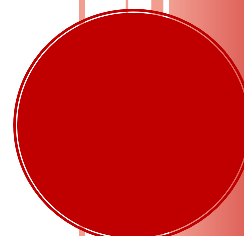
MINISTRY OF HEALTH

IN COLLABORATION WITH

JOINT UNITED NATIONS PROGRAMME ON HIV & AIDS (UNAIDS)

SPENDING ASSESSMENT - JAMAICA

An Assessment of HIV and AIDS Financing Flows and Expenditure April 2011-March 2013



Document prepared for the National HIV/STI Programme and
the Joint United Nations Programme on HIV and AIDS
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The NASA Task Force is also acknowledged for their professional and invaluable guidance of the overall process. We are pleased with the output of this assessment and hope that (1) NASA will provide decision makers with strategic information that enables Jamaica to mobilize resources, have a stronger accountability and enhances the efficiency and effectiveness of programme implementation going forward and (2) fulfil the requirement of HIV spending at the country level in accordance with GARPR indicator 6.1.

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ACRONYMS

ARV	Anti-Retro Virals
ASC	AIDS Spending Category
ASHE	Ashe Performing Arts Company
CD4 Test	Test to determine T-cell count
CDA	Combined Disabilities Association
CDC	Center for Disease Control and Prevention
CF	Children First
CHARES	CENTRE for HIV/AIDS Research, Education, and Services
CHART	Caribbean HIV/AIDS Regional Training Programme
CIDA	Canadian International Development Agency
CIMA	Chartered Institute of Management Accountants
CoF	Children of Faith
CSO	Civil Society Organization
EFL	Eve for Life
FBO	Faith Based Organization
GARPR	Global AIDS Response Progress Reporting
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV & AIDS
GOJ	Government of Jamaica
HRSA	Health Resources and Services Administration
HWW	Hope Worldwide
ITECH	International Training and Education Centre on HIV
JaPPAIDS	Jamaica Perinatal Paediatric and Adolescent AIDS
JASL	Jamaica AIDS Support for Life
JN+	Jamaican Network of Seropositives
JRC	Jamaica Red Cross
JYAN	Jamaica Youth Advocacy Network
KSA	Kingston and St. Andrew
M&E	Monitoring and Evaluation
MARP	Most at Risk Populations
MLSS	Ministry of Labour and Social Security
MNS	Ministry of National Security
MOE	Ministry of Education
MOH	Ministry of Health
MOTE	Ministry of Tourism and Entertainment
MSM	Men who have sex with men
NAC	National AIDS Committee
NAPS	National AIDS Programme Secretariat

NASA	National AIDS Spending Assessment
NCDA	National Council on Drug Abuse
NCU	Northern Caribbean University
NFPB	National Family Planning Board
NGO	Non-Governmental Organisation
NHP	National HIV/STI Programme
NHPL	National Public Health Lab
NSP	National Strategic Plan
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAA	Parish AIDS Association
PAHO	Pan-American Health Organization
PCHA	Presidents Commission of HIV & AIDS
PCR	Polymerase Chain Reaction
PEPFAR	US Presidents Emergency Plan for AIDS Relief
PLWH	People Living with HIV & AIDS
PMTCT	Prevention of Mother to Child Transmission Programme
RHA	Regional Health Authority
SP&SS	Social Protection and Social Services
SW	Sex Worker
TB	Tuberculosis
UA	Universal Access
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV & AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Sessions on HIV and AIDS
UNICEF	United Nations Children Fund
UNIFEM	United Nations Development Fund for Women
UNTG	United Nations Theme Group on HIV & AIDS
USAID	The United States Agency for International Development
UWI	University of the West Indies
UWI HARP	University of the West Indies HIV/AIDS Response Programme
VCT	Voluntary Counselling & Testing
WHO	World Health Organization
YMP	Young Peoples Movement Youth Centre

EXECUTIVE SUMMARY

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Fact Sheets on Jamaica HIV & AIDS Expenditure for the period 2011/2012 and 2012/2013

	2011/2012	%	2012/2013	%
HIV and AIDS Spending by Financing Source				
Public Funds	3,706,165	21.99	3,807,538	18.67
Private Funds	2,203,668	13.08	2,391,429	11.73
International Funds	10,941,612	64.93	14,193,526	69.60
Grand Total	**16,851,445**	**100.00**	**20,392,493**	**100.00**
HIV and AIDS Spending by Financing Agents				
Public Funds	11,264,510	66.85	14,258,235	69.92
Private Funds	2,235,779	13.27	2,517,515	12.35
Bilateral Agencies	1,532,051	9.09	1,654,864	8.12
Multilateral Agencies	1,122,435	6.66	771,677	3.78
International non-profit making organizations and foundations	696,671	4.13	1,190,201	5.84
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**
HIV and AIDS Spending by AIDS Spending Categories				
Prevention	6,063,711	35.98	6,865,831	33.67
Care and Treatment	3,068,996	18.21	5,865,810	28.76
Orphans and Vulnerable Children	248,885	1.48	284,640	1.40
Programme Management and Administration	6,599,214	39.16	6,195,537	30.38
Human Resources	186,517	1.11	748,941	3.67
Social Protection and Social Services (excluding OVC)	231,379	1.37	103,582	0.51
Enabling Environment	325,347	1.93	313,574	1.54
HIV Related Research	127,396	0.76	14,578	0.07
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**

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	2011/2012	%	2012/2013	%
HIV and AIDS Spending by Provider of Services				
Governmental Organizations	**7,477,682**	44.37	10,245,062	50.24
Parastatal Organizations	**3,043,333**	18.06	2,601,062	12.75
Non-Profit Providers	**4,190,664**	24.87	5,889,590	28.88
Profit Making Private Sector Providers (includ. Profit Making FBOs)	**868,956**	5.16	725,669	3.56
Bilateral & Multilateral entities- in country offices	**1,270,810**	7.54	931,109	4.57
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**
HIV and AIDS Spending by Beneficiary Population				
People living with HIV	3,506,048	20.81	5,812,442	28.50
Most at risk populations	1,427,128	8.47	2,140,423	10.50
Other key populations	1,256,758	7.46	1,257,496	6.17
Specfic "accessible" populations	3,418,654	20.29	2,432,886	11.93
General population	6,699,893	39.76	8,266,982	40.54
Non-targeted interventions	542,964	3.22	482,264	2.36
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**
HIV and AIDS Spending by Production Factors				
Current Expenditures	16,383,985	97.23	18,733,660	91.87
Capital Expenditures	467,460	2.77	1,658,832	8.13
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**

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Production Factors (PF) - The greatest concentration of Spending

Wages as a Production Factor consumed US$7,009,938 (41.60%) in 2011/2012 and US$5,841,307 (28.64%) in 2012/2013.

ARV total spending is US$803,356 (4.77%) and US$3,305,111 (16.21%) respectively in the two (2) periods under review. This is directly associated with Care and Treatment as an AIDS Spending Category (ASC), and solely to the benefit (BP) of PLWHIV.

Over US$1M was spent on Medical and Surgical supplies in both years (US$1,253,412) in 2011/2012 and (US$1,702,811) in 2012/2013. Ora Quick Test, HIV Rapid Test kits and Syphilis test kits are some of the specific items reported for the study.

Reagents and Materials cost US$835,252 and US$660,511 respectively for the periods of the assessment. These were mainly for PCR and CDR machines.

Logistics of events as a production factor captured the entire training workshop and these were multifaceted. In both years of the study Prevention as a AIDS Spending Category (ASC) dominated the Logistic of event PF. Spending for this PF totalled US$2,336,313(13.86%) and US$2,467,519 (12.10%) respectively.

Publisher, motion picture, broadcasting and programming services as a Production Factor, includes all the IEC materials and Media Campaigns. The spending in both years was less than 5%, that is, US$779,287(4.62%) in 2011/2012 and US$803,663(4.07%) in 2012/2013.

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1. BACKGROUND AND OVERVIEW OF THE COUNTRY CONTEXT

1.1 Regional Context

HIV and AIDs is recognized as a major development challenge in the Caribbean. Of the global population living with the disease, the Caribbean region is estimated to represent 0.7% of the total numbers. The Caribbean, after sub-Saharan Africa, is one of the most heavily affected regions in the HIV epidemic. Adult HIV prevalence at the end of 2012 was approximately 1% with an estimated 250,000 persons living with HIV in the region. The Caribbean region recorded the sharpest decline in the number of new HIV infections worldwide since 2001, with a reduction of over 50% from 25,000 in 2001 to 12,000 in 2012. AIDS-related deaths in the Caribbean also experienced a 46% decline moving from 24,000 in 2001 to 11,000 in 2012. The region as a whole has been able to achieve 67 percent access to antiretroviral drugs (ARVs) in the general population, and 79 percent access for pregnant women to prevent mother-to-child transmission (PMTCT) of HIV.

Overall, the main route of HIV transmission in the Caribbean is heterosexual sex, with many new infections linked with commercial sex work. Sex between men is emerging as another major route of transmission in Caribbean countries. The spread of HIV in the Caribbean has taken place against a common background of poverty, gender inequalities, lack of confidentiality and a high degree of HIV-related stigma. Cultural and behavioural patterns, such as early initiation of sexual acts, and taboos related to sex and sexuality, are also factors influencing vulnerability to HIV and AIDS in the Caribbean.

1.2 Jamaican Socio-Economic Context

Jamaica is the largest English-speaking Island in the Caribbean with a land area of 10,991 square kilometres divided into fourteen (14) parishes. The total population of 2,717,991 (STATIN 2013 population figures) is almost equally divided between males (49.5%) and females (50.5%). Jamaica is currently at the intermediate stage of demographic transition. The changes in the population are consistent with changing age structures of any population at this stage – a declining 0-14 age group, and an increasing working age population (15-64 years) and dependent elderly age group (65+ years).

Jamaica is classified as an upper middle income country. For the last two decades Jamaica's economy has been characterized by slow growth and high debt. Jamaica's debt was estimated at 146.2 percent of GDP in March 2013, making the country one of the most indebted middle income nations in the world. Government efforts to stabilize the economy yielded positive results in 2009-2011, but were set back by fiscal and environmental challenges. The International Monetary Fund (IMF) approved in May 2013 a four-year Extended Fund Facility (EFF) yielding a total support package of US$932 million to facilitate the Government of Jamaica's (GoJ) economic reform agenda to stabilize the economy, reduce debt and create the conditions for growth and resilience. In coordination with the IMF, the World Bank and the Inter-American Development Bank (IDB) have each allocated US$510 million over the same period to support these efforts.

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The country is also confronted by serious social issues, such as high levels of crime and violence and high unemployment. From the early 1990s until 2007 Jamaica achieved significant advances in reducing poverty and lowering inequality. However poverty and inequality have increased in Jamaica between 2007 and 2010. In 2010 poverty rates soared to 17.6 percent from just under 10 percent in 2007. This has been attributed to the global crisis, together with increasing food and energy prices. The unemployment rate stands at about 15.2 percent at the end of 2013 with youth unemployment at about 30 percent. However, among Jamaica's assets are its skilled labour force and strong social and governance indicators.

The GOJ's has signalled its commitment to the fight against HIV and AIDS. The MOH was allocated an overall budget of JA$34.599B (US$407,049M) in 2011/2012 and JA$32.386B (US$359,853M) in 2012/2013. The capital B portion of this amount which is purely dedicated to supporting the National HIV Programme stood at JA$1.348B (US$15.866M) and JA$1.310M (US$14.562) for the corresponding two (2) years respectively. The National HIV Programme amounts are 3.90% and 4.05% respectively of the MOH allocation respectively. The MOH has also stated in the Budget Estimates, one of its 202/2013 priorities as "continuing several programmes to mitigate the transmission of and the social and economic impact of HIV/AIDS".. These allocations reflect mainly central government funding along with formal arrangements with International Development Partners (IDPs) namely, United States Agency for International Development (USAID), International Bank Reconstruction and Development (IBRD), World Bank and the Global Fund. Additionally, these amounts are further supplemented by inputs form non-governmental organizations (NGOs) and United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), International Development Bank (IDB), European Union (EU) and Pan American Health Organisation (PAHO)/World Health Organisation (WHO).

1.3 HIV and AIDS Situation in Jamaica

Jamaica's epidemiological profile is marked by a declining burden of communicable diseases and a considerable increase in non-communicable diseases. Despite this, HIV continues to play a significant role in morbidity and mortality levels of the population and carries great financial and human resource cost to the health sector. Moreover, the epidemic threatens national productivity because the majority of cases occur in the reproductive and working age groups. Approximately 74% of all AIDS cases reported 1982 - 2012 are in the 20-49 year old age group and 86% of all AIDS cases reported 1982 - 2012 are between 20 and 59 years old.

At the end of 2012 Jamaica had a HIV prevalence rate of 1.7% of the adult population with an estimated 30,265 persons living with HIV. Since the first case of AIDS was identified in 1982, 30,620 cases of HIV have been reported to the Ministry of Health. All 14 parishes are affected by the HIV epidemic but the most urbanized parishes have the highest cumulative number of reported HIV cases.

Though the general HIV prevalence rate has remained under 2%, surveillance data show higher HIV prevalence in key populations, among men who have sex with men (MSM) (32.8%), female sex workers (SW) (4.1%), and homeless persons (12%) (Ministry of Health 2012). The main

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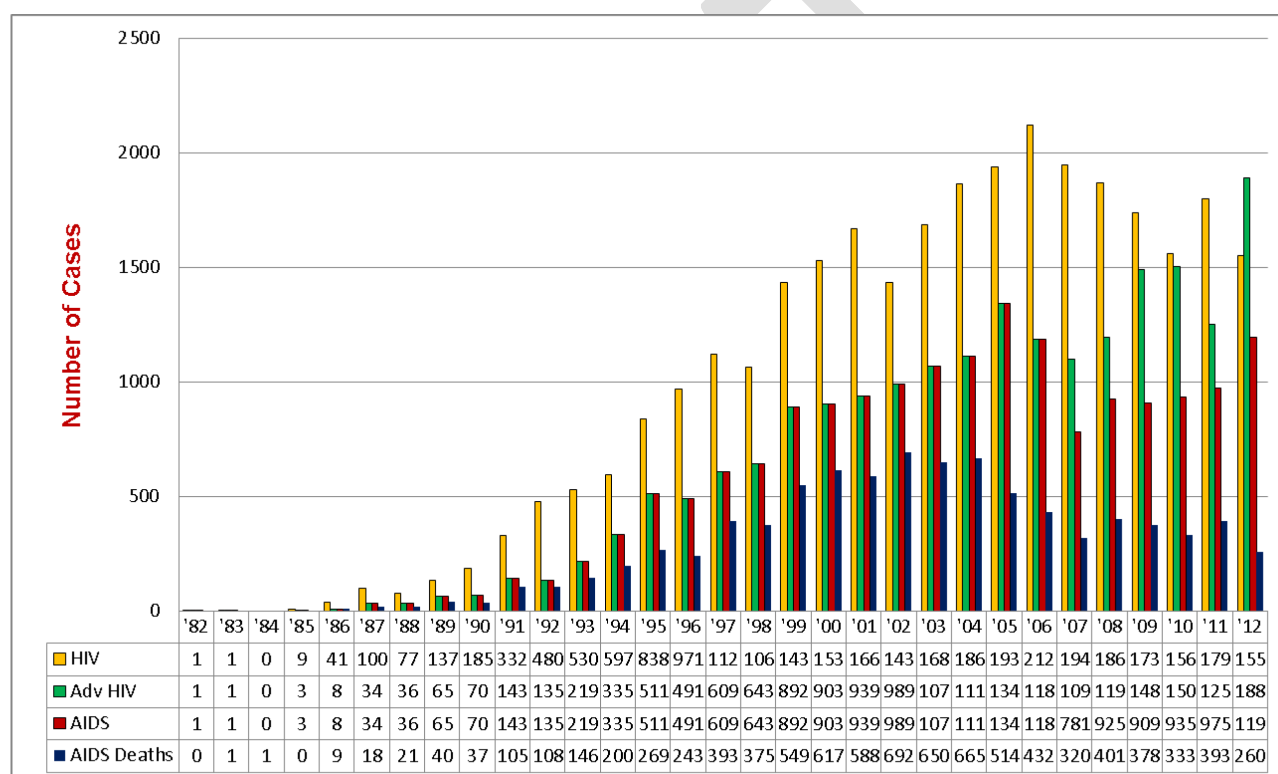
drivers of the HIV epidemic are closely tied to poverty and related development issues, including the slow rate of economic growth, high levels of unemployment, low academic achievement, early sexual debut, multiple sexual partnerships, and transactional and commercial sex.

There continues to be a decline in the number of HIV cases reported each year (Figure 1). In 2006 the largest number of HIV cases was reported at 2121. Since then there has been a steady decrease in the numbers of reported HIV cases each year. AIDS related deaths have reduced by 61% since the introduction of public universal access to ARVs in 2004. Two hundred and sixty (260) AIDS related deaths were reported in 2012 compared to 665 in 2004.

Figure 1: Reported cases and deaths annually in Jamaica, 1982 - 2012



	'82	'83	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96
HIV	1	1	0	9	41	100	77	137	185	332	480	530	597	838	971
Adv HIV	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491
AIDS	1	1	0	3	8	34	36	65	70	143	135	219	335	511	491
AIDS Deaths	0	1	1	0	9	18	21	40	37	105	108	146	200	269	243

	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12
HIV	112	106	143	153	166	143	168	186	193	212	194	186	173	156	179	155
Adv HIV	609	643	892	903	939	989	107	111	134	118	109	119	148	150	125	188
AIDS	609	643	892	903	939	989	107	111	134	118	781	925	909	935	975	119
AIDS Deaths	393	375	549	617	588	692	650	665	514	432	320	401	378	333	393	260

Though Jamaica has successful increased access to treatment and care services, analysis of data related to retention in care has shown increased loss-to-follow-up among patients on highly active antiretroviral therapy (HAART). Failure to adhere to treatment and care is a barrier to further reducing AIDS morbidity and mortality.

Jamaica has experienced great success with its prevention of mother to child transmission (PMTCT) programme. The programme which was implemented in 2004 has resulted in HIV testing of more than 95% of pregnant women and ARV treatment or prophylaxis for 85% of HIV infected mothers in the public sector in 2012. More than 98% of infants born to HIV infected women in public health sector received ARV for PMTCT. In 2012, for every one thousand pregnant women attending public antenatal clinics, at least 9 were HIV infected. In 2012, a total

of 19 paediatric AIDS cases (children 0 to 9 years old) were reported compared to 78 paediatric AIDS cases in 2005.

Among reported HIV cases on whom risk data are available, the main risk factors are multiple sex partners, history of STIs, crack/cocaine use, and sex with sex workers. 'No high risk behaviour' was reported for a notable proportion of HIV cases and this may represent persons who have one sex partner who was HIV infected by another partner.

1.4 National Response to HIV

Jamaica's national response is guided by a five (5) year National Strategic Plan for HIV/AIDS (NSP). The goal of the draft National Strategic Plan for HIV/AIDS 2012 – 2017 is to significantly reduce new HIV and STI infections and mitigate the impact of HIV on the people of Jamaica, particularly in Key Affected Populations/Most at Risk Populations (MARPs), through universal access to HIV/STI prevention, treatment, and care through an effective multi-sectoral response and an enabling, supportive environment free of stigma and discrimination. The NSP lists six areas of concentrated focus namely,

- Prevention
- Treatment, Care and Support
- Enabling Environment & Human Rights
- Governance and Empowerment
- Monitoring and Evaluation
- Sustainability.

The National HIV/AIDS Policy was developed in 2005 continues to be a key point of reference in the national response. The guiding principles of the National HIV/AIDS Policy are similar to those of the NSP and include:

- Political Leadership and Commitment
- Good Governance, Transparency and Accountability
- Multi-sectoral Approach and Partnerships
- Greater involvement of PLHIV
- Equity (including gender equality)
- Promotion and Protection of Human Rights
- Social justice
- Evidence-based interventions
- Participation of those being targeted in design of programmes
- Sustainability

Prevention

The strategies identified in the prevention area are designed to influence underlying factors that determine risky behaviour in key populations. The key populations include men who have sex with men, persons with multiple sexual partners, persons with a history of STIs, sex workers, adolescent boys and girls, youth, inmates, and homeless drug users.

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Treatment, Care and Support
This programme area aims to increase access to HIV testing as well as access to high quality multidisciplinary care for all PLHIV resulting in improved adherence and overall decreased morbidity and mortality due to HIV. Focus on improving the health systems to lessen the impact of stigma and discrimination, and providing gender-sensitive health care delivery is a main priority area for Treatment, Care and Support.

Enabling Environment and Human Rights
This component focuses on engaging policy makers, faith based organizations, people living with HIV (PLHIV) and others in the review of relevant legislation and policies and advocating for legislative change in order to reduce stigma and discrimination against key affected populations.

Governance and Empowerment
The UNAIDS “Three Ones” key principles for the coordination of national responses to HIV and AIDS which includes one national multi-sectoral strategy, one national coordination platform with a multi-sectoral mandate; and, one monitoring and evaluation framework is being applied in the Jamaica’s response to HIV/AIDS. During this reporting period, the Components of the National HIV/STI Programme were integrated into the National Family Planning Board to form one sexual and reproductive health authority now known as the National Family Planning Board-Sexual Health Agency (NFPB-SHA). A new Integrated National Strategic Plan will be developed to guide this new integrated response.

Monitoring and Evaluation
The M&E component of the national strategic plan focuses on capacity building, strengthening of data collection, implementation of electronic information systems, increased operational research and data analysis and dissemination of information for improved programme management.

Sustainability
The national HIV response in Jamaica has been primarily financed through a loan agreement with the International Bank for Reconstruction and Development (IBRD/ World Bank), grants from the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and the United States Agency for International Development President Emergency Plan for AIDS Relief (USAID/PEPFAR) with support from the Government of Jamaica (GOJ). However, Jamaica’s reclassification as an upper middle-income country by the World Bank has affected the country’s ability to qualify for international aid from some sources, which has implications for the sustainability of various government programmes, including health (PIOJ, 2004). The major response strategy for sustainability of the national programme hinges on allocative efficiency: paying particular attention to allocating scarce HIV/AIDS resources more effectively, to ensure resources target those at highest risk of transmitting HIV and geographic areas of high transmission, with proven, cost-effective interventions aligned to epidemic context.

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2. STUDY DESIGN AND METHODOLOGY

2.1 Context for the Assessment

Jamaica in its effort to monitor and evaluate the national response to HIV and AIDS and achieve the financing goals set out in the 2001 UNGASS Declaration and fulfil the requirements of the HIV spending at the country level in accordance with GARP indicator 6.1, decided to track the flow of financial resources from financing source to beneficiary population. The data collected through this process is used to measure national commitment and action, an important component of the UNGASS Declaration.

With support from UNAIDS, the NHP has undertaken a National AIDS Spending Assessment (NASA). NASA 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 contributing to 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 NASA also allows for comparison of results across countries.

The argument for conducting a NASA in Jamaica is further strengthened as two of the key financing arrangements have expired: the World Bank No. 7556-JM in October 2012 and Global Fund Round 7 in July 2013. At present Global Fund support continues through the Transitional Funding Model (TFM) for a 2 year period and is limited to key populations. Also, the PEPFAR Caribbean Regional Programme under which Jamaica receives financial support expires in 2015.

Against the background of the country's contracting economy, the global financial crisis and the reduction in external funding, a major concern is the potential loss of gains due to challenges in the wider health system which limits the full integration and expansion of HIV services necessary to achieve and maintain sustainability.

Sustainability of the national response to HIV will depend largely on, and can only be achieved through careful costing of the national strategic plan, documentation of the human resources needs for sustainability of programmes, negotiation with the Ministry of Health and other relevant ministries for absorption of essential posts, negotiation with external donors for additional funds, and increased allocations in the MOH recurrent budget for the HIV/STI programme. The NASA is expected to inform these processes.

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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, an assessment of this nature, is appropriate at this time.

2.2 NASA Design and Methodology

NASA is based on standardized methods, definitions and accounting rules of the globally available and internationally accepted System for National Accounts (SNA), National Health Accounts (NHA) and National AIDS Accounts (NAA). NASA follows the basic framework and templates of the National Health Accounts, but is not limited to health expenditures. It embraces other expenditures to track the multi-sectorial response to HIV and AIDS.

The NASA methodology seeks to provide answers to six different questions:

1. Who finances the AIDS response?
2. Who manages the funds?
3. Who provides the services?
4. Which intervention was provided?
5. Who benefits from the funds?
6. What was bought to realize the intervention?

To answer these questions, the NASA methodology reconstructs all the financial transactions related to the national response to the HIV and AIDS epidemic. 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:

1. The **financing sources (FS)** are entities that make available the funds to finance the HIV and AIDS services (e.g. PEPFAR, the Global Fund, Public sources, out of pocket expenditures).
2. 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.
3. The **providers (PS)** are entities that engage in the production, provision, and delivery of HIV and AIDS services. They carry out the different interventions.
4. The **production factors (PF)** are the resources bought to produce the interventions (e.g. wages, services, consumables, capital).
5. The **AIDS Spending Categories (ASC)** are the activities and services provided as the multi-sectorial response to HIV and AIDS (e.g. prevention, care and treatment, OVC, social mitigation, research).
6. The **Beneficiary population (BP)** are the intended part of the population benefiting from a specific intervention (e.g. PLWH, most at risk populations, general population)

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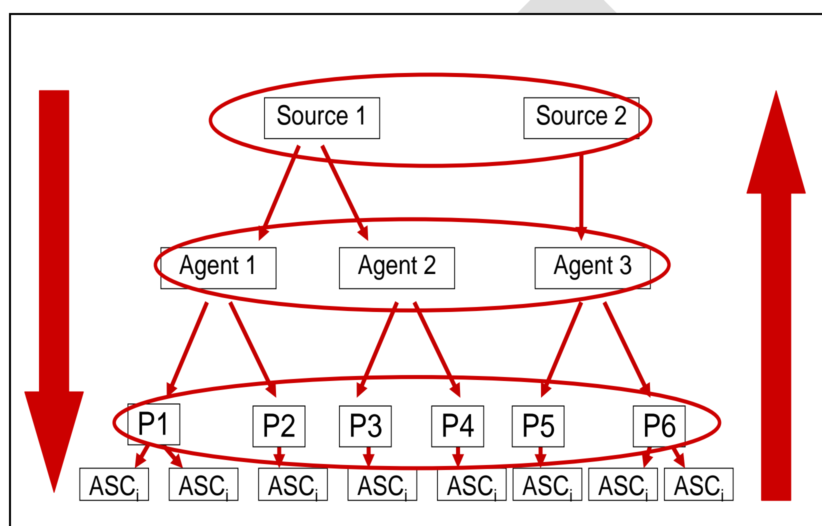
2.2.1 Approach

NASA reconstructs all the transactions to report the actual spending, consumption and delivery of service 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" approach** to estimate 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 2: NASA Methodology, Top-down and Bottom-up Approach



The 2011-2013 NASA in Jamaica was guided by a NASA Task Force consisting of representatives from the MOH Monitoring and Evaluation Unit, UNAIDS and two local NASA consultants. The Tasks Force provided supervision and overall guidance for the execution of the assignment. The group met on an ongoing basis as the need arose, and the Lead Consultant provided regular updates to the Task Force via email and telephone.

The Jamaica NASA Process involved several phases. These include:

Phase 1: Preparatory activities
Phase 2: Sensitization of NASA participants & Dispatch of Data Collection Tool
Phase 3: Data collection
Phase 4: Data Entry, Data Processing and Database updating
Phase 5: Data Analysis
Phase 6: Completion of Draft & Final Reports

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2.2.2 Preparatory Activities

During this phase the NASA Tasks Force met to discuss the scope of the assignment, gaps from the previous NASA to be addressed, logistics for a training to refresh select participating entities and the way forward for executing the current NASA. The Preparatory phase also entailed a review of the Guideline Manuals, and finalization of the data collection tool.

2.2.3 Sensitization of NASA Participants & Dispatch of Data Collection Tool

All approved participating entities received formal correspondence notifying them of the NASA exercise with the data collection tool accompanying this correspondence. Representatives from the four (4) Regional Health Authorities (RHA), five (5) Civil Society Organizations and representatives of the National HIV/STI Programme and National Family Planning Board participated in a sensitization and refresher training exercise on 14th and 15th April 2014. A total of seventeen (17) persons participated in the training which was facilitated by the two consultants. The training focused on: (1) Understanding the data collection tool (2) Presentation of basic information on NASA, including the NASA codes and the purpose of conducting a NASA exercise. (3) Developing Estimates (4) Defining Assumptions. The training was also used to enhance institutional strengthening and capacity building for future NASA.

2.2.4 Data Collection

Data collection was scheduled for an initial period of 6 weeks. However, following the workshop a second data collection tool to capture additional data was developed and the submission time extended for this particular tool. Responses were slow and low during the initial 6 weeks period, and collection continued into the third week of August to facilitate inclusiveness and comprehensive reporting from majority of the stakeholders engaged. Follow up was done through emails, telephone calls and face to face meetings in order to assist in the completion of the data collection tool. Table 1 shows the response rate of organizations/institutions targeted for the HIV and AIDS expenditure data collection and appendix 1 shows the targeted organizations/institutions and the status of data collected. Overall, the study had an 81% response rate. The participating institutions were grouped into the following categories; Government Sector, International Development Partners, NGOs /CSOs /FBOs and Private Sector.

Table 1: Response Rate of Organizations/Institutions Targeted

Type of Organization/ Institution	Targeted	Responded	Response Rate
Government Sector	19	16	84%
International Development Partners	15	12	80%
NGOs / CSOs / FBOs	47	36	77%
Private Sector *	14	13	93%
TOTALS	**95**	**77**	**81%**

* Six (6) of the Private Sector respondents had no data to report

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2.2.5 Data Entry, Data Processing and Database updating

The majority of stakeholders provided their data via the data collection tool. However, the Ministry of Health / National HIV/STI Programme, as well as a few other stakeholders, provided either copies of their general ledger (GL) or excel spreadsheets rather than use of the tool provided. For the organizations that provided GL, the expenditures had to be summarized ahead of data entry. This resulted in significant delay in the completion of data entry. Once summarised, all the data collected was transferred and captured in the NASA Microsoft Excel database using the NASA codes.

As a part of the triangulation, checks and balances were performed to verify the figures as far as possible, to ensure the validity of the data from source, the agents and the providers, and also to avoid double counting.

2.2.6 Data Analysis

After the data is entered in the NASA database, matrices, pivot tables and charts were generated to produce the results related to spending categories, including financial agents, service providers and resources on which HIV funds were expended.

The database will be submitted to the MOH/UNAIDS. The matrices are also included as a part of this report. The matrices which were analysed per year include:

1. Financing Sources (FS) x Financing Agents (FA) 2012 & 2013
2. Financing Sources (FS) x AIDS Spending Categories (ASC) 2012 & 2013
3. Financing Agents (FA) x AIDS Spending Categories (ASC) 2012 & 2013
4. Financing Agents (FA) x Providers of Services (PS) 2012 & 2013
5. Financing Agents (FA) x Beneficiary Populations (BP) 2012 & 2013
6. AIDS Spending Categories (ASC) x Beneficiary Populations (BP) 2012 & 2013
7. Providers of services (PS) x Production Factors (PF) 2012 & 2013
8. Providers of services (PS) x AIDS Spending Categories (ASC) 2012 & 2013
9. AIDS Spending Categories (ASC) x Production Factors (PF) 2012 & 2013
10. The UNGASS Matrix / Indicator n°1

2.2.7 Completion of Draft and Final Reports

The NASA report was completed in draft format for review and feedback by the NASA Task Force and key stakeholders. The comments and feedback received were incorporated to produce the final report.

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3. Findings – NASA Estimation

3.1 Financing Sources (FS)

In excess of thirty-five distinct entities were captured as funding source to Jamaica's National HIV Response in each of the fiscal periods under review. The financial results of the National AIDS Spending Assessment estimates that the total spending on HIV and AIDS related activities in Jamaica were JA$1,432,375,592 (US$16,851,445) and JA$1,834,140,422 (US$20,392,492) for the fiscal periods 1st April 2011 to 31st March 2012 and 1st April 2012 through to 31st March 2013 respectively. Table 2 is a representation of the amount by Financing Sources. Over the two years period, it shows a growth of 2.74% in Public Sector Funds spent, 8.52% in Private Sector spending and 29.72% for International Funds. This represents an overall increase of 21.01% in funds expended in the fiscal year ending 2013, over the 2012 corresponding period. Figure 3 is a graphical representation which compares the US$ value of each of the Financing Source for both years under review. Coincidentally, Financing Sources are entities that provide money to Financing Agents to be pooled and distributed in support to the response of the HIV epidemic in countries.

Table 2: Financing Sources for HIV and AIDS Expenditure, 2011/2012 - 2012/2013 (US$)

Source	2011/2012	%	2012/2013	%	% change in financing source
Public Funds	3,706,165	21.99	3,807,538	18.67	2.74
Private Funds	2,203,668	13.08	2,391,429	11.73	8.52
International Funds	10,941,612	64.93	14,193,526	69.60	29.72
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**	**21.01**

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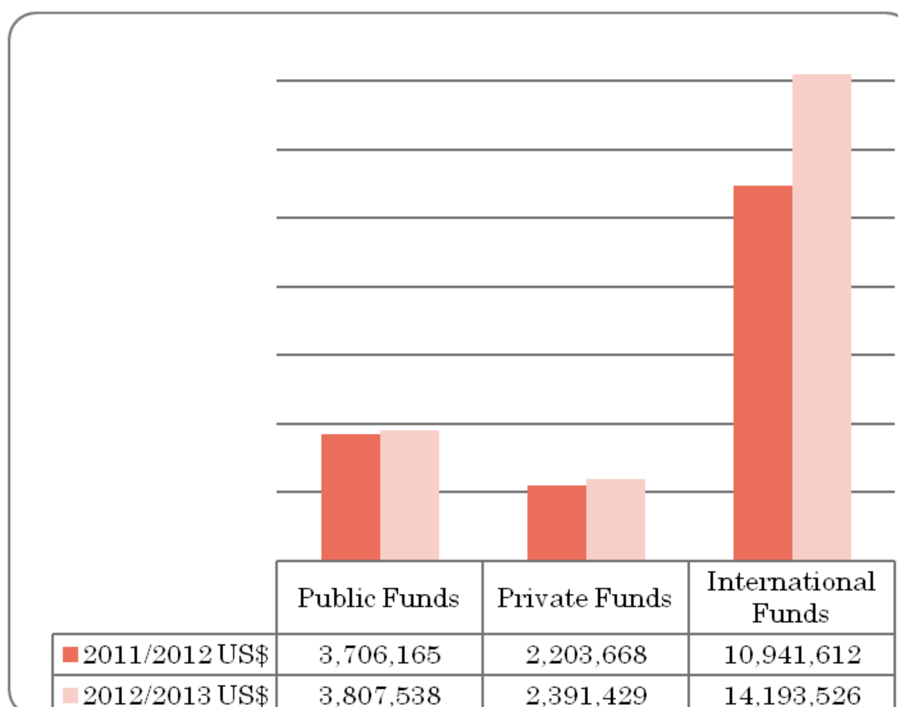
Figure 3: Financing Sources (FS) for HIV and AIDS 2011/2012 – 2012/2013



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Public Funds

Public Funds in support of the National HIV Response represents 21.99% and 18.67% of the overall spent by Financing Source, that is a movement from US$3,706,165 to US$3,807,538, for the fiscal period 2011/2012 and 2012/2013. The Public Funds were mainly a combination of counterpart resources (Government of Jamaica contribution) to projects supported by the World Bank loan and United States Agency for International Development (USAID), central government funding from the Ministry of Youth and Culture and the World Bank loan resources. The classification of World Bank Loan resources as public funds is a follow on from the previous NASA of 2009-2011 and is in tandem with the Global Fund classification of loans funds. In effect, the loan resource is an obligation of the Government of Jamaica, which has to be re-paid at a future date. The breakdown of the public funds is shown in Table 3.

Table 3: Public Sector HIV and AIDS Spending, 2011/2012 - 2012/2013 (US$)

Public Funding Sources:	2011/2012	2012/2013
Central Government	1,137,570	1,081,171
World Bank Loan	2,568,595	2,726,367
Total	**3,706,165**	**3,807,538**

Private Funds

Private funds as a Financing Source, reported as spent US$2,203,668 and US$2,391,429 for the years under review. The amounts analysed from respondents were dominated by spending on condoms by a Private Pharmaceutical Distribution Company, Cari-Med Limited, the amounts spent being estimated at US$1,283,671 for 2011/2012 and US$1,561,783 for 2012/2013. The spiralling of the condom expenditure by 21.67% in year two (2) of the assessment is the single most impactful transaction on Private Funds dollar value growth, as other sending such as within the Insurance Companies and Private Laboratories on HIV test done saw an overall decrease of 13.50% over the two (2) years period.

The amounts spent on condoms by Cari-Med Limited represents 58.25% and 65.31% respectively of total Private Funds for the years being reviewed. Spending on HIV Tests done by private laboratories and two (2) high ranking Insurance Companies, Sagicor Life Jamaica and Guardian Life Limited, also formed significant portions of the Private Funds for the two years period. Table 4 depicts the level of spending from these two (2) private categories.

Table 4: Insurance Companies & Private Laboratories HIV and AIDS Spending 2011/2012 - 2012/2013 (US$)

Funding Source:	2011/2012	%	2012/2013	%	% change in funding source
Insurance Companies	173,934	22.09	111,039	16.30	-36.16
Private Laboratories	613,465	77.91	570,098	83.70	-7.07
Grand Total	**787,398**	**100.00**	**681,137**	**100.00**	**-13.50**

Generally speaking, the Private Sector as a Financing Source and its spending in both fiscal periods exceeded 10% of the entire amounts recorded, standing at 13.08% in the fiscal period ending 2012 and 11.73% for the period ending 2013.

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International Funds

Table 5: International Funds by Type as FS for Jamaica's National HIV Response 2011/2012 - 2012/2013 (US$)

Types of International Funds	2011/2012	%	2012/2013	%	% change in funding source amount
Direct Bilateral Contributions	3,360,181	30.71	4,527,211	31.90	34.73
Multilateral Agencies	7,208,344	65.88	9,043,610	63.72	25.46
International non-profit-making organizations and foundations	355,439	3.25	577,417	4.07	62.45
International profit-making organizations	16,471	0.15	43,621	0.31	164.84
International funds n.e.c	1,176	0.01	1,667	0.01	41.67
Total	**10,941,612**	**100.00**	**14,193,526**	**100.00**	**29.72**

International Funds represents the largest tranche of Financing Source, supporting Jamaica's HIV response. Direct bilateral contributions which represent mainly the Government of the United States spending through the PEPFAR mechanism with the United States Agency for International Development (USAID) spent in excess of 30% of International Funds in both fiscal periods. Multilateral agencies, which includes the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the UN agencies such as UNAIDS, UNICEF, UNDP, UNFPA, UNESCO and UNIFEM among others are the largest FS and spenders. Multilateral agencies spending increased by 25.46% over the two fiscal year periods from US$7,208,344 to US9,043,610.

Of the International Funds expended, the GFATM and the Government of the United States have incurred the largest proportions in both fiscal periods being examined. In the fiscal period 1st April 2012 to 31st March 2013, the last year of the study, the GF and the Government of the United States spending stood at US$8,271,933 and US$4,527,211 respectively. These are the largest of all the financing sources and the amounts represent 40.56% and 22.22% of the overall amount spend for the year. Of note though is the significant increase in amounts spent on Antiretroviral Drugs by the GFATM in fiscal period ending 2013, US$3,249,777 compared to US$764,453 the previous fiscal period. This has directly caused the multilateral agencies increase in spending in 2012/2013.

Philanthropic organizations, Universities, other non-profit making organizations and foundations spent just under 5% of total international funds within each of the two (2) fiscal periods. A commercial bank, Scotia Bank Limited, with headquarters outside of Jamaica, from which the funds originated (FS), spent 0.15% and 0.31% of total international funds for the two (2) fiscal periods respectively.

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3.2 Financing Agents (FA)

Financing Agents are the recipient of financial resources collected from different financial sources, which are subsequently transferred to finance a program or as a payment to the providers of services or goods. Financing Agents (FA) in effect are the organizations that make the programmatic decisions on the use of funds. Financing Agents to the Jamaica National HIV response cross cuts the public sector, the private sector and international purchasing organizations in the form of bilateral agencies, multilateral agencies and international non-profit making organizations and foundations.

The **public sector** represents the largest Financing Agent that spent resources towards the National HIV response in Jamaica for both fiscal periods, with amounts of US$11,264,510 in 2011/2012 and US$14,258,235 in 2012/2013. These amounts represent 66.85% and 69.92% respectively of total amounts spent by Financing Agents. The organizations that responded to the study and were considered Public Sector includes Ministry of Health - National HIV Programme, which leads the implementation of Jamaica's National Response and spent US$10,861,313 in 2011/2012 and US$13,723,380 in 2012/2013, an increase of 26.35%, Ministry of Labour and Social Security (MLSS), Ministry of Youth (MoY), National Health Fund(NHF), Jamaica Social Investment Fund (JSIF) that supported an intervention undertaken by Hope World Wide Jamaica.

Financing Agents of the **private sector** spent US$2,235,779 (13.27%) and US$2,517,515 (12.35%) respectively over each of the two (2) fiscal periods under review. Private sector entities that participated in the study includes Cari-Med Limited, that spent the highest, US$1,561,783 and US$1,283,671 annually on Condoms in the years being studied. This category of Financing Agents also includes private laboratories and the cost associated with HIV test done along with the two prominent insurance companies, Sagicor Life Jamaica and Guardian Life Ltd that require mandatory HIV test for prospective policy holders. Table 6 shows the spending by Financing Agents, which is a pictorial view of the Public sector dominating the programmatic decisions of Jamaica's National Response.

Table 6: Financing Agents for HIV and AIDS Expenditure, 2011/2012 - 2012/2013 (US$)

Financing Agents	2011/2012	%	2012/2013	%
Public Sector	**11,264,510**	**66.85**	**14,258,235**	**69.92**
Private Sector	**2,235,779**	**13.27**	**2,517,515**	**12.35**
International Purchasing Organization	**3,351,157**	**19.89**	**3,616,741**	**17.74**
Bilateral Agencies	**1,532,051**	**9.09**	**1,654,864**	**8.12**
Multilateral Agencies	**1,122,435**	**6.66**	**771,677**	**3.78**
International non-profit making organizations and foundations	**696,671**	**4.13**	**1,190,201**	**5.84**
Grand Total	**16,851,445**	**100**	**20,392,492**	**100**

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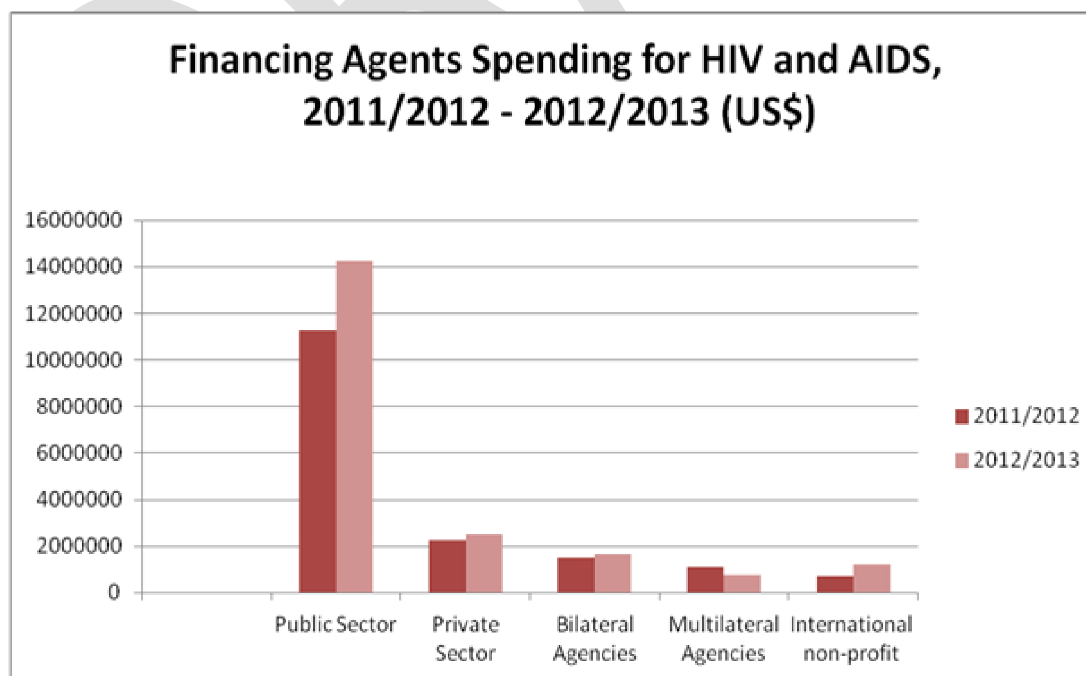
Bi-lateral Agencies were Financing Agents for 9.09% and 8.12%, respectively of amounts spent in 2011/2012 and 2012/2013 fiscal years. The Government of the United States is the Bilateral Agency that serves as a Financing Agent to the National HIV Response. Specific entities under this umbrella includes USAID, CDC and US Peace Corp. These entities have a country level presence in Jamaica and the amounts represent mainly there Staff and Administrative Cost to operate.

As a Financing Source (FS), Multilateral Agencies were the biggest contributor to Jamaica's National HIV Response mainly because of the Global Fund contribution. However as a Financing Agent (FA), Multilateral agencies only recorded US$1,122,435 (6.66%) and US$771,677 (3.78%) for the fiscal periods 2011/2012 and 2012/2013. The key point of note here is the Global Fund, the largest multilateral funder, is not a Financing Agent to Jamaica's National HIV Response. The Global Fund does not have a country-level presence, therefore are no associated staff and administration cost to the National HIV response. Even though the Global Fund hires a Local Fund Agent to oversee, verify and report on grant performance, the Local Fund Agent is not permitted to undertake any programmatic decisions and no funds flow directly to them as a part of the National response. Majority of the Global Fund resources as a Financing Source flows to the MoH-NHP, the Financing Agent.

International non-profit organizations and foundations as Financing Agents includes, Futures Group/HPP, FHI360, World Learning, MAC AIDS Funds, AIDS Free World and Circle of Hands foundation. Figure 4 is a graphical representation of Financing Agents spending for the two (2) years of assessment.

Figure 4: Financing Agents Spending for HIV and AIDS, 2011/2012 – 2012/2013



A detailed tabular depiction of Fiancing Agents is displayed below (Table 7), showing further information on Public, Private, Bi-lateral, Multilateral and International non-profit making orgainzations and foundations.

Table 7: **Financing Agents Spending for HIV and AIDS, 2011/2012 - 2012/2013 (US$)**

Financing Agents	2011/2012	%	2012/2013	%
Public Sector	**11,264,510**	**66.85**	**14,258,235**	**69.92**
Ministry of Health (or equivalent sector entity)	11,001,019	65.28	13,955,178	68.43
Ministry of Labour (or equivalent sector entity)	52,681	0.31	49,667	0.24
Other ministries (or equivalent sector entities)	183,294	1.09	222,222	1.09
Parastatal organizations	27,515	0.16	31,168	0.15
Private Sector	**2,235,779**	**13.27**	**2,517,515**	**12.35**
Private insurance enterprises (other than social insurance)	173,934	1.03	111,039	0.54
Private households' (out-of-pocket payments)	1,412	0.01	2,353	0.01
Not-for-profit institutions (other than social insurance)	61,773	0.37	107,252	0.53
Private non-parastatal organizations and corporations (other than health insurance)	1,970,156	11.69	2,276,861	11.17
Other private financing agents n.e.c.	28,505	0.17	20,010	0.10
International Purchasing Organization	**3,351,157**	**19.89**	**3,616,741**	**17.74**
Bilateral Agencies	**1,532,051**	**9.09**	**1,654,864**	**8.12**
Government of United States	1,532,051	9.09	1,654,864	8.12
Multilateral Agencies	**1,122,435**	**6.66**	**771,677**	**3.78**
UNAIDS Secretariat	456,555	2.71	262,993	1.29
United Nations Children's Fund (UNICEF)	538,630	3.20	411,206	2.02
United Nations Development Fund for Women (UNIFEM)	657	0.00	-	0.00
United Nations Development Programme (UNDP)	-	0.00	32,446	0.16
United Nations Population Fund (UNFPA)	104,936	0.62	27,454	0.13
Other Multilateral entities n.e.c.	21,657	0.13	37,578	0.18
International non-profit making organizations and foundations	**696,671**	**4.13**	**1,190,201**	**5.84**
International HIV/AIDS Alliance	10,011	0.06	-	0.00
International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies	11,000	0.07	-	0.00
Other International not-for-profit organizations n.e.c.	675,660	4.01	1,190,201	5.84
Grand Total	**16,851,445**	**100**	**20,392,492**	**100**

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3.3 Financing Sources to Financing Agents (FS) X (FA)

In this section we will examine a cross matrices of Funding Sources versus Funding Agents. Basically what this highlight is, the origination and type of financing (FS), supporting the various entities by type, i.e. the Financing Agents (FA) participating in the National HIV response in US$ value. Tables 8 and 9 show the cross matrix for 2011/2012 and 2012/2013 respectively.

Table 8: Financing Sources to Financing Agents, 2011/2012 (US$)

		Financing Sources							
	Financing Sources to Financing Agents	**Public Funds**	**Private Funds**	**Direct Bilateral contribution**	**Multilateral Agencies**	**Int'l non profit making organization and foundation**	**Int'l profit making organization**	**Int'l funds n.e.c**	**Total**
Financing Agents	**Public Sector**	3,706,165	-	1,479,328	6,063,595	15,421	-	-	11,264,510
	Private Sector	-	2,203,668	-	15,640	-	16,471	-	2,235,779
	Bilateral Agencies	-	-	1,532,051	-	-	-	-	1,532,051
	Multilateral Agencies	-	-	-	1,122,435	-	-	-	1,122,435
	International non-profit making organizations and foundation	-	-	348,802	8,905	337,787	-	-	695,494
	International profit making organization								-
	Other International financing agents							1,176	1,176
	Grand Total	**3,706,165**	**2,203,668**	**3,360,181**	**7,210,576**	**353,208**	**16,471**	**1,176**	**16,851,445**

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The Public Sector received funding from four (4) financing sources (FS) totalling US$11,264,510 (66.85%) and US$14,258,235(69.9%) in fiscal periods 2011/2012 and 2012/2013 respectively. The Public Sector, which includes the NHP which leads Jamaica's National HIV Response, has been financed by:

- Public Funds, totalling 32.90% and 26.70% of the amounts for each year,
- Bi-lateral funds of 13.13% and 15.64% of the total amounts,
- Multilateral funds the largest supporter to the public sector, financing 53.83% and 57.44% of the full amounts directed to the Sector.
- International non-profit making organizations that spent 0.14% and 0.22%, respectively.

Table 9: Financing Sources to Financing Agents, 2012/2013 (US$)

		Financing Sources							
	Financing Sources to Financing Agents	**Public Funds**	**Private Funds**	**Direct Bilateral contribution**	**Multilateral Agencies**	**Int'l non-profit making organization and foundation**	**Int'l profit making organization**	**Int'l funds n.e.c**	**Total**
Financing Agents	**Public Sector**	3,807,538	-	2,230,062	8,189,467	31,168			14,258,235
	Private Sector		2,391,429		82,465		43,621		2,517,515
	Bilateral Agencies			1,429,864		225,000			1,654,864
	Multilateral Agencies				771,677				771,677
	International non-profit making organizations and foundation			867,285		321,249			1,188,534
	International profit making organization								-
	Other International financing agents							1,667	1,667
	Grand Total	**3,807,538**	**2,391,429**	**4,527,211**	**9,043,610**	**577,417**	**43,621**	**1,667**	**20,392,492**

The Private Sector as a Financing Agent received and spent from Private funds 98.56% and 94.99% respectively of the total expended in the sector.
Multilateral Agencies were the direct source for all the funds expended by Multilaterals as a Financing Agent in both periods.

For both years, International non-profit organizations as a sector and Financing Agent received their funding mainly from Direct Bilateral and International non-profit making organizations and foundations.

3.4 AIDS Spending Categories (ASC)

The AIDS Spending Categories of the National HIV and AIDS response for the purposes of the NASA study are broken down into eight (8) functional classifications as displayed in Table 10 below. This is where the interventions and activities are rolled out and spending is concentrated based on the objectives of the NSP. Spending was dominated in three (3) of the eight (8) functional areas, namely, Prevention, Care and Treatment, and Programme Management and Administration. Of the total amounts captured as spent in the study the totals of the three (3) classifications represents 93.36% for 11/12 and 92.82% for 12/13. Spending in all the other five

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(5) functional classifications represented less than 2% each in both years with the exception of Human Resources which amounted to 3.67% in 2012/2013.

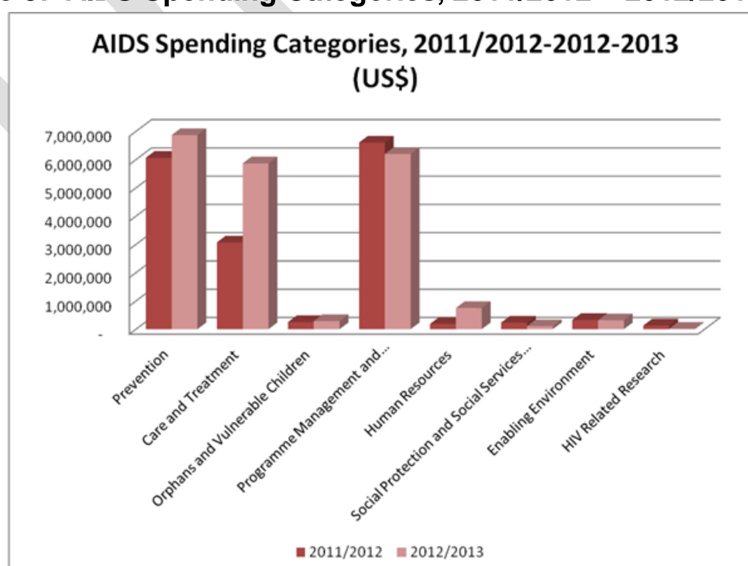
Spending year on year increased in two (2) of the three (3) major spending areas identified, that is Prevention grew by 13.23% between 11/12 and 12/13 and Care and Treatment by a massive 91.13% resulting from the high amounts spent on ARV in 12/13 versus 11/12. Total spend on the functional area of Programme Management, while sitting in excess of 30% of the total each year under assessment, saw a decline of 6.12% from US$6,599,214 in 11/12 to US$6,195,537 in 12/13.

Table 10: Total Spending on AIDS Spending Categories, 2011/2012-2012-2013 (US$)

AIDS Spending Categories	2011/2012	%	2012/2013	%	% change in ASC
Prevention	6,063,711	35.98	6,865,831	33.67	13.23
Care and Treatment	3,068,996	18.21	5,865,810	28.76	91.13
Orphans and Vulnerable Children	248,885	1.48	284,640	1.40	14.37
Programme Management and Administration	6,599,214	39.16	6,195,537	30.38	-6.12
Human Resources	186,517	1.11	748,941	3.67	301.54
Social Protection and Social Services (excluding OVC)	231,379	1.37	103,582	0.51	-55.23
Enabling Environment	325,347	1.93	313,574	1.54	-3.62
HIV Related Research	127,396	0.76	14,578	0.07	-88.56
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**	21.01

Figure 5 depicts a comparison of the AIDS Spending Categories (ASC) for the two fiscal periods under review.

Figure 5: AIDS Spending Categories, 2011/2012 – 2012/2013 (US$)



In the proceeding paragraphs the AIDS Spending Categories (ASC) by Financing Sources (FS) will be examined in further details for the fiscal periods 2011/2012 and 2012/2013.

Tables 11 and 12 and Figures 6 and 7 present findings on the AIDS Spending Categories by Funding Source for the fiscal periods 2011/2012 and 2012/2013 respectively.

Table 11: Spending Priorities by Funding Source, 2011/2012(US$)

AIDS Spending Categories	Public Sector	%	Private Sector	%	International Organization	%	Grand Total
Prevention	767,422	12.66	1,289,189	21.26	4,007,101	66.08	6,063,711
Care and Treatment	145,284	4.73	652,368	21.26	2,271,344	74.01	3,068,996
Orphans and Vulnerable Children	183,294	73.65	39,035	15.68	26,555	10.67	248,885
Programme Management and Administration	2,495,904	37.82	198,793	3.01	3,904,517	59.17	6,599,214
Human Resources	104,886	56.23	-	0.00	81,631	43.77	186,517
Social Protection and Social Services (excluding OVC)	59	0.03	10,283	4.44	221,037	95.53	231,379
Enabling Environment	9,316	2.86	14,000	4.30	302,031	92.83	325,347
HIV Related Research	-	0.00	-	0.00	127,396	100.00	127,396
Grand Total	**3,706,165**	**-**	**2,203,668**		**10,941,612**		**16,851,445**

Table 12: Spending Priorities by Funding Source, 2012/2013 (US$)

Key Areas of Expenditures	Public Sector	%	Private Sector	%	International Organization	%	Grand Total
Prevention	699,434	10.19	1,578,111	22.98	4,588,287	66.83	6,865,831
Care and Treatment	133,000	2.27	627,963	10.71	5,104,847	87.03	5,865,810
Orphans and Vulnerable Children	222,222	78.07	37,222	13.08	25,196	8.85	284,640
Programme Management and Administration	2,550,308	41.16	116,203	1.88	3,529,025	56.96	6,195,537
Human Resources	90,987	12.15	-	0.00	657,954	87.85	748,941
Social Protection and Social Services (excluding OVC)	-	0.00	17,889	17.27	85,693	82.73	103,582
Enabling Environment	20,830	6.64	14,041	4.48	278,702	88.88	313,574
HIV Related Research	-	0.00	-	0.00	14,578	100.00	14,578
Grand Total	**3,716,782**		**2,391,429**		**14,284,281**		**20,392,492**

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Figure 6: AIDS Spending Categories by Financing Source, 2011/2012 (US$)

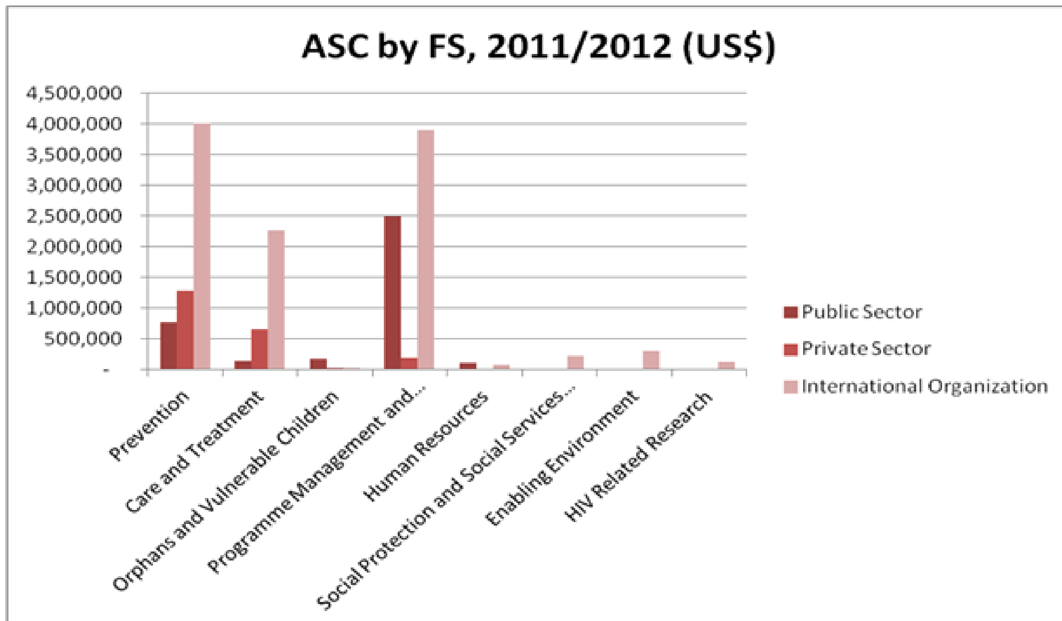
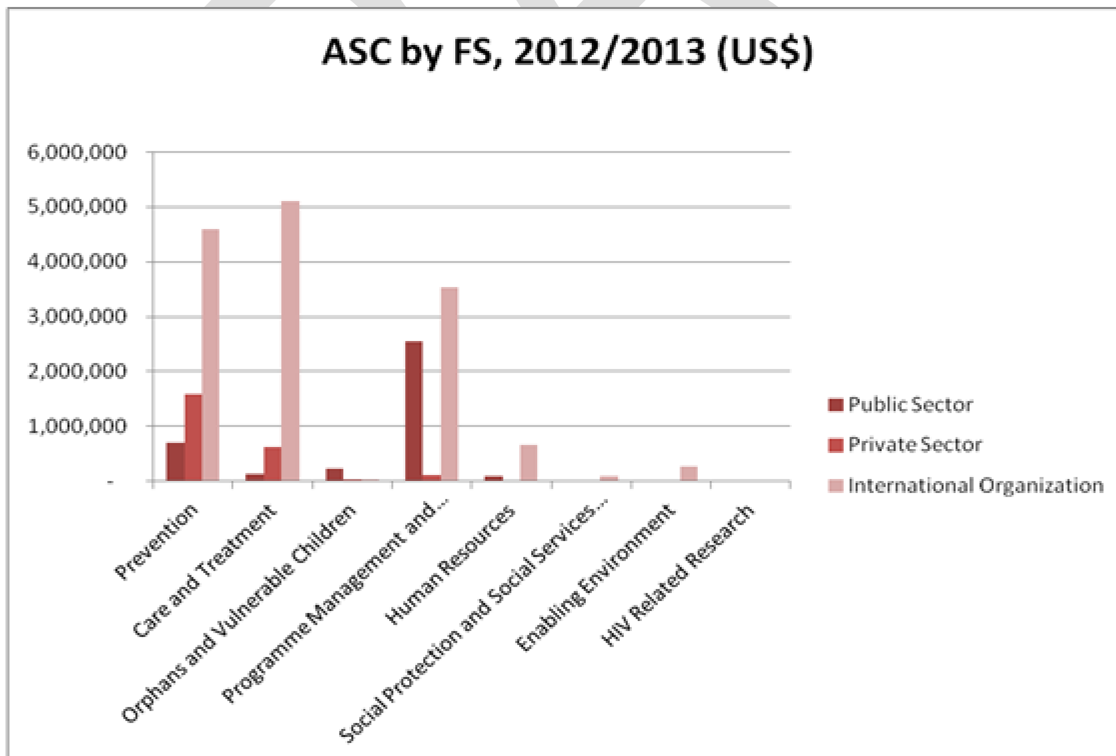


Figure 7: AIDS Spending Categories by Financing Source, 2012/2013 (US$)



Prevention

International Funds represents 66.08% or US$4,007,101 of the full amount expended on Prevention functional areas for the fiscal period 2011/2012. This was followed by 21.26% or US$1,289,189 of Private Funds and 12.66% or US$767,422 of Public Funds. The trend was similar for 2012/2013 with the allocation spent reading as follows, US$4,588,287 (66.83%), Public funds US$1,578,111 (22.98%) and Public US$699,434 (10.19%).

Public Funds and International Funds covered several interventions. Intervention activities are wide ranging and included Health related communication for social and behaviour change, community mobilization, Voluntary Counselling and Testing, Risk Reduction for Vulnerable and Accessible population, condom provision, Prevention activities for in school and out of school youth, programme for Sex Workers and their clients, Men Having Sex with Men and Drug users. In 2011/12, 99.57% of the Private Funds which supported of the Prevention functional area related to Condom expenditure by a sole corporate company, that is US$1,283,671 and in 2012/2013 this similar expenditure was estimated to be US$1,561,783 or 98.97% of Private Funds for the Prevention functional area.

Table 13: Prevention Spending Activities, 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
Health-related communication for social and behavioural change	361,388	5.96	316,361	4.61
Non-health-related communication for social and behavioural change	-	0.00	1,111	0.02
Communication for Social and behavioural change not disaggregated by type	668,141	11.02	753,274	10.97
Community mobilization	613,402	10.12	459,966	6.70
Voluntary counselling and testing (VCT)	49,637	0.82	43,805	0.64
Risk Reduction for Vulnerable and Accessible Populations	376	0.01	9,779	0.14
VCT as part of programmes for vulnerable and accessible populations	186,391	3.07	219,722	3.20
Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	127,111	2.10	290,070	4.22
Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	212,111	3.50	279,128	4.07
Programmatic interventions for vulnerable and accessible population not disaggregated by type	1,006,800	16.60	1,001,320	14.58
Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c.)	513,201	8.46	490,000	7.14
Prevention – youth in school	131,936	2.18	38,610	0.56
Prevention – youth out-of-school	178,541	2.94	85,810	1.25
Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV	93,837	1.55	17,530	0.26

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AIDS Spending Categories	2011/12	%	2012/2013	%
Prevention of HIV transmission aimed at PLHIV not broken down by type	-	0.00	13,661	0.20
VCT as part of programmes for sex workers and their clients	-	0.00	8,721	0.13
Behaviour change communication (BCC) as part of programmes for sex workers and their clients	53,693	0.89	3,123	0.05
Programmatic interventions for sex workers and their clients not disaggregated by type	22,072	0.36	15,718	0.23
Other programmatic interventions for sex workers and their clients, n.e.c.	- 6	0.00	8,268	0.12
Behaviour change communication (BCC) as part of programmes for MSM	47,344	0.78	14,956	0.22
Programmatic interventions for MSM not disaggregated by type	255,302	4.21	935,257	13.62
Programmatic interventions for IDUs not disaggregated by type	43,362	0.72	24,378	0.36
Other programmatic interventions for IDUs, n.e.c.	9,773	0.16	-	0.00
Behaviour change communication (BCC) as part of programmes in the workplace	27,581	0.45	2,423	0.04
ASC.01.12 Condom social marketing	1,283,671	21.17	1,582,894	23.05
Pregnant women counselling and testing in PMTCT programmes	20,386	0.34	15,275	0.22
PMTCT not disaggregated by intervention	105,605	1.74	214,407	3.12
PMTCT activities n.e.c.	16,084	0.27	11,952	0.17
Blood safety	5,436	0.09	200	0.00
Prevention activities not disaggregated by intervention	-	0.00	4,002	0.06
Prevention activities n.e.c.	30,537	0.50	4,109	0.06
Grand Total Prevention activities	**6,063,711**	**100**	**6,865,831**	**100**

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Care and Treatment

Care and Treatment functional area, has a similar trend to Prevention. For 2011/2012 International Funds recorded a 74.01% (US$2,271,344) level of spending, Private Funds (US$652,368 (21.26%) and the Public Funds 4.73% (US$145,284) in this area. The corresponding amounts for 2012/2013 are International Funds US$5,104,847 (87.03%), Private Funds 10.71% or US$627,963 and Public Funds 2.27% (US$133,000).

The key interventions supported by International funds were Provider Initiated Testing and Counselling, Antiretroviral Therapy, some HIV related laboratory monitoring and Nutritional support. Private Funding spent related to testing done at the private laboratories, along with private sale of Antiretroviral by Cari-Med Limited, a Corporate Pharmaceutical Company. Public spending was mainly used to support nutrition, which is usually Infant formula. Amounts spent

on Antiretroviral supported by International Funds in 2012/2013(US$3,249,777) over 2011/2012 (US$764,453) is mainly responsible for the significant moment is US$ for this source. The private laboratories participating in the study are Central, Biomedical, Microlab, Consolidated, Hargreaves, Andrews Memorial, Medical Associates, Eagle Medical and Peoples' Medical.

Table 14: Care & Treatment Spending Activities, 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
Provider- initiated testing and counselling (PITC)	1,008,448	32.86	1,547,493	26.38
OI outpatient treatment	4,155	0.14	-	0.00
Antiretroviral therapy not disaggregated neither by age nor by line of treatment	803,356	26.18	3,307,642	56.39
Nutritional support associated to ARV therapy	145,284	4.73	133,000	2.27
Specific HIV-related laboratory monitoring	835,507	27.22	580,511	9.90
Outpatient care services not disaggregated by intervention	272,245	8.87	297,164	5.07
Grand Total Care and Treatment activities	**3,068,996**	**100**	**5,865,810**	**100**

Orphans and Vulnerable Children (OVC)

The spending captured for Orphans and Vulnerable Children(OVC) as a functional area was dominated by Public Funds for the two (2) periods under review, 2011/2012 recorded 73.65%(US$183,294) and the corresponding amount for 2012/2013 is 78.07% (US$222,222), while Private funds remained similar in nominal terms over the two (2) years, that is, standing at 15.68% (US$39,035) in 2011/2012 and US$37,222 (13.08%) in 2012/2013. International Funds are 10.67% (US$26,555) and 8.85%(US$25,196) for 11/12 and 12/13 respectively.

The main interventions supported across the three funding sources were similar and concentrated particularly in OVC Institutional Care. A popular non-profit organization, Mustard Seed Communities, dedicated to caring for the most vulnerable population and also serves as a home to these children was the key respondent for this functional area.

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Table 15: Orphans and Vulnerable Children Spending Activities, 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
ASC.03.01 OVC Education	7,228	2.90	-	0
ASC.03.02 OVC Basic health care	1,807	0.73	-	0
ASC.03.05 OVC Social Services and Administrative costs	-	0.00	4,640	1.63
ASC.03.06 OVC Institutional care	232,824	93.55	-	0
ASC.03.06 OVC Institutional care Total	-	0.00	280,000	98.37
ASC.03.98 OVC Services not disaggregated by intervention	7,026	2.82	-	0
Grand Total Orphans and Vulnerable Children activities	248,885	100	284,640	100

Programme Management and Administration

The functional area of Programme Management and Administration includes spending at the administrative level, outside the point of health care delivery. The main areas supported in the Jamaica response, included staff cost, administrative fees to support Programme implementing partners, monitoring and evaluation, drug management system support, Information Technology cost, upgrade of laboratory and new equipment, upgrade and construction of infrastructure and mandatory HIV testing initiated by the two (2) insurance companies, Sagicor Jamaica and Guardian Life, participating in the study. The breakdown across types of funding sources for the two (2) fiscal periods under study are as follows, for 2011/12 - Public US$2,495,904(37.82%), Private US$198,793 (3.01%) and International US$6,599,214 (59.17%) and for 2012/2013 - Public US$2,550,308 (41.16%), Private US$116,203 (1.88%) and International US$3,529,025 (56.96%).

Table 16: Programme Management and Administration Activities 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
Planning, coordination and programme management	4,189,990	63.49	3,351,738	54.10
Administration and transaction costs associated with managing and disbursing funds	645,379	9.78	424,099	6.85
Monitoring and evaluation	829,321	12.57	390,014	6.30
Serological-surveillance (serosurveillance)	7,579	0.11	30,281	0.49
Drug supply systems	201,481	3.05	358,406	5.78

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AIDS Spending Categories	2011/12	%	2012/2013	%
Information technology	84,014	1.27	65,157	1.05
Upgrading laboratory infrastructure and new equipment	223,089	3.38	793,403	12.81
Upgrading and construction of infrastructure not disaggregated by intervention	12,054	0.18	202,443	3.27
Upgrading and construction of infrastructure n.e.c.	4,531	0.07	209,150	3.38
Mandatory HIV testing (not VCT)	173,934	2.64	111,039	1.79
Programme management and administration not disaggregated by type	141,986	2.15	145,443	2.35
Programme management and administration n.e.c	85,857	1.30	114,363	1.85
Grand Total Programme Management and Administration activities	**6,599,214**	**100**	**6,195,537**	**100**

Human Resources

The Human Resources functional areas supported training only which was funded in the following proportions, for 2011/2012 - Public funds US$104,886(56.23%) and International Funds US$81,631(43.77%) and for 2012/2013 - Public funds US$90,987(12.15%) and International Funds US$657,954(87.85%). A significant amount of International Funds were spent in 2012/2013 versus 2011/2012 and more was invested in training which covered a wide spectrum, to include tuition for staff, overseas training, local HIV and AIDS Management training, Training of Health Care Workers and Public Health Management training.

Table 17: Human Resources Spending Activities, 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
ASC.05.03 Training	186,517	100	748,941	100
Grand Total Human Resources activities	**186,517**	**100**	**748,941**	**100**

Social Protection and Social Services (excluding OVC)

The functional area of Social Protection and Social Services (excluding OVC) concentrated funding in three (3) categories Social Protection through money benefits, Social Protection through in-kind benefits and Income generation projects. The spread of the amounts analysed are for 2011/2012 - Public Funds US$59 (0.03%), Private Funds US$10,283 (4.44%) and International US$221,037 (95.53%) and for 2012/2013 - Public Funds nil, Private Funds US$17,889 (17.27%) and International US$85,693 (82.73%).

Table 18: Social Protection and Social Services (excluding OVC) Activities 2011/2012 and 2012/2013 (US$)

AIDS spending Categories	2011/12	%	2012/2013	%
Social protection through monetary benefits	3,613	1.56	15,141	14.62
Social protection through in-kind benefits	12,246	5.29	16,560	15.99
Social protection through provision of social services	-	0.00	428	0.41
HIV-specific income generation projects	206,670	89.32	69,977	67.56
Social protection services and social services not disaggregated by type	8,850	3.83	1,475	1.42
Grand Total Social Protection and Social Services activities	231,379	100	103,582	100

Enabling Environment

Enabling Environment as a functional area has spending concentrated on AIDS Specific Programme focused on women in 2011/2012 and other interventions pertaining to enabling environment for both years. In 2011/2012 the split over the three (3) categories of funding source are, Public Funds US$9,316(2.86%), Private Funds US$14,000 (4.30%) and International Funds US$302,031 (92.83%). For 2012/2013 the amounts are Public Funds US$20,830(6.64%), Private Funds US$14,041 (4.48%) and International Funds US$278,702 (88.88%).

Table 19: Enabling Environment Spending Activities, 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
Advocacy	142,818	43.90	128,594	41.01
Human rights programmes empowering individuals to claim their rights	-	0.00	5,995	1.91
Capacity building in human rights	8,344	2.56	6,503	2.07
Human rights programmes not disaggregated by type	2,281	0.70	12,521	3.99
AIDS-specific programmes focused on women	11,704	3.60	5,826	1.86
Programmes to reduce Gender Based Violence	-	0.00	14,270	4.55
Enabling environment not disaggregated by type	76,480	23.51	58,115	18.53
Enabling environment n.e.c.	83,720	25.73	81,750	26.07
Grand Total Enabling Environment activities	**325,347**	**100.00**	**313,574**	**100.00**

HIV-Related Research (excluding operational research)

HIV-Related Research (excluding operational research) the least funded functional area in both periods under review, has US$127,396 (100%) of the amount being expended by International Funding source on Behavioural and other Social Science research. For 2012/2013 the HIV-Related Research spending was US$14,578 of International Funds spent on Social Science research.

Table 20: HIV-Related Research Activities, 2011/2012 and 2012/2013 (US$)

AIDS Spending Categories	2011/12	%	2012/2013	%
Clinical research	19,518	15.32	-	0
Behavioural research	73,288	57.53	-	0
Social science research not disaggregated by type	34,590	27.15	14,578	100
Grand Total HIV-Related Research activities	127,396	100	14,578	100

3.5 AIDS Spending Categories by Financing Agents (ASC X FA)

In examination of the cross matrices of ACS and FA, further details are observed with respect to Financing Agents. Some key highlights are:

Public Sector

- The Public Sector emphasize was on Prevention, Treatment & Programme Management and Administration. These three (3) AIDS Spending Categories consumed US$10,556,949 or 93.72% of total Public Sector spending for 2011/2012 and US$13,595,681 or 95.35% for fiscal period 2012/2013. A significant increase in ARV purchase in year two (2) of the study results in the US$ increase.
- In the Public Sector, Care and Treatment Expenditures were concentrated in the Ministry of Health, the Financing Agent.
- The Ministry of Youth is the Financing Agent for 96.31% of the US$190,320 spent on OVC through the Public Sector in 2011/2012 and 97.95% of the US$226,862 for 2012/2013. Resources amounting to approximately US$183,294 and US$222,222 was provided to Mustard Seed Communities for interventions in 2011/2012 and 2012/2013 respectively.

Private Sector

- Insurance Companies participating in the study, reported purely HIV test data. The test is mandatory as a pre-requisite for accessing some Life Insurance policy. An estimated US$173,934 and US$111,039 was spent respectively for the review periods.
- Across the ASC, Private Sector invested most in Prevention, that is US$1,313,090 (58.73%) and US$1,681,962 (66.81%) of the total Private Sector Spending in the capacity of a FA.

- Amounts spent for Care and Treatment in the private sector are directly related to private ARV sales by Pharmaceutical companies to individuals. Lasco Pharmaceutical Division was the key supplier.

Bi-laterals, Multilateral and International Non-Profit Making Organization

- Bi-Lateral as Financing Agents, highest spending was concentrated in Programme Management and Administration, where 78.75% and 53.01% respectively was allocated to this ASC.
- Prevention and Programme Management ASC were the focus of Multilaterals as a Financing Agent for both years. The said two (2) ASC along with Social Protection and Social Services were the concentration of Non-Profit Organizations and Foundation in their capacity as Financing Agents.

Table 21: Financing Agent (FA) X AIDS Spending Categories (ASC), 2011/2012

	AIDS Spending Category to Financing Agents	Prevention	Care & Treatment	OVC	PM & Admin	HR	SP & SS	Enabling Env.	Research	Total
Financial Agents	**Public Sector**	**3,525,649**	**2,416,628**	**190,320**	**4,614,672**	**182,175**	**205,372**	**129,693**	**-**	**11,264,510**
	Ministry of Health (or equivalent sector entity)	3,476,000	2,416,628	7,026	4,584,245	182,056	205,372	129,693	-	11,001,019
	Ministry of Labour (or equivalent sector entities)	37,555	-	-	15,006	120	-	-	-	52,681
	Other ministries (or equivalent sector entities)	-	-	183,294	-	-	-	-	-	183,294
	Parastatal organizations	12,094	-	-	15,421	-	-	-	-	27,515
	Private Sector	**1,313,090**	**652,368**	**39,035**	**207,001**	**-**	**10,286**	**14,000**	**-**	**2,235,779**
	Private Insurance enterprises (other than social insurance)	-	-	-	173,934	-	-	-	-	173,934
	Private households' (out-of-pocket payments)	-	-	-	1,412	-	-	-	-	1,412
	Not-for-profit institutions (other than social insurance	11,186	-	5,294	31,216	-	78	14,000	-	61,773
	Private non-parastatal organizations and corporations (other than health insurance)	1,300,141	652,368	17,647	-	-	-	-	-	1,970,156
	Other private financing agents n.e.c.	1,763	-	16,094	439	-	10,208	-	-	28,505
	Bilateral	**321,214**	**-**	**-**	**1,206,496**	**4,342**	**-**	**-**	**-**	**1,532,051**
	Government of United States	321,214	-	-	1,206,496	4,342	-	-	-	1,532,051
	Multilateral	**636,557**	**-**	**-**	**369,273**	**-**	**5,094**	**11,704**	**99,806**	**1,122,435**
	UNAIDS Secretariat	61,470	-	-	352,299	-	-	-	42,787	456,555
	United Nations Children's Fund (UNICEF)	521,866	-	-	11,670	-	5,094	-	-	538,630

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	United Nations Development Fund for Women (UNIFEM)	-	-	-	-	-	-	657	-	657
	United Nations Development Programme (UNDP)	-	-	-	-	-	-	-	-	-
	United National Population Fund (UNFPA)	47,917	-	-	-	-	-	-	57,019	104,936
	Other Multilateral entities n.e.c	5,305	-	-	5,305	-	-	11,047	-	21,657
	International non-profit organizations and foundations	**267,201**	**-**	**19,529**	**201,772**	**-**	**10,627**	**169,951**	**27,590**	**696,671**
	Int'l HIV/AIDS Alliance	10,011	-	-	-	-	-	-	-	10,011
	Int'l Federation of Red Cross and Red Crescent Societies, Int'l Committee of Red Cross & National Red Cross Societies	-	-	-	-	-	-	-	11,000	11,000
	Other Int'l not-for-profit organizations n.e.c.	257,191	-	19,529	201,772	-	10,627	169,951	16,590	675,660
	Grand Total	**6,063,711**	**3,068,996**	**248,885**	**6,599,214**	**186,517**	**231,379**	**325,347**	**127,396**	**16,851,445**

Table 22: AIDS Spending Categories x Financial Agents (FA), 2012/2013

	ASC to Financing Agents	**Prevention**	**Care & Treatment**	**OVC**	**PM & Admin**	**HR**	**SP & SS**	**Enabling Env.**	**Research**	**Total**
Financial Agents	**Pulbic Sector**	**3,942,805**	**5,237,847**	**226,862**	**4,415,029**	**254,463**	**74,670**	**106,559**	**-**	**14,258,235**
	Ministry of Health (or equivalent sector entity)	3,942,004	5,237,847	4,640	4,335,870	253,588	74,670	106,559		13,955,178
	Ministry of Labour (or equivalent sector entities)	801			47,991	875				49,667
	Other ministries (or equivalent sector entities)			222,222						222,222
	Parastatal organizations				31,168					31,168
	Private Sector	**1,681,962**	**627,963**	**37,222**	**138,439**	**-**	**17,889**	**14,041**	**-**	**2,517,515**
	Private Insurance enterprises (other than social insurance)				111,039					111,039
	Private households' (out-of-pocket payments)				2,353					2,353
	Not-for-profit institutions (other than social insurance	63,079	-	5,556	24,576			14,041		107,252
	Private non-parastatal organizations and corporations (other than health insurance)	1,618,869	627,963	17,222	363		12,444			2,276,861
	Other private financing agents n.e.c.	13		14,444	108		5,444			20,010

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Bilateral	**348,153**	**-**	**-**	**877,224**	**429,487**	**-**	**-**	**-**	**1,654,864**
Government of United States	348,153			877,224	429,487				1,654,864
Multilateral	**197,081**	**-**	**-**	**496,493**	**64,992**	**-**	**8,612**	**4,500**	**771,677**
UNAIDS Secretariat	328			262,665					262,993
United Nations Children's Fund (UNICEF)	138,621			203,093	64,992			4,500	411,206
United Nations Development Fund for Women (UNIFEM)					-				-
United Nations Development Programme (UNDP)	14,801			14,859			2,786		32,446
United National Population Fund (UNFPA)	27,454								27,454
Other Multilateral entities n.e.c	15,876			15,876			5,826		37,578
International non-profit organizations and foundations	**695,831**	**-**	**20,556**	**268,351**	**-**	**11,023**	**184,362**	**10,078**	**1,190,201**
International HIV/AIDS Alliance									-
International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies									-
Other International not-for-profit organizations n.e.c. Total	695,831		20,556	268,351		11,023	184,362	10,078	1,190,201
Grand Total	**6,865,831**	**5,865,810**	**284,640**	**6,195,537**	**748,941**	**103,582**	**313,574**	**14,578**	**20,392,492**

3.6 Providers of Services (PS)

Providers are entities that engage in the production, provision and delivery of HIV Services. Providers are not limited to the health sector. HIV and AIDS services are provided in a wide range of settings outside the health sector. Providers are owned by non-profit organizations, government, and others that fall within the NASA boundaries.

The provider of services (PS) is contracted by the Financing Agent (FA) for the provision of specific service, and is ultimately responsible for the delivery of those services.
For the Jamaica NASA study, over the two (2) fiscal periods being reviewed, Provider of Services falls into three (3) categories.

- Public Sector Providers
- Private Sector Providers
- Bi-lateral and Multilateral- in country offices

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Table 23 and Figure 8 display a broad based breakdown of Jamaica's National Response by the Providers of Services (PS).

Table 23: Provider of Services, 2011/2012 - 2012-2013 (US$)

Provider of Services	2011/2012	%	2012/2013	%
Public Sector Providers	**10,521,015**	**62.43**	**12,846,124**	**62.99**
Governmental Organizations	7,477,682	**44.37**	10,245,062	**50.24**
Parastatal Organizations	3,043,333	**18.06**	2,601,062	**12.75**
Private Sector Providers	**5,059,620**	**30.02**	**6,615,259**	**32.44**
Non-Profit Providers	4,190,664	**24.87**	**5,889,590**	**28.88**
Profit Making Private Sector Providers (incd. Profit Making FBOs)	868,956	**5.16**	**725,669**	**3.56**
Bilateral & Multilateral entities- in country offices	**1,270,810**	**7.54**	**931,109**	**4.57**
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**

The Public Sector was the major player, as a Provider of Services (PS) to Jamaica National HIV Response, with service provision spending amounting to 62.43% and 62.99% of the overall expended on the provision of services. Next in line was the private sector, spending 30.02% and 32.44% respectively for the periods of the assessment. Multilateral amounts were relatively minute standing at 7.54% of the full amount spent by Providers in 2011/2012 and down to 4.57% in 2012/2013. The Public sector has been further disaggregated by Governmental and Parastatal organizations. Government providers included the MOH-NHP, MOE, MNS, MOIT and NCYD. Some Parastatal providers participating in the study were NCDA, NPHL and RHAs.

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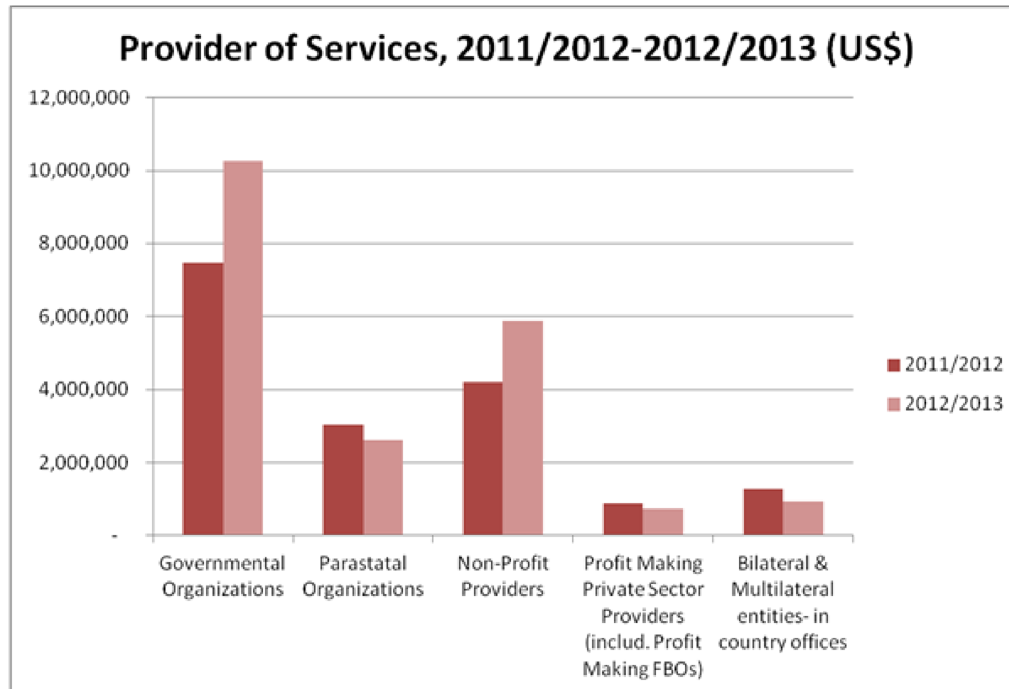
Figure 8: Provider of Services, 2011/2012 – 2012/2013



Some specific Private Sector providers, profit making and non-profit making, includes Cari-Med Limited, Lasco Pharmaceuticals Division, Scotia Bank Jamaica, JASL, GIPA, Grata Foundation, ASHE, 3Ds, CDA, Children First, Children of Faith, Eve for Life, HWW, JRC, J-Flag, JN+, J-YAN, KSA PAA, Trelawny PAA, Joy Town Foundation and Mustard Seeds Communities.
Bi-lateral and Multilateral -in country office providers included USAID, UNAIDS, UNDP and UNICEF.

3.7 Beneficiary Population (BP)

Beneficiary population refers to the populations that is explicitly targeted or intended to benefit from specific activities. For the purposes of the NASA study, the Beneficiary population is dissected into six (6) broad groupings. An examination of the spending in relation to the fiscal periods sought to track resources from the financing sources(FS) through to the Beneficiary Population (BP). Below table XX gives a summary of how the funds were disbursed across the BP. The greatest portions of the spending were directed to the General Population with a result of US$6,699,893(39.76%) of the overall being spent in the first year of the study and US$8,266,982 (40.54%) in the second. Next in line were PLWHIV, that recorded spending of US$3,506,048 (20.81%) in 2011/2012 and US$5,812,442 (28.50%) in 2012/2013. The least spending was on non-targeted intervention and includes mainly administration cost within the various entities participating in the study. The non-targeted spending captured totalled US$542,964 (3.22%) in year one (1) and US$482,264 (2.36%) in year two (2). This is very instructive as an indicator that 96.78% and 97.64% respectively of resources spent during the periods of the study were explicitly targeted.

Table 24: Beneficiary Population for HIV and AIDS Spending 2011-2012 - 2012/2013 (US$)

Targeted/intended beneficiary populations	2011/2012	%	2012/2013	%
People living with HIV	3,506,048	20.81	5,812,442	28.50
Most at risk populations	1,427,128	8.47	2,140,423	10.50
Other key populations	1,256,758	7.46	1,257,496	6.17
Specific "accessible" populations	3,418,654	20.29	2,432,886	11.93
General population	6,699,893	39.76	8,266,982	40.54
Non-targeted interventions	542,964	3.22	482,264	2.36
Grand Total	**16,851,445**	**100.00**	**20,392,492**	**100.00**

Figure 9: Beneficiary Population for HIV and AIDS Spending 2011/2012 – 2012/2013

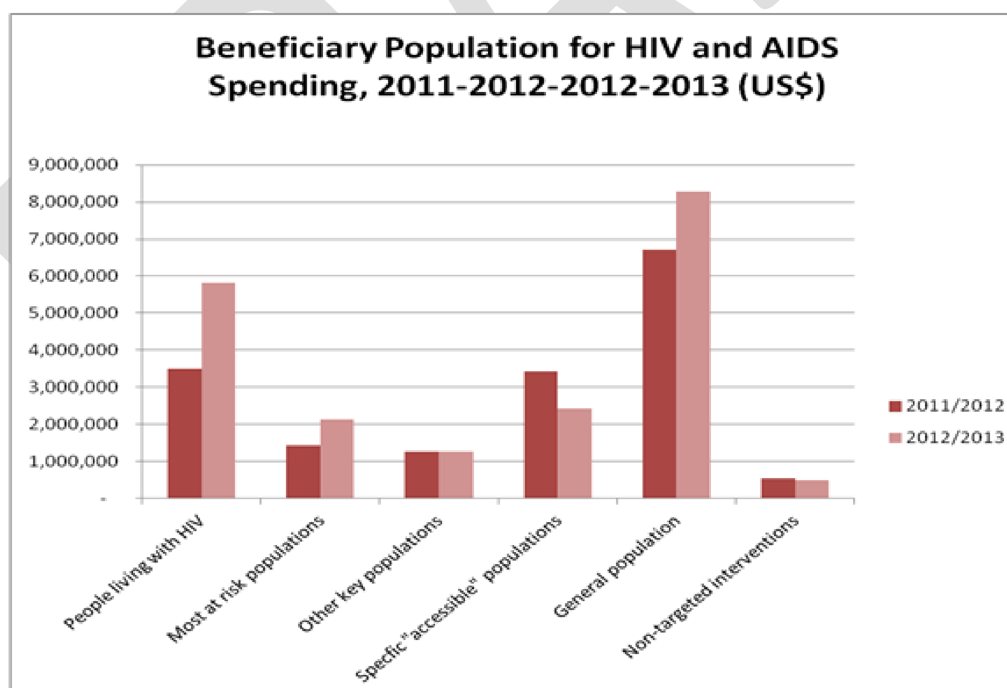


Figure 9 above is a graphical representation, comparing each of the two (2) years spending in respect of Beneficiary population. The pie chart below gives an annual pictured representation of the split in beneficiary population by percentage rounded to the nearest ten.

Figure 10: Beneficiary Population for HIV and AIDS Expenditure, 2011/2012 (%tage)

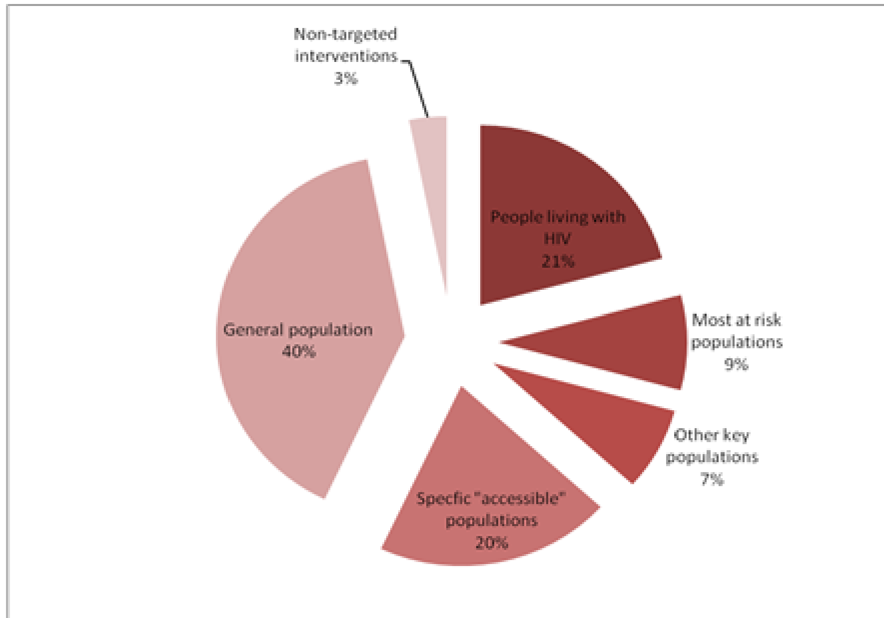


Figure 11: Beneficiary Population for HIV and AIDS Expenditure, 2012/2013 (%tage)

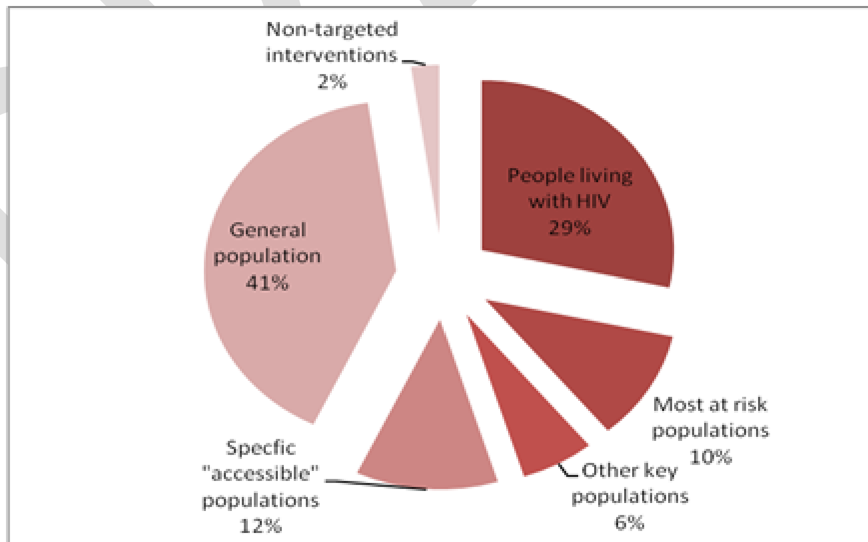


Table 25 is a further detailed representation of the BP and spending for both fiscal periods.

Table 25: Beneficiary Population for HIV and AIDS Expenditure 2011-2012 - 2012/2013 (US$)

Targeted/intended beneficiary populations	2011/2012	%	2012/2013	%
People living with HIV	**3,506,048**	**20.81**	**5,812,442**	**28.50**
Adult and young women (15 years and over) living with HIV	123,856	0.73	18,977	0.09
Adult and young people (15 years and over) living with HIV not disaggregated by gender	14,000	0.08	49,000	0.24
Children (under 15 years) living with HIV not disaggregated by gender	300,369	1.78	133,000	0.65
People living with HIV not disaggregated by age or gender	3,067,822	18.21	5,611,465	27.52
Most at risk populations	**1,427,128**	**8.47**	**2,140,423**	**10.50**
Injecting drug users (IDU) and their sexual partners	56,659	0.34	27,267	0.13
Female sex workers and their clients	5,305	0.03	15,876	0.08
Male non-transvestite sex workers (and their clients)	2,382	0.01	-	0.00
Sex workers, not disaggregated by gender, and their clients	195,813	1.16	262,641	1.29
Men who have sex with men (MSM)	612,645	3.64	1,226,959	6.02
"Most at risk populations" not disaggregated by type	554,324	3.29	607,680	2.98
Other key populations	**1,256,758**	**7.46**	**1,257,496**	**6.17**
Orphans and vulnerable children (OVC)	248,885	1.48	284,640	1.40
Children Born to or to be born of women living with HIV	125,990	0.75	229,683	1.13
Prisoners and other institutionalized persons	13,328	0.08	22,134	0.11
Children and youth out of school	190,978	1.13	179,961	0.88
Institutionalized children and youth	189,401	1.12	47,846	0.23
Other key populations not disaggregated by type	249,647	1.48	308,484	1.51
Other key populations n.e.c.	238,530	1.42	184,748	0.91
Specfic "accessible" populations	**3,418,654**	**20.29**	**2,432,886**	**11.93**
Junior high/high school students	0	0.00	25,568	0.13
University students	35,000	0.21	-	0.00
Health care workers	982,621	5.83	468,277	2.30
Factory employees (e.g. for workplace		0.08		0.22

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Targeted/intended beneficiary populations	2011/2012	%	2012/2013	%
interventions)	13,176		45,560	
Specific "accessible " populations not disaggregated by type	2,220,548	13.18	1,566,927	7.68
Specific "accessible " populations n.e.c.	167,308	0.99	326,554	1.60
General population	**6,699,893**	**39.76**	**8,266,982**	**40.54**
Female adult population	-	0.00	2,167	0.01
General adult population (older than 24 years) not disaggregated by gender	5,041	0.03	14,034	0.07
Children (under 15 years) not disaggregated by gender	-	0.00	22,852	0.11
Young females	11,704	0.07	5,826	0.03
Youth (age 15 to 24 years) not disaggregated by gender	19,471	0.12	5,595	0.03
General population not disaggregated by age or gender.	6,663,677	39.54	8,216,508	40.29
Non-targeted interventions	**542,964**	**3.22**	**482,264**	**2.36**
BP.06 Non-targeted interventions	542,964	3.22	482,264	2.36
Grand Total	**16,851,445**	**100**	**20,392,492**	**100**

3.8 Production Factor (PF)

Production Factors are the input resources in the form of current and capital expenditures that contribute to the creation of outputs to the HIV response. An analysis of resource spending can have policy implications regarding payment for inputs such as human resources, for ARV expenditures, for Capital investment and other significant inputs. In this section an examination will be done of the cross matrix showing funds flow from the AIDS Spending Categories (ASC) to the broad categories of the actual Production Factor (PF)/inputs on which funds were spent for the period of the study in response to Jamaica HIV epidemic.

Generally speaking it was observed that, in 2011/2012 fiscal year 97.23% of resources dedicated the Jamaica's National HIV response was spent on Current Expenditure with a mere 2.77% flowing to Capital expenditure. The trend was similar in 2012/2013 with 91.87% allocated to Current Expenditure and 8.13% to Capital Expenditure.
Some highlights of the Production Factor Analysis are as follows:

Current Expenditures

Wages as a Production Factor consumed US$7,009,938 (41.60%) in 2011/2012 and US$5,841,307 (28.64%) in 2012/2013. Wages were paid to a myriad of staff in the Public Sector and NGO stakeholders responsible for the implementation of the programme. Bilateral and Multilateral salaries reported were also captured in this line item.

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ARV total spending is US$803,356 (4.77%) and US$3,305,111 (16.21%) respectively in the two (2) periods under review. This is purely a Care and Treatment spending and is solely to the benefit of PLWHIV.

Over US$1M was spent on Medical and Surgical supplies in both years (US$1,253,412) in 2011/2012 and (US$1,702,811) in 2012/2013. Ora Quick Test, HIV Rapid Test kits and Syphilis test kits are some of the specific items captured for this Production Factor.

Reagents and Materials cost US$835,252 and US$660,511 respectively for the periods of the study. These were mainly for PCR and CDR machines.

Logistics of events as a production factor captured all the training workshop and these were multifaceted, covering areas such as Risk reduction intervention targeting CSW, MSM and Out of School Youths, training of Health Care Workers (HCW)-some being specific to PMTCT, VCT training, Prevention for In School youths, training in Monitoring and Evaluation, Training for the BCC team, training targeting adolescents, training in Public Health Management, training in Capacity Building, Policy workshops and training that created awareness for Safer Sex Week (SSW) and World AIDS Day (WAD). In both years of the study Prevention AIDS Spending Category dominated the Logistic of event PF, US$2,336,313(13.86%) and US$2,467,519 (12.10%) in total was spent for the Production Factor.

Publisher, motion picture, broadcasting and programming services as a Production Factor, includes all the IEC materials and Media Campaigns. The Jamaica's National Response spent on Promotional material of WAD and SSW, Abstinence Campaign, Adherence Campaign, Posters of HFLE and Media Recall Surveys - Condom Use and Yes I can. The spending in both years was less than 5%, that is, US$779,287(4.62%) in 2011/2012 and US$803,663(4.07%) in 2012/2013.

Capital Expenditure

Of note is the US$904,697 (4.44%) spent on Laboratory and other medical equipment in 2011/2012. This resulted from a major investment in the Waste Management Site, which was established between 2006-2008 under the first World Bank HIV Project and Loan to Jamaica.

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Table 26: AIDS Spending Categories to Production Factors

	AIDS Spending Categories to Production Factors	Prevention	Care & Treatment	OVC	PM & Admin	HR	SP & SS	Enabling Env.	Research	Total
Production Factors	**Current Expenditures**	**6,053,488**	**3,068,996**	**208,591**	**6,182,271**	**186,517**	**231,379**	**325,347**	**127,396**	**16,383,985**
	Wages	1,987,918	272,245	69,412	4,543,902	882	-	135,579	-	**7,009,938**
	Social contributions	-	-	-	-	-	-	-	-	**-**
	Labour income not disaggregated by type	-	-	-	86	-	-	-	-	**86**
	Antiretrovirals	-	803,356	-	-	-	-	-	-	**803,356**
	Other drugs and pharmaceuticals (excluding antiretrovirals)	3,624	4,155	11,176	8,194	-	-	-	-	**27,149**
	Medical and surgical supplies	1,788	1,008,703	-	242,921	-	-	-	-	**1,253,412**
	Condoms	1,407,435								**1,407,435**
	Reagents and materials		835,252							**835,252**
	Food and nutrients	10,220	145,284	24,219			8,824			**188,547**
	Uniforms and school materials			32,875			1,742			**34,617**
	Material supplies not disaggregated by type	3,303			4,467		16,001	3,919		**27,689**
	Other material supplies n.e.c						118			**118**
	Adminstrative Services	58,805			498,333	13,316	23,720	2,707		**596,880**
	Maintenance and repair services	21,474			54,231					**75,704**
	Publisher,motion picture, broadcasting and programming services	761,005				266		18,016		**779,287**
	Consulting Services	368,783			217,925	3,529		46,444	110,588	**747,269**
	Transportation and travel services	44,042		4,353	2,225	2,506	3,981	1,845		**58,952**
	Housing services	1,082					2,223			**3,305**
	Logistics of events, including catering services	1,298,669		18,908	600,768	130,774	164,657	112,030	10,508	**2,336,313**
	Services not disaggregated by type	85,339		47647.06	9220.3747	6517.883	10116.13	4807.435	6299.676	**169,948**
	Current expenditures not disaggregated by type					28,726				**28,726**
	Current expenditures n.e.c.									**-**
	Capital Expenditures	**10,224**	**-**	**40,294**	**416,943**	**-**	**-**	**-**	**-**	**467,460**
	Laboratory and other infrastructure upgrading				**2,815**					**2,815**
	Construction of new health centres									**-**
	Buildings not disaggregated by type									**-**
	Vehicles									**-**
	Information technology (hardware and software)	2,291			76,315					**78,606**
	Laboratory and other medical equipments				10,033					**10,033**

	Equipment not disaggregated by type	1,112		37,647	8,538					**47,297**
	Equipment n.e.c.	1,633			310,918					**312,551**
	Capital expenditure not disaggregated by type	5,188		2,647	8,324					**16,159**
	Grand Total	**6,063,711**	**3,068,996**	**248,885**	**6,599,214**	**186,517**	**231,379**	**325,347**	**127,396**	**16,851,445**

Table 27: AIDS Spending Categories to Production Factors

	AIDS Spending Categories to Production Factors	**Prevention**	**Care & Treatment**	**OVC**	**PM & Admin**	**HR**	**SP & SS**	**Enabling Env.**	**Research**	**Total**
Production Factors	**Current Expenditures**	**6,846,335**	**5,865,810**	**237,973**	**4,742,868**	**608,941**	**103,582**	**313,574**	**14,578**	**18,733,660**
	Wages	1,956,224	294,070	60,000	3,409,871	-	9,161	111,982	-	**5,841,307**
	Social contributions	-	-	-	-	-	1,751	-	-	**1,751**
	Labour income not disaggregated by type	72	-	-	17	-	-	-	-	**90**
	Antiretrovirals	-	3,305,111	-	-	-	-	-	-	**3,305,111**
	Other drugs and pharmaceuticals (excluding antiretrovirals)	1,333	-	8,889	-	-	-	-	-	**10,222**
	Medical and surgical supplies	2,344	1,550,024	-	150,443	-	-	-	-	**1,702,811**
	Condoms	1,845,957	-	-	-	-	-	-	-	**1,845,957**
	Reagents and materials		580,511			80,000			-	**660,511**
	Food and nutrients	4,637	133,000	62,222			6,000		-	**205,859**
	Uniforms and school materials	-		22,222			40,028		-	**62,250**
	Material supplies not disaggregated by type				13,484		15,737	4,946	-	**34,168**
	Other material supplies n.e.c	-	-	-	-	-	-	-	-	**-**
	Adminstrative Services	75,863			764,329		4,860	3,172	-	**848,225**
	Maintenance and repair services	14,300			24,839				-	**39,139**
	Publisher,motion picture, broadcasting and programming services	817,932			1,522			11,208	-	**830,663**
	Consulting Services	212,855			262,243			79,191	-	**554,289**
	Transportation and travel services	87,364		3,333	5,688	21,099	803	2,344	-	**120,632**
	Housing services						1,953		-	**1,953**
	Logistics of events, including catering services	1,786,485		18,529	106,382	450,481	3,148	92,418	10,078	**2,467,519**
	Services not disaggregated by type	40,967	3,094	62,778	4,050	3,811	18,911	8,313	4,500	**146,425**
	Current expenditures not disaggregated by type					53,550				**53,550**
	Current expenditures n.e.c.						1,229			**1,229**
	Capital Expenditures	**19,496**	**-**	**46,667**	**1,452,669**	**140,000**	**-**	**-**	**-**	**1,658,832**

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	Construction of new health centres				182,802					**182,802**
	Buildings not disaggregated by type			3,889	174,550					**178,439**
	Vehicles				21,044					**21,044**
	Information technology (hardware and software)				217,834					**217,834**
	Laboratory and other medical equipments				764,697	140,000				**904,697**
	Equipment not disaggregated by type	11,618		40,000	50,439					**102,056**
	Equipment n.e.c.	7,879			41,303					**49,181**
	Capital expenditure not disaggregated by type			2,778						**2,778**
	Grand Total	**6,865,831**	**5,865,810**	**284,640**	**6,195,537**	**748,941**	**103,582**	**313,574**	**14,578**	**20,392,492**

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4. Assumptions, Estimations and Limitations

4.1 Assumptions and Estimations

- An exchange rate of JA$85.00:US$1.00 and JA$90.00:US$1.00 for 2011/2012 and 2012/2013, respectively was applied consistently throughout the report for all local currency data collection tools submitted. In the instances of US$ reporting these were maintained.

- The MoH-NHP General Ledger for the Global Fund, World Bank, USAID and Counterpart resources was the originating and only entry point for several stakeholders funded through the Programme. This approach was taken as the MoH-NHP is subject to annual audits, which enhances the integrity of the numbers reported and also to avoid duplication of entries. Stakeholders that reported data pertaining to MoH-NHP funding, had the benefit of validation and triangulation of the numbers reported.

- Where spending reported are pooled together towards more than one beneficiary population or multiple production factors, a percentage share is done across the applicable NASA vector based on reasonableness and trend.

- Data on ARV consumption from some stakeholders responsible for its distribution were not forthcoming, thus spending was accessed for inclusion in the report based on amounts spent. For the 2011/2012 period, spending recorded between April 2011 and August 2011 were deemed consumed and captured in the report. For the 2012/2013 period, spending recorded between April 2012 and October 2012 were deemed consumed within the fiscal period and included for the purposes of NASA.

- HIV Test done by the Private Laboratories and reported through the MoH-NHP, were assume to cost JA$1,500(US$17.65) in 2011/2012 and JA$1600 (US$17.78) in 2012/2013.

4.2 Limitations

- NASA requires that data be reported by six (6) vectors. Stakeholders participating in NASA study have not kept a single database for reporting purposes corresponding to the vectors. The result is respondents to NASA finds it time consuming and this tend to also affect the completeness and accuracy of the data stakeholders respond to the NASA invitation with.

- Knowingly missing data is absence from the report. In two (2) instances stakeholders that are Financing Source and Financing Agents indicated names of Providers of Services (PS), however the PS failed to response to NASA. These were not substantial amounts and would not have changed the output of the report significantly.

- Private profit making corporation inclusion in the study was concentrated to specific industries. A commercial bank, two (2) pharmaceutical companies, two (2) insurance companies and nine (9) private laboratories participated in the study.

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- In some instances, there has been under-reporting as some of the stakeholders engaged failed to report staff and administrative cost. There focus was more activity based.

- There has been some resistance to reporting, some stakeholders participating in the study expressed that there was no direct benefit to responding, hence were not committed in a serious way to meeting the requirements.

- There is still some newness and unfamiliarity with the methodology and the NASA classifications and definitions. This intensified the challenges some stakeholders.

- Some stakeholders either failed to use the data collection tool to submit the requested information or completed it incorrectly, leading to inefficiencies in the process.

- 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.

- There is limitation in the comprehensiveness of information maintained and reported by stakeholders in respect of the NASA requirements. This resulted in reasonable judgement being applied for estimation purposes and further contact with stakeholders as a last resort.

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5. KEY MESSAGES

The principal objectives of the NASA exercise was to determine how much financial resources is being spent, across six (6) vectors, towards Jamaica National HIV Response for two (2) previous fiscal periods. This was required to continue the strengthening of exhaustive tracking of actual spending from various sources, (public, private and international) that constitute our National Response. In undertaking the study:

- The NASA project in Jamaica was able to achieve the multi-level and multi-sectoral participation of key stakeholders.
- The involvement of private sector expanded over the previous NASA, and includes Non-Profit NGOs, Profit Making corporation - Pharmaceuticals distributors, Private Laboratories, Insurance Companies and a Commercial Bank. There is still room for a more broad based inclusion of this sector with financing source support to the National response standing at 13.08% and 11.73% of the overall amounts respectively.
- FBOs participation was limited and several FBOs contacted did not have any data to report as no HIV and AIDS related activities were undertaken during the period of the study.
- RHAs and a limited number of CSO were engaged in a NASA training workshop as a first step to the assessment that sought to create awareness and an understanding of the NASA requirements.
- In country capacity still needs to be developed for data collection, triangulation and the construction of the databases and matrices.
- A greater overall enhancement to the process could be, to have a structured mechanism to institutionalized NASA requirements to ensure that data is captured and reported on an ongoing basis. This will do several things including ensure greater understanding of the information, ensure that the data is collected on an ongoing basis in tandem with other standard work, ensure that the information is readily available and reduce the resistance to not submit due to time consumption to compile historical data and also ensure a greater level of accuracy as the intervention and collection of the data will be simultaneous.
- The packaging of the strategic benefits of NASA could be enhanced and sold at a policy level to all stakeholders to create awareness, buy-in and willingness to enhance record keeping and reporting among stakeholders.

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6. RECOMMENDATIONS

- With the classification of Jamaica as an Upper Middle Income country and the implications for future funding, every effort will need to be made to ensure continued funding to the General Population and maintenance of a low HIV prevalence rate.

- Additional Private sector involvement in the National HIV response should be encouraged, thus there is a need to galvanize more private sector entities to help in the mobilization of funds for HIV and related activities.

- 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. From the NASA study, HIV research had the lowest expenditure in both years. More emphasis should be placed on research in order to support programmatic decision-making and be more economical in the allocation of resources.

- Every effort ought to be made to build and establish a pool of NASA experts, through formal training to enhance the quality of the data collected through better knowledge on areas such as estimations and valuing other household and out of pocket expenditures.

- 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.
- From a policy level the institutionalization of NASA should be examined and a strategy devise for its roll-out to add efficiency to the process of completing the report.

- The spending trends from NASA are to be used in combination with other methods to identified spending gaps of the National Strategic plan and seek external grant funding to address the national response to the epidemic in an informed manner.

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7. Next Steps

1. Streamline the processes in place to meet the UNGASS indicator and enhance financial flow tracking for HIV spending in relation to the National Response to the epidemic.

2. Packaging the strategic benefits of NASA to enhanced stakeholders awareness, create buy-in and willingness to enhance record keeping and reporting among stakeholders.

3. 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.

4. 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. Use the report to facilitate decision making especially at the donor, governmental and civil society sectors.
    c. Identification of potential gaps in the costed NSP based on current spending trends identified in NASA. Allocate indicative budgets to Priorities, Specific Objectives and Strategic Activities.
    d. Examination of methods and strategies to enhance future NASA studies.

5. Institutionalize the NASA
    a. Using the existing mechanism and structures that exist in Jamaica, take additional steps to institutionalize the NASA process. This involves several steps:
        i. Establish a county wide NASA task force, the core NASA team, of about 7-10 persons, including the M&E focal points from the NHP and UNAIDS, as well as, RHA personnel and the local consultant.
        ii. Incorporate NASA at the highest level of Management, ensuring that the fulfilment of its requirements become a standard part of any MOU agreements signed and concurrently edit or redesign, current stakeholder monthly reporting formats to capture data related to the six vectors required by NASA.
        iii. Dedicate at least 8-12 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 with the increased frequency of NASAs' being conducted.

    b. Outlined in Appendix 4 is the previous NASA Implementation plan that should be discussed with the current Task Force, giving consideration to the lessons learnt during this current NASA and thereby revised for the upcoming NASA.

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REFERENCES

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APPENDICES

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Appendix 1: List of Organizations Engaged for NASA 2011 – 2013

Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
CSO	ASHE	Conroy WIlson	960-2985	asheperforms@gmail.com	√			
CSO	Caribbean HIV&AIDS Alliance	Dylis McDonald Technical Director	(868) 233-9714 (868) 233-7209	dmcdonald@alliancecarib.tt.org	√			
CSO	Caribbean Vulnerable Communities (CVC)	Carolyn Gomes Ivan Cruickshank	870-9307	cgomes@cvccoalition.org Ivan.crucickshank@gmail.com			√	
CSO	Central Village Benevolent Society	Mark Lewis		centralvillagebs@hotmail.com markal72@yahoo.com	√			
CSO	CHARES	Dr. Geoffrey Barrow	383-7550	barrow.geoggrey@gmail.com	√			
CSO	Children's First	Claudette Pious Vandrea Thompson	984-0367	Claudettepious@yahoo.com vandreat@yahoo.com	√			
CSO	Children of Faith	Gloria Meredith	940-4615/ 822-6807 471-7073	gloriam@cwjamaica.com	√			
CSO	Colour Pink	Jermaine Burton	823-2461	rickardoburton@yahoo.com	√			
CSO	Combined Disabilities Association	Gloria Goffe Project Coordinator	929-1177	advocacy1981@yahoo.com	√			Technical Reports received. Spending captured solely from the MOH/NHP General Ledger.
CSO	Council of Voluntary Social Sciences	Mrs. Winsome Wilkins	922-9365-66	wowilkins@yahoo.com			√	Did not respond. US State Department - Public Affairs Section listed CVSS as a sub-grantee.
CSO	Eve for Life	Patricia Watson Marjorie Samuels	632-1838/816-1365 342-6107	Jamaique22@gmail.com marsammy@gmail.com		√		No details reported for UNESCO funding.
CSO	Flankers Resource Centre	Marilyn McIntosh Nash		flankerpjc@yahoo.com	√			
CSO	Food For the Poor	Susan Moore	984-5005	susanm@foodforthepoorja.org			√	Did not respond

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
CSO	Grata Foundation	Yohan White	322-3810/375-5070	yohanwhite@gmail.com		√		Funds received from US State Dept - Public Affairs Section excluded from report submitted.
CSO	Hope Worldwide	Karen Daye/Peter Swaby	754-4446	Kadaye73@yahoo.comhopeja@gmail.com		√		Reported amount submitted is outside the National Programme stream.
CSO	Jamaica AIDS Support for Life	Kandasi Levermore Executive Director	925-0021	klevermorejasl@gmail.com	√			
CSO	Jamaica Red Cross	Lois Hue - Deputy General Stacy-Ann Tomlinson Sandre Barrett	984-7860-2	loishue@jamaicaredcross.org stomlinson@jamaicaredcross.org youth@jamaicaredcross.org			√	Funding Sources/Agents (UNFPA and Caribbean HIV and AIDS Alliance) - reported funds flow, however no report submitted.
CSO	Jamaica Youth Advocacy Network (J-Yan)	Monique Long Executive Director Javan Campbell	857-8503/ 922-9477 451-8981	long.monique@live.com javan.campbell2012@gmail.com	√			
CSO	Jamaican Network of Seropositives	Devon Gabourel Paula Samuels	929-7340	gabourel@hotmail.com admin@jnplus.org paulasag14@hotmail.com	√			
CSO	JFLAG	Dane Lewis	844-9366	danelew@gmail.com	√			
CSO	Joy Town Community Development Foundation	Major Richard Cooke Mr. Wayne Rochester Dvoraw Bennett	930-0841 564-1518 363-7734	joytown@cwjamica.com majorc@flowja.com wdsrochester@yshoo.com acct.clerk.joytown@gmail.com	√			
CSO	Kingston & St. Andrew PAA	Claudette Hobbins		claudettehobbins@flowja.com	√			
CSO	Mustard Seed Communities	Donna Reynolds, Administrator Clovel Folkes	574-0071 575-8707	donna.reynolds@mustardseed.com dare.to.care@mustardseed.com	√			

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
CSO	National AIDS Committee (NAC)	Carla Ledgister Acting Executive Director	322-0589	blessedcl@live.com			√	Data not available to report
CSO	National Council on Drug Abuse	Johanille Brooks Assistant Dir, Client Services	564-7139/ 618-6233	jbrooks@ncda.org.jm		√		Funds received from US State Department - Public Affairs Section excluded from report submitted.
CSO	Panos Caribbean Institute	Adene Chung	920-0070-1	adene@panoscaribbean.org, indidlk@yahoo.com	√			
CSO	Pride in Action	Mark Clifford	622-4468/ 6204412	Indefenseofequality@gmail.com			√	Did not respond
CSO	St. Ann's PAA	Oral Higgins		oghiggings2000@yahoo.com		√		Private funding,donations not reported.
CSO	St. James PAA	Sharlene Kessna Ducan		skessnaduncan@gmail.com				
CSO	Trelawny PAA	Carla Ledgister	322-0589	blessedcl@live.com	√			
CSO	Women Centre Foundation of Jamaica	Velma MonteithZoe Simpson	929-7608, 929-0977	adminwomen@cwjamaica.com; womenscentre@cwjamaica.co m	√			
CSO	YPM Youth Centre	Ingrid Reid	399-2862/ 838-5344	ingridereid@yahoo.com ypmyouthcentre@yahoo.com			√	Did not respond
CSO	3 D's	Ms. Fay-Ann Swell	984-2840	threedprojects@hotmail.com			√	Did not respond
GOJ	Jamaica Defence Force	Major Gail Ranglin Edwards	322-6331	Gail.Ranglin@jdf.mil.jm			√	Did not respond
GOJ	Ministry of Education (MOE)	Ms. Marcia Carvalho Anna-Kay Magnus Watson Sonia Banton	612-5770 924-9309 279-8116/ 612-5770	Marcia.carvalho@moe.gov.jm annakay.magnuswatson@moey .gov.jm Sonia.banton@moe.gov.jm	√			
GOJ	Ministry of Labour & Social Security (MLSS)	Peta Gay Pryce Robert Chung	457-5646 922-0365/ 382-9271	Pryce.a.petagay@gmail.com rstfchung@yahoo.co.uk	√			
GOJ	National Health Fund (NHF)	Everton Anderson		eanderson@nhf.org.jm	√			
GOJ	NHP Global Fund	Andrew Brown	340-0897	brownan@moh.gov.jm	√			
GOJ	NHP World Bank/USAID	Denice Douglas	537-1800	douglasd@moh.gov.jm	√			

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
GOJ	TPDCo - Ministry of Tourism	Deanne Keating, -Dir of Product Qlty Sheryll Lewis Ricky Pascoe	908-5342 908 5378	Deanne.keating-campbell@tpdco.org Sheryll.lewis@tpdco.org ricky.pascoe@tpdco.org	√			Technical Reports received. Spending captured soley at the MOH/NHP General Ledger.
Int'l	Centre for Disease Control	Deborah Henningham	702-6462	henninghamd@state.gov	√			
Int'l	Clinton Health Access Initiative	Ingrid Thame Country Director	881 5571	ithame@clintonhealthaccess.or g	√			
Int'l	Global Fund	Lilian Pedrosa		lilian.pedrosa@the globalfund.org	√			
Int'l	KfW	Mr. Michael Dumke	926-6728	info@kingston.diplo.de			√	Did not respond
Int'l	PAHO	Dr. Kam Mung Debbie Esty	967-1540/ 970-0016	mungkams@jam.paho.org estydebb@jam.paho.org			√	Did not submit
Int'l	USAID	Dr. Jennifer Knight Johnson	702-6000	jknight-johnson@usaid.gov	√			
Int'l	US Department of Defense	Anya Cushnie Mills	291-4106	cushniea@state.gov	√			
Int'l	U.S. Peace Corps/Jamaica	Anthony Hron	929-0495-8 ext. 263 564-8046	ahron@jm.peacecorps.gov	√			
Int'l	US State Department/ Ambassador Small Grants Programme	Shayzan McBeam	448-8729 702-6113	mcbeams@state,gov	√			Eleven (11) sub-grantees reported over the 2 year period. Four (4) responded to invitation to participate in NASA.
Int'l	UNAIDS	Kate Spring Erva Jean Stevens	960-6538	springk@unaids.orgstevense@ unaids.org	√			
Int'l	UNDP	Rachel Morrison	978-2390	rachel.morrison@undp.org	√			
Int'l	UNESCO	Ms. Christine Norton Director & Representative Janelle Babb – Programme Coordinator	630 5300 361-1696	ca.norton@unesco.org J.babb@unesco.org	√			

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
Int'l	UNFPA	Sheila Roseau, Director Marvin Gunter Ms. Ashman	906-8591	roseau@unfpa.org gunter@unfpa.org ashman@unfpa.org	√			Eight (8) recipients of resources reported over the 2 year period. Five (5) responded to invitation to participate in NASA.
Int'l	UNICEF	Novia Condell	968-8164	ncondell@unicef.org	√			
Int'l	World Bank	Carmen Carpio		ccarpio@worldbank.org			√	Did not submit
Int'l NGO	Health Policy Project	Sandra McLeish Kerian Richards Gray	322-6622 416-5905	smcleish@futuresgroup.com krichards-gray@futuresgroup.com	√			
Int'l NGO	Population Services Int'l (PSI)	Marina Hilaire-Bartlett Ms. Italia Gill Meisha Graham	620-8300	mhilaire-bartlett@psicarib.org igill@psicarib.org mgraham@psjamaica.org	√			
Int'l NGO	World Learning	Ruth Jankee	927-6216/ 4216114	Ruth.Jankee@worldlearning.org	√			
Private	Abbvie (Abbott)	Ms. Secque Allen	927-7098; 935-1952	secque.allen@abbvie.com				Purchase drug only for MOH/NHP, thus captured in NHF database
Private	Aurobindo Pharma	Krishnamachary Sridhar	581-4501	krishsri56@gmail.com				Purchase drug only for MOH/NHP, thus captured in NHF database
Private	Bank of Nova Scotia	Joylene Griffith-Irving Rochelle Dixon		joylene.griffiths-irving@scotiabank.com rochelle.dixon@scotiabank.com		√		Donation to JABCHA not adequately reported
Private	Cari Med	Vevinne Walker Manager/Pharmacist	978-3082/ 3277098	vevinnew@carimed.com	√			
Private	Cipla Ltd	Krishnamachary Sridhar	581-4501	krishsri56@gmail.com				Purchase drug only for MOH/NHP, thus captured in NHF database
Private	Guardian Life Limited	Mrs. Debby Livingstone	978-8815	debby.livingstone@ghl.com.jm	√			
Private	Jamaica Biscuit Company	Mrs. Aida Neil Promotions Supervisor	923-6477	aneil@bermudezcaribbean.com			√	did not submit

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
Private	Janssen-Cilag-Ethnor Limited	Ms. Diane Dawson	927-7098 935-1952	abyfield@its.jnj.com	√			
Private	Lasco Pharmaceuticals	Joy Mitchell Grant	968-3456-65	joyMG@lascoja.com	√			Direct Corporate sale to private individuals reported.
Private	Merck Sharp & Dohme (Singapore) & (Netherlands)	Ms. Heather Campbell	927-7098; 935-1952	heatherc@carimed.com				Purchase drug only for MOH/NHP, thus captured in NHF database
Private	*Pvt Laboratories	Various			√			Reported through MOH/NHP
Private	Ranbaxy	Mr. Richard Edwards	260-6571	erichard96@yahoo.com				Purchase drug only for MOH/NHP, thus captured in NHF database
Private	Sagicor	Audrey Flowers Clarke		audrey_flowers-clarke@sagicor.com	√			
Pvt./Edu	University of Technology	Dr. Ellen Campbell-Grizzle	927-1680 Ext.2316	Ellen.Grizzle@utech.edu.jm; rlewis@utech.edu.jm				no data to report
Quasi GoJ	Blood Bank				√			
Quasi GoJ	ERTU/CHART	Dr. Tina Hylton Kong Dahlia Graham	948-8002	tinak@cwjamaica.com; ertuchartja@chartcaribbean.org dahlia.graham25@gmail.com	√			
Quasi GoJ	JAPPAIDS	Dr. Celia Christie Samuels Shree-Ann Simpson	326-5815/ 927-2095	celia.christiesamuels@uwimona.edu.jm shreeann.simon@uwimona.edu.jm	√			
Quasi GoJ	National Centre for Youth Development	Takisha Barnes	978-5347, 978-7881	tbarbes@mysc.gov.jm	√			
Quasi GOJ	National Family Planning Board	Sannia Sutherland - Acting ED Joseph Reynolds Edmond Montague	968-1627 / 838-2973 838-3270 881 6954	ssutherland@jnfpb.org jreynolds@jnfpb.org montaquee@moh.gov.jm			√	Did not submit
Quasi GoJ	National Public Health Lab					√		Only Human Resources cost reported.

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
Quasi GoJ	North East Regional Health Authority	Dr. Patrick Wheatle, Regional Technical Director Odeth Latouche Jeanette Parris	795-3107 770-6147 454-9083 770-6492	Patrick.wheatle@nerha.gov.jm odeth.latouche@nerha.gov.jm Jeanette.parris@nerha.gov.jm	√			
Quasi GoJ	South East Regional Health Authority	Dr. Heather Reid Jones, - Regional Technical Director Dr. Melody Ennis - Regional HIV Coordinator Venice Gordon Muschette - Rgnal Admin Officer, HIV Simone Burke - Regional, TC&S Officer	317-8998 317-9980 539-2415 539-2415 349-7531	heatherrj@serha.gov.jm melodyennis5@gmail.com VeniceG@serha.gov.jm simonebr@serha.gov.jm	√			
Quasi GoJ	Southern Regional Health Authority	Dr. Michael Coombs, - Regional Technical DirectorJoy AndersonDeborah Phillips	625-0612-3 962- 9491	joy.anderson@srha.gov.jm	√			
Quasi GoJ	UWI HAARP	Marjan de Bruin, Director Yolanda Paul, Project Manager	970-0580 977-5134	marjan.debruin@uwimona.edu.jm; marjandebruin@gmail.com yolandapaul@gmail.com	√			
Quasi GoJ	UWI Health Centre	Dr. Blossom Anglin-Brown Director of Health Services Mrs. Baines	970-0017 927-2520	Blossom.anglinbrown@uwimona.edu.jm Juliette.bowen@uwimona.edu.jm			√	Did not submit
Quasi GoJ	Western Regional Health Authority	Dr. Maung Aung, Regional Technical Director Jasper Cunningham, Finance Dir.	952-1124/3678	jasper.cunningham@wrha.gov.jm	√			
FBO	Anglican	Patrick Cunningham		fatherpatrick@yahoo.com				
FBO	Church of God of Prophecy	Lasmine Scaffe		cogop@cwjamaica.com				no data to report
FBO	Jamaica Council of Church	Gary Harriott		Garionne.harriott@gmail.com			√	Did not submit

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Sector	Sub-Recipient	Representative	Contact Information	Email	Data Collected	Partial Data Collected	No Data Collected	Comments
FBO	Jamaica Union of Seventh Day Adventist	Milton Gregory General Secretary		mgregory@jmsda.net	√			
FBO	Methodist	Everald Galbraith	925-2032 /924-1218 445-4809	Jamaicamethodist@cwjamaica.com; evergalbraith@yahoo.com				did not submit
FBO	Northern Caribbean University	Dr. Orlean Brown Earle, Associate Professor	382-7034 /963-7497 618-1652	Orllean.brown-earle@ncu.edu.jm	√			Email sent with info on PEPFAR grant. To be extracted to the tool and approved by Dr. Brown Earle. (input query sent back)
FBO	Salvation Army	Ivaline Nickie, Focal Point Major Stanley Hazel, Divisional Commander		renaissance52@yahoo.com anniedawsonchildren@gmail.com				no data to report
FBO	Stewart Town Circuit of Baptist Churches	Rev. Steven Henry	370-5040	yawyah@yahoo.com	√			
FBO	United Church	Delroy Harris	864-3807	delroy-harris@ucjci.com				No data to report
FBO	Universal Centre of Truth	Claudia Fletcher					√	No data to report
FBO	UTCWI	Rev Marjorie Lewis		mlewis@utcwi.edu.jm			√	Did not submit

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Appendix 2: Data Collection Tool

FORM 1 - INSTITUTIONAL ROLE - ALL INSTITUTIONS ARE REQUIRED TO COMPLETE THIS FORM

FORM 1 HAS 4 PARTS - A, B, C & D

PART A

Years(s) of the expenditure estimate: ________________

Objective of Form 1: To identify the roles of the institution to determine the most suitable form to be used for data collection.

Name of the Institution:
Contact Person (Name and Title):
Address:
Phone:
Email:
Fax:

Instructions: Please place an 'X' in the box that applies to your institution.

PART B

1. Is your institution the originating entity of funds spent on HIV, AIDS and related activities? (Financing Sources)	Yes	No
2. Does your institution transfer funds to other institutions for activities connected to the HIV&AIDS Response? (Financing Agents)	Yes	No
3. Is your institution engaged in the production, provision and delivery of HIV, AIDS and related services? (Provider of Services)	Yes	No

PART C

4. Legal Status: Please select the category of your institution

Central Government	
Regional Health Authorities	
Line Ministries	
Private (for profit national)	
Private (for profit international)	
Non Profit (NGO/CSO/FBO/CBO)	
Bi-lateral Agency	
Multi-lateral Agency	

PART D

GUIDELINE NOTES - PLEASE REFER TO SECTION 'B' ABOVE

If your institution is a 'Source' and/or an 'Agent' - Please move to the next worksheet and complete FORM 2 - 'DATA COLLECTION (SOURCES/AGENTS)'

If your institution is a 'Provider of Services' - Please skip the next worksheet 'DATA COLLECTION (SOURCES/AGENTS) and complete FORM 3 -'DATA COLLECTION (PROVIDERS)'

If your institution is a 'Source' and/or an 'Agent' and a 'Provider of Services' - Please complete FORM 2 - 'DATA COLLECTION (SOURCES/AGENTS)' & FORM 3 - 'DATA COLLECTION (PROVIDERS)'

Preparer: ______________________ **Tel #:** ____________

Title: ______________________ **email:** ______________________

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FORM 2 -DATA COLLECTION (SOURCES/AGENTS)

FORM 2 CONSIST OF 3 PARTS - A, B & C

PART A

Year(s) of the expenditure estimate: ___________________

Objective of Form 2:

(a)To identify the origin of the funds used or managed by the institution during the year understudy.

(b)To identify the recipient of those funds.

Indicate what currency will be used throughout the form with an 'X'		Local Currency	US$ Exchange rate
Period:	1st Apr 2011 - 31st Mar 2012		
Period:	1st Apr 2012 - 31st Mar 2013		

Instructions: All Financing Agents only are required to completed section B (See form 1).

PART B

Origin of the Funds Transferred to your institution. Please list the institutions from which your organization received funds during 1st Apr 2011 - 31st Mar 2013

No. of institutions	*Origin of the Funds (Name of the Institutions)*	*Funds received for HIV and AIDS and related activities (1st Apr 2011 - 31st Mar 2012)*	*Funds received for HIV and AIDS and related activities (1st Apr 2012 - 31st Mar 2013)*	*Contact within Originating Organization*
1				
2				
3				
4				
5				
6				
	Total	0	0	

Origin of non financial resources Transferred to your institution. Please list the institutions from which your organization received non-financial resources during 1st Apr 2011 - 31st Mar 2013

No. of institutions	*Origin of the non finanical resources (Name of the Institutions)*	*Type of Goods/Services donated*	*Quantity Received*	*Monetary Valuefor HIV and AIDS and related activities (1st Apr 2011 - 31st Mar 2012)*	*Monetary Valuefor HIV and AIDS and related activities (1st Apr 2012 - 31st Mar 2013)*	*Contact within Originating Organization*
1						
2						
3						
4						
5						
6						
	Total			0	0	

Instructions: All 'Financing Sources' and 'Financing Agents' are required to completed section C (See form 1).

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PART C

Destination of the Funds Transferred to your institution:
(a) Please list the institutions to which your organization transferred funds during 1st Apr 2011 - 31st Mar 2013.
(b) Quantify the transferred funds.
(c) Quantify the transferred funds reported as spent during the period 1st Apr 2011 - 31st Mar 2013. If no Data is available regarding the amount spent, state 'No Data' in the cell.

No. of institutions	*Destination of the Funds (Name of the Institutions)*	*Funds **transferred** for HIV and AIDS and related activities (1st Apr 2011 - 31st Mar 2012)*	*Funds **spent** for HIV and AIDS and related activities (1st Apr 2011 - 31st Mar 2012)*	*Funds **transferred** for HIV and AIDS and related activities (1st Apr 2012 - 31st Mar 2013)*	*Funds **spent** for HIV and AIDS and related activities (1st Apr 2012 - 31st Mar 2013)*	*Contact within Destination Organization*
1						
2						
3						
4						
5						
6						
	Total	0	0		0	

Recipients of non financial resources Transferred from your institution. Please list the institutions to which your organization donated non-financial resources during 1st Apr 2011 - 31st Mar 2013

No. of institutions	*Destination of the non finanical resources (Name of the Institutions)*	*Type of Goods/Services donated*	*Quantity Dispatched*	*Monetary Valuefor HIV and AIDS and related activities (1st Apr 2011 - 31st Mar 2012)*	*Monetary Valuefor HIV and AIDS and related activities (1st Apr 2012 - 31st Mar 2013)*	*Contact within Destination Organization*
1						
2						
3						
4						
5						
6						
	Total			0	0	

Preparer: ______________________________ Tel #: ______________

Title: __________________________________ email: _____________________________

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FORM 3 -DATA COLLECTION (PROVIDERS OF SERVICES)

Instructions: (a) All recipient of transferred funds that are spent as recorded in the Data Collection (Source & Agent)sheet are required to complete this section

(b) If your institution consumed resources in producing services or goods including administrative cost in managing the fund, please include below

(c)Please complete a table per funding source eg. Global fund, World Bank, USAID - each of these sources will be in a separate table below

Period: **1st Apr 2011 - 31st Mar 2012**

Financing		Use		Provision of HIV Services		Amt. Spent on Resources for Activity
Funding Source	Funding Agency	Activity	Targeted Population	Input Resources	Service Provider	
	Subtotal					0

Financing		Use		Provision of HIV Services		Amt. Spent on Resources for Activity
Funding Source	Funding Agency	Activity	Targeted Population	Input Resources	Service Provider	
	Subtotal					0

	Total 1st Apr 2011 - 31st Mar 2012					***0***

Period: **1st Apr 2012 - 31st Mar 2013**

Financing		Use		Provision of HIV Services		Amt. Spent on Resources for Activity
Funding Source	Funding Agency	Activity	Targeted Population	Input Resources	Service Provider	
	Subtotal					0

Financing		Use		Provision of HIV Services		Amt. Spent on Resources for Activity
Funding Source	Funding Agency	Activity	Targeted Population	Input Resources	Service Provider	
	Subtotal					0

	Total 1st Apr 2012 - 31st Mar 2013					***0***

Preparer: ________________________________ Tel #: _______________

Title: ____________________________________ email: _______________________________

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Appendix 3: Sample of Letter sent to Participating Entities

MINISTRY OF HEALTH
National HIV/STI Programme

OCEANA COMPLEX, 2 – 4 KING STREET, KINGSTON, JAMAICA
TEL: (876-967-1100/3/5/7 967-4286 FAX: (876)967-1643
WEBSITE: www.moh.gov.jm EMAIL: ____________________

ANY REPLY TO THIS COMMUNICATION SHOULD BE ADDRESSED TO THE PERMANENT SECRETARY AND THE FOLLOWING REFERENCE QUOTED

REF NO: ______________________

7th April 2014

The Director
Jamaica Perinatal Paediatric and Adolescent AIDS
Department of Child Health (Paediatrics)
University of the West Indies, Kingston

Dear Dr. Celia Christie-Samuels,

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, the Ministry of Health in collaboration with the Joint United Nations Programme on HIV and AIDS (UNAIDS) is undertaking a National AIDS Spending Assessment (NASA) project for the period 1st April 2011 through to 31st March 2013. The NASA is a resource-tracking framework for monitoring the annual flow of funds used to finance the national response to HIV & AIDS. In addition to the financing, the framework aims to capture HIV & AIDS expenditures that reflect the range of services employed in the response and how these services are targeted towards beneficiary populations. In order to execute this project, kindly note the following:

- A data collection tool is appended for completion by your organization. It is highly recommended that the technical and finance teams work together to complete the required data.
- The completed data collection tool is to be returned no later than 17th April 2014.
- **Mrs. Janice Walters and Ms. Renee Johnson** are authorized to conduct data collection for the NASA on behalf of the Ministry of Health and UNAIDS. They will serve as resource persons to support stakeholders in the completion of the data collection tool. We are requesting that the above-named individuals be accorded the necessary courtesies to facilitate the completion of this assessment in a timely manner.
- 'The National AIDS Spending Assessment (NASA): Classification and Definition 09', the NASA coding instrumental to the production of NASA is attached for your reference.

Please be advised that the information supplied through this process will be treated confidentially.

Thank you in advance for your co-operation in this very important exercise which will assist in improved planning for the national HIV/AIDS response.

Sincerely,
Dr. Jeremy Knight
Acting Director National HIV/STI Programme

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Appendix 4: NASA Implementation Plan

IMPLEMENTATION PLAN - National AIDS Spending Assessment (NASA) – Jamaica

NASA Process	Activity	Responsible agency/person	Notes				
			March	April	May	June	
Planning and training (March-April)	Sign contract with Lead Consultant	MOH/NHP					• This activity engages a consultant to undertake the NASA assignment for the years 2012 & 2013
	Lead Consultant hires Sub-Contractor	Lead Consultant					• This activity engages a sub-contractor to support the lead consultant in completing the NASA assignment for the years 2012 & 2013
	Meet with NASA Task Force to discuss the assignment	NASA core team					• Identification & approval of participating/targeted entities; refine data collection tools used for previous NASA; identify gaps and propose areas to be enhanced during this consultancy; discuss and refine approach to the assignment.
	Contact participating entities to confirm the contacts for facilitating NASA	Consultants fulfilling the requirements of the assignment					• Confirmation of the contacts facilitating the data request. Ensuring that 'buy-in' is established at a senior level in the participating entities.
	Prepare and dispatch correspondences to participating entities. These are to be affixed with MOH Senior Officer Signature	Consultants fulfilling the requirements of the assignment					• Refine the data collection tool (and guide) and seek approval for same from the NASA Task Force. • Update the previous correspondences sent to participating entities (to account for any gaps) and dispatch along with data collection tool. Target date for dispatch is 1st April 2014.
	Prepare/ Plan the refresher workshop for key participating entities.	Consultants fulfilling the requirements of the assignment					• Review the slides from the previous training sessions. Discuss areas for strengthening based on feedback reflected in the data collection exercise of the previous NASA. • Include overview of NASA, discuss with entities steps being taken to institutionalize NASA.

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	Execute the workshops	Consultants in collaboration with NHP staff (for the logistics)				• Book venue/ prepare workshop folders/refreshment (if warranted). • Present NASA training using practical examples and potentially 'walk through', with the tool.
Data Collection (April – June)	Follow up participating entities re: data collection. Constant assessment of progress and 'hand holding' where necessary to compete the assignment timely	Consultants fulfilling the requirements of the assignment				• Members of the core team will be assigned to support and facilitate return of the data collection tool from all entities - ensuring timeliness, accuracy and completeness.
	Review and validate data presented by the entities	Consultants fulfilling the requirements of the assignment				• Conduct key informant interviews that will determine the validity of the information collected. Where applicable cross referencing to MOU/MOA and Financial Statements for period under review. •
	Organize a file maintaining all records of data collected, assumptions made, estimates derived, approximation done	Consultants fulfilling the requirements of the assignment				• Feed into the final report. Facilitate consistency in practice year on year. Reference point for explaining some actions decisions made.
Data Processing	Conduct preliminary validation prior to data input to NASA Database. Input data in the database. Extract Matrices	Consultants fulfilling the requirements of the assignment				• Professionals previously trained from the RHA and CSOs will group in a central area for hands on training while they enter data and conduct analyses along with other members of the NASA team. (Day 2 of Training Workshop). • Consultants supporting this Project will complete data entry from collection tools returned by the participating entities.
Data Analys is	Triangulate	NASA core team				• Triangulate data and verify to make sure there is no double counting and similarly no data gaps

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	Initial validation	NASA core team								• During analysis the NASA core team will check the accuracy of data with stakeholders on a one on one basis.
Report and validation	Prepare Draft Report- noting assumptions, estimates and approximation	Consultants fulfilling the requirements of the assignment								• Output as per deliverables schedule. The prior period report will be updated on an ongoing basis, as information becomes available.
	Review/validate	NASA core team								• The first draft of the report will be reviewed by the Ministry of Health. The second validation will be done with stakeholders and the third at a national level.
	Prepare Final Report- Amend draft report with feedback received & finalize.	Consultants fulfilling the requirements of the assignment t								• This will be done by the consultants (assistance will come from the NASA Task Force)
Dissemination	Prepare audience specific material for dissemination.	UNAIDS/NHP								• These will include hard copy of the reports, pamphlets with key messages, etc

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