

Sri Lanka: National AIDS Spending Assessment

2009-2010



NATIONAL
STD/AIDS
CONTROL
PROGRAMME



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Any enquiries about or comments on this publication should be directed to:

Health Accounts Unit
Institute for Health Policy
72, Park Street, Colombo 2, Sri Lanka.
Tel: +94-11-231-4041/2/3
Fax: +94-11-2314040
www.ihp.lk

Director
National STD/AIDS Control Programme
29, De Saram Place, Colombo 10, Sri Lanka.
Tel: +94-11-266-7163
Fax: +94-11-533-6873/268-2859
www.aidscontrol.gov.lk/nsacp



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Preface

Tracking of national HIV expenditures and financing flows are an essential requirement to monitor and plan the resources for tackling HIV. The National AIDS Spending Assessment (NASA) tool, assists to monitor these scarce resources for HIV, considering not just the health components, but also education, social protection services, and others, in order to evaluate and quantify the multi-sectoral approach of the national AIDS response. NASA will help to identify funding gaps and duplication of funding in the national response to HIV epidemic.

This publication provides estimates of overall HIV spending in the country for the years 2009–2010, and will be of much value to the Ministry of Health (MOH), as well as the stakeholders who are interested in understanding the financial flows of the national AIDS response.

I wish to express my appreciation to the Institute for Health Policy for conducting the NASA activity in Sri Lanka for the first time, and also my gratitude for the funding support provided for this project through the Joint United Nations Program on HIV/AIDS (UNAIDS) Technical Assistance Fund managed by the Technical Support Facility for South Asia (TSF), and the many counterparts in both the public and private sectors who extended their cooperation to this exercise.

Dr Nimal Edirisinghe
Director
National STD/AIDS Control Programme
Ministry of Health

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The collection and analysis of the data and the writing of this publication was done by Dr Ravi P. Rannan-Eliya, Mr Sanil De Alwis, Dr Shanti Dalpatadu, Ms Sarasi Amarasinghe, Ms Ruwanthi Elwelegedara and Ms Shanaz Saleem. The graphic design and desktop layout was by Mr Harees Hashim of IHP.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ABST	Antibiotic Sensitivity Test
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
ASC	AIDS spending category
BCC	Behaviour Change Communication
BP	Beneficiary Population
CBSL	Central Bank of Sri Lanka
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DCS	Department of Census and Statistics
DDG-PHS-I	Deputy Director General (Public health1)
ERC	Ethical Review Committee
ERD	External Resources Department
FA	Financing Agent
FS	Financing Sources
FSW	Female Sex Workers
GC	Gonococci
GDP	Gross Domestic Product
GoSL	Government of Sri Lanka
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
ICHA	International Classification for Health Accounts
IDH	Infectious Diseases Hospital
IDU	Injecting drug users
IHP	Institute for Health Policy
MARP	Most At Risk Population
MOH	Ministry of Health
MSD	Medical Supplies Division
MSM	Men who have Sex with Men
NAC	National AIDS Committee
NASA	National AIDS Spending Assessment
NBTS	National Blood Transfusion Service
NGO	Non-Government Organizations
NHA	National Health Accounts
NPI	Non-Profit Institution

NPISH	Non-Profit Institutions Serving Households
NSACP	National STD/AIDS Control Programme
NSP	National Strategic Plan
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OI	Opportunistic Infections
OPD	Out Patients Department
OVC	Orphans and vulnerable children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RDOH	Regional Department of Health
RMSD	Regional Medical Supplies Division
SC	Steering Committee
SFD	Sanofi Fujirabio Diagnostics
SHA	System of Health Accounts
SLHA	Sri Lanka Health Accounts
SLPA	Sri Lanka Pharmaceutical Audit
STI	Sexually Transmitted Infections
SMT	Senior Management Team
SW	Sex Workers
TB	Tuberculosis
THE	Total Health Expenditure
TPPA	Treponema pallidum Particle Agglutination
TSF	Technical Support Facility for South Asia
UNAIDS	Joint United Nations Program on HIV/AIDS
VCT	Voluntary Counselling and Testing
VD	Venereal Disease
WHO	World Health Organization

Executive Summary

- **Total HIV/AIDS expenditure in Sri Lanka during 2009 and 2010 is estimated at Rs.518 and 534 million, equivalent to USD 4.5 and 4.7 million respectively.** This was equivalent to per capita spending of Rs. 25 and 26. As a proportion to Gross Domestic Product (GDP), the expenditure incurred on HIV/AIDS was 0.011% and 0.010% in 2009 and 2010 respectively. The HIV/AIDS spending as a proportion to Total Health Expenditure (THE) in Sri Lanka was 0.32%(2009) and 0.29% (2010) respectively.
- **Central government was the largest financing source, contributing 46% (2009) and 48% (2010) of total financing for HIV/AIDS activities,** followed by donor agencies at 42% (2009) and 40% (2010). International non-profit institutions contributed 6% (2009) and 3%(2010).
- **Central government was the main financing agent, spending Rs. 197.7million in 2009, and Rs. 197.9 million in 2010. The financing agents for the private sector were mainly donor agencies in 2009 (21%) and in 2010 (22%).** Overall, the public sector was the largest financing agent, contributing 58% in both years.
- **Most spending (56%) is for services delivered by the public sector, principally the Central STI Clinic, Colombo and peripheral STI clinics.** Non-Profit Institutions (NPIs) are the largest providers in terms of spending in the private sector, accounting for 33% (2009) and 27% (2010) of total expenditure.
- **The largest share of expenditure by AIDS spending category was on prevention at 68% in 2009 and 74% in 2010.**This is followed by expenditure on human resources (10-14%), which mainly constitutes expenditure on training. Care and treatment expenditure was approximately 5-6% of total expenditure. Programme management and administration expenditure was 5% in both years. Central and provincial governments incur more than 60% of the spending on prevention.
- **Public sector spending was primarily on prevention, which accounted for over 80%, which was followed by spending on care and treatment, which was 8-9%.**
- **HIV/AIDS expenditure on prevention was distributed** to prevention, diagnosis, and treatment of STI (33%), prevention programmes for sex workers and their clients (14%), blood safety (11%), communication for social and behaviour change (11%), voluntary counselling and testing (VCT) (9%), risk reduction for vulnerable and accessible populations (9%), programmes for MSM (5%), prevention programmes in the workplace (3%) and other prevention categories (5%).
- **The largest HIV/AIDS expenditure was for people attending the STI clinics, 28% (2009) and 30% (2010). Expenditure targeted at Most at Risk Populations (MARPs) and People Living with HIV (PLHIV) accounted for 21% (2009) and 22% (2010).**
- **The highest level of HIV/AIDS spending was in the Western Province in both 2009 (Rs. 166.1 million) and 2010 (Rs.207.5 million).** The central STI clinic, Colombo is situated in the Western province, which also contributes to the higher spending in this province. The geographical distribution of expenditures closely matches the geographical distribution of the HIV/AIDS caseload.
- **The pilot NASA exercise demonstrated that IHP's Sri Lanka Health Accounts system can be easily adapted also to track HIV/AIDS spending annually, as an extension to SLHA's annual tracking of overall health expenditure.**

1. Introduction

1.1 HIV Epidemic in Sri Lanka

Sri Lanka, with a population of 20.7 million in 2010, is classified as a country with a low level HIV epidemic in the South-East Asia region (NSACP 2010). As of end-December 2010, a cumulative total of 1,317 HIV-positive cases had been reported to the National STD/AIDS Control Programme (NSACP) (Figure 1). Of these, 326 have been reported as developing AIDS, and 221 have succumbed to the illness. The majority (80%) of those infected were in the 25-49 year age group.

Although classified as a lower middle-income country, Sri Lanka, has achieved remarkable social and health indicators, some of which are on par with those of developed nations. The HIV prevalence in the general population was estimated at less than 0.1% at end-2009. Even amongst most-at-risk populations (MARPs), such as female sex workers (FSW), men who have sex with men (MSM) and their sex partners, HIV prevalence has remained less than one per cent. It is estimated that, as of December 2009, there were 3,000 (2,100–3,800) people living with HIV (PLHIV) in Sri Lanka.

Over the years, there has been a gradual increase in the number of reported cases, which may be due to an increase in testing and screening procedures. Availability of antiretroviral therapy (ART) free of

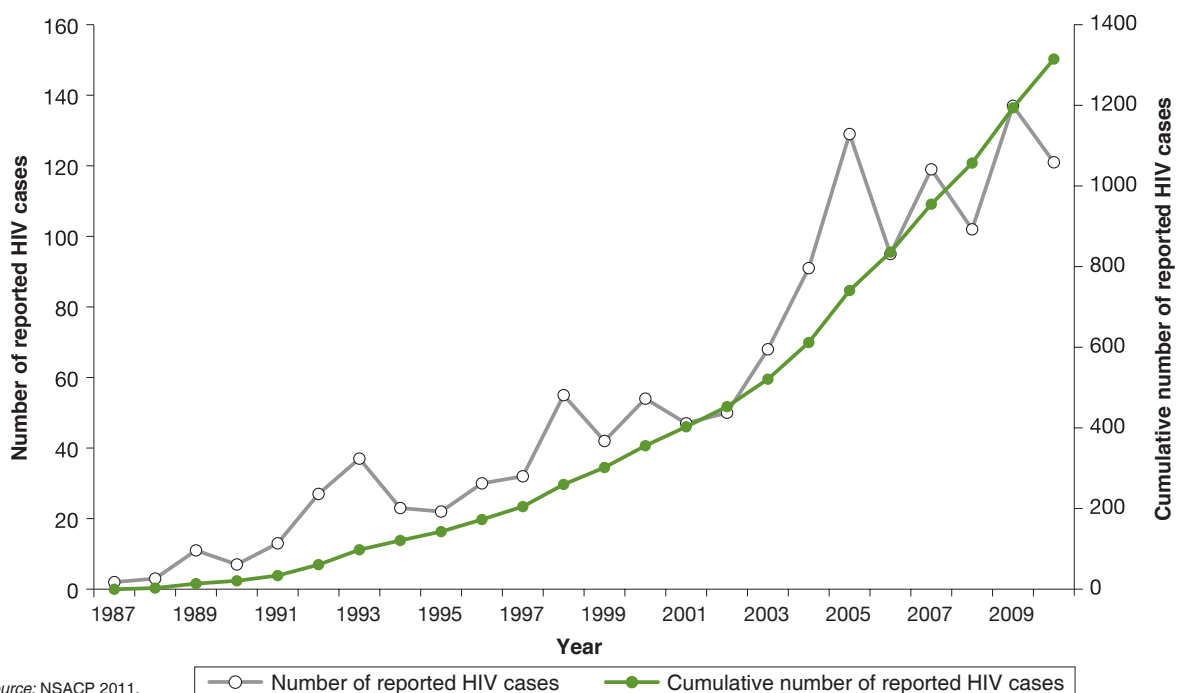
charge in the country has encouraged more people to come forward for HIV testing. According to NSACP, 234 people living with HIV were receiving ART as of end-2010.

The main mode of transmission is due to unprotected sex between men and women (82.5%). MSM have accounted for 11.3% of the transmission while mother to child transmission was 4.4% (Table 1). For every seven HIV positive men, there are five HIV positive women in Sri Lanka. Transmission through blood and blood products was infrequent (0.3%), mainly due to the blood safety policy adopted in Sri Lanka since 1988.

However, methodical HIV surveillance continues to be needed, since certain socioeconomic and behavioural factors, which are present in the country, may facilitate epidemics of HIV/STI at any time in the future. The presence of a large youth population, internal and external migration, a clandestine but flourishing sex industry, low levels of condom use, and concurrent sexual relationships among MARPs are some such factors.

Although currently injecting drug use is not a common phenomenon in Sri Lanka, those who inhale and snort drugs do engage in sex with other men and patronize the sex trade. Evidences show that there is high risk behaviour interaction between

Figure 1: Number of HIV cases reported up to end of December 2010



female sex workers, MSM and people who use drugs, even though the absolute size of this population is relatively small, this is considered a potential source of HIV infection within this subset and beyond in Sri Lanka. Reassuringly, HIV sentinel sero-surveillance amongst armed forces has found zero HIV prevalence to date (Table 2).

It should be noted that while the total number of confirmed HIV positive cases is available to the NSACP, the numbers of HIV screening tests carried out in the private sector are not reported to NSACP. Although the number of paediatric cases reported were very few, numbers may be under-estimated, since diagnosis of paediatric HIV/AIDS cases is limited, as Polymerase Chain Reaction (PCR)-DNA testing is not available at present in Sri Lanka.

Low STI rates have been observed among MARPs and in the general population. Similar to the global trends, the STI surveillance data shows that the bacterial STI are declining but viral STI trends are increasing, i.e. Herpes Simplex Virus (HSV) and Human Papilloma Virus (HPV). Genital herpes is the

leading STI in the country (Table 3). The presence of genital ulcers increases the risk of HIV transmission. Antenatal screening for syphilis is a routine procedure in the country, and the reported prevalence of syphilis among antenatal mothers is low.

Availability and accessibility to free health care services from the government health sector, high literacy rates and health awareness, and a low level of drug injectors are some of the factors considered to be protective, which may have contributed to the low level of STI in Sri Lanka. In addition, blood safety measures, improving the management of services, empowerment of women and safeguarding rights have contributed immensely, to control sexually transmitted infections including HIV to a low level in Sri Lanka, compared with other countries in South and South-East Asia.

Table 1: Cumulative cases by probable mode of HIV transmission as of end December 2010

Mode of transmission	Cumulative	Percentage
Unprotected heterosexual contact	733	82.5
Unprotected homosexual/bisexual contact	100	11.3
Injecting drug users (IDU)	5	0.6
Blood transfusion	3	0.3
Mother to child transmissions	47	5.3
Total (excluding 429 unknown)	888	100

Source: NSACP 2011.

Table 2: HIV sero-prevalence among sentinel population groups in Sri Lanka, 2005-2009

Population group	Year of sentinel surveillance survey				
	2005	2006	2007	2008	2009
Female sex workers	0%	0.20%	0%	not included	0%
	0/1,136	2/1,216	0/1,218		0/1,032
MSM	not included	not included	not included	0%	0.48%
				0/242	2/411
Drug users	not included	not included	not included	0.19%	0%
				1/539	0/1,004
STI clinic attendees	0.04%	0.40%	0.08%	not included	0.15%
	2/1,528	8/2,215	5/2,456		4/2,476
TB patients	0.10%	0.10%	0.08%	not included	0%
	2/1,528	1/1,332	1/1,233		0/1,547
Military	0%	0%	0%	not included	0%
	0/3,200	0/1,200	0/1,241		0/1,380

Source: Sri Lanka UNGASS Country Progress Report 2008-2009.

Table 3: Number of new episodes of STIs reported to STI clinics, 2010

Disease Category	Disease	Male	Female
Isolated Bacterial Infections	Infectious Syphilis	153	57
	Late Syphilis	272	285
	Early Congenital Syphilis	4	2
	Late Congenital Syphilis	0	0
	Gonorrhoea and Presumptive GC	270	107
	Chlamydia	13	13
	Trichomoniasis	11	96
	Bacterial Vaginosis	0	1,075
Isolated Viral Infections	HIV Infection	50	14
	Genital Herpes	1,172	1,356
	Genital Warts	924	631
	Chancroid	10	10
Infections with multiple etiologies	Ophthalmia neonatorum	6	4
	Non Gonococcal Urethritis/Cervicitis	531	1,201
	Other STI	540	168
Fungal Infections	Candidiasis	900	1,502
Total		9,441	9,391

Source: NSACP 2011.

1.2 National Response

The Government of Sri Lanka (GoSL) already had in place structures to respond to HIV/AIDS before the detection of the first HIV case in Sri Lanka. The Anti-Venereal Disease (VD) Campaign which was established in 1952, based on a British model for control and prevention of venereal diseases, was re-structured in 1985 and was renamed the NSACP.

NSACP is a specialized public health programme that comes under the Deputy Director General (Public health1) (DDG-PHS-1) of the Ministry of Health. Director/NSACP, in consultation with the senior management team (SMT), provides leadership and technical guidance to both preventive and curative services provided by NSACP. The Central STI Clinic, Colombo administratively comes under the line ministry, while most of the peripheral STI clinics are under the direct administration of district health managers working in the provincial health departments.

To provide policy directions and for coordination of inter-ministerial activities, the National AIDS Council was constituted in 2006 and is the highest governing body, chaired by His Excellency the President of Sri Lanka with relevant ministers as members.

The National AIDS Committee (NAC), which was formed earlier in 1988, is chaired by the Secretary for the Ministry of Health (MOH), and functions as the policy formulating and policy implementation body of the MOH on HIV/AIDS. It has continued its commitment by overseeing implementation of the response to HIV/AIDS since 2008.

The NAC has recommended that more focus should be given to targeted interventions for the identified MARPs. Thus, the main aim of the National Strategic Plan (2007–2011) (NSP) is to increase the coverage and quality of targeted interventions for the MARPs, and to increase the coverage and quality of treatment, care and support. The strategic objectives of the NSP are increased coverage and effectiveness of prevention interventions, and increase coverage and effectiveness of care, support and treatment.

Other objectives to support the above core strategies are improved generation and use of information for planning and policy development, increased involvement of relevant sectors and levels of government in the response, a more supportive public policy and legal environment for HIV control, and improved management and coordination of the response.

GoSL recognizes the importance of the participation of multiple stakeholders in the national response. The NSP, which was developed with the participation of several stakeholders, has identified roles and responsibilities of the government, Non-Profit Institutions (NPIs) and PLHIV. HIV care, support and treatment, comprehensive management of STI, counselling, behavioural change communication (BCC) activities targeting the general public and specific risk groups, HIV surveillance system, condom promotion, laboratory facilities, screening blood and blood products, instituting infection control measures including universal precautions in all

medical institutions and in the field services, were strengthened and improved during the assessment period 2008-09 (NSACP 2010) in keeping with objectives and targets of NSP. In addition, a strategic plan to eliminate congenital syphilis in Sri Lanka by 2015 has been also launched and antenatal screening for syphilis has been strengthened.

2. Study Approach

2.1 Background of the study

In 2005, the Joint United Nations Program on HIV/AIDS (UNAIDS) developed the National AIDS Spending Assessment (NASA) tool, based on previous HIV resource tracking methods (including National Health Account HIV Sub-Analysis). This incorporated feedback from international experts, including those at the Institute for Health Policy (IHP). The objective was to develop a tool for the National AIDS Authorities to monitor the resources for HIV/AIDS, considering not just the health components of the response, but education, social protection services, and others, in order to evaluate and quantify the multi-sectoral approach of the national AIDS response.

In an effort to initiate NASA exercises for interested countries in the region, UNAIDS organized a NASA training workshop in India in 2006 for regional collaborators. Sri Lankan representatives from the Institute of Policy Studies attended, but this failed to generate any follow-up. Subsequently, UNAIDS Headquarters and the Regional Support Team in Asia-Pacific organized a NASA Regional Workshop in Hanoi, Vietnam, in May 2010. This workshop brought together experts from UNAIDS Headquarters, regional consultants and participants from 10 countries in the Asia-Pacific region, including Sri Lanka, which was represented by MOH and IHP.

NSACP is undertaking a review of its response to AIDS for the five-year period 2007–2011. A key step in this review and a key piece of strategic information, which will inform the process for the development of the next National Strategic Plan on AIDS 2012–2016, will be the undertaking of a NASA.

NASA is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV/AIDS. It describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease using the bottom-up and top-down approach. Financial resources are tracked by financing source whether it is public, private or international, and among the different providers.

IHP carried out as a pilot project the Sri Lankan NASA exercise for the period 2009 and 2010. The

project was a public-private partnership between IHP and the NSACP, MOH. Funding support was provided through the UNAIDS Technical Assistance Fund managed by Technical Support Facility for South Asia (TSF), through a contract with Health Policy Research Associates (Pvt) Ltd. IHP's consulting affiliate.

IHP and IHP staff developed and have maintained since 1998 the Sri Lanka Health Accounts (SLHA) system, which tracks national health expenditure according to international standards. IHP is a leading global centre for expertise in health accounts and health expenditure estimation, providing technical expertise to WHO, OECD and World Bank. The current SLHA estimates cover the period 1990 to 2009. IHP developed NASA as an extension to the existing SLHA process.

Overall objectives of the NASA project

The overall objective of this pilot project was to develop, implement and institutionalize HIV/AIDS resource tracking in Sri Lanka based on the NASA methodology. Specifically, the project aimed:

- To develop and implement a methodology for systematic monitoring of HIV/AIDS financial flows at national and regional/district level using NASA methodology and linked to the SLHA system.
- To develop a strategy involving multi-sectoral and multi-level key partners to track HIV and AIDS spending in Sri Lanka, and
- To build national level and regional/district capacity for systematic monitoring of HIV/AIDS financing flows.

2.2 Conceptual framework

SLHA framework

The SLHA estimates national health expenditure in Sri Lanka and is compiled by the Institute for Health Policy. The objective of the SLHA activity is to track overall health expenditure flows in Sri Lanka. The SLHA framework is based on and is compatible with the System of Health Accounts (SHA), the statistical standard for international reporting of health accounts, published in 2000 by the Organisation for Economic Co-operation and Development (OECD),

and endorsed for international reporting of health accounts statistics by (WHO 2003). It accordingly uses a definition of health expenditure that corresponds to the OECD SHA concept of Total Health Expenditure (THE). THE includes as health spending all expenditure in categories corresponding to personal health services, collective health services, health administration and investment in plant and equipment. Not included in the THE scope are health-related expenditure, such as those for training, environmental health, research and payment of cash benefits to patients. The SLHA database tracks expenditure according to the dimensions of source of funds, provider, and function, using Sri Lanka-specific classification systems based on those of the International Classification for Health Accounts or ICHA (OECD 2000). The SLHA also tracks expenditure geographically by province and district.

The SLHA was developed in four phases. The first phase was between 1998-2000, the first Sri Lanka National Health Accounts (NHA) project, where Sri Lanka released its first estimates, which were compatible with SHA. The second phase was a consolidation of the SLHA system and updating of estimates during 2002-04. Regular annual tracking of the health accounts was achieved and sustained in the third phase (2005-08). In the fourth phase (2009-11), continuous improvements and revisions to the core methodologies were made and estimates further updated on an annual basis. Estimates under the fifth phase, which is piloting the introduction of the SHA 2011 standard (OECD 2011), are currently being prepared.

A wide range of stakeholders including the GoSL and other local and foreign organizations use the SLHA estimates. MOH and WHO have used IHP's SLHA estimates as the basis for WHO's annual statistics on national health expenditure in Sri Lanka. The SLHA reports are available from the IHP web site (www.ihp.lk).

NASA framework

NASA seeks to ascertain the flows of funds used to finance national responses to the HIV epidemic. Therefore, the NASA process follows financial flows from their origin down to the final destination (i.e., the beneficiaries receiving goods and services). Most of the key elements of the NASA framework correspond to the dimensions found in the SLHA/SHA frameworks. However, NASA is not limited

to tracking health expenditure, as it also tracks non-health expenditure such as for social mitigation, education, labour, justice, and spending in other sectors related to the multi-sectoral HIV response.

The NASA framework (UNAIDS 2009) requires that estimates be developed according to the following NASA classifications:

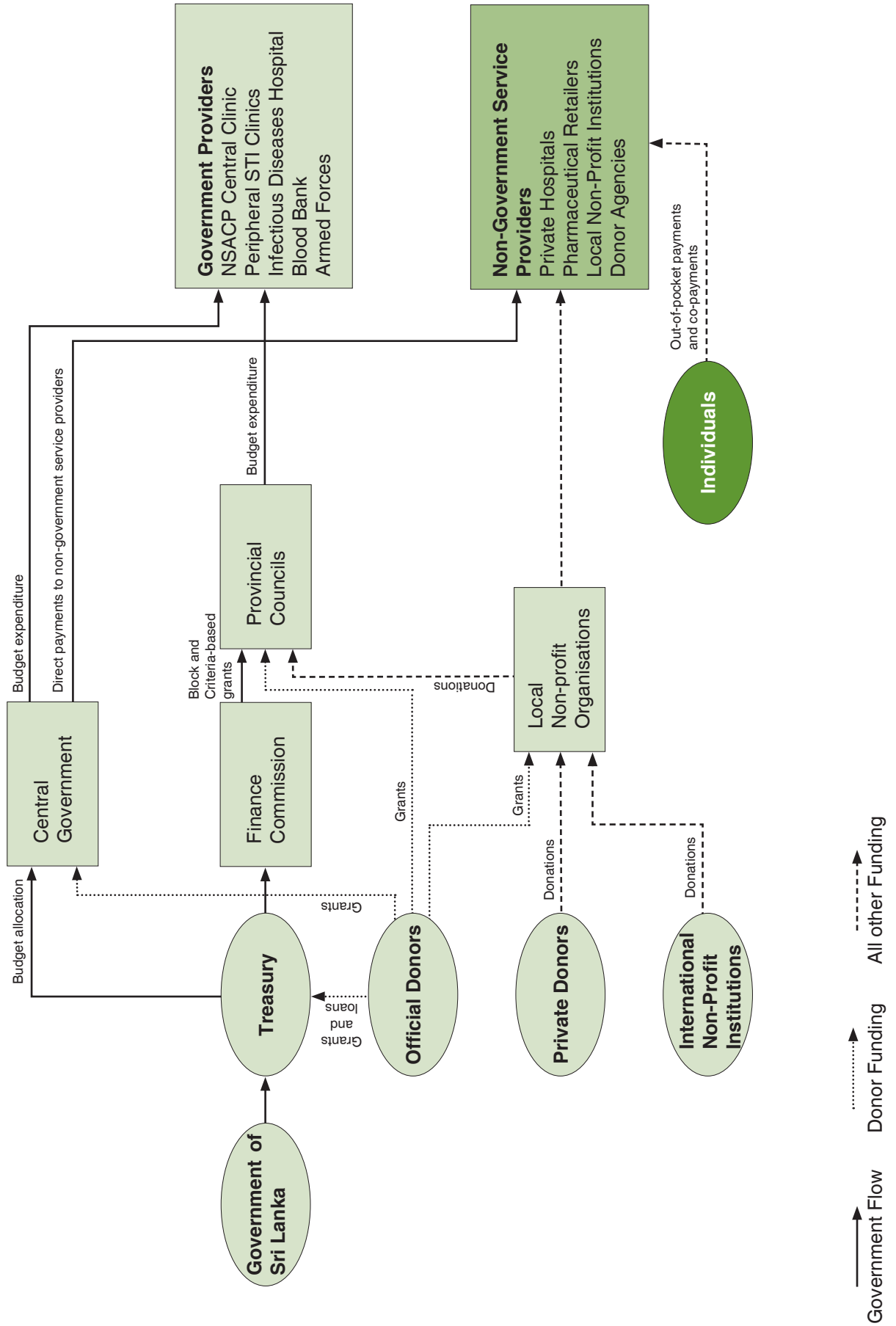
- Financing sources (FS) – entities that provide money to financing agents.
- Financing agents (FA) – entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent).
- Providers (PS) – entities that engage in the production, provision, and delivery of HIV services.
- AIDS spending categories (ASC) – HIV-related interventions and activities.
- Beneficiary segments of the population (BP) – the population that ultimately benefit from the expenditure. E.g., men who have sex with men, injecting drug users, etc.

To develop these, the Sri Lanka NASA pilot aimed to use the underlying SLHA expenditure estimates and data collection methodology as the basis for all NASA expenditure estimations, relying as necessary on further analysis and data collection to either introduce the greater detail required or to supplement the SLHA estimates with estimates of spending not covered by SLHA. Data sources and collection methods were revised and expanded to collect the necessary data to estimate the additional requirements imposed by the NASA framework and classifications.

Flow of funds for HIV/AIDS expenditure in Sri Lanka

Health care expenditure on HIV/AIDS in Sri Lanka is provided mainly by the government and donor agencies. Funds from donor agencies are channelled through treasury as well as directly provided to MOH, Provincial Councils and to NPIs. The public sector providers are Central STI clinic, peripheral STI clinics and Infectious Diseases Hospital (IDH), which are mainly financed by general revenue taxation and donor funding. Private sector providers are private hospitals, NPIs, and donor agencies.

Figure 2: Flow of funds for HIV/AIDS expenditure in Sri Lanka, 2010



3. Methodology

Different approaches were used for the collection of data and estimation of HIV/AIDS spending by the public sector, private sector and donor agencies.

3.1 Public sector

Four categories of public sector expenditure on HIV/AIDS were identified: (i) NSACP activities other than patient treatment and management, (ii) patient services provided at STI clinics of NSACP in Sri Lanka (Annex Table 1), (iii) expenditure incurred in treating PLHIV at government facilities and (iv) expenditure incurred for HIV screening at the National Blood Transfusion Service (NBTS).

NSACP program activities

NSACP spending on administrative, surveillance, coordination, training and health education activities were estimated using the personnel related staff costs incurred for each area.

STI Clinics

Specialist clinical services are provided for PLHIV through the STI clinics, which are monitored and supported by the NSACP. Most of these clinics are operated at district level by Regional Departments of Health (RDOHs), but a few are financed and operated directly by the line ministry. In most cases, STI clinics have their own operating funds, but are situated within hospital facilities, where some of the overhead costs of the hospital are shared with the clinics. Therefore, a full cost analysis of the hospital is necessary to apportion the relevant overhead expenditure to the STI clinic, as well as estimating the operating costs of each facility. Except for a few STI clinics, the RDOHs provide the budgetary resources for these STI clinics, as they are administered directly by the district health authorities.

Within the current district financial accounting systems, the STI clinics are not treated as separate cost centres, and their operating expenses are grouped within the budgetary allocations for Public Health Services, and tracked on that basis. Consequently, the operating expenditures of the STI clinics must be estimated as a share of the budgetary spending on Public Health Services, using appropriate apportionment methods.

Altogether in Sri Lanka, the government operates one central STI clinic, 30 full time peripheral STI clinics and 19 branch STI clinics. During the NASA project, field visits were made to nine STI clinics as follows: Central STI clinic, Colombo South (Kalubowila), Anuradhapura, Jaffna, Mannar, Vavuniya, Balapitiya, Mahamodara and Hambantota. The visits were made in order to obtain an overview of the functioning of the STI clinics, and to collect cost-related data from the clinics and also the host hospitals. During the field visits to the STI clinics, data were collected on the number of staff, number of tests conducted, volumes of medicines distributed to patients, number of patients attending the clinic, total patient visits and the actual expenditure (for available details). The data were collected for the period 2009–2010. Institutional cost data were also collected from the host hospitals, where applicable.

Expenditures at STI clinics can be classified into five separate categories, each of which was separately estimated:

- Personnel-related expenditure
- Reagent cost of laboratory tests
- Cost of medicines for patients attending the clinics
- Cost of condoms distributed from the STI clinics
- Other facility operational and overhead expenditures.

The staffing numbers at clinics were compiled using the staffing numbers available at the NSACP for each of the STI clinics. These staffing numbers were then multiplied by the average wage levels for each staff category (Government of Sri Lanka 2004) to derive an initial estimate of the wage cost at each clinic. This estimated wage cost does not include the staff overtime and other emolument expenditures that are incurred for the STI clinic staff. Therefore, the RDOHs were requested to compile the actual personnel related expenditure incurred in the nine surveyed STI clinics, inclusive of these other costs. This information is not readily available at the RDOHs, so it had to be compiled by the RDOHs by using the cashbook or voucher level information in some instances. This second set of estimates, based on actual financial records, can be considered accurate. The ratios of the overall personnel expenditure costs computed in this way to the wage costs estimated using only the staffing numbers and wage rates data were then computed for each of the surveyed clinics.

This average ratio was then used to adjust the wage costs estimated using the first method at the other non-surveyed STI clinics, in order to estimate their overall personnel-related expenditure.

The expenditure at STI clinics attributable to cost of reagents for the laboratory tests were estimated by multiplying the number of lab tests with the cost of reagents per test (Annex Table 2). The central laboratory of the NSACP was able to furnish the usual cost of reagents per test and the number of tests conducted at each STI clinic.

The STI clinics receive their own supply of medicines directly from the district-level Regional Medical Supplies Division (RMSD), which are supplied by the Medical Supplies Division (MSD), but the current inventory tracking system at the RMSDs does not track the volumes or costs of the medicines sent to the STI clinics. The RMSDs also supply medicines to other provincial health facilities in their district, so the actual quantities sent to the STI clinics are hidden within the total RMSD operational costs. In addition, STI clinics sometimes obtain medicines from the Out-Patient Department (OPD) pharmacies located in the hospital. Therefore, data on the actual quantities of medicines distributed by the STI clinics to their patients were collected from the surveyed STI clinics. These quantities were multiplied by the costs per unit of medicine provided by MSD, to derive an estimate of the expenditure incurred on medicines by each of the surveyed STI clinics. The cost of medicines distributed at the other non-surveyed STI clinics was then estimated by multiplying the number of patients at those clinics by the average ratio of medicines costs to patients in the surveyed clinics.

The spending for condoms was estimated from the number of condoms distributed to the STI clinics provided by the NSACP. This was multiplied by the unit cost of condoms provided by the NSACP to arrive at the overall expenditure incurred on condoms.

All other facility operational and overhead expenditures were estimated on a pro-rata basis as a general overhead cost. The cost of all expenditures other than on personnel, and medicines and medical supplies provided by MSD, was obtained for each host hospital using information collected during the hospital visits and the expenditure information available in the government accounting database for the

relevant line ministry hospitals. The ratio of this to personnel costs was then computed for each hospital. The mean ratio for the surveyed hospitals was then compared with the same ratio derived for the free-standing Central STI clinic, Colombo, and the two ratios were approximately equal. It was then assumed that the ratio of other or overhead facility costs to personnel costs was the same at each STI clinic as in the host hospitals, and in most instances, since the STI clinic is within the hospitals premises itself, this is a valid assumption. This average ratio of other or overhead costs to personnel related costs in the surveyed hospitals was then applied to the cost of personnel related expenditure at all the other STI clinics in order to derive an estimate of the overhead and other costs associated with each STI clinic. This procedure was adopted since overhead expenditure of STI clinics is not tracked separately in the current district accounting system.

Expenditures incurred on Antiretroviral drugs (ARVs) were estimated from the quantities of ARVs distributed to patients by the ART distribution centres, multiplied by the unit cost of ARVs. These details were obtained from the central pharmacy at the NSACP, which is responsible for the distribution of ARVs to all facilities.

The distribution of clinic spending to different beneficiary groups was estimated using information provided by the NSACP. Discussions were held with the Co-ordinator of the Strategic Information Management Unit of the NSACP, and estimates were developed using the available program statistics and by an internal analysis done by the NSACP.

Infectious Diseases Hospital (IDH)

IDH at Angoda is the only public sector hospital having a ward catering exclusively for inpatient care for PLHIV in Sri Lanka. From this designated ward for PLHIV, a field survey team collected data on the number of staff, number of lab tests conducted, and medicines utilized. The cost estimates for staff, lab tests and medicines utilized for the ward at IDH were derived using a similar methodology as explained in the section above for STI clinics. Although IDH is the only hospital with a ward designated for PLHIV, in practice PLHIV receive inpatient treatment for Opportunistic Infections (OI) at other public hospitals as well. Therefore, these treatment expenditure at other government medical institutions were estimated by assuming

these expenditures were equivalent to 50% of IDH expenditure. This was an arbitrary percentage, as there was no available data on these activities at other institutions.

Armed Forces

The Armed Forces incur expenditure on HIV awareness programs conducted as part of the in-service training curriculum, the distribution of condoms and HIV testing. The Armed Forces were contacted to obtain information on the HIV related spending that the forces incur. The Armed Forces were able to provide details of the number of HIV awareness programs conducted, and the estimated cost of the programs. They also provided information on the number of HIV screening tests conducted. The expenditure incurred for HIV screening tests by the Armed Forces was estimated by multiplying the number of HIV screening tests by the cost of reagents per test furnished by the NSACP by central laboratory.

National Blood Transfusion Service (NBTS)

The NBTS is responsible for the safe supply of blood and blood products to the people of Sri Lanka. NBTS provides all blood and blood products utilized by government medical institutions, and provides the same on request to private providers who have registered with the NBTS. In practice, almost all private hospitals obtain their blood supplies from NBTS, so close to 99% of the blood supply in the country is accounted for by NBTS, with major exception being blood donated by a patient's relatives at private hospitals. NBTS conducts HIV testing on blood samples by all donors. The number of tests conducted for the relevant period and the number of staff involved with HIV testing were obtained from the NBTS. Estimates were derived for the cost of HIV tests done by NBTS, using the cost of reagents per test and the number of tests provided by the NBTS. Personnel related expenditure for conducting the HIV testing at NBTS was estimated using the percentage of staff time incurred on HIV testing multiplied by the relevant personnel related expenditure.

3.2 Private sector

Non-Profit Institutions (NPIs)

IHP routinely tracks health expenditure by non-profit institutions serving households (NPISH) in Sri Lanka for the purposes of SLHA estimation. NPISHs are commonly termed non-government organizations (NGOs), and some are also described as Civil Society Organizations (CSOs), as in the NASA framework. However, for most part of this report refers to all of them as NPIs (non-profit institutions).

IHP tracks health expenditure of NPIs by way of an NGO mail survey. To meet the needs of the NASA pilot, this survey was modified and expanded in order to obtain more detailed and comprehensive data on NPIs HIV/AIDS spending. Two changes were made: (i) the routine survey form was supplemented by an additional module (Annex Figure 1), which asked for more detailed information on HIV/AIDS projects including spending, and (ii) the sampling strategy for the survey was revised to provide better coverage of NPIs thought to be involved in HIV/AIDS activities.

There is no single or comprehensive list of NPIs working in health in Sri Lanka, since these organizations can exist in different legal forms, subject to different reporting and regulatory requirements. Consequently, IHP constructs each year a listing of NPIs from which it surveys a sample. The sampling frame for the NGO-survey in 2011 was based on (i) the list of major NPIs routinely tracked by IHP, (ii) the list of NPIs receiving funding from MOH, (iii) a list of other NPIs known to UNAIDS and NSACP as working in the HIV/AIDS field, (iv) and two directories of health-related NGOs published by WHO (2003, 2010). The total sampling frame consisted of 315 NPIs. From this, a stratified sample of NPIs was selected and surveyed using the mail questionnaire. One stratum consisted of the major NPIs routinely tracked by IHP and those receiving funding from MOH: all of these were surveyed (n=29). A second stratum consisted of the other HIV/AIDS-related NPIs known to NSACP/UNAIDS: all of these were surveyed (n=21). Finally, any other NPIs identified from the WHO directories were divided into those where the available information indicated they might have HIV/AIDS activities out of which 20% was sampled (n=16) and the rest: where all (100%) of these were surveyed (n=185). Overall, a total of 251 NPIs were surveyed.

The main survey form with the additional HIV/AIDS module was sent to the sampled NPIs. The survey form used was provided in all three languages – English, Sinhala and Tamil. During the pilot testing, it was found that some NPIs expressed preference to use soft copy of the survey forms and hence soft copies of the survey forms were made available via the IHP website.

The NGO survey was reviewed and cleared by IHP's Ethical Review Committee (ERC). All surveyed NGOs were provided a guarantee of data confidentiality, and the assurance that respondent-specific information would not be published or shared by IHP, without their permission.

A meeting was convened in September 2011 in conjunction with the NSACP for the NPIs that were identified as having HIV related programmes, and an overview of the NASA project was provided to them by MOH, UNAIDS and IHP, and participants urged to cooperate. Survey forms were also distributed at the meeting. The NPIs were followed up through mail, email and telephone as appropriate. In order to increase the response rates a second round of mailings was done to the NPIs that did not provide any response in the first round of mailings.

A problem encountered during the survey was that some of the NPIs listed, especially in the WHO directories, did not have valid telephone numbers and mailing addresses, and the survey forms were returned undelivered and they could not be contacted by telephone. Most of these NPIs probably no longer exist. These returned survey forms were recorded in order to estimate later the percentage of NPIs in the listings that are no longer in operation. The survey data received were reviewed, clarifications were sought from the NPIs where needed, and the data entered into a database. Subsequent analysis and production of overall estimates of spend-

ing used sample weights to reflect the design of the stratified survey, and response rates.

Results

Out of the surveyed NPIs which were thought to have HIV-related programmes (n=44), there were 15 positive responses (34%), four indicated that they had no health related programmes (9%), one refusal to respond (2%), a delivery failure for five (11%), and no response for 19 (44%). The delivery failure, which was common to all strata, was due to some of the NPIs discontinuing operations in Sri Lanka, or due to change of addresses by NPIs, or incomplete addresses provided by the sources when compiling the NPIs sampling frame. Out of the NPIs that may not have HIV related programmes, but are the major NPIs routinely tracked by IHP and those receiving funding from MOH (n=22), there were ten positive responses (45%), two indicated that they had no health related programmes (9%), a delivery failure for one (5%), and no response for nine (41%). Out of the remaining surveyed NPIs that did not evidence prior information on having HIV related programmes (n=185), there were 10 positive responses (5%), 10 indicated that they had no health related programmes (5%), a delivery failure for 62 (34%), and no response for 103 (56%). Table 4 indicates the response rates for this survey.

Private medical providers

There are no reliable or routine statistics on the treatment of PLHIV in the private sector. Key informant interviews were done with representatives of NSACP and leading clinicians, including Consultant Venereologists, involved in HIV/STI patient care, to ask them whether they were aware of or could estimate the numbers of PLHIV treated in the private sector for HIV/AIDS. The question was also posed to members of the Steering Committee (SC).

Table 4: Response rates in IHP Survey of NGO-funded Health Expenditures Sri Lanka 2011

Description	Sampled	Reponses	No health activities	Refusals to respond	Delivery failure	No Responses
NPIs with HIV related health programmes ^{(a)(b)(c)}	44	15 (34%)	4 (9%)	1 (2%)	5 (11%)	19 (44%)
NPIs with non-HIV related health programmes ^(a)	22	10 (45%)	2 (9%)	- (0%)	1 (5%)	9 (41%)
NPIs with non-HIV related health programmes ^(c)	185	10 (5%)	10 (5%)	- (0%)	62 (34%)	103 (56%)

(a) Major NPIs routinely tracked by IHP and those receiving funding from MOH.

(b) HIV/AIDS-related NPIs known to NSACP/UNAIDS.

(c) NPIs identified from the WHO directories.

Source: IHP Survey of NGO-funded Health Expenditures Sri Lanka 2011.

The common response was that the informants believed that the number of PLHIV seeking treatment in the private sector is very small or close to zero. To validate this claim, IHP undertook a number of additional investigations.

The volume of ARV medicines sold in the private pharmacy sector was checked using the estimates produced by IMS-Health (Sri Lanka) in its regular audit of pharmacy sales (Sri Lanka Pharmaceutical Audit, SLPA). No sales of ARVs were identified in the SLPA data for 2000–2009, except for Lamivudine, which is also used for the treatment of other diseases. Given the absence of any other reported sales of other ARV medicines, it is likely that none of the Lamivudine sales were for HIV treatment. The IMS-Health data are themselves from a survey of pharmacies and data provided by wholesalers, so this does not exclude the possibility of private ARV sales, but they do imply that any sales if they occur must be so rare that they are not being picked up by the IMS-Health pharmacy sample. A separate validation of this finding was done by interviewing the two best known pharmacies in the Colombo district and in Sri Lanka, namely OsuSala (Colombo) and Union Chemist (Colombo), to find out if ARV drugs are sold in the pharmacy retail sector. It was found that Lamivudine was available, but that Zidovudine and Abacavir were not routinely stocked, but had been available previously at these pharmacies, and could be ordered if required. These findings lead to the conclusion that there are almost zero retail sales in Sri Lanka of ARVs, either to patients or to doctors. This implies that if ARVs are being utilized privately, then they must be limited to quantities imported on a personal basis from India or elsewhere.

Interviews were also done with several leading private hospitals, asking them the number of HIV screening tests conducted and the number of admissions by PLHIV. The feedback from the hospitals was that there were small numbers of PLHIV ad-

mitted for treatment annually in most of the larger hospitals. Some of the largest private hospitals reported an annual case-load of 2–11 patients/year.

Based on these findings, it was concluded that significant numbers of HIV screening tests are done in the private sector (often for insurance purposes), and that only a small, but not zero, number of patients are actually provided medical treatment for HIV/AIDS.

Expenditure on HIV screening tests were estimated by multiplying the number of HIV screening tests reported by the price per test obtained from a few of the leading private hospitals to estimate the expenditure incurred in the private sector for HIV screening tests.

An estimate was derived for the private sector expenditure incurred for the inpatient treatment costs of OI for PLHIV by using the number of admissions by PLHIV reported by a few of the private hospitals multiplied by the revenue generated on average by an admission in the private hospital sector, using information from IHP's SLHA estimates.

3.3 External donors

IHP routinely tracks official donor health expenditure in Sri Lanka, relying primarily on a questionnaire survey of all health sector donors. This questionnaire was redesigned and expanded for the NASA pilot, to collect more detailed information on HIV/AIDS projects and expenditure, using an additional module. The listing of major donors is based on previous findings, information from MOH on current donor projects, the donor project database of the External Resources Department (ERD) of the Ministry of Finance and Planning, and the annual data on ODA disbursements in Sri Lanka reported by OECD Development Assistance Committee (DAC).

Table 5: Response rates in IHP Survey of Donor-funded Health Expenditures Sri Lanka 2011

	Donors contacted	Responded	Completed survey
Donors with HIV related health programmes	10	10	10 (100%)
Donors with non-HIV related health programmes	5	3	3 (60%)
Donors with non-health/ insignificant health expenditure	10	10	0
No response/closed down operations	5	0	0
Total donors contacted	30	23	13

Source: IHP Survey of Donor-funded Health Expenditures Sri Lanka 2011.

There were 30 donors identified in Sri Lanka with operations during 2008–2010, and these were all surveyed in the IHP Donor Health Expenditure Survey 2011. The survey forms were distributed via post and email, and, in addition, soft copies of the survey forms were made available via the IHP website (Annex Figure 2). Follow-up was done using telephone calls, emails and selective interview/visits. The survey data received were reviewed, clarifications sought with the donors where needed, and the data entered into the IHP Donor Expenditure database. The IHP Donor Survey 2011 was reviewed and cleared by IHP's ERC.

Results

Out of the 30 donors that were initially surveyed for the health expenditure tracking, 15 donors gave feedback stating that they had health related programmes (50%), there were 10 donors with no health related programmes (33%), and five donors which did not respond at all (20%). Out of the 15 donors that have health related programmes, 10 were identified as having HIV related programmes where all (100%) responded with data. From the five donors who have non-HIV related health programmes, three (60%) responded with data (Table 5).

3.4 Data processing

Using the data collected and estimations made, IHP's SLHA database, which tracks all health expenditure in the country, was modified so as to further disaggregate and mark HIV-related expenditures. In some cases, this meant tagging existing expenditure amounts, or further disaggregating the database records to apportion existing elements of spending to HIV and non-HIV activities. In other cases, new records had to be set aside to track non-health expenditures related to HIV/AIDS, which are desired for NASA reporting purposes. Further modification was also done to enable tracking of HIV-related expenditure by beneficiary grouping.

These modifications and adaptations extended the core SLHA database, and enable it to report both SLHA indicators of total health spending, as well as NASA indicators of HIV-related spending. The main benefit of this is that the NASA estimates are consistent with the overlapping SLHA estimates of national health expenditure.

3.5 Limitations

In the public sector, expenditure for STI clinics are aggregated within the total health budgets of the province. Therefore, various estimations had to be done to derive the cost of these cost centres. Inevitably, there is some degree of error between the clinics' actual expenditure and the estimated amounts.

Since there is no single or comprehensive list of NPIs, several sources were used in the compilation of the list of NPIs to survey. One of the sources used (WHO 2003) had identified many NPIs as working in the health sector, but many of them had incomplete mailing addresses. An effort was made independently to verify these addresses, but the contact details listed in the WHO directory were often outdated or invalid. Consequently, they could not be contacted, and there is some uncertainty over whether these organizations are still operational.

Some of the responses provided by donors and NPIs did not have sufficient detail to disaggregate reliably all spending by NASA relevant classifications. In most of these cases, survey forms were filled with project level descriptions where activity level breakdowns were not submitted. The geographical location of the expenditures was often not given, and assumptions had to be made to disaggregate the expenditures by location.

Although several follows-up were made, the overall response rate in the NPIs survey was low. This coupled with the heterogeneity of NPIs means that the NPI expenditure estimates are subject to larger errors.

4. Results

4.1 Key expenditure indicators for HIV/AIDS

According to the results of the first pilot NASA project, total spending on HIV/AIDS for the years 2009 and 2010 is estimated at Rs. million 518 and 534 (Table 6), equivalent to Rs. 25 and 26 per capita for 2009 and 2010 respectively. When compared with Gross Domestic Product (GDP) for the same years, the spending is equivalent to 0.011% and 0.010% of GDP, respectively. As a ratio to THE in Sri Lanka, HIV/AIDS spending was 0.32% (2009) and 0.29% (2010). However, when comparing HIV/AIDS expenditure to THE, one should interpret the ratio with caution, since the expenditure included in the boundary of THE differ from those measured in the NASA.

4.2 HIV/AIDS expenditure by Financing Source

The central government is the largest financing source for HIV/AIDS spending during both years under review, accounting for 46% (2009) and 48% (2010) of total spending. This is followed by donor agencies, which contributed 42% (2009) and 40% (2010). International non-profit institutions contributed six per cent in 2009 and three per cent in 2010 (Table 7 and Figure 3).

Table 6: Total health expenditure and Total expenditure for HIV/AIDS, 2009-2010

		Year	
		2009	2010
Total expenditure for HIV / AIDS	(Rs. million)	518	534
	(USD million)	4.5	4.7
	Per capita (Rs.)	25	26
	Per capita (USD)	0.2	0.2
	% of GDP	0.011	0.010
	% of THE	0.32	0.29
THE	(Rs. million)	163,511	184,423
	(USD million)	1,423	1,631
	Per capita (Rs.)	7,996	8,931
	Per capita (USD)	70	79
	% of GDP	3.4	3.3

Note: SLHA estimates of THE are provisional for 2009 and 2010, since work is still ongoing.

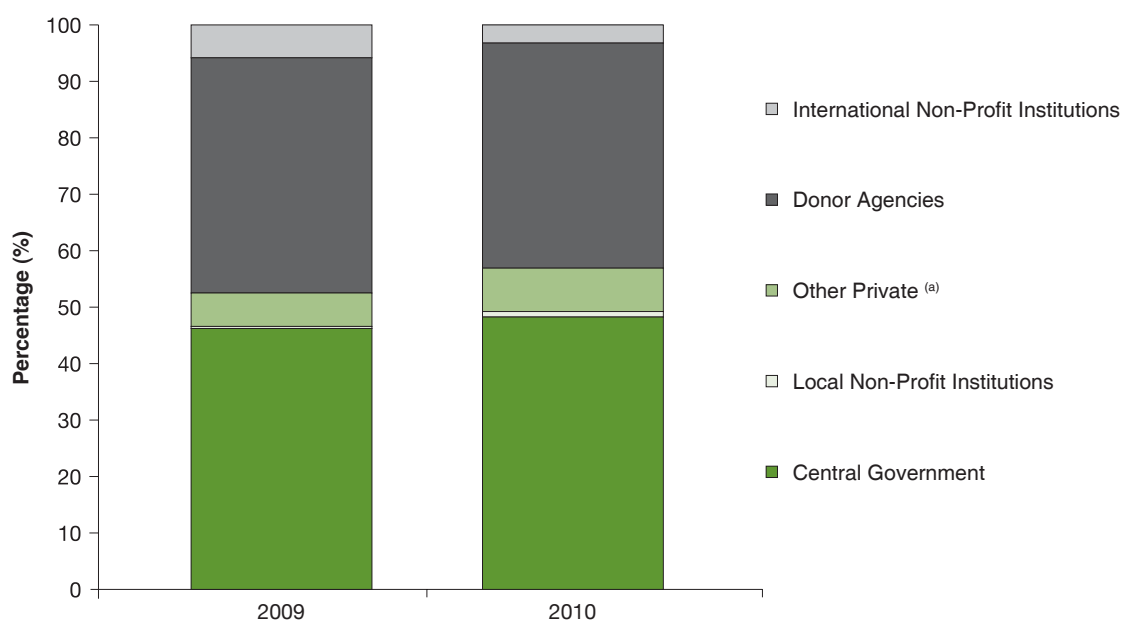
Source: IHP Sri Lanka NASA Database 2011 and IHP Sri Lanka Health Accounts Database 2011.

Table 7: HIV/AIDS expenditure by financing source, 2009-2010

Financing source	2009			2010		
	Rs. million	USD million	%	Rs. million	USD million	%
Central Government	239.5	2.1	46	257.8	2.3	48
Local Non-Profit Institutions	1.9	0.0	0	5.2	0.0	1
Other Private ^(a)	30.7	0.3	6	41.1	0.4	8
Donor Agencies	215.9	1.9	42	213.1	1.9	40
International Non-Profit Institutions	30.2	0.3	6	17.2	0.2	3
Total	518.2	4.5		534.4	4.7	

(a) Financing sources to households.

Source: IHP Sri Lanka NASA Database 2011.

Figure 3: HIV/AIDS expenditure by financing source (%), 2009–2010

(a) Financing sources to households.

Source: Table 7.

4.3 Expenditure by Financing Agents

Central government was the main financing agent, spending Rs. 197.7 million in 2009, and Rs. 197.9 million in 2010 (Table 8). Provincial governments accounted for one fifth of financing, 20% in 2009, and 21% in 2010. Consequently, the public sector as a whole was the largest financing agent, contributing 58% in both years under consideration. The financing agents for activities in the private sector were mainly donor agencies during 2009 (21%) and 2010 (22%).

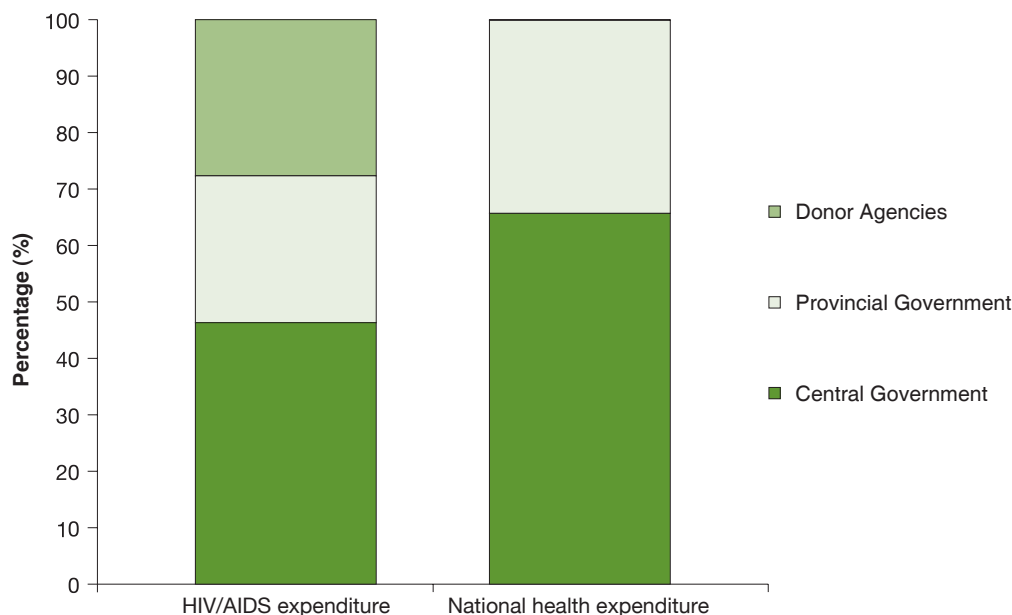
If private sector expenditures are excluded, it can be observed that donor agencies account for a comparatively large share of HIV/AIDS expenditure, when compared to the overall national health expenditure (Figure 4). The contribution by provincial governments is similar in both cases.

Table 8: HIV/AIDS expenditure by financing agents, 2009-2010

Financing agent	2009			2010		
	Rs. million	USD million	%	Rs. million	USD million	%
Central Government	197.7	1.7	38	197.9	1.8	37
Provincial Government	103.6	0.9	20	111.1	1.0	21
Local Non-Profit Institutions	56.6	0.5	11	55.3	0.5	10
Households	42.7	0.4	8	48.4	0.4	9
Donor Agencies	108.5	0.9	21	118.2	1.0	22
International Non-Profit Institutions	9.1	0.1	2	3.4	0.0	1
Total	518.2	4.4		534.4	4.7	

Source: IHP Sri Lanka NASA Database 2011.

Figure 4: Composition of financing by public sector/donor financing agents in national health expenditure and HIV/AIDS expenditure (%), 2010



Note: Estimates above exclude privately-financed expenditures.

Source: IHP Sri Lanka NASA Database 2011 and IHP Sri Lanka Health Accounts Database 2011.

4.4 HIV/AIDS expenditure by Providers

Approximately 56% of HIV/AIDS expenditure is through public sector providers in both years under review (Table 9 and Figure 5). The largest providers in the public sector are the Central STI clinic, Colombo and peripheral STI clinics. In the private sector, most of the HIV/AIDS expenditure has been at NPIs and private hospitals. There was a slight decrease in the share of spending at NPI providers from 33% (2009) to 27% (2010).

When examined by financing source, over 80% of the central government financing was spent at the peripheral STI clinics, IDH and the Central STI clinic, Colombo (Figure 6). In contrast, over 60% of the financing by donor agencies was to NPI providers.

Table 9: HIV/AIDS expenditure by providers, 2009-2010

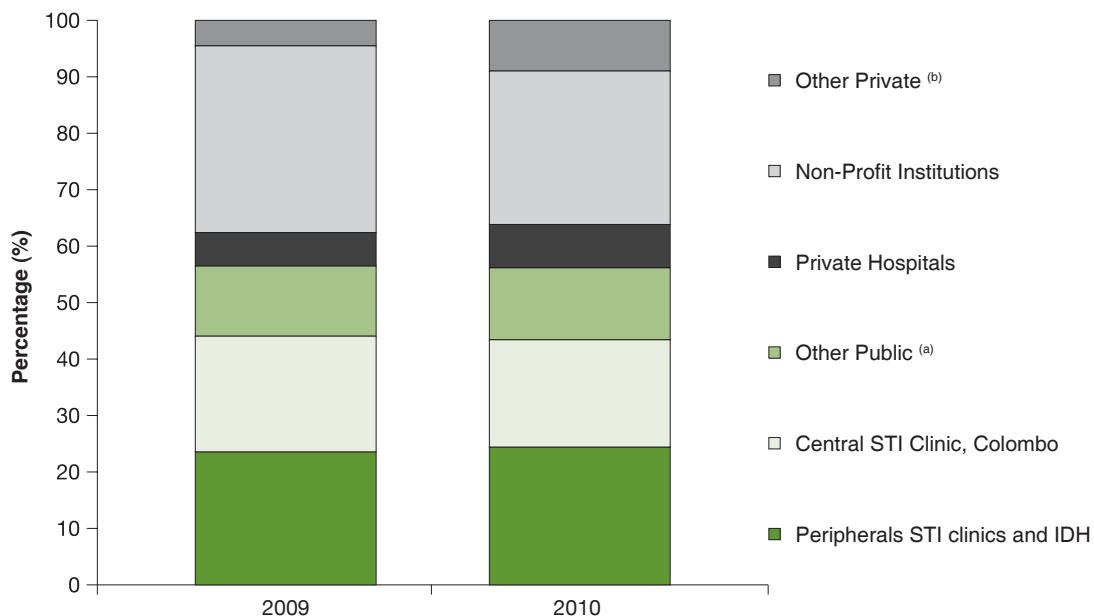
Providers	2009			2010			
	Rs. million	USD million	%	Rs. million	USD million	%	
Public sector	Peripheral STI clinics and IDH	121.9	1.1	24	130.3	1.2	24
	Central STI Clinic, Colombo	106.4	0.9	21	101.7	0.9	19
	Other ^(a)	64.3	0.6	12	68.1	0.6	13
Private sector	Hospitals	30.7	0.3	6	41.1	0.4	8
	Non-Profit Institutions	171.5	1.5	33	145.3	1.3	27
	Other ^(b)	23.4	0.2	5	48.0	0.4	9
Total	518.2	4.5		534.4	4.7		

(a) Blood bank and other government entities.

(b) Donor agencies, consultancy firms, etc.

Source: IHP Sri Lanka NASA Database 2011.

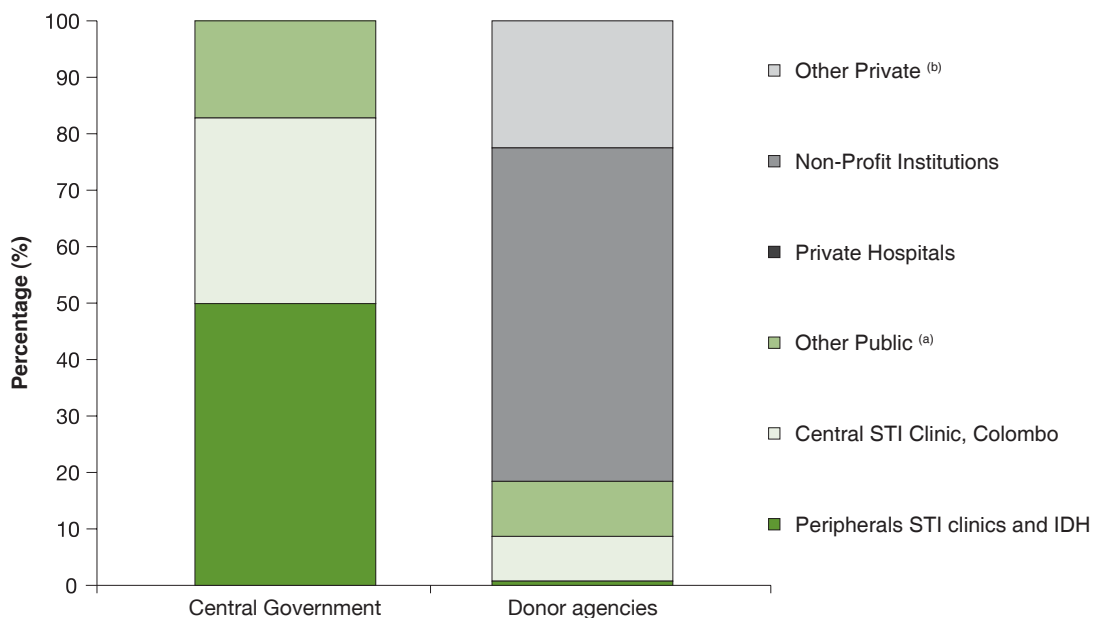
Figure 5: HIV/AIDS expenditure by providers (%), 2009–2010



(a) Blood bank and other government entities.
 (b) Donor agencies, consultancy firms etc.

Source: Table 9.

Figure 6: HIV/AIDS expenditure on providers by selected financing sources (%) (central government, donor agencies), 2010



(a) Blood bank and other government entities.
 (b) Donor agencies, consultancy firms etc.

Source: Annex Table 11.

4.5 HIV/AIDS expenditure by AIDS spending categories

The largest share of expenditure by AIDS spending category (ASC) is on prevention: 68% in 2009 and 74% in 2010. This is followed by expenditure on human resources, which mainly constituted expenditure on training. Care and treatment expenditure represents only five to six per cent of the total expenditure. Programme management and administration expenditure was five per cent in both years (Table 10). Detailed spending by ASCs is provided in Annex Table 3.

Central government and provincial governments have been the largest financing agents for prevention, accounting for over 60% of the total expenditure on prevention in both 2009 and 2010. Donor agencies increased their share of spending in prevention from 2009 to 2010 (Figure 7).

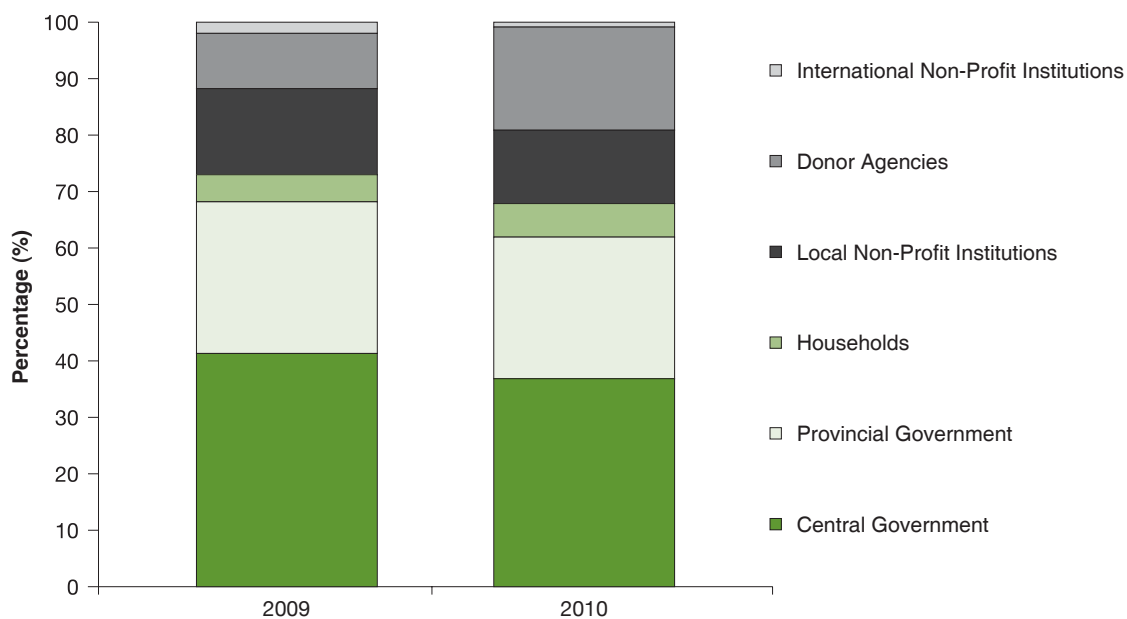
Approximately 80% of public sector spending was on prevention followed by expenditure on care and treatment, which was approximately eight to nine per cent. Human resources (which mainly constituted of training), programme management and administration were around 8% to 10% (Figure 8).

Table 10: HIV/AIDS expenditure by AIDS spending categories, 2009-2010

AIDS spending categories	2009			2010		
	Rs. million	USD million	%	Rs. million	USD million	%
Prevention	354.2	3.1	68	396.1	3.5	74
Care and treatment	28.0	0.2	5	30.1	0.3	6
Orphans and vulnerable children (OVC)	0.0	0.0	0	0.3	0.0	0
Programme management and administration	25.8	0.2	5	29.1	0.3	5
Human resources	71.3	0.6	14	50.9	0.4	10
Social protection and social services	3.9	0.0	1	4.7	0.0	1
Enabling environment	14.2	0.1	3	12.9	0.1	2
HIV related research	20.8	0.2	4	10.3	0.1	2
Total	518.2	4.5		534.4	4.7	

Source: IHP Sri Lanka NASA Database 2011.

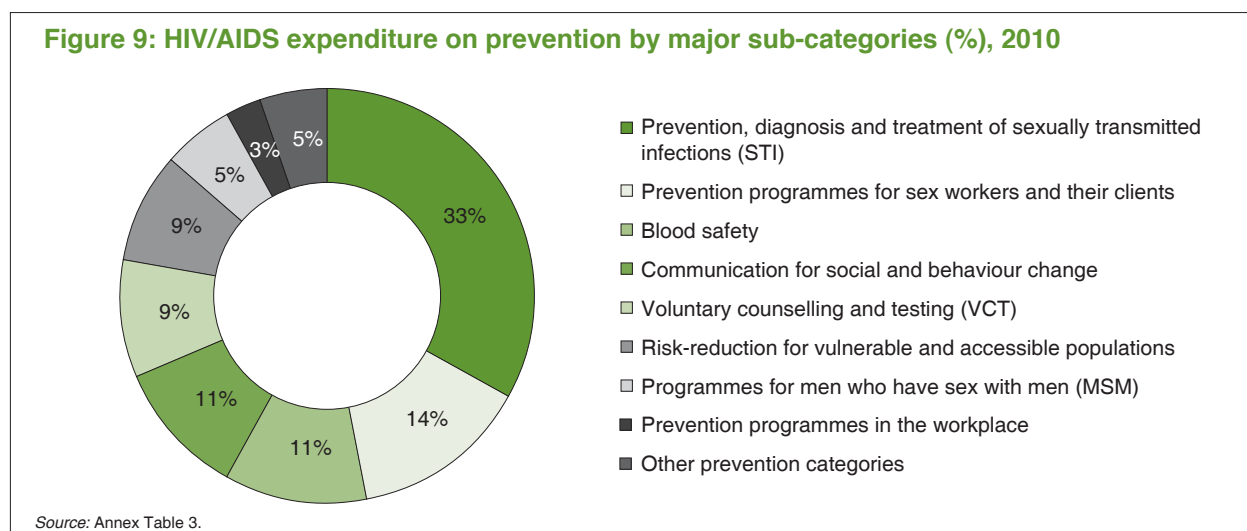
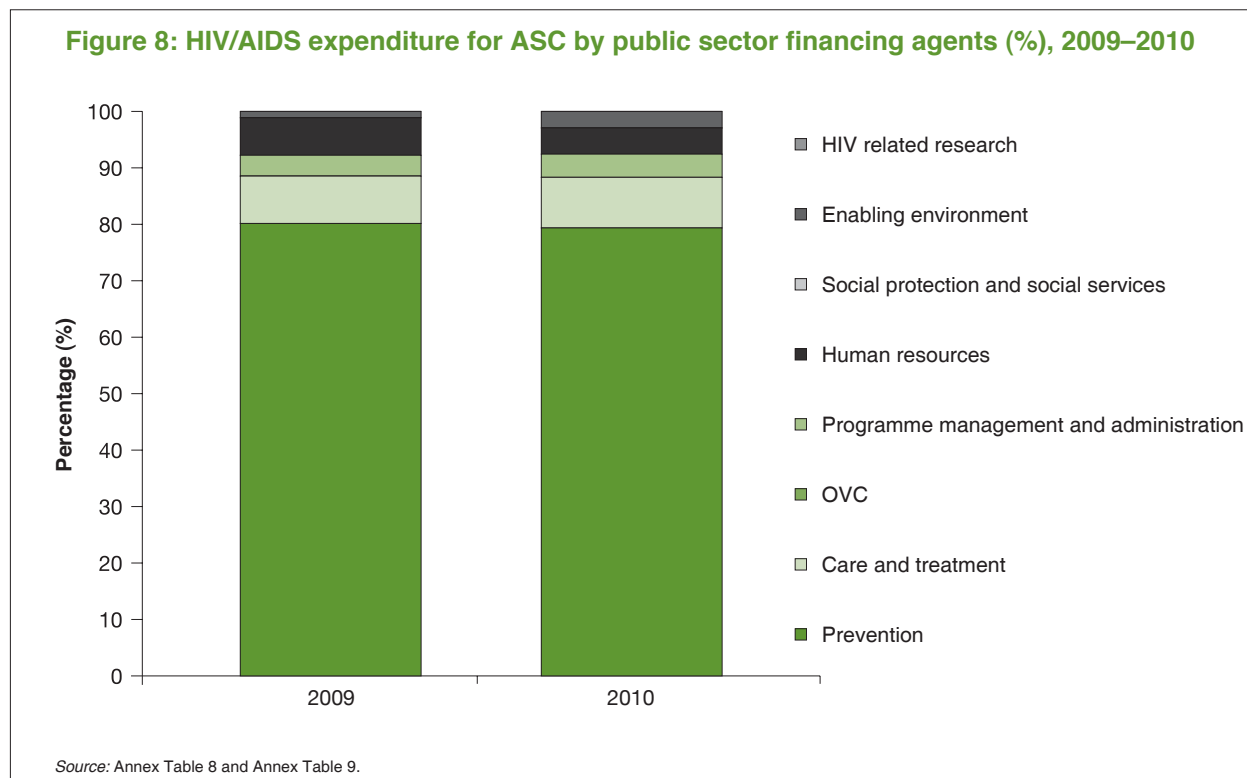
Figure 7: HIV/AIDS expenditure on prevention by financing agents (%), 2009–2010



Source: Annex Table 8 and Annex Table 9.

Figure 9 depicts the HIV/AIDS expenditure on prevention, further analysed by major sub-categories (2010). Spending was distributed across prevention, diagnosis, and treatment of STI (33%), prevention programmes for sex workers and their clients (14%), blood safety (11%), communication for social and

behaviour change (11%), voluntary counselling and testing (VCT) (9%), risk reduction for vulnerable and accessible populations (9%), programmes for MSM (5%), prevention programmes in the workplace (3%) and other prevention categories (5%).



4.6 HIV/AIDS expenditure by Beneficiary Population

The largest share of HIV/AIDS expenditure was for people attending the STI clinics, 28% (2009) and 30% (2010). Expenditure on MARPs and PLHIV was 21% (2009) and 22% (2010). The general population accounted for approximately one fourth of the spending (Table 11).

It should be noted that owing to NASA definitions of beneficiary populations, there is overlap between many population groups. In most cases it is not possible uniquely to categorize individuals to a particular population. Hence, the estimates reported here with regard to population categories should be used with a certain degree of caution.

When examined by financing agent, over two thirds of public sector spending was on the people attending the STI clinics, MARPs and PLHIV (Figure 10). In the case of financing by donor agencies, over half of the spending was on MARPs, health care workers and migrant/mobile populations.

Table 11: HIV/AIDS expenditure by beneficiary populations, 2009-2010

Beneficiary population	2009			2010		
	Rs. million	USD million	%	Rs. million	USD million	%
PLHIV	24.6	0.2	5	22.6	0.2	4
MARP ^(a)	83.5	0.7	16	97.2	0.9	18
Migrants / mobile populations	11.1	0.1	2	12.5	0.1	2
People attending STI clinics ^(b)	146.3	1.3	28	159.8	1.4	30
Students	9.0	0.1	2	0.8	0.0	0
Health care workers	29.0	0.3	6	20.2	0.2	4
Military	2.1	0.0	0	1.5	0.0	0
Factory employees	9.0	0.1	2	13.1	0.1	2
General population	136.3	1.2	26	131.1	1.2	25
Other populations ^(c)	67.4	0.6	13	75.7	0.7	14
Total	518.2	4.5		534.4	4.7	

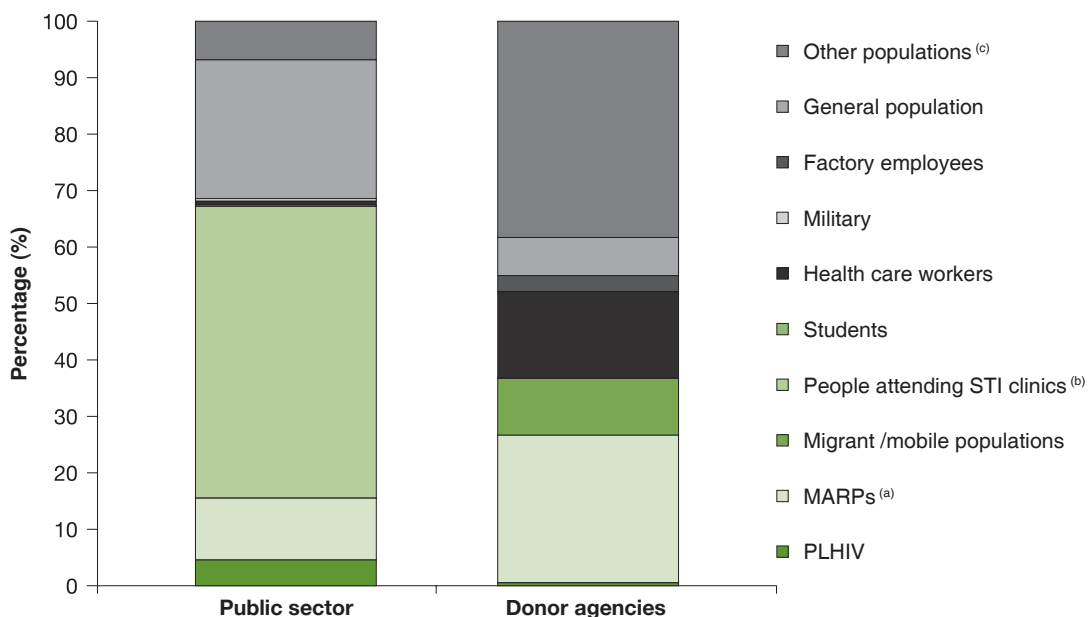
(a) MARPs includes Sex Workers (SW), MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g., Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011.

Figure 10: HIV/AIDS expenditure for beneficiary populations, by selected financing agents (%) (public sector, donor agencies), 2010



(a) MARPs includes SW, MSM and IDUs.
 (b) The population attending the STI clinics excluding MARPs and PLHIV.
 (c) Includes populations that cannot be directly attributable to populations classified above. E.g., Fishing communities, plantation sector workers, etc.

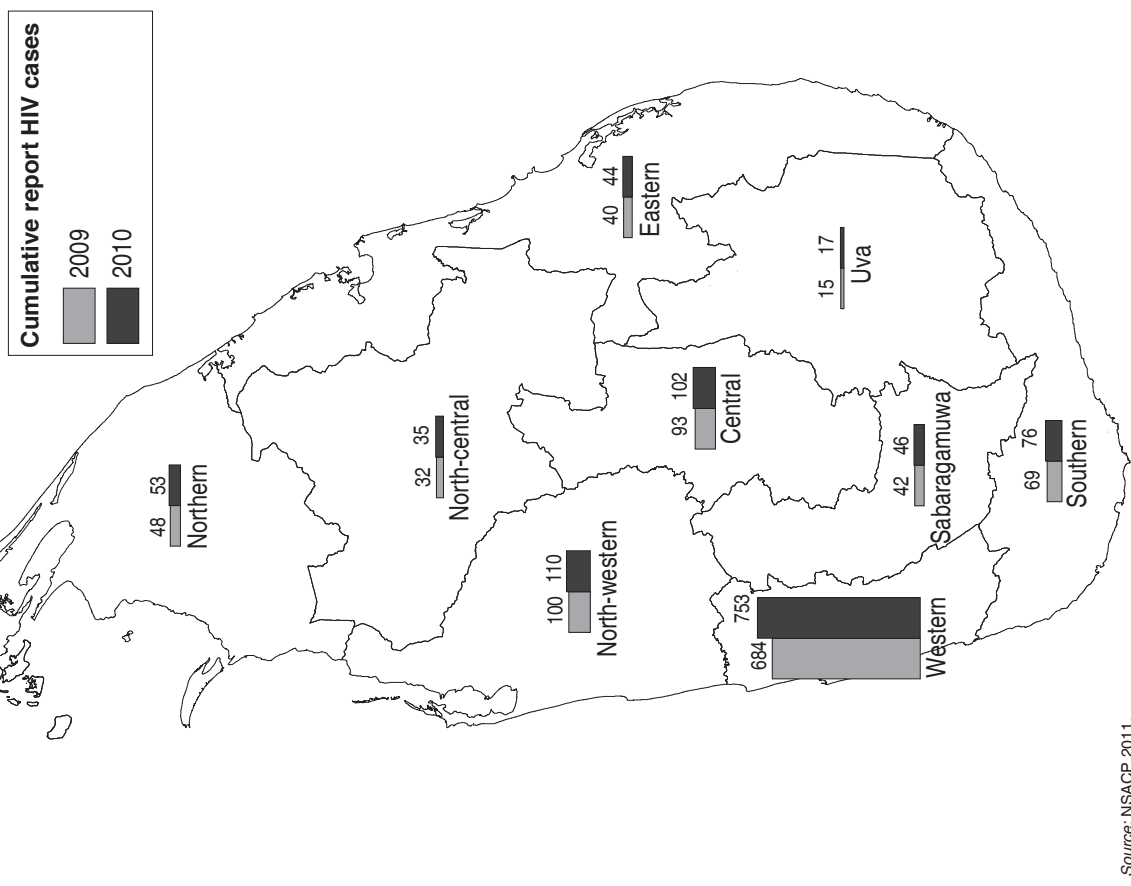
Source: Annex Table 17.

4.7 Geographical distribution of HIV/AIDS expenditure

The NASA pilot exercise also disaggregated spending by province, and this is illustrated in Figure 11. The highest HIV/AIDS spending was incurred in the Western Province during both 2009 (Rs. 166.1 million) and 2010 (Rs. 207.5 million). As shown in Figure 12, Western province also has the largest numbers of cumulative HIV cases reported, at 684 (1987 to 2009) and 753 (1987 to 2010). The central STI clinic, Colombo is situated in the Western province, which also contributes to the higher spending

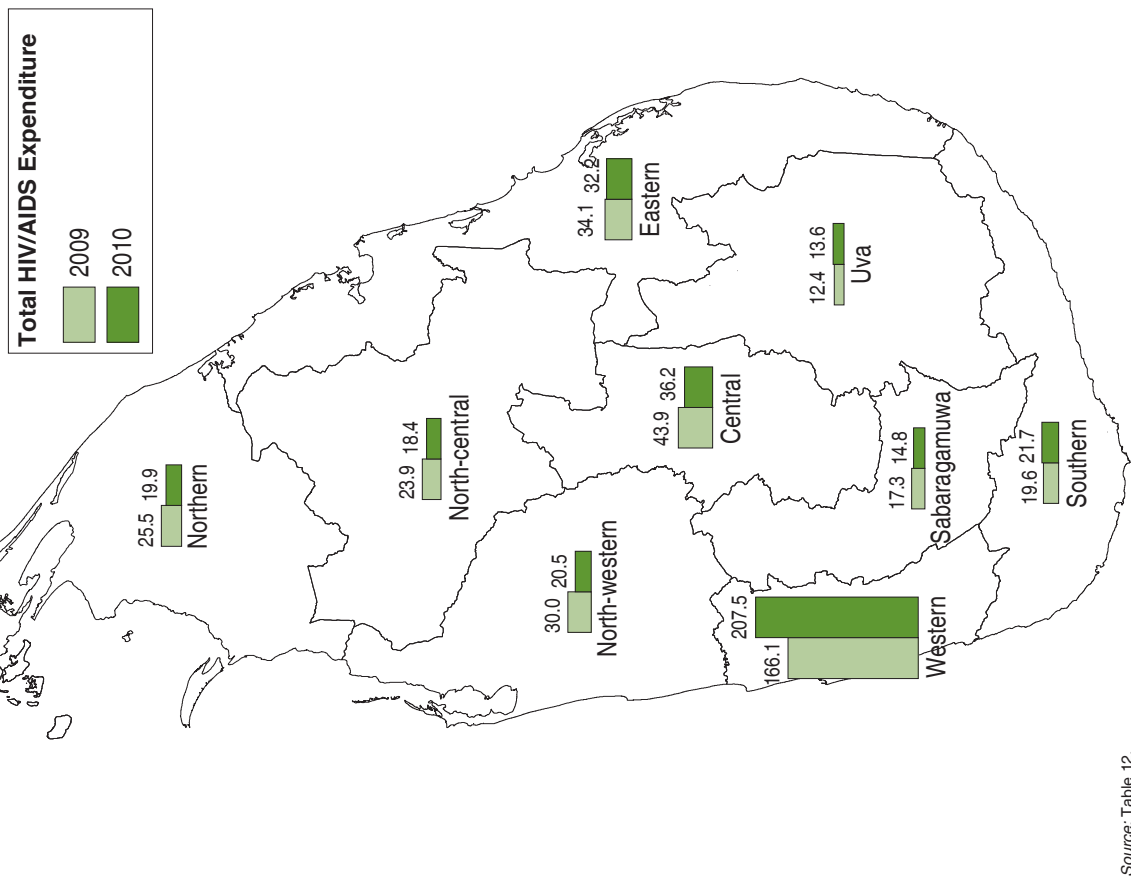
in this province. Consequently, it can be concluded that the geographical distribution of expenditures closely matches the geographical distribution of the HIV/AIDS caseload. Central, Eastern and North Western Provinces together accounted for approximately 28% of the total HIV/AIDS spending in 2009 and 2010.

Figure 12: Cumulative reported HIV cases by resident province, 2009-2010



Source: NSACP 2011.

Figure 11: Total HIV/AIDS expenditure by province (Rs. million), 2009-2010



Source: Table 12.

Table 12: Total HIV/AIDS expenditure by province, 2009-2010

Province	2009			2010		
	Amount		Cumulative reported HIV cases (%)	Amount		Cumulative reported HIV cases (%)
	Rs.million	Share (%)		Rs.million	Share (%)	
Western	166.1	44.5	60.9	207.5	53.9	60.9
Central	43.9	11.8	8.3	36.2	9.4	8.3
Eastern	34.1	9.1	3.6	32.2	8.4	3.6
North Western	30	8	8.9	20.5	5.3	8.9
Northern	25.5	6.8	4.3	19.9	5.2	4.3
Southern	19.6	5.3	6.1	21.7	5.6	6.1
North Central	23.9	6.4	2.8	18.4	4.8	2.8
Sabaragamuwa	17.3	4.6	3.7	14.8	3.9	3.7
Uva	12.4	3.3	1.4	13.6	3.5	1.4

Note: Excludes the expenditure that could not be directly attributable to a province.

Source: IHP Sri Lanka NASA Database 2011.

4.8 Conclusions and lessons learnt of NASA

The pilot Sri Lanka NASA exercise has shown that it is quite feasible to produce NASA estimates for Sri Lanka, by linkage to the existing national system for tracking health expenditures, i.e., SLHA. Only a modest amount of work was needed to modify or develop new estimation methods and data sources, as well as to modify the existing SLHA reporting database. Given this, it would be feasible to continue reporting NASA estimates every year in future, if needed, and at modest annual cost by linkage to the SLHA activity. If linked to the SLHA activity, it would also ensure institutionalization of NASA reporting in Sri Lanka, since the SLHA estimates are updated every year, and the SLHA team has the necessary skills and familiarity with data sources and counterpart agencies required for NASA.

If additional resources are available, the NASA estimates can be further improved in terms of accuracy and comprehensiveness by developing better methods and new data sources. High priorities for this type of improvement would be to improve the tracking of patient treatment expenditure in the private sector, and such expenditure in government medical institutions other than IDH.

The responsiveness of NGOs and donors to the surveys was not entirely satisfactory. Given the considerable heterogeneity of these entities, future tracking of their expenditure will need to invest more resources and time in these surveys, and additionally in respondent education to encourage cooperation.

The major difficulty in estimating government expenditures on HIV was that STI clinics are not a separate cost centre within the provincial financial accounting systems. This is part of a larger problem in that the provincial accounting systems do not currently record expenditures by individual institutions. Improvement and reform of this has been proposed before to improve transparency and utility of expenditure tracking by provincial councils, and such changes would also significantly facilitate NASA estimations.

Many of the NASA functional categories fall within the preventive health category tracked by SLHA. Further division and detail in the core SLHA tracking of preventive expenditures would facilitate easier and more precise tracking of NASA relevant categories. However, this issue needs to be examined also in relation to the revised global health accounts standard that was introduced in 2011, to which IHP plans to transition.

5. Annex A – Public Sector

Annex Table 1: STI clinics in Sri Lanka

Clinics	Address	
Ampara	District General Hospital, Ampara	
Anuradhapura	Teaching Hospital, Anuradhapura	
Badulla	Provincial General Hospital, Badulla	
Balapitiya	Base Hospital, Balapitiya	
Batticaloa	Teaching Hospital, Batticaloa	
Colombo Central Clinic	National STD/AIDS Control Programme, No 29, De Saram Place, Colombo 10	
Chilaw	District General Hospital, Chilaw	
	Branch clinics –Chilaw	
	Puttlam	Base Hospital, Puttlam
	Dankotuwa	District Hospital, Dankotuwa
	Kalpitiya	District Hospital, Kalpitiya
Embilipitiya	Base Hospital, Embilipitiya	
Gampaha	Base Hospital, Gampaha	
Hambantota	Base Hospital, Hambantota	
Jaffna	Teaching Hospital, Jaffna	
Kalubowila	Teaching Hospital, Kalubowila	
Kalutara	District General Hospital, Kalutara	
	Branch Clinics –Kalutara	
	Panadura	Base Hospital, Panadura
	Horana	Base Hospital, Horana
Kalmunai	Base Hospital A, Kalmunai	
Kandy	Teaching Hospital, Kandy	
	Branch Clinics – Kandy	
	Nawalapitiya	District General Hospital, Nawalapitiya
	Bogambara	Prison Hospital, Bogambara
	Pallekele	Open Prison, Pallekele
Kegalle	District General Hospital, Kegalle	
Kurunegala	Teaching Hospital, Kurunegala	
	Branch Clinics –Kurunegala	
	Kuliyapitiya	Base Hospital, Kuliyapitiya
	Nikaweratiya	Base Hospital, Nikaweratiya
Mahamodara	Teaching Hospital, Mahamodara	
Mannar	District General Hospital, Mannar	
Matale	District General Hospital, Matale	
Matara	District General Hospital, Matara	
Monaragala	District General Hospital, Monaragala	
Mahiyangana	Base Hospital, Mahiyangana	
Negombo	Base Hospital, Negombo	
Nuwara Eliya	District General Hospital, Nuwara Eliya	
Polonnaruwa	District General Hospital, Polonnaruwa	
	Branch Clinics –Polonnaruwa	
	Welikanda	Base Hospital, Welikanda
	Aralaganwila	Peripheral Unit, Aralaganwila
	Hingurakgoda	District Hospital, Hingurakgoda
	Pulasthigama	Rural Hospital, Pulasthigama
Ragama	Teaching Hospital, Ragama	
Ratnapura	Provincial General Hospital, Ratnapura	
Trincomalee	District General Hospital, Trincomalee	
Vavuniya	District General Hospital, Vavuniya	


Annex Table 2: Cost of reagents per test

Test	Rs.
Antibiotic Sensitivity Test (ABST) for Gonococci (GC)	1,000
CD4/CD8	2,500
Candida KOH	10
Candida scraping (Male)	10
Cervical cytology	50
Dark ground microscopy	50
GC Gram stain	10
GC culture	700
Giant cells	10
HIV ELISA	100
HIV rapid	110
HIV viral load	10,000
HSV culture	2,000
Hepatitis B S Antigen test	90
Western blot	4,886
Microscopy Smear wet	10
Sanofi Fujirabio Diagnostics (SFD) test	220
Trichomonasvaginalis. wet smear	10
Treponemapallidum Particle Agglutination (TPPA)	90
Urine Full Report	100
Urine deposits for GC	10
VDRL	1


Source: NSACP 2011

6. Annex B – Survey forms used for NASA data collection

Annex Figure 2: Donor-funded Health Expenditures Sri Lanka 2011 Survey Form



IHP
INSTITUTE FOR HEALTH POLICY



**SURVEY OF DONOR FUNDED
HEALTH EXPENDITURES SRI LANKA 2011**

GENERAL INSTRUCTIONS

- The Institute for Health Policy (IHP) conducts this annual survey in order to improve the availability of statistics on donor contributions to the health services of Sri Lanka.
- This survey covers the years 2008, 2009 and 2010. Please provide the details of health related projects of your agency that were active during the years 2008, 2009 and 2010.
- Please do read the given instructions and footnotes carefully before filling the form.
- Upon completion, please return the form using the enclosed self addressed stamped envelope. A softcopy of the survey form in Ms-Excel format is available at our website. To download the survey form kindly visit: <http://www.ihp.lk/resources/surveyformsdonors.html>
- The information collected in this survey will remain strictly confidential and the Donor's individual information will not be divulged by IHP to any other person or agency. Only aggregate statistics for the sector are ever reported by IHP. These strict data confidentiality procedures have been agreed with the Ministry of Health and UNAIDS.
- Upon completion, please return the form using enclosed self-addressed, stamped envelope or mail to ihpsurveys2011@gmail.com
- We appreciate if you could return the completed survey form on or **before the 12th of October, 2011.**

Name of agency: _____
 Address: _____
 Contact person's name: (Dr./Mr./Ms.) _____
 Telephone: _____ Fax: _____ E-mail: _____

For queries please contact:
Shanaz Saleem
 72, Park Street
 Colombo 2
 Tel:(011)231-4041/2/3 ext: 210
 Email: ihpsurveys2011@gmail.com

Project Name ^(a)	Agency Assigned Project Code	Cost Disbursed			Currency	Geographical Location	Channeling Source ^(b)	Implementing Agency/Agencies
		2008	2009	2010				

Footnotes.
 (a) Name of the project. Whether money was spent on patient care/communicable disease/non-communicable disease prevention/construction of buildings or indirect spending on health such as Capacity building of health workers/Technical assistance programmes/ Research and Development in the health sector etc.
 (b) The funds for the projects could be channeled through the Treasury of Sri Lanka / other Ministry of Sri Lanka or direct channeling to the provider of services by your own agency. This section is to list the source through which the funds were channeled for the projects.

Please turn over

Project Name ^(a)	Agency Assigned Project Code	Currency	Cost Disbursed			Geographical Location	Channeling Source ^(b)	Implementing Agency/ Agencies
			2008	2009	2010			

Footnotes.
(a) Name of the project. Whether money was spent on patient care/communicable disease/non-communicable disease prevention/construction of buildings or indirect spending on health such as Capacity building of health workers/Technical assistance programmes/ Research and Development in the health sector etc.
(b) The funds for the projects could be channeled through the Treasury of Sri Lanka / other Ministry of Sri Lanka or direct channeling to the provider of services by your own agency. This section is to list the source through which the funds were channeled for the projects.

7. Annex C – Detailed tables

Annex Table 3: HIV/AIDS expenditure by AIDS spending categories, 2009-2010

AIDS spending categories	2009			2010		
	Rs. million	USD million	%	Rs. million	USD million	%
Prevention	354.2	3.1	68	396.1	3.5	74
Communication for social and behaviour change	32.9	0.3	6	41.1	0.4	8
Community mobilization	5.9	0.1	1	2.5	0.0	0
Voluntary counselling and testing (VCT)	34.7	0.3	7	36.3	0.3	7
Risk-reduction for vulnerable and accessible populations	31.1	0.3	6	34.7	0.3	6
Prevention – youth in school	8.6	0.1	2	0.8	0.0	0
Prevention – youth out-of-school	-	-	-	2.3	0.0	0
Prevention of HIV transmission aimed at people living with HIV (PLHIV)	6.0	0.1	1	2.6	0.0	0
Prevention programmes for sex workers and their clients	35.0	0.3	7	55.6	0.5	10
Programmes for men who have sex with men (MSM)	14.5	0.1	3	21.3	0.2	4
Harm-reduction programmes for injecting drug users (IDUs)	3.3	0.0	1	3.6	0.0	1
Prevention programmes in the workplace	8.2	0.1	2	11.9	0.1	2
Condom social marketing	6.0	0.1	1	4.7	0.0	1
Public and commercial sector male condom provision	-	-	-	-	-	-
Public and commercial sector female condom provision	-	-	-	-	-	-
Microbicides	-	-	-	-	-	-
Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	120.3	1.0	23	131.0	1.2	25
Prevention of mother-to-child transmission (PMTCT)	3.5	0.0	1	3.4	0.0	1
Male circumcision	-	-	-	-	-	-
Blood safety	44.2	0.4	9	44.4	0.4	8
Safe medical injections	-	-	-	-	-	-
Universal precautions	-	-	-	-	-	-
Post-exposure prophylaxis (PEP)	-	-	-	-	-	-
Prevention activities not broken down by intervention	-	-	-	-	-	-
Prevention activities n.e.c.	-	-	-	-	-	-
Care and treatment	28.0	0.2	5	30.1	0.3	6
Outpatient care	24.3	0.2	5	27.0	0.2	5
Provider-initiated testing and counselling (PITC)	13.7	0.1	3	15.3	0.1	3
Opportunistic infection (OI) outpatient prophylaxis and treatment	-	-	-	-	-	-
Antiretroviral therapy	4.7	0.0	1	5.1	0.0	1
Nutritional support associated with antiretroviral therapy	0.3	0.0	0	0.0	0.0	0
Specific HIV-related laboratory monitoring	2.6	0.0	0	2.4	0.0	0
Dental programmes for PLHIV	-	-	-	-	-	-
Psychological treatment and support services	-	-	-	0.0	0.0	0
Outpatient palliative care	-	-	-	-	-	-
Home-based care	-	-	-	-	-	-
Traditional medicine and informal care and treatment services	-	-	-	-	-	-
Outpatient care services not broken down by intervention	3.0	0.0	1	3.6	0.0	1
Outpatient care services n.e.c.	-	-	-	0.5	0.0	0
Inpatient care	3.7	0.0	1	3.1	0.0	1
Inpatient treatment of opportunistic infections (OI)	3.7	0.0	1	3.1	0.0	1
Inpatient palliative care	-	-	-	-	-	-
Inpatient care services not broken down by intervention	-	-	-	-	-	-
Inpatient care services n.e.c.	-	-	-	-	-	-
Patient transport and emergency rescue	-	-	-	-	-	-
Care and treatment services not broken down by intervention	-	-	-	-	-	-
Care and treatment services n.e.c.	-	-	-	-	-	-

(continued)

Annex Table 3 (continued): HIV/AIDS expenditure by AIDS spending categories, 2009-2010

AIDS spending categories	2009			2010		
	Rs. million	USD million	%	Rs. million	USD million	%
Orphans and vulnerable children (OVC)	0.0	0.0	0	0.3	0.0	0
OVC Education	0.0	0.0	0	0.0	0.0	0
OVC Basic health care	-	-	-	0.3	0.0	0
OVC Family/home support	-	-	-	-	-	-
OVC Community support	-	-	-	-	-	-
OVC Social services and administrative costs	-	-	-	-	-	-
OVC Institutional care	-	-	-	-	-	-
OVC Services not broken down by intervention	-	-	-	-	-	-
OVC services n.e.c.	-	-	-	-	-	-
Programme management and administration	25.8	0.2	5	29.1	0.3	5
Planning, coordination, and programme management	6.6	0.1	1	7.7	0.1	1
Administration and transaction costs associated with managing and disbursing funds	-	-	-	-	-	-
Monitoring and evaluation	4.5	0.0	1	5.5	0.0	1
Operations research	-	-	-	-	-	-
Serological-surveillance (serosurveillance)	0.3	0.0	0	-	-	-
HIV drug-resistance surveillance	-	-	-	-	-	-
Drug supply systems	-	-	-	-	-	-
Information technology	0.3	0.0	0	0.2	0.0	0
Patient tracking	-	-	-	-	-	-
Upgrading and construction of infrastructure	2.1	0.0	0	-	-	-
Mandatory HIV testing (not VCT)	11.3	0.1	2	15.7	0.1	3
Programme management and administration not broken down by type	0.7	0.0	0	-	-	-
Programme management and administration n.e.c.	-	-	-	-	-	-
Human resources	71.3	0.6	14	50.9	0.4	10
Monetary incentives for human resources	-	-	-	-	-	-
Formative education to build-up an HIV workforce	-	-	-	-	-	-
Training	71.2	0.6	14	50.8	0.4	9
Human resources not broken down by type	-	-	-	-	-	-
Human resources n.e.c.	0.1	0.0	0	0.1	0.0	0
Social protection and social services (excluding OVC)	3.9	0.0	1	4.7	0.0	1
Social protection through monetary benefits	1.2	0.0	0	1.7	0.0	0
Social protection through in-kind benefits	0.3	0.0	0	3.1	0.0	1
Social protection through provision of social services	-	-	-	-	-	-
HIV-specific income generation projects	2.4	0.0	0	0.0	0.0	0
Social protection services and social services not broken down by type	-	-	-	-	-	-
Social protection services and social services n.e.c.	-	-	-	-	-	-
Enabling environment	14.2	0.1	3	12.9	0.1	2
Advocacy	9.5	0.1	2	6.7	0.1	1
Human rights programmes	-	-	-	0.3	0.0	0
AIDS-specific institutional development	1.7	0.0	0	-	-	-
AIDS-specific programmes focused on women	-	-	-	-	-	-
Programmes to reduce Gender Based Violence	3.0	0.0	1	5.8	0.1	1
Enabling environment not broken down by type	-	-	-	-	-	-
Enabling environment n.e.c.	-	-	-	-	-	-
HIV-related research(excluding operations research)	20.8	0.2	4	10.3	0.1	2
Biomedical research	-	-	-	-	-	-
Clinical research	-	-	-	-	-	-
Epidemiological research	10.2	0.1	2	9.1	0.1	2
Social science research	9.8	0.1	2	1.0	0.0	0
Vaccine-related research	-	-	-	-	-	-
HIV-related research activities not broken down by type	0.8	0.0	0	0.2	0.0	0
HIV-related research activities n.e.c.	-	-	-	-	-	-
Total	518.2	4.5		534.4	4.7	

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 4: HIV/AIDS expenditure by financing source and financing agents (Rs. million), 2009

Financing Source	Financing Agent						Total
	Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies	International Non-Profit Institutions	
Central Government	138.9	100.6	0.0	0.0	0.0	0.0	239.5
Non Profit-Institutions	0.0	0.0	0.0	1.9	0.0	0.0	1.9
Other Private ^(a)	0.0	0.0	30.7	0.0	0.0	0.0	30.7
Donor Agencies	58.8	3.0	0.0	45.6	108.5	0.0	215.9
International Non-Profit Institutions	0.0	0.0	0.0	21.0	0.0	9.1	30.2
Total	197.7	103.6	30.7	68.5	108.5	9.1	518.2

(a) Financing sources to households.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 5: HIV/AIDS expenditure by financing source and financing agents (Rs. million), 2010

Financing Source	Financing Agent						Total
	Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies	International Non-Profit Institutions	
Central Government	152.5	105.3	0.0	0.0	0.0	0.0	257.8
Non Profit-Institutions	0.0	0.0	0.0	5.2	0.0	0.0	5.2
Other Private ^(a)	0.0	0.0	41.1	0.0	0.0	0.0	41.1
Donor Agencies	45.4	5.8	0.0	43.6	118.2	0.0	213.1
International Non-Profit Institutions	0.0	0.0	0.0	13.8	0.0	3.4	17.2
Total	197.9	111.1	41.1	62.6	118.2	3.4	534.4

(a) Financing sources to households.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 6: HIV/AIDS expenditure by AIDS spending categories and financing source (Rs. million), 2009

AIDS spending categories	Financing Source					Total
	Central Government	Non-Profit Institutions	Other Private ^(a)	Donor Agencies	International Non-Profit Institutions	
Prevention	206.4	0.9	17.0	110.4	19.5	354.2
Care and treatment	20.6	0.0	2.4	4.7	0.3	28.0
OVC	0.0	0.0	0.0	0.0	0.0	0.0
Programme management and administration	10.6	0.0	11.3	1.5	2.5	25.8
Human resources	2.0	0.0	0.0	68.8	0.5	71.3
Social protection and social services	0.0	0.3	0.0	2.2	1.4	3.9
Enabling environment	0.0	0.6	0.0	7.5	6.0	14.2
HIV related research	0.0	0.0	0.0	20.8	0.0	20.8
Total	239.5	1.9	30.7	215.9	30.2	518.2

(a) Financing sources to households.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 7: HIV/AIDS expenditure by AIDS spending categories and financing source (Rs. million), 2010

AIDS spending categories	Financing Source					Total
	Central Government	Non-Profit Institutions	Other Private ^(a)	Donor Agencies	International Non-Profit Institutions	
Prevention	220.4	0.9	23.5	138.5	12.7	396.1
Care and treatment	22.6	0.5	1.8	5.1	0.0	30.1
OVC	0.0	0.2	0.0	0.0	0.1	0.3
Programme management and administration	12.7	0.0	15.7	0.7	0.0	29.1
Human resources	2.0	0.0	0.0	47.7	1.2	50.9
Social protection and social services	0.0	2.4	0.0	0.0	2.3	4.7
Enabling environment	0.0	1.1	0.0	10.9	0.9	12.9
HIV related research	0.0	0.0	0.0	10.3	0.0	10.3
Total	257.8	5.2	41.1	213.1	17.2	534.4

(a) Financing sources to households.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 8: HIV/AIDS expenditure by AIDS spending categories and financing agent (Rs. million), 2009

AIDS spending categories	Financing Agent						Total
	Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies	International Non-Profit Institutions	
Prevention	146.4	95.2	17.0	54.0	34.7	7.0	354.2
Care and treatment	19.8	5.5	2.4	0.3	0.0	0.0	28.0
OVC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Programme management and administration	11.1	0.0	11.3	0.6	0.7	2.1	25.8
Human resources	20.0	0.0	0.0	0.5	50.8	0.0	71.3
Social protection and social services	0.0	0.0	0.0	3.9	0.0	0.0	3.9
Enabling environment	0.4	3.0	0.0	8.4	2.4	0.0	14.2
HIV related research	0.0	0.0	0.0	0.8	20.0	0.0	20.8
Total	197.7	103.6	30.7	68.5	108.5	9.1	518.2

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 9: HIV/AIDS expenditure by AIDS spending categories and financing agent (Rs. million), 2010

AIDS spending categories	Financing Agent						Total
	Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies	International Non-Profit Institutions	
Prevention	145.9	99.3	23.5	51.5	72.4	3.4	396.1
Care and treatment	21.7	6.0	1.8	0.6	0.0	0.0	30.1
OVC	0.0	0.0	0.0	0.3	0.0	0.0	0.3
Programme management and administration	12.7	0.0	15.7	0.2	0.5	0.0	29.1
Human resources	14.3	0.0	0.0	1.2	35.3	0.0	50.9
Social protection and social services	0.0	0.0	0.0	4.7	0.0	0.0	4.7
Enabling environment	3.2	5.8	0.0	2.9	0.9	0.0	12.9
HIV related research	0.0	0.0	0.0	1.2	9.1	0.0	10.3
Total	197.9	111.1	41.1	62.6	118.2	3.4	534.4

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 10: HIV/AIDS expenditure by providers and financing source (Rs. million), 2009

Providers		Financing Source					Total
		Central Government	Non-Profit Institutions	Other Private ^(a)	Donor Agencies	International Non-Profit Institutions	
Public sector	Peripheral STI clinics and IDH	119.9	0.0	0.0	2.1	0.0	121.9
	Central STI Clinic, Colombo	75.5	0.0	0.0	30.9	0.0	106.4
	Other ^(b)	44.2	0.0	0.0	20.2	0.0	64.3
Private sector	Hospitals	0.0	0.0	30.7	0.0	0.0	30.7
	Non-Profit Institutions	0.0	1.9	0.0	139.4	30.2	171.5
	Other ^(c)	0.0	0.0	0.0	23.4	0.0	23.4
Total		239.5	1.9	30.7	215.9	30.2	518.2

(a) Financing sources to households.
(b) Blood bank and other government entities.
(c) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 11: HIV/AIDS expenditure by providers and financing source (Rs. million), 2010

Providers		Financing Source					Total
		Central Government	Non-Profit Institutions	Other Private ^(a)	Donor Agencies	International Non-Profit Institutions	
Public sector	Peripheral STI clinics and IDH	128.7	0.0	0.0	1.6	0.0	130.3
	Central STI Clinic, Colombo	84.8	0.0	0.0	16.9	0.0	101.7
	Other ^(b)	44.4	0.0	0.0	20.8	3.0	68.1
Private sector	Hospitals	0.0	0.0	41.1	0.0	0.0	41.1
	Non-Profit Institutions	0.0	5.2	0.0	125.9	14.2	145.3
	Other ^(c)	0.0	0.0	0.0	48.0	0.0	48.0
Total		257.8	5.2	41.1	213.1	17.2	534.4

(a) Financing sources to households.
(b) Blood bank and other government entities.
(c) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 12: HIV/AIDS expenditure by beneficiary population and financing source (Rs. million), 2009

Beneficiary Population	Financing Source					Total	
	Central Government	Non-Profit Institutions	Other Private ^(a)	Donor Agencies	International Non-Profit Institutions		
PLHIV	8.4	0.4	2.4	8.3	5.1	24.6	
MARPs ^(b)	28.0	0.0	0.0	46.3	9.2	83.5	
Migrants / mobile populations	0.0	0.0	0.0	10.1	1.0	11.1	
People attending STI clinics ^(c)	146.3	0.0	0.0	0.0	0.0	146.3	
Students	0.0	0.0	0.0	8.6	0.5	9.0	
Health care workers	2.0	0.0	0.0	26.9	0.0	29.0	
Military	2.1	0.0	0.0	0.0	0.0	2.1	
Factory employees	0.0	1.3	0.0	7.7	0.0	9.0	
General population	52.7	0.2	28.3	45.5	9.5	136.3	
Other populations ^(d)	0.0	0.0	0.0	62.5	4.9	67.5	
Total		239.5	1.9	30.7	215.9	30.2	518.3

(a) Financing sources to households.
(b) MARPs includes SW, MSM and IDUs.
(c) The population attending the STI clinics excluding MARPs and PLHIV.
(d) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 13: HIV/AIDS expenditure by beneficiary population and financing source (Rs. million), 2010

Beneficiary Population	Financing Source					Total
	Central Government	Non-Profit Institutions	Other Private ^(a)	Donor Agencies	International Non-Profit Institutions	
PLHIV	9.0	3.0	1.8	5.9	2.8	22.6
MARPs ^(b)	30.5	0.0	0.0	61.1	5.7	97.2
Migrants / mobile populations	0.0	0.0	0.0	11.9	0.6	12.5
People attending STI clinics ^(c)	159.8	0.0	0.0	0.0	0.0	159.8
Students	0.0	0.0	0.0	0.8	0.0	0.8
Health care workers	2.0	0.0	0.0	18.1	0.0	20.2
Military	1.5	0.0	0.0	0.0	0.0	1.5
Factory employees	0.0	1.9	0.0	11.2	0.0	13.1
General population	55.0	0.1	39.2	31.1	5.6	131.1
Other populations ^(d)	0.0	0.2	0.0	73.0	2.5	75.7
Total	257.8	5.2	41.1	213.1	17.2	534.4

(a) Financing sources to households.

(b) MARPs includes SW, MSM and IDUs.

(c) The population attending the STI clinics excluding MARPs and PLHIV.

(d) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 14: HIV/AIDS expenditure by providers and financing agents (Rs. million), 2009

Providers		Financing Agent					Total	
		Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies		International Non-Profit Institutions
Public sector	Peripheral STI clinics and IDH	21.3	100.6	0.0	0.0	0.0	0.0	121.9
	Central STI Clinic, Colombo	106.4	0.0	0.0	0.0	0.0	0.0	106.4
	Other ^(a)	52.2	3.0	0.0	0.0	9.2	0.0	64.3
Private sector	Hospitals	0.0	0.0	30.7	0.0	0.0	0.0	30.7
	Non-Profit Institutions	17.9	0.0	0.0	68.5	75.9	9.1	171.5
	Other ^(b)	0.0	0.0	0.0	0.0	23.4	0.0	23.4
Total		197.7	103.6	30.7	68.5	108.5	9.1	518.2

(a) Blood bank and other government entities.

(b) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 15: HIV/AIDS expenditure by providers and financing agents (Rs. million), 2010

Providers		Financing Agent					Total	
		Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies		International Non-Profit Institutions
Public sector	Peripheral STI clinics and IDH	25.0	105.3	0.0	0.0	0.0	0.0	130.3
	Central STI Clinic, Colombo	101.7	0.0	0.0	0.0	0.0	0.0	101.7
	Other ^(a)	59.3	5.8	0.0	0.0	0.0	3.0	68.1
Private sector	Hospitals	0.0	0.0	41.1	0.0	0.0	0.0	41.1
	Non-Profit Institutions	12.0	0.0	0.0	62.6	70.2	0.4	145.3
	Other ^(b)	0.0	0.0	0.0	0.0	48.0	0.0	48.0
Total		197.9	111.1	41.1	62.6	118.2	3.4	534.4

(a) Blood bank and other government entities.

(b) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 16: HIV/AIDS expenditure by beneficiary population and financing agents (Rs. million), 2009

Beneficiary Population	Financing Agent						Total
	Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies	International Non-Profit Institutions	
PLHIV	12.1	1.0	2.4	5.3	1.6	2.1	24.6
MARPs ^(a)	11.6	16.9	0.0	29.5	25.5	0.0	83.5
Migrants / mobile populations	0.0	0.0	0.0	1.0	10.1	0.0	11.1
People attending STI clinics ^(b)	63.6	82.7	0.0	0.0	0.0	0.0	146.3
Students	8.6	0.0	0.0	0.0	0.0	0.5	9.0
Health care workers	2.8	0.0	0.0	0.0	26.2	0.0	29.0
Military	2.1	0.0	0.0	0.0	0.0	0.0	2.1
Factory employees	0.0	0.0	0.0	1.7	7.3	0.0	9.0
General population	75.0	0.0	28.3	16.1	10.3	6.5	136.3
Other populations ^(c)	21.9	3.0	0.0	15.0	27.5	0.0	67.4
Total	197.7	103.6	30.7	68.5	108.5	9.1	518.2

(a) MARPs includes SW, MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 17: HIV/AIDS expenditure by beneficiary population and financing agents (Rs. million), 2010

Beneficiary Population	Financing Agent						Total
	Central Government	Provincial Government	Households	Local Non-Profit Institutions	Donor Agencies	International Non-Profit Institutions	
PLHIV	13.1	1.0	1.8	6.0	0.6	0.0	22.6
MARPs ^(a)	16.2	17.6	0.0	32.5	30.9	0.0	97.2
Migrants / mobile populations	0.0	0.0	0.0	0.6	11.9	0.0	12.5
People attending STI clinics ^(b)	73.1	86.6	0.0	0.0	0.0	0.0	159.8
Students	0.8	0.0	0.0	0.0	0.0	0.0	0.8
Health care workers	2.0	0.0	0.0	0.0	18.1	0.0	20.2
Military	1.5	0.0	0.0	0.0	0.0	0.0	1.5
Factory employees	0.0	0.0	0.0	9.7	3.4	0.0	13.1
General population	75.9	0.0	39.2	4.5	8.0	3.4	131.1
Other populations ^(c)	15.3	5.8	0.0	9.2	45.3	0.0	75.7
Total	197.9	111.1	41.1	62.6	118.2	3.4	534.4

(a) MARPs includes SW, MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 18: HIV/AIDS expenditure by providers and AIDS spending categories (Rs. million), 2009

Providers		AIDS spending categories								Total
		Prevention	Care and treatment	OVC	Programme management and administration	Human resources	Social protection and social services	Enabling environment	HIV related research	
Public sector	Peripheral STI clinics and IDH	112.3	9.6	0.0	0.0	0.0	0.0	0.0	0.0	121.9
	Central STI Clinic, Colombo	76.2	15.6	0.0	11.1	3.4	0.0	0.0	0.0	106.4
	Other ^(a)	61.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	64.3
Private sector	Hospitals	17.0	2.4	0.0	11.3	0.0	0.0	0.0	0.0	30.7
	Non-Profit Institutions	85.0	0.3	0.0	2.7	67.9	3.9	10.8	0.8	171.5
	Other ^(b)	2.8	0.0	0.0	0.7	0.0	0.0	0.0	20.0	23.4
Total		354.2	28.0	0.0	25.8	71.3	3.9	14.2	20.8	518.2

(a) Blood bank and other government entities.

(b) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 19: HIV/AIDS expenditure by providers and AIDS spending categories (Rs. million), 2010

Providers		AIDS spending categories								Total
		Prevention	Care and treatment	OVC	Programme management and administration	Human resources	Social protection and social services	Enabling environment	HIV related research	
Public sector	Peripheral STI clinics and IDH	119.5	10.8	0.0	0.0	0.0	0.0	0.0	0.0	130.3
	Central STI Clinic, Colombo	69.0	16.9	0.0	12.7	3.1	0.0	0.0	0.0	101.7
	Other ^(a)	59.1	0.0	0.0	0.0	0.0	0.0	9.0	0.0	68.1
Private sector	Hospitals	23.5	1.8	0.0	15.7	0.0	0.0	0.0	0.0	41.1
	Non-Profit Institutions	86.9	0.6	0.3	0.7	47.8	4.7	3.1	1.2	145.3
	Other ^(b)	38.1	0.0	0.0	0.0	0.0	0.0	0.8	9.1	48.0
Total		396.1	30.1	0.3	29.1	50.9	4.7	12.9	10.3	534.4

(a) Blood bank and other government entities.

(b) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011.

Annex Table 20: HIV/AIDS expenditure by AIDS spending categories and beneficiary population (Rs. million), 2009

AIDS spending categories	Beneficiary Population										Total
	PLHIV	MARPs ^(a)	Migrants / mobile populations	People attending STI clinics ^(b)	Students	Health care workers	Military	Factory employees	General population	Other populations ^(c)	
Prevention	5.1	54.9	11.1	132.6	9.0	0.3	2.1	8.0	110.2	20.9	354.2
Care and treatment	14.3	0.0	0.0	13.7	0.0	0.0	0.0	0.0	0.0	0.0	28.0
OVC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Programme management and administration	2.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	22.8	0.9	25.8
Human resources	0.4	1.8	0.0	0.0	0.0	28.7	0.0	0.0	0.6	39.7	71.3
Social protection and social services	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	1.1	3.9
Enabling environment	0.0	8.4	0.0	0.0	0.0	0.0	0.0	1.0	0.0	4.7	14.2
HIV related research	2.0	18.4	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0	20.8
Total	24.6	83.5	11.1	146.3	9.0	29.0	2.1	9.0	136.3	67.4	518.2

(a) MARPs includes SW, MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011

Annex Table 21: HIV/AIDS expenditure by AIDS spending categories and beneficiary population (Rs. million), 2010

AIDS spending categories	Beneficiary Population										Total
	PLHIV	MARPs ^(a)	Migrants / mobile populations	People attending STI clinics ^(b)	Students	Health care workers	Military	Factory employees	General population	Other populations ^(c)	
Prevention	2.2	84.1	12.5	144.5	0.8	1.7	1.5	11.7	98.4	38.8	396.1
Care and treatment	14.8	0.0	0.0	15.3	0.0	0.0	0.0	0.0	0.0	0.0	30.1
OVC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3
Programme management and administration	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	29.1	0.0	29.1
Human resources	1.1	0.6	0.0	0.0	0.0	18.5	0.0	0.0	1.0	29.6	50.9
Social protection and social services	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	4.7
Enabling environment	0.0	4.1	0.0	0.0	0.0	0.0	0.0	1.4	1.5	5.8	12.9
HIV related research	0.8	8.5	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	10.3
Total	22.6	97.2	12.5	159.8	0.8	20.2	1.5	13.1	131.1	75.7	534.4

(a) MARPs includes SW, MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

Source: IHP Sri Lanka NASA Database 2011

Annex Table 22: HIV/AIDS expenditure by providers and beneficiary populations (Rs. million), 2009

Providers		Beneficiary Population										Total
		PLHIV	MARPs ^(a)	Migrants / mobile populations	People attending STI clinics ^(b)	Students	Health care workers	Military	Factory employees	General population	Other populations ^(c)	
Public sector	Peripheral STI clinics and IDH	3.6	19.4	0.0	96.1	0.0	0.0	2.1	0.0	0.7	0.0	121.9
	Central STI Clinic, Colombo	9.5	8.8	0.0	50.2	8.6	2.8	0.0	0.0	25.9	0.6	106.4
	Other ^(d)	0.0	0.4	9.2	0.0	0.0	0.0	0.0	0.0	48.3	6.5	64.3
Private sector	Hospitals	2.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	28.3	0.0	30.7
	Non-Profit Institutions	7.4	36.6	1.9	0.0	0.5	26.2	0.0	6.5	32.1	60.3	171.5
	Other ^(e)	1.6	18.4	0.0	0.0	0.0	0.0	0.0	2.5	0.9	0.0	23.4
Total		24.6	83.5	11.1	146.3	9.0	29.0	2.1	9.0	136.3	67.4	518.2

(a) MARPs includes SW, MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

(d) Blood bank and other government entities.

(e) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011

Annex Table 23: HIV/AIDS expenditure by providers and beneficiary populations (Rs. million), 2010

Providers		Beneficiary Population										Total
		PLHIV	MARPs ^(a)	Migrants / mobile populations	People attending STI clinics ^(b)	Students	Health care workers	Military	Factory employees	General population	Other populations ^(c)	
Public sector	Peripheral STI clinics and IDH	3.4	20.7	0.0	104.2	0.0	0.0	1.5	0.0	0.5	0.0	130.3
	Central STI Clinic, Colombo	10.7	10.0	0.0	55.6	0.8	2.0	0.0	0.0	22.6	0.0	101.7
	Other ^(d)	0.0	3.2	0.0	0.0	0.0	0.0	0.0	0.0	55.6	9.3	68.1
Private sector	Hospitals	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	39.2	0.0	41.1
	Non-Profit Institutions	6.0	43.6	4.1	0.0	0.0	18.1	0.0	12.1	11.8	49.4	145.3
	Other ^(e)	0.6	19.8	8.4	0.0	0.0	0.0	0.0	0.9	1.3	16.9	48.0
Total		22.6	97.2	12.5	159.8	0.8	20.2	1.5	13.1	131.1	75.7	534.4

(a) MARPs includes SW, MSM and IDUs.

(b) The population attending the STI clinics excluding MARPs and PLHIV.

(c) Includes populations that cannot be directly attributable to populations classified above. E.g. Fishing communities, plantation sector workers, etc.

(d) Blood bank and other government entities.

(e) Donor agencies, consultancy firms etc.

Source: IHP Sri Lanka NASA Database 2011

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“Sri Lanka: National AIDS Spending Assessment 2009-2010” examines the flow of resources intended to combat HIV/AIDS. It tracks the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease using the bottom-up and top-down approach. Financial resources are tracked by financing source whether it is public, private or international, and among the different providers. Total HIV/AIDS expenditure in Sri Lanka during 2010 is estimated at Rs.534 million (USD 4.7 million), which is equivalent to 0.010% of GDP. Central government was the largest financing source, contributing 48% followed by donor agencies at 40% and International non-profit institutions contributing 3%.

The report presents HIV/AIDS expenditure estimates:

- on key expenditure indicators
- by financing sources and agents
- by providers and AIDS spending categories
- disaggregation amongst beneficiary populations
- geographical distribution



Institute for Health Policy
72, Park Street, Colombo 2, Sri Lanka.

Tel: +94-11-231-4041/2/3
Fax: +94-11-2314040

www.ihp.lk



Ministry of Health

385, Ven.Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka.

Tel: +94-11-269-8507/269-4033/267-5449/266-9192
Fax: +94-11-269-2913/269-4860

www.moh.lk

