# NATIONAL HEALTH ACCOUNTS RWANDA 2006

## WITH HIV/AIDS, MALARIA, AND REPRODUCTIVE HEALTH SUBACCOUNTS

USAID | RWANDA
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World Health Organization

TWUBAKANE

National University of Rwanda
School of Public Health

Health Systems 20/20

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The Health Systems 20/20 cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. HS 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

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# NATIONAL HEALTH ACCOUNTS RWANDA 2006

## WITH HIV/AIDS, MALARIA, AND REPRODUCTIVE HEALTH SUBACCOUNTS

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# ACRONYMS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ART** | Antiretroviral Therapy |
| **BTC** | Belgian Technical Cooperation |
| **CAMERWA** | *Centrale d'Achat des Médicaments Essentiels au Rwanda* (National Medical Stores of Rwanda) |
| **ARBEF** | *Association Rwandaise Pour le Bien-Etre Familial* |
| **CHUB** | *Centre Hospitalier Universitaire de Butare* (University Hospital of Butare) |
| **CHUK** | *Centre Hospitalier Universitaire de Kigali* (University Hospital of Kigali) |
| **CHW** | Community Health Worker |
| **CMH** | Commission on Macroeconomics and Health |
| **CNLS** | *Commission Nationale de Lutte contre le SIDA* (National AIDS Commission) |
| **CPI** | Consumer Price Index |
| **CSR** | *Caisse Sociale du Rwanda* (Social Security) |
| **DFID** | Department for International Development |
| **DSGAS** | Department of Health, Gender and Social Affairs |
| **DHS** | Demographic and Health Survey |
| **EICV** | *Enquête Intégrale sur les Conditions de Vie des Ménages* (Integrated Living Conditions Survey) |
| **FARG** | *Fonds National pour l'Assistance aux Rescapés du Génocide* (Victims of Genocide Fund) |
| **GDP** | Gross Domestic Product |
| **GF** | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| **GoR** | Government of Rwanda |
| **HBM** | Home-based Management |
| **HH** | Household |
| **HIV** | Human Immunodeficiency Virus |
| **IEC** | Information, Education and Communication |
| **IPPF** | International Planned Parenthood Federation |
| **IPT** | Intermittent Preventive Therapy |

| | |
|---|---|
| **JSI** | John Snow International |
| **LLIN** | Long-lasting Insecticide-treated Net |
| **MAP** | Multicountry AIDS Program |
| **MIFOTRA** | Ministry of Public Service, Skills Development and Labour |
| **MoF** | Ministry of Finance and Economic Planning |
| **MoH** | Ministry of Health |
| **NGO** | Nongovernmental Organization |
| **NHA** | National Health Accounts |
| **NISR** | National Institute of Statistics, Rwanda |
| **NUR** | National University of Rwanda |
| **OECD** | Organisation for Economic Co-operation and Development |
| **ONAPO** | *Office National de la Population* (National Population Office) |
| **OOP** | Out of Pocket |
| **PACFA** | Protection and Care of Families against AIDS |
| **PBF** | Performance-based Financing |
| **PEPFAR** | President's Emergency Plan for AIDS Relief |
| **PLHIV** | Person/People Living with HIV |
| **PMI** | President's Malaria Initiative |
| **PMTCT** | Prevention of Mother-to-Child Transmission |
| **PNLP** | *Programme National de Lutte contre le Paludisme* (National Program to Fight Malaria) |
| **PRB** | Population Reference Bureau |
| **PSI** | Population Services International |
| **RAMA** | *Rwandaise d'Assurance Maladie* |
| **RH** | Reproductive Health |
| **RWF** | Rwandan Franc |
| **SIS** | *Sistème d'Information Sanitaire* (Health Information System) |
| **UNGASS** | United Nations General Assembly Special Session |
| **USAID** | United States Agency for International Development |
| **VCT** | Voluntary Counseling and Testing |

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# EXECUTIVE SUMMARY

## BACKGROUND

Rwanda, a small country in the sub-Saharan Africa region and one of the poorest countries in the world, is nevertheless a leader in doing National Health Accounts (NHA) estimations. The full report that accompanies this executive summary describes Rwanda's fifth general NHA estimation (1998, 2000, 2002, 2003, 2006). In addition, Rwanda has carried out multiple NHA subaccounts: for HIV and AIDS, for malaria, and for reproductive health (RH). NHA provides trend data that allow policymakers to understand the current financing and future financing needs of the country's health care system.

## THE NHA CONCEPT AND APPLICATIONS

NHA is an internationally recognized methodology for tracking all financial resource flows in the health care system of a given entity. Actual expenditures, rather than budget data, are used to fill a series of tables that document resource flows from sources, through programs, to the final providers and uses of health finances. All actors in the health system – public, private, and donor – are included. NHA subaccounts are done for individual diseases (HIV/AIDS, malaria, tuberculosis) and specific health care areas (RH, child health).

While the NHA methodology allows some flexibility to disaggregate by certain health functions or include country-specific providers or programs, it also urges the country's NHA steering committee and technical team to follow the standard NHA framework to the extent possible. This allows for comparisons of the country's expenditures over time, and with other countries that carry out NHA. Most importantly, it contributes to transparent and effective use of NHA findings in advocacy and policymaking, and later in evaluating if intended policy goals – for example, equity in the burden of households' health expenditures, and quality improvement through performance-based financing of health service provision – are being achieved in a sustainable way.

## METHODOLOGY

The 2006 Rwanda NHA and HIV/AIDS, malaria, and RH subaccounts followed the methodology and estimation techniques presented in the *Guide to Producing National Health Accounts: with special applications for low- and middle-income countries* (published in 2003 by the World Health Organization with contributions from the World Bank and United States Agency for International Development) and built upon earlier NHA and subaccounts estimations.

Data collection, which took place in 2007, relied on both secondary and primary sources. (See Annex C of the full report for a detailed description of data sources and overall methodology.) Sources of secondary data include Ministry of Finance budgets, National Institute of Statistics data, findings of the World Bank-supported Integrated Living Conditions Survey, executed program budgets, and health care facility and *mutuelle* (mutual health organization) records. Primary data collection – done to triangulate secondary data as well as capture expenditures where such information did not exist – included surveys of nongovernmental organizations (NGOs), employers, and insurance companies. With the numbers of NGOs, donors, employers, insurance companies, etc. increasing in Rwanda every year, the health system in 2006 is considerably more complex than in previous estimations. This complexity made it

necessary to sample the entities targeted by the NHA surveys. Information on donor spending came from the records of the Ministries of Health and Finance and of organizations that implement donor programs, and from donor surveys. In all, the NHA team cleaned and analyzed 30 datasets in October–November 2007, contacting respondents where data were ambiguous. Report writing took place in early 2008.

# FINDINGS

### General health expenditures

**Increases in spending by all major financing sources (public, private, donor) more than doubled total health expenditure (THE) in Rwanda between 2003 and 2006.** As Table ES-1 shows, $THE_{general}$ rose from RWF 78.4 billion (US$ 142.1 million) to RWF 170 billion (US$ 307.3 million).

**TABLE ES-1: NHA TREND STATISTICS, 1998–2006**

| Indicators | 1998* | 2000* | 2002* | 2003* | 2006 |
|---|---|---|---|---|---|
| Total population** | 7,883,000 | 7,691,783 | 8,128,553 | 8,388,667 | 9,058,392 |
| Exchange rate US$ 1=RWF*** | 317 | 393 | 475 | 539 | 552 |
| Total real GDP$^{\delta}$ | RWF 903,596,620,489 US$ 1,637,721,790 | RWF 995,646,509,881 US$ 1,804,557,418 | RWF 1,091,939,192,568 US$ 1,979,082,888 | RWF 1,183,678,667,693 US$ 2,145,355,906 | RWF 1,583,000,000,000 US$ 2,869,105,013 |
| Total GoR expenditure and net lending$^{\delta\delta}$ | RWF 167,981,026,375 US$ 304,456,857 | RWF 212,334,986,166 US$ 384,846,098 | RWF 180,677,536,165 US$ 327,468,620 | RWF 238,444,711,887 US$ 432,168,615 | RWF 417,200,000,000 US$ 756,153,261 |
| $THE_{general}$ per NHA (US$ 2006) | RWF 45,482,827,219 US$ 82,435,254 | RWF 40,262,074,605 US$ 72,972,912 | RWF 44,570,823,334 US$ 80,782,294 | RWF 78,417,516,472 US$ 142,127,662 | RWF 169,574,434,271 US$ 307,344,825 |
| $THE_{general}$ per capita (US$ 2006) | RWF 5748 US$ 10.42 | RWF 5234 US$ 9.49 | RWF 5483 US$ 9.94 | RWF 9348 US$ 16.94 | RWF 18720 US$ 33.93 |
| $THE_{general}$ as % of nominal GDP | 5% | 4% | 4% | 8.8% | 11% |
| GoR health expenditure as % of GoR total expenditure | 2.5% | 4.7% | 6.1% | 9% | 6.5% |
| **Financing sources distribution as a % of $THE_{general}$** | | | | | |
| Public (include loans & grants) | 10% | 18% | 25% | 32% | 19% |

| Indicators | 1998* | 2000* | 2002* | 2003* | 2006 |
|---|---|---|---|---|---|
| Private | 40% | 30% | 42% | 25% | 28% |
| Donor | 50% | 52% | 33% | 42% | 53% |
| Other | 0% | 0% | 0% | 1% | 0% |
| **Household (HH) spending[δδδ]** | | | | | |
| as % of $THE_{general}$ | 32% | 26% | 31% | 20% | 26% |
| Out-of-pocket (OOP)[ξ] as % of $THE_{general}$ | 33%[ξξ] | 25% | 25% | 17% | 23% |
| HH spending per capita (US$) | RWF 1870<br>US$ 3.39 | RWF 1297<br>US$ 2.35 | RWF 1712<br>US$ 3.10 | RWF 1626<br>US$ 2.95 | RWF 4228<br>US$ 7.66 |
| **Financing agents distribution as a % of $THE_{general}$** | | | | | |
| Public | 38% | 30% | 48% | 45% | 49% |
| Private | 40% | 64% | 51% | 47% | 23% |
| Donor | 22% | 6% | 2% | 8% | 28% |
| **Provider distribution as a % of $THE_{general}$[ξξξ]** | | | | | |
| Public facilities | 66% | 39% | 55% | 53% | 56% |
| *Agréé* facilities | 10% | 40% | 25% | 23% | 7% |
| Private facilities | 24% | 21% | 20% | 24% | 37% |

* All US$ amounts for 1998, 2000, 2002, and 2003 are in constant 2006 US$ to facilitate comparison across years. The Consumer Price Index (CPI) was used for the conversion (69.91 for 1998, 70.88 for 2000, 74.71 for 2002, and 80.27 for 2003). Source for CPI data: NISR (http://www.statistics.gov.rw).

** The 1998 population figure is based on the 1992 census and the 2000 and 2002 figures are based on the 2002 census. The 2003 figure is estimated from the 2002 census at a growth rate of 3.2%. Due to the genocide and subsequent repatriation, it is difficult to determine precise population trends for Rwanda during the 1990s. The 2006 number is a projected amount from the 2005 census report.

*** The exchange was derived from an un-weighted average of monthly official exchange rates from National Bank of Rwanda (BNR) official statistics (see www.bnr.rw)

[δ] From BNR (see www.bnr.rw); 2006 GDP from NISR, accessed January 2008.

[δδ] Includes spending on recurrent budget, development budget, net lending, arrears, and increase in BNR government deposit.

[δδδ] Includes contributions to insurance and direct payments to providers.

[ξ] OOP includes only direct payments to providers.

[ξξ] OOP expenditures are higher than HH expenditures because public firms and private firms are noted as giving funds to HH OOP.

[ξξξ] For time comparison purposes, provider expenditures have been broken down into the three categories of public facilities, government-assisted health facilities (*agréés*) and private facilities in keeping with all previous NHAs. The above percentages represent the share of total facility expenditure broken down into public, *agréé* and private providers. However, greater disaggregation is available for the 2006 NHA as detailed in Annex A. It should be noted that expenditures on for-profit providers like "traditional healers" and "independent pharmacies" were allocated to private facilities.

**The largest share of THE came from donor spending.** Donor spending decreased from Rwanda's first NHA estimation in 1998, until the third one, in 2002, reflecting a fall-off in the post-genocide assistance given to Rwanda. Since then, donor spending on health has steadily increased, due largely to the funds flowing from new global disease initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative. Donor expenditures now are responsible for the largest share of $THE_{general}$, from 42 percent of THE in 2003 to 53 percent in 2006, or RWF 32.6 billion (US$ 59.0 million) to RWF 90.5 billion (US$ 164.0 million).

**Private spending on health overall grew by almost two-and-a-half times.** Household spending on health care (the major portion of private spending on health) increased substantially. In fact, out-of-pocket (OOP) expenditures tripled, from RWF 15.5 billion (US$ 28.1 million) to RWF 44.4 billion (US$ 70.7 million). This may be attributable to several factors: Though THE has more than doubled, most of the new monies go to programs for targeted diseases, whereas households spend on curative services and pharmaceuticals; OOP spending is increasingly on proprietary drugs/independent pharmacies (see below) rather than generic drugs offered at public facilities; gross domestic product has risen, and people may have more discretionary income for health care; data for traditional healers has become more robust; more households are participating in mutuelles and pay co-payments; health care utilization has risen from 0.3 per capita in 2003 to 0.7 per capita in 2006.

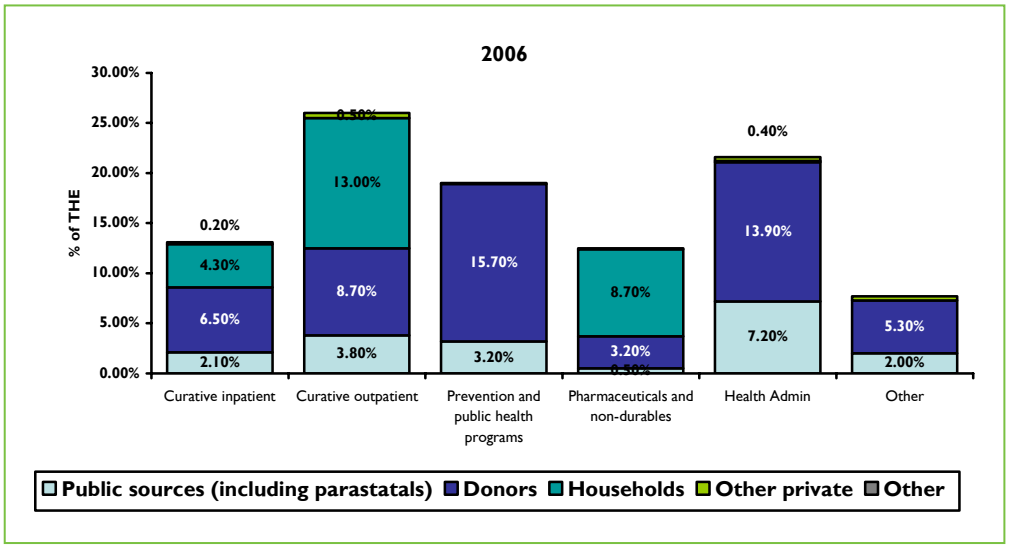
**Government spending on health increased absolutely, though its relative share has declined.** Public financing of health increased from RWF 24.9 billion (US$ 45.1 million) in 2003 to RWF 32.8 billion (US$ 57.8 million) in 2006. A part of this increment may actually be from donors, who increasingly contribute directly to the Ministry of Finance (MoF) for general budget support rather than earmarking their funds for health. The government share of THE fell (from 32 percent to 19 percent of THE) over the period due to the increase in donor contributions outside the MoF. Government expenditure on health as a percentage of total government expenditure declined between 2003 and 2006, from 9 percent to 7 percent, meaning that Rwanda fell short of the Abuja declaration target (15 percent of public spending going to essential health services by 2015) after having moved steadily toward the target from 1998 to 2003.

**Government agencies (Ministry of Health and other ministries, National AIDS Control Commission [CNLS]) manage 40 percent of health funds.** Other major financing agents are NGOs and other implementing agencies (28 percent) and households, via OOP spending (23 percent). Private groups manage less than in previous years.

**Mutuelles are largely financed by households.** While households finance 70% of mutuelles, these schemes are still subsidized by donors (13%), the government (9%), and private firms (8%).

Figure ES-1 shows the spending, by major finance source, on various health care functions in 2006.

**FIGURE ES-1: FINANCING SOURCES OF OVERALL HEALTH CARE FUNCTIONS IN 2006**




**THE$_{general}$ 2006: RWF 169,574,434,271 ($ 307,344,826)**

**A little more than half of $THE_{general}$ goes to personal care.** In 2006, absolute funding on virtually all health care functions increased from 2003. Thirty-nine percent of THE goes to curative care (two-thirds to outpatient care, one-third to inpatient care), 13 percent to drugs and other nondurables. The remaining 48 percent is distributed as follows: prevention and public health programs 19 percent, administration and insurance 21 percent, and capital formation and health system strengthening 7 percent.

**Households and donors finance most curative services.** This contrasts with 2003, when donors and government bore expenditure on curative services about equally (about 10 percent of THE). In 2006, households spend primarily on outpatient services, and are the largest financier of this function (13 percent of THE). They also cover the largest share of spending on pharmaceuticals/nondurables (nearly 9 percent); indeed, their spending increased at every type of provider, but rose most dramatically at independent pharmacies. Nearly 9 percent of THE is donor spending on outpatient services.

**Spending on prevention and public health programs increased.** In 2003, spending on this function was RWF 18.4 billion (US$ 33.4 million); by 2006, it had risen to RWF 32.3 billion (US$ 58.6 million). Most of this increase is from donor contributions.

**More than one-third of government spending on health goes to administration.** This is more than government covers of curative care, but probably reflects government's role as regulator of the health system.

### HIV/AIDS health expenditures

The latest Demographic and Health Survey (DHS) estimates adult HIV prevalence in Rwanda at 3 percent (Table ES-2), and the Joint United Nations Programme on HIV/AIDS estimates the total number of people living with HIV (PLHIV) at 160,000. Recent years have seen a dramatic scale-up of HIV/AIDS programs, with funding from initiatives like the Global Fund and PEPFAR. CNLS coordinates more of HIV/AIDS funding.

**TABLE ES-2: HIV/AIDS INDICATORS AND NHA FINDINGS FOR EXPENDITURE ON HIV/AIDS SERVICES, 2000-2006**

| Indicators | 2000* | 2002* | 2006 |
|---|---|---|---|
| HIV seroprevalence rate (adults) | 5.1% (estimated) | 5.1%** | 3%*** |
| Number of PLHIV | 200,000 (estimated) | 199,279** | 160,000[δ] |
| $THE_{general}$ | RWF 41,027,685,265 (US$ 74 million) | RWF 44,570,823,334 (US$ 94 million) | RWF169,574,434,270 (US$ 307 million) |
| Total HIV/AIDS health expenditure ($THE_{HIV}$) | RWF 3,161,151,656 (US$ 5,729,423) | RWF 6,557,070,605 (US$ 13,804,359) | RWF 40,482,722,686 (US$ 73,373,091) |
| HIV/AIDS health spending per PLHIV | RWF 15,806 (US$ 28.65) | RWF 32,903 (US$ 69.27) | RWF 253,017 (US$ 459.58) |
| HIV/AIDS health spending as a % of $THE_{general}$ | 8.0% | 14.7% | 24% |
| HIV/AIDS health spending as a % of GDP | 0.3% | 0.6% | 2.6% |
| $THE_{HIV}$ as a % of total HIV/AIDS spending (health and non-health) | - | - | 84% |
| Percent of $THE_{HIV}$ that is targeted for HIV/AIDS | - | - | 99% |

| Indicators | 2000* | 2002* | 2006 |
|---|---|---|---|
| **Financing sources distribution as a % of $THE_{HIV}$** | | | |
| Public | 8% | 9% | 3% |
| Private | 43% | 17% | 2.4% |
| *Households account for* | *41%* | *16%* | 2% |
| Donors | 49% | 75% | 94% |
| **Financing agents distribution as a % of $THE_{HIV}$** | | | |
| Public | 25% | 27% | 39%[δδ] |
| Private | 43% | 16% | 54% |
| Donor and NGO | 32% | 57% | 7% |
| **Providers distribution as a % of $THE_{HIV}$** | | | |
| Public providers | 33% | 16% | 27% |
| -Public hospitals | 24% | 11% | 17% |
| -Public health centers | 9% | 5% | 10% |
| Private providers | 9% | 3% | 5% |
| -Private for-profit hospitals | 8% | 2% | 5% |
| -Private for-profit health centers/clinics | 1% | 1% | 0% |
| Government assisted not-for-profit providers (*agréés*) | 5% | 3% | 8% |
| -*Agréé* hospitals | 2.6% | 1% | 2% |
| -*Agréé* health centers | 2.8% | 2% | 6% |
| Private pharmacies | 7% | 3% | 0.4% |
| Provision and administration of public health programs | 46% | 66% | 57% |
| Traditional healers | - | - | 0.2% |
| Other | 0% | 9% | 2.4% |
| **HIV/AIDS health spending by function** | | | |
| Prevention and public health programs | 46% | 66% | 29.7% |
| Curative care | 48% | 23% | 37.7% |
| -Inpatient | 14% | 7% | 9.8% |
| -Outpatient | 34% | 15% | 27.9% |
| Administration | 0% | 9% | 23% |
| Capital formation | - | - | 8% |
| Pharmaceuticals and other non-durables from independent pharmacies | 7% | 3% | 11.9% |
| Other | - | - | 1.1% |

*All US$ amounts for 2000 and 2002 are in constant 2006 US$ to facilitate comparison across years. The CPI was used for the conversion (70.88 for 2000 and 74.71 for 2002). Source for CPI data: NISR (http://www.statistics.gov.rw).

**UNAIDS (2004)

***DHS 2005

[δ] UNAIDS estimate, 2006

[δδ] Includes projects funded by donors that are housed under CNLS (e.g., World Bank MAP, UNDP, African Development Bank)

**The total amount of HIV/AIDS funds has increased dramatically, both absolutely and proportionately.** HIV/AIDS programs now receive 24 percent of $THE_{general}$ in Rwanda. Funding has tripled since 2002 (the previous NHA HIV/AIDS subaccount), going from RWF 6.6 billion (US$ 13.8 million) to RWF 40.5 billion (US$ 73.4 million).

**Nearly all HIV/AIDS funding (94 percent) comes from donors.** Donor spending has increased almost eightfold, going from RWF 4.9 billion (US$ 8.9 million) in 2002 to RWF 38.2 billion (US$ 69.3) in 2006. This donor subsidization has allowed a proportionate decrease in financing from other sources: Households contribute a much smaller percentage than in 2002 (2 percent, down from 16 percent) but only slightly less in absolute terms (about RWF 1.0 billion [US$ 1.8 million] in 2006). The government

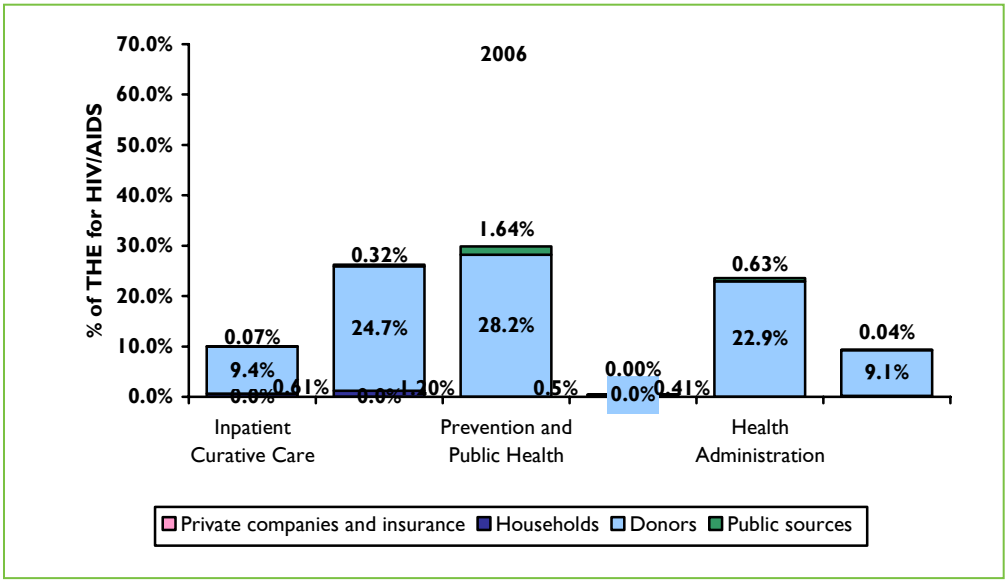
contribution also has dropped proportionately (from 8 percent to 3 percent), but has almost doubled absolutely (from RWF 563.2 million [US$ 1.0 million] in 2002 to RWF 1.1 billion [US$ 2.0 million] in 2006).

**The health expenditure burden on PLHIV relative to the general population's burden has abated.** In 2002, PLHIV spent four times more on the health than did the general population. In 2006, they spend 1.5 times more. (For reasons for the increase in household spending, see the above section, General health expenditures.) However, a disparity in OOP spending should be noted: while the richest Rwandans spend six times more per year than the poorest ones, this represents only 2 percent of their total consumption of services, whereas it is 4 percent for poorer Rwandans.

**NGOs and CNLS projects manage most HIV/AIDS funds. In 2002, NGOs and other projects managed the bulk (76 percent) of HIV/AIDS funds.** In 2006, NGOs manage a smaller but still significant 52 percent; CNLS and programs under its auspices (Global Fund, World Bank MAP, etc.) manage 35 percent.

Figure ES-2 shows the spending, by major financing source, on HIV/AIDS functions in 2006.

**FIGURE ES-2: FINANCING SOURCES OF HIV/AIDS HEALTH CARE FUNCTIONS IN 2006**




**Donors finance the largest share of all HIV and AIDS health and health-related functions.** Most overall $THE_{HIV}$ funding goes to prevention and public health programs (29.7 percent of $THE_{HIV}$), administration (23 percent) and outpatient curative care (27.9 percent); lesser percentages go to inpatient care (9.8 percent) and pharmaceuticals/nondurables (less than 1 percent). The largest share of public funding for HIV/AIDS goes to prevention and public health programs (1.64 percent of $THE_{HIV}$) and the largest share of household funding goes to outpatient care.

### Malaria expenditures

Malaria continues to be the leading cause of morbidity in Rwanda. In 2006, health facilities diagnosed more than 1.3 million cases. Major interventions to decrease morbidity are: government distribution of long-lasting insecticide-treated nets (LLINs), adoption of artemisinin-based combination therapy (ACT),

intermittent preventive treatment (IPT) for pregnant women, and the Home-based Management Strategy for community health workers.

**Spending on malaria nearly doubled between 2003 and 2006, though malaria's share of THE fell from 18 percent to 14 percent.** In 2003, RWF 13.8 billion (US$ 25.0 million) was spent on malaria; that figure in 2006 is RWF 23.6 billion (US$ 42.7 million) (Table ES-3). The fact that malaria receives a smaller share of health spending is attributable to the larger share going to HIV and AIDS. It should be noted that only about 35 percent of malaria expenditures are actually targeted to malaria.

**TABLE ES-3: MALARIA INDICATORS AND NHA SUBACCOUNT FINDINGS FOR EXPENDITURE ON MALARIA SERVICES, 2003 AND 2006**

| Indicators | 2003* | 2006 |
|---|---|---|
| Malaria morbidity rate (adults) | 67.5% | 34% |
| Malaria morbidity rate (< 5 years) | 32.5% | 38% |
| THE | RWF 78,417,516,472 ($142,128,178) | RWF 169,574,434,271 ($307,345,940) |
| Total malaria expenditure ($THE_{malaria}$) | RWF 13,782,993,174 ($24,981,047) | RWF 23,570,420,722 ($42,720,314) |
| Malaria spending per capita | RWF 1,643 ($2.98) | RWF 2,602 ($4.72) |
| Malaria OOP spending per capita | RWF 481 (<$1) | RWF 1,056 ($1.91) |
| % of total health expenditures allocated to malaria | 17.58% | 13.9% |
| Total malaria spending as % of GDP | 1% | 1.49% |
| Targeted spending on malaria | RWF1,639,996,778 ($2,972,409) | RWF 8,324,615,580 ($15,087,932) |
| Targeted spending as % of $THE_{malaria}$ | 12% | 35% |
| **Financing sources of malaria spending** | | |
| Public | 24% | 5% |
| Private | 37% | 45% |
| *Households account for* | 29% | 44% |
| Donors | 38% | 50% |
| **Financing agents of malaria spending** | | |
| Public | 40% | 40% |
| Private | 34% | 60% |
| *Household OOP accounts for* | 27% | *41%* |
| Donor** | 26% | 20% |
| Providers of malaria care and activities | | |
| Public Providers | 63% | 33% |
| -Public hospitals | 22% | 13% |
| -Public health centers | 41% | 20% |
| Private providers | 14% | 10% |
| -Private for-profit hospitals | 3% | 2% |
| -Private for-profit health centers/clinics | 11% | 8% |
| Government assisted not-for-profit providers (*Agrées*) | 15% | 12% |
| -*Agrée* hospitals | 5% | 4% |
| -*Agrée* health centers | 9% | 8% |
| Independent pharmacies | 4% | 16% |
| Provision and administration of public health programs | 4% | 5% |

| Indicators | 2003* | 2006 |
|---|---|---|
| General health care administration and insurance (for malaria) | - | 2% |
| Community health workers | - | 20% |
| Traditional healers | 0.4% | 0.4% |
| Other | 0.1% | 1.6% |
| **Malaria health spending by function** | | |
| Prevention and public health programs | 3% | 4.6% |
| Curative Care | 91% | 76.8% |
| -Inpatient | 48% | 13.2% |
| -Outpatient | 43% | 63.6% |
| Administration | 2% | 1.2% |
| Pharmaceuticals and other non-durables from independent pharmacies | 4% | 16.1% |
| Other | 0% | 1.4% |
| **Spending on preventive activities** | | |
| Insecticide-treated nets | 6% | 27% |
| Repellents | 3% | 0% |
| Prevention programs | 3% | 5% |

* All US$ amounts for 2003 are in constant 2006 US$ to facilitate comparison across years. The CPI was used for the conversion (80.27 for 2003). Source for CPI data: NISR (http://www.statistics.gov.rw)

**Includes NPISH (in 2003) and NGOs/Implementing Agencies (in 2006), which are mainly funded by donors.

**Donors and households are the largest financing sources of malaria care.** In 2006, donors contribute 50 percent, households 44 percent. In absolute terms, donor spending doubled between 2003 and 2006, going from RWF 5.3 billion (US$ 9.6 million) to RWF 11.8 billion (US$ 21.3 million), and household spending tripled, going from RWF 4.0 billion (US$ 9.6 million) to RWF 11.8 billion (US$ 21.3 million). (For reasons for the increase in household spending, see the above section, General health expenditures.)

**Most spending on Malaria is non-earmarked funds.** Of $THE_{Malaria}$, only 35% is actually earmarked for spending on malaria. The costs of malaria treatment are higher than what financing sources program for malaria.

**Private sector expenditures on malaria are the highest of all categories of private sector expenditures on health.** Twenty-two percent of private expenditure on health goes to malaria, though this is slightly less than the 26 percent of 2003. In 2006, donors spend 13 percent of their health funds on malaria, while they spend more than three times that, 42 percent of their funding, on HIV and AIDS. In 2003, 16 percent of donor monies went to malaria. Public sources spend about 4 percent of their resources on malaria, down from 13 percent in 2003 but about the same percentage that they spend on other priority diseases.

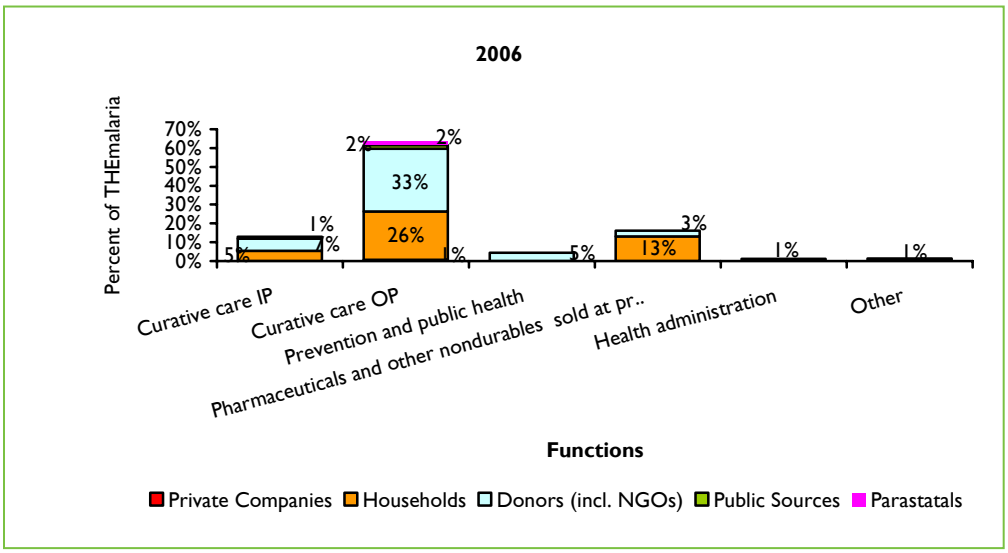
**Concomitant with the above, the private sector is the main financing agent of malaria funds in 2006.** It manages 60 percent of malaria funds (with household OOP spending managing 41 percent), while the public sector manages 40 percent. NGOs and implementing agencies (including direct donor transfers) manage 20% of malaria funds, down from 34% in 2003 (although with higher absolute value of managed funds).

**Income and age influence the seeking of malaria care.** Care seeking diminishes with income quintile: Only 17 percent of malaria goes untreated in the richest income quintile; this percentage grows steadily larger through the income quintiles, reaching 48 percent in the lowest quintile. (The opposite is true for care seeking in health centers and hospitals: 47 percent of the rich seek this care, while only 18

percent of the poorest do.) There is more equality in self-treatment: about a third of malaria cases in all quintiles self-medicate. Children under five are most likely to be treated at health facilities (42 percent vs. 25 percent for those over 50 years of age); again, the percentages are reversed for non-treatment, and percentages show less variation for self-medication.

Figure ES-3 shows the spending, by major financing source, on malaria functions in 2006.

**FIGURE ES-3: FINANCING SOURCES OF MALARIA HEALTH CARE FUNCTIONS IN 2006**




**The bulk of malaria expenditures cover curative care services.** In 2006, almost 77 percent of expenditures on malaria go to curative services, 64 percent on outpatient care, 13 percent on inpatient. This is less than in 2003, when 91 percent went to curative care.

**Spending on LLINs care increased tenfold between 2003 and 2006, though malaria prevention overall receives only 5 percent of malaria expenditures.** This contrasts with the 77 percent of malaria spending going to curative care. In 2006, the government strongly advocated for distribution of LLINs. As a result, its expenditure on nets (financed largely with donor funds) expanded from 13 percent to 82 percent between 2003 and 2006, while household spending on LLINs fell from 73 percent to 3 percent.

**Spending on drugs and other nondurables increased in both absolute and relative terms.** In 2003, this was 4 percent; in 2006, it is 16 percent. Most of this spending comes from households.

**Reproductive health expenditures**

The poor RH status of Rwandans – including a high fertility and high population growth rate leading to high population density, one of the highest maternal mortality ratios in East and Southern Africa, and one of lowest rates of contraceptive prevalence in the region – has a negative effect on the country's economic development. Based in part on the present NHA RH subaccount findings, the government of Rwanda acknowledges that improving the health status of women should be a key element of any development strategy.

**Spending on RH increased 65 percent between 2002 and 2006 but represents a smaller percentage of THE.** As with other aspects of health care financing, this smaller percentage (6.2percent from 15.7percent ) is because total spending, in particular the HIV and AIDS "piece of the expenditure pie," has grown so much. RH expenditures increased from RWF 7.0 billion (US$ 12.7 million) in 2002 to RWF 10.6 billion (US$ 19.1 million) in 2006 (see Table ES-4). It should be kept in mind that the bulk of RH expenditures goes to 25 percent of the population, women of reproductive age.

**TABLE ES-4: SUMMARY OF RH SUBACCOUNTS FINDINGS, 2002 AND 2006**

| Indicators | 2002* | 2006 |
|---|---|---|
| Total RH ($THE_{RH}$) expenditures | RWF 6,982,368,741 (US $12,655,180) | RWF 10,561,325,959 (US $19,141,922) |
| RH expenditures per woman of reproductive age | RWF 3,378 (US $6) | RWF 4,609 (US $8) |
| RH expenditures as a % of GDP | 0.6% | 0.7% |
| RH expenditures as a % of total of overall health spending | 15.67% | 6.23% |
| OOP spending per woman of reproductive age | RWF 339 (US$0.61) | RWF 431.38 (US$0.78) |
| % of RH spending that is targeted for RH | | 40% |
| THE as percent of total RH spending on health and non-health | 99.7% | 98.4% |
| **Financing sources of RH spending** | | |
| Public | 7.7% | 14.4% |
| Private | 12.4% | 14.3% |
| *Households account for* | *10.6%* | *13.2%* |
| Donor | 79.8% | 71.2% |
| **Financing agents of RH spending** | | |
| Public | 52% | 35% |
| Private | 12% | 10% |
| *Household OOP accounts for* | 10% | 9% |
| Donor | 36% | 55% |
| **Providers of RH care and activities** | | |
| Public providers | 9% | 53% |
| -Public hospitals | 4.3% | 45% |
| -Public health centers | 4.3% | 8% |
| Private providers | 9% | 12% |
| -Private for-profit hospitals | 4% | 6% |
| -Private for-profit health centers/clinics | 5% | 6% |
| Government assisted not-for-profit providers (*Agréés*) | | 13% |
| -*Agréé* hospitals | | 6.3% |
| -*Agréé* health centers | | 6.2% |
| Independent pharmacies | 3% | 4% |
| Provision and administration of public health programs | 72% | 12% |
| Community health workers | | 5% |
| Other | 8% | 2% |
| **RH health spending by function** | | |
| Prevention and public health programs | 66% | 12% |
| Curative care | 18% | 83% |
| -Inpatient | 7% | 50.6% |
| -Outpatient | 11% | 32.8% |

| Indicators | 2002* | 2006 |
|---|---|---|
| Administration | 7% | 0% |
| Capital formation | 0% | 1% |
| Pharmaceuticals and other non-durables from independent pharmacies | 3% | 4% |
| Other | 6% | |

- All US$ amounts for 2002 are in constant 2006 US$ to facilitate comparison across years. The CPI was used for the conversion (74.71 for 2002). Source for CPI data: NISR (http://www.statistics.gov.rw).
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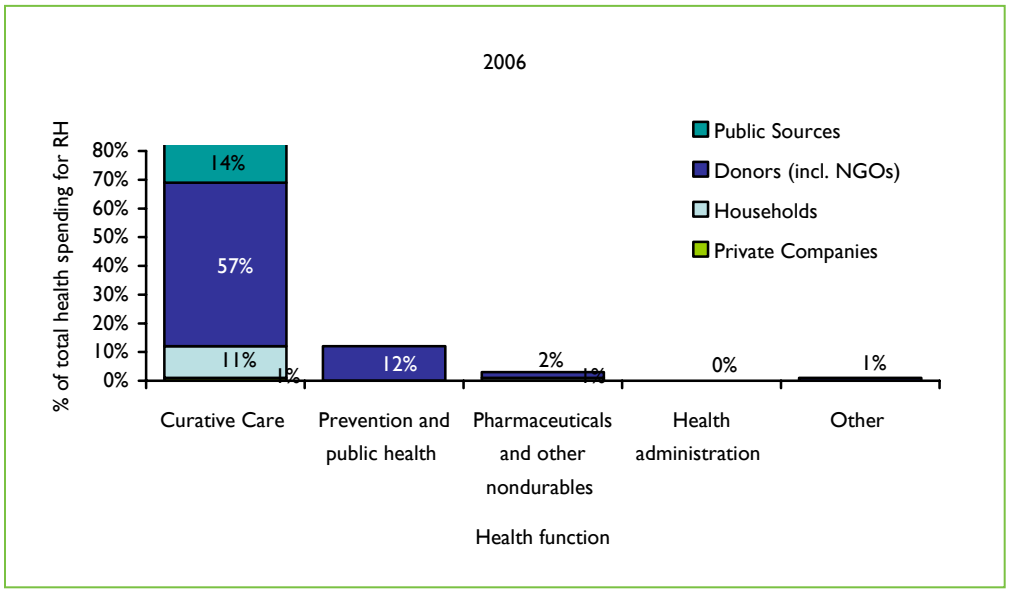
**Donors are still by far the biggest provider of RH financing, but households and public sources increased their relative contributions between 2002 and 2006.** Donors increased their real contributions to RH over this period (from RWF 5.6 billion [US$ 10.0 million] to RWF 7.5 billion [US$ 13.6 million]), but this represents a relative decline, from 80 percent to 71 percent. Households doubled their expenditures in real terms (they now finance 13 percent of RH care). Public financing sources nearly tripled theirs, and their percentage grew from 8 percent to 14 percent.

**OOP spending on RH care increased slightly from 2002 to 2006. In 2002, OOP spending was RWF 701.0 million (US$ 1.3 million), in 2006, RWF 988.4 million (US$ 1.8 million).** Due to the growth in OOP spending overall, however, this represented a drop from 6 percent to 3 percent of total OOP expenditures on health. OOP spending on RH at independent pharmacies and private health centers has declined, likely because family planning commodities are now widely distributed through public and NGO facilities.

Figure ES-4 shows the spending, by major financing source, on RH functions in 2006.

**FIGURE ES-4: FINANCING SOURCES OF RH FUNCTIONS IN 2006**




**Curative care consumes 82 percent of RH expenditures.** In 2002, curative care consumed only 18 percent of RH expenditures. Curative care includes personal preventive care services (as opposed to collective preventive care programs) such as family planning commodities. Donors pay for over half (57 percent) of these services, public financing sources for 14 percent, and households for 11 percent. Donors also pay the bulk of other health care functions (prevention, pharmaceuticals, administration, and other).

**Breaking RH expenditures down another way shows that maternal health services consume 73 percent of RH expenditures.** In absolute terms, this is RWF 733.4 million (US$ 1.4 million), a sevenfold increase in maternal care expenditures since 2002. Hospital deliveries account for 51 percent of total RH spending (71 percent of maternal health care spending), prenatal care for 21 percent (29 percent of maternal health care spending). Postnatal care is negligible.

**There is a notable shift in financing of contraceptive commodities.** Absolute spending on contraceptive commodities has nearly tripled since 2002, with donors via NGOs and the Ministry of Health now funding most; previously, household OOP spending financed most of these commodities.

## CONCLUDING REMARKS

Rwanda remains dependent on donor funding in the health sector. Where donor and government financing fails to fully cover health services, households incur the financial burden through OOP payments, or they do not seek care. Households continue to spend the majority of their health funds on curative care directly from a provider rather than through insurance schemes, although this trend may be changing. As the 2006 NHA findings reveal the level of spending from each financing source, the sustainability of health financing as well as the goal of increasing health care utilization should be considered. NHA subaccounts are useful for policymakers to determine whether health funds are properly allocated in the health sector. PLHIV have seen a relative improvement in their level of OOP spending while persons using RH services and malaria goods and services still bear a growing financial burden.

The 2006 NHA estimation shows that the government generally has a larger stewardship role over health funds than in past years. NGOs and implementing agencies still play a large role in the sector as well. As mutuelles and other insurance are scaled up, future NHA estimations should reflect their larger role and the estimation can serve as a useful monitoring and evaluation tool on the schemes' success. This latest NHA also reveals that the private sector is still small but has grown in recent years, especially independent pharmacies that sell pharmaceuticals and other non-durables to households. Spending on preventive care should be maintained to lower overall spending on curative care, but funds for preventive care should be spent efficiently and effectively. Spending on general administration may be affected by more efficient programming, but may not decrease if additional programs and staff are introduced into the growing health sector.

The 2006 NHA report is Rwanda's longest, due to the increasing complexity of the health sector and from having five years of data to draw on and compare. As additional NHA estimations are completed, the country will also be able to draw on the 2006 NHA to analyze trends in Rwanda's health financing.

# 1. INTRODUCTION

## 1.1 THE NHA CONCEPT AND POLICY OBJECTIVES

National Health Accounts (NHA) is an internationally recognized framework that aims to comprehensively track and document resource flows in the health care system of a country. The framework describes health expenditures in a consistent and transparent manner from financing sources to end uses. The process involves a compilation of available data, the commissioning of primary data collection to fill any gaps, and the analysis and presentation of the data in a user-friendly format as per the international norms described in the Guide to Producing National Health Accounts; with special application for low- and middle-income countries (World Health Organization [WHO], World Bank, and United States Agency for International Development [USAID] 2003).[1] NHA is intended to be carried out as a regular exercise in a country, to allow policymakers and stakeholders to monitor spending patterns in the country across years, priority health areas, and diseases. When measuring expenditure on individual priority health areas and diseases, the estimation produced is called a subaccount.

Rwanda has conducted NHA five times (1998, 2000, 2002, 2003, and now for 2006), with subaccount estimations often included in the exercise. Specific objectives of the 2006 NHA and subaccounts are to:

- Inform the policy process in setting health care policy priorities;
- Determine whether resource allocation is aligned to key health care policy priorities;
- Provide data for gauging health system performance and management;
- Uncover equity issues in the distribution of health care resources;
- Compile relevant descriptive statistics for the health system in Rwanda;
- Aid monitoring and evaluation by tracking health expenditure trends;
- Serve as a baseline to contribute to monitoring the effect of ongoing health initiatives such as decentralization, scale-up of *mutuelles de santé* (mutual health organizations), and performance-based financing;
- Contribute to institutionalizing the NHA process through the involvement of local players in all facets of the process including additional training and technical development initiatives;

[1] The *Guide to Producing National Health Accounts; with special application for low- and middle-income countries* is commonly known as the Producers Guide, or PG, and will be referred to as such in this report.

- Ascertain trends in sources and uses of funding (pre- and post-donor influx)[2] for three priorities, namely HIV/AIDS, malaria, and reproductive health (RH); and

- Identify the financial priority of each subaccount relative to each other and in the context of general health spending.

## 1.2 SOCIOECONOMIC STATUS OF RWANDA

According to the National Institute of Statistics of Rwanda (NISR), the country had an estimated nominal gross domestic product (GDP) of RWF 174,755 (US $317) per capita in 2006.[3] When compared with the overall sub-Saharan Africa average GPD per capita of RWF 415,526 (US$ 745, 2005), Rwanda ranks as one of the poorest countries in the world (United Nations Development Programme [UNDP] 2007).

Rwanda's economy is recuperating from the war and genocide of 1994, facilitated by both foreign aid inflow and the recovery of domestic production. The second Integrated Living Conditions Survey 2005/06 (*Enquête intégrale sur les conditions de vie des ménage*, or EICV2) revealed that, between 2001 and 2006, consumption per capita grew, in real terms, at an average rate of around 3.0 percent per year. As a result, poverty declined from 60.4 to 56.9 percent (NISR and World Bank 2006).

Nevertheless, Rwanda's social indicators remain poor. Along with progress in economic growth and poverty reduction, there has also been significant population growth, approximately 3.5 per year. Therefore, although the percentage of the population living in poverty has fallen, population growth has increased the total number of Rwandans living in poverty, from an estimated 4.8 million in 2000/01 to 5.4 million in 2005/06 (NISR and World Bank 2006).

## 1.3 OVERVIEW OF THE RWANDAN HEALTH SYSTEM

### 1.3.1 PUBLIC SECTOR

Rwanda's public health system is based on a primary health care approach and is organized in three tiers, with the Ministry of Health (MoH) responsible for setting policy and overall health sector planning.[4] This organization resulted from the decentralization process of 2005.

The three-tier system applies to health care administration and facilities. Regarding the administrative structure, the first tier is the central-level MoH, which acts as the steward, coordinating the sector from the national perspective. The second tier comprises 30 health districts charged mainly with planning, supervision, and delivery of health services throughout the health district. The third tier is the primary "sector" level.[5] Each sector is served on average by one health center that delivers most of the primary health services such as prevention, community health promotion (family planning, sensitization on hygiene, prevention of sexually transmitted infections [STIs]) and curative treatment of uncomplicated diseases like diarrhea, respiratory tract infections, malaria, and normal deliveries.

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[2] Donor influx refers to an increase in donor spending due to the introduction of new funding mechanisms like the Global Fund to Fight AIDS, Tuberculosis and Malaria, President's Malaria Initiative (PMI), and President's Emergency Plan for AIDS Relief (PEPFAR) etc.

[3] http://www.statistics.gov.rw/, accessed January 2008.

[4] *Administratively*, Rwanda's health system was a two-tier system in 2006: MoH and the District Health System. Facilities, the third tier, are organized further into another three tiers, as mentioned in the following paragraph

[5] MoH HMIS 2006 and Rwanda Service Provisional Assessment (SPA) Survey 2007.

The health facilities are also organized into three tiers: referral hospitals, district hospitals, and health centers. Rwanda has two fully public referral hospitals, namely the University Hospital of Butare (*Centre Hospitalier Universitaire de Butare* [CHUB]) and University Teaching Hospital of Kigali (*Centre Hospitalier Universitaire de Kigali* [CHUK]). There are 34 district hospitals that aim at providing a complementary health care package, and 402 health centers that aim at providing a minimum health care package as determined by the national standards for health care. A fourth tier of primary health delivery is being formalized and will be anchored in the use of community health workers (CHWs) at the cell and *umudugudu* (village) levels; it will deliver new initiatives such as home-based management of under-5 (children under 5 years of age) uncomplicated malaria, simple diarrhea, and provision of family planning commodities.

### 1.3.2 GOVERNMENT-ASSISTED NOT-FOR-PROFIT HEALTH FACILITIES

Forty percent of all health facilities are under the management of faith-based organizations, mainly Catholic and Protestant, which operate under a memorandum of understanding with the Government of Rwanda (GoR). The agreement integrates these *agréé* facilities into the mainstream public health care delivery, based on MoH policies. It commits them to provide almost all the functions of public facilities; in turn, the GoR provides them with staff and staff salaries, covers some of their operating costs, and offers them access to financial resources via performance-based financing. Their staff can also access government-sponsored training and sit on district health management teams.[6]

### 1.3.3 PRIVATE SECTOR

The private health sector remains small.[7] Private facilities are found throughout the main Rwandan cities such as Kigali, Huye, Musanze, and Rubavu; there are very few private facilities in rural areas. The GoR is strengthening its collaboration with the private sector, based on (i) a greater participation of the private sector in the provision of services to the entire population, (ii) improved accessibility of this sector to facilities services, such as GoR in-service training, (iii) improved supervision of the sector by the Health Care Task Force through information sharing and access to norms and standards, and (iv) a reinforcement of the MoH Health Care Task Force charged with accreditation and supervision of the private sector. A formal agreement detailing the nature of cooperation between the MoH and private sector has been established to ensure good collaboration.

### 1.3.4 TRADITIONAL MEDICINE

Historically, traditional practitioners and traditional birth attendants provided health services and medicine to much of the population. The health sector has modernized over time; nevertheless, a significant proportion of the population still accesses traditional health services for various reasons. The GoR recognizing this fact through a legal framework that allows traditional medical services to operate alongside modern health services at the district level. Collaboration with the Butare Institute for Scientific and Technological Research ensures the rational development of traditional health care in the country. The Pharmacy Task Force has also embraced research into the use of traditional medicines.

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[6] MoH, National Population Office [*National de la Population*, ONAPO], and ORC Macro 2003.

[7] King Fayçal Hospital and the Neuropsychiatric Hospital of Ndera are categorized in the provider figures as private institutions in the 2006 NHA report. In the NHA tables, the former was labeled a private referral hospital and the latter was given a separate code. There are varying views of how these hospitals should be categorized. Both receive funding through both public and private sources but are run with relative autonomy from the government, unlike public referral hospitals, which are run exclusively by the government. During the planning stages of the 2006 NHA, the team decided to classify the two institutions as "private providers" to distinguish them from public referral hospitals.

## 1.4 HEALTH POLICY OBJECTIVES, 2006

Four major interventions were implemented in 2006 to improve the health system and reduce the financial burden of people seeking health care.

- The second phase of the administrative reforms, which led to the elimination of the health district structure;
- Public administrative reforms, which led to a strong reduction of manpower at the national/central level (MoH) in favor of increasing capacity at the service delivery level;
- Scale-up of community-based health insurance coverage to all 30 districts in the form of *mutuelles de santé* and introduction of a national subsidy for those too poor to pay the insurance premium;
- Roll-out of performance-based financing for health centers and district hospitals in 23 districts, and an introduction of community performance-based financing.

The 2006 NHA will be useful to measure the effects of these interventions on health financing patterns in the country. Future NHA estimations can be compared with the 2006 findings for this purpose.

While Rwanda has made important policy decisions in recent years, comparisons with health status indicators of other sub-Saharan Africa countries show that Rwanda needs to implement changes that will improve the health status of its population.

**TABLE 1.0: KEY DEVELOPMENT AND HEALTH INDICATORS, SELECTED SUB-SAHARAN AFRICA COUNTRIES, 2005**

| Development Indicator | Kenya | Tanzania | Uganda | Rwanda | Burundi | Ethiopia | Malawi | South Africa |
|---|---|---|---|---|---|---|---|---|
| Population (millions) | 35.6 | 38.5 | 28.9 | 9.2 | 7.9 | 79.0 | 13.2 | 47.9 |
| Population growth rate (%) | 2.6 | 2.4 | 3.2 | 2.7 | 3.6 | 2.5 | 2.5 | 0.5 |
| GDP per capita (US$) | 547 | 316 | 303 | 238 | 106 | 157 | 161 | 5,109 |
| Infant mortality rate (per 1,000 births) | 79 | 76 | 79 | 118 | 114 | 109 | 79 | 55 |
| Maternal mortality rate (per 100,000 live births) | 560 | 950 | 435 | 750 | 1100 | 720 | 980 | 400 |
| Literacy rate (%) | 73.6 | 69.4 | 66.8 | 64.9 | 59.3 | 35.9 | | 82.4 |

Source: UNDP (2007) and Demographic and Health Survey (DHS) (2005)

## 1.5 ORGANIZATION OF THE REPORT

This report presents the findings of Rwanda's 2006 NHA exercise. Where applicable, it compares the 2006 findings to past NHA findings (Table 1.1) to illustrate shifts in health financing and entities operating in the health sector over time.

**TABLE 1.1: YEAR OF PREVIOUS ESTIMATION COMPARED WITH 2006 DATA**

| Health area | 1998 | 2000 | 2002 | 2003 |
|---|---|---|---|---|
| General NHA | X | X | X | X |
| HIV/AIDS | | X | X | |
| Malaria | | | | X |
| RH | | | X | |

A chapter is dedicated to each area of the exercise: general (overall) health, and the HIV/AIDS, malaria, and RH subaccounts. The chapters present levels of expenditure and the entities involved in the spending of health funds.

Each chapter is organized by discussing the patterns and trends of:

- the overall envelope of health financing;
- financing sources (the source of health resources);
- financing agents (entities that manage health funds and determine the amount and targeted use of health resources);
- household out-of-pocket (OOP) (resources originating at and managed by households);
- providers (entities that ultimately provide the health service);
- health functions (the end use of health funds, or types of services being produced); and
- additional analyses (e.g., family planning commodities within the RH subaccount chapter).

Following the chapters on findings is a concluding chapter and annexes with a detailed methodology and the NHA tables (including both targeted and untargeted spending).

The reader should keep the following in mind while reading the report. Due to rounding, percentages in figures may not always add up to 100 percent. Also, values on absolute spending are in constant 2006 Rwandan francs (RWF) and U.S. dollars to adjust for inflation and allow for comparisons of expenditure over time.

The Rwanda NHA technical team, which did the estimations and wrote this report, hope other health experts will find the NHA results useful for research purposes and for additional analysis to explain the underlying causes behind certain findings.

## 1.6 BOUNDARIES/SCOPE OF THE 2006 NHA

The 2006 NHA and subaccounts track the flow of health funds through the health sector within the 2006 calendar year. They include goods and services accounted for in the year they were provided, rather than when they were actually paid for.

"Health-related activities" were captured by the 2006 NHA and can be viewed in the NHA tables in Annex A. A health-related activity is an activity that may overlap with sectors other than health, such as education, overall "social" expenditure, research and development, and infrastructure.

Certain health services or products, such as condom provision, could fall into more than one subaccount (Table 1.2). In these cases, the NHA team must decide where to allocate that particular expenditure.

**TABLE 1.2: OVERLAPPING SERVICES AND SUBACCOUNT ALLOCATION**

| Overlapping service | HIV/AIDS | Malaria | RH |
|---|---|---|---|
| STI services | XX | | X |
| Condoms (depends on primary purpose of purchase) | X | | X |
| HIV/AIDS services | XX | | X |
| PMTCT for HIV/AIDS | XX | | X |
| Intermittent preventive therapy (IPT) and antimalarial chemoprophylaxis (given to pregnant mothers for malaria prevention) | | XX | X |
| HIV/AIDS curative care (as a co-infection of malaria) | XX | X | |

Note: X refers to where a service could be allocated. XX refers to where the service was allocated in this round of NHA

As a general rule, the NHA team followed the boundaries defined in the System of Health Accounts and the Producers' Guide.

# 2. NHA FINDINGS: GENERAL HEALTH EXPENDITURES

## 2.1 DEFINITION OF TOTAL HEALTH EXPENDITURE

NHA tracks all health expenditures and estimates total health expenditure ($THE_{general}$) in Rwanda for a given year. $THE_{general}$ is the total value of consumed goods and services for "activities whose primary purpose is to restore, improve and maintain health for the nation and for individuals during a defined period of time" (Producers' Guide: 20, 3.02). It comprises expenditures from all sources, public, private, and donor.

## 2.2 SUMMARY STATISTICS OF GENERAL NHA 2006

As Rwanda has conducted NHA estimations for five separate years, trend statistics are available (Table 2.0). All time series comparisons of absolute amounts in the report are adjusted to constant RWF and US$ 2006 to account for inflation.

**TABLE 2.0: NHA TREND STATISTICS, 1998–2006**

| Indicators | 1998* | 2000* | 2002* | 2003* | 2006 |
|---|---|---|---|---|---|
| Total population** | 7,883,000 | 7,691,783 | 8,128,553 | 8,388,667 | 9,058,392 |
| Exchange rate US$ 1=RWF*** | 317 | 393 | 475 | 539 | 552 |
| Total real GDP[δ] | RWF 903,596,620,489 US$ 1,637,721,790 | RWF 995,646,509,881 US$ 1,804,557,418 | RWF 1,091,939,192,568 US$ 1,979,082,888 | RWF 1,183,678,667,693 US$ 2,145,355,906 | RWF 1,583,000,000,000 US$ 2,869,105,013 |
| Total GoR expenditure and net lending[δδ] | RWF 167,981,026,375 US$ 304,456,857 | RWF 212,334,986,166 US$ 384,846,098 | RWF 180,677,536,165 US$ 327,468,620 | RWF 238,444,711,887 US$ 432,168,615 | RWF 417,200,000,000 US$ 756,153,261 |
| $THE_{general}$ per NHA (US$ 2006) | RWF 45,482,827,219 US$ 82,435,254 | RWF 40,262,074,605 US$ 72,972,912 | RWF 44,570,823,334 US$ 80,782,294 | RWF 78,417,516,472 US$ 142,127,662 | RWF 169,574,434,271 US$ 307,344,825 |
| $THE_{general}$ per capita (US$ 2006) | RWF 5748 US$ 10.42 | RWF 5234 US$ 9.49 | RWF 5483 US$ 9.94 | RWF 9348 US$ 16.94 | RWF 18720 US$ 33.93 |
| $THE_{general}$ as % of nominal GDP | 5% | 4% | 4% | 7% | 11% |
| GoR health expenditure as % of GoR total expenditure | 2.5% | 4.7% | 6.1% | 8.8% | 6.5% |

| Indicators | 1998* | 2000* | 2002* | 2003* | 2006 |
|---|---|---|---|---|---|
| **Financing sources distribution as a % of $THE_{general}$** | | | | | |
| Public (include loans & grants) | 10% | 18% | 25% | 32% | 19% |
| Private | 40% | 30% | 42% | 25% | 28% |
| Donor | 50% | 52% | 33% | 42% | 53% |
| Other | 0% | 0% | 0% | 1% | 0% |
| **Household (HH) spending[δδδ]** | | | | | |
| As % of $THE_{general}$ | 32% | 26% | 31% | 20% | 26% |
| Out-of-pocket (OOP)[ξ] as % of $THE_{general}$ | 33%[ξξ] | 25% | 25% | 17% | 23% |
| HH spending per capita (US$) | RWF 1870<br>US$ 3.39 | RWF 1297<br>US$ 2.35 | RWF 1712<br>US$ 3.10 | RWF 1626<br>US$ 2.95 | RWF 4228<br>US$ 7.66 |
| **Financing agents distribution as a % of $THE_{general}$** | | | | | |
| Public | 38% | 30% | 48% | 45% | 49% |
| Private | 40% | 64% | 51% | 47% | 23% |
| Donor | 22% | 6% | 2% | 8% | 28% |
| **Provider distribution as a % of $THE_{general}$[ξξξ]** | | | | | |
| Public facilities | 66% | 39% | 55% | 53% | 56% |
| *Agréé* facilities | 10% | 40% | 25% | 23% | 7% |
| Private facilities | 24% | 21% | 20% | 24% | 37% |

* All US$ amounts for 1998, 2000, 2002, and 2003 are in constant 2006 currency to facilitate comparison across years. The Consumer Price Index (CPI) was used for the conversion (69.91 for 1998, 70.88 for 2000, 74.71 for 2002, and 80.27 for 2003). Source for CPI data: NISR (http://www.statistics.gov.rw).

** The 1998 population figure is based on the 1992 census and the 2000 and 2002 figures are based on the 2002 census. The 2003 figure is estimated from the 2002 census at a growth rate of 3.2%. Due to the genocide and subsequent repatriation, it is difficult to determine precise population trends for Rwanda during the 1990s. The 2006 number is a projected amount from the 2005 census report.

*** The exchange was derived from an unweighted average of monthly official exchange rates from National Bank of Rwanda (BNR) official statistics (see www.bnr.rw)

[δ] From BNR (see www.bnr.rw); 2006 GDP from NISR, accessed January 2008.

[δδ] Includes spending on recurrent budget, development budget, net lending, arrears, and increase in BNR government deposit.

[δδδ] Includes contributions to insurance and direct payments to providers.

[ξ] OOP includes only direct payments to providers.

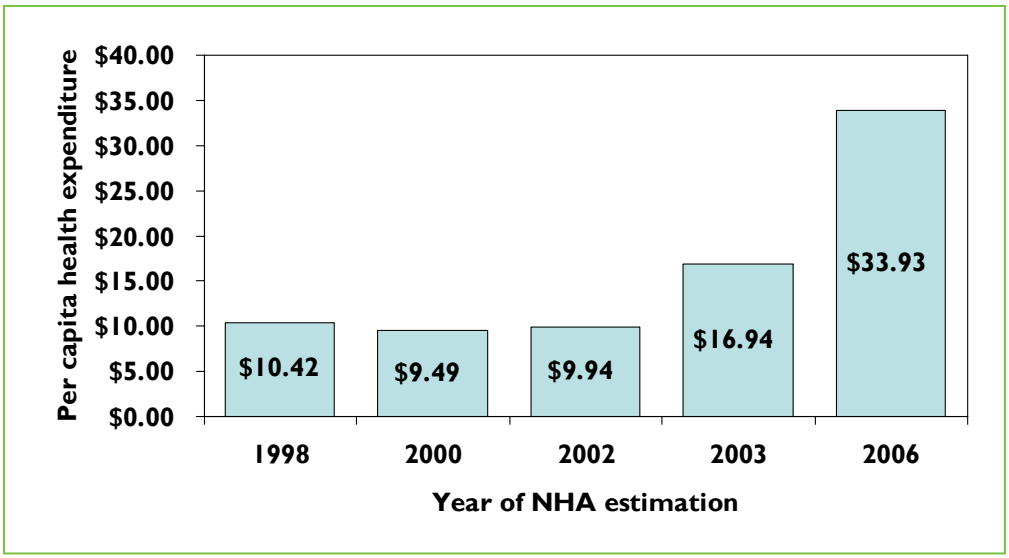
[ξξ] OOP expenditures are higher than HH expenditures because public firms and private firms are noted as giving funds to HH OOP.

[ξξξ] For time comparison purposes, provider expenditures have been broken down into the three categories of public facilities, government-assisted health facilities (*agréés*) and private facilities in keeping with all previous NHAs. The above percentages represent the share of total facility expenditure broken down into public, *agréé* and private providers. However, greater disaggregation is available for the 2006 NHA as detailed in Annex A. It should be noted that expenditures on for-profit providers like "traditional healers" and "independent pharmacies" were allocated to private facilities.

## 2.3 TOTAL RESOURCE ENVELOPE AND TRENDS IN THE$_{GENERAL}$

In 2006, THE$_{general}$ was RWF 169,574,434,271 (US$ 307,344,825). This represents a 2.2-fold increase from the last NHA estimation (2003). Health expenditure per capita has increased dramatically in recent years, in an upward trend since 2002 (Figure 2.0).

**FIGURE 2.0: PER CAPITA THE$_{GENERAL}$ TRENDS, 1998-2006**




* Reported in constant 2006 currency to facilitate comparisons across years

In 2006, per capita spending in Rwanda was US$ 34. This includes all health services rendered in the country, including public health campaigns, administrative costs, and other services. It also includes funding targeted for subgroups of the population, such as people living with HIV (PLHIV). The WHO Commission on Macroeconomics and Health (CMH) recommends US$ 34 per capita health spending to provide basic health services to the population (not specific to Rwanda). While Rwanda has made impressive strides in the level of per capita spending on health, the level of spending on basic health services has not reached the CMH's recommended target.

## 2.4 FINANCING SOURCES OF OVERALL HEALTH SPENDING

As noted above, $THE_{general}$ includes contributions from public sources (taxes, loans, grants, and parastatal employers), donors, and private sources (households, private companies, local foundations, etc.). The contribution from each financing source and its share of the total is presented in Figure 2.1.

**FIGURE 2.1: CONTRIBUTIONS TO $THE_{GENERAL}$, BY FINANCING SOURCE, 2006**

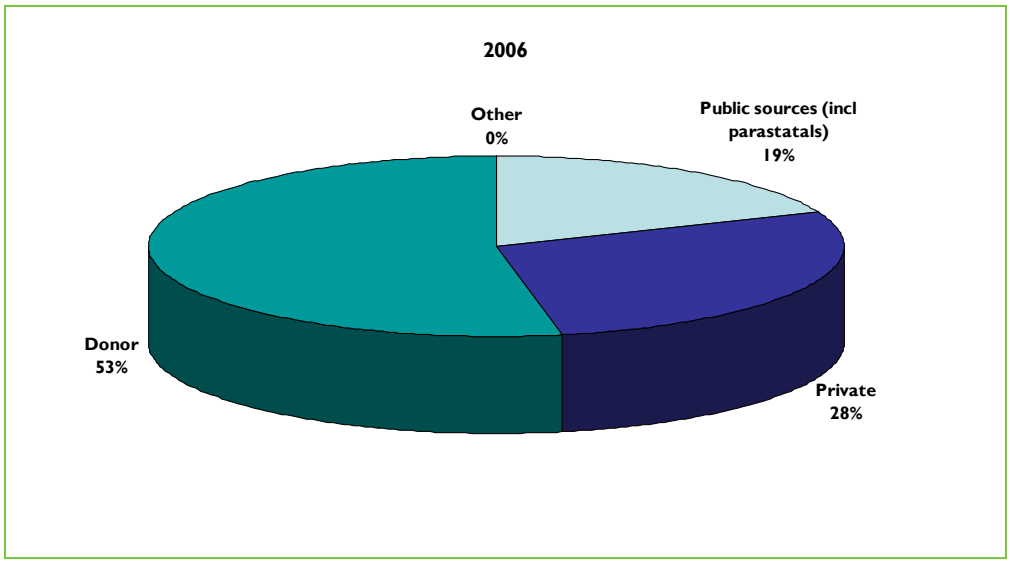


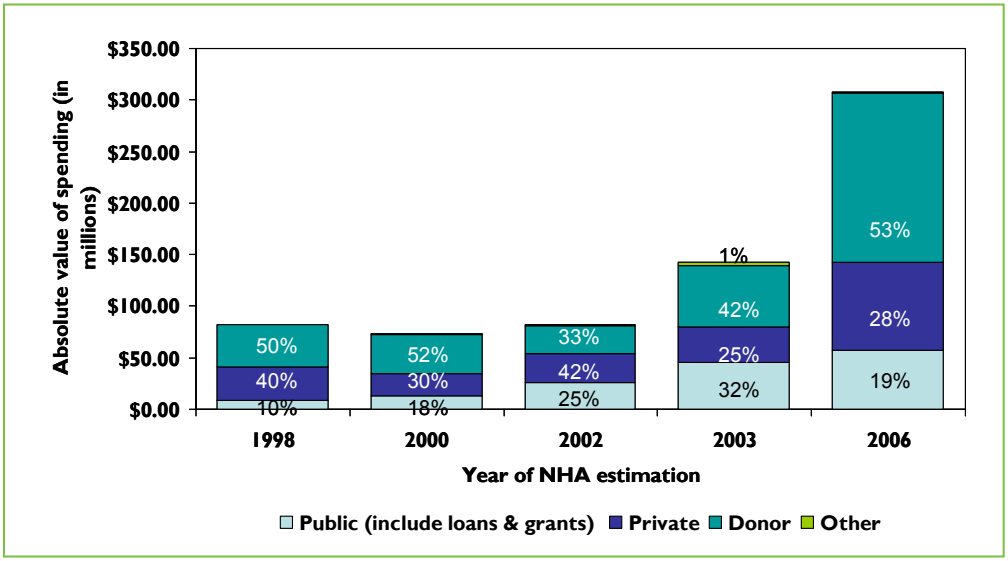

Table 2.1 and Figure 2.2 show trends in expenditure amounts coming of financing sources for the five NHA estimations from 1998 to 2006. There is variation among the sources, both in absolute amounts and percentages; this volatility impedes long-term health planning. Nevertheless, certain trends can be identified.

**TABLE 2.1: TRENDS IN FINANCING OF GENRAL HEALTH CARE, 1998-2006, IN US$ 2006**

| | 1998* | 2000* | 2002* | 2003* | 2006 | Magnitude of increase from 2003 |
|---|---|---|---|---|---|---|
| Public | RWF 4,652,741,247<br>$ 8,432,851 | RWF 7,235,474,461<br>$ 13,113,920 | RWF 14,259,477,274<br>$ 425,844,560 | RWF 24,856,760,099<br>$ 45,051,582 | RWF 31,838,175,784<br>$ 57,705,035 | 1.3 |
| Private | RWF 17,940,680,371<br>$ 32,516,548 | RWF 12,029,847,607<br>$ 21,803,472 | RWF 15,356,686,968<br>$ 27,833,195 | RWF 19,472,274,551<br>$ 35,292,483 | RWF 47,044,952,681<br>$ 85,266,525 | 2.4 |
| Donor | RWF 22,889,405,602<br>$ 41,485,855 | RWF 20,920,250,822<br>$ 37,916,865 | RWF 14,901,755,474<br>$ 27,008,655 | RWF 32,582,985,641<br>$ 59,054,964 | RWF 90,477,444,573<br>$ 163,985,654 | 2.8 |
| Other | - | RWF 76,501,716<br>$ 138,655 | RWF 52,903,617<br>$ 95,885 | RWF 1,505,496,181<br>$ 2,728,633 | RWF 213,861,233<br>$ 387,612 | 0.1 |
| THE | RWF 45,482,827,220<br>$ 82,435,254 | RWF 40,262,074,606<br>$ 72,972,912 | RWF 44,570,823,334<br>$ 80,782,295 | RWF 78,417,516,472<br>$ 142,127,662 | RWF 169,574,434,271<br>$ 307,344,826 | 2.2 |

* Reported in constant 2006 currency to facilitate comparisons across years

**FIGURE 2.2: ABSOLUTE CONTRIBUTION TO $THE_{GENERAL}$ BY SOURCE, 1998-2006**




* Reported in constant 2006 currency to facilitate comparisons across years

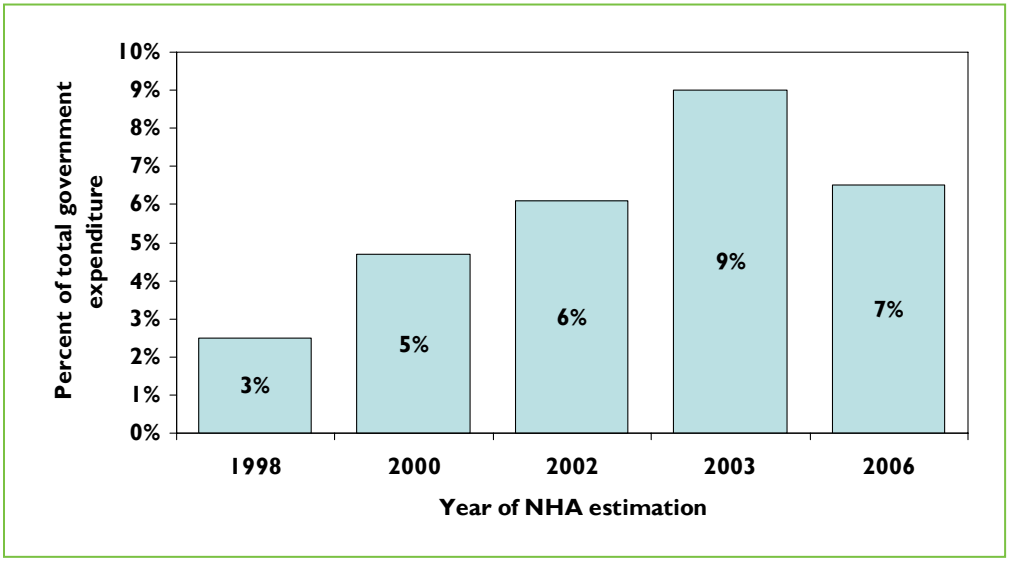
Donors have been the largest contributor to $THE_{general}$ in Rwanda overall. In 1998, health financing was donor dependent due to the heavy infrastructure and reconstruction efforts following the genocide and war. The donor share decreased as public and private contributions increased. Then, between 2003 and 2006, donor funding nearly tripled, to RWF 90.5 billion (US $164 million) or 53 percent, reverting somewhat to 1998 dependency levels.

The recent jump in growth in $THE_{general}$ is attributable primarily to donor spending, and to a smaller extent to private expenditures, which contributed RWF 47 billion (US$ 85.3 million). Private spending on health (largely by households) rose each year since 2000 and more than doubled between 2003 and 2006. It now exceeds public spending levels, unlike in previous years. Some reasons for this increase are cited in section 2.5.2.

Public spending has increased steadily, though its 2006 expenditure of RWF 31.8 billion (US$ 57.7 million) represented the smallest percentage (19 percent) of health spending.

Figure 2.3 shows the trend of government spending on health as a percentage of total government expenditure. As part of the Abuja declaration of 2001, African governments pledged to allocate 15 percent of government spending to health.

**FIGURE 2.3: GOVERNMENT EXPENDITURE ON HEALTH AS A PERCENTAGE OF TOTAL GOVERNMENT EXPENDITURE, 1998-2006**




While Rwanda's percentage allocation to health has declined, this does not mean the government is contributing less to health. In fact, in 2006, total government spending on health has increased immensely (see Tables 2.0 and 2.1), perhaps because more donors are not earmarking funds for health but rather are contributing directly to the Ministry of Finance and Economic Planning (MoF) for general budget support.

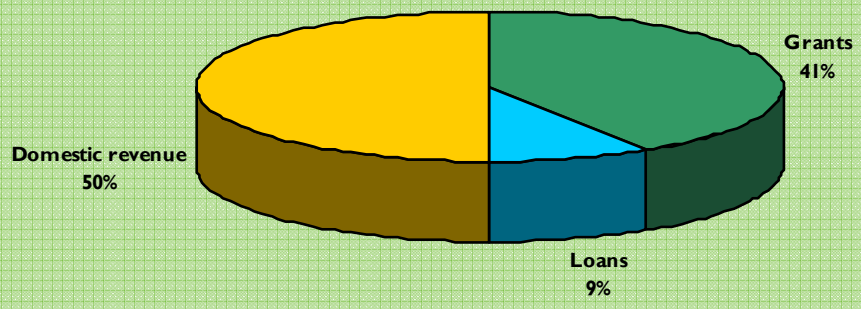
## 2.5 FINANCING AGENTS: MANAGERS AND IMPLEMENTERS OF OVERALL HEALTH FUNDS

Financing agents receive funds from financing sources to pay providers for health care functions (health

**UNAIDS/NHA Collaboration for NASA Matrix and HIV Subaccounts Tables**

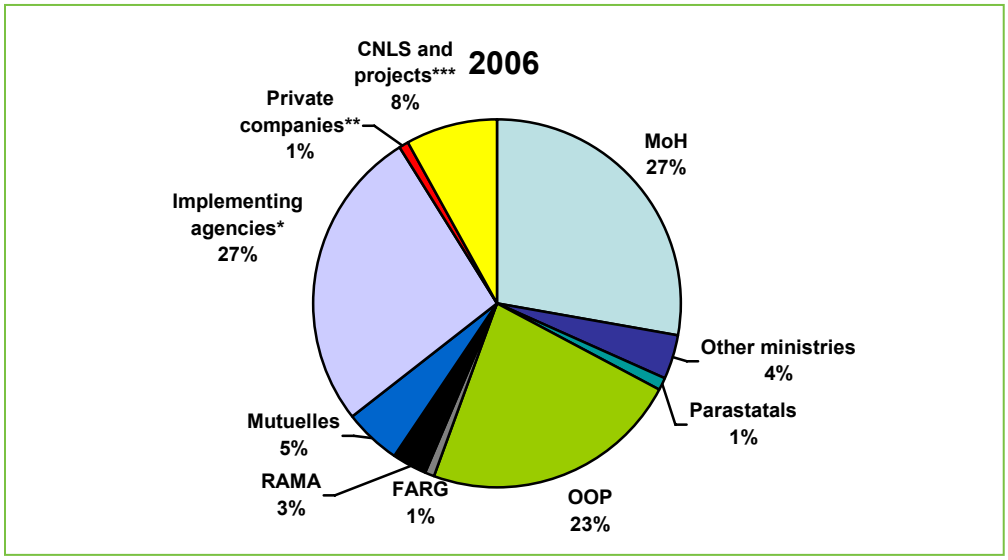
*NHA defines public spending at the financing source level as any funding coming from the Ministry of Finance. However, as the figure below shows, the MoF pools loans, grants, and domestic revenue, and therefore may include donor monies in the form of budgetary support.*

**RWANDA MOF FINANCING SOURCES, 2006**



services and products that are rendered). They are managers of funds, exercising programmatic control over the allocation of resources, and not mere intermediaries or pass-throughs. Figure 2.4 shows the managers of health care funds in 2006.

**FIGURE 2.4: MANAGERS OF TOTAL HEALTH EXPENDITURE IN RWANDA, 2006**




* Includes direct donor transfers

** Direct transfer to health facilities

***Includes National AIDS Commission (*Commission Nationale de Lutte contre le SIDA*, CNLS) administration costs as well as projects operating under CNLS auspices, such as the World Bank Multicountry AIDS Program (MAP); Global Fund to Fight AIDS, Tuberculosis and Malaria; African Development Bank; and UNDP.

Overall, there were 17 financing agents in Rwanda (Table 2.2), which demonstrates the pluralistic nature of the country's health system. Government financing agents (including the MoH, other ministries, and the CNLS) manage the largest share of health spending. Households (in terms of OOP spending), the MoH, and nongovernmental organizations (NGOs)/implementing agencies each manage around a quarter of $THE_{general}$.

**TABLE 2.2: SHARE OF THE$_{GENERAL}$ BY FINANCING AGENT, 2003 AND 2006**

| | Financing Agent (Managers) | 2003* | 2006 | Magnitude of increase from 2003 |
|---|---|---|---|---|
| Public | MoH (MINISANTE) | RWF 15,645,293,666<br>$28,356,280 | RWF 47,309,782,878<br>$ 85,746,516 | 3.0 |
| | Other ministries | RWF 871,722,369<br>$1,579,951 | RWF 7,067,972,109<br>$ 12,810,331 | 8.0 |
| | CNLS proper | | RWF 1,046,758,213<br>$ 1,897,195 | |
| | CNLS projects | | RWF 12,627,650,198<br>$22,886,958 | |
| | Local municipal govts (districts) | RWF 6,736,289,255<br>$12,209,173 | RWF 65,222,465<br>$118,212 | 0.0 |
| | Social Security Fund (CSR) | RWF 1,795,845,677<br>$3,254,877 | RWF 11,961,537<br>$21,680 | 0.0 |
| | FARG | RWF 5,346,613,577<br>$9,690,459 | RWF 1,009,461,573<br>$1,829,597 | 0.2 |
| | Social insurance (RAMA+MMI) | RWF 3,705,899,154<br>$6,716,749 | RWF 4,742,882,011<br>$8,596,227 | 1.3 |
| | Mutuelles (premium paid by employer)** | | RWF 334,470,816<br>$606,211 | |
| | Mutuelles (community based) | | RWF 8,104,396,820<br>$14,688,797 | |
| | Parastatal companies | RWF 1,384,054,866<br>$2,508,527 | RWF 885,923,877<br>$1,605,691 | 0.6 |
| Public | Private employees insurance programme | | RWF 327,506,739<br>$593,589 | |
| | Private insurance (SORAS, COGEAR, etc) | RWF 470,921,922<br>$853,521 | RWF 326,327,506<br>$591,452 | 0.7 |
| | Private household OOP payments | RWF 13,641,572,643<br>$24,724,640 | RWF 38,295,662,832<br>$69,408,893 | 2.8 |
| | Private nonparastatal firms | RWF 1,766,947,677<br>$3,202,501 | RWF 852,802,486<br>$1,545,660 | 0.5 |
| | Non-governmental organizations (NGOs) | RWF 21,098,399,426<br>$38,239,750 | RWF 38,389,951,169<br>$69,579,786 | 1.8 |
| | Rest of World*** | RWF 5,874,042,555<br>$10,646,396 | RWF 8,175,701,041<br>$14,818,032 | 1.4 |
| | Other/not specified by kind | RWF 79,913,685<br>$144,839 | | |
| | Total | RWF 78,417,516,472<br>$ 142,127,662 | RWF 169,574,434,271<br>$307,344,826 | 2.2 |

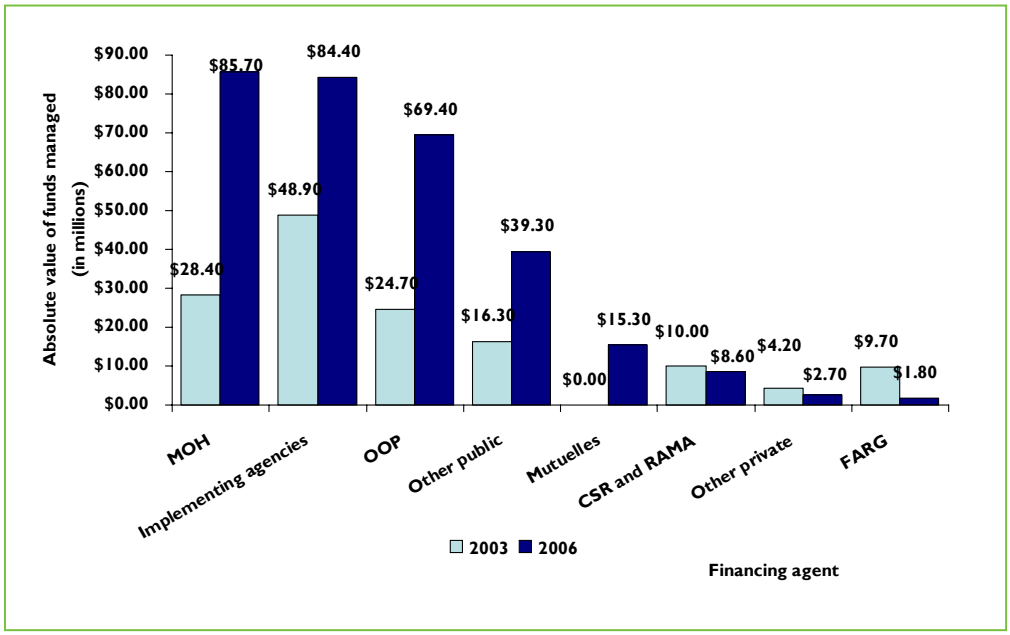
* Reported in constant 2006 currency to facilitate comparisons across years

**This category of mutuelles includes mutuelles for employees (and their families) of firms, where the employer pays the premiums as part of an employee's benefits package. They are distinct from mutuelles open to the general public.

*** Rest of the world includes direct-donor transfers. For example, the GFATM (an external financing source) can contract directly with a provider, thereby exercising programmatic control over those funds rather than directing them through another implementing agency.

As Figure 2.5 shows, the share of funds managed by the MoH tripled between 2003 and 2006. Household OOP spending also grew significantly. Mutuelles were still in a nascent stage in 2003 and thus data are not available for tracking the change in the level of spending by mutuelles.

**FIGURE 2.5: FINANCING AGENTS SHARE OF THE$_{GENERAL}$, 2003 AND 2006**



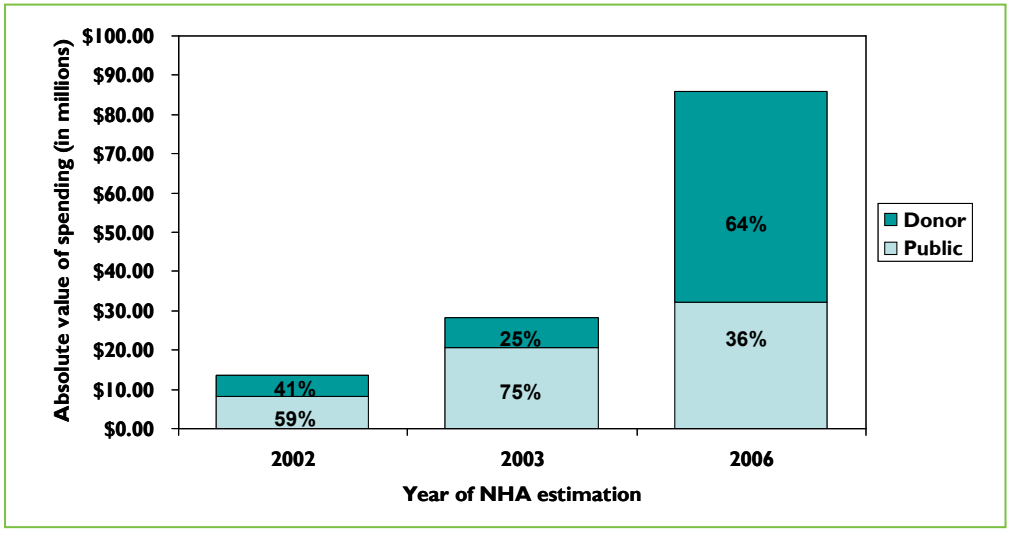

* Reported in constant 2006 currency to facilitate comparisons across years

The share of funds managed by Social Security *(Caisse Sociale du Rwanda* [CSR]), *Rwandaise d'Assurance Maladie* (RAMA), Victims of Genocide Fund (*Fonds National pour l'Assistance aux Rescapés du Génocide* [FARG]), and other private financing agents such as private companies decreased between 2003 and 2006.

## 2.5.1 THE MOH AS A FINANCING AGENT

Previous NHA estimates show that the MoH was mainly funded from public sources (Figure 2.6). However, in 2006 donors contributed 64 percent of the RWF 47 billion (US$ 85.7 million) that was under the programmatic control of the MoH.

**FIGURE 2.6: TRENDS IN MOH FUNDING, 2002-2006**



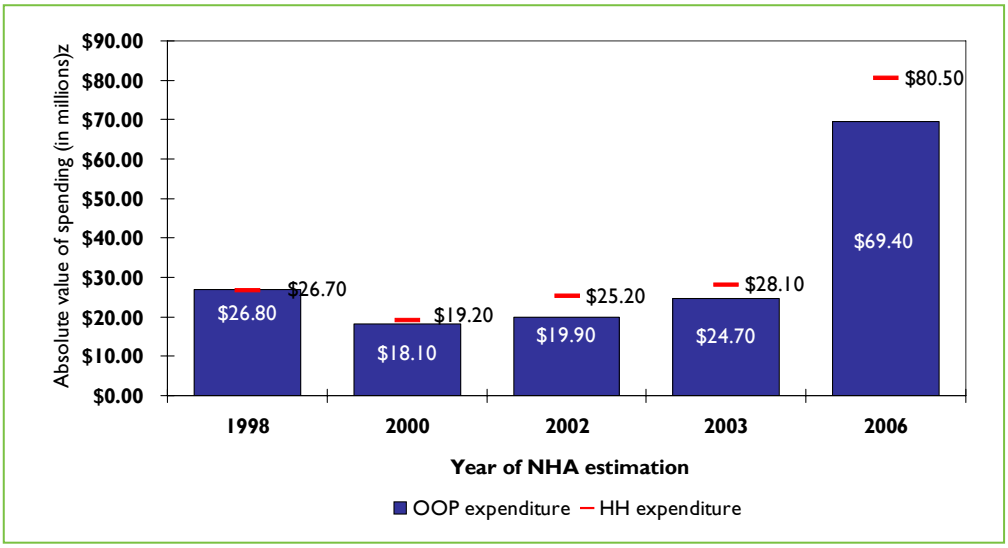

* Reported in constant 2006 currency to facilitate comparisons across years

## 2.5.2 OOP SPENDING: HOUSEHOLDS AS FINANCING AGENTS

Household spending occurs mainly in the form of OOP expenditures. The remaining household amount accounts for household contributions to insurance schemes.

Figure 2.7 shows household and OOP spending as percentages of $THE_{general}$; they constitute about a quarter of all spending. In 2006, OOP spending on health increased markedly in absolute terms: In 2003 households contributed RWF 15.5 billion (US$ 28.1 million) to $THE_{general}$; by 2006, household OOP spending had increased threefold, to RWF 44.4 billion (US $70.7 million).

**FIGURE 2.7: TRENDS IN HOUSEHOLD AND OOP SPENDING, 1998-2006**



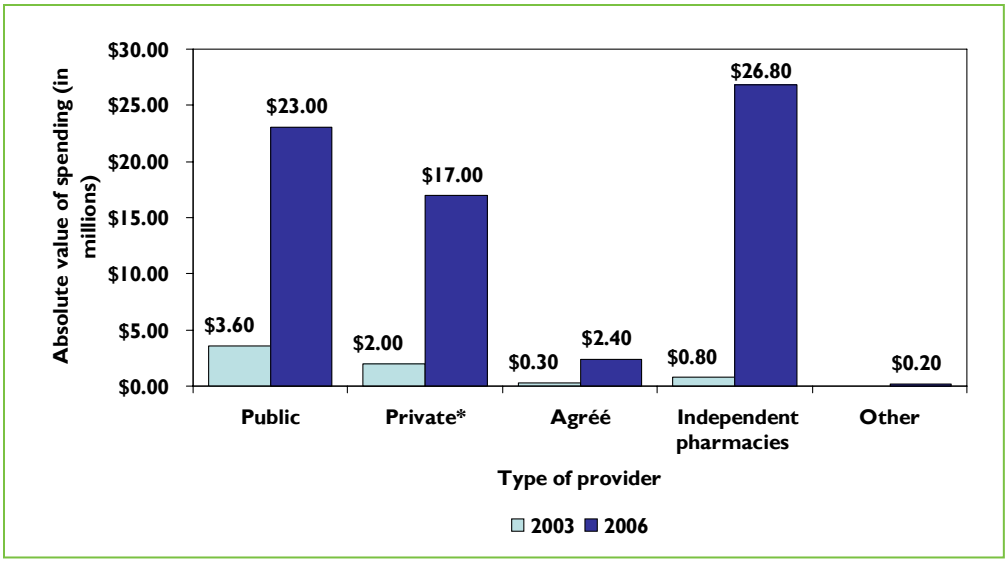

* Reported in constant 2006 currency to facilitate comparisons across years

Some factors that may explain the increase in household spending are:

- Households are paying increased copayments to mutuelles.
- Though $THE_{general}$ more than doubled between 2003 and 2006, most of the increase was in the area of targeted spending on diseases.
- Most of the OOP spending went to private pharmacies (39 percent, as shown in Figure 2.8). The Rwandan population may have had a higher propensity for proprietary drugs compared with generic medicines offered in the public sector and insurance mechanisms.
- 2006 data for traditional healers, who are paid out of pocket, were more robust than those data in previous years.
- GDP increased, so there may have been an increase in disposable income and therefore an increase in utilization. While the private sector is small, it is growing.
- Health care utilization was 0.3 per capita in 2003 and 0.7 per capita in 2006.

As Figure 2.8 shows, household spending has increased at every type of health provider since 2003, but it rose the most dramatically at independent pharmacies. Public health facilities receive more OOP payments than private or *agréé* facilities.

**FIGURE 2.8: PROVIDERS CONSUMING HOUSEHOLD OOP FUNDS, 2003 AND 2006**




*Note*: Reported in constant 2006 currency to facilitate comparisons across years

* Includes traditional healers

### 2.5.3 MUTUELLES AS FINANCING AGENTS

One of the ongoing policy actions to stabilize and improve the health care financing mechanisms in Rwanda is through concerted and effective community health insurance (mutuelles).[8] NHA findings show that mutuelles had limited control over the total health care resource envelope (5.2 percent). In actual numbers, their contribution amounted to RWF 8.8 billion (US $15.9 million). However, the situation may not change significantly even if enrollment increases to 100 percent because the overall premium level paid by each member is relatively small.

Households were the main financing source for mutuelles, providing 70 percent of expenditures on mutuelles (Figure 2.9).

**FIGURE 2.9: FINANCING SOURCES OF MUTUELLES, 2006**

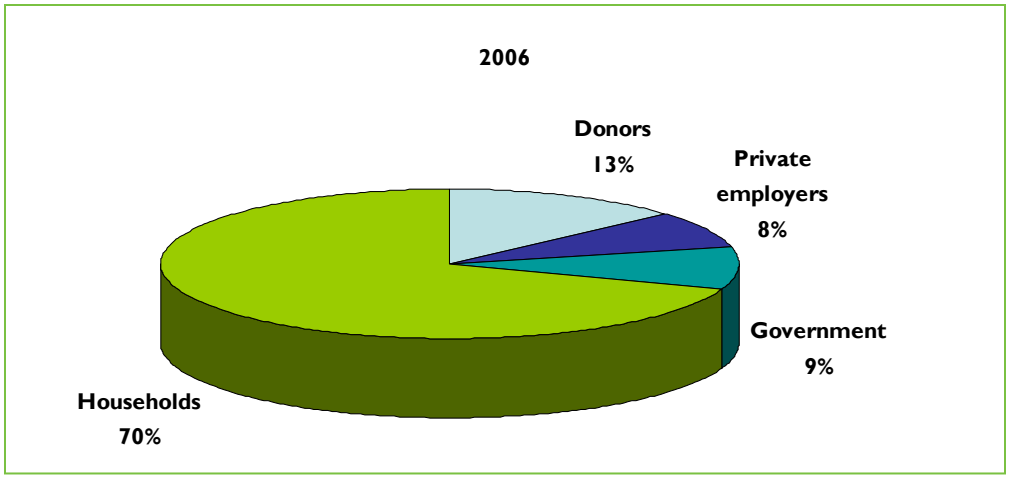
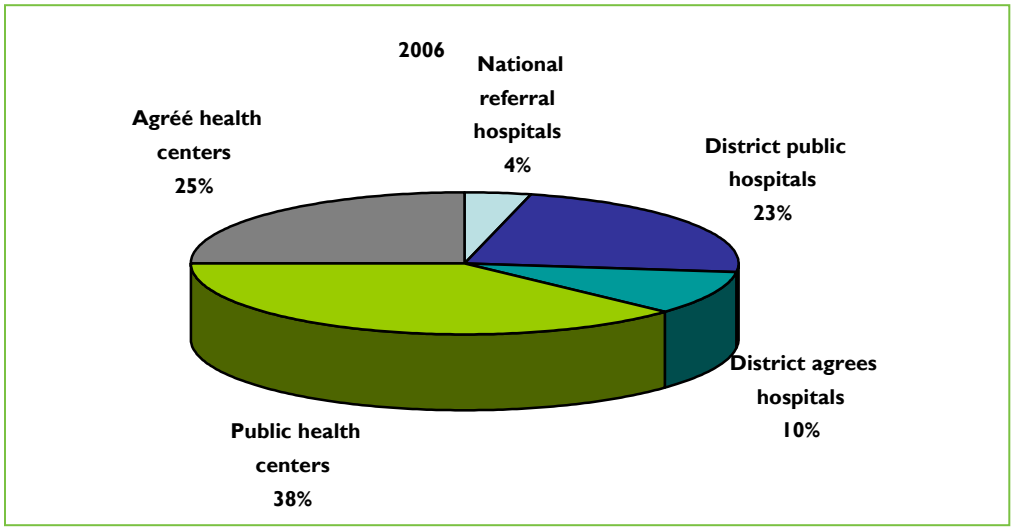



**FIGURE 2.10: PROVIDERS CONSUMING MUTUELLES FUNDS, 2006**




[8] Mutuelles are community-based social insurance schemes. Mutuelles aim to increase access to health care by reducing household OOP payments.

## 2.6 PROVIDERS OF OVERALL HEALTH

NHA data can be used to track which entities are providing health services in the country. Figure 2.11 shows the breakdown of all providers of health activities in 2006; Figure 2.12 shows this spending breakdown by public and private providers, and details each by type of facility.

The flow of funds from the financing agents to providers and from providers to health functions are detailed in Annex A.

**FIGURE 2.11: DISTRIBUTION OF PROVIDERS OF SERVICES AND COMMODITIES, 2006**

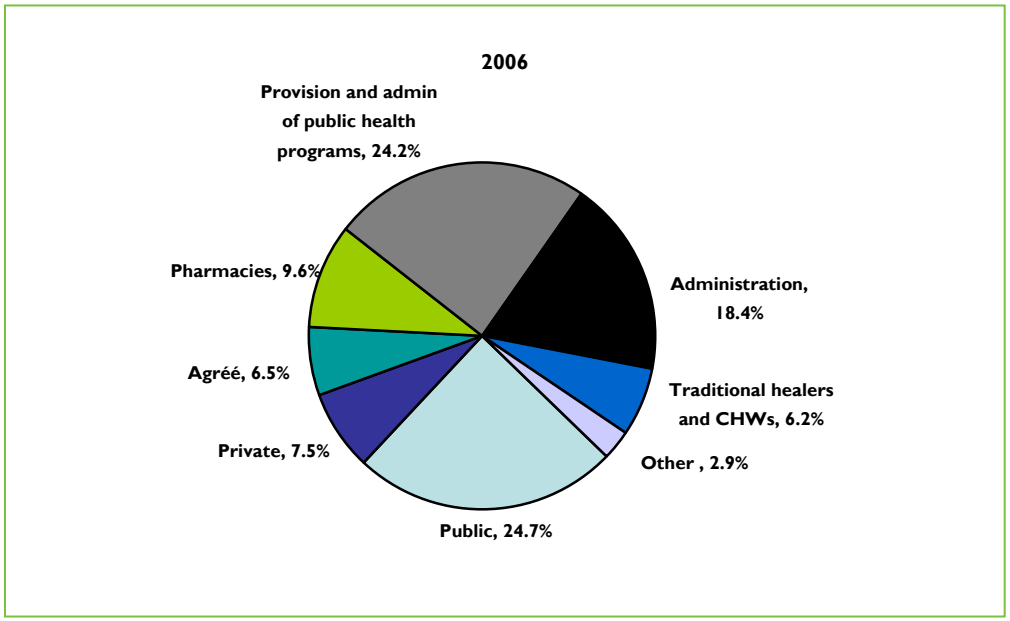
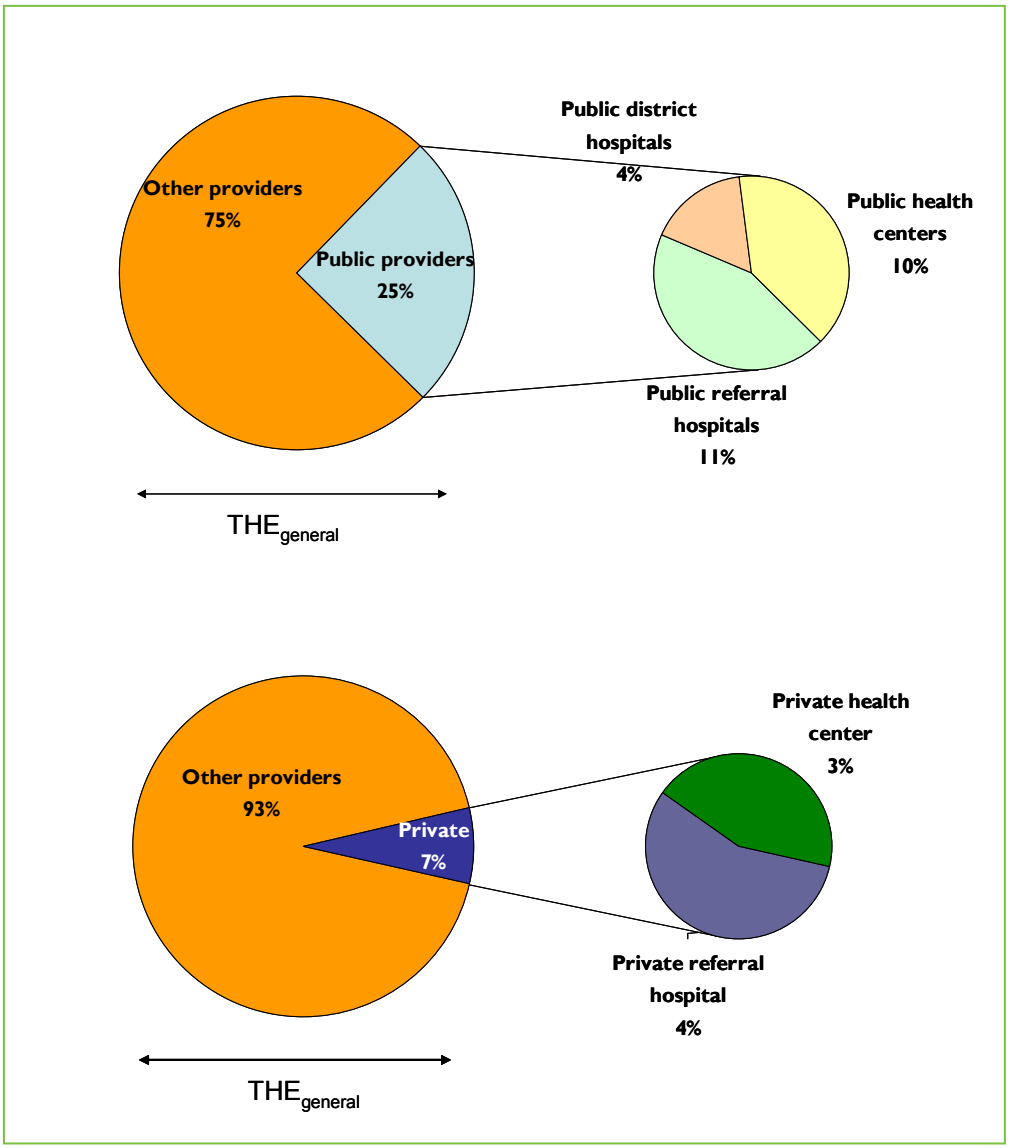


**FIGURE 2.12: BREAKDOWN BY PUBLIC AND PRIVATE PROVIDERS, 2006**



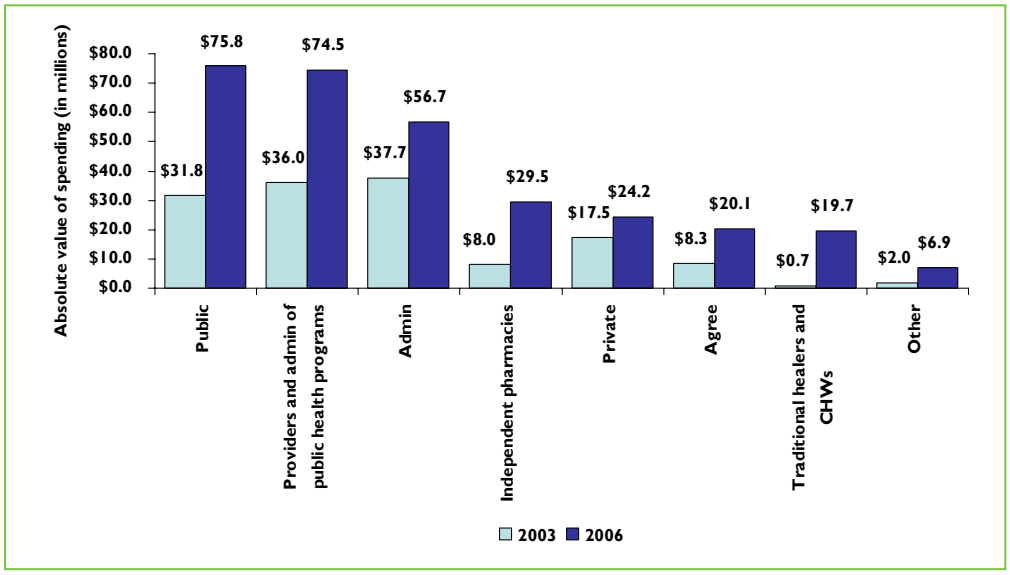

Public facilities (national referral and district hospitals, and health centers) consumed the largest amount of funds (Table 2.3 and Figure 2.13) in 2003 and 2006. Providers of public health programs also received large amounts of funds.

**TABLE 2.3: ABSOLUTE VALUES OF FUNDS CONSUMED, BY PROVIDER, 2003 AND 2006**

| Provider | 2003* | 2006 | Magnitude of increase from 2003 |
|---|---|---|---|
| Public (hospitals and health centers) | RWF 17,546,587,489<br>$ 31,802,276 | RWF 41,819,705,198<br>$ 75,796,037 | 2.4 |
| Private (hospitals and clinics) | RWF 9,669,414,814<br>$ 17,525,310 | RWF 13,333,644,395<br>$ 24,166,536 | 1.3 |
| *Agréé* (district hospitals and health centers) | RWF 4,599,037,043<br>$ 8,335,515 | RWF 11,089,337,894<br>$ 20,098,847 | 2.4 |
| Independent pharmacies | RWF 4,434,774,095<br>$ 8,037,797 | RWF 16,273,418,809<br>$ 29,494,724 | 3.7 |
| Providers and admin. of public health programs | RWF 19,880,194,975<br>$ 36,031,817 | RWF 41,115,591,300<br>$ 74,519,867 | 2.1 |
| General health administration | RWF 20,801,415,079<br>$ 37,701,481 | RWF 31,278,832,851<br>$ 56,691,255 | 1.5 |
| Traditional healers and community health workers | RWF 381,012,905<br>$ 690,566 | RWF 10,848,811,036<br>$ 19,662,905 | 28.5 |
| Other | RWF 1,105,080,072<br>$ 2,002,900 | RWF 3,815,092,789<br>$ 6,914,657 | 4.3 |
| Total | RWF 78,417,516,472<br>$ 142,127,662 | RWF 169,574,434,271<br>$ 307,344,826 | 2.2 |

* Reported in constant 2006 currency to facilitate comparisons across years

**FIGURE 2.13: COMPARISON OF LEVEL OF FUNDS CONSUMED, BY TYPE OF PROVIDER, 2003 AND 2006**




* Reported in constant 2006 currency to facilitate comparisons across years

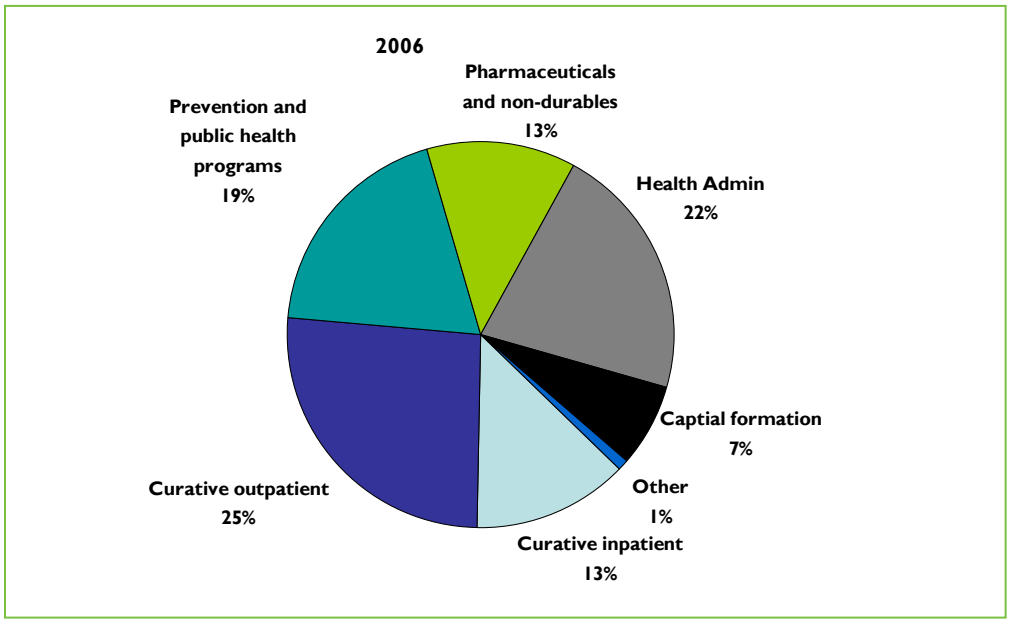
Excluding traditional healers and community health workers,[9] spending at independent pharmacies experienced the largest percentage increase, nearly quadrupling from 2003 to 2006. In the same period, spending on providers of general health administration grew, but at a lower rate, and so their share of $THE_{general}$ decreased. Spending at private facilities (largely clinics) grew less rapidly than spending at public and *agréé* facilities.

Between 2003 and 2006, the government worked towards regulating the private sector (independent pharmacies and clinics) through accreditation programs. Many back-street drug shops and clinics closed, which may explain the increase in utilization of independent pharmacies and public health facilities between 2003 and 2006.

## 2.7 USES OF HEALTH CARE FUNDS

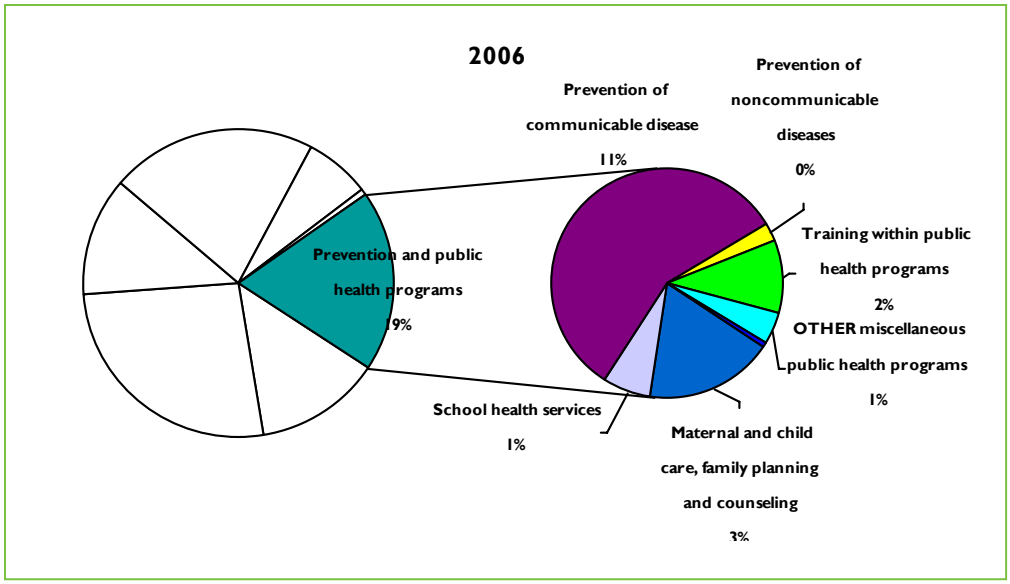
General health care functions include personal care, population-level care (prevention and public health programs), health administration, and capital formation. Personal care includes inpatient and outpatient care,[10] drugs purchased at independent pharmacies, home-based care, and even preventive services offered to individuals, such as vaccinations. Figure 2.14 shows the services on which health expenditures were made in 2006; Figure 2.15 breaks out spending on prevention and public health services.

**FIGURE 2.14: WHAT DO HEALTH FUNDS BUY? HEALTH SERVICES CONSUMED IN 2006**




[9] Excluded because data were more robust in 2006 than in previous years; thus data may not be comparable.
[10] An inpatient is a patient who is formally admitted to an institution for treatment and/or care and stays for a minimum of one night. Outpatient care is medical and paramedical services delivered to outpatients (someone not formally admitted to the facility and who does not stay overnight) (Organisation for Economic Co-operation and Development [OECD] 2000)

**FIGURE 2.15: PREVENTION AND PUBLIC HEALTH PROGRAMS DISAGGREGATED, 2006**




The total spent on personal care in 2006 represented 52 percent of $THE_{general}$: Curative services accounted for 38 percent of $THE_{general}$, of which outpatient care consumed 25 percent and inpatient care (hospitalizations) consumed 13 percent; another 13 percent of $THE_{general}$ was expended on drugs and other nondurables, mainly at private pharmacies. Prevention and pubic health programs consumed 19 percent, while health administration and insurance accounted for 22 percent. Capital formation, health system strengthening and infrastructure, accounted for 7 percent of $THE_{general}$.

Among prevention and public health programs, those targeting communicable diseases consumed the largest percentage, followed by maternal and child care.

In 2006, absolute spending was higher on every health function with the exception of functions not specified by kind, or other (Table 2.4, Figure 2.16). Spending on pharmaceuticals and other nondurables increased by the largest magnitude (five times higher in 2006 than in 2003). Outpatient curative care increased the most in value and became the largest end use of health funds in 2006.

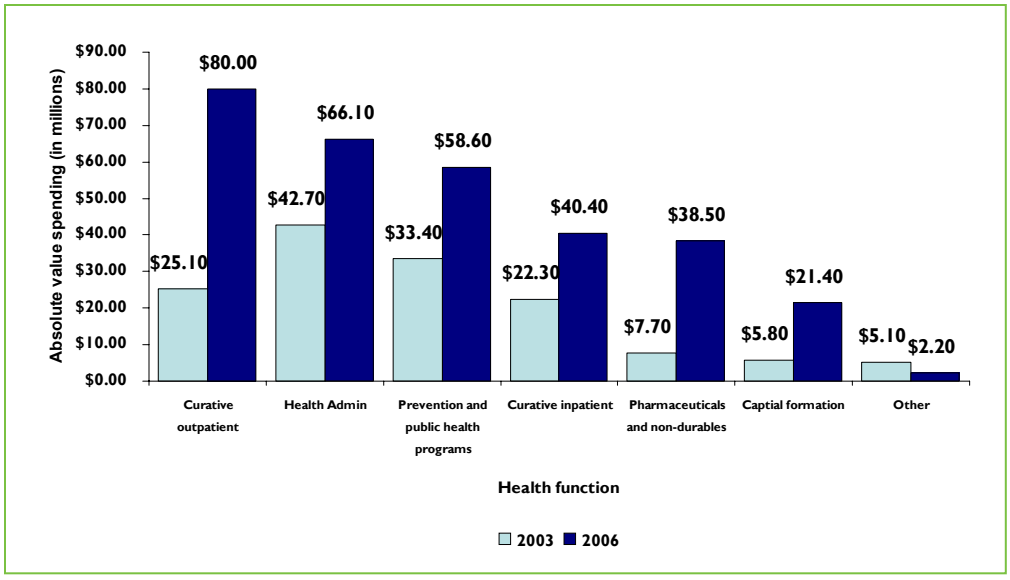
**TABLE 2.4: ABSOLUTE VALUES OF SPENDING BY TYPE OF HEALTH FUNCTION, 2003 AND 2006**

| Health function | 2003 | 2006 | Magnitude of increase from 2003 |
|---|---|---|---|
| Curative inpatient | RWF 12,320,398,874<br>$ 22,330,081 | RWF 22,309,316,746<br>$ 40,434,474 | 1.8 |
| Curative outpatient | RWF13,849,937,515<br>$ 25,102,290 | RWF 44,134,254,211<br>$ 79,991,036 | 3.2 |
| Prevention and public health programs | RWF18,431,756,084<br>$ 33,406,597 | RWF 32,311,125,588<br>$ 58,562,231 | 1.8 |
| Pharmaceuticals and nondurables | RWF 4,221,056,191<br>$ 7,650,444 | RWF 21,251,457,433<br>$ 38,517,159 | 5 |
| Health administration | RWF 23,576,846,490<br>$ 42,731,806 | RWF 36,491,542,125<br>$ 66,139,019 | 1.5 |

| Health function | 2003 | 2006 | Magnitude of increase from 2003 |
|---|---|---|---|
| Capital formation | RWF 3,190,281,786<br>$ 5,782,219 | RWF11,829,084,546<br>$ 21,439,599 | 3.7 |
| Other | RWF 2,827,239,532<br>$ 5,124,224 | RWF 1,224,865,331<br>$ 2,220,005 | 0.4 |
| Total | RWF 78,417,516,472<br>$ 142,127,662 | RWF 169,574,434,271<br>$ 307,344,826 | 2.2 |

* Reported in constant 2006 currency to facilitate comparisons across years

**FIGURE 2.16: COMPARISON OF ABSOLUTE VALUES OF SPENDING ON HEALTH FUNCTIONS, 2003 AND 2006**

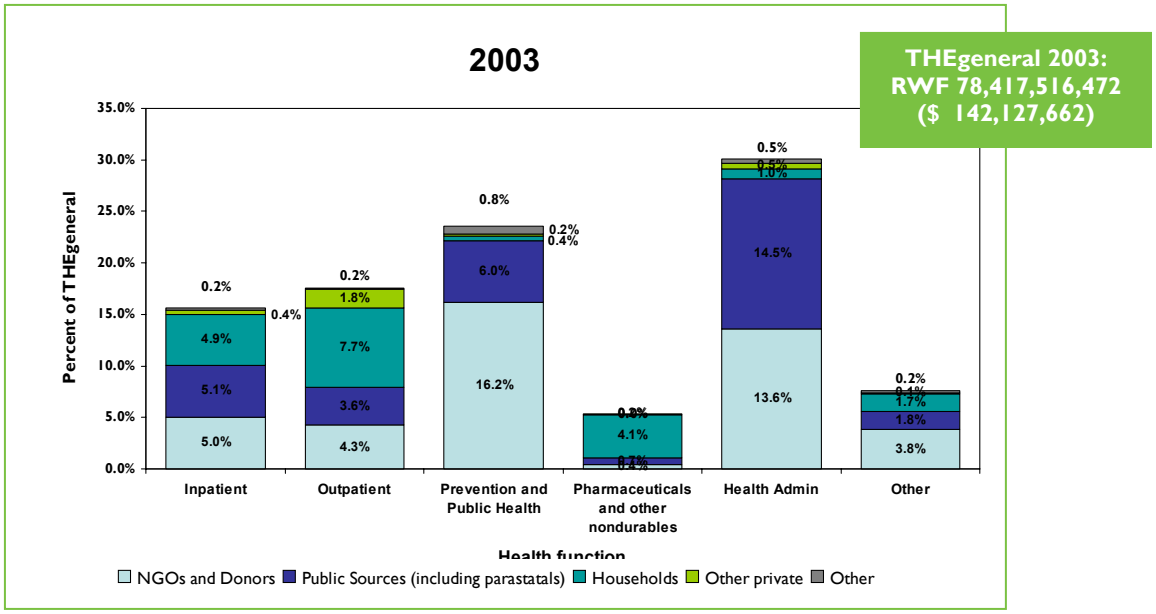


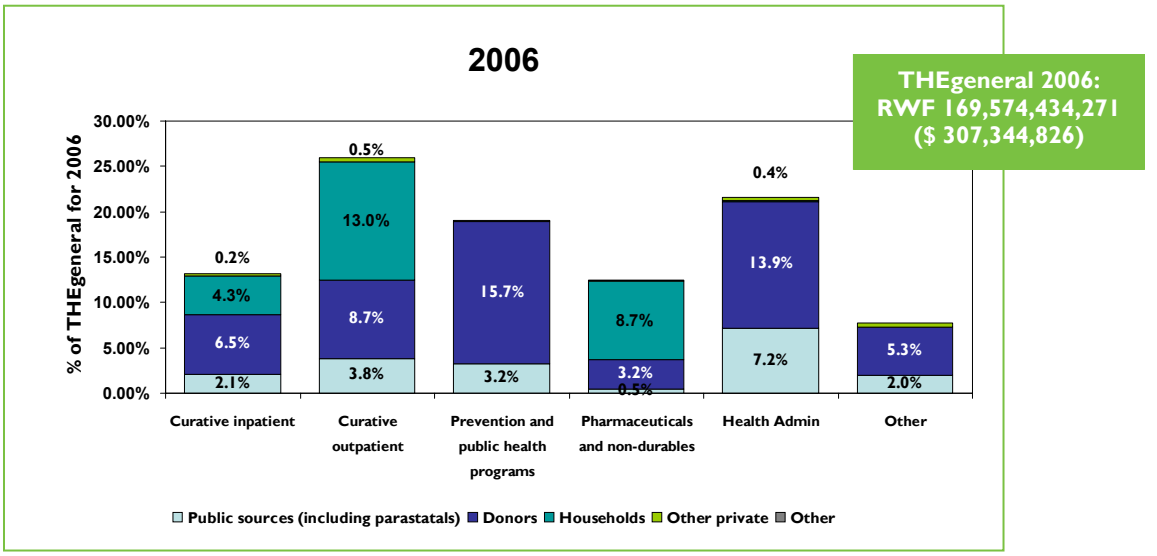

* Reported in constant 2006 currency to facilitate comparisons across years

## 2.7.1 WHO FINANCES WHAT HEALTH FUNCTIONS?

A third of all government spending on health is on administration, more than what public sources spent on curative care (see Figure 2.17). This does not necessarily mean that too much is spent on administration if the role of the government is primarily regulation of the health sector.

**FIGURE 2.17: FINANCING SOURCES OF OVERALL HEALTH CARE FUNCTIONS IN 2003 AND 2006**




In 2003, households, donors, and public financing sources spent on curative services in about the same proportions. By 2006, the financial burden fell mostly on households and donors. Households spent health funds primarily on outpatient services (and are the largest financier of this function) and pharmaceuticals in 2006. Private companies and private insurance also spent their health funds primarily on outpatient services.

In absolute terms, spending on prevention and public health increased, principally due to contributions by donors on these health services.

Funding for pharmaceuticals and nondurables rose dramatically, from 4.2 percent to 13 percent of $THE_{general,}$ and was shouldered mainly by households.

### 2.7.2 PRIORITY AREAS OF HEALTH

HIV/AIDS, malaria, and RH are the three major priority areas for the GoR, consuming 42.9 percent of total health resources (Figure 2.18).

**FIGURE 2.18. RWANDA'S HEALTH CARE PRIORITIES, 2006**

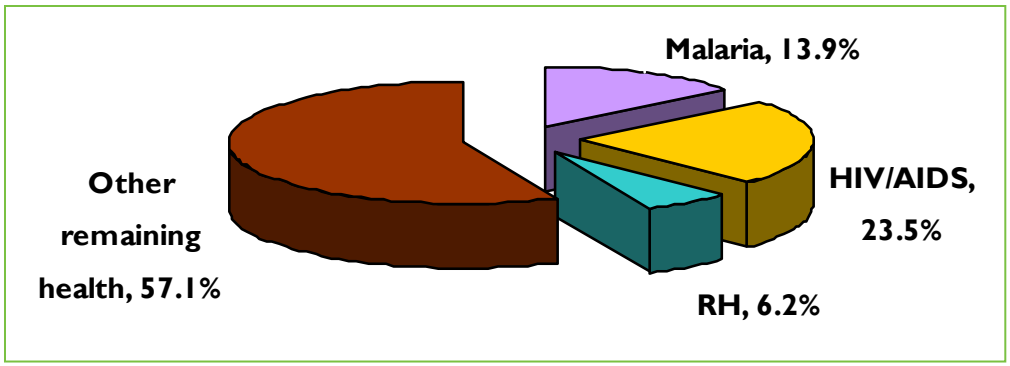



Figure 2.19 shows the level of spending by each financier on the different areas of health in 2006. The figure also shows how each financing source allocates its resources to specific health areas.

Donors allocate a significant proportion of their resources to HIV/AIDS. In 2006, PEPFAR and the Global Fund, among many other donors, stepped up the level of funding for this disease.

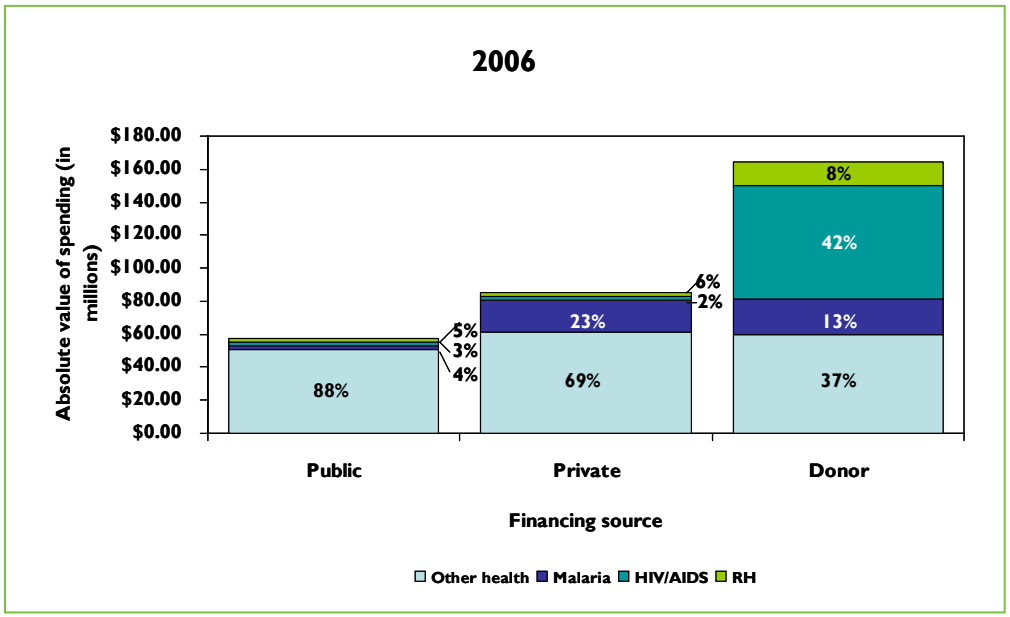
In contrast, the private sector is incurring a significant burden of costs for treating or preventing malaria (which was the leading cause of morbidity in Rwanda).

The Rwandan Demographic and Health Survey (DHS) 2005 (NISR and ORC Macro 2005)[11] reported poor health outcomes for RH. As a health area, RH received fewer contributions from health sector development partners in comparison with the other diseases noted here.

The next three chapters discuss the subaccount estimations conducted in tandem with the NHA on general health.

[11] This publication will be referred to henceforth in this report as the DHS 2005.

**FIGURE 2.19. WHO IS FINANCING WHAT PRIORITY AREAS IN RWANDA?**




* Reported in constant 2006 currency to facilitate comparisons across years

## 2.8 SUMMARY FINDINGS OF THE GENERAL NHA 2006

- **Total health care expenditure has doubled.** Between 2003 and 2006, $THE_{general}$ rose from RWF 78.4 billion (US$142 million) to 169.6 billion (US$307 million) largely due to increases in donor spending followed by household spending. Public spending increased from RWF 24.9 billion (US$ 45 million) to RWF 31.8 billion (US$ 58 million). $THE_{general}$ as a percentage of GDP increased from 7 percent to 11 percent.

- **Expenditure by donors and households has increased sizably.** Donor spending increased nearly threefold, from RWF 32.6 billion (US$ 59 million) to RWF 90.5 billion (US$ 164 million), while private spending (mainly by households) increased from RWF 19.5 billion (US$ 35 million) to RWF 47 billion (US$ 85 million). Possible reasons for this are the following:
    - Households pay increased copayments to mutuelles.
    - Though $THE_{general}$ has more than doubled between 2003 and 2006, most of the increase was in the area of targeted spending on diseases.
    - Most of the OOP spending went to private pharmacies (39 percent). The Rwandan population may have had a higher utility for proprietary drugs compared with generic medicines offered in the public sector and insurance mechanisms.
    - Data for traditional healers in 2006 were more robust than in previous years.
    - GDP increased, which may have led to an increase in disposable income and therefore an increase in utilization. While the private sector is small, it is growing,
    - Health care utilization was 0.3 per capita in 2003 and 0.7 per capita in 2006.

- **Spending on curative care has increased greatly, likely due to an increase in health-seeking behavior, which often falls on households.**

- **Households also shoulder the largest burden of curative care spending and drugs bought at independent pharmacies.**

- **Donors now contribute over half of all health expenditures.** In 2006, donors now contribute 53 percent of $THE_{general}$, followed by private sources at 28 percent and the public sector at 19 percent. The high donor contribution is due partly to an influx in HIV/AIDS and other disease-specific spending.

- **Donors direct their health funding primarily to prevention and public health programs, health administration, and curative care.**

- **The MoH is now largely financed by donors (64 percent); the government funds 36 percent.**

- **MoH programmatic control over health care funds has increased.** The NHA findings show that the MoH now controls 28 percent of health funds in Rwanda, closely followed by implementing agencies at 27 percent and households at 23 percent.

- **Mutuelles are largely financed by households (70 percent). However, in 2006, mutuelles were subsidized by donors, private firms, and the government.**

- **Government investment in health as a share of overall government spending decreased from 9 percent in 2003 to 6.5 percent in 2006.** The goals of the Abuja declaration state that governments should spend 15 percent of their funds on health by the year 2015. However, total government spending was dramatically higher in 2006, which accounts for the decreased percentage for health care. Absolute government spending on health continues to increase.

# 3. HIV/AIDS SUBACCOUNTS

## 3.1 BACKGROUND

The Republic of Rwanda, with one of the highest population densities in the world, faces a challenge in fighting the HIV/AIDS epidemic. It desperately needs qualified health professionals to address the epidemic. There is one doctor for every 50,000 people and one nurse for every 3,900 people; the impact of this lack of human resources is most severe in rural areas (United Nations General Assembly Special Session on HIV/AIDS [UNGASS] 2008). However, Rwanda has strong political leadership in the HIV/AIDS area and this is a critical catalyst for action at the national level.

In recent years, the country experienced a dramatic scale-up of HIV/AIDS programs due to an increase in available funding. In particular, donor funds for HIV/AIDS rose dramatically with the introduction of such funding mechanisms as the Global Fund to Fight AIDS, Tuberculosis and Malaria (2003), and PEPFAR (2004). The government created the National AIDS Control Commission (*Commission Nationale de Lutte contre le SIDA* [CNLS]) in 2000 after restructuring the National Program for HIV/AIDS Control, which has helped the government coordinate many of the ongoing activities from donors and public funding. The NHA HIV/AIDS subaccount sheds light on actual expenditures by these sources and others. It also provides insight into the financial burden of HIV/AIDS on PLHIV in comparison with the general population and the financial impact before and since the donor influx began.

## 3.2 HIV PREVALENCE IN RWANDA

UNAIDS estimates the total number of PLHIV in Rwanda was 160,000 in 2006.[12] Of the 160,000, an estimated 6 percent of adults were considered in need of antiretroviral therapy (ART) but not receiving it, 20 percent were in need and on ART, and 74 percent did not need ART.[13]

Recognizing the threat of the disease, both the GoR and donors working on the issue of HIV are committed to halt and reverse the spread of the epidemic in the period 2008-2012. The health sector during the timeframe of Rwanda's Economic Development and Poverty Reduction Strategy aims to ensure that (i) HIV counseling and prevention of mother-to-child transmission (PMTCT) services are routine during prenatal and postnatal visits, (ii) circumcision of young males will be promoted to reduce transmission, (iii) screening and testing of children will be expanded, (iv) evidence-based measures will be taken to combat ignorance and disseminate knowledge about the causes of HIV, (v) promotion of condom use will be scaled up, (vi) awareness programs will take into account the drivers of the epidemic including cultural norms, poverty, and gender inequality, and (vii) populations at high risk of exposure are targeted.

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[12] Similar estimates exist, such as one from the spectrum mathematical model within the GoR at 151,504. The NHA selected the UNAIDS estimate based on the level of detail indicated in computing the number, and because it is the internationally accepted number.

[13] Figures based on *World Health Report* (www.who.int/whr/en/) and Rwandan MoH data. See methodology in Annex C for further information on sources of data.

## 3.3 TOTAL RESOURCE ENVELOPE FOR HIV/AIDS HEALTH CARE

As Table 3.0 shows, total spending on HIV/AIDS ($THE_{HIV}$)-related health services in 2006 is RWF 40,482,722,686 (US$ 73 million), 24 percent of $THE_{general}$. In absolute terms, HIV/AIDS health spending has increased fivefold. HIV/AIDS health spending is 84 percent of total HIV/AIDS (including non-health spending like legal support to PLHIV, stigma reduction campaigns, and income support).

**TABLE 3.0: HIV/AIDS INDICATORS AND NHA FINDINGS FOR EXPENDITURE ON HIV/AIDS SERVICES, 2000-2006**

| Indicators | 2000* | 2002* | 2006 |
|---|---|---|---|
| HIV seroprevalence rate (adults) | 5.1% (estimated) | 5.1%** | 3%*** |
| Number of PLHIV | 200,000 (estimated) | 199,279** | 160,000[δ] |
| Total HIV/AIDS health expenditure ($THE_{HIV}$) | RWF 3,161,151,656 (US$ 5,729,423) | RWF 6,557,070,605 (US$ 13,804,359) | RWF 40,482,722,686 (US$ 73,373,091) |
| HIV/AIDS health spending per PLHIV | RWF 15,806 (US$ 28.65) | RWF 32,903 (US$ 69.27) | RWF 253,017 (US$ 459.58) |
| HIV/AIDS health spending as a % of $THE_{general}$ | 8.0% | 14.7% | 24% |
| HIV/AIDS health spending as a % of GDP | 0.3% | 0.6% | 2.6% |
| $THE_{HIV}$ as a % of total HIV/AIDS spending (health and non-health) | - | - | 84% |
| Percent of $THE_{HIV}$ that is targeted for HIV/AIDS | - | - | 99% |
| **Financing sources distribution as a % of $THE_{HIV}$** | | | |
| Public | 8% | 9% | 3% |
| Private | 43% | 17% | 2.4% |
| *Households account for* | *41%* | *16%* | *2%* |
| Donors | 49% | 75% | 94% |
| **Financing agents distribution as a % of $THE_{HIV}$** | | | |
| Public | 25% | 27% | 39%[δδ] |
| Private | 43% | 16% | 54% |
| Donor and NGO | 32% | 57% | 7% |
| **Providers distribution as a % of $THE_{HIV}$** | | | |
| Public providers | 33% | 16% | 27% |
| -Public hospitals | 24% | 11% | 17% |
| -Public health centers | 9% | 5% | 10% |
| Private providers | 9% | 3% | 5% |
| -Private for-profit hospitals | 8% | 2% | 5% |
| -Private for-profit health centers/clinics | 1% | 1% | 0% |
| Government assisted not-for-profit providers (*agréés*) | 5% | 3% | 8% |
| -*Agréé* hospitals | 2.6% | 1% | 2% |
| -*Agréé* health centers | 2.8% | 2% | 6% |
| Private pharmacies | 7% | 3% | 0.4% |
| Provision and administration of public health programs | 46% | 66% | 57% |
| Traditional healers | - | - | 0.2% |
| Other | 0% | 9% | 2.4% |
| **HIV/AIDS health spending by function** | | | |
| Prevention and public health programs | 46% | 66% | 29.7% |
| Curative care | 48% | 23% | 37.7% |

| Indicators | 2000* | 2002* | 2006 |
|---|---|---|---|
| -Inpatient | 14% | 7% | 9.8% |
| -Outpatient | 34% | 15% | 27.9% |
| Administration | 0% | 9% | 23% |
| Capital formation | - | - | 8% |
| Pharmaceuticals and other non-durables from independent pharmacies | 7% | 3% | 11.9% |
| Other | - | - | 1.1% |

*All US$ amounts for 2000 and 2002 are in constant 2006 US$ to facilitate comparison across years. The CPI was used for the conversion (70.88 for 2000 and 74.71 for 2002). Source for CPI data: NISR (http://www.statistics.gov.rw).

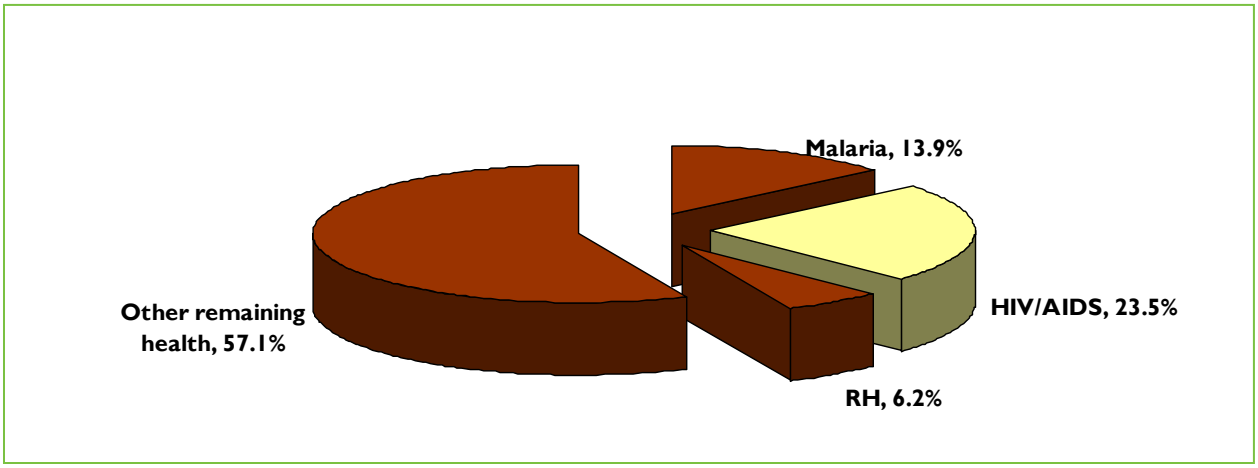
**UNAIDS (2004) www.unaids.org

***DHS 2005

 UNAIDS estimate, 2006 www.unaids.org

  Includes projects funded by donors that are housed under CNLS (e.g., World Bank MAP, UNDP, African Development Bank)

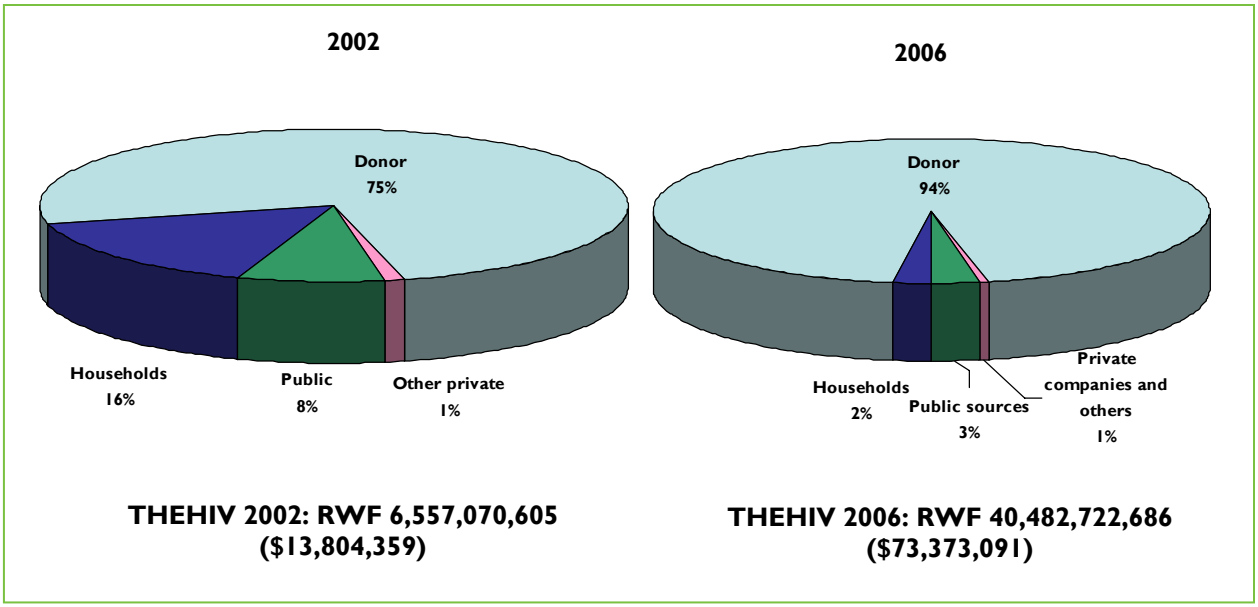
**FIGURE 3.0. MALARIA, HIV/AIDS, AND RH IN THE CONTEXT OF GENERAL HEALTH EXPENDITURES, 2006**




## 3.4 FINANCING SOURCES FOR HIV/AIDS SERVICES

Most funding for HIV/AIDS services in Rwanda comes from donors (94 percent in 2006, up from 75 percent in 2002), followed by public sources at 3 percent, households at 2 percent, and other private sources below 1 percent (Figure 3.1). In absolute terms, donor contributions increased eightfold between 2002 and 2006 (Table 3.1) – perhaps not surprisingly, as grant monies had begun to flow from new global initiatives such as the Global Fund and PEPFAR. The level of the household contribution is smaller in 2006 than in 2002, in absolute and relative terms. Relatively, the percentage contribution from public financing sources is smaller for $THE_{HIV}$, even though the contribution has almost doubled in absolute terms.

**FIGURE 3.1: WHERE DO HIV/AIDS MONIES COME FROM, 2002 AND 2006?**




* Reported in constant 2006 currency to facilitate comparisons across years

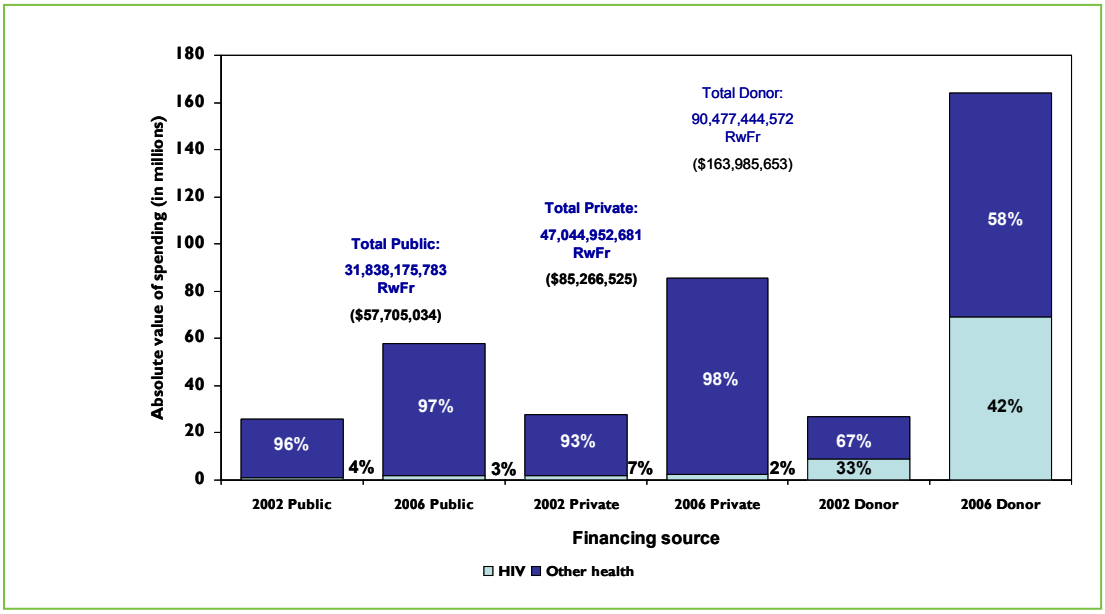
**TABLE 3.1: ABSOLUTE VALUES OF FINANCING SOURCE CONTRIBUTIONS TO HIV/AIDS SERVICES, 2002 AND 2006**

| Financing source | 2002* | | 2006 | | Magnitude of increase from 2002 |
|---|---|---|---|---|---|
| Public (incl parastatals) | RWF 563,167,283 | US$ 1,020,711 | RWF 1,079,984,145 | US$ 1,957,415 | 1.9 |
| Households | RWF 1,020,258,690 | US$ 1,849,166 | RWF 950,475,493 | US$ 1,722,687 | 0.9 |
| Other private | RWF 74,743,084 | US$ 135,468 | RWF 11,272,061 | US$ 20,430 | 0.2 |
| Donor | RWF 4,897,853,051 | US$ 8,877,103 | RWF 38,227,129,752 r | US$ 69,284,680 | 7.8 |
| Other | RWF 1,048,496 | US$ 1,900 | RWF 213,861,233 | US$ 387,612 | 204.0 |

* Reported in 2006 currency to adjust for inflation when comparing across years

Figure 3.2 shows the financing source contributions to HIV/AIDS services in the context of general health. As noted above, in absolute terms, public spending on HIV/AIDS has doubled since 2002; private spending has decreased slightly. Donor allocations to HIV/AIDS have doubled, from 11 percent to 22.5 percent of total health spending, a result of a dramatic increase in absolute donor spending on HIV/AIDS.

**FIGURE 3.2: SHARE OF FINANCING SOURCES' HEALTH RESOURCES GOING TO HIV/AIDS, 2002 AND 2006**




Reported in constant 2006 currency to facilitate comparisons across years

The figure also illustrates how public and donor sources financially prioritize HIV/AIDS. In 2002, 4 percent of public expenditures went to HIV/AIDS activities. This percentage stayed relatively constant in 2006. In 2002, one-third, or 33 percent, of donor expenditure was for HIV/AIDS; in 2006, this percentage was 42 percent.[14]

## 3.5 FINANCING AGENTS: MANAGERS AND IMPLEMENTERS OF HIV/AIDS HEALTH FUNDS

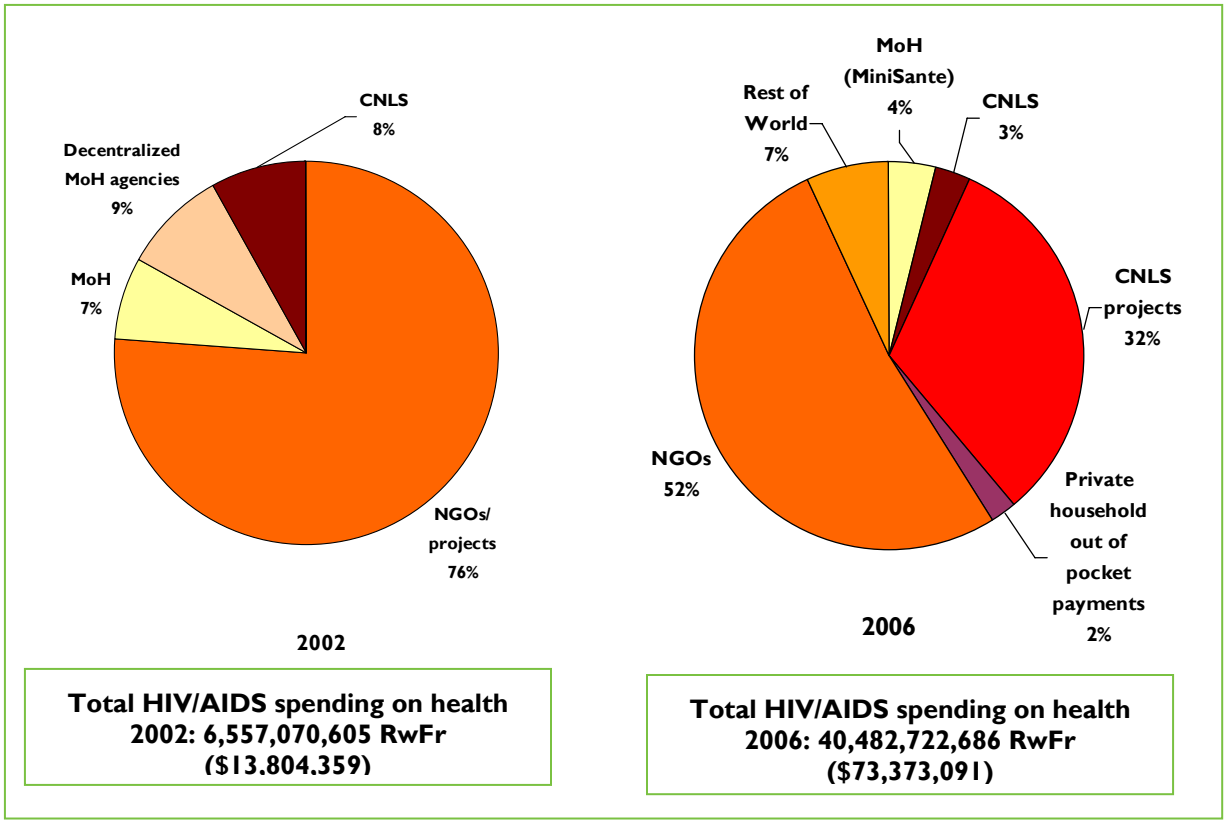
As mentioned above, financing agents are entities that exercise programmatic control over the funds received from financing sources. It should be noted that particularly in regard to HIV/AIDS spending, funds may have multiple pass-throughs before they reach providers. The NHA team interviewed key informants to identify the entity with the most programmatic control over the funds; that entity was then treated as the financing agent.

As Figure 3.3 shows, a major shift in financing agents occurred between 2002 and 2006: In 2002, NGOs managed 76 percent of $THE_{HIV}$; by 2006, their share had shrunk to 52 percent. In contrast, the CNLS, which managed only 8 percent of $THE_{HIV}$ in 2002, in 2006 had projects that represented one-third of $THE_{HIV}$. CNLS projects now include grants from the Global Fund, World Bank MAP, UNDP, and others;

[14] These percentages include untargeted spending counted under the HIV subaccount in order to account for "general" health spending in facilities that see AIDS patients. For example, the HIV subaccount counts a percentage of a doctor's salary when the doctor sees PLHIV. See Annex C on the NHA methodology for further information on untargeted spending.

in 2002, these funds were in the NGO/projects category. This is the result of better coordination of HIV/AIDS programs on the part of the GoR.[15]

**FIGURE 3.3: MANAGERS OF THE$_{HIV}$ IN RWANDA, 2002 AND 2006**

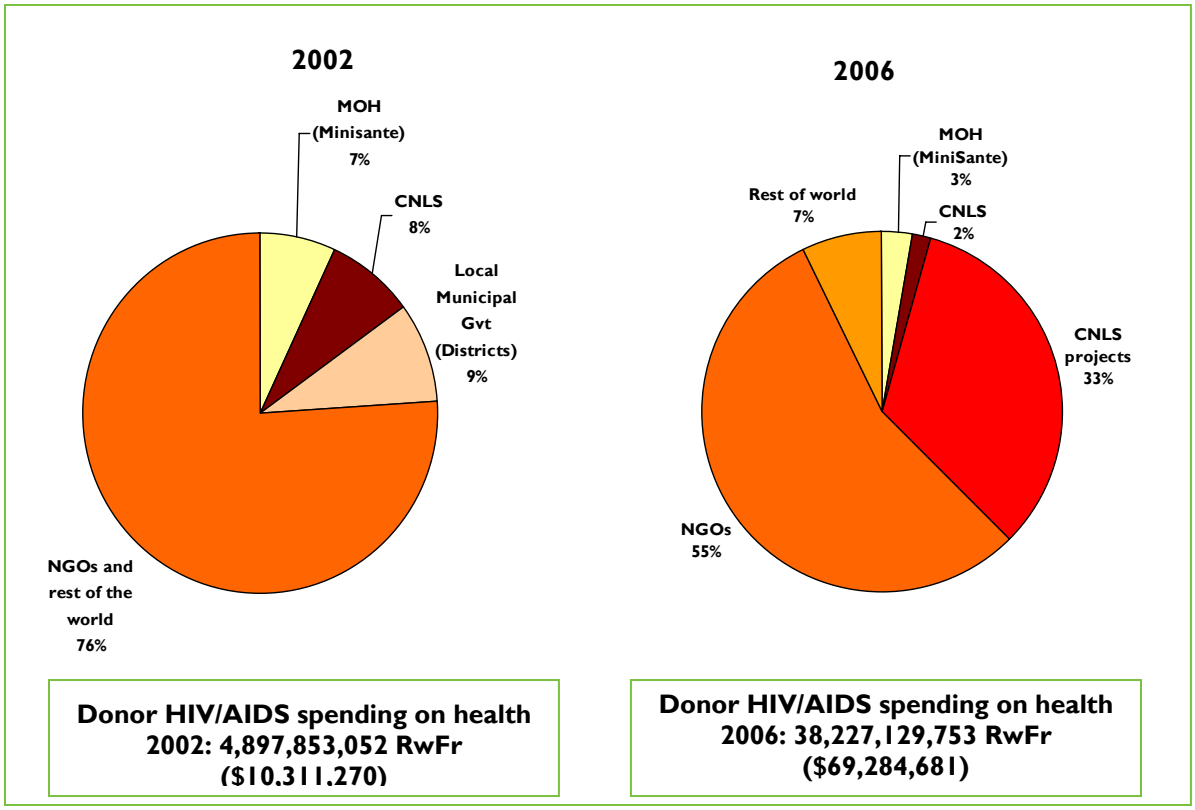



* Reported in constant 2006 currency to facilitate comparisons across years

As Figure 3.4 illustrates, because donor funding comprises so great a percentage of THE$_{HIV}$, managers of donor funds for HIV services are virtually identical to those of overall HIV funding in both 2002 and 2006.

[15] The category "CNLS projects" in Figure 3.5 was created as a result of the issue of multiple financing agents. The Global Fund, for example, passes funding through its country office, but the country office is housed within the CNLS, which helps program the funds. To recognize the government's coordination of these country program funds, NHA created the category of CNLS programs. Expenditures on CNLS programs is distinct from expenditure on the CNLS proper (the CNLS office housing public employees), which exists mainly for administration and program management purposes.

**FIGURE 3.4: MANAGERS OF DONOR HIV/AIDS FUNDS IN RWANDA, 2002 AND 2006**




* Reported in constant 2006 currency to facilitate comparisons across years

## 3.6 HOUSEHOLD OOP SPENDING ON HIV SERVICES

As households make decisions on whether and how to spend OOP on health, and HIV services in particular, they act as both financing sources and agents.

As noted above, households spent RWF 1,020,258,690 (US$ 1,849,166) on HIV/AIDS services in 2002 and RWF 950,475,493 (US$ 1,722,687) in 2006; this likely lowered OOP spending per HIV-positive individual from $10.16 to $9.78 (Table 3.2). Given that PLHIV tend to seek more health care than the general population, it is expected that they will spend slightly more on health care. Nevertheless, in 2006, PLHIV spend only 1.5 times more on health care than does the general population; in 2002, they had spent four times more. While this is due in part to increased subsidization of health care and a drop in HIV prevalence, it is mainly due to the doubling of OOP spending on general health care. (See section 2.5.2 for possible reasons for increased general OOP spending.)

**TABLE 3.2: HOUSEHOLDS IN RWANDA AS FINANCING AGENTS: OOP SPENDING ON HEALTH BY PLHIV AND THE GENERAL POPULATION, 2002 AND 2006**

| | 2002* | 2006 |
|---|---|---|
| HIV OOP per HIV-positive individual | $10.16 | $9.78 |
| General OOP per capita | $2.85 | $ 7.66 |
| Magnitude of increase in OOP spending by HIV-positive individuals | 4 | 1.5 |

* Reported in constant 2006 currency to facilitate comparisons across years

In 2006, OOP spending goes primarily to public hospitals and public health centers (each at 23 percent of OOP), followed by independent pharmacies at 19 percent and traditional healers at 11 percent (Figure 3.5). This represents a decrease in OOP expenditures at public facilities since 2002 (from 35 percent at hospitals and 27 percent at health centers), but an increase in OOP expenditures at private/independent pharmacies (up from 16 percent in 2002). It should be noted that the decrease in OOP spending at public hospitals does not necessarily indicate a lower utilization rate of the hospitals for HIV/AIDS care.

**FIGURE 3.5: PROVIDERS CONSUMING HOUSEHOLD OOP HIV/AIDS FUNDS, 2002 AND 2006**

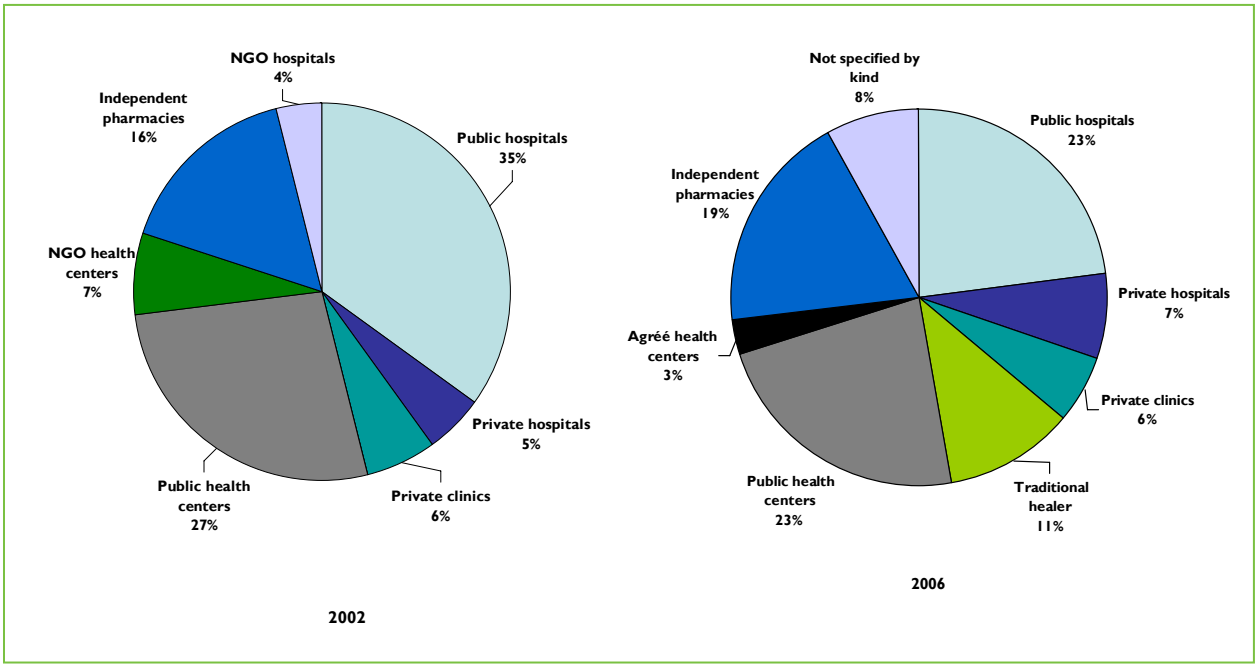
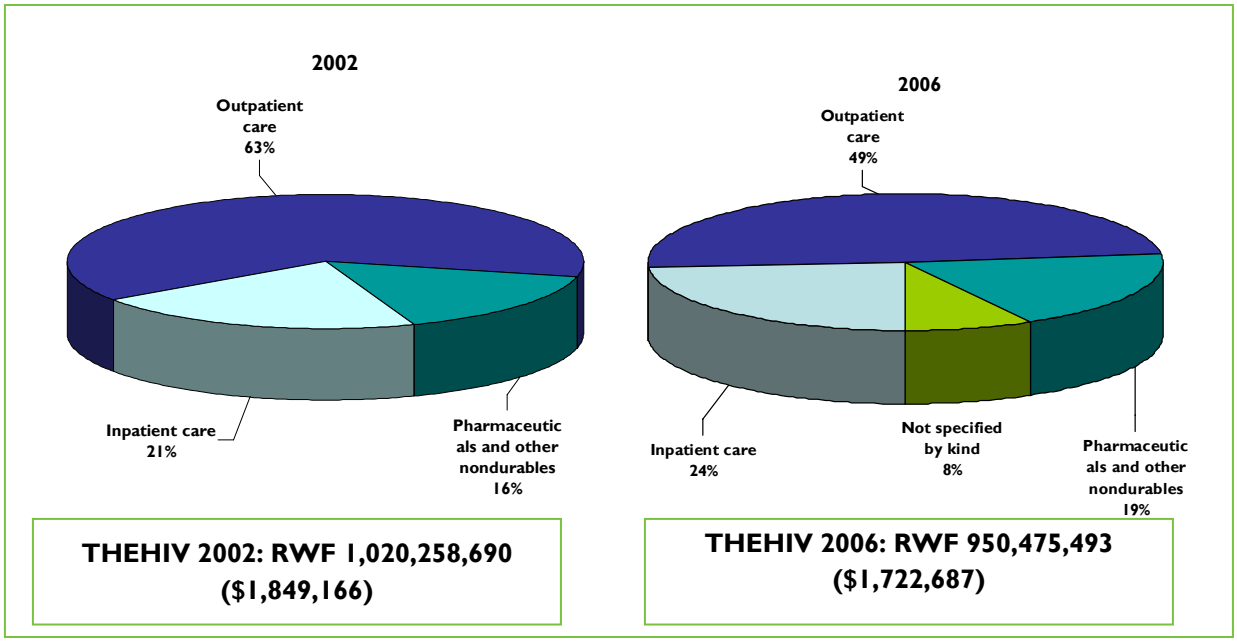



Figure 3.6 shows the breakdown of household OOP spending on inpatient and outpatient care and pharmacies. The relative share of expenditures has shifted from outpatient care (which decreased from 63 percent of household OOP expenditures on HIV services in 2002 to 49 percent in 2006) to inpatient care (which has increased from 21 percent in 2002 to 24 percent in 2006).

Subaccount findings from 2006 show a significant percentage (11 percent) of household OOP spending going to traditional healers, a category not included in 2002 findings due to a lack of quality data for that year (see Annex C for data sources of spending on traditional healers in 2006).

**FIGURE 3.6. HIV SERVICES BOUGHT WITH HOUSEHOLD OOP SPENDING, 2002 AND 2006**




* Reported in constant 2006 currency to facilitate comparisons across years

## 3.7 ADDITIONAL ANALYSIS OF PLHIV OOP SPENDING AND UTILIZATION

The Rwandan DHS 2005, a nationally representative population-based survey, revealed HIV prevalence in adults to be 3 percent. The study also estimated prevalence among urban populations at 7.3 percent compared with 2.2 percent in rural populations. The relative ease of movement within a small country and frequent contact with people in the urban areas poses a high risk of infection to the large rural population (83 percent of the population).

Nurses provided a majority of the medical care for people living with HIV, even for the wealthiest Rwandans (Table 3.3). For the urban poor, nurses provide 94 percent of outpatient visits; only 3 percent of urban patients are much more likely to visit a doctor instead of a nurse. For the richest fifth of city-dwellers, 44 percent of outpatient visits are to doctors.

**TABLE 3.3: OOP SPENDING PER VISIT, BY PERSON PROVIDING CARE**

| | | For those with non-zero spending, amount spent on visit (RWF) | | |
|---|---|---|---|---|
| | No spending | Lower Quartile | Median | Upper Quartile |
| Doctor | 20.6% | 150 | 400 | 1,200 |
| Nurse | 16.5% | 100 | 200 | 395 |
| Healer | 49.6% | 200 | 500 | 1,000 |
| Other | 52.1% | 100 | 200 | 500 |
| Total | 23.9% | 100 | 200 | 500 |

Traditional healers are mentioned in 15 percent of PLHIV outpatient visits. Most of these are in rural areas. (Because five out of every six respondents are rural, the table for rural areas closely resembles the national total, and is not shown separately here.)

The poorest Rwandans living with HIV use fewer traditional healers than those with slightly higher incomes, perhaps because traditional healers charge nearly as much as doctors, and substantially more than nurses (Table 3.3).

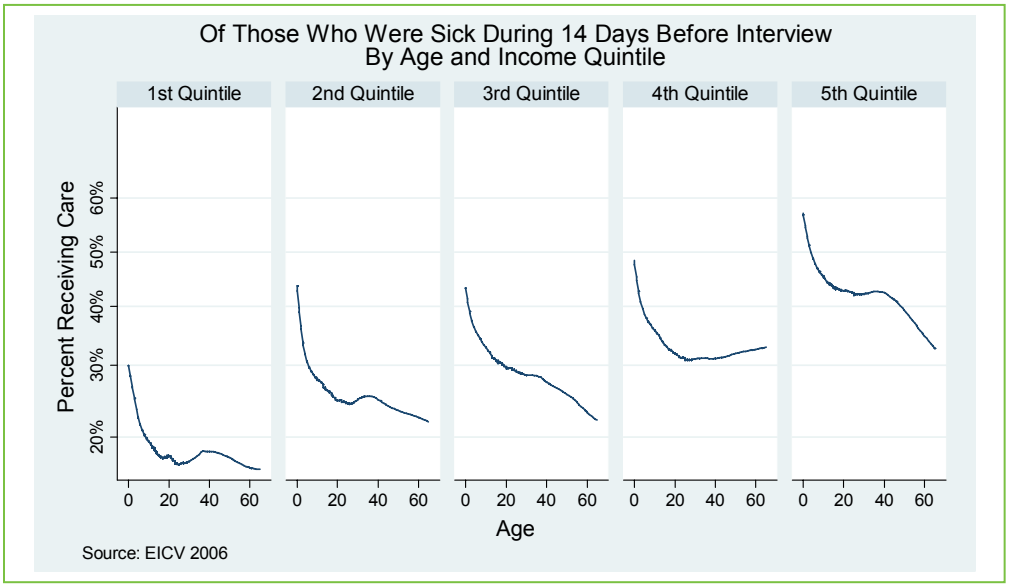
The richest Rwandans spent more than six times as much annually as the poorest (Table 3.4).[16] As a share of their total income, however, the richest spend about 2 percent of total consumption, compared with nearly 4 percent for the poorest quintile. The greatest difference is between the richest fifth and the remaining 80 percent of the population.

**TABLE 3.4: SPENDING ON CARE, BY INCOME QUINTILE**

| | Annual Spending | Percent of Income |
|---|---|---|
| Poorest | 1,149 | 3.6% |
| Second Quintile | 2,294 | 4.0% |
| Third Quintile | 2,181 | 2.7% |
| Fourth Quintile | 3,481 | 2.9% |
| Richest | 7,368 | 1.9% |

Nearly 20 percent of the respondents to the EICV2 interview said they had experienced a health problem during the two weeks preceding the interview. Just under a third of these saw a health provider during that period. (Some patients with an illness that began more than 14 days before the interview might have seen a provider outside the two-week recall period.) Children were significantly more likely to receive care than adults (Figure 3.7).

**FIGURE 3.7: PATIENTS WHO RECEIVED MEDICAL CARE, BY AGE AND INCOME QUINTILE**




[16] The 95% confidence interval is that the richest quintile spent 4.5 to 8 times as much as the poorest quintile.

At every age, high-income households (PLHIV) are more likely to obtain care. Adults and children over the age of two in the richest fifth of the households (as measured by consumption) are about twice as likely to receive care as those in the poorest fifth (Table 3.5). Infants of two years or younger are about 70 percent more likely to receive care if they live in a high-income household than if they live in the poorest households.

**TABLE 3.5: PATIENTS WHO RECEIVED MEDICAL CARE, BY AGE AND INCOME QUINTILE**

| | Expenditure quintile | | | | | |
|---|---|---|---|---|---|---|
| **Age** | **Poorest** | **2nd Quintile** | **3rd Quintile** | **4th Quintile** | **Richest** | **Total** |
| Less than 2 | 31% | 45% | 45% | 46% | 54% | 45% |
| 2 to 4 | 25% | 33% | 35% | 42% | 51% | 37% |
| 5 to 14 | 16% | 20% | 29% | 29% | 39% | 26% |
| 15 to 24 | 15% | 28% | 34% | 34% | 41% | 31% |
| 25 to 34 | 22% | 29% | 26% | 28% | 45% | 32% |
| 35 to 44 | 20% | 25% | 34% | 34% | 48% | 31% |
| 45 to 55 | 17% | 24% | 21% | 31% | 37% | 26% |
| Over 55 | 18% | 23% | 19% | 27% | 35% | 25% |
| Total | 20% | 27% | 31% | 34% | 43% | 31% |

About half of all visits occurred at health care centers (Table 3.6). However, richer households, and those in urban areas are more likely to visit other types of providers. Among the richest fifth of urban households, nearly one-third of outpatient visits are to hospitals and another 9 percent are to clinics. Very few poor people visit hospitals, and almost none visit clinics. The "other" locations in Table 3.6 include the homes of patients and providers, which are common locations for traditional healers, as well as pharmacies and a few other less common venues.

**TABLE 3.6: PLACE OF MEDICAL CARE, BY INCOME AND PLACE OF RESIDENCE**

| | Expenditure quintile | | | | | |
|---|---|---|---|---|---|---|
| | **Poorest** | **2nd Quintile** | **3rd Quintile** | **4th Quintile** | **Richest** | **Total** |
| **Rwanda** | | | | | | |
| Hospital | 7% | 8% | 8% | 11% | 23% | 13% |
| Clinic | 0% | 0% | 0% | 1% | 4% | 1% |
| Dispensary | 13% | 10% | 11% | 16% | 17% | 14% |
| Health care center | 51% | 52% | 54% | 52% | 40% | 49% |
| Other | 30% | 31% | 27% | 20% | 16% | 23% |
| | | | | | | |
| **Urban Areas** | | | | | | |
| Hospital | 3% | 21% | 12% | 15% | 30% | 24% |
| Clinic | 0% | 0% | 0% | 3% | 9% | 6% |
| Dispensary | 12% | 6% | 21% | 39% | 23% | 23% |
| Health care center | 45% | 22% | 54% | 35% | 27% | 31% |
| Other | 39% | 51% | 13% | 8% | 11% | 15% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

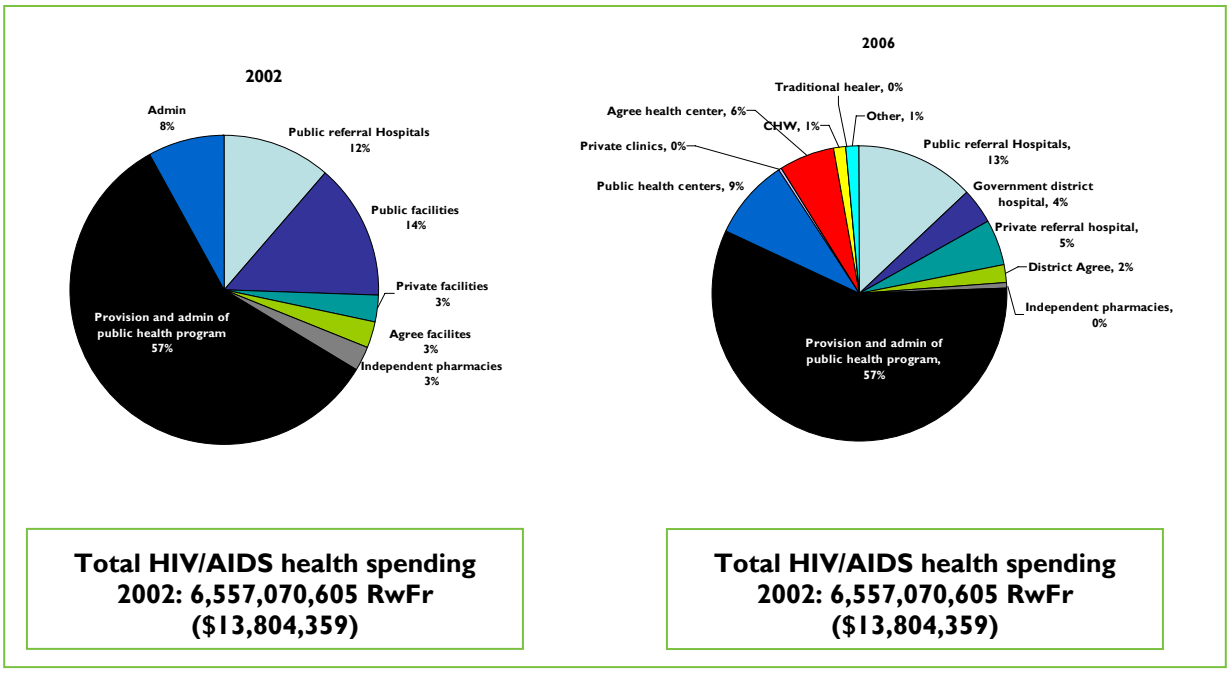
**TABLE 3.7: PERSON CONSULTED FOR MEDICAL CARE, BY INCOME AND PLACE OF RESIDENCE**

| | Expenditure quintile | | | | | |
|---|---|---|---|---|---|---|
| | Poorest | 2nd Quintile | 3rd Quintile | 4th Quintile | Richest | Total |
| **Rwanda** | | | | | | |
| Doctor | 12% | 10% | 13% | 17% | 31% | 19% |
| Nurse | 65% | 64% | 60% | 66% | 56% | 61% |
| Healer | 17% | 22% | 19% | 13% | 8% | 15% |
| Other | 7% | 4% | 8% | 5% | 5% | 5% |
| **Urban Areas** | | | | | | |
| Doctor | 3% | 21% | 15% | 32% | 44% | 35% |
| Nurse | 94% | 69% | 71% | 64% | 50% | 58% |
| Healer | 3% | 7% | 13% | 3% | 3% | 4% |
| Other | 0% | 3% | 1% | 0% | 3% | 2% |
| Total | 100% | 100% | 100% | 100% | 100% | 100% |

## 3.8 PROVIDERS OF HIV/AIDS HEALTH SERVICES

As Figure 3.8 shows, in 2006, expenditures on HIV/AIDS services are made mainly at providers and administrators of public health programs (57 percent), followed by public referral hospitals at 13 percent. This is similar to the provider breakdown in 2002, although *agréé* hospitals and health centers comprise a larger share in 2006.

**FIGURE 3.8: DISTRIBUTION OF PROVIDERS OF HIV/AIDS SERVICES AND COMMODITIES, 2002 AND 2006**



## 3.9 HIV-RELATED HEALTH FUNCTIONS

### 3.9.1 HIV/AIDS HEALTH SERVICES CONSUMED

As Figure 3.9 shows, HIV/AIDS funds are consumed mainly by prevention and public health programs (29.7 percent) and outpatient curative care (27.9 percent).

**FIGURE 3.9: WHAT DO HEALTH FUNDS BUY? HIV/AIDS HEALTH SERVICES CONSUMED, 2006**

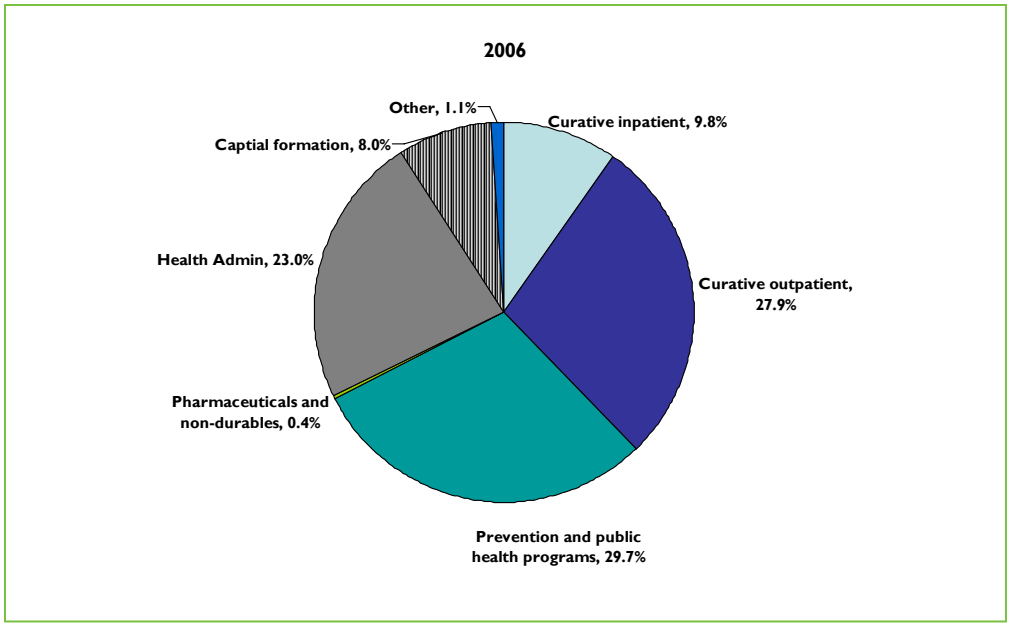
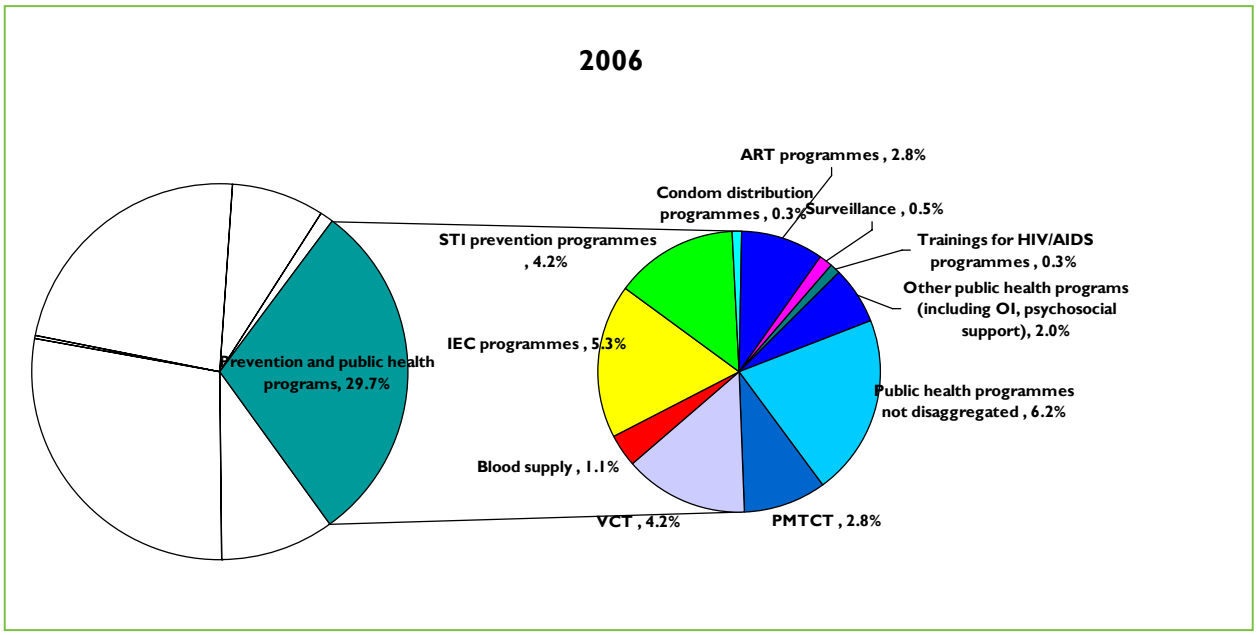



Figure 3.10 shows the disaggregation of prevention and public health programs achieved by the 2006 subaccount. Out of the amount of prevention and public health programs that could be disaggregated, 18 percent went to information, education and communication (IEC) programs (5.3 percent of $THE_{HIV}$). STI prevention programs and voluntary counseling and testing (VCT) also consume significant portions of prevention and public health programs.

Spending on these health functions was counted under THE because they were considered expenditures with the primary purpose of improving or maintaining health. The 2006 subaccount also captured health-related and non-health functions, listed in Annex A.

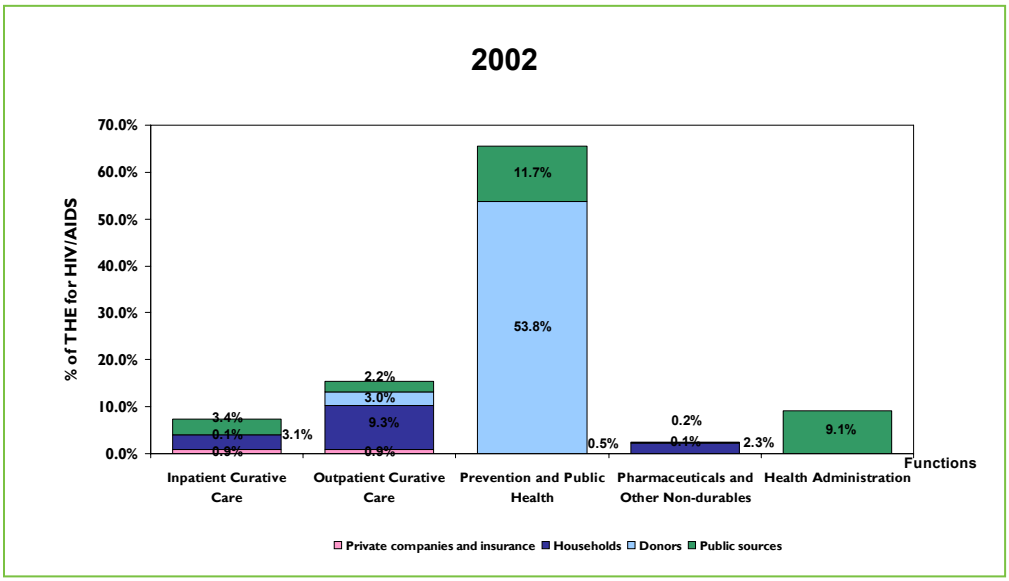
**FIGURE 3.10: BREAKDOWN OF EXPENDITURES ON PREVENTION AND PUBLIC HEALTH PROGRAMS, 2006**

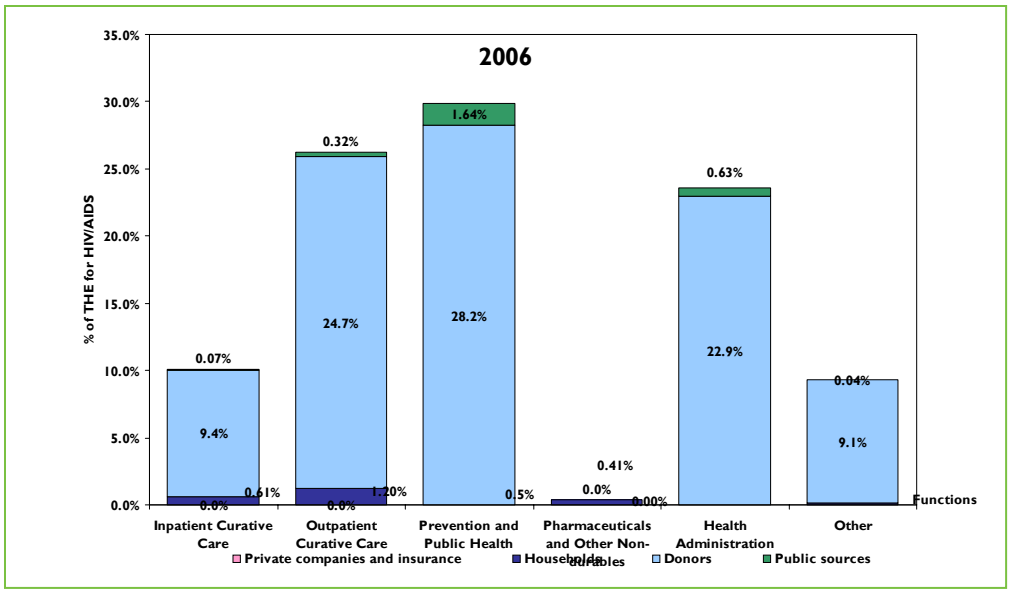



## 3.9.2 WHO FINANCES WHAT HEALTH FUNCTIONS?

Figure 3.11 shows which financing source spent on which HIV-related health function in 2002 and 2006. In 2006, donors finance the largest share of services across all functional categories. Public sources contribute the highest percentage (1.7 percent) of their HIV/AIDS monies to prevention and public health programs. Households contribute the largest percentage (1.2 percent) of their funds to outpatient care. Donor monies are distributed to prevention and public health (28.2 percent), health administration (22.9 percent), and outpatient curative care (24.7 percent).

**FIGURE 3.11: FINANCING SOURCES FOR HIV/AIDS-RELATED HEALTH CARE FUNCTIONS, 2002 AND 2006**




2006
% of THE for HIV/AIDS
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
0.07%
9.4%
0.61%
0.0%
0.32%
24.7%
1.20%
0.0%
1.64%
28.2%
0.5%
0.41%
0.0%
0.00%
0.63%
22.9%
0.04%
9.1%
Functions
Inpatient Curative Care
Outpatient Curative Care
Prevention and Public Health
Pharmaceuticals and Other Non-durables
Health Administration
Other
Private companies and insurance
Households
Donors
Public sources

**UNAIDS/NHA Collaboration for NASA Matrix and HIV Subaccounts Tables**

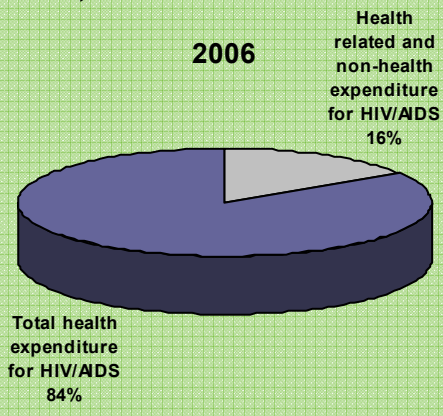
In addition to tracking HIV/AIDS health expenditures, the HIV subaccounts captured spending on health-related or non-health HIV/AIDS activities, such as income generation and legal services for PLHIV. The non-health spending component is considered external to $THE_{HIV}$ (in order to maintain consistency with the general NHA framework) and analyzed separately. Data collection on HIV/AIDS spending was conducted by the NHA team, CNLS, and UNAIDS.

To track HIV-related expenditure for 2006, Rwanda submitted reports using two different frameworks, the National AIDS Spending Assessment (NASA) and the HIV subaccounts. The subaccounts and NASA matrix differ slightly to cater to different groups of stakeholders, but both report on HIV spending in a calendar year (as is the case in Rwanda). The subaccounts preserve the distinction between health and non-health expenditures to help meet the needs of health stakeholders. The NASA approach aims to inform a multisectoral AIDS perspective and can contribute to the HIV and AIDS resource gap estimation process. The NASA matrix is also necessary for reporting purposes to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS.

As per international NHA norms, the HIV/AIDS subaccounts reflect expenditures. Therefore, it differs from commitments and from disbursements, and captures in monetary terms the transactions for actual services rendered. To ensure complementary and harmonized findings, the two teams worked together during the data analysis stage. NASA spending categories were mapped to NHA codes and then populated using the values from the HIV subaccounts tables.

UNAIDS considers all spending on condoms to be an HIV expenditure while NHA attributes some of it to family planning. Therefore, data from the NHA RH subaccount was added to the NASA table. For trend analysis, spending data for 2005 collected according to NASA methodology were used, as reported in the 2006 UNGASS Report. The chapter on findings from this report can be found in Annex D.

**HIV/AIDS health, health-related and non-health spending**



## 3.10 SUMMARY

- **HIV/AIDS health expenditure increased fivefold between 2002 and 2006** (from RWF 6,557,070,605 [US$ 14 million] to RWF 40,482,722,686 [US$ 73 million]), **fueled mainly by donors**. HIV/AIDS health expenditures represent 24 percent of THE in Rwanda, making it the largest priority area.

- **In 2006, donors account for the vast share of HIV/AIDS expenditures**. Donors account for 94 percent of $THE_{HIV}$, followed by public sources (3 percent), households (2 percent), and other private sources (1 percent). Donor funds coming into Rwanda in 2006 were twice as likely to be spent on HIV/AIDS services as in 2002.

- **The government now manages a larger share of HIV/AIDS activities (39 percent in 2006 as compared with 27 percent in 2002)**. By housing major projects such as World Bank's MAP, Global Fund, UNDP, and others under the auspices of CNLS, the government is able to track and coordinate HIV programs. As a result, independent NGOs and implementing agencies (via direct donor transfers) are managing smaller proportions of HIV/AIDS monies.

- **PLHIV in the richest quintile in Rwanda spend six times more annually on health than the poorest**, but only spend 2 percent of their total consumption as opposed to 4 percent by the latter. Nurses provide 94 percent of health care, mainly outpatient. In every income quintile, children are the most likely to obtain care.

- **Prevention and public health programs consume the largest share of HIV/AIDS funds, followed by curative care and health administration**. Within public health programs, IEC programs accounted for 18 percent (5.3 percent) of $THE_{HIV}$.

- **Households have shifted some of their spending to inpatient care from outpatient care since 2002**.

- **The burden of health expenditure on PLHIV compared with the general population's health spending has decreased slightly since 2002**. Per capita spending by PLHIV has fallen, from $10.16 to $9.78.

# 4. MALARIA SUBACCOUNTS

## 4.1 INTRODUCTION

Malaria is the leading cause of morbidity in Rwanda, with a reported 1,357,170 cases diagnosed at the country's health facilities in 2006 (NISR 2006). Major interventions that were targeted at drastically decreasing the malaria burden include the following:

- The distribution of 1.4 million long-lasting insecticide-treated nets (LLINs) for children was integrated with a one-week measles vaccination campaign, bringing the rate of coverage from 17.4 percent in 2005 to 91 percent in 2006 among children under five.
- The MoH adopted a new policy for malaria treatment using the artemisinin-based combination therapy (ACT) of arthemether and lumefantrine (Coartem®), and purchased 2,649,600 doses of Coartem® for the 12-month period October 1, 2006 to September 30, 2007. The ACTs were introduced for distribution through public, private, and community-level channels. Other lines of treatment were prohibited to curb the then-increasing cases of malaria drug resistance.
- National IPT coverage in pregnant women includes the administration of two doses of sulfadoxine–pyrimethamine (SP) during the second and the third quarters of the pregnancy. This is combined with folic acid, iron, and mebendazole. The coverage of women on IPT increased to 43 percent in May 2006 and over 63 percent by the end of 2006 for the second dose.
- The Home-Based Management (HBM) Strategy of CHWs trained to detect malaria, provide preliminary treatment, and refer patients to health facilities was scaled up in six additional endemic districts and, by December 2006, boasted coverage over the catchment areas of 100 health centers and 7,719 CHWs. In most HBM districts, more than 80 percent of children are treated within 24 hours after developing a fever.

This chapter investigates the structures and relative financial burdens associated with malaria, and uses subaccount expenditure findings to identify causal or effective explanations. The cost-effective interventions listed above were scaled up in 2006, and in response, malaria health outcomes showed a significantly positive response (WHO 2006). In respect to changes from 2003 subaccount findings, readers should keep in mind that 2003 was before Global Fund and PMI contributions to the malaria funding basket started arriving, whereas 2006 is post-Global Fund and PMI.

The 2006 malaria subaccount findings are useful not only in comparison with the 2003 baseline, but will also help to measure the true effects of the aforementioned interventions in the future.

## 4.2 TOTAL RESOURCE ENVELOPE FOR MALARIA

As Table 4.0 shows, absolute spending on malaria ($THE_{malaria}$) has nearly doubled, from RWF 13 billion (US$ 25 million) in 2003 to RWF 23 billion (US$ 43 million) in 2006. There has been a decrease in malaria's relative share of THE, from 17.6 percent to 13.9 percent (Figures 4.0 and 4.1), attributable to an increase in spending on HIV/AIDS.

**TABLE 4.0: MALARIA INDICATORS AND NHA SUBACCOUNT FINDINGS FOR EXPENDITURE ON MALARIA SERVICES, 2003 AND 2006**

| Indicators | 2003* | 2006 |
|---|---|---|
| Malaria morbidity rate (adults) | 67.5% | 34% |
| Malaria morbidity rate (< 5 years) | 32.5% | 38% |
| THE | RWF 78,417,516,472 ($142,128,178) | RWF 169,574,434,271 ($307,345,940) |
| Total malaria expenditure ($THE_{malaria}$) | RWF 13,782,993,174 ($24,981,047) | RWF 23,570,420,722 ($42,720,314) |
| Malaria spending per capita | RWF 1,643 ($2.98) | RWF 2,602 ($4.72) |
| Malaria OOP spending per capita | RWF 481 (<$1) | RWF 1,056 ($1.91) |
| % of total health expenditures allocated to malaria | 17.58% | 13.9% |
| Total malaria spending as % of GDP | 1% | 1.49% |
| Targeted spending on malaria | RWF1,639,996,778 ($2,972,409) | RWF 8,324,615,580 ($15,087,932) |
| Targeted spending as % of $THE_{malaria}$ | 12% | 35% |
| **Financing sources of malaria spending** | | |
| Public | 24% | 5% |
| Private | 37% | 45% |
| *Households account for* | 29% | 44% |
| Donors | 38% | 50% |
| **Providers of malaria care and activities** | | |
| Public Providers | 63% | 33% |
| -Public hospitals | 22% | 13% |
| -Public health centers | 41% | 20% |
| Private providers | 14% | 10% |
| -Private for-profit hospitals | 3% | 2% |
| -Private for-profit health centers/clinics | 11% | 8% |
| Government assisted not-for-profit providers (*Agrées*) | 15% | 12% |
| -*Agrée* hospitals | 5% | 4% |
| -*Agrée* health centers | 9% | 8% |
| Independent pharmacies | 4% | 16% |
| Provision and administration of public health programs | 4% | 5% |
| General health care administration and insurance (for malaria) | - | 2% |
| Community health workers | - | 20% |
| Traditional healers | 0.4% | 0.4% |
| Other | 0.1% | 1.6% |
| **Malaria health spending by function** | | |
| Prevention and public health programs | 3% | 4.6% |
| Curative care | 91% | 76.8% |
| -Inpatient | 48% | 13.2% |
| -Outpatient | 43% | 63.6% |
| Administration | 2% | 1.2% |
| Pharmaceuticals and other non-durables from independent pharmacies | 4% | 16.1% |
| Other | 0% | 1.4% |
| **Spending on preventive activities** | | |
| Insecticide-treated nets | 6% | 27% |
| Repellents | 3% | 0% |
| Prevention programs | 3% | 5% |

* All US$ amounts for 2003 are in constant 2006 US$ to facilitate comparison across years. The CPI was used for the conversion (80.27 for 2003). Source for CPI data: NISR (http://www.statistics.gov.rw)

**FIGURE 4.0: MALARIA, HIV/AIDS, AND RH IN THE CONTEXT OF GENERAL HEALTH EXPENDITURES, 2006**

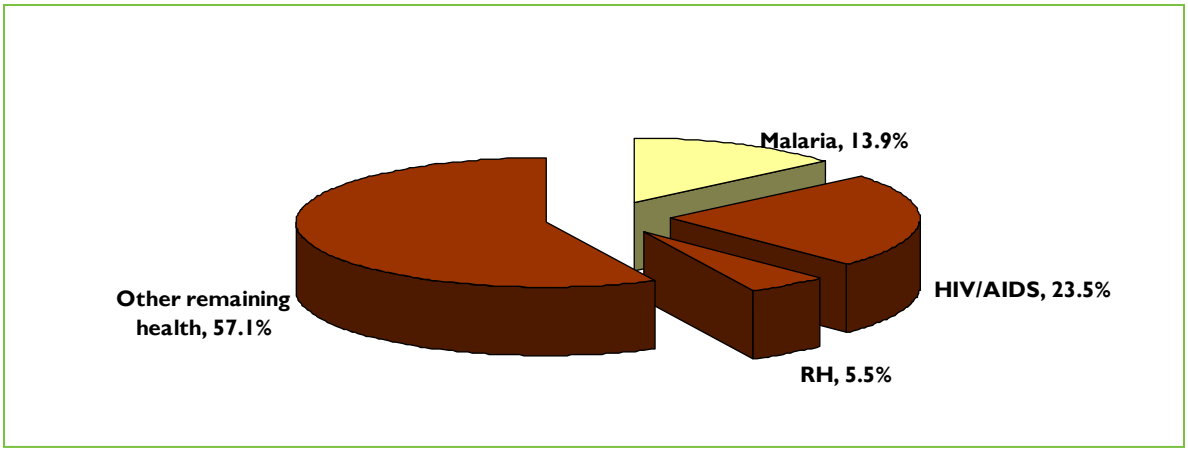
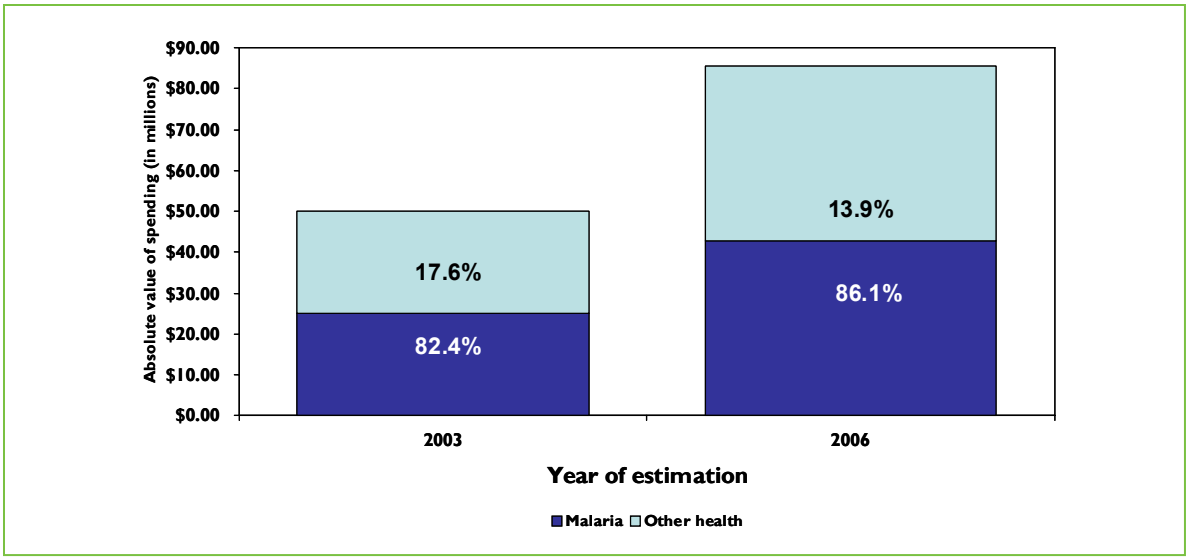



**FIGURE 4.1: SPENDING ON MALARIA AND GENERAL HEALTH CARE, 2003 AND 2006**




* Reported in constant 2006 currency to facilitate comparisons across years

It should be noted that targeted, or earmarked, spending on malaria represents 35 percent of this estimate. Earmarked funds are those whose primary purpose is explicitly treatment and/or control of malaria. Sixty-five percent of spending on malaria is untargeted, that is, expenditures are incurred to provide health services in general and are not specific to the treatment of any particular disease or health condition.[17]

[17] Examples of untargeted expenditures are staff salaries and maintenance/other operating costs of public health facilities.

## 4.3 FINANCING SOURCES OF MALARIA FUNDING

In 2006, donors are the largest financing sources of malaria, contributing 50 percent of all malaria resources (Figure 4.2). Households are the second largest contributor, at 44 percent, followed by public sources (5 percent) and other private sources (1 percent). In relative terms, donors and households now contribute significantly larger percentages of malaria funding than they did in 2003, while the percentage from public sources is decreasing.

**FIGURE 4.2: WHERE DO MALARIA FUNDS COME FROM, 2003 AND 2006?**

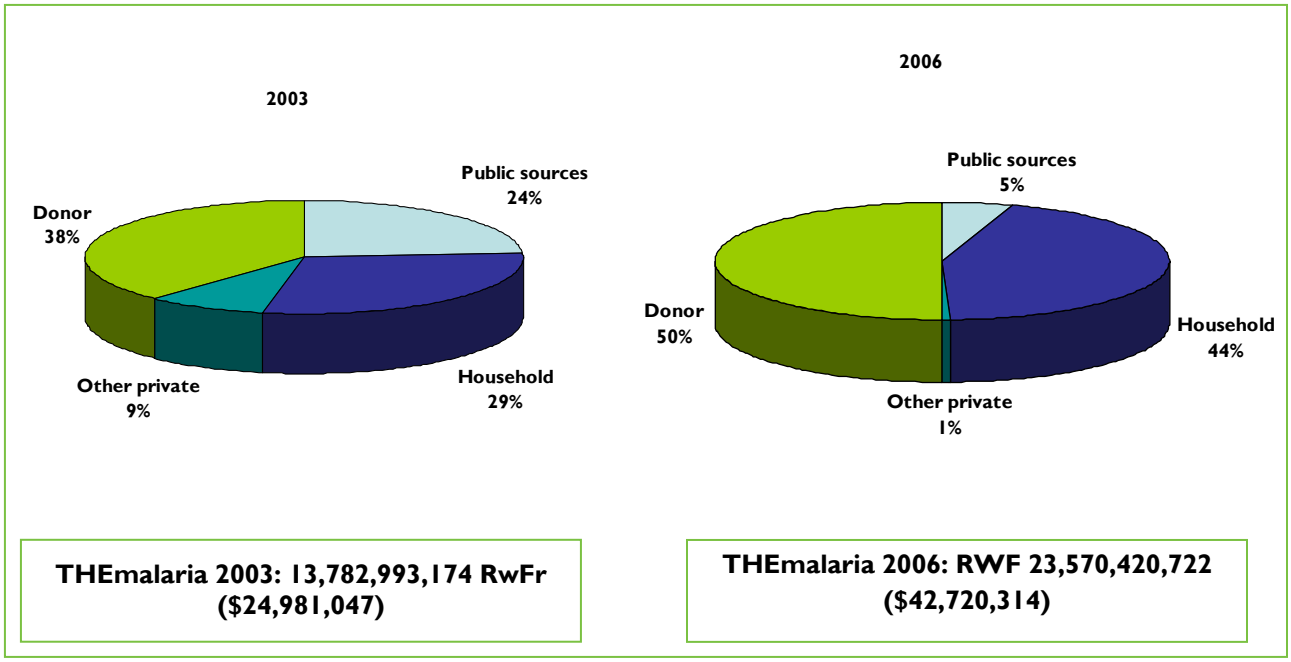



Table 4.1 compares absolute spending on malaria by financing source across years. In 2006, public sources contributes less than half of what they did in 2003. Household contributions almost tripled, while donor contributions doubled.

**TABLE 4.1: ABSOLUTE VALUES OF FINANCING SOURCE CONTRIBUTIONS TO MALARIA SERVICES, 2003 AND 2006**

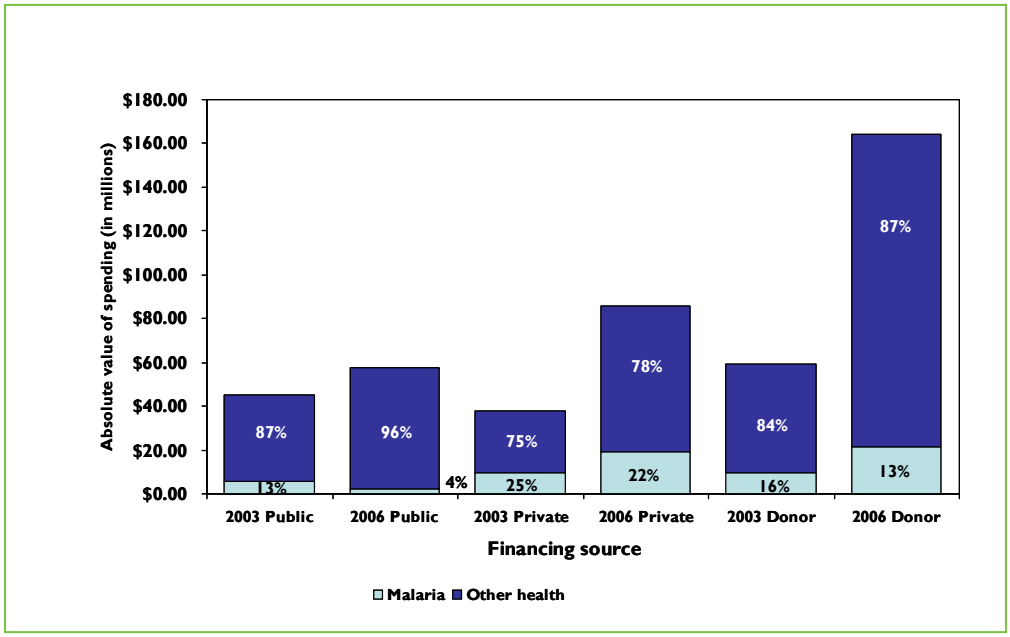
| Financing source | 2003* | | 2006 | | Magnitude of increase from 2003 |
|---|---|---|---|---|---|
| | RWF | US$ | RWF | US$ | |
| Public (incl parastatals) | 3,269,757,737 | 5,926,287 | 1,187,280,318 | 2,151,892 | 0.4 |
| Households | 3,991,014,186 | 7,233,531 | 10,461,212,952 | 18,960,472 | 2.6 |
| Other private | 1,066,100,339 | 1,932,258 | 154,808,934 | 280,584 | 0.1 |
| Donor | 5,285,272,943 | 9,579,317 | 11,767,118,518 | 21,327,366 | 2.2 |
| Other | 170,847,970 | 309,654 | 0 | 0 | 0.0 |

* Reported in constant 2006 currency to facilitate comparisons across years

Household contributions likely increased so greatly for reasons similar to the increased OOP spending on general health: much of the increase in total health spending was targeted on HIV/AIDS; GDP increased and may have provided people with more disposable income, leading to increased utilization of health services; in-kind contributions for traditional healers was well documented in 2006; etc.

As Figure 4.3 shows, in 2006, private contributions to malaria rank highest among private source contributions to health (22 percent). Donors spend 13 percent of their health funds on malaria; HIV/AIDS gets three times more (42 percent) of their spending. Public sources contribute approximately 4 percent of their resources to malaria, similar to other priority areas. Private sources contribute more funds in absolute terms, but less than in 2003 relative to general health.

**FIGURE 4.3: SHARE OF FINANCING SOURCES' HEALTH RESOURCES GOING TO MALARIA SERVICES, 2003 AND 2006**

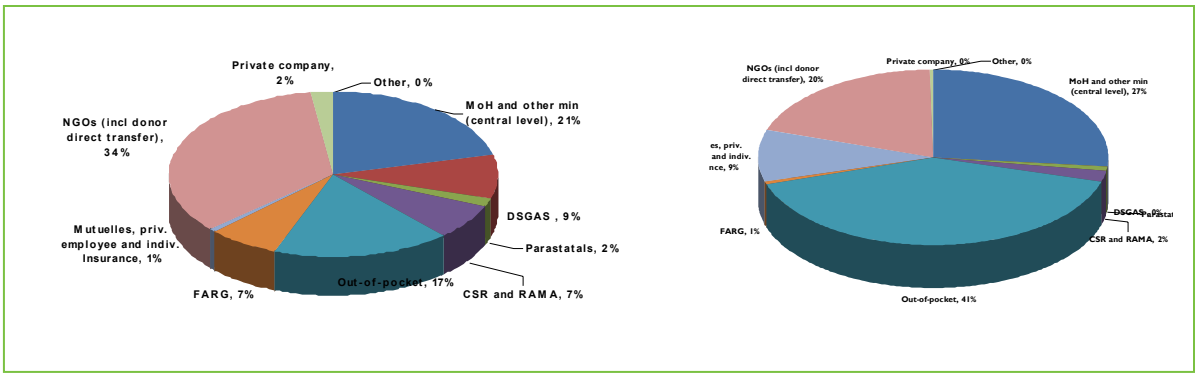



* Reported in constant 2006 currency to facilitate comparisons across years

## 4.4 FINANCING AGENTS: MANAGERS AND IMPLEMENTERS OF MALARIA HEALTH FUNDS

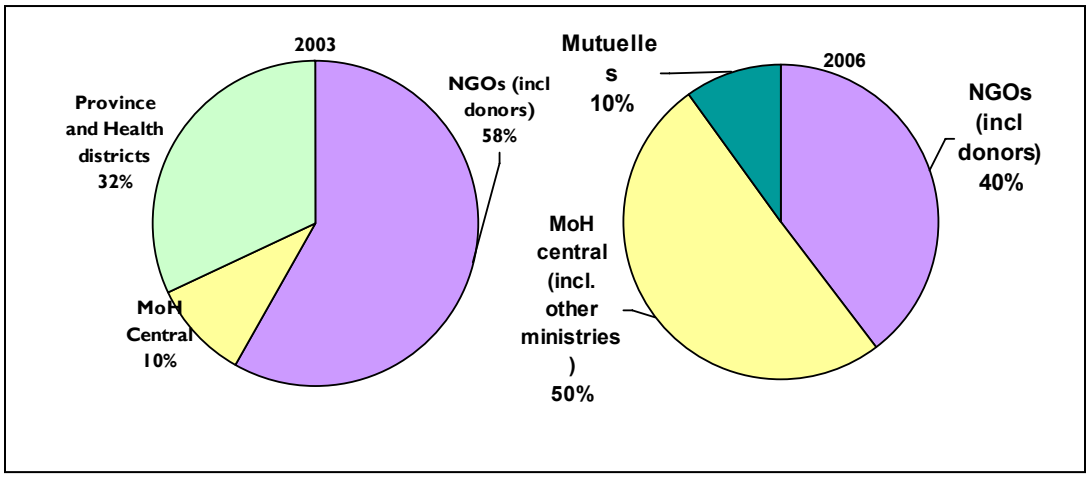
In 2006, 59 percent of financing agents were private, with household OOP spending managing up to 41 percent of funds, followed by public (39 percent), and the rest of the world (2 percent) (Figure 4.4). This represents a shift in the financial management of malaria. The GoR is managing more funds than it did in 2003 (from RWF 1.5 billion [US$ 2.8 million] in 2003 to RWF 6 billion [US$ 11 million] in 2006). NGOs and donors managed RWF 3.6 billion (US$ 6.5 million) in 2003 and RWF 4.7 billion (US$ 8.4 million) in 2006. The increased public management and resource allocation has taken the form of procurement and distribution of LLINs, distribution of free nets at health facilities for infants participating in measles vaccination campaigns and pregnant women seeking antenatal, etc. For a detailed look at the flow of funds and malaria commodities through the health system in 2006, please see Annex C.

**FIGURE 4.4: MANAGERS OF MALARIA FUNDS IN RWANDA, 2003 AND 2006**




In 2003, NGOs and donors managed the largest share of malaria funds, followed by the MoH and the Department of Health, Gender and Social Affairs (DSGAS).[18] In 2006, households manage the largest share, followed by the government and then NGOs.

**FIGURE 4.5: FINANCING AGENTS OF DONOR MALARIA FUNDS, 2003 AND 2006**




[18] DSGAS (provincial level) no longer exists; it was an agency of the health system, which was revamped in 2005.

The MoH manages a larger percentage and absolute value of donor malaria funds in 2006 than it did in 2003 (RWF 546 million [US$ 990 thousand] in 2003 compared with RWF 5.9 billion [US$ 10.8 million] in 2006) (Figure 4.5). In 2003, 58 percent of donor funding for malaria was channeled through NGOs, with only 10 percent handled by the MoH and 32 percent by province and health districts (presumably through NGO projects). In 2006, the MoH and other ministries handle 50 percent of donor malaria funds. NGOs handle 40 percent of these funds (18 percent less than in 2003).

The shift to increased GoR management of these donor funds through the MoH shows that the government is more aware of the ongoing interventions and donor monies are increasingly coordinated with the government's strategic plan for battling malaria. This is in part due to the 2003 malaria subaccount findings that showed that the government was managing a small percentage of malaria resources.

## 4.5 HOUSEHOLD OOP SPENDING

Table 4.2 shows amounts of OOP spending on malaria in 2003 and 2006.

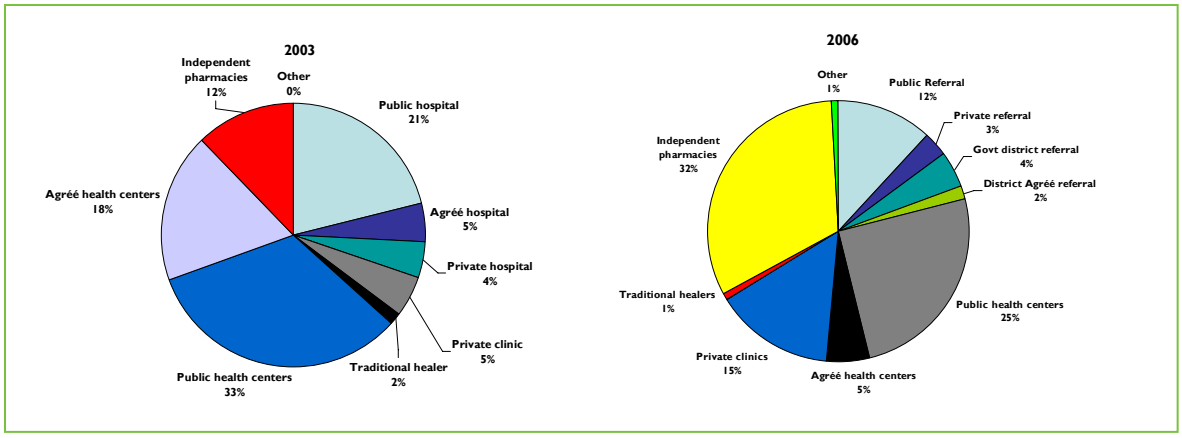
**TABLE 4.2: HOUSEHOLDS AS FINANCING AGENTS: OOP SPENDING ON MALARIA SERVICES, 2003 AND 2006**

| | 2003* | 2006 |
|---|---|---|
| Malaria OOP expenditure | RWF 3,748,897,207<br>US$ 6,794,681 | RWF 9,568,284,436<br>US$ 17,342,017 |
| Malaria OOP per capita | RWF 447<br>US$ 0.81 | RWF 1,056<br>US$ 1.91 |
| Malaria HH as a percentage of general HH | 26% | 24% |

* Reported in constant 2006 currency to facilitate comparisons across years

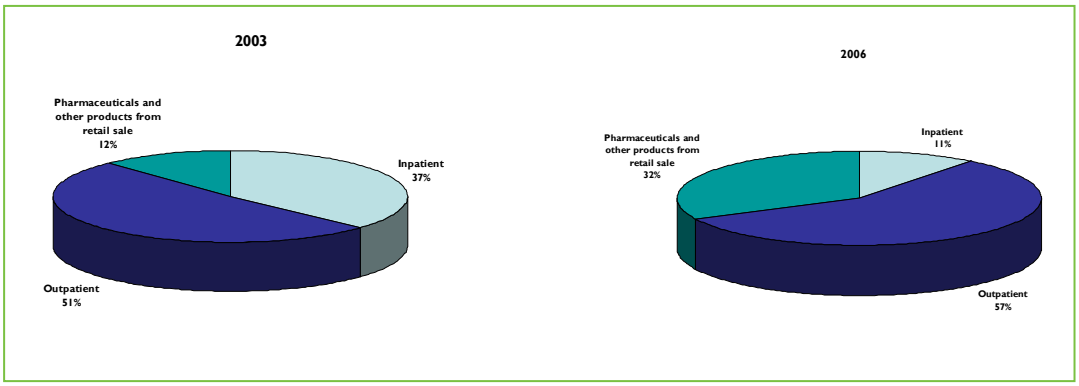
In 2006, public hospitals and health centers consume a combined 41 percent of total household OOP spending on malaria (Figure 4.6). Independent pharmacies consume 32 percent followed by private hospitals and clinics at 18 percent. Spending at independent pharmacies grew in both absolute and relative terms (12 percent to 32 percent in 2006). *Agréé* hospitals and health centers consumed 23 percent of OOP health funds in 2003 and 7 percent in 2006, representing less in both relative and absolute terms. Spending at traditional healers increased slightly.

**FIGURE 4.6: PROVIDERS CONSUMING HOUSEHOLD OOP MALARIA FUNDS, 2003 AND 2006**




Outpatient care receives the largest allocation of malaria OOP spending in 2006, followed by pharmaceuticals and inpatient care (Figure 4.7). In 2003, inpatient care consumed more spending, in absolute and relative terms. OOP spending on pharmaceuticals increased between 2003 and 2006.

**FIGURE 4.7: SERVICES BOUGHT WITH HOUSEHOLD OOP SPENDING, 2003 AND 2006**

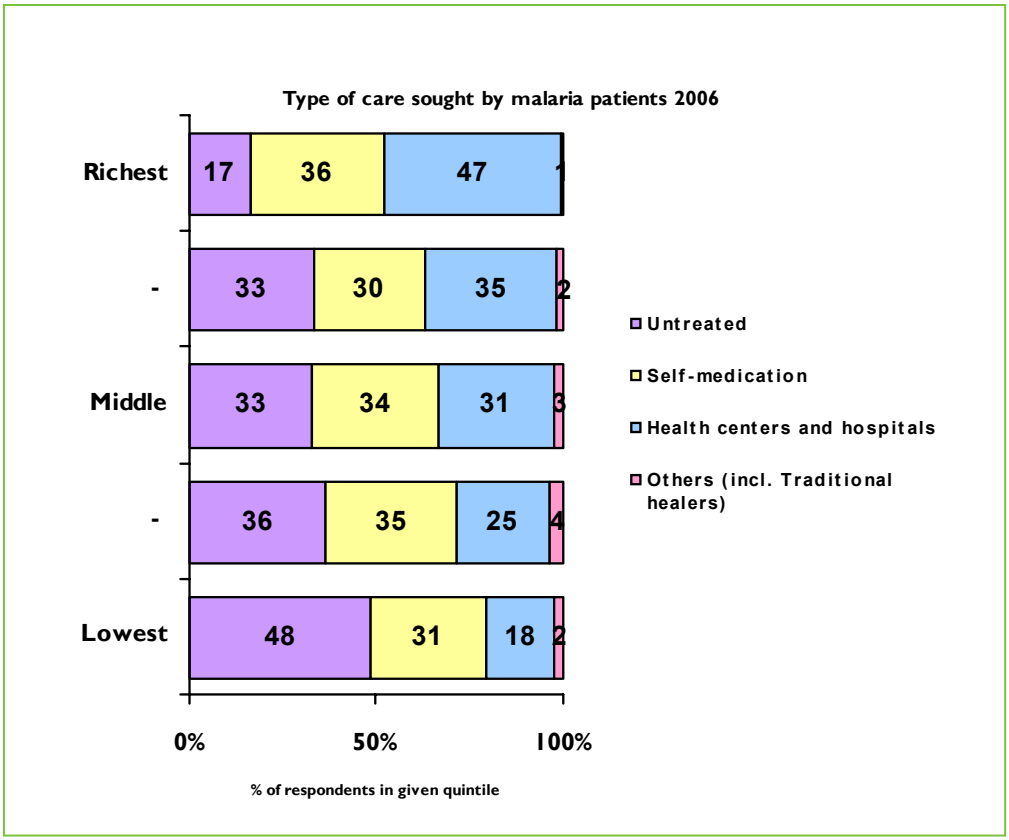



## 4.6 INCOME INEQUALITIES ON HEALTH CARE-SEEKING BEHAVIOR BY HOUSEHOLDS

This section describes a special analysis done regarding the health-seeking behavior of malaria patients. See Annex C for the methodology of this special analysis.

Rwandans in the lower-income quintiles are likely to go untreated for malaria (Figure 4.8). About a third of those afflicted self-medicate for malaria regardless of income. The richest are most likely to seek care at health facilities and least likely to use traditional healers.

**FIGURE 4.8: INCOME DETERMINANTS OF MALARIA CARE-SEEKING BEHAVIOR, 2006**

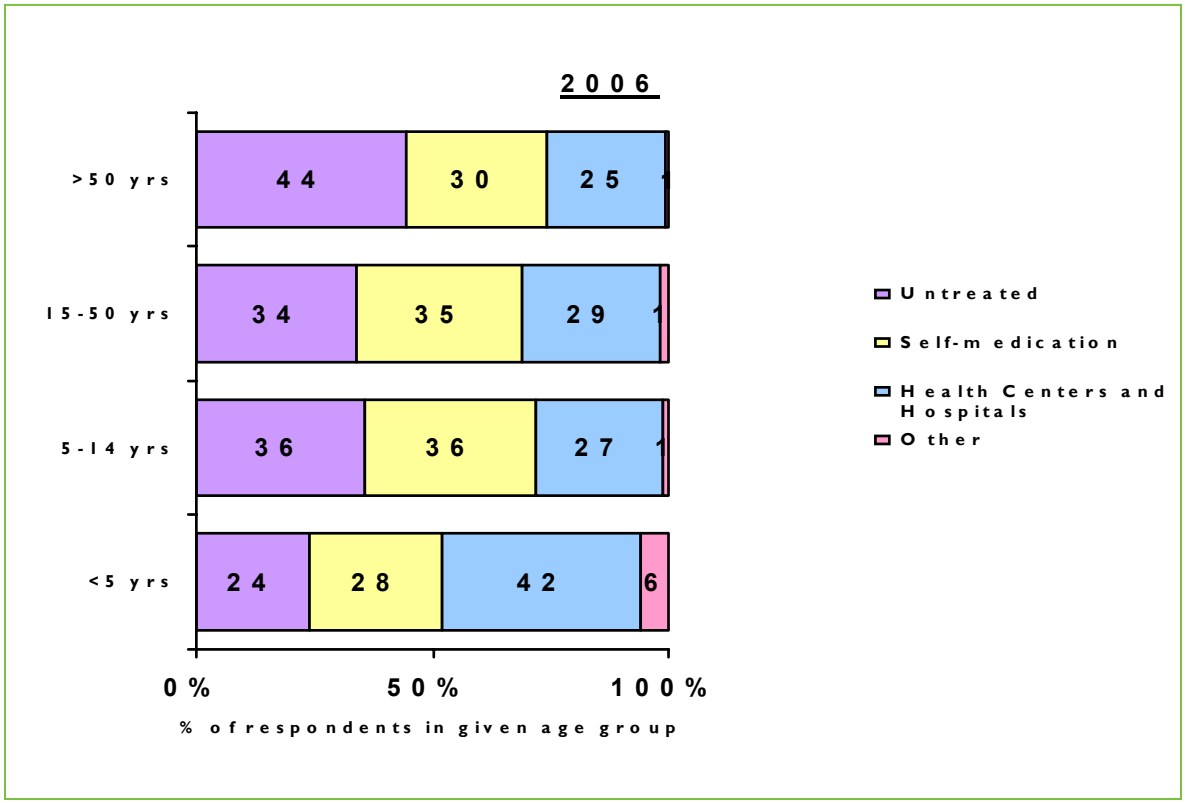



*Source* 2006 data: EICV data (2000 HH)

*Note*: Some patients classified as untreated may have received treatment before the 14-day recall period. See Annex C for further explanation of EICV2 data and the NHA team's analysis.

Children under five are the most likely age group to be treated at health facilities and the least likely to go untreated or be self-medicated (Figure 4.9). People over 50 are the most likely to go untreated for malaria.

**FIGURE 4.9: AGE DETERMINES TYPE OF MALARIA CARE SOUGHT**

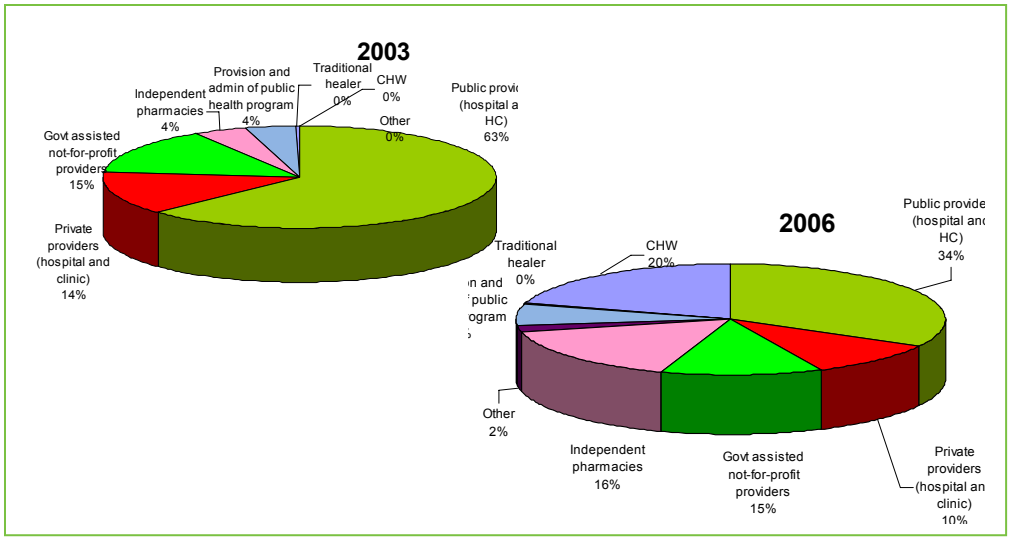



## 4.7 PROVIDERS OF MALARIA HEALTH SERVICES IN RWANDA

In 2006, public and agréé providers account for half of all spending due to a growth in numbers of CHWs and independent pharmacies (Figure 4.10). In 2006, CHWs are providing much of the MoH-funded malaria services, primarily bednet distribution. Independent pharmacies consume 16 percent of total malaria spending.

In contrast, in 2003 public and agréé providers counted for three-quarters of spending, due to the lack of CHWs at that time.

**FIGURE 4.10: DISTRIBUTION OF PROVIDERS OF MALARIA SERVICES AND COMMODITIES, 2003 AND 2006**




## 4.8 HEALTH FUNCTIONS: MALARIA HEALTH SERVICES CONSUMED IN RWANDA

Figure 4.11 shows that, in 2006, 76.8 percent of $THE_{malaria}$ is spent on inpatient and outpatient curative malaria services. Drugs and other nondurables account for to 16.1 percent.

**FIGURE 4.11: WHAT DO HEALTH FUNDS BUY?**

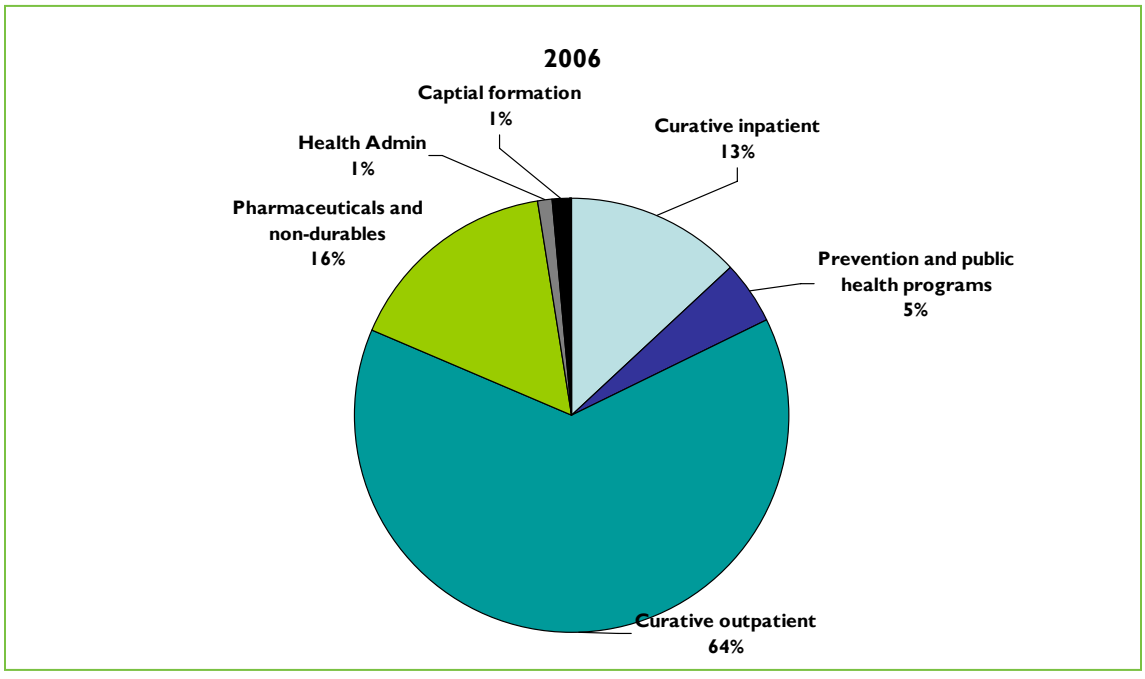
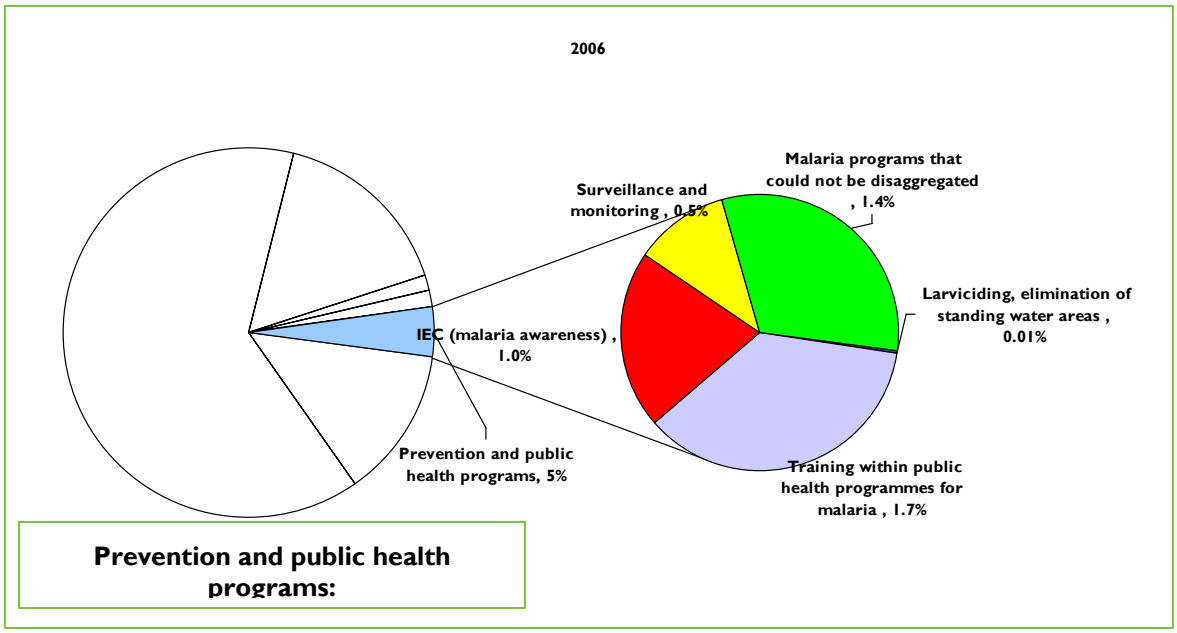


Figure 4.12 breaks down spending on malaria prevention and public health programs. Training programs consume the largest share (1.7 percent of $THE_{malaria}$), followed by IEC, surveillance and monitoring, and larviciding.

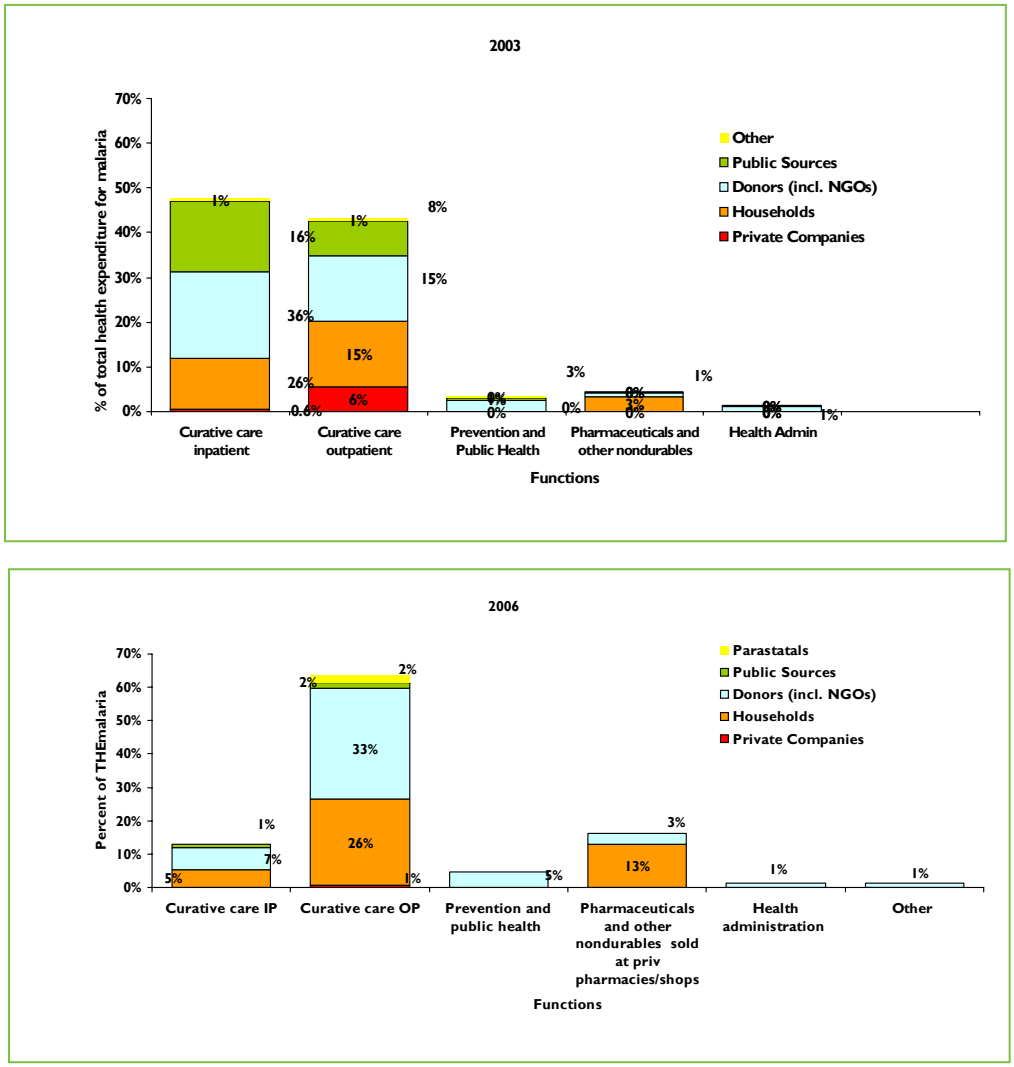
**FIGURE 4.12: BREAKDOWN OF 2006 PREVENTION AND PUBLIC HEALTH PROGRAMS**




## 4.9 WHO FINANCES WHAT HEALTH FUNCTIONS?

Figure 4.13 shows the malaria-related health care functions on which financing sources spent their resources in 2003 and 2006. The findings reveal slight shifts from 2003.

**FIGURE 4.13: FINANCING SOURCES OF MALARIA HEALTH CARE FUNCTIONS, 2003 AND 2006**




In 2006, 16 percent of $THE_{malaria}$ goes to pharmaceuticals and nondurables sold at private shops and pharmacies. About 76 percent of $THE_{malaria}$ is spent on inpatient and outpatient curative services. Inpatient care consumes 13 percent, outpatient care 64 percent.) This level of spending on curative care is a relative decrease overall from 2003, when spending on inpatient and outpatient curative care totaled 86 percent, but the share of spending on outpatient care rose significantly relative to the other functions. It should be noted, however, that $THE_{malaria}$ increased in real terms: actual spending on curative care increased from RWF 14,392,433,912 (US$ 26,085,536) in 2003 to RWF 18,101,913,306 ($ 32,808,775) in 2006, in constant 2006 dollars.

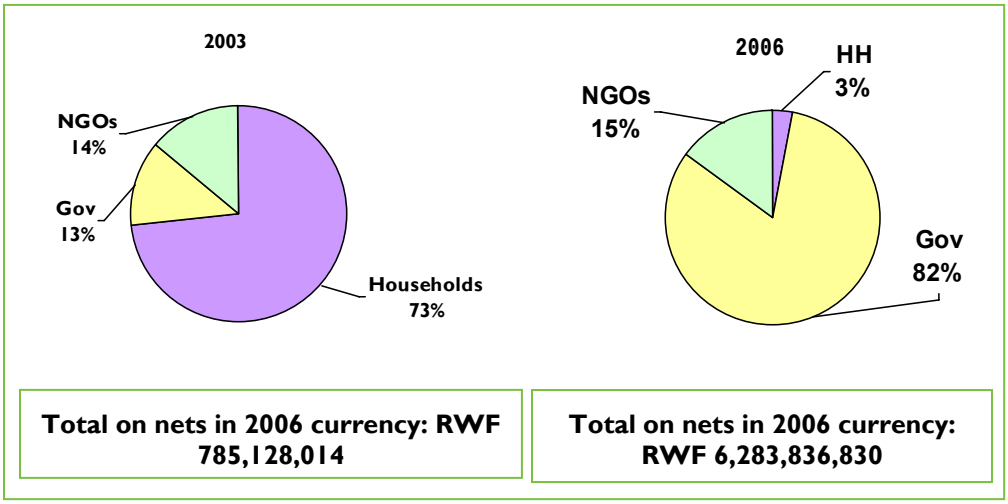
Most of the increased spending on drugs and other nondurables (from 4 percent to 16 percent) was financed by households. The percentage of $THE_{malaria}$ for prevention and public health programs remained relatively constant and was financed almost entirely by donors.

In 2006, donors still finance the largest portion of curative care (40 percent), followed by households (31 percent). Households have increased spending at private pharmacies and shops and spend more than the government on curative care.

## 4.10 ADDITIONAL ANALYSIS ON MALARIA PREVENTIVE COMMODITIES

The GoR was a strong advocate of prevention interventions in 2006, and the NHA findings reveal that in effect there has been a tenfold increase in spending on LLINs. Household spending on LLINs decreased from 73 percent in 2003 to 3 percent in 2006, while the contribution of government (largely through use of donor funds) increased from 13 to 82 percent.

**FIGURE 4.14: PAYERS (FINANCING AGENTS) OF PREVENTIVE COMMODITIES FOR MALARIA, 2003 AND 2006**




## 4.11 SUMMARY

- **Malaria spending has doubled since 2003.** Malaria expenditures decreased relative to other health priorities from 2003 to 2006, but in absolute terms, malaria spending has doubled since 2003, from RWF 13.8 billion (US$ 25 million) to RWF 23.6 (US$ 42.7 million). However, it should be noted that only 35 percent of this is specifically targeted for malaria.

- **Relative financial priority of malaria has decreased for public sources but remains the same for donors and private sources.** In 2003, 13 percent of public health funds went to malaria versus 3.7 percent in 2006. In 2003, 16 percent of all donor health funds went to malaria versus 13 percent in 2006. In 2003, 26 percent of all private health funds (mainly households) went to malaria versus 22 percent in 2006.

- **Donor and household shares of all malaria funds contribute substantially more than public malaria funds.** In 2006, households contribute RWF 10.5 billion (US$ 19 million) and donors contribute RWF 11.8 billion (US$ 21.3). Public sources contribute RWF 1.2 billion (US$ 2.2 million). In 2003, NGOs and donors managed the largest share of malaria funds. By 2006, this had shifted; malaria spending is managed mostly by households through OOP spending (41 percent), followed by the government (27 percent) and NGOs (20 percent). This in particular illustrates the increase in MoH programmatic management of health funds.

- **There has been an increase in spending on public health and prevention programs, (largely by donors); however, a large portion of malaria resources are spent on curative care.** In 2003, RWF 6.6 billion (US$ 11.9 million) was spent on inpatient curative care and RWF 6 billion (US$ 10.8 million) was spent on outpatient curative care. In 2006, RWF 3.1 billion (US$ 5.6 million) was spent on inpatient curative care and RWF 15 billion (US$ 27.2 million) was spent on outpatient curative care.

- **LLINs are subsidized substantially by the government, decreasing the burden on households.**

- **CHWs now consume a larger share of malaria resources, reflective of their role in providing home-based malaria care and LLIN distribution.**

# 5. REPRODUCTIVE HEALTH SUBACCOUNTS

## 5.1 INTRODUCTION

RH is a critical issue in Rwanda. The country has one of the highest maternal mortality ratios in East and Southern Africa (Table 5.0), one of lowest rates of contraceptive prevalence in the region, and a relatively high number of births per woman of reproductive age.

This poor RH status of Rwandans has grave implications for the country's development. Evidence from the EICV2 confirms that the high population growth rate, fertility rate, and population density have constrained economic development. Acknowledging that improving the health status of women should be a key element of any development strategy, the GoR has placed it at the forefront of the national agenda.[19]

Investments in women yield strong benefits to the family as a whole; a woman's death during childbirth often means death for the newborn, and both death and disability translate into emotional, social, and economic hardships for her children, extended family, and even the community at large. Ensuring access to quality RH care can reduce maternal morbidity and mortality.

**TABLE 5.0: RWANDA RH INDICATORS, 2006**

| Table 5.0: Rwanda RH Indicators (2006) | |
|---|---|
| Number of women of reproductive age | 2,291,233 |
| Population growth rate | 2.6% |
| **Sexual and RH Indicators** | |
| Maternal mortality ratio (per 100,000 live births) | 750 |
| Fertility Indicators | |
| Total fertility rate (# of children/ woman in reproductive years) | 6.1 |
| **Family Planning Indicators** (DHS 2005) | |
| % of women in union using traditional contraceptive method | 18% |
| % of women in union using periodic abstinence | 7% |
| % of all women 15-49 using any modern contraceptive method | 6% |
| Total contraceptive commodity rate | 10% |
| **Deliveries** (DHS 2005) | |
| % of women with access to antenatal care | 94% |
| % of births taking place at home | 70% |
| % of births attended by health professional | 39% |
| % of births followed by at least one postnatal visit (doesn't include deliveries in facilities, which are assumed to include postnatal evaluation) | 33% |

[19] This decision was in part informed by the preliminary 2006 NHA subaccount findings.

The national health strategy (HSSP) outlined the following strategies to improve the RH status of women and to reduce the population growth rate:

- Increase contraceptive utilization through;
    - Sensitization to increase public demand and utilisation of contraceptives
    - Ensured availability of contraceptives through improved distribution

In order to achieve such goals, the government has outlined specific actions:

- Implement incentives to improve use of health services among women
- Ensure access to pharmaceuticals (offer subsidies for RH-related drugs)
- Decentralize primary care, including RH services
- Train health workers to deliver RH services
- Develop community-based interventions and train CHWs
- Design and implement performance-based payment contracting schemes for high-impact services, including deliveries.

Similar to the last RH subaccounts (2002), the 2006 subaccounts created four core tables for RH expenditures, on services and products whose primary purpose was to

- Limit and space births
- Support and promote the limiting/spacing of births and maternal health through training and IEC campaigns
- Deliver healthy babies, followed by postnatal care.

It should be noted that the subaccounts did not track expenditures on general gynecological care, largely because this is extremely difficult to estimate due to current record-keeping practices, and the paucity of fertility counseling services in the country.

Expenditures on social marketing or general provision of condoms were included in RH spending if condoms were used primarily for family planning purposes, and not primarily for preventing the spread of HIV/AIDS.

## 5.2 TOTAL RESOURCE ENVELOPE FOR RH HEALTH CARE

Total RH expenditure in 2006 was RWF 10,561,325,959 (US$ 19,141,922), 6.2 percent of $THE_{general}$ and 0.7 percent of the GDP (Table 5.1, Figure 5.0). While there was a 1.5-fold increase in absolute RH expenditure between 2002 and 2006, RH spending fell relative to other health services. Total RH expenditure in 2002 was RWF 6,982,368,741 (US$ 12,655,179) in constant 2006 dollars, or 16 percent of 2002 $THE_{general}$ (Figure 5.1).

RH spending is targeted to 25 percent of the population, principally (but not exclusively) women of reproductive age. Spending equated to RWF 3,378 (US$ 6.12) per woman of reproductive age in 2002 and to RWF 4,609 (US$ 8.40) per woman of reproductive age in 2006.

**TABLE 5.1: SUMMARY OF RH SUBACCOUNTS FINDINGS, 2002 AND 2006**

| Indicators | 2002* | 2006 |
|---|---|---|
| Total RH (THErh) expenditures | RWF 6,982,368,741 (US $12,655,180) | RWF 10,561,325,959 (US $19,141,922) |
| RH expenditures per woman of reproductive age | RWF 3,378 (US $6) | RWF 4,609 (US $8) |
| RH expenditures as a % of GDP | 0.6% | 0.7% |
| RH expenditures as a % of total of overall health spending | 15.67% | 6.23% |
| OOP spending per woman of reproductive age | RWF 339 (US$0.61) | RWF 431.38 (US$0.78) |
| % of RH spending that is targeted for RH | | 40% |
| THE as percent of total RH spending on health and non-health | 99.7% | 98.4% |
| Financing Sources of RH spending | | |
| Public | 7.7% | 14.4% |
| Private | 12.4% | 14.3% |
| *Households account for* | 10.6% | 13.2% |
| Donor | 79.8% | 71.2% |
| Financing agents of RH spending | | |
| Public | 52% | 35% |
| Private | 12% | 10% |
| *Household OOP accounts for* | 10% | 9% |
| Donor | 36% | 55% |
| Providers of RH care and activities | | |
| Public providers | 9% | 53% |
| -Public hospitals | 4.3% | 45% |
| -Public health centers | 4.3% | 8% |
| Private providers | 9% | 12% |
| -Private for-profit hospitals | 4% | 6% |
| -Private for-profit health centers/clinics | 5% | 6% |
| Government assisted not-for-profit providers (*Agréés*) | | 13% |
| -*Agréé* hospitals | | 6.3% |
| -*Agréé* health centers | | 6.2% |
| Independent pharmacies | 3% | 4% |
| Provision and administration of public health programs | 72% | 12% |
| Community health workers | | 5% |
| Other | 8% | 2% |
| RH health spending by function | | |
| Prevention and public health programs | 66% | 12% |
| Curative care | 18% | 83% |
| -Inpatient | 7% | 50.6% |
| -Outpatient | 11% | 32.8% |
| Administration | 7% | 0% |
| Capital formation | 0% | 1% |
| Pharmaceuticals and other non-durables from independent pharmacies | 3% | 4% |
| Other | 6% | |

* All US$ amounts for 2002 are in constant 2006 US$ to facilitate comparison across years. The CPI was used for the conversion (74.71 for 2002). Source for CPI data: NISR (http://www.statistics.gov.rw).

**FIGURE 5.0: MALARIA, HIV/AIDS, AND RH IN THE CONTEXT OF GENERAL HEALTH EXPENDITURES, 2006**

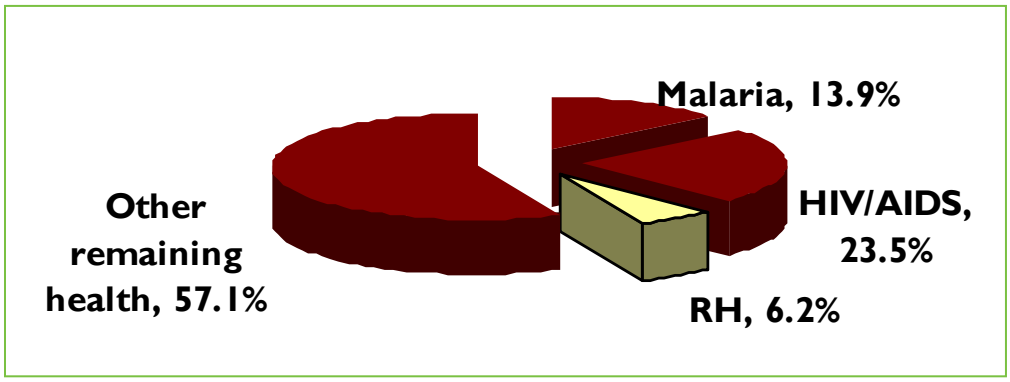
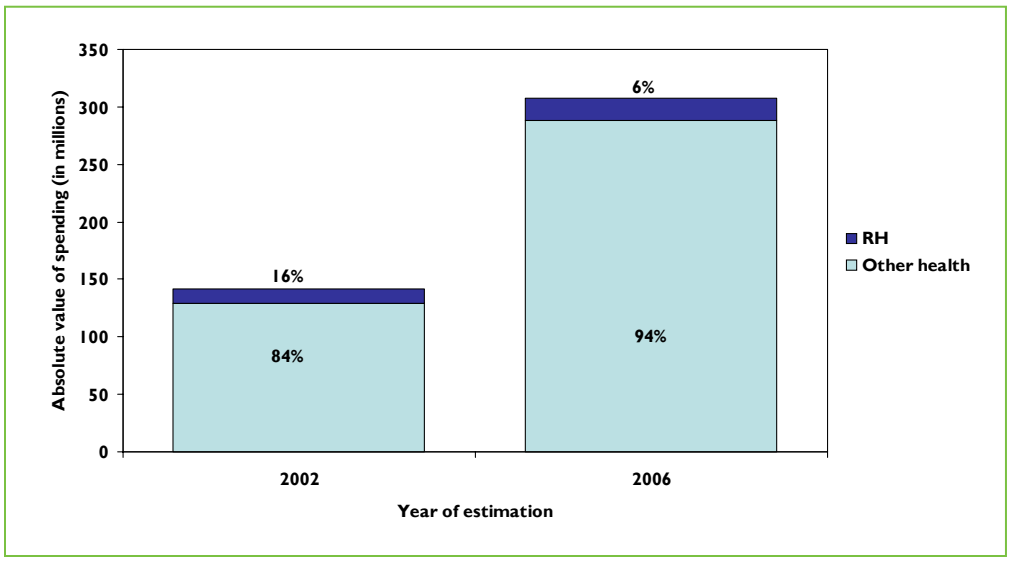



**FIGURE 5.1: RH AND GENERAL HEALTH SPENDING, 2002 AND 2006**

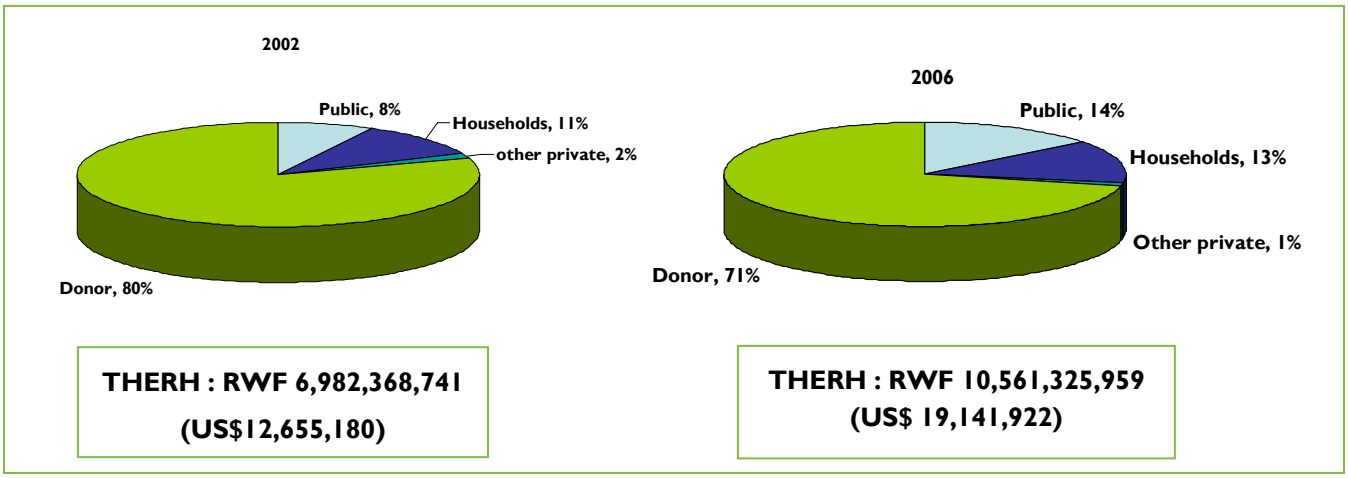



* Reported in constant 2006 currency to facilitate comparisons across years

## 5.3 FINANCING SOURCES OF RH FUNDING

$THE_{RH}$ has slightly increased since 2002. Public sources have increased their contribution to $THE_{RH}$, from 8 percent to 14 percent (Figure 5.2); however, donors were the major contributor in both years (80 percent and 71 percent, respectively).

**FIGURE 5.2: FINANCING SOURCES OF RH AS A PROPORTION OF RH EXPENDITURES, 2002 AND 2006**




In absolute terms, household spending on RH health has doubled since 2002, and public spending has tripled (Table 5.2). Donor spending has stayed relatively the same.

**TABLE 5.2: ABSOLUTE VALUES OF FINANCING SOURCES' CONTRIBUTIONS TO RH SERVICES, 2002 AND 2006**

| Financing source | 2002* | | 2006 | | Magnitude of increase from 2002 |
|---|---|---|---|---|---|
| | RWF | US$ | RWF | US$ | |
| Public (incl parastatals) | 538,343,178 | 975,719 | 1,525,779,422 | 2,765,396 | 2.8 |
| Households | 742,259,301 | 1,345,306 | 1,390,099,133 | 2,519,482 | 1.9 |
| Other private | 127,171,924 | 230,492 | 77,054,441 | 139,657 | 0.6 |
| Donor | 5,571,021,853 | 10,097,187 | 7,524,476,170 | 13,637,721 | 1.3 |
| Other | 3,572,483 | 6,475 | 0 | 0 | - |

* Reported in constant 2006 currency to facilitate comparisons across years

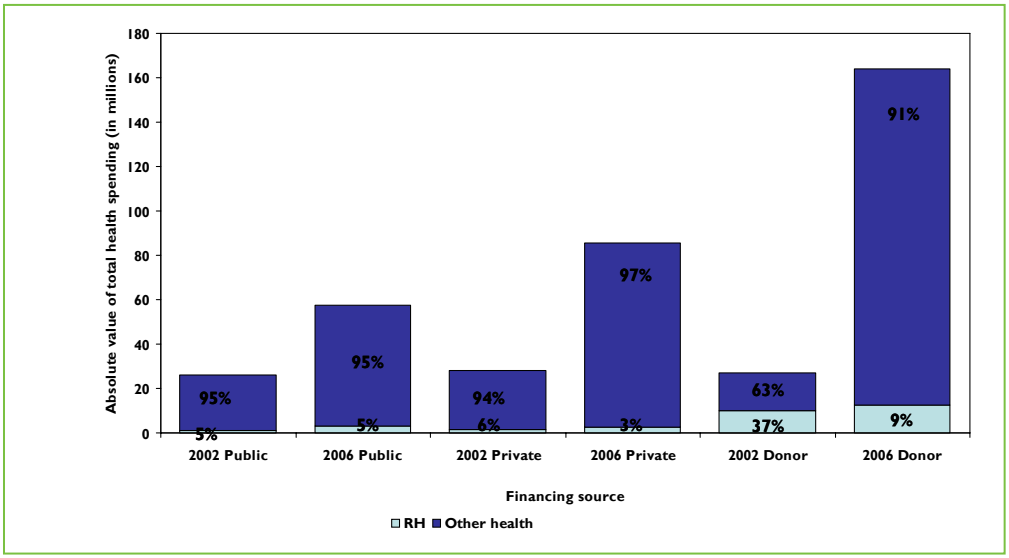
## 5.4 FINANCING SOURCE CONTRIBUTION IN THE CONTEXT OF GENERAL HEALTH

When looked at by sector (public, private, and donor), absolute spending on RH has not increased dramatically from any single financing source. As already noted, donors remain the largest financiers of RH services in the country.

As Figure 5.3 shows, donor RH allocations as a percentage of $THE_{general}$ have decreased (in constant terms) from 37 percent to 9 percent. This is largely due to the denominator increments through HIV

and AIDS funds. Also in relative terms, public spending has remained constant (5 percent) as a proportion of $THE_{general}$.

**FIGURE 5.3: SHARE OF FINANCING SOURCES' HEALTH RESOURCES GOING TO RH, 2002 AND 2006**

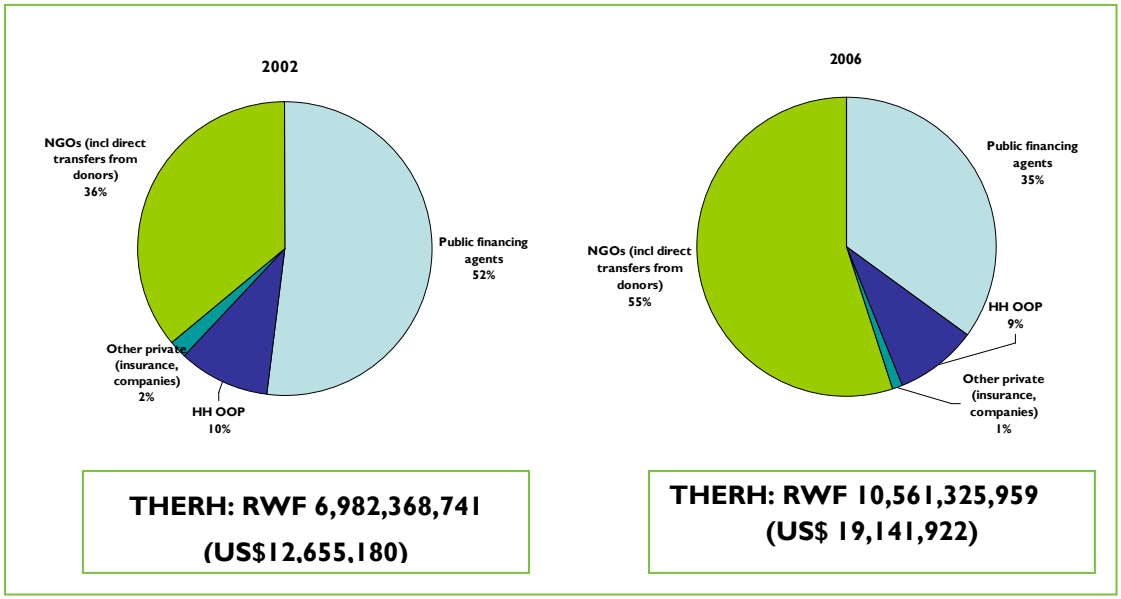



* Reported in constant 2006 currency to facilitate comparisons across years

## 5.5 FINANCING AGENTS: MANAGERS AND IMPLEMENTERS OF RH FUNDS

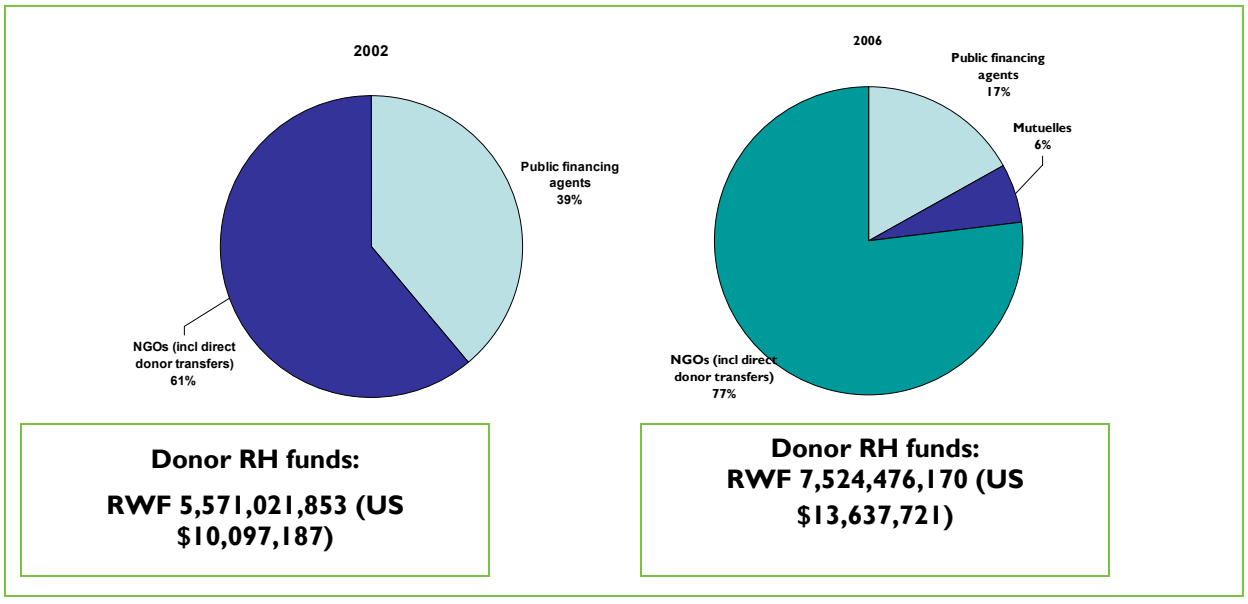
Figure 5.4 shows the percentage of funds that are managed by various financing agents. More than half (55 percent) of all RH funds were channeled through implementing NGOs in 2006, followed by public financing agents (35 percent) and household OOP payments (9 percent). (Mutuelles are included under public financing agents in 2006.) This represents a shift away from public financing agents like the MoH, which managed 52 percent of RH funds in 2002, and contrasts with the other priority areas (HIV and malaria), for which the government is managing more of the resource envelopes.

**FIGURE 5.4: MANAGERS OF RH FUNDS IN RWANDA, 2002 AND 2006**




Donors, which finance 71.2 percent of RH spending, transfer 17 percent of their RH funds to government entities, 6 percent to mutuelles (untargeted spending), and the remaining 77 percent to implementing agencies/NGOs (Figure 5.5). Households, whose share of RH spending was 13.3 percent, contributed 71 percent of their RH funds through direct OOP payments. Central government revenue, making up 14.4 percent of total RH funds, was channeled largely to the MoH (71 percent) and the remainder to other financing agents.

**FIGURE 5.5: MANAGERS OF DONOR RH FUNDS IN RWANDA, 2002 AND 2006**



## 5.6 HOUSEHOLD OOP SPENDING

OOP spending, as well as OOP spending per woman of reproductive age, is slightly higher in 2006 than in 2002 (Table 5.3). RH OOP spending as a percentage of general OOP spending halved as a result of the large increase in general OOP spending.

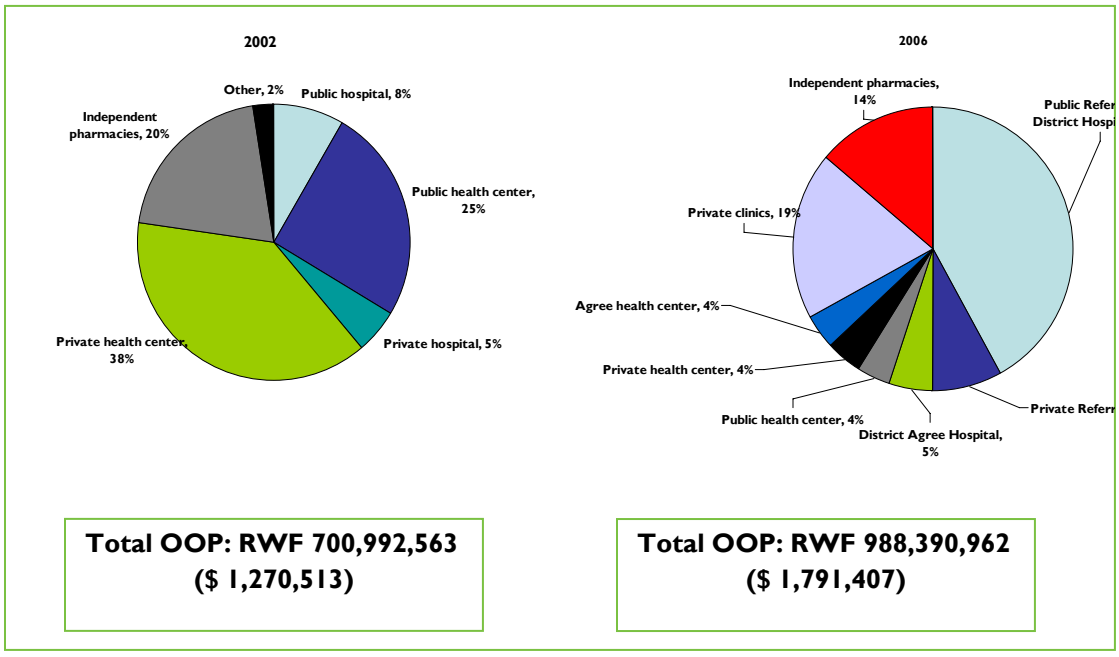
**TABLE 5.3: HOUSEHOLD OOP SPENDING, 2002 AND 2006**

| | Rwanda 2002* | Rwanda 2006 |
|---|---|---|
| RH OOP expenditure | RWF 700,992,563 (US$ 1,270,512) | RWF 988,390,962 (US$ 1,791,407) |
| RH OOP per woman of reproductive age | RWF 339 (US$0.61) | RWF 431.38 (US$0.78) |
| RH OOP as a percentage of general OOP | 6% | 3% |

* Reported in constant 2006 currency to facilitate comparisons across years

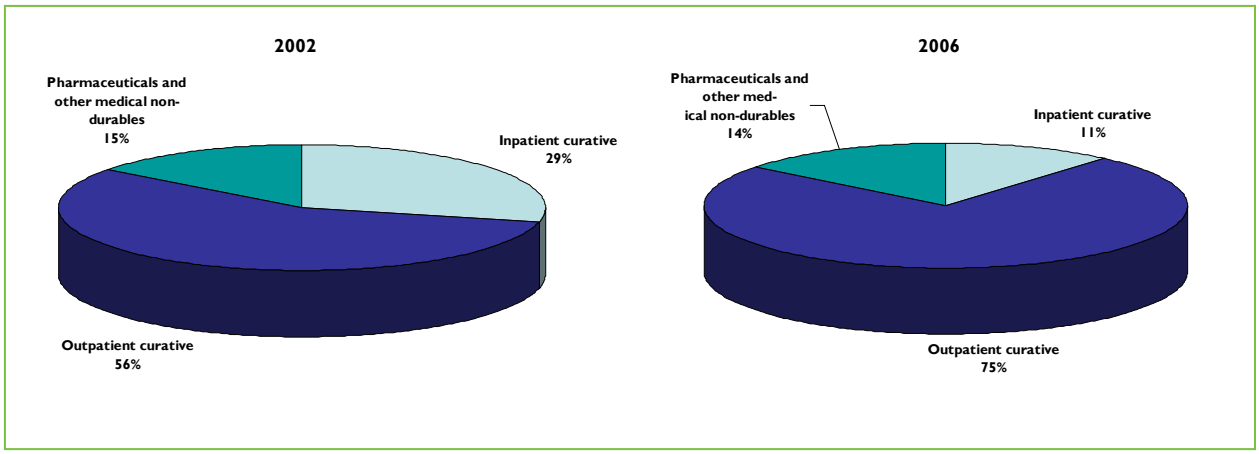
In 2006, households are spending less out of pocket at independent pharmacies for RH (14 percent, in contrast to 20 percent in 2002) (Figure 5.6). Family planning commodities were widely distributed through facilities and NGOs in 2006, which likely explains this trend.

**FIGURE 5.6: RH OOP SPENDING BY PROVIDER, 2002 AND 2006**



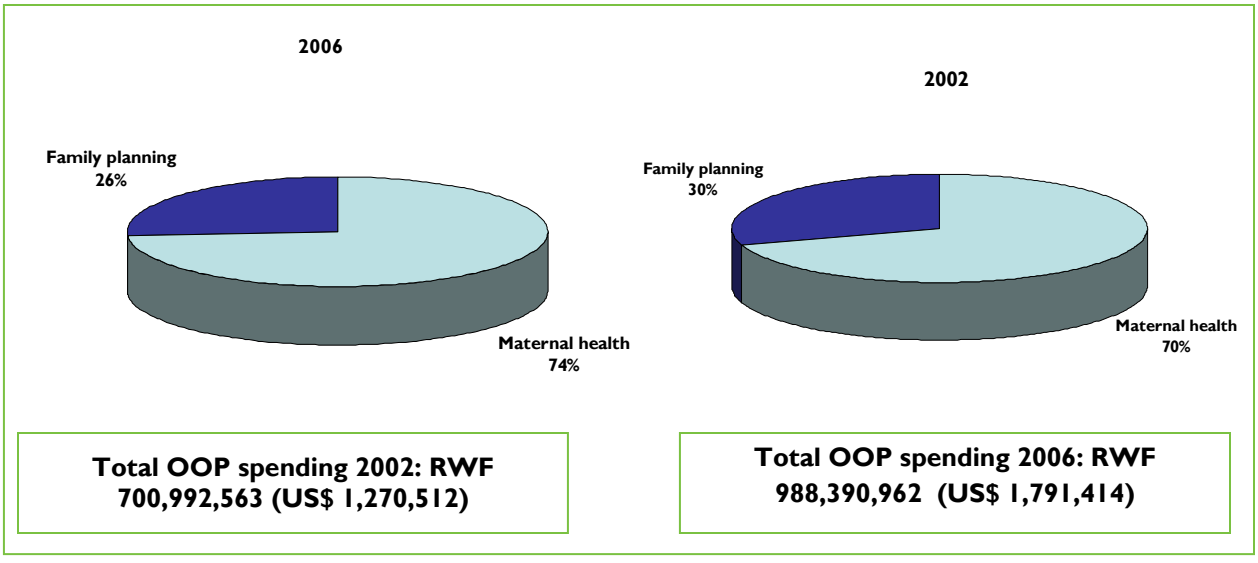

In 2006, 75 percent of household OOP spending on RH goes to outpatient curative care, followed by pharmaceuticals (mostly contraceptives) at 14 percent and inpatient curative care at 11 percent (Figure 5.7). In 2002, 56 percent went to outpatient curative care, 29 percent to inpatient curative care, and 15 percent to pharmaceuticals.

**FIGURE 5.7: SERVICES BOUGHT WITH HOUSEHOLD OOP SPENDING, 2002 AND 2006**




Between 2002 and 2006, households increased their spending on maternal health and decreased spending on family planning (Figure 5.8). This could be explained by the fact that donors provide more family planning commodities for free or at discounted rates in 2006.

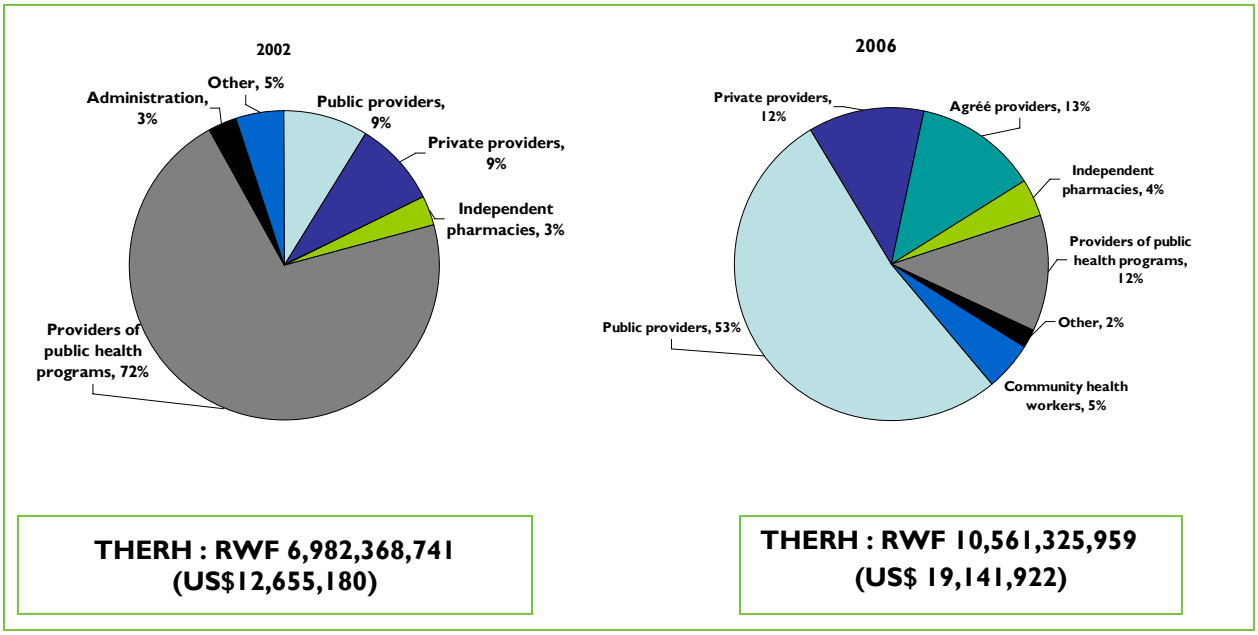
**FIGURE 5.8: BREAKDOWN OF OOP SPENDING BY AREA OF RH CARE, 2002 AND 2006**



## 5.7 PROVIDERS OF RH SERVICES IN RWANDA

Figure 5.9 shows the proportion of spending that went to various providers of RH services.

**FIGURE 5.9: RH SPENDING BY PROVIDER**



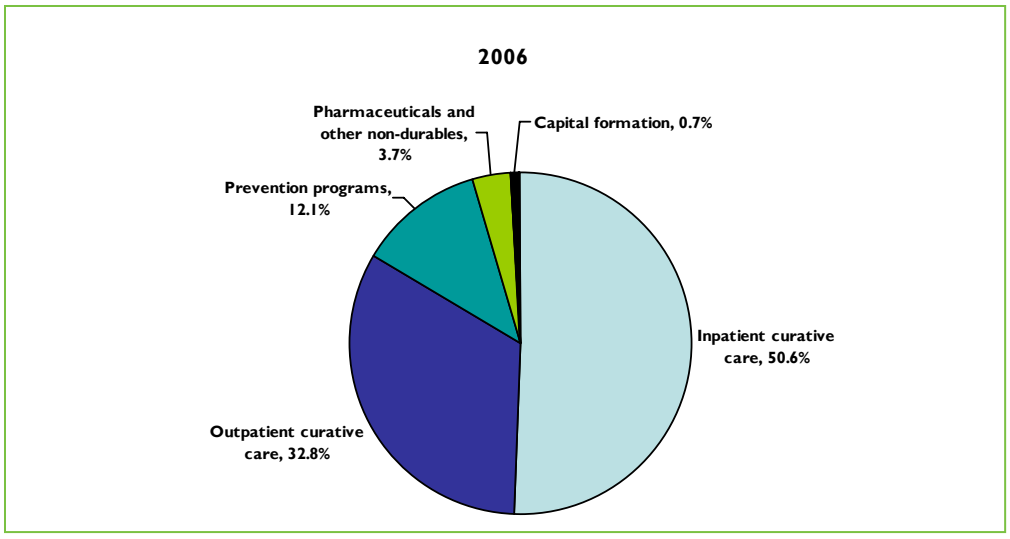

The 2006 NHA disaggregates public providers into public referral hospitals, district hospitals, and public health centers (see RH subaccount tables Annex A). Public referral hospitals consume the largest percentage of $THE_{RH}$ spending at 40 percent. Eight-six percent of spending at public referral hospitals is for inpatient care such as deliveries. *Agréé* providers consume the second largest percentage at 13 percent of $THE_{RH}$. The share of provision of public health programs decreased to 12 percent, from 72 percent in 2002.

A higher percentage of spending (19 percent) goes to private clinics from all household OOP payments. Households also spend at public hospitals (31 percent public referral and 11 percent government district) and independent pharmacies (14 percent).

## 5.8 HEALTH FUNCTIONS: RH HEALTH SERVICES CONSUMED IN RWANDA

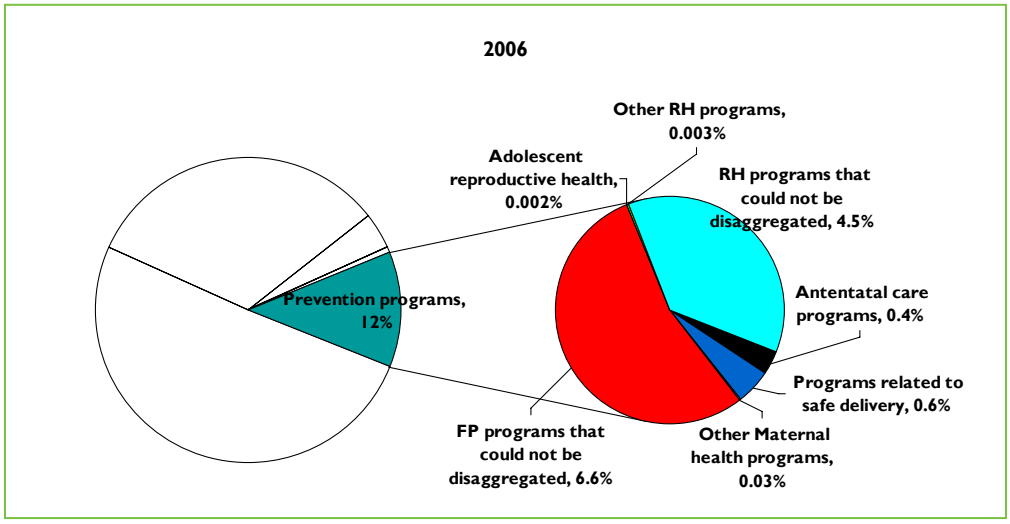
Figure 5.10 shows the proportion of spending that went to various RH functions.

**FIGURE 5.10: WHAT DO HEALTH FUNDS BUY? RH HEALTH SERVICES CONSUMED IN 2006**




As Figure 5.11 shows, family planning programs consume the largest portion of prevention program funds in 2006 (6.6 percent of $THE_{RH}$, as well as an assumed portion of RH programs that could not be disaggregated).[20]

**FIGURE 5.11: BREAKDOWN OF PREVENTION AND PUBLIC HEALTH PROGRAMS**

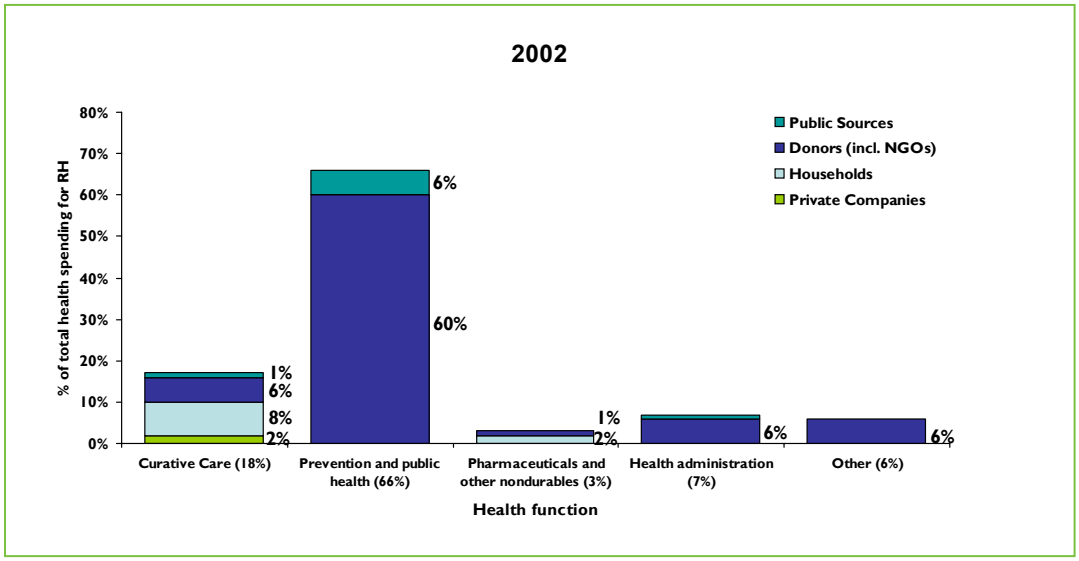


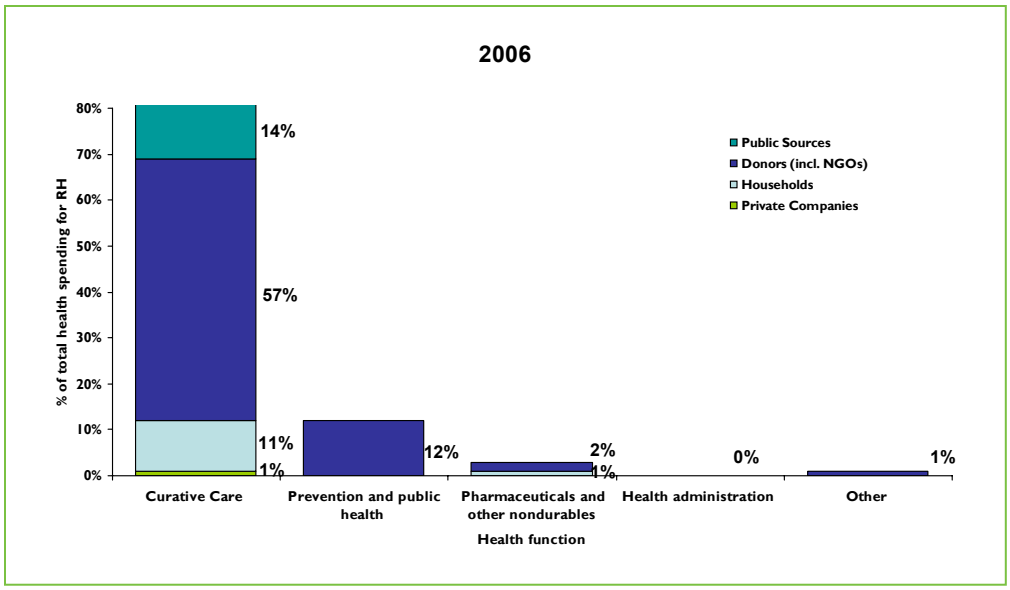

[20] Whereas the process attempted to ensure that personal and administrative costs were teased out of program expenditures, analysis was limited by the level of disaggregation provided by the original expenditure records. Where a program was unable to clearly disaggregate the portion of program expenses that went to an actual service, the amount was kept under the program expenditure budget line.

## 5.9 WHO FINANCES WHAT HEALTH FUNCTIONS?

In 2006 RH expenditures principally pay for the provision of curative care,[21] the cost of which is heavily borne by donors (57 percent), and households (11 percent) (Figure 5.12).

**FIGURE 5.12: FINANCING SOURCES OF RH HEALTH CARE FUNCTIONS, 2002 AND 2006**




Spending patterns on services changed dramatically between 2002 and 2006. In 2002, most expenditure on RH went to prevention and public health programs. Public sources funded 6 percent of all spending on these prevention services; donors funded the rest. In 2006, public sources do not contribute

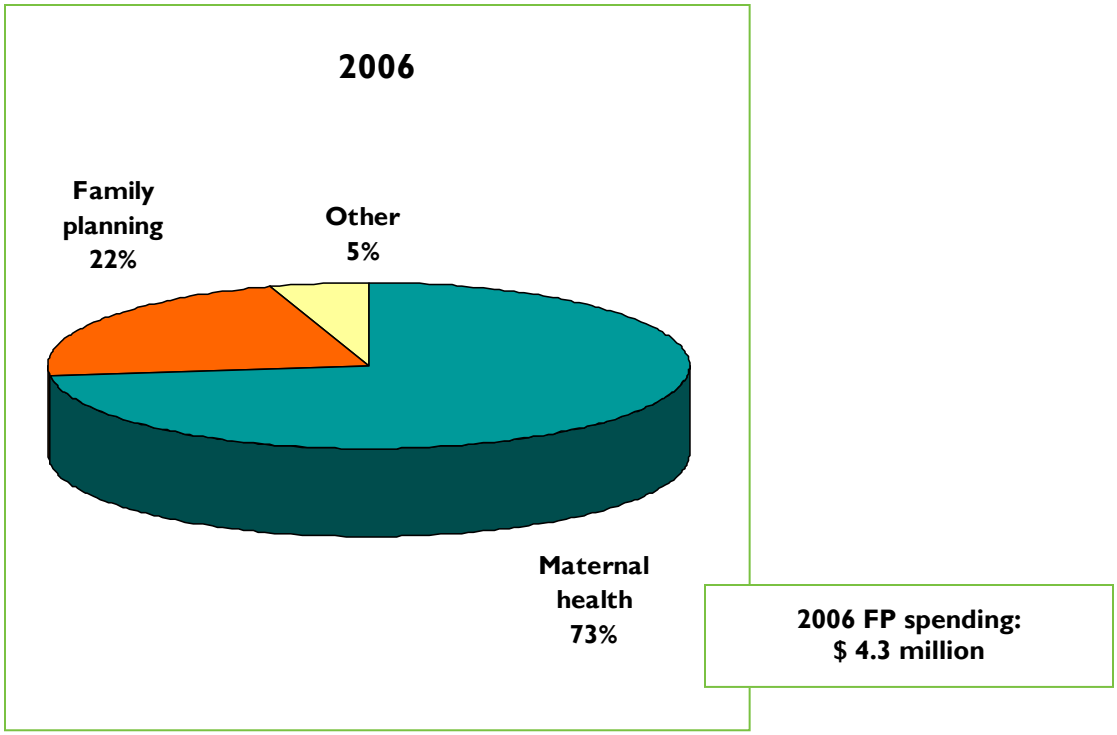
[21] Curative is used here in keeping with the NHA terminology in the *Producers Guide* and OECD System of Health Accounts. It refers to personal health care as opposed to collective health care (such as that delivered through public health prevention programs) and includes preventive personal care services such as family planning given as both inpatient and outpatient care.

significantly to RH prevention and public health programs. The share of $THE_{RH}$ of these programs also dropped, from 66 percent to 12 percent.

## 5.10 MATERNAL HEALTH SPENDING IN RWANDA

In 2006, RH funds are largely consumed by maternal health care (Figure 5.13).[22]

**FIGURE 5.13: BREAKDOWN OF RH SPENDING BY RH CATEGORIES, 2006**




From 2002 to 2006, a shift occurred in RH spending, with expenditure increasingly going to maternal health care provided at facilities (Table 5.4). Figure 62 shows this large increase in total expenditure on maternal care, broken down by types of maternal care. In 2006, 21 percent of $THE_{RH}$ were for prenatal care. Inpatient care, i.e., deliveries in hospitals, accounts for 51 percent of $THE_{RH}$. While RH spending increased by 65 percent between 2002 and 2006, curative maternal care increased sevenfold. Figure 5.13 shows that OOP spending in fact decreased. This is principally accounted for by the increase in curative care funding coming from donors.

[22] These findings are unavailable for 2002 because prevention and public health programs were not broken down into maternal-child health or family planning in that year. Only OOP spending achieved that level of disaggregation, which is shown in Figure 5.8.

**TABLE 5.4: MATERNAL HEALTH INDICATORS AND OOP SPENDING ON MATERNAL CARE, 2002 AND 2006**

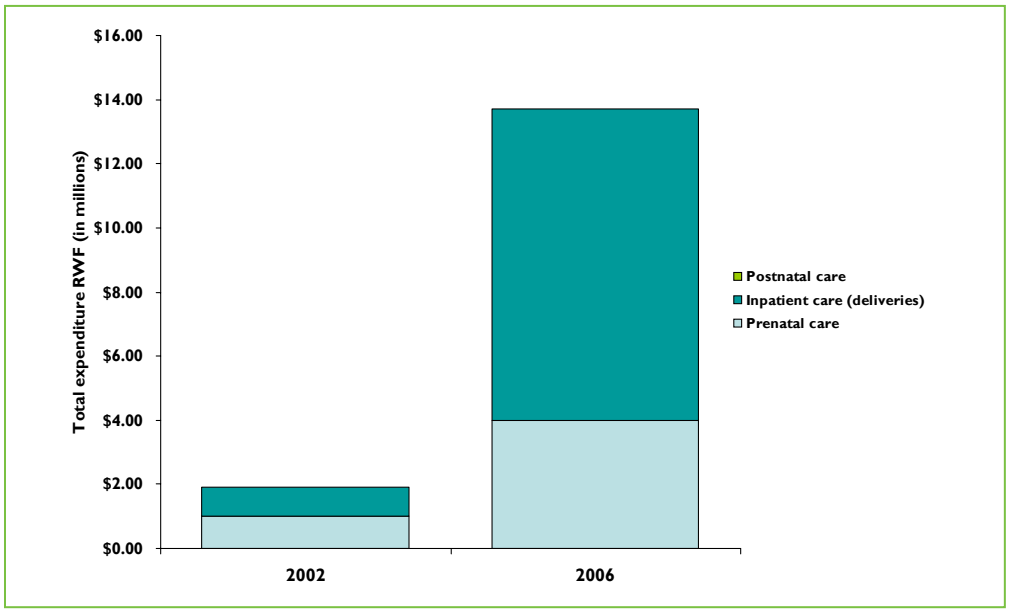
| | Rwanda 2002* | Rwanda 2006 |
|---|---|---|
| OOP spending on maternal health care | RWF 492,681,480<br>US$ 892,960 | RWF 733,412,735<br>US$ 1,329,272 |
| Total number of births at a facility | 99,201** | 132,734** |
| OOP spending per birth at a facility | RWF 8,286<br>US$ 15.02 | RWF 5,525<br>US$ 10.01 |
| Number of women of reproductive age | 2,067,022*** | 2,291,233*** |
| OOP spending per woman of reproductive age | RWF 253<br>US$ >1 | RWF 320<br>US$ >1 |

* Reported in constant 2006 currency to facilitate comparisons across years

**DHS 2000, 2004

***Rwandan Census 2002, 2006

**FIGURE 5.14: SPENDING TRENDS IN MATERNAL CARE, 2002 AND 2006**

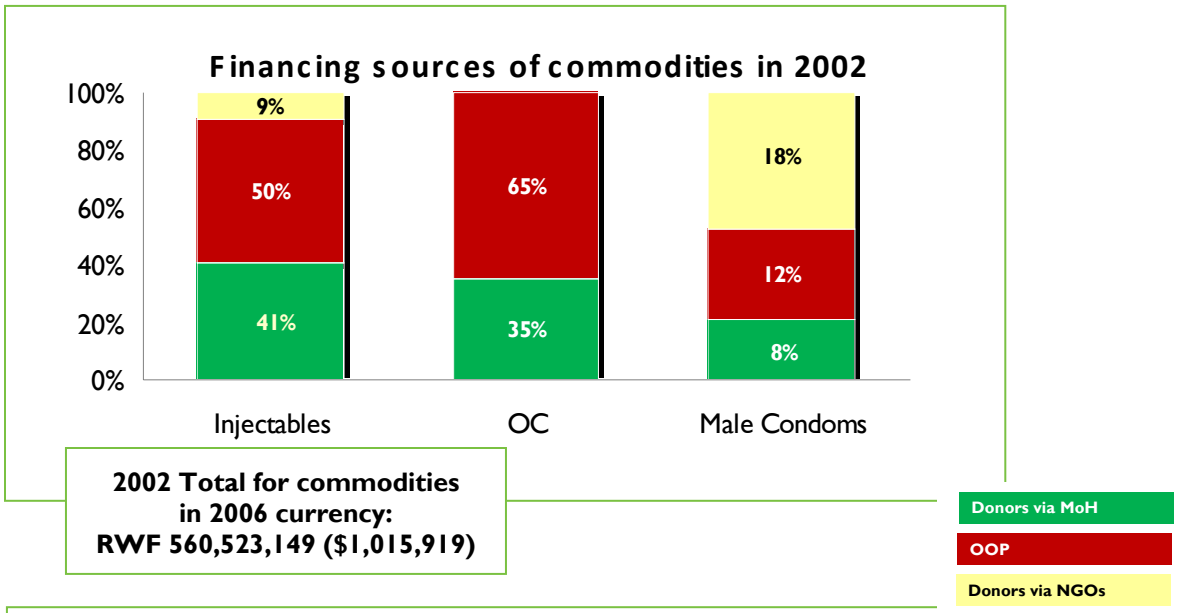



* Reported in constant 2006 currency to facilitate comparisons across years

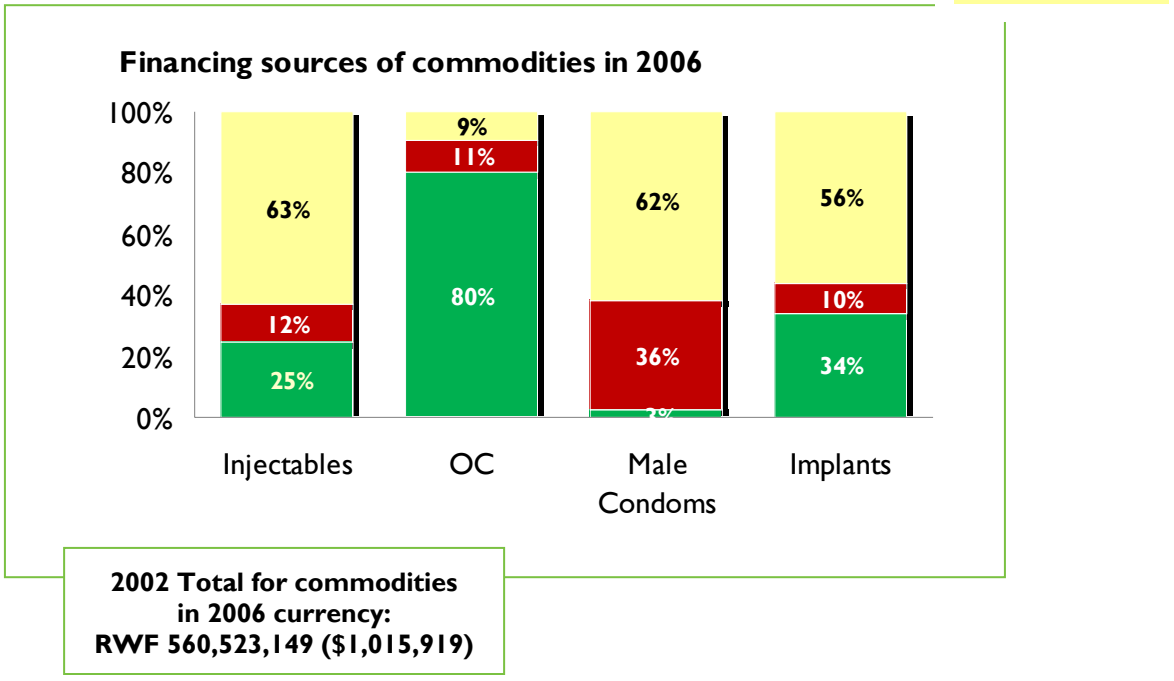
## 5.11 FAMILY PLANNING COMMODITIES

Absolute spending on contraceptive commodities has nearly tripled since 2002 (Figure 5.15). Donors channeled funds through NGOs and the MoH (see Annex C for more details on RH commodities funding flows). Donor plus household OOP spending amounted to RWF 560,523,149 (US$ 1,015,919) in 2002 and RWF 1,493,897,845 (US$ 2,707,612) in 2006. The donor via NGO route (social marketing) accounts for the largest share of expenditures for each commodity type (except for oral contraceptives) in 2006. Compared with 2002, the household OOP share has decreased.

**FIGURE 5.15: FINANCING SOURCES OF RH COMMODITIES IN RWANDA**




5.12



## 5.12 SUMMARY OF RH FINDINGS

- **Total RH spending is RWF 10.6 billion (US$ 19.1 million) in 2006, representing a slight increase from the 2002 level of spending. RH accounts for 6.2 percent of $THE_{general}$.**

- **The proportion of funds allocated to RH in comparison to $THE_{general}$ is smaller than the proportion of funds allocated to the other major disease interventions**. RH received fewer contributions from health sector development partners than other disease interventions like HIV/AIDS and malaria.

  **More than half of all RH funds are channeled through implementing NGOs in 2006.** This level represents movement away from public financing agents like the MoH (which managed over half the RH funds in 2002). This trend is also happening with donor funds. The shift in management of RH funds is different from what those we observed in HIV/AIDS and malaria priority interventions, where the government is becoming an increasingly larger manager in relative and absolute terms. As the GoR targets efforts on RH, it will be essential to ensure strong leadership and coordination of RH funds to priority interventions.

- **In 2006 RH expenditures are principally spent on the provision of curative care [23] rather than programs, the cost of which is heavily borne by donors (57 percent) and households (11 percent).** Curative care is spending largely associated with deliveries and antenatal care.

- **There was a shift in spending towards maternal care services, and away from family planning (particularly by households).** More contraceptive commodities were subsidized by donors than in earlier years. The spending on maternal care is happening mainly at public facilities

[23] Curative is used here in keeping with the NHA terminology in the *Producers Guide* and System of Health Accounts. It refers to personal health care as opposed to collective health care (such as that delivered through public health prevention programs) and includes preventive personal care services such as family planning given as both inpatient and outpatient care.

# 6. CONCLUSION

Rwanda is one of the few countries in the sub-Saharan Africa region with multiple years of comparable expenditure data. The NHA framework allows for expenditure to fall within certain categories yet is flexible to disaggregate within those categories, according to the country context, at each level: financing sources, financing agents, providers, and health functions. While the 2006 NHA exercise provides policymakers and stakeholders insight into the country's complex health financing system in its entirety, the four earlier years of NHA data grant an opportunity to observe trends.

## 6.1 OVERALL HEALTH SPENDING

Findings from the 2006 NHA reveal that THE has more than doubled since 2003 due to an increase in absolute spending from all financing sources (public, private, and donor). Donors increased spending by the largest percentage; they also constitute the largest source of funding for health (53 percent). Public spending on health increased in absolute value by US$ 10 million since the last NHA estimation in 2003. THE is 11 percent of nominal GDP in 2006, the latter figure having increased from US$ 2.15 to US$ 2.87 billion (constant US$ 2006) since 2003. Household spending on health has also risen substantially and in 2006 is 2.4 times higher than in 2003.

Public programmatic control over health funds has increased overall; the MoH now controls three times more funds than it did in 2003. Sixty-four percent of these funds derive from donors, and the remaining 36 percent come from public sources. Mutuelles have emerged as a growing force in the country in 2006 and are financed mainly by households (70 percent). Funds flowing through mutuelles go to public or *agréé* providers. However, households spend the majority of their health funds at independent pharmacies or directly at the provider, rather than through insurance schemes.

Public providers consume slightly more funds than providers of public health programs, a reverse from the 2003 NHA findings. Administration, the largest consumer of funds in 2003, is the third largest in 2006. Curative care is the largest consumed health service, jumping dramatically from 2003. Curative care (especially outpatient) is financed mainly by households in 2006, although donors and the public contribute significantly to overall curative care consumption. Prevention and public health programs consume a large portion of THE as well.

## 6.2 HIV/AIDS HEALTH SPENDING

Total HIV/AIDS health expenditure, at 24 percent of $THE_{general}$, reached RWF 40.5 billion (US$ 73.4 million) in 2006. This level of spending represents a threefold increase since the last HIV/AIDS subaccount in the pre-Global Fund and PEPFAR year of 2002.

The main financiers of HIV/AIDS health spending in Rwanda are donors, at 94 percent of all spending, followed by public sources (3 percent), households (2 percent), and other private sources (1 percent). Donor funds coming into Rwanda in 2006 are twice as likely to be spent on HIV/AIDS services as in 2002.

Public agents like the MoH and CNLS manage 39 percent of HIV/AIDS health funds in 2006 compared with 27 percent in 2002, indicating a coordinated government approach to this priority health area. Households affected by HIV/AIDS act as financing agents with their OOP payments. In 2006, spending is $9.78 per PLHIV, a slight decrease from its level in 2002. However, since general OOP spending has increased in recent years, the OOP burden on PLHIV is only 1.5 times higher than that for the general population, compared with four times higher in 2002. Households have shifted some of their HIV/AIDS funds to inpatient care from outpatient care since 2002.

The richest quintile of PLHIV in Rwanda spends six times more annually on health than the poorest, but spends only 2 percent of their total consumption as opposed to 4 percent by the poorest. Nurses provide 94 percent of health care, mainly outpatient. In every income quintile, children are the most likely to obtain care. Prevention and public health programs consume the largest share of HIV/AIDS funds, followed by curative care and health administration. Within public health programs, IEC programs account for 18 percent (5.3 percent) of $THE_{HIV}$.

Most of HIV/AIDS spending is on health; however, 16 percent of HIV/AIDS monies are allocated to non-health and health-related programs and functions.

## 6.3 MALARIA HEALTH SPENDING

The total resource envelope for malaria reached RWF 23.6 billion (US$ 42.7 million) in 2006, double the amount from the last malaria subaccount, in 2003. It is 14 percent of THE, although malaria is the leading cause of morbidity in the country. A notable finding from the malaria subaccount is that only 35 percent of total malaria spending is actually targeted for the disease; the remainder is made up of untargeted spending at providers that is considered a malaria expenditure, to account for certain expenses like capital formation of facilities used to treat malaria patients and doctors' salaries.

Donors and households are the main financiers of malaria funds in Rwanda. Additionally, the public allocation of funding to malaria has decreased from 13 percent to 3.7 percent since 2003. Twenty-six percent of all private spending (mainly household spending), goes to malaria.

There has been an increase in spending on public health and prevention programs (largely by donors); however, a large portion of malaria resources are spent on curative care. In 2003, RWF 6.6 billion (US$ 11.9 million) was spent on inpatient curative care and RWF 6 billion (US$ 10.8 million) was spent on outpatient curative. In 2006, RWF 3.1 billion (US$ 5.6 million) is spent on inpatient and RWF 15 billion (US$ 27.2 million) is spent on outpatient curative. Bednets are substantially subsidized by the government, decreasing the burden on households.

CHWs now consume a larger share of malaria resources, reflective of their role in providing home-based malaria care and bednet distribution.

## 6.4 RH SPENDING

RH accounts for 5.5 percent of total health spending, RWF 10.6 billion (US$ 19.1 million) in 2006. Absolute spending increased slightly from the 2002 level of spending. RH receives fewer contributions from health sector development partners in comparison with other disease interventions like HIV/AIDS and malaria.

Additionally, more than half of all RH funds are channeled through implementing NGOs in 2006, which is a different trend than observed in HIV/AIDS and malaria priority interventions, where the government is becoming an increasingly larger manager in relative and absolute terms.

More contraceptive commodities are subsidized by donors than in earlier years. Curative care, spending largely associated with deliveries and antenatal care, consumes the most funds, primarily from donors (57 percent), and households (11 percent). There has been a shift in spending to maternal care services, mainly at public facilities. This shift away from family planning was a result in part of household spending.

# 7. NEXT STEPS

The findings from overall health, HIV/AIDS, malaria, and RH bring to light issues related to the equity, efficiency, and sustainability of the health financing system in Rwanda. This report highlights allocation levels and funding flows to different priority areas, health services, providers, and end users. Temporal analyses allow the government and relevant stakeholders to observe trends in health financing and management. The next steps are to translate the findings from the report into actionable items to improve health financing and to inform policy decisions to strengthen the health system more broadly.

The 2006 NHA captures an enormous volume of information and can serve as a useful baseline in future estimations. NHA should be produced on a regular basis, resulting in regular updates serving to achieve the health system's strategic objectives..

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# ANNEX A. NHA TABLES: GENERAL AND HIV/AIDS, MALARIA, AND RH SUBACCOUNTS

# FINANCING SOURCE x FINANCING AGENT (FSxHF)

## General NHA 2006

**Financing Source (FS)**

| Code | Financing Agent (HF) | | | FS.2 Private Funds | | | | FS.3 | FS.nsk | Row Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FS.1.1.1 Central Gov Revenue<br>FS.1.1.1.4 could not be disaggregated | FS. 1.2 Other Public funds | FS.2.1.1 Parastatal Employers | FS.2.1.2 Private Employers | FS.2.2 Households | FS.2.4 Other private funds | Rest of the World (Donors) | Not specified by any kind | |
| HF.1.1.1.1 | MoH (MiniSante) | 17,358,485,575 | 338,016,744 | | | | | 29,613,280,559 | | 47,309,782,878 |
| HF.1.1.1.2 | Other Ministries | 7,004,214,161 | | | | | | 63,757,948 | | 7,067,972,109 |
| HF.1.1.1.3.1 | CNLS proper | 288,080,280 | 530,000 | | | | | 544,286,700 | 213,861,233 | 1,046,758,213 |
| HF.1.1.1.3.2 | CNLS projects | 13,584,348 | | | | | | 12,614,065,851 | | 12,627,650,198 |
| HF.1.1.3 | Local Municipal Gvt (Districts) | | | | | | | 65,222,465 | | 65,222,465 |
| HF.1.2 | Social Security Fund (CSR)* | | | 7,497,442 | 4,464,095 | | | | | 11,961,537 |
| HF.1.3 | FARG | 993,516,344 | | | | 15,945,229 | | | | 1,009,461,573 |
| HF.2.1.1 | Gvt Employees Insurance Programme (RAMA+MMI) | 542,375,328 | | 3,429,305,194 | | 188,560,896 | 582,640,593 | | | 4,742,882,011 |
| HF.2.1.2 | Private Employees Insurance Programme | | | | 301,824,745 | 25,681,994 | | | | 327,506,739 |
| HF.2.1.3.1 | Mutuelles (premium paid by employer) | | | 165,725,571 | 1,668,347 | 167,076,897 | | | | 334,470,816 |
| HF.2.1.3.2 | Mutuelles (Community Based) | 742,955,220 | | | 655,362,000 | 5,636,026,600 | | 1,070,053,000 | | 8,104,396,820 |
| HF. 2.5.1 | Parastatal companies | | | 885,923,877 | | | | | | 885,923,877 |
| HF.2.2 | Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)* | | | 25,036,769 | 249,705,435 | 51,585,303 | | | | 326,327,506 |
| HF.2.3. | Private household out of pocket payments | | | | | 38,295,662,832 | | | | 38,295,662,832 |
| HF.2.4 | Non profit institutions (NGOs) | 42,928,931 | | | | 15,945,229 | | 38,331,077,009 | | 38,389,951,169 |
| HF.2.5.2 | Private Non Parastatal Firms | | | | 852,802,486 | | | | | 852,802,486 |
| HF.3 | Rest of World | | | | | | | 8,175,701,041 | | 8,175,701,041 |
| HF.nsk | Not specified by any kind | | | | | | | | | 0 |
| | **Column Total (THE)** | 26,986,140,186 | 338,546,744 | 4,513,488,853 | 2,065,827,108 | 44,396,484,980 | 582,640,593 | 90,477,444,573 | 213,861,233 | **169,574,434,271** |
| HF.4 | Financing Agents spending on Health Related Items | 1,061,575,817 | | | | | | 2,818,675,229 | | 3,880,251,046 |
| | **Column Total (NHE)** | 28,047,716,004 | 338,546,744 | 4,513,488,853 | 2,065,827,108 | 44,396,484,980 | 582,640,593 | 93,296,119,802 | 213,861,233 | **173,454,685,317** |

*Includes only the portion of CSR going to health

*note Parastatals add to their employees' salaries a fixed amount intended for health care. However it is not known how much of this is actually used for health care. So this amount has been excluded from the tables.

# FINANCING AGENT x PROVIDER (HFxP)

## General NHA

**Financing Agent**

| | | HF.A Public Sector | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3.1 | HF.1.1.1.3.2 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 |
| | **Provider** | MoH (MiniSante) | Other Ministries | CNLS proper | CNLS projects | Local Municipal Gvt (Districts) | Social Security Fund (CSR)* | FARG | Gvt Employees Insurance Programme (RAMA+MMI) | Private Employees Insurance Programme |
| HP.1.1.1.1 | National Referral Gvt Hospital | 1,786,016,490 | 875,995,773 | | 3,203,973,446 | | | 327,860,394 | | |
| HP.1.1.1.2 | National Referral Private Hospital | 2,050,495,044 | | | 1,552,591,126 | | 3,035,017 | 168,897,778 | 1,069,786,379 | 68,519,012 |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | |
| HP.1.1.2.1 | District Gvt. Hospitals | 87,188,937 | 268,454,559 | | 1,095,946,677 | | 2,142,365 | 119,221,961 | 647,240,801 | 44,614,988 |
| HP.1.1.2.2 | District Agrees Hospitals | 29,675,270 | 97,260,392 | | 456,644,449 | | 892,652 | 49,675,817 | 186,672,851 | 18,589,578 |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | |
| HP.1.2 | Mental health hospitals | 134,150,895 | | | | | | 15,945,229 | | |
| HP.3.1 | Office of physicians (private clinics)* | | | | | | | | 728,136,940 | 14,637,654 |
| HP.3.3.1 | Community health workers | 4,485,321,000 | | | | | | | | |
| HP.3.3.2 | Traditional healer | | | | | | | | | |
| HP.3.3.3 | Other health practitioners | 128,584,047 | | | | | | | | |
| HP.3.4.2 | Outpatient mental health institutions | | | | | | | | | |
| HP.3.4.5.1 | Public health centers (incl. TRAC HC - just in General NHA) | 2,195,968,823 | 389,041,569 | | 1,431,020,340 | | 3,570,608 | 198,703,269 | 851,897,162 | 74,489,350 |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 91,908,914 | 252,877,020 | | 930,163,221 | | 2,320,895 | 129,157,125 | 540,072,889 | 48,418,078 |
| HP.3.4.5.3 | NGO health centers | 14,367,737 | | | | | | | | |
| HP.3.5 | Medical and diagnostic laboratories | 51,046,767 | | | | | | | | |
| HP.3.9.1 | Ambulance services | | | | | | | | | |
| HP.3.6 | Providers of home health care | 1,382,582,579 | | | | | | | | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | 1,499,733,751 | | | | | | | | |
| HP.4.1 | Dispensing chemists | | | | | | | | 715,969,471 | 55,679,953 |
| HP.5 | Providers + admin of public health | 19,765,392,090 | | 1,006,810,380 | 3,267,465,761 | | | | | |
| HP.6 | General health administration and insurance | 13,560,268,146 | 5,184,342,797 | 39,947,833 | 682,313,955 | | | | | |
| HP.9 | Rest of the world | | | | 7,531,224 | | | | | |
| HP.nsk | Providers not specified by any kind | 47,082,389 | | | | 65,222,465 | | | 3,105,518 | 2,558,126 |
| | **Column Total THE** | 47,309,782,878 | 7,067,972,109 | 1,046,758,213 | 12,627,650,198 | 65,222,465 | 11,961,537 | 1,009,461,573 | 4,742,882,011 | 327,506,739 |
| | **HF Totals From FS x HF Table** | 47,309,782,878 | 7,067,972,109 | 1,046,758,213 | 12,627,650,198 | 65,222,465 | 11,961,537 | 1,009,461,573 | 4,742,882,011 | 327,506,739 |
| HP.8.1 | Research Institutions | 2,848,184,712 | | | | | | | | |
| HP.8.2 | Education and training institutions | | 847,931,983 | | 42,207,976 | | | | | |
| | **Subtotal for health related** | 2,848,184,712 | 847,931,983 | - | 42,207,976 | - | - | - | - | - |
| | **Column Total: NHE** | 50,157,967,590 | 7,915,904,092 | 1,046,758,213 | 12,669,858,174 | 65,222,465 | 11,961,537 | 1,009,461,573 | 4,742,882,011 | 327,506,739 |

*=Many private clinics are headed by a nurse, not a physician

213,643,834
2,634,540,878

# FINANCING AGENT x PROVIDER (HFxP)

**General NHA**

| | | HF.A Public Sector | | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.2.1.3.1 | HF.2.1.3.2 | HF. 2.5.1 | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | |
| | **Provider** | Mutuelles (premium paid by employer) | Mutuelles (Community Based) | Parastatal companies | Private Insurance Enterprises (other than social insurance: COGEAR, SONARWA | Private household out of pocket payments | Non profit institutions (NGOs) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HP.1.1.1.1 | National Referral Gvt Hospital | 334,470,816 | | | | 5,728,373,681 | 1,840,601,838 | | 4,644,935,357 | | 18,742,227,793 |
| HP.1.1.1.2 | National Referral Private Hospital | | | | 68,272,300 | 1,679,367,213 | | 319,781,607 | - | | 6,980,745,476 |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | | - |
| HP.1.1.2.1 | District Gvt. Hospitals | | 1,945,055,237 | | 44,454,346 | 2,118,713,553 | 688,555,450 | 442,689 | - | | 7,062,031,563 |
| HP.1.1.2.2 | District Agrees Hospitals | | 810,439,682 | | 18,522,644 | 1,326,581,338 | 1,796,889,758 | 191,604 | - | | 4,792,036,036 |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | | - |
| HP.1.2 | Mental health hospitals | | | | | 50,796,368 | 15,945,229 | | 82,244,968 | | 299,082,689 |
| HP.3.1 | Office of physicians (private clinics)* | | | 618,843,331 | 14,584,949 | 3,519,525,545 | | 493,046,371 | | | 5,388,774,790 |
| HP.3.3.1 | Community health workers | | | | | | 1,823,992,966 | | | | 6,309,313,966 |
| HP.3.3.2 | Traditional healer | | | | | 4,148,660,041 | | | | | 4,148,660,041 |
| HP.3.3.3 | Other health practitioners | | | | | 262,252,983 | | | | | 390,837,030 |
| HP.3.4.2 | Outpatient mental health institutions | | | | | | | | | | - |
| HP.3.4.5.1 | Public health centers (incl. TRAC HC- - just in General NHA) | | 3,241,758,728 | | 74,221,141 | 4,585,506,592 | 2,969,268,261 | | - | | 16,015,445,842 |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | | 2,107,143,173 | | 48,243,742 | 1,009 | 2,146,995,793 | | - | | 6,297,301,858 |
| HP.3.4.5.3 | NGO health centers | | | | | 38,620,612 | 612,053,092 | | | | 665,041,441 |
| HP.3.5 | Medical and diagnostic laboratories | | | | | | | | | | 51,046,767 |
| HP.3.9.1 | Ambulance services | | | | | | | | | | - |
| HP.3.6 | Providers of home health care | | | | | | | | | | 1,382,582,579 |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | | 1,499,733,751 |
| HP.4.1 | Dispensing chemists | | | 93,789,820 | 55,479,470 | 14,767,197,470 | 585,302,625 | | | | 16,273,418,809 |
| HP.5 | Providers + admin of public health | | | | | | 13,849,285,821 | | 3,226,637,248 | | 41,115,591,300 |
| HP.6 | General health administration and insurance | | | | | | 11,590,076,650 | | 221,883,469 | | 31,278,832,851 |
| HP.9 | Rest of the world | | | 173,290,726 | | | | 38,822,880 | | | 219,644,829 |
| HP.nsk | Providers not specified by any kind | | | | 2,548,915 | 70,066,428 | 470,983,686 | 517,337 | | | 662,084,863 |
| | **Column Total THE** | 334,470,816 | 8,104,396,820 | 885,923,877 | 326,327,506 | 38,295,662,832 | 38,389,951,169 | 852,802,486 | 8,175,701,041 | - | **169,574,434,271** |
| | **HF Totals From FS x HF Table** | 334,470,816 | 8,104,396,820 | 885,923,877 | 326,327,506 | 38,295,662,832 | 38,389,951,169 | 852,802,486 | 8,175,701,041 | - | 169,574,434,271 |
| HP.8.1 | Research Institutions | | | | | | 102,774,265 | | | | 2,950,958,977 |
| HP.8.2 | Education and training institutions | | | | | | 2,461,534 | | | | 892,601,493 |
| | **Subtotal for health related** | - | - | - | - | - | 105,235,799 | - | - | - | 3,843,560,470 |
| | **Column Total: NHE** | 334,470,816 | 8,104,396,820 | 885,923,877 | 326,327,506 | 38,295,662,832 | 38,495,186,968 | 852,802,486 | 8,175,701,041 | - | **173,417,994,741** |

*=Many private clinics are headed by a nurse, not a physician

As a % of HH

Annex A-3

## FINANCING AGENTS x FUNCTION (HF x HC)

**General NHA**

**Financing Agent**

| Function | | HF.A Public Sector | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3.1 | HF.1.1.1.3.2 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3.1 | HF.2.1.3.2 | HF. 2.5.1 |
| | | MoH (MiniSante) | Other Ministries | CNLS proper | CNLS projects | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA+MMI) | Private Employees Insurance Programme | Mutuelles (premium paid by employer) | Mutuelles (Community Based) | Parastatal companies |
| HC.1.1 | In patient curative care | 3,541,524,393 | 841,482,972 | - | 1,766,209,544 | - | 3,950,878 | 473,360,936 | 406,907,797 | 23,083,060 | 247,508,404 | 2,539,917,963 | 237,797,439 |
| HC.1.3 | Out patient curative care | 6,762,779,734 | 619,947,789 | - | 1,484,163,660 | - | 8,010,659 | 536,100,638 | 1,372,622,268 | 33,598,822 | 86,962,412 | 5,564,478,857 | 508,881,137 |
| HC.1.4 | Services of curative home | 1,446,980,647 | - | - | - | - | - | - | - | - | - | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, | 6,820,000 | - | - | - | - | - | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | 15,968,290 | - | - | - | - | - | - | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other | 284,790,232 | - | - | 4,653,248,393 | - | - | - | 715,969,471 | 55,679,953 | - | - | 93,501,139 |
| HC.5.2.1 | Glasses and other vision | - | - | - | - | - | - | - | - | - | - | - | 288,681 |
| HC.6.1 | Maternal and child care, | 2,072,842,247 | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.2 | School health services | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3 | Prevention of communicable | 8,293,641,987 | 149,275,175 | 1,006,810,380 | 1,142,785,838 | - | - | - | - | - | - | - | - |
| HC.6.3.1.2 | Blood supply | 1,499,733,751 | - | - | - | - | - | - | - | - | - | - | - |
| HC 6.4 | Prevention of | 195,076,499 | - | - | - | - | - | - | - | - | - | - | - |
| HC 6.6 | Training within public health programs | 821,176,196 | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.9 | OTHER miscellaneous public health programs | 432,528,681 | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.10 | Public health programs that could not be disaggregated | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.1 + | local and external | 17,926,977 | - | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.3 | Health administration and insurance (not disaggregated) | 14,047,638,784 | 5,035,067,622 | 39,947,833 | 2,814,525,102 | - | - | - | 2,247,382,475 | 215,144,904 | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | 7,166,778,468 | 422,198,552 | - | 766,717,662 | - | - | - | - | - | - | - | 27,889,331 |
| HC.nsk | Not specified by kind | 703,575,993 | - | - | - | 65,222,465 | - | - | - | - | - | - | 17,566,149 |
| | **Column Total THE** | 47,309,782,878 | 7,067,972,109 | 1,046,758,213 | | 65,222,465 | 11,961,537 | 1,009,461,573 | 4,742,882,011 | 327,506,739 | 334,470,816 | 8,104,396,820 | 885,923,877 |
| HCR.2 | Education & Training | - | 847,931,983 | - | 42,207,976 | - | - | - | - | - | - | - | - |
| HCR.3 | Research & Development | 2,848,184,712 | - | - | - | - | - | - | - | - | - | - | - |
| | *Sub total column* | 2,848,184,712 | 847,931,983 | - | 42,207,976 | - | - | - | - | - | - | - | - |
| | **Column Total NHE** | 50,157,967,590 | 7,915,904,092 | 1,046,758,213 | | 65,222,465 | 11,961,537 | 1,009,461,573 | 4,742,882,011 | 327,506,739 | 334,470,816 | 8,104,396,820 | 885,923,877 |

Annex A-3

# FINANCING AGENTS x FUNCTION (HF x HC)

## General NHA

| | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | - |
| | Function | Private Insurance Enterprises (other than social insurance: COGEAR, SONARWA, etc) | Private household out of pocket payments | Non profit institutions (NGOs) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HC.1.1 | In patient curative care | 22,999,946 | 5,438,768,459 | 3,218,019,617 | 54,419,252 | 3,493,366,088 | - | 22,309,316,746 |
| HC.1.3 | Out patient curative care | 33,477,845 | 18,019,630,475 | 6,230,193,096 | 192,611,937 | 1,233,814,237 | - | 42,687,273,565 |
| HC.1.4 | Services of curative home care | - | - | - | - | - | - | 1,446,980,647 |
| HC.4.1 | Clinical lab (BNC, biolab, | - | - | - | - | - | - | 6,820,000 |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | - | 15,968,290 |
| HC.5.1 | Pharmaceuticals and other | 55,479,470 | 14,767,197,470 | 585,302,625 | - | - | - | 21,211,168,753 |
| HC.5.2.1 | Glasses and other vision | - | - | 40,000,000 | - | - | - | 40,288,681 |
| HC.6.1 | Maternal and child care, family | - | - | 1,695,533,768 | - | 1,956,499,326 | - | 5,724,875,341 |
| HC.6.2 | School health services | - | - | 2,192,741,602 | - | - | - | 2,192,741,602 |
| HC.6.3 | Prevention of communicable | - | - | 6,148,734,427 | - | 442,866,124 | - | 17,184,113,932 |
| HC.6.3.1.2 | Blood supply | - | - | - | - | - | - | 1,499,733,751 |
| HC 6.4 | Prevention of | - | - | 610,012,423 | - | - | - | 805,088,922 |
| HC 6.6 | Training within public health programs | - | - | 2,479,386,057 | - | - | - | 3,300,562,253 |
| HC.6.9 | OTHER miscellaneous public health programs | - | - | 988,717,015 | - | 27,035,161 | - | 1,448,280,857 |
| HC.6.10 | Public health programs that could not be disaggregated | - | - | 155,728,930 | - | - | - | 155,728,930 |
| HC.7.2.2.1 + | local and external | - | - | 2,919,225,631 | - | - | - | 2,937,152,608 |
| HC.7.2.2.3 | Health administration and insurance (not disaggregated) | 214,370,245 | - | 7,933,931,536 | - | 1,006,381,017 | - | 33,554,389,517 |
| HCR.1 | Capital formation for health care provider institutions | - | - | 2,905,924,384 | 539,576,150 | - | - | 11,829,084,546 |
| HC.nsk | Not specified by kind | - | 70,066,428 | 286,500,059 | 66,195,148 | 15,739,089 | - | 1,224,865,331 |
| | **Column Total THE** | 326,327,506 | 38,295,662,832 | 38,389,951,169 | 852,802,486 | 8,175,701,041 | - | **169,574,434,271** |
| HCR.2 | Education & Training | - | - | - | - | - | - | 892,601,493 |
| HCR.3 | Research & Development | - | - | - | - | - | - | 2,950,958,977 |
| | *Sub total column* | - | - | - | - | - | - | 3,843,560,470 |
| | **Column Total NHE** | 326,327,506 | 38,295,662,832 | 38,389,951,169 | 852,802,486 | 8,175,701,041 | - | **173,417,994,741** |

Annex A-4

## PROVIDER x FUNCTION (HP x HC)

**General NHA**

| | | Provider | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.2.1 | HP.1.1.2.2 | HP.1.2 | - | HP.3.3.1 | HP.3.3.2 | HP.3.3.3 | HP.3.4.5.1 | HP.3.4.5.2 |
| | **Function** | National Referral Gvt Hospital | National Referral Private Hospital | District Gvt. Hospitals | District Agrees Hospitals | Mental health hospitals | Office of physicians (private clinics)* | Community health workers | Traditional healer | Other health practitioners | Public health centers (incl. TRAC HC-- just in General NHA) | Government assisted not-for-profit health centers (Agrees) |
| HC.1.1 | In patient curative care | 10,718,356,485 | 2,104,408,975 | 3,572,770,109 | 2,144,871,830 | 204,057,508 | 79,468,793 | - | - | - | 874,846,295 | 911,555,905 |
| HC.1.3 | Out patient curative care | 6,235,282,510 | 2,955,947,836 | 2,170,904,587 | 2,104,502,299 | 95,025,181 | 4,978,378,162 | 4,485,321,000 | 4,148,660,041 | 390,837,030 | 10,528,975,995 | 3,636,489,496 |
| HC.1.4 | Services of curative home care | - | - | - | - | - | - | - | - | - | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, | - | - | - | - | - | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | 15,968,290 | - | - | - | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other | 1,535,571,970 | 791,052,227 | 558,389,807 | 232,662,420 | - | - | - | - | - | 930,649,679 | 604,922,291 |
| HC.5.2.1 | Glasses and other vision | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.1 | Maternal and child care, family | - | - | - | - | - | - | - | - | - | 1,224,130,901 | - |
| HC.6.2 | School health services | - | - | - | - | - | - | 76,932,761 | - | - | - | - |
| HC.6.3 | Prevention of communicable disease (e.g., HIV/AIDS, | - | - | - | - | - | - | 528,673,323 | - | - | - | - |
| HC.6.3.1.2 | Blood supply | - | - | - | - | - | - | - | - | - | - | - |
| HC 6.4 | Prevention of noncommunicable diseases | - | - | - | - | - | - | - | - | - | 158,755,445 | - |
| HC 6.6 | Training within public health | - | - | - | - | - | - | 932,077,665 | - | - | - | - |
| HC.6.9 | OTHER miscellaneous public | - | - | - | - | - | - | 82,498,465 | - | - | - | - |
| HC.6.10 | Public health programs that | - | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.1 + HC.7.2.2.2 | local and external consultancies | - | - | - | - | - | - | 81,076,437 | - | - | - | - |
| HC.7.2.2.3 | Health administration and insurance (not disaggregated) | - | 679,212,830 | 479,444,351 | 199,768,479 | - | - | 122,734,315 | - | - | 1,336,647,344 | 519,398,046 |
| HCR.1 | Capital formation for health care provider institutions | 253,016,828 | 450,123,609 | 264,554,419 | 110,231,008 | - | 247,683,874 | - | - | - | 961,440,184 | 624,936,119 |
| HC.nsk | Not specified by kind | - | - | - | - | - | 83,243,961 | - | - | - | - | - |
| | **Column Total-THE** | **18,742,227,793** | **6,980,745,476** | **7,062,031,563** | **4,792,036,036** | **299,082,689** | **5,388,774,790** | **6,309,313,966** | **4,148,660,041** | **390,837,030** | **16,015,445,842** | **6,297,301,858** |
| HCR.2 | Education & Training | | | | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | | | | |

Annex A-4

## PROVIDER x FUNCTION (HP x HC)

**General NHA**

| | | HP.3.4.5.3 | HP.3.5 | HP.3.6 | HP.3.9.2 | HP.4.1 | HP.5 | HP.6 | HP.9 | HP.nsk | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Function** | NGO health centers | Medical and diagnostic laboratories | Providers of home health care services | Blood banks (CNTS transfusion) | Dispensing chemists | Providers + admin of public health programs | General health administration and insurance | Rest of the world | Providers not specified by any kind | **THE Row Total** |
| HC.1.1 | In patient curative care | - | - | - | - | - | 1,196,126,056 | 286,634,907 | 212,113,606 | 4,106,279 | 22,309,316,746 |
| HC.1.3 | Out patient curative care | 665,041,441 | 51,046,767 | - | - | - | - | - | - | 240,861,221 | 42,687,273,565 |
| HC.1.4 | Services of curative home care | - | - | 1,382,582,579 | - | - | 56,272,636 | 8,125,432 | - | - | 1,446,980,647 |
| HC.4.1 | Clinical lab (BNC, biolab, | - | - | - | - | - | - | 6,820,000 | - | - | 6,820,000 |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | - | - | - | - | 15,968,290 |
| HC.5.1 | Pharmaceuticals and other | - | - | - | - | 16,273,130,128 | 129,283,904 | 155,506,328 | - | - | 21,211,168,753 |
| HC.5.2.1 | Glasses and other vision | - | - | - | - | 288,681 | 40,000,000 | - | - | - | 40,288,681 |
| HC.6.1 | Maternal and child care, family | - | - | - | - | - | 3,652,033,094 | 848,711,346 | - | - | 5,724,875,341 |
| HC.6.2 | School health services | - | - | - | - | - | 2,115,808,841 | - | - | - | 2,192,741,602 |
| HC.6.3 | Prevention of communicable disease (e.g., HIV/AIDS, | - | - | - | - | - | 16,167,437,864 | 480,471,522 | 7,531,224 | - | 17,184,113,932 |
| HC.6.3.1.2 | Blood supply | - | - | - | 1,499,733,751 | - | - | - | - | - | 1,499,733,751 |
| HC 6.4 | Prevention of noncommunicable diseases | - | - | - | - | - | 646,333,477 | - | - | - | 805,088,922 |
| HC 6.6 | Training within public health | - | - | - | - | - | 2,350,967,889 | 17,516,699 | - | - | 3,300,562,253 |
| HC.6.9 | OTHER miscellaneous public | - | - | - | - | - | 949,782,106 | 416,000,287 | - | - | 1,448,280,857 |
| HC.6.10 | Public health programs that | - | - | - | - | - | 155,728,930 | - | - | - | 155,728,930 |
| HC.7.2.2.1 + HC.7.2.2.2 | local and external consultancies | - | - | - | - | - | 334,691,502 | 2,521,384,669 | - | - | 2,937,152,608 |
| HC.7.2.2.3 | Health administration and insurance (not disaggregated) | - | - | - | - | - | 6,332,899,366 | 23,884,284,787 | - | - | 33,554,389,517 |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 6,935,954,322 | 1,981,144,182 | - | - | 11,829,084,546 |
| HC.nsk | Not specified by kind | - | - | - | - | - | 52,271,314 | 672,232,693 | - | 417,117,363 | 1,224,865,331 |
| | **Column Total-THE** | **665,041,441** | **51,046,767** | **1,382,582,579** | **1,499,733,751** | **16,273,418,809** | **41,115,591,300** | **31,278,832,851** | **219,644,829** | **662,084,863** | **169,574,434,271** |
| HCR.2 | Education & Training | | | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | | | |

Annex A-4

# PROVIDER x FUNCTION (HP x HC)

## General NHA

| | | HP.8.1 | HP.8.2 | HP.8.3 | |
|---|---|---|---|---|---|
| | **Function** | Research Institutions | Education and training institutions | Other health related institutions | NHE Row Total |
| HC.1.1 | In patient curative care | | | | |
| HC.1.3 | Out patient curative care | | | | |
| HC.1.4 | Services of curative home | | | | |
| HC.4.1 | Clinical lab (BNC, biolab, | | | | |
| HC.4.2 | Diagnostic imaging | | | | |
| HC.5.1 | Pharmaceuticals and other | | | | |
| HC.5.2.1 | Glasses and other vision | | | | |
| HC.6.1 | Maternal and child care, family | | | | |
| HC.6.2 | School health services | | | | |
| HC.6.3 | Prevention of communicable disease (e.g., HIV/AIDS, | | | | |
| HC.6.3.1.2 | Blood supply | | | | |
| HC 6.4 | Prevention of noncommunicable diseases | | | | |
| HC 6.6 | Training within public health | | | | |
| HC.6.9 | OTHER miscellaneous public | | | | |
| HC.6.10 | Public health programs that | | | | |
| HC.7.2.2.1 + HC.7.2.2.2 | local and external consultancies | | | | |
| HC.7.2.2.3 | Health administration and insurance (not disaggregated) | | | | |
| HCR.1 | Capital formation for health care provider institutions | | | | |
| HC.nsk | Not specified by kind | | | | |
| | **Column Total-THE** | | | | |
| HCR.2 | Education & Training | 0 | 892,601,493 | 0 | 892,601,493 |
| HCR.3 | Research & Development | 2,950,958,977 | 0 | 0 | 2,950,958,977 |
| | **Column Total-NHE** | 2,950,958,977 | 892,601,493 | - | **173,417,994,741** |

Annex A-5

## FINANCING SOURCE x FINANCING AGENT (FSxHF)

### HIV/AIDS Subaccounts (Targeted and untargeted)

**Financing Source (FS)**

| Code | Financing Agent (HF) | | | FS.2 Private Funds | | | | FS.3 | FS.nsk | Row Total | FS.Addendum - Govt | FS.Addendum - Donors |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FS.1.1.1 Central Gov Revenue<br>FS.1.1.1.4 could not be disaggregated | FS. 1.2 Other Public funds | FS.2.1.1 Parastatal Employers | FS.2.1.2 Private Employers | FS.2.2 Households | FS.2.4 Other private funds | Rest of the World (Donors) | Not specified by any kind | | Non-health spending | Non-health spending |
| HF.1.1.1.1 | MoH (MiniSante) | 556,520,854 | 560,534 | | | | | 1,102,439,970 | | 1,659,521,358 | | |
| HF.1.1.1.2 | Other Ministries (except CNLS) | 165,528,526 | | | | | | 5,506,336 | | 171,034,863 | | |
| HF.1.1.1.3.1 | CNLS | 288,080,280 | 530,000 | | | | | 587,134,348 | 213,861,233 | 1,089,605,861 | | |
| HF.1.1.1.3.2.1 | CNLS-UNDP | | | | | | | 160,410,358 | | 160,410,358 | | |
| HF.1.1.1.3.2.2 | CNLS-BAD | 13,584,348 | | | | | | 251,801,927 | | 265,386,274 | | |
| HF.1.1.1.3.2.3 | CNLS-MAP | | | | | | | 5,063,564,586 | | 5,063,564,586 | | |
| HF.1.1.1.3.2.4 | CNLS-GF | | | | | | | 7,138,288,980 | | 7,138,288,980 | | |
| HF.1.1.3 | Local Municipal Gvt (Districts) | | | | | | | 65,222,465 | | 65,222,465 | | |
| HF.1.2 | Social Security Fund (CSR) | | | 125,483 | 74,714 | | | | | 200,197 | | |
| HF.1.3 | FARG | 14,559,589 | | | | 233,671 | | | | 14,793,260 | | |
| HF.2.1.1 | Gvt Employees Insurance Programme (RAMA) | 2,272,508 | | 14,368,505 | | 790,055 | 2,441,216 | | | 19,872,283 | | |
| HF.2.1.2 | Private Employees Insurance Programme | | | | 673,900 | 57,342 | | | | 731,242 | | |
| HF.2.1.3 | Mutuelles (Employer-paid & Community based) | 8,487,928 | | 1,846,183 | 7,505,801 | 86,036,787 | | 12,224,873 | | 116,101,571 | | |
| HF. 2.5.1 | Parastatal companies | | | 28,113 | | | | | | 28,113 | | |
| HF.2.2 | Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)* | | | 55,901 | 557,531 | 115,177 | | | | 728,609 | | |
| HF.2.3. | Private household out of pocket payments | | | | | 863,188,381 | | | | 863,188,381 | | |
| HF.2.4 | Non profit institutions (NGOs, SWAA, PROFEMME) | 13,435,394 | | | | 54,081 | | 21,138,402,799 | | 21,151,892,275 | | |
| HF.2.5.2 | Private Non Parastatal Firms | | | | 18,900 | | | | | 18,900 | | |
| HF.3 | Rest of World | | | | | | | 2,702,133,111 | | 2,702,133,111 | | |
| HF.nsk | Not specified by any kind | | | | | | | | | 0 | | |
| | **Column Total (THE)** | 1,062,469,427 | 1,090,534 | 16,424,185 | 8,830,846 | 950,475,494 | 2,441,216 | 38,227,129,753 | 213,861,233 | **40,482,722,687** | | |
| HF. Health | Financing Agents spending on Health Related Items | | | | | | | 358,001,504 | | 358,001,504 | | |
| | **Column Total (NHE)** | 1,062,469,427 | 1,090,534 | 16,424,185 | 8,830,846 | 950,475,494 | 2,441,216 | 38,585,131,257 | 213,861,233 | **40,840,724,191** | | |
| Addendum | Financing agents spending on NONHEALTH | | | | | | | | | | 1,325,396,756 | 5,832,134,709 |
| | **Column Total (THAE)** | 1,062,469,427 | 1,090,534 | 16,424,185 | 8,830,846 | 950,475,494 | 2,441,216 | 38,585,131,257 | 213,861,233 | **47,998,255,657** | | |

Annex A-6

**FINANCING AGENT x PROVIDER (HFxP)**

**HIV/AIDS Subaccounts (Targeted and untargeted)**

| | | Financing Agent | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | HF.A Public Sector | | | | | | | |
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3.1 | HF.1.1.1.3.2.1 | HF.1.1.1.3.2.2 | HF.1.1.1.3.2.3 | HF.1.1.1.3.2.4 | HF.1.1.3 |
| | **Provider** | MoH (MiniSante) | Other Ministries (except CNLS) | CNLS | CNLS-UNDP | CNLS-BAD | CNLS-MAP | CNLS-GF | Local Municipal Gvt (Districts) |
| HP.1.1.1.1 | National Referral Gvt Hospital | 25,106,822 | 9,851,042 | | | | 996,459,831 | 2,207,513,615 | |
| HP.1.1.1.2 | National Referral Private Hospital | 51,631,465 | | | | | 513,327,792 | 1,039,263,335 | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | |
| HP.1.1.2.1 | District Gvt. Hospitals | | 2,239,501 | | | | 362,349,029 | 733,597,648 | |
| HP.1.1.2.2 | District Agrees Hospitals | | 1,370,509 | | | | 150,978,762 | 305,665,687 | |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | |
| HP.1.2 | Mental health hospitals | | | | | | | | |
| HP.3.1 | Office of physicians (private clinics)* | | | | | | | | |
| HP.3.3.1 | Community health workers | | | | | | | | |
| HP.3.3.2 | Traditional healer | | | | | | | | |
| HP.3.3.3 | Other health practitioners | | | | | | | | |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | | | | | |
| HP.3.4.5.1 | Public health centers | 72,226,483 | 2,487,832 | | | | 208,357,593 | 1,222,662,747 | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 14,900,745 | 2,003,476 | | | | 135,432,435 | 794,730,785 | |
| HP.3.4.5.3 | NGO health centers | | | | | | | | |
| HP.3.4.5.9 | Mobile health centers | | | | | | | | |
| HP. 3.4.9 | TRAC HIV/AIDS Center | 113,114,054 | | | | | | | |
| HP.3.9.1 | Ambulance services | | | | | | | | |
| HP.3.6 | Providers of home health care services | 47,961,153 | | | | | | | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | |
| HP.4.1 | Dispensing chemists | | | | | | | | |
| HP.5 | Providers + admin of public health programs | 599,348,858 | 5,344,394 | 1,049,658,028 | 160,410,358 | 265,386,274 | 2,696,659,143 | 145,009,985 | |
| | | | | | | | | | |
| | | | | | | | | | |
| HP.6 | General health administration and insurance | 735,231,779 | 147,738,109 | 39,947,833 | | | | 682,313,955 | |
| HP. 8 | Institutions providing health related services | | | | | | | | |
| HP.9 | Rest of the world | | | | | | | 7,531,224 | |
| HP.nsk | Providers not specified by any kind | | | | | | | | 65,222,465 |
| | **Column Total THE** | 1,659,521,358 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,063,564,586 | 7,138,288,980 | 65,222,465 |
| | **HF Totals From FS x HF Table** | 1,659,521,358 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,063,564,586 | 7,138,288,980 | 65,222,465 |
| HP.8.1 | Research Institutions | 117,683,834 | | | | | | | |
| HP.8.2 | Education and training institutions | 33,203,875 | | | | | 5,517,400 | 36,690,576 | |
| HP.8.3 | Other health related institutions | | | | | | | | |
| | **Subtotal for health related** | 150,887,709 | - | - | - | - | 5,517,400 | 36,690,576 | - |
| | **Column Total: NHE** | 1,810,409,068 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,069,081,986 | 7,174,979,556 | 65,222,465 |
| HP.Addend | Providers of NONHEALTH programs | | | | | | #REF! | | |
| | **subtotal for nonhealth** | - | - | - | - | - | #REF! | | - |
| | **Column total: THAE (health, health related, nonh** | 1,810,409,068 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | #REF! | 7,174,979,556 | 65,222,465 |

*=Many private clinics are headed by a nurse, not a physician

Annex A-6

**FINANCING AGENT x PROVIDER (HFxP)**

**HIV/AIDS Subaccounts (Targeted and untargeted)**

| | | HF.A Public Sector | | | | | | HF B: Non Public Sector | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 | HF.2.2 | HF.2.3. | HF.2.4 |
| | **Provider** | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme | Mutuelles (Employer-paid & Community based) | Parastatal companies | Private Insurance Enterprises (other than social insurance: COGEAR, | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) |
| HP.1.1.1.1 | National Referral Gvt Hospital | | 3,652,365 | | | 3,726,005 | | | 114,409,397 | 1,173,792,043 |
| HP.1.1.1.2 | National Referral Private Hospital | 76,422 | 4,252,846 | 12,578,795 | 281,808 | | | 280,793 | 20,687,995 | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | |
| HP.1.1.2.1 | District Gvt. Hospitals | 28,708 | 1,597,574 | 3,279,309 | 84,827 | 26,063,740 | | 84,521 | 84,143,557 | 428,634,575 |
| HP.1.1.2.2 | District Agrees Hospitals | 22,227 | 1,236,928 | 472,048 | 60,956 | 20,179,948 | | 60,736 | 41,863,317 | 188,222,217 |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | |
| HP.1.2 | Mental health hospitals | | | | | | | | | |
| HP.3.1 | Office of physicians (private clinics)* | | | 40,226 | 809 | | 28,113 | 806 | 49,611,576 | |
| HP.3.3.1 | Community health workers | | | | | | | | 194,438 | 572,880,180 |
| HP.3.3.2 | Traditional healer | | | | | | | | 94,023,410 | |
| HP.3.3.3 | Other health practitioners | | | | | | | | 4,673,784 | |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | | | | | | |
| HP.3.4.5.1 | Public health centers | 40,348 | 2,245,347 | 2,045,715 | 160,348 | 36,631,874 | | 159,771 | 196,679,980 | 1,187,532,695 |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 32,493 | 1,808,200 | 1,456,190 | 142,495 | 29,500,004 | | 141,982 | 25,898,452 | 779,231,412 |
| HP.3.4.5.3 | NGO health centers | | | | | | | | | |
| HP.3.4.5.9 | Mobile health centers | | | | | | | | 16,670 | |
| HP. 3.4.9 | TRAC HIV/AIDS Center | | | | | | | | | |
| HP.3.9.1 | Ambulance services | | | | | | | | | |
| HP.3.6 | Providers of home health care services | | | | | | | | | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | |
| HP.4.1 | Dispensing chemists | | | | | | | | 160,919,378 | |
| HP.5 | Providers + admin of public health programs | | | | | | | | | 8,002,935,487 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| HP.6 | General health administration and insurance | | | | | | | | | 8,584,434,921 |
| HP. 8 | Institutions providing health related services | | | | | | | | | |
| HP.9 | Rest of the world | | | | | | | | | |
| HP.nsk | Providers not specified by any kind | | | | | | | | 70,066,428 | 234,228,745 |
| | **Column Total THE** | 200,197 | 14,793,260 | 19,872,283 | 731,242 | 116,101,571 | 28,113 | 728,609 | 863,188,381 | 21,151,892,275 |
| | **HF Totals From FS x HF Table** | 200,197 | 14,793,260 | 19,872,283 | 731,242 | 116,101,571 | 28,113 | 728,609 | 863,188,381 | 21,151,892,275 |
| HP.8.1 | Research Institutions | | | | | | | | | 150,100,038 |
| HP.8.2 | Education and training institutions | | | | | | | | | 14,805,781 |
| HP.8.3 | Other health related institutions | | | | | | | | | |
| | **Subtotal for health related** | - | - | - | - | - | - | - | - | 164,905,819 |
| | **Column Total: NHE** | 200,197 | 14,793,260 | 19,872,283 | 731,242 | 116,101,571 | 28,113 | 728,609 | 863,188,381 | 21,316,798,094 |
| HP.Addend | Providers of NONHEALTH programs | | #REF! | | | | | | | 1,940,314,689 |
| | **subtotal for nonhealth** | - | #REF! | - | - | - | - | - | - | 1,940,314,689 |
| | **Column total: THAE (health, health related, nonhe** | 200,197 | #REF! | 19,872,283 | 731,242 | 116,101,571 | 28,113 | 728,609 | 863,188,381 | 23,257,112,783 |

*=Many private clinics are headed by a nurse, not a physician

Annex A-6

**FINANCING AGENT x PROVIDER (HFxP)**

**HIV/AIDS Subaccounts (Targeted and untargeted)**

| | | Non Public | HF.3 ROW | HF.nsk | | HF, Addendum |
|---|---|---|---|---|---|---|
| | | HF.2.5.2 | HF.3 | HF.nsk | | |
| | **Provider** | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total | Non health addendums |
| HP.1.1.1.1 | National Referral Gvt Hospital | | 723,686,225 | | 5,258,197,343 | |
| HP.1.1.1.2 | National Referral Private Hospital | | 248,211,108 | | 1,890,592,358 | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | - | |
| HP.1.1.2.1 | District Gvt. Hospitals | 4,427 | 175,207,841 | | 1,817,315,256 | |
| HP.1.1.2.2 | District Agrees Hospitals | 3,832 | 73,003,267 | | 783,140,435 | |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | - | |
| HP.1.2 | Mental health hospitals | | | | - | |
| HP.3.1 | Office of physicians (private clinics)* | 10,641 | | | 49,692,171 | |
| HP.3.3.1 | Community health workers | | | | 573,074,618 | |
| HP.3.3.2 | Traditional healer | | | | 94,023,410 | |
| HP.3.3.3 | Other health practitioners | | | | 4,673,784 | |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | - | |
| HP.3.4.5.1 | Public health centers | | 855,475,046 | | 3,786,705,778 | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | | 556,058,780 | | 2,341,337,448 | |
| HP.3.4.5.3 | NGO health centers | | | | - | |
| HP.3.4.5.9 | Mobile health centers | | | | 16,670 | |
| HP. 3.4.9 | TRAC HIV/AIDS Center | | | | 113,114,054 | |
| HP.3.9.1 | Ambulance services | | | | - | |
| HP.3.6 | Providers of home health care services | | | | 47,961,153 | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | - | |
| HP.4.1 | Dispensing chemists | | | | 160,919,378 | |
| HP.5 | Providers + admin of public health programs | | 54,037,045 | | 12,978,789,572 | |
| | | | | | - | |
| | | | | | - | |
| HP.6 | General health administration and insurance | | 16,453,800 | | 10,206,120,397 | |
| HP. 8 | Institutions providing health related services | | | | - | |
| HP.9 | Rest of the world | | | | 7,531,224 | |
| HP.nsk | Providers not specified by any kind | | | | 369,517,638 | |
| | **Column Total THE** | 18,900 | 2,702,133,111 | - | **40,482,722,687** | |
| | **HF Totals From FS x HF Table** | 18,900 | 2,702,133,111 | - | 40,482,722,687 | |
| HP.8.1 | Research Institutions | | | | 267,783,872 | |
| HP.8.2 | Education and training institutions | | | | 90,217,632 | |
| HP.8.3 | Other health related institutions | | | | - | |
| | **Subtotal for health related** | - | - | - | 358,001,504 | |
| | **Column Total: NHE** | 18,900 | 2,702,133,111 | - | **40,840,724,191** | |
| HP.Addend | Providers of NONHEALTH programs | | #REF! | | | |
| | **subtotal for nonhealth** | - | #REF! | - | | **#REF!** |
| | **Column total: THAE (health, health related, nonh** | 18,900 | #REF! | - | | **#REF!** |

*=Many private clinics are headed by a nurse, not a physician

Annex A-7

## FINANCING AGENTS x FUNCTION (HF x HC)

**HIV/AIDS Subaccounts (Targeted and untargeted)**

**Financing Agent**

| Function | | HF.A Public Sector | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3.1 | HF.1.1.1.3.2.1 | HF.1.1.1.3.2.2 | HF.1.1.1.3.2.3 | HF.1.1.1.3.2.4 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | | MoH (MiniSante) | Other Ministries (except CNLS) | CNLS | CNLS-UNDP | CNLS-BAD | CNLS-MAP | CNLS-GF | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme | Mutuelles (Employer-paid & Community based) | Parastatal companies |
| HC. 1.1.1 | IP ARV curative care | - | - | - | - | - | - | 912,036,685 | - | - | - | - | - | - | - |
| HC. 1.1.2 | IP OI Treatment | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.1.1.4 | IP care that cannot be disaggregated | 49,928,388 | 3,741,371 | - | - | - | 945,860,266 | 820,349,277 | - | 47,607 | 2,891,927 | 3,093,159 | 302,989 | 42,422,789 | - |
| HC. 1.3.5 | OP STI Management | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC. 1.3.6 | OP opportunistic infection treatment | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC .1.3.7 | OP ARV treatment | - | - | - | - | - | - | 3,741,211,708 | - | - | - | - | - | - | - |
| HC1.3.8 | OP Psychosocial support | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC 1.3.10 | OP care that cannot be disaggregated | 227,051,180 | 14,210,988 | - | - | - | 654,327,514 | 829,836,146 | - | 152,590 | 11,901,332 | 16,779,124 | 428,252 | 73,678,782 | 28,113 |
| HC.1.3.11 | VCT as part of OP care | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.1.3.12 | PMTCT service delivery | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. | 3,689,319 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1 | PMTCT | 47,961,153 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC. 6.3.1.1 | VCT | 307,574,200 | 147,738,109 | - | - | - | - | - | - | - | - | - | - | - | - |
| HC. 6.3.1.2 | Blood supply | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.4 | IEC programmes | 10,050,091 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.5 | STI prevention programmes | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.7 | Condom distribution programmes | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.8 | ART programmes | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.9 | Surveillance | 23,508,299 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | 46,316,535 | - | - | - | - | 65,516,008 | - | - | - | - | - | - | - | - |
| HC.6.3.1.12 | Other public health programs (including | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | 205,876,046 | 5,344,394 | 1,049,658,028 | 12,383,828 | 25,966,091 | 886,378,702 | 152,541,208 | - | - | - | - | - | - | - |
| HC.7.2.2.1 | Local consultancies | 17,926,977 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | 675,219,721 | - | 39,947,833 | 148,026,530 | 239,420,183 | 1,744,764,434 | 682,313,955 | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | 44,419,448 | - | - | - | - | 766,717,662 | - | - | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | 65,222,465 | - | - | - | - | - | - |
| | **Column Total THE** | 1,659,521,358 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,063,564,586 | 7,138,288,980 | 65,222,465 | 200,197 | 14,793,260 | 19,872,283 | 731,242 | 116,101,571 | 28,113 |
| HCR.2 | Education & Training | 33,203,875 | - | - | - | - | 5,517,400 | 36,690,576 | - | - | - | - | - | - | - |
| HCR.3 | Research & Development | 117,683,834 | - | - | - | - | - | - | - | - | - | - | - | - | - |
| | *Sub total column* | 150,887,709 | - | - | - | - | 5,517,400 | 36,690,576 | - | - | - | - | - | - | - |
| | **Column Total NHE** | 1,810,409,068 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,069,081,986 | 7,174,979,556 | 65,222,465 | 200,197 | 14,793,260 | 19,872,283 | 731,242 | 116,101,571 | 28,113 |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| AD.1.2.3 | School fees to OVC | - | - | - | - | - | 1,318,535,777 | - | - | - | 1,325,396,756 | - | - | - | - |
| AD.1.2.5 | Social support to OVCs not disaggregated | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| AD.1.3.1 | Income-generating activities | - | - | - | - | - | 1,411,665,314 | - | - | - | - | - | - | - | - |
| AD.2 | Policy advocacy | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| AD.3 | Non-helath IEC- social stigma reductin | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| AD.4 | Empowerment and organization (incl. Legal services) | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| - | subtotal column | - | - | - | - | - | 2,730,201,091 | - | - | - | 1,325,396,756 | - | - | - | - |
| - | **Column total -- THAE (health, hea** | 1,810,409,068 | 171,034,863 | 1,089,605,861 | 160,410,358 | 265,386,274 | 7,799,283,077 | | 65,222,465 | 200,197 | 1,340,190,016 | 19,872,283 | 731,242 | 116,101,571 | 28,113 |

Annex A-7

## FINANCING AGENTS x FUNCTION (HF x HC)

**HIV/AIDS Subaccounts (Targeted and untargeted)**

| | | | | | - | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | - |
| | Function | Private Insurance Enterprises (other than social insurance: COGEAR, | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HC. 1.1.1 | IP ARV curative care | - | - | - | - | - | - | 912,036,685 |
| HC. 1.1.2 | IP OI Treatment | - | - | 126,441,201 | - | - | - | 126,441,201 |
| HC.1.1.4 | IP care that cannot be disaggregated | 301,898 | 210,795,503 | 37,229,480 | 8,259 | 823,786,529 | - | 2,940,759,445 |
| HC. 1.3.5 | OP STI Management | - | - | 131,893,843 | - | - | - | 131,893,843 |
| HC. 1.3.6 | OP opportunistic infection treatment and | - | - | 505,764,805 | - | - | - | 505,764,805 |
| HC .1.3.7 | OP ARV treatment | - | - | 892,116,670 | - | - | - | 4,633,328,378 |
| HC1.3.8 | OP Psychosocial support | - | - | 516,147,976 | - | - | - | 516,147,976 |
| HC 1.3.10 | OP care that cannot be disaggregated | 426,710 | 419,604,854 | 92,173,999 | 10,641 | 878,143,474 | - | 3,218,753,701 |
| HC.1.3.11 | VCT as part of OP care | - | - | 876,795,887 | - | - | - | 876,795,887 |
| HC.1.3.12 | PMTCT service delivery | - | - | 482,270,240 | - | 929,712,263 | - | 1,411,982,503 |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | 160,919,378 | - | - | - | - | 160,919,378 |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. | - | - | - | - | - | - | 3,689,319 |
| HC.6.1.1 | PMTCT | - | - | 1,104,440,127 | - | - | - | 1,152,401,280 |
| HC. 6.3.1.1 | VCT | - | - | 1,236,646,405 | - | - | - | 1,691,958,714 |
| HC. 6.3.1.2 | Blood supply | - | - | 445,982,651 | - | - | - | 445,982,651 |
| HC.6.3.1.4 | IEC programmes | - | - | 2,138,497,958 | - | - | - | 2,148,548,049 |
| HC.6.3.1.5 | STI prevention programmes | - | - | 1,680,803,596 | - | - | - | 1,680,803,596 |
| HC.6.3.1.7 | Condom distribution programmes | - | - | 141,646,500 | - | - | - | 141,646,500 |
| HC.6.3.1.8 | ART programmes | - | - | 1,122,316,065 | - | - | - | 1,122,316,065 |
| HC.6.3.1.9 | Surveillance | - | - | 174,251,628 | - | - | - | 197,759,927 |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | - | 27,546,639 | - | - | - | 139,379,181 |
| HC.6.3.1.12 | Other public health programs (including | - | - | 791,001,187 | - | - | - | 791,001,187 |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | - | 120,600,278 | - | 70,490,845 | - | 2,529,239,421 |
| HC.7.2.2.1 | Local consultancies | - | - | - | - | - | - | 17,926,977 |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | - | 5,775,470,604 | - | - | - | 9,305,163,260 |
| HCR.1 | Capital formation for health care provider institutions | - | - | 2,426,830,003 | - | - | - | 3,237,967,113 |
| HC.nsk | Not specified by kind | - | 71,868,647 | 305,024,535 | - | - | - | 442,115,647 |
| | **Column Total THE** | 728,609 | 863,188,381 | 21,151,892,275 | 18,900 | 2,702,133,111 | - | **40,482,722,687** |
| HCR.2 | Education & Training | - | - | 14,805,781 | - | - | - | 90,217,632 |
| HCR.3 | Research & Development | - | - | 150,100,038 | - | - | - | 267,783,872 |
| | *Sub total column* | - | - | 164,905,819 | - | - | - | 358,001,504 |
| | **Column Total NHE** | 728,609 | 863,188,381 | 21,316,798,094 | 18,900 | 2,702,133,111 | - | **40,840,724,191** |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | - | - | 25,054,513 | - | - | - | 25,054,513 |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | - | - | 510,395,391 | - | - | - | 510,395,391 |
| AD.1.2.3 | School fees to OVC | - | - | - | - | - | - | 2,643,932,534 |
| AD.1.2.5 | Social support to OVCs not disaggregated | - | - | 1,236,971,795 | - | - | - | 1,236,971,795 |
| AD.1.3.1 | Income-generating activities | - | - | - | - | 1,161,618,929 | - | 2,573,284,243 |
| AD.2 | Policy advocacy | - | - | 7,228,213 | - | - | - | 7,228,213 |
| AD.3 | Non-helath IEC- social stigma reductin | - | - | 59,719,881 | - | - | - | 59,719,881 |
| AD.4 | Empowerment and organization (incl. Legal services) | - | - | 100,944,896 | - | - | - | 100,944,896 |
| - | subtotal column | - | - | 1,940,314,689 | - | 1,161,618,929 | - | 7,157,531,466 |
| - | **Column total -- THAE (health, healt** | 728,609 | 863,188,381 | 23,257,112,783 | 18,900 | 3,863,752,040 | - | **47,998,255,657** |

Annex A-8

## PROVIDER x FUNCTION (HP x HC)

**HIV/AIDS Subaccounts (Targeted and untargeted)**

| | | Provider | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.2.1 | HP.1.1.2.2 | HP.3.1 | HP.3.3.1 | HP.3.3.2 | HP.3.3.3 | HP.3.4.5.1 | HP.3.4.5.2 |
| | Function | National Referral Gvt Hospital | National Referral Private Hospital | District Gvt. Hospitals | District Agrees Hospitals | Office of physicians (private clinics)* | Community health workers | Traditional healer | Other health practitioners | Public health centers | Government assisted not-for-profit health |
| HC. 1.1.1 | IP ARV curative care | 153,557,197 | 79,105,223 | 502,550,826 | 23,266,242 | - | - | - | - | 93,064,968 | 60,492,229 |
| HC. 1.1.2 | IP OI Treatment | 24,708,957 | - | 8,985,075 | 2,632,582 | - | - | - | - | 54,614,902 | 35,499,686 |
| HC. 1.1.3 | Other IP care | - | - | - | - | - | - | - | - | - | - |
| HC.1.1.4 | IP care that cannot be disaggregated | 1,610,309,142 | 345,446,262 | 473,296,892 | 178,674,638 | 2,470,338 | - | - | 207,400 | 165,477,734 | 116,899,217 |
| HC. 1.3.5 | OP STI Management | 70,063,028 | - | 25,477,465 | 2,464,157 | - | - | - | - | 20,538,906 | 13,350,289 |
| HC. 1.3.6 | OP opportunistic infection treatment and | 98,835,826 | - | 35,940,300 | 10,530,327 | - | - | - | - | 218,459,607 | 141,998,744 |
| HC .1.3.7 | OP ARV treatment | 1,658,609,159 | 711,947,004 | 156,418,758 | 249,812,309 | - | - | - | - | 1,125,176,454 | 731,364,695 |
| HC1.3.8 | OP Psychosocial support | 168,406,582 | - | 61,238,757 | 20,089,042 | - | 97,760,629 | - | - | 101,628,457 | 66,058,497 |
| HC .1.3.9 | Other OP care | - | - | - | - | - | - | - | - | - | - |
| HC 1.3.10 | OP care that cannot be disaggregated | 705,849,590 | 623,751,867 | 274,186,142 | 192,116,104 | 47,221,833 | 194,438 | 94,023,410 | 2,664,165 | 765,949,907 | 399,682,191 |
| HC.1.3.11 | VCT as part of OP care | 363,765,329 | - | 132,278,301 | 42,328,894 | - | - | - | - | 203,746,453 | 132,435,195 |
| HC.1.3.12 | PMTCT service delivery | 151,075,706 | - | 54,936,620 | 22,890,259 | - | - | - | - | 717,018,132 | 466,061,786 |
| HC 1.4 | Services of curative home care (HIV/AIDS) | - | - | - | - | - | - | - | - | - | - |
| HC 5.1.1.1 | ARV durgs | - | - | - | - | - | - | - | - | - | - |
| HC 5.1.1.2 | Other drugs | - | - | - | - | - | - | - | - | - | - |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | - | - | - | - | - | - | - | - | - |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. of | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1 | PMTCT | - | - | - | - | - | - | - | - | 47,961,153 | - |
| HC. 6.2 | School health services | - | - | - | - | - | - | - | - | - | - |
| HC. 6.3.1.1 | VCT | - | - | - | - | - | - | - | - | 1,059,054 | 688,385 |
| HC. 6.3.1.2 | Blood supply | - | - | - | - | - | 34,567,473 | - | - | 118,666,519 | 77,133,238 |
| HC.6.3.1.3 | Post exposure phrophalaxis | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.4 | IEC programmes | - | - | - | - | - | 3,681,595 | - | - | - | - |
| HC.6.3.1.5 | STI prevention programmes | - | - | - | - | - | 368,581,836 | - | - | - | - |
| HC. 6.3.1.6 | Needle Programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.7 | Condom distribution programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.8 | ART programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.9 | Surveillance | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.10 | Nutritional programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.12 | Other public health programs (including OI , psychosocial support) | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | - | - | - | - | - | - | - | - | - |
| HC.7 | Health administration and health insurance (not disaggregated) | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.1 | Local consultancies | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.2 | External consultancies | - | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | - | - | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | 253,016,828 | 130,342,003 | 92,006,119 | 38,335,883 | - | - | - | - | 153,343,532 | 99,673,296 |
| HC.nsk | Not specified by kind | - | - | - | - | - | 68,288,647 | - | 1,802,219 | - | - |
| | **Column Total-THE** | **5,258,197,343** | **1,890,592,358** | **1,817,315,256** | **783,140,435** | **49,692,171** | **573,074,618** | **94,023,410** | **4,673,784** | **3,786,705,778** | **2,341,337,448** |
| HCR.2 | Education & Training | | | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | | | |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | | | | | | | | | | |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | | | | | | | | | | |
| AD.1.2.3 | School fees to OVC | | | | | | | | | | |
| AD.1.2.5 | Social support to OVCs not disaggregated | | | | | | | | | | |
| AD.1.3.1 | Income-generating activities | | | | | | | | | | |
| AD.2 | Policy advocacy | | | | | | | | | | |
| AD.3 | Non-helath IEC- social stigma reductin | | | | | | | | | | |
| AD.4 | Empowerment and organization (incl. Legal services) | | | | | | | | | | |
| - | **Column total -- THAE (health, health related, nonhealth)** | | | | | | | | | | |

Annex A-8

## PROVIDER x FUNCTION (HP x HC)

**HIV/AIDS Subaccounts (Targeted and untargeted)**

| | | HP.3.4.5.9 | HP.3.4.5.9 | HP.3.6 | HP.4.1 | HP.5 | HP.6 | HP.9 | HP.nsk | | HP.8.1 | HP.8.2 | HP.8.3 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Function** | Mobile health centers | TRAC HIV/AIDS Center | Providers of home health care services | Dispensing chemists | Providers + admin of public health programs | General health administration and insurance | Rest of the world | Providers not specified by any kind | **THE Row Total** | Research Institutions | Education and training institutions | Other health related institutions | NHE Row Total | Providers of NONHEALTH programs |
| HC. 1.1.1 | IP ARV curative care | - | - | - | - | - | - | - | - | 912,036,685 | | | | | |
| HC. 1.1.2 | IP OI Treatment | - | - | - | - | - | - | - | - | 126,441,201 | | | | | |
| HC. 1.1.3 | Other IP care | - | - | - | - | - | - | - | - | - | | | | | |
| HC.1.1.4 | IP care that cannot be disaggregated | 16,670 | - | 47,961,153 | - | - | - | - | - | 2,940,759,445 | | | | | |
| HC. 1.3.5 | OP STI Management | - | - | - | - | - | - | - | - | 131,893,843 | | | | | |
| HC. 1.3.6 | OP opportunistic infection treatment and | - | - | - | - | - | - | - | - | 505,764,805 | | | | | |
| HC .1.3.7 | OP ARV treatment | - | - | - | - | - | - | - | - | 4,633,328,378 | | | | | |
| HC1.3.8 | OP Psychosocial support | - | - | - | - | 966,012 | - | - | - | 516,147,976 | | | | | |
| HC .1.3.9 | Other OP care | - | - | - | - | - | - | - | - | - | | | | | |
| HC 1.3.10 | OP care that cannot be disaggregated | - | 113,114,054 | - | - | - | - | - | - | 3,218,753,701 | | | | | |
| HC.1.3.11 | VCT as part of OP care | - | - | - | - | 2,241,714 | - | - | - | 876,795,887 | | | | | |
| HC.1.3.12 | PMTCT service delivery | - | - | - | - | - | - | - | - | 1,411,982,503 | | | | | |
| HC 1.4 | Services of curative home care (HIV/AIDS) | - | - | - | - | - | - | - | - | - | | | | | |
| HC 5.1.1.1 | ARV durgs | - | - | - | - | - | - | - | - | - | | | | | |
| HC 5.1.1.2 | Other drugs | - | - | - | - | - | - | - | - | - | | | | | |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | - | - | 160,919,378 | - | - | - | - | 160,919,378 | | | | | |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. of | - | - | - | - | 3,689,319 | - | - | - | 3,689,319 | | | | | |
| HC.6.1.1 | PMTCT | - | - | - | - | 1,104,440,127 | - | - | - | 1,152,401,280 | | | | | |
| HC. 6.2 | School health services | - | - | - | - | - | - | - | - | - | | | | | |
| HC. 6.3.1.1 | VCT | - | - | - | - | 1,542,473,165 | 147,738,109 | - | - | 1,691,958,714 | | | | | |
| HC. 6.3.1.2 | Blood supply | - | - | - | - | 215,615,420 | - | - | - | 445,982,651 | | | | | |
| HC.6.3.1.3 | Post exposure phrophalaxis | - | - | - | - | - | - | - | - | - | | | | | |
| HC.6.3.1.4 | IEC programmes | - | - | - | - | 1,972,016,280 | 172,850,174 | - | - | 2,148,548,049 | | | | | |
| HC.6.3.1.5 | STI prevention programmes | - | - | - | - | 1,202,388,718 | 109,833,043 | - | - | 1,680,803,596 | | | | | |
| HC. 6.3.1.6 | Needle Programmes | - | - | - | - | - | - | - | - | - | | | | | |
| HC.6.3.1.7 | Condom distribution programmes | - | - | - | - | 131,988,114 | 9,658,386 | - | - | 141,646,500 | | | | | |
| HC.6.3.1.8 | ART programmes | - | - | - | - | 1,122,316,065 | - | - | - | 1,122,316,065 | | | | | |
| HC.6.3.1.9 | Surveillance | - | - | - | - | 110,356,454 | 87,403,473 | - | - | 197,759,927 | | | | | |
| HC.6.3.1.10 | Nutritional programmes | - | - | - | - | - | - | - | - | - | | | | | |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | - | - | - | 66,338,316 | 73,040,865 | - | - | 139,379,181 | | | | | |
| HC.6.3.1.12 | Other public health programs (including OI , psychosocial support) | - | - | - | - | 791,001,187 | - | - | - | 791,001,187 | | | | | |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | - | - | - | 2,505,254,397 | 16,453,800 | 7,531,224 | - | 2,529,239,421 | | | | | |
| HC.7 | Health administration and health insurance (not disaggregated) | - | - | - | - | - | - | - | - | - | | | | | |
| HC.7.2.2.1 | Local consultancies | - | - | - | - | - | 17,926,977 | - | - | 17,926,977 | | | | | |
| HC.7.2.2.2 | External consultancies | - | - | - | - | - | - | - | - | - | | | | | |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | - | - | - | 2,205,197,140 | 7,099,966,120 | - | - | 9,305,163,260 | | | | | |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 2,471,249,451 | - | - | 3,237,967,113 | | | | | |
| HC.nsk | Not specified by kind | - | - | - | - | 2,507,143 | - | - | 369,517,638 | 442,115,647 | | | | | |
| | **Column Total-THE** | **16,670** | **113,114,054** | **47,961,153** | **160,919,378** | **12,978,789,572** | **10,206,120,397** | **7,531,224** | **369,517,638** | **40,482,722,687** | | | | | |
| HCR.2 | Education & Training | | | | | | | | | | 0 | 90,217,632 | 0 | 90,217,632 | |
| HCR.3 | Research & Development | | | | | | | | | | 267,783,872 | 0 | 0 | 267,783,872 | |
| | **Column Total-NHE** | | | | | | | | | | 267,783,872 | 90,217,632 | - | **40,840,724,191** | |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | | | | | | | | | | | | | | **25,054,513** |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | | | | | | | | | | | | | | **510,395,391** |
| AD.1.2.3 | School fees to OVC | | | | | | | | | | | | | | **2,643,932,534** |
| AD.1.2.5 | Social support to OVCs not disaggregated | | | | | | | | | | | | | | **1,236,971,795** |
| AD.1.3.1 | Income-generating activities | | | | | | | | | | | | | | **2,573,284,243** |
| AD.2 | Policy advocacy | | | | | | | | | | | | | | **7,228,213** |
| AD.3 | Non-helath IEC- social stigma reductin | | | | | | | | | | | | | | **59,719,881** |
| AD.4 | Empowerment and organization (incl. Legal services) | | | | | | | | | | | | | | **100,944,896** |
| - | **Column total -- THAE (health, health related, nonhealth)** | | | | | | | | | | | | | | **47,998,255,657** |

## FINANCING AGENT x PROVIDER (HFxP)

**Malaria Subaccounts targeted and untargeted**

**Financing Agent**

| | | HF.A Public Sector | | | | | | | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | |
| | **Provider** | MoH (MiniSante) | Other Ministries | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme | Mutuelles (Private & Community based) | Parastatal companies | Private Insurance Enterprises (other than social | Private household out of pocket payments | Non profit institutions (NGOs) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HP.1.1.1.1 | National Referral Gvt Hospital | 89,221,908 | 45,655,865 | | 17,114,313 | | | 17,459,377 | | | 1,133,558,339 | 326,411,562 | | 242,465,626 | | 1,871,886,989 |
| HP.1.1.1.2 | National Referral Private Hospital | 84,890,495 | | 125,650 | 6,992,368 | 20,681,577 | 629,741 | | | 627,473 | 305,146,201 | | | | | 419,093,504 |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | | | | | | | - |
| HP.1.1.2.1 | District Gvt. Hospitals | 39,086,500 | 33,960,187 | 435,329 | 24,225,903 | 49,728,026 | 1,229,108 | 395,235,224 | | 1,224,682 | 421,585,082 | 229,965,530 | 92,965 | | | 1,196,768,536 |
| HP.1.1.2.2 | District Agrees Hospitals | 16,646,582 | 13,837,191 | 224,413 | 12,488,500 | 4,765,976 | 667,014 | 203,744,536 | | 664,613 | 157,365,218 | 448,867,840 | 61,313 | | | 859,333,197 |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | | | | | | | - |
| HP.1.2 | Mental health hospitals | | | | | | | | | | | | | | | - |
| HP.3.1 | Office of physicians (private clinics)* | | | | | 288,966,096 | 5,809,052 | | 201,952,939 | 5,788,136 | 1,396,747,643 | | 76,439,357 | | | 1,975,703,223 |
| HP.3.3.1 | Community health workers | 4,485,321,000 | | | | | | | | | | 294,186,724 | | | | 4,779,507,724 |
| HP.3.3.2 | Traditional healer | | | | | | | | | | 83,780,058 | | | | | 83,780,058 |
| HP.3.3.3 | Other health | 128,584,047 | | | | | | | | | 68,065,140 | | | | | 196,649,187 |
| HP.3.4.2 | Outpatient mental | | | | | | | | | | | | | | | - |
| HP.3.4.5.1 | Public health centers | 351,082,525 | 63,847,023 | 1,035,476 | 57,623,948 | 52,500,649 | 2,977,427 | 940,110,031 | | 2,966,707 | 2,404,950,486 | 818,060,736 | | | | 4,695,155,009 |
| HP.3.4.5.2 | Government assisted not-for-profit health | 200,708,228 | 41,500,565 | 673,060 | 37,455,566 | 30,163,945 | 1,935,328 | 611,071,520 | | 1,928,359 | 507,518,673 | 594,066,022 | | | | 2,027,021,267 |
| HP.3.4.5.3 | NGO health centers | | | | | | | | | | | | | | | - |
| HP.3.5 | Medical and diagnostic laboratories | 2,000,000 | | | | | | | | | | | | | | 2,000,000 |
| HP.3.9.1 | Ambulance services | | | | | | | | | | | | | | | - |
| HP.3.6 | Providers of home | 6,208,098 | | | | | | | | | | | | | | 6,208,098 |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | | | | | | | - |
| HP.4.1 | Dispensing chemists | | | | | | | | | | 3,089,567,595 | 698,695,027 | | | | 3,788,262,622 |
| HP.5 | Providers + admin of | 602,670,461 | | | | | | | | | | 288,129,742 | | 185,704,394 | | 1,076,504,598 |
| HP.nsk | Providers not | | | | | | | | | | | 236,754,941 | | | | 236,754,941 |
| | **Column Total THE** | 6,070,603,761 | 198,800,831 | 2,493,927 | 155,900,598 | 446,806,269 | 13,247,670 | 2,167,620,688 | 201,952,939 | 13,199,970 | 9,568,284,436 | 4,152,123,415 | 76,593,635 | 502,792,583 | - | **23,570,420,722** |
| | **HF Totals From FS** | 6,070,603,761 | 198,800,831 | 2,493,927 | 155,900,598 | 446,806,269 | 13,247,670 | 2,167,620,688 | 201,952,939 | 13,199,970 | 9,568,284,436 | 4,152,123,415 | 76,593,635 | 502,792,583 | - | 23,570,420,722 |
| HP.8.1 | Research Institutions | 103,220,675 | | | | | | | | | | | | | | 103,220,675 |
| HP.8.2 | Education and training institutions | | | | | | | | | | | | | | | - |
| HP.8.3 | Other health related institutions | | | | | | | | | | | 29,806,595 | | | | 29,806,595 |
| | **Subtotal for healt** | 103,220,675 | - | - | - | - | - | - | - | - | - | 29,806,595 | - | - | - | 133,027,270 |
| | **Column Total: NHE** | 6,173,824,436 | 198,800,831 | 2,493,927 | 155,900,598 | 446,806,269 | 13,247,670 | ########### | 201,952,939 | 13,199,970 | 9,568,284,436 | 4,181,930,010 | 76,593,635 | 502,792,583 | - | **23,703,447,992** |

*=Many private clinics are headed by a nurse, not a physician

| | | |
|---|---|---|
| | Public hospital | 7.9% |
| | Public health cer | 19.9% |
| | Agree hospital | 3.6% |
| | Agree health cer | 8.6% |
| | Private hospital | 0.0% |
| | Private clinic | 8.4% |
| | Pharmacies | 16.1% |
| | Provision of publ | 4.6% |
| As a % of OOP | Admnistration | 1.5% |
| | Other Providers | 1.0% |
| | | 72% |

As a % of HH

Annex A-11

# FINANCING AGENTS x FUNCTION (HF x HC)

## Malaria Subaccounts targeted and untargeted

**Financing Agent**

| Function | | HF.A Public Sector | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | | MoH (MiniSante) | Other Ministries | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme | Private Employees Insurance Programme | Mutuelles (Private & Community based) | Parastatal companies |
| HC.1.1 | In patient curative care (incl. For severe malaria) | 164,898,044 | 87,498,614 | 781,035 | 58,021,354 | 61,260,452 | 4,449,805 | 661,127,524 | - |
| HC 1.3.9 | Nets given as part of Outpatient care | 5,172,227,862 | - | - | - | - | - | - | - |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | - | - | - | - | - | - |
| HC 1.3.12 | OP care that could not be | 106,653,676 | 111,302,217 | 1,712,892 | 97,879,243 | 385,545,817 | 8,797,865 | 1,506,493,164 | 201,952,939 |
| HC.1.4 | Services of curative home care | 6,208,098 | - | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | 625,634 | - | - | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other medical | - | - | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing | - | - | - | - | - | - | - | - |
| HC.6.3.2.2 | Training within public health programmes for malaria | 108,172,218 | - | - | - | - | - | - | - |
| HC. 6.3.2.3 | IEC (malaria awareness) | 51,780,529 | - | - | - | - | - | - | - |
| HC. 6.3.2.4 | Surveillance and monitoring | 44,910,796 | - | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be disaggregated | 78,266,051 | - | - | - | - | - | - | - |
| HC.7 | Health administration and insurance | 69,435,246 | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | 267,425,607 | - | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - |
| | **Column Total THE** | 6,070,603,761 | 198,800,831 | 2,493,927 | 155,900,598 | 446,806,269 | 13,247,670 | 2,167,620,688 | 201,952,939 |
| HCR.3 | Research & Development | 103,220,675 | - | - | - | - | - | - | - |
| HCR.5 | Environmental health | - | - | - | - | - | - | - | - |
| | *Sub total column* | 103,220,675 | - | - | - | - | - | - | - |
| | **Column Total NHE** | 6,173,824,436 | 198,800,831 | 2,493,927 | 155,900,598 | 446,806,269 | 13,247,670 | 2,167,620,688 | 201,952,939 |

Annex A-11

# FINANCING AGENTS x FUNCTION (HF x HC)

## Malaria Subaccounts targeted and untargeted

| Function | | | | | - | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | |
| | | Private Insurance Enterprises (other than social | Private household out of pocket payments | Non profit institutions (NGOs) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HC.1.1 | In patient curative care (incl. For severe malaria) | 4,433,783 | 1,012,072,015 | 854,193,009 | 154,278 | 206,235,130 | - | 3,115,125,043 |
| HC 1.3.9 | Nets given as part of Outpatient care | - | 41,381,600 | 236,754,941 | - | - | - | 5,450,364,403 |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | 66,208,800 | - | - | - | 66,208,800 |
| HC 1.3.12 | OP care that could not be | 8,766,187 | 5,425,263,226 | 1,496,969,881 | 76,439,357 | 36,230,496 | - | 9,464,006,961 |
| HC.1.4 | Services of curative home care | - | - | - | - | - | - | 6,208,098 |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | - | 625,634 |
| HC.5.1 | Pharmaceuticals and other medical | - | 2,954,790,195 | - | - | - | - | 2,954,790,195 |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | 134,777,400 | 698,695,027 | - | - | - | 833,472,427 |
| HC.6.3.2.1 | Larviciding, elimination of standing | - | - | 2,587,600 | - | - | - | 2,587,600 |
| HC.6.3.2.2 | Training within public health programmes for malaria | - | - | 281,320,369 | - | - | - | 389,492,587 |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | 171,752,507 | - | - | - | 223,533,036 |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | 75,353,714 | - | - | - | 120,264,510 |
| HC.6.3.2.6 | malaria programs that could not be disaggregated | - | - | - | - | 260,326,957 | - | 338,593,008 |
| HC.7 | Health administration and insurance | - | - | 213,328,668 | - | - | - | 282,763,915 |
| HCR.1 | Capital formation for health care provider institutions | - | - | 54,958,899 | - | - | - | 322,384,506 |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - |
| | **Column Total THE** | 13,199,970 | 9,568,284,436 | 4,152,123,415 | 76,593,635 | 502,792,583 | - | **23,570,420,722** |
| HCR.3 | Research & Development | - | - | - | - | - | - | 103,220,675 |
| HCR.5 | Environmental health | - | - | 29,806,595 | - | - | - | 29,806,595 |
| | *Sub total column* | - | - | 29,806,595 | - | - | - | 133,027,270 |
| | **Column Total NHE** | 13,199,970 | 9,568,284,436 | 4,181,930,010 | 76,593,635 | 502,792,583 | - | **23,703,447,992** |

Annex A-12

## PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted and untargeted**

| | | Provider | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.2.1 | HP.1.1.2.2 | HP.3.1 | HP.3.3.1 | HP.3.3.2 | HP.3.3.3 |
| | **Function** | National Referral Gvt Hospital | National Referral Private Hospital | District Gvt. Hospitals | District Agrees Hospitals | Office of physicians (private clinics)* | Community health workers | Traditional healer | Other health practitioners |
| HC.1.1 | In patient curative care (incl. For severe | 1,055,163,406 | 286,137,902 | 669,660,095 | 480,321,103 | - | - | - | - |
| HC 1.3.9 | Nets given as part of Outpatient care | - | - | 40,784,646 | 17,652,357 | - | 4,485,321,000 | - | 136,353,006 |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | 43,981,172 | - | 22,227,628 | - | - | - | - | - |
| HC 1.3.12 | OP care that could not be disaggregated | 772,742,411 | 132,955,602 | 463,470,534 | 361,359,737 | 1,975,703,223 | - | 83,780,058 | 60,296,180 |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | - | - | - | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | 625,634 | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | - | - | - | - | - | - |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | - | - | - | - |
| HC.6.1.2 | IPTp | - | - | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water | - | - | - | - | - | - | - | - |
| HC.6.3.2.2 | Training within public health programmes | - | - | - | - | - | 220,628,969 | - | - |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | - | - | - | 18,598,857 | - | - |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | - | - | - | - | - | - |
| HC.6.3.2.5 | OTHER miscellaneous public health | - | - | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be | - | - | - | - | - | - | - | - |
| HC.7 | Health administration and insurance | - | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 54,958,899 | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - |
| | **Column Total-THE** | **1,871,886,989** | **419,093,504** | **1,196,768,536** | **859,333,197** | **1,975,703,223** | **4,779,507,724** | **83,780,058** | **196,649,187** |
| HCR.2 | Education & Training | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | |
| HCR.4 | Food, hygiene and drinking water contr | | | | | | | | |
| HCR.5 | Environmental health | | | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | |

Annex A-12

# PROVIDER x FUNCTION (HP x HC)

## Malaria Subaccounts targeted and untargeted

| | | HP.3.4.5.1 | HP.3.4.5.2 | HP.3.5 | HP.3.6 | HP.4.1 | HP.5 |
|---|---|---|---|---|---|---|---|
| | **Function** | Public health centers | Government assisted not-for-profit health centers (Agrees) | Medical and diagnostic laboratories | Providers of home health care services | Dispensing chemists | Providers + admin of public health programs |
| HC.1.1 | In patient curative care (incl. For severe | 291,705,878 | 285,272,730 | - | - | - | 46,863,930 |
| HC 1.3.9 | Nets given as part of Outpatient care | 323,200,503 | 208,297,949 | 2,000,000 | - | - | - |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | - | - | - | - |
| HC 1.3.12 | OP care that could not be disaggregated | 4,080,248,628 | 1,533,450,587 | - | - | - | - |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | 6,208,098 | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | - | - | 2,954,790,195 | - |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | 833,472,427 | - |
| HC.6.1.2 | IPTp | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water | - | - | - | - | - | 2,587,600 |
| HC.6.3.2.2 | Training within public health programmes | - | - | - | - | - | 157,828,818 |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | - | - | - | 204,934,179 |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | - | - | - | 120,022,375 |
| HC.6.3.2.5 | OTHER miscellaneous public health | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be | - | - | - | - | - | 263,970,445 |
| HC.7 | Health administration and insurance | - | - | - | - | - | 12,871,644 |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 267,425,607 |
| HC.nsk | Not specified by kind | - | - | - | - | - | - |
| | **Column Total-THE** | **4,695,155,009** | **2,027,021,267** | **2,000,000** | **6,208,098** | **3,788,262,622** | **1,076,504,598** |
| HCR.2 | Education & Training | | | | | | |
| HCR.3 | Research & Development | | | | | | |
| HCR.4 | Food, hygiene and drinking water cont | | | | | | |
| HCR.5 | Environmental health | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | |
| | **Column Total-NHE** | | | | | | |

Annex A-12

## PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted and untargeted**

| | | HP.6 | HP.nsk | | HP.8.1 | HP.8.2 | HP.8.3 | |
|---|---|---|---|---|---|---|---|---|
| | **Function** | General health administration and insurance | Providers not specified by any kind | **THE Row Total** | Research Institutions | Education and training institutions | Other health related institutions | NHE Row Total |
| HC.1.1 | In patient curative care (incl. For severe | - | - | 3,115,125,043 | | | | |
| HC 1.3.9 | Nets given as part of Outpatient care | - | 236,754,941 | 5,450,364,403 | | | | |
| HC 1.3.10 | ACT as part of OP care | - | - | - | | | | |
| HC 1.3.11 | Other OP care | - | - | 66,208,800 | | | | |
| HC 1.3.12 | OP care that could not be disaggregated | - | - | 9,464,006,961 | | | | |
| HC.1.4 | Services of curative home care (malaria) | - | - | 6,208,098 | | | | |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | | | | |
| HC.4.2 | Diagnostic imaging | - | - | 625,634 | | | | |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | 2,954,790,195 | | | | |
| HC 5.1.3.2 | Repellants for nets | - | - | - | | | | |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | 833,472,427 | | | | |
| HC.6.1.2 | IPTp | - | - | - | | | | |
| HC.6.3.2.1 | Larviciding, elimination of standing water | - | - | 2,587,600 | | | | |
| HC.6.3.2.2 | Training within public health programmes | 11,034,800 | - | 389,492,587 | | | | |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | 223,533,036 | | | | |
| HC. 6.3.2.4 | Surveillance and monitoring | 242,135 | - | 120,264,510 | | | | |
| HC.6.3.2.5 | OTHER miscellaneous public health | - | - | - | | | | |
| HC.6.3.2.6 | malaria programs that could not be | 74,622,563 | - | 338,593,008 | | | | |
| HC.7 | Health administration and insurance | 269,892,271 | - | 282,763,915 | | | | |
| HCR.1 | Capital formation for health care provider institutions | - | - | 322,384,506 | | | | |
| HC.nsk | Not specified by kind | - | - | - | | | | |
| | **Column Total-THE** | **355,791,768** | **236,754,941** | **23,570,420,722** | | | | |
| HCR.2 | Education & Training | | | | 0 | 0 | 0 | - |
| HCR.3 | Research & Development | | | | 103,220,675 | 0 | 0 | 103,220,675 |
| HCR.4 | Food, hygiene and drinking water cont | | | | 0 | 0 | 0 | - |
| HCR.5 | Environmental health | | | | 0 | 0 | 29,806,595 | 29,806,595 |
| HCR.nsk | HCR expenditure not specified by kind | | | | 0 | 0 | 0 | - |
| | **Column Total-NHE** | | | | 103,220,675 | - | 29,806,595 | **23,703,447,992** |

# FINANCING SOURCE x FINANCING AGENT (FSxHF)

## Malaria Subaccounts targeted and untargeted

**Financing Source (FS)**

| Code | Financing Agent (HF) | FS.1.1.1 Central Gov Revenue<br>FS.1.1.1.4 could not be disaggregated | FS. 1.2 Other Public funds | FS.2 Private Funds | | | | FS.3 | FS.nsk | Row Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | FS.2.1.1 Parastatal Employers | FS.2.1.2 Private Employers | FS.2.2 Households | FS.2.4 Other private funds | Rest of the World (Donors) | Not specified by any kind | |
| HF.1.1.1.1 | MoH (MiniSante) | 123,944,862 | 1,599,461 | | | | | 5,945,059,438 | | 6,070,603,761 |
| HF.1.1.1.2 | Other Ministries | 197,007,511 | | | | | | 1,793,320 | | 198,800,831 |
| HF.1.2 | Social Security Fund (CSR) | | | 1,563,183 | 930,744 | | | | | 2,493,927 |
| HF.1.3 | FARG | 153,438,027 | | | | 2,462,571 | | | | 155,900,598 |
| HF.2.1.1 | Gvt Employees Insurance Programme (RAMA) | 51,094,819 | | 323,059,915 | | 17,763,501 | 54,888,034 | | | 446,806,269 |
| HF.2.1.2 | Private Employees Insurance Programme | | | | 12,208,832 | 1,038,838 | | | | 13,247,670 |
| HF.2.1.3 | Mutuelles (Private & Community based) | 121,826,297 | | 8,650,875 | 87,088 | 868,785,939 | | 1,168,270,490 | | 2,167,620,688 |
| HF. 2.5.1 | Parastatal companies | | | 201,952,939 | | | | | | 201,952,939 |
| HF.2.2 | Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)* | | | 1,012,739 | 10,100,602 | 2,086,629 | | | | 13,199,970 |
| HF.2.3. | Private household out of pocket payments | | | | | 9,568,284,436 | | | | 9,568,284,436 |
| HF.2.4 | Non profit institutions (NGOs) | 2,129,690 | | | | 791,037 | | 4,149,202,688 | | 4,152,123,415 |
| HF.2.5.2 | Private Non Parastatal Firms | | | | 76,593,635 | | | | | 76,593,635 |
| HF.3 | Rest of World | | | | | | | 502,792,583 | | 502,792,583 |
| HF.nsk | Not specified by any kind | | | | | | | | | 0 |
| | **Column Total (THE)** | 649,441,206 | 1,599,461 | 536,239,651 | 99,920,900 | 10,461,212,952 | 54,888,034 | 11,767,118,518 | 0 | **23,570,420,722** |
| HF.4 | Financing Agents spending on Health Related Items | | | | | | | 133,027,270 | | 133,027,270 |
| | **Column Total (NHE)** | 649,441,206 | 1,599,461 | 536,239,651 | 99,920,900 | 10,461,212,952 | 54,888,034 | 11,900,145,788 | 0 | **23,703,447,992** |

*Includes only the portion of CSR going to health

# FINANCING AGENT x PROVIDER (HFxP)

**RH Subaccounts targeted and untargeted**

**Financing Agent**

| | | HF.A Public Sector | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | **Provider** | MoH (MiniSante) | Other Ministries | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme | Mutuelles (Private & Community based) | Parastatal companies |
| HP.1.1.1.1 | National Referral Gvt Hospital | 684,916,022 | 327,535,778 | | 123,013,220 | | | 125,493,450 | |
| HP.1.1.1.2 | National Referral Private Hospital | 421,160,081 | | 614,287 | 34,184,910 | 101,109,933 | 3,668,046 | | |
| HP.1.1.2.1 | District Gvt. Hospitals | 15,893,350 | 17,414,624 | 223,234 | 12,422,928 | 25,500,297 | 677,040 | 202,674,756 | |
| HP.1.1.2.2 | District Agrees Hospitals | 6,878,939 | 11,189,741 | 181,476 | 10,099,094 | 3,854,109 | 478,768 | 164,762,387 | |
| HP.3.1 | Office of physicians (private clinics)* | 6,982,331 | | | | | | | |
| HP.3.3.1 | Community health workers | 2,302,366 | | | | 204,483,235 | 4,110,703 | | 142,909,466 |
| HP.3.3.3 | Other health practitioners | | | | | | | | |
| HP.3.4.5.1 | Public health centers | 180,804,456 | 15,279,253 | 247,800 | 13,790,007 | 12,563,948 | 2,397,117 | 224,978,056 | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 111,297,661 | 13,738,118 | 222,806 | 12,399,084 | 9,985,306 | 1,572,896 | 202,285,745 | |
| HP.3.4.5.3 | NGO health centers | 20,904,568 | | | | | | | |
| HP.4.1 | Dispensing chemists | 22,527,922 | | | | | | | |
| HP.5 | Providers + admin of public health | 176,506,718 | 480,290 | | | | | | |
| HP.6 | General health administration and insurance | 5,141,792 | | | | | | | |
| HP.nsk | Providers not specified by any kind | | | | | | | | |
| | **Column Total THE** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |
| | **HF Totals From FS x HF Table** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |
| HP.8.2 | Education and training institutions | | | | | | | | |
| | **Subtotal for health related** | - | - | - | - | - | - | - | - |
| | **Column Total: NHE** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |
| | Providers of NONHEALTH RH programs | | | | | | | | |
| | **Subtotal for nonhealth** | - | - | - | - | - | - | - | - |
| | **Column Total: RHE (health, health related and nonhealth)** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |

*=Many private clinics are headed by a nurse, not a physician

# FINANCING AGENT x PROVIDER (HFxP)

## RH Subaccounts targeted and untargeted

| | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | |
| | **Provider** | Private Insurance Enterprises (other than social insurance: COGEAR, SONARWA, etc) | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HP.1.1.1.1 | National Referral Gvt Hospital | | 303,597,085 | 928,456,771 | | 1,742,779,746 | | 4,235,792,072 |
| HP.1.1.1.2 | National Referral Private Hospital | 3,654,839 | 79,656,074 | | | | | 644,048,171 |
| HP.1.1.2.1 | District Gvt. Hospitals | 674,602 | 107,781,802 | 157,148,996 | 26,561 | | | 540,438,190 |
| HP.1.1.2.2 | District Agrees Hospitals | 477,044 | 46,649,979 | 421,371,951 | 22,992 | | | 665,966,481 |
| HP.3.1 | Office of physicians (private clinics)* | | 191,954,634 | | | | | 198,936,965 |
| HP.3.3.1 | Community health workers | 4,095,902 | | 69,985,930 | 54,091,353 | | | 481,978,956 |
| HP.3.3.3 | Other health practitioners | | 3,170,884 | | | | | 3,170,884 |
| HP.3.4.5.1 | Public health centers | 2,388,486 | 39,344,208 | 312,893,816 | | | | 804,687,148 |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 1,567,232 | 35,741,758 | 266,549,161 | | | | 655,359,766 |
| HP.3.4.5.3 | NGO health centers | | 38,620,612 | 597,791,165 | | | | 657,316,345 |
| HP.4.1 | Dispensing chemists | | 141,873,925 | 226,054,768 | | | | 390,456,615 |
| HP.5 | Providers + admin of public health | | | 809,496,598 | | 291,548,970 | | 1,278,032,575 |
| HP.6 | General health administration and insurance | | | | | | | 5,141,792 |
| HP.nsk | Providers not specified by any kind | | | | | | | - |
| | **Column Total THE** | 12,858,106 | 988,390,962 | 3,789,749,155 | 54,140,906 | 2,034,328,716 | - | **10,561,325,959** |
| | **HF Totals From FS x HF Table** | 12,858,106 | 988,390,962 | 3,789,749,155 | 54,140,906 | 2,034,328,716 | - | 10,561,325,959 |
| HP.8.2 | Education and training institutions | | | 171,590,514 | | | | 171,590,514 |
| | **Subtotal for health related** | - | - | 171,590,514 | - | - | - | 171,590,514 |
| | **Column Total: NHE** | 12,858,106 | 988,390,962 | ########### | 54,140,906 | 2,034,328,716 | - | **10,732,916,474** |
| | Providers of NONHEALTH RH programs | | | | | | | - |
| | **Subtotal for nonhealth** | - | - | - | - | - | - | - |
| | **Column Total: RHE (health, health related and nonhealth)** | 12,858,106 | 988,390,962 | ########### | 54,140,906 | 2,034,328,716 | - | 10,732,916,474 |

*=Many private clinics are headed by a nurse, not a physician

Annex A-15

# FINANCING AGENTS x FUNCTION (HF x HC)

## RH Subaccounts targeted and untargeted

**Financing Agent**

| Function | | HF.A Public Sector | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | | MoH (MiniSante) | Other Ministries | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme | Mutuelles (Private & Community based) | Parastatal companies |
| HC. 1.1. | IP curative care (deliveries) | 983,617,620 | 355,816,760 | 1,087,464 | 181,825,413 | 123,501,754 | 7,754,587 | 587,520,205 | - |
| HC.1.3.11 | Antenatal care | 74,981,832 | 29,340,754 | 402,140 | 24,083,830 | 233,995,074 | 5,149,984 | 332,674,188 | 142,909,466 |
| HC.1.3.12 | Postnatal care | - | - | - | - | - | - | - | - |
| HC1.3.13.1 | FP consultation and issuance of | 139,293,169 | - | - | - | - | - | - | - |
| HC.1.3.13.2 | FP consultation and issuance of | 3,173,669 | - | - | - | - | - | - | - |
| HC.1.3.13.4 | FP consultation and issuance of | 61,405,352 | - | - | - | - | - | - | - |
| HC.1.3.13.5 | FP consultation and issuance of | 188,668,132 | - | - | - | - | - | - | - |
| HC.1.3.13.7 | FP consultations not disaggregated. | - | - | - | - | - | - | - | - |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES | 12,663,015 | - | - | - | - | - | - | - |
| HC.5.1.1.3 | INJECATBLES purchased at private | 3,914,277 | - | - | - | - | - | - | - |
| HC.5.1.3.1 | CONDOMS purchased at private | 5,950,630 | - | - | - | - | - | - | - |
| HC.6.1.1.1 | Antentatal care programs | - | - | - | - | - | - | - | - |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | - | - | - | - | - | - |
| HC.6.1.1.4 | Other Maternal health programs | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.7 | FP programs that could not be | - | - | - | - | - | - | - | - |
| HC.6.1.3 | Adolescent reproductive health | - | 185,113 | - | - | - | - | - | - |
| HC.6.1.5 | Other RH programs | - | 295,177 | - | - | - | - | - | - |
| HC.6.1.6 | RH programs that could not be disaggregated | 181,648,510 | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - |
| | **Column Total THE** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |
| HCR.2 | Education & Training | - | - | - | - | - | - | - | - |
| | **Sub total column** | - | - | - | - | - | - | - | - |
| | **Column Total NHE** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |
| AD.5 | Prevention and treatment of victim | - | - | - | - | - | - | - | - |
| AD.6 | Gender non-health programs (Wor | - | - | - | - | - | - | - | - |
| | **sub total column** | - | - | - | - | - | - | - | - |
| | **Column Total- RH health, health related, nonhealth** | 1,655,316,206 | 385,637,804 | 1,489,604 | 205,909,243 | 357,496,828 | 12,904,570 | 920,194,393 | 142,909,466 |

Annex A-15

## FINANCING AGENTS x FUNCTION (HF x HC)

**RH Subaccounts targeted and untargeted**

| | | | | | - | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | - |
| | Function | Private Insurance Enterprises (other than social insurance: COGEAR, | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HC. 1.1. | IP curative care (deliveries) | 7,726,665 | 112,919,822 | 1,265,045,861 | 49,554 | 1,718,626,082 | - | 5,345,491,787 |
| HC.1.3.11 | Antenatal care | 5,131,440 | 620,492,914 | 636,333,330 | 54,091,353 | 24,153,664 | - | 2,183,739,969 |
| HC.1.3.12 | Postnatal care | - | - | - | - | - | - | - |
| HC1.3.13.1 | FP consultation and issuance of ORAL | - | 3,459,800 | 8,208,313 | - | - | - | 150,961,282 |
| HC.1.3.13.2 | FP consultation and issuance of | - | 61,832 | 426,440 | - | - | - | 3,661,941 |
| HC.1.3.13.4 | FP consultation and issuance of | - | 17,617,600 | 102,343,908 | - | - | - | 181,366,859 |
| HC.1.3.13.5 | FP consultation and issuance of | - | 91,965,070 | 486,812,504 | - | - | - | 767,445,705 |
| HC.1.3.13.7 | FP consultations not disaggregated. | - | - | 185,041,504 | - | - | - | 185,041,504 |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased | - | 16,840,000 | 8,755,068 | - | - | - | 38,258,083 |
| HC.5.1.1.3 | INJECATBLES purchased at private | - | - | - | - | - | - | 3,914,277 |
| HC.5.1.3.1 | CONDOMS purchased at private | - | 125,033,925 | 217,299,700 | - | - | - | 348,284,255 |
| HC.6.1.1.1 | Antentatal care programs | - | - | 42,828,792 | - | - | - | 42,828,792 |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | 64,967,157 | - | - | - | 64,967,157 |
| HC.6.1.1.4 | Other Maternal health programs | - | - | 3,132,000 | - | - | - | 3,132,000 |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | 540,055,990 | - | - | - | 540,055,990 |
| HC.6.1.1.2.7 | FP programs that could not be | - | - | 158,512,659 | - | - | - | 158,512,659 |
| HC.6.1.3 | Adolescent reproductive health | - | - | - | - | - | - | 185,113 |
| HC.6.1.5 | Other RH programs | - | - | - | - | - | - | 295,177 |
| HC.6.1.6 | RH programs that could not be disaggregated | - | - | - | - | 291,548,970 | - | 473,197,479 |
| HCR.1 | Capital formation for health care provider institutions | - | - | 69,985,930 | - | - | - | 69,985,930 |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - |
| | **Column Total THE** | 12,858,106 | 988,390,962 | 3,789,749,155 | 54,140,906 | 2,034,328,716 | - | **10,561,325,959** |
| HCR.2 | Education & Training | - | - | 171,590,514 | - | - | - | 171,590,514 |
| | **Sub total column** | - | - | 171,590,514 | - | - | - | 171,590,514 |
| | **Column Total NHE** | 12,858,106 | 988,390,962 | 3,961,339,669 | 54,140,906 | 2,034,328,716 | - | **10,732,916,474** |
| AD.5 | Prevention and treatment of victims | - | - | - | - | - | - | - |
| AD.6 | Gender non-health programs (Wor | - | - | - | - | - | - | - |
| | **sub total column** | - | - | - | - | - | - | - |
| | **Column Total- RH health, health related, nonhealth** | 12,858,106 | 988,390,962 | 3,961,339,669 | 54,140,906 | 2,034,328,716 | - | 10,732,916,474 |

Annex A-16

## PROVIDER x FUNCTION (HP x HC)

**RH Subaccounts targeted and untargeted**

| | | Provider | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.2.1 | HP.1.1.2.2 | HP.3.1 | HP.3.3.1 | HP.3.3.3 | HP.3.4.5.1 | HP.3.4.5.2 |
| | **Function** | National Referral Gvt Hospital | National Referral Private Hospital | District Gvt. Hospitals | District Agrees Hospitals | Office of physicians (private clinics)* | Community health workers | Other health practitioners | Public health centers | Government assisted not-for-profit health centers (Agrees) |
| HC. 1.1. | IP curative care (deliveries) | 3,645,298,714 | 575,665,939 | 155,699,379 | 147,356,849 | 43,719,159 | - | 3,170,884 | 381,326,552 | 393,254,311 |
| HC.1.3.11 | Antenatal care | 461,784,938 | 54,417,239 | 338,386,231 | 506,240,535 | 141,267,300 | 409,690,659 | - | 160,029,259 | 99,799,480 |
| HC1.3.13.1 | FP consultation and issuance of ORAL | 7,630,433 | 1,866,888 | 2,708,925 | 1,172,474 | 1,586,662 | 2,302,366 | - | 71,604,989 | 44,664,516 |
| HC.1.3.13.2 | FP consultation and issuance of CONDOMS | 262,952 | 107,225 | 93,352 | 40,405 | 289,484 | - | - | 1,206,179 | 777,364 |
| HC.1.3.13.4 | FP consultation and issuance of IMPLANTS | 27,699,573 | 5,993,273 | 9,833,790 | 4,256,248 | 5,093,662 | - | - | 8,470,657 | 5,459,213 |
| HC.1.3.13.5 | FP consultation and issuance of | 16,664,545 | 5,997,608 | 5,916,179 | 2,560,633 | 6,980,699 | - | - | 135,715,624 | 81,287,853 |
| HC.1.3.13.7 | FP consultations not disaggregated. | 76,450,916 | - | 27,800,333 | 4,339,338 | - | - | - | 46,333,889 | 30,117,028 |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased at | - | - | - | - | - | - | - | - | - |
| HC.5.1.1.3 | INJECATBLES purchased at private | - | - | - | - | - | - | - | - | - |
| HC.5.1.3.1 | CONDOMS purchased at private | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.1 | Antentatal care programs | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.4 | Other Maternal health programs | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.7 | FP programs that could not be disaggregated | - | - | - | - | - | - | - | - | - |
| HC.6.1.3 | Adolescent reproductive health | - | - | - | - | - | - | - | - | - |
| HC.6.1.5 | Other RH programs | - | - | - | - | - | - | - | - | - |
| HC.6.1.6 | RH programs that could not be disaggregated | - | - | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 69,985,930 | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - | - |
| | **Column Total-THE** | **4,235,792,072** | **644,048,171** | **540,438,190** | **665,966,481** | **198,936,965** | **481,978,956** | **3,170,884** | **804,687,148** | **655,359,766** |
| HCR.2 | Education & Training | | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | | | | |
| HCR.5 | Environmental health | | | | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | | |
| - | - | | | | | | | | | |
| AD.5 | Prevention and treatment of victims of sexual violence | | | | | | | | | |
| AD.6 | Gender non-health programs (Women's empowerment, equity) | | | | | | | | | |
| - | - | | | | | | | | | |
| | **Column Total- RH health, health related, nonhealth** | | | | | | | | | |

Annex A-16

## PROVIDER x FUNCTION (HP x HC)

**RH Subaccounts targeted and untargeted**

| | | HP.3.4.5.3 | HP.4.1 | HP.5 | HP.6 | HP.nsk | | HP.8.2 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Function** | NGO health centers | Dispensing chemists | Providers + admin of public health programs | General health administration and insurance | Providers not specified by any kind | **THE Row Total** | Education and training institutions | NHE Row Total | Providers of NONHEALTH RH programs |
| HC. 1.1. | IP curative care (deliveries) | - | - | - | - | - | 5,345,491,787 | | | |
| HC.1.3.11 | Antenatal care | 12,124,327 | - | - | - | - | 2,183,739,969 | | | |
| HC1.3.13.1 | FP consultation and issuance of ORAL | 17,424,029 | - | - | - | - | 150,961,282 | | | |
| HC.1.3.13.2 | FP consultation and issuance of CONDOMS | 884,981 | - | - | - | - | 3,661,941 | | | |
| HC.1.3.13.4 | FP consultation and issuance of IMPLANTS | 114,560,443 | - | - | - | - | 181,366,859 | | | |
| HC.1.3.13.5 | FP consultation and issuance of | 512,322,565 | - | - | - | - | 767,445,705 | | | |
| HC.1.3.13.7 | FP consultations not disaggregated. | - | - | - | - | - | 185,041,504 | | | |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased at | - | 38,258,083 | - | - | - | 38,258,083 | | | |
| HC.5.1.1.3 | INJECATBLES purchased at private | - | 3,914,277 | - | - | - | 3,914,277 | | | |
| HC.5.1.3.1 | CONDOMS purchased at private | - | 348,284,255 | - | - | - | 348,284,255 | | | |
| HC.6.1.1.1 | Antentatal care programs | - | - | 42,828,792 | - | - | 42,828,792 | | | |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | 64,967,157 | - | - | 64,967,157 | | | |
| HC.6.1.1.4 | Other Maternal health programs | - | - | 3,132,000 | - | - | 3,132,000 | | | |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | 540,055,990 | - | - | 540,055,990 | | | |
| HC.6.1.1.2.7 | FP programs that could not be disaggregated | - | - | 158,512,659 | - | - | 158,512,659 | | | |
| HC.6.1.3 | Adolescent reproductive health | - | - | 185,113 | - | - | 185,113 | | | |
| HC.6.1.5 | Other RH programs | - | - | 295,177 | - | - | 295,177 | | | |
| HC.6.1.6 | RH programs that could not be disaggregated | - | - | 468,055,687 | 5,141,792 | - | 473,197,479 | | | |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 69,985,930 | | | |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | | | |
| | **Column Total-THE** | **657,316,345** | **390,456,615** | **1,278,032,575** | **5,141,792** | **-** | **10,561,325,959** | | | |
| HCR.2 | Education & Training | | | | | | | 171,590,514 | 171,590,514 | |
| HCR.3 | Research & Development | | | | | | | 0 | - | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | | 0 | - | |
| HCR.5 | Environmental health | | | | | | | 0 | - | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | 0 | - | |
| | **Column Total-NHE** | | | | | | | 171,590,514 | **10,732,916,474** | |
| - | - | | | | | | | | | - |
| AD.5 | Prevention and treatment of victims of sexual violence | | | | | | | | | - |
| AD.6 | Gender non-health programs (Women's empowerment, equity) | | | | | | | | | - |
| - | - | | | | | | | | | - |
| | **Column Total- RH health, health related, nonhealth** | | | | | | | | | **10,732,916,474** |

# ANNEX B. NHA TABLES: HIV/AIDS, MALARIA, AND RH SUBACCOUNTS, TARGETED EXPENDITURES

# FINANCING SOURCE x FINANCING AGENT (FSxHF)

## HIV/AIDS Subaccounts (Targeted only)

**Financing Source (FS)**

| Code | Financing Agent (HF) | | | FS.2 Private Funds | | | | FS.3 | FS.nsk | Row Total | FS.Addendum - Govt | FS.Addendum - Donors |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FS.1.1.1 Central Gov Revenue FS.1.1.1.4 could not be disaggregated | FS. 1.2 Other Public funds | FS.2.1.1 Parastatal Employers | FS.2.1.2 Private Employers | FS.2.2 Households | FS.2.4 Other private funds | Rest of the World (Donors) | Not specified by any kind | | Non-health spending | Non-health spending |
| HF.1.1.1.1 | MoH (MiniSante) | 527,735,246 | | | | | | 1,053,332,213 | | 1,581,067,459 | | |
| HF.1.1.1.2 | Other Ministries (except CNLS) | 147,738,109 | | | | | | 5,344,394 | | 153,082,503 | | |
| HF.1.1.1.3.1 | CNLS | 288,080,280 | 530,000 | | | | | 587,134,348 | 213,861,233 | 1,089,605,861 | | |
| HF.1.1.1.3.2.1 | CNLS-UNDP | | | | | | | 160,410,358 | | 160,410,358 | | |
| HF.1.1.1.3.2.2 | CNLS-BAD | 13,584,348 | | | | | | 251,801,927 | | 265,386,274 | | |
| HF.1.1.1.3.2.3 | CNLS-MAP | | | | | | | 5,063,564,586 | | 5,063,564,586 | | |
| HF.1.1.1.3.2.4 | CNLS-GF | | | | | | | 7,138,288,980 | | 7,138,288,980 | | |
| HF.1.1.3 | Local Municipal Gvt (Districts) | | | | | | | 65,222,465 | | 65,222,465 | | |
| HF.1.2 | Social Security Fund (CSR) | | | | | | | | | 0 | | |
| HF.1.3 | FARG | | | | | | | | | 0 | | |
| HF.2.1.1 | Gvt Employees Insurance Programme (RAMA) | | | | | | | | | 0 | | |
| HF.2.1.2 | Private Employees Insurance Programme | | | | | | | | | 0 | | |
| HF.2.1.3 | Mutuelles (Employer-paid & Community based) | | | | | | | | | 0 | | |
| HF. 2.5.1 | Parastatal companies | | | | | | | | | 0 | | |
| HF.2.2 | Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)* | | | | | | | | | 0 | | |
| HF.2.3. | Private household out of pocket payments | | | | | 863,188,381 | | | | 863,188,381 | | |
| HF.2.4 | Non profit institutions (NGOs, SWAA, PROFEMME) | 13,289,793 | | | | | | 21,009,199,003 | | 21,022,488,796 | | |
| HF.2.5.2 | Private Non Parastatal Firms | | | | | | | | | 0 | | |
| HF.3 | Rest of World | | | | | | | 2,650,388,531 | | 2,650,388,531 | | |
| HF.nsk | Not specified by any kind | | | | | | | | | 0 | | |
| | **Column Total (THE)** | 990,427,776 | 530,000 | 0 | 0 | 863,188,381 | 0 | 37,984,686,804 | 213,861,233 | **40,052,694,195** | | |
| HF. Health re | Financing Agents spending on Health Related Items | | | | | | | 358,001,504 | | 358,001,504 | | |
| | **Column Total (NHE)** | 990,427,776 | 530,000 | 0 | 0 | 863,188,381 | 0 | 38,342,688,309 | 213,861,233 | **40,410,695,699** | | |
| Addendum | Financing agents spending on NONHEALTH | | | | | | | | | | 1,325,396,756 | 5,832,134,709 |
| | **Column Total (THAE)** | 990,427,776 | 530,000 | 0 | 0 | 863,188,381 | 0 | 38,342,688,309 | 213,861,233 | **47,568,227,165** | | |

*Includes only the portion of CSR going to health

# FINANCING AGENT x PROVIDER (HFxP)

**HIV/AIDS Subaccounts (Targeted only)**

**Financing Agent**

| | | HF.A Public Sector | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3.1 | HF.1.1.1.3.2.1 | HF.1.1.1.3.2.2 | HF.1.1.1.3.2.3 | HF.1.1.1.3.2.4 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 |
| | **Provider** | MoH (MiniSante) | Other Ministries (except CNLS) | CNLS | CNLS-UNDP | CNLS-BAD | CNLS-MAP | CNLS-GF | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) |
| HP.1.1.1.1 | National Referral Gvt Hospital | | | | | | 996,459,831 | 2,207,513,615 | | | | |
| HP.1.1.1.2 | National Referral Private Hospital | | | | | | 513,327,792 | 1,039,263,335 | | | | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | | | |
| HP.1.1.2.1 | District Gvt. Hospitals | | | | | | 362,349,029 | 733,597,648 | | | | |
| HP.1.1.2.2 | District Agrees Hospitals | | | | | | 150,978,762 | 305,665,687 | | | | |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | | | |
| HP.1.2 | Mental health hospitals | | | | | | | | | | | |
| HP.3.1 | Office of physicians (private clinics)* | | | | | | | | | | | |
| HP.3.3.1 | Community health workers | | | | | | | | | | | |
| HP.3.3.2 | Traditional healer | | | | | | | | | | | |
| HP.3.3.3 | Other health practitioners | | | | | | | | | | | |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | | | | | | | | |
| HP.3.4.5.1 | Public health centers | 70,658,403 | | | | | 208,357,593 | 1,222,662,747 | | | | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 14,753,213 | | | | | 135,432,435 | 794,730,785 | | | | |
| HP.3.4.5.3 | NGO health centers | | | | | | | | | | | |
| HP.3.4.5.9 | Mobile health centers | | | | | | | | | | | |
| HP. 3.4.9 | TRAC HIV/AIDS Center | 113,114,054 | | | | | | | | | | |
| HP.3.9.1 | Ambulance services | | | | | | | | | | | |
| HP.3.6 | Providers of home health care services | 47,961,153 | | | | | | | | | | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | | | |
| HP.4.1 | Dispensing chemists | | | | | | | | | | | |
| HP.5 | Providers + admin of public health programs | 599,348,858 | 5,344,394 | 1,049,658,028 | 160,410,358 | 265,386,274 | 2,696,659,143 | 145,009,985 | | | | |
| HP.6 | General health administration and insurance | 735,231,779 | 147,738,109 | 39,947,833 | | | | 682,313,955 | | | | |
| HP. 8 | Institutions providing health related services | | | | | | | | | | | |
| HP.9 | Rest of the world | | | | | | | 7,531,224 | | | | |
| HP.nsk | Providers not specified by any kind | | | | | | | | 65,222,465 | | | |
| | **Column Total THE** | 1,581,067,459 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,063,564,586 | 7,138,288,980 | 65,222,465 | - | - | - |
| | **HF Totals From FS x HF Table** | 1,581,067,459 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,063,564,586 | 7,138,288,980 | 65,222,465 | - | - | - |
| HP.8.1 | Research Institutions | 117,683,834 | | | | | | | | | | |
| HP.8.2 | Education and training institutions | 33,203,875 | | | | | 5,517,400 | 36,690,576 | | | | |
| HP.8.3 | Other health related institutions | | | | | | | | | | | |
| | **Subtotal for health related** | 150,887,709 | - | - | - | - | 5,517,400 | 36,690,576 | - | - | - | - |
| | **Column Total: NHE** | 1,731,955,169 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,069,081,986 | 7,174,979,556 | 65,222,465 | - | - | - |
| HP.Addendum | Providers of NONHEALTH programs | | | | | | 2,730,201,091 | | | | 1,325,396,756 | |
| | **subtotal for nonhealth** | - | - | - | - | - | 2,730,201,091 | | - | - | 1,325,396,756 | - |
| | **Column total: THAE (health, health related,** | 1,731,955,169 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 7,799,283,077 | 7,174,979,556 | 65,222,465 | - | 1,325,396,756 | - |

*=Many private clinics are headed by a nurse, not a physician

# FINANCING AGENT x PROVIDER (HFxP)

**HIV/AIDS Subaccounts (Targeted only)**

| | | HF.A Public Sector | | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | | HF, Addendum |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | | |
| | **Provider** | Private Employees Insurance Programme | Mutuelles (Employer-paid & Community based) | Parastatal companies | Private Insurance Enterprises (other than | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total | Non health addendums |
| HP.1.1.1.1 | National Referral Gvt Hospital | | | | | 114,409,397 | 1,153,449,813 | | 671,941,645 | | 5,143,774,300 | |
| HP.1.1.1.2 | National Referral Private Hospital | | | | | 20,687,995 | | | 248,211,108 | | 1,821,490,229 | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | | - | |
| HP.1.1.2.1 | District Gvt. Hospitals | | | | | 84,143,557 | 419,436,296 | | 175,207,841 | | 1,774,734,371 | |
| HP.1.1.2.2 | District Agrees Hospitals | | | | | 41,863,317 | 141,351,390 | | 73,003,267 | | 712,862,424 | |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | | - | |
| HP.1.2 | Mental health hospitals | | | | | | | | | | - | |
| HP.3.1 | Office of physicians (private clinics)* | | | | | 49,611,576 | | | | | 49,611,576 | |
| HP.3.3.1 | Community health workers | | | | | 194,438 | 572,880,180 | | | | 573,074,618 | |
| HP.3.3.2 | Traditional healer | | | | | 94,023,410 | | | | | 94,023,410 | |
| HP.3.3.3 | Other health practitioners | | | | | 4,673,784 | | | | | 4,673,784 | |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | | | | | | | - | |
| HP.3.4.5.1 | Public health centers | | | | | 196,679,980 | 1,159,861,796 | | 855,475,046 | | 3,713,695,565 | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | | | | | 25,898,452 | 753,910,168 | | 556,058,780 | | 2,280,783,833 | |
| HP.3.4.5.3 | NGO health centers | | | | | | | | | | - | |
| HP.3.4.5.9 | Mobile health centers | | | | | 16,670 | | | | | 16,670 | |
| HP. 3.4.9 | TRAC HIV/AIDS Center | | | | | | | | | | 113,114,054 | |
| HP.3.9.1 | Ambulance services | | | | | | | | | | - | |
| HP.3.6 | Providers of home health care services | | | | | | | | | | 47,961,153 | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | | - | |
| HP.4.1 | Dispensing chemists | | | | | 160,919,378 | | | | | 160,919,378 | |
| HP.5 | Providers + admin of public health programs | | | | | | 8,002,935,487 | | 54,037,045 | | 12,978,789,572 | |
| HP.6 | General health administration and insurance | | | | | | 8,584,434,921 | | 16,453,800 | | 10,206,120,397 | |
| HP. 8 | Institutions providing health related services | | | | | | | | | | - | |
| HP.9 | Rest of the world | | | | | | | | | | 7,531,224 | |
| HP.nsk | Providers not specified by any kind | | | | | 70,066,428 | 234,228,745 | | | | 369,517,638 | |
| | **Column Total THE** | - | - | - | - | 863,188,381 | 21,022,488,796 | - | 2,650,388,531 | - | **40,052,694,195** | |
| | **HF Totals From FS x HF Table** | - | - | - | - | 863,188,381 | 21,022,488,796 | - | 2,650,388,531 | - | 40,052,694,195 | |
| HP.8.1 | Research Institutions | | | | | | 150,100,038 | | | | 267,783,872 | |
| HP.8.2 | Education and training institutions | | | | | | 14,805,781 | | | | 90,217,632 | |
| HP.8.3 | Other health related institutions | | | | | | | | | | - | |
| | **Subtotal for health related** | - | - | - | - | - | 164,905,819 | - | - | - | 358,001,504 | |
| | **Column Total: NHE** | - | - | - | - | 863,188,381 | 21,187,394,615 | - | 2,650,388,531 | - | **40,410,695,699** | |
| HP.Addendum | Providers of NONHEALTH programs | | | | | | 1,940,314,689 | | 1,161,618,929 | | | |
| | **subtotal for nonhealth** | - | - | - | - | - | 1,940,314,689 | - | 1,161,618,929 | - | | **7,157,531,466** |
| | **Column total: THAE (health, health related,** | - | - | - | - | 863,188,381 | 23,127,709,304 | - | 3,812,007,460 | - | | **47,568,227,165** |

*=Many private clinics are headed by a nurse, not a physician

As a % of HH

Annex B-3

## FINANCING AGENTS x FUNCTION (HF x HC)

**HIV/AIDS Subaccounts (Targeted only)**

| | | Financing Agent | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | HF.A Public Sector | | | | | | | |
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3.1 | HF.1.1.1.3.2.1 | HF.1.1.1.3.2.2 | HF.1.1.1.3.2.3 | HF.1.1.1.3.2.4 | HF.1.1.3 |
| | | MoH (MiniSante) | Other Ministries (except CNLS) | CNLS | CNLS-UNDP | CNLS-BAD | CNLS-MAP | CNLS-GF | Local Municipal Gvt (Districts) |
| | Function | | | | | | | | |
| HC. 1.1.1 | IP ARV curative care | - | - | - | - | - | - | 912,036,685 | - |
| HC. 1.1.2 | IP OI Treatment | - | - | - | - | - | - | - | - |
| HC.1.1.4 | IP care that cannot be disaggregated | 47,961,153 | - | - | - | - | 945,860,266 | 820,349,277 | - |
| HC. 1.3.5 | OP STI Management | - | - | - | - | - | - | - | - |
| HC. 1.3.6 | OP opportunistic infection treatment and | - | - | - | - | - | - | - | - |
| HC .1.3.7 | OP ARV treatment | - | - | - | - | - | - | 3,741,211,708 | - |
| HC1.3.8 | OP Psychosocial support | - | - | - | - | - | - | - | - |
| HC 1.3.10 | OP care that cannot be disaggregated | 150,564,517 | - | - | - | - | 654,327,514 | 829,836,146 | - |
| HC.1.3.11 | VCT as part of OP care | - | - | - | - | - | - | - | - |
| HC.1.3.12 | PMTCT service delivery | - | - | - | - | - | - | - | - |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | - | - | - | - | - | - | - |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. | 3,689,319 | - | - | - | - | - | - | - |
| HC.6.1.1 | PMTCT | 47,961,153 | - | - | - | - | - | - | - |
| HC. 6.3.1.1 | VCT | 307,574,200 | 147,738,109 | - | - | - | - | - | - |
| HC. 6.3.1.2 | Blood supply | - | - | - | - | - | - | - | - |
| HC.6.3.1.4 | IEC programmes | 10,050,091 | - | - | - | - | - | - | - |
| HC.6.3.1.5 | STI prevention programmes | - | - | - | - | - | - | - | - |
| HC.6.3.1.7 | Condom distribution programmes | - | - | - | - | - | - | - | - |
| HC.6.3.1.8 | ART programmes | - | - | - | - | - | - | - | - |
| HC.6.3.1.9 | Surveillance | 23,508,299 | - | - | - | - | - | - | - |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | 46,316,535 | - | - | - | - | 65,516,008 | - | - |
| HC.6.3.1.12 | Other public health programs (including | - | - | - | - | - | - | - | - |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | 205,876,046 | 5,344,394 | 1,049,658,028 | 12,383,828 | 25,966,091 | 886,378,702 | 152,541,208 | - |
| HC.7.2.2.1 | Local consultancies | 17,926,977 | - | - | - | - | - | - | - |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | 675,219,721 | - | 39,947,833 | 148,026,530 | 239,420,183 | 1,744,764,434 | 682,313,955 | - |
| HCR.1 | Capital formation for health care provider institutions | 44,419,448 | - | - | - | - | 766,717,662 | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | 65,222,465 |
| | **Column Total THE** | 1,581,067,459 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,063,564,586 | 7,138,288,980 | 65,222,465 |
| HCR.2 | Education & Training | 33,203,875 | - | - | - | - | 5,517,400 | 36,690,576 | - |
| HCR.3 | Research & Development | 117,683,834 | - | - | - | - | - | - | - |
| | *Sub total column* | 150,887,709 | - | - | - | - | 5,517,400 | 36,690,576 | - |
| | **Column Total NHE** | 1,731,955,169 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 5,069,081,986 | 7,174,979,556 | 65,222,465 |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | - | - | - | - | - | - | - | - |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | - | - | - | - | - | - | - | - |
| AD.1.2.3 | School fees to OVC | - | - | - | - | - | 1,318,535,777 | - | - |
| AD.1.2.5 | Social support to OVCs not disaggregated | - | - | - | - | - | - | - | - |
| AD.1.3.1 | Income-generating activities | - | - | - | - | - | 1,411,665,314 | - | - |
| AD.2 | Policy advocacy | - | - | - | - | - | - | - | - |
| AD.3 | Non-helath IEC- social stigma reductin | - | - | - | - | - | - | - | - |
| AD.4 | Empowerment and organization (incl. Legal services) | - | - | - | - | - | - | - | - |
| - | subtotal column | - | - | - | - | - | 2,730,201,091 | - | - |
| - | **Column total -- THAE (health, healt** | 1,731,955,169 | 153,082,503 | 1,089,605,861 | 160,410,358 | 265,386,274 | 7,799,283,077 | | 65,222,465 |
| | **HF as a % of THE** | 4% | 0% | 3% | 0% | 1% | 13% | | 0% |

Annex B-3

## FINANCING AGENTS x FUNCTION (HF x HC)

**HIV/AIDS Subaccounts (Targeted only)**

| | | - | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|
| | | HF.2.3. | HF.2.4 | HF.3 | HF.nsk | - |
| | Function | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) | Rest of World | Not specified by any kind | Row Total |
| HC. 1.1.1 | IP ARV curative care | - | - | - | - | 912,036,685 |
| HC. 1.1.2 | IP OI Treatment | - | 126,441,201 | - | - | 126,441,201 |
| HC.1.1.4 | IP care that cannot be disaggregated | 210,795,503 | - | 820,349,277 | - | 2,845,315,477 |
| HC. 1.3.5 | OP STI Management | - | 131,893,843 | - | - | 131,893,843 |
| HC. 1.3.6 | OP opportunistic infection treatment | - | 505,764,805 | - | - | 505,764,805 |
| HC .1.3.7 | OP ARV treatment | - | 892,116,670 | - | - | 4,633,328,378 |
| HC1.3.8 | OP Psychosocial support | - | 516,147,976 | - | - | 516,147,976 |
| HC 1.3.10 | OP care that cannot be disaggregated | 419,604,854 | - | 829,836,146 | - | 2,884,169,177 |
| HC.1.3.11 | VCT as part of OP care | - | 876,795,887 | - | - | 876,795,887 |
| HC.1.3.12 | PMTCT service delivery | - | 482,270,240 | 929,712,263 | - | 1,411,982,503 |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | 160,919,378 | - | - | - | 160,919,378 |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. | - | - | - | - | 3,689,319 |
| HC.6.1.1 | PMTCT | - | 1,104,440,127 | - | - | 1,152,401,280 |
| HC. 6.3.1.1 | VCT | - | 1,236,646,405 | - | - | 1,691,958,714 |
| HC. 6.3.1.2 | Blood supply | - | 445,982,651 | - | - | 445,982,651 |
| HC.6.3.1.4 | IEC programmes | - | 2,138,497,958 | - | - | 2,148,548,049 |
| HC.6.3.1.5 | STI prevention programmes | - | 1,680,803,596 | - | - | 1,680,803,596 |
| HC.6.3.1.7 | Condom distribution programmes | - | 141,646,500 | - | - | 141,646,500 |
| HC.6.3.1.8 | ART programmes | - | 1,122,316,065 | - | - | 1,122,316,065 |
| HC.6.3.1.9 | Surveillance | - | 174,251,628 | - | - | 197,759,927 |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | 27,546,639 | - | - | 139,379,181 |
| HC.6.3.1.12 | Other public health programs (including | - | 791,001,187 | - | - | 791,001,187 |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | 120,600,278 | 70,490,845 | - | 2,529,239,421 |
| HC.7.2.2.1 | Local consultancies | - | - | - | - | 17,926,977 |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | 5,775,470,604 | - | - | 9,305,163,260 |
| HCR.1 | Capital formation for health care provider institutions | - | 2,426,830,003 | - | - | 3,237,967,113 |
| HC.nsk | Not specified by kind | 71,868,647 | 305,024,535 | - | - | 442,115,647 |
| | **Column Total THE** | 863,188,381 | 21,022,488,796 | 2,650,388,531 | - | **40,052,694,195** |
| HCR.2 | Education & Training | - | 14,805,781 | - | - | 90,217,632 |
| HCR.3 | Research & Development | - | 150,100,038 | - | - | 267,783,872 |
| | *Sub total column* | - | 164,905,819 | - | - | 358,001,504 |
| | **Column Total NHE** | 863,188,381 | 21,187,394,615 | 2,650,388,531 | - | **40,410,695,699** |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | - | 25,054,513 | - | - | 25,054,513 |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | - | 510,395,391 | - | - | 510,395,391 |
| AD.1.2.3 | School fees to OVC | - | - | - | - | 2,643,932,534 |
| AD.1.2.5 | Social support to OVCs not disaggregated | - | 1,236,971,795 | - | - | 1,236,971,795 |
| AD.1.3.1 | Income-generating activities | - | - | 1,161,618,929 | - | 2,573,284,243 |
| AD.2 | Policy advocacy | - | 7,228,213 | - | - | 7,228,213 |
| AD.3 | Non-helath IEC- social stigma reductin | - | 59,719,881 | - | - | 59,719,881 |
| AD.4 | Empowerment and organization (incl. Legal services) | - | 100,944,896 | - | - | 100,944,896 |
| - | subtotal column | - | 1,940,314,689 | 1,161,618,929 | - | 7,157,531,466 |
| - | **Column total -- THAE (health, healt** | 863,188,381 | 23,127,709,304 | 3,812,007,460 | - | **47,568,227,165** |
| | **HF as a % of THE** | 2% | 52% | 7% | 0% | |

Annex B-4

## PROVIDER x FUNCTION (HP x HC)

**HIV/AIDS Subaccounts (Targeted only)**

| | | Provider | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.2.1 | HP.1.1.2.2 | HP.3.1 | HP.3.3.1 | HP.3.3.2 | HP.3.3.3 | HP.3.4.5.1 |
| | | National Referral Gvt Hospital | National Referral Private Hospital | District Gvt. Hospitals | District Agrees Hospitals | Office of physicians (private clinics)* | Community health workers | Traditional healer | Other health practitioners | Public health centers |
| | **Function** | | | | | | | | | |
| HC. 1.1.1 | IP ARV curative care | 153,557,197 | 79,105,223 | 502,550,826 | 23,266,242 | - | - | - | - | 93,064,968 |
| HC. 1.1.2 | IP OI Treatment | 24,708,957 | - | 8,985,075 | 2,632,582 | - | - | - | - | 54,614,902 |
| HC.1.1.4 | IP care that cannot be disaggregated | 1,603,181,650 | 344,397,811 | 452,289,570 | 155,001,861 | 2,470,338 | - | - | 207,400 | 148,883,078 |
| HC. 1.3.5 | OP STI Management | 70,063,028 | - | 25,477,465 | 2,464,157 | - | - | - | - | 20,538,906 |
| HC. 1.3.6 | OP opportunistic infection treatment and | 98,835,826 | - | 35,940,300 | 10,530,327 | - | - | - | - | 218,459,607 |
| HC .1.3.7 | OP ARV treatment | 1,658,609,159 | 711,947,004 | 156,418,758 | 249,812,309 | - | - | - | - | 1,125,176,454 |
| HC1.3.8 | OP Psychosocial support | 168,406,582 | - | 61,238,757 | 20,089,042 | - | 97,760,629 | - | - | 101,628,457 |
| HC 1.3.10 | OP care that cannot be disaggregated | 598,554,039 | 555,698,189 | 252,612,579 | 145,510,870 | 47,141,238 | 194,438 | 94,023,410 | 2,664,165 | 709,534,349 |
| HC.1.3.11 | VCT as part of OP care | 363,765,329 | - | 132,278,301 | 42,328,894 | - | - | - | - | 203,746,453 |
| HC.1.3.12 | PMTCT service delivery | 151,075,706 | - | 54,936,620 | 22,890,259 | - | - | - | - | 717,018,132 |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | - | - | - | - | - | - | - | - |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. of | - | - | - | - | - | - | - | - | - |
| HC.6.1.1 | PMTCT | - | - | - | - | - | - | - | - | 47,961,153 |
| HC. 6.3.1.1 | VCT | - | - | - | - | - | - | - | - | 1,059,054 |
| HC. 6.3.1.2 | Blood supply | - | - | - | - | - | 34,567,473 | - | - | 118,666,519 |
| HC.6.3.1.4 | IEC programmes | - | - | - | - | - | 3,681,595 | - | - | - |
| HC.6.3.1.5 | STI prevention programmes | - | - | - | - | - | 368,581,836 | - | - | - |
| HC.6.3.1.7 | Condom distribution programmes | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.8 | ART programmes | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.9 | Surveillance | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.12 | Other public health programs (including OI , psychosocial support) | - | - | - | - | - | - | - | - | - |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.1 | Local consultancies | - | - | - | - | - | - | - | - | - |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | - | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | 253,016,828 | 130,342,003 | 92,006,119 | 38,335,883 | - | - | - | - | 153,343,532 |
| HC.nsk | Not specified by kind | - | - | - | - | - | 68,288,647 | - | 1,802,219 | - |
| | **Column Total-THE** | **5,143,774,300** | **1,821,490,229** | **1,774,734,371** | **712,862,424** | **49,611,576** | **573,074,618** | **94,023,410** | **4,673,784** | **3,713,695,565** |
| HCR.2 | Education & Training | | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | | | | |
| HCR.5 | Environmental health | | | | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | | |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | | | | | | | | | |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | | | | | | | | | |
| AD.1.2.3 | School fees to OVC | | | | | | | | | |
| AD.1.2.5 | Social support to OVCs not disaggregated | | | | | | | | | |
| AD.1.3.1 | Income-generating activities | | | | | | | | | |
| AD.2 | Policy advocacy | | | | | | | | | |
| AD.3 | Non-helath IEC- social stigma reductin | | | | | | | | | |
| AD.4 | Empowerment and organization (incl. Legal services) | | | | | | | | | |
| - | **Column total -- THAE (health, health related, nonhealth)** | | | | | | | | | |

Annex B-4

## PROVIDER x FUNCTION (HP x HC)

**HIV/AIDS Subaccounts (Targeted only)**

| | | HP.3.4.5.2 | HP.3.4.5.9 | HP.3.4.5.9 | HP.3.6 | HP.4.1 | HP.5 | HP.6 | HP.9 |
|---|---|---|---|---|---|---|---|---|---|
| | | Government assisted not-for-profit health centers (Agrees) | Mobile health centers | TRAC HIV/AIDS Center | Providers of home health care services | Dispensing chemists | Providers + admin of public health programs | General health administration and insurance | Rest of the world |
| | **Function** | | | | | | | | |
| HC. 1.1.1 | IP ARV curative care | 60,492,229 | - | - | - | - | - | - | - |
| HC. 1.1.2 | IP OI Treatment | 35,499,686 | - | - | - | - | - | - | - |
| HC.1.1.4 | IP care that cannot be disaggregated | 90,905,946 | 16,670 | - | 47,961,153 | - | - | - | - |
| HC. 1.3.5 | OP STI Management | 13,350,289 | - | - | - | - | - | - | - |
| HC. 1.3.6 | OP opportunistic infection treatment and | 141,998,744 | - | - | - | - | - | - | - |
| HC .1.3.7 | OP ARV treatment | 731,364,695 | - | - | - | - | - | - | - |
| HC1.3.8 | OP Psychosocial support | 66,058,497 | - | - | - | - | 966,012 | - | - |
| HC 1.3.10 | OP care that cannot be disaggregated | 365,121,847 | - | 113,114,054 | - | - | - | - | - |
| HC.1.3.11 | VCT as part of OP care | 132,435,195 | - | - | - | - | 2,241,714 | - | - |
| HC.1.3.12 | PMTCT service delivery | 466,061,786 | - | - | - | - | - | - | - |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | - | - | - | 160,919,378 | - | - | - |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. of | - | - | - | - | - | 3,689,319 | - | - |
| HC.6.1.1 | PMTCT | - | - | - | - | - | 1,104,440,127 | - | - |
| HC. 6.3.1.1 | VCT | 688,385 | - | - | - | - | 1,542,473,165 | 147,738,109 | - |
| HC. 6.3.1.2 | Blood supply | 77,133,238 | - | - | - | - | 215,615,420 | - | - |
| HC.6.3.1.4 | IEC programmes | - | - | - | - | - | 1,972,016,280 | 172,850,174 | - |
| HC.6.3.1.5 | STI prevention programmes | - | - | - | - | - | 1,202,388,718 | 109,833,043 | - |
| HC.6.3.1.7 | Condom distribution programmes | - | - | - | - | - | 131,988,114 | 9,658,386 | - |
| HC.6.3.1.8 | ART programmes | - | - | - | - | - | 1,122,316,065 | - | - |
| HC.6.3.1.9 | Surveillance | - | - | - | - | - | 110,356,454 | 87,403,473 | - |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | - | - | - | - | 66,338,316 | 73,040,865 | - |
| HC.6.3.1.12 | Other public health programs (including OI , psychosocial support) | - | - | - | - | - | 791,001,187 | - | - |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | - | - | - | - | 2,505,254,397 | 16,453,800 | 7,531,224 |
| HC.7.2.2.1 | Local consultancies | - | - | - | - | - | - | 17,926,977 | - |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | - | - | - | - | 2,205,197,140 | 7,099,966,120 | - |
| HCR.1 | Capital formation for health care provider institutions | 99,673,296 | - | - | - | - | - | 2,471,249,451 | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | 2,507,143 | - | - |
| | **Column Total-THE** | **2,280,783,833** | **16,670** | **113,114,054** | **47,961,153** | **160,919,378** | **12,978,789,572** | **10,206,120,397** | **7,531,224** |
| HCR.2 | Education & Training | | | | | | | | |
| HCR.3 | Research & Development | | | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | | | |
| HCR.5 | Environmental health | | | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | | |
| | **Column Total-NHE** | | | | | | | | |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | | | | | | | | |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | | | | | | | | |
| AD.1.2.3 | School fees to OVC | | | | | | | | |
| AD.1.2.5 | Social support to OVCs not disaggregated | | | | | | | | |
| AD.1.3.1 | Income-generating activities | | | | | | | | |
| AD.2 | Policy advocacy | | | | | | | | |
| AD.3 | Non-helath IEC- social stigma reductin | | | | | | | | |
| AD.4 | Empowerment and organization (incl. Legal services) | | | | | | | | |
| - | **Column total -- THAE (health, health related, nonhealth)** | | | | | | | | |

Annex B-4

## PROVIDER x FUNCTION (HP x HC)

**HIV/AIDS Subaccounts (Targeted only)**

| | | HP.nsk | | HP.8.1 | HP.8.2 | HP.8.3 | | |
|---|---|---|---|---|---|---|---|---|
| | **Function** | Providers not specified by any kind | **THE Row Total** | Research Institutions | Education and training institutions | Other health related institutions | NHE Row Total | Providers of NONHEALTH programs |
| HC. 1.1.1 | IP ARV curative care | - | 912,036,685 | | | | | |
| HC. 1.1.2 | IP OI Treatment | - | 126,441,201 | | | | | |
| HC.1.1.4 | IP care that cannot be disaggregated | - | 2,845,315,477 | | | | | |
| HC. 1.3.5 | OP STI Management | - | 131,893,843 | | | | | |
| HC. 1.3.6 | OP opportunistic infection treatment and | - | 505,764,805 | | | | | |
| HC .1.3.7 | OP ARV treatment | - | 4,633,328,378 | | | | | |
| HC1.3.8 | OP Psychosocial support | - | 516,147,976 | | | | | |
| HC 1.3.10 | OP care that cannot be disaggregated | - | 2,884,169,177 | | | | | |
| HC.1.3.11 | VCT as part of OP care | - | 876,795,887 | | | | | |
| HC.1.3.12 | PMTCT service delivery | - | 1,411,982,503 | | | | | |
| HC 5.1.1.3 | Drugs that could not be disaggregagted | - | 160,919,378 | | | | | |
| HC.5.1.3.1 | Condoms (donated/contributed for prev. of | - | 3,689,319 | | | | | |
| HC.6.1.1 | PMTCT | - | 1,152,401,280 | | | | | |
| HC. 6.3.1.1 | VCT | - | 1,691,958,714 | | | | | |
| HC. 6.3.1.2 | Blood supply | - | 445,982,651 | | | | | |
| HC.6.3.1.4 | IEC programmes | - | 2,148,548,049 | | | | | |
| HC.6.3.1.5 | STI prevention programmes | - | 1,680,803,596 | | | | | |
| HC.6.3.1.7 | Condom distribution programmes | - | 141,646,500 | | | | | |
| HC.6.3.1.8 | ART programmes | - | 1,122,316,065 | | | | | |
| HC.6.3.1.9 | Surveillance | - | 197,759,927 | | | | | |
| HC.6.3.1.11 | Trainings for HIV/AIDS programmes | - | 139,379,181 | | | | | |
| HC.6.3.1.12 | Other public health programs (including OI , psychosocial support) | - | 791,001,187 | | | | | |
| HC.6.3.1.13 | public health ptrogrammes not disaggregated | - | 2,529,239,421 | | | | | |
| HC.7.2.2.1 | Local consultancies | - | 17,926,977 | | | | | |
| HC.7.2.2.3 | Health administration and health insurance (not disaggregated) | - | 9,305,163,260 | | | | | |
| HCR.1 | Capital formation for health care provider institutions | - | 3,237,967,113 | | | | | |
| HC.nsk | Not specified by kind | 369,517,638 | 442,115,647 | | | | | |
| | **Column Total-THE** | **369,517,638** | **40,052,694,195** | | | | | |
| HCR.2 | Education & Training | | | 0 | 90,217,632 | 0 | 90,217,632 | |
| HCR.3 | Research & Development | | | 267,783,872 | 0 | 0 | 267,783,872 | |
| HCR.4 | Food, hygiene and drinking water control | | | 0 | 0 | 0 | - | |
| HCR.5 | Environmental health | | | 0 | 0 | 0 | - | |
| HCR.nsk | HCR expenditure not specified by kind | | | 0 | 0 | 0 | - | |
| | **Column Total-NHE** | | | 267,783,872 | 90,217,632 | - | **40,410,695,699** | |
| AD.1.1.2 | Monetary benefits to PLWHA,widows, and families | | | | | | | **25,054,513** |
| AD.1.1.5 | Social support to PLWHA, widows, and families not disaggregated. | | | | | | | **510,395,391** |
| AD.1.2.3 | School fees to OVC | | | | | | | **2,643,932,534** |
| AD.1.2.5 | Social support to OVCs not disaggregated | | | | | | | **1,236,971,795** |
| AD.1.3.1 | Income-generating activities | | | | | | | **2,573,284,243** |
| AD.2 | Policy advocacy | | | | | | | **7,228,213** |
| AD.3 | Non-helath IEC- social stigma reductin | | | | | | | **59,719,881** |
| AD.4 | Empowerment and organization (incl. Legal services) | | | | | | | **100,944,896** |
| - | **Column total -- THAE (health, health related, nonhealth)** | | | | | | | **47,568,227,165** |

# FINANCING SOURCE x FINANCING AGENT (FSxHF)

**Malaria Subaccounts targeted only**

**Financing Source (FS)**

| Code | Financing Agent (HF) | | | | FS.2 Private Funds | | | | | FS.3 | FS.nsk | Row Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | FS.1.1.1 Central Gov Revenue<br>FS.1.1.1.4 could not be disaggregated | FS.1.1.2 District gov. revenue | FS. 1.2 Other Public funds | FS.2.1.1 Parastatal Employers | FS.2.1.2 Private Employers | FS.2.2 Households | FS .2.3 NPISH ( *Local foundations)* | FS.2.4 Other private funds | Rest of the World (Donors) | Not specified by any kind | |
| HF.1.1.1.1 | MoH (MiniSante) | 41,806,250 | | | | | | | | 5,804,932,365 | | 5,846,738,615 |
| HF.1.1.1.2 | Other Ministries | | | | | | | | | | | 0 |
| HF.1.1.3 | Local Municipal Gvt (Districts) | | | | | | | | | | | 0 |
| HF.1.2 | Social Security Fund (CSR) | | | | | | | | | | | 0 |
| HF.1.3 | FARG | | | | | | | | | | | 0 |
| HF.2.1.1 | Gvt Employees Insurance Programme (RAMA) | | | | | | | | | | | 0 |
| HF.2.1.2 | Private Employees Insurance Programme | | | | | | | | | | | 0 |
| HF.2.1.3 | Mutuelles (Private & Community based) | | | | | | | | | | | 0 |
| HF. 2.5.1 | Parastatal companies | | | | | | | | | | | 0 |
| HF.2.2 | Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)* | | | | | | | | | | | 0 |
| HF.2.3. | Private household out of pocket payments | | | | | | 9,568,284,436 | | | | | 9,568,284,436 |
| HF.2.4 | Non profit institutions (NGOs) | | | | | | | | | 2,259,356,258 | | 2,259,356,258 |
| HF.2.5.2 | Private Non Parastatal Firms | | | | | | | | | | | 0 |
| HF.3 | Rest of World | | | | | | | | | 260,326,957 | | 260,326,957 |
| HF.nsk | Not specified by any kind | | | | | | | | | | | 0 |
| | **Column Total (THE)** | 41,806,250 | 0 | 0 | 0 | 0 | 9,568,284,436 | 0 | 0 | 8,324,615,580 | 0 | **17,934,706,266** |
| HF.4 | Financing Agents spending on Health Related Items | | | | | | | | | 133,027,270 | | 133,027,270 |
| | **Column Total (NHE)** | 41,806,250 | 0 | 0 | 0 | 0 | 9,568,284,436 | 0 | 0 | 8,457,642,850 | 0 | **18,067,733,536** |

# FINANCING AGENT x PROVIDER (HFxP)

**Malaria Subaccounts targeted only**

| | | Financing Agent | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.A Public Sector | | | | | | | | |
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | **Provider** | MoH (MiniSante) | Other Ministries | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme | Mutuelles (Private & Community based) | Parastatal companies |
| HP.1.1.1.1 | National Referral Gvt Hospital | | | | | | | | | |
| HP.1.1.1.2 | National Referral Private Hospital | | | | | | | | | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | |
| HP.1.1.2.1 | District Gvt. Hospitals | 39,086,500 | | | | | | | | |
| HP.1.1.2.2 | District Agrees Hospitals | 16,646,582 | | | | | | | | |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | |
| HP.1.2 | Mental health hospitals | | | | | | | | | |
| HP.3.1 | Office of physicians (private clinics)* | | | | | | | | | |
| HP.3.3.1 | Community health workers | 4,485,321,000 | | | | | | | | |
| HP.3.3.2 | Traditional healer | | | | | | | | | |
| HP.3.3.3 | Other health practitioners | 128,584,047 | | | | | | | | |
| HP.3.4.2 | Outpatient mental health | | | | | | | | | |
| HP.3.4.5.1 | Public health centers | 305,608,214 | | | | | | | | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 196,429,797 | | | | | | | | |
| HP.3.4.5.3 | NGO health centers | | | | | | | | | |
| HP.3.5 | Medical and diagnostic laboratories | 2,000,000 | | | | | | | | |
| HP.3.9.1 | Ambulance services | | | | | | | | | |
| HP.3.6 | Providers of home health | 6,208,098 | | | | | | | | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | |
| HP.4.1 | Dispensing chemists | | | | | | | | | |
| HP.5 | Providers + admin of public | 602,670,461 | | | | | | | | |
| HP.nsk | Providers not specified by | | | | | | | | | |
| | **Column Total THE** | 5,846,738,615 | - | - | - | - | - | - | - | - |
| | **HF Totals From FS x HF T** | 5,846,738,615 | - | - | - | - | - | - | - | - |
| HP.8.1 | Research Institutions | 103,220,675 | | | | | | | | |
| HP.8.2 | Education and training institutions | | | | | | | | | |
| HP.8.3 | Other health related institutions | | | | | | | | | |
| | **Subtotal for health relat** | 103,220,675 | - | - | - | - | - | - | - | - |
| | **Column Total: NHE** | 5,949,959,290 | - | - | - | - | - | - | - | - |

# FINANCING AGENT x PROVIDER (HFxP)

**Malaria Subaccounts targeted only**

| | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | |
| | **Provider** | Private Insurance Enterprises (other than social insurance: | Private household out of pocket payments | Non profit institutions (NGOs) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HP.1.1.1.1 | National Referral Gvt Hospital | | 1,133,558,339 | 230,207,473 | | | | 1,363,765,812 |
| HP.1.1.1.2 | National Referral Private Hospital | | 305,146,201 | | | | | 305,146,201 |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | - |
| HP.1.1.2.1 | District Gvt. Hospitals | | 421,585,082 | 89,994,334 | | | | 550,665,917 |
| HP.1.1.2.2 | District Agrees Hospitals | | 157,365,218 | 26,925,564 | | | | 200,937,364 |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | - |
| HP.1.2 | Mental health hospitals | | | | | | | - |
| HP.3.1 | Office of physicians (private clinics)* | | 1,396,747,643 | | | | | 1,396,747,643 |
| HP.3.3.1 | Community health workers | | | 294,186,724 | | | | 4,779,507,724 |
| HP.3.3.2 | Traditional healer | | 83,780,058 | | | | | 83,780,058 |
| HP.3.3.3 | Other health practitioners | | 68,065,140 | | | | | 196,649,187 |
| HP.3.4.2 | Outpatient mental health | | | | | | | - |
| HP.3.4.5.1 | Public health centers | | 2,404,950,486 | 107,922,624 | | | | 2,818,481,324 |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | | 507,518,673 | 69,554,537 | | | | 773,503,007 |
| HP.3.4.5.3 | NGO health centers | | | | | | | - |
| HP.3.5 | Medical and diagnostic laboratories | | | | | | | 2,000,000 |
| HP.3.9.1 | Ambulance services | | | | | | | - |
| HP.3.6 | Providers of home health | | | | | | | 6,208,098 |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | - |
| HP.4.1 | Dispensing chemists | | 3,089,567,595 | 698,695,027 | | | | 3,788,262,622 |
| HP.5 | Providers + admin of public | | | 288,129,742 | | 185,704,394 | | 1,076,504,598 |
| HP.nsk | Providers not specified by | | | 236,754,941 | | | | 236,754,941 |
| | **Column Total THE** | - | 9,568,284,436 | 2,259,356,258 | - | 260,326,957 | - | **17,934,706,266** |
| | **HF Totals From FS x HF T** | - | 9,568,284,436 | 2,259,356,258 | - | 260,326,957 | - | 17,934,706,266 |
| HP.8.1 | Research Institutions | | | | | | | 103,220,675 |
| HP.8.2 | Education and training institutions | | | | | | | - |
| HP.8.3 | Other health related institutions | | | 29,806,595 | | | | 29,806,595 |
| | **Subtotal for health relat** | - | - | 29,806,595 | - | - | - | 133,027,270 |
| | **Column Total: NHE** | - | 9,568,284,436 | 2,289,162,853 | - | 260,326,957 | - | **18,067,733,536** |

Annex B-7

# FINANCING AGENTS x FUNCTION (HF x HC)

**Malaria Subaccounts targeted only**

**Financing Agent**

| Function | | HF.A Public Sector | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.1.3 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | | MoH (MiniSante) | Other Ministries | CNLS | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme | Private Employees Insurance | Mutuelles (Private & Community | Parastatal companies |
| HC.1.1 | In patient curative care (incl. For severe malaria) | 46,863,930 | - | - | - | - | - | - | - | - | - |
| HC 1.3.9 | Nets given as part of Outpatient care | 5,172,227,862 | - | - | - | - | - | - | - | - | - |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | - | - | - | - | - | - | - | - |
| HC 1.3.12 | OP care that could not be disaggregated | 822,644 | - | - | - | - | - | - | - | - | - |
| HC.1.4 | Services of curative home care (malaria) | 6,208,098 | - | - | - | - | - | - | - | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | 625,634 | - | - | - | - | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | - | - | - | - | - | - | - | - |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.2 | IPTp | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.2.2 | Training within public health programmes for malaria | 108,172,218 | - | - | - | - | - | - | - | - | - |
| HC. 6.3.2.3 | IEC (malaria awareness) | 51,780,529 | - | - | - | - | - | - | - | - | - |
| HC. 6.3.2.4 | Surveillance and monitoring | 44,910,796 | - | - | - | - | - | - | - | - | - |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | - | - | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be disaggregated | 78,266,051 | - | - | - | - | - | - | - | - | - |
| HC.7 | Health administration and insurance | 69,435,246 | - | - | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | 267,425,607 | - | - | - | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - | - | - |
| | **Column Total THE** | 5,846,738,615 | - | - | - | - | - | - | - | - | - |
| HCR.2 | Education & Training | - | - | - | - | - | - | - | - | - | - |
| HCR.3 | Research & Development | 103,220,675 | - | - | - | - | - | - | - | - | - |
| HCR.4 | Food, hygiene and drinking water co | - | - | - | - | - | - | - | - | - | - |
| HCR.5 | Environmental health | - | - | - | - | - | - | - | - | - | - |
| | *Sub total column* | - | - | - | - | - | - | - | - | - | - |
| | **Column Total NHE** | 5,846,738,615 | - | - | - | - | - | - | - | - | - |

Annex B-7

# FINANCING AGENTS x FUNCTION (HF x HC)

**Malaria Subaccounts targeted only**

| | | | | | - | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | - |
| | Function | Private Insurance Enterprises (other | Private household out of pocket payments | Non profit institutions (NGOs) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HC.1.1 | In patient curative care (incl. For severe malaria) | - | 1,012,072,015 | 253,823,556 | - | - | - | 1,312,759,501 |
| HC 1.3.9 | Nets given as part of Outpatient care | - | 41,381,600 | 236,754,941 | - | - | - | 5,450,364,403 |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | 66,208,800 | - | - | - | 66,208,800 |
| HC 1.3.12 | OP care that could not be disaggregated | - | 5,425,263,226 | 204,572,177 | - | - | - | 5,630,658,047 |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | - | - | - | 6,208,098 |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | - | 625,634 |
| HC.5.1 | Pharmaceuticals and other medical non | - | 2,954,790,195 | - | - | - | - | 2,954,790,195 |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | 134,777,400 | 698,695,027 | - | - | - | 833,472,427 |
| HC.6.1.2 | IPTp | - | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water | - | - | 2,587,600 | - | - | - | 2,587,600 |
| HC.6.3.2.2 | Training within public health programmes for malaria | - | - | 281,320,369 | - | - | - | 389,492,587 |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | 171,752,507 | - | - | - | 223,533,036 |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | 75,353,714 | - | - | - | 120,264,510 |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be disaggregated | - | - | - | - | 260,326,957 | - | 338,593,008 |
| HC.7 | Health administration and insurance | - | - | 213,328,668 | - | - | - | 282,763,915 |
| HCR.1 | Capital formation for health care provider institutions | - | - | 54,958,899 | - | - | - | 322,384,506 |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - |
| | **Column Total THE** | - | 9,568,284,436 | 2,259,356,258 | - | 260,326,957 | - | **17,934,706,266** |
| HCR.2 | Education & Training | - | - | - | - | - | - | - |
| HCR.3 | Research & Development | - | - | - | - | - | - | 103,220,675 |
| HCR.4 | Food, hygiene and drinking water co | - | - | - | - | - | - | - |
| HCR.5 | Environmental health | - | - | 29,806,595 | - | - | - | - |
| | *Sub total column* | - | - | - | - | - | - | *103,220,675* |
| | **Column Total NHE** | - | 9,568,284,436 | 2,259,356,258 | - | 260,326,957 | - | **18,037,926,941** |

Annex B-8

# PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted only**

| | | Provider | | | | | |
|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.1.3 | HP.1.1.2.1 | HP.1.1.2.2 | HP.1.1.2.3 |
| | **Function** | National Referral Gvt Hospital | National Referral Private Hospital | National Referral Hospital (could not be disaggregated) | District Gvt. Hospitals | District Agrees Hospitals | District Hospitals (could not be disaggregated) |
| HC.1.1 | In patient curative care (incl. For severe | 627,513,893 | 223,230,857 | - | 228,506,328 | 101,556,677 | - |
| HC 1.3.9 | Nets given as part of Outpatient care | - | - | - | 40,784,646 | 17,652,357 | - |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | 43,981,172 | - | - | 22,227,628 | - | - |
| HC 1.3.12 | OP care that could not be disaggregated | 692,270,747 | 81,915,344 | - | 258,521,682 | 81,728,330 | - |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | - | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | - | 625,634 | - | - |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | - | - | - | - |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | - | - |
| HC.6.1.2 | IPTp | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water areas | - | - | - | - | - | - |
| HC.6.3.2.2 | Training within public health programmes for | - | - | - | - | - | - |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | - | - | - | - |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | - | - | - | - |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be | - | - | - | - | - | - |
| HC.7 | Health administration and insurance | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - |
| | **Column Total-THE** | **1,363,765,812** | **305,146,201** | **-** | **550,665,917** | **200,937,364** | **-** |
| HCR.2 | Education & Training | | | | | | |
| HCR.3 | Research & Development | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | |
| HCR.5 | Environmental health | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | |
| | **Column Total-NHE** | | | | | | |

Annex B-8

# PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted only**

| | | Provider | | | | | |
|---|---|---|---|---|---|---|---|
| | | HP.1.2 | HP.3.1 | HP.3.3.1 | HP.3.3.2 | HP.3.3.3 | HP.3.4.1 |
| | **Function** | Mental health hospitals | Office of physicians (private clinics)* | Community health workers | Traditional healer | Other health practitioners | Family planning centers |
| HC.1.1 | In patient curative care (incl. For severe | - | - | - | - | - | |
| HC 1.3.9 | Nets given as part of Outpatient care | - | - | 4,485,321,000 | - | 136,353,006 | |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | |
| HC 1.3.11 | Other OP care | - | - | - | - | - | |
| HC 1.3.12 | OP care that could not be disaggregated | - | 1,396,747,643 | - | 83,780,058 | 60,296,180 | |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | - | - | |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | - | - | - | |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | - | |
| HC.6.1.2 | IPTp | - | - | - | - | - | |
| HC.6.3.2.1 | Larviciding, elimination of standing water areas | - | - | - | - | - | |
| HC.6.3.2.2 | Training within public health programmes for | - | - | 220,628,969 | - | - | |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | 18,598,857 | - | - | |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | - | - | - | |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | - | - | - | |
| HC.6.3.2.6 | malaria programs that could not be | - | - | - | - | - | |
| HC.7 | Health administration and insurance | - | - | - | - | - | |
| HCR.1 | Capital formation for health care provider institutions | - | - | 54,958,899 | - | - | |
| HC.nsk | Not specified by kind | - | - | - | - | - | |
| | **Column Total-THE** | **-** | **1,396,747,643** | **4,779,507,724** | **83,780,058** | **196,649,187** | **-** |
| HCR.2 | Education & Training | | | | | | |
| HCR.3 | Research & Development | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | |
| HCR.5 | Environmental health | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | |
| | **Column Total-NHE** | | | | | | |

Annex B-8

# PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted only**

| | | HP.3.4.2 | HP.3.4.5.1 | HP.3.4.5.2 | HP.3.4.5.3 | HP.3.6 | HP.3.9.2 |
|---|---|---|---|---|---|---|---|
| | **Function** | Outpatient mental health institutions (SCPS) | Public health centers | Government assisted not-for-profit health centers (Agrees) | NGO health centers | Providers of home health care services | Blood banks (CNTS transfusion) |
| HC.1.1 | In patient curative care (incl. For severe | - | 51,083,375 | 34,004,440 | - | - | - |
| HC 1.3.9 | Nets given as part of Outpatient care | - | 323,200,503 | 208,297,949 | - | - | - |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | - | - | - | - |
| HC 1.3.12 | OP care that could not be disaggregated | - | 2,444,197,445 | 531,200,617 | - | - | - |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | - | 6,208,098 | - |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other medical non | - | - | - | - | - | - |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | - | - | - | - | - |
| HC.6.1.2 | IPTp | - | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water areas | - | - | - | - | - | - |
| HC.6.3.2.2 | Training within public health programmes for | - | - | - | - | - | - |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | - | - | - | - | - |
| HC. 6.3.2.4 | Surveillance and monitoring | - | - | - | - | - | - |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be | - | - | - | - | - | - |
| HC.7 | Health administration and insurance | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - |
| | **Column Total-THE** | **-** | **2,818,481,324** | **773,503,007** | **-** | **6,208,098** | **-** |
| HCR.2 | Education & Training | | | | | | |
| HCR.3 | Research & Development | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | |
| HCR.5 | Environmental health | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | |
| | **Column Total-NHE** | | | | | | |

Annex B-8

## PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted only**

| | | HP.4.1 | HP.5 | HP.6 | HP. 8 | HP.9 |
|---|---|---|---|---|---|---|
| | **Function** | Dispensing chemists | Providers + admin of public health programs | General health administration and insurance | Institutions providing health related services | Rest of the world |
| HC.1.1 | In patient curative care (incl. For severe | - | 46,863,930 | - | - | - |
| HC 1.3.9 | Nets given as part of Outpatient care | - | - | - | - | - |
| HC 1.3.10 | ACT as part of OP care | - | - | - | - | - |
| HC 1.3.11 | Other OP care | - | - | - | - | - |
| HC 1.3.12 | OP care that could not be disaggregated | - | - | - | - | - |
| HC.1.4 | Services of curative home care (malaria) | - | - | - | - | - |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | - | - | - |
| HC.4.2 | Diagnostic imaging | - | - | - | - | - |
| HC.5.1 | Pharmaceuticals and other medical non | 2,954,790,195 | - | - | - | - |
| HC 5.1.3.2 | Repellants for nets | - | - | - | - | - |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | 833,472,427 | - | - | - | - |
| HC.6.1.2 | IPTp | - | - | - | - | - |
| HC.6.3.2.1 | Larviciding, elimination of standing water areas | - | 2,587,600 | - | - | - |
| HC.6.3.2.2 | Training within public health programmes for | - | 157,828,818 | 11,034,800 | - | - |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | 204,934,179 | - | - | - |
| HC. 6.3.2.4 | Surveillance and monitoring | - | 120,022,375 | 242,135 | - | - |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | - | - | - |
| HC.6.3.2.6 | malaria programs that could not be | - | 263,970,445 | 74,622,563 | - | - |
| HC.7 | Health administration and insurance | - | 12,871,644 | 269,892,271 | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | 267,425,607 | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - |
| | **Column Total-THE** | **3,788,262,622** | **1,076,504,598** | **355,791,768** | **-** | **-** |
| HCR.2 | Education & Training | | | | | |
| HCR.3 | Research & Development | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | |
| HCR.5 | Environmental health | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | |
| | **Column Total-NHE** | | | | | |

Annex B-8

# PROVIDER x FUNCTION (HP x HC)

**Malaria Subaccounts targeted only**

| | | HP.nsk | | HP.8.1 | HP.8.2 | HP.8.3 | |
|---|---|---|---|---|---|---|---|
| | **Function** | Providers not specified by any kind | **THE Row Total** | Research Institutions | Education and training institutions | Other health related institutions | NHE Row Total |
| HC.1.1 | In patient curative care (incl. For severe | - | 1,312,759,501 | | | | |
| HC 1.3.9 | Nets given as part of Outpatient care | 236,754,941 | 5,450,364,403 | | | | |
| HC 1.3.10 | ACT as part of OP care | - | - | | | | |
| HC 1.3.11 | Other OP care | - | 66,208,800 | | | | |
| HC 1.3.12 | OP care that could not be disaggregated | - | 5,630,658,047 | | | | |
| HC.1.4 | Services of curative home care (malaria) | - | 6,208,098 | | | | |
| HC.4.1 | Clinical lab (BNC, biolab, biomed, etc) | - | - | | | | |
| HC.4.2 | Diagnostic imaging | - | 625,634 | | | | |
| HC.5.1 | Pharmaceuticals and other medical non | - | 2,954,790,195 | | | | |
| HC 5.1.3.2 | Repellants for nets | - | - | | | | |
| HC.5.2.5.1 | Insecticide treated nets (ITNs) | - | 833,472,427 | | | | |
| HC.6.1.2 | IPTp | - | - | | | | |
| HC.6.3.2.1 | Larviciding, elimination of standing water areas | - | 2,587,600 | | | | |
| HC.6.3.2.2 | Training within public health programmes for | - | 389,492,587 | | | | |
| HC. 6.3.2.3 | IEC (malaria awareness) | - | 223,533,036 | | | | |
| HC. 6.3.2.4 | Surveillance and monitoring | - | 120,264,510 | | | | |
| HC.6.3.2.5 | OTHER miscellaneous public health programs | - | - | | | | |
| HC.6.3.2.6 | malaria programs that could not be | - | 338,593,008 | | | | |
| HC.7 | Health administration and insurance | - | 282,763,915 | | | | |
| HCR.1 | Capital formation for health care provider institutions | - | 322,384,506 | | | | |
| HC.nsk | Not specified by kind | - | - | | | | |
| | **Column Total-THE** | **236,754,941** | **17,934,706,266** | | | | |
| HCR.2 | Education & Training | | | 0 | 0 | 0 | - |
| HCR.3 | Research & Development | | | 103,220,675 | 0 | 0 | 103,220,675 |
| HCR.4 | Food, hygiene and drinking water control | | | 0 | 0 | 0 | - |
| HCR.5 | Environmental health | | | 0 | 0 | 29,806,595 | 29,806,595 |
| HCR.nsk | HCR expenditure not specified by kind | | | 0 | 0 | 0 | - |
| | **Column Total-NHE** | | | 103,220,675 | - | 29,806,595 | **18,037,926,941** |

# FINANCING SOURCE x FINANCING AGENT (FSxHF)

**RH Subaccounts targeted only**

| Code | Financing Agent (HF) | FS.1.1.1.4 could not be disaggregated | FS. 1.2 Other Public funds | FS.2 Private Funds | | | | | FS.3 | FS.nsk | Row Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | FS.2.1.1 Parastatal Employers | FS.2.1.2 Private Employers | FS.2.2 Households | FS .2.3 NPISH ( *Local foundations)* | FS.2.4 Other private funds | Rest of the World (Donors) | Not specified by any kind | |
| HF.1.1.1.1 | MoH (MiniSante) | 5,141,792 | | | | | | | 625,740,044 | | 630,881,836 |
| HF.1.1.1.2 | Other Ministries | | | | | | | | 480,290 | | 480,290 |
| HF.1.1.3 | Local Municipal Gvt (Districts) | | | | | | | | | | 0 |
| HF.1.2 | Social Security Fund (CSR) | | | | | | | | | | 0 |
| HF.1.3 | FARG | | | | | | | | | | 0 |
| HF.2.1.1 | Gvt Employees Insurance Programme (RAMA) | | | | | | | | | | 0 |
| HF.2.1.2 | Private Employees Insurance Programme | | | | | | | | | | 0 |
| HF.2.1.3 | Mutuelles (Private & Community based) | | | | | | | | | | 0 |
| HF. 2.5.1 | Parastatal companies | | | | | | | | | | 0 |
| HF.2.2 | Private Insurance Enterprises *(other than social insurance: COGEAR, SONARWA, etc)* | | | | | | | | | | 0 |
| HF.2.3. | Private household out of pocket payments | | | | | 988,390,962 | | | | | 988,390,962 |
| HF.2.4 | Non profit institutions (NGOs, SWAA, PROFEMME) | | | | | | | | 2,280,718,735 | | 2,280,718,735 |
| HF.2.5.2 | Private Non Parastatal Firms | | | | | | | | | | 0 |
| HF.3 | Rest of World | | | | | | | | 291,548,970 | | 291,548,970 |
| HF.nsk | Not specified by any kind | | | | | | | | | | 0 |
| | **Column Total (THE)** | 5,141,792 | 0 | 0 | 0 | 988,390,962 | 0 | 0 | 3,198,488,039 | 0 | **4,192,020,793** |
| HF. Health re | Financing Agents spending on Health Related Items | | | | | | | | 171,590,514 | | 171,590,514 |
| | **Column Total (NHE)** | 5,141,792 | 0 | 0 | 0 | 988,390,962 | 0 | 0 | 3,370,078,553 | 0 | **4,363,611,307** |
| Addendum | Financing Agents spending on NONHEALTH | | | | | | | | | | 0 |
| | **Column Total: RHE (health, health related and nonhealth)** | 5,141,792 | 0 | 0 | 0 | 988,390,962 | 0 | 0 | 3,370,078,553 | 0 | **4,363,611,307** |

# FINANCING AGENT x PROVIDER (HFxP)

**RH Subaccounts targeted only**

**Financing Agent**

| | | HF.A Public Sector | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | HF.1.1.1.1 | HF.1.1.1.2 | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 |
| | **Provider** | MoH (MiniSante) | Other Ministries | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme (RAMA) | Private Employees Insurance Programme |
| HP.1.1.1.1 | National Referral Gvt Hospital | 78,933,073 | | | | | | |
| HP.1.1.1.2 | National Referral Private Hospital | 6,139,884 | | | | | | |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | |
| HP.1.1.2.1 | District Gvt. Hospitals | 15,893,350 | | | | | | |
| HP.1.1.2.2 | District Agrees Hospitals | 6,878,939 | | | | | | |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | |
| HP.1.2 | Mental health hospitals | | | | | | | |
| HP.3.1 | Office of physicians (private clinics)* | 6,982,331 | | | | | | |
| HP.3.3.1 | Community health workers | 2,302,366 | | | | | | |
| HP.3.3.2 | Traditional healer | | | | | | | |
| HP.3.3.3 | Other health practitioners | | | | | | | |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | | | | |
| HP.3.4.5.1 | Public health centers | 177,668,296 | | | | | | |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | 111,002,596 | | | | | | |
| HP.3.4.5.3 | NGO health centers | 20,904,568 | | | | | | |
| HP.3.6 | Providers of home health care services | | | | | | | |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | |
| HP.4.1 | Dispensing chemists | 22,527,922 | | | | | | |
| HP.5 | Providers + admin of public health programs | 176,506,718 | 480,290 | | | | | |
| HP.6 | General health administration and insurance | 5,141,792 | | | | | | |
| HP. 8 | Institutions providing health related services | | | | | | | |
| HP.9 | Rest of the world | | | | | | | |
| HP.nsk | Providers not specified by any kind | | | | | | | |
| | **Column Total THE** | 630,881,836 | 480,290 | - | - | - | - | - |
| | **HF Totals From FS x HF Table** | 630,881,836 | 480,290 | - | - | - | - | - |
| HP.8.1 | Research Institutions | | | | | | | |
| HP.8.2 | Education and training institutions | | | | | | | |
| HP.8.3 | Other health related institutions | | | | | | | |
| | **Subtotal for health related** | - | - | - | - | - | - | - |
| | **Column Total: NHE** | 630,881,836 | 480,290 | - | - | - | - | - |
| | Providers of NONHEALTH RH programs | | | | | | | |
| | **Subtotal for nonhealth** | - | - | - | - | - | - | - |
| | **Column Total: RHE (health, health related and nonhealth)** | 630,881,836 | 480,290 | - | - | - | - | - |

# FINANCING AGENT x PROVIDER (HFxP)

**RH Subaccounts targeted only**

| | | HF.A Public Sector | | HF B: Non Public Sector | | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.2.1.3 | HF. 2.5.1 | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | HF.3 | HF.nsk | |
| | **Provider** | Mutuelles (Private & Community based) | Parastatal companies | Private Insurance Enterprises (other than social | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, PROFEMME) | Private Non Parastatal Firms | Rest of World | Not specified by any kind | Row Total |
| HP.1.1.1.1 | National Referral Gvt Hospital | | | | 303,597,085 | 235,868,193 | | | | 618,398,352 |
| HP.1.1.1.2 | National Referral Private Hospital | | | | 79,656,074 | | | | | 85,795,958 |
| HP.1.1.1.3 | National Referral Hospital (could not be disaggregated) | | | | | | | | | - |
| HP.1.1.2.1 | District Gvt. Hospitals | | | | 107,781,802 | 85,770,252 | | | | 209,445,404 |
| HP.1.1.2.2 | District Agrees Hospitals | | | | 46,649,979 | 19,883,637 | | | | 73,412,554 |
| HP.1.1.2.3 | District Hospitals (could not be disaggregated) | | | | | | | | | - |
| HP.1.2 | Mental health hospitals | | | | | | | | | - |
| HP.3.1 | Office of physicians (private clinics)* | | | | 191,954,634 | | | | | 198,936,965 |
| HP.3.3.1 | Community health workers | | | | | 69,985,930 | | | | 72,288,296 |
| HP.3.3.2 | Traditional healer | | | | | | | | | - |
| HP.3.3.3 | Other health practitioners | | | | 3,170,884 | | | | | 3,170,884 |
| HP.3.4.2 | Outpatient mental health institutions (SCPS) | | | | | | | | | - |
| HP.3.4.5.1 | Public health centers | | | | 39,344,208 | 142,950,420 | | | | 359,962,925 |
| HP.3.4.5.2 | Government assisted not-for-profit health centers (Agrees) | | | | 35,741,758 | 92,917,773 | | | | 239,662,127 |
| HP.3.4.5.3 | NGO health centers | | | | 38,620,612 | 597,791,165 | | | | 657,316,345 |
| HP.3.6 | Providers of home health care services | | | | | | | | | - |
| HP.3.9.2 | Blood banks (CNTS transfusion) | | | | | | | | | - |
| HP.4.1 | Dispensing chemists | | | | 141,873,925 | 226,054,768 | | | | 390,456,615 |
| HP.5 | Providers + admin of public health programs | | | | | 809,496,598 | | 291,548,970 | | 1,278,032,575 |
| HP.6 | General health administration and insurance | | | | | | | | | 5,141,792 |
| HP. 8 | Institutions providing health related services | | | | | | | | | - |
| HP.9 | Rest of the world | | | | | | | | | - |
| HP.nsk | Providers not specified by any kind | | | | | | | | | - |
| | **Column Total THE** | - | - | - | 988,390,962 | 2,280,718,735 | - | 291,548,970 | - | **4,192,020,793** |
| | **HF Totals From FS x HF Table** | - | - | - | 988,390,962 | 2,280,718,735 | - | 291,548,970 | - | 4,192,020,793 |
| HP.8.1 | Research Institutions | | | | | | | | | - |
| HP.8.2 | Education and training institutions | | | | | 171,590,514 | | | | 171,590,514 |
| HP.8.3 | Other health related institutions | | | | | | | | | - |
| | **Subtotal for health related** | - | - | - | - | 171,590,514 | - | - | - | 171,590,514 |
| | **Column Total: NHE** | - | - | - | 988,390,962 | ########### | - | 291,548,970 | - | **4,363,611,307** |
| | Providers of NONHEALTH RH programs | | | | | | | | | - |
| | **Subtotal for nonhealth** | - | - | - | - | - | - | - | - | - |
| | **Column Total: RHE (health, health related and nonhealth)** | - | - | - | 988,390,962 | ########### | - | 291,548,970 | - | 4,363,611,307 |

Annex B-11

## FINANCING AGENTS x FUNCTION (HF x HC)

**RH Subaccounts targeted only**

| | | Financing Agent | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.A Public Sector | | | | | | | | | |
| | | HF.1.1.1.1 | HF.1.1.1.2 | #REF! | HF.1.1.3 | HF.1.2 | HF.1.3 | HF.2.1.1 | HF.2.1.2 | HF.2.1.3 | HF. 2.5.1 |
| | | MoH (MiniSante) | Other Ministries | #REF! | Local Municipal Gvt (Districts) | Social Security Fund (CSR) | FARG | Gvt Employees Insurance Programme | Private Employees Insurance | Mutuelles (Private & Community | Parastatal companies |
| Function | | | | | | | | | | | |
| HC. 1.1. | IP curative care (deliveries) | - | - | - | - | - | - | - | - | - | - |
| HC.1.3.11 | Antenatal care | 34,165,083 | - | - | - | - | - | - | - | - | - |
| HC.1.3.12 | Postnatal care | - | - | - | - | - | - | - | - | - | - |
| HC1.3.13.1 | FP consultation and issuance of ORAL | 139,293,169 | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.2 | FP consultation and issuance of | 3,173,669 | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.3 | FP consultation and issuance of IUD | - | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.4 | FP consultation and issuance of | 61,405,352 | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.5 | FP consultation and issuance of | 188,668,132 | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.6 | FP consultation and issuance of | - | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.6 | Other FP consultations | - | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.7 | FP consultations not disaggregated. | - | - | - | - | - | - | - | - | - | - |
| HC.1.3.14 | General gynecological care | - | - | - | - | - | - | - | - | - | - |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased at | 12,663,015 | - | - | - | - | - | - | - | - | - |
| HC.5.1.1.2 | IMPLANTS purchased at private | - | - | - | - | - | - | - | - | - | - |
| HC.5.1.1.3 | INJECATBLES purchased at private | 3,914,277 | - | - | - | - | - | - | - | - | - |
| HC.5.1.3.1 | CONDOMS purchased at private | 5,950,630 | - | - | - | - | - | - | - | - | - |
| HC.5.1.3.2 | IUDs purchased at private pharmacy/shop | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.1 | Antentatal care programs | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.3 | Emergency obstetric care programs | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.4 | Other Maternal health programs | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.5 | Maternal health programs that could not be disaggregated. | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.1 | ORAL CONTRACEPTIVES FP programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.2 | CONDOM FP programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.3 | IUD FP programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.4 | IMPLANTS FP programmes | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.5 | INJECTABLES FP programs | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.7 | FP programs that could not be | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.3 | Adolescent reproductive health | - | 185,113 | - | - | - | - | - | - | - | - |
| HC.6.1.4 | Programs for general gynecological care | - | - | - | - | - | - | - | - | - | - |
| HC.6.1.5 | Other RH programs | - | 295,177 | - | - | - | - | - | - | - | - |
| HC.6.1.6 | RH programs that could not be disaggregated | 181,648,510 | - | - | - | - | - | - | - | - | - |
| HC.7 | Health administration and health insurance | - | - | - | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | - | - | - | - | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - | - | - |
| | **Column Total THE** | 630,881,836 | 480,290 | - | - | - | - | - | - | - | - |
| HCR.2 | Education & Training | - | - | - | - | - | - | - | - | - | - |
| HCR.3 | Research & Development | - | - | - | - | - | - | - | - | - | - |
| HCR.4 | Food, hygiene and drinking water contr | - | - | - | - | - | - | - | - | - | - |
| HCR.5 | Environmental health | - | - | - | - | - | - | - | - | - | - |
| | *Sub total column* | - | - | - | - | - | - | - | - | - | - |
| | **Column Total NHE** | 630,881,836 | 480,290 | - | - | - | - | - | - | - | - |
| AD.5 | Prevention and treatment of victims of s | - | - | - | - | - | - | - | - | - | - |
| AD.6 | Gender non-health programs (Women's | - | - | - | - | - | - | - | - | - | - |
| | **sub total column** | - | - | - | - | - | - | - | - | - | - |
| | **Column Total- RH health, health related, nonhealth** | 630,881,836 | 480,290 | - | - | - | - | - | - | - | - |

Annex B-11

## FINANCING AGENTS x FUNCTION (HF x HC)

**RH Subaccounts targeted only**

| | | | | | - | | | HF.3 ROW | HF.nsk | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | HF.2.2 | HF.2.3. | HF.2.4 | HF.2.5.2 | | | HF.3 | HF.nsk | - |
| | Function | Private Insurance Enterprises | Private household out of pocket payments | Non profit institutions (NGOs, SWAA, | Private Non Parastatal Firms | | | Rest of World | Not specified by any kind | Row Total |
| HC. 1.1. | IP curative care (deliveries) | - | 112,919,822 | 198,049,995 | - | - | - | - | - | 310,969,817 |
| HC.1.3.11 | Antenatal care | - | 620,492,914 | 194,298,776 | - | - | - | - | - | 848,956,772 |
| HC.1.3.12 | Postnatal care | - | - | - | - | - | - | - | - | - |
| HC1.3.13.1 | FP consultation and issuance of ORAL | - | 3,459,800 | 8,208,313 | - | - | - | - | - | 150,961,282 |
| HC.1.3.13.2 | FP consultation and issuance of | - | 61,832 | 426,440 | - | - | - | - | - | 3,661,941 |
| HC.1.3.13.3 | FP consultation and issuance of IUD | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.4 | FP consultation and issuance of | - | 17,617,600 | 102,343,908 | - | - | - | - | - | 181,366,859 |
| HC.1.3.13.5 | FP consultation and issuance of | - | 91,965,070 | 486,812,504 | - | - | - | - | - | 767,445,705 |
| HC.1.3.13.6 | FP consultation and issuance of | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.6 | Other FP consultations | - | - | - | - | - | - | - | - | - |
| HC.1.3.13.7 | FP consultations not disaggregated. | - | - | 185,041,504 | - | - | - | - | - | 185,041,504 |
| HC.1.3.14 | General gynecological care | - | - | - | - | - | - | - | - | - |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased at | - | 16,840,000 | 8,755,068 | - | - | - | - | - | 38,258,083 |
| HC.5.1.1.2 | IMPLANTS purchased at private | - | - | - | - | - | - | - | - | - |
| HC.5.1.1.3 | INJECATBLES purchased at private | - | - | - | - | - | - | - | - | 3,914,277 |
| HC.5.1.3.1 | CONDOMS purchased at private | - | 125,033,925 | 217,299,700 | - | - | - | - | - | 348,284,255 |
| HC.5.1.3.2 | IUDs purchased at private pharmacy/shop | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.1 | Antentatal care programs | - | - | 42,828,792 | - | - | - | - | - | 42,828,792 |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | 64,967,157 | - | - | - | - | - | 64,967,157 |
| HC.6.1.1.3 | Emergency obstetric care programs | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.4 | Other Maternal health programs | - | - | 3,132,000 | - | - | - | - | - | 3,132,000 |
| HC.6.1.1.5 | Maternal health programs that could not be disaggregated. | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.1 | ORAL CONTRACEPTIVES FP programmes | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.2 | CONDOM FP programmes | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.3 | IUD FP programmes | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.4 | IMPLANTS FP programmes | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.5 | INJECTABLES FP programs | - | - | - | - | - | - | - | - | - |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | 540,055,990 | - | - | - | - | - | 540,055,990 |
| HC.6.1.1.2.7 | FP programs that could not be | - | - | 158,512,659 | - | - | - | - | - | 158,512,659 |
| HC.6.1.3 | Adolescent reproductive health | - | - | - | - | - | - | - | - | 185,113 |
| HC.6.1.4 | Programs for general gynecological care | - | - | - | - | - | - | - | - | - |
| HC.6.1.5 | Other RH programs | - | - | - | - | - | - | - | - | 295,177 |
| HC.6.1.6 | RH programs that could not be disaggregated | - | - | - | - | - | - | 291,548,970 | - | 473,197,479 |
| HC.7 | Health administration and health insurance | - | - | - | - | - | - | - | - | |
| HCR.1 | Capital formation for health care provider institutions | - | - | 69,985,930 | - | - | - | - | - | 69,985,930 |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | - | - |
| | **Column Total THE** | - | 988,390,962 | 2,280,718,735 | - | - | - | 291,548,970 | - | **4,192,020,793** |
| HCR.2 | Education & Training | - | - | 171,590,514 | - | | | - | - | 171,590,514 |
| HCR.3 | Research & Development | - | - | - | - | | | - | - | - |
| HCR.4 | Food, hygiene and drinking water contr | - | - | - | - | | | - | - | - |
| HCR.5 | Environmental health | - | - | - | - | | | - | - | - |
| | *Sub total column* | - | - | 171,590,514 | - | - | - | - | - | *171,590,514* |
| | **Column Total NHE** | - | 988,390,962 | 2,452,309,249 | - | | | 291,548,970 | - | **4,363,611,307** |
| AD.5 | Prevention and treatment of victims of | - | - | - | - | | | - | - | - |
| AD.6 | Gender non-health programs (Women' | - | - | - | - | | | - | - | - |
| | **sub total column** | - | - | - | - | | | - | - | - |
| | **Column Total- RH health, health related, nonhealth** | - | 988,390,962 | 2,452,309,249 | - | | | 291,548,970 | - | 4,363,611,307 |

Annex B-12

## PROVIDER x FUNCTION (HP x HC)

**RH Subaccounts targeted only**

| | | Provider | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | HP.1.1.1.1 | HP.1.1.1.2 | HP.1.1.2.1 | HP.1.1.2.2 | HP.3.1 | HP.3.3.1 | HP.3.3.3 |
| | Function | National Referral Gvt Hospital | National Referral Private Hospital | District Gvt. Hospitals | District Agrees Hospitals | Office of physicians (private clinics)* | Community health workers | Other health practitioners |
| HC. 1.1. | IP curative care (deliveries) | 81,552,769 | 51,440,565 | 29,655,445 | 5,320,189 | 43,719,159 | - | 3,170,884 |
| HC.1.3.11 | Antenatal care | 408,137,162 | 20,390,400 | 133,437,379 | 55,723,268 | 141,267,300 | - | - |
| HC.1.3.12 | Postnatal care | - | - | - | - | - | - | - |
| HC1.3.13.1 | FP consultation and issuance of ORAL | 7,630,433 | 1,866,888 | 2,708,925 | 1,172,474 | 1,586,662 | 2,302,366 | - |
| HC.1.3.13.2 | FP consultation and issuance of CONDOMS | 262,952 | 107,225 | 93,352 | 40,405 | 289,484 | - | - |
| HC.1.3.13.3 | FP consultation and issuance of IUD | - | - | - | - | - | - | - |
| HC.1.3.13.4 | FP consultation and issuance of IMPLANTS | 27,699,573 | 5,993,273 | 9,833,790 | 4,256,248 | 5,093,662 | - | - |
| HC.1.3.13.5 | FP consultation and issuance of | 16,664,545 | 5,997,608 | 5,916,179 | 2,560,633 | 6,980,699 | - | - |
| HC.1.3.13.6 | FP consultation and issuance of | - | - | - | - | - | - | - |
| HC.1.3.13.6 | Other FP consultations | - | - | - | - | - | - | - |
| HC.1.3.13.7 | FP consultations not disaggregated. | 76,450,916 | - | 27,800,333 | 4,339,338 | - | - | - |
| HC.1.3.14 | General gynecological care | - | - | - | - | - | - | - |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased at | - | - | - | - | - | - | - |
| HC.5.1.1.2 | IMPLANTS purchased at private | - | - | - | - | - | - | - |
| HC.5.1.1.3 | INJECATBLES purchased at private | - | - | - | - | - | - | - |
| HC.5.1.3.1 | CONDOMS purchased at private | - | - | - | - | - | - | - |
| HC.5.1.3.2 | IUDs purchased at private pharmacy/shop | - | - | - | - | - | - | - |
| HC.6.1.1.1 | Antentatal care programs | - | - | - | - | - | - | - |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | - | - | - | - | - |
| HC.6.1.1.3 | Emergency obstetric care programs | - | - | - | - | - | - | - |
| HC.6.1.1.4 | Other Maternal health programs | - | - | - | - | - | - | - |
| HC.6.1.1.5 | Maternal health programs that could not be | - | - | - | - | - | - | - |
| HC.6.1.1.2.1 | ORAL CONTRACEPTIVES FP programmes | - | - | - | - | - | - | - |
| HC.6.1.1.2.2 | CONDOM FP programmes | - | - | - | - | - | - | - |
| HC.6.1.1.2.3 | IUD FP programmes | - | - | - | - | - | - | - |
| HC.6.1.1.2.4 | IMPLANTS FP programmes | - | - | - | - | - | - | - |
| HC.6.1.1.2.5 | INJECTABLES FP programs | - | - | - | - | - | - | - |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | - | - | - | - | - |
| HC.6.1.1.2.7 | FP programs that could not be disaggregated | - | - | - | - | - | - | - |
| HC.6.1.3 | Adolescent reproductive health | - | - | - | - | - | - | - |
| HC.6.1.4 | Programs for general gynecological care | - | - | - | - | - | - | - |
| HC.6.1.5 | Other RH programs | - | - | - | - | - | - | - |
| HC.6.1.6 | RH programs that could not be disaggregated | - | - | - | - | - | - | - |
| HC.7 | Health administration and health insurance | - | - | - | - | - | - | - |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | 69,985,930 | - |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - |
| | **Column Total-THE** | **618,398,352** | **85,795,958** | **209,445,404** | **73,412,554** | **198,936,965** | **72,288,296** | **3,170,884** |
| HCR.2 | Education & Training | | | | | | | |
| HCR.3 | Research & Development | | | | | | | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | | |
| HCR.5 | Environmental health | | | | | | | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | |
| | **Column Total-NHE** | | | | | | | |
| - | - | | | | | | | |
| AD.5 | Prevention and treatment of victims of sexual violence | | | | | | | |
| AD.6 | Gender non-health programs (Women's empowerment, equity) | | | | | | | |
| - | - | | | | | | | |
| | **Column Total- RH health, health related, nonhealth** | | | | | | | |

Annex B-12

## PROVIDER x FUNCTION (HP x HC)

**RH Subaccounts targeted only**

| | | HP.3.4.5.1 | HP.3.4.5.2 | HP.3.4.5.3 | HP.4.1 | HP.5 | HP.6 | | HP.8.1 | HP.8.2 | HP.8.3 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Function** | Public health centers | Government assisted not-for-profit health centers (Agrees) | NGO health centers | Dispensing chemists | Providers + admin of public health programs | General health administration and insurance | **THE Row Total** | Research Institutions | Education and training institutions | Other health related institutions | NHE Row Total | Providers of NONHEALTH RH programs |
| HC. 1.1. | IP curative care (deliveries) | 49,433,445 | 46,677,360 | - | - | - | - | 310,969,817 | | | | | |
| HC.1.3.11 | Antenatal care | 47,198,143 | 30,678,793 | 12,124,327 | - | - | - | 848,956,772 | | | | | |
| HC.1.3.12 | Postnatal care | - | - | - | - | - | - | - | | | | | |
| HC1.3.13.1 | FP consultation and issuance of ORAL | 71,604,989 | 44,664,516 | 17,424,029 | - | - | - | 150,961,282 | | | | | |
| HC.1.3.13.2 | FP consultation and issuance of CONDOMS | 1,206,179 | 777,364 | 884,981 | - | - | - | 3,661,941 | | | | | |
| HC.1.3.13.3 | FP consultation and issuance of IUD | - | - | - | - | - | - | - | | | | | |
| HC.1.3.13.4 | FP consultation and issuance of IMPLANTS | 8,470,657 | 5,459,213 | 114,560,443 | - | - | - | 181,366,859 | | | | | |
| HC.1.3.13.5 | FP consultation and issuance of | 135,715,624 | 81,287,853 | 512,322,565 | - | - | - | 767,445,705 | | | | | |
| HC.1.3.13.6 | FP consultation and issuance of | - | - | - | - | - | - | - | | | | | |
| HC.1.3.13.6 | Other FP consultations | - | - | - | - | - | - | - | | | | | |
| HC.1.3.13.7 | FP consultations not disaggregated. | 46,333,889 | 30,117,028 | - | - | - | - | 185,041,504 | | | | | |
| HC.1.3.14 | General gynecological care | - | - | - | - | - | - | - | | | | | |
| HC.5.1.1.1 | ORAL CONTRACEPTIVES purchased at | - | - | - | 38,258,083 | - | - | 38,258,083 | | | | | |
| HC.5.1.1.2 | IMPLANTS purchased at private | - | - | - | - | - | - | - | | | | | |
| HC.5.1.1.3 | INJECATBLES purchased at private | - | - | - | 3,914,277 | - | - | 3,914,277 | | | | | |
| HC.5.1.3.1 | CONDOMS purchased at private | - | - | - | 348,284,255 | - | - | 348,284,255 | | | | | |
| HC.5.1.3.2 | IUDs purchased at private pharmacy/shop | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.1 | Antentatal care programs | - | - | - | - | 42,828,792 | - | 42,828,792 | | | | | |
| HC.6.1.1.2 | Programs related to safe delivery | - | - | - | - | 64,967,157 | - | 64,967,157 | | | | | |
| HC.6.1.1.3 | Emergency obstetric care programs | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.4 | Other Maternal health programs | - | - | - | - | 3,132,000 | - | 3,132,000 | | | | | |
| HC.6.1.1.5 | Maternal health programs that could not be | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.2.1 | ORAL CONTRACEPTIVES FP programmes | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.2.2 | CONDOM FP programmes | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.2.3 | IUD FP programmes | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.2.4 | IMPLANTS FP programmes | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.2.5 | INJECTABLES FP programs | - | - | - | - | - | - | - | | | | | |
| HC.6.1.1.2.6 | OTHER FP programs | - | - | - | - | 540,055,990 | - | 540,055,990 | | | | | |
| HC.6.1.1.2.7 | FP programs that could not be disaggregated | - | - | - | - | 158,512,659 | - | 158,512,659 | | | | | |
| HC.6.1.3 | Adolescent reproductive health | - | - | - | - | 185,113 | - | 185,113 | | | | | |
| HC.6.1.4 | Programs for general gynecological care | - | - | - | - | - | - | - | | | | | |
| HC.6.1.5 | Other RH programs | - | - | - | - | 295,177 | - | 295,177 | | | | | |
| HC.6.1.6 | RH programs that could not be disaggregated | - | - | - | - | 468,055,687 | 5,141,792 | 473,197,479 | | | | | |
| HC.7 | Health administration and health insurance | - | - | - | - | - | - | - | | | | | |
| HCR.1 | Capital formation for health care provider institutions | - | - | - | - | - | - | 69,985,930 | | | | | |
| HC.nsk | Not specified by kind | - | - | - | - | - | - | - | | | | | |
| | **Column Total-THE** | **359,962,925** | **239,662,127** | **657,316,345** | **390,456,615** | **1,278,032,575** | **5,141,792** | **4,192,020,793** | | | | | |
| HCR.2 | Education & Training | | | | | | | | 0 | 171,590,514 | 0 | 171,590,514 | |
| HCR.3 | Research & Development | | | | | | | | 0 | 0 | 0 | - | |
| HCR.4 | Food, hygiene and drinking water control | | | | | | | | 0 | 0 | 0 | - | |
| HCR.5 | Environmental health | | | | | | | | 0 | 0 | 0 | - | |
| HCR.nsk | HCR expenditure not specified by kind | | | | | | | | 0 | 0 | 0 | - | |
| | **Column Total-NHE** | | | | | | | | - | 171,590,514 | - | **4,363,611,307** | |
| - | - | | | | | | | | | | | | - |
| AD.5 | Prevention and treatment of victims of sexual violence | | | | | | | | | | | | - |
| AD.6 | Gender non-health programs (Women's empowerment, equity) | | | | | | | | | | | | - |
| - | - | | | | | | | | | | | | - |
| | **Column Total- RH health, health related, nonhealth** | | | | | | | | | | | | **4,363,611,307** |

# ANNEX C. METHODOLOGY

## OVERVIEW OF APPROACH

The 2006 Rwanda National Health Accounts (NHA) and HIV/AIDS, malaria, and reproductive health (RH) subaccounts followed the methodology and estimation techniques presented in the *Guide to Producing National Health Accounts: with special applications for low- and middle-income countries,* (World Health Organization [WHO], World Bank, and USAID 2003), commonly referred to as '*the Producers' Guide'* and built upon previous NHA and subaccounts estimations in Rwanda. For this round of NHA, the team collected secondary and primary data for analysis. When secondary data did not capture health expenditures or could not be obtained to complete the estimation, the team engaged in primary data collection.

This chapter describes the methodology that the NHA team used to do the data collection and analysis. Some secondary datasets required specific methodologies that are documented in the section on data analysis, below.

This is the approach for the 2006 NHA. It builds upon the methodology followed by the previous rounds of NHA. In future rounds, this methodology will be improved as data are more routinely collected in the country. The purpose of this exercise was to capture expenditure information as much as possible. The NHA team tried to reduce the amount of "guesstimates" used in this estimation.

## DATA SOURCES

The NHA team collected primary and secondary data on general, HIV/AIDS, malaria, and RH spending. The complexity of the health system in Rwanda made it necessary for the NHA team to clean and analyze more than 30 different datasets. Tables 1.0–1.3 list the ultimate data sources used to populate the NHA tables. However, it is important to note that these tables exclude some data sources which were used to cross-check and triangulate the selected data ultimately selected. For example, in some cases data from implementing sources were selected over donor data because implementers can frequently provide better data disaggregation and more accurate data on actual expenditures, not just disbursements or commitments.[24] In the case of the National AIDS Commission (CNLS), we cross-checked the CNLS records with donor and nongovernemental organization (NGO) surveys. For further specifics of each data source used, please consult the Microsoft Excel files of the NHA tables, which are kept at the Ministry of Health (MoH).

[24] Expenditure is a measurement in monetary terms of the value of consumption of the goods and services of interest. It implies that a service or product has been rendered. A commitment happens at the point at which funding that is readily available to the funder is legally promised to the recipients. A disbursement happens when the funds are transferred from the funding mechanism to a recipient.

**ANNEX C TABLE 1.0: GENERAL HEALTH DATA**

| Data | Source | Primary/ Secondary |
|---|---|---|
| Household out-of-pocket (OOP) spending | OOP spending: *Enquête Intégrale sur les Conditions de Vie des Ménages* (Integrated Living Conditions Survey [EICV II]) (World Bank); Population Services International (PSI) records* | Secondary |
| | Ndera Mental Health Hospital records | Secondary |
| MoH and other ministries | Public funding: Ministry of Finance (MoF) executed budgets, *Centre National de Transfusion Sanguine* (National Center for Blood Transfusion) general ledger, CHUB, CHUK and King Fayçal Hospital records, cross-checked with NHA donor surveys | Secondary/ primary (for donor survey) |
| | Public funding: untargeted spending in MoF executed budgets (see section on untargeted spending) | Secondary |
| | Donor funding: MoH data from MoF,** NHA donor surveys | Secondary, Primary |
| | Donor funding (value of bednets bought by donors and given to MoH): PSI finance records | Secondary |
| CNLS (spending on CNLS as an organization) | CNLS annual report 2006 | Secondary |
| CNLS projects (World Bank MAP, UNDP, etc) | CNLS annual report 2006, NHA donor surveys | Secondary, Primary |
| | CNLS projects expenditure records | Secondary |
| Health insurance | Victims of Genocide (FARG) annual report and expenditure records | Secondary |
| | NHA insurance surveys | Primary |
| | NHA employer surveys | Primary |
| | Mutuelle records*** | Secondary |
| | Ndera Mental Health Hospital records | Secondary |
| Local governments | CNLS annual report 2006 | Secondary |
| Parastatal and private employers | NHA employer surveys | Primary |
| Implementing agencies | CNLS projects expenditure records | Secondary |
| | NHA implementing organizations surveys | Primary |
| | PSI finance records | Secondary |
| | Ndera Mental Health Hospital records | Secondary |
| Rest of the world | Ndera Mental Health Hospital records | Secondary |
| | NHA implementing organizations surveys | Primary |
| Providers | Provider expenditure records (CHUB, CHUK, Roi Faisal, CNTS [blood bank], etc). | Secondary |
| | MoH and other ministries data from MoF | Secondary |
| | EICV II and PSI data | Secondary |
| | Treatment and Research AIDS Center (TRAC) expenditure records | Secondary |
| | CNLS annual reports | Secondary |
| | NHA insurance surveys | Primary |
| | Mutuelle records | Secondary |
| | NHA donor surveys | Primary |
| | NHA employer surveys | Primary |

* PSI records were used in this case to account for in-kind donations of bed-nets, which were not included in the EICV 2 household survey.

** NHA data analysts decided to use the amount reported by MoH; while it was only 10 percent of what donors reported giving to the MoH, NHA estimates should reflect monies actually spent. In addition, we include the value of bednets donated to the MoH (obtained from PSI data summary), which are not in the MoH expenditure records.

*** See sections on data sources and methodology for calculating mutuelles numbers.

## ANNEX C TABLE 1.1. MALARIA DATA

| Data | Source | Primary/ Secondary |
|---|---|---|
| Household OOP spending | Curative care: *Enquête Intégrale sur les Conditions de Vie des Ménages* (Integrated Living Conditions Survey, EICV II) (World Bank)<br>Prevention: PSI records and informant interviews | Secondary |
| MoH | Public funding: MoF executed budgets | Secondary |
| | Public funding: untargeted spending MoF executed budgets (see section on untargeted spending) | Secondary |
| | Donor funding: MoH data from MoF* | Secondary |
| | Donor funding (value of bednets bought by donors and given to MoH): PSI finance records | Secondary |
| Other ministries | Untargeted spending (MoF executed budget) | Secondary |
| Insurance agencies (public, private, mutuelle) | Untargeted spending (MoF executed budget, NHA employer surveys, FARG report, mutuelle records) | Secondary |
| | Untargeted spending (NHA insurance surveys) | Primary |
| Private and parastatal firms | Untargeted spending (NHA employer surveys) | Primary |
| NGOs | Public funding: untargeted spending (MoF executed budget) | Secondary |
| | Private funding: untargeted spending (households, EICV II, implementing agencies, NHA surveys) | Secondary and primary |
| | Prevention: PSI records | Secondary |
| | Donor funding: NHA NGO surveys | Primary |
| Rest of the world | NHA donor surveys (target and untargeted), NHA NGO surveys | Primary |
| Malaria ratios | Health Information System (SIS), obtained from the National Institute of Statistics | Secondary |
| Providers | Same as in general NHA | |

* NHA data analysts decided to use the amount reported by MoH; while it was only 10 percent of what donors reported giving to the MoH, NHA estimates should reflect monies actually spent.

## ANNEX C TABLE 1.2: HIV/AIDS DATA

| Data | Source | Primary/ Secondary |
|---|---|---|
| Household OOP spending | Performance-based financing (PBF) HIV survey, World Bank | Secondary |
| MoH and other ministries | Public funding: MoF executed budgets | Secondary |
| | Public funding: untargeted spending MoF executed budgets (see section on untargeted spending) | Secondary |
| | Donor funding: MoH data from MoF | Secondary |
| | Donor funding: TRAC expenditure records | Secondary |
| | Donor funding: NHA donor surveys for UNAIDS amount to MIFOTRA | Primary |
| CNLS proper | CNLS annual report 2006 | Secondary |
| | NHA donor surveys (for UNAIDS technical assistance to CNLS) | Primary |
| CNLS projects | CNLS annual report 2006 | Secondary |
| | CNLS project expenditure records | Secondary |
| | NHA donor surveys (for World Bank MAP) | Primary |
| Local governments | CNLS expenditure records | Secondary |
| Insurance agencies (public, private, mutuelle) | Untargeted spending (MoF executed budget, FARG report, mutuelles records, EICV II) | Secondary |
| | Untargeted spending (NHA insurance surveys, NHA employer surveys) | Primary |
| Parastatal and private firms | Untargeted spending (NHA employer surveys) | Primary |
| NGOs | Public funding: CNLS annual report 2006 | Secondary |

| Data | Source | Primary/ Secondary |
|---|---|---|
| | Untargeted public spending (NHA NGO surveys and African Development Bank executed budget) | Secondary and primary |
| | Untargeted private spending (households, PBF HIV study) | Secondary and primary |
| | Donor funding: CNLS annual report 2006 and expenditure records | Secondary |
| | Donor funding: NHA NGO surveys | Primary |
| Rest of the World | NHA donor surveys, NHA NGO surveys | Primary |
| HIV/AIDS ratios | SIS | Secondary |
| Providers | Same as in general NHA | |

**ANNEX C TABLE 1.3: RH DATA**

| Data | Source | Primary/ Secondary |
|---|---|---|
| Household OOP spending | Demographic and Health Survey (DHS) 2005, records from USAID DELIVER, PSI | Secondary and Primary |
| MoH and other ministries | Public funding: MoF executed budgets | Secondary |
| | Public funding: untargeted spending MoF executed budgets (see section on untargeted spending) | Secondary |
| | Donor funding: NHA donor surveys, USAID DELIVER and PSI | Secondary and primary |
| | Donor funding: NHA donor surveys | Primary |
| | Donor funding: untargeted spending MoF executed budgets (see section on untargeted spending) | Secondary |
| Insurance agencies (public, private, mutuelle) | Untargeted spending (MoF executed budget, FARG report, mutuelle records, EICV2) | Secondary |
| | Untargeted spending (NHA insurance surveys, NHA employer surveys, NHA NGO surveys) | Primary |
| Parastatal and private firms | Untargeted spending (NHA employer surveys) | Primary |
| NGOs | Untargeted public spending (NHA NGO surveys and African Development Bank executed budget) | Secondary and Primary |
| | Untargeted private spending (EICV general health spending) | Secondary |
| | Donor funding: NHA NGO surveys | Primary |
| | Donor funding: RH OOP expenditures survey | Secondary |
| Rest of the World | NHA donor surveys, NHA NGO surveys | Primary |
| RH ratios | Derived from SIS | Secondary |
| Providers | Same as in general NHA | |

Should further questions arise on the data sources, please direct questions to info@moh.gov.rw.

# PRIMARY DATA COLLECTION

### Survey instrument development

To triangulate secondary data, or capture expenditures where secondary data did not exist, the NHA team administered surveys to i) donors, ii) financing agents/NGOs, iii) employers, and iv) insurance entities. Surveys asked questions on overall health spending as well as targeted spending on HIV/AIDS, malaria, and RH.

Each survey instrument was pre-tested on two typical entities to ensure that survey questions i) were understandable and feasible for the respondent to answer, ii) were translated properly, and iii) estimated the time necessary for completion. Feedback was sought from those respondents and applied to the questionnaires before finalization.

### Survey administration

Survey administrators from the NHA technical team came from the MoH, the School of Public Health at the National University of Rwanda, and USAID projects Health Systems 20/20 and Twubakane. Survey administration for the 2006 NHA followed a similar process to the one used for Rwanda's 2003 NHA. Most survey questionnaires were delivered in person; after explaining the questionnaire to the respondent, the survey administrator left the questionnaire with the respondent for him/her to fill out. The administrators' instructions and explanations to the respondents facilitated and encouraged the complete reporting of expenditures. The survey administrator retrieved completed questionnaires in a personal visit, or via ground mail or email.

### Sampling and weighting approach

The objective of NHA is to capture all spending on health in the country in a given time period. However, the numbers of NGOs, donors, employers, insurance companies, etc. are increasing in Rwanda every year. In 2006, Rwanda's health system was considerably more complex than in previous years' estimations. This complexity made it necessary to sample the entities targeted by the NHA surveys for primary data collection. A census was created of the following types of entities that contributed to health in 2006: i) donors, ii) NGOs, iii) employers, and iv) insurance agencies. If the universe of targeted entities was not surveyed, the NHA team applied weights to the entities that were surveyed to account for the expenditures by those omitted.

The NHA team decided not to survey providers because expenditures at providers would be captured through other sources, including NGOs, employers, and household OOP spending.

*Donors*

The NHA team attempted to solicit expenditure information from every donor that contributed to health in Rwanda in 2006. The NHA team compiled a census of all known donors that fit the profile. Data were obtained from all major donors. Some smaller donors emerged later in the process, and some did not return completed surveys. From the surveys that were returned, the NHA team calculated weights for all expenditures counted in data collection.

To apply weights, the NHA team placed each donor into a quartile, based on its percentage contribution to the total amount of funds contributed by donors, as noted in the census. The contribution of each donor was divided by the total contributions of all donors to obtain the percentage. The low percentage was 0.001 and the high percentage was 0.4. In Table C-1.4, N represents the number of donors from

the census that fell into each quartile, while n represents the number of donors from the surveyed donors. The NHA team surveyed 57 percent of all donors in quartile 1 (lowest contributors) and 100 percent of all donors in the other three quartiles. All expenditures by donors in quartile 1 were therefore weighted 157 percent in the data summaries.

**ANNEX C TABLE 1.4: DONORS CONTRIBUTING TO GENERAL HEALTH**

| High % | Low % | Quartile range | | | |
|---|---|---|---|---|---|
| 0.397 | 0.001 | 0.10 | | | |
| **Quartile** | **Low** | **High** | **N** | **n** | **Weighting factor** |
| 1 | 0.001 | 0.100 | 30 | 17 | 57% |
| 2 | 0.100 | 0.199 | 1 | 1 | 100% |
| 3 | 0.199 | 0.298 | 1 | 1 | 100% |
| 4 | 0.298 | 0.397 | 1 | 1 | 100% |

Based on team knowledge, surveys were distributed to and returned from 100 percent of donors who contributed to HIV/AIDS, malaria, and RH. Thus, no weights were applied to donor data summaries for the subaccounts.

*NGOs*

As with donors, it was necessary to apply weights to NGOs. Because there was a higher number of NGOs in the census and survey sample, the NHA team distributed NGOs into quintiles based on the percentage of total funds going to health in Rwanda in 2006 that each NGO managed. Eighty-four percent of NGOs in quintile 1 (contributing the least to health) were surveyed, and 86 percent of NGOs in quintile 2 were surveyed. The NHA team captured expenditure information from 100 percent of all NGOs in quintiles 3, 4, and 5.

**ANNEX C TABLE 1.5: NGOS CONTRIBUTING TO GENERAL HEALTH**

| High % | Low % | Quintile range | | | |
|---|---|---|---|---|---|
| 0.014 | 0.0001 | 0.0028 | | | |
| **Quintile** | **Low** | **High** | **N** | **n** | **Weighting factor** |
| 1 | 0.0001 | 0.0029 | 65 | 46 | 71% |
| 2 | 0.0029 | 0.0057 | 8 | 7 | 88% |
| 3 | 0.0057 | 0.0084 | 4 | 4 | 100% |
| 4 | 0.0084 | 0.0112 | 3 | 3 | 100% |
| 5 | 0.0112 | 0.0140 | 2 | 2 | 100% |

Also as with donors, based on NHA team knowledge, all NGOs that contributed to malaria, and RH were included in the sample. No weights were applied to expenditures in these priority areas. However, the NHA team applied the following weights to NGOs with HIV/AIDS programs.

**ANNEX C TABLE 1.6: NGOS CONTRIBUTING TO HIV/AIDS**

| High % | Low % | Quintile range | | | |
|---|---|---|---|---|---|
| 0.0153 | 0.0001 | 0.0030 | | | |
| **Quintile** | **Low** | **High** | **N** | **n** | **Weighting factor** |
| 1 | 0.0001 | 0.0031 | 37 | 31 | 84% |
| 2 | 0.0031 | 0.0062 | 7 | 6 | 86% |
| 3 | 0.0062 | 0.0092 | 4 | 4 | 100% |
| 4 | 0.0092 | 0.0123 | 3 | 3 | 100% |
| 5 | 0.0123 | 0.0153 | 2 | 2 | 100% |

*Employers*

The NHA team created a sampling of the 78 companies located in Rwanda that contribute financially to health. The objective was to select a random sample of companies that would be representative of both type (industry) and size (measured by number of employees in the company). The number of employees varied from a low of 10 to a high of 8,000. In view of the importance of the contribution of large companies to characteristics of interest, it was decided to include very large companies in the sample with certainty. Therefore, all six companies with 1,000 or more employees were included in the sample with certainty. Table C-1.7 gives the distribution of the remaining 72 companies by type of industry and size.

**ANNEX C TABLE 1.7: TYPE OF COMPANY BY SIZE**

| Type of Company (Industry) | Number of Employees | | | | | |
|---|---|---|---|---|---|---|
| | **<50** | **50-100** | **101-500** | **500+** | **Unknown** | **Total** |
| Communication | 8 | 0 | 1 | 0 | 0 | 9 |
| Transport | 0 | 1 | 2 | 0 | 1 | 4 |
| Finance | 0 | 3 | 9 | 1 | 0 | 13 |
| Construction | 1 | 1 | 4 | 0 | 1 | 7 |
| Distribution | 4 | 2 | 1 | 0 | 2 | 9 |
| Education | 0 | 0 | 3 | 1 | 0 | 4 |
| Heath | 0 | 1 | 2 | 0 | 0 | 3 |
| Business | 0 | 6 | 12 | 4 | 1 | 23 |
| Total | 13 | 14 | 34 | 6 | 5 | 72 |

Resources in terms of cost and time did not permit a complete enumeration of all 78 companies; thus a sample selection was required. One method of determining the appropriate sample size is to look at the resulting margin of error that the estimates will have based on a certain sample size (see Table C-1.8).

**ANNEX C TABLE 1.8: MARGIN OF ERROR ASSOCIATED WITH VARIOUS SAMPLE SIZES**

| Margin of error at 95% confidence level | Required sample size from a population of 78 businesses |
|---|---|
| Plus or minus 5 percentage points | 65 |
| Plus or minus 6 percentage points | 61 |
| Plus or minus 7 percentage points | 56 |
| Plus or minus 8 percentage points | 52 |
| Plus or minus 9 percentage points | 48 |
| Plus or minus 10 percentage points | 44 |
| Plus or minus 11 percentage points | 40 |
| Plus or minus 12 percentage points | 36 |

It was decided to survey a sample of 45 companies. A simple random sample of companies from a population of 78 would estimate population percentages with a margin of error of plus or minus 10 percentage points. The reliability of this survey may actually be higher, because it includes very large companies with certainty and selected the samples after stratification by size and type of industry. Since we had already selected six companies with certainty, we needed to select 39 companies from the remaining 72 in the population. The total sample of 39 was allocated to type of industry in proportion to the number in the population.

The number in each type was further allocated to each size group in proportion to the number in the population in the size group. Table C-1.9 shows the distribution of the non-certainty units in the sample.

**ANNEX C TABLE 1.9: DISTRIBUTION OF THE SAMPLE BY STRATA**

| Type of Company | Number of Employees | | | | | |
|---|---|---|---|---|---|---|
| | <50 | 50-100 | 101-500 | 500+ | Unknown | Total |
| Communication | 4 | 0 | 0 | 0 | 0 | 4 |
| Transport | 0 | 1 | 1 | 0 | 0 | 2 |
| Finance | 0 | 2 | 5 | 1 | 0 | 8 |
| Construction | 1 | 1 | 2 | 0 | 1 | 5 |
| Distribution | 2 | 1 | 1 | 0 | 1 | 5 |
| Education | 0 | 0 | 2 | 1 | 0 | 3 |
| Heath | 0 | 1 | 1 | 0 | 0 | 2 |
| Business | 0 | 2 | 6 | 2 | 0 | 10 |
| Total | 7 | 8 | 18 | 4 | 2 | 39 |

*Insurance*

Based on team knowledge, the NHA insurance surveys captured expenditure data from all insurance companies whose expenditure records were not obtained from secondary sources.

## DATA ENTRY AND ANALYSIS

Entry of primary data took place in October and November 2007 and a data analysis workshop was held November 4–27, 2007. While cleaning the dataset, the analysis team contacted survey respondents if it was necessary to clarify responses. If the team could not reach a respondent, relevant individuals were sought for triangulation of the ambiguous data. The team contacted these people by phone and usually held in-person interviews.

### Mutuelles calculations

Calculating the amount spent on and by mutuelles in Rwanda called for rigorous data collection from many sources by the NHA team. At the time of data analysis, there was no reliable and consistent data source for mutuelles in the country. This section details the specific methodology undertaken by the NHA team to calculate the contribution to health through mutuelles.

Data collection

The NHA team started with data from mutuelles that had been collected (for NHA purposes) by the government of Rwanda from 53 mutuelle sections across 15 districts. Completion of the questionnaire varied by section; questionnaire layout and sequencing, and lack of survey team members to answer questions throughout the response process may have influenced reporting.

Given these limitations, the NHA team supplemented and/or replaced the data with more robust data from the following sources[25]:

- "Mid-term evaluation of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GF) 5th Round Project on Health Systems Strengthening: Assuring Access to Quality Care: The Missing Link to Combat AIDS, Tuberculosis and Malaria in Rwanda." Draft. Vijay Kalavakonda, Natalie Groos, and Jean-Claude Karasi. December 2007.
- "Rwanda Poverty and Health Country Status Report." Draft. World Bank. 2007.
- "Rapports mensuels venant des districts, Janvier-Decembre 2006" and other data provided by Dr. Hertilan Inyarbuga of the MoH Health Scheme Technical Support Unit (CTAMS).
- "Etude sur les articulations entre les systèmes légaux de securité sociale et les mécanismes de protection sociale à base communautaire." International Labour Organization (ILO). Available at www.ilo.org/gimi/resource.do?page=/wiki%20linkages/home/fr/rwanda2.pdf
- Rwanda Central Government Budget Execution for Year 2006

[25] These were the data of which the NHA team was aware of during data analysis in November 2007.

Calculations

*Central government spending (FS 1.1.1.4)*

This amount was calculated based on central government transfers to the national risk pool and the solidarity funds (FARG, PACFA, Gacaca, etc.) that subsidize mutuelle enrollment fees for indigents and persons living with HIV/AIDS. It also covers the amount that the central government spent on supportive activities for mutuelles (RWF 199 million).

*Household spending (FS 2.2)*

Households are the largest contributor to mutuelles. Household expenditure on mutuelle premiums (collected from enrollees who are not subsidized) was extracted from data on mutuelle enrollment levels in each district, and totals more than RWF 5.5 billion. (Health centers must transfer 10 percent of collected premiums to the district level and is therefore included in the household expenditure figure for mutuelles.) According to the ILO report cited above, households also pay a co-payment of 10 percent when they seek services; CMS data estimate the total of these co-payments to be more than RWF 87 million, making total household expenditure an estimated RWF 5.6 billion.

*Rest of the world (FS 3)*

Donors subsidize enrolment fees for people living with HIV (PLHIV) and indigents. The total of these subsidies is estimated to be RWF 1 billion, based on Global Fund contributions to government solidarity funds and CTAMS data, collected at the district level, on revenue sources of enrollment fees for indigents.

*Private employers*

From data provided by CTAMS, we calculated that a relatively small share of mutuelle revenue, RWF 655 million, comes from private employers. These payments are considered charitable contributions; based on information that the mutuelles reported on revenue sources, the funds go to subsidize care for indigents and/or PLHIV. We assumed that mutuelle premiums that private employers paid on behalf of employees is captured in the private employer data collected (see above).

Data limitations

The following limitations on data are noted:

- We do not have actual household-level data, only estimates based on number of enrolled and who are not otherwise subsidized. Thus the amount households actually pay versus what is estimated could differ.
- There is limited ability to cross-check calculations with other sources/studies so numbers should be interpreted with caution.
- The data sources listed in subsection 1.3.x.1 are still in draft form; to the best of our knowledge, the data have not been validated.
- Assumptions for the private employer data need to be clarified with CTAMS to ensure that funds are used for subsidizing indigent and/or PLHIV enrollment.

- There was some uncertainty about the classifications for the data provided to us by CTAMS on sources of revenue for the indigent and PLHIV, given that we were not able to identify all of the sources. Unidentified sources (probably 5–6) were assumed to be "Rest of world" (FS 3); the total amount was marginal and should not impact final tallies.

**Ratios between providers**

If funding allocations reported by financing agents did not specify the provider(s) to which their funds went (identifying them only in a general sense, such as "hospitals"), it was necessary to apply ratios to disaggregate these expenditures among the six types of hospitals and health centers that the government wished to track. For example, if a financing agent gave funding to health centers, this expenditure was disaggregated among public and *agréé* health centers. Again, if facilities did not have sufficient breakdown between inpatient (IP) and outpatient (OP) care, then a ratio was used.

The NHA team used SIS health management information system (HMIS) data to calculate OP and IP ratios for government and *agréé* facilities. However, GESIS (HMIS software) has limitations as it is based on MS Access version 3.1 and needs to be updated to be compatible with more recent versions. This prevented our exporting some parts of GESIS into MS Excel for analysis; instead, we copied data out manually. For referral hospitals (CHUK, CHUB, King Fayçal Hospital, and Ndera Mental Health Hospital) we used their expenditure and income records. The dataset provided information such as OP volume, number of admissions, and income and expenditure by service type/departments. Health facilities were grouped by size. To fill gaps in the dataset, we used averages to impute missing data.

We then allocated all expenditure to OP or IP care. Health facilities were grouped by ownership (public, *agréé*, private) and category (referral hospital, district hospital, health center, clinic); districts hospitals and health centers also were grouped by size (big, medium, small), based on number of beds. These classifications helped us to impute data gaps by allowing for calculation of weighted average expenditures of health facilities in the same class:

$$A = \frac{\sum_{i=1}^{n} EiUi}{n}$$

Where A= Weighted average

E=Facility unit expenditure

U=Volume of services utilization

n=number of facilities in dataset

The completion rate was used to improve the quality of HMIS data by generalizing expenditures to the national level. Where the unit cost and service utilization were not available by OP and IP, in the last

resort we divided services that were clearly related to OP or IP, calculated an expenditure ratio based on their expenditures, and used the ratio to apportion remaining expenditure data.

The weighted totals are then used to compute ratios:

**ANNEX C TABLE 1.10: INPATIENT AND OUTPATIENT RATIOS BY PROVIDER**

| Provider type | IP/OP | % | Source |
|---|---|---|---|
| Govt referral hospitals | IP | 0.74 | Referral hospital expenditure records |
| | OP | 0.26 | Referral hospital expenditure records |
| Private referral | IP | 0.38 | Referral hospital expenditure records |
| | OP | 0.62 | Referral hospital expenditure records |
| Govt district | IP | 0.66 | SIS |
| | OP | 0.34 | SIS |
| Agrée district hospital | IP | 0.51 | SIS |
| | OP | 0.49 | SIS |
| Govt health center | IP | 0.13 | SIS |
| | OP | 0.87 | SIS |
| Agree health center | IP | 0.2 | SIS |
| | OP | 0.8 | SIS |

These apportioned expenditures were then mapped to predetermined NHA classifications (FS, HF, HP, and HC).

To assign expenditures by provider type, we apportioned total expenditures by the same percentage that each provider type was of all providers. For example, of the RWF 24.8 billion spent on all providers, RWF 8.2 billion was assigned to government referral hospitals, which represent 33 percent of all providers. For district hospitals and health centers, expenditures were gleaned from HMIS records and MoH salary records.

**ANNEX C TABLE 1.11: PROVIDER RATIOS**

| Provider type | % | Source | Total expenditure | Expenditure from SIS | Salaries from MoH |
|---|---|---|---|---|---|
| Govt referral hospitals | 33% | Expenditure records | 8,193,920,289 | | |
| Private referral hospitals | 17% | Expenditure records | 4,141,122,254 | | |
| Govt district hospitals | 12% | SIS | 2,908,972,247 | 339,217,675 | 2,569,754,571 |
| Agréé district hospitals | 5% | SIS | 1,259,057,573 | 263,187,573 | 995,870,000 |
| Govt health center | 20% | SIS | 5,046,534,797 | 3,798,353,495 | 1,248,181,302 |
| Agréé health center | 13% | SIS | 3,252,417,121 | 2,399,132,541 | 853,284,580 |
| Total | 100% | | 24,802,024,281 | 6,799,891,284 | 5,667,090,454 |

## Untargeted spending

Untargeted spending is relevant to the three subaccounts (HIV/AIDS, malaria, and RH) carried out with the general NHA. Untargeted spending refers to general facility revenue (not targeted for HIV/AIDS, malaria, or RH) that is spent on the targeted diseases. For example, it includes the percentage of the salary of a general doctor (who treats multiple diseases) that is spent to treat malaria patients. Untargeted spending also comprises the amount that insurance funds may contribute to malaria, an amount not broken out in insurance company records.

To account for untargeted funds, the team applied ratios to each provider type, by IP and OP care. Based on SIS expenditure records, we assumed that the percentages in the tables below should be applied to general IP and OP revenue to determine untargeted spending at the various nonmarket provider types (where price charged to patients does not include all input costs) likely to offer malaria, HIV/AIDS, or RH care.

**ANNEX C TABLE 1.12: RATIOS FOR MALARIA**

| Provider Type | IP | OP |
|---|---|---|
| Govt referral hospitals | 6.0% | 3.0% |
| Private referral hospital | 6.0% | 3.0% |
| Govt district hospital | 21.0% | 19.0% |
| Agréé district hospital | 32.0% | 18.0% |
| Govt health center | 29.0% | 29.0% |
| Agréé health center | 29.0% | 29.0% |

**ANNEX C TABLE 1.13: RATIOS FOR HIV/AIDS**

| Provider Type | IP | OP |
|---|---|---|
| Govt referral hospitals | 0.1% | 4.0% |
| Private referral hospital | 0.1% | 4.0% |
| Govt district hospital | 1.0% | 2.0% |
| Agréé district hospital | 2.0% | 3.0% |
| Govt health center | 2.0% | 1.0% |
| Agréé health center | 3.0% | 1.0% |

**ANNEX C TABLE 1.14: RATIOS FOR RH**

| Provider Type | In patient | Outpatient |
|---|---|---|
| Govt referral hospitals | 50.0% | 2.0% |
| Private referral hospital | 50.0% | 2.0% |
| Govt district hospital | 6.0% | 19.0% |
| Agréé district hospital | 12.0% | 29.0% |
| Govt health center | 40.0% | 2.0% |
| Agréé health center | 40.0% | 2.0% |

These ratios were derived by applying unit costs and utilization rates to the untargeted spending at providers. Each of the six providers listed in Tables 1.12 – 1.14 were analyzed individually to ensure accuracy of the ratios.

To track the funds from the financing agents that distributed untargeted monies to the providers in Tables 1.12-1.14, the team distributed the expenditures across the sources of the agents' funds.[26] While the agents executed programmatic control over funds, they were not always the source of the funds. For example, the MoH (acting as a financing agent) distributes funds to the providers, but these funds come from the MoF, other public funds, and donors. To account for this, untargeted monies that contribute to HIV/AIDS, malaria or RH were distributed across sources accordingly.

The subaccounts therefore involved the following steps:

- Looking at the percentage distribution of sources to each of the financing agents such as the MoH that received *untargeted* funds going to malaria care
- Distributing the untargeted spending for each function across the table of percentage distribution of sources
- Adding all targeted spending

**Household spending on curative care**

The EICV II surveyed a stratified cluster sample of 34,785 people in 6,900 households. The data were collected from October 12, 2005 through September 20, 2006. Interviews were evenly distributed throughout the year to avoid seasonal effects. The households were drawn from 620 geographic locations randomly selected from 32 strata. The survey responses are weighted to reflect a total national population of 9.5 million people.

Estimates of spending were based on the following questions:

| 6 | Primary health problem |
|---|---|
| 11 | Consulted a physician (health care worker) in the last two weeks |
| 13 | Person consulted |
| 14 | Place of consultation |
| 15 | Public or private establishment |
| 16 | Amount paid for the consultation |
| 18 | Undertake medical tests in the last two weeks |
| 19 | Amount paid for health exams |
| 21 | Hospitalized in the last two weeks |
| 22 | Amount paid for hospitalization |
| 24 | Purchased medication or other health related items |
| 25 | Amount paid for medication and supplies |

Because the questions refer to the last two weeks, we multiplied the estimated number of visits by 26 to produce an estimate of the number of visits in 52 weeks. Only one visit in the two-week interval was recorded. Because some patients make two or more visits, this slightly underestimates the true number

[26] No ratios were applied to household OOP spending; it was assumed that all household spending is targeted for a specific health activity.

of visits.[27] A total of 2,255 health care visits were recorded in the survey responses. When weighted to produce national totals, this implies that 6.5 percent of the population saw a health care provider during a two-week period, producing 613,000 visits. As this is based on a sample, this total has a range of uncertainty from 572,000 to 654,000 visits. In annual terms, this comes to 15.9 million visits, with a 95 percent confidence interval of 14.9 to 17.0 million visits.

To estimate outpatient costs, we combined the answers to questions 16 (amount paid for consultation) and 19 (amount paid for health exams). About a quarter of the OP visits involved no OOP costs. The remainder ranged from RWF 10 to RWF 45,000, with half the visits falling between RWF 100 and RWF 600. The average inpatient visit cost RWF 492 (including those with zero cost), with a 95 percent confidence interval of RWF 400 to RWF 575. Summing all the costs produces a national estimated total cost of RWF 7.8 billion, with a 95 percent confidence interval of RWF 6.5 to RWF 9.2 billion.

The survey does not include a question about where IP care took place. For those who listed a hospital as the place of consultation in question 14 we assumed their IP care took place in the same hospital. For all others, we allocated the costs according to the place of OP care; that is, those who used public facilities for OP care were assumed to be admitted to public hospitals, and so on. Total IP costs were RWF 4.1 billion, with a 95 percent confidence interval of RWF 1.8 to RWF 6.4 billion.

Approximately 9 percent of respondents reported purchasing medicine in the two weeks before the survey. Payments ranged from RWF 10 to RWF 74,000, with half the (non-zero) payments falling between RWF 200 and RWF 1,000. No question was asked about where patients bought medicine. For those who visited only a pharmacy, we assumed the purchase was made at that pharmacy. Some respondents who did not consult a medical provider also purchased medicine. We assumed these are also pharmacy purchases. We allocated the others to IP care if the respondent was admitted for an overnight stay. The remainder were allocated to OP care if the respondent mentioned an OP visit but no IP visit. Annualized, the total spending for medicine is RWF 19.2 billion, with a 95 percent confidence interval of RWF 17.3 to RWF 21.2 billion.

**Household spending on care by PLHIV**

According to WHO[28] 41,000 adults needed antiretroviral therapy (ART) in September 2006 (estimates range from 27,000 to 47,000), and 27,550 adults received it. (For adults and children, 30,000 received ART.)

The MoH report says that by December 2006, 34,136 adults and children received ART, which is close to the WHO estimate. We accepted this as the number with ART. For those needing ART and not receiving it, we worked from the WHO numbers: WHO says 92 percent of those receiving ART are adults, so if we apply this to the MOH 34,136, we get 31,400 adults with ART, which leaves 9,600 needing ART but not receiving it.

The source for the number who are HIV-positive but do not need ART is UNAIDS.[29] For these people, we used average spending for the general population. We divided total spending in each category by 9.5 million (the population estimate we used in computing total spending) and multiplied by 119,000, which is the difference between the adult prevalence of 160,000 and the estimated 41,000 who need treatment.

---

[27] We decided not to attempt a correction for this underestimate because the survey appeared to overestimate visits to public facilities, when compared with official estimates for these facilities.
[28] http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf
[29] http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN1R-T_en.pdf

Per capita spending is based on a survey of 7,557 adults in 1,956 households, from which 1,376 PLHIV were identified based on internal survey responses. (The survey intentionally includes households where no one was known to have AIDS; these were excluded from our analysis.) Of these, 787 were identified as receiving ART, and another 458 were receiving either Cotrimox (a treatment for Pneumocystis carinii pneumonia) or no identified medication. These two groups are analyzed as though they were samples from the 31,400 treated and 9,600 untreated PLHIV, respectively.

OP and IP questions refer to a six-month recall period. We doubled this to estimate annual spending. We are not confident that is period can be accurately recalled by all respondents.

The largest cost for PLHIV is associated with care for "other" illness, that is anything other than the AIDS treatment. In the survey, this is recorded as a single item, and cannot be disaggregated by type of provider. Unlike other expenses, the survey question refers to a four-week recall period. We multiply these estimates by 13 to produce annual estimates.

*Household spending on curative care for malaria*

Of the stratified cluster sample of 34,785 people in 6,900 households surveyed in the EIVC, 2,279 reported that they had suffered malaria during the two weeks preceding the survey. All of the calculations described in the section above on general household spending were repeated separately for this subgroup to produce the malaria subaccount.

**Malaria prevention commodities**

The EICV did not ask questions on expenditures on malaria prevention commodities. All prevention commodities are handled by PSI, and the value of all commodities purchased in Rwanda in 2006 is therefore captured in PSI expenditure records. This includes both private and public sector spending.

In 2006, bednets were provided to users in Rwanda via i) the private sector, and ii) the public sector.

Private sector

The number of nets bought in the private sector in 2006 was 311,986. For practical purposes, the team assumed that all commodities were used that calendar year. Bednets were purchased by the Central Medical Store (CAMERWA) with Global Fund monies from rounds 3 and 5. The cost per net, as budgeted in the Global Fund round 5 proposal submitted February 2006, was US$6.00 (RWF 3,310.20). Therefore, the total value of nets purchased at this level was US$1.9 million (RWF 1.0 billion).

Some of these costs, however, were offset by revenue from bednet sales. Global Fund monies (via PSI) recovered RWF 600 per net for those sold to NGOs (87,357 nets), for a recovery of RWF 52.4 million. (The NGOs gave the nets to consumers for free.) Therefore, the net cost of bednets in this transaction was RWF 236.8 million.

| | | | | |
|---|---|---|---|---|
| FS 3 Rest of the world | HF 2.4 NGOs | HP nsk Provider not specified by kind | HC 1.3.9 Nets given as part of OP care | RWF 236,754,941 |

Additionally, donor spending on bednets for the private sector also included RWF 698.7 million, which is the total cost of nets (224,629 nets) at US$6.00 minus the amount recovered from selling the nets to wholesalers at RWF 200 per net.

| | | | | |
|---|---|---|---|---|
| FS 3 Rest of the world | HF 2.4 NGOs | HP 4.1 Provider not specified by kind | HC 5.2.5.1 Insecticide treated nets | RWF 698,695,026 |

Households purchased those 224,629 nets at RWF 600 per net from retailers. The amount recovered by wholesalers in the transactions with retailers is not counted because the wholesalers act as pass-throughs and the NHA is concerned with the actual expenditures by end users. Household expenditure on malaria commodities was therefore RWF 134.8 million.

| | | | | |
|---|---|---|---|---|
| FS 2.2 Households | HF 2.3 OOP spending | HP 4.1 Dispensing chemists | HC 5.2.5.1 Insecticide treated nets | RWF 134,777,400 |

Public sector

More than 1.5 million MAMANET-brand bednets were bought and distributed in the public sector in 2006.[30] These nets were purchased by CAMERWA with Global Fund monies at the international price for a total value of RWF 5.2 billion. Of that total number of bednets, nearly 1.4 million[31] were distributed for free during public campaigns to i) children under five with vaccinations, and ii) PLHIV. The financing agent in this case is Minisanté because CAMERWA and PNLP develop the distribution plan and PSI is a pass-through. The total donor expenditure for those nets that were distributed for free is RWF 4.5 billion.

| | | | | |
|---|---|---|---|---|
| FS 3 Rest of the world | HF 1.1.1.1 Minisanté | HP 3.3.1 Community health workers | HC 1.3.9 Nets given as part of OP care | RWF 4,485,321,000 |

Finally, 206,908 bednets were bought with donor funds to sell to pregnant women through this campaign for a total of RWF 684.9 million (PNLP 2006). Pregnant women could buy these MAMANET bednets at RWF 200 per net for a total of RWF 41.4 million in OOP spending. Because OOP funds are retained at the facility level, there is no need to deduct the OOP amount from the donor contribution. The NHA team distributed the total value of nets bought for and spent by pregnant women across different providers according to ratios calculated from SIS data.

[30] Personal communication with Yves Cyaka of PSI
[31] Ibid.

| | | | | | |
|---|---|---|---|---|---|
| **FS 3 Rest of the world** | **HF 1.1.1.1 Minisanté** | **HP 1.1.2.1 District government hospitals** | **6%** | **38,460,866.55** | **HC 1.3.9** |
| | | HP 1.1.2.2 District *agrée* hospitals | 2% | 16,646,582.08 | HC 1.3.9 |
| | | HP 3.4.5.1 Public health sectors | 45% | 304,785,569.44 | HC 1.3.9 |
| | | HP 3.4.5.2 Govt assisted not for profit health centers (agrées) | 29% | 196,429,796.71 | HC 1.3.9 |
| | | HP 3.3.3 Other health practitioners | 19% | 128,584,046.81 | HC 1.3.9 |

| | | | | | |
|---|---|---|---|---|---|
| **FS 2.2 Households** | **HF 2.3 OOP spending** | **HP 1.1.2.1 District government hospitals** | **6%** | **2323779.02** | **HC 1.3.9** |
| | | HP 1.1.2.2 District *agrée* hospitals | 2% | 1005775.003 | HC 1.3.9 |
| | | HP 3.4.5.1 Public health sectors | 45% | 18414933.81 | HC 1.3.9 |
| | | HP 3.4.5.2 Govt assisted not for profit health centers (agrées) | 29% | 11868152.78 | HC 1.3.9 |
| | | HP 3.3.3 Other health practitioners | 19% | 7768959.387 | HC 1.3.9 |

## RH spending

Commodities

*Public Sector*

To account for the amount spent on commodities in Rwanda in 2006, the NHA team started by holding interviews with key informants in the family planning sector to get a clear picture of the flow of funds. Interviewees included UNFPA, JSI/USAID, PSI, Dr. Ferdinand at the MoH, and the director of an ARBEF (*Association Rwandaise pour le Bien-Etre Familial*) clinic.

In 2006, USAID and UNFPA donated commodities to the MoH via CAMERWA for free. CAMERWA turned the commodities over to a district storage facility for free, which in turn distributed the commodities free to i) government and *agrée* health centers and hospitals, ii) private clinics, and iii) ARBEF clinics (NGO health centers). Government and *agrée* health centers and hospitals, as well as private clinics, distributed the commodities free to consumers, but the ARBEF clinics charged a fee for the medical act (i.e., inserting the implant, giving injection). ARBEF also received commodities from International Planned Parenthood Foundation (IPPF) and charged a fee for those commodities.

While USAID and UNFPA could provide the total number of contraceptives sent to the government in 2006, the intention is to have enough commodities plus a 20-month supply at one time. Therefore, the NHA team counted the number of commodities actually distributed to consumers in 2006, which was obtained from detailed UNFPA and USAID reports.

### ANNEX C TABLE 1.15: NUMBER OF FAMILY PLANNING COMMODITIES BY TYPE

| Commodity type | Number consumed in 2006 | Unit |
|---|---|---|
| Oral contraceptives | 478606 | one cycle |
| Injectables | 390699 | one dose and syringe |
| Implants | 4122 | one implant |
| Male condoms | 833863 | one condom |

*Source*: Dr. Jovitt, USAID DELIVER project, November 2007

The NHA team then used data from the 2005 DHS to determine the providers of these commodities based on a percentage distribution of women using each provider.

### ANNEX C TABLE 1.16: DISTRIBUTION OF WHERE WOMEN OBTAINED THEIR COMMODITIES

| | Public sector | | | Private medical sector | | | | | | Other source | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Govt./ *agrée* hosp | Govt./ *agrée* health center | Animateur de santé | Private hosp/ clinic | Pharma - cy | Private doctor | ARBEF clinic | Infir-mary | Other private | Boutique /kiosque | Relative/ friend |
| Oral contraceptives | 8% | 75% | 2% | 2% | 8% | 0% | 4% | 2% | 0% | 1% | 0% |
| Injectables | 10% | 80% | 0% | 1% | 2% | 0% | 4% | 2% | 0% | 0% | 0% |
| Implants | 60% | 20% | 0% | 10% | 0% | 0% | 10% | 0% | 0% | 0% | 0% |
| Condoms | 4% | 21% | 0% | 2% | 21% | 2% | 4% | 0% | 0% | 42% | 4% |

*Source*: DHS 2006

The NHA applied this percentage distribution of providers to the total number of each commodity consumed in 2006 to obtain the number of each commodity type per provider.

### ANNEX C TABLE 1.17: NUMBER OF COMMODITIES DISTRIBUTED THROUGH DISTRICT STORAGE AT THE FOLLOWING FACILITIES

| | Public sector | | | Private medical sector | | | | | | Other source | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Govt./ *agrée* hosp | Govt./ *agrée* health center | Anima-teur de santé | Private hosp/ clinic | Pharmacy | Private doctor | ARBEF clinic | Infir-mary | Other private | Boutique /kiosque | Relative/ friend |
| Oral contraceptives | 36,258 | 358,955 | 7,252 | 10,877 | 36,258 | - | 18,129 | 7,252 | - | 3,626 | - |
| Injectables | 38,117 | 314,465 | - | 3,176 | 7,941 | 1,588 | 17,470 | 6,353 | 1,588 | - | - |
| Implants | 2,473 | 824 | - | 412 | - | - | 412 | - | - | - | - |
| Condoms | 34,744 | 173,721 | - | 17,372 | 173,721 | 17,372 | 34,744 | - | - | 347,443 | 34,744 |

The NHA team obtained the prices of each commodity for USAID and UNFPA based on international prices and from discussions with Dr. Jovitt of USAID's DELIVER project. The unit costs were multiplied by the total commodities at each facility to produce the total amount spent. The NHA team repeated this using the prices charged to consumers to obtain each commodity. While commodities were supposed to be free to the consumer, there were sometimes OOP costs associated with the medical

act. The donor cost and the consumer cost are considered additive because the profit from consumer spending is retained at the facility level.

The NHA team then accounted for the fees charged by ARBEF clinics for commodities from IPPF.

**ANNEX C TABLE 1.18: UNIT PRICES OF FAMILY PLANNING COMMODITIES**

| | Units | Unit value as purchased by donor | Unit price charged to patients |
|---|---|---|---|
| Injectables | 18170 | | |
| Depo | 3499 | RWF 15,918 | RWF 500 |
| Noristerat | 13542 | RWF 31,835* | RWF 1,000 |
| Norigynon | 1129 | RWF 386 | RWF 200 |
| Oral contraceptives | 17299 | RWF 474** | RWF 200 |
| Male condoms | 30916 | RWF 14*** | RWF 2 |
| Implants | 803 | RWF 127,452 | RWF 5,000 |

*NHA did not have a price for this, so assumed that since it cost twice as much for patients the unit value is also twice as high

**Used the base unit for Microgynon since that product is used by the majority

***Taken from IPPF customs receipt

*Private Sector*

The private sector information was provided by PSI key informants. The UK Department for International Development (DFID) buys condoms and oral contraceptives to be sold in the private sector. DFID provides funding to the German NGO KFW, who gives the funds to the MoH. The MoH then contracts to PSI. PSI uses the money to procure in-kind commodities from PSI Washington. The oral contraceptives are sold to pharmacies and then consumers. Condoms are sold to wholesalers, who sell to semi-wholesalers, who sell to retailers, who sell to consumers.

*Oral contraceptives*

The NHA team determined that the total amount spent on contraceptives is the net value spent by PSI plus the OOP spending by the consumer. As previously mentioned, because the profit from consumer spending is retained at the facility level, it is necessary to add this amount to the net spending on commodities by the source (DFID).

PSI bought 8,420 boxes of oral contraceptives in 2006. Each box contains 20 cycles. The total spending by PSI was RWF 20.5 million. PSI then sold those boxes to pharmacies at RWF 1,400/box to recover RWF11.8 million. The net spending by PSI was therefore RWF 8.8 million. Additionally, the amount spent at pharmacies by consumers (at RWF 2000/box) came to RWF 16.8 million.

*Condoms*

PSI's MIS reported 10 million condoms (3,859 cartons), were bought in 2006. Based on PSI's total condom procurement figure, the NHA could deduct that the price per carton was therefore RWF 66,209 at that level. PSI then sold the cartons of condoms to wholesalers at RWF 9,900/carton, recovering some money and making the donor's net spending via PSI RWF 217.3 million.

Ultimately, the condoms were sold to consumers at RWF 32,400/carton, or RWF 50/box of four condoms. Total OOP spending, which is added to donor's net spending via PSI, was RWF 125.0 million.

Maternal health and family planning

The 2006 RH subaccount also accounted for OOP spending on prenatal and postnatal visits and deliveries. To account for spending by government or donors on IP care, the NHA team relied on untargeted spending (see section on untargeted spending). As with the 2002 RH subaccount, sterilization numbers were too low to warrant estimation or costly data collection.

One limitation with the RH subaccount is that the NHA team was unable to estimate expenditure on birth attendants making house calls due to a lack of resources and data available at the time, as most of this is likely in-kind gifts. RH OOP spending is therefore likely to be an underestimate.

*Prenatal care*

The DHS reported that 95 percent of births were preceded with prenatal consultations from either doctors or nurses, and of those the average number of prenatal consultations was 2.4. The total number of births in 2006 was 389,510 according to data from the Census and the Population Reference Bureau fact sheet. By multiplying the total number of births by the average consultations and 95 percent, the total number of prenatal visits was 889,117.

The NHA team conducted interviews and primary data collection at providers to estimate the average cost per provider per visit.

| | **Public sector** | | | **Private medical sector** | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Govt./ *agrée* hosp** | **Govt./ *agrée* health center** | **Other public** | **Private hospital/ clinic** | **Private doctor** | **ARBEF clinic** | **Infirmary** | **Other private medical** |
| Avg amount paid per visit at given provider | 2500 | 0 | 0 | 3500 | 3500 | 2250 | 2250 | 2250 |

According to key informants, prenatal care at health centers was free due to a new policy, started in 2006, that says if a woman attends three consultations the delivery is free. At ARBEF clinics the ultrasound cost RWF 3,000, the first visit RWF 1,000, and the second visit RWF 500, making the average cost estimate of all three visits RWF 2,250.

The DHS data supplied the percentage distribution of prenatal visits at various providers for their last visit, in the previous 12 months.

| | Public sector | | | Private medical sector | | | | |
|---|---|---|---|---|---|---|---|---|
| | Govt./ agrée hosp | Govt./ agrée health center | Other public | Private hospital/ clinic | Private doctor | ARBEF clinic | Infirmary | Other private medical |
| Total | 20.0 | 73.3 | 0.0 | 1.2 | 2.4 | 0.6 | 1.2 | 1.2 |

*Source:* DHS

These ratios were then applied to the total number of prenatal visits to find the total number of visits by provider, which were in turn multiplied by the average cost of the visit at each provider to reach the total amount spent at each provider on prenatal care.

| | Public sector | | | Private medical sector | | | | |
|---|---|---|---|---|---|---|---|---|
| | Govt./ agrée hosp | Govt./ agrée health center | Other public | Private hospital/ clinic | Private doctor | ARBEF clinic | Infirmary | Other private medical |
| Total | 444,558,673 | | | 37,720,130 | 75,440,260 | 12,124,328 | 24,248,655 | 24,248,655 |

The DHS providers were then mapped to NHA provider codes using provider breakdown ratios (see section x).

| | Govt./ *agrée* hospital | | | Govt./ agrée health center + Infirmary | | Private hospital/ clinic + other private medical (clinic) | | ARBEF clinic |
|---|---|---|---|---|---|---|---|---|
| | HP.1.1.1.1 govt referral | HP.1.1.2.1 district govt | HP.1.1.2.2 agrée district | HP.3.4.5.1 govt health centers | HP.3.4.5.2 agrée health centers | HP.1.1.1.2 private referral | HP.3.1 private clinics | HP.3.4.5.3 NGO clinic |
| Total | 294,668,584 | 104,612,042 | 45,278,047 | 0 | 0 | 20,390,400 | 141,267,300 | 12,124,327 |

*Postnatal care*

According to the DHS, 4.8 percent of births in Rwanda in 2006 were followed by a postnatal visit. Therefore, assuming one postnatal visit per birth, there were 18,696 postnatal visits that year.

The percent distribution of postnatal visits at providers was as follows:

| | Domicile | | Public sector | | | | Private medical sector | |
|---|---|---|---|---|---|---|---|---|
| | Own home | Other domicile | Govt hospital | Govt health center | Dispensary | Other public | Private hosp/ clinic | Other private medical |
| Percent | 62.2 | 7.1 | 4.6 | 21.6 | 4.5 | 0.0 | 0.0 | 0.0 |

*Source:* DHS

By applying the percentage distribution to the total number of postnatal visits, and then multiplying the average cost of visits across providers (based on interviews of key informants), the NHA team could estimate the total spending at the following providers.

| | Domicile | | Public sector | | | | Private medical sector | |
|---|---|---|---|---|---|---|---|---|
| | Own home | Other domicile | Govt hospital | Govt health center | Dispensary | Other public | Private hosp/ clinic | Other private medical |
| Total | Unknown | Unknown | 2,152,214 | 0 | 0 | 0 | 0 | 0 |

*Source*: Key informant interviews at providers

The total spending by providers was then mapped to NHA codes as with prenatal care.

| | Govt hospital | | | Govt./ agrée health center + dispensary + other public | | Private hospital/ clinic + other private medical (clinic) | |
|---|---|---|---|---|---|---|---|
| | HP.1.1.1.1 govt referral | HP.1.1.2.1 district govt | HP.1.1.2.2 agrée district | HP.3.4.5.1 govt health centers | HP.3.4.5.2 agrée health centers | HP.1.1.1.2 pivate referral | HP.3.1 private clinics |
| Total | 1,426,560 | 506,452 | 219,202 | 0 | 0 | 0 | 0 |

*Deliveries*

DHS reported that 32.8 percent of deliveries occurred at health facilities, making the total 127,775 in 2006. The percentage distribution at facilities is in the table below:

| | Domicile | | Public sector | | | Private medical sector | | Other |
|---|---|---|---|---|---|---|---|---|
| | Own home | Other domicile | Govt hospital | Govt health center | Other public | Private hosp/ clinic | Other private medical | |
| Total | 63.9 | 3.3 | 10.4 | 19.4 | - | 1.5 | 0.0 | 1.5 |

*Source*: DHS

The same methodology was applied to the deliveries as described in the sections on prenatal and postnatal care. Ultimately, total OOP spending at health facilities according to NHA codes can be summarized in the table below.

| | Govt. hospital | | | Govt health center | | Private hospital/clinic | | Other private medical |
|---|---|---|---|---|---|---|---|---|
| | HP.1.1.1.1 (govt referral) | HP.1.1.2.1 district govt | HP.1.1.2.2 agree district | HP.3.4.5.1 govt health centers | HP.3.4.5.2 agrée health centers | HP.1.1.1.2 Private referral | HP.3.1 private clinics | HP.3.3.3. other health practioners |
| Total | 12,428 | 4,412 | 1,910 | 15,056 | 14,555,407 | 51,440,565 | 43,719,159 | 3,170,884 |

Ordinarily, it is good to get prices of Caesarean sections because this procedure is more expensive than vaginal deliveries. These data were not available from secondary sources in the country for 2006. However, because the percentage of Caesarean sections performed in Rwanda is so small (2.9 percent, estimated by DHS), the difference would be almost negligible and would not justify additional resources to collect the data.

## LIMITATIONS

NHA primary data were collected via a self-administered questionnaire. As NHA is not an audit, there is no reason to believe that respondents are inclined to provide incorrect data. However, it may be difficult for respondents to provide accurate disaggregation of programs to report on administrative costs. According to the NHA classification system, administrative costs captured are those at central and program level and classified under prevention and public health programs administration. These are designated as HP.5/HC 6. The second category is Health Administration and Insurance and is denoted as HP 6/HC 7. This classification excludes administrative costs at health facilities and for personal care.

The NHA classification system may be different from the general accounting system that reports all administrative costs together. Thus, even if efforts are made to separate these expenditures, there is a potential for inaccuracy. Interpretation of administrative expenditure must therefore be treated with caution.

# ANNEX D. UNITED NATIONS GENERAL ASSEMBLY (UNGASS)
## SPECIAL SESSION ON HIV/AIDS (EXCERPT)

# 3 NATIONAL RESPONSE TO THE AIDS EPIDEMIC

## 3.1 NATIONAL COMMITMENT

### 3.1.1 HIV AND AIDS EXPENDITURE *(Ref, Indicator 1)*

#### *Methodology used for data collection*

To track HIV-related expenditure for 2006, Rwanda used two different frameworks, the National AIDS Spending Assessment (NASA) and the National Health Accounts (NHA) with particular focus on the HIV and AIDS subaccount. Data from an existing household survey on out-of-pocket spending by people living with HIV (PLHIV)[3] commissioned by CNLS were also included.

The subaccounts and NASA matrix differ slightly to cater to different groups of stakeholders, but both report on HIV spending in a calendar year (as is the case in Rwanda). The subaccounts preserve the distinction between health and non-health expenditures to help meet the needs of health stakeholders. The NASA approach aims to inform a multisectoral AIDS perspective and can contribute to the HIV and AIDS resource gap estimation process.

The computation of NASA data was lead by CNLS in collaboration with the Joint United Nations Programme on HIV and AIDS (UNAIDS). Two national consultants collected secondary data (declared expenditure) from the state budget execution report of 2006 from the Ministry of Finance and Economic Planning (MINECOFIN), relevant line ministries (MOH, MOE, Ministry of Youth, Culture and Sports and Ministry of Local Government), annual transaction and audit reports from CNLS, TRAC, UN agencies, the Presidential Emergency Plan for AIDS Relief (PEPFAR), the GFATM and the African Development Bank (ADB) projects.

The NHA was lead by the MOH with support from the United States Agency for International Development (USAID)/ Health Systems 2020. Fifteen data collectors tracked funding flows from the financing source to the provider for HIV health and non-health components. The data collection approach used for the NHA involved the following sequence of steps: 1) Where possible, access original expenditure records from institutions (e.g. executed budgets/reports from the MOH, referral hospitals, the Genocide Survivors Fund (FARG), and the National Blood Transfusion Centre (CNTS) as well as those listed above as collected by the NASA team), 2) Examine other secondary (already available) data, including the Health Information System, existing studies etc., 3) Use ongoing surveys (eg. PLHIV household survey as referenced above) and finally, 4) Develop and implement targeted NHA surveys for donors, NGOs, private and public employers/corporations and insurance companies. As per international NHA norms, the HIV and AIDS sub account reflects expenditures, which are monetary or in-kind transactions associated with the actual delivery of the service or product. Therefore, it differs from commitments and from disbursements, and captures in monetary terms the transactions for actual rendered services.

To ensure complimentary and harmonised findings, the two teams (CNLS and MOH) worked together during the data analysis stage. A mapping of coding was undertaken to match NHA spending categories with the NASA codes, which are more disaggregated. NHA values were selected because they capture actual expenditures by provider, while NASA numbers were based on spending declarations by donor (which in some cases may reflect the disbursements rather than expenditures depending on the records kept by the donor). When there was not information collected through NHA questionnaires, for instance for income generating activities, NASA values were exploited. Since NASA considers all expenditure on condoms under HIV, while NHA makes a distinction with family planning, data from the reproductive health subaccount of NHA were also included.

For trend analysis, spending data for 2005 collected according to NASA methodology were used, as reported in the UNGASS Report 2006.

3 Unpublished results (as of November 2007) from an HIV and AIDS household survey conducted as part of a baseline evaluation of performance-based contracting in Rwanda are reported here. The household survey was conducted in 2006 by CNLS with technical support from the World Bank and the Rwandan School of Public Health

**Recommendation for 2008**

Conduct only one resource tracking effort for a given year, but produce two outputs, namely NHA tables and the NASA tables. Harmonisation efforts should inform the exercise from the beginning. This will help meet the needs of both health and HIV stakeholders, and will also avoid redundant and duplicative gathering of similar data. If NHA are used, ensure that non-health HIV items are also included with the NASA level of breakdown and maintain separation between donors (rather than only using an aggregate category of donors). Also, care must be taken to ensure that CNLS representatives are included in the MOH team as well as the NHA Steering Committee. Moreover, continued use should be made of existing data collection in the country, in particular the information on expenditure by stakeholders at the district level that is captured by the database CNLSnet.

## *Findings and interpretation*

### *Part 1: Financing Sources*

The financing of the HIV and AIDS response in Rwanda is through government ministries and other public institutions, the private sector which includes corporations, out-of-pocket household expenditures, and international partners such as UN agencies, the ADB, the World Bank's Multi-sector AIDS Project (MAP), the Global Fund, the United States Government (USG) through PEPFAR, and other bilateral donors.

The table below shows the sources of financing for HIV and AIDS in 2006[5].

**TABLE 4: Source of Financing for HIV and AIDS in Rwanda, RwF**

| Financing Sources | Amount spent 2006 |
|---|---|
| Government | 2,426,172,514 |
| UN agencies | 1,211,907,456 |
| ADB | 478,773,163 |
| MAP | 6,387,617,763 |
| Global Fund | 7,174,979,556 |
| USG-PEPFAR | 15,914,838,678 |
| Other donors (bilateral donors, foundations) | 13,429,287,334 |
| Corporations | 25,255,030 |
| Out-of- pocket | 1,953,813,665 |
| All other private | 216,302,449 |
| **Total** | **48,340,589,281** |

*Exchange rate 2006: 1$ = 551.74 RwF*

Total HIV spending in 2006 is Rwandan Francs (RwF) 48.3 billion (United States Dollars (USD) 87.6 million). When comparing with previous years we note an increasing trend in expenditures. Declared expenditure in 2005 was USD 81.4 million, in 2004 USD 44.85 million and in 2003 USD 9.6 million. It should be borne in mind that data for 2005 and previous years refer to declared expenditure by donors while data for 2006 reflect actual expenditure by providers. Therefore, these figures may in fact underestimate the increase that happened in 2006.

Since the amounts reported track expenditure by implementing partners for a particular service/product, some funds disbursed by donors may not have been spent in their entirety in 2006 for a number of reasons; for example, the disbursement was made late in 2006 or the disbursement was intended for use over multiple years. Consequently, in these cases, actual spending is only a fraction of what donors report to have disbursed.

The total amount of spending for 2006 represents 3.3% of the GDP in Rwanda.

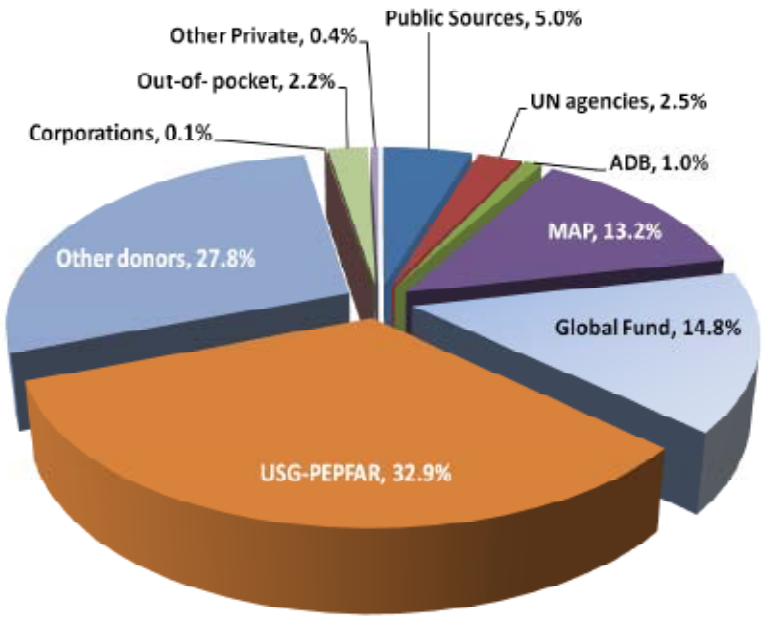
92% of the HIV and AIDS spending is incurred by donors. However, we note that Government contributions increased by about 767 million in real 2006 RwF (USD 1.4 m) since 2005 (UNGASS Report, 2006).

5 Based on NHA/NASA findings as of January 28, 2008

Private AIDS expenditure is largely based on analysis of PLHIV out of pocket (OOP) spending on health care (note this amount does not include non-health OOP spending on HIV). OOP spending by PLHIV is 1.2 times more than the general population. This represents a decrease from 2.99 times more in 2002 (NHA records). Expenditure from private sources, including out-of pocket spending by PLHIV, represents only 2.7% of the total.

The figure below shows the percentage contribution to the total by each financing source.

**Figure 2: Expenditure per Financing Source, 2006**




## *Part 2: Financing by HIV Programme Intervention*

Table 5 presents a breakdown per AIDS spending category in 2005 and 2006. To facilitate comparison between years, all the 2005 estimates have been adjusted to 2006 real RwF, accounting for inflation.

**Table 5: Breakdown by spending category in 2005 and 2006**

| Spending category | Indicative Expenditures 2005<br>Adjusted to constant 2006 RwF | Amount spent 2006 |
|---|---|---|
| Prevention programmes | 10,831,999,496 | 11,519,430,542 |
| Treatment and care components | 17,421,116,845 | 14,975,375,517 |
| Programme management and administration strengthening | 10,948,334,363 | 14,250,590,951 |
| Incentives for human resources | Not available | 229,596,813 |
| Social protection and social services excluding OVC | 2,532,628,274 | 3,108,734,148 |
| Orphans and vulnerable children | 3,129,429,767<br>3,812,717,238 (including FARG) | 3,880,904,328 |
| Enabling environment and community development | 62,483,758 | 108,173,109 |
| HIV- and AIDS-related research (excluding operations research) | 2,562,567<br>(Updated value: 1,137,763,548) | 267,783,872 |
| **Total** | **44,928,555,072** | **48,340,589,281** |

*Exchange rate 2005: 1$ = 550 Rwf, Exchange rate 2006: 1$ = 551.74 RwF*
*Adjustment of 2005 data to 2006 constant Rwandan francs was made using International Monetary Fund, World Economic Outlook Database, September 2005 Source for 2005: UNGASS report 2006, Expenditure records e.g. Ministry of Finance execution report, CEPEX, annual and audit reports from CNLS,TRAC, GF, PEPFAR, WB/MAP project and NHA data.*

***HIV prevention programme expenditure increased from 10.8 to 11.5 RwF billions.*** This is attributable to the commitment of Government and donors with regard to HIV prevention programmes as a means to reduce HIV infection rates. Government funds are spent mainly on programmes covering blood safety, community mobilisation, school HIV prevention programmes, and programmes for vulnerable populations. Of all USG-PEPFAR funds that could be disaggregated, 38% were used for prevention, mainly voluntary counselling and testing (VCT), mass media, management of STIs and prevention of mother-to-child transmission (PMTCT).

***There is a decline in spending for care and treatment programmes by RWF 2.5 billion.*** Although the number of patients increased by more than 12,000 from 2005 to 2006, we report a significant reduction in the prices for ARVs (by about 30% for the most-used drugs, such as *Efavirenz* and *Lamivudine*) and for some tests (by 30% for CD4 fascount and more than 60% for the Tri test CD3/CD4/CD45). This reduction in prices more than compensated the increase in quantities and balanced the overall increased costs for opportunistic infections (OIs) and other tests (including rapid HIV tests). Therefore, from 2005 to 2006 the overall cost of treatment remained almost stable in Rwanda (Central Purchasing of Essential Medicines in Rwanda (CAMERWA)). The decrease we observe in NHA/NASA values may be due to the change in methodology as already explained above (declared expenditure in 2005 versus real expenditure in 2006).

HIV health-related expenditure as a percentage of the total spending on HIV is 84.3%. Overall, HIV and AIDS health care spending accounts for 24% of all health care spending in 2006. This represents an increase from 15% in 2005, according to NHA records.

***Funding for orphans and other vulnerable children.*** The government amounts include an estimated proportion (20%) of the Genocide Survivals Fund (FARG) to support education for OVC in the country. This proportion relates to the percentage of OVC infected or affected by HIV. Much of this amount goes for OVC education in terms of school fees. MAP, with 1.3 billion (2.4 million) was the second large contributor for OVC in 2006.

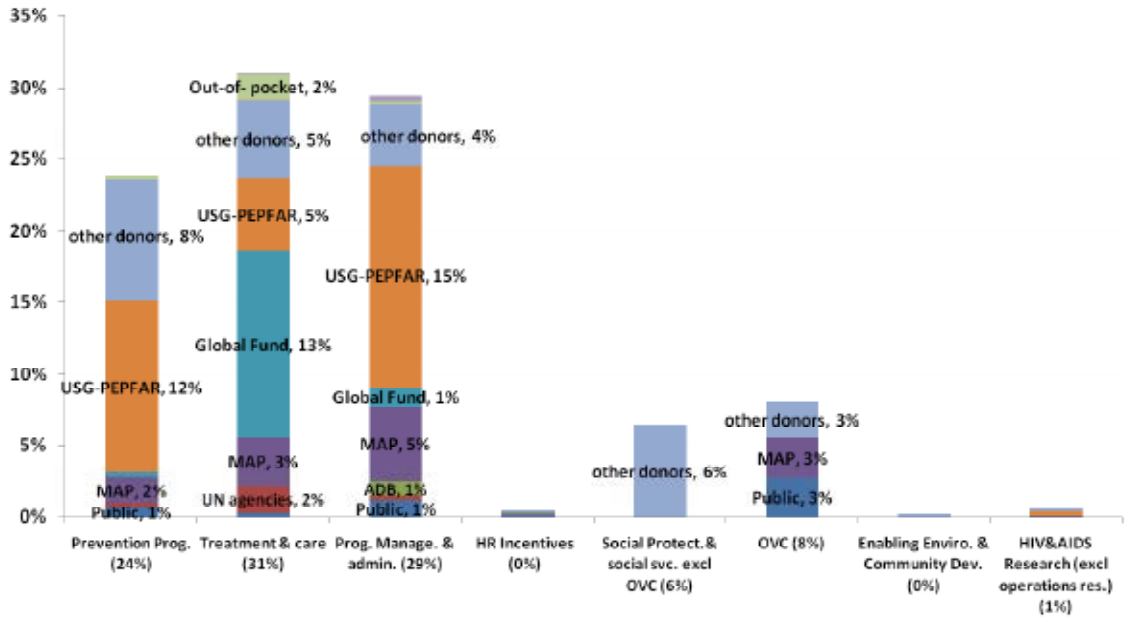
***Programme management and administration strengthening.*** The management and administrative costs of HIV programmes have also increased by more than 40%. According to expenditure records, USG-PEPFAR, followed by MAP, spent more than any other donor in programme management and upgrading laboratory infrastructure.

***Social protection.*** According to NASA-NHA data, there has been an increase in social protection interventions, excluding OVC, from RwF 2.5 billion (USD 4.6 million) in 2005 to RwF 3.1 billion (USD 5.7 million) in 2006. This is attributable to a large increase in funding for income-generating activities for PLHIV.

***HIV- and AIDS-Related Research (excluding operations research).*** It is difficult to make a comparison with 2005 data as reported in the UNGASS 2006 Report, since the value did not take into account the spending for two big studies, the RDHS 2005 and the PLACE study. If we were to take into account an amount of about 2 million USD, the funds spend for research diminished in 2006.

The figure below plots expenditure by spending categories in 2006, highlighting the percentage contributions by financing source. GFATM finances the largest share of treatment and care while USG finances the largest share of prevention programmes.

**Figure 3: Expenditure per Category and Financing Source, 2006**



The table below presents how much was spent on rendered HIV services/products in the country in 2006 (RwF). These amounts are in some cases different from disbursed amounts by donors.

**Table 6: National AIDS Spending Assessment**

| | Financing sources | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Public sources | | | | | | | | | | Private Sources | | | |
| | Public sub-Total | Central / National | All Other Public | International sub-Total | UN Agencies | Global Fund | MAP Project | ADB | PEPFAR | Other donors | Private Sub-Total | Corporations | Out-of-pocket | All other private |
| TOTAL 48,340,589,281 RwF | 2,426,172,514 | 2,425.022,015 | 1,141,499 | 44,597,403,950 | 1,211,907,456 | 7,174,979,556 | 6,387,617,763 | 478,773,163 | 15,914,838,678 | 13,429,287,334 | 1,328,127,598 | 25,255,030 | 1,953,813,665 | 216,302,449 |
| AIDS Spending Categories | | | | | | | | | | | | | | |
| **1. Prevention (sub-total)** | **342,554,476** | **342,360,208** | **194,268** | **11,051,647,704** | **119,347,361** | **152,541,208** | **886,378,702** | **0** | **5,787,038,599** | **4,106,341,833** | **125,228,363** | 0 | **125,228,363** | **0** |
| 1.1 Mass media *** | | 3,370,300 | 3,395 | | 17,006,672 | | | | 1,283,490,922 | 904,396,641 | | | | |
| 1.2 Community mobilization | | | | | | | | | 104,423,547 | 468,456,634 | | | 194,438 | |
| 1.3 Voluntary counseling and testing | | 246,126,870 | 103,889 | | 15,300,771 | | | | 1,454,249,605 | 852,973,465 | | | | |
| 1.12 Condom social marketing | | | | | | | | | | 217,299,700 | | | | |
| 1.13 Public and commercial sector condom provision | | 1,237,214 | 1,246 | | 4,043,149 | | | | 81,318,814 | 58,735,396 | | | 125,033,925 | |
| 1.16 Improving management of STIs | | | | | 6,058,498 | | | | 1,024,846,871 | 781,792,071 | | | | |
| 1.17 Prevention of mother-to-child transmission | | 16,083,783 | 16,200 | | | | | | 907,824,353 | 228,476,944 | | | | |
| 1.18 Blood safety | | | | | | | | | 175,969,133 | 270,013,518 | | | | |
| 1.99 Others / Not-elsewhere classified | | 75,542,041 | 69,538 | | 76,938,271 | 152,541,208 ** | 886,378,702 ** | | 754,915,354 | 324,197,465 | | | | |
| **2. Care and treatment (sub-total)** | **135,673,136** | **135,579,581** | **93,555** | **13,933,647,807** | **929,712,263** | **6,303,433,816** | **1,600,187,781** | **0** | **2,470,811,661** | **2,629,502,286** | **906,054,574** | **25,255,030** | **878,358,328** | **2,441,216** |
| 2.1 Outpatient care | | 108,913,761 | 76,691 | | 929,712,263 | 829,836,146 ** | 654,327,514 ** | | 485,340,279 | 553,415,573 | | 19,012,118 | 380,942,595 | 2,061,236 |
| 2.4 Antiretroviral therapy | | | | | | 1,482,044,977 | | | 1,387,599,411 | 626,833,323 | | | | |
| 2.8 Psychological care | | | | | | | | | 187,292,084 | 328,855,892 | | | | |
| 2.9 Palliative care | | | | | | | | | | | | | | |
| 2.11 Additional/informal providers | | | | | | | | | | | | | 94,023,410 | |
| 2.12 Hospital care | | 26,665,820 | 16,864 | | | 820,349,277 | 945,860,266 | | | 898,771,380 | | 6,242,912 | 242,472,944 | 379,980 |
| 2.13 Opportunistic infection (OI) treatment | | | | | | | | | 410,579,887 | 221,626,118 | | | | |
| 2.99 Others / Not-elsewhere classified | | | | | | 3,171,203,416 | | | | | | | 160,919,378 | |
| **3. Orphans and other vulnerable children** | **1,325,396,756** | **1,325,396,756** | **0** | **2,555,507,572** | **0** | **0** | **1,318,535,777** | **0** | **0** | **1,236,971,795** | **0** | **0** | **0** | **0** |
| 3.1 Education | | 1,325,396,756 | | | | | 1,318,535,777 | | | | | | | |
| 3.4 Community support | | | | | | | | | | 1,236,971,795 | | | | |
| **4. Program management and administration strengthening** | **556,349,050** | **555,561,983** | **787,067** | **13,408,512,022** | **159,998,262** | **682,313,955** | **2,511,482,095** | **478,773,163** | **7,476,696,603** | **2,099,247,945** | **285,729,880** | **0** | **71,868,647** | **213,861,233** |

| | Financing sources | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Public sources | | | | | | | | | | Private Sources | | | |
| | Public sub-Total | Central / National | All Other Public | International sub-Total | UN Agencies | Global Fund | MAP Project | ADB | PEPFAR | Other donors | Private Sub-Total | Corporations | Out-of-pocket | All other private |
| **TOTAL 48,340,589,281 RwF** | **2,426,172,514** | **2,425.022,015** | **1,141,499** | **44,597,403,950** | **1,211,907,456** | **7,174,979,556** | **6,387,617,763** | **478,773,163** | **15,914,838,678** | **13,429,287,334** | **1,328,127,598** | **25,255,030** | **1,953,813,665** | **216,302,449** |
| **AIDS Spending Categories** | | | | | | | | | | | | | | |
| 4.1 Program management | | 244,702,118 | 234,123 | | 114,468,144 | 682,313,955 | 1,744,764,434 | 257,834,211 | 5,044,273,421 | 1,194,551,998 | | | | |
| 4.2 Planning and coordination | | 288,080,280 | 530,000 | | | | | | | 587,134,348 | | | | 213,861,233 |
| 4.5 Sero-surveillance | | 7,883,513 | 7,940 | | 645,856 | | | | 156,830,411 | 32,392,207 | | | | |
| 4.10 Upgrading laboratory infrastructure | | 14,896,072 | 15,003 | | 1,211,700 | | 766,717,662 | | 2,275,592,771 | 179,533,906 | | | | |
| 4.99 Others / Not-elsewhere classified | | | | | 43,672,562 | | | 220,938,952 | | 105,635,486 | | | 71,868,647 | |
| **5. Incentives for human resources** | **26,694,046** | **26,667,187** | **26,859** | **202,902,767** | **0** | **36,690,576** | **71,033,408** | **0** | **27,804,706** | **67,374,077** | **0** | **0** | **0** | |
| 5.4 Formative education and build-up of an AIDS workforce | | 11,134,927 | 11,215 | | | 36,690,576 | 5,517,400 | | | 36,863,514 | | | | |
| 5.5 Training | | 15,532,260 | 15,644 | | | | 65,516,008 | | 27,804,706 | 30,510,563 | | | | |
| **6. Social protection and social services excluding orphans and other vulnerable children (sub-total)** | | **0** | **0** | **3,108,734,148** | **0** | **0** | **0** | **0** | **0** | **3,108,734,148** | **0** | **0** | **0** | |
| 6.1 Monetary benefits | | | | | | | | | | 25,054,513 | | | | |
| 6.3 Social services | | | | | | | | | | 510,395,391 | | | | |
| 6.4 Income generation | | | | | | | | | | 2,573,284,243 | | | | |
| **7. Enabling environment and community development** | **0** | **0** | **0** | **108,173,109** | **0** | **0** | **0** | **0** | **0** | **108,173,109** | **0** | **0** | **0** | |
| 7.1 Advocacy and strategic communication | | | | | | | | | | 7,228,213 | | | | |
| 7.2 Human rights | | | | | | | | | | 100,944,896 | | | | |
| **8. Research excluding operations research which is included under (sub-total)** | **39,505,050** | **39,465,300** | **39,750** | **228,278,822** | **2,849,570** | **0** | **0** | **0** | **152,487,110** | **72,942,142** | **0** | **0** | **0** | |

*Calendar year 2006 (January- December)*
*Average exchange rate for 2006: 1$=551.74 Rw*

** Amounts under “others” may relate to different categories under the same section; however, information was not available at the time of the report to further disaggregate the amounts. Also, portion of spending on antiretroviral (ARV) drugs may be embedded in a category for outpatient care if more specific/disaggregated information was not available from implementers.