS Alliance.

Funding sources were the German Development Bank KfW and USAID although with the USAID funding the financial agent was identified as the Red Cross.

6.6 Children of Faith –

The main beneficiary population was OVC. AIDS Spending categories were focused on support and education of OVC. Administrative cost were covered by UNICEF in both 2009 and 2010 this was cross-checked and validated in UNICEF data. In 2010 there was spending on income generation projects for infected and affected person with HIV which was funded by Global Fund. Non-traditional source such as Food for the Poor and private donations assisted in care and support.

6.7 Jamaica AIDS Support.

With only one funding source identified by the organization the data submission was cross referenced against the GF data submission.

6.8 Children First Agency.

CFA is funded via GF, USAID and 'other International' agencies.

Dimension	Cost Allocation
Financial Source	Determined from Data sheet
Financial Agent	Determined from Data sheet
Provider	CFA
AIDS Spending Category	For the GF expenditure there were a number of stages in allocating the expenditure by activity: 1 Allocate expenditure by activity and Beneficiary Population 2 Determine Overheads (which were given by CFA) 3 Determine Expenditure profile of Programmatic Expenditure. Based on the expenditure profile by activity expenditure is split:

	Youth 26%, Peer Education 36%, VCT 0.41%, Safe Spaces 36%. 4 Allocate Overhead to programmatic based on rates in stage 3
Beneficiary Population	See notes above
Resource Cost	See notes above

6.9 Jamaica Red Cross.

The funding sources for the JRC are the IFRC, GF, USAID, AMCROSS and KfW. The financial data given by the organisation separated out the programmatic expenditure from the Overhead expenditure. The estimation exercise had to link overheads with the relevant activity for the organisation.

Dimension	Cost Allocation
Financial Source	Determined from Data sheet
Financial Agent	Determined from Data sheet
Provider	JRC
AIDS Spending Category	For the GF expenditure overhead costs were charged back to programmatic activities based on the proportion of activities targeting specific populations. For the General Population JRC indicated that 70% of activities are targeted towards this group with 30% targeting PLWHIV. Administration was therefore distributed to activities on the basis of these proportions. There was also cross referencing against the GF data submission. The same approach was used for the USAID expenditure where overhead costs were charged back to programmatic activities based on the proportion of activities targeting specific populations. In this case the proportion was 68.71% to MSM and 31% to Out of School Youth.
Beneficiary Population	See notes above
Resource Cost	See notes above

6.10 Caribbean Vulnerable Coalition.

The main funding source was DFID and the information submitted detailed the activities, beneficiary population and the Resource Costs.

6.11 JFLAG.

Funded mainly by International Civil Society each activity targeted MSM and other high risk groups in the proportion of 70%:30%. As such each activity cost was split 70:30 in respect to the target population dimension in the database.

6.11 ASHE

Two funding streams were noted for ASHE, they were Global Fund and USAID. The AIDS Spending Category was In School Prevention targeting high school youth. Their information was cross-referenced with the general Global Fund and USAID expenditure presented from the NHP.

6.12 PANOS.

This organization works across the Caribbean so the first task was to determine the level of activity related to Jamaica. This was determined by PANOS as 40% of total activity. Costs were given by activity and target group and the Jamaica percentage was applied these to estimate the Jamaica relevant expenditure.

6.13 Eve for Life

The information was not broken down sufficiently, however in order to capture 2010 data, the figures quoted were divided by two to apportion the expenditure of the year in question. The funding stream was from PEPFAR and managed by the US Embassy. Their beneficiary population were females and children with HIV.

7. Other Entities

7.1 University of the West Indies.

Dimension	Cost Allocation
Financial Source	Three distinct financial sources were identified
Financial Agent	Three distinct financial agents were identified
Provider	The UWI health centre
AIDS Spending Category	There was two distinct activities and the expenditure had to cross referenced against the data submissions submitted by two of the financial sources for UWI to avoid double counting the information. A third financial sources was based in the USA and no data sheet was submitted by this organisation.
Beneficiary Population	All activities targeted university students
Resource Cost	The data submission was able to separate out the resource cost by financial source between supplies and HR costs.

7.2 Tourism Product Development Company.

HIV related activities were funded through the GOJ/WB and NHP. The provider was always the TPDC and tourism workers were the target group of the activities and were classified as the General Population. Expenditure was broken down by activity and resource cost.

7.3 National Council on Drug Abuse.

With only one funding source identified by the organization the data submission was cross referenced against the GF data submission.

7.4 CHART.

Funded through ITECH the data submitted identified the activities which ranged from Prevention through to Treatment and advocacy. Extensive financial data was submitted on the cost of each training programme and which included the target groups for the training and the resources costs. In 2009 the GF monies were cross referenced to the GF data submission.

7.5 Jamaica National Family Planning Board

Funding and support of programmes were through Central Government, Global Fund through NHP and UNFPA. The beneficiary population was mainly the general public with the main AIDS Spending categories being condom distribution and behavior change communication activities.

7.6 Jamaica Paediatric, Perinatal & Adolescent HIV/AIDS Program -University of the West Indies (JAPPAIDS)

Information was received from JAPPAIDS for 2009 only.

Dimension	Cost Allocation
Financial Source	Elizabeth Glaser Pediatric AIDS Foundation/Univ. of California San Francisco National Institutes of Health/University of California San Francisco Fogarty International Clinical Research Scholars Support Cent/Vanderbilt Univ. University of the West Indies National HIV/STI Program, Ministry of Health
Financial Agent	JAPPAIDS
Provider	JAPPAIDS
AIDS Spending Category	Clinical Observation of infants and children and Treatment, care and support. For each financial source JAPPAIDS split out the expenditure by activity and target population
Beneficiary Population	Mothers, children & youth
Resource Cost	Salaries and Wages

Appendix IV- Data Collection Tools

1st Phase Data Collection Tool

Five Questions

1. Legal Status: Please indicate the type of organization that you are: Public, Private, CSO, for Profit, Bi-lateral or Multi-Lateral Agency

2. Please indicate the names and amounts of all resources received, for example, Private Sector, International Donor Agency (Global Fund, etc), and Government. Etc.

Name of Financial Source	$ 2009	$ 2010
1		
2		
3		

3. Are intermediate agencies used for the transfer of the funds? For example the Global Fund, World Bank and USAID use the Ministry of Health as the financial agent. However, Civil Society may be in receipt of funds that are outside of these arrangements and where other financial agents are used. If this is the case please indicate the name of these organisations.

4. Identification of Activities and Target Groups: For each financial source describe the activity that was performed and the target group

Activity	**$**	**Target Group**	**$**	**Region**

What was the expenditure on Operational Costs in undertaking the activities (as indicated in Question 4?) for each fiscal year?

Activity	$	Resource Cost	$

2nd Phase Data Collection Tool

Name of Organization:	**AIDS Service Organization**
Name of Contact Person:	John Brown
Position:	EXECUTIVE DIRECTOR
Telephone No.	960-8888
Email:	Johnnbrown@email.com
Legal Status of Entity	Civil Society
Financial Agency	MOH
Financial Source	Global Fund

	Year	Activity	Target Population	Resources	Region/Parish	Money Spent on Resources for Activity
	2009-2010					
Subtotal 2009-2010						
	2010-2011					
Subtotal 2010-2011						

Instructions, Terms and Definitions		
Term	Definition	Example
Financial Source	This is the where the funding originates. For each funding source fill out a sheet and give a total amount received from each funding source.	Private Sector, International Donor Agency (Global Fund, etc), and Government. etc.
Financial Agent	The intermediate agency which administers the funds from funding agency. Civil Society organizations may be in receipt of funds that are outside of the NHP arrangements and where other financial agents are used. If this is the case please indicate the name of these organisations.	For example the Global Fund, World Bank and USAID use the Ministry of Health as the financial agent.
Activities	This is the activity which the resources was spent on. This can be found in workplans or MOUs. Also include the objective of the activity. That is to say if it is a training workshop to build capacity of Sex workers which would be a part of the bigger objective to create a cadre of empowered Sex workers. Please indicate all activities which resources were spent on.	Training Workshop, Development of IEC Material, HIV Testing
Resources	These are the individual resources needed to implement activity. As best you can name all inputs for each activity. It is possible that each resource for an activity may have different funding source, if this is the case, be sure to make notes indicating that resources were from another funding stream.	Hiring Consultant, Staff Salaries, Workshop material, Venue, Refreshments, etc
Target Population	The audience who the activity was geared towards. If the activity had more than one audience name all.	PLHIV, SW, Out of School Youth, General Population
Region/Parish	Indicate the Health Region or Parishes which activities took place	North East, St. Elizabeth, All Island

Appendix V: List of Contributing Organizations

The following is a list of all individuals who contributed to the Jamaica NASA by sending data and thereby ensuring its success.

Sector	Sub-Recipient	Representative	Contact Information	Email
CSO	Combined Disabilities Association	Gloria Goffe, Project Coordinator	929-1177	advocacy@cwjamaica.com
CSO	Jamaica Youth Advocacy Network	Jaevion Nelson, Executive Director	922-9477	jaevion@gmail.com
CSO	Jamaican Network of Seropositives	Denton Dewar, Programme Manager		dentondewar@yahoo.com
CSO	Children of Faith	Gloria Meredith		gloriam@cwjamaica.com
CSO	Caribbean HIV&AIDS Alliance	Denise Chevannes Regional Technical Hub Manager	631-2279	dchevannes@alliancecarib.tt.org
CSO	Jamaica AIDS Support for Life	Kandasi Levermore, Executive Director	978-4668/2345	klevermorejasl@gmail.com
CSO	National Council on Drug Abuse	Collette Browne, Programnme Coordinator	564-7139/618-6233	cbrowne@ncda.org.jm
CSO	ASHE	Jumoke Patrick/ Conroy WIlson	960-2985	asheperforms@gmail.com
CSO	Jamaica Red Cross	Lois Hue	984-7860-2	loishue@jamaicaredcross.org
CSO	Children's First	Claudette Pious/Vandrea Thompson	984-0367	Claudettepious@yahoo.com/vandreat@yahoo.com

CSO	Hope Worldwide	Karen Daye/Peter Swaby	7544446	Kadaye73@yahoo.com/hopeja@gmail.com
CSO	Eve for Life	Marjorie Samuels	8161365	marsammy@gmail.com
CSO	JFLAG	Dane Lewis	8449366	danelew@gmail.com
CSO	CVC	Ivan Cruickshank	8709307	Ivan.crucickshank@gmail.com
GOJ	TPDCo - Ministry of Tourism	Rachel Morrison, Tourism Development Company,	908 5378, 381 2210	rachel.morrison@tpdco.org
Health Vertical	NHP	Dr. Nicola Skyers, Actg Director, NHP		skyersn@moh.gov.jm
Health Vertical	NHP	Suzanne Davis, Director M&E	(876) 967 1277	srobinsondavis@gmail.com
Health Vertical	NHP Global Fund	Stacy-Ann Howell	482 6284	HowellS@moh.gov.jm
Health Vertical	NHP World Bank	Andrew Brown	340-0897	brownan@moh.gov.jm
Health Vertical	NHP USAID	Edmond Montague	881 6954	montaquee@moh.gov.jm
I'national	KfW	Julia Roberts Country Manager		jroberts@psicarib.org
I'national	US State Department	Emma Lewis		
I'national	Centre for Disease Control	Sandra Knight	8767026462, (c) 8764024120	sknight@tt.cdc.gov, iyf9@cdc.gov
I'national	Ambassador Small Grants	Hanan Ghannoum	(876) 702-6229	ghannoumh@state.gov

	Programme			
I'national	Clinton Foundation	Ingrid Thame, Country Manager	881 5571	ithame@clintonhealthaccess.org
I'national	UNAIDS	Erva Jean Stevens	876-960-6538	stevense@unaids.org
I'national	UNESCO	Dr. Kwame Boafo, Jeneille Babb	876) 630 5300, (876) 361-1696 (cell)	k.boafo@unesco.org/ J.babb@unesco.org
I'national	UNDP	Ms Akiko Fujii / Keesha Raymond	(876) 978-2390	Akiko.fujii@undp.org / keesha.raymond@undp.org
I'national	UNFPA	Marvin Gunter	906-8591	gunter@unfpa.org
I'national	UNICEF	Novia Condell	968-8164	ncondell@unicef.org
I'national	PAHO	Dr. Kam Mung	967-4691	mungkams@jam.paho.org
Private	JABCHA	Earl Moore	926-6762/906-8370	jabcha@gmail.com
Private	Bank of Nova Scotia	Joylene Griffith-Irving/Rochelle Dixon		joylene.griffiths-irving@scotiabank.com/ rochelle.dixon@scotiabank.com
Quasi GoJ	UWI Health Centre	Jasneth Mullings, Consultant	838-7867	jasneth@gmail.com

Quasi GoJ	UWI HAARP	Marijan Debruin		marijan.debruin@uwimona.edu.jm
Quasi GoJ	ERTU/CHART	Dr. Tina Hylton Kong	948-8002	tinak@cwjamaica.com
Quasi GOJ	National Family Planning Board	Joseph Reynolds	968-1627	jreynolds@jnfpb.org
Quasi GoJ	Southern Regional Health Authority	Dr. Michael Coombs, Regional Technical Director Joy Anderson,	625-0612-3, 962 9491	joy.anderson@srha.gov.jm ,
Quasi GoJ	North East Regional Health Authority	Acting Regional Technical Director	795-3107, 454 9083	Odeth Latouche, odeth.latouche@nerha.gov.jm ,
Quasi GoJ	Western Regional Health Authority	Dr. Maung Aung, Regional Technical Director Jasper Cunningham, Finance Director,	952-1124/3678	jasper.cunningham@wrha.gov.jm

Appendix VI- Matrices

1. Financing Sources (FS) x Financing Agents (FA) 2009
2. Financing Sources (FS) x AIDS Spending Categories (ASC) 2009
3. Financing Agents (FA) x AIDS Spending Categories (ASC) 2009
4. Financing Agents (FA) x Providers of Services (PS) 2009
5. Financing Agents (FA) x Beneficiary Populations (BP) 2009
6. AIDS Spending Categories (ASC) x Beneficiary Populations (BP) 2009
7. Providers of services (PS) x Production Factors (PF) 2009
8. Providers of services (PS) x AIDS Spending Categories (ASC) 2009
9. AIDS Spending Categories (ASC) x Production Factors (PF) 2009
10. Financing Sources (FS) x Financing Agents (FA) 2010
11. Financing Sources (FS) x AIDS Spending Categories (ASC) 2010
12. Financing Agents (FA) x AIDS Spending Categories (ASC) 2010
13. Financing Agents (FA) x Providers of Services (PS) 2010
14. Financing Agents (FA) x Beneficiary Populations (BP) 2010
15. AIDS Spending Categories (ASC) x Beneficiary Populations (BP) 2010
16. Providers of services (PS) x Production Factors (PF) 2010
17. Providers of services (PS) x AIDS Spending Categories (ASC) 2010
18. AIDS Spending Categories (ASC) x Production Factors (PF) 2010
19. The UNGASS Matrix / Indicator n°1 – Submitted in a separate excel file

Appendix VII- Human Resource Costs

Table 3 Human Resources- Service Provider Expenditure SERHA 2009-2010

2009 - 2010

SERHA - Treatment Site Costs for HIV

A	*B* Cost Per OP	*C* *Sub total/3*
NERHA	143.66	
SRHA	926.41	
WRHA	513.93	
Sub Total	**1,584.00**	
Average Cost per OP		**528.00**

SERHA - Treatment Sites Cost of HIV

A	*B*	*C* OP Visit PA	*D* *B*C* Total OP visit PA	*E* Cost Per OP Visit	*F* Total HR Cost OP

PLWHIV SERHA 2009	8283	12	99397	528.00	52,481,513.52

Table 4 Human Resource Expenditure SERHA 2010-11

2010 - 2011

SERHA - Treatment Site Costs for HIV

A	*B* Cost Per OP	*C* *Sub total/3*
NERHA	167.93	
SRHA	874.09	
WRHA	770.74	
Sub Total	1,812.76	
Average Cost per OP		604.25

SERHA - Treatment Sites Cost of HIV					
A	*B*	*C*	*D* *B*C* Total OP visit PA	*E* Cost Per OP Visit	*F* Total HR Cost OP
		OP Visit PA			
PLWHIV SERHA 2010	8952	12	**107422**	604.25	**64,910,211.44**

Table 5 Human Resource Service Provider Expenditure NERHA 2009-2010

2009-2010 NERHA - Treatment Site Staff Costs				
A Parish	*B* Total Staff Costs Apr 2010-Mar 2011	*C* *Total of B*	*D* OP vists 2008	*E* *C/D* Cost per OP J$
St Ann	5,305,574			
St Mary	955,686			
Portland	317,010			

Buff Bay	116,279			
Sub-Total		6,694,548	45582	
Paediatric				
St Ann	367,696			
Port Maria	114,239			
Sub -Total		481,936	4372	
Total Cost per OP		7,176,483	49954	143.66

NERHA - Treatment Sites Cost of HIV

A	*B*	*C*	*D*	*E*	*F*
		OP Visit PA	*B*C* Total OP visit PA	Cost Per OP Visit	Total HR Cost OP
PLWHIV NERHA 2009	1829	12	21945	143.66	3,152,666.73

Table 6 Human Resources Service Provider Expenditure NERHA 2010-2011

2010 - 2011

NERHA - Treatment Site Staff Costs

A Parish	*B* Total Staff Costs Apr 2010-Mar 2011	*C* *Total of B*	*D* OP vists 2009	*E* *C/D* Cost per OP J$
St Ann	5,389,698			
St Mary	1,773,682			
Portland	1,263,401			
Buff Bay	117,819			
Sub-Total		**8,544,601**	54167	
Paediatric				
St Ann	1,392,790			
Port Maria	110,921			
Sub -Total		**1,503,711**	5669	
Total Cost per OP		**10,048,311**	**59836**	**167.93**

NERHA - Treatment Sites Cost of HIV

A	*B*	*C*	*D* *B*C* Total OP visit PA	*E* Cost Per OP Visit	*F* Total HR Cost OP
		OP Visit PA			
PLWHIV NERHA 2010	1963	12	**23558**	167.93	**3,956,144.67**

Table 7 Human Resources Service Provider Expenditure WRHA 2009-2010

2009-2010

WRHA - Treatment Site Costs for HIV

A Hospital	*B* Salaries - Govt Funds	*C* Total OP & Paed visit 2008	*D* *B/C* Cost per OP Visit
CRH – Medical Clinic	21,015,966.03		
Sav-la-mar Hospital – Medical Clinic	17,838,342.96		
Montego Bay Type V – Medical Clinic	29,905,805.65		
Sub Total	**68,760,114.64**	133793	**513.93**
		Statistical Data	

WRHA - Treatment Sites Cost of HIV					
A	*B*	*C*	*D* *B*C*	*E*	*F*
		OP Visit PA	Total OP visit PA	Cost Per OP Visit	Total HR Cost OP
PLWHIV WRHA 2009	3975	12	**47694**	513.93	**24,511,373.91**

Table 8 Human Resource Service Provider Expenditure WRHA 2010-2011

2010 - 2011

WRHA - Treatment Site Costs for HIV

A	*B*	*C*	*D* *B/C*
Hospital	Salaries - Govt Funds	Total OP & Paed visit 2009	Cost per OP Visit
CRH – Medical Clinic	34,209,257.29		
Sav-la-mar Hospital – Medical Clinic	38,974,478.23		
Montego Bay Type V – Medical Clinic	32,680,163.83		
Sub Total	**105,863,899.35**	137354	**770.74**

WRHA - Treatment Sites Cost of HIV					
A	*B*	*C*	*D* *B*C*	*E*	*F*
		OP Visit PA	Total OP visit PA	Cost Per OP Visit	Total HR Cost OP
PLWHIV WRHA 2010	4278	12	**51336**	770.74	**39,566,653.25**

Table 9 Human Resources Service Provider Expenditure SRHA 2009-2010

2009-2010 SRHA - Treatment Site Costs for HIV			
A	*B*	*C*	*D* *B/C*
Hospital	Salaries - Govt Funds	Total OP & Paed visit 2008	Cost per OP Visit
Black River	28,809,878.17		
May Pen	45,431,665.61		
Sub Total	**74,241,543.78**	80139	**926.41**

SRHA - Treatment Sites Cost of HIV

A	B	C	D B*C	E	F
		OP Visit PA	Total OP visit PA	Cost Per OP Visit	Total HR Cost OP
PLWHIV SRHA 2009	1437	12	**17238**	926.41	**15,969,674.96**

Table 10 Human Resources Expenditure 2010-2011

2010 - 2011

SRHA - Treatment Site Costs for HIV			
A	*B*	*C*	*D*
			B/C
Hospital	Salaries - Govt Funds	Total OP & Paed visit 2009	Cost per OP Visit
Black River	28,809,878.17		
May Pen	45,431,665.61		
Sub Total	**74,241,543.78**	84936	**874.09**

SRHA - Treatment Sites Cost of HIV					
A	*B*	*C*	*D*	*E*	*F*
			*B*C*		
		OP Visit PA	Total OP visit PA	Cost Per OP Visit	Total HR Cost OP
PLWHIV SRHA 2010	1833	12	**21991**	874.09	**19,221,935.18**