National Agency for the Control of AIDS (NACA)

# NATIONAL AIDS SPENDING ASSESSMENT IN NIGERIA

PERIOD OF ASSESSMENT: 2019-2021

LEVEL AND FLOW OF RESOURCES AND EXPENDITURES OF THE NATIONAL HIV AND AIDS RESPONSE

**NASA Steering Committee**

Dr. Temitope Ilori – Director General, National Agency for the Control of AIDS (NACA)

Dr. Gambo Aliyu – Director General, National Agency for the Control of AIDS (NACA)

Dr. Akudo Ikpeazu – National Coordinator, National HIV/AIDS, Hepatitis and STIs Control Programme (NASCP)

Dr. Adebobola Bashorun – National Coordinator, National HIV/AIDS, Hepatitis and STIs Control Programme (NASCP)

Dr. Leo Zekeng – Country Director, UNAIDS Nigeria

Funmi Adesanya – Country Coordinator, PEPFAR Nigeria

Dr. Jekwu Ozoemene- MD/CEO, Nigerian Business Coalition Against AIDS (NiBUCAA)

Dr Uche Okoro – Project Manager, FCT Agency for the Control of AIDS Control (FACA)

Dr Fatima Daggash – Programme Coordinator, FCT AIDS and STI Control Programme (FASCP)

Abdulkadir Ibrahim – National Coordinator, Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)

Ikenna Nwakamma – Co-chair, Coalition of Civil Society Networks on HIV and AIDS in Nigeria (CoCSHAN)

Hamza Aliyu – Executive Secretary, Civil Society for HIV/AIDS in Nigeria (CiSHAN)

Dr. Omokhudu Idogho – Managing Director, Society for Family Health Nigeria

Dr Echey Ijezie – Program Director, AHF Nigeria

**NASA Technical Committee**

| | |
|---|---|
| Dr. Ashefor Gregory | NACA |
| Dr. James Anenih | NACA |
| Monday Yanet | NACA |
| Francis Agbo | NACA |
| Dr. Uduak Essen | NACA |
| Dr. Fatimah Jajere | NACA |
| Dr. Rose Aguolu | NACA |
| Olutosin Adebanjo | NACA |
| Deepak Mattur | UNAIDS |
| Teresa Guthrie | UNAIDS |
| Dr. Takpa Koubaguine | UNAIDS |
| Doris Ada Ogbang | UNAIDS |
| Ogbuke Njideka | Federal Ministry of Education |
| Katerina Sharapka | International Consultant – UNAIDS |
| Anastasiya Nitsoy | International Consultant – OPM/GFATM |
| Christian Aran | International Consultant – OPM/GFATM |
| Dr Ali Onoja | National Consultant |
| Louise Allen | OPM |
| Margaret Shelleng | PEPFAR Nigeria |
| Delmy Vasquez | PEPFAR Nigeria |
| Kenneth Chibiko | USAID Nigeria |
| Tochukwu Ngamegbulam | CDC Nigeria |
| Joy Nwanyanwu | DoD Nigeria |
| Dr Segun Oyedeji | SFH Nigeria |
| Terkaa Simon | FHI360 |
| Adekogbe Adebola Sunday | CIHP |
| Terwase Joy Faeren | PHIS3 |
| Ukpai Kelechi | Heartland Alliance |
| Ebere Babatunde | Heartland Alliance |
| Abuh Ogli | Heartland Alliance |
| Ayorinde Samuel Lemah | Data Manager |
| Chukwuemeka Comfort | Data Manager |
| Joshua Opara | Data Manager |
| Nuraini Usman | Data Manager |
| Ojukwu Chinonso Nnenna Adaobi | Data Manager |
| Idepefo Festus | NACA |
| Michael Iyevhobu | NACA |
| Pele Austin-Agba | NACA |
| Osita Christain Uzoana | NACA |
| Chioma Esther Umeadi | NACA |
| Kenti Winifred | NACA |
| Iluyomade Oluseyi | NACA |
| Joy Nnenna Egwuowu | NACA |
| Omaga Ejembi Emmanuel | NACA |

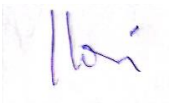
# Foreword

The National AIDS Spending Assessment (NASA) is a UNAIDS global standard for reporting financial expenditure on HIV and AIDS programs in a format that enables comparability across countries. In Nigeria, this report is the fifth round of NASA covering the calendar years 2019 to 2021.

NASA provides evidence to support decision-making on funding priorities of the government, international entities, and civil society groups. It also provides a lens to review policies, strategies, and plans for HIV and AIDS response in the country to evaluate the extent of implementation, efficiency, and effectiveness.

This current exercise allowed the country to undertake an accountability exercise to gauge the financing landscape, gain insights into the financing situation, and produce financing data useful for analysis. The knowledge gained is used to inform advocacy, planning, and priority setting. It will also enable the alignment of activities, resource mobilization, and evidence-based target setting.

Given the insights generated by this assessment, I wish to recommend the use of this report to policymakers and key stakeholders. I also wish to express my gratitude to all our HIV and AIDS stakeholders for their contributions to the conduct of this NASA and in particular their continued commitment to the HIV response as we move towards achieving epidemic control and also press towards domestic ownership and sustainability.



Dr. Temitope Ilori
Director General
National Agency for the Control of AIDS (NACA)

# Acknowledgements

The 2022 National AIDS Spending Assessment (NASA) in Nigeria represents an analysis of spending on HIV and AIDS interventions for the period 2019-2021. The implementation of this fifth round of NASA leading up to the production of the final NASA report is a collaborative effort of the Government of Nigeria led by the National Agency for the Control of AIDS (NACA), National AIDS and STI Control Programme (NASCP), working with UNAIDS and other key stakeholders.

It is important to recognize the enabling environment and support provided by the Management of NACA led by Dr. Temitope Ilori the Director General of NACA. The National AIDS and STI Control Programme of the Federal Ministry of Health (FMOH) led by its National Coordinator Dr. Adebobola Bashorun played a very important role throughout the various phases of the assessment. The collaboration with the UNAIDS Nigeria team led by Dr. Leo Zekeng and staff is highly appreciated. The UNAIDS Global Centre was a key enabler in the implementation of this project.

Critical to the successful conduct of this exercise was the partnership, support, and involvement of key stakeholders particularly PEPFAR and GFATM. The contributions of federal ministries, departments, and agencies (MDAs) and state governments through their State Agencies for the Control of AIDS (SACAs) in providing financial data were invaluable. We wish to thank the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) for funding support for this project study and their agent, Oxford Policy Management (OPM) for their management and coordination role in the study implementation.

Our donors, implementing partners, and service providers are key actors whose work generates the reported data, and this is duly recognized and appreciated. I wish also to recognize and appreciate the painstaking efforts of the international and national consultants whose outputs culminated in this report that is now available for public use.

I also wish to thank the NASA steering committee, technical committee, core team, and staff of the Research, Monitoring & Evaluation Directorate at NACA for their dedication, technical support, and coordination throughout the implementation of this NASA.

Thank you all.

Francis Agbo

**Francis Agbo**
**Acting Director, Research, Monitoring and Evaluation**
**National Agency for the Control of AIDS (NACA)**

# Table of Contents

# List of figures and tables

# Acronyms and Abbreviations

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| ASC | AIDS Spending Category |
| BP | Beneficiary Population |
| CIRAS | Comprehensive, Integrated, Resilient ART System |
| CDC | Centre for Disease Control |
| COVID-19 | Coronavirus disease caused by SARS-Cov-2 virus |
| CSO | Civil society organisation |
| DCF | Data collection form |
| DCT | Data consolidation tool |
| DoD | Department of Defence |
| FAP | Financing Agent-Purchaser |
| FE | Financing Entity |
| FMOH | Federal Ministry of Health |
| FSW | Female Sex Worker |
| GAM | Global AIDS Monitoring |
| GC | Global Centre |
| GDP | Gross Domestic Product |
| GFATM / GF | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GoN | Government of Nigeria |
| HIV | Human Immunodeficiency Virus |
| HQ | Headquarters |
| HR | Human Resources |
| HCT | HIV Counselling and Testing |
| IBBS | Integrated behavioural and biological survey |
| iNGO | International non-governmental organization |
| IP | Implementing Partner |
| KP | Key Populations |
| M&E | Monitoring and Evaluation |
| MOH | Ministry of Health |
| MSM | Men who have Sex with Men |
| NACA | National Agency for the Control of AIDS |
| NASA | National AIDS Spending Assessment |
| NASCP | National AIDS and STDs Control Program |
| NGO | Non-Governmental Organization |
| NGN | Nigerian Naira |
| NHIS | National Health Insurance Scheme |
| OOPP | Out of pocket payments |
| OVC | Orphans and Vulnerable Children |
| P | Price |
| PEP | Post-exposure prophylaxis |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PrEP | Pre-exposure prophylaxis |
| PF | Production Factor |
| PHC | Primary Healthcare |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PR | Principal Recipient |
| PS | Provider of Services |
| PUDR | Performance Update / Disbursement Request |
| PWID | People Who Inject Drugs |
| Q | Quantity |
| REV | Revenue of the Financing Scheme |
| RTT | NASA Resource Tracking Tool |

| | |
|---|---|
| SCH | Financing Scheme |
| SDM | Service Delivery Modality |
| SHIF | Social Health Insurance Fund |
| SHI | Social Health Insurance |
| STI | Sexually Transmitted Infection |
| TA | Technical assistance |
| TB | Tuberculosis |
| TG | Transgender |
| THE | Total Health Expenditure |
| UBRAF | UNAIDS Unified Budget, Results, and Accountability Framework |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# KEY INDICATORS OF HIV SPENDING IN NIGERIA

| Indicator | 2019 | 2020 | 2021 |
|---|---|---|---|
| Total HIV spending in million Naira (NGN) | NGN104,361 | NGN172,063 | NGN174,822 |
| Total HIV spending in million US Dollars (US$) | US$340 | US$482 | US$438 |
| Total spending on HIV in millions of constant dollars (2015 values) | US$365 | US$558 | US$515 |
| Total spending on HIV in current international dollars (PPP)[1] | US$772 | US$1,199 | US$1,122 |
| Public financing as a percentage of total HIV spending (%) | 6.8% | 4.1% | 3.9% |
| Private financing as a percentage of total HIV spending (%) | 0.1% | 0.2% | 0.0% |
| International financing as a percentage of total HIV spending (%) | 93.1% | 95.7% | 96.1% |
| HIV spending as a percentage of GDP (%) | 0.072% | 0.112% | 0.099% |
| Spending on HIV as a percentage of national health spending (%)[2] | 2.40% | 3.30% | n/a |
| HIV spending per capita in dollars | US$1.67 | US$2.31 | US$2.05 |
| Total spending on HIV per PLHIV in US$ | US$189.1 | US$283.6 | US$230.4 |
| HIV Prevention[3] in million US Dollars (US$) | US$9.17 | US$11.76 | US$39.45 |
| HIV Prevention as percentage of total spending (%) | 2.7% | 2.4% | 9.0% |
| HIV testing and counselling (HTC) in million US Dollars (US$) | US$23.57 | US$57.69 | US$50.85 |
| HIV testing and counselling (HTC) as a percentage of total spending (%) | 6.9% | 12.0% | 11.6% |
| HIV care and treatment in million US Dollars (US$) | US$193.98 | US$309.36 | US$261.38 |
| HIV care and treatment as a percentage of total HIV expenditure (%) | 57.0% | 64.2% | 59.7% |
| HIV Prevention spending on key populations (including HIV testing and counselling) in million US Dollars (US$) | US$4.32 | US$10.73 | US$38.80 |
| HIV Prevention spending on key populations, including HIV testing and counselling, as a percentage of total HIV spending (%) | 1.3% | 2.2% | 8.9% |
| Prevention of vertical transmission of HIV infection (PMTCT) including HIV testing and counselling in million US Dollars (US$) | US$4.99 | US$2.74 | US$1.60 |
| Prevention of vertical transmission of HIV infection (PMTCT) including HIV testing and counselling as a percentage of total HIV expenditure (%) | 1.5% | 0.6% | 0.4% |
| Antiretroviral therapy in million US Dollars (US$) | US$105.10 | US$175.64 | US$129.74 |
| Antiretroviral therapy as a percentage of total HIV expenditure (%) | 30.9% | 36.4% | 29.6% |

[1] PPP coefficients retrieved from the World Bank Data for Nigeria. PPP coefficient for 2021 estimated using linear forecast

[2] Nigerian Current Health Spending retrieved from World Health Organization National Health Accounts (NHA) database. Value not available for the year 2021.

[3] Prevention expenditures excluding HTC

# EXECUTIVE SUMMARY

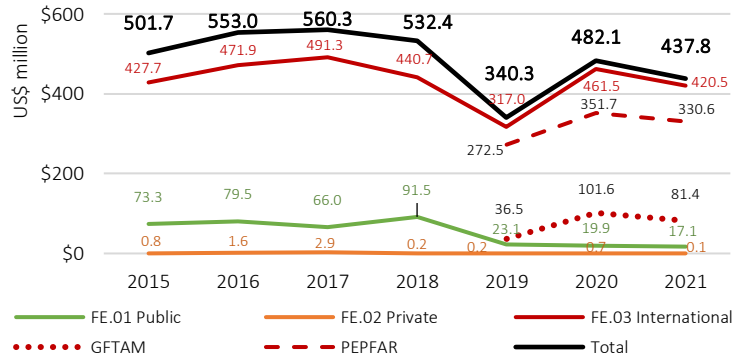
Nigeria faces a significant HIV burden, with an estimated 1.9 million individuals living with the virus in 2021. Key populations bear a disproportionately higher burden. Given the involvement of numerous development and implementing partners, and an expanding HIV response, it is crucial to monitor financial efforts to curb HIV incidence and provide necessary care and treatment. This is essential for the country's progress towards achieving international declarations and goals. To this end, the Government of Nigeria employed the National AIDS Spending Assessment (NASA), a tool designed to track the flow of spending on the final consumption of goods and services in HIV responses worldwide, measuring the spending from its origin to the final beneficiary.

Nigeria has consistently conducted National AIDS Spending Assessment (NASA) exercises, which are crucial for monitoring financial flows and expenditures related to HIV/AIDS programs. These assessments track the country's progress toward achieving international health goals and declarations, such as the Sustainable Development Goals (SDGs) and the UNGASS declarations, alongside major programs like PEPFAR. The first NASA provided baseline data for 2007 and 2008, with the most recent assessment in 2019 evaluating financial trends from 2015 to 2018. This NASA covered the period from 2019 to 2021 and aims to inform global discussions and advocacy efforts by providing vital data on the current state and future needs of HIV/AIDS programs in Nigeria. An attempt to introduce a geographical breakdown (by State) of the HIV expenditure was made for the spending occurred in the year 2021.

Essential commodities like antiretroviral medications for ART and PrEP, HIV tests, CD4 and viral load tests were recorded based on procurement values rather than the value those commodities that were used (i.e.: when the commodities are distributed to the final service provider or consumed by beneficiaries in the implementation of programmes). This presents certain limitations for analysing spending trends.

The assessment revealed that the expenditure to implement HIV response in Nigeria amounted to US$340.3 million in 2019, US$482.1 million in 2020 and US$437.8 million in 2021, which was less than estimated in the previous NASA round – totalling US$560.3 million in 2017 and US$532.4 million in 2018.

*HIV expenditure trends in Nigeria by financing entity, 2015-2021, US$ million*




The key findings of the NASA highlight several critical areas. The majority of HIV funding in Nigeria was provided by international donors, primarily PEPFAR and The Global Fund, indicating a high dependence on external funding. In 2019-2021, PEPFAR funded 80%, 73% and 76% of the country's HIV spending. Financial contribution from The Global Fund amounted to 11%, 21% and 19% of the national HIV expenditure during the study years. UN agencies (UNAIDS, UNICEF, UNDP, UNFPA, WHO and The World Bank) supported 1.18% of the country's HIV spending 2019, 0.85% in 2020 and 0.97% in 2021. Heavy reliance on external funding makes the sustainability and implementation of HIV programs vulnerable to fluctuations in funding levels and priorities from key donors.

In 2019, public financing entities contributed with US$23.1 million, constituting 7% of the total country's HIV spending. However, this figure experienced a decline to US$19.9 million in 2020 and further to US$17.1 million in 2021. Domestic public expenditure on HIV from the central and state governments represented 4% in both 2020 and 2021. One of the largest reductions of the public expenditure was observed in the data reported under NACA's HIV Coordination Programme (HCP), which amounted to over US$5.5 million in 2019, but faced significant decrease in 2020 with only US$0.22 million reported that year and only US$1 million in 2021. Due to the lack of updated information regarding the publicly-funded shared costs within the health sector, this estimate was not included in the current NASA.

There was minimal contribution from domestic private entities to the HIV response. According to the findings, domestic corporations funded only a small portion of the HIV response: 0.04% in 2019 and 0.03% in both 2020 and 2021. Domestic not-for-profit institutions contributed 0.03% in 2019, 0.12% in 2020 and 0.01% in 2021. Out-of-pocket payments were not accounted for in the current NASA, despite Nigeria having high out-of-pocket health expenditure rates.

HIV service provision in Nigeria was primarily distributed between public sector providers, constituting 32% (US$110.4 million), 36% (US$172.1 million), and 32% (US$141.5 million) in 2019, 2020, and 2021, respectively, and private sector non-profit providers, implementing 43% (US$144.8 million), 48% (US$229.6 million), and 49% (US$ 213.0 million) of the country's HIV response during the same period. International NGOs and foundations implemented 24%, 16%, and 18% of the total HIV expenditure in Nigeria, although their seemingly high role in the direct HIV service delivery may be a result of the lack of details in the primary data provided by the organizations-respondents.

The largest programmatic area of HIV expenditure was observed in HIV care and treatment, with US$194.0 million reported under the ASC.03 in 2019, US$309.4 million in 2020 and US$261.4 million in 2021, representing 57, 64 and 60 per cent of the country's HIV spending correspondingly. It was followed by ASC.06 Programme enablers and systems strengthening, which represented 27% of the total HIV spending in 2019 and 14% in both 2020 and 2021, and consecutively – ASC.01 HIV prevention and ASC.02 HIV testing and counselling, which amounted to 3%, 2% and 9% in 2019-2021. Very small amounts went towards development synergies and HIV-related research. Only minimal funding was allocated to development synergies and HIV-related research, with joint totals of US$140,000 in 2019, US$122,000 in 2020, and US$478,000 in 2021.

PEPFAR was the main financing entity for ASC.01 Prevention (94%), ASC.02 HIV testing and counselling (HTC) (90%), ASC.03 HIV Care and Treatment (69%), ASC.04 Social protection and economic support (99%) and ASC.06 Programme enablers and systems strengthening (71%) in 2021. The Global Fund was the main financing source for ASC.08 HIV-related research (100%) in 2021, but for a small nominal amount. It also financed 27% of the country's expenditure on HIV care and treatment, 15% of the Programme enablers and systems strengthening, 13% of the social enablers and 3% of the HIV testing and counselling.

Spending on pre-exposure prophylaxis (PrEP), an important part of HIV prevention, grew exponentially, from only US$44.5 thousand in 2019 to US$23.2 million in 2021, due to an increased investment from PEPFAR.

Nigeria is making progress towards the National HIV/AIDS Strategic Plan (NSP) Target 6 for prevention expenditure; however, spending on HIV prevention programs remains low. Accurate distribution data for HIV commodities and detailed expenditure data from key partners are crucial for effective resource allocation. Government contributions seemed to have met targets for antiretroviral drug purchases, yet the national HIV response heavily relies on international financing agents for managing funds.

People living with HIV (PLHIV) was the main beneficiary group, which represented a substantial portion of the nation's HIV expenditure: 57% (US$194.2 million) in 2019, 64% (US$309.4 million) in 2020, and 60% (US$261.5 million) in 2021. The largest portion of funding for the programmes targeting PLHIV was

financed by international financing entities, particularly PEPFAR and The Global Fund, financing each year 95% or more of these programmes. Expenditure on Key populations, though relatively modest, has shown a consistent increase over the assessment period, rising from just US$4.3 million in 2019 to US$38.8 million in 2021. The rapid increase in spending targeting KP was attributed to the expanding PrEP program, financed by PEPFAR.

The predominant mode of HIV service delivery in Nigeria was facility-based, particularly outpatient services, accounting for 59% (US$201.0 million) in 2019, 73% (nearly US$353.7 million) in 2020, and reduced to 66% (nearly US$289.9 million) of total HIV spending in 2021. Importantly, community-based service delivery, showed a slight increase, representing 6%, 11%, and 13% in 2019, 2020, and 2021, respectively.

For the first time in Nigeria, the NASA team endeavoured to collect and break down HIV expenditure by geographical location, where subnational spending is measured with all the dimensions of the NASA for each individual State. This analysis was only carried out for the year 2021, due to the additional complexity required in the preparation of data by the institutions that provide their spending information, as well as the additional work necessary to process this data by the NASA team. Results show that only 36% of spending could be attributed to the specific state where services are delivered. The challenge of allocating and reporting expenditure according to its geographic location of implementation represented an obstacle for both public and international institutions. This high level of spending not disaggregated by geographic location, impedes meaningful analysis and understanding of resource allocation at the subnational level, critical for co-ordinated, optimal and sustainable planning of the future response.

Based on these findings, the following recommendations are proposed:

It is essential to scale up HIV prevention activities by increasing funding from both central and state governments. Expanding domestic public funding for antiretroviral therapy (ART) is crucial to ensure sustainable access to treatment.

Conduct an in-depth examination of the shared public health systems costs to gain a comprehensive understanding of the value of government’s investments in the HIV response, such as human resources and infrastructure.

It is important to raise awareness among government entities about the significance of comprehensive data submission for effective planning and resource allocation. The private sector should be encouraged to contribute more actively to the HIV response. Exploring the potential role of social health insurance for government employees in providing HIV services could offer additional support. Including HIV-related out-of-pocket expenditure questionnaires in upcoming household surveys will help capture comprehensive spending data.

Future NASA exercises should adopt a consumption-based estimation methodology to provide a more accurate representation of service and program values. Improving the detail and accuracy of data from organizations overseeing extensive HIV programs is also necessary.

It is recommended to improve the granularity of expenditure data in future NASAs, particularly from organizations with extensive HIV programs, and work on disaggregating data from major donors like PEPFAR and the Global Fund. Special emphasis should be placed on disaggregating data from major donors like PEPFAR and the Global Fund to accurately identify financial agents (FAP), service delivery modalities (SDM), service providers (PS), beneficiary populations (BP), and sub-national data (SND).

Finally, continuing to build the technical skills and knowledge of the NASA team is vital for better data collection, analysis, and interpretation. These steps aim to enhance the sustainability and effectiveness of Nigeria's HIV response, ensuring better health outcomes and progress towards ending AIDS by 2030.

Integrating insights from NASA into the formulation of the new National HIV/AIDS Strategic Plan, with robust monitoring mechanisms for implementation at both national and state levels, will streamline efforts and enable thorough financial gap analysis. These steps aim to enhance the sustainability and effectiveness of Nigeria's HIV response, ensuring better health outcomes and progress towards ending AIDS by 2030.

# INTRODUCTION

Nigeria has a long history of conducting National AIDS Spending Assessment (NASA) exercises to track financial flows and expenditures related to HIV/AIDS programs. The upcoming NASA is scheduled to cover the period of 2019 to 2021 and will serve as a crucial monitoring mechanism for the country's progress towards achieving international declarations and goals, such as the Sustainable Development Goals (SDGs), the United Nations General Assembly Special Session (UNGASS) declarations, and major bilateral programs like the President's Emergency Plan for AIDS Relief (PEPFAR).

The data generated from this assessment is critical to inform global discussions and advocacy efforts about the current status of HIV/AIDS programs and the estimated future needs for such programs. The country's first NASA served as a baseline for the years 2007 and 2008, while the most recent one in 2019 tracked financial flows and expenditure trends for the years from 2015 to 2018.

# 1. SCOPE OF THE NATIONAL AIDS SPENDING ASSESSMENT

The National AIDS Spending Assessment is a tool developed to track the flow of spending on the final consumption of goods and services in HIV responses worldwide. It measures the flow of spending from its origin to the final beneficiary and includes nine classifications to describe expenditure, activities, and organisations involved in the national HIV response.

This round of the National AIDS Spending Assessment in Nigeria tracks HIV expenditure in three calendar years, 2019, 2020 and 2021, across all NASA vectors and dimensions: financing schemes (SCH), revenues of the financing schemes (REV), financing entities (FE), financing agents-purchasers (FAP), providers of services (PS), production factors (PF), AIDS spending categories (ASC) and service delivery modalities (SDM).

This NASA assessment provides answers to the following questions regarding past expenditure:

- Who paid for HIV services in Nigeria?
- What mechanisms were in place to provide resources to financing schemes?
- What were the modalities through which populations access services?
- Who pooled funds and purchased HIV services?
- Who were the providers of HIV services?
- What HIV services were provided, what was spent on them, and what service delivery modes were being used?
- Who were the beneficiaries of HIV spending?
- What were the key cost drivers of HIV spending?

An attempt to introduce a geographical breakdown (by State) of the HIV expenditure was made for the spending occurred in the year 2021. All HIV expenditures are presented in United States dollars (US$).

NASA aimed at including all relevant entities involved in financing or implementation of the HIV response in Nigeria (please refer to ANNEX 4. LIST OF ORGANISATIONS REPORTING TO NASA 2019-2021). Although response rates were low (around half of the contacted organisations responded with data – refer to Annex 2.2 RESPONSE RATE for details), we successfully captured the vast majority of resources financing the HIV response. This was achieved by collecting data directly from the largest financing entities and purchasing agents. Therefore, even if some institutions failed to report, we still obtained their data in most cases through top-down reporting.

Due to the scarcity of data out-of-pocket expenditure analysis and publicly funded HIV shared health system cost were not included in this NASA. Additionally, the NHIS did not report data for this

assessment regarding covered HIV-related services. See the Annex 1 and 2 for more details on data collection, methods and limitations.

# 2. COUNTRY CONTEXT

## 2.1. HEALTH SYSTEM STRUCTURE AND HEALTH FINANCING

Nigeria faces significant health challenges despite being Africa's largest economy, with widespread poverty, health inequities, and high out-of-pocket healthcare costs. The Nigerian healthcare system faces multifaceted challenges, reflecting the broader socio-economic and infrastructural complexities of the country[4]. The system is decentralized, with states wielding considerable autonomy, resulting in variations in healthcare quality and accessibility.

Infrastructure deficits, including inadequately equipped health facilities and insufficient medical personnel, contribute to healthcare inequities. Urban areas generally possess better-equipped facilities and a higher concentration of healthcare professionals compared to rural regions[5].

Nigeria's health financing landscape is characterized by a mix of public and private funding sources. The National Health Insurance Scheme (NHIS) aims to provide financial risk protection and improve access to quality healthcare. However, its coverage remains limited, and achieving universal health coverage faces substantial challenges[6]. The quest for universal health coverage in Nigeria has resulted in the development of various laws, policies, plans, and strategies to expand coverage, improve access, and address implementation challenges. Accordingly, the National Health Insurance Authority (NHIA) Act was signed into law on May 19, 2022, addressing many of its inherent challenges. Basic benefit package now includes ART, HIV testing and opportunistic infections treatment.

Public healthcare funding is often insufficient, leading to operational constraints, including drug stockouts and inadequate infrastructure maintenance[7]. Budgetary allocations to the health sector require substantial augmentation to meet the population's diverse healthcare needs. External funding from organizations like the World Bank and international health initiatives like GAVI complements domestic efforts. In the context of HIV/AIDS, support from PEPFAR and the Global Fund is vital for scaling up prevention, treatment, and care services.

National Agency for the Control of AIDS through the Federal Ministry of Health places emphasis on prevention, care and treatment, social support and health systems strengthening, including health governance, health financing and resource mobilization. Health financing is always part of the policy agenda of government authorities around the world. Health financing includes the “mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system” and has two goals: “to raise sufficient funds and ... provide financial risk protection to the population”.

[4] World Bank. (2024). Country Profile: Nigeria.
[5] Knight Frank. (2020). Healthcare in Africa – 2020 report. Available at: https://www.knightfrank.ae/research/healthcare-in-africa-2020-7198.aspx
[6] Alawode, G.O., Adewole, D.A. Assessment of the design and implementation challenges of the National Health Insurance Scheme in Nigeria: a qualitative study among sub-national level actors, healthcare and insurance providers. BMC Public Health 21, 124 (2021). https://doi.org/10.1186/s12889-020-10133-5
[7] Abubakar I et al. The Lancet Nigeria Commission: investing in health and the future of the nation. Lancet. 2022 Mar 19;399(10330):1155-1200. doi: 10.1016/S0140-6736(21)02488-0. Epub 2022 Mar 15. PMID: 35303470; PMCID: PMC8943278. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8943278/

## 2.2. EPIDEMIOLOGICAL CONTEXT AND HIV RESPONSE

Nigeria grapples with a considerable HIV burden, with 1.9 million individuals living with the virus in 2021, as per UNAIDS estimates.

The overall HIV prevalence within the general population, aged 15-49, stands at 1.3%[8]. However, this figure undergoes significant variation across diverse population groups and geographical locations[9]. Notably, key populations (KPs) bear a disproportionately higher burden, exemplified by brothel-based female sex workers reporting a prevalence of 15% in 2020. Among men who have sex with men, HIV prevalence has seen an upward trajectory from 13.50% in 2007 to 25% in 2020. Conversely, people who inject drugs witnessed fluctuating prevalence rates, moving from 5.6% in 2007 to 3.4% in 2014, only to rise to 10.9% in 2020. The transgender population experienced a prevalence of 29% in 2020, as documented by data from various years[10].

Mother-to-child transmission remains a considerable concern, contributing to paediatric HIV cases. Efforts to prevent transmission during childbirth and breastfeeding constitute essential components of the response.

The national response framework comprises a comprehensive roadmap aligning with global goals, including the UNAIDS 90-90-90 targets. Prevention strategies encompass safer sexual practices promotion, harm reduction for substance users, and educational campaigns to reduce stigma. Condom distribution and advocating for HIV testing are important components.

Antiretroviral treatment efforts focus on early diagnosis, linkage to care, and retention in treatment programs. As of 2021, an estimated 1.9 million people in Nigeria were infected with HIV. Ninety-four percent of them, equal to 1.79 million people, were receiving ART. Between 2010 and 2021, the share of people on ART grew consistently.

In 2019 the CDC and the State Ministries of Health, and other partners initiated the Surge initiative to boost testing and treatment access for people living with HIV in 19 states, supported by the CIRAS (Comprehensive, Integrated, Resilient ART System) platform. As a result, the Nigeria HIV treatment Surge increased the number of people with HIV on treatment in these 18 states from 454,000 in 2019 to 903,000 in 2021 – in essence doubling the number of people on treatment in just two years.

The financial sustainability of the HIV response in Nigeria faces a variety of challenges, including heavy reliance on donor funding, a low level of domestic funding, and a low level of private-sector financing. In an effort to improve financing sustainability, integrating HIV testing and treatment services into social health insurance schemes has been slow due to concerns over the high cost of antiretroviral drugs[11].

[8] Nigerian HIV/AIDS Indicator and Impact Survey, 2018.
[9] National Agency for the Control of AIDS (NACA). (2019). Revised National HIV and AIDS Strategic Framework 2019-2021. Available at: https://naca.gov.ng/nigeria-prevalence-rate/
[10] FMOH 2007, 2010, 2014, 2020
[11] Ogbuabor D, Olwande C, Semini I, Onwujekwe O, Olaifa Y, Ukanwa C. Stakeholders' perspectives on the financial sustainability of the HIV response in Nigeria: a qualitative study. Glob Health Sci Pract. 2023;11(2):e2200430. https://doi.org/10.9745/GHSP-D-22-00430

# 3. NASA RESULTS

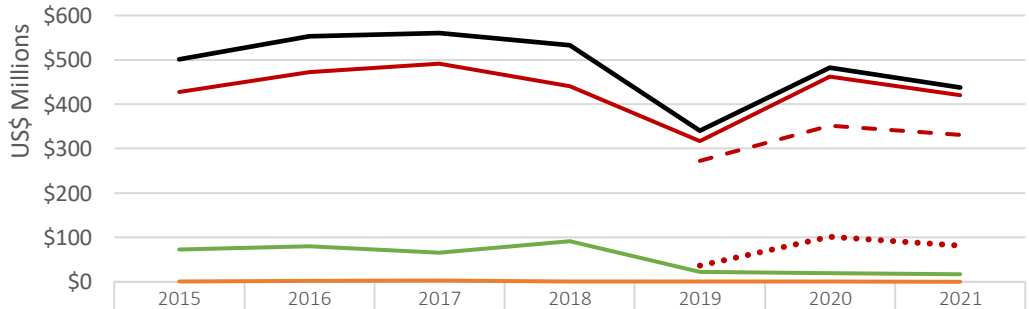
## 3.1. TRENDS IN HIV EXPENDITURE

Expenditure on HIV in Nigeria consistently exceeded US$500 million until 2018. Notably, there was a 36% decline from the 2018 financing levels, observed in both international funding and public sources (see Figure 1).

It is worth mentioning that previous NASA reports[12] included estimates of the government expenditure on human resources for HIV health services in Nigeria. These represented a significant portion of domestic public spending, adding up to approximately US$70 million annually (see section 2.7. for more details). This is the main reason for the apparent decline in the HIV domestic public spending in this assessment compared to the previous NASA exercises. While the MOH has continued to contribute these costs to the HIV response, future efforts are required to better measure them and incorporate them in the next NASA.

Findings of this NASA report confirmed that there is still a high[13] dependency on donor resources for the implementation of the national HIV/AIDS response in Nigeria. In 2018, 83% of the resources came from international financing entities. For the years 2019, 2020, and 2021, this figure was 93%, 96%, and 96%, respectively. As mentioned above, the absence of HIV-related human resources expenditure in the health sector reduced the amount of public financing for the 2019-2021 results. However, it's important to highlight that even if public expenditure levels in 2019-2021 had matched those recorded in 2018, the profile of the national response would still show a high dependence on international donors to finance HIV response in Nigeria[14].

*Figure 1. HIV expenditure trends in Nigeria by financing entity, 2015-2021, US$ million*




| | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| FE.01 Public | 73,299,196 | 79,543,466 | 66,045,257 | 91,477,782 | 23,110,492 | 19,869,076 | 17,106,073 |
| FE.02 Private | 760,194 | 1,559,340 | 2,936,398 | 197,273 | 236,616 | 732,884 | 146,480 |
| FE.03 International | 427,677,071 | 471,936,348 | 491,314,743 | 440,696,444 | 316,989,764 | 461,462,928 | 420,504,065 |
| GFTAM | | | | | 36,504,534 | 101,554,554 | 81,445,795 |
| PEPFAR | | | | | 272,460,166 | 351,681,244 | 330,641,645 |
| Total | 501,736,461 | 553,039,154 | 560,296,399 | 532,371,499 | 340,336,872 | 482,064,889 | 437,756,619 |

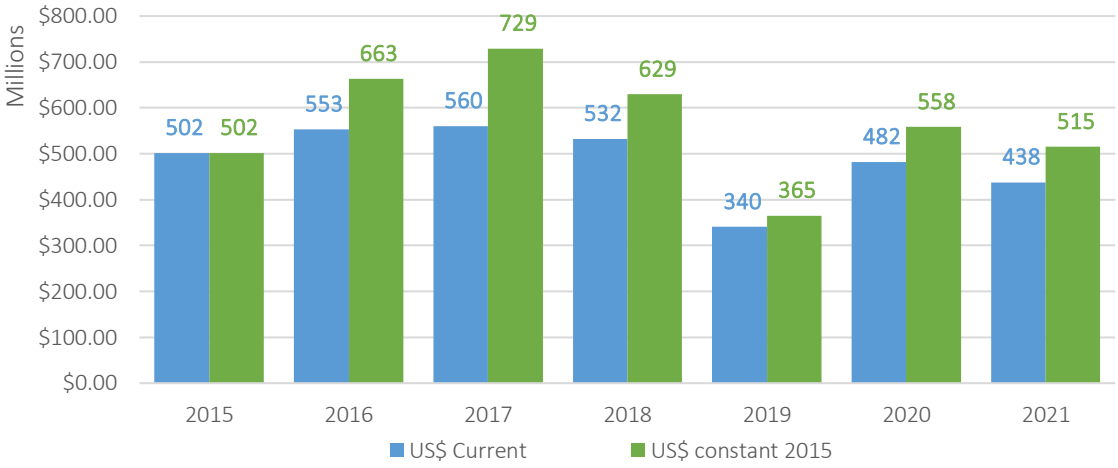
[12] National AIDS Spending Assessment (NASA) for the period: 2015 – 2018. Level and flow of resources and expenditures of the national HIV and aids response. Published in 2019.

[13] What is considered high dependency on donor funding is not represented by a specific value and relates to several variables. Lensink and White (1992) define it as exceeding 30%, while UNAIDS in its 2012 global report identifies it as higher than 75%. Another aspect of high dependency is when donors have a significant influence on health policy. High dependency is also considered in terms of sustainability risk. If the withdrawal of donor funds would significantly disrupt the delivery of essential health services or the ability of the health system to function, the dependency level is considered high. Lastly, High dependency can also be characterized by reliance on a small number of donors for a significant portion of health sector funding.

[14] Assuming public funding in 2019-2021 remained at 2018 levels ($91 million), international contributions would still constitute 78%, 83%, and 82% of total funding for those years, respectively.

Figure 2 shows the trend in spending taking into constant dollars, to accurately compare the real growth or decline in spending over time, without the distortions caused by inflation.

*Figure 2. HIV expenditure in current and constant US$ millions*




The values expressed in constant 2015 dollars maintained the spending trend during the analysed period in relation to the values expressed in current dollars. It's important to note the dollar's decreasing purchasing power in Nigeria since 2015. According to World Bank data, US$1 in 2015 was equivalent to US$1.07 in 2019, US$1.16 in 2020, and US$1.18 in 2021[15].

## 3.2. FUNDING FLOWS: FROM FINANCING ENTITIES TO SERVICE PROVIDERS

Figure 3 schematically outlines the resource flows in the HIV response in Nigeria in 2021. The diagram allows us to see how resources flow between financing entities, agents-purchasers, and providers. As we can observe, the primary resource flows come from international financing entities, PEPFAR and the Global Fund, and are managed by bilateral agencies and international NGOs. These financing agents-purchasers channel funds to public hospitals and clinics as well as national and international non-profit organizations based in the country. The predominant flows are associated with funding from the US government through PEPFAR, signifying a substantial majority of the bilateral organizations as the financing source for the HIV response (99% or more of bilateral financing came from the US government in the years of this study).

[15] The World Bank, World Development Indicators (Dec-2023). GDP per capita (constant 2015 US$) and GDP per capita (current US$). Retrieved from https://data.worldbank.org/country/NG

*Figure 3. Resource flows Financing entities (FE) – Financing agents-purchasers (FAP) – Providers of services (PS)*

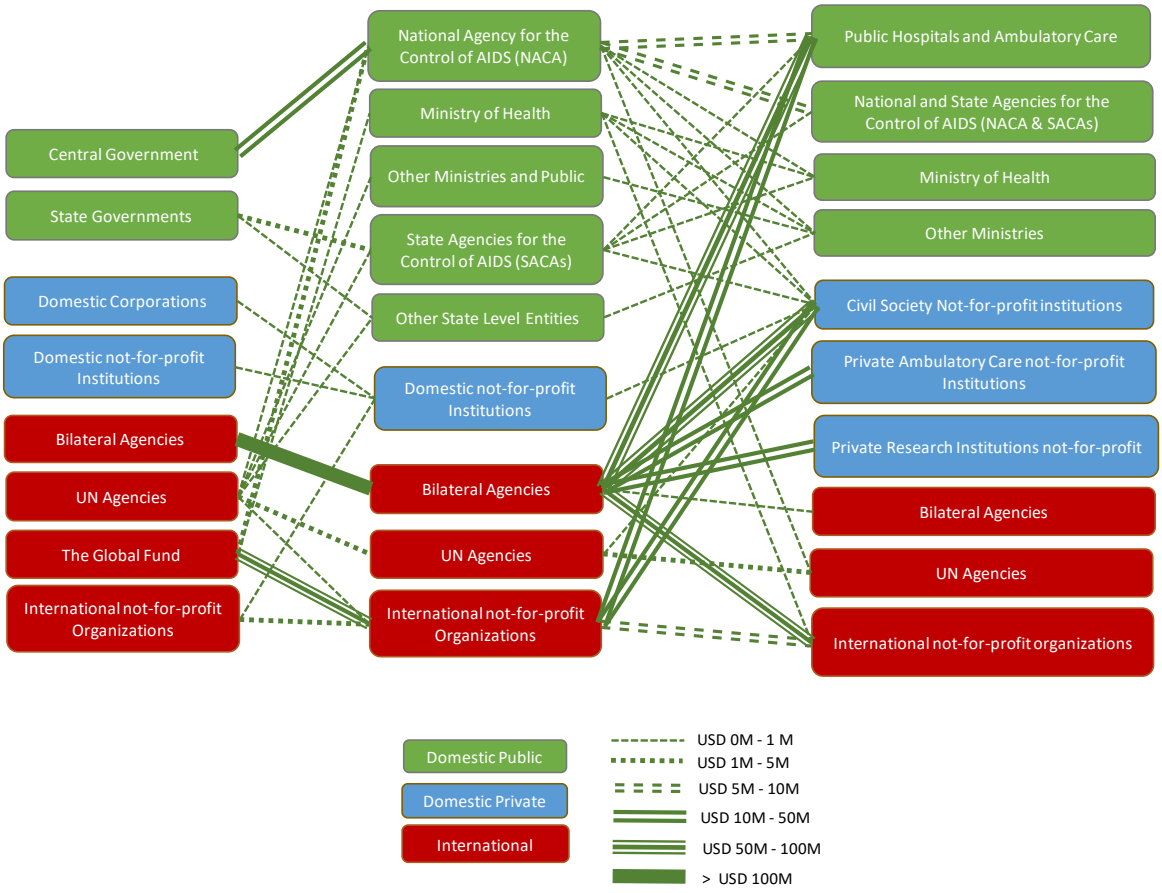
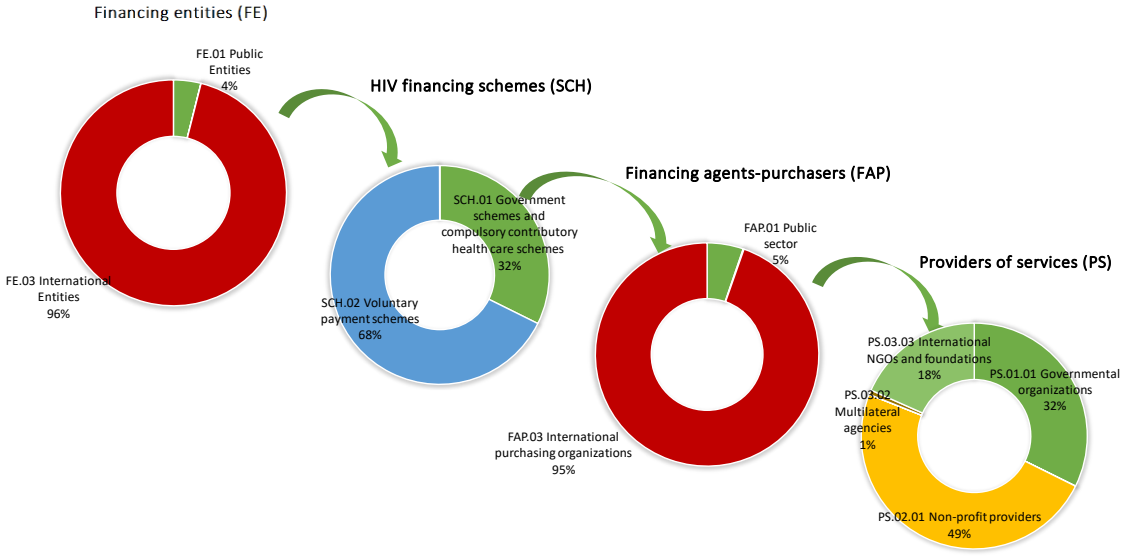



Figure 4Error! Reference source not found. illustrates the flow of resources for the year 2021, expressed in relative values, from financing entities through specific financing schemes, managed by various financing agents-purchasers. These agents select providers of services and transfer financial and/or in-kind resources to them to implement HIV programs.

*Figure 4. Resource flows Financing entities (FE) – HIV Financing schemes (SCH) - Financing agents-purchasers (FAP) –– Providers of services (PS)*



The funds that finance the response mainly came from international financing entities to finance voluntary and government schemes, and were mostly managed by international financing agents-purchasers.

## 3.3. NASA DIMENSION: FINANCING

This section includes the analysis of the expenditure by financing entity (FE), HIV financing scheme (SCH), source of revenue of the scheme (REV) and financing agent-purchaser (FAP).

### 3.3.1. Financing entities (FE)

International financing entities played a prominent role in Nigeria's national HIV response: their contribution in the overall HIV expenditure amounted to US$316.9 million in 2019, US$461.5 million in 2020 and US$420.5 million in 2021. The share of international financing entities in total HIV spending reached nearly 93% in 2019 and expanded further to 96% in both 2020 and 2021 (see Figure 5, Figure 6)[16].

*Figure 5. Financing entities (FE) (1st digit) of the HIV expenditure in Nigeria in2019-2021, US$ million*

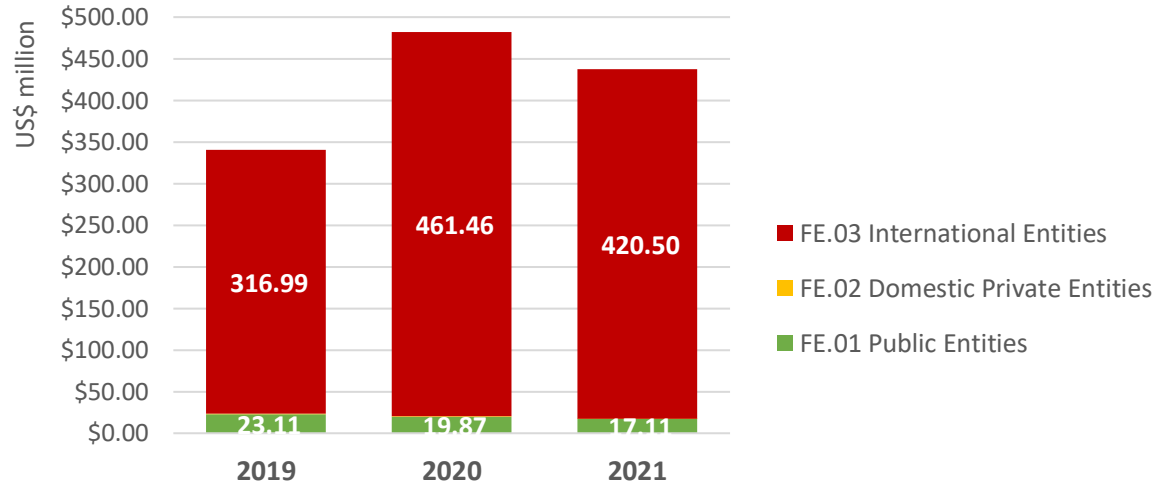
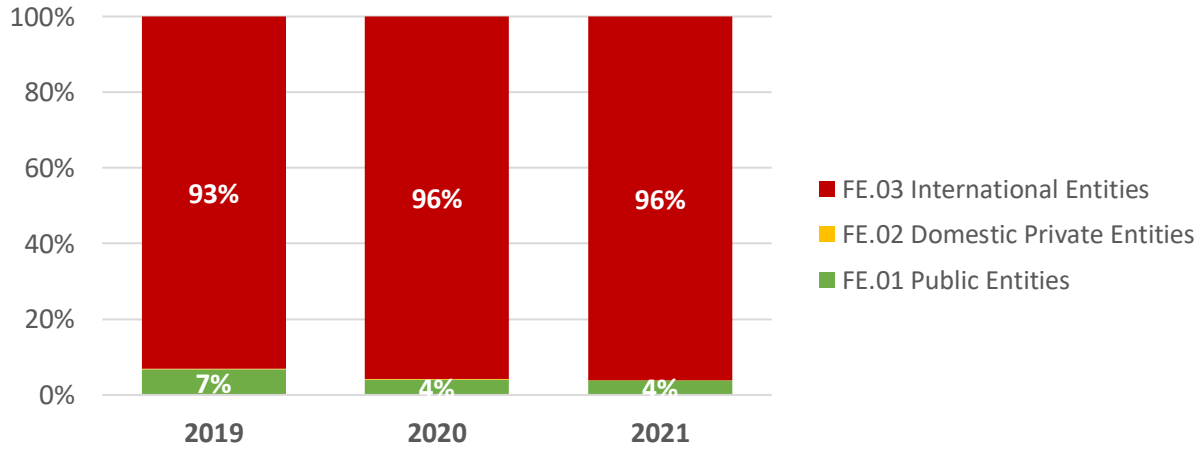



*Figure 6. Financing entities (FE) (1st digit) of the HIV expenditure in Nigeria in 2019-2021, %*




[16] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated.

A detailed analysis of financing entities (Table 7 in the Annex 3) underscores that the United States government (USG), through PEPFAR, stands as the predominant donor in Nigeria. In 2019, their contribution accounted for 80% of the country's total HIV spending, amounting to US$272.5 million. In the period under review, PEPFAR investment in the HIV response peaked in 2020 at US$351.7 million and dropped to US$330.7 million in 2021, representing 73% and 76% of the country's total HIV expenditure respectively.

Multilateral organizations, including GFATM, UN agencies, and the World Bank, constituted 12% of the total spending (US$40.6 million) in 2019. This figure more than doubled in 2020, reaching US$106.2 million, and decreased by US$20 million to US$86.0 million in 2021, contributing 22% and 20% in each year. It is worth mentioning that GFATM was the largest multilateral financing entity, contributing to 90% or more of the total multilateral funding each year.

In 2019, public financing entities contributed with US$23.1 million, constituting 7% of the total country's HIV spending[17]. However, this figure experienced a decline to US$19.9 million in 2020 and further to US$17.1 million in 2021. By 2021, public financing entities represented 4% of the total HIV spending. The majority of governmental spending originated from the central government, while state governments contributed approximately a tenth of the central government's investment: US$2.5 million in 2019, US$2.6 million in 2020 and US$1.7 million in 2021. From the state level governmental which submitted data, 16 reported spending financed by the state government (13 SACAs and 3 state-level ministries).

One of the largest reductions of the public expenditure was observed in the data reported under NACA's HIV Coordination Programme (HCP), which amounted to over US$5.5 million in 2019, but faced significant decrease in 2020 with only US$0.22 million reported that year and only US$1 million in 2021. Another area where NACA's expenditure declined was The West African Countries Response Programme (WACRP), an HIV/AIDS prevention project along the Lagos-Abidjan corridor (ALCO), totalling almost US$0.5 million in 2019, but reporting US$0.08 million in 2020 and US$0.07 million in 2021.

Other significant fluctuations on public funding were also observed in the procurements of HIV tests, where public expenditure comprised US$0.7 million in 2019, US$9.1 million in 2020 and US$0.3 million in 2021, and antiretroviral (ARV) drugs, with the reported public expenditure of US$6.2 million in 2019, US$4.0 million in 2020 and US$8.0 million in 2021.

The contribution of domestic private entities remained small, amounting to US$0.24 million in 2019, US$0.73 million in 2020, and reaching its lowest in 2021 with only US$0.15 million. The domestic private expenditure compiled was reported by 15 non-profit organisations that contributed data to the study, citing private sector donations as sources of funding for their activities.

According to a report of the African Philanthropy Forum from 2023[18], there are over 3,700 nonprofits around the country focused on education, health, environment, gender, agriculture, social protection, youth, poverty, good governance, and other areas of progressing national development. It also indicates that private foundations are the most common type of foundation in Nigeria and are more likely to use direct giving to support causes than other types of foundations. Corporate foundations are the second most common type of foundation and are more likely to use corporate sponsorships to support causes.

[17] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated.

[18] Scanning the philanthropy ecosystem in Nigeria. African Philanthropy Forum, 2023. Available at: https://africanpf.org/wp-content/uploads/2023/11/Scanning-the-Philanthropy-Ecosystem-in-Nigeria.pdf

Considering this information, it is reasonable to assume that the actual expenditure financed by the private sector entities may have been higher than what was recorded in this NASA.

While there are no specific studies detailing the OOPP for HIV treatment and prevention in Nigeria, it's important to highlight that the World Health Organization (WHO) identifies Nigeria as having the highest out-of-pocket expenditure rate in West Africa as a share of current health expenditure (CHE). In 2020, this expenditure accounted for an estimated 75% of CHE[19]. Therefore, it's reasonable to expect that even with ART being provided for free, households still incur OOPP for HIV in the country. If studies are conducted in the future to estimate these expenses, it will be possible to incorporate them into future NASA analyses.

### 3.3.2. HIV financing schemes (SCH)

A financing scheme represents the mechanisms through which funds are collected, pooled, and allocated to cover the health needs of the population. Given the constraints in data, accurately pinpointing the financing scheme was a complex task. Nonetheless, the outcomes revealed two predominant financing schemes in the Nigerian HIV Response (**Figure 7**, Figure 8). The category of voluntary payment schemes included resident foreign agency schemes as well as not-for-profit organizations.

*Figure 7. Financing schemes (SCH) of the HIV response in Nigeria (1st digit) in 2019-2021, US$ million*

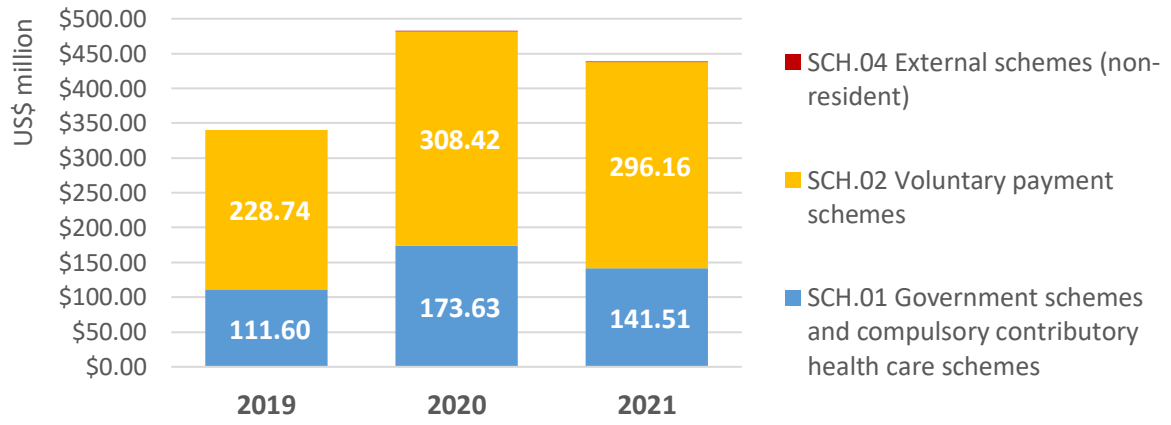
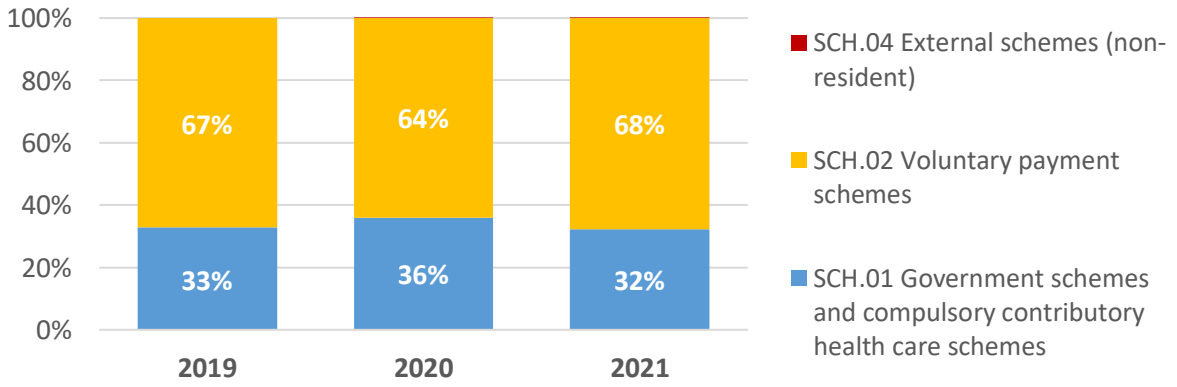



*Figure 8. Financing schemes (SCH) of the HIV response in Nigeria (1st digit) in 2019-2021, %*

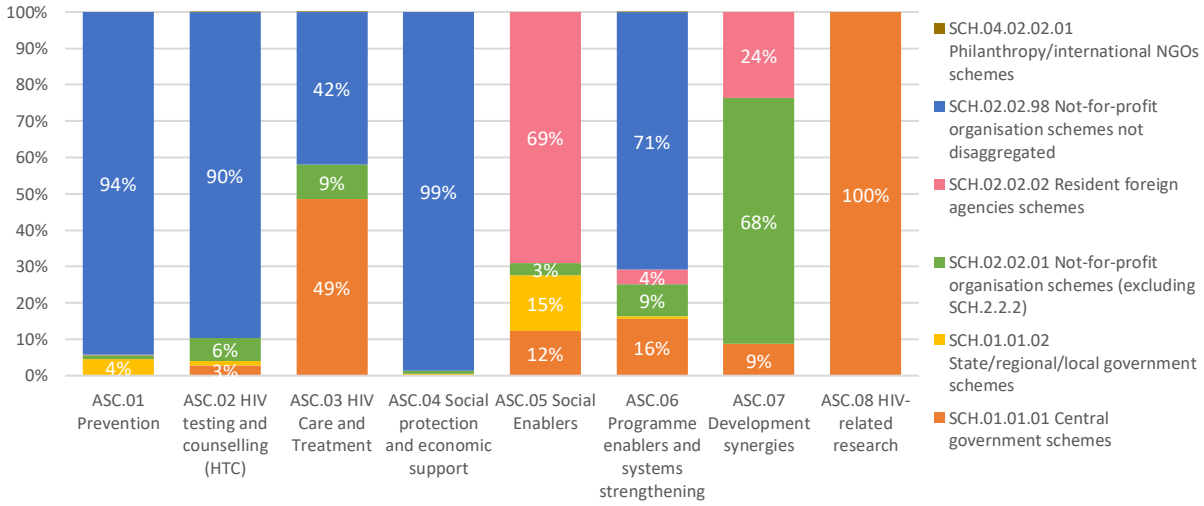



[19] World Health Organization. Global Health Expenditure Database. Accessed in March 2024. https://apps.who.int/nha/database.

Voluntary payment schemes constituted 67% of the national HIV response in 2019, 64% in 2020, and 68% in 2021. On the other hand, government schemes, central and state-level, accounted for 33% in 2019, 36% in 2020, and 32% in 2021[20].

Both these schemes are notably influenced by expenditures on ASC.03 HIV Treatment and Care. Figure 9 illustrates the scheme distribution of key ASCs, with SCH.01.01.01 Central government schemes comprised nearly half of ASC.03 and SCH.02.02.98 Not-for-profit organisations schemes not disaggregated constituted 42%[21]. Furthermore, SCH.02.02.98 Not-for-profit organisations schemes not disaggregated made up 94% of ASC.01 HIV Prevention, 90% of ASC.02 HIV Testing and Counselling, 99% of ASC.04 Social protection and economic support, and 71% of ASC.06 Programme enablers and systems strengthening.

*Figure 9. Financing schemes (SCH) of the 1st digit AIDS spending categories (ASC) in 2021, %*

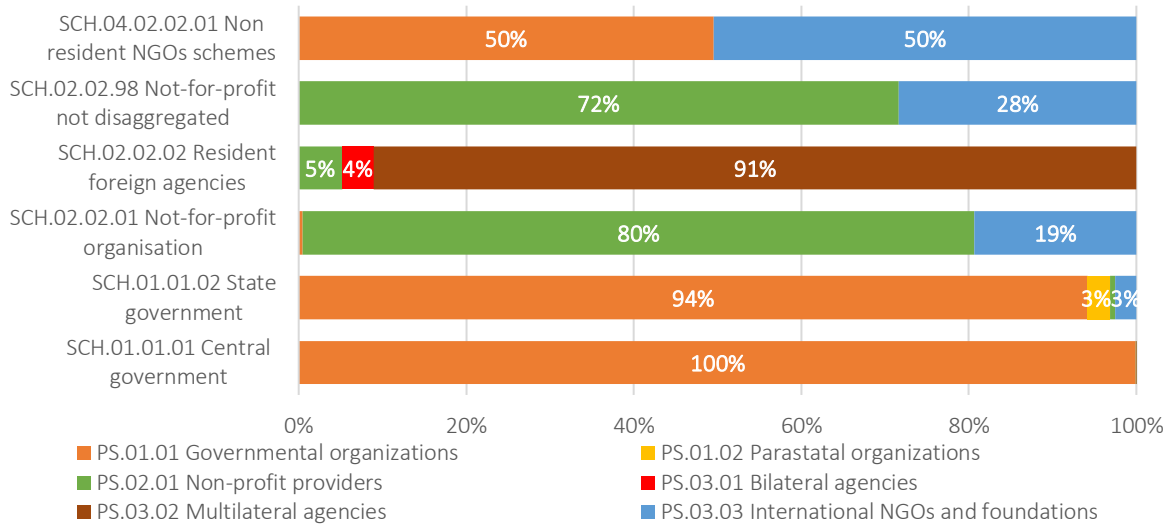



Data shows that 100% of service delivery within the central government scheme were executed by public sector providers (**Figure 10**). In contrast, within the non-profit and resident foreign agencies scheme, service delivery was distributed between private sector providers and bilateral and multilateral organizations.

[20] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report- thus Public Financing is underestimated. Including this expenditure in the study would increase the share of the governmental scheme.

[21] The code SCH.02.02.98 exclusively captures PEPFAR funds. More info at: ANNEX 2. ASSUMPTIONS AND LIMITATIONS 2.9.1 Identifying PS and SCH code.

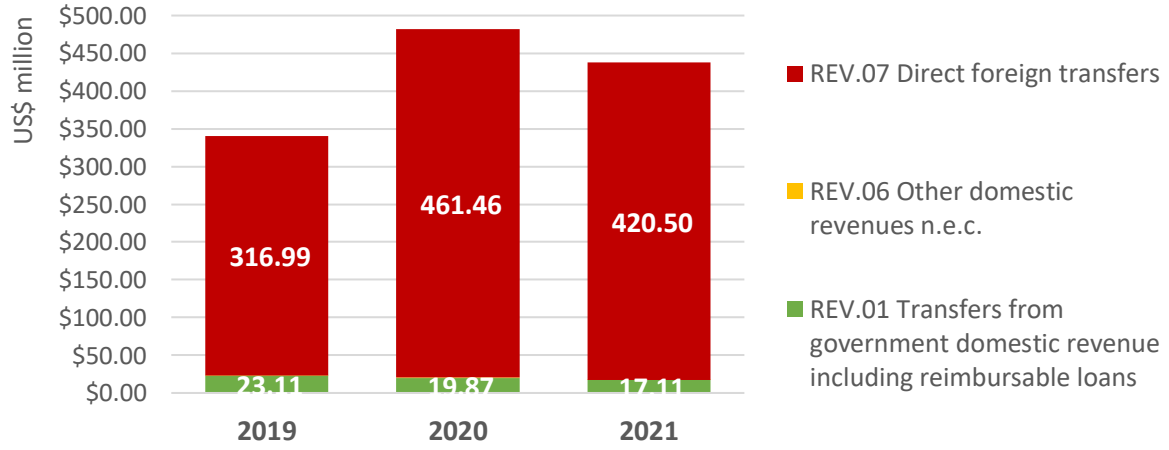
*Figure 10. Providers of services (PS) of the HIV financing schemes (SCH) in 2021, %*




### 3.3.3. Sources of revenue (REV)

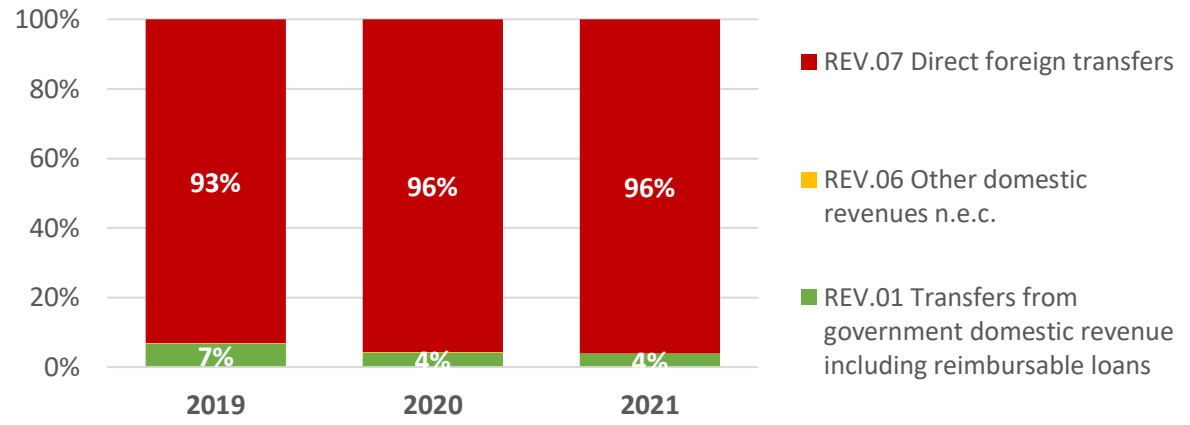
The principal revenue sources for the HIV response in Nigeria were direct foreign transfers reflecting the large contributions from international financing entities (Figure 11, Figure 12).

*Figure 11. Sources of revenues (REV) of the Financing schemes in 2019-2021, US$ million*



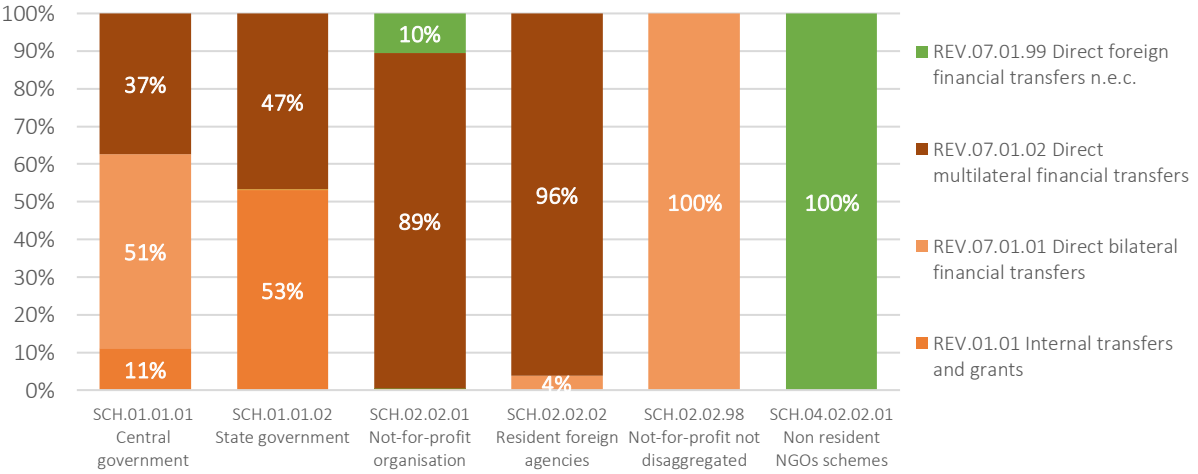

In 2019, direct foreign transfers comprised 93% of the total national expenditure on HIV, rising to 96% by 2021 (see Figure 12).

*Figure 12. Sources of revenues (REV) of the Financing schemes in 2019-2021, %*




In 2021, revenues from internal transfers and grants[22] represented 11% of the central government schemes and 53% of the state government schemes (**Figure 13**). Fifty-one percent of the central government scheme was financed through the direct bilateral financial transfers, indicating high reliance of the HIV response on the external funding.

*Figure 13. Sources of revenues (REV) of the financing schemes (SCH) of the HIV expenditure in Nigeria, 2021, %*

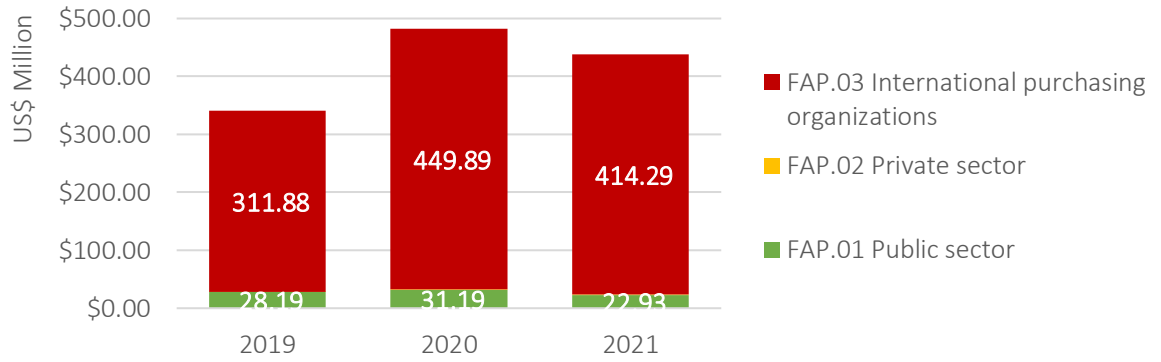



### 3.3.4. Financing agents-purchasers (FAP)

While financing entities (FE) make resources available for the country's HIV response, financing agents-purchasers (FAP) are responsible for collecting and managing revenues from financing sources. They oversee financing schemes, make programmatic decisions, manage procurements, and select service providers. Spending by FAP type is presented in Figure 14 and Figure 15, with international agents-purchasers having managed 92, 93 and 95 per cent of the HIV expenditure in Nigeria in 2019, 2020 and 2021 respectively.

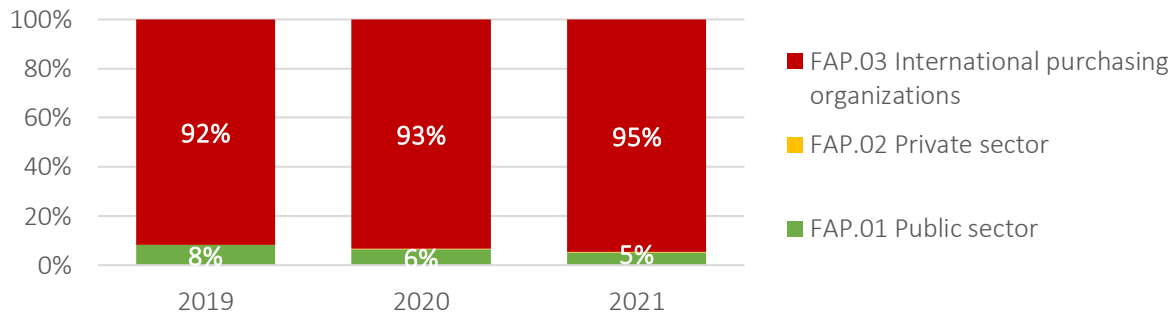
[22] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated. Including this expenditure in the study would increase the share of the transfers from government domestic revenue (REV.01).

*Figure 14. Financing agents-purchasers (FAP) of the HIV response in Nigeria in 2019-2021, US$ million*




In the public sector, FAPs were represented by various federal and state-level ministries and agencies, which managed 8%, 6% and 5% of the HIV expenditure in Nigeria from all sources in 2019, 2020 and 2021 respectively.

*Figure 15. Financing agents-purchasers (FAP) of the HIV response in Nigeria in 2019-2021, %*




Among the public FAPs, the National Agency for the Control of AIDS (NACA) stood out as the largest, managing 6.3% of the HIV response in 2019, 4.6% in 2020 and 4.5% in 2021 (**Table 8** in the Annex 3). NACA emerged as the most significant FAP for public financing (FE.01), administering 86% or more of the annual public financing for the years under review. On the other hand, NACA's role in managing international financing was minimal, handling 1% or less of the total international financing (FE.03), mostly coming from The Global Fund, for which NACA is one of the Principal Recipients.

The majority of HIV funding was administered by US agencies (country offices of bilateral agencies), who are responsible for overseeing the contributions from PEPFAR. They managed 80.0% of the HIV response in 2019, 72.9% in 2020 and 75.5% in 2021.

In its role of the GFATM's Principal Recipient, FHI 360 emerged as another pivotal FAP in Nigeria, overseeing nearly 10% of total HIV expenditure in 2019, 19% in 2020 and 18% in 2021 (US$32.7 million, US$91.6 million and US$77.0 million respectively).

Private sector financing agents-purchasers were represented by not-for-profit institutions, which managed 0.08% the total HIV spending in 2019, 0.20% in 2020 and 0.12% in 2021.

## 3.4. NASA DIMENSION: PROVISION

### 3.4.1. Providers of services (PS)

In Nigeria, HIV service provision was primarily distributed between public sector providers, constituting 32% (US$110.4 million), 36% (US$172.1 million), and 32% (US$141.5 million) in 2019, 2020, and 2021, respectively, and private sector non-profit providers, implementing 43% (US$144.8 million), 48% (US$229.6 million), and 49% (US$ 213.0 million) of the country's HIV response during the same period. International NGOs and foundations implemented 24%, 16%, and 18% of the total HIV expenditure in Nigeria (see **Figure 16** and **Figure 17**).

*Figure 16. Providers of services (PS) of the HIV response in Nigeria in 2019-2021, US$ million*

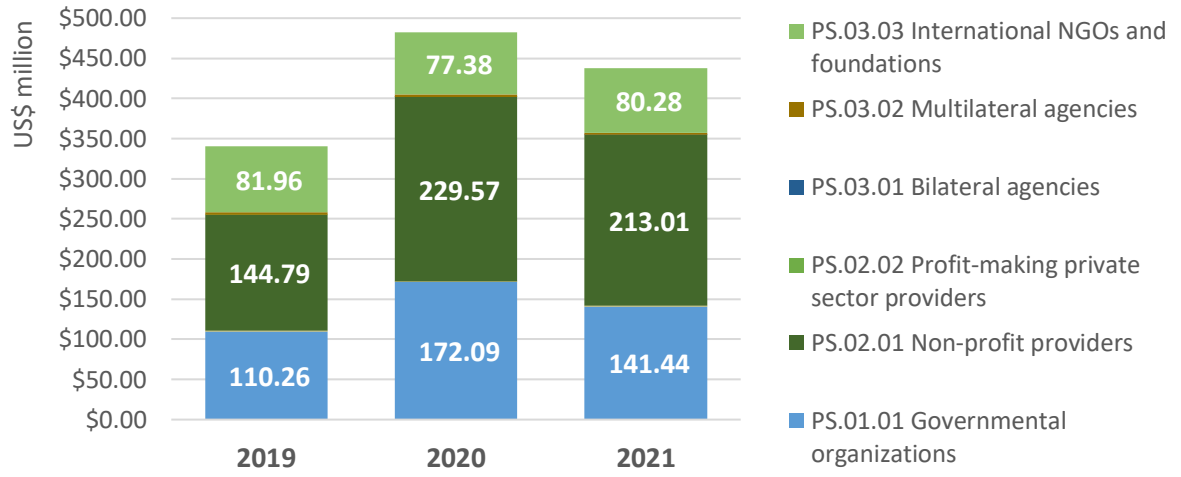
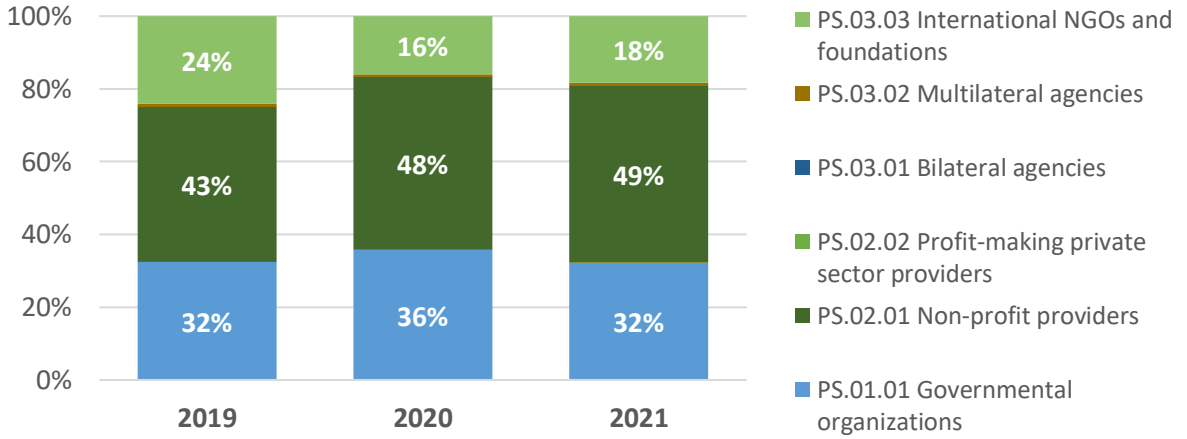



*Figure 17. Providers of services (PS) of the HIV response in Nigeria in 2019-2021, %*




A more detailed breakdown of the HIV expenditure by provider of services reveals that the majority of governmental service providers were not disaggregated by type.

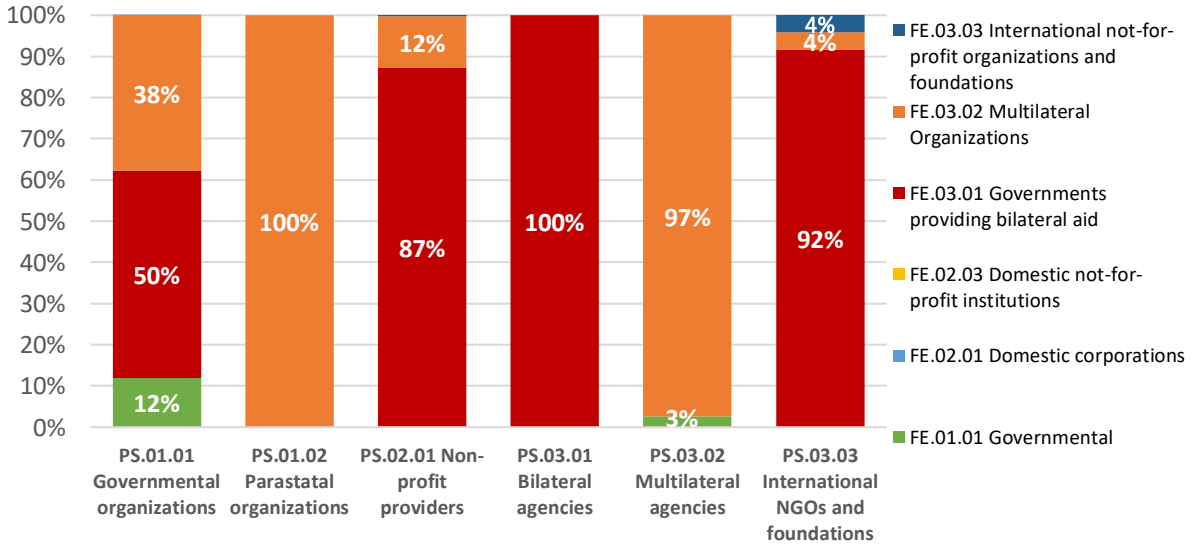
| Providers of services (PS) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **PS.01 Public sector providers** | **110,374,165** | **32.43%** | **172,108,991** | **35.70%** | **141,528,319** | **32.33%** |
| **PS.01.01 Governmental organizations** | **110,261,309** | **32.40%** | **172,085,275** | **35.70%** | **141,443,186** | **32.31%** |
| PS.01.01.02 Ambulatory care (public) | 9,899,619 | 2.91% | 14,790,493 | 3.07% | 10,378,848 | 2.37% |
| PS.01.01.13.01 National AIDS Coordinating Authority (NACs) | 12,653,966 | 3.72% | 8,244,800 | 1.71% | 10,747,002 | 2.46% |
| PS.01.01.13.02 Departments inside the Ministry of Health or equivalent | 1,068,645 | 0.31% | 873,962 | 0.18% | 230,116 | 0.05% |

| | | | | | | |
|---|---|---|---|---|---|---|
| PS.01.01.13.99 Government entities n.e.c. | 93,263 | 0.03% | 120,843 | 0.03% | 104,299 | 0.02% |
| PS.01.01.98 Governmental organizations not disaggregated | 86,545,816 | 25.43% | 148,055,177 | 30.71% | 119,982,920 | 27.41% |
| **PS.01.02 Parastatal organizations** | **112,856** | **0.03%** | **23,716** | **0.00%** | **85,133** | **0.02%** |
| PS.01.02.98 Parastatal organizations not disaggregated | 112,856 | 0.03% | 23,716 | 0.00% | 85,133 | 0.02% |
| **PS.02 Private sector providers** | **144,875,947** | **42.57%** | **229,687,148** | **47.65%** | **213,011,719** | **48.66%** |
| **PS.02.01 Non-profit providers** | **144,785,606** | **42.54%** | **229,566,622** | **47.62%** | **213,011,719** | **48.66%** |
| PS.02.01.01.02 Ambulatory care (private non-profit non-faith based) | 6,545,368 | 1.92% | 17,269,834 | 3.58% | 15,697,746 | 3.59% |
| PS.02.01.01.12 Research institutions (private non-profit non-faith based) | 23,344,059 | 6.86% | 40,408,468 | 8.38% | 29,502,000 | 6.74% |
| PS.02.01.01.13 Self-help and informal community-based organizations (private non-profit non-faith based) | 6,634,054 | 1.95% | 17,846,403 | 3.70% | 16,930,271 | 3.87% |
| PS.02.01.01.14 Civil society organizations (private non-profit non-faith based) | 70,452,926 | 20.70% | 89,151,518 | 18.49% | 97,459,686 | 22.26% |
| PS.02.01.02.13 Civil society organizations (private non-profit faith based) | 40,636 | 0.01% | 207,034 | 0.04% | 151,217 | 0.03% |
| PS.02.01.98 Other non-profit private sector providers not disaggregated | 37,768,562 | 11.10% | 64,683,365 | 13.42% | 53,270,799 | 12.17% |
| **PS.02.02 Profit-making private sector providers** | **90,341** | **0.03%** | **120,526** | **0.03%** | | **0.00%** |
| PS.02.02.98 Profit-making private sector providers not disaggregated | 90,341 | 0.03% | 120,526 | 0.03% | | 0.00% |
| **PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices** | **85,086,759** | **25.00%** | **80,268,750** | **16.65%** | **83,216,581** | **19.01%** |
| **PS.03.01 Bilateral agencies** | | **0.00%** | **144,206** | **0.03%** | **113,811** | **0.03%** |
| **PS.03.02 Multilateral agencies** | **3,124,996** | **0.92%** | **2,742,042** | **0.57%** | **2,821,423** | **0.64%** |
| **PS.03.03 International NGOs and foundations** | **81,961,764** | **24.08%** | **77,382,502** | **16.05%** | **80,281,347** | **18.34%** |
| **Total** | **340,336,872** | **100.00%** | **482,064,889** | **100.00%** | **437,756,619** | **100.00%** |

Table 9 in the Annex 3 displays the providers of services utilized each year in greater detail, showcasing the service providers at a third- and fourth-digit level of analysis.

The majority of the public sector service providers were funded by international organizations, with 50% of spending within PS.01.01 Governmental organizations coming from the Governments providing bilateral aid (specifically, PEPFAR) and 38% from multilateral organizations in 2021. Public financing entities financed 12%[23] of the service provision carried out by public sector entities (Figure 18).

*Figure 18. Financing entities (FE) of the providers of services (PS) of the HIV expenditure in Nigeria in 2021, %*




[23] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated. Including this expenditure in the study would increase the share of the governmental provider of services.

In the case of private non-profit service providers, their funding was predominantly sourced from international financing entities. In 2021, 87% of HIV expenditure implemented by private non-profit service providers came from the bilateral financing entities, specifically PEPFAR, and 12% from the multilateral organizations, mainly The Global Fund. Financing entities for services provided by international non-governmental organizations (INGOs) were predominantly bilateral, with 92% of the funding sourced from the Government of the United States in 2021. The remaining 8% was derived from multilateral financing entities and the INGOs themselves.

Further efforts should be put to better identify providers of various services in the next NASA round. Main challenges in this NASA included lack of details on the final service providers in the expenditure reports of the GFATM grants, in the expenditure reporting dataset of PEPFAR and in the Government of Nigeria's expenditure data provided by NACA.

### 3.4.2. Production Factors (PF)

Figure 19 and Figure 20 demonstrate the breakdown of the country's HIV expenditure by production factor.

*Figure 19. Production factors (PF) of the HIV expenditure in Nigeria in 2019-2021, US$ million*

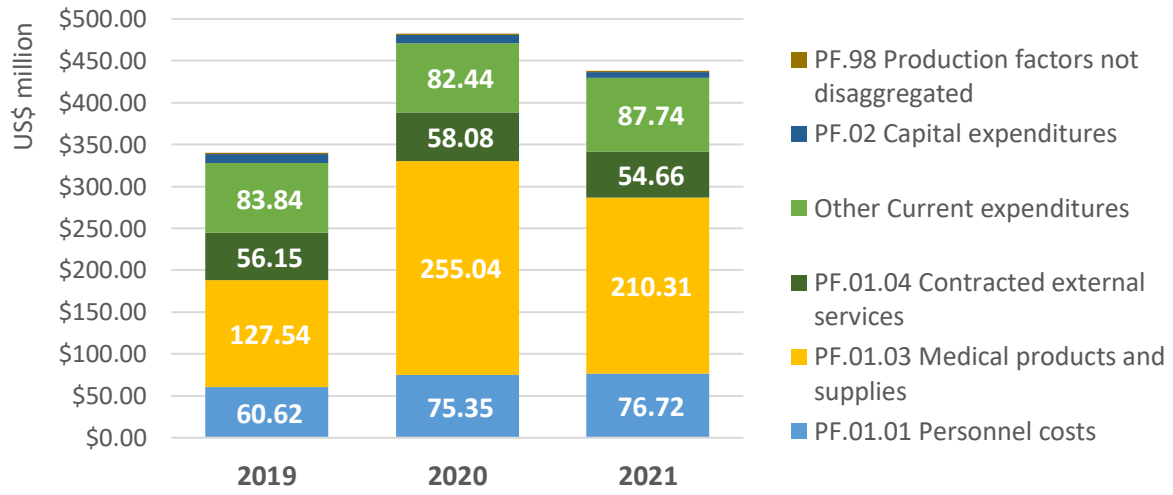
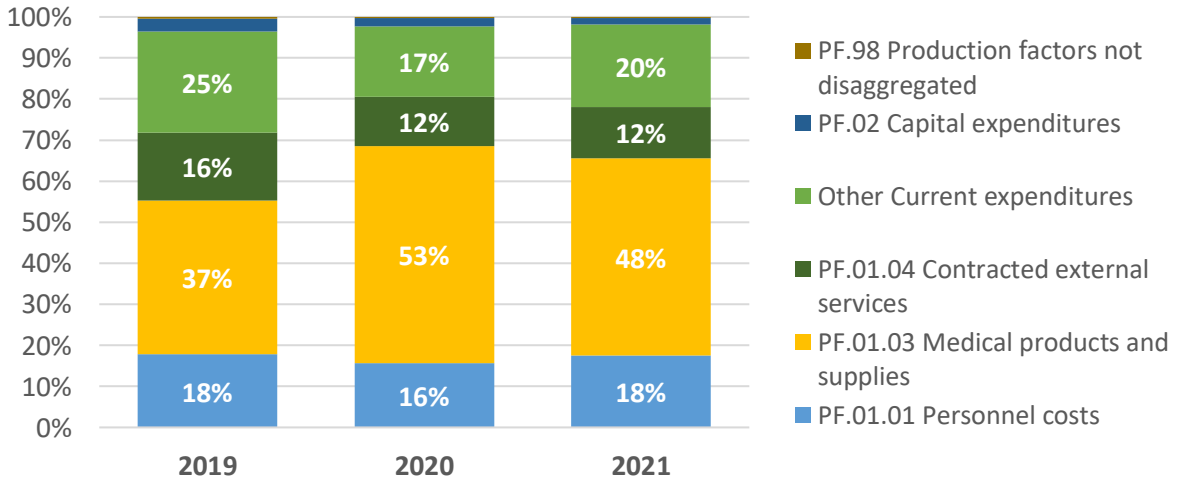



*Figure 20. Production factors (PF) of the HIV expenditure in Nigeria in 2019-2021, %*



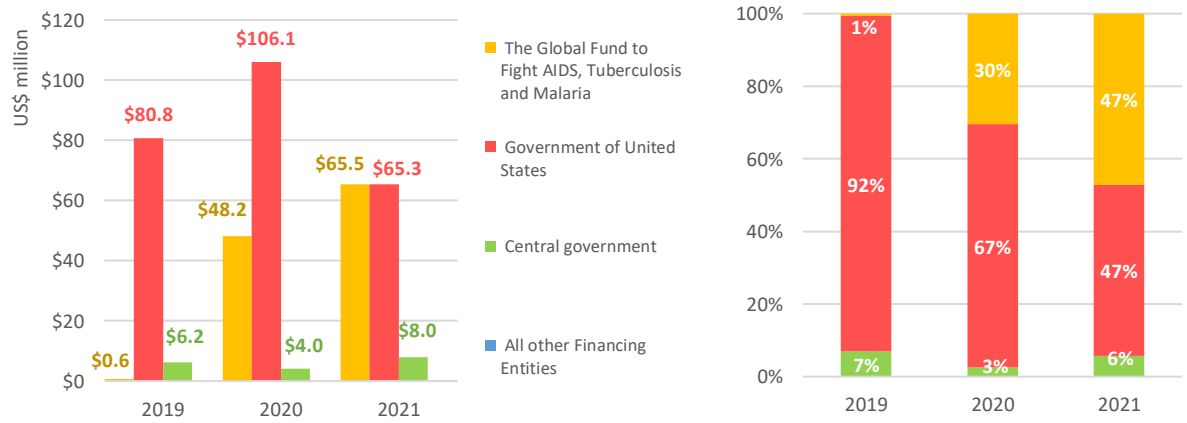
HIV expenditure in Nigeria is categorized into current expenditure, constituting an average of 98% of the total, and capital expenditure, accounting for approximately 2%. Over a half of spending, especially in 2020 and 2021, was recorded under PF.01.03 Medical products and supplies, encompassing the costs of diverse drugs and tests used in HIV service delivery. Personnel costs made up 18% of the total in both 2019 and 2021. However, in absolute figures, personnel costs increased from nearly US$60.6 million in 2019 to US$76.7 million in 2021.

Table 10 of the Annex 3 provides a detailed analysis of the cost components within the key production factors. The single largest production factor in this NASA, antiretroviral drugs, accounted for US$87.6 million in 2019, US$158.4 million in 2020 and US$138.8 million in 2021. Their share in the total country's HIV spending was 26% in 2019, 33% in 2020 and 32% in 2021.

PEPFAR was one of the key financers of the antiretrovirals. In 2019, it financed 92% of all procured ARVs in the country (US$80.8 million). In 2020, PEPFAR's expenditure on ARVs increased to US$106.1 million, but proportionally its share dropped to 67%, due to the increased contribution of the Global Fund, which was covering 30% of all procured ARV drugs that year. In 2021, PEPFAR and GFATM contributed almost equally to the procurements of the antiretrovirals (US$ 65 million each) (Figure 21).

Public Financing entities funded 7%, 3%, and 6% of antiretroviral purchases in 2019, 2020, and 2021. Public spending on antiretrovirals was US$6.2 million in 2019, US$4.0 million in 2020, and US$8.0 million in 2021. With this funding level, Nigeria has likely achieved and surpassed NSP 2021-2025 Target 27 of the Sustainable Financing Result Framework: "*Target 27: GoN effectively increases annual contribution to cover treatment costs of at least 50,000 PLHIV per year*" [24]. While the data on the number of people who received ART financed by the GoN was not available, based on the analysis of the projected costs in the NSP 2021-2025 (US$ 84.34 per person on 1st line ART) and public ARV expenditure in 2021 (US$ 8 million), the country would have financed treatment access for more than 95,000 people in 2021.

*Figure 21. Financing entities (FE) of the ARV drugs in 2019-2021, US$ million and % of PF.01.03.01.01 Antiretrovirals*




PF.01.04 Contracted external service is the second largest production factor identified in this NASA, it accounted for US$56.2 million in 2019, US$58.1 million in 2020 and US$54.7 million in 2021. Eighty-nine per cent of expenditure in this production factor in 2019 was reported by PEPFAR. In 2020 and in 2021 96% of PF.01.04 Contracted external service was paid by PEPFAR programs.

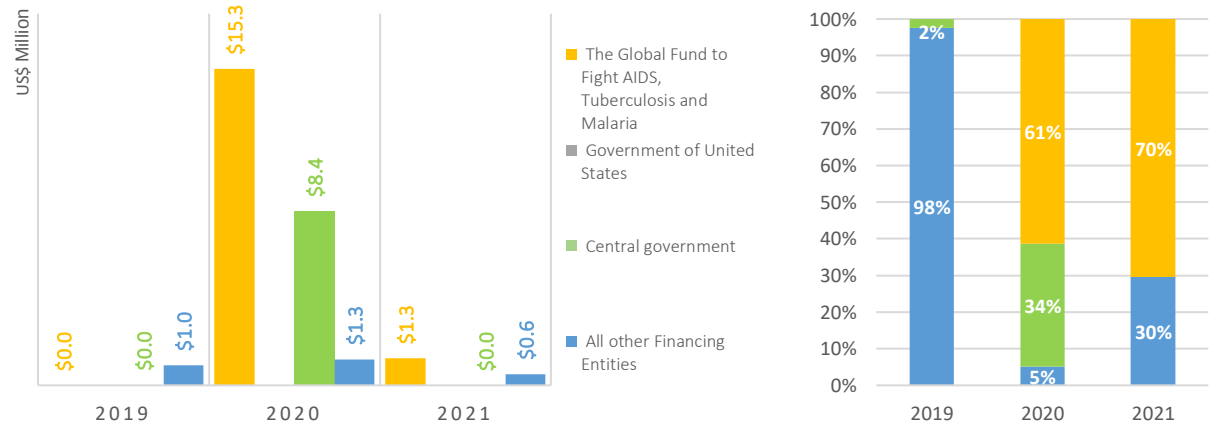
Expenditure on PF.01.03.03.01 HIV tests screening/diagnostics amounted to US$1 million in 2019, US$25 million in 2020 and US$1.9 million in 2021. The actual expenditure on HIV tests might surpass the figures reported here. This discrepancy arises because PEPFAR's spending on HIV Testing and

[24] National Agency for the Control of AIDS (NACA). (2021). National HIV and AIDS Strategic Framework 2021-2025 for Nigeria.

Counselling (HTC) was captured under a broad Production Factor code, which doesn't explicitly single out the expenditure on HIV tests. Hence, the real spending on HIV tests kits could be underestimated by approximately US$8.1 million in 2019, US$10.4 million in 2020, and US$13.5 million in 2021[25].

Overall funding structure of PF.01.03.03.01 HIV tests screening/diagnostics shows notable variation. The Global Fund emerged as the primary source in 2020 and 2021, but it did not finance HIV test purchases in 2019 (**Figure 22**). Central government resources for procurement of the HIV tests, channelled through NACA, grew significantly in 2020, amounting to US$8.4 million. In 2021 however, no such spending was reported. Category "All other sources" include state-level financing (SACAs), the World Bank, and the AIDS Healthcare Foundation. HIV test purchases by SACAs amounted to US$0.67 million in 2019, US$0.70 million in 2020, and US$0.32 million in 2021.

*Figure 22. Financing entities of the HIV tests in 2019-2021, US$ million and % of PF.01.03.03.01 HIV tests screening / diagnostics*




### 3.4.3. Service Delivery Modalities (SDM)

The predominant mode of HIV service delivery in Nigeria was facility-based, particularly outpatient services, accounting for 59% (US$201.0 million) in 2019, 73% (nearly US$353.7 million) in 2020, and reduced to 66% (nearly US$289.9 million) of total HIV spending in 2021. Importantly, community-based service delivery, showed a slight increase, representing 6%, 11%, and 13% in 2019, 2020, and 2021, respectively (**Figure 23** and **Figure 24**). Community-based service delivery grew also in absolute numbers from US$24.2 million in 2019, to US$51.84million in 2020 and US$55.4 million in 2021. The largest increase was observed in the community-based service delivery reported by PEPFAR, which indicated an expenditure of nearly US$22.3 million in 2019, coded under SDM.02.98 Home and Community-based service delivery not disaggregated by type, which increased to reach nearly US$44.3 million in 2020 and nearly US$41.3 million in 2021. PEPFAR data also indicated expenditure on services coded as SDM.02.99 Home and Community-based service delivery not elsewhere classified, which also increased from nearly US$0.6 million in 2019 to US$5.9 million in 2020 and consequently to US$11.8 million in 2021. Growth in the expenditure on community-based interventions was also observed in the GFATM data, provided by FHI 360, who report over US$1.2 million on SDM.02.07 HIV self-testing in 2021, while nothing was reported under this code in the previous years.

[25] This underreporting refers exclusively to the Production Factor HIV tests (PF.01.03.03.01 HIV tests screening/diagnostics), not to the category ASC.02 HIV testing and counselling (HTC). Expenditure on HIV tests procured within PEPFAR portfolio may have been reported under the category of PF.01.03 Medical products and supplies.

*Figure 23. Service delivery modalities (SDM) of the HIV expenditure in Nigeria in 2019-2021, US$ million*

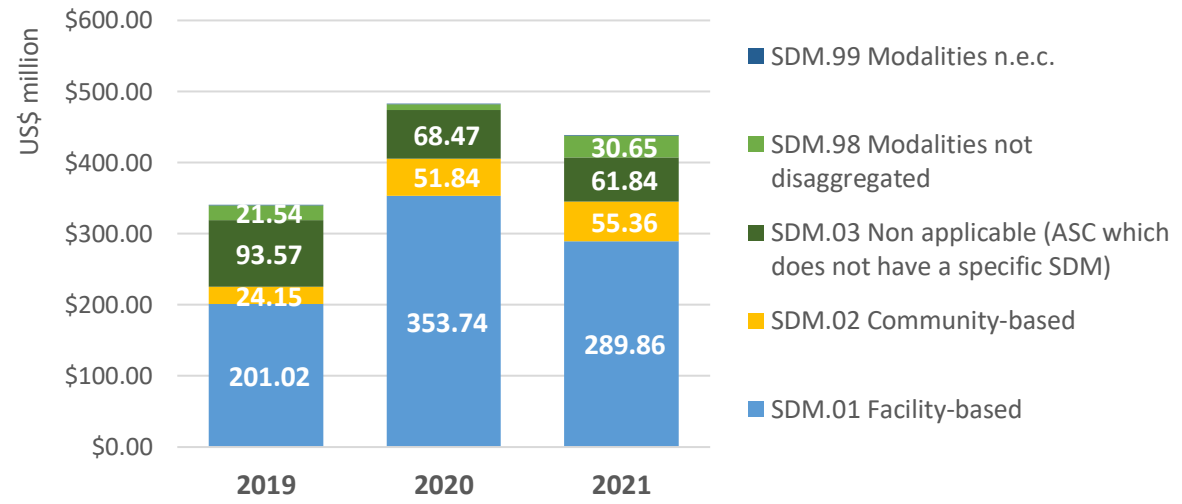
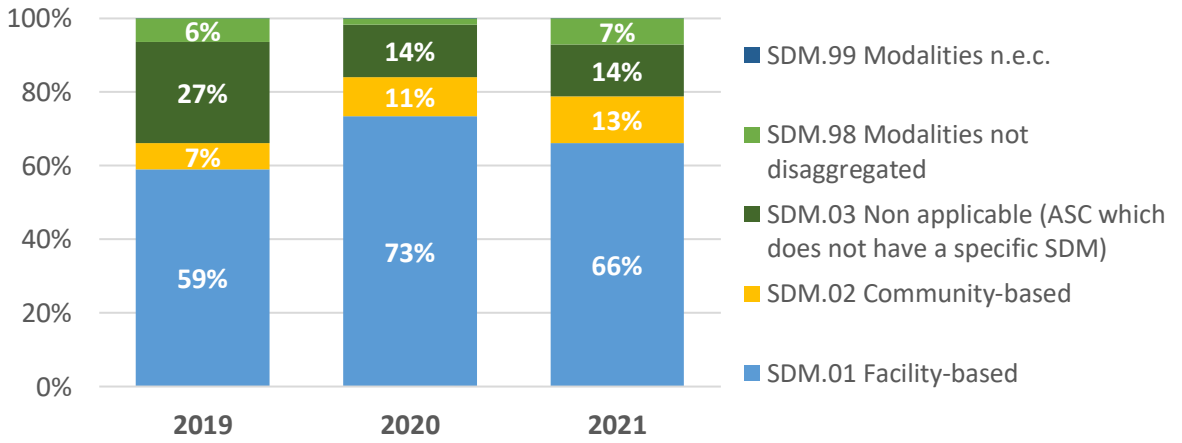


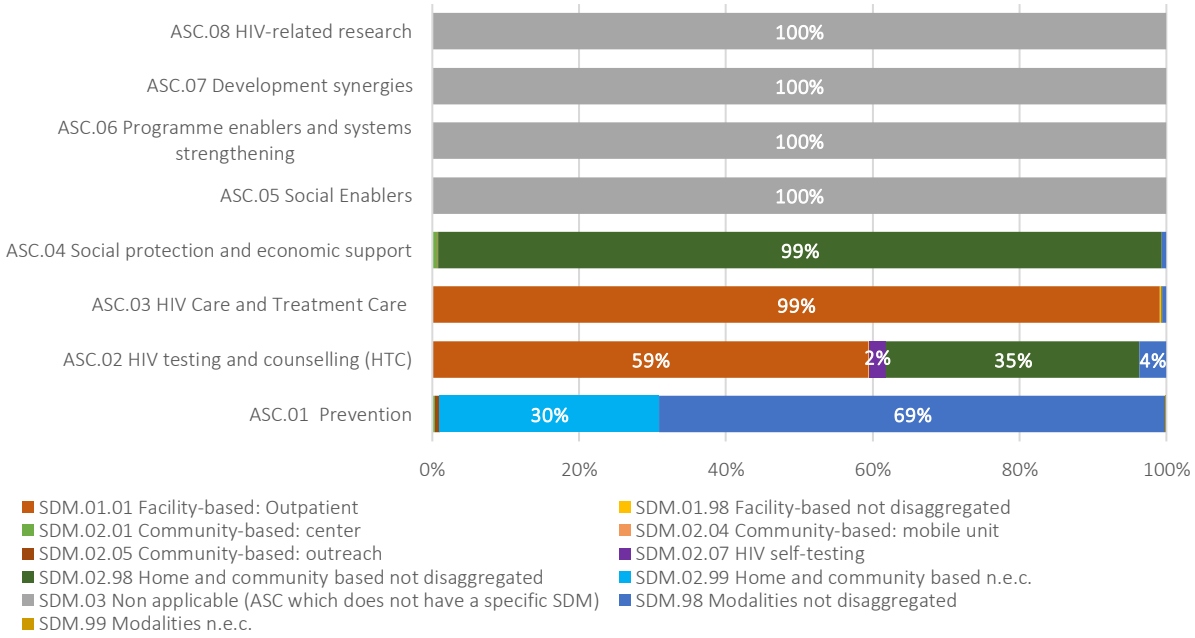

*Figure 24. Service delivery modalities (SDM) of the HIV expenditure in Nigeria in 2019-2021, %*




Above site services and other non-client specific interventions would not have a specified modality and made up 27% of total HIV spending in 2019, decreasing subsequently to 14% in both 2020 and 2021.

In terms of prevention interventions (ASC.01 HIV Prevention), the data revealed fluctuations in the identified SDMs, suggesting a lack of specificity in expenditure records. Eighty percent of prevention spending in 2019 was reported under SDM.98 Modalities not disaggregated. This situation improved in 2020, with the share of expenditure coded as SDM.98 dropping to 29%. However, it increased again to 69% of prevention interventions not being disaggregated by SDM in 2021 (**Figure 25**). Ninety-three percent of expenditure tracked under SDM.98 in ASC.01 HIV prevention in 2021, an equivalent of US$25.3 million, was reported by PEPFAR without a specific 1st-digit SDM code (SDM.98). Notably, 30% of all expenditure under ASC.01 HIV prevention in 2021 was provided through community-based services.

*Figure 25. Service delivery modalities (SDM) of the key AIDS spending categories (ASC) in 2021, %*




In 2021, 59% of the expenditure under ASC.02 HIV testing and counselling (HTC) was implemented through facility-based modality, 2% of HTC was implemented through self-testing[26], and for 35% of the HTC services the service delivery modality was identified as SDM.02.98 Home and community-based not disaggregated by type.

Ninety-nine per cent of HIV care and treatment services were provided in out-patient healthcare facilities in 2021[27].

**Table 11** in the Annex 3 displays the Service delivery modalities implemented each year in greater detail, showcasing the second digit level of analysis.

## 3.5. NASA DIMENSION: CONSUMPTION

This section includes the analysis of the expenditure by programmatic area, or AIDS spending category (ASC), beneficiary population (BP) and geographical area (SND) of the expenditure.

### 3.5.1. AIDS spending categories (ASC)

The largest programmatic area of HIV expenditure was observed in ASC.03 HIV care and treatment, with US$194.0 million reported under this ASC in 2019, US$309.4 million in 2020 and US$261.4 million in 2021. It was followed by ASC.06 Programme enablers and systems strengthening, and consecutively – ASC.01 HIV prevention and ASC.02 HIV testing and counselling. Only minimal funding was allocated to development synergies and HIV-related research, with joint totals of US$140,000 in 2019, US$122,000 in 2020, and US$478,000 in 2021. (**Figure 26**).

**ASC.01 HIV prevention (excluding HIV testing and counselling)** spending started at just US$9.2 million (3% of total HIV spending) in 2019, increasing to US$11.8 million (but proportionally reducing to 2% of total) in 2020, and further to US$39.5 million in 2021 (see **Figure 26**). Despite this significant surge

[26] In 2021, 99% of the HTC implemented through self-testing was reported by FHI360 as part of the Global Fund grant.

[27] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated. Including this expenditure in the study would increase the share of SDM Facility based In-Patient, capturing HIV related hospitalization costs.

compared to the preceding years, it still constituted only 9% of the total recorded HIV spending in 2021 (Figure 27).

*Figure 26. AIDS spending categories (ASC) of the HIV response in Nigeria in 2019-2021, US$ million*

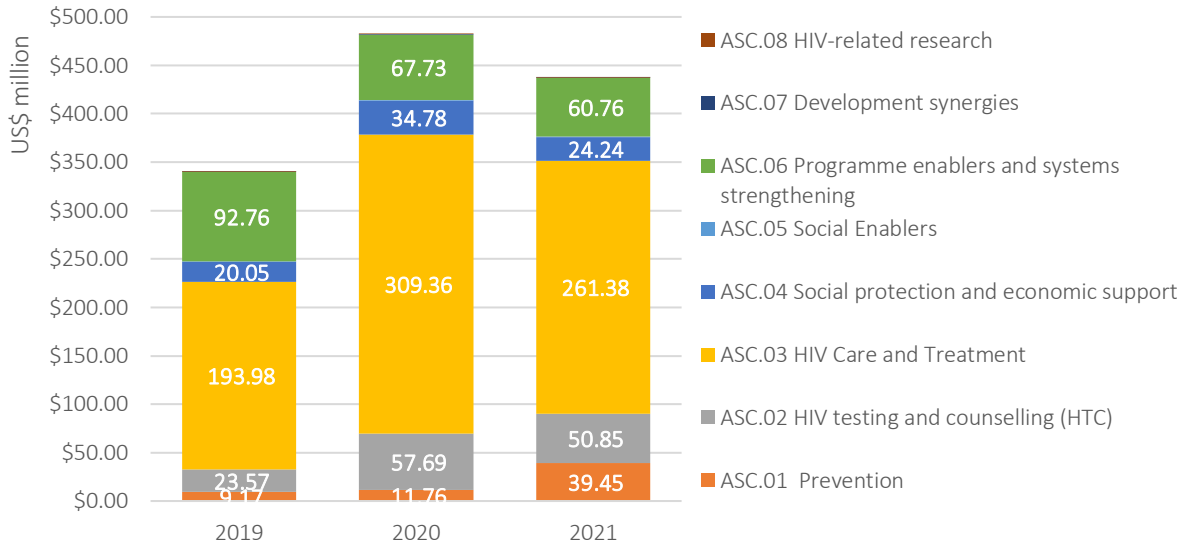



*Figure 27. AIDS spending categories (ASC) of the HIV response in Nigeria in 2019-2021, %*

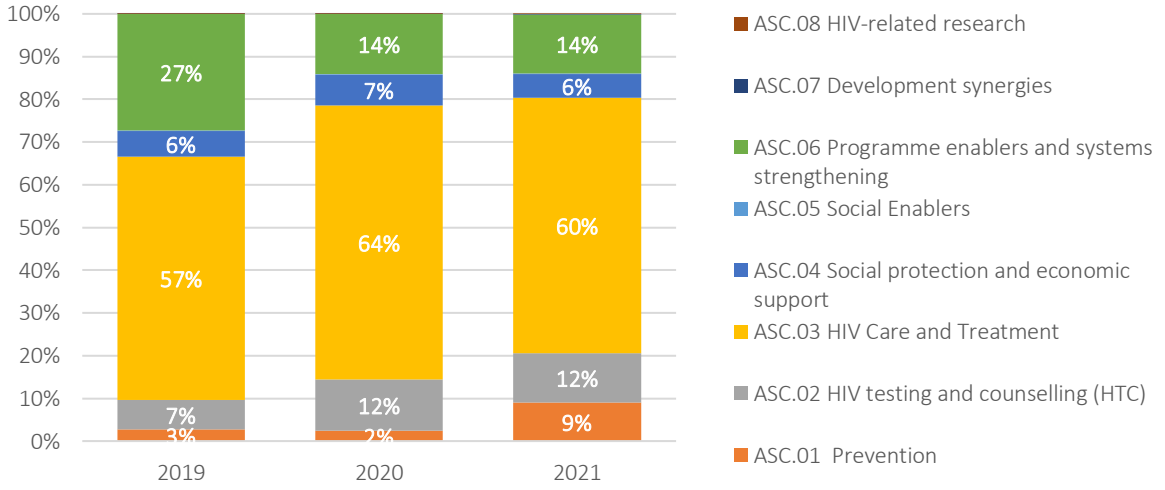



Table 12 in the Annex 3 shows detailed spending across the various preventive programs implemented in the country.

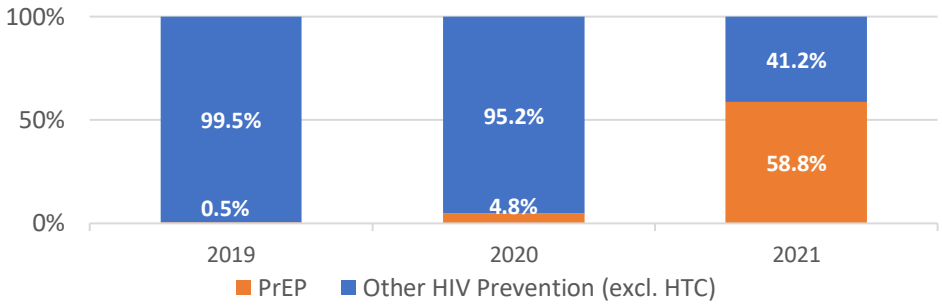
The five pillars of prevention[28], captured 42% of preventive spending in 2019, 63% in 2020, and 87% of the total HIV prevention spending in 2021, showing an important shift towards the high-impact prevention interventions. The expenditure also grew in the absolute terms, from US$3.9 million in 2019, to US$7.4 million in 2020 and US$34.1 million in 2021.

The growing HIV prevention spending was mainly supported by an increased funding by PEPFAR towards HIV prevention, which grew from US$6.3 million in 2019 to US$37.1 million in 2021, driven primarily by

[28] These pillars are: 1) Prevention among key populations and their sexual partners; 2) Prevention among young women and girls; 3) Pre-exposure prophylaxis (PrEP); 4) Condom promotion and provision; and 5) Voluntary Medical Male Circumcision (VMMC). *HIV PREVENTION 2025 – ROAD MAP: Getting on track to end AIDS as a public health threat by 2030*. Geneva: Joint United Nations Programme on HIV/AIDS; 2022. Licence: CC BY-NC-SA 3.0 IGO.

the increase in their Pre-exposure Prophylaxis (PrEP) programme targeted at key populations. Total expenditure on PrEP from all financing entities has increased from US$0.04 million in 2019 to US$0.56 million in 2020 and subsequently to nearly US$23.2 million in 2021. In 2021, expenditure on PrEP constituted 59% of the total country's spending on ASC.01 HIV prevention (excluding HTC), compared to only 5% in 2020 (see Figure 28).

*Figure 28. Expenditure on PrEP as a share of the annual spending on HIV Prevention in 2019-2021, %*




Expenditure data on PrEP had two origins: PEPFAR and The Global Fund. In 2019 and 2020 all PrEP expenditure came from PEPFAR, and in 2021 PEPFAR supported 99.9% of PrEP interventions. The expenditure provided by The Global Fund amounted to only US$ 6,637, representing 0.03% of all PrEP in 2021.

Expenditure on prevention of mother-to-child transmission (PMTCT) amounted to nearly US$4.1 million in 2019, which represented 45% of all ASC.01 HIV prevention (excluding HTC) that year. Since 2020, however, PMTCT expenditure experienced a decrease to US$2.7 million and further to US$1.5 million in 2021, representing 23% and 4% of total prevention respectively. This does not include expenditure on HIV testing and counselling for pregnant women, which is captured under ASC.02 HIV testing and counselling, nor does it reflect the ARVs for pregnant women, which would have been captured under ASC.03.01.

Expenditure on prevention among vulnerable and accessible populations as part of ASC.01 HIV prevention (excluding HTC) was US$0.5 million in 2019, US$0.7 million in both 2020 and 2021.

Spending on **ASC.02 HIV testing and counselling (HTC)** totalled US$23.6 million in 2019, reaching US$57.7 million in 2020. In 2021, it reduced in absolute terms to US$50.9 million. HTC expenditure represented only 7% of the total HIV expenditure in Nigeria in 2019, increasing to 12% in both 2020 and 2021 (Table 12).

When examining these financial variations, it's important to consider that shifts in HTC expenditure shown in this NASA, similar to PrEP and ARVs, were tied to the purchase values of these commodities, representing procurement rather than consumption of the HIV tests (due to the lack of distribution expenditures as a proxy for consumption). The yearly purchase amounts varied significantly. For a comprehensive breakdown of expenditure by commodity, consult Table 10 in the Annex 3.

The sub-category of testing and counselling among general population (ASC.02.09 Voluntary HIV testing and counselling for general population) constituted 6%, 7% and 9% of total HIV spending in 2019-2021 (which represented 81% of the ASC.02 HIV testing and counselling in 2019, 58% in 2020 and 80% in 2021).

A large portion of expenditure tracked under ASC.02 HIV testing and counselling is not disaggregated by population (ASC.02.98). In 2019, it amounted to US$2.6 million (representing 11% of ASC.02), increasing

significantly to US$20.7 million in 2020 (representing 36% of ASC.02). In 2021, the unclassified expenditure on HIV testing and counselling comprised US$6.7 million (representing 13% of ASC.02). This calls for improvements in data granularity during data collection.

ASC.03 HIV Care and Treatment expenditure constituted the largest portion of HIV spending in Nigeria (Table 12 in the Annex 3), reaching US$194.0 million in 2019, accounting for 57% of the total HIV expenditure. Subsequently, this expenditure increased, reaching US$309.4 million in 2020, representing 64% of the total HIV spending. However, in 2021, care and treatment spending experienced a decrease, settling at US$261.4 million USD in 2021, constituting 60% of the country's expenditure on HIV.

Expenditure tracked under ASC.03.01 Antiretroviral therapy (ART) represented a large portion of the ASC.03 HIV care and treatment: in 2019 it accounted for US$105.1 million, 54% of ASC.03 HIV care and treatment and 31% of the total country's spending on HIV. In 2020, ART spending increased to US$175.6 million, representing 57% of ASC.03 HIV care and treatment and 36% of the overall national HIV expenditure, and in 2021, ASC.03.01 Antiretroviral therapy accounted for US$129.7 million, representing 50% of ASC.03 HIV care and treatment and 30% of the total HIV expenditure in Nigeria. Expenditure on ARV drugs as a part of the ART service, similarly to PrEP and HIV tests described above, was based on the amounts spent on the procurement of the drugs, which may not represent the actual consumed quantities per year.

Breaking down ART expenditure by age and line of treatment was challenging, therefore 17, 34 and 62 per cent of the ASC.03.01 Antiretroviral therapy remained unclassified by type due to lack of details in the data collection forms and expenditure reports made available to the NASA team.

Spending on ASC.04 Social protection and economic support was US$20.05 million in 2019, US$34.78 in 2020 and US$24.24 million in 2021, representing 6, 7 and 6 percent of the total HIV spending in Nigeria in the respective years.

ASC.05 Social enablers accounted for US$0.66 million in 2019, US$0.62 million in 2020 and US$0.6 million in 2021, which represented 0.2, 0.1 and 0.1 percent of the total HIV expenditure in 2019, 2020 and 2021.

ASC.06 Programme enablers and systems strengthening, the second-largest AIDS Spending Category in Nigeria's HIV response, amounted to US$92.8 million in 2019, subsequently reducing to US$67.7 million in 2020 and US$60.8 million in 2021. Although ASC.06 represented 27% of the overall spending on HIV in 2019, its share dropped to 14% in 2020 and 2021, as more spending was registered under the spending categories related to direct service delivery.

The majority of ASC.06 spending was allocated to ASC.06.03 Programme administration and management costs (above service-delivery level). This AIDS spending category alone represented 15, 10 and 9 percent of the total HIV spending in Nigeria in 2019, 2020 and 2021 respectively. The largest financing entity for the expenditure tracked under ASC.06.03 was the US Government: in 2019 it financed 66% of the ASC.06.03, 72% in 2020 and 86% in 2021. The second largest financing entity for this ASC was The Global Fund, which financed 32% of the ASC.06.03 in 2019, 28% in 2020 and 13% in 2021.

Expenditure on strategic information under ASC.06.04 experienced a decline, from US$20.9 million in 2019, US$11.8 million in 2020, to US$6.8 million in 2021. Strategic information spending represented 6% of the total HIV spending in the country in 2019, and 2% in 2020 and 2021.

ASC.07 Development synergies, which included ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) using HIV earmarked

resources and ASC.07.02 Reducing gender-based violence, constituted a small part of the HIV expenditure in Nigeria: US$0.12 million in 2019, US$0.1 million in 2020 and US$0.16 million in 2021.

Recorded expenditure on **ASC.08 HIV-related research**, including ASC.08.03 Epidemiological research, ASC.08.04 Socio-behavioural research and ASC.08.05 Economic research, was US$0.02 million in 2019 and in 2020, increasing to US$0.32 in 2021.

### 3.5.2. AIDS spending categories (ASC) by financing entity (FE)

Over the NASA study period, the Nigerian HIV response was highly dependent on donor funding. PEPFAR was the main financing entity for ASC.01 Prevention (94%), ASC.02 HIV testing and counselling (HTC) (90%), ASC.03 HIV Care and Treatment (69%), ASC.04 Social protection and economic support (99%) and ASC.06 Programme enablers and systems strengthening (71%) in 2021 (**Figure 29**). These programmatic areas of Nigeria's HIV response may be considered the most vulnerable to fluctuations in PEPFAR funding. The largest investment of PEPFAR in Nigeria is HIV care and treatment which amounted to US$181 million in 2021 (**Figure 30**).

The Global Fund was the main financing source for ASC.08 HIV-related research (100%) in 2021, but for a small nominal amount (Figure 30). It also financed 27% of the country's expenditure on HIV care and treatment, 15% of the Programme enablers and systems strengthening, 13% of the social enablers and 3% of the HIV testing and counselling.

In 2021, US$ 600,000 were spent on ASC.05 Social Enablers. Of this, 69% was financed by other multilateral organizations, mainly UNAIDS, as shown in Figure 30.

*Figure 29. AIDS spending categories (ASC) by Financial Entity (FE) (1st digit) in Nigeria in 2021, %*

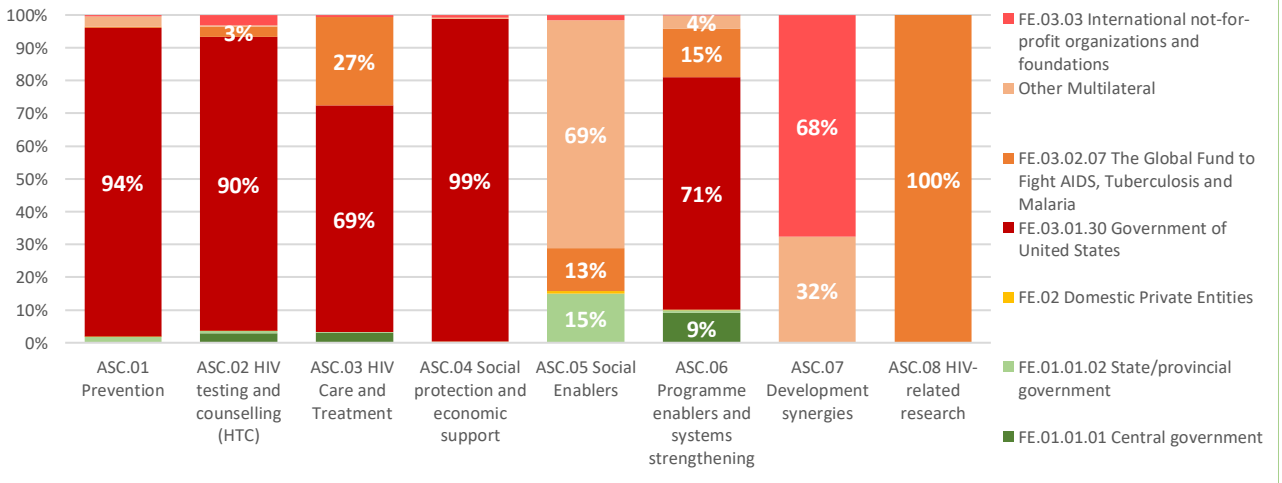
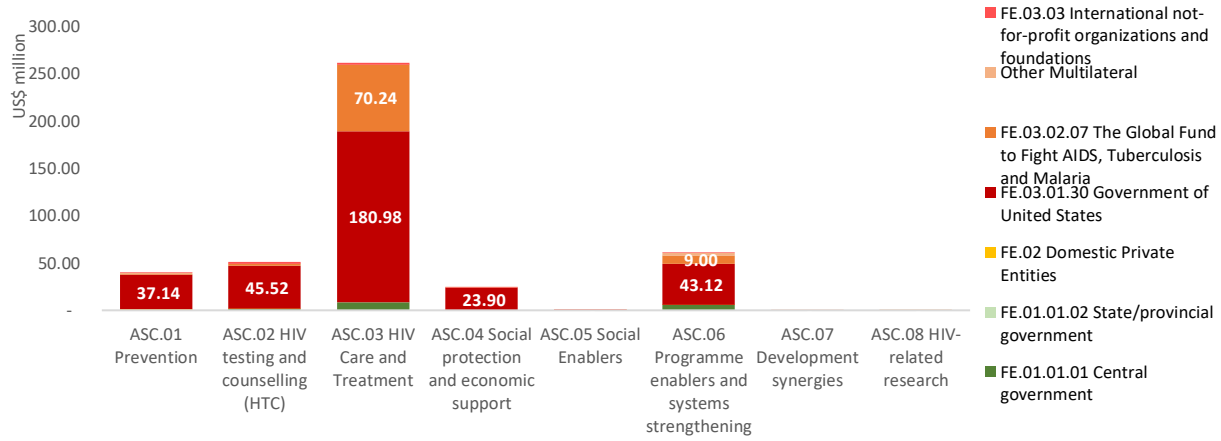


*Figure 30. AIDS spending categories (ASC) by Financial Entity (FE) (1st digit) in Nigeria in 2021, US$ million*




When analysing donor dependency in selected key programs (see **Figure 31**), it is noted that Nigeria maintained a high dependency on donor funds for the implementation of all of them in all the years of study[29].

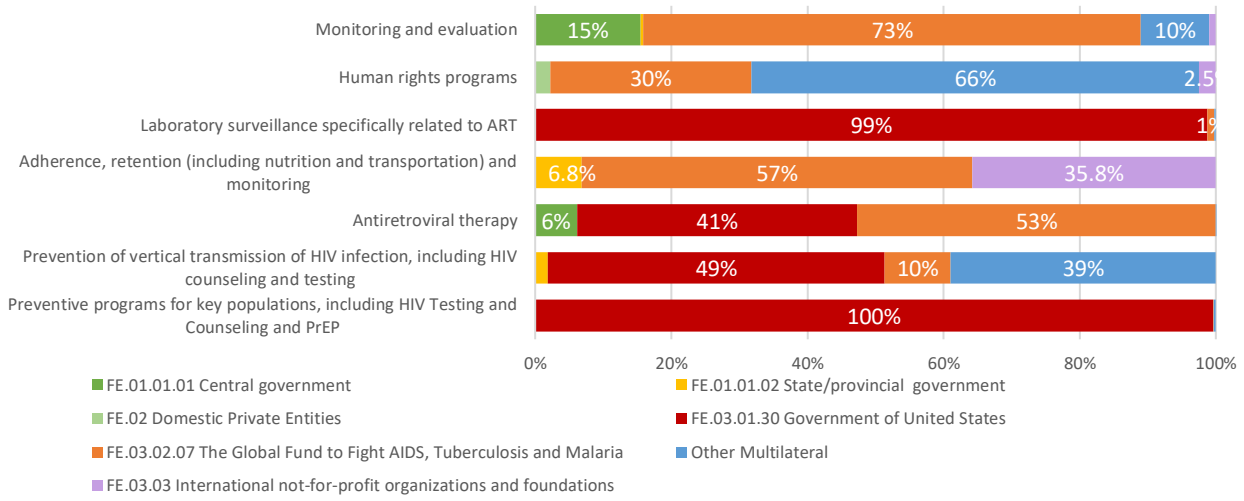
PEPFAR was the main source of funding for Preventive programs for key populations (including HIV Testing and Counselling and PrEP), Laboratory surveillance specifically related to ART, and Prevention of vertical transmission of HIV infection (including HIV counselling and testing), funding 99.6%, 99%, and 49% of the total for these programs in 2021, respectively.

The Global Fund, for its part, in 2021 was the main source of financing for Monitoring and evaluation (73%), Adherence, retention and monitoring (57%), and Antiretroviral therapy, funding 53% of the total ART expenditure.

Multilaterals were the largest contributors to human rights programmes (66%) and contributed 39% to PMTCT in 2021. UNAIDS being the main financing entity for human rights programmes and UNICEF for PMTCT.

[29] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated.

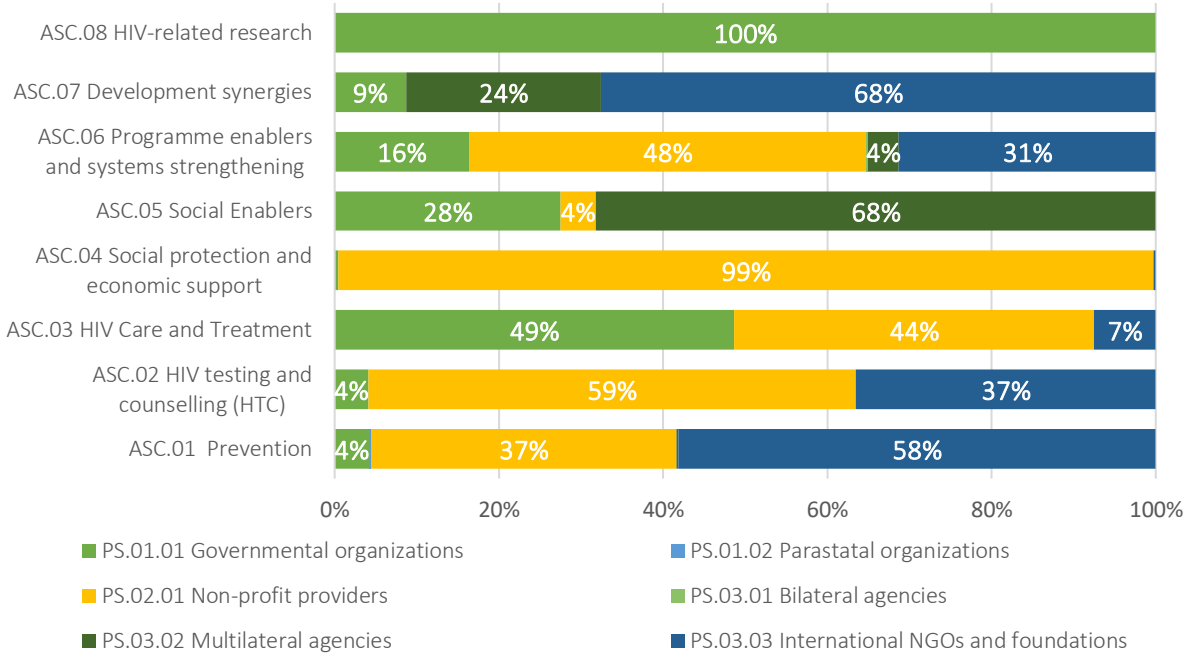
*Figure 31. Selected AIDS spending categories (ASC) by Financial Entity (FE) (2nd and 3rd digits) in Nigeria in 2021, % of ASC [30]*




### 3.5.3. AIDS spending categories (ASC) by provider of services (PS)

The Figure 32 shows the HIV programmatic area by their providers of services for 2021.

*Figure 32. Providers of services (PS) of main AIDS spending categories (ASC) in 2021, % of ASC*




International NGOs and foundations (PS.03.03) resulted as the main providers for prevention programs (ASC.01), implementing 58% of these programs in 2021. Ninety-four per cent of the HIV Prevention activities in 2021 were financed by PEPFAR, implemented through local NGOs or public sector health facilities.

[30] To better reflect the total prevention activities targeting key populations, HTC for Key Populations has been aggregated with all other KP prevention activities in this graph. Similarly, HTC for PMTCT has been combined with all PMTCT prevention spending. The categories selected for this analysis aim to capture relevant elements of the National Strategic Plan (NSP) for 2021-2025. These include ensuring Universal Health Coverage (UHC) to provide all Nigerians with access to quality HIV prevention, care, and treatment services, strengthening efforts to eliminate mother-to-child transmission of HIV (PMTCT) and enhancing the monitoring and evaluation systems to ensure data accuracy and inform strategic decisions.

Domestic non-profit providers (PS.02.01) were the leading providers for HIV testing and counselling (HTC) (ASC.02) with 59% of spending in this area, most of social protection and economic support interventions (ASC.04) (99%), and 48% of program enablers and systems strengthening (ASC.06). As shown in section 3.4.1, the national NGOs play an important role in the delivery of key services in the country with almost half of the total HIV expenditure attributed to them in 2021.

Governmental providers (PS.01.01) were the principal providers for ASC.03 HIV Care and Treatment: 49% of the total ASC.03 was implemented by public healthcare facilities in 2021. All 100% of the expenditure captured under ASC.08 HIV-related research was implemented by NACA.

### 3.5.4. Expenditure per beneficiary population (BP)

Table 13 in the Annex 3 shows the beneficiary populations at a second-digit level, offering a more detailed analysis of spending by beneficiary population.

BP.01 People living with HIV (PLHIV) was the main beneficiary group (Figure 33 and Figure 34), which represented a substantial portion of the nation's HIV expenditure: 57% in 2019, 64% in 2020, and 60% in 2021, which amounted to US$194.2 million in 2019, US$309.4 million in 2020, and US$261.5 million in 2021.

The largest portion of funding for the programmes targeting PLHIV, mainly Care and Treatment services, was financed by international financing entities, particularly the US Government and the Global Fund, financing each year 95% or more of these programmes..

*Figure 33. Beneficiary populations (BP) of the HIV response in 2019-2021, US$ million*

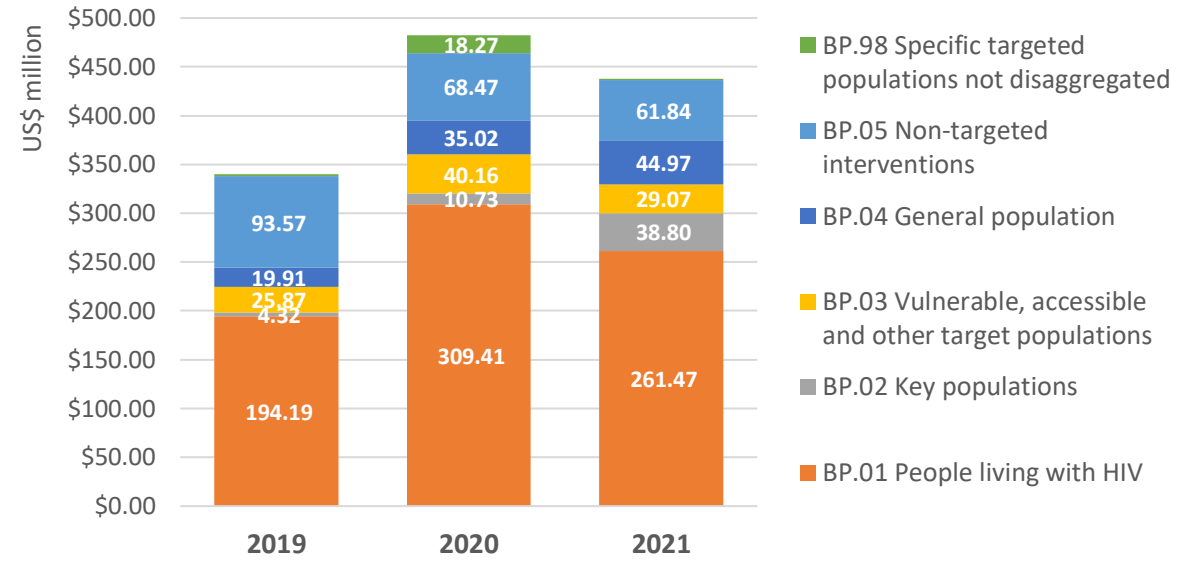
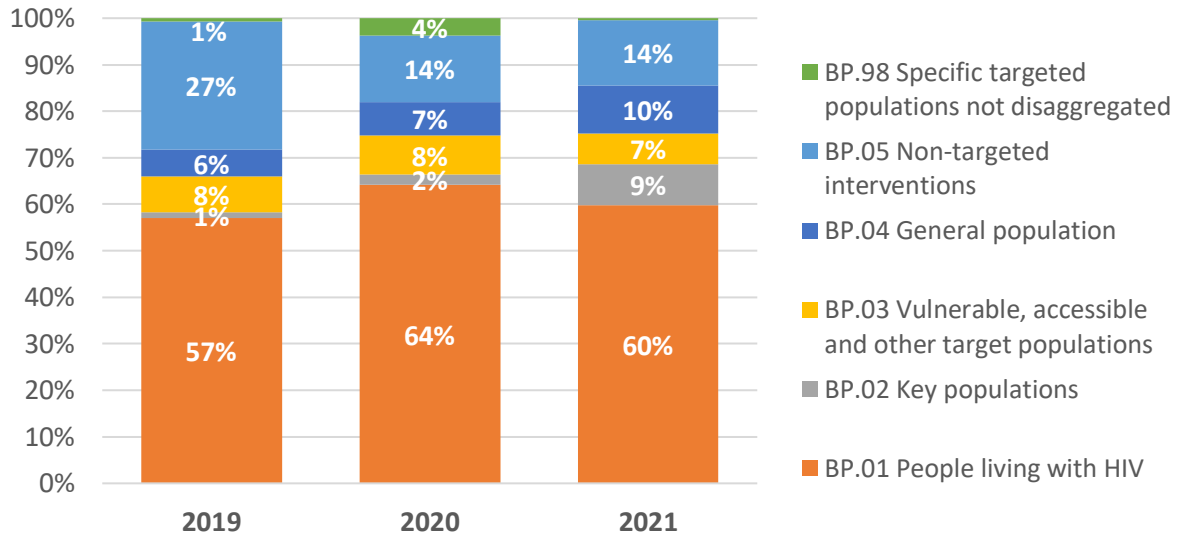



*Figure 34. Beneficiary populations (BP) of the HIV response in 2019-2021, %*




Expenditure on **BP.05 Non-targeted interventions** (that is, not targeted to a specific population, or interventions benefiting a population in an indirect way) encompasses ASC.05 Social enablers, ASC.06 Programmatic enablers and systems strengthening, ASC.07 Development synergies, and ASC.08 HIV-related research. In Nigeria, these non-targeted interventions accounted for 27% of the overall HIV spending in 2019, decreasing to 14% in both 2020 and 2021. In absolute terms, the spending declined from US$93.6 million in 2019 to US$61.8 million in 2021.

Expenditure on **BP.02 Key populations**, though relatively modest, has shown a consistent increase over the assessment period, rising from just US$4.3 million in 2019 to US$38.8 million in 2021. The rapid increase in spending targeting KP was attributed to the expanding PrEP program.

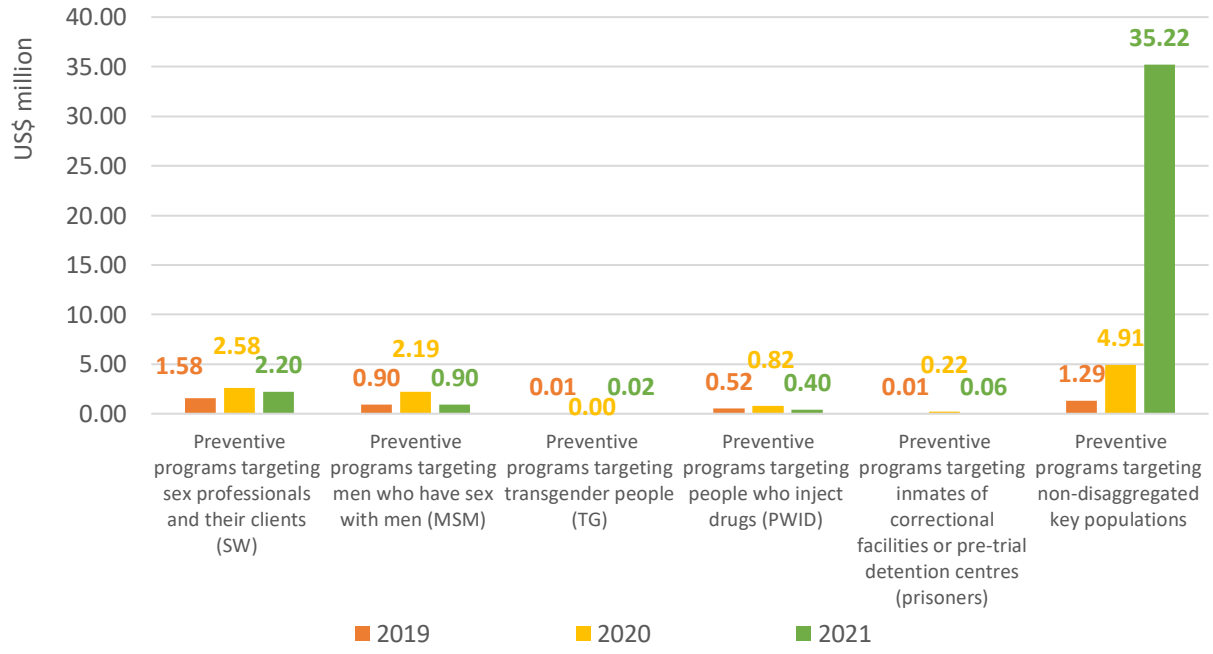
The spending on the general population, although increasing (6%, 7%, and 10%), remains relatively small, indicating that Nigeria's HIV expenditures are more targeted towards specific groups.

For data reported as ASC.02.98, which includes HIV testing and counselling activities that are not disaggregated, and for which the beneficiary population (BP) is unknown, UNAIDS GC recommended coding these interventions under BP.98, which denotes specific targeted populations that are not disaggregated (i.e. are unknown). A total of US$2.5 million was coded as BP.98 in 2019, US$18.3 million in 2020 and US$1.6 million in 2021.

Figure 35 illustrates key population preventive spending, including spending on HIV testing and counselling (HTC) and PrEP, by key population type to provide an overall view of expenditures aimed at reducing new cases among key populations.

Spending, for which key populations remain not disaggregated by type, stands out in 2021, reaching US$35.2 million; it surpasses the spending on all other KP combined in previous years. This increase was primarily driven by funding from PEPFAR for PrEP targeting key populations. However, no further details were provided to the NASA team regarding which specific key populations were targeted.

*Figure 35. Prevention spending on key populations (including HIV Counselling and Testing and PrEP) in Nigeria in 2019-2021, US$ million*

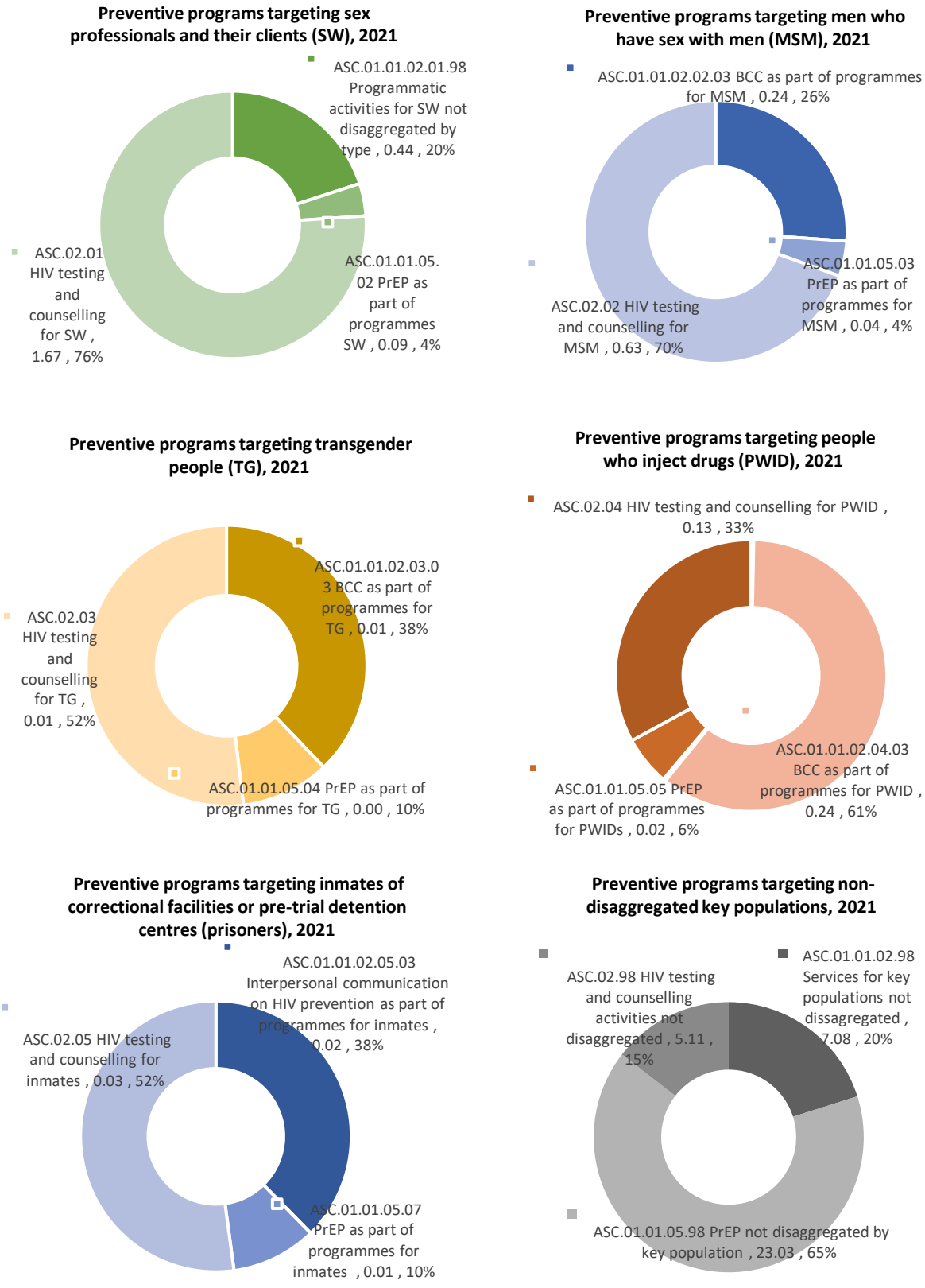



Preventive programs for sex workers and their clients accounted for US$1.6 million, US$2.6 million, and US$2.3 million in 2019, 2020, and 2021, respectively. Sex workers benefited the most from the funding targeting key populations (excluding BP.02.98 Key populations not disaggregated by type), compared to other KP.

Figure 36 displays how spending was allocated among different programs for each of the key populations.

The expenditure recorded as "Preventive programs targeting non-disaggregated key populations" refers to spending for which institutions could not report expenditure broken down by the key population reached. It is known that these funds were directed at key populations, but not the proportion allocated to each group in particular. This category accounted for an expenditure of US$1.3 million in 2019, US$4.1 million in 2020, and US$35.2 million in 2021. This increase was mainly due to spending on HIV testing and PrEP reported by PEPFAR as targeted at key populations in 2021.

*Figure 36. HIV spending per key population (Prevention including PrEP, and HIV Testing and Counselling) in 2021, %*



### 3.5.5. Geographical breakdown – Sub National Data (SND) of expenditure in 2021

For the first time in Nigeria, the NASA team endeavoured to collect and break down HIV expenditure by geographical location, where subnational spending is measured with all the dimensions of the NASA for each individual State. This analysis was only carried out for the year 2021, due to the additional complexity required in the preparation of data by the institutions that provide their spending information, as well as the additional work necessary to process this data by the NASA team. Ideally, if the entire national HIV expenditure is classified by state, it could be considered equivalent to having 37 NASAs, one for each state (or SASAs in this case, since they would be State AIDS Spending Assessments).

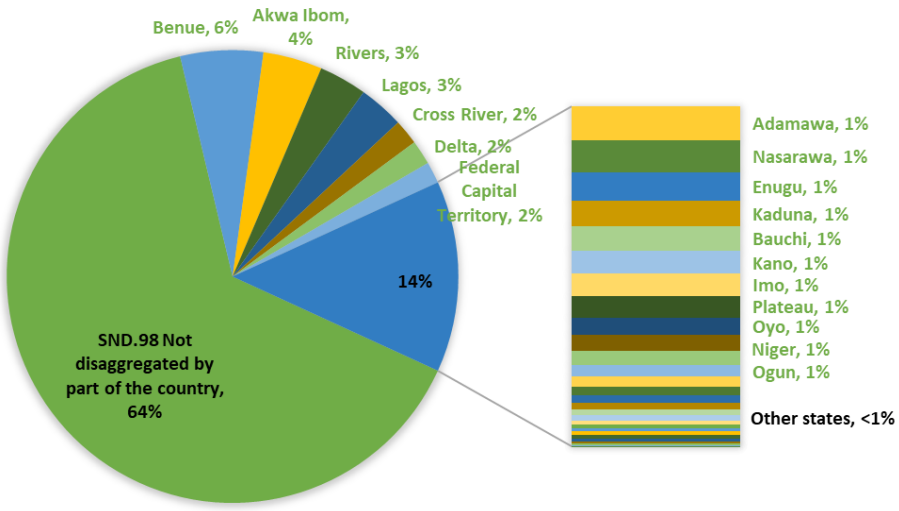
The analysis covered executed expenditure across 35 of Nigeria's 36 states and Federal Capital Territory, incorporating public international and private sector financing entities. State-level data were reported by SACAs (16 SACAs), state-level line ministries, as well UN agencies, GFATM grants reported by their principal recipients, PEPFAR data and other organizations-respondents. Out of this, sixteen state-level government entities (13 SACAs and 3 state line ministries) reported spending financed by the state government.

Spending data from SACAs might be considered underreported as only seven SACAs reported their human resource costs in their data collection forms, out of which two SACAs reported expenditures of less than US$1,000. Only one SACA reported labour costs for all three years of the assessment, one SACA reported two years, and the remaining five SACAs reported their labour costs for just one year of the assessment. The variable spending patterns and, in some cases, minimal spending figures suggest that there has been underreporting from SACAs regarding personnel costs.

The exercise demonstrated that it is possible to conduct a NASA in Nigeria with a geographical allocation of spending in the country, however, despite all efforts, 67% of the financial data in 2021 remains non disaggregated by state (see Figure 37). This means that for two-thirds of the total spending in 2021, the data received by the NASA team was not assigned to a specific geographical location. Therefore, the results presented below must be viewed with caution, and limited conclusions should be drawn.

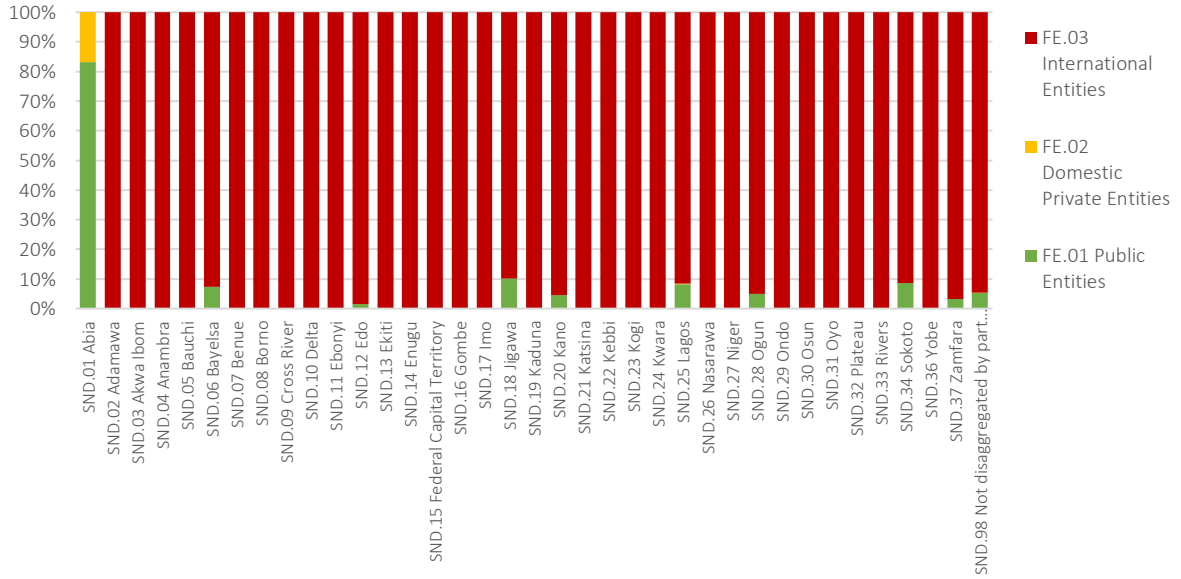
The results obtained reveals that 6% of the total HIV expenditure is allocated to Benue state, 4% to Akwa Ibom, 3% to Rivers, 3% to Lagos, 2% to Delta and Cross River states each. The remaining expenditure is dispersed among the remaining 31 states.

*Figure 37. Geographical breakdown (SNU) of the HIV expenditure in Nigeria in 2021, %*



Geographical breakdown of the financing entities of the HIV expenditure in Nigeria in 2021 is shown in the Figure 38. Except for Abia, all other states show international funding representing 90% or more of total funds[31].

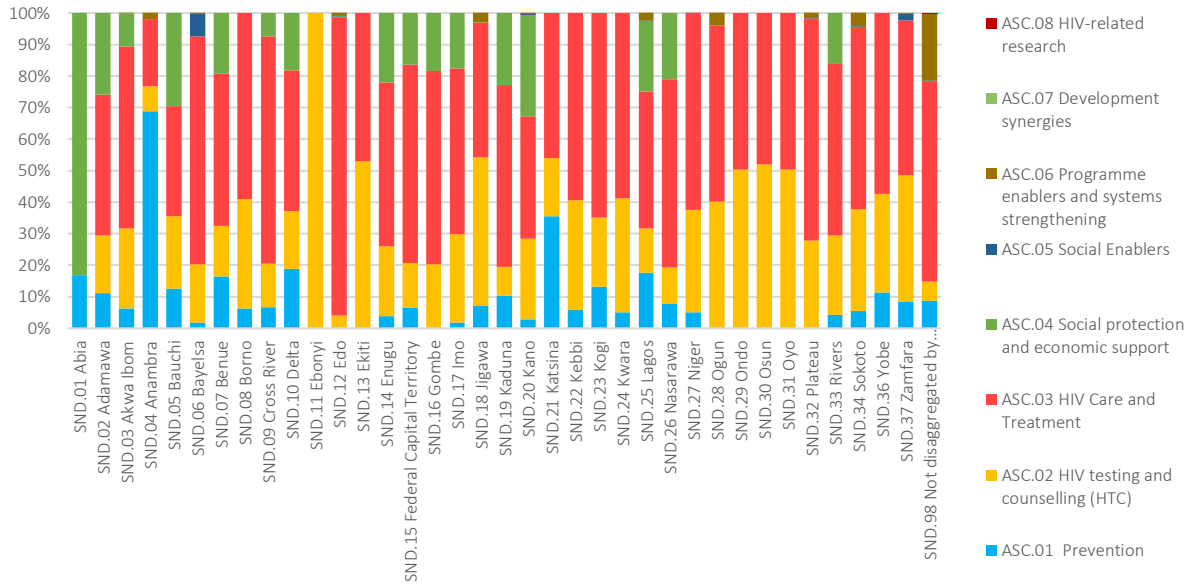
*Figure 38. Financing entities (FE) of the HIV expenditure by State (SND) in 2021, %*




Programmatic breakdown of the state level HIV expenditure is presented in the **Figure 39**. Similar analysis could be done for all the other NASA classifications, providers of services, beneficiary populations, etc. As a matter of fact, a full report with a similar content as this NASA report could be produced for each individual state. However, due to a significant portion of the expenditure data lacking specific state coding (labelling or identification), the results presented here are intended more to showcase the analytical possibilities rather than to draw definitive conclusions. Given the current state of uncoded data, any attempt to derive substantial insights at this stage would be premature and possibly misleading.

[31] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilties was not included in the findings of this NASA report - thus Public Financing is underestimated.

*Figure 39. AIDS spending categories (ASC) of the HIV expenditure by State (SND) in 2021, %*




## 3.6. ANALYSIS OF SPENDING BY KEY FINANCIERS

### 3.6.1. HIV spending portfolio of the Government of the United States

The United States of America, through the President's Emergency Plan for AIDS Relief (PEPFAR), stands as the primary contributor to HIV expenditure in Nigeria, encompassing 80% of the total spending in 2019 (US$272.5 million), increasing by 29% to reach US$351.7million (73%) in 2020, then declining again to US$330.6 million in 2021, but maintaining a significant share of 76% (see **Figure 40**).

PEPFAR channels its HIV funding in Nigeria through various agencies, including the United States Agency for International Development (USAID), the US Centre for Disease Control and Prevention (US CDC), and the Department of Defence (DoD). Acting on the advice of the PEPFAR Coordination Office in Nigeria, all these US government agencies were designated as Financing Agent-Purchasers in this NASA (FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles).

As explained in the annex detailed the methods employed in this NASA, the PEPFAR expenditure reporting (ER) data were provided with only their IPs' type of organisation coded, without further break down by their sub-recipients' types, as the actual providers of services. Thus, detailed PS codes could not be easily and accurately applied. For instance, according to the PEPFAR ER data, none of the PEPFAR-financed interventions in the area of HIV prevention and HIV testing and counselling were implemented by the public sector entities. Similarly, no involvement of public clinics and hospitals was indicated in the PEPFAR ER dataset for their HIV care and treatment expenditure. For the particular case of ART service provision, the NASA team worked with the stakeholders to come up with assumptions to distinguish public and private non-profit sector service provision (see Annex 2.9.1 for more details).

PEPFAR-supported HIV spending portfolio primarily focused on providing HIV care and treatment services. In 2019, 62% of PEPFAR's HIV expenditure was allocated to ASC.03 HIV care and treatment, increasing to 68% in 2020 and 55% in 2021 (see **Figure 41**). The decrease in spending on care and treatment (ASC.03) in 2021 was primarily driven by a reduction in the procurement of ARVs. Since these

figures reflect procurement data, they do not reflect the variation in the implementation of programs such as ART, which has actually been increasing throughout the period analysed.

PEPFAR's second-largest spending area was ASC.06 Programme enablers and systems strengthening, accounting for 22% in 2019, 12% in 2020, and 13% in 2021. Expenditure on ASC.02 HIV testing and counselling has seen consistent growth, reaching US$45.5 million in 2021, representing 14% of total PEPFAR HIV resources. Importantly, ASC.01 HIV prevention (excluding HTC) spending increased from US$6.3 million to $37.1 million between 2019 and 2021, constituting 11% of PEPFAR's HIV portfolio in Nigeria. This increase was mainly driven by the investment in PrEP, which came up from only US$44,580 in 2019, US$560,772 in 2020 to US$23,179,570 in 2021.

*Figure 40. PEPFAR-supported HIV expenditure by AIDS Spending Category (ASC) (1st digit), 2019-2021, US$ million*

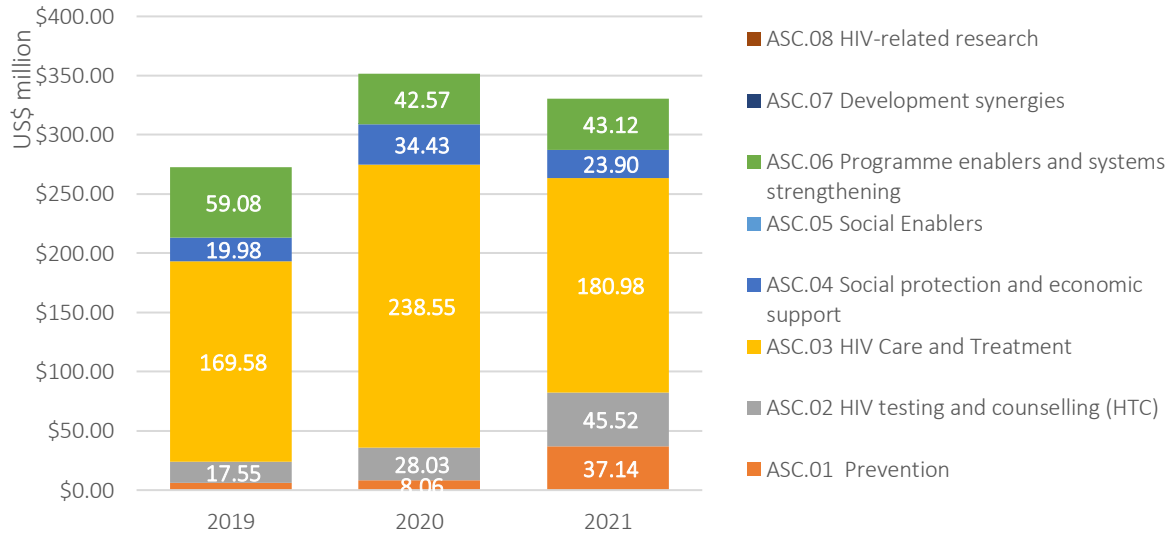
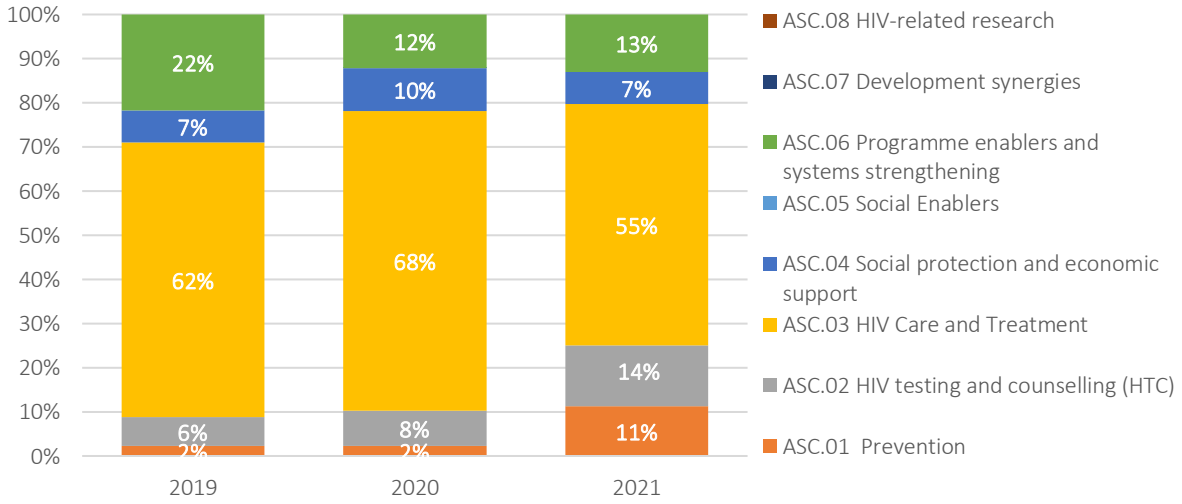



*Figure 41. PEPFAR-supported HIV expenditure by AIDS Spending Category (ASC) (1st digit), 2019-2021, %*

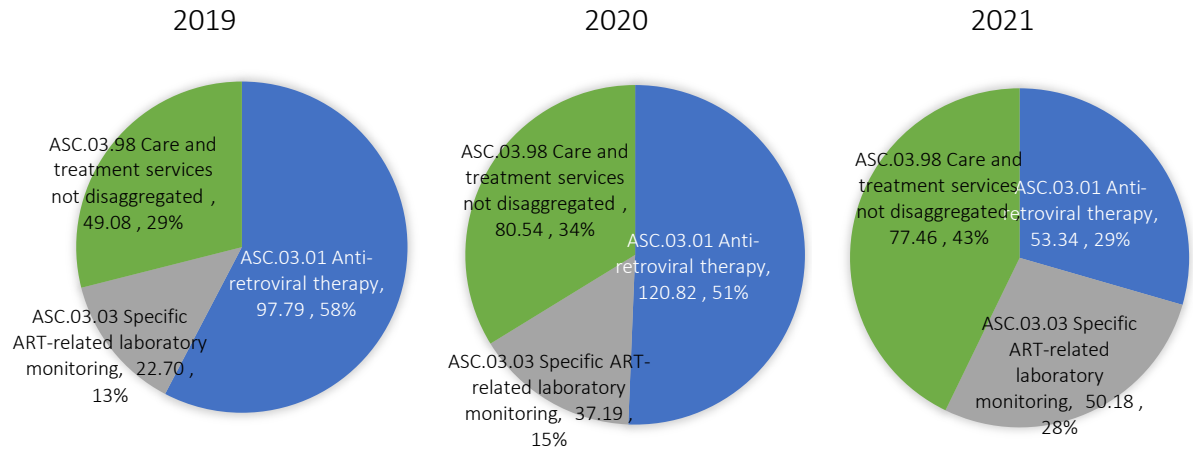



The provision of antiretroviral therapy (ART) constitutes the major portion of the ASC.03 HIV care and treatment in PEPFAR's HIV portfolio (see **Figure 42**). In 2019, it represented 58%, equivalent to US$97.8 million, and in 2020, it accounted for 51%, amounting to US$120.8 million. In 2021, ART spending decreased by more than a half, to US$53.3 million. Antiretroviral drugs were the major production factor of the PEPFAR's antiretroviral therapy program expenditure, amounting to US$80.8 million in 2019, US$106.1 million in 2020 and US$45.3 million in 2021. Expenditure on Contracted external services

within PEPFAR-supported ART expenditure was another significant component of the ART program: in 2019 it amounted to US$16.6 million, in 2020 US$14.0 million, and US$7.9 million in 2021. This expenditure was likely associated with the cost of the in-country drug distribution to the health facilities, managed by Chemonics.

PEPFAR's expenditure on ART-related laboratory monitoring has expanded, from US$22.7 million in 2019 reaching US$50.2 million in 2021. Their not disaggregated HIV care and treatment (ASC.03.98) spending (comprising mainly of their 'HIV clinical services' category), has increased over the assessment years, representing 24% of all PEPFAR-funded care and treatment in 2019, 28% in 2020, and 36% in 2021. This reflects the lack of disaggregation in some of the categories in the ER datasets, notably 'HIV clinical services'.

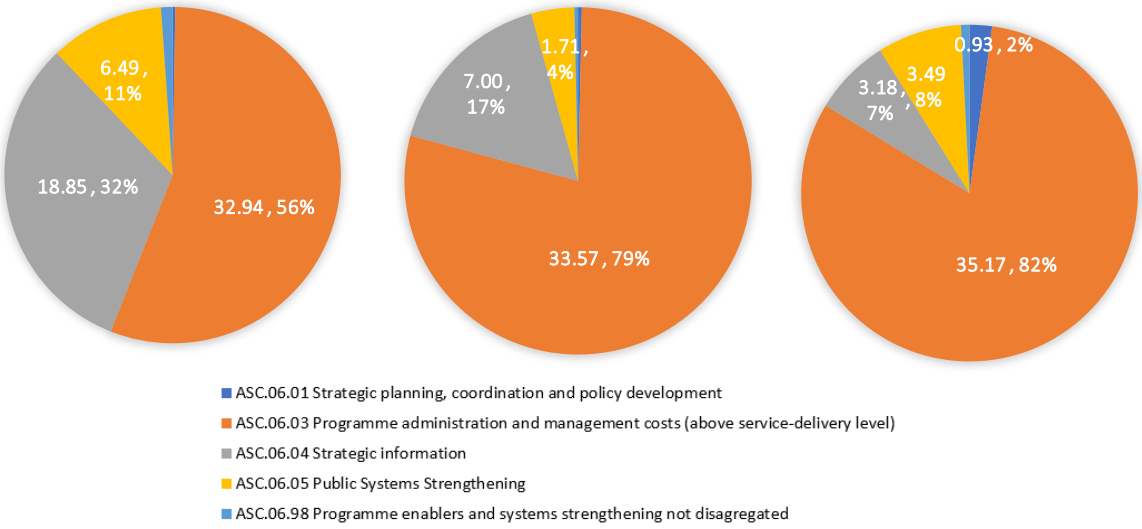
*Figure 42. Breakdown of PEPFAR-supported expenditure in ASC.03 HIV Care and Treatment, 2019-2021, US$ million and %*




Programme enablers, tracked under ASC.06, represent a significant amount in PEPFAR's HIV portfolio in Nigeria, totalling US$59 million (22%) in 2019, US$42.6 million (12%) in 2020 and US$43.1 million (13%) in 2021. A majority of these resources were directed towards programme administration and management, $32.9 million in 2019, $33.6 in 2020 and $35.2 million in 2021, remaining more or less constant over the period, despite PEPFAR's total investment declining in the last year of study (2021), thus increasing proportionally to 82% of the PEPFAR-financed ASC.06 (see **Figure 43Figure 43**).

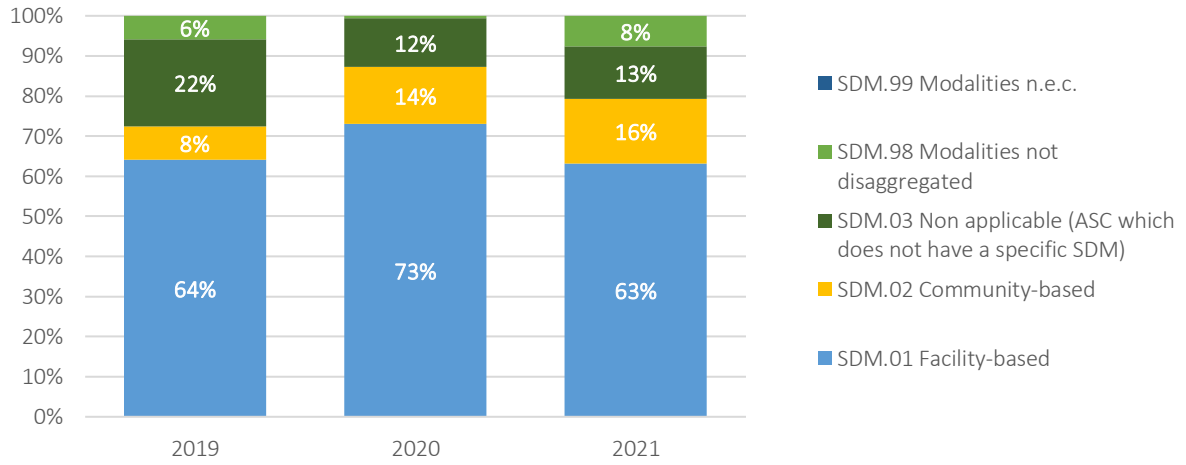
Investment in strategic information activities, tracked under ASC.06.04 was US$18.9 million in 2019, shrank to US$7.0 million in 2020 and ending 2021 with US$3.2 million, representing less than 1% of the total PEPFAR's expenditure on the HIV response in 2021 in Nigeria.

*Figure 43. Breakdown of PEPFAR-supported expenditure in ASC.06 Programme enablers and systems strengthening, 2019-2021, US$ million and %*




The distribution of PEPFAR's HIV spending among various service delivery modalities is presented in Figure 44, which shows facility-based interventions prevailed in all years, declining in the outer year. Community-based interventions comprised 8, 14 and increased to 16 percent of PEPFAR's HIV portfolio in 2019-2021.

*Figure 44. Service delivery modalities (SDM) of PEPFAR's HIV spending in Nigeria in 2019-2021, %*




Following the trends in the programmatic interventions of PEPFAR expenditure, PLHIV as the beneficiaries of all HIV care and treatment interventions, dominated PEPFAR's portfolio, representing 62% in 2019, 68% in 2020 and declined to 55% in 2021 (see Figure 45). PEPFARs spending on key populations increased to 11% in the 2021 from 3% in 2020, mainly due to the increased spending on PrEP for KPs. General population as a beneficiary of various prevention interventions and HIV testing activities, constituted 6% of total PEPFAR expenditure in 2019, 7% in 2020 and 13% in 2021. Expenditure towards non-targeted interventions accounted for 22% of PEPFAR's total HIV spending in 2019, 12% in 2020 and 13% in 2021.

*Figure 45. Beneficiary populations (BP) of PEPFAR HIV expenditure in Nigeria in 2019-2021, %*

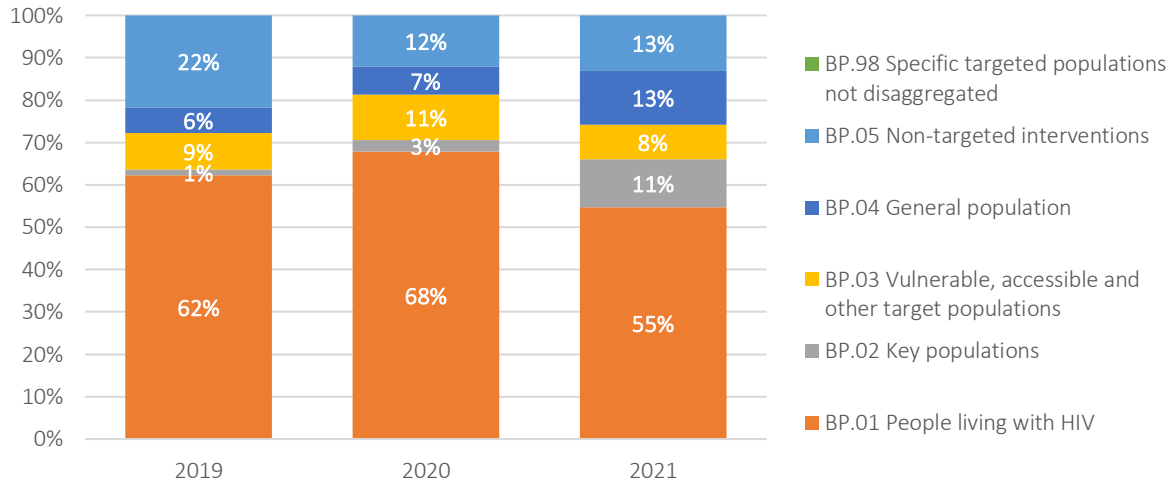



*Table 1. AIDS Spending Categories (2nd digit) of the HIV expenditure in Nigeria in 2019-2021, Funded by PEPFAR million US$ and %*

| ASC x FE.03.01.30 Government of United States | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **ASC.01 Prevention** | **6.27** | **2.30%** | **8.06** | **2.29%** | **37.14** | **11.23%** |
| ASC.01.01 Five Pillars of Prevention | 2.90 | 1.06% | 5.99 | 1.70% | 33.18 | 10.03% |
| ASC.01.02 Other prevention activities | 3.37 | 1.24% | 2.08 | 0.59% | 3.96 | 1.20% |
| **ASC.02 HIV testing and counselling (HTC)** | **17.55** | **6.44%** | **28.03** | **7.97%** | **45.52** | **13.77%** |
| ASC.02.01 HIV testing and counselling for sex workers | 0.57 | 0.21% | 1.57 | 0.45% | 0.52 | 0.16% |
| ASC.02.02 HIV testing and counselling for MSM | 0.23 | 0.08% | 0.77 | 0.22% | 0.28 | 0.08% |
| ASC.02.03 HIV testing and counselling for TG | 0.01 | 0.00% | 0.00 | 0.00% | 0.01 | 0.00% |
| ASC.02.04 HIV testing and counselling for PWID | 0.10 | 0.04% | 0.44 | 0.12% | 0.13 | 0.04% |
| ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities | 0.01 | 0.00% | 0.13 | 0.04% | 0.03 | 0.01% |
| ASC.02.06 HIV testing and counselling for pregnant women (PMTCT) | 0.37 | 0.14% | | 0.00% | | 0.00% |
| ASC.02.08 HIV testing and counselling for vulnerable and accessible populations | | 0.00% | 0.41 | 0.12% | 0.71 | 0.22% |
| ASC.02.09 Voluntary HIV testing and counselling for general population | 16.20 | 5.95% | 22.27 | 6.33% | 38.73 | 11.71% |
| ASC.02.11 HIV screening in blood banks | | 0.00% | 0.00 | 0.00% | | 0.00% |
| ASC.02.98 HIV testing and counselling activities not disaggregated | 0.07 | 0.03% | 2.44 | 0.69% | 5.11 | 1.54% |
| **ASC.03 HIV Care and Treatment** | **169.58** | **62.24%** | **238.55** | **67.83%** | **180.98** | **54.74%** |
| ASC.03.01 Anti-retroviral therapy | 97.79 | 35.89% | 120.82 | 34.35% | 53.34 | 16.13% |
| ASC.03.03 Specific ART-related laboratory monitoring | 22.70 | 8.33% | 37.19 | 10.58% | 50.18 | 15.18% |
| ASC.03.98 Care and treatment services not disaggregated | 49.08 | 18.02% | 80.54 | 22.90% | 77.46 | 23.43% |
| **ASC.04 Social protection and economic support** | **19.98** | **7.33%** | **34.43** | **9.79%** | **23.90** | **7.23%** |
| ASC.04.01 Social protection and economic support for OVC | 19.77 | 7.26% | 34.43 | 9.79% | 23.90 | 7.23% |
| ASC.04.02 Other social protection and economic support (non-OVC) | 0.21 | 0.08% | | 0.00% | | 0.00% |
| **ASC.05 Social Enablers** | | **0.00%** | **0.03** | **0.01%** | | **0.00%** |
| ASC.05.98 Social enablers not disaggregated by type | | 0.00% | 0.03 | 0.01% | | 0.00% |
| **ASC.06 Programme enablers and systems strengthening** | **59.08** | **21.68%** | **42.57** | **12.10%** | **43.12** | **13.04%** |
| ASC.06.01 Strategic planning, coordination and policy development | 0.15 | 0.06% | 0.15 | 0.04% | 0.93 | 0.28% |
| ASC.06.03 Programme administration and management costs (above service-delivery level) | 32.94 | 12.09% | 33.57 | 9.55% | 35.17 | 10.64% |
| ASC.06.04 Strategic information | 18.85 | 6.92% | 7.00 | 1.99% | 3.18 | 0.96% |
| ASC.06.05 Public Systems Strengthening | 6.49 | 2.38% | 1.71 | 0.49% | 3.49 | 1.06% |
| ASC.06.98 Programme enablers and systems strengthening not disaggregated | 0.66 | 0.24% | 0.14 | 0.04% | 0.35 | 0.11% |
| **Total** | **272.46** | **100.00%** | **351.68** | **100.00%** | **330.64** | **100.00%** |

### 3.6.2. HIV spending portfolio of the Global Fund

The Global Fund (GFATM) played a substantial role in Nigeria's HIV response. In 2019, it comprised 11% of the total HIV expenditure at US$36.5 million, while in 2020 its presence grew significantly to US$101.6 million (21%) driven by the procurement of ARVs specifically, but then declined to US$81.5 million (19% of total HIV spending). For the purposes of this NASA, any identifiable COVID-19-related components within all grants (HIV, TB/HIV, and RSSH) have been excluded from the expenditure analysis (US$ 2.1 million in 2020 and US$ 3.8 million in 2021).

The management of the Global Fund-supported HIV programmes in Nigeria involved three Principal Recipients: NACA, the Lagos State Ministry of Health, and FHI360 (see **Figure 46**).

*Figure 46. Financing agents-purchasers (FAP) of the expenditure originated from The Global Fund in 2019-2021, %*

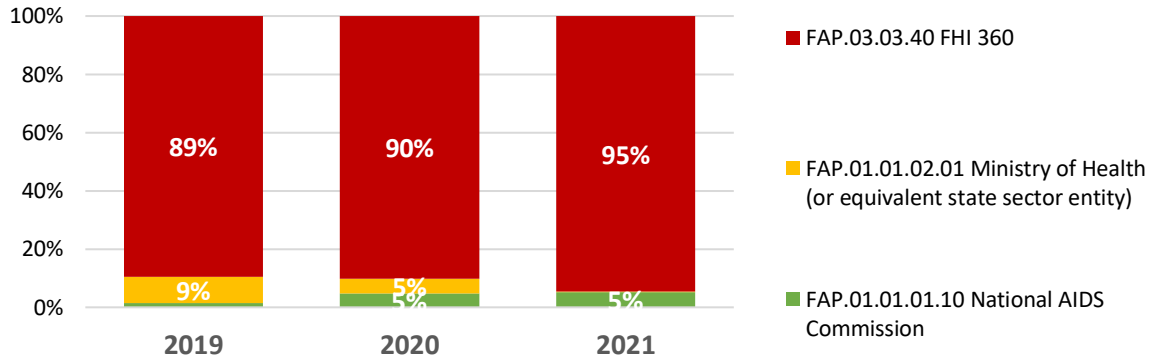
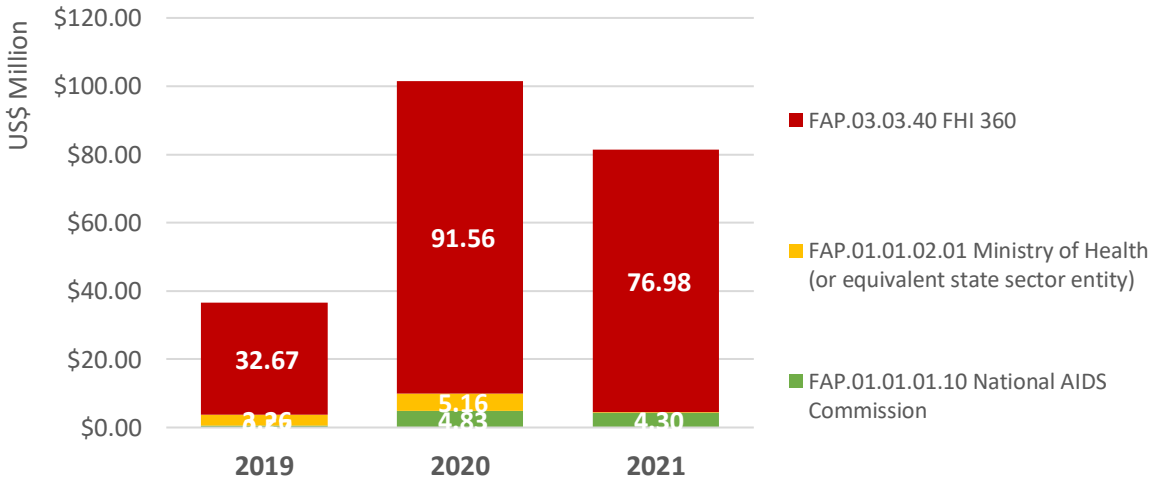



*Figure 47. Financing agents-purchasers (FAP) of the expenditure originated from The Global Fund in 2019-2021, US$ million*




FHI360, an international NGO, emerged as the primary financial agent-purchaser of Global Fund expenditure on HIV in Nigeria, overseeing 95% of the GFATM-funded HIV expenditure in 2021. NACA managed 5% of the GFATM-funded HIV resources in 2020 and 2021. Lagos State Ministry of Health was responsible for TB and TB/HIV grants, but only TB/HIV activities were included in this NASA: US$3.3 million, US$5.2 million and US$162 thousand in 2019, 2020 and 2021 respectively.

Programmatic breakdown of the GFATM HIV expenditure in shown in the **Figure 48** and **Figure 49**).

*Figure 48. GFATM HIV expenditure by AIDS Spending Category (ASC) (1st digit) in 2019-2021, US$ million*

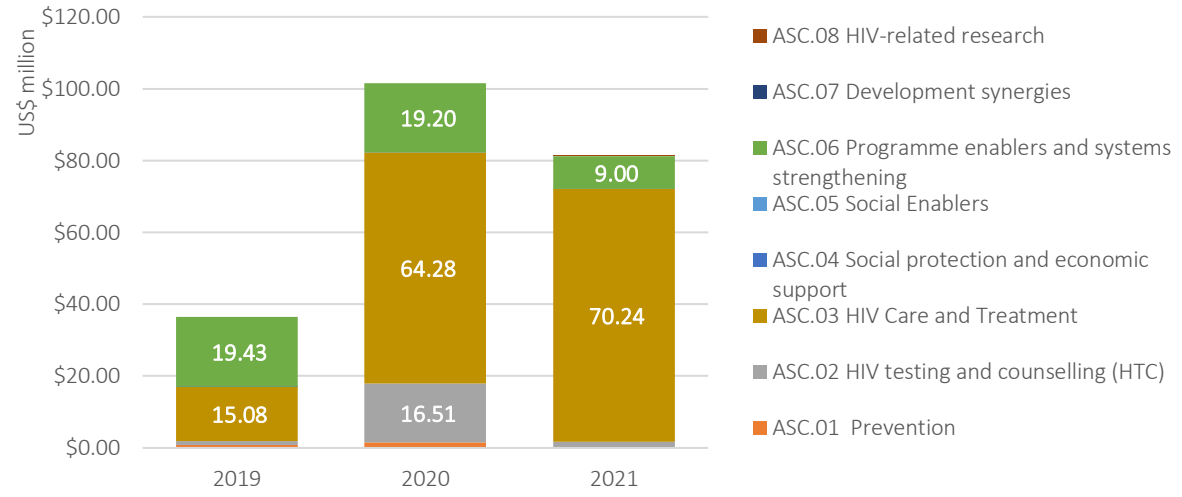
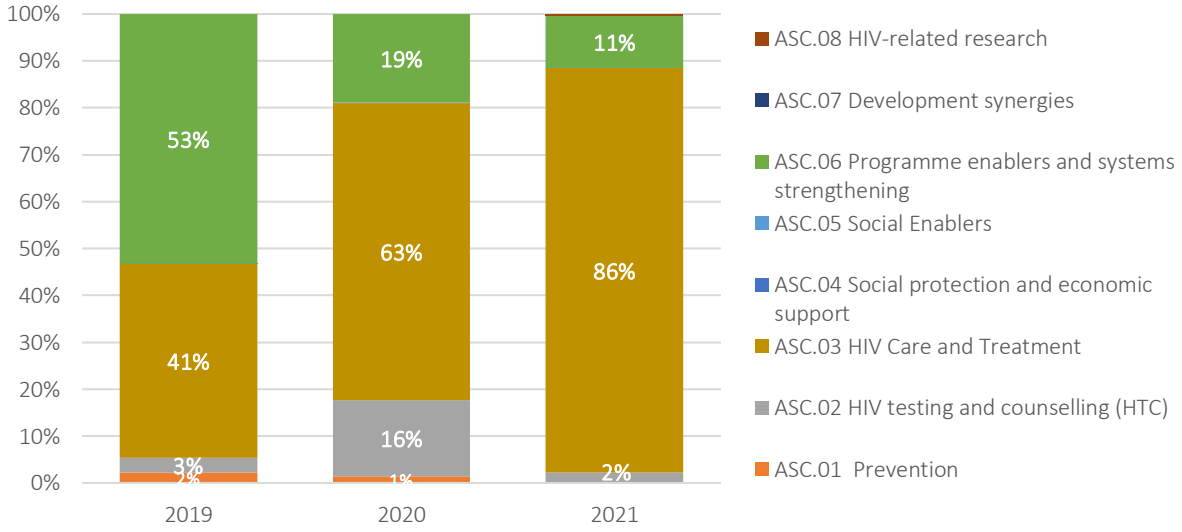



*Figure 49. GFATM HIV expenditure by AIDS Spending Category (ASC) (1st digit) in 2019-2021, %*




HIV care and treatment emerged as the most significant program component in GFATM's spending, reaching US$15.1 million in 2019, increasing to US$64.3 million in 2020, and US$70.2 million in 2021. Notably, a substantial portion of GFATM-funded HIV care and treatment in 2020 and 2021, 79% and 97%, was allocated to the provision of antiretroviral therapy (**Table 2Error! Reference source not found.**). In 2019, spending on ASC.03.98 HIV care and treatment not disaggregated by intervention dominated, representing 86% of ASC.03 and indicating a lack of specificity in the primary financial data obtained by the NASA team. However, there was an improvement in the level of detail in 2020, where only 16% of GFATM spending on treatment and care was not broken down by intervention, reducing further to 1% in 2021, showcasing a significant enhancement in data granularity.

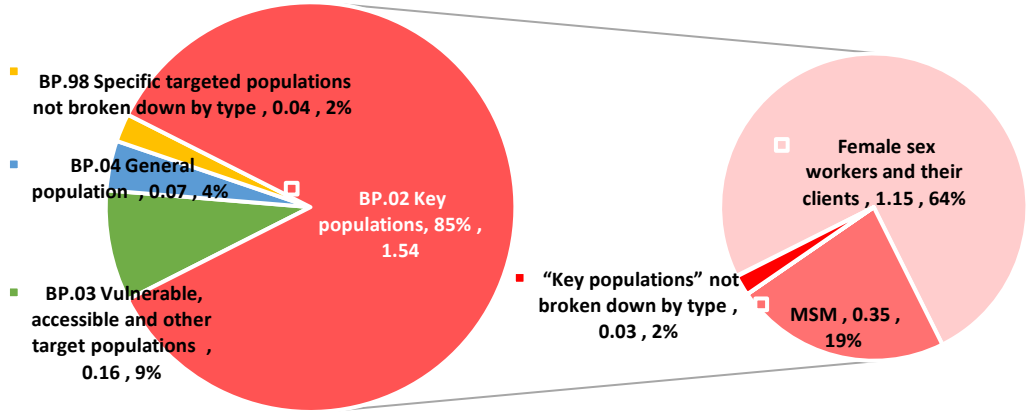
Of note is the limited GFATM spending on prevention interventions in the first two years of the study, and which then declined to almost nothing in the third year. Similarly, spending on HTC made up 3% and 16% in 2019 and 2020 respectively, but then also reduced to close to zero in 2021.

*Table 2. Breakdown of GFATM-supported expenditure in ASC.03 HIV Care and Treatment in 2019-2021, US$ million and %*

| ASC.03 HIV care and treatment | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| ASC.03.01 Anti-retroviral therapy | 1.13 | 7% | 50.48 | 79% | 68.36 | 97% |
| ASC.03.02 Adherence and retention on ART - support and monitoring | 0.50 | 3% | 0.22 | 0% | 0.37 | 1% |
| ASC.03.03 Specific ART-related laboratory monitoring | 0.06 | 0% | 0.05 | 0% | 0.54 | 1% |
| ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs | 0.41 | 3% | 3.19 | 5% | 0.10 | 0% |
| ASC.03.05 Psychological treatment and support services | 0.06 | 0% | 0.08 | 0% | 0.00 | 0% |
| ASC.03.98 Care and treatment services not disaggregated | 12.92 | 86% | 10.25 | 16% | 0.86 | 1% |
| **Total** | **15.08** | **100%** | **64.28** | **100%** | **70.24** | **100%** |

Figure 50 shows the distribution of resources funded by GFATM for prevention, HIV testing, and counselling interventions by beneficiary population in 2021. These two broad GFATM-funded ASCs totalled US$1.8 million in 2021. A significant portion of these funds, amounting to US$1.5 million and representing 85% of GFATM-funded prevention and HIV testing programs, was directed towards initiatives focusing on key populations. Of these funds, three-quarters (US$1.2 million) were dedicated to programs for female sex workers and their clients, while a smaller fraction was targeting men who have sex with men (US$0.35 million).

*Figure 50. Beneficiary populations of the GFATM-supported expenditure under ASC.01 HIV Prevention and ASC.02.HIV Testing and counseling in 2021, %*




In 2019, more than half of the principal recipients' spending went towards Programme enablers and systems strengthening (under ASC.06), accounting for US$19.4 million (53% of GFATM HIV spending). Although the reported expenditure on programme enablers and systems strengthening was similar in 2020, the proportion dropped to 19% of GFATM-originated expenditure. It further declined to US$9 million in the following year, representing 11% of GFATM expenditure on HIV in Nigeria (see Figure 48 and Figure 49).

In all three years of assessment, the majority of spending on programme enablers and systems strengthening went towards Program administration and management costs (above service-delivery level) (US$ 15.8 million, US$ 13.3 million and US$5.4 million respectively). Resources allocated to ASC.06.04 Strategic information fluctuated between US$1.3 million in 2019, US$4.2 million in 2020, and US$2.7 million in 2021 (Table 3Error! Reference source not found.).

*Table 3. Breakdown of GFATM expenditure in ASC.06 Programme enablers and systems strengthening in 2019-2021, US$ million*

| ASC.06 Programme enablers and systems strengthening | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| ASC.06.01 Strategic planning, coordination and policy development | 0.40 | 2% | 0.40 | 2% | 0.14 | 2% |
| ASC.06.03 Programme administration and management costs (above service-delivery level) | 15.83 | 81% | 13.30 | 69% | 5.44 | 60% |
| ASC.06.04 Strategic information | 1.33 | 7% | 4.15 | 22% | 2.68 | 30% |
| ASC.06.05 Public Systems Strengthening | 1.85 | 10% | 1.36 | 7% | 0.63 | 7% |
| ASC.06.06 Community system strengthening | 0.00 | 0% | - | 0% | 0.03 | 0% |
| ASC.06.07 Human resources for health (above-site programmes) | 0.01 | 0% | - | 0% | 0.08 | 1% |
| **Total** | **19.43** | **100%** | **19.20** | **100%** | **9.00** | **100%** |

The breakdown of all GFATM expenditure by beneficiary population, revealed trends consistent with their programmatic focus described earlier (see **Figure 51** and **Figure 52**). People living with HIV, recipients of all ASC.03 HIV care and treatment services, constituted the largest beneficiary population in the GFATM portfolio in 2019-2021. Non-targeted interventions represented 53%, 19%, and 12% of GFATM spending in Nigeria (mostly under ASC.06 Programme enablers and systems strengthening). A significant portion of spending in 2020, 15% or US$15.7 million, was not specified by a particular beneficiary population, indicating a lack of detailed programmatic and commodity distribution data on HTC.

Mirroring the situation with HIV prevention and testing, key populations, vulnerable and accessible groups, along with the general population, constituted only a small fraction of the GFATM grants during 2019-2021. This underscores the portfolio's continued emphasis on PLHIV during the assessed years.

*Figure 51. Beneficiary populations (BP) of the GFATM HIV expenditure in 2019-2021, US$ million*

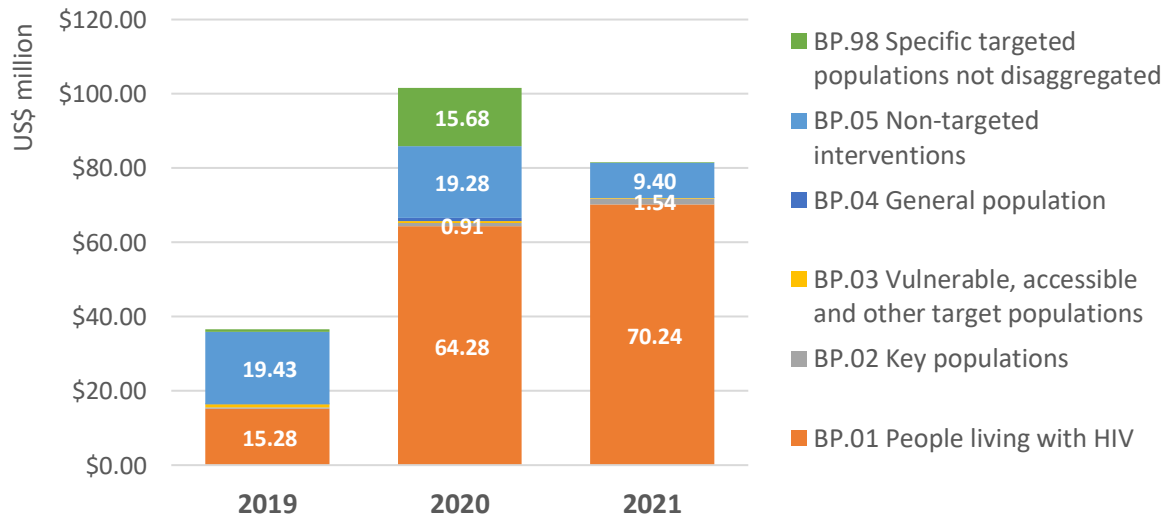
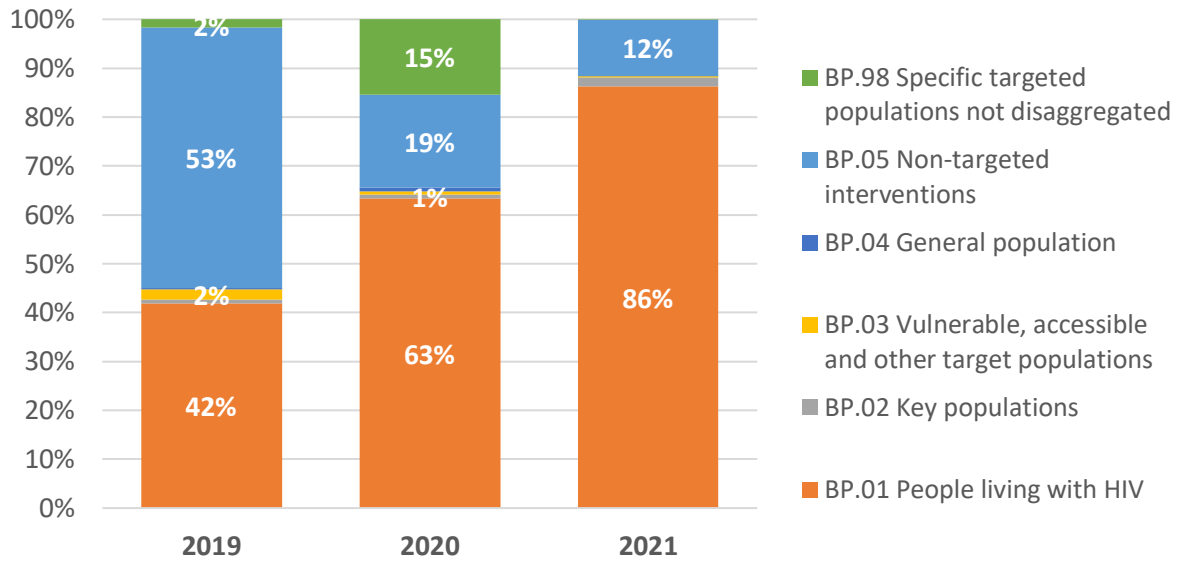


*Figure 52. Beneficiary populations (BP) of the GFATMd HIV expenditure in 2019-2021, %*




At the service provision level, Figure 53 and Figure 54 demonstrate that public providers played the dominant and increasing role in the two outer years (minimal in the first year), delivering 42% of all HIV services under the GFATM umbrella in 2020 and 64% in 2021, followed by the non-profit organisations, with 44%, 29% and 32% in each year. International NGOs initially played the key delivery role in 2019 (46%), but reducing to 29% in 2020, and then only 4% in 2021.

*Figure 53. Providers of services for GFATM-originated expenditure, 2019-2021, US$ million*

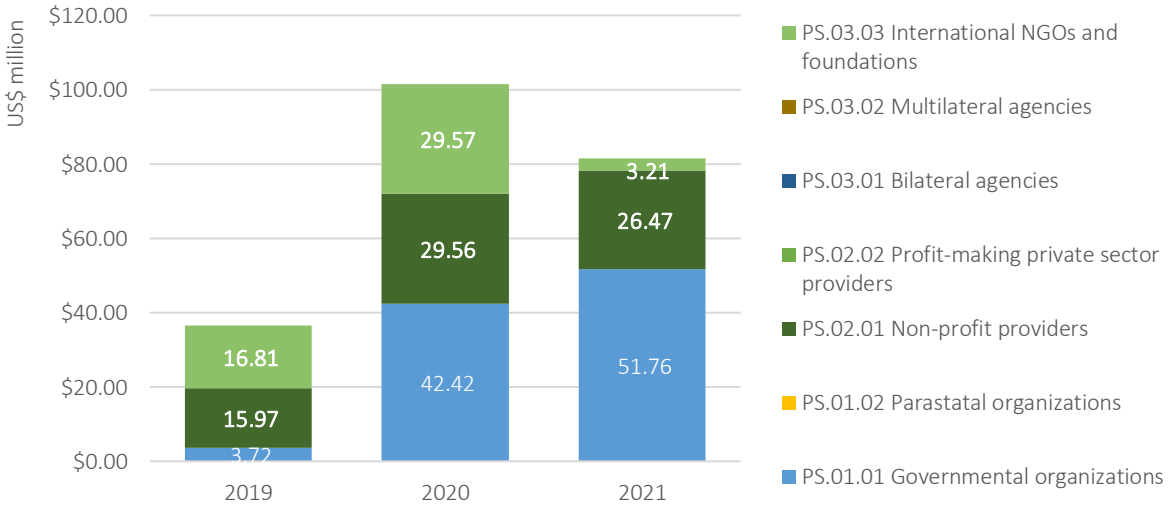
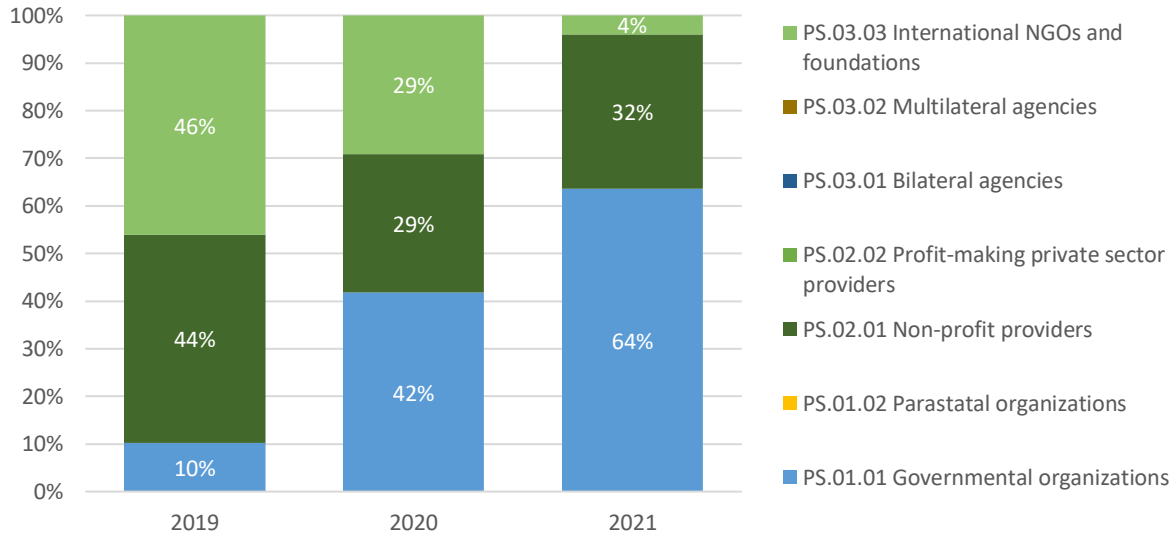
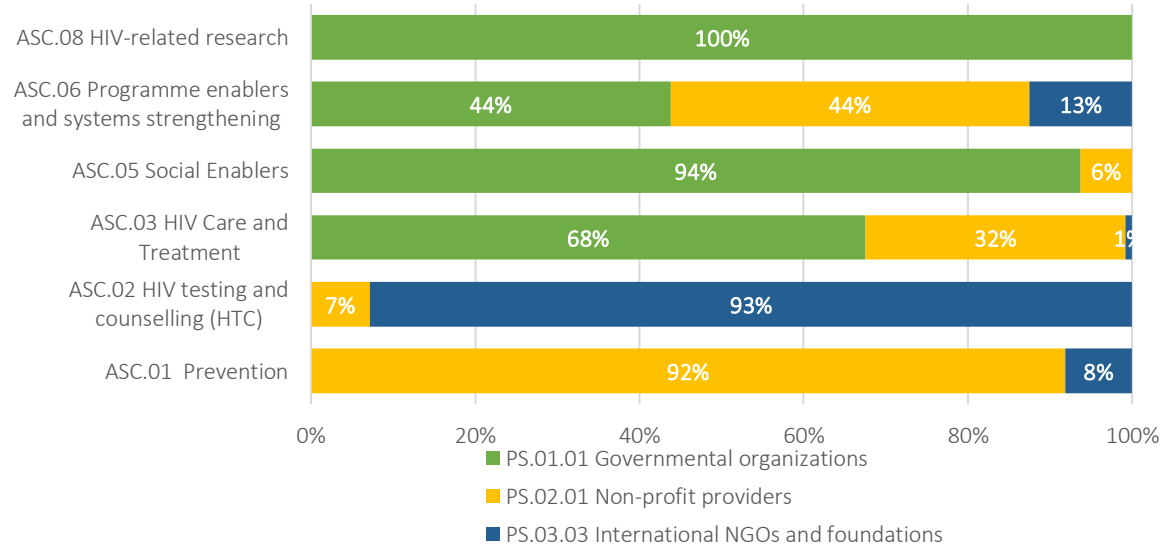


*Figure 54. Providers of services for GFATM-originated expenditure, 2019-2021, %*



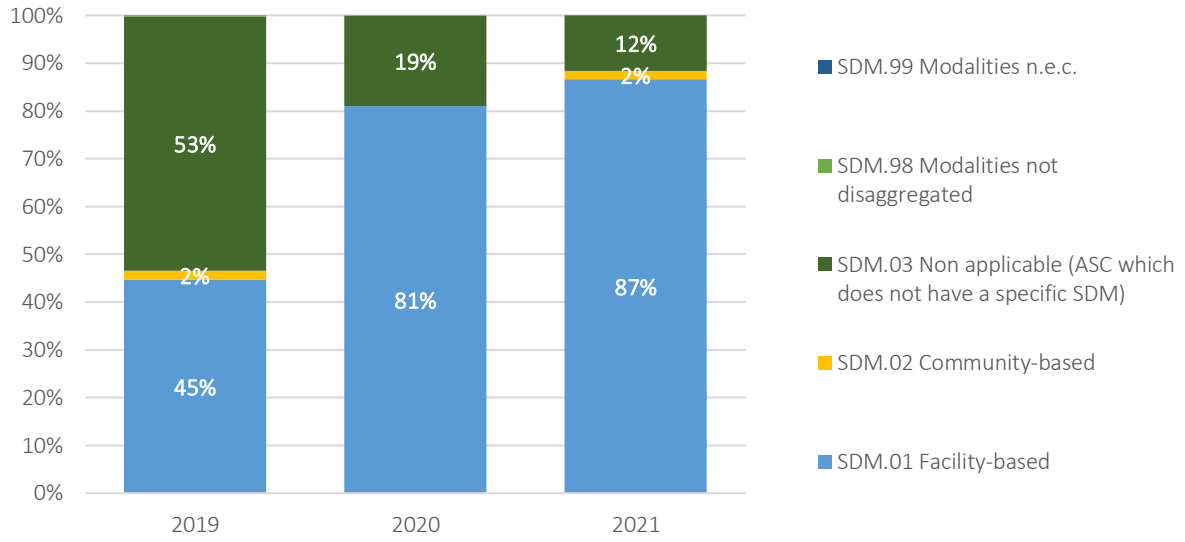

In 2021, the majority of GF-suppported interventions categorized under ASC.01 HIV prevention were delivered by domestic private sector non-profit providers, primarily represented by NGOs. On the other hand, HIV testing and counselling was predominantly facilitated by international NGOs as service providers (see **Figure 55**). Regarding care and treatment interventions, public entities were the primary service providers (68% of ASC.03), and NGOs constituted 32% of GFATM-supported HIV care and treatment in 2021.

*Figure 55. Providers of services (PS) of the main AIDS spending categories (ASC) for GFATM-financed activities in 2021, %*




As illustrated in **Figure 56**, service provision supported by GFATM was primarily facility-based, because of the predominant focus on HIV treatment and care interventions. Community-based service delivery remained relatively limited in the GFATM portfolio in Nigeria, constituting only 2% of the total GFATM spending in 2021.

*Figure 56. Service delivery modalities of the GFATM-supported interventions, 2019-2021, %*



# 4. CONCLUSIONS AND RECOMMENDATIONS

## 4.1. CONCLUSIONS

1. **High reliance on development partners' support raises concerns about the sustainability of the Nigerian HIV response**. The NASA data revealed a significant dependence on external funding sources, with the Government of the United States, through PEPFAR, emerging as the largest contributor, with 76% of HIV spending in Nigeria in 2021. The Global Fund (GFATM) is the second largest donor of the country's HIV response (19% in 2021). The lack of data on the government's HIV shared health system costs in this NASA2.7[32] inflates the share of donor dependency. Nonetheless, even if public funding in 2019-2021 remained at the 2018 estimated figure of $91 million (previous NASA), development partners' contributions would still constitute a vast majority of the funding (around 78%, 83%, and 82% of total HIV funding for the study years, under the mentioned scenario).

2. **Fluctuations in the levels and programmatic priorities of the financial allocations from main development partners may have a major impact on the HIV response implementation and sustainability**. Several key programmatic areas and interventions of the Nigerian HIV response were highly susceptible to changes in funding from development partners. In 2021, GFATM and PEPFAR together financed 100% of the preventive programs for key populations (in particular PrEP), 94% of the Antiretroviral therapy, 93% of HIV testing and counselling programmes, and 63% of Prevention of vertical transmission of HIV infection.

3. **Funding from domestic private for-profit entities captured in this assessment was minimal**. Only a few organizations reported expenditure financed by private foundations or corporations, and no direct efforts were made by the data collection team to contact private for-profit entities for their HIV donations. Considering that there are over 3,700 non-profit organisations around the country focused on different areas of the national development it is reasonable to assume that the actual expenditure financed by the private sector entities may have been higher than what was recorded in this NASA.

4. **Out-of-pocket payments (OOPP) on HIV remain excluded from HIV spending analysis in Nigeria.** Due to the lack of available estimates out-of-pocket HIV spending has never been analysed in the NASAs conducted in Nigeria. However, it's important to highlight that the World Health Organization (WHO) identifies Nigeria as having the highest out-of-pocket health expenditure rate in West Africa as a share of current health expenditure (CHE). In 2020, this expenditure accounted for an estimated 75% of CHE. Therefore, it's reasonable to expect that households may also incur considerable out-of-pocket payments for HIV in the country, although ARVs are provided free by the government.

5. **The country is on the path to achieving NSP Target 6: "Allocate 26% of all HIV expenditures on prevention by 2025."** This target was calculated based on the average prevention expenditure

[32] For further details see Appendix PROCESSING GOVERNMENT OF NIGERIA DATA (CENTRAL LEVEL), page- 71-

values from the previous NASA study 2015-2018[33]. This target includes HIV testing and counselling services as well as all other prevention interventions. Based on the current NASA results it is confirmed that the country is progressing towards meeting the objectives set in its NSP target, when considering HTC spending as well. In 2020, expenditure on prevention and HTC accounted for 14% of total HIV spending, while by the year 2021, this figure rose to 21%. The increased proportion was largely driven by PrEP funding from PEPFAR.

6. **Excluding spending on HIV testing and counselling, the funds dedicated solely to HIV prevention programs[34] were remarkably low in 2019 and 2020**, amounting to 3% and 2% of the total expenditure respectively. This proportion increased to 9% of the total HIV expenditure (equal to US$39.45 million) in 2021, driven by the expansion of PrEP programmes. Other prevention efforts, such as VMMC, condoms, key population interventions remained concerningly low.

7. **The availability of distribution data for HIV commodities is crucial for accurately estimating their consumption value.** In this report, key commodities such as antiretroviral medications, HIV testing kits, and CD4 and viral load tests are documented according to purchase records instead of the value of their actual usage. It is only through evaluating the value of commodities actually utilized in the HIV response that decision-makers can thoroughly examine the execution of the National Strategic Plan or identify funding gaps using the NASA results.

8. **Provision of data to NASA by some key donors presented a significant challenge due to a lack of necessary granularity,** particularly in data received from PEPFAR, Global Fund, and the Government of Nigeria. A substantial portion of the data reported by these organizations lacks the level of detail required for accurately identifying service providers, financing schemes, AIDS spending categories, production factors, beneficiary populations, or geographical locations where programs were implemented.

9. The financial contributions from the Government of Nigeria to antiretroviral drug purchases in 2019-2021, suggest that **Nigeria met the National HIV and AIDS Strategic Framework 2021-2025 Target 27** of the Sustainable Financing Result Framework, of **"GoN effectively increases annual contribution to cover treatment costs of at least 50,000 PLHIV per year".** While the data on the number of people who received ART financed by the Government of Nigeria was not available, based on the analysis of the costs in the NSP 2021-2025 (US$ 84.34 per person on ART) and public antiretroviral expenditure recorded in NASA in 2021 (US$ 8 million), the government of Nigeria may have financed ART for more than 95,000 PLHIV in 2021.

10. **Financing schemes of non-profit organizations** (both national and resident foreign agencies, such as international NGOs, bilateral and multilateral organizations) **were the primary financing mechanisms for prevention programs, HIV testing, and social protection and economic support**. On the other hand, **the central government's financing scheme was the main mechanism for care and treatment programs in the assessment period**.

11. **The national HIV response in Nigeria was mostly managed by international Financing Agent Purchasers,** which managed 90% or more of total HIV spending each year of assessment. This

[33] NSP 2021-2025 Target 6: percentage of total HIV spending on prevention, all sources; baseline = 18% [NASA 2015-2018 prevention average]; target for 2025 = 26%")

[34] Prevention excluding HIV testing and counselling (i.e. ASC.01 Prevention as defined in the latest NASA classifications)

dynamic requires continued enhanced coordination and collaborative effort to ensure that the priorities of development partners are consistently aligned with those of the government and the national strategic priorities, out lined in the NSP.

12. Nigeria HIV response is aligning with global PrEP strategies for HIV prevention. PEPFAR-funded spending on PrEP significantly increased spending on preventive programs. PrEP spending went from 0.01% of total HIV spending in 2019 to 5.3% in 2021. PrEP was the preventive program with the highest funding in 2021, capturing 59% of preventive spending that year. Sustainability of this initiative in the short to medium term hinges on the availability of external funding.

13. Spending targeted at key populations grew exponentially in the analysed period. Spending directed towards key populations increased by 800% between 2019 and 2021, reaching 9% of the total HIV expenditure in 2021 (US$ 38.8 million) from a mere 1% in 2019 (US$ 4.3 million). This expansion is largely driven by PEPFAR spending on PrEP.

14. People living with HIV continue to be the primary beneficiaries of HIV-related spending. Each study year, approximately two-thirds of the total expenditure was allocated to this group, primarily to support care and treatment needs.

15. There was a sizable gap in data showing how HIV resources were distributed across the country. NASA exercise aimed at disaggregating all reported HIV expenditure for the year 2021 by geographical area (State) through adapted data collections forms and additional data requests to organizations-respondents. Results show that only 36% of spending could be attributed to the specific state where services are delivered. Consequently, a significant 64% of the expenditures lacked precise geographical allocation. The challenge of allocating and reporting expenditure according to its geographic location of implementation represented an obstacle for both public and international institutions: 90% percent of governmental institutions' spending and 63% of donor spending lacked attribution to specific states. This high level of spending not disaggregated by geographic location, impedes meaningful analysis and understanding of resource allocation at the subnational level, critical for co-ordinated, optimal and sustainable planning of the future response.

## 4.2. RECOMMENDATIONS

These recommendations are based on the NASA findings and conclusions:

1. **Scale up HIV prevention activities** by securing increased funding from both central and state governments to achieve Target 6 of the National HIV/AIDS Strategic Plan 2021-2025 to "Allocate 26% of all HIV expenditures on prevention by 2025". Develop a comprehensive sustainability plan to guarantee uninterrupted access to comprehensive HIV prevention packages, including interventions targeting key populations and Pre-Exposure Prophylaxis, which represents a relatively recent but rapidly expanding service in Nigeria.

2. **Expand domestic public funding for antiretroviral therapy** to ensure sustainable access to treatment for people living with HIV. Ensure that individuals have a clear and accessible pathway from HIV testing to receiving timely and effective treatment and care, including adherence support and viral load monitoring.

3. **Enhance the next NASA** exercise through a shift **towards a consumption-based estimation methodology**, providing a more accurate representation of the value of service and programs implemented in each year. Leverage available consumption data for bottom-up estimations of HIV commodities' utilization, such as ARV drugs, HIV tests, tests for laboratory monitoring of ART, OI drugs, and other relevant items. This should also extend to geographical breakdown of the HIV expenditure on commodities.

4. **Improve expenditure data granularity**, especially from organizations overseeing extensive HIV programs, managing multiple financing streams, disbursing funds to diverse service providers, and handling procurement activities. Dedicate additional efforts to disaggregate PEPFAR and Global Fund data, to provide detailed information to correctly identify financing agent-purchasers (FAP), service delivery modalities (SDM), providers of services (PS), beneficiary populations (BP) and sub-national data (SND).

5. **Conduct an in-depth examination of the shared public health systems costs** to gain a comprehensive understanding of the value of government's investments in the HIV response, such as human resources and infrastructure.

6. **Raise awareness among different government** entities at both central and state levels, responsible for managing or directly executing HIV-related programs or services, **regarding the significance of submitting comprehensive data for the NASA exercise and the level of detail necessary**. Enhancing the reporting of personnel cost associated with the HIV response, particularly within the SACAs, is critical. It is suggested that a dedicated segment on estimating such costs be incorporated into virtual training workshops, especially before the commencement of NASA data collection.

7. **Enhance collaboration with the National Health Insurance Authority (NHIA)** to obtain detailed information on the HIV-related expenditure under the national health insurance scheme in the next round of NASA.

8. **Explore and expand the involvement of the private sector in the HIV response**, harnessing the potential contributions of domestic and international corporations operating in Nigeria, particularly in implementing workplace-based HIV prevention and treatment programs.

9. **Consider exploring the possibility of incorporating an HIV-related out-of-pocket expenditure questionnaire in upcoming household surveys** planned for Nigeria, such as the General Household Survey or the Demographic and Health Surveys.

10. **Integrate insights derived from NASA into the formulation of the new National HIV/AIDS Strategic Plan**, ensuring the inclusion of robust financial monitoring mechanisms for implementation at both national and state levels. Enhance the NSP costing by providing a comprehensive description of unit cost components, methodologies for resource needs estimation, and approaches to defining targets and coverage. This will streamline monitoring efforts for NSP implementation and enable thorough financial gap analysis. This will inform more effective sustainability planning.

11. **Continue developing expertise within the NASA team in the country**, focusing on expanding the knowledge of the national HIV response and improvement of the technical skills required for data collection, processing, analysis and interpretation.

***

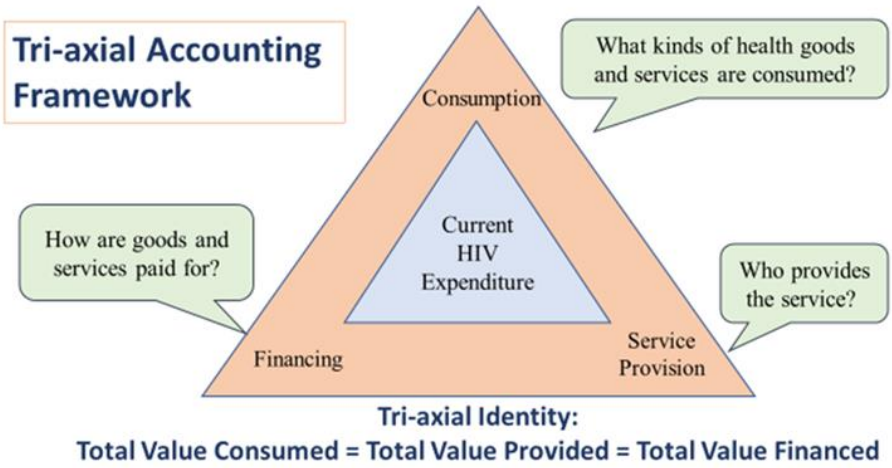
# ANNEX 1. NASA FRAMEWORK AND PROCESS

## 1.1. NASA FRAMEWORK

The National AIDS Spending Assessment (NASA) is designed to measure spending on the final consumption of goods and services in HIV responses worldwide by tracking the flow of spending from its origin to the final beneficiary. This comprehensive assessment utilizes nine classifications to describe expenditure activities and interventions. The classifications include Financing Entities (FE), Financing Schemes (SCH), Revenues of Financing Schemes (REV), Financing Agents-Purchasers (FAP), Providers of Services (PS), AIDS Spending Categories (ASC), Service Delivery Modalities (SDM), Beneficiary Populations (BP), and Production Factors (PF).

Notably, NASA's framework extends beyond health care service delivery systems, encompassing activities in education, social and institutional development, welfare sectors, and research. To avoid double-counting of expenses, NASA employs tables and double-entry matrices, representing the origin and destination of resources and facilitating the reconstruction of resource flows for all HIV transactions.

*Figure 57. NASA accounting framework*




The tri-axial system of analysis in the NASA framework revolves around consumption, provision, and financing (see **Figure 57**). Consumption is represented by AIDS spending categories, beneficiary populations and sub-national unit, provision is represented by providers of services, service delivery modalities, and production factors, and financing is represented by financing schemes, their revenues, financing entities, and financing agents.

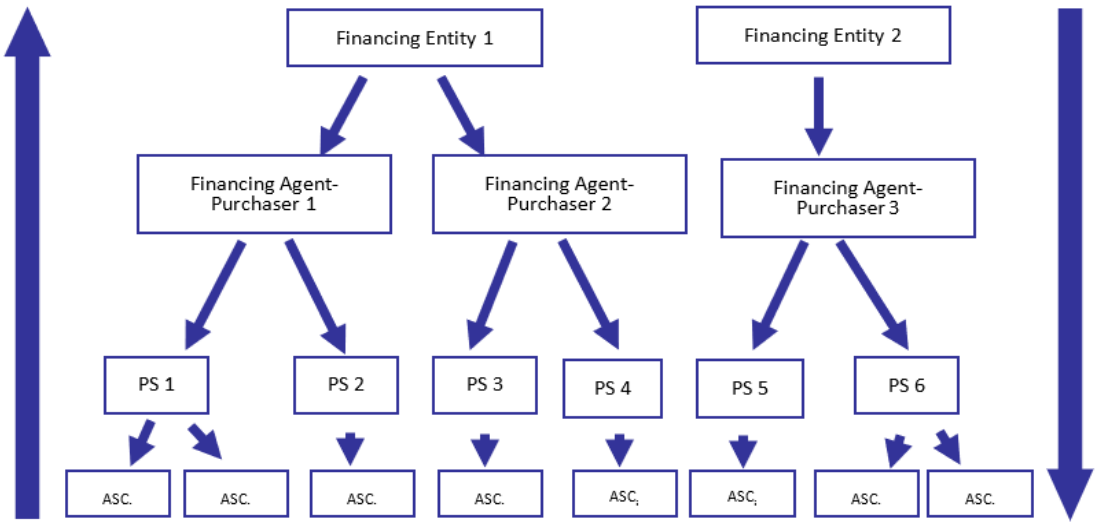
The NASA Team's role involves collecting data from various economic agents and reconstructing resource flows in the form of transactions, tracing the money from its origin to final consumption. The triangulation between consumption, provision, and financing ensures the equality of total values for resources consumed, provided, and financed. The collection of expenditure data from the FE, FAP and PS allows the reconstruction of the financing flows from origin to use, identifying the flow of resources from financing entities, through financing agents and purchasers, to providers of HIV services and, finally, to the beneficiaries. In this way, each financial transaction must be recreated to eventually add up to the national total (or any subnational unit) and each dimension can be tabulated in relation to any other of the dimensions.

It is important in any resource tracking evaluation to avoid double counting. Especially in HIV responses, where there are several layers of intermediary institutions before resources reach the service provider. Care must be taken to avoid double-counting expenses because the disbursements of one entity may

be the income of another, and these flows must be managed to capture resources only when they are finally incurred. Identifying the relationship between economic agents and financing entity-financing agent/purchaser-provider is a fundamental mechanism to do so.

During data analysis, all transactions should be completed and cross-checked by doing "bottom-up" and "top-down" reconciliation to avoid double counting and to ensure that the amounts entered into the transaction reflect the value of the programmes implemented in the country´s HIV response. (see Figure 58**Error! Reference source not found.**).

*Figure 58. Data collection "Top-down and Bottom-up"*




For resource tracking, NASA adopts the matching accounting principle. In NASA the team aims at accounting for expenditure/costs involved in delivering services consumed within a defined period. The team relies on various data sources, including consumption reports, procurement reports, and budget execution / expenditure reports.

NASA presents estimates by calendar or fiscal year, with expenditures consumed within each fiscal or calendar year.[35] In cases where consumption information is lacking of commodities, procurement or distribution data are used, clearly indicated in the annex dedicated to Assumptions and Limitations.

## 1.2. NASA CLASSIFICATIONS

The NASA describes the flow of resources from their origin to the beneficiary populations. Financial flows for the national HIV response are organized into three dimensions: financing, provision and use. Expenses are reconciled from these three dimensions using data triangulation. The classification of the three dimensions and the nine categories makes up the framework of the NASA system.

### 1.2.1. Financing

**Financing Entities (FE):** These are entities or pools tapped by purchasers and financial intermediation institutions to fund HIV services through various financing schemes. Analysis of FE is crucial in countries heavily reliant on donor support or with few management entities.

**Financing Schemes (SCH):** These are the main types of arrangements through which individuals access health services.

[35] For NASA in Nigeria 2019-2021 we compiled all data into calendar years to the extent possible. See ANNEX 2. ASSUMPTIONS AND LIMITATIONS for more details.

**Revenues of Financing Schemes (REV):** Describes specific contribution mechanisms of Financing Schemes, grouped by type of revenues into mutually exclusive classes.

**Financing Agents-Purchasers (FAP):** Entities that collect financial resources to fund service provision programs and make decisions related to the program.

#### 1.2.2. Provision

**Providers of Services (PS):** Entities engaged in the production, supply, and provision of services related to HIV and AIDS.

**Service Delivery Modalities (SDM):** Describes the ways services are provided to beneficiaries, reflecting differences in costs through different modalities, such as facility-based or community- or home-based.

**Production Factors (PF):** Inputs consumed during the production of the goods and services that make up the interventions and programs of the HIV response.

#### 1.2.3. Consumption

**AIDS Spending Categories (ASC):** Interventions and activities related to HIV and AIDS offered to beneficiaries.

**Beneficiary Populations (BP):** Direct intended beneficiaries of interventions, populations receiving services within the HIV Response. Assigning Beneficiary population codes align closely with the AIDS Spending Categories' classification, ensuring logical and streamlined categorization.

**Sub National Data (SND):** The location where the programs are implemented. It allows monitoring the distribution of resources and implementation of programs at the subnational level.

### 1.3. NASA TOOLS AND THEIR APPLICATION

The NASA Team utilizes a diverse set of tools to efficiently collect, process, and analyse data. These tools are instrumental in organizing and systematizing tasks, allowing seamless collaboration among NASA team members who are simultaneously engaged with numerous files and datasets. The members of the NASA Team are trained in utilizing these tools at the beginning of the assessment.

#### 1.3.1. Dropbox and file system management

Utilizing file-sharing platforms offered several key advantages, such as time efficiency, version control and data security. Cloud-based file management greatly facilitated teamwork, allowing for collaboration from different locations.

The structure of the NASA Dropbox is meticulously designed to mirror the organizational status outlined in the NASA Control File. This ensures a coherent representation of each organization's standing within the broader context of NASA's operations (**Table 4**).

*Table 4. Composition of the Dropbox NASA folder*

| | | |
|---|---|---|
| | 0-Control Files | This folder contains the NASA Control File and any other control file needed for the assessment, such as Global Fund or PEPFAR control file. |
| | 1-Data | This folder contains all the data received. The focal point for receiving data should create a folder inside this folder for each organization that has reported their data. |
| | 2-Transactions | This folder contains all the transactions files, DCT (Data Consolidation Tool). |

| | | |
|---|---|---|
| 0-Ctrl_Files<br>1-Data<br>2-Transactions<br>3-RTT<br>4-Results<br>5-Report<br>6-Backg_Material<br>a_File_Sharing | 3-RTT | This folder contains all the data extracted from the RTT (Resource Tracking Tool) as well as all the project Backup files. (Note: It is important to back-up the RTT file once the team started entering data into the RTT, ideally once a day). |
| | 4-Results | All the data analysis including charts and tables should be saved in this folder. |
| | 5-Report | The report of the assessment should be saved in this folder. The final power point presentation should also be saved here. |
| | 6-Bacgkround Material | All relevant background material for the assessment should be saved in this folder. (e.g. the most recent National Strategic Plan, epidemiological data, available costing studies, available resource need studies). |
| | a.File Sharing | This folder is used to share files among the NASA team members. |
| | Other folders | Other folders could be created as needed by the team members. |

### 1.3.2. NASA Control Table

The NASA Control Table serves multiple utility purposes within the project. It tracks the outreach to organizations, monitoring the number of entities approached for data submission and keeping a record of responses. Additionally, it records communication regarding data clarification or the acquisition of supplementary information. The control file plays a pivotal role in identifying focal points within each respondent organization and tracking the NASA team member responsible for processing their data.

Moreover, the control table serves as a comprehensive status tracker for data processing and subsequent validation (Figure 59 and Figure 60). It compiles a summary of the total reported expenditure by each organization and consolidates comments provided by NASA team members. This centralized tool ensures efficient oversight and coordination throughout the data collection and processing phases.

*Figure 59. Example of the Control Table (1)*

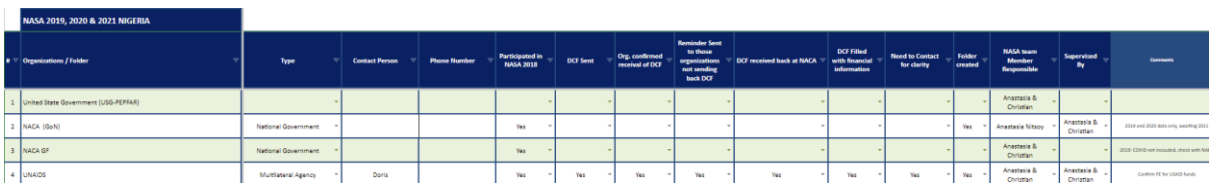
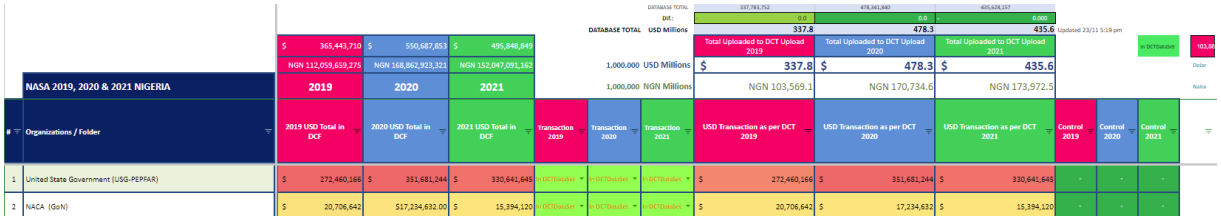


*Figure 60. Example of the Control Table (2)*



| | NASA 2019, 2020 & 2021 NIGERIA | 2019 | 2020 | 2021 | Transaction 2019 | Transaction 2020 | Transaction 2021 | Total Uploaded to DCT Upload 2019 | Total Uploaded to DCT Upload 2020 | Total Uploaded to DCT Upload 2021 | Control 2019 | Control 2020 | Control 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | $ 365,443,710 | $ 550,687,853 | $ 495,848,849 | | | | 337.8 | 478.3 | 435.6 | | | |
| | | NGN 112,059,659,275 | NGN 168,862,923,321 | NGN 152,047,091,162 | | | | 1,000,000 USD Millions | $ 337.8 | $ 478.3 | $ 435.6 | | |
| | | | | | | | | 1,000,000 NGN Millions | NGN 103,569.1 | NGN 170,734.6 | NGN 173,972.5 | | |
| # | Organizations / Folder | 2019 USD Total in DCF | 2020 USD Total in DCF | 2021 USD Total in DCF | Transaction 2019 | Transaction 2020 | Transaction 2021 | USD Transaction as per DCT 2019 | USD Transaction as per DCT 2020 | USD Transaction as per DCT 2021 | Control 2019 | Control 2020 | Control 2021 |
| 1 | United State Government (USG-PEPFAR) | $ 272,460,166 | $ 351,681,244 | $ 330,641,645 | | | | $ 272,460,166 | $ 351,681,244 | $ 330,641,645 | - | - | - |
| 2 | NACA (GoN) | $ 20,706,642 | $17,234,632.00 | $ 15,394,120 | | | | $ 20,706,642 | $ 17,234,632 | $ 15,394,120 | - | - | - |

To ensure a simultaneous access to the Control file by all team members, the Control Table was created as a Google sheet.

### 1.3.3. NASA Data collection form

The NASA Nigeria specific Data Collection Form (DCF) was adapted by the NASA Team to reflect the requirements of the data collection. This is a self-administered tool which includes sections dedicated to financial and in-kind resource tracking (see Annex 5)

### 1.3.4. NASA Data consolidation tool

The Data Consolidation Tool (DCT), is a spreadsheet developed by UNAIDS, and is an integral part of the Data preparation and consolidation process, accessible only by the NASA Team members. The DCT is built to allow a logical conversion of the data provided by the organization-respondents into the NASA codes. When data are fully processed and validated, the DCT allows for uploading directly to the RTT software. The DCT is used for the reconstruction of the transactions and financial flows for each institution reporting data, allowing for a harmonized and standardized process of coding the data into each NASA category.

### 1.3.5. NASA RTT

The RTT (Resource Tracking Tool) developed by UNAIDS is a specialized software designed to enhance the efficiency of the NASA process. Its primary goal is to facilitate the consolidation, validation, analysis, and interpretation of data related to HIV/AIDS spending. The RTT addresses the need for a more accessible and technologically advanced tool to streamline the NASA process.

RTT serves as an important instrument in strengthening the strategic information system related to HIV/AIDS spending data, fostering collaboration, and providing valuable insights for evidence-based decision-making at both national and global levels.

In this NASA round in Nigeria the NASA Team opted for utilizing Alternative import function, which allows for an upload of one consolidated dataset per year of assessment. The RTT-based outputs for this NASA exercise are: RTT input datasets, GAM Matrixes, RTT Database, RTT Couch file, RTT Excel output, and RTT Zip file.

## 1.4. IMPLEMENTATION SCHEDULE AND KEY STEPS

The assessment involved the recruitment of institutions in consultation with NACA and UNAIDS. A diverse range of entities, including national and State-level government bodies, UN agencies, NGOs, health and other departments and ministries, specialized organizations, clinics and hospitals, submitted data to the NASA team (more details on the data submission in the Annex 2). Rigorous steps, including sensitization meetings, official letters, personal confirmations, and targeted offline and online training, were undertaken to ensure accurate and comprehensive data collection. The process underscores the commitment to methodological precision and thoroughness in NASA's data-driven approach.

### 1.4.1. Implementation schedule

Revisions were made to the initial planning to incorporate the mentioned considerations. However, owing to delays in obtaining the necessary data by the NASA Team, the completion of data processing and analysis of the findings has been further postponed until April 2024 (Table 5Error! Reference source not found.).

*Table 5. NASA actual implementation schedule*

| No | Activity | NASA Nigeria Exercise | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
| 1 | NASA Steering Committee meeting | | | | | | | | | | | | | |
| 2 | Contracting international consultants | | | | | | | | | | | | | |
| 3 | Contracting national consultants | | | | | | | | | | | | | |
| 4 | NASA Technical working group intro | | | | | | | | | | | | | |
| 5 | NASA Team training | | | | | | | | | | | | | |
| 6 | Data collection tools updated | | | | | | | | | | | | | |
| 7 | Data collection launch | | | | | | | | | | | | | |
| 8 | "Learning by doing" supervised by international consultants | | | | | | | | | | | | | |
| 9 | Organizations complete the data collection forms | | | | | | | | | | | | | |
| 10 | Data collection assistance to organizations-respondents | | | | | | | | | | | | | |
| 11 | Data collection and processing | | | | | | | | | | | | | |
| 12 | Consolidation of the datasets for Alternative import to RTT | | | | | | | | | | | | | |
| 13 | External quality assurance by UNAIDS GC | | | | | | | | | | | | | |
| 14 | Updating datasets and RTT per QA feedback | | | | | | | | | | | | | |
| 15 | Report writing - 1st draft | | | | | | | | | | | | | |
| 16 | Revision and changes for the report | | | | | | | | | | | | | |
| 17 | Validation Meeting with key stakeholders | | | | | | | | | | | | | |
| 18 | Final report, RTT files, PPT presentation, GAM matrix etc | | | | | | | | | | | | | |

### 1.4.2. In-country mission: NASA training and team work

The first in-country mission of the two international consultants lasted two weeks and encompassed several objectives.

The first week was dedicated to a comprehensive NASA training session for the NASA Core team, as well as an extended group of participants, which included NACA staff, representatives of GF PRs, UNAIDS, and SACAs (state agencies for control of AIDS). The NASA training is a crucial component of the exercise, as it ensures the quality of the current assignment and builds in-country capacity to work with NASA data in the long term. The international consultants have implemented a 5-day training program for the local NASA team during their first in-country mission. The international consultants created a comprehensive set of training materials for the NASA exercise, which included visual presentations, a list of documents to read, data processing exercises, and a data collection form. These materials were designed to provide the NASA team with the necessary skills and knowledge to carry out the exercise effectively and efficiently.

The second in-country NASA Core Team working week was aimed at achieving multiple objectives, each crucial to the success of our project. The Team has successfully developed and established internal work process protocols to ensure smooth coordination, effective communication, and streamlined workflows within the team. International consultants introduced the NASA RTT software to the team of data managers and agreed on the way the data should be uploaded in the software. During the second in-

country working week all data managers received training in utilizing the Data Consolidation Tool (DCT) and furthered their skills by actively analysing and coding data received from GFTAM. Additionally, NASA Team thoroughly examined the implementation process of previous NASA assessments. Learning from past experiences served as a valuable guidance in making informed decisions and improving data collection approach. Sufficient time was dedicated to reviewing HIV Response architecture in Nigeria, its governance structure, service delivery schemes, information and resource flows. During the mission one of the key objectives was to develop a comprehensive data collection plan that would serve as a roadmap for our activities. NASA team finalized the data collection form, which proved to be instrumental in capturing the necessary information accurately.

In recognition of the importance of engaging various stakeholders to discuss data access and its format, the NASA Team set up meetings, whether virtual or in-person, with some key partners including the GF Country Team, PEPFAR Coordination Office, Chemonics, NACA GF implementation team, UNAIDS. These discussions aimed to ensure collaboration, address data-related queries, and establish a shared understanding of expectations and requirements.

Starting from June 2023 had regular virtual meetings, with international consultants working remotely throughout all data collection and processing.

#### 1.4.3. External quality assurance by UNAIDS Global Centre

Ensuring data quality is paramount when dealing with large datasets, constituting a fundamental aspect of the NASA team's internal processes. UNAIDS Global Centre (GC) offered methodological support to the NASA team throughout the assignment and provided quality assurance for the DCTs and datasets within the Resource Tracking Tool (RTT). The NASA team submitted the RTT files to UNAIDS GC on November 27, 2023, and promptly received feedback by December 4, 2023. Subsequently, the NASA dataset underwent necessary adjustments based on the received feedback.

#### 1.4.4. NASA Results and production of the final report

The NASA datasets were finalized, uploaded to RTT, and final results were generated in January 2024. A draft report, inclusive of the methodological chapter, assumptions, limitations, and result descriptions, was shared with the extended NASA team for feedback and contributions on January 30, 2024. The potential next steps involve conducting an online presentation for the extended NASA team and Steering Committee members, as well as presenting the findings to the UNAIDS Country Office, PEPFAR Coordination office and Global Fund Principal Recipients.

### 1.5. NASA Team

The coordination of the NASA process was overseen by the National Agency for the Control of AIDS (NACA), receiving technical support from UNAIDS and collaborating with various stakeholders in the HIV national response. The management and execution of the NASA was structured as follows:

1. Steering Committee: A NASA Steering Committee was established, consisting of policy-level representatives from NACA, NASCP (FMoH), UNAIDS, the PLHIV community, PEPFAR, CCM, States, Private Sector, IPs, CSOs, and other pertinent stakeholder organizations. This committee was tasked with providing general direction and oversight for the NASA.

2. International Consultants: UNAIDS enlisted two international consultants responsible for working throughout the study period, especially focusing on reviewing NASA tools, central training to create a pool of national NASA practitioners, lead data analysis and the writing of the NASA report.

3. Lead Consultant: NACA engaged a lead consultant to manage day-to-day activities of the NASA study. This consultant kept the steering committee updated on study progress and collaborated with the international consultant.

4. Data Managers: NACA hired 5 data managers under the lead consultant's supervision for a 2-month period. These managers, responsible for processing the data collection forms and working in the data consolidation tool, were all based in Abuja.

5. Data Collection Teams: Data collection was conducted in the states by teams comprising NACA staff from national and zonal offices, state-level government staff, and CSO representatives. Distribution of data collectors was based on the burden and volume of HIV activities in the states. These teams reported directly to NACA and the lead consultant.

# ANNEX 2. ASSUMPTIONS AND LIMITATIONS

## 2.1. APPLICATION OF THE EXCHANGE RATES

All data were processed and recorded in the NASA database in US dollars. The following exchange rates, as provided by NACA[36], were utilized to convert the amounts reported in Nigerian Naira (NGN) into US dollars:

| Year | US$ to NGN |
|---|---|
| 2019 | 1 US$ = 306.64 NGN |
| 2020 | 1 US$ = 356.93 NGN |
| 2021 | 1 US$ = 399.36 NGN |

National spending trends were also analysed in constant values to neutralize variations in the currency's deflation in the country. For this purpose, deflators and conversion values to constant dollars from the World Bank were utilized:

| Year | Conversion Factor from Current US$ to Constant 2015 US$ for Nigeria: |
|---|---|
| 2019 | 1.073 |
| 2020 | 1.157 |
| 2021 | 1.176 |

Source: World Development Indicators database, Last Updated: 12/18/2023

## 2.2. RESPONSE RATE

In total, 324 organisations, both domestic and international, were contacted to submit their data in this NASA round (Table 6). Almost half of them did not respond back. For the expenditure data related to 2019 and 2020 18% and 17% of the organisations, which were contacted by the NASA team, reported having no HIV-related activity in the respective years. Data was obtained from 34% and 35% of the organisations contacted. Data submission improved for the year 2021, when 38% of the organisations submitted their HIV expenditure data. Full list of the organizations is presented in the ANNEX 4. LIST OF ORGANISATIONS REPORTING TO NASA 2019-2021. Despite low response rates, we successfully captured the majority of resources financing the HIV response by collecting data directly from the largest financing entities and purchasing agents. This approach ensured that even if some institutions did not report, we still obtained their data through top-down reporting methods in most cases.

*Table 6. Response rates in this NASA round, 2019-2021*

| Organisations-respondents: | 2019 | | 2020 | | 2021 | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| Reported data | 109 | 34% | 113 | 35% | 122 | 38% |
| Reported no activity during the period | 58 | 18% | 54 | 17% | 42 | 13% |
| Did not respond back | 157 | 48% | 157 | 48% | 157 | 49% |
| **Total organisations-respondents** | **324** | **100%** | **324** | **100%** | **321** | **100%** |

## 2.3. HIV COMMODITIES: PROCUREMENT VS VALUE OF CONSUMPTION

To gain a more accurate understanding of the fluctuations in HIV expenditures, it is crucial to consider that for this report, essential commodities like antiretroviral medications for ART and PrEP, HIV tests, CD4 and viral load tests were recorded based on procurement values rather than the value those commodities that were used (i.e.: when the commodities are distributed to the final service provider or

[36] Central Bank of Nigeria. (2023). Available at: https://www.cbn.gov.ng/rates/exchratebycurrency.asp

consumed by beneficiaries in the implementation of programmes). This presents certain limitations for analysing spending trends.

For instance, the expenditure on antiretroviral drugs was US$105.1 million in 2019, increased to US$175.6 million in 2020, and then reduced to US$129.7 million in 2021. This fluctuation does not mirror changes in the number of individuals receiving treatment. The number of people receiving ART by the end of each year increased from 1.1 million in 2019, to 1.5 million in 2020 and to 1.8 million in 2021. As a result, the increase in Antiretroviral spending by 67% from 2019 to 2020 was not accompanied by a corresponding increase in the patient count. Similarly, the 26% decrease of related spending in 2021 does not indicate a reduction in patient numbers. Likewise, these financial trends do not align with any significant changes in drug pricing; they are more reflective of when the purchases were accounted for financially rather than their actual consumption or utilisation within the fiscal or calendar year.

This example demonstrates the importance of accounting for the value of what is used and not what is purchased in the NASA, which significantly limits the conclusions. Only by accounting for the value of what is actually used in the HIV response can decision makers fully assess the implementation of the National Strategic Plan or analyse funding gaps using the NASA results.

This is a crucial point on which the actors involved in the national HIV response must work together to ensure that data on what has been implemented is accurately presented in subsequent NASA reports, especially the implementers of the Global Fund and PEPFAR funds.

## 2.4. IDENTIFYING FE CODE FOR UBRAF FUNDING OF UN AGENCIES

For this NASA round, a total of six UN agencies have provided their data. The majority of the expenditure in their data collection forms was reported as originating from UBRAF. UBRAF stands for "UNAIDS Unified Budget, Results, and Accountability Framework." It is a funding mechanism that provides financial resources to UNAIDS to support its work in addressing the global HIV/AIDS epidemic. The UBRAF is designed to enhance the coordination, efficiency, and effectiveness of the joint United Nations response to HIV/AIDS. It allows for pooled funding from multiple donors to support UNAIDS activities and programs. For the purpose of this NASA, the Financing Entity (FE) code for all funding marked as UBRAF has been categorized as FE.03.02.08 UNAIDS Secretariat, while the UN agency recipient of the funds was coded as the FAP.

## 2.5. PROCESSING GLOBAL FUND EXPENDITURE

In this round of the NASA assessment, a significant effort was directed towards acquiring, interpreting, and processing the expenditure records of the Principal Recipients (PRs) of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) in Nigeria. The PRs involved were NACA, FHI360, and LSMOH, and the Geneva-based GF Country Team for Nigeria played a supportive role in facilitating collaboration with the PRs and obtaining the necessary data.

The standard expenditure report available in the Performance Update/Disbursement Request (PUDR) from the GFATM grants was found to lack the necessary detail required to recreate the full transactions for the NASA purposes. Consequently, the NASA team engaged with each PR separately to secure more detailed expenditure records. These detailed records included key parameters such as year, grant ID, Module, Intervention, Activity (budget line), budget line number, Cost input, Sub-recipient, and, for 2021 expenditure, geographical location. It's worth noting that all COVID-19-related expenditures, even if part of HIV-specific grants, were excluded from the NASA analysis based on advice from the GF Country Team.

To process the data from FHI360 and LSMOH, which included grant-specific budget lines, we mapped each to a corresponding NASA code for ASC and BP. The detailed descriptions of each activity in the grant budget documentation were valuable for this effort. This process was crucial to accurately attribute expenditures to the appropriate intervention and activity, enabling precise coding in accordance with NASA codes.

Similar to a majority of the financial records processed in this NASA round, GFATM-related data has its set of challenges:

- Expenditure is available only at the level of procurement of the HIV commodities, not the consumption;
- Procured HIV commodities remain largely non disaggregated by provider of services, service delivery modality and geographical location in 2021;
- No details of involvement of the public-sector institutions, specifically clinics and hospitals, in the provision of key prevention and treatment services, funded by the GF;
- Challenges identifying final beneficiary population, unless it was clearly stated in the Module, Intervention or Activity description. When coding a BP into a specific category was not feasible, the corresponding "98" category was employed.

## 2.6. PROCESSING PEPFAR EXPENDITURE

The U.S. Department of State's Office of the U.S. Global AIDS Coordinator and Health Diplomacy (S/GAC) oversees and monitors the implementation of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR's Implementing Partners (IPs) annually submit expenditure reports (ER), including those of their sub-recipients, to S/GAC. These reports follow a structure and classification set by the S/GAC team, detailing interventions, program areas, sub-programs, beneficiary populations and cost categories. The NASA team received the ER dataset from PEPFAR Coordination Office (PCO) in Nigeria in August 2023. The NASA team collaborated with the PCO and pertinent agencies to seek enhancements and estimations aimed at addressing limitations wherever feasible. Despite these efforts, the limitations outlined in this section remained.

However, there are challenges in using the current ER data for optimal NASA transaction recreation. The ER reports no longer indicate the geographic location of expenditure, hence some assumptions should have been applied to selected program expenditure based on their coverage / performance indicators (eg. VMMC spending was split per region based on the numbers of circumcisions that were performed per region).

However, the majority of the expenditures related to the procurement of the HIV commodities (52% of the PEPFAR expenditure in 2021) were not broken down by geographic location. Additionally, ER data did not contain indication of the service delivery modality (SDM), nor could the IP and SR identifying information be shared.

The ER data does not provide information about the financing scheme, hence the financing scheme must be identified by the NASA team. For this, it is necessary to accurately identify the PS and the FAP. The coding of the PS in the ER dataset does not necessarily match the coding of the PS in the transaction. For example, some consulting firms appear as providers of care and treatment services, but in reality, they perform the distribution of supplies and medications to clinics and hospitals, and these are ultimately the service providers. However, to properly code the SCH, the NASA team must identify whether these providers are part of the public or private scheme. Therefore, certain assumptions had to be made to identify the SCH (see section 2.9.1).

Lastly, there is a mismatch between the U.S. Government's fiscal year (October to September) and the NASA reporting period (calendar year January to December). As a result, PEPFAR data were recorded in NASA as follows: data from October 2018 to September 2019 served as a proxy for 2019 data; data from October 2019 to September 2020 as a proxy for 2020 data; and data from October 2020 to September 2021 as a proxy for 2021 data.

The selected code to identify the Financing Agent-Purchaser for all PEPFAR-originated resource flows was "FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles." This code encompasses USAID, CDC, and DoD in their role as FAP, and it reflects the corporate agreements between the agencies and the IPs, and the fact that any change to the proposed workplan needs to be approved by the agency in-country office.

Assumptions and distribution approach to identify different PS and SCH for the ASCs related to the provision of the ART and laboratory monitoring of ART are listed in the section 2.9.

Whenever ER data contained expenditures coded as Cost Category "Supplies Pharmaceutical" or "Supplies Health- Non Pharmaceutical" and the programmatic description of the expenditure indicated HIV drugs or clinical services, or HIV testing, the NASA team applied the PF code PF.01.03.01.01 Antiretrovirals or PF.01.03.03.01 HIV tests screening/diagnostics respectively, instead of more aggregated PF.01.03.01.98 Pharmaceuticals not disaggregated or PF.01.03.03.98 Reagents and materials not disaggregated, suggested in the ER data.

## 2.7. PROCESSING GOVERNMENT OF NIGERIA DATA (CENTRAL LEVEL)

In previous NASA reports, a significant portion of domestic public spending had been estimated as the share of the Ministry of Health's health system costs that could be attributed to HIV service provision. The NASA team attempted to include an assessment of these expenditures, but there were several limitations regarding data availability to conduct a reliable estimation. The latest study, "GOVERNMENT EXPENDITURE ON HUMAN RESOURCES FOR HIV/AIDS SERVICES IN NIGERIA 2011", estimates a total of $71 million spent in 2010 related to the salaries of the staff of the ART/OI clinics. This report[37], made in 2011, is based on data from different sources from 2007 – 2009, and was done to inform the 2009-2010 NASA on government spending on human resources for HIV and has been also used to inform subsequent NASAs. Due to the lack of updated information regarding the shared costs within the health sector, this estimate was not included in the current NASA. Undertaking complementary studies would be necessary to obtain such data, extending beyond the outlined work plan and limits of this NASA.

A large part of the public-sector expenditure on HIV was implemented and reported by NACA. Below are the examples of the programmes implemented by NACA and their related data limitations:

- NACA COMPREHENSIVE AIDS PROGRAMME WITH STATES (NCAPS):
    - Included the procurement of tests, reagents, OI medications and ARVs, programme management cost, and logistics services.
    - Expenditure on HIV tests were not broken down by beneficiary populations so they were coded as BP.04.98 General population not broken down by age or gender.
    - When the expenditure of logistics services was not split by the type of the commodity it was spent on, their value was apportioned among the relevant ASC categories in proportion to the procurement values. This approach involved adding the logistic service costs to the specific PF associated with each commodity.
    - When final providers were not indicated, for direct service delivery programmes the selected PS was PS.01.01.02 Ambulatory care (public)

[37] Government Expenditure on Human Resources For HIV/AIDS Services in Nigeria, Public Health and Disaster Management, November 2011

- HIV SERVICE PROVISION PROGRAMME:
    - These were medical outreaches conducted in several constituencies mainly targeted at prevention and empowerment packages for the vulnerable communities.
    - Final providers were not indicated, the selected PS was PS.01.01.02 Ambulatory care (public).

- ABIDJAN LAGOS CORRIDOR PROJECT (ALCO):
    - This referred to the Nigerian contribution to the West African countries' HIV/AIDS response project. It is mainly a prevention programme along the Lagos-Abidjan corridor.
    - Lacking specifics on the activities implemented, as well as service delivery modalities. The ASC selected was ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type, which captures most of the activities carried out in the project.
    - Being a multilateral regional initiative, the PS was coded as PS.03.02 Multilateral agencies.

- STAFF SALARIES OF NACA were reported as one amount annually, not broken down by departments or job descriptions, and were coded ASC.06.98 Programme enablers and systems strengthening not disaggregated / PF.01.01.02.98 Program management personnel not disaggregated.

- THE NATIONAL HEALTH INSURANCE SCHEME (NHIS): In 2023 the NHIS Basic Minimum Package[38] covered HIV testing, ART and treatment of opportunistic infections for HIV-positive affiliates. No data from the NHIS was reported for this assessment.

## 2.8. PROCESSING DATA FROM THE STATE GOVERNMENTS

The analysis covers executed expenditure across 36 of Nigeria's 37 states, incorporating public international and private sector financing entities. State-level data was reported by SACAs (16 SACAs), state-level line ministries (4 ministries), as well as UN agencies, GFATM grants reported by their principal recipients, PEPFAR data etc. Data from NACA was not disaggregated by state. Procurements of HIV commodities are not disaggregated by state.

Out of the total SACAs in the country, information from 16 SACAs that reported within the set deadline for form submission was processed. Two SACAs only reported spending financed by UNICEF.

Only 7 SACAs reported human resources (HR) cost in their data collection forms. Two of them reported expenditure less than US$1,000. Only one SACA reported HR cost for all three years of the assessment, one SACA reported two years, the rest of the SACAs reported their HR cost for just one year of the assessment.

[38] NHIS Operational Guideline for 2023 https://www.nhis.gov.ng/wp-content/uploads/2023/10/NHIA-OPERATIONAL-GUIDELINES-2023.pdf.

## 2.9. PROCESSING ART-RELATED SPENDING

### 2.9.1. Identifying PS and SCH code

Accurately discerning the financing scheme of HIV expenditure hinges on several factors. In the context of HIV response, financing schemes are the primary structures through which individuals access HIV services and healthcare expenses are covered. A substantial portion of data, particularly from PEPFAR and the Global Fund, lacked details about the ultimate service providers—entities directly delivering HIV services to the beneficiaries, and hence it was difficult to correctly identify the financing schemes.

The NASA team utilized secondary data to establish assumptions distinguishing public and private sector service provision and financing schemes for antiretroviral therapy (ART)-related care and treatment services. By compiling a list of healthcare facilities along with the respective number of patients on ART in each facility, the team categorized each facility as either public or private sector.

Out of a list of 1,971 facilities, it was found that 69% of ART patients were receiving treatment in public healthcare facilities, while the remaining 31% are obtaining their ART and related laboratory monitoring from the private sector. These percentages were then applied as the distribution key for the coding of the ART service provider and financing scheme in the ART-related expenditure of both the Global Fund and the PEPFAR in each of three years of the assessment.

The transactions for the estimated public providers were constructed using the following codes:

| FE | SCH Code | FAP Name | FAP code | PS Name | PS Code |
|---|---|---|---|---|---|
| GFATM PR: LSMOH | SCH.01.01.02 State/regional/local government schemes | LSMOH | FAP.01.01.02.01 Ministry of Health (or equivalent state sector entity) | Public clinics and hospitals | PS.01.01.98 Governmental organizations not disaggregated |
| GFATM PR: FHI | SCH.01.01.01 Central government schemes | FHI 360 PR | FAP.03.03.40 FHI 360 | Public clinics and hospitals | PS.01.01.98 Governmental organizations not disaggregated |
| PEPFAR | SCH.01.01.01 Central government schemes | USAID-CDC (PEPFAR) | FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles | Public clinics and hospitals | PS.01.01.98 Governmental organizations not disaggregated |

The transactions for the estimated private providers were constructed using the following codes:

| FE | SCH Code | FAP Name | FAP code | PS Name | PS Code |
|---|---|---|---|---|---|
| GFATM PR: LSMOH | SCH.02.02.98 Not-for-profit organisation schemes not disaggregated | LSMOH | FAP.01.01.02.01 Ministry of Health (or equivalent state sector entity) | Lagos State Ministry of Health (ART non-specified providers) | PS.02.01.98 Other non-profit private sector providers not disaggregated |
| GFATM PR: FHI | SCH.02.02.98 Not-for-profit organisation schemes not disaggregated | FHI 360 PR | FAP.03.03.40 FHI 360 | Family Health International (FHI360) (ART non-specified providers) | PS.02.01.98 Other non-profit private sector providers not disaggregated |
| PEPFAR | SCH.02.02.98 Not-for-profit organisation schemes not disaggregated | USAID-CDC (PEPFAR) | FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles | PEPFAR IP (ART non-specified providers) | PS.02.01.98 Other non-profit private sector providers not disaggregated |

### 2.9.2. Identifying ASC and BP code for ARV drugs

Expenditure related to the procurement of ARV drugs was derived from three primary sources of data: NACA GoN data, GFATM data (via FHI360), and PEPFAR data in the ER dataset. Although the GFATM and NACA's data pertaining to ARV drug procurement included information on the line of treatment, it lacked specific details regarding whether it was intended for adults or paediatric use. Due to this absence of information, the following ASC/BP codes were selected to process the expenditure:

- ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT

- BP.01.98 People living with HIV not broken down by age or gender

## 2.10. OUT-OF-POCKET SPENDING

It's worth noting that out-of-pocket payments (OOPP) was not analysed previously in any NASA report in Nigeria, nor it is included in this assessment, due to the lack of studies that have estimated this component of national HIV expenditure.

Nevertheless, the importance of understanding the contribution of households and individuals is acknowledged, and it is recommended that this analysis is considered in future, provided there is adequate funding and time to undertake a representative survey of households.

## 2.11. APPLICATION OF NASA CODES

The accounting framework of NASA allows for the recording of spending on detailed activities within a program. This means that there is specific third, fourth-, or fifth-digit level codes to record activities such as Behaviour change communication (BCC) or promotion and provision of condoms and lubricants targeted at a specific key population. However, even if the NASA categories allow for such detail, this level of detail is not always available in the collected expenditure data, or it would require a longer period of data collection and analysis to obtain it. For reasons already mentioned, a significant portion of the preventive spending aimed at key populations was coded under ".98 non-disaggregated type" interventions.

For example, an organization reporting an expenditure that included condom distribution activities and HTC aimed at sex workers. Each of these activities has a specific ASC code, but because the data is aggregated, the NASA team has two options: go back to the organization for further clarification by dividing this figure into two or more specific categories, or classify it under a ".98" category, where the spending is not broken down into a specific activity. The application of the .98 code in prevention primarily targets 4th and 5th digit level codes, examples include: ASC.01.02.01.98 PMTCT not disaggregated by activity or ASC.01.01.05.98 PrEP not disaggregated by key population.

Efforts were always made to obtain greater clarity and precision in the spending to be coded, particularly with the larger figures reported, but this was not always possible. In fact, there was a very low response rate to communications made by the NASA team to the organizations involved in the national HIV response, which prevented reducing the use of ".98" categories due to not having precise data for more accurate coding.

# ANNEX 3. DETAILED NASA TABLES

*Table 7. Financing entities (FE) (1st, 2nd and 3rd digit) of the HIV expenditure in Nigeria in 2019-2021, US$ and %*

| Financing entities (FE) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **FE.01 Public Entities[39]** | **23,110,492** | **6.79%** | **19,869,076** | **4.12%** | **17,106,073** | **3.91%** |
| **FE.01.01 Governmental** | **23,110,492** | **6.79%** | **19,869,076** | **4.12%** | **17,106,073** | **3.91%** |
| FE.01.01.01 Central government | 20,647,379 | 6.07% | 17,232,407 | 3.57% | 15,401,541 | 3.52% |
| FE.01.01.02 State/provincial government[40] | 2,463,113 | 0.72% | 2,636,669 | 0.55% | 1,704,532 | 0.39% |
| **FE.02 Domestic Private Entities** | **236,616** | **0.07%** | **732,884** | **0.15%** | **146,480** | **0.03%** |
| **FE.02.01 Domestic corporations** | **144,465** | **0.04%** | **134,586** | **0.03%** | **123,476** | **0.03%** |
| **FE.02.03 Domestic not-for-profit institutions** | **92,150** | **0.03%** | **598,298** | **0.12%** | **23,004** | **0.01%** |
| **FE.03 International Entities** | **316,989,764** | **93.14%** | **461,462,928** | **95.73%** | **420,504,065** | **96.06%** |
| **FE.03.01 Governments providing bilateral aid** | **272,470,602** | **80.06%** | **351,681,244** | **72.95%** | **330,641,645** | **75.53%** |
| FE.03.01.05 Government of Canada | 10,436 | 0.00% | | 0.00% | | 0.00% |
| FE.03.01.30 Government of United States | 272,460,166 | 80.06% | 351,681,244 | 72.95% | 330,641,645 | 75.53% |
| **FE.03.02 Multilateral Organizations** | **40,641,195** | **11.94%** | **106,199,996** | **22.03%** | **86,015,348** | **19.65%** |
| FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria | 36,504,534 | 10.73% | 101,554,554 | 21.07% | 81,445,795 | 18.61% |
| FE.03.02.08 UNAIDS Secretariat | 2,795,331 | 0.82% | 2,720,542 | 0.56% | 2,844,152 | 0.65% |
| FE.03.02.09 United Nations Children's Fund (UNICEF) | 835,362 | 0.25% | 628,095 | 0.13% | 1,238,548 | 0.28% |
| FE.03.02.11 United Nations Development Programme (UNDP) | | 0.00% | 12,103 | 0.00% | 33,699 | 0.01% |
| FE.03.02.17 United Nations Population Fund (UNFPA) | | 0.00% | 72,157 | 0.01% | | 0.00% |
| FE.03.02.18 World Bank Group (WB) | 248,145 | 0.07% | 535,460 | 0.11% | | 0.00% |
| FE.03.02.20 World Health Organization (WHO) | 150,000 | 0.04% | 150,000 | 0.03% | 150,000 | 0.03% |
| FE.03.02.99 Other Multilateral organizations n.e.c. | 107,823 | 0.03% | 527,085 | 0.11% | 303,154 | 0.07% |
| **FE.03.03 International not-for-profit organizations and foundations** | **3,877,967** | **1.14%** | **3,581,689** | **0.74%** | **3,847,073** | **0.88%** |
| FE.03.03.09 Caritas Internationalis/Catholic Relief Services | | 0.00% | 157,435 | 0.03% | 145,232 | 0.03% |
| FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c. | 3,877,967 | 1.14% | 3,424,254 | 0.71% | 3,701,840 | 0.85% |
| **Total** | **340,336,872** | **100.00%** | **482,064,889** | **100.00%** | **437,756,619** | **100.00%** |

[39] Due to a lack of available data to provide a reliable estimation, the public expenditure on human resources in the health care facilities was not included in the findings of this NASA repor, thus Public Financing is underestimated.

[40] State governments' funding is underreported in this analysis. Of all the SACAs in the country, only the data from 16 met the submission deadline and was processed.

*Table 8. Financing agents-purchasers (FAP) (1st, 2nd and 3rd digit) of the HIV response in 2019-2021, US$ and % of total national HIV spending*

| Financing agents-purchasers (FAP) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **FAP.01 Public sector[41]** | **28,188,595** | **8.28%** | **31,187,175** | **6.47%** | **22,932,461** | **5.24%** |
| FAP.01.01.01.10 National AIDS Commission | 21,295,365 | 6.26% | 22,077,603 | 4.58% | 19,729,734 | 4.51% |
| FAP.01.01.02.01 Ministry of Health (or equivalent state sector entity) | 3,938,026 | 1.16% | 5,419,545 | 1.12% | 896,443 | 0.20% |
| FAP.01.01.02.03 Ministry of Social Development (or equivalent state sector entity) | | 0.00% | 107,923 | 0.02% | 24,219 | 0.01% |
| FAP.01.01.02.04 Other ministries (or equivalent state sector entities) | 283,172 | 0.08% | 260,367 | 0.05% | 83,904 | 0.02% |
| FAP.01.01.02.06 State/Province/Department AIDS Commission | 2,471,431 | 0.73% | 3,187,420 | 0.66% | 1,965,266 | 0.45% |
| FAP.01.01.02.99 State/provincial/regional entities n.e.c. | 87,746 | 0.03% | 110,602 | 0.02% | 147,763 | 0.03% |
| FAP.01.04 Parastatal organizations | 112,856 | 0.03% | 23,716 | 0.00% | 85,133 | 0.02% |
| **FAP.02 Private sector** | **265,538** | **0.08%** | **984,885** | **0.20%** | **531,570** | **0.12%** |
| FAP.02.05 Not-for-profit institutions (other than social insurance) | 265,538 | 0.08% | 984,885 | 0.20% | 531,570 | 0.12% |
| **FAP.03 International purchasing organizations** | **311,882,738** | **91.64%** | **449,892,828** | **93.33%** | **414,292,588** | **94.64%** |
| FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles | 272,460,166 | 80.06% | 351,681,244 | 72.95% | 330,641,645 | 75.53% |
| FAP.03.02.07 UNAIDS Secretariat | 2,240,086 | 0.66% | 2,076,658 | 0.43% | 2,121,460 | 0.48% |
| FAP.03.02.08 United Nations Children's Fund (UNICEF) | | 0.00% | | 0.00% | 39,517 | 0.01% |
| FAP.03.02.10 United Nations Development Programme (UNDP) | 20,000 | 0.01% | 112,103 | 0.02% | 133,699 | 0.03% |
| FAP.03.02.15 United Nations Office on Drugs and Crime (UNODC) | 100,600 | 0.03% | 100,000 | 0.02% | 100,000 | 0.02% |
| FAP.03.02.16 United Nations Population Fund (UNFPA) | 60,958 | 0.02% | 67,020 | 0.01% | 35,544 | 0.01% |
| FAP.03.02.19 World Health Organization (WHO) | 350,000 | 0.10% | 475,000 | 0.10% | 475,000 | 0.11% |
| FAP.03.03.06 Bill and Melinda Gates Foundation | 911 | 0.00% | | 0.00% | | 0.00% |
| FAP.03.03.25 The Clinton Foundation | 107,823 | 0.03% | 527,085 | 0.11% | 395,424 | 0.09% |
| FAP.03.03.40 FHI 360 | 32,670,356 | 9.60% | 91,558,256 | 18.99% | 76,978,696 | 17.58% |
| FAP.03.03.99 Other International not-for-profit organizations n.e.c. | 3,871,838 | 1.14% | 3,295,461 | 0.68% | 3,371,603 | 0.77% |
| **Total** | **340,336,872** | **100.00%** | **482,064,889** | **100.00%** | **437,756,619** | **100.00%** |

[41] Due to a lack of reliable data to provide an updated estimation, the public expenditure of human resources in the health sector was not included in the findings of this NASA report -thus Public Financing is underestimated.

*Table 9. Providers of services (PS), US$ and % of the annual total HIV expenditure*

| Providers of services (PS) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **PS.01 Public sector providers** | **110,374,165** | **32.43%** | **172,108,991** | **35.70%** | **141,528,319** | **32.33%** |
| **PS.01.01 Governmental organizations** | **110,261,309** | **32.40%** | **172,085,275** | **35.70%** | **141,443,186** | **32.31%** |
| PS.01.01.02 Ambulatory care (public) | 9,899,619 | 2.91% | 14,790,493 | 3.07% | 10,378,848 | 2.37% |
| PS.01.01.13.01 National AIDS Coordinating Authority (NACs) | 12,653,966 | 3.72% | 8,244,800 | 1.71% | 10,747,002 | 2.46% |
| PS.01.01.13.02 Departments inside the Ministry of Health or equivalent | 1,068,645 | 0.31% | 873,962 | 0.18% | 230,116 | 0.05% |
| PS.01.01.13.99 Government entities n.e.c. | 93,263 | 0.03% | 120,843 | 0.03% | 104,299 | 0.02% |
| PS.01.01.98 Governmental organizations not disaggregated | 86,545,816 | 25.43% | 148,055,177 | 30.71% | 119,982,920 | 27.41% |
| **PS.01.02 Parastatal organizations** | **112,856** | **0.03%** | **23,716** | **0.00%** | **85,133** | **0.02%** |
| PS.01.02.98 Parastatal organizations not disaggregated | 112,856 | 0.03% | 23,716 | 0.00% | 85,133 | 0.02% |
| **PS.02 Private sector providers** | **144,875,947** | **42.57%** | **229,687,148** | **47.65%** | **213,011,719** | **48.66%** |
| **PS.02.01 Non-profit providers** | **144,785,606** | **42.54%** | **229,566,622** | **47.62%** | **213,011,719** | **48.66%** |
| PS.02.01.01.02 Ambulatory care (private non-profit non-faith based) | 6,545,368 | 1.92% | 17,269,834 | 3.58% | 15,697,746 | 3.59% |
| PS.02.01.01.12 Research institutions (private non-profit non-faith based) | 23,344,059 | 6.86% | 40,408,468 | 8.38% | 29,502,000 | 6.74% |
| PS.02.01.01.13 Self-help and informal community-based organizations (private non-profit non-faith based) | 6,634,054 | 1.95% | 17,846,403 | 3.70% | 16,930,271 | 3.87% |
| PS.02.01.01.14 Civil society organizations (private non-profit non-faith based) | 70,452,926 | 20.70% | 89,151,518 | 18.49% | 97,459,686 | 22.26% |
| PS.02.01.02.13 Civil society organizations (private non-profit faith based) | 40,636 | 0.01% | 207,034 | 0.04% | 151,217 | 0.03% |
| PS.02.01.98 Other non-profit private sector providers not disaggregated | 37,768,562 | 11.10% | 64,683,365 | 13.42% | 53,270,799 | 12.17% |
| **PS.02.02 Profit-making private sector providers** | **90,341** | **0.03%** | **120,526** | **0.03%** | | **0.00%** |
| PS.02.02.98 Profit-making private sector providers not disaggregated | 90,341 | 0.03% | 120,526 | 0.03% | | 0.00% |
| **PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices** | **85,086,759** | **25.00%** | **80,268,750** | **16.65%** | **83,216,581** | **19.01%** |
| **PS.03.01 Bilateral agencies** | | **0.00%** | **144,206** | **0.03%** | **113,811** | **0.03%** |
| **PS.03.02 Multilateral agencies** | **3,124,996** | **0.92%** | **2,742,042** | **0.57%** | **2,821,423** | **0.64%** |
| **PS.03.03 International NGOs and foundations** | **81,961,764** | **24.08%** | **77,382,502** | **16.05%** | **80,281,347** | **18.34%** |
| **Total** | **340,336,872** | **100.00%** | **482,064,889** | **100.00%** | **437,756,619** | **100.00%** |

*Table 10. Production factors (PF) of the HIV expenditure in 2019-2021, US$ and % of the total HIV spending by year*

| Production factors (PF) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **PF.01.01 Personnel costs** | **60,615,201** | **17.81%** | **75,347,544** | **15.63%** | **76,716,913** | **17.53%** |
| PF.01.01.01.01 Labor costs - Direct service providers | 5,166,073 | 1.52% | 8,878,389 | 1.84% | 17,153,794 | 3.92% |
| PF.01.01.01.02 Fringe Benefits - Direct service providers | 7,544,770 | 2.22% | 10,196,846 | 2.12% | 11,075,907 | 2.53% |
| PF.01.01.01.03 Performance based supplements, incentives | 1,372 | 0.00% | 5,461 | 0.00% | 873,895 | 0.20% |
| PF.01.01.01.04 Consultants (external) | 1,470,004 | 0.43% | 1,156,267 | 0.24% | 496,984 | 0.11% |
| PF.01.01.01.98 Direct service providers not disaggregated | 1,530,782 | 0.45% | 9,483,696 | 1.97% | 9,174,997 | 2.10% |
| PF.01.01.02.01 Labor costs - Program management | 31,809,928 | 9.35% | 32,411,527 | 6.72% | 33,697,715 | 7.70% |
| PF.01.01.02.02 Fringe Benefits - Program management | 38,990 | 0.01% | | 0.00% | 67,169 | 0.02% |
| PF.01.01.02.04 Program Management Consultants (external) | 22,998 | 0.01% | 24,384 | 0.01% | 11,644 | 0.00% |
| PF.01.01.02.98 Program management personnel not disaggregated | 2,368,618 | 0.70% | 2,207,920 | 0.46% | 2,372,043 | 0.54% |
| PF.01.01.98 Personnel not disaggregated | 10,661,667 | 3.13% | 10,983,055 | 2.28% | 1,792,766 | 0.41% |
| **PF.01.02 Other operational and programme management current expenditures** | **20,368,322** | **5.98%** | **13,993,502** | **2.90%** | **9,602,256** | **2.19%** |
| PF.01.02.01 Office rental costs | 94,127 | 0.03% | 48,316 | 0.01% | 136,553 | 0.03% |
| PF.01.02.02 Office utilities costs (electricity, water, heating, etc.) | 631,870 | 0.19% | 2,067,901 | 0.43% | 795,947 | 0.18% |
| PF.01.02.03 Travel expenditure | 12,837,423 | 3.77% | 7,692,033 | 1.60% | 7,198,168 | 1.64% |
| PF.01.02.04 Administrative and programme management costs | 3,100,592 | 0.91% | 3,228,692 | 0.67% | 339,910 | 0.08% |
| PF.01.02.98 Other current costs not disaggregated | 3,704,309 | 1.09% | 799,450 | 0.17% | 964,374 | 0.22% |
| PF.01.02.99 Other current costs n.e.c. | | 0.00% | 157,110 | 0.03% | 167,303 | 0.04% |
| **PF.01.03 Medical products and supplies** | **127,537,097** | **37.47%** | **255,041,694** | **52.91%** | **210,306,900** | **48.04%** |
| PF.01.03.01.01 Antiretrovirals | 87,596,709 | 25.74% | 158,383,174 | 32.86% | 138,837,954 | 31.72% |
| PF.01.03.01.03 OST drugs | | 0.00% | | 0.00% | 1,216 | 0.00% |
| PF.01.03.01.04 STI drugs | 1,957 | 0.00% | | 0.00% | | 0.00% |
| PF.01.03.01.07 OI other than TB drugs | 923,352 | 0.27% | 337,867 | 0.07% | 56,130 | 0.01% |
| PF.01.03.01.98 Pharmaceuticals not disaggregated | 2,770,052 | 0.81% | 8,984,419 | 1.86% | 7,516,540 | 1.72% |
| PF.01.03.01.99 Pharmaceuticals n.e.c. | | 0.00% | | 0.00% | 6,139 | 0.00% |
| PF.01.03.02.01 Syringes and needles | 3,261 | 0.00% | 4,203 | 0.00% | | 0.00% |
| PF.01.03.02.02 Condoms | 67,959 | 0.02% | 194,663 | 0.04% | 190,986 | 0.04% |
| PF.01.03.02.98 Medical supplies not disaggregated | 23,423,664 | 6.88% | 44,769,314 | 9.29% | 46,144,392 | 10.54% |
| PF.01.03.02.99 Medical supplies n.e.c. | 3,073,312 | 0.90% | 244,853 | 0.05% | 2,831,965 | 0.65% |
| PF.01.03.03.01 HIV tests screening/diagnostics | 994,895 | 0.29% | 25,011,214 | 5.19% | 1,855,063 | 0.42% |
| PF.01.03.03.03 CD4 tests | | 0.00% | | 0.00% | 100,495 | 0.02% |
| PF.01.03.03.06 Diagnostic tests for hepatitis (including rapid testing) | | 0.00% | 875 | 0.00% | | 0.00% |
| PF.01.03.03.98 Reagents and materials not disaggregated | 2,147,894 | 0.63% | 1,154,503 | 0.24% | 543,629 | 0.12% |
| PF.01.03.04.01 Food and nutrients | 15,575 | 0.00% | 107,144 | 0.02% | 111,759 | 0.03% |
| PF.01.03.04.02 Promotion and information materials | 229,459 | 0.07% | 322,506 | 0.07% | 233,771 | 0.05% |
| PF.01.03.04.98 Non-medical supplies not disaggregated | 5,117,331 | 1.50% | 12,456,342 | 2.58% | 11,313,946 | 2.58% |
| PF.01.03.04.99 Non-medical supplies n.e.c. | | 0.00% | 2,418 | 0.00% | 23,976 | 0.01% |
| PF.01.03.05 Office Supplies | 24,660 | 0.01% | 19,710 | 0.00% | 18,309 | 0.00% |
| PF.01.03.98 Medical products and supplies not disaggregated | 918,329 | 0.27% | 2,905,234 | 0.60% | 182,444 | 0.04% |
| PF.01.03.99 Medical products and supplies n.e.c. | 228,689 | 0.07% | 143,255 | 0.03% | 338,186 | 0.08% |
| **PF.01.04 Contracted external services** | **56,149,072** | **16.50%** | **58,079,740** | **12.05%** | **54,661,790** | **12.49%** |
| **PF.01.05 Transportation related to beneficiaries** | **8,410** | **0.00%** | **25,350** | **0.01%** | **49,727** | **0.01%** |

| Production factors (PF) (continued) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **PF.01.07 Financial support for beneficiaries** | **317,598** | **0.09%** | **2,909,459** | **0.60%** | **3,413,841** | **0.78%** |
| **PF.01.08 Training- Training related per diems/transport/other costs** | **8,431,818** | **2.48%** | **5,542,289** | **1.15%** | **10,321,582** | **2.36%** |
| **PF.01.09 Logistics of events, including catering services** | **786,999** | **0.23%** | **569,646** | **0.12%** | **1,031,639** | **0.24%** |
| **PF.01.10 Indirect costs** | **16,321,332** | **4.80%** | **12,883,519** | **2.67%** | **16,101,113** | **3.68%** |
| PF.01.10.01 Financial intermediary services | 38,625 | 0.01% | 172 | 0.00% | 934 | 0.00% |
| PF.01.10.02 Indirect cost rate | 373,459 | 0.11% | 9,418 | 0.00% | 384,614 | 0.09% |
| PF.01.10.98 Indirect costs not disaggregated | 15,909,249 | 4.67% | 12,873,929 | 2.67% | 15,715,564 | 3.59% |
| **PF.01.98 Current direct and indirect expenditures not disaggregated** | **36,272,138** | **10.66%** | **44,053,399** | **9.14%** | **45,999,930** | **10.51%** |
| **PF.01.99 Current direct and indirect expenditures n.e.c.** | **1,330,234** | **0.39%** | **2,467,413** | **0.51%** | **1,218,093** | **0.28%** |
| **PF.02.01 Building** | **65,008** | **0.02%** | **220,076** | **0.05%** | **61,023** | **0.01%** |
| PF.02.01.01 Laboratory and other infrastructure upgrading | | 0.00% | 44,750 | 0.01% | 34,183 | 0.01% |
| PF.02.01.02 Construction and renovation | 65,008 | 0.02% | 116,486 | 0.02% | 26,839 | 0.01% |
| PF.02.01.98 Building not disaggregated | | 0.00% | 58,840 | 0.01% | | 0.00% |
| **PF.02.02 Vehicles** | **40,598** | **0.01%** | **14,795** | **0.00%** | **363,034** | **0.08%** |
| **PF.02.03 Other capital investment** | **10,561,675** | **3.10%** | **9,365,215** | **1.94%** | **6,617,763** | **1.51%** |
| PF.02.03.01 Information technology (hardware and software) | 318,459 | 0.09% | 148,507 | 0.03% | 2,255,718 | 0.52% |
| PF.02.03.02 Laboratory and other medical equipment | 729,561 | 0.21% | 940,920 | 0.20% | 2,158,650 | 0.49% |
| PF.02.03.03 Non medical equipment and furniture | 3,064,746 | 0.90% | 5,730,646 | 1.19% | 2,194,483 | 0.50% |
| PF.02.03.98 Other capital investment not disaggregated | 6,448,909 | 1.89% | 2,545,141 | 0.53% | 8,912 | 0.00% |
| **PF.02.98 Capital expenditure not disaggregated** | **71,761** | **0.02%** | **154,699** | **0.03%** | **182,359** | **0.04%** |
| **PF.98 Production factors not disaggregated** | **1,459,609** | **0.43%** | **1,396,548** | **0.29%** | **1,108,655** | **0.25%** |
| **Total** | **340,336,872** | **100.00%** | **482,064,889** | **100.00%** | **437,756,619** | **100.00%** |

*Table 11. Service delivery modalities (SDM) in Nigeria in 2019-2021, US$ and % of the annual total HIV spending*

| Service delivery modalities (SDM) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **SDM.01 Facility-based** | **201,024,760** | **59%** | **353,744,464** | **73%** | **289,860,001** | **66%** |
| SDM.01.01 Facility-based: Outpatient | 191,393,063 | 56% | 322,345,555 | 67% | 289,278,987 | 66% |
| SDM.01.02 Facility-based: Inpatient | 16,271 | 0% | - | 0% | - | 0% |
| SDM.01.98 Facility-based not disaggregated | 9,615,426 | 3% | 31,398,909 | 7% | 581,014 | 0% |
| **SDM.02 Community-based** | **24,153,784** | **7%** | **51,843,472** | **11%** | **55,360,163** | **13%** |
| SDM.02.01 Community-based: center | 816,092 | 0% | 233,297 | 0% | 316,254 | 0% |
| SDM.02.03 Community-based: automated distribution unit/dispensing machine | - | 0% | 8,965 | 0% | - | 0% |
| SDM.02.04 Community-based: mobile unit | 67,790 | 0% | - | 0% | 1,244 | 0% |
| SDM.02.05 Community-based: outreach | 354,687 | 0% | 301,870 | 0% | 271,191 | 0% |
| SDM.02.06 Community-based: home-based (including door-to-door) | - | 0% | 1,496 | 0% | - | 0% |
| SDM.02.07 HIV self-testing | - | 0% | 300,899 | 0% | 1,168,781 | 0% |
| SDM.02.98 Home and community based not disaggregated | 22,336,286 | 7% | 45,125,895 | 9% | 41,798,279 | 10% |
| SDM.02.99 Home and community based n.e.c. | 578,928 | 0% | 5,871,049 | 1% | 11,804,415 | 3% |
| **SDM.03 Non applicable (ASC which does not have a specific SDM)** | **93,568,574** | **27%** | **68,469,460** | **14%** | **61,837,218** | **14%** |
| **SDM.98 Modalities not disaggregated** | **21,542,704** | **6%** | **8,000,969** | **2%** | **30,648,973** | **7%** |
| **SDM.99 Modalities n.e.c.** | **47,050** | **0%** | **6,524** | **0%** | **50,264** | **0%** |
| **Total** | **340,336,872** | **100%** | **482,064,889** | **100%** | **437,756,619** | **100%** |

*Table 12. AIDS spending categories (ASC) in Nigeria in 2019-2021, US$ and % of the annual total HIV spending*

| AIDS Spending Categories (ASC) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **ASC.01 Prevention** | **9,165,741** | **2.7%** | **11,763,860** | **2.4%** | **38,965,000** | **8.9%** |
| **ASC.01.01 Five Pillars of Prevention** | **3,885,470** | **1.1%** | **7,434,198** | **1.5%** | **34,069,202** | **7.8%** |
| ASC.01.01.01 Prevention for adolescent girls and young women (AGYW) and their male partners in settings with high HIV prevalence | 475,000 | 0.1% | 1,536,369 | 0.3% | 2,372,818 | 0.5% |
| ASC.01.01.01.03 Behaviour change communication (BCC) as part of programmes for AGYW and their male partners - only if earmarked HIV funds are spent | 13,702 | 0.0% | 1,195,086 | 0.2% | 1,805,938 | 0.4% |
| ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as part of programmes for AGYW - only if earmarked HIV funds are spent | 152,174 | 0.0% | 121,766 | 0.0% | | 0.0% |
| ASC.01.01.01.98 Programmatic activities for AGYW not disaggregated by type | 309,124 | 0.1% | 219,517 | 0.0% | 566,880 | 0.1% |
| ASC.01.01.02 Services for key populations | 3,297,572 | 1.0% | 4,815,787 | 1.0% | 8,031,994 | 1.8% |
| ASC.01.01.02.01.03 Peer education for sex workers - only if earmarked HIV funds are spent | 13,269 | 0.0% | | 0.0% | | 0.0% |
| ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type | 997,733 | 0.3% | 829,713 | 0.2% | 439,339 | 0.1% |
| ASC.01.01.02.02.02 STI/SRH services for MSM (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent | 295,422 | 0.1% | 904,172 | 0.2% | | 0.0% |
| ASC.01.01.02.02.03 Behaviour change communication (BCC) as part of programmes for MSM | | 0.0% | 407,671 | 0.1% | 236,407 | 0.1% |
| ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type | 383,029 | 0.1% | 16,127 | 0.0% | | 0.0% |
| ASC.01.01.02.03.03 Behaviour change communication (BCC) as part of programmes for TG | | 0.0% | 705 | 0.0% | 5,782 | 0.0% |
| ASC.01.01.02.03.98 Programmatic activities for TG not disaggregated by type | 7,032 | 0.0% | | 0.0% | | 0.0% |
| ASC.01.01.02.04.01 Condom and lubricant programme as part of programmes for PWID | | 0.0% | | 0.0% | 1,265 | 0.0% |
| ASC.01.01.02.04.03 Behaviour change communication (BCC) as part of programmes for PWID | 100,600 | 0.0% | 329,309 | 0.1% | 242,158 | 0.1% |
| ASC.01.01.02.04.06.01 Provision of drug substitution treatment for PWID | | 0.0% | | 0.0% | 1,216 | 0.0% |
| ASC.01.01.02.04.98 Other programmatic activities for PWID not disaggregated by type | 326,091 | 0.1% | | 0.0% | | 0.0% |
| ASC.01.01.02.05.03 Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners) | | 0.0% | 70,794 | 0.0% | 23,126 | 0.0% |
| ASC.01.01.02.05.98 Programmatic activities for inmates not disaggregated by type | 5,598 | 0.0% | | 0.0% | | 0.0% |
| ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described) | 1,168,798 | 0.3% | 2,257,296 | 0.5% | 7,082,701 | 1.6% |
| ASC.01.01.03 Condoms (for HIV prevention) for the general population (excluding KPs and AGYW above) | 68,318 | 0.0% | 521,271 | 0.1% | 478,184 | 0.1% |
| ASC.01.01.03.01 Provision of free condoms for HIV prevention (excluding for KPs and AGYW) | 67,959 | 0.0% | 194,663 | 0.0% | 189,721 | 0.0% |
| ASC.01.01.03.02 Social marketing of condoms for HIV prevention (excluding for KPs and AGYW) | 359 | 0.0% | | 0.0% | | 0.0% |
| ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated | | 0.0% | 326,608 | 0.1% | 288,463 | 0.1% |
| ASC.01.01.05 Pre-Exposure Prophilaxis (PrEP) | 44,580 | 0.0% | 560,772 | 0.1% | 23,186,207 | 5.3% |
| ASC.01.01.05.02 PrEP as part of programmes for sex workers and their clients | | 0.0% | 189,748 | 0.0% | 86,079 | 0.0% |
| ASC.01.01.05.03 PrEP as part of programmes for gay men and other men who have sex with men (MSM) | | 0.0% | 86,248 | 0.0% | 39,127 | 0.0% |

| AIDS Spending Categories (ASC) (continued) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| ASC.01.01.05.04 PrEP as part of programmes for Transgenders (TG) | | 0.0% | 139 | 0.0% | 1,564 | 0.0% |
| ASC.01.01.05.05 PrEP as part of programmes for PWIDs | | 0.0% | 51,750 | 0.0% | 23,476 | 0.0% |
| ASC.01.01.05.07 PrEP as part of programmes for inmates of correctional facilities or pre-trial detention centres (prisoners) | | 0.0% | 17,075 | 0.0% | 6,260 | 0.0% |
| ASC.01.01.05.98 PrEP not disaggregated by key population | 44,580 | 0.0% | 215,812 | 0.0% | 23,029,701 | 5.3% |
| **ASC.01.02 Other prevention activities** | **5,280,271** | **1.6%** | **4,329,662** | **0.9%** | **4,895,798** | **1.1%** |
| ASC.01.02.01 Prevention of vertical transmission of HIV infection (PMTCT) | 4,089,299 | 1.2% | 2,733,928 | 0.6% | 1,501,911 | 0.3% |
| ASC.01.02.01.02 Delivery practices as part of PMTCT programmes | 16,271 | 0.0% | 539 | 0.0% | | 0.0% |
| ASC.01.02.01.03 Reproductive health and family planning services as part of PMTCT programmes | | 0.0% | | 0.0% | 137,475 | 0.0% |
| ASC.01.02.01.98 PMTCT not disaggregated by activity | 3,637,464 | 1.1% | 2,300,068 | 0.5% | 1,352,476 | 0.3% |
| ASC.01.02.01.99 PMTCT activities n.e.c. | 435,564 | 0.1% | 433,321 | 0.1% | 11,960 | 0.0% |
| ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations | 105,741 | 0.0% | 53,623 | 0.0% | 79,234 | 0.0% |
| ASC.01.02.03 Community mobilization for populations other than key populations | 114,888 | 0.0% | 264,399 | 0.1% | 2,089,063 | 0.5% |
| ASC.01.02.03 Community mobilization for populations other than key populations | 114,888 | 0.0% | 264,399 | 0.1% | 2,089,063 | 0.5% |
| ASC.01.02.04 Programmatic activities for other vulnerable and accessible populations | 489,862 | 0.1% | 739,154 | 0.2% | 73,743 | 0.0% |
| ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations | | 0.0% | 655,655 | 0.1% | | 0.0% |
| ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type | 489,862 | 0.1% | 83,499 | 0.0% | 73,743 | 0.0% |
| ASC.01.02.05 Prevention for children and youth (excluding for AGYW in countries with high HIV prevalence) | 54,171 | 0.0% | 11,889 | 0.0% | 38,301 | 0.0% |
| ASC.01.02.05.01 Prevention activities implemented in school | 31,307 | 0.0% | 1,933 | 0.0% | 23,490 | 0.0% |
| ASC.01.02.05.02 Prevention activities implemented out-of-school | 22,863 | 0.0% | 9,955 | 0.0% | 14,810 | 0.0% |
| ASC.01.02.06 Prevention of HIV transmission aimed at people living with HIV and their partners (including sero-discordant couples) | | 0.0% | | 0.0% | 21,243 | 0.0% |
| ASC.01.02.06.01 BCC for PLHIV and SDC | | 0.0% | | 0.0% | 21,243 | 0.0% |
| ASC.01.02.07 Prevention and wellness programmes in the workplace | 3,913 | 0.0% | | 0.0% | 15,142 | 0.0% |
| ASC.01.02.10 STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets | 2,935 | 0.0% | | 0.0% | | 0.0% |
| ASC.01.02.98 Prevention activities not disaggregated | 419,463 | 0.1% | 526,669 | 0.1% | 1,077,161 | 0.2% |
| **ASC.02 HIV testing and counselling (HTC)** | **23,571,230** | **6.9%** | **57,692,239** | **12.0%** | **50,847,775** | **11.6%** |
| ASC.02.01 HIV testing and counselling for sex workers | 566,993 | 0.2% | 1,565,442 | 0.3% | 1,671,136 | 0.4% |
| ASC.02.02 HIV testing and counselling for MSM | 225,276 | 0.1% | 773,931 | 0.2% | 629,085 | 0.1% |
| ASC.02.03 HIV testing and counselling for TG | 5,929 | 0.0% | 1,327 | 0.0% | 7,937 | 0.0% |
| ASC.02.04 HIV testing and counselling for PWID | 96,360 | 0.0% | 435,325 | 0.1% | 131,769 | 0.0% |
| ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities | 5,529 | 0.0% | 134,398 | 0.0% | 32,010 | 0.0% |
| ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme) | 893,999 | 0.3% | 10,288 | 0.0% | 98,291 | 0.0% |
| ASC.02.07 Early infant diagnosis (EID) of HIV | 9,827 | 0.0% | | 0.0% | | 0.0% |
| ASC.02.08 HIV testing and counselling for vulnerable and accessible populations | 12,696 | 0.0% | 408,775 | 0.1% | 811,433 | 0.2% |

| AIDS Spending Categories (ASC) (continued) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| ASC.02.09 Voluntary HIV testing and counselling for general population | 19,178,261 | 5.6% | 33,646,005 | 7.0% | 40,689,537 | 9.3% |
| ASC.02.10 Provider initiated testing and counselling (PITC) | 14,525 | 0.0% | | 0.0% | 63,602 | 0.0% |
| ASC.02.11 HIV screening in blood banks | | 0.0% | 1,617 | 0.0% | | 0.0% |
| ASC.02.98 HIV testing and counselling activities not disaggregated | 2,561,834 | 0.8% | 20,715,131 | 4.3% | 6,712,974 | 1.5% |
| **ASC.03 HIV Care and Treatment** | **193,976,875** | **57.0%** | **309,356,354** | **64.2%** | **261,379,240** | **59.8%** |
| **ASC.03.01 Anti-retroviral therapy** | **105,101,617** | **30.9%** | **175,644,915** | **36.4%** | **129,739,853** | **29.7%** |
| ASC.03.01.01 ART for adults | 74,346,164 | 21.8% | 110,279,876 | 22.9% | 45,577,691 | 10.4% |
| ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment | 74,346,164 | 21.8% | 110,279,876 | 22.9% | 45,577,691 | 10.4% |
| ASC.03.01.02 ART for paediatrics | 13,025,135 | 3.8% | 5,818,525 | 1.2% | 3,951,025 | 0.9% |
| ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment | 13,025,135 | 3.8% | 5,818,525 | 1.2% | 3,951,025 | 0.9% |
| ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment) | | 0.0% | | 0.0% | 121,086 | 0.0% |
| ASC.03.01.03 ART for PMTCT (for pregnant women not previously on treatment) | | 0.0% | | 0.0% | 121,086 | 0.0% |
| ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT | 17,730,318 | 5.2% | 59,546,514 | 12.4% | 80,090,051 | 18.3% |
| ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT | 17,730,318 | 5.2% | 59,546,514 | 12.4% | 80,090,051 | 18.3% |
| **ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring** | **510,768** | **0.2%** | **398,906** | **0.1%** | **644,600** | **0.1%** |
| **ASC.03.03 Specific ART-related laboratory monitoring** | **22,850,779** | **6.7%** | **37,819,413** | **7.8%** | **50,821,209** | **11.6%** |
| **ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs** | **1,330,524** | **0.4%** | **3,190,555** | **0.7%** | **156,198** | **0.0%** |
| ASC.03.04.01 TB prevention, case finding, screening, diagnosis, treatment and adherence for PLHIV and KPs | 407,172 | 0.1% | 419,662 | 0.1% | 99,167 | 0.0% |
| ASC.03.04.01.02 TB screening, case detection and diagnosis | 186,760 | 0.1% | 341,587 | 0.1% | | 0.0% |
| ASC.03.04.01.03.98 TB treatment not disaggregated by type of TB | 50,708 | 0.0% | 46,029 | 0.0% | 99,046 | 0.0% |
| ASC.03.04.01.04 TB adherence and retention support | | 0.0% | | 0.0% | 121 | 0.0% |
| ASC.03.04.01.98 TB activities not disaggregated by type | 169,704 | 0.0% | 32,046 | 0.0% | | 0.0% |
| ASC.03.04.02 Hepatitis prevention, screening, diagnosis, treatment and adherence for PLHIV and KPs | | 0.0% | 875 | 0.0% | | 0.0% |
| ASC.03.04.02.02 Hepatitis screening and diagnosis | | 0.0% | 875 | 0.0% | | 0.0% |
| ASC.03.04.04 Other OI treatment (excluding TB and Hepatitis) | | 0.0% | | 0.0% | 56,130 | 0.0% |
| ASC.03.04.98 Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis) | 923,352 | 0.3% | 2,770,018 | 0.6% | 901 | 0.0% |
| **ASC.03.05 Psychological treatment and support services** | **61,885** | **0.0%** | **82,559** | **0.0%** | **5,325** | **0.0%** |
| **ASC.03.06 Palliative care** | | **0.0%** | **1,496** | **0.0%** | | **0.0%** |
| **ASC.03.98 Care and treatment services not disaggregated** | **64,121,302** | **18.8%** | **92,218,510** | **19.1%** | **80,012,054** | **18.3%** |
| **ASC.04 Social protection and economic support** | **20,054,451** | **5.9%** | **34,782,977** | **7.2%** | **24,244,750** | **5.5%** |
| **ASC.04.01 Social protection and economic support for OVC** | **19,814,943** | **5.8%** | **34,698,009** | **7.2%** | **24,077,714** | **5.5%** |
| ASC.04.01.01 OVC Basic needs (health, education, housing) | 774,423 | 0.2% | 8,679,404 | 1.8% | 7,568,790 | 1.7% |
| ASC.04.01.02 OVC Institutional and Community support | | 0.0% | 83,462 | 0.0% | | 0.0% |

| AIDS Spending Categories (ASC) (continued) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| ASC.04.01.03 OVC Social Services (including financial benefits) | 2,428,802 | 0.7% | 15,481,871 | 3.2% | 8,222,816 | 1.9% |
| ASC.04.01.98 OVC Services not disaggregated by activity | 16,515,542 | 4.9% | 8,787,422 | 1.8% | 6,203,150 | 1.4% |
| ASC.04.01.99 OVC services n.e.c. | 96,176 | 0.0% | 1,665,850 | 0.3% | 2,082,958 | 0.5% |
| **ASC.04.02 Other social protection and economic support (non-OVC)** | **239,509** | **0.1%** | **84,968** | **0.0%** | **167,036** | **0.0%** |
| ASC.04.02.01 Social protection through monetary or in-kind benefits | 15,389 | 0.0% | 84,968 | 0.0% | 103,039 | 0.0% |
| ASC.04.02.03 HIV-specific income generation projects | 620 | 0.0% | | 0.0% | | 0.0% |
| ASC.04.02.98 Social protection services and social services not disaggregated by type | 223,500 | 0.1% | | 0.0% | 63,997 | 0.0% |
| **ASC.05 Social Enablers** | **664,849** | **0.2%** | **619,697** | **0.1%** | **602,881** | **0.1%** |
| **ASC.05.01 Advocacy** | **500,359** | **0.1%** | **392,138** | **0.1%** | **350,402** | **0.1%** |
| **ASC.05.02 Human rights programmes** | **164,490** | **0.0%** | **201,861** | **0.0%** | **252,479** | **0.1%** |
| ASC.05.02.01 Stigma and discrimination reduction | 37,666 | 0.0% | 38,720 | 0.0% | 16,933 | 0.0% |
| ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV | 44,766 | 0.0% | | 0.0% | 73,988 | 0.0% |
| ASC.05.02.06 Capacity building in human rights | | 0.0% | 3,105 | 0.0% | | 0.0% |
| ASC.05.02.98 Human rights programmes not disaggregated by type | 82,057 | 0.0% | 160,035 | 0.0% | 161,558 | 0.0% |
| **ASC.05.98 Social enablers not disaggregated by type** | | **0.0%** | **25,698** | **0.0%** | | **0.0%** |
| **ASC.06 Programme enablers and systems strengthening** | **92,763,384** | **27.3%** | **67,727,708** | **14.0%** | **60,756,326** | **13.9%** |
| **ASC.06.01 Strategic planning, coordination and policy development** | **2,283,653** | **0.7%** | **2,321,149** | **0.5%** | **2,988,666** | **0.7%** |
| **ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes** | **30,362** | **0.0%** | **700** | **0.0%** | **1,252** | **0.0%** |
| ASC.06.02.01 Representation of PLHIV in key processes | 30,362 | 0.0% | | 0.0% | | 0.0% |
| ASC.06.02.01 Representation of PLHIV in key processes | 30,362 | 0.0% | | 0.0% | | 0.0% |
| ASC.06.02.02 Representation of youth in key processes | | 0.0% | 700 | 0.0% | 1,252 | 0.0% |
| ASC.06.02.02 Representation of youth in key processes | | 0.0% | 700 | 0.0% | 1,252 | 0.0% |
| **ASC.06.03 Programme administration and management costs (above service-delivery level)** | **49,590,768** | **14.6%** | **46,938,797** | **9.7%** | **40,768,256** | **9.3%** |
| **ASC.06.04 Strategic information** | **20,877,709** | **6.1%** | **11,756,541** | **2.4%** | **6,831,613** | **1.6%** |
| ASC.06.04.01 Monitoring and evaluation | 2,019,327 | 0.6% | 4,709,481 | 1.0% | 3,401,604 | 0.8% |
| ASC.06.04.02 Operations and implementation science research | 2,126 | 0.0% | | 0.0% | 195,826 | 0.0% |
| ASC.06.04.03 Serological-surveillance (sero-surveillance) | | 0.0% | 18,210 | 0.0% | | 0.0% |
| ASC.06.04.04 Management information systems | 7,788 | 0.0% | 29,533 | 0.0% | 52,820 | 0.0% |
| ASC.06.04.98 Strategic information not disaggregated by type | 18,848,468 | 5.5% | 6,999,317 | 1.5% | 3,181,362 | 0.7% |
| **ASC.06.05 Public Systems Strengthening** | **8,377,598** | **2.5%** | **3,373,558** | **0.7%** | **4,196,001** | **1.0%** |
| ASC.06.05.01 Procurement and supply chain | 4,560,507 | 1.3% | 1,410,065 | 0.3% | 3,868,544 | 0.9% |
| ASC.06.05.02 Laboratory system strengthening | 3,552,239 | 1.0% | 1,057,156 | 0.2% | 172,323 | 0.0% |
| ASC.06.05.03 Institutional & organisational development (health, social, educational etc) | 16,143 | 0.0% | 12,187 | 0.0% | 7,512 | 0.0% |
| ASC.06.05.04 Financial and accounting systems strengthening | 165,173 | 0.0% | 577,574 | 0.1% | 147,622 | 0.0% |
| ASC.06.05.98 Public system strengthening not disaggregated | 83,535 | 0.0% | 316,575 | 0.1% | | 0.0% |

| AIDS Spending Categories (ASC) (continued) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **ASC.06.06 Community system strengthening** | **693** | **0.0%** | **337,103** | **0.1%** | **513,203** | **0.1%** |
| ASC.06.06.01 Civil society institutional and NGO development | | 0.0% | | 0.0% | 470 | 0.0% |
| ASC.06.06.02 Community worker education, training and support | | 0.0% | | 0.0% | 118,445 | 0.0% |
| ASC.06.06.03 Resource mobilisation for community-based organisations | 693 | 0.0% | | 0.0% | | 0.0% |
| ASC.06.06.98 Community system strengthening not disaggregated | | 0.0% | 337,103 | 0.1% | 394,288 | 0.1% |
| **ASC.06.07 Human resources for health (above-site programmes)** | **8,329** | **0.0%** | **204,828** | **0.0%** | **102,496** | **0.0%** |
| ASC.06.07.01 Capacity building for health workers, excluding those at community level | 8,329 | 0.0% | 204,828 | 0.0% | 102,496 | 0.0% |
| **ASC.06.98 Programme enablers and systems strengthening not disaggregated** | **11,594,273** | **3.4%** | **2,795,031** | **0.6%** | **5,354,838** | **1.2%** |
| **ASC.07 Development synergies** | **120,390** | **0.0%** | **97,671** | **0.0%** | **156,598** | **0.0%** |
| **ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) using HIV earmarked resources** | **65,244** | **0.0%** | **61,522** | **0.0%** | **105,876** | **0.0%** |
| **ASC.07.02 Reducing gender-based violence** | **55,146** | **0.0%** | **36,149** | **0.0%** | **50,722** | **0.0%** |
| **ASC.08 HIV-related research** | **19,951** | **0.0%** | **24,384** | **0.0%** | **321,412** | **0.1%** |
| **ASC.08.03 Epidemiological research** | **19,951** | **0.0%** | **8,428** | **0.0%** | | **0.0%** |
| **ASC.08.04 Socio-behavioural research** | | **0.0%** | | **0.0%** | **321,412** | **0.1%** |
| **ASC.08.05 Economic research** | | **0.0%** | **15,956** | **0.0%** | | **0.0%** |
| **Total** | **340,336,872** | **100.0%** | **482,064,889** | **100.0%** | **437,273,983** | **100.0%** |

*Table 13. Beneficiary populations (BP) in Nigeria in 2019-2021, US$ and % of the annual total HIV spending*

| Beneficiary populations (BP) | 2019 | % | 2020 | % | 2021 | % |
|---|---|---|---|---|---|---|
| **BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)** | **194,187,415** | **57.06%** | **309,414,705** | **64.19%** | **261,474,877** | **59.73%** |
| BP.01.01.02 Adult and young women (aged 15 over) living with HIV | 546,428 | 0.16% | 14,133 | 0.00% | | 0.00% |
| BP.01.01.03 Pregnant and breastfeeding women (and not on ART) | 242,229 | 0.07% | 42,429 | 0.01% | 121,086 | 0.03% |
| BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender | 75,105,349 | 22.07% | 110,401,664 | 22.90% | 45,787,995 | 10.46% |
| BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender | 13,117,478 | 3.85% | 6,726,181 | 1.40% | 4,165,129 | 0.95% |
| BP.01.98 People living with HIV not broken down by age or gender | 105,175,932 | 30.90% | 192,230,298 | 39.88% | 211,400,667 | 48.29% |
| **BP.02 Key populations** | **4,316,831** | **1.27%** | **10,727,338** | **2.23%** | **38,799,822** | **8.86%** |
| BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners | 523,051 | 0.15% | 816,384 | 0.17% | 399,884 | 0.09% |
| BP.02.02.01 Female sex workers and their clients | 13,269 | 0.00% | 5,113 | 0.00% | 1,152,430 | 0.26% |
| BP.02.02.98 Sex workers, not broken down by gender, and their clients | 1,564,726 | 0.46% | 2,579,790 | 0.54% | 1,044,124 | 0.24% |
| BP.02.03 Gay men and other men who have sex with men (MSM) | 903,727 | 0.27% | 2,188,149 | 0.45% | 904,619 | 0.21% |
| BP.02.04 Transgender | 12,961 | 0.00% | 2,171 | 0.00% | 15,283 | 0.00% |
| BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons | 11,127 | 0.00% | 222,267 | 0.05% | 61,396 | 0.01% |
| BP.02.98 “Key populations” not broken down by type | 1,287,970 | 0.38% | 4,913,464 | 1.02% | 35,222,086 | 8.05% |
| **BP.03 Vulnerable, accessible and other target populations** | **25,867,813** | **7.60%** | **40,156,687** | **8.33%** | **29,067,184** | **6.64%** |
| BP.03.01 Orphans and vulnerable children (OVC) | 19,814,943 | 5.82% | 35,761,318 | 7.42% | 24,790,047 | 5.66% |
| BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns | 4,808,268 | 1.41% | 2,744,216 | 0.57% | 1,600,201 | 0.37% |
| BP.03.03 Adolescent girls and young women in countries with high HIV prevalence | 475,000 | 0.14% | 1,536,369 | 0.32% | 2,529,655 | 0.58% |
| BP.03.05 Internally displaced populations (because of an emergency) | | 0.00% | | 0.00% | 6,260 | 0.00% |
| BP.03.11 Children and youth out of school | 17,998 | 0.01% | | 0.00% | | 0.00% |
| BP.03.13 Partners of people living with HIV (including sero-discordant couples) | | 0.00% | | 0.00% | 4,670 | 0.00% |
| BP.03.14 Recipients of blood or blood products | | 0.00% | 1,617 | 0.00% | | 0.00% |
| BP.03.16 Elementary school students | | 0.00% | | 0.00% | 1,252 | 0.00% |
| BP.03.17 Junior high/high school students | | 0.00% | | 0.00% | 22,238 | 0.01% |
| BP.03.18 University students | 1,957 | 0.00% | 1,933 | 0.00% | | 0.00% |
| BP.03.21 Military | | 0.00% | 958 | 0.00% | | 0.00% |
| BP.03.24 Employees (e.g. for workplace interventions) | 3,913 | 0.00% | | 0.00% | 15,142 | 0.00% |
| BP.03.98 Vulnerable, accessible and other target populations not broken down by type | 745,734 | 0.22% | 110,277 | 0.02% | 97,719 | 0.02% |
| **BP.04 General population** | **19,908,996** | **5.85%** | **35,021,923** | **7.26%** | **44,974,228** | **10.27%** |
| BP.04.01.01 Male adult population | | 0.00% | | 0.00% | 2,624 | 0.00% |
| BP.04.01.98 General adult population (aged older than 24) not broken down by gender | 34,765 | 0.01% | 4,006 | 0.00% | | 0.00% |
| BP.04.02.98 Children (aged under 15) not broken down by gender | 1,565 | 0.00% | 6,281 | 0.00% | 13,877 | 0.00% |
| BP.04.03.02 Young females (excluding the AGYW programmes in high HIV prevalence countries) | | 0.00% | 10,513 | 0.00% | | 0.00% |
| BP.04.03.98 Youth (aged 15 to 24) not broken down by gender | 11,496 | 0.00% | 15,973 | 0.00% | 27,835 | 0.01% |
| BP.04.98 General population not broken down by age or gender. | 19,861,170 | 5.84% | 34,985,149 | 7.26% | 44,929,893 | 10.26% |
| **BP.05 Non-targeted interventions** | **93,568,574** | **27.49%** | **68,469,460** | **14.20%** | **61,837,218** | **14.13%** |
| **BP.98 Specific targeted populations not disaggregated** | **2,487,242** | **0.73%** | **18,274,775** | **3.79%** | **1,603,290** | **0.37%** |
| **Total** | **340,336,872** | **100.00%** | **482,064,889** | **100.00%** | **437,756,619** | **100.00%** |

*Table 14. AIDS spending categories (ASC) 1st digit by State - 2021, US$*

| Sub-national data (SND) | ASC.01 Prevention | ASC.02 HIV testing and counselling (HTC) | ASC.03 HIV Care and Treatment | ASC.04 Social protection and economic support | ASC.05 Social Enablers | ASC.06 Programme enablers and systems strengthening | ASC.07 Development synergies | ASC.08 HIV-related research |
|---|---|---|---|---|---|---|---|---|
| SND.01 Abia | 1,265 | - | - | 6,260 | - | - | - | - |
| SND.02 Adamawa | 657,497 | 1,070,488 | 2,608,233 | 1,521,664 | - | - | - | - |
| SND.03 Akwa Ibom | 1,153,796 | 4,709,766 | 10,659,150 | 1,956,069 | - | 36,216 | - | - |
| SND.04 Anambra | 32,185 | 3,668 | 10,002 | - | - | 880 | - | - |
| SND.05 Bauchi | 559,066 | 1,008,177 | 1,542,762 | 1,306,782 | - | - | - | - |
| SND.06 Bayelsa | 5,864 | 61,148 | 240,205 | - | 23,788 | 682 | - | - |
| SND.07 Benue | 4,266,415 | 4,168,643 | 12,538,065 | 4,976,515 | - | - | - | - |
| SND.08 Borno | 64,318 | 356,883 | 606,835 | - | - | - | - | - |
| SND.09 Cross River | 533,213 | 1,080,279 | 5,681,632 | 590,251 | - | - | - | - |
| SND.10 Delta | 1,449,400 | 1,394,480 | 3,412,045 | 1,385,978 | - | - | - | - |
| SND.11 Ebonyi | - | 25,735 | - | - | - | - | - | - |
| SND.12 Edo | 1,007 | 23,983 | 578,909 | 1,157 | 2,494 | 4,431 | - | - |
| SND.13 Ekiti | - | 350,679 | 311,952 | - | - | - | - | - |
| SND.14 Enugu | 192,703 | 1,110,718 | 2,604,656 | 1,101,558 | - | - | - | - |
| SND.15 Federal Capital Territory | 435,206 | 955,194 | 4,207,868 | 1,098,694 | - | - | - | - |
| SND.16 Gombe | - | 429,155 | 1,294,743 | 389,692 | - | - | - | - |
| SND.17 Imo | 70,799 | 1,083,880 | 2,030,527 | 682,045 | - | - | - | - |
| SND.18 Jigawa | 64,131 | 420,174 | 380,782 | 1,803 | - | 25,741 | - | - |
| SND.19 Kaduna | 455,846 | 407,433 | 2,565,937 | 1,017,475 | - | - | - | - |
| SND.20 Kano | 114,463 | 1,024,952 | 1,559,755 | 1,289,921 | 12,195 | 16,356 | - | - |
| SND.21 Katsina | 431,046 | 225,135 | 558,340 | - | - | - | - | - |
| SND.22 Kebbi | 37,999 | 228,279 | 390,038 | - | - | - | - | - |
| SND.23 Kogi | 226,320 | 371,658 | 1,107,800 | - | - | - | - | - |
| SND.24 Kwara | 31,971 | 229,067 | 373,140 | - | - | - | - | - |
| SND.25 Lagos | 2,515,248 | 1,976,902 | 6,145,079 | 3,175,055 | 38,882 | 321,494 | - | - |
| SND.26 Nasarawa | 444,393 | 656,769 | 3,398,511 | 1,193,589 | - | - | - | - |
| SND.27 Niger | 137,871 | 897,565 | 1,718,314 | - | 1,252 | 5,509 | - | - |
| SND.28 Ogun | - | 991,594 | 1,372,406 | - | - | 99,937 | - | - |
| SND.29 Ondo | - | 805,287 | 794,536 | - | - | - | - | - |
| SND.30 Osun | - | 641,085 | 592,882 | - | - | - | - | - |
| SND.31 Oyo | - | 1,556,787 | 1,538,541 | - | - | - | - | - |
| SND.32 Plateau | 3,582 | 1,058,322 | 2,694,468 | - | 15,028 | 47,879 | - | - |
| SND.33 Rivers | 644,978 | 3,770,086 | 8,188,394 | 2,416,402 | - | - | - | - |
| SND.34 Sokoto | 31,971 | 191,498 | 342,319 | - | 801 | 25,040 | - | - |
| SND.36 Yobe | 64,131 | 175,298 | 322,581 | - | - | - | - | - |
| SND.37 Zamfara | 35,727 | 166,677 | 205,154 | - | 8,764 | 751 | - | - |
| SND.98 Not disaggregated by part of the country | 24,785,223 | 17,220,332 | 178,802,681 | 133,841 | 499,678 | 60,171,410 | 156,598 | 321,412 |
| **Total** | **39,447,636** | **50,847,775** | **261,379,240** | **24,244,750** | **602,881** | **60,756,326** | **156,598** | **321,412** |

*Table 15. Financing entities (FE) 1st digit by State - 2021, US$*

| Sub-national data (SND) | FE.01 Public Entities | FE.02 Private Entities | FE.03 International Entities |
|---|---|---|---|
| SND.01 Abia | 6,260 | 1,265 | - |
| SND.02 Adamawa | - | - | 5,857,882 |
| SND.03 Akwa Ibom | - | - | 18,514,996 |
| SND.04 Anambra | - | - | 46,735 |
| SND.05 Bauchi | - | - | 4,416,787 |
| SND.06 Bayelsa | 24,470 | - | 307,217 |
| SND.07 Benue | - | - | 25,949,638 |
| SND.08 Borno | - | - | 1,028,035 |
| SND.09 Cross River | - | - | 7,885,375 |
| SND.10 Delta | - | 2,830 | 7,639,074 |
| SND.11 Ebonyi | - | - | 25,735 |
| SND.12 Edo | 9,326 | - | 602,654 |
| SND.13 Ekiti | - | - | 662,631 |
| SND.14 Enugu | - | - | 5,009,634 |
| SND.15 Federal Capital Territory | - | 2,151 | 6,694,810 |
| SND.16 Gombe | - | - | 2,113,590 |
| SND.17 Imo | - | - | 3,867,251 |
| SND.18 Jigawa | 90,271 | - | 802,361 |
| SND.19 Kaduna | - | - | 4,446,692 |
| SND.20 Kano | 185,796 | - | 3,831,845 |
| SND.21 Katsina | - | - | 1,214,520 |
| SND.22 Kebbi | - | - | 656,316 |
| SND.23 Kogi | - | 5,434 | 1,700,345 |
| SND.24 Kwara | - | - | 634,177 |
| SND.25 Lagos | 1,173,527 | 31,002 | 12,968,132 |
| SND.26 Nasarawa | - | - | 5,693,263 |
| SND.27 Niger | 6,761 | - | 2,753,750 |
| SND.28 Ogun | 122,473 | - | 2,341,463 |
| SND.29 Ondo | - | - | 1,599,823 |
| SND.30 Osun | - | - | 1,233,967 |
| SND.31 Oyo | - | - | 3,095,328 |
| SND.32 Plateau | 3,005 | 5,977 | 3,810,297 |
| SND.33 Rivers | - | - | 15,019,860 |
| SND.34 Sokoto | 51,650 | - | 539,979 |
| SND.36 Yobe | - | - | 562,010 |
| SND.37 Zamfara | 13,271 | - | 403,801 |
| SND.98 Not disaggregated by part of the country | 15,419,263 | 97,822 | 266,574,090 |
| **Total** | **17,106,073** | **146,480** | **420,504,065** |

*Table 16. Financing entities (FE) (1st digit) and AIDS spending categories (ASC) (2nd digit) - 2021, US$*

| AIDS spending category (ASC) | FE.01 Public Entities | FE.02 Domestic Private Entities | FE.03 International Entities | Total, 2021 |
|---|---|---|---|---|
| **ASC.01 Prevention** | **722,505** | **36,387** | **38,688,744** | **39,447,636** |
| ASC.01.01 Five Pillars of Prevention | 75,746 | 1,265 | 33,992,192 | 34,069,202 |
| ASC.01.02 Other prevention activities | 646,758 | 35,122 | 4,696,553 | 5,378,433 |
| **ASC.02 HIV testing and counselling (HTC)** | **1,878,175** | **18,372** | **48,951,228** | **50,847,775** |
| ASC.02.01 HIV testing and counselling for sex workers | | | 1,671,136 | 1,671,136 |
| ASC.02.02 HIV testing and counselling for MSM | | | 629,085 | 629,085 |
| ASC.02.03 HIV testing and counselling for TG | | | 7,937 | 7,937 |
| ASC.02.04 HIV testing and counselling for PWID | | | 131,769 | 131,769 |
| ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities | | | 32,010 | 32,010 |
| ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme) | | | 98,291 | 98,291 |
| ASC.02.08 HIV testing and counselling for vulnerable and accessible populations | | | 811,433 | 811,433 |
| ASC.02.09 Voluntary HIV testing and counselling for general population | 1,849,362 | 18,372 | 38,821,804 | 40,689,537 |
| ASC.02.10 Provider initiated testing and counselling (PITC) | | | 63,602 | 63,602 |
| ASC.02.98 HIV testing and counselling activities not disaggregated | 28,813 | | 6,684,161 | 6,712,974 |
| **ASC.03 HIV Care and Treatment** | **8,347,772** | | **253,031,468** | **261,379,240** |
| ASC.03.01 Anti-retroviral therapy | 8,024,740 | | 121,715,113 | 129,739,853 |
| ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring | 43,945 | | 600,655 | 644,600 |
| ASC.03.03 Specific ART-related laboratory monitoring | 791 | | 50,820,418 | 50,821,209 |
| ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs | 901 | | 155,297 | 156,198 |
| ASC.03.05 Psychological treatment and support services | 676 | | 4,649 | 5,325 |
| ASC.03.98 Care and treatment services not disaggregated | 276,718 | | 79,735,336 | 80,012,054 |
| **ASC.04 Social protection and economic support** | **57,414** | **10,342** | **24,176,994** | **24,244,750** |
| ASC.04.01 Social protection and economic support for OVC | 24,219 | 10,342 | 24,043,153 | 24,077,714 |
| ASC.04.02 Other social protection and economic support (non-OVC) | 33,196 | | 133,841 | 167,036 |
| **ASC.05 Social Enablers** | **90,129** | **5,509** | **507,243** | **602,881** |
| ASC.05.01 Advocacy | 90,129 | | 260,273 | 350,402 |
| ASC.05.02 Human rights programmes | | 5,509 | 246,970 | 252,479 |
| **ASC.06 Programme enablers and systems strengthening** | **6,010,078** | **75,871** | **54,670,377** | **60,756,326** |
| ASC.06.01 Strategic planning, coordination and policy development | 249,670 | | 2,738,996 | 2,988,666 |
| ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes | | | 1,252 | 1,252 |
| ASC.06.03 Programme administration and management costs (above service-delivery level) | 163,045 | | 40,605,211 | 40,768,256 |
| ASC.06.04 Strategic information | 548,721 | | 6,282,891 | 6,831,613 |
| ASC.06.05 Public Systems Strengthening | 8,075 | | 4,187,926 | 4,196,001 |
| ASC.06.06 Community system strengthening | 33,241 | 75,871 | 404,091 | 513,203 |
| ASC.06.07 Human resources for health (above-site programmes) | 250 | | 102,246 | 102,496 |
| ASC.06.98 Programme enablers and systems strengthening not disaggregated | 5,007,074 | | 347,764 | 5,354,838 |
| **ASC.07 Development synergies** | | | **156,598** | **156,598** |
| ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) using HIV earmarked resources | | | 105,876 | 105,876 |
| ASC.07.02 Reducing gender-based violence | | | 50,722 | 50,722 |
| **ASC.08 HIV-related research** | | | **321,412** | **321,412** |
| ASC.08.04 Socio-behavioural research | | | 321,412 | 321,412 |
| **Total** | **17,106,073** | **146,480** | **420,504,065** | **437,756,619** |

*Table 17. Financing entities (FE) 1st digit and production factors (PF) 2nd digit - 2021, US$*

| Production factor (PF) | FE.01 Public Entities | FE.02 Domestic Private Entities | FE.03 International Entities | Total, 2021 |
|---|---|---|---|---|
| **PF.01 Current direct and indirect expenditures** | **16,367,869** | **146,480** | **412,909,436** | **429,423,785** |
| PF.01.01 Personnel costs | 2,205,036 | 13,271 | 74,498,606 | 76,716,913 |
| PF.01.02 Other operational and programme management current expenditures | 1,108,537 | 12,258 | 8,481,461 | 9,602,256 |
| PF.01.03 Medical products and supplies | 8,559,504 | 36,741 | 201,710,655 | 210,306,900 |
| PF.01.04 Contracted external services | 1,070,471 | | 53,591,319 | 54,661,790 |
| PF.01.05 Transportation related to beneficiaries | 5,008 | | 44,719 | 49,727 |
| PF.01.07 Financial support for beneficiaries | 52,008 | 2,830 | 3,359,003 | 3,413,841 |
| PF.01.08 Training- Training related per diems/transport/other costs | 788,928 | 5,509 | 9,527,146 | 10,321,582 |
| PF.01.09 Logistics of events, including catering services | 462,585 | | 569,054 | 1,031,639 |
| PF.01.10 Indirect costs | | | 16,101,113 | 16,101,113 |
| PF.01.98 Current direct and indirect expenditures not disaggregated | 2,115,793 | | 43,884,138 | 45,999,930 |
| PF.01.99 Current direct and indirect expenditures n.e.c. | | 75,871 | 1,142,222 | 1,218,093 |
| **PF.02 Capital expenditures** | **738,204** | | **6,485,975** | **7,224,179** |
| PF.02.01 Building | 22,949 | | 38,074 | 61,023 |
| PF.02.02 Vehicles | 356,221 | | 6,814 | 363,034 |
| PF.02.03 Other capital investment | 359,034 | | 6,258,729 | 6,617,763 |
| PF.02.98 Capital expenditure not disaggregated | | | 182,359 | 182,359 |
| **PF.98 Production factors not disaggregated** | | | **1,108,655** | **1,108,655** |
| **Total** | **17,106,073** | **146,480** | **420,504,065** | **437,756,619** |

*Table 18. Financing agents-purchasers (FAP) (1st digit) and providers of services (PS) (2nd digit) - 2021, US$*

| Provider of services (PS) | FAP.01 Public sector | FAP.02 Private sector | FAP.03 International purchasing organizations | Total, 2021 |
|---|---|---|---|---|
| **PS.01 Public sector providers** | **22,739,606** | | **118,788,713** | **141,528,319** |
| **PS.01.01 Governmental organizations** | **22,654,473** | | **118,788,713** | **141,443,186** |
| PS.01.01.02 Ambulatory care (public) | 10,162,370 | | 216,478 | 10,378,848 |
| PS.01.01.13.01 National AIDS Coordinating Authority (NACs) | 10,747,002 | | | 10,747,002 |
| PS.01.01.13.02 Departments inside the Ministry of Health or equivalent | 230,116 | | | 230,116 |
| PS.01.01.13.99 Government entities n.e.c. | 104,299 | | | 104,299 |
| PS.01.01.98 Governmental organizations not disaggregated | 1,410,685 | | 118,572,234 | 119,982,920 |
| **PS.01.02 Parastatal organizations** | **85,133** | | | **85,133** |
| PS.01.02.98 Parastatal organizations not disaggregated | 85,133 | | | 85,133 |
| **PS.02 Private sector providers** | **38,391** | **531,570** | **212,441,758** | **213,011,719** |
| **PS.02.01 Non-profit providers** | **38,391** | **531,570** | **212,441,758** | **213,011,719** |
| PS.02.01.01.02 Ambulatory care (private non-profit non-faith based) | | | 15,697,746 | 15,697,746 |
| PS.02.01.01.12 Research institutions (private non-profit non-faith based) | | | 29,502,000 | 29,502,000 |
| PS.02.01.01.13 Self-help and informal community-based organizations (private non-profit non-faith based) | | | 16,930,271 | 16,930,271 |
| PS.02.01.01.14 Civil society organizations (private non-profit non-faith based) | 38,391 | 380,353 | 97,040,942 | 97,459,686 |
| PS.02.01.02.13 Civil society organizations (private non-profit faith based) | | 151,217 | | 151,217 |
| PS.02.01.98 Other non-profit private sector providers not disaggregated | | | 53,270,799 | 53,270,799 |
| **PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices** | **154,463** | | **83,062,117** | **83,216,581** |
| PS.03.01 Bilateral agencies | | | 113,811 | 113,811 |
| PS.03.02 Multilateral agencies | 73,743 | | 2,747,680 | 2,821,423 |
| PS.03.03 International NGOs and foundations | 80,720 | | 80,200,626 | 80,281,347 |
| **Total** | **22,932,461** | **531,570** | **414,292,588** | **437,756,619** |

*Table 19. Providers of services (PS) (1st digit) and AIDS spending categories (ASC) (2nd digit) - 2021, US$*

| AIDS spending category (ASC) | PS.01 Public sector providers | PS.02 Private sector providers | PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices | Total, 2021 |
|---|---|---|---|---|
| **ASC.01 Prevention** | **1,744,984** | **14,679,386** | **23,023,266** | **39,447,636** |
| ASC.01.01 Five Pillars of Prevention | 641,176 | 11,028,879 | 22,399,147 | 34,069,202 |
| ASC.01.02 Other prevention activities | 1,103,807 | 3,650,507 | 624,119 | 5,378,433 |
| **ASC.02 HIV testing and counselling (HTC)** | **2,073,699** | **30,207,679** | **18,566,397** | **50,847,775** |
| ASC.02.01 HIV testing and counselling for sex workers | | 518,706 | 1,152,430 | 1,671,136 |
| ASC.02.02 HIV testing and counselling for MSM | | 279,312 | 349,773 | 629,085 |
| ASC.02.03 HIV testing and counselling for TG | | 7,937 | | 7,937 |
| ASC.02.04 HIV testing and counselling for PWID | | 131,769 | | 131,769 |
| ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities | | 32,010 | | 32,010 |
| ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme) | 92,840 | 5,450 | | 98,291 |
| ASC.02.08 HIV testing and counselling for vulnerable and accessible populations | 92,840 | 718,593 | | 811,433 |
| ASC.02.09 Voluntary HIV testing and counselling for general population | 1,862,210 | 23,300,514 | 15,526,813 | 40,689,537 |
| ASC.02.10 Provider initiated testing and counselling (PITC) | | 63,602 | | 63,602 |
| ASC.02.98 HIV testing and counselling activities not disaggregated | 25,808 | 5,149,785 | 1,537,381 | 6,712,974 |
| **ASC.03 HIV Care and Treatment** | **127,158,139** | **114,631,297** | **19,589,804** | **261,379,240** |
| ASC.03.01 Anti-retroviral therapy | 91,739,395 | 38,000,458 | | 129,739,853 |
| ASC.03.02 Adherence and retention on ART – support and monitoring | 64,282 | 577,386 | 2,932 | 644,600 |
| ASC.03.03 Specific ART-related laboratory monitoring | 34,982,905 | 15,838,304 | | 50,821,209 |
| ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs | 94,162 | 1,022 | 61,014 | 156,198 |
| ASC.03.05 Psychological treatment and support services | 676 | 4,649 | | 5,325 |
| ASC.03.98 Care and treatment services not disaggregated | 276,718 | 60,209,478 | 19,525,858 | 80,012,054 |
| **ASC.04 Social protection and economic support** | **118,452** | **24,056,455** | **69,844** | **24,244,750** |
| ASC.04.01 Social protection and economic support for OVC | 24,219 | 24,053,495 | | 24,077,714 |
| ASC.04.02 Other social protection and economic support (non-OVC) | 94,233 | 2,960 | 69,844 | 167,036 |
| **ASC.05 Social Enablers** | **166,021** | **25,704** | **411,156** | **602,881** |
| ASC.05.01 Advocacy | 89,829 | 13,253 | 247,321 | 350,402 |
| ASC.05.02 Human rights programmes | 76,193 | 12,451 | 163,835 | 252,479 |
| **ASC.06 Programme enablers and systems strengthening** | **9,931,956** | **29,411,198** | **21,413,172** | **60,756,326** |
| ASC.06.01 Strategic planning, coordination and policy development | 339,117 | 54,864 | 2,594,685 | 2,988,666 |
| ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes | | | 1,252 | 1,252 |
| ASC.06.03 Programme administration and management costs (above service-delivery level) | 1,522,223 | 28,100,835 | 11,145,197 | 40,768,256 |
| ASC.06.04 Strategic information | 3,018,279 | 188,665 | 3,624,669 | 6,831,613 |
| ASC.06.05 Public Systems Strengthening | 24,060 | 611,778 | 3,560,163 | 4,196,001 |
| ASC.06.06 Community system strengthening | 11,831 | 152,238 | 349,134 | 513,203 |
| ASC.06.07 Human resources for health (above-site programmes) | 9,371 | 68,863 | 24,261 | 102,496 |
| ASC.06.98 Programme enablers and systems strengthening not disaggregated | 5,007,074 | 233,954 | 113,810 | 5,354,838 |
| **ASC.07 Development synergies** | **13,656** | | **142,942** | **156,598** |
| ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) | | | 105,876 | 105,876 |
| ASC.07.02 Reducing gender-based violence | 13,656 | | 37,066 | 50,722 |
| **ASC.08 HIV-related research** | **321,412** | | | **321,412** |
| ASC.08.04 Socio-behavioural research | 321,412 | | | 321,412 |
| **Total** | **141,528,319** | **213,011,719** | **83,216,581** | **437,756,619** |

*Table 20. AIDS spending categories (ASC) (1st digit) and production factors (PF)( 2nd digit) - 2021, US$*

| Production factor (PF) | ASC.01 Prevention | ASC.02 HIV testing and counselling (HTC) | ASC.03 HIV Care and Treatment | ASC.04 Social protection and economic support | ASC.05 Social Enablers | ASC.06 Programme enablers and systems strengthening | ASC.07 Development synergies | ASC.08 HIV-related research | Total, 2021 |
|---|---|---|---|---|---|---|---|---|---|
| **PF.01 Current direct and indirect expenditures** | **38,203,588** | **50,115,859** | **258,486,785** | **23,998,771** | **597,598** | **57,543,478** | **156,294** | **321,412** | **429,423,785** |
| PF.01.01 Personnel costs | 4,005,243 | 10,046,557 | 33,288,143 | 6,814,437 | 290,513 | 21,950,608 | | 321,412 | 76,716,913 |
| PF.01.02 Other operational and programme management current expenditures | 206,914 | 1,617,344 | 3,558,938 | 563,549 | 63,465 | 3,541,627 | 50,418 | | 9,602,256 |
| PF.01.03 Medical products and supplies | 22,097,649 | 17,417,349 | 166,713,220 | 1,167,457 | 9,606 | 2,901,618 | | | 210,306,900 |
| PF.01.04 Contracted external services | 6,053,458 | 7,045,713 | 27,640,283 | 5,116,258 | 10,771 | 8,795,307 | | | 54,661,790 |
| PF.01.05 Transportation related to beneficiaries | 10,393 | 1,252 | 38,083 | | | | | | 49,727 |
| PF.01.07 Financial support for beneficiaries | 437,509 | 567,828 | 419,975 | 1,988,529 | | | | | 3,413,841 |
| PF.01.08 Training-Training related per diems/transport/other costs | 625,353 | 1,564,401 | 4,013,807 | 1,468,332 | 89,208 | 2,454,605 | 105,876 | | 10,321,582 |
| PF.01.09 Logistics of events, including catering services | 63,712 | | 79,542 | | 125,620 | 762,765 | | | 1,031,639 |
| PF.01.10 Indirect costs | | | 934 | | | 16,100,178 | | | 16,101,113 |
| PF.01.98 Current direct and indirect expenditures not disaggregated | 4,628,655 | 11,654,573 | 22,445,668 | 6,516,843 | 8,415 | 745,776 | | | 45,999,930 |
| PF.01.99 Current direct and indirect expenditures n.e.c. | 74,701 | 200,841 | 288,192 | 363,366 | | 290,993 | | | 1,218,093 |
| **PF.02 Capital expenditures** | **247,545** | **670,902** | **2,892,455** | **245,979** | **2,024** | **3,164,969** | **304** | | **7,224,179** |
| PF.02.01 Building | 135 | 1,878 | 1,878 | | | 57,132 | | | 61,023 |
| PF.02.02 Vehicles | | | | | 881 | 362,021 | 132 | | 363,034 |
| PF.02.03 Other capital investment | 133,378 | 661,562 | 2,883,115 | 245,979 | 1,143 | 2,692,414 | 172 | | 6,617,763 |
| PF.02.98 Capital expenditure not disaggregated | 114,032 | 7,462 | 7,462 | | | 53,402 | | | 182,359 |
| **PF.98 Production factors not disaggregated** | **996,503** | **61,014** | | | **3,259** | **47,879** | | | **1,108,655** |
| PF.98 Production factors not disaggregated | 996,503 | 61,014 | | | 3,259 | 47,879 | | | 1,108,655 |
| **Total** | **39,447,636** | **50,847,775** | **261,379,240** | **24,244,750** | **602,881** | **60,756,326** | **156,598** | **321,412** | **437,756,619** |

*Table 21. AIDS spending categories (ASC) (1st digit) and beneficiary population (BP) (2nd digit) - 2021, US$*

| Beneficiary population (BP) | ASC.01 Prevention | ASC.02 HIV testing and counselling (HTC) | ASC.03 HIV Care and Treatment | ASC.04 Social protection and economic support | ASC.05 Social Enablers | ASC.06 Programme enablers and systems strengthening | ASC.07 Development synergies | ASC.08 HIV-related research | Total |
|---|---|---|---|---|---|---|---|---|---|
| **BP.01 People living with HIV** | **16,573** | | **261,379,240** | **79,064** | | | | | **261,474,877** |
| BP.01.01 Adult and young people (aged 15 and over) living with HIV | | | 45,909,081 | | | | | | 45,909,081 |
| BP.01.02 Children (aged under 15) living with HIV | | | 4,165,129 | | | | | | 4,165,129 |
| BP.01.98 People living with HIV not broken down by age or gender | 16,573 | | 211,305,030 | 79,064 | | | | | 211,400,667 |
| **BP.02 Key populations** | **31,218,200** | **7,581,622** | | | | | | | **38,799,822** |
| BP.02.01 Persons who Inject drug users (PWID) and their sexual partners | 268,115 | 131,769 | | | | | | | 399,884 |
| BP.02.02 Sex workers (SW) and their clients | 525,418 | 1,671,136 | | | | | | | 2,196,554 |
| BP.02.03 Gay men and other men who have sex with men (MSM) | 275,534 | 629,085 | | | | | | | 904,619 |
| BP.02.04 Transgender | 7,346 | 7,937 | | | | | | | 15,283 |
| BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons | 29,386 | 32,010 | | | | | | | 61,396 |
| BP.02.98 "Key populations" not broken down by type | 30,112,402 | 5,109,685 | | | | | | | 35,222,086 |
| **BP.03 Vulnerable, accessible and other target populations** | **3,991,773** | **909,724** | | **24,165,686** | | | | | **29,067,184** |
| BP.03.01 Orphans and vulnerable children (OVC) | | 712,333 | | 24,077,714 | | | | | 24,790,047 |
| BP.03.02 Pregnant and breastfeeding HIV-positive women and their children to be born and new borns | 1,501,911 | 98,291 | | | | | | | 1,600,201 |
| BP.03.03 Adolescent girls and young women in countries with high HIV prevalence | 2,372,818 | 92,840 | | 63,997 | | | | | 2,529,655 |
| BP.03.05 Internally displaced populations (because of an emergency) | | 6,260 | | | | | | | 6,260 |
| BP.03.13 Partners of people living with HIV (including sero-discordant couples) | 4,670 | | | | | | | | 4,670 |
| BP.03.16 Elementary school students | 1,252 | | | | | | | | 1,252 |
| BP.03.17 Junior high/high school students | 22,238 | | | | | | | | 22,238 |
| BP.03.24 Employees | 15,142 | | | | | | | | 15,142 |
| BP.03.98 Vulnerable, accessible and other target populations not broken down by type | 73,743 | | | 23,976 | | | | | 97,719 |
| **BP.04 General population** | **4,221,089** | **40,753,139** | | | | | | | **44,974,228** |
| BP.04.01 General adult population (aged older than 24) | 2,624 | | | | | | | | 2,624 |
| BP.04.02 Children (aged under 15) | 3,376 | 10,501 | | | | | | | 13,877 |
| BP.04.03 Youth (aged 15 to 24) | 12,499 | 15,336 | | | | | | | 27,835 |
| BP.04.98 General population not broken down by age or gender. | 4,202,590 | 40,727,303 | | | | | | | 44,929,893 |
| **BP.05 Non-targeted interventions** | | | | | **602,881** | **60,756,326** | **156,598** | **321,412** | **61,837,218** |
| **BP.98 Specific targeted populations not broken down by type** | | **1,603,290** | | | | | | | **1,603,290** |
| **Total** | **39,447,636** | **50,847,775** | **261,379,240** | **24,244,750** | **602,881** | **60,756,326** | **156,598** | **321,412** | **437,756,619** |

*Table 22. Global AIDS Monitoring (GAM) Indicator 8.3 HIV expenditure by origin of resources - 2021, US$ (1/3)*

| | | Public Sources | | | Private Sources | | | International Sources | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Central / National | Sub-National | Total Public | For-profit institutions / Corporations | Non-profit institutions | Total Private | PEPFAR | Global Fund | All Other Multilateral | All Other International | Total International | |
| 01 | **Treatment, care and support (sub-** | 9,753,753 | 472,194 | 10,225,947 | 12,470 | 5,902 | 18,372 | 225,523,857 | 70,127,925 | 263,613 | 3,276,820 | 299,192,216 | 309,436,534 |
| 01.01 | **HIV testing and counselling (HTC):** | 1,452,295 | 425,880 | 1,878,175 | 12,470 | 5,902 | 18,372 | 44,547,146 | 110,991 | 92,840 | 1,630,023 | 46,381,001 | 48,277,547 |
| 01.01.01 | HIV tests (commodities) | - | 317,602 | 317,602 | 12,470 | 468 | 12,938 | - | - | 92,840 | 34,178 | 127,019 | 457,558 |
| 01.01.02 | Other direct and indirect costs | - | 13,772 | 13,772 | - | 5,434 | 5,434 | 34,414,170 | 110,991 | - | 1,534,831 | 36,059,992 | 36,079,198 |
| 01.01.03 | Not disaggregated by type of cost | 1,452,295 | 94,506 | 1,546,801 | - | - | - | 10,132,976 | - | - | 61,014 | 10,193,990 | 11,740,791 |
| 01.02 | **Antiretroviral treatment (sub-total)** | 8,024,740 | - | 8,024,740 | - | - | - | 53,343,054 | 68,236,825 | 14,148 | - | 121,594,027 | 129,618,767 |
| 01.02.01 | **Adult antiretroviral treatment** | - | - | - | - | - | - | 45,577,691 | - | - | - | 45,577,691 | 45,577,691 |
| 02.01.01 | ARVs | - | - | - | - | - | - | 41,710,540 | - | - | - | 41,710,540 | 41,710,540 |
| 02.01.02 | Other direct and indirect costs | - | - | - | - | - | - | 3,867,151 | - | - | - | 3,867,151 | 3,867,151 |
| 02.01.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 01.02.02 | **Paediatric antiretroviral treatment, including:** | - | - | - | - | - | - | 3,936,877 | - | 14,148 | - | 3,951,025 | 3,951,025 |
| 02.02.01 | ARVs | - | - | - | - | - | - | 3,602,843 | - | 14,148 | - | 3,616,991 | 3,616,991 |
| 02.02.02 | Other direct and indirect costs | - | - | - | - | - | - | 334,034 | - | - | - | 334,034 | 334,034 |
| 02.02.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 01.02.03 | Antiretroviral therapy not broken down by either age or line of treatment | 8,024,740 | - | 8,024,740 | - | - | - | 3,828,486 | 68,236,825 | - | - | 72,065,311 | 80,090,051 |
| 01.03 | **Specific HIV-related laboratory monitoring (CD4, viral load),** | - | 791 | 791 | - | - | - | 50,176,857 | 543,066 | 100,495 | - | 50,820,418 | 50,821,209 |
| 01.03.01 | CD4 cell count, viral load tests (commodities) | - | - | - | - | - | - | - | - | 100,495 | - | 100,495 | 100,495 |
| 01.03.02 | Other direct and indirect costs | - | 791 | 791 | - | - | - | 46,540,947 | - | - | - | 46,540,947 | 46,541,738 |
| 01.03.03 | Not disaggregated by type of cost | - | - | - | - | - | - | 3,635,910 | 543,066 | - | - | 4,178,976 | 4,178,976 |
| 01.04 | Opportunistic infections (OI) prophylaxis and treatment, excluding Treatment and prevention of tuberculosis for people living with HIV | - | 901 | 901 | - | - | - | - | - | 56,130 | - | 56,130 | 57,031 |
| 01.05 | Palliative care | - | - | - | - | - | - | - | - | - | - | - | - |
| 01.06 | Support and retention | - | 43,945 | 43,945 | - | - | - | - | 370,014 | - | 230,641 | 600,655 | 644,600 |
| 01.98 | Treatment, care and support not broken down by type | 276,718 | 676 | 277,394 | - | - | - | 77,456,800 | 867,030 | - | 1,416,155 | 79,739,985 | 80,017,379 |
| 02 | **Prevention of vertical transmission of HIV (sub-total)** | - | 30,048 | 30,048 | - | - | - | 791,636 | 275,971 | 623,632 | - | 1,691,239 | 1,721,287 |
| 02.01 | **HIV testing and counselling (HTC) for pregnant women, including:** | - | - | - | - | - | - | - | 5,450 | 92,840 | - | 98,291 | 98,291 |
| 02.01.01 | HIV tests (commodities) | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.01.02 | Other direct and indirect costs | - | - | - | - | - | - | - | 5,450 | 92,840 | - | 98,291 | 98,291 |
| 02.01.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.02 | **Early infant diagnosis, including:** | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.02.01 | HIV tests (commodities) | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.02.02 | Other direct and indirect costs | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.02.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.03 | **Antiretroviral treatment to reduce vertical transmission of** | - | - | - | - | - | - | - | 121,086 | - | - | 121,086 | 121,086 |
| 02.03.01 | ARVs | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.03.02 | Other direct and indirect costs | - | - | - | - | - | - | - | 121,086 | - | - | 121,086 | 121,086 |
| 02.03.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 02.04 | Non ARV related component of PMTCT | - | - | - | - | - | - | - | 137,475 | - | - | 137,475 | 137,475 |
| 02.98 | Programmatic activities for verticial transmission of HIV not disaggregated | - | 30,048 | 30,048 | - | - | - | 791,636 | 11,960 | 530,792 | - | 1,334,388 | 1,364,436 |

*Global AIDS Monitoring (GAM) Indicator 8.3 HIV expenditure by origin of resources - 2021, US$ (2/3)*

| | | Public Sources | | | Private Sources | | | International Sources | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Central / National | Sub-National | Total Public | For-profit institutions / Corporations | Non-profit institutions | Total Private | PEPFAR | Global Fund | All Other Multilateral | All Other International | Total International | TOTAL |
| 03 | **Prevention (sub-total)** | 79,987 | 612,470 | 692,457 | 12,897 | - | 12,897 | 35,223,779 | 1,539,829 | 691,065 | 130,273 | 37,584,946 | 38,290,299 |
| 03.01 | Social and behavior change (SBC) programmes | 6,244 | 54,088 | 60,332 | 11,632 | - | 11,632 | - | - | 1,064 | 6,206 | 7,271 | 79,234 |
| 03.02 | **Condoms** | - | 75,746 | 75,746 | - | - | - | 288,463 | - | 5,051 | 108,924 | 402,438 | 478,184 |
| 03.02.01 | Condoms (commodities) | - | 75,746 | 75,746 | - | - | - | - | - | 5,051 | 108,924 | 113,975 | 189,721 |
| 03.02.02 | Other direct and indirect costs | - | - | - | - | - | - | 288,463 | - | - | - | 288,463 | 288,463 |
| 03.02.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.03 | **Pre-Exposure Prophylaxis (PrEP) disaggregated by key populations (sub-total)** | - | - | - | - | - | - | 156,506 | - | - | - | 156,506 | 156,506 |
| 03.03.01 | PrEP for gay men and other men who have sex with men (MSM) | - | - | - | - | - | - | 39,127 | - | - | - | 39,127 | 39,127 |
| 03.03.02 | PrEP for sex workers | - | - | - | - | - | - | 86,079 | - | - | - | 86,079 | 86,079 |
| 03.03.03 | PrEP for persons who inject drugs (PWID) | - | - | - | - | - | - | 23,476 | - | - | - | 23,476 | 23,476 |
| 03.03.04 | PrEP for transgender persons | - | - | - | - | - | - | 1,564 | - | - | - | 1,564 | 1,564 |
| 03.03.05 | PrEP for prisoners | - | - | - | - | - | - | 6,260 | - | - | - | 6,260 | 6,260 |
| 03.03.06 | PrEP for young women and adolescent girls in high-prevalence countries | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.03.07 | Pre-exposure prophylaxis for serodiscordant couples | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.04 | Voluntary medical male circumcision (VMMC) in high prevalence countries | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.05 | **Prevention, promotion of testing and linkage to care programmes for gay men and other men who have sex with men (MSM),** | - | - | - | - | - | - | 515,719 | 349,773 | - | - | 865,492 | 865,492 |
| 03.05.01 | HIV tests (commodities) | - | - | - | - | - | - | - | 152,235 | - | - | 152,235 | 152,235 |
| 03.05.02 | Condoms, lubricants, and other commodities | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.05.03 | Other direct and indirect costs | - | - | - | - | - | - | 325,362 | - | - | - | 325,362 | 325,362 |
| 03.05.04 | Not disaggregated by type of cost | - | - | - | - | - | - | 190,357 | 197,538 | - | - | 387,895 | 387,895 |
| 03.06 | **Prevention, promotion of testing and linkage to care programmes for sex workers and their clients,** | - | - | - | - | - | - | 958,045 | 1,152,430 | - | - | 2,110,475 | 2,110,475 |
| 03.06.01 | HIV tests (commodities) | - | - | - | - | - | - | - | 1,152,430 | - | - | 1,152,430 | 1,152,430 |
| 03.06.02 | Condoms, lubricants, and other commodities | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.06.03 | Other direct and indirect costs | - | - | - | - | - | - | 715,499 | - | - | - | 715,499 | 715,499 |
| 03.06.04 | Not disaggregated by type of cost | - | - | - | - | - | - | 242,546 | - | - | - | 242,546 | 242,546 |
| 03.07 | **Prevention, promotion of testing and linkage to care programmes for persons who inject drugs (sub-** | - | - | - | 1,265 | - | 1,265 | 273,927 | 1,216 | 100,000 | - | 375,143 | 376,408 |
| 03.07.01 | **Needle and syringe exchange, and prevention, promotion of testing and linkage to care prevention programmes for people** | - | - | - | 1,265 | - | 1,265 | 273,927 | - | 100,000 | - | 373,927 | 375,192 |
| 07.01.01 | Injecting equipment | - | - | - | - | - | - | - | - | - | - | - | - |
| 07.01.02 | HIV tests (commodities) | - | - | - | - | - | - | - | - | - | - | - | - |
| 07.01.03 | Condoms, lubricants, and other commodities | - | - | - | 1,265 | - | 1,265 | - | - | - | - | - | 1,265 |
| 07.01.04 | Other direct and indirect costs | - | - | - | - | - | - | 195,215 | - | 100,000 | - | 295,215 | 295,215 |
| 07.01.05 | Not disaggregated by type of cost | - | - | - | - | - | - | 78,712 | - | - | - | 78,712 | 78,712 |
| 03.07.02 | **Substitution therapy, including:** | - | - | - | - | - | - | - | 1,216 | - | - | 1,216 | 1,216 |
| 07.02.01 | Replacement drug, such as methadone or buprenorphine (commodities) | - | - | - | - | - | - | - | 1,216 | - | - | 1,216 | 1,216 |
| 07.02.02 | Other direct and indirect costs | - | - | - | - | - | - | - | - | - | - | - | - |
| 07.02.03 | Not disaggregated by type of cost | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.08 | Prevention, promotion of testing and linkage to care programmes for transgender persons | - | - | - | - | - | - | 13,719 | - | - | - | 13,719 | 13,719 |

*Global AIDS Monitoring (GAM) Indicator 8.3 HIV expenditure by origin of resources - 2021, US$ (3/3)*

| | | Public Sources | | | Private Sources | | | International Sources | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Central / National | Sub-National | Total Public | For-profit institutions / Corporations | Non-profit institutions | Total Private | PEPFAR | Global Fund | All Other Multilateral | All Other International | Total International | |
| 03.09 | Prevention, promotion of testing and linkage to care programmes for prisoners | - | - | - | - | - | - | 54,879 | 257 | - | - | 55,136 | 55,136 |
| 03.10 | Prevention, promotion of testing and linkage to care programmes targeting young women and adolescent girls (high-prevalence countries) | - | - | - | - | - | - | 1,805,640 | 3,471 | 563,706 | - | 2,372,818 | 2,372,818 |
| 03.11 | Cash transfers to girls (high-prevalence countries), including: from HIV earmarked budgets | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.12 | Prevention programmes for vulnerable and accessible populations | 73,743 | - | 73,743 | - | - | - | - | - | - | - | - | 73,743 |
| 03.13 | Post-exposure prophylaxis (PEP) | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.14 | Workplace | - | - | - | - | - | - | - | - | - | 15,142 | 15,142 | 15,142 |
| 03.15 | Synergies with health sector | - | - | - | - | - | - | - | - | - | - | - | - |
| 03.16 | Prevention of HIV transmission aimed at PLHIV not broken down by type | - | - | - | - | - | - | - | - | 21,243 | - | 21,243 | 21,243 |
| 03.98 | Prevention (five pillars) not disaggregated | - | 482,636 | 482,636 | - | - | - | 31,156,881 | 32,682 | - | - | 31,189,563 | 31,672,198 |
| 04 | **Gender programmes** | - | - | - | - | - | - | - | - | 50,722 | - | 50,722 | 50,722 |
| 05 | **Programmes for children and** | - | - | - | 22,238 | 1,252 | 23,490 | - | - | - | 14,810 | 14,810 | 38,301 |
| 06 | **Social protection** | - | 57,414 | 57,414 | - | 10,342 | 10,342 | 23,897,921 | - | 63,997 | 215,076 | 24,176,994 | 24,244,750 |
| 07 | **Community mobilization** | - | - | - | - | - | - | 2,089,063 | - | - | - | 2,089,063 | 2,089,063 |
| 08 | **Governance and sustainability** | 5,567,801 | 434,765 | 6,002,566 | 75,871 | - | 75,871 | 43,115,389 | 9,323,960 | 2,456,489 | 200,575 | 55,096,413 | 61,174,850 |
| 08.01 | Strategic information | 526,803 | 21,918 | 548,721 | - | - | - | 3,181,362 | 2,681,870 | 385,706 | 33,953 | 6,282,891 | 6,831,613 |
| 08.02 | Planning and coordination | 682 | 412,033 | 412,715 | - | - | - | 36,093,551 | 5,583,776 | 1,654,497 | 12,382 | 43,344,207 | 43,756,922 |
| 08.03 | Procurement and logistics | - | 563 | 563 | - | - | - | 3,351,711 | 483,413 | 32,856 | - | 3,867,980 | 3,868,544 |
| 08.04 | Health systems strengthening | - | - | - | - | - | - | 141,001 | 144,762 | - | 34,183 | 319,946 | 319,946 |
| 08.05 | Education | - | - | - | - | - | - | - | - | - | 105,876 | 105,876 | 105,876 |
| 08.06 | HIV and AIDS related research | - | - | - | - | - | - | - | 321,412 | - | - | 321,412 | 321,412 |
| 08.98 | Governance and sustainability not disaggregated | 5,040,315 | 250 | 5,040,566 | 75,871 | - | 75,871 | 347,764 | 108,727 | 383,430 | 14,180 | 854,101 | 5,970,538 |
| 09 | **Critical enablers (sub-total)** | - | 97,641 | 97,641 | - | 5,509 | 5,509 | - | 78,943 | 420,033 | 9,519 | 508,495 | 611,645 |
| 09.01 | Policy dialogue | - | 90,129 | 90,129 | - | - | - | - | 4,273 | 253,993 | 3,259 | 261,525 | 351,654 |
| 09.02 | Key human rights programmes | - | - | - | - | 5,509 | 5,509 | - | 74,670 | 166,040 | 6,260 | 246,970 | 252,479 |
| 09.03 | AIDS-specific institutional development | - | 7,512 | 7,512 | - | - | - | - | - | - | - | - | 7,512 |
| 09.98 | Critical social enablers not disaggregated | - | - | - | - | - | - | - | - | - | - | - | - |
| 10 | **TB / HIV co-infection, diagnosis and treatment (sub-total)** | - | - | - | - | - | - | - | 99,167 | - | - | 99,167 | 99,167 |
| 10.01 | TB screening and diagnosis in PLHIV | - | - | - | - | - | - | - | - | - | - | - | - |
| 10.02 | TB prevention and treatment for PLHIV | - | - | - | - | - | - | - | 99,046 | - | - | 99,046 | 99,046 |
| 10.98 | TB-HIV coinfection, diagnosis and treatment not disaggregated | - | - | - | - | - | - | - | 121 | - | - | 121 | 121 |
| | **Total ( excluding other essential programs )** | 15,401,541 | 1,704,532 | 17,106,073 | 123,476 | 23,004 | 146,480 | 330,641,645 | 81,445,795 | 4,569,552 | 3,847,073 | 420,504,065 | 437,756,619 |
| | **Other essential programs outside the suggested framework of core HIV and AIDS programs (please** | - | - | - | - | - | - | - | - | - | - | - | - |

# ANNEX 4. LIST OF ORGANISATIONS REPORTING TO NASA 2019-2021

| # | Name and Role[42] | FE | FAP | PS |
|---|---|---|---|---|
| 1 | Abia State Agency for the Control of HIV/AIDS | | ✓ | ✓ |
| 2 | Access to Good Health Initiative (AGHI) | | | ✓ |
| 3 | Achieving Health Nigeria Initiative (AHNi) | | | ✓ |
| 4 | Adolescent Health Support Organisation (AHSO) | | | ✓ |
| 5 | African Health Project (AHP) | | | ✓ |
| 6 | AIDS Care Education and Training Society (ACET) | ✓ | ✓ | ✓ |
| 7 | AIDS Healthcare Foundation (AHF) | ✓ | ✓ | ✓ |
| 8 | Akwa Ibom State Agency for the Control of AIDS (SACA) | | ✓ | ✓ |
| 9 | Ananda Marga Universal Relief Team (AMURT) | | | ✓ |
| 10 | APIN Public Health Initiatives | | | ✓ |
| 11 | Association of Positive Youths Living with HIV/AIDS in Nigeria (APYIN). | | | ✓ |
| 12 | Association for Reproductive and Family Health (ARFH) | | | ✓ |
| 13 | Bauchi State Agency for the Control of HIV/AIDS, Tuberculosis/Leprosy and Malaria (BACATMA) | | ✓ | ✓ |
| 14 | Bauchi State Hospitals Management Board | | | ✓ |
| 15 | Bayelsa State Agency for the Control of AIDS (BYSACA) | | ✓ | ✓ |
| 16 | Bo State Agency for the Control of AIDS (BOSACA) | | ✓ | ✓ |
| 17 | Catholic Caritas Foundation of Nigeria (CCFN) | ✓ | | ✓ |
| 18 | Centre for Integrated Health Programs (CIHP) | | | ✓ |
| 19 | Centre For Youth Challenge & Development (CYCD) | | | ✓ |
| 20 | Civil Society on HIV Aids Ebonyi State | | | ✓ |
| 21 | Clinton Health Access Initiative (CHAI) | | ✓ | ✓ |
| 22 | Community Information & Advocacy Initiative (CIAI) | | | ✓ |
| 23 | Delta State Agency for the Control of HIV/AIDS (DELSACA) | | ✓ | ✓ |
| 24 | Delta State AIDS and STI Control Programme (Delta SASCP) | | ✓ | ✓ |
| 25 | Drug Free and Preventive Healthcare Org (DAPHO) | | | ✓ |
| 26 | Ebonyi State Agency for the Control of AIDS (EBSACA) | | ✓ | ✓ |
| 27 | Edo State Agency for the Control of HIV/AIDS (EDSACA) | | ✓ | ✓ |
| 28 | Ekiti State Agency for the Control of HIV/AIDS (EKSACA) | | ✓ | ✓ |
| 29 | Enhancing Communities Action for Peace and Better Health Initiative (e-CAPH) | | | ✓ |
| 30 | Enugu State Agency for the Control of HIV/AIDS (ENSACA) | | ✓ | ✓ |
| 31 | Enugu State Ministry of Health | | ✓ | ✓ |
| 32 | Equitable Health for Women and Empowerment Initiative (EHWEI) | | | ✓ |
| 33 | Esther Mallo Women Initiative (EMWI) | ✓ | ✓ | ✓ |
| 34 | Excellence Community Education Welfare Scheme (ECEWS) | | | ✓ |
| 35 | Excellent community health and socioeconomic empowerment Africa initiative (EXCOHSEAI) | | | ✓ |
| 36 | Family Health Care Foundation (FAHCI) | | | ✓ |
| 37 | Federal Ministry of Power | | ✓ | ✓ |
| 38 | Federal Ministry of Education | | ✓ | ✓ |
| 39 | Federal Ministry of Labour | | ✓ | ✓ |
| 40 | FHI 360 (GFTAM PR) | | ✓ | ✓ |

[42] This table lists the organizations contacted during data collection that submitted data to NASA. It is possible for other institutions to be included in the analysis as Financing Entities or Providers of Services even if they were not directly contacted. This occurs because their data was provided by another organization that either received funds from them or implemented programs using their funds.

| | | | | |
|---|---|---|---|---|
| 41 | First Step Action for Children Initiative | | | ✓ |
| 42 | Flame Of Hope Centre for Disease Control | | | ✓ |
| 43 | Global Alliance For Public Health Intervention (GAPHI) | | | ✓ |
| 44 | Global Health and Social Awareness foundation | | | ✓ |
| 45 | Global Hope for Women and Child Foundation (GLOHWOC) | | | ✓ |
| 46 | Global Initiative for Women & Children (GIWAC) | | | ✓ |
| 47 | Global Women's Health Rights and Empowerment Initiative (GWHREI | | | ✓ |
| 48 | Golden Women Initiative Nigeria | | | ✓ |
| 49 | Gom State Agency for the Control of AIDS (GOSACA) | | ✓ | ✓ |
| 50 | Good Women Association | | | ✓ |
| 51 | Heal The Youth Foundation | | | ✓ |
| 52 | Health Awareness and Gender Advocacy Initiative (HAGAI) | | | ✓ |
| 53 | Health For All Development Forum | | | ✓ |
| 54 | Heartland Alliance International - Nigeria (HALG) | | | ✓ |
| 55 | Help for Progressive Women Foundation | | | ✓ |
| 56 | Heros Health Community Support Initiative | | | ✓ |
| 57 | Hikima Community Mobilisationand Development Initiative (HCOMDI) | | | ✓ |
| 58 | Hope for Family Development Initiative (HFDI) | | | ✓ |
| 59 | Hope Givers Care and Support Organisation | | | ✓ |
| 60 | Humanity Family Foundation For Peace And Development | | | ✓ |
| 61 | Hurting Hearts Foundation | | | ✓ |
| 62 | ICAP at Columbia University | | | ✓ |
| 63 | Initiative For Health and Social Development (IHSD) | | | ✓ |
| 64 | Initiative for Grassroot Advancement in Nigeria (INGRA) | | | ✓ |
| 65 | Initiative For Health and Rights (IHR) | | | ✓ |
| 66 | Initiative for Young Women's Health and development (IY-WHAD) | | | ✓ |
| 67 | Institute of Human Virology (IHVN) | | | ✓ |
| 68 | Integrated Life Support for Women and Children Initiative (ILSWACI) | | | ✓ |
| 69 | Jabiwu Hope Foundation | | | ✓ |
| 70 | Jigawa State Agency for the Control of AIDS (JISACA) | | ✓ | ✓ |
| 71 | Joint United Nations Programme on HIV/AIDS (UNAIDS) | ✓ | ✓ | ✓ |
| 72 | Kaduna State AIDS Control Agency | | ✓ | ✓ |
| 73 | Kano State Agency for the Control of AIDS (KANO) | | ✓ | ✓ |
| 74 | Kano State Ministry Of Women Affairs and Social Development | | ✓ | ✓ |
| 75 | Katsina State Agency for the Control of AIDS (KATSACA) | | ✓ | ✓ |
| 76 | KAUNA Support Group | | | ✓ |
| 77 | Kebbi State Agency for the Control of AIDS (SACA) | | ✓ | ✓ |
| 78 | Kids & Teen Resource Centre | | | ✓ |
| 79 | Knightingale Women Health Initiative | | | ✓ |
| 80 | Kwara State Ministry of Health (SMOH KWARA) | | ✓ | ✓ |
| 81 | La Vie Mot Global Mission | | | ✓ |
| 82 | Lagos State AIDS Control Agency (BOTH DCTs) | | ✓ | ✓ |
| 83 | Lagos State Ministry of Health (LSMOH) PR - GLOBAL FUND | | ✓ | ✓ |
| 84 | Lagos State Ministry of Youth and Social Development | | ✓ | ✓ |
| 85 | Lucina Care Initiative | | | ✓ |
| 86 | Mashiah Foundation | | | ✓ |
| 87 | Men's Health Support Initiative (MHSI) | | | ✓ |
| 88 | Ministry of Education (Ebonyi State) | | ✓ | ✓ |
| 89 | Ministry Of Health Umahia Abia SASCP | | ✓ | ✓ |

| | | | | |
|---|---|---|---|---|
| 90 | Ministry of Labour and Employment (Occupational Safety and Health Department) | | ✓ | ✓ |
| 91 | Ministry of Women Affairs | | ✓ | ✓ |
| 92 | Ministry of Youth & Sports Enugu State | | ✓ | ✓ |
| 93 | Murna Foundation | | | ✓ |
| 94 | Nagarta Community health & Gender Education Initiative (NCHANGEi) | | | ✓ |
| 95 | Nasarawa State Action Committee on AIDS (SACA) | | ✓ | ✓ |
| 96 | National Agency for the Control of AIDS (NACA) | ✓ | ✓ | ✓ |
| 97 | National Agency for the Control of AIDS (NACA) as GFTAM PR | | ✓ | ✓ |
| 98 | National Human Rights Commission Ebonyi | | | ✓ |
| 99 | Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) | | | ✓ |
| 100 | Niger State Agency for Control of HIV/AIDS | | ✓ | ✓ |
| 101 | Niger State Ministry of Health (SMOH) | | ✓ | ✓ |
| 102 | Nigeria Centre for Disease Control and Prevention | | | ✓ |
| 103 | Nigeria Police Force | | | ✓ |
| 104 | Nigerian Business Coalition Against Aids (NIBUCAA) | | | ✓ |
| 105 | Ogun State Action Committee on AIDS (OGSACA) | | ✓ | ✓ |
| 106 | Ogun State Ministry of Education, Science and Technology | | ✓ | ✓ |
| 107 | Olive Community Development Initiative (OCDI) | | | ✓ |
| 108 | Ondo State Action Committee on AIDS (ODSACA) | | ✓ | ✓ |
| 109 | Osun State Action Committee on AIDS (OSSACA) | | ✓ | ✓ |
| 110 | Pathfinder | | | ✓ |
| 111 | Plateau State Action Committee on AIDS (SACA) | | ✓ | ✓ |
| 112 | Police Action Committee on AIDS (PACA) | | | ✓ |
| 113 | Productive Community for Sustainable Development Initiative (PCSDI) Sokoto | | | ✓ |
| 114 | Pro-Health International (PHI) | | | ✓ |
| 115 | Relief and Hope Foundation - Plateau (RHF) | | ✓ | ✓ |
| 116 | Rhema Care Integrated Development Centre | | | ✓ |
| 117 | Rivers State Agency for the Control of AIDS (RIVSACA) | | ✓ | ✓ |
| 118 | Rivers State Primary Health Care Management Board (SPHCMB) | | | ✓ |
| 119 | Rural Linkage Network | | | ✓ |
| 120 | Save the Child Initiative (STCI) | | | ✓ |
| 121 | Sisters Against HIV and Cancer Initiative (SACHI) | | | ✓ |
| 122 | Society for Family Health (SFH) | | | ✓ |
| 123 | Society for the Improvement of rural People (SIRP) | | | ✓ |
| 124 | Society For Women Development & Empowerment of Nigeria (SWODEN) | | | ✓ |
| 125 | Sokoto State Agency for the Control of AIDS and TB (SOSACAT) | | ✓ | ✓ |
| 126 | State AIDS and STDs Control Programme Abia | | ✓ | ✓ |
| 127 | State AIDS and STDs Control Programme Anambra | | ✓ | ✓ |
| 128 | State AIDS and STDs Control Programme Borno | | ✓ | ✓ |
| 129 | State AIDS and STDs Control Programme Edo | | ✓ | ✓ |
| 130 | State AIDS and STDs Control Programme Katsina | | ✓ | ✓ |
| 131 | State AIDS and STDs Control Programme Adamawa | | ✓ | ✓ |
| 132 | State AIDS and STDs Control Programme Ebonyi | | ✓ | ✓ |
| 133 | State AIDS and STDs Control Programme Ekiti | | ✓ | ✓ |
| 134 | State AIDS and STDs Control Programme Taraba | | ✓ | ✓ |
| 135 | State Ministry of Health Kaduna | | ✓ | ✓ |
| 136 | State Primary Health Care Board Oyo | | ✓ | ✓ |
| 137 | Sufabel Community Development Initiative (SCDI) | | | ✓ |
| 138 | Taraba Aids Control Agency (TACA) | | ✓ | ✓ |

| | | | | |
|---|---|---|---|---|
| 139 | United Nations Children's Fund (UNICEF) | | ✓ | ✓ |
| 140 | United Nations Development Programme (UNDP) | ✓ | ✓ | ✓ |
| 141 | United Nations Office on Drugs and Crime (UNODC) | ✓ | ✓ | ✓ |
| 142 | United Nations Population Fund (UNFPA) | | ✓ | ✓ |
| 143 | United State Government (USG-PEPFAR) | ✓ | ✓ | ✓ |
| 144 | Wavemakers initiative for health and youth empowerment | | | ✓ |
| 145 | Women and Community Livelihood Foundation | | | ✓ |
| 146 | Women Initiative Sustainable Community Development | | | ✓ |
| 147 | women Protection Organisation (WOPO) | | | ✓ |
| 148 | Women United for Economic Empowerment | | | ✓ |
| 149 | World Health Organization (WHO) | ✓ | ✓ | ✓ |
| 150 | Young & Useful Generations Initiative (YUGi) | | | ✓ |
| 151 | Youth Development & Empowerment Initiative | | | ✓ |
| 152 | Zadchlo International Foundation (ZIF) | | | ✓ |
| 153 | Zamfara AIDS Control Agency (ZAMSACA) | | ✓ | ✓ |

# ANNEX 5: DATA COLLECTION FORM

NATIONAL AGENCY FOR THE CONTROL OF AIDS NACA

**NASA NIGERIA 2021**

Year 2021

This study aims to measure how much the country has spent in its response to HIV/AIDS. Through this document we invite you to participate in the national effort to establish spending. The information reported will be used only in aggregate. The information reported is confidential.

### A. Reporting Period

**Instruction: Please fill one form (excel file) for each reporting year (modify if necesary both month and year).**

| | | | |
|---|---|---|---|
| Reporting Period | From: | January | 2021 |
| | To: | December | 2021 |

### B. Identification of the Institution submitting data

| | |
|---|---|
| Name of the Institution submitting data: | |
| Contact (Full Name): | |
| Contact (Position): | |
| Address: | |
| E-mail: | |
| Telephone: | |
| Are you filling out this form on behalf of another institution, such as a sub-recipient? (select an option from drop-down menue) | |
| | |

### C. Type of Institution

**Instruction: Mark an [x] against the type of the institution**

| Type of institution | National | International |
|---|---|---|
| Public | | |
| Private For profit | | |
| Private Not For profit Non Faith Based | | |
| Private Not For profit Faith Based | | |
| Bilateral agency | | |
| Multilateral agency | | |

### D. Currency

**Instruction: Select the currency of report using the drop down menue (if needed, complete "Other" Currency name)**

| | |
|---|---|
| Currency: | |
| | |

### E. Funds Transfered to another organization for expenditure

**Please provide accurate information regarding funds transferred for expenditure by other organizations.**

**Please utilize this table solely for financial resources. For items/goods provided to another institution, kindly refer to table G**

| # | Source of Funds | Which organisations did you transfer funds to / Name of the institution receiving the funds | Name of the project (if applicable) | Amount Transferred |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| | | | Total | 0 |

***Note: A new data collection form should be filled on behalf of the recipient organisation if expenditure reports are submitted. Mark X if you are submitting on behalf of another organization***

**F. Funds used implementing activities or programmes by your institution. Please complete if applicable. Fill with appropriate data about funds received from all sources**

Use one row per production factor for the same activity. Complete the following row for an additional production factor used in the same activity.

Only report amounts for activities or programmes implemented (e.g. condoms distributed). Do NOT report supplies or materials purchased that were left in stock to be used another year or that were donated to another institution.

Insert more lines within the table if necessary. Consult the NASA team).

Total in 0 | 0

| # | Origin of funds, including funds received from other institutions and from your headquarters (Name of institution) | State where the activity/programme was implemented" (if possible separate so that each line corresponds to a specific department. For aggregated reporting select "SNO.98 Not disaggregated by department".) | Name of the project (if applicable) | Name of the activity or programme | Description of the activity or programme (Provide a brief description of the scope of each activity in 1-2 sentences) | Amount of funds used to implement the activity or programme. | Production Factor (Select the Production Factor from the drop-down list - see the third sheet of the file as a guide "Production Factors". If this is not possible, please describe in your own words the beneficiary population of the intervention. For aditional Production Factors for the same activity use another row) | Beneficiary Population (Select the Beneficiary Population from the drop-down list - see the third sheet of the file as a guide "Beneficiary Populations". If this is not possible, please describe in your own words the beneficiary population of the intervention. An intervention with more than one beneficiary population should be reported on separate | Comments (space for comments that you consider relevant to pass on to the NASA team). |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |

# ANNEX 6: RTT RESOURCE FLOWS

*Figure 61. Flow of revenues (REV) to financing schemes (SCH)*

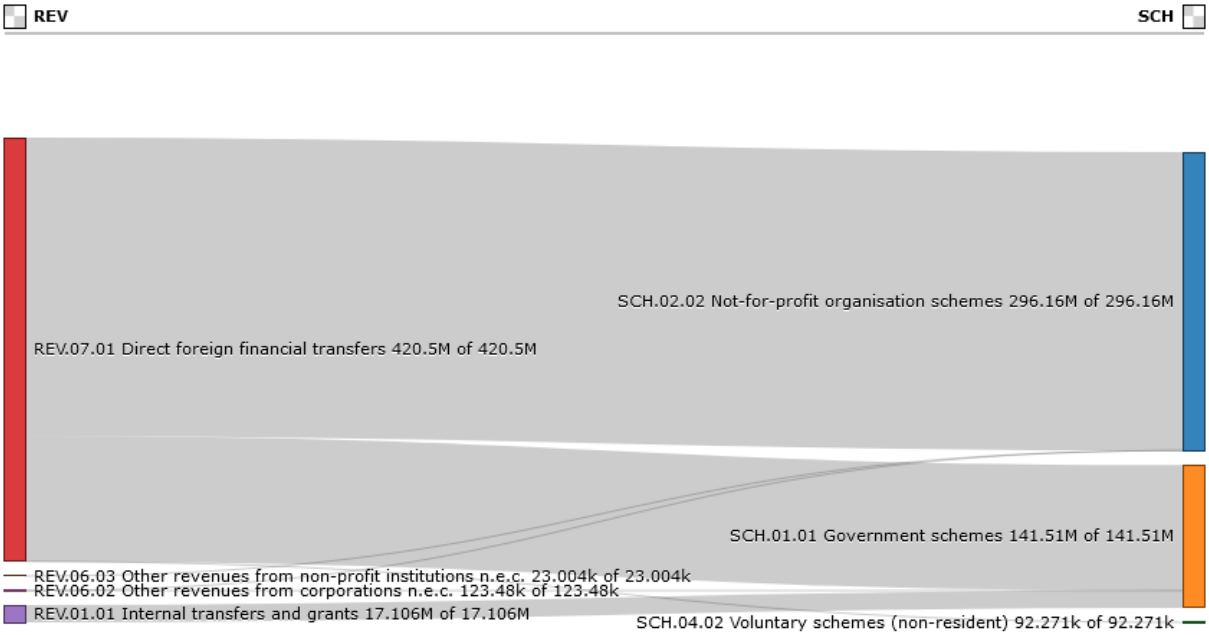



*Figure 62. Flow of financing agents-purchasers (FAP) to beneficiary populations (BP)*

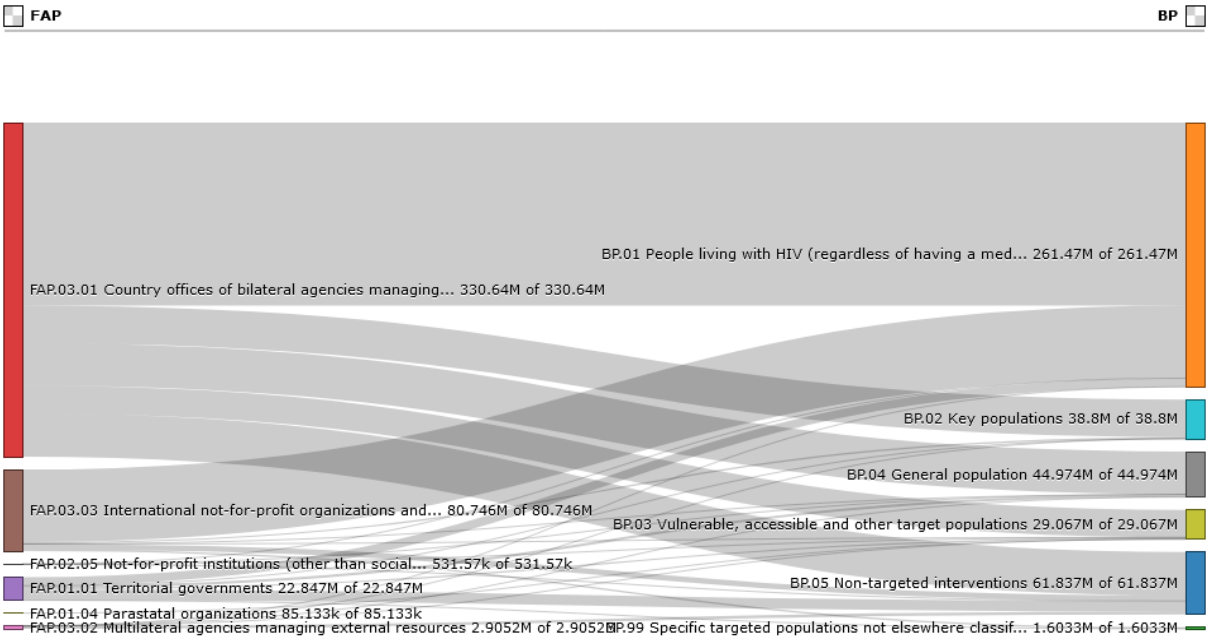
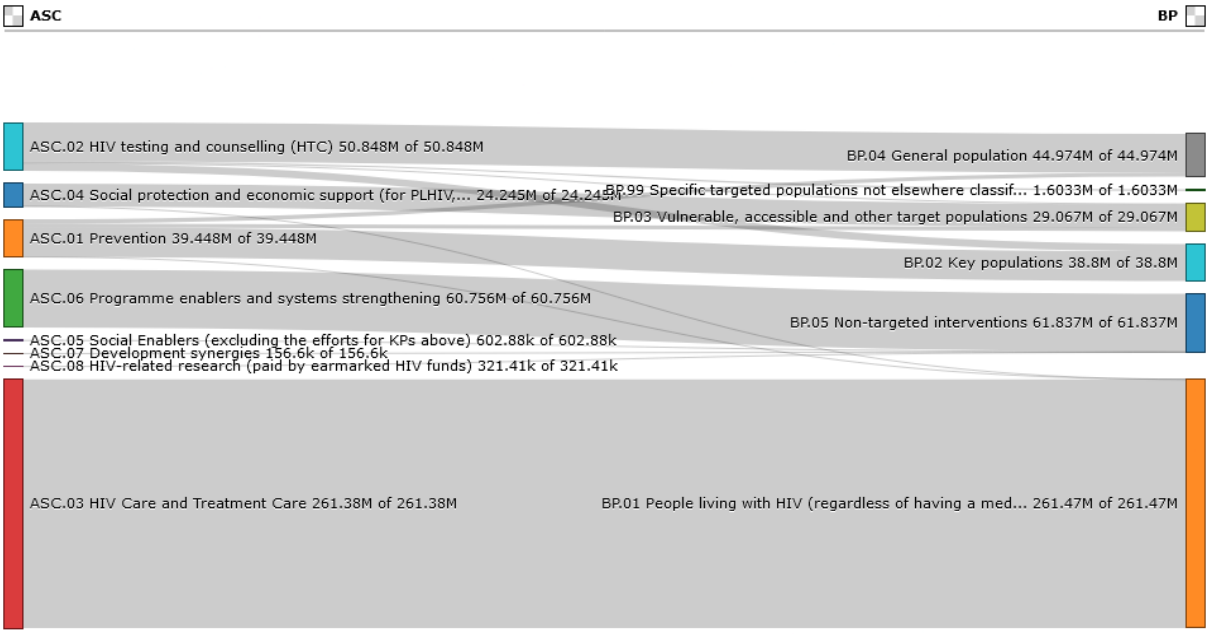



*Figure 63. Flow of AIDS spending categories (ASC) to beneficiary populations (BP)*


ASC
BP
ASC.02 HIV testing and counselling (HTC) 50.848M of 50.848M
ASC.04 Social protection and economic support (for PLHIV,... 24.245M of 24.245M
ASC.01 Prevention 39.448M of 39.448M
ASC.06 Programme enablers and systems strengthening 60.756M of 60.756M
ASC.05 Social Enablers (excluding the efforts for KPs above) 602.88k of 602.88k
ASC.07 Development synergies 156.6k of 156.6k
ASC.08 HIV-related research (paid by earmarked HIV funds) 321.41k of 321.41k
ASC.03 HIV Care and Treatment Care 261.38M of 261.38M
BP.04 General population 44.974M of 44.974M
BP.99 Specific targeted populations not elsewhere classif... 1.6033M of 1.6033M
BP.03 Vulnerable, accessible and other target populations 29.067M of 29.067M
BP.02 Key populations 38.8M of 38.8M
BP.05 Non-targeted interventions 61.837M of 61.837M
BP.01 People living with HIV (regardless of having a med... 261.47M of 261.47M