ZAMBIA NATIONAL AIDS SPENDING ASSESSMENT (NASA): 2019 – 2021 Final Draft Report

February 2023

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List of acronyms

ART	Antiretroviral therapy	NGO	Non-governmental organisation
ARV	Antiretroviral	NHA	National Health Accounts
ARVs	Antiretroviral drugs	NHSP	National Health Strategic Plan
ASC	Aids Spending Category	OI	Opportunistic Infection
BP	Beneficiary Population	OOPE	Out-of-pocket Expenditure
CHAZ	Churches Health Association Zambia	OVC	Orphans and vulnerable children
CMSA	Compulsory Medical Saving Accounts	PEP	Post-exposure prophylaxis
COP	Country Operational Plan	PEPFAR	(United States) President's Emergency Plan for AIDS Relief
CPUP	Community-based: pick up points	PF	Production Factor
DHIS	District Health Information System	PHC	Primary Health Care
DOT	Directly observed treatment	PITC	Provider initiated testing and counselling
ER	Expenditure reporting (PEPFAR data)	PLHIV	People Living With HIV
ECOSOC	Economic and Social Council	PMTCT	Prevention of mother-to-child transmission
eMTCT	Elimination of mother-to-child transmission	PPP	Public Private Partnerships VII
EU	European Union	PR	Principal Recipient (of Global Fund)
FAO	Food and Agriculture Organization	PrEP	Pre-Exposure Prophylaxis
FAP	Financing agent Purchaser	PS	Provider of Services
FS	Financing source	PSI	Population Services International
GAM	Global AIDS Monitor (formerly GARPR)	PWID	People who injects drugs
GDP	Gross Domestic Product	RTT	Resource Tracking Tool (NASA)
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria	SADC	Southern African Development Community
GRZ	Government of the Republic of Zambia	SBCC	Social and behavioural communication for change

HA	Health Accounts	SDGs	Sustainable Development Goals
HAPT	Health Accounts Production Tool	SHA	System of Health Accounts
HBC	Home-based Care	SR	Sub-recipient (of Global Fund)
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
HSS	Health Systems Strengthening	SW	Sex Worker
HTS	HIV Testing Services	T&T	Test and Treat
IFMIS	Integrated Financial Management Information System	TB	Tuberculosis
IGA	Income Generation Activities VI	TWG	Technical working group
ILO	International Labour Organization	UNAIDS	Joint United Nations Programme on AIDS
INGO	International Non-governmental Organization	UNDP	United Nations Development Programme
IOM	International Organization for Migration	UNESCO	United Nations Educational, Scientific and Cultural Organization
IP	Implementing Partners (of PEPFAR)	UNFPA	United Nations Population Fund
IT	Information Technology	UNGASS	United Nations General Assembly on HIV/AIDS
KP	Key Population	UN-HABITAT	United Nations Human Settlements Programme
LFA	Local Fund Agents (for GF)	UNHCR	United Nations High Commissioner for Refugees
LIC	Low Income Country	UNICEF	United Nations Children's Fund
LMIC	Lower-Middle Income Country	UNIFEM	United Nations Development Fund for Women
M&E	Monitoring and Evaluation	UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
MDG	Millennium Development Goals	UNODC	United Nations Office on Drugs and Crime
MDR- TB	Multidrug-resistant Tuberculosis	USD	United States Dollar
MOE	Ministry of Education	USG	United States Government
MoF	Ministry of Finance	VMMC	Voluntary Medical Male Circumcision
MoH	Ministry of Health	WB	World Bank
MSM	Men who have sex with men	WFP	World Food Programme
NAC	National AIDS Council	WHO	World Health Organization
NASA	National AIDS Spending Assessment	ZAMPHIA	Zambia Population-based HIV Impact Assessment
NASF	National AIDS Strategic Framework	ZMW	Zambian Kwacha
NDP	National Development Plan		
NEC	Not elsewhere classified		

Foreword

To be Completed by NAC

Acknowledgements

To be Completed by NAC

Executive summary

The results show that total expenditure on HIV and AIDS interventions in Zambia increased moderately from **US$450 297 453** in 2019, US$ **494 349 981** in 2020 and US$ **504 412 065** in 2021, representing an increase of **10%** in 2020 and **2%** in 2021. Total expenditure over the three-year period amounted **US$ 1 449 059 499**. From 2019 to 2021, the increase rate in expenditure for the fight against HIV/AIDS was **12%.**

The bulk of the expenditures on HIV/AIDS in Zambia came from international sources accounting for about **92.20%**. Government of Zambia is the second largest source of financing of the HIV response contributing about **7.77%.** Domestic corporations accounted for about **0.02%** of the total expenditures. It is therefore evident that the fight against HIV/AIDS in Zambia depends largely on external funding. High donor dependence on HIV & AIDS external financing poses risk for sustainably of financing the Zambian National Strategic Framework for HIV & AIDS.

The national response to the fight against HIV/AIDS in Zambia **depends essentially on two external donors: United States Government and Global Fund.** During the period 2019 to 2021, the United States of America contributed **76.32%** of national HIV/AIDS expenditures followed by the Global Fund with **17.32%.** The contributions of these two donors alone amount to **91.75%** in 2019, **91.37%** in 2020 and **89.35%** in 2021.

To ensure the sustainability of funding for the fight against HIV/AIDS, this situation must be changed by the Government by taking measures committing it to gradually increase its contribution.

From 2019 to 2021, the funds were sourced from various pools: direct bilateral financial transfers entities accounted for the highest proportion of HIV and AIDS financing **(74%)** followed by direct multilateral financial transfers **(18%)** and internal transfers and grants **(8%).** Other classifications represent **0.02%** of shares.

People obtained health services through the main types of financing arrangements as follows: Central government schemes were the most used **(86%)** followed by Resident foreign agencies schemes **(10%).** The third largest scheme used was Not-for-profit organisation **(4%).** For-profit enterprises not elsewhere classified accounted for **0.02%** of shares.

The entities that pooled financial resources to finance service provision programs and also make programmatic decisions show that the resources for funding the response to HIV/AIDS mainly were managed by Public sector **(86%)** followed International purchasing organizations **(10%)** and the private sector **(4%).**

The entities that engaged in the production, provision, and delivery of HIV & AIDS Services show that mainly Public sector provided **69%** of shares followed by Bilateral, multilateral entities, international NGOs and foundations with **16%** of shares and Private sector providers (Non-profit providers and Profit-making private sector providers) with **15%** of shares.

The health providers provided services using various Service Delivery Modalities: Facility-based service modalities took the largest share, at **67%** followed by Non applicable (ASC which does not have a specific SDM), at **22%.** The third largest expenditure was on Home and community based service modalities with **8%** of share. Modalities not disaggregated took the fourth place with for **3%** of share**.**

The inputs (labor, capital, workshop facilities, promotion materials, travel etc.) that were used by providers to provide services show that current expenditures accounted for the largest share of spending for the entire period **(94%)** followed by production factors not disaggregated **(3.30%)** and capital expenditures **(2.62%).**

HIV-related interventions and activities done in order to reach the expected achievements in addressing the pandemic showed that care and treatment took the highest share, at **56%** followed by Programme enablers and systems strengthening, at **23%.** The third largest expenditure was on Prevention with **12%** of share. HIV with testing and counselling (HTC), accounted for **5%** of share. Development synergies accounted for **3%** of shares, Social protection and economic support accounted for **2%** of shares. The remaining subcategories (social enablers, research) combined accounted for **0.08%** of total HIV and AIDS spending.

From 2019 to 2021, people living with HIV accounted for **56%** of total expenditure followed by Non-targeted interventions, at **26%** of share. The third largest expenditure was on Vulnerable, accessible and other target populations with **5%** of share. The fourth was Key populations with **2%** of share and the fifth was Specific targeted populations not elsewhere classified which accounted for **0.15%** of share. As can be shown, the epidemic vectors (key populations) do not even benefit from **3%** of the total expenditure. Resource allocation should increasingly be evidence-based.

The main limitations of the exercise related to challenges in obtaining data from some stakeholders including Government (due to the current planning and budgeting system which does not allow for disaggregated expenditure data) and the Private Sector which had a very low response rate.

Policy implications and Recommendations

i) It may be necessary to provide the framework for resource tracking at intervention level by developing a National Operational Plan for the NASF, which will provide the basis for tracking resources at intervention level. This will also enhance resource allocation once there is visibility regarding where resources are spent.
ii) Though there is increased Government spending on Health and the HIV national response, clearly demonstrating commitment towards increased resource allocation and the achievement of the Abuja target, more still needs to be done in order to reduce dependence on donor funding. An exit strategy for reducing donor funds and achieving sustainability needs to be developed.
iii) Institutionalize the NASA process in Zambia for ease of data collection and reporting on HIV and AIDS spending.
iv) Develop innovative ways of compelling the private sector to report HIV and AIDS spending, such as tying the issuance of annual licences to HIV and AIDS reporting as a matter of compliance.

I. Introduction & background

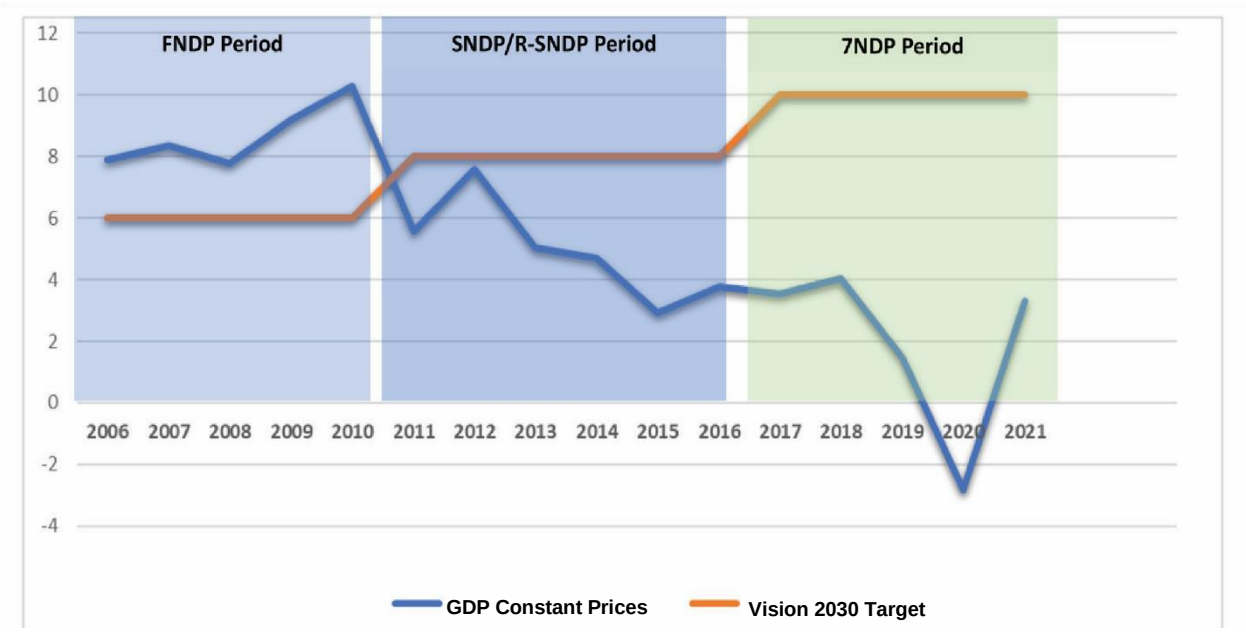
I.1. Zambia socio-economic profile

Economic Growth

Zambia's economy is heavily dependent on copper mining and rain-fed agriculture. Although economic diversification has been on the agenda for three decades, the country remains heavily reliant on the same sectors (mining and quarrying, wholesale and retail trade, agriculture, forestry, and fisheries). Retrospective analysis shows that Zambia's past growth (averaging 7.4% between 2004 and 2014) helped achieve middle-income status but had a limited impact on poverty.
Zambia's economy is showing encouraging signs of stabilizing after a period of macroeconomic imbalances that weakened economic performance. Between 2015 and 2021, economic growth slowed down and averaged 2.5% per year, lower than the annual population growth rate of 2.8%.

In the Vision 2030, the Government's objective is to attain and sustain an annual real economic growth rate of between 6 and 10 percent. During the period 2006 to 2010, annual real Gross Domestic Product (GDP) growth rate was favourable, averaging 8.7 percent, with the highest annual growth rate registered at 10.3 percent in 2010. Growth was mainly driven by the construction, transport, and mining sectors, spurred by increased investment in the mining sector (see Figure 1). Between 2011 and 2016, however, the economic growth rate slowed down, and averaged 4.9 percent. The growth was driven by ICT, wholesale and retail trade, as well as the construction sector. The ICT sector experienced significant structural growth due to the progressive migration from 2G to 4G technologies, and the resultant increased adoption rates, increased data usage, and wider signal penetration rates, especially in rural areas. Growth in wholesale and retail trade was mainly driven by increase in consumption, import and export of manufactured food products, as well as investment in retail outlets. The performance of the construction sector was mainly driven by increased public sector investment in infrastructure. During the period 2017-2021, growth declined further with the real growth rate averaging 1.4 percent largely due to unfavourable weather conditions which impacted the agriculture and energy sectors in the earlier years of the period. Another notable development was in 2020 when economic growth contracted by 2.8 percent, registering the first recession since 1998. This was mainly due to the effect of disruptions in supply chains and containment measures associated with the COVID-19 pandemic on sectors such as tourism, construction, wholesale and retail trade as well as manufacturing. The situation was compounded by the country's worsening fiscal position resulting from increased borrowing on the domestic market which crowded out the private sector. In 2021, real GDP growth recovered to 3.6 percent, with the agriculture, manufacturing, energy, wholesale and retail trade as well as the ICT sectors driving growth. Mining output declined despite a pick-up in global economic activity and commodity prices. The average real GDP growth of 5.2 percent attained over the period 2006 to 2021, falls below the Vision 2030 target of between 6 to 10 percent. Growth will, therefore, have to be significantly higher over the next two Plan periods to attain the aspirations of the Vision 2030.

Figure 1: Real GDP Growth (%) vs Targeted Growth (2006-2021)

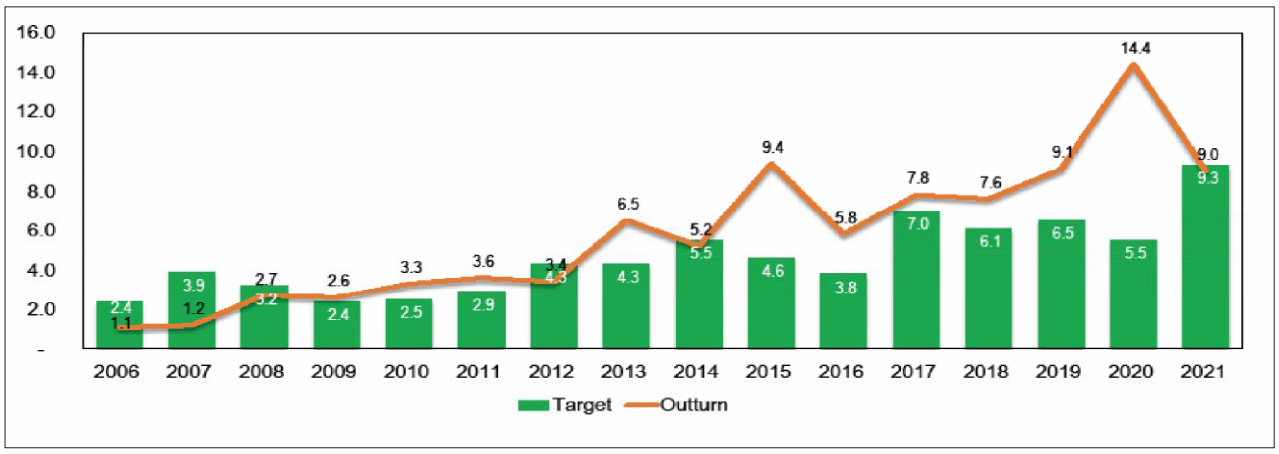


Source: *Eighth national development plan (2022-2026), August 2022*

Fiscal Performance

Over the period 2006 to 2021, fiscal performance was characterised by a deterioration in the overall deficit (see Figure 2). During the period from 2006 to 2010, the overall fiscal deficits were below target between 2006 and 2008, while in 2009 and 2010 the deficits were above target. The fiscal deficit during the FNDP period averaged 2.2 percent. In the earlier years of the Plan, this was attained due to relatively favourable revenue performance and expenditure policy which focused on poverty reduction. In the latter years, fiscal operations were affected by the global financial crisis. Total domestic revenue collections during the FNDP period averaged 17.5 percent, broadly in line with the target of 17.7 percent of GDP. Expenditure averaged 23.1 percent of GDP, against an average target of 23.8 percent of GDP.

Figure 2: Fiscal Deficit as a Percentage of GDP (2006-2021)



Source: *Eighth national development plan (2022-2026), August 2022*

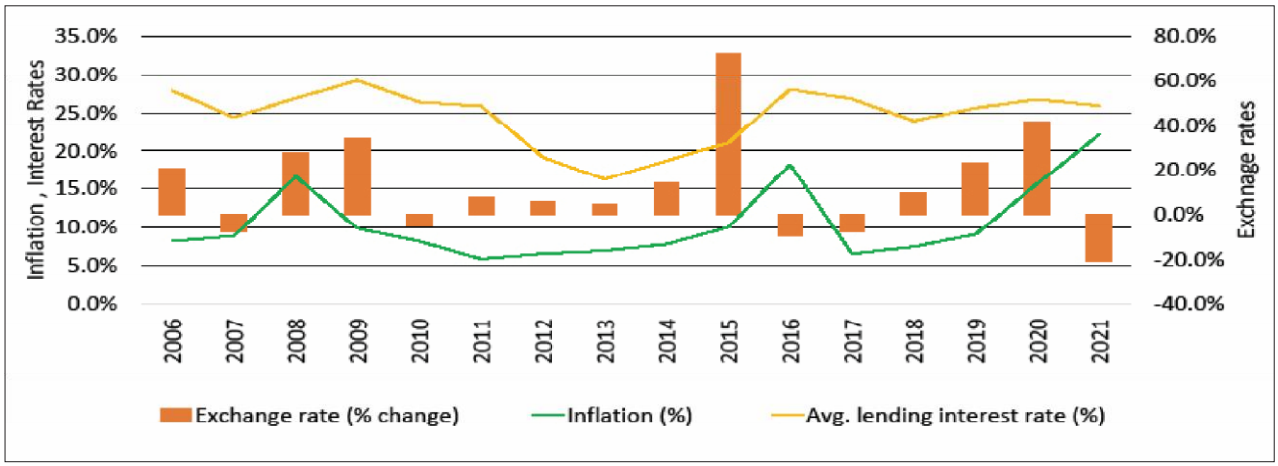
Debt Position

In tandem with the increase in the fiscal deficit, the debt position of the country increased substantially over the review period. As a proportion of GDP, the public debt stock (domestic and external) significantly increased from 22 percent in 2006 to 119 percent in 2021. The stock of domestic debt (government securities and bonds) increased to K193.00 billion by the end of 2021 from K6.24 billion in 2006. The rapid increase in the debt stock over the period reflected increasing recourse to domestic borrowing as external financing sources reduced. In addition, there was a sharp rise in domestic arrears, excluding fuel and electricity, which more than doubled to K45.5 billion at the end of September 2021 from K20.92 billion at the close of 2017. The pending bills were owed to road contractors, suppliers of goods and services, value-added tax (VAT) refunds and personnel-related emoluments for public service workers.

Monetary and Financial Sector Performance

During the period 2006 to 2021, inflation averaged 11.0 percent (see Figure 3). However, this outturn was higher than the single-digit inflation envisaged in the Vision 2030. During the 7NDP period, inflationary pressures increased, and inflation averaged 12.0 percent, up from 9.2 percent during the SNDP period. The rise in inflation was on account of increased food prices arising from the adverse impact of erratic rainfall on agricultural output and the pass-through effect from the depreciation of the Kwacha. High food prices that characterised the review period were a reflection of structural bottlenecks in the agriculture sector, particularly the high dependence on rainfall, which tends to adversely impact crop production during periods of drought.

Figure 3: Inflation, Exchange Rate and Lending Rates (2006-2021)



Source: *Eighth national development plan (2022-2026), August 2022*

External Sector Performance

During the period 2006 to 2020, the performance of the external sector was generally favourable as an average current account surplus of 1.4 percent of GDP per annum was recorded. During the 7NDP period, the current account surplus rose to an average of 3.6 percent of GDP. The rise in net exports on the back of the increase in copper earnings largely underpinned the current account surplus.

Merchandise exports continued to be dominated by traditional exports, particularly copper, over the period 2006 to 2020 (see Figure 4). Traditional exports accounted for an average of 75 percent of total exports with the balance coming from non-traditional exports such as sugar, cement and agricultural products. This reflects the country's narrow export base and the need to diversify the sources of export earnings.

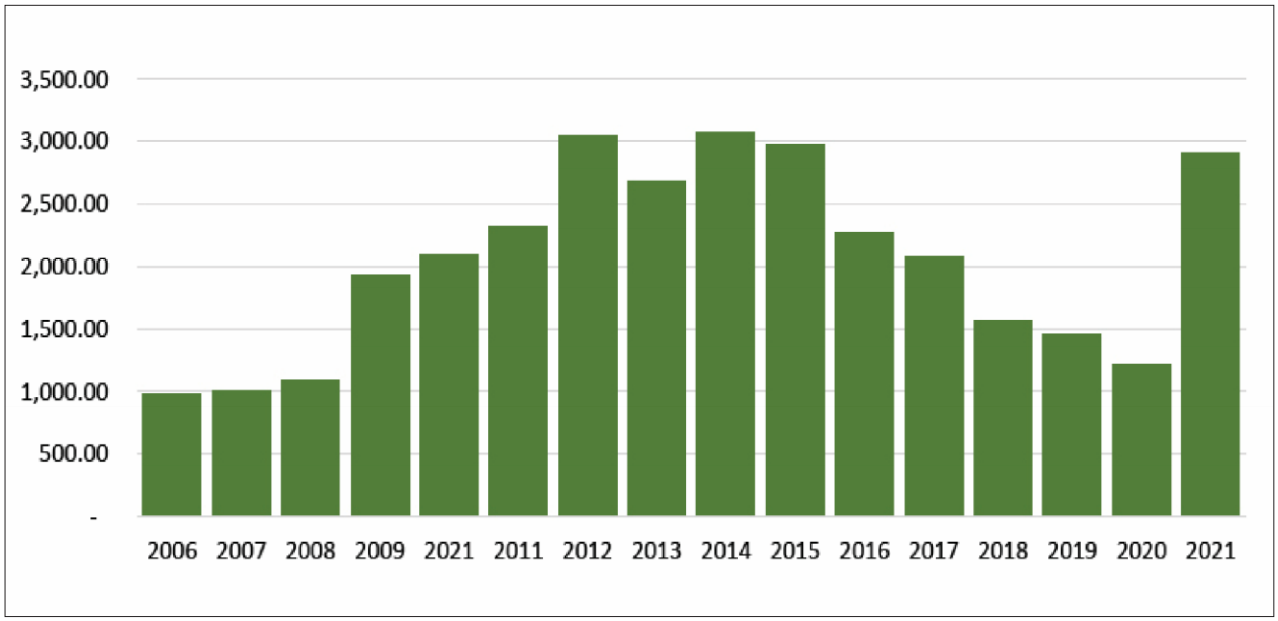
Figure 4: Non-Traditional Exports and Traditional Exports (US$' million)

Source: *Eighth national development plan (2022-2026), August 2022*

Gross International Reserves (GIRs)

Gross international reserves (GIRs) steadily increased between 2006 and 2014 (see Figure 5). This was in part due to Zambia's attainment of the Highly Indebted Poor Country (HIPC) Initiative Completion Point in 2006 which resulted in significant debt relief that eased pressure on international reserves. Additionally, the issuance of three Eurobonds amounting to US$3.0 billion increased GIRs to an all-time high of US$3.1 billion in 2014.

Figure 5: Gross International Reserves (US$' million)



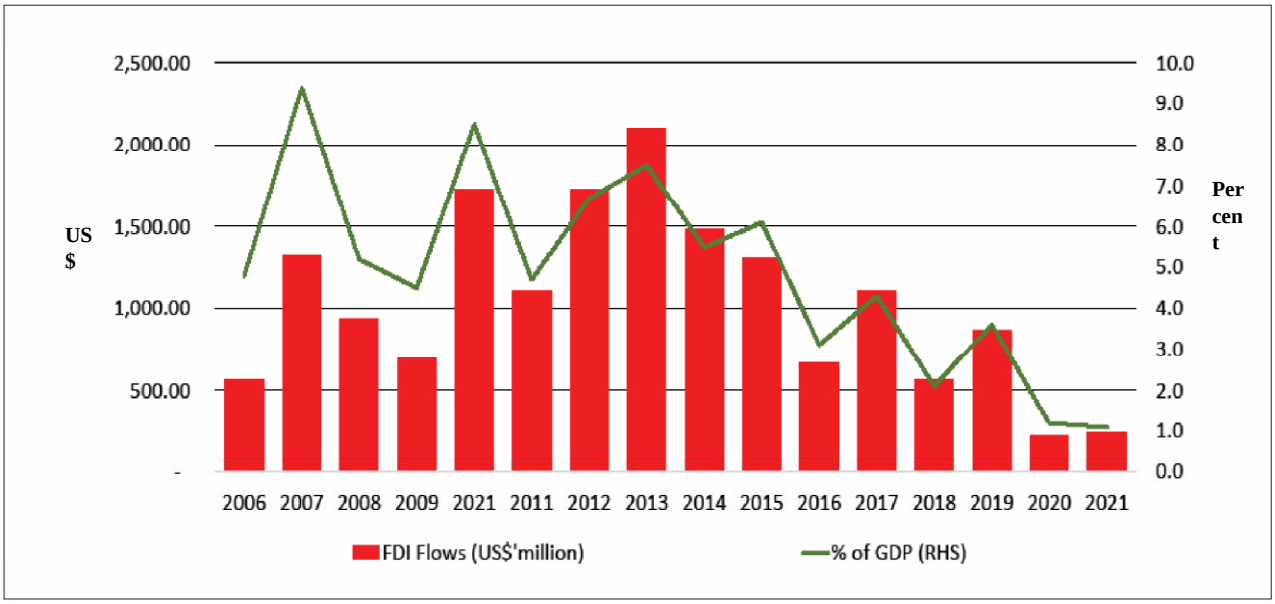
Source: *Eighth national development plan (2022-2026), August 2022*

International reserves declined steadily to US$1.2 billion (equivalent to 2.4 months of import cover) in 2020 from US$2.1 billion (equivalent to 2.9 months of import cover) in 2017. The decline was mainly due to

increased external debt service. In 2021, however, international reserves rose to US$2.8 billion (equivalent of 4.4 months of import cover). This followed the receipt of Special Drawing Rights (SDRs) 937.6 million (equivalent of US$1.3 billion) from the International Monetary Fund IMF). At 4.4 months of import cover, international reserves, however, remain far below the Vision 2030 target of at least 12 months of import cover. In this regard, there is need to step up efforts to enhance the accumulation of international reserves.

Foreign direct investment (FDI) inflows averaged US$1.1 billion per annum between 2006 and 2021 (see Figure 6). Mining continued to be the largest destination for FDI inflows. FDI declined steadily after 2013 largely attributed to changes in tax policy for the mining sector, volatile international commodity prices, particularly for copper, and the unfavourable macroeconomic environment. The concentration of FDI inflows in the mining sector calls for concerted efforts to attract investments in other key sectors such as manufacturing, agriculture and tourism, if the economy is to be transformed so as to create jobs and enhance livelihoods.

Figure 6: Foreign Direct Investment Inflows (2006-2021)



Source: *Eighth national development plan (2022-2026), August 2022*

Employment and Job Creation

The country's overall unemployment rate reduced during the period from 16.0 percent in 2005 to 7.8 percent in 2012. However, the trend was reversed thereafter with the unemployment rate rising to 12.5 percent in 2021. In 2021, the youth unemployment rate was estimated at 17.4 percent compared to 14 percent in 2005. The unemployment rate was also higher in urban areas than in rural areas (see Table 1). Further, disparities in gender were observed, with unemployment among females being higher.

Table 1: Unemployment Rates (%) 2005-2020

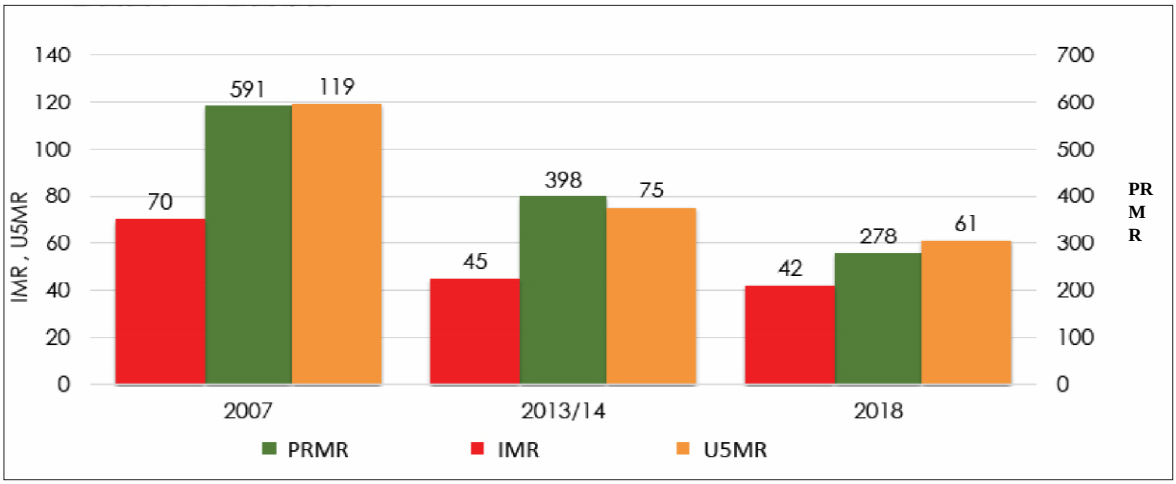
Year	Overall Unemployment Rate	Youth Unemployment rate				
		Both Sexes	Male	Female	Rural	Urban
2005	16.0	14.0	4.0	22.0	7.0	23.0
2008	7.9	14.0	14.9	13.1	5.5	36.0
2012	7.8	10	8.5	11.3	4.4	17.2
2017	12.6	17.4	16.2	19.1	15.7	18.5
2018	11.4	16	14.6	18.2	13.6	17.5
2019	12.8	17.9	17.4	18.6	17.6	18.1
2020	13.8	19.9	17.6.	22.9	18.	20.8
2021	12.5	17.4	14.9	21.2	17.8	17.1

Source: *Eighth national development plan (2022-2026), August 2022*

Population Dynamics

Population growth between 2006 and 2020 averaged 2.8 percent per annum. In 2010, the population was 13.1 million and was estimated at 17.9 million in 2020. Further, the population was higher in rural than in urban areas. The rural population was 7.9 million in 2010 and was estimated at 10.1 million in 2020. Over the same period, the urban population was 5.2 million in 2010 and was estimated at 7.8 million in 2020. This high rate of population growth is attributed to the interplay between high fertility and reducing mortality. While the country experienced a slight reduction in the total fertility rate (TFR) from an average of 6.2 births per woman in 2007 to 4.7 births in 2018, mortality rates reduced during the same period (see Figure 7). Pregnancy-related mortality (PRMR) reduced from 591 deaths per 100,000 live births in 2007 to 278 deaths per 100,000 live births in 2018, a reduction from 398 per 1,000 live births in 2014. The maternal mortality ratio (MMR) was 252 deaths per 100,000 live births in 2018. The infant mortality rate (IMR) reduced to 42 deaths in 2018 from 70 deaths per 1,000 live births in 2007, while the under-five mortality rate (U5MR) reduced to 61 deaths in 2018 from 119 deaths per 1,000 live births in 2007.

Figure 7: Selected Demographic Indicators 2007 - 2018

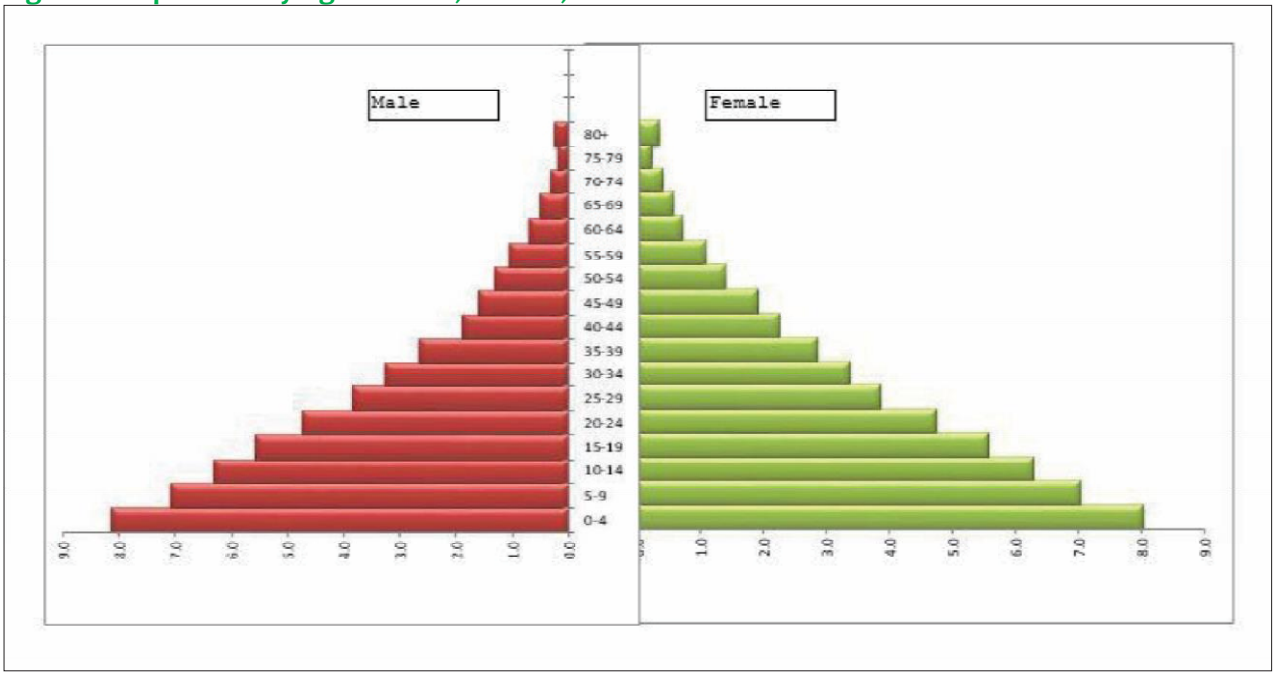


Source: *Eighth national development plan (2022-2026), August 2022*

The relatively high population growth rate for Zambia has culminated into a young population with about 46 percent of the population aged below 15 years, and approximately 80 percent of the population aged

below 35 years. This implies that the child dependency ratio remains high at an average of 88 persons aged 0-15 years per 100 persons aged 15-64 years. (see Figure 8).

Figure 8: Population by Age and Sex, Zambia, 2021



Source: *Eighth national development plan (2022-2026), August 2022*

The population age structure is expected to remain relatively unchanged up to 2035, unless the implementation of interventions aimed at attaining the demographic dividend are put in place (see Figure 9). To attain the demographic dividend, there is a need to prioritise strategic investments in human capital (health and education), implement sound economic and governance policies, as well as sustain all necessary commitments for opening the demographic window of opportunity. This entails the prioritisation of investments aimed at creating opportunities and a supportive environment for innovation and entrepreneurship for the growing labour force, particularly the young people, persons with disabilities (PWDs), and women.

Poverty and Inequality

Zambia still ranks among the countries with high incidences of poverty and inequality in Africa, as well as globally. This is despite several interventions made in education and skills development, health, water and sanitation, as well as job creation and empowerment of citizens. However, some reduction in poverty levels were recorded during the previous NDP periods. Poverty levels in the period 2006-2015 reduced by 8.4 percentage points to 54.4 percent in 2015 from 62.8 percent in 2006. This notwithstanding, extreme poverty or the proportion of individuals whose consumption was less than the cost of the food basket only marginally improved to 41 percent of the total population in 2015 from 43 percent in 2006.

Analysis by rural-urban residence indicates that poverty in rural areas remained higher at 76.6 percent compared to 23.4 percent in urban areas as of 2015. Extreme poverty was also higher in the rural areas at 60.8 percent. These persistently high poverty levels in rural areas were mostly attributed to inadequate nutrition, households' inability to afford agricultural inputs, low wages or salaries and lack of capital to start or expand own business. Figure 9 below shows poverty trends for the period between 2006 and 2015.

Figure 9: Poverty Trends (%), 2006-2015

Source: *Eighth national development plan (2022-2026), August 2022*

Macroeconomic objectives and policies

The Government of Zambia seeks to restore macroeconomic stability by raising real GDP growth as well as attaining fiscal and debt sustainability to improve the livelihoods of the Zambian people, especially the vulnerable. Attaining this will require strong policy action and the implementation of structural reforms. Pursuant to the above, the macroeconomic objectives are to:

a) Achieve an annual real GDP growth rate of at least 4.5 percent by 2026;
b) Reduce the fiscal deficit to 3.6 percent of GDP by 2026;
c) Maintain an annual domestic revenue to GDP ratio of at least 21 percent;
d) Contain domestic borrowing to less than 4.8 percent of GDP by 2026;
e) Dismantle domestic arrears and curtail accumulation of new arrears;
f) Reduce and maintain inflation within the target range of 6-8 percent;
g) Maintain international reserves of at least 3 months of import cover; and
h) Reduce the external debt to 60 percent of GDP and ensure sustainability.

Refer to Table 2 for key macroeconomic targets, including the real GDP growth rate, inflation and domestic borrowing.

Table 2: Key Macroeconomic Indicators, 2022-2026

Key Performance Indicator	Baseline (2021)*	2022	2023	2024	2025	2026	Source of Statistics
Real GDP growth rate (%)	3.6	3.5	3.7	4.4	4.2	4.5	ZamStats/MoFNP
GDP at constant prices (ZMW millions)	143,447.6	147,197.00	152,506.50	158,467.20	165,188.00	172,686.60	ZamStats/MoFNP
GDP at market prices (ZMW millions	424,269.0	460,616.5	522,881.0	583,733.2	649,115.8	717,592.7	ZamStats/MoFNP
CPI* inflation (%, end period)	16.4	<10	6-8	6-8	6-8	6-8	ZamStats/BoZ

Key Performance Indicator	Baseline (2021)*	2022	2023	2024	2025	2026	Source of Statistics
Domestic borrowing (% of GDP)	7.7	5.9	5.6	5.8	5.9	4.8	MoFNP
Domestic revenue (% of GDP)	23.6	21.2	21.8	22.3	22.9	23.0	MoFNP
Overall fiscal deficit (% of GDP)	9.0	6.7	6.3	5.2	4.6	3.6	MoFNP
Gross international reserves (months of import cover)	4.4	≥3.0	≥3.0	≥3.0	≥3.0	≥3.0	BoZ
*Note that all baseline data is preliminary with the exception of CPI inflation and gross international reserves							
*CPI: Consumer Price Index							

Source: *Eighth national development plan (2022-2026), August 2022*

MACROECONOMIC POLICIES

Achieving Higher and Inclusive Growth

The policy over the Plan period (2022-2026) is to improve living standards as well as to reduce poverty and inequality by creating conditions for strong and inclusive growth. This is anchored on ***Economic Transformation and Job Creation*** through implementation of interventions to enhance production and productivity in the agriculture, tourism, mining and manufacturing sectors. Further, the Government will pursue an export oriented economic transformation agenda.

Fiscal Policy and Reforms

To achieve fiscal sustainability, a combination of measures, including enhancements in domestic resource mobilisation, expenditure rationalisation and debt restructuring, will be pursued.
Key interventions in tax policy will include enhancing compliance while streamlining the structure of tax incentives to support economic transformation. The capacity of local authorities will also be strengthened to enhance revenue collection.

Total expenditure (including amortisation) is projected to reduce to 30.0 percent of GDP in 2026 from 33.9 percent in 2021 This will largely be attained through significant reforms on subsidies, particularly in the energy and agriculture sectors, as well as rationalising spending on capital projects with emphasis on public private partnership (PPP) due to fiscal constraints. In this regard, the focus will be on reducing the pace of debt accumulation to attain long-term debt sustainability.

Debt Management Strategy

During the Plan period, the Government will revise the Loans and Guarantees (Authorisation) Act of 1969 to enhance transparency in debt management and provide for parliamentary oversight in the contraction of loans. Further, a Medium-Term Debt Management Strategy covering the period 2023 to 2025 will be developed for the country to return to sustainable debt levels. Under domestic debt, the focus will be on the issuance of longer-dated instruments, taking into account market conditions and costs to reduce the refinancing risk. With regard to external debt, the Government will seek to restructure debt under the auspices of the G20 Common Framework on Debt Treatment.

Dismantling of Domestic Arrears

The Government has prioritised the dismantling of domestic arrears and will, therefore, develop an arrears dismantling strategy to be implemented over the Plan period. The strategy will address the existing stock of arrears relating to personal emoluments, bills for consumption of public utilities, value-added tax (VAT) refunds, FISP, crop purchases under the Food Reserve Agency, pension benefits, awards and compensation, capital expenditure on civil works including road construction, as well as that of other

suppliers of goods and services. Further, arrears on fuel and electricity (debt to independent power producers and power imports) which are foreign currency-denominated will be addressed through this strategy.

The key measures of the strategy include increasing budgetary allocations to liquidate the arrears, undertaking debt and/or cheque swaps, debt refinancing and restructuring, as well as halting or slowing down the pace of accumulation of new arrears. The aim is to clear all domestic arrears within the medium to long-term.

Monetary and Financial Sector Policies

During the Plan period, monetary and financial sector policies will aim at maintaining price and financial system stability which are critical to promoting sustainable growth. Monetary policy will continue to rely on the forward-looking monetary policy framework anchored on the Policy Rate as a key signal of the policy stance.

To ensure financial system stability, the Bank of Zambia will strengthen both micro and macro-prudential regulations and supervision to mitigate the build-up in vulnerabilities and risks to the financial system. In addition, a Deposit Protection Scheme and Problem Bank Framework will be implemented.

The Government will also repeal and replace the Bank of Zambia Act of 1996 during the Plan period to strengthen central bank autonomy and enhance monetary policy credibility in line with the Constitutional (Amendment) Act No. 2 of 2016 and the adoption of the SADC Central Bank Model Law.

External Sector Policies

During the 8NDP period, the Government will continue to promote exports as a strategy for long-term economic growth. In addition to increasing traditional exports of commodities such as copper, widening the export base of non-traditional exports will be the focus to increase export earnings. This strategy will positively impact the country's international competitiveness, buttress the stability of the exchange rate and ensure current account sustainability. In this regard, focus will be on expanding export earnings from various sectors, especially mining, agriculture, manufacturing and tourism. Further, the Government will continue facilitating and formalising trade with neighbouring countries. With regard to the exchange rate policy, a flexible system will be maintained while mitigating excessive volatility.

To maintain reserves to at least three months of import cover, the Government will, in addition to promoting increased exports, continue with the policy requiring all mining companies to pay their tax obligations in United States dollars. Further, the Bank of Zambia will continue to build up its stock of gold bullion as part of the interventions to increase foreign reserves, through the purchase of locally-mined gold.

This socio-economic profile highlights the efforts necessary in order to achieve effective resource allocation in the country's HIV and AIDS response. The epidemiology of HIV and AISD in the country now follows, before the NASA exercise is addressed.

I.2. ZAMBIA HIV & AIDS Epidemiology

Zambia has an estimated 1.2 million People Living with HIV (PLHIV). According to the 2021 Zambia Demographic Health Survey (ZDHS), 9.9% of persons aged between 15 and 49 years are living with HIV with 13.2 % females and 6.3 % male. Prevalence of HIV among adults aged 15+ years in Zambia was 11.0%. HIV prevalence was 13.9% among women and 8.0% among men (ZDHS, 2021). Accordingly, the annual incidence of HIV among adults aged between 15 and 49 years in Zambia is 0.34 % with 0.63 % among females and 0.05 % among males. Annual incidence of HIV among adults aged 15+ years in Zambia was 0.31%, which

corresponds to approximately 28,000 new cases of HIV per year among adults. HIV incidence was 0.56% among women and 0.06% among men (ZAMPHIA, 2021) across the country.
Prevalence of VLS among adults aged 15+ years living with HIV in Zambia was 86.2%: 86.6% among women and 85.5% among men. Note that these estimates of VLS prevalence are among all adults living with HIV, regardless of their knowledge of HIV status or use of antiretroviral therapy (ART).

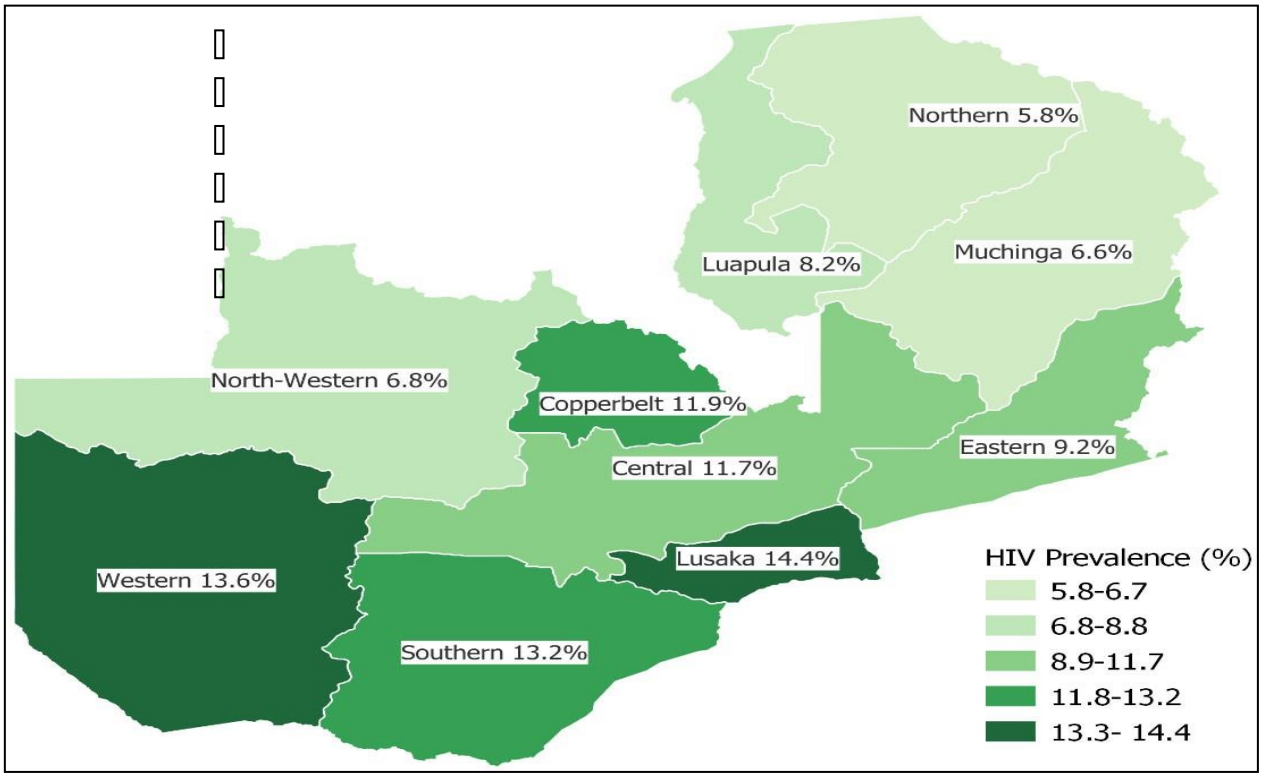
Table 3: HIV Prevalence, annual incidence and viral load suppression among Adults (15-49) and adults aged 15+ years in Zambia

HIV Indicator Women		95% CI	Men	95% CI	Total	95% CI
Annual incidence (%)						
15-49	0.63	(0.24 - 1.02)	0.05	(0 - 0.15)	0.34	(0.14 - 0.53)
15+	0.56	(0.22 - 0.90)	0.06	(0 - 0.16)	0.31	(0.14 - 0.48)
Prevalence (%)						
15-49	13.2	(12.2 - 14.3)	6.3	(5.0 - 7.7)	9.9	(9.1 - 10.7)
15+	13.9	(12.8 - 15.1)	8	(7.0 - 9.0)	11	(10.3 - 11.8)
Viral load suppression (%)						
15-49	85.4	(80.7 - 90.0)	82	(77.3 - 86.7)	84.3	(80.7 - 88.0)
15+	86.6	(83.1 - 90.1)	85.5	(82.3 - 88.7)	86.2	(83.9 - 88.5)

Source: *ZAMPHIA, 2021*

There are regional variations in the HIV situation in Zambia. Among adults aged 15+ years, HIV prevalence varied geographically across Zambia, ranging from 5.8% to 14.4%. Lusaka province has the highest HIV prevalence of 14.4 % followed by Western (13.6%), Southern province is at 13.2 %, Copperbelt (11.9%), Central 11.7 %, Eastern 9.2 %, Luapula 8.2%, North-Western province 6.8%, Muchinga and Northern provinces have the lowest prevalence rates, estimated at 6.6 % and 5.8 % respectively as indicated in Figure 10 below.

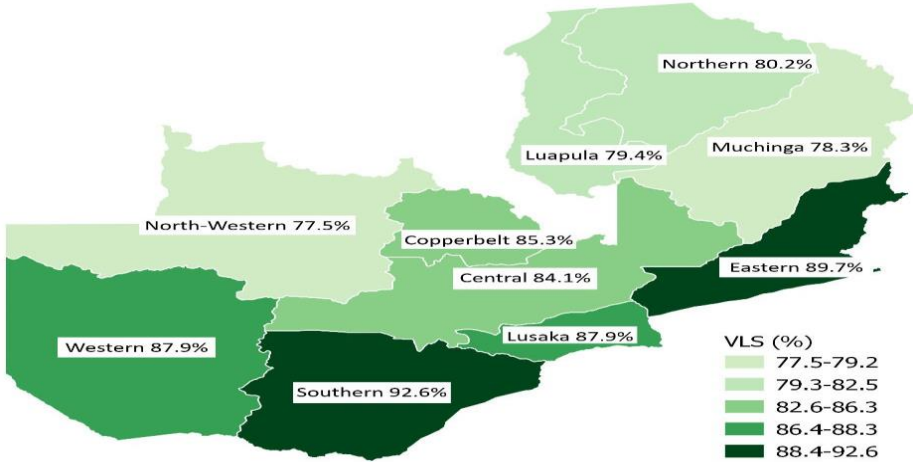
Figure 10: HIV Prevalence by Province



Source: *ZAMPHIA, 2021*

There are regional variations in prevalence of VLS situation in Zambia. Among adults aged 15+ years, living with HIV, prevalence of VLS varied geographically across Zambia, ranging from 77.5% to 92.6%. Southern province has the highest prevalence of of VLS (92.6 %) followed by Eastern (89.7%), Lusaka and Western provinces are both at 87.9 %. Copperbelt is at 85.3 %, Central (84.1 %), Luapula 79.4%, North- Muchinga and Northern provinces have the lowest of VLS rates, estimated at 78.3% and 77.5% respectively as indicated in Figure 11 below.

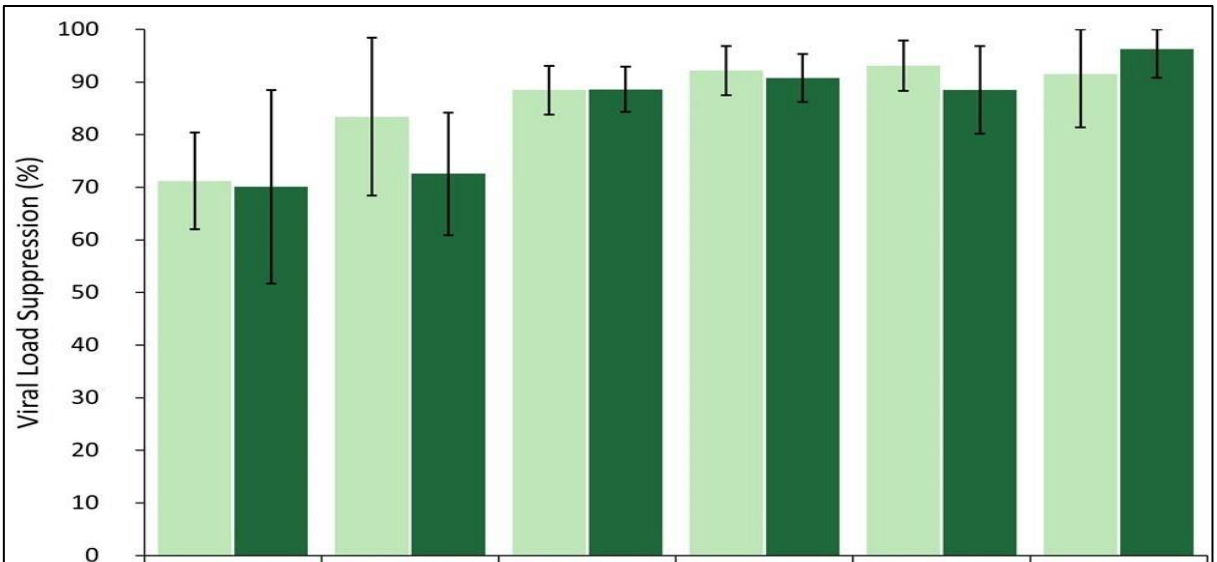
Figure 11: Viral load suppression among adults living with HIV, by province



Source: *ZAMPHIA, 2021*

Among adults living with HIV in Zambia, the prevalence of VLS ranged from 71.2% among women aged 15-24 years to 93.1% among women aged 55-64 years, and from 70.1% among men aged 15-24 years to 96.3% among men aged 65+ years. VLS was similar for women and men across all age groups. The figure below illustrates what is announced.

Figure 12: Viral load suppression, by age and sex



Ages (years)	15-24	25-34	35-44	45-54	55-64	65+
Women	71.2%	83.4%	88.5%	92.2%	93.1%	(91.5%)
Men	70.1%	72.6%	88.6%	90.8%	88.5%	(96.3%)

The Joint United Nations Programme on HIV/AIDS (UNAIDS) set the 95-95-95 targets with the aim that by 2025, 95% of all people living with HIV will know their HIV status; 95% of all people with diagnosed HIV infection will receive sustained ART; and 95% of all people receiving ART will have VLS.

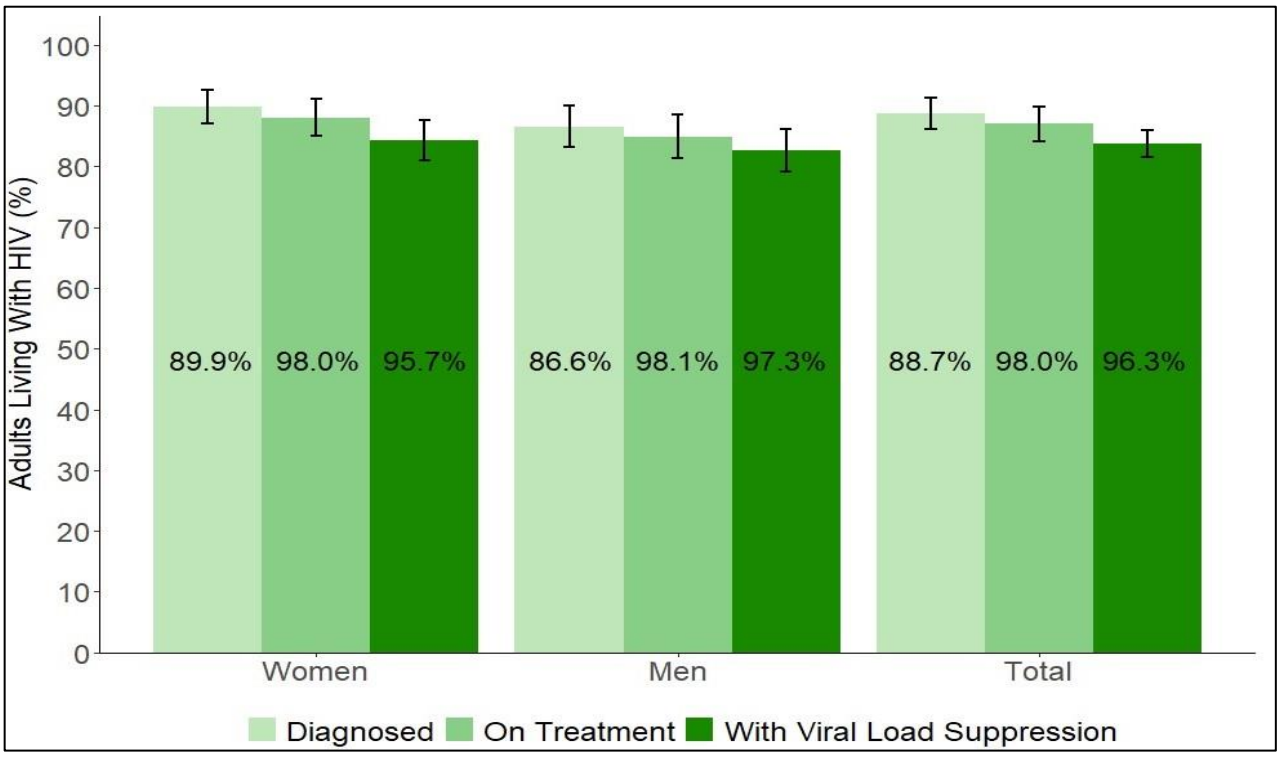
Diagnosed: In Zambia, 88.7% of adults (15+ years) living with HIV were aware of their HIV status: 89.9% of women and 86.6% of men. Individuals were classified as aware if they reported their HIV-positive status or had a detectable antiretroviral (ARV) in their blood.

On Treatment: In Zambia, among adults living with HIV who were aware of their status, 98.0% were on ART: 98.0% of women and 98.1% of men. Individuals were classified as being on ART if they reported current ART use or had a detectable ARV in their blood.

Viral Load Suppression: Among adults who were on ART, 96.3% had VLS: 95.7% of women and 97.3% of men.

Percentages shown in the graph refer to the conditional 95-95-95 targets described in the text to the right. The heights of the bars represent the unconditional (overall) percentages for each indicator among all people living with HIV. Male, female, and total percentages apply to adults aged 15-64 years. Error bars represent 95% CIs.

Figure 13: Achievement of the 95-95-95 targets, by age and sex



Source: *ZAMPHIA, 2021*

- Among all adults living with HIV, VLS prevalence was 86%, suggesting that Zambia is well-positioned to achieve the UNAIDS goal of ending the AIDS epidemic by 2030.
- Zambia has met the 2nd and 3rd 95 targets of people (15+ years) who know their HIV status receiving ART and having VLS. The country is approaching the overall 95-95-95 target of 86% (95*95*95) with nearly 84% of all adults achieving VLS with ART use.
- While recognizing the remarkable accomplishments of Zambia in controlling HIV at the national level, key gaps remain. Zambia has not yet reached the first 95 target among adults aged 15+ years and VLS prevalence among men aged 15-34 years and women aged 15-24 years is lagging behind other age groups. Geographic variation in VLS prevalence indicates some provinces (Muchinga and North-western) are below targets.
- Moving forward, Zambia is well-positioned to achieve the UNAIDS 95-95-95 targets by closing the programmatic gaps in diagnosis, treatment, and adherence. The country can ensure that all people benefit from these achievements by increasing diagnosis among people who do not yet know they are living with HIV and helping younger people achieve viral load suppression.

II. NASA study design and methodology

II.1. Nasa concepts

NASA is a comprehensive and systematic methodology to track the flow of resources for the AIDS response from the source through the different agents to the beneficiaries. The NASA resource tracking algorithm is designed to describe financial flows and expenditures using the same categories in the global resource needs estimation. It has been designed as a core-tracking framework without substituting for other methods and tools already in use. The NASA framework is based on globally accepted standardized methods and definitions, that are compatible with, but more disaggregated than, the National Health Accounts (NHA) – now called System of Health Accounts (SHA).

NASA can therefore generate useful evidence to assist with the planning and financing of HIV services and can be used to measure the potential financial gap and thus to mobilize for additional resources. It is a very powerful tool for policy makers and all actors involved in the HIV/AIDS response, including governments, donors, persons affected by HIV and civil society more broadly. NASA provides useful insights on the extent of harmonization and alignment of the resource envelope to the programmatic priorities. This is particularly important when future HIV funding is threatened by competing global priorities and the economic down turn while expectations to achieve more remain high.

National AIDS Spending Assessment (NASA) is a framework that calls for the embodiment and resource tracking of HIV & AIDS related activities occurring in all sectors (not only health sector) given the multi-sectoral nature of the response. Expenditures are in but not limited to education, social development, welfare and other non-healthcare delivery branches that are intimately related to the policy perception of the problem by Heads of State, Governments, National and International Authorities. The process follows a harmonized framework of several classifications around HIV & AIDS activities, interventions and programmatic areas. The framework was produced in 2006 and revised in 2009 to incorporate comments from the stakeholders. Further reviews have been conducted since then to capture lessons learnt in almost a decade of implementing NASA in various countries. The latest NASA classifications were produced in 2018 and they have been used in this study.[1]

II.2. Nasa Classifications

NASA classifications are summarized in three dimensions: financing, provision, and utilization. The classification of the three dimensions and nine categories comprise the framework of the NASA system. These dimensions incorporate nine categories:

(A) Financing HIV & AIDS Services

1. Financing Entities (FE) are entities that provide money to financing agents (see Table 1.a, Annex 1).
2. The funds are sourced from various pools (Revenues), e.g. transfer from government domestic revenue, transfers distributed by government from foreign origin etc.(see Table 1.b, Annex 1).
3. Financing Schemes (SCH) are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements e.g. through compulsory contributory health insurance schemes, transfer through social health insurance etc. (see Table 1.c, Annex 1).
4. Financing Agents – Purchasers (FAP) are entities that pool financial resources to finance service provision programs and also make programmatic decisions (purchaser-agent) [see Table 1.d, Annex 1].

(B) Provision of HIV & AIDS Services

1. Providers of Services (PS) are entities that engage in the production, provision, and delivery of HIV & AIDS Services (see Table 1.e, Annex 1).
2. The health providers provide services using various Service Delivery Modalities (SDMs) e.g. inpatient care, outpatient care, community outreach programs etc. (see Table 1.f, Annex 1).
3. Production Factors (PF)/resource costs are inputs (labor, capital, workshop facilities, promotion materials, travel etc.) that are used by providers to provide services [see Table 1.g, Annex 1].

[1] See UNAIDS (2018), NASA Data Consolidation Tool (DCT) and NASA RTT Software, Geneva.

(C) Utilization of HIV & AIDS Services

1. AIDS Spending Categories (ASC) are HIV-related interventions and activities, what is done in order to reach the expected achievements in addressing the pandemic (see Table 1.h, Annex 1).
2. Beneficiary segments of the population (BP), e.g., men who have sex with men, injecting drug users, general population, pregnant women etc. (see Table 1.i, Annex 1).

NASA seeks to answer the following questions:

1. Where does the money come from? Who provides the funds? (Financial Entities)
2. Who pools the funds? (Revenues)
3. What mechanism allows payment? (Financing schemes)
4. Which entity manages the funds? Who makes the decision of what services or goods to purchase? (Financing Agents – Purchasers)
5. Who provides the services or the goods? (Services and goods providers)
6. How are the services provided? (Service Delivery Modalities))
7. What does a provider buy to produce the AIDS Spending Categories? (Production factors e.g. medical supplies, time of health providers (by paying salaries and other incentives), office rent, utilities, catering services, etc.
8. What does a provider deliver? (AIDS Spending Categories-ASC: e.g. Prevention services, treatment services, etc.)
9. Who are the recipients of the services and goods? (Beneficiaries of the services or target groups)

II.3. Rationale for conducting NASA in 2022

The 2001 United Nations General Assembly Special Session on HIV and AIDS urged countries to invest in monitoring and evaluation systems of their HIV and AIDS responses. This entails the institutionalization of a monitoring system that enables implementers to routinely collect financial and health service delivery data on the HIV and AIDS response.

The NASA methodology produces information that can guide decision-making to determine the level of expenditure incurred in each programme area, to measure the potential financing gap, and to improve future allocative decisions and mobilize additional resources in an evidence-based planning process. Additionally, the NASA result informs the processes of developing or improving key national strategies such as sustainability plans and allocative or productive efficiency analyses, and permits monitoring of implementation of the National Strategic Framework.

This is particularly important when future HIV and AIDS financing is threatened by competing global priorities and economic downturns but expectations to achieve more remain high. NASA data allow for further examination of aspects of equity, efficiency, absorptive capacity and allocative efficiency, and are critical for informing the sustainability discourse.

Zambia faces challenges related to timely financial reporting for HIV and AIDS services, resource mobilization, allocation and absorptive capacity at all levels. At the same time, the size of the HIV and AIDS resource envelope is unpredictable, and it is not easy to understand how these resources are used. Information on financing of the national response and spending of the public, civil society and private sectors remains largely uncoordinated and with data deficiencies. The effective tracking of such resources is therefore an important policy issue for all stakeholders.

Tracking HIV and AIDS expenditure produces estimates of the flow of resources into a country's health system. To answer policy questions around financial sustainability, it is vital to understand and explain the financial flows; to demonstrate how the funds are dispersed to different economic agents and the channels used to access financing; to determine the level of expenditure incurred in each programme area and the targeted beneficiary populations; and to measure the potential financing gap.

Against such a background, Zambia NAC, in collaboration with UNAIDS, commissioned NASA for the period 2019 to 2021.

II.4. Objectives of NASA in Zambia

The primary objective for this exercise is to collect data on HIV and TB/HIV Coinfection expenditures in ZAMBIA from 2019 to 2021 using the National AIDS Spending Assessment methodology. Specific objectives are:

1. To implement a methodology for systematic monitoring of HIV and HIV/TB coinfection financial flows at national and regional level using the NASA methodology in ZAMBIA;
2. Build national level capacity for systematic monitoring of HIV/AIDS financing flows using the NASA methodology, with a view to a yearly, fully-institutionalized NASA.
3. To conduct an HIV and HIV/TB coinfection spending assessment focusing on public and development partner (external) resources, and including private (both for-profit and not-for-profit) entities known to be contributing to HIV and TB activities.
4. To identify and measure the flow of resources for HIV HIV/TB coinfection by the funding entity *(FE)*, revenue *(REV)*, financing scheme *(SCH)*, financing agent-purchaser *(FAP)*, service provider *(PS)*, the service delivery modality *(SDM)*, function/ intervention *(ASC)*, cost components (factors of production, *PF*) and beneficiary populations *(BP)*.
5. To prepare a report of expenditure trends that will contribute to the country's next Global Fund Request for Funding and to their Sustainability Plan including steps to incorporate the NASA findings into relevant documents and processes, such as the NSP mid-term review, the sustainable financing plan, the investment case update, resource mobilization strategies.

The NASA will answer the following questions:

- ✓ Who are the sources of funding for HIV and TB coinfection in Zambia?
- ✓ Are the funds adequate to achieve the NASF targets?
- ✓ Who are the agents/ manager of funding for HIV and TB?
- ✓ Who are the providers of HIV and TB services?
- ✓ What HIV and TB services are being provided, and what is being spent on these?
- ✓ Is there need to reallocate towards interventions of greater impact, as per the Investment Case findings?
- ✓ Which activities are most dependent on external support and may need sustainability planning?
- ✓ What is the spending on HIV and TB across the provinces, and does it match the provincial burden of disease?
- ✓ Who are the beneficiaries of the HIV and TB spending?
- ✓ What are the key cost drivers, the production factors, of the HIV and TB spending in Zambia?

II.5. Methodology and Scope

II.5.1. Methodology

The NASA methodology, as promoted by UNAIDS, has been applied, with transactions being reconstructed from the transfer of resources between different economic agents, following the money through the financing flows, buyers, providers and the description of its factors of the production function, so as to generate the intended intervention to benefit specific beneficiary populations. Where expenditure data are missing, costing methods have been used to estimate the expenditure. The most logical estimation approach has been applied, based on available data, but generally estimations have been used as little as possible.
NASA implementation occurred in the following phases:

Planning, Mapping of Actors and Capacity Building

a) Awareness-raising with key national HIV response and TB response stakeholders: government ministries, cooperating/development partners, private sector, NGOs and civil society – this has been done by NAC and UNAIDS.
b) Mobilization of funds for the project - this was done by NAC and UNAIDS.
c) Establishment of the core steering committee comprising of NAC, government ministries, private sector, civil society and cooperating/development partners - this has been done by NAC. A technical committee has also been set up for oversight of the operational phase of the exercise. The members of the technical committee are listed below:

#	Title	Names	Organization
1	Mr.	Akapelwa Imwiko	Ministry of Finance
2	Mrs.	Onida Moyo	Ministry of Finance
3	Dr.	Patricia Bobo	Ministry of Health
4	Dr.	Dean Phiri	Global Fund PMU
5	Mr.	Michael Kachumi	CHAZ
6	Mr.	Patrick Banda	Ministry of Health
7	Mr.	Christopher Chikatula	Global Fund CCM Secretariat
8	Ms.	Mildred L. Miti Kanyenge	Ministry of Community Development and Social Services
9	Mrs.	Dieneke Huurne	GIZ
10	Mrs.	Annie Kaleshe	NAC
11	Mr.	Peter Ndemena	NAC
12	Mr.	Audace Niyongere	UNAIDS
13	Ms.	Lenganji Nanyangwe	SAT Zambia
14	Ms.	Hilda Shakwelele	CHA
15	Mr.	Chungu Fred	NZP+
16	Mr.	Mwanza Felix	TALC
17	Mr.	Sibusiso Malunga	KPC
18	Mr.	Collen Zulu	USAID

d) Preparation of letters to institutions requesting access to financial expenditure records, as well as the required letters of permission to access provinces, districts, health facilities, etc. The NAC and MOH (PS) arranging for this.

e) Undertake a mapping of all actors involved in the HIV/TB response in Zambia at national and regional levels. NAC has provided a list of NASA Cooperating Partners and Stakeholders:

- Ministry of Finance (Budgeting)
- Ministry of Health (Planning and Budgeting)
- CDC, USAID and other PEPFAR IPs
- Global Fund – PMU
- CHAZ
- UNFPA
- UNICEF
- GIZ
- UNAIDS
- Zambia Federation of Employers
- Manufacturers Association of Zambia
- Bankers Association of Zambia
- Mining Association of Zambia

f) Orientation and training of the core team on the updated NASA guidelines, classifications and tools.
g) Review and adjust the NASA data collection tools by the International consultant. The NASA classifications and vectors were revised in 2019, with some nomenclature revised and the number of vectors increased from six to nine. This necessitated the adjustment of the data collection tools to ensure that they could be used under this new classification.
h) Plan for data collection (develop a plan) by International and Local consultants, with NAC, who arranged all the logistics.

Sampling, Data Collection

The mapping of all actors, at national and regional levels, have been assisted in identifying data collection strategies from which the majority of respondents have been included, time and resources permitting. *All the funding sources and agents-purchasers have been included, without sampling.*

In the case of service providers, those with the largest portfolio of services and expenditure have been purposively sampled by strata, so as to ensure that the different levels and sizes of providers are represented and that approximately 80% of all the HIV expenditure in the country will be captured. This selection will be informed by the NAC and UNAIDS.

The financial transactions have been reconstructed from the origin to the final user by identifying three dimensions and nine vectors:

- **FINANCING:**
  1) Financing entities (Sources) FE
  2) Financing scheme SCH
  3) Revenue of financing schemes REV
  4) Financing agent & purchaser (Agents) FAP

- **PROVISION:**
  5) Providers of services PS
  6) Production Factors PF

- **USE/CONSUMPTION:**
  7) AIDS Spending categories ASC
  8) Service delivery model SDM
  9) Intended Beneficiary Populations BP

The NASA data collection tools for financing entities, revenues, schemes, financing agents-purchasers, and providers have been applied through face-to-face interviews. Service delivery modalities, production factors and beneficiaries have been identified. The Data Consolidation Tool have been utilized in this exercise.

The consultants led and undertook the data collection with rigorous quality control measure, so as to ensure the correct application of the tools and quality of the data collected. Twenty (20) data collectors have been engaged for this exercise and have been deployed in at least 5 provinces (Lusaka, Copperbelt, Northwestern, Northern, and Southern provinces). For PEPFAR, data was downloaded from their Panorama website and cross-walked to NASA classifications.

The following is the list of data collectors engaged:

NO.	NAME	SEX	QUALIFICATION
1.	Jennipher Makondo	F	BA Computer Science
1.	Fatima Phiri	F	BA Nursing
2.	Lorraine Goma	F	BA Education
3.	Victoria Mwanza	F	BA Political Science
4.	Koniwayi Chingoma	F	Medical Student (7th Year)
5.	Martha Chuma	F	MSc Education
6.	Rita Banda	F	BA Human Resources
7.	Gilbert Kalumbi	M	Accounts
8.	Mathews Lungu	M	BA Psychology
9.	Maurice Telebwe Luchen	M	BA Economics
10.	Mary Hamangaba	F	BA Demography
11.	Naminda Momba	F	MSc Economics
12.	Martin Chuma	M	BA Development Studies
13.	Maimbolwa Akufuna	F	BA Nursing
14.	Ziwase Mambo	F	BA Economics
15.	Thombi Nguluwe	F	BA Adult Education
16.	Muma Obino	M	BA Human Resource
17.	Madaliso Mbewe	F	BA Education
18.	Eliud Musonda	M	BA Commerce
19.	Cynthia Phiri	F	BA Development Studies
20.	Clara Kaloza	F	BA Library Studies

The data collectors have been trained in the NASA methodology, the taxonomy, use of the data collection tools and also on the appropriate allocation of expenditure between the different categories.
Training of the resource tracking team on the use of RTT software have been provided by UNAIDS Geneva.

Quality Control

Data processing occurred in the field – the collected have been checked, cleaned and validated, before entry into the NASA Resource Tracking Tool (RTT). The field supervisors checked daily the capturing of all the transactions by all the data collectors. During data processing, we traced the transactions by cross-checking the data collected from multiple sources, agents and providers. This process has been designed to carefully and methodically eliminate any potential double-counting of resources and ensure that each transaction has all the vectors labelled correctly. Once collected, the data was entered into MS Excel and then exported to the NASA RTT once triangulated and verified. After data analysis, the findings were presented at a stakeholder meeting to validate the preliminary findings; this included a clear explanation of the methods applied, estimations, assumptions, missing data and other limitations, and how the results could be interpreted or used.

Data Analysis, Validation and Report Writing

This phase focused on data entry, analysis, triangulation and report writing – all to be undertaken by the research team, with strict quality control and internal validity checks by the team leaders and senior consultants. Data has been entered into MS Excel and then exported to the NASA RTT once triangulated and verified. We undertook the analysis and prepared the presentation of the preliminary findings, in PowerPoint initially during a stakeholder meeting which validated the preliminary findings after a presentation with a clear explanation of the methods applied, estimations, assumptions, missing data and other limitations. Thereafter, any omissions and errors have been addressed before drafting the technical report.
For quality assurance purposes, the draft report with data sets have been submitted to UNAIDS Geneva for midterm and final review before submission and clearance by national authorities.
An in-depth data cleaning and validation of the database have been required based on the DCT and the RTT respective databases.
The draft report has been submitted to the NAC, UNAIDS, the Core Steering Team, donors and other key actors for comments and suggestions.

II.5.2. Scope of NASA

The following are the parameters of the NASA:

- ✓ Calendar years: 2019, 2020, 2021.
- ✓ HIV and TB/HIV Coinfection interventions.
- ✓ Financial sources included: public, external, private (businesses and not-for-profit).
- ✓ Level of the assessment: national and sub-national.
- ✓ All the variables have been collected referring to the NASA methodology of 2019 as outlined above.

II.5.3. Assumptions and limitations

- The Ministry of Health changed their approach for planning, beginning from the year 2020, from an activity-based approach to an output-based approach. The output-based approach aggregates costs at a much higher level, and disaggregated data by intervention, activity, production factor, etc. This information can only be obtained at district level where the activities actually take place. It was not possible to visit the 116 districts, and attempting to obtain information remotely has yielded a very low response rate in the past. This issue was unknown and therefore not taken into account during the planning phase, resulting in a lack of resources to sample districts around the

country. However, an attempt was made to sample some districts in the Southern Province (though not representative for the country), but the MoH was undergoing two audits at the time and the data, though promised, has never been received. Faced with this scenario, MoH expenditure for 2020 and 2021 was estimated by applying the ratio of HIV spending against total expenditure for the year 2017. 2019 was ignored, as the MoH experienced uncharacteristically lower expenditure in that year. The detailed calculations for these estimated are attached in a separate Excel file.

-
- An estimation of the Ministry of Health's human resource costs incurred in delivering integrated HIV services, but which are not specifically labelled as HIV, was included based on the same criteria applied in the previous NASA. For this estimation, the MOH suggested that 9% of their annual salary bill be attributed to HIV, based on the SHA allocative key. The detailed calculations are attached in the Excel file.
-
- The general approach used for data collection was to collect data directly from the source as far as possible, rather than from the implementers providing services directly to beneficiaries. For example, Global Fund expenditure was obtained directly from the two Global Fund Principal Recipients, and United States Government (USG) spending was obtained from PEPFAR directly. Any data obtained from implementers who were receiving funds from such sources were excluded to avoid double counting.
-
- PEPFAR data was downloaded from their Panorama website and cross-walked to NASA classifications. The data did not indicate their implementing partners, and therefore all the USG funds had to be classified under one service provider category (PS.99) which meant that they could not be specifically identified. Where the services were provided through Government facilities, the FAP was assumed to be the GRZ. The SDM was determined by the nature of the intervention (ASC) and the beneficiary population.
-
- Similarly, Global Fund implementers were not indicated and classified under one service provider category.
-
- Where details were not available on the beneficiaries of programme spending, the most obvious classification was selected, based on the Aids Spending Categories. For example, administration costs of other organisations were assumed to be non-targeted; M&E activities were assumed to be non-targeted interventions; training received by health workers (trained health workers, peer educators, opinion leaders, etc.) was assumed to benefit the beneficiary population that receives the services that health workers were trained on, mostly PLHIV, unless the training related to above-site HR.
-
- Expenditure data was provided and collected either in ZMW or USD by stakeholders. The following Bank of Zambia annual average exchange rates were applied to all currency conversions so that all figures could be presented in USD.
-

Average Exchange Rates for the Financial Years	2019	2020	2021
US$1.00	ZMW 12.8900	ZMW 18.3441	ZMW 20.0185

III. Main findings of NASA 2019-2021 and Analysis

III.1. Financial flows related to HIV and AIDS response in Zambia, 2019-2021

The financial flows of funds from source to providers for ZAMBIA are illustrated in figure 14, 15 and 16, respectively.

Figure 14: Financial flows (2019)

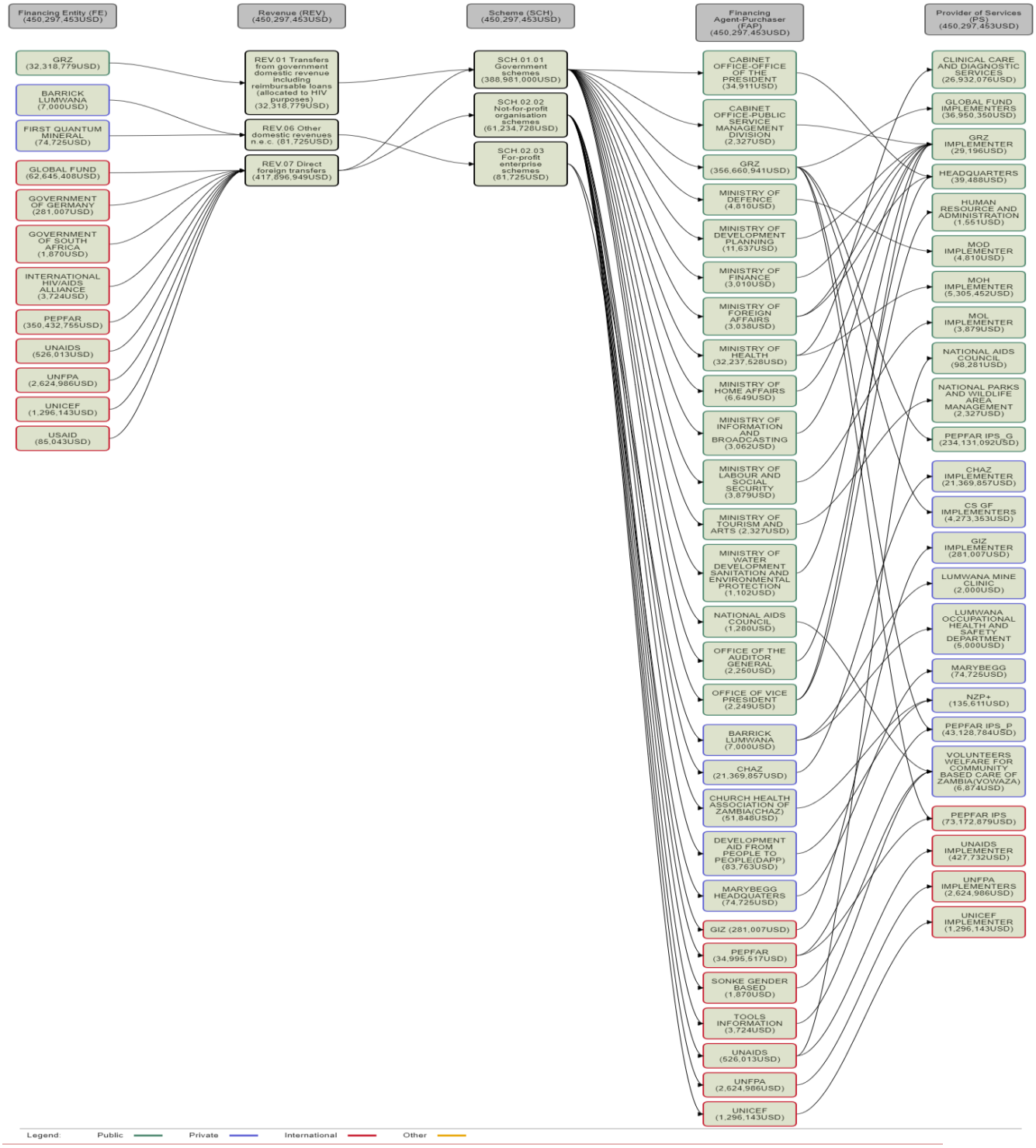


Figure 15: Financial flows (2020)

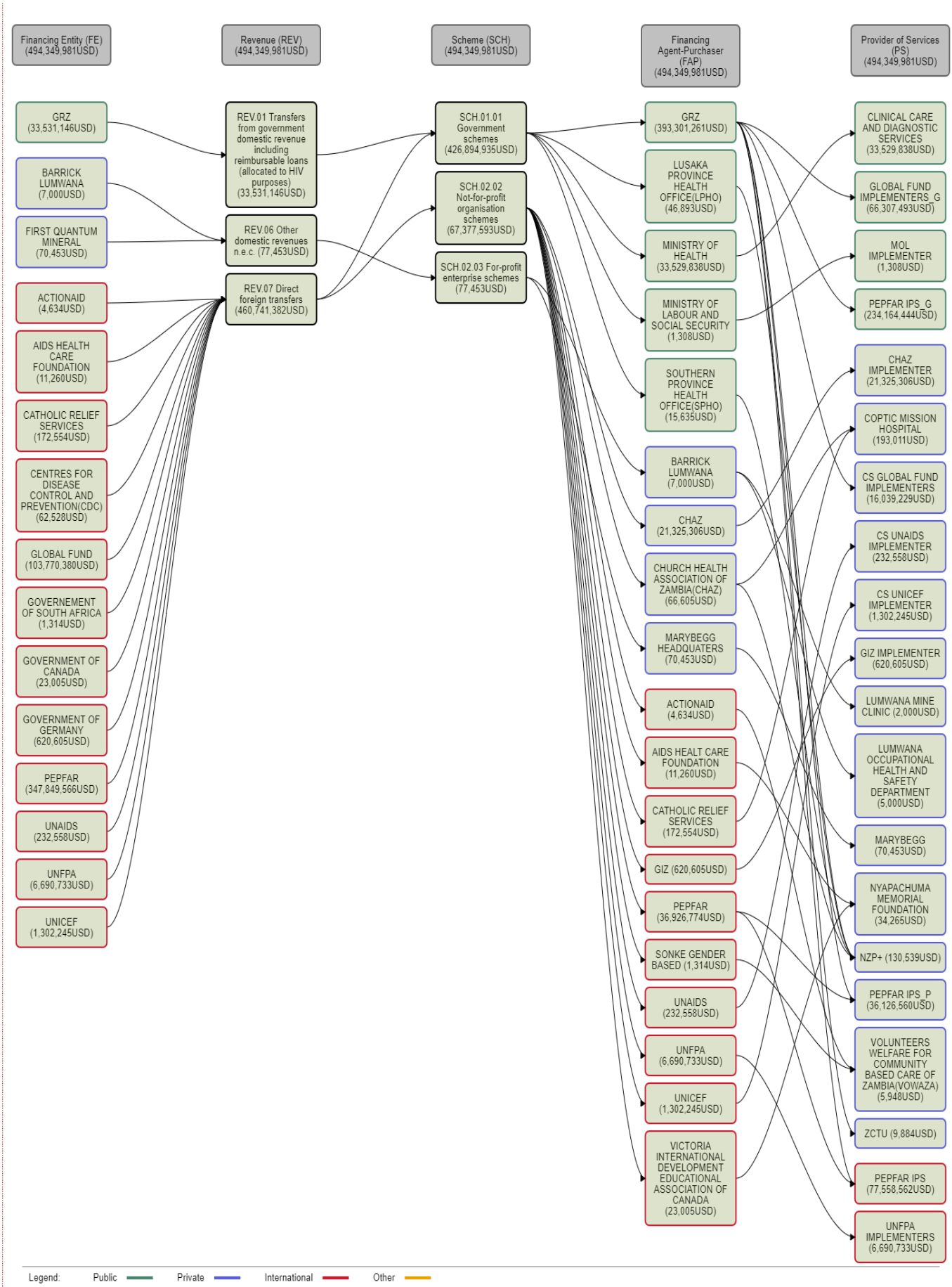
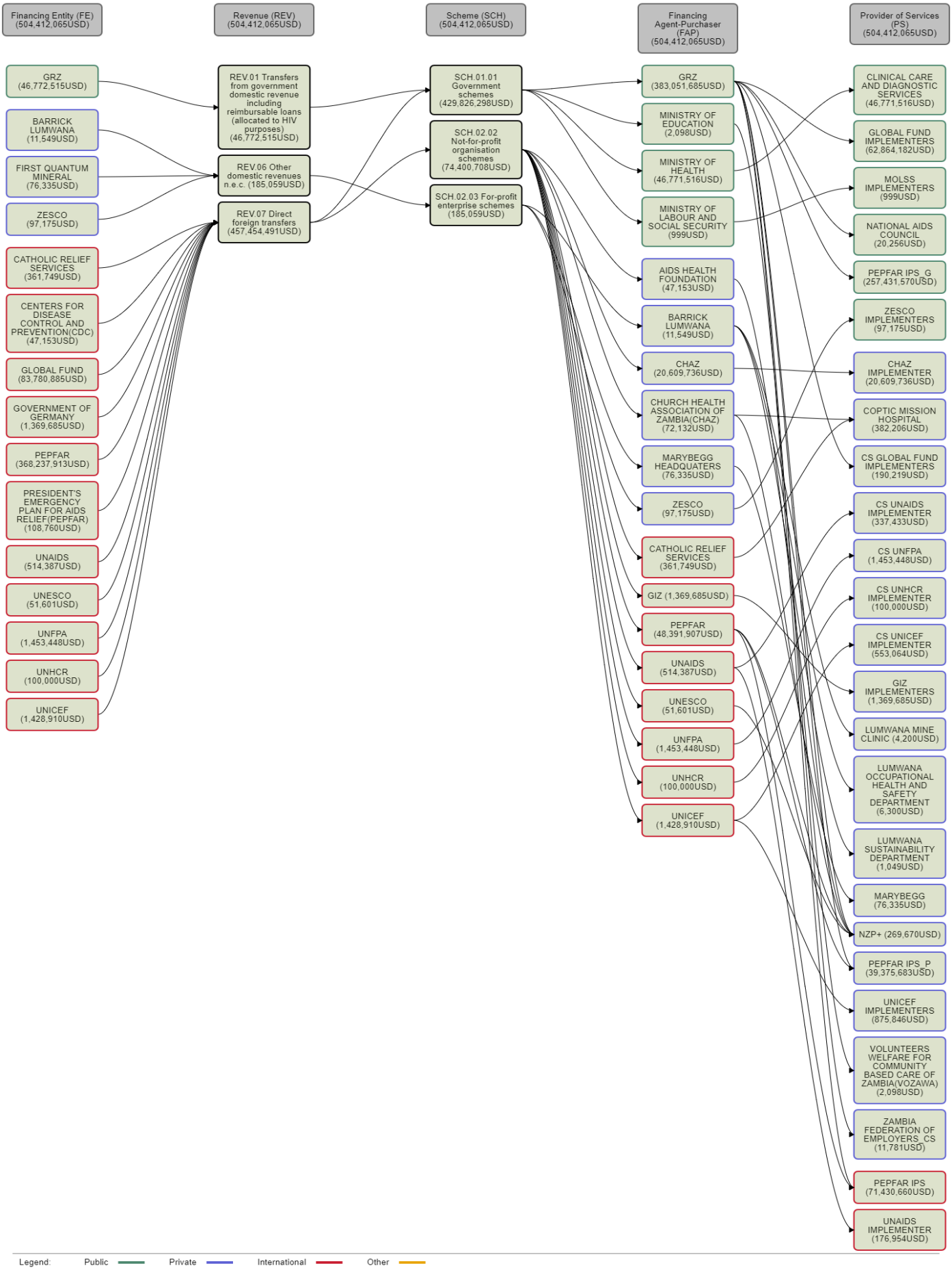


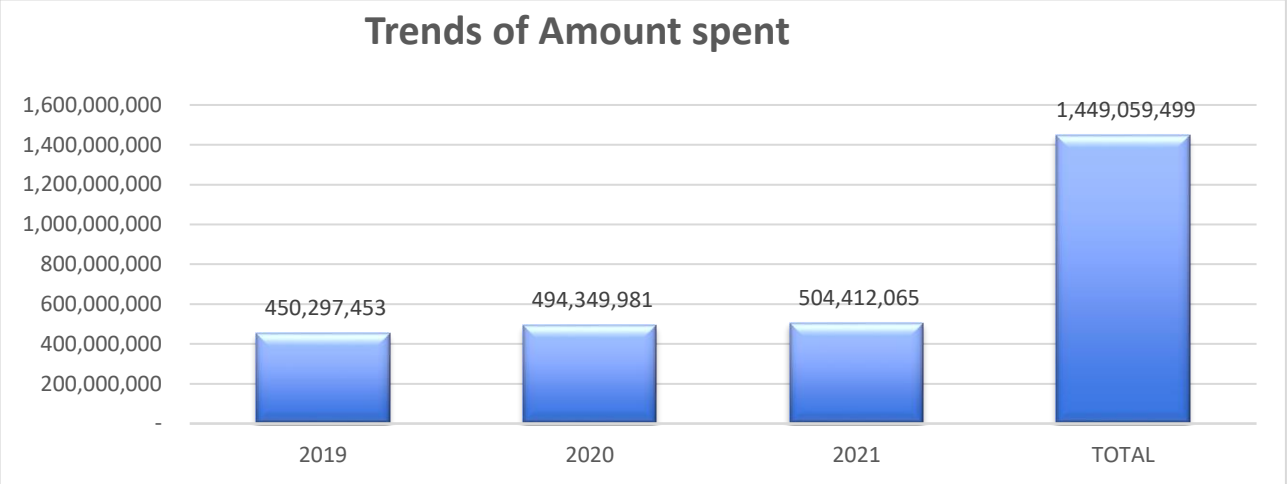
Figure 16: Financial flows (2021)



III.2. Main findings of the nasa study in zambia (2019-2021)

III.2.1. Total HIV and AIDS spending in Zambia, *2019 – 2021*

Figure 17: Trends in HIV and AIDS spending in Zambia, 2019 – 2021

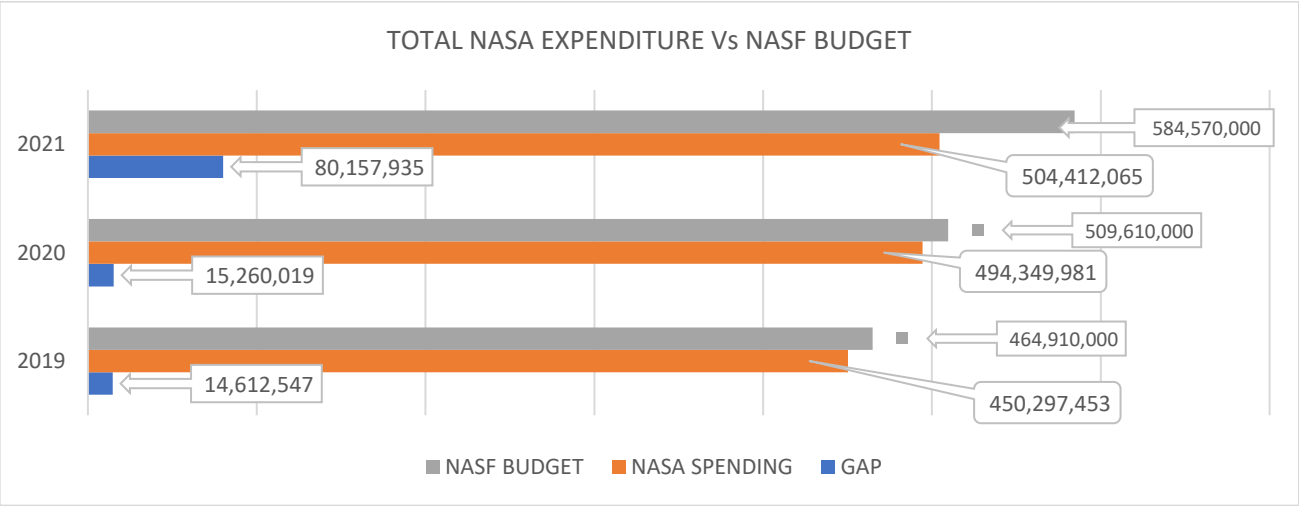


During the period of this NASA study (2019 to 2021), the total expenditure for the fight against HIV/AIDS amounts to US$ 1 449 059 499. The results show that total expenditure on HIV and AIDS interventions in Zambia increased moderately from US$450 297 453 in 2019, US$ 494 349 981 in 2020 and US$ 504 412 065 in 2021, representing an increase of 10 % between 2019 and 2020 and only 2% between 2020 and 2021. The increase rate between 2019 and 2021 was 12%.

III.2.2. Total HIV and AIDS spending in Zambia compared to NSAF budget, *2019 – 2021*

AIDS spending was estimated at US$450 297 453 in 2019, US$494 349 981 in 2020 and US$ 504 412 065 in 2021 while during the same period the NASF budget was US$ 464 910 000, US$ 509 610 000 and US$ 584 570 000 as illustrated in the below figure:

Figure 18: Total NASA expenditure compared to NASF budget



The NASA expenditure for the 3 years compared to NASF budget shows that the financing gap is reduced in 2019 and 2020, it becomes significant in 2021. In 2019 and 2020, the gap was **3%** of NASF budget, but in 2021 the gap rose to **14%** of NASF budget. With these figures, if the NASF budget is well estimated, we can safely say that the mobilization of financing in Zambia was at a good level in 2019 and 2020 but in 2021, efforts should be made in the mobilization of financing because the gap became significant.

III.2.3. HIV & AIDS Financing

III.2.3.1. Financing entities (FE) spending

Analysis of total funding

The following table shows that funding for the fight against HIV/AIDS was mainly provided by the US Government **(74%)** followed by the Global Fund **(17%),** the Government of Zambia **(8%)**, UNFPA (**1 %**) and other international and national donors **(1%).**

Table 4: HIV/AIDS Financing entities (FE) spending breakdown (2019-2021)

FINANCING ENTITIES (FE)	2019	%	2020	%	2021	%	TOTAL	%
FE010101 Central government	32 318 779	7.18%	33 531 146	6.78%	46 772 515	9.27%	112 622 440	7.77%
FE0201 Domestic corporations	81 725	0.02%	77 453	0.02%	185 059	0.04%	344 237	0.02%
FE030105 Government of Canada	-	0.00%	23 005	0.00%	-	0.00%	23 005	0.00%
FE030109 Government of Germany	281 007	0.06%	620 605	0.13%	1 369 685	0.27%	2 271 297	0.16%
FE030124 Government of South Africa	1 870	0.00%	1 314	0.00%	-	0.00%	3 184	0.00%
FE030130 Government of United States	350 517 798	77.84%	347 912 094	70.38%	368 393 826	73.03%	1 066 823 718	73.62%
FE030207 The Global Fund to Fight AIDS. Tuberculosis and Malaria	62 645 408	13.91%	103 770 380	20.99%	83 830 885	16.62%	250 246 673	17.27%
FE030208 UNAIDS Secretariat	526 013	0.12%	232 558	0.05%	514 387	0.10%	1 272 958	0.09%
FE030209 United Nations Children's Fund (UNICEF)	1 296 143	0.29%	1 302 245	0.26%	1 428 910	0.28%	4 027 298	0.28%
FE030212 United Nations Educational, Scientific and Cultural Organization (UNESCO)	-	0.00%	-	0.00%	51 601	0.01%	51 601	0.00%
FE030213 United Nations High Commissioner for Refugees (UNHCR)	-	0.00%	-	0.00%	50 000	0.01%	50 000	0.00%
FE030217 United Nations Population Fund (UNFPA)	2 624 986	0.58%	6 690 733	1.35%	1 453 448	0.29%	10 769 167	0.74%
FE030301 International HIV/AIDS Alliance	3 724	0.00%	-	0.00%	-	0.00%	3 724	0.00%
FE030302 ActionAID	-	0.00%	4 634	0.00%	-	0.00%	4 634	0.00%
FE030309 Caritas Internationalis/Catholic Relief Services	-	0.00%	172 554	0.03%	361 749	0.07%	534 303	0.04%
FE030399 Other International not-for-profit organizations and foundations nec	-	0.00%	11 260	0.00%	-	0.00%	11 260	0.00%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

III.2.3.1.1. Financing entities (FE) spending: International Vs local Entities (2019-2021)

Table 5: Breakdown of Financing entities (FE) spending: International Vs domestic Entities (2019-2021)

FINANCING ENTITIES	2019	%	2020	%	2021	%	TOTAL	%
International Sources	417 896 949	92.80%	460 741 382	93.20%	457 454 491	90.69%	1 336 092 822	92.20%
Government	32 318 779	7.18%	33 531 146	6.78%	46 772 515	9.27%	112 622 440	7.77%
Domestic corporations	81 725	0.02%	77 453	0.02%	185 059	0.04%	344 237	0.02%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total funding (2019-2021)

Analysis of the data in the above table clearly shows that the response to HIV/AIDS was mainly funded during the period from 2019 to 2021 by international entities at **92%**. The national contribution in the financing is **8%** including the financing of the Government at the rate of **7.77%** and the private sector at the rate of **0.02%**

Analysis of trends by financing source

In 2020, spending on international financing increased by **10%** and domestic funding increased by **4%.** In 2021, expenses of international financing decreased by **1%** and domestic funding increased by **40%**. Between 2019 and 2021, Spending on international funding increased by **9%** when spending on domestic funding increased by **45%**.

Analysis of shares in annual spending

In 2019, the shares in total expenditure show that international funding represented 93% and local funding represented 7%.

In 2020, the shares in total expenditure show that international funding represented 93% and local funding represented 7%.

In 2021, the shares in total expenditure show that international funding represented 91% and local funding represented 9%.

The figure below illustrates this analysis:

Figure 19: Breakdown of funding (international/national)

Figure 19.a: Total spending (2019-2021)

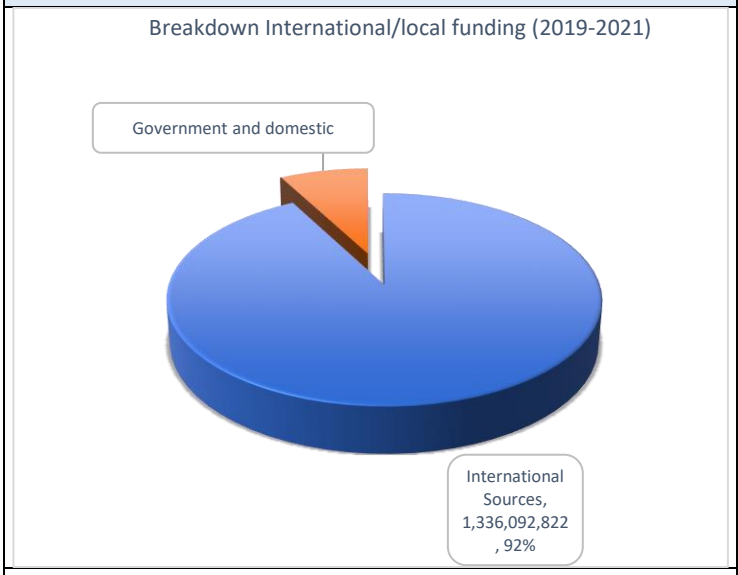


Figure 19.b: Year 2019

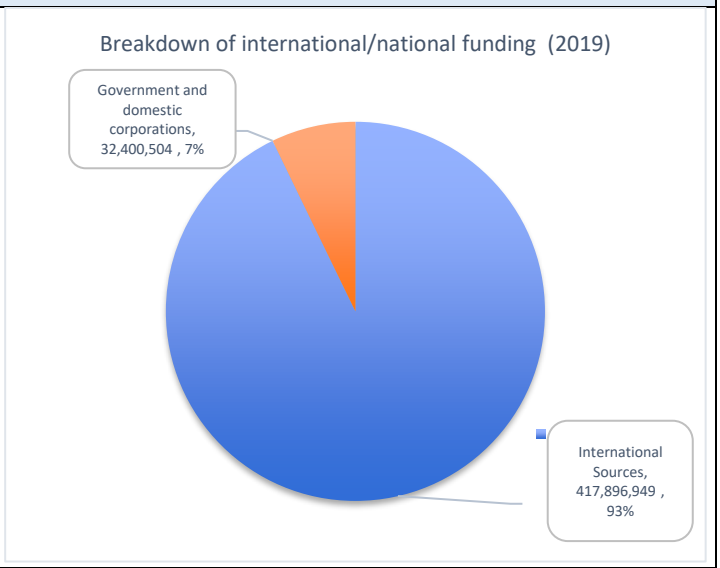


Figure 19.c: Year 2020

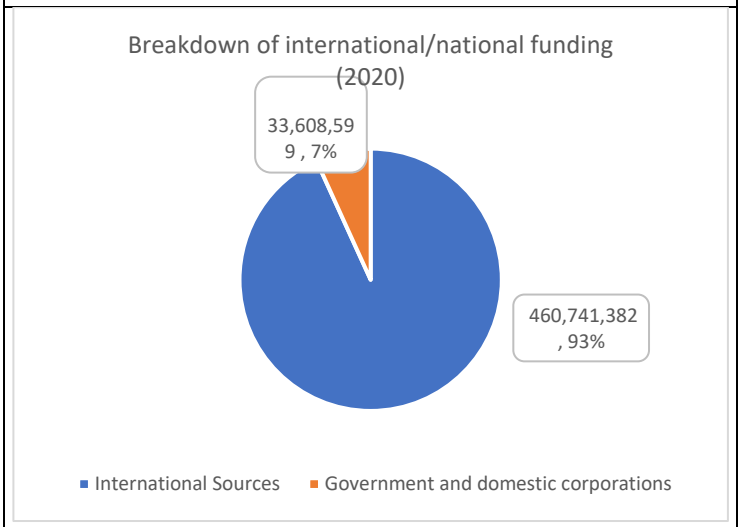
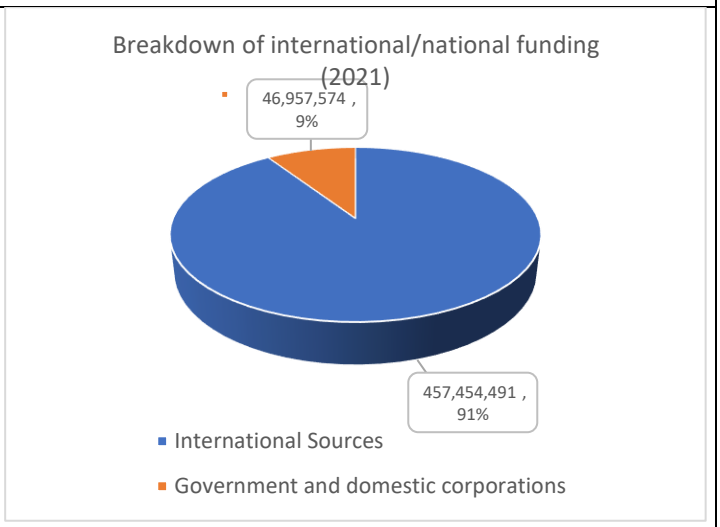


Figure 19.d: Year 2021



IV.2.3.1.2. Breakdown of external financing

Table 6: Breakdown of external Financing entities spending (2019-2021)

INTERNATIONAL FINANCING	2019	%	2020	%	2021	%	TOTAL	%
Government of United States	350 517 798	83.88%	347 912 094	75.51%	368 393 826	80.53%	1 066 823 718	79.85%
The Global Fund to Fight AIDS. Tuberculosis and Malaria	62 645 408	14.99%	103 770 380	22.52%	83 830 885	18.33%	250 246 673	18.73%
United Nations Population Fund (UNFPA)	2 624 986	0.63%	6 690 733	1.45%	1 453 448	0.32%	10 769 167	0.81%
Other external partners	2 108 757	0.50%	2 363 541	0.51%	3 776 332	0.83%	8 248 630	0.62%
TOTAL	417 896 949	100%	460 736 748	100%	457 454 491	100%	1 336 088 188	100.00%

Analysis of total spending (2019-2021)

External funding for the response includes funds from bilateral, the Global Fund, the United Nations and other international organizations. During the period from 2019 to 2021, the main external donor was the United States Government (**80**% of external funding) followed by the Global Fund to Fight AIDS, Malaria and Tuberculosis (**19**% of external funding). UNFPA and other external partners accounted for **1**% of shares (including **0.81**% for UNFPA and **0.62**% for other external partners)**.**

Analysis of trends by type of external financing

Between 2019 and 2020, spending on total external financing increased by **10**%. Between 2020 and2021, expenses decreased by **1**%. Between 2019 and 2021, spending increased by **9**%.

Between 2019 and 2020, expenditure from the Government of the United States of America funding decreased by **1**%. Between 2020 and 2021, expenses increased by **6**%. Between 2019 and 2021, the increase in spending on American funding increased by **5**%.

Between 2019 and 2020, spending on Global Fund financing increased by **66**%. Between 2020 and 2021, there was a **19**% decrease and between 2019 and 2021, the increase in spending on GF funding was **34**%.

Between 2019 and 2020, spending on UNFPA financing increased by **155**%. Between 2020 and 2021, there was a **78**% decrease and between 2019 and 2021, a decrease in spending on UNFPA funding was **45**%.

Between 2019 and 2020, spending on Other external partners financing increased by **12**%. Between 2020 and 2021, there was a **60**% increase and between 2019 and 2021, an increase in spending on Other external partners funding was **79**%.

Analysis of shares in annual spending

In 2019, the shares in external financing show that the US Government represents **84**% of the shares, the GF represents **15**% of the shares, UNFPA and other external partners accounted for **1**% of shares (including **0.63**% for UNFPA and **0.50**% for other external partners)**.**

In 2020, the shares in external financing show that the US Government represents **75**% of the shares, the GF represents **23**% of the shares, UNFPA and other external partners accounted for **2**% of shares (including **1.45**% for UNFPA and **0.51**% for other external partners)**.**

In 2021, the shares in external financing show that the US Government represents **81**% of the shares, the GF represents **18**% of the shares, and the other partners represent **1**% of the shares (including **0.32**% for UNFPA and **0.83**% for other external partners)**.**
The figure below illustrates this analysis:

Figure 20: Breakdown of funding by types of international partners (2019, 2020 and 2021)

Figure 20.a: Total spending (2019-2021)

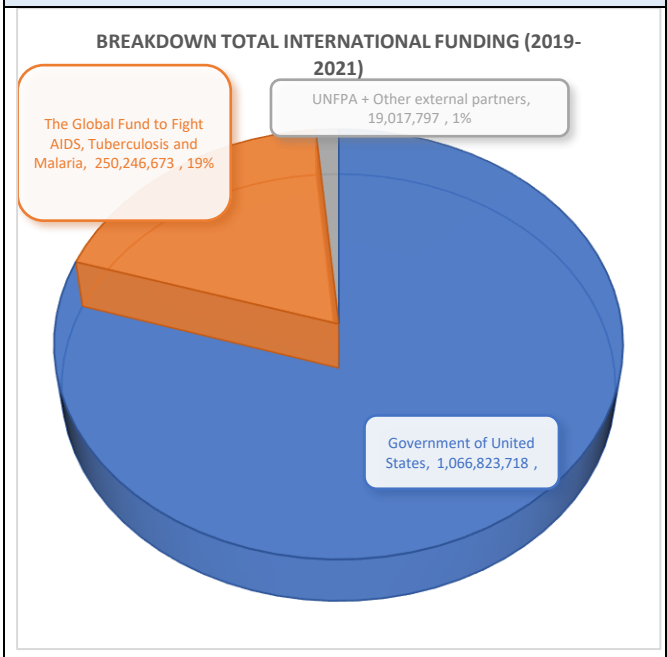


Figure 20.b: Year 2019 spending

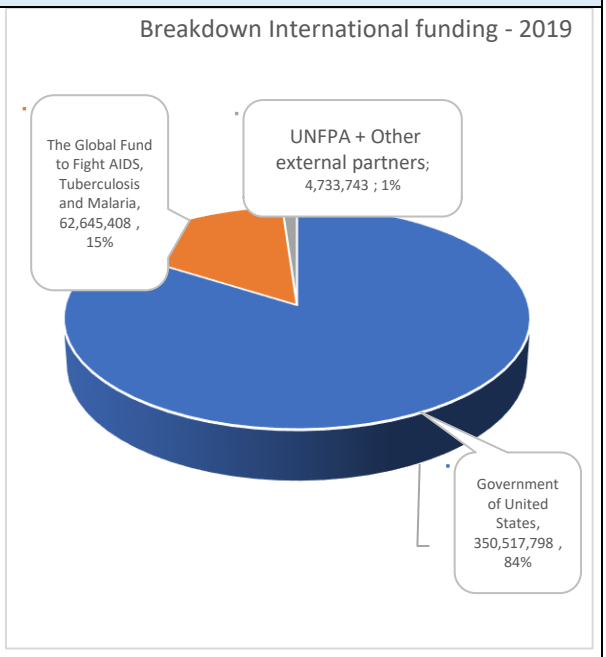


Figure 20.c: Year 2020 spending

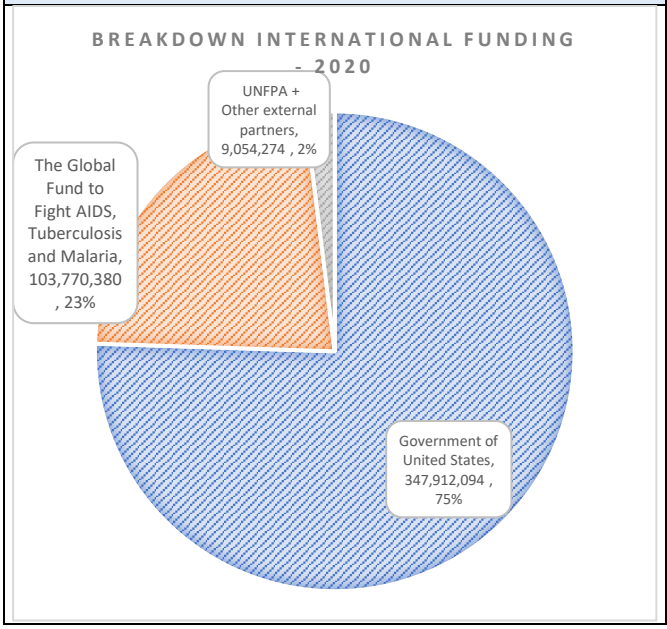
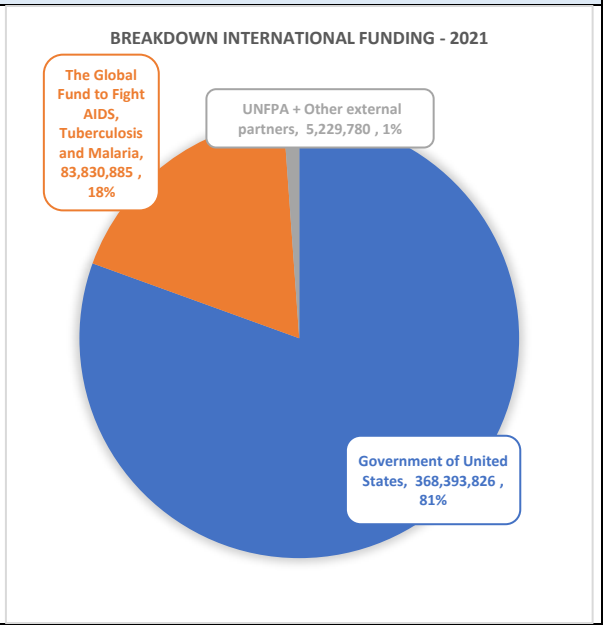


Figure 20.d: Year 2021 spending



III.2.3.2. HIV & AIDS revenues spending

NASA provides classifications on how the funds are pooled from the financing entities/sources. Although the financial flow is between the economic agents (FE, FAP and PS), resource tracking allows us to identify what type of pools/resources are transferred and how the financing mechanism is organized for guaranteeing access, according to the legal provisions in force in the country. Examples of such pools/resources include: transfers from government domestic revenue including reimbursable loans allocated to HIV purposes (REV.01); transfers distributed by government from foreign origin (REV.02); social insurance contributions (REV.03), direct foreign transfers (REV.07) etc. (see Table 1.b, Annex 1 for REV classifications).

Table 7: Breakdown of revenue spending (2019-2020)

REVENUES (REV)	2019	%	2020	%	2021	%	TOTAL	%
REV.01.01 Internal transfers and grants	32 318 779	7.18%	33 531 146	6.78%	46 772 515	9.27%	112 622 440	7.77%
REV.06.02 Other revenues from corporations n.e.c.	81 725	0.02%	77 453	0.02%	185 059	0.04%	344 237	0.02%
REV.07.01.01 Direct bilateral financial transfers	350 800 675	77.90%	348 557 018	70.51%	369 763 511	73.31%	1 069 121 204	73.78%
REV.07.01.02 Direct multilateral financial transfers	67 092 550	14.90%	112 184 364	22.69%	87 690 980	17.38%	266 967 894	18.42%
REV.07.99 Other direct foreign transfers n.e.c.	3 724	0.00%	0	0.00%	0	0.00%	3 724	0.00%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, direct bilateral financial transfers entities accounted for the highest proportion of HIV and AIDS financing **(74%),** followed by direct multilateral financial transfers **(18%)** and internal transfers and grants **(8%).** Other classifications represent **0.02%** of shares.

Analysis of trends by type of revenue

In 2020, direct bilateral financial transfers decreased by **1%**. In 2021, expenses increased by **6%** and between 2019 and 2021, the increase in spending for direct financial transfers was **5%**.
In 2020, spending on Direct multilateral financial transfers increased by **67%**. In 2021, there was a **22%** decrease and between 2019 and 2021, the increase in spending on direct multilateral financial transfers was **31%**.
In 2020, spending on Internal transfers and grants increased by **4%**. In 2021, there was a **39%** increase and between 2019 and 2021, the increase in spending on Internal transfers and grants was **45%**.

Analysis of shares in annual spending

In 2019, the shares in revenues financing show that Direct bilateral financial transfers represent **78%** of shares followed by Direct multilateral financial transfers with **15%** of shares and Internal transfers and grants with **7%** of shares. Other classifications represent **0.02%** of shares.

In 2020, the shares in revenues financing show that Direct bilateral financial transfers represent **70%** of the shares followed by Direct multilateral financial transfers with **23%** of shares and Internal transfers and grants with **7%** of shares. Other classifications represent **0.02%** of shares.

In 2021, the shares in revenues financing show that Direct bilateral financial transfers represent **73%** of the shares followed by Direct multilateral financial transfers with **17%** of shares and Internal transfers and grants with **9%** of shares. Other classifications represent **0.04%** of shares.
The figure below illustrates this analysis:

Figure 21: Breakdown of revenue spending

Figure 21.a: Total spending (2019-2021)

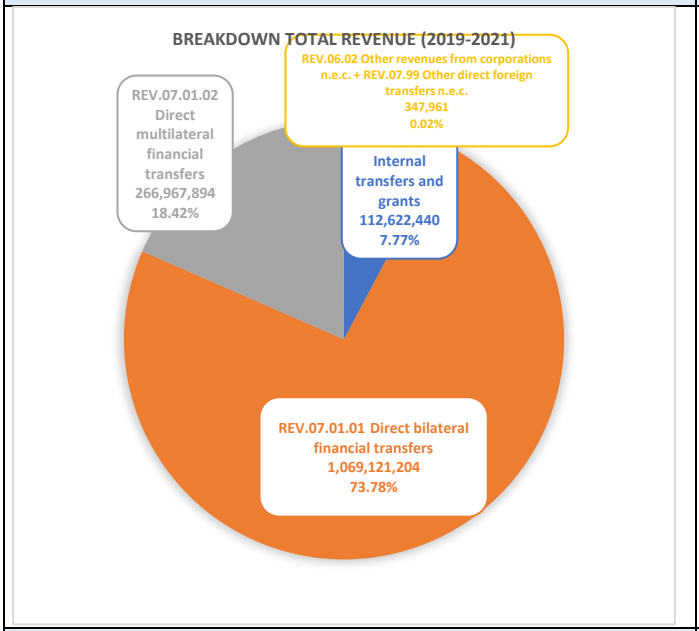


Figure 21.b: Year 2019

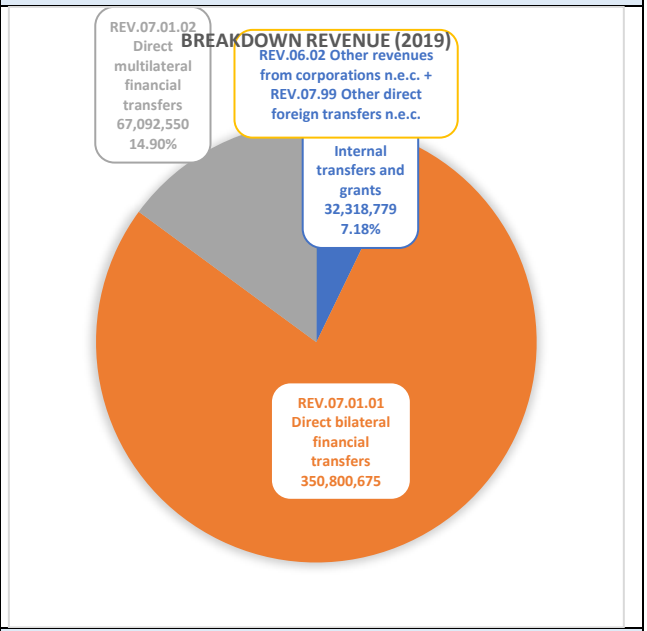


Figure 21.c: Year 2020

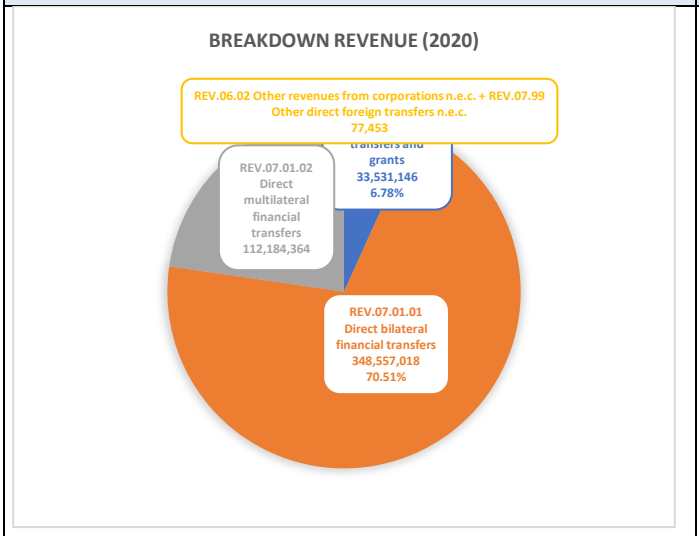
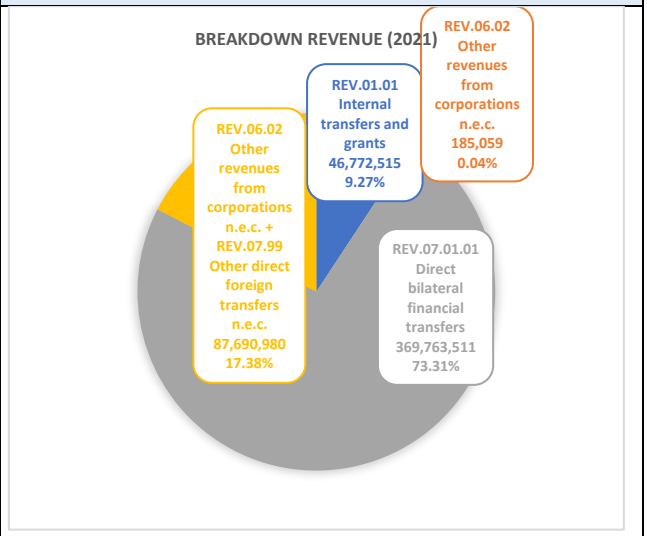


Figure 21.d: Year 2021



III.2.3.3. HIV & AIDS financing Schemes spending

NASA classifies the schemes from which HIV & AIDS expenditures come from. Financing Schemes (SCH) are financing modalities through which the population has access to HIV & AIDS goods and services. SCHs mobilize and allocate resources within the system to satisfy the needs of individuals and collective populations, both current and future. They are a set of rules or laws that regulate the modality of participation, the right to access health services and how to obtain and pool resources. Financing schemes are classified according to the following criteria: mode of participation, benefit entitlement, basic method for fund-raising and pooling. SCHs include direct payments by households for services and goods and third-party financing arrangements. An example of the third party scheme is where the services are provided for free at the health facility but certain organizations have paid for the services e.g. the government or any international organization.

Table 8: Breakdown of Schemes spending (2019-2021)

SCHEMES	2019	%	2020	%	2021	%	TOTAL	%
SCH.01.01.01 Central government schemes	388 981 000	86.38%	426 894 935	86.35%	429 826 298	85.21%	1 245 702 233	85.97%
SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.02.02.02)	21 509 192	4.78%	21 429 550	4.33%	21 251 131	4.21%	64 189 873	4.43%
SCH.02.02.02 Resident foreign agencies schemes	39 725 536	8.82%	45 948 043	9.29%	53 149 577	10.54%	138 823 156	9.58%
SCH.02.03.99 For-profit enterprises not elsewhere classified (n.e.c.)	81 725	0.02%	77 453	0.02%	185 059	0.04%	344 237	0.02%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, Central government schemes were the most used **(86%),** followed by Resident foreign agencies schemes **(10%).** The third largest scheme used was Not-for-profit organisation **(4%).** For-profit enterprises not elsewhere classified accounted for **0.02%** of shares (see figure 22.a).

Analysis of trends by type of Scheme

In 2020, spending on Central government schemes increased by **10%.** In 2021, expenses increased by **1%** and between 2019 and 2021, the increase in spending for Resident Central government schemes was **11%.**

In 2020, spending on Resident foreign agencies schemes increased by **16%.** In 2021, there was a **16%** increase and between 2019 and 2021, the increase in spending on Resident foreign agencies schemes was **34%.**

In 2020, spending on Not-for-profit organisation schemes didn't increase. In 2021, expenses decreased by **1%** and between 2019 and 2021, the decrease in spending for Not-for-profit organisation schemes was **1%.**

In 2020, spending on For-profit enterprises not elsewhere classified decreased by **5%.** In 2021, there was a **139%** increase and between 2019 and 2021, the increase in spending on For-profit enterprises not elsewhere classified schemes was **126%.**

Analysis of shares in annual spending

In 2019, the shares in financing schemes show that Central government schemes represent **86%** of the shares followed by Resident Foreign agencies schemes with **9%.** The third largest scheme was Not-for-profit organisation with **5%** of shares and For-profit enterprises not elsewhere classified accounted for **0.02% (see figure 22.b).**

In 2020, the shares in financing schemes show that Central government schemes represent **86%** of the shares followed by Resident Foreign agencies schemes with **9%.** The third largest scheme was Not-for-profit organisation with **5%** of shares and For-profit enterprises not elsewhere classified accounted for **0.02% (see figure 22.c).**

In 2021, the shares in financing schemes show that Central government schemes represent **85%** of the shares followed by Resident Foreign agencies schemes with **11%.** The third largest scheme was Not-for-profit organisation with **4%** of shares and For-profit enterprises not elsewhere classified accounted for **0.04% (see figure 22.d).**

The figure below illustrates this analysis:

Figure 22: Breakdown of Schemes spending

Figure 22.a: Total spending (2019-2021)

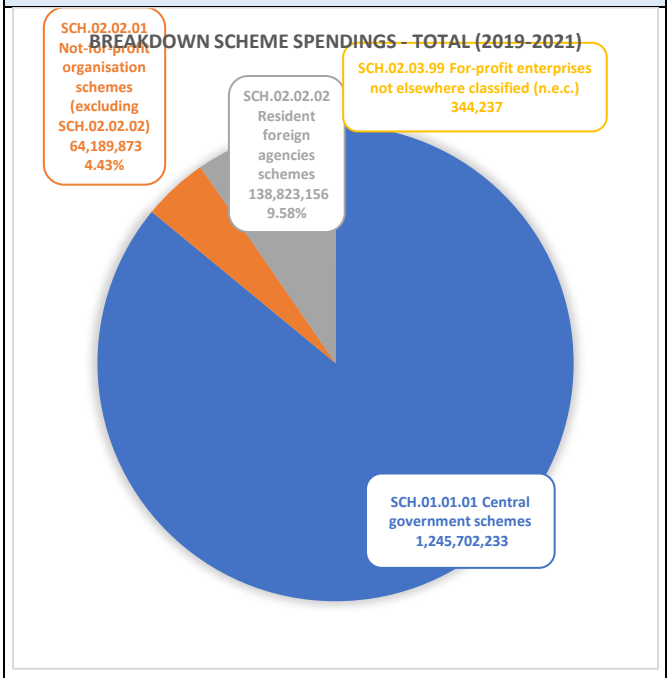


Figure 22.b: Year 2019

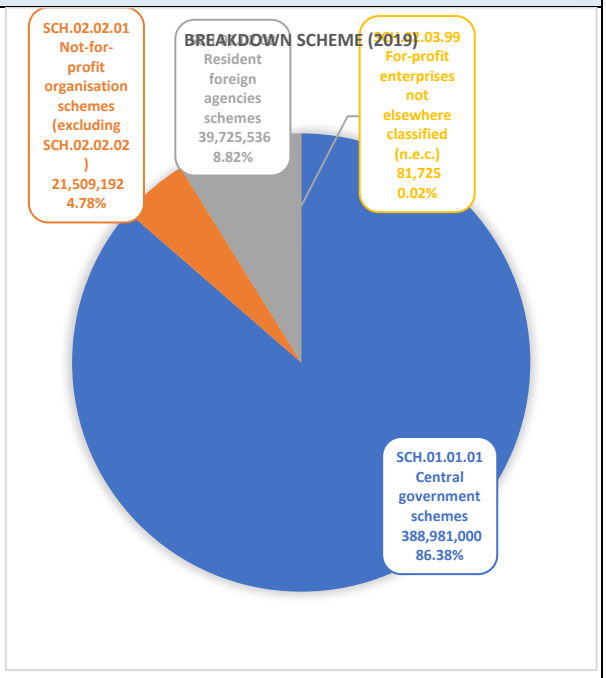


Figure 6.c: Year 2020

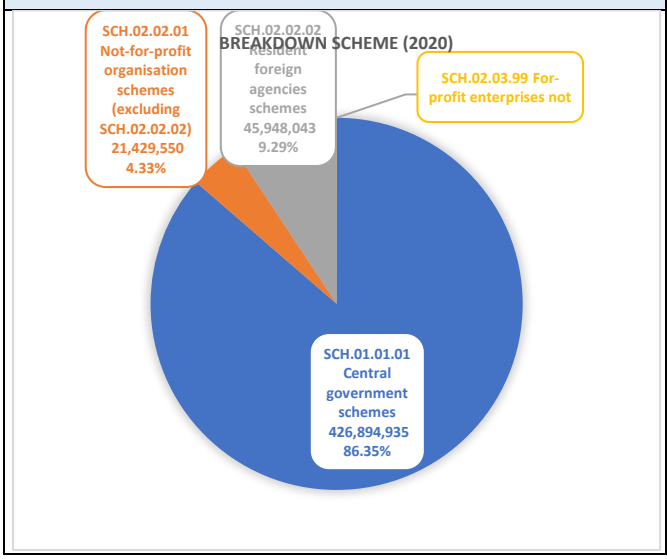
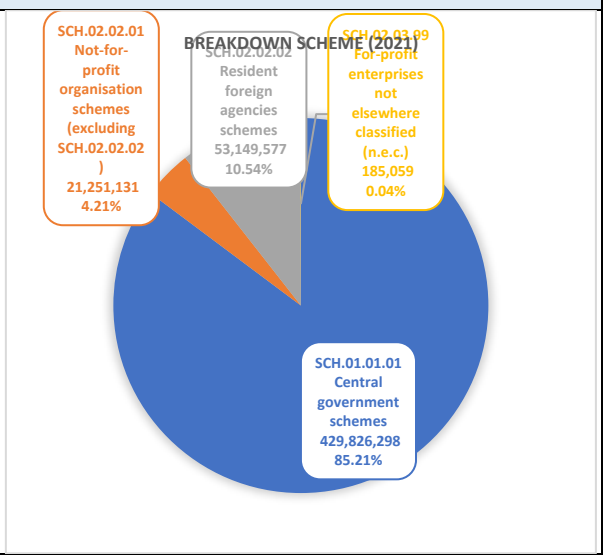


Figure 6.d: Year 2021



III.2.3.4. HIV & AIDS Financing Agents – Purchasers spending

A health-care financing agent or purchaser is an institutional unit that mobilizes and pools funds and makes decisions to allocate and make payments to providers for the services rendered. Financing agents are mainly involved in the management of one or more financing schemes.

Table 9: Financing Agent-Purchaser spending breakdown (2019-2021)

Financing Agent Purchaser	2019	%	2020	%	2021	%	TOTAL	%
FAP.01.01.01.01 Ministry of Health (or equivalent sector entity)	388 898 469	86.36%	426 893 627	86.35%	429 823 201	85.21%	1 245 615 297	85.96%
FAP.01.01.01.02 Ministry of Education (or equivalent sector entity)	-	0.00%		0.00%	2 098	0.00%	2 098	0.00%
FAP.01.01.01.04 Ministry of Defence (or equivalent sector entity)	4 810	0.00%		0.00%		0.00%	4 810	0.00%
FAP.01.01.01.05 Ministry of Finance (or equivalent sector entity)	3 010	0.00%		0.00%		0.00%	3 010	0.00%
FAP.01.01.01.06 Ministry of Labour (or equivalent sector entity)	3 879	0.00%	1 308	0.00%	999	0.00%	6 186	0.00%
FAP.01.01.01.08 Other ministries (or equivalent sector entities)	69 552	0.02%		0.00%		0.00%	69 552	0.00%
FAP.01.01.01.10 National AIDS Commission	1 280	0.00%		0.00%		0.00%	1 280	0.00%
FAP.02.05 Not-for-profit institutions (other than social insurance)	21 505 468	4.78%	21 391 911	4.33%	20 729 021	4.11%	63 626 400	4.39%
FAP.02.06 Corporations other than providers of health services (nonparastatal)	81 725	0.02%	77 453	0.02%	185 059	0.04%	344 237	0.02%
FAP.03.01 Country offices of bilateral agencies managing external resources and fulfilling financing agent roles	35 276 524	7.83%	37 547 379	7.60%	49 652 832	9.84%	122 476 735	8.45%
FAP.03.02.07 UNAIDS Secretariat	526 013	0.12%	232 558	0.05%	514 387	0.10%	1 272 958	0.09%
FAP.03.02.08 United Nations Children's Fund (UNICEF)	1 296 143	0.29%	1 302 245	0.26%	1 428 910	0.28%	4 027 298	0.28%
FAP.03.02.11 United Nations Educational, Scientific and Cultural Organization (UNESCO)	-	0.00%		0.00%	51 601	0.01%	51 601	0.00%
FAP.03.02.12 United Nations High Commissioner for Refugees (UNHCR)	-	0.00%		0.00%	100 000	0.02%	100 000	0.01%
FAP.03.02.16 United Nations Population Fund (UNFPA)	2 624 986	0.58%	6 690 733	1.35%	1 453 448	0.29%	10 769 167	0.74%
FAP.03.02.99 Other Multilateral entities n.e.c.	-	0.00%		0.00%	108 760	0.02%	108 760	0.01%
FAP.03.03.01 International HIV/AIDS Alliance	5 594	0.00%	1 314	0.00%		0.00%	6 908	0.00%
FAP.03.03.02 ActionAID	-	0.00%	4 634	0.00%		0.00%	4 634	0.00%
FAP.03.03.09 Caritas Internationalis/Catholic Relief Services	-	0.00%	172 554	0.03%		0.00%	172 554	0.01%
FAP.03.03.99 Other International not-for-profit organizations n.e.c.	-	0.00%	34 265	0.01%	361 749	0.07%	396 014	0.03%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, the analysis of expenditure by financing agent-purchaser type shows that the resources for funding the response to HIV/AIDS mainly have been managed by Public sector **(86%)** followed by International purchasing organizations **(10%)** and the private sector **(4%)** (see figure 23.a).

Analysis of trends by type of Financing Agent-Purchaser

In 2020, the funds managed by public sector increased by **9%.** In 2021, expenses increased by **1%** and between 2019 and 2021, spending increased by **11%.**

In 2020, the funds managed by International purchasing organizations increased by **16%.** In 2021, funds managed by this sector increased by **17%** and between 2019 and 2021, the funds managed by this sector increased by **35%.**

In 2020, the funds managed by private sector decreased by **1%.** In 2021, funds managed by this sector decreased by **3%** and between 2019 and 2021, the funds managed by this sector decreased by **3%.**

Analysis of shares in annual spending

In 2019, the shares show that funds managed by public sector represent **86%** of the shares followed by International purchasing organizations with **9%** of shares and Private sector with **5%** of shares (see figure 23.b).

In 2020, the shares show that funds managed by public sector represent **87%** of the shares followed by International purchasing organizations with **9%** of shares and Private sector with **4%** of shares (see figure 23.c).

In 2021, the shares show that funds managed by public sector represent **85%** of the shares followed by International purchasing organizations with **1%** of shares and Private sector with **4%** of shares (see figure 23.d).
The figure below illustrates this analysis:

Figure 23: Breakdown of spending by type of FAP

Figure 23.a: Total spending (2019-2021)

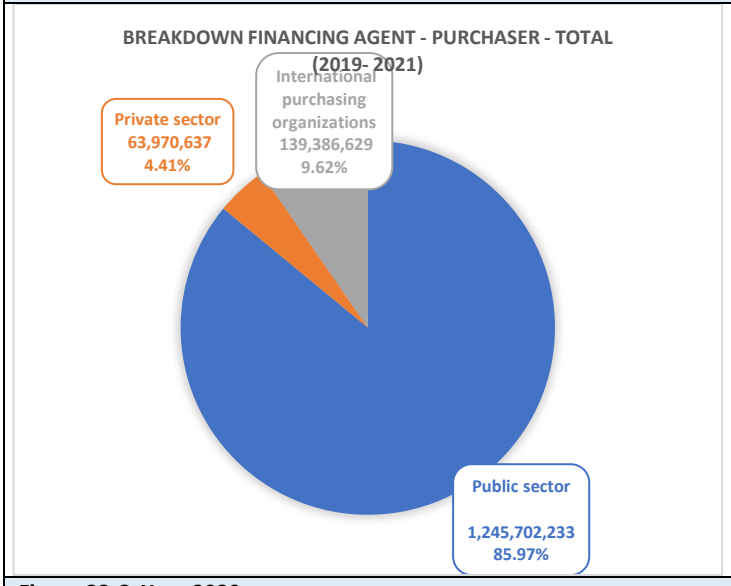


Figure 23.b: Year 2019

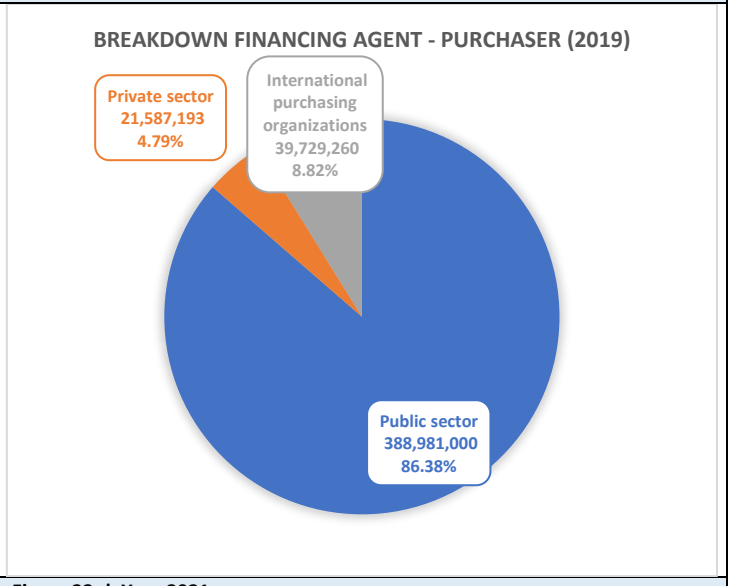
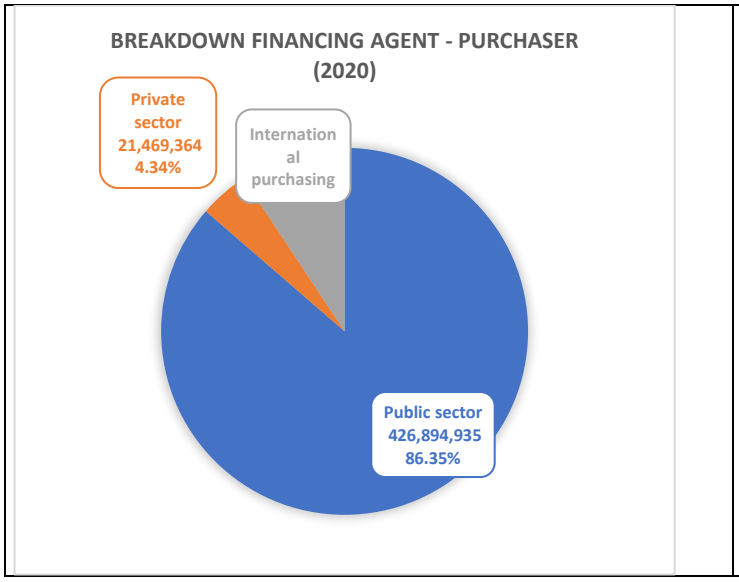
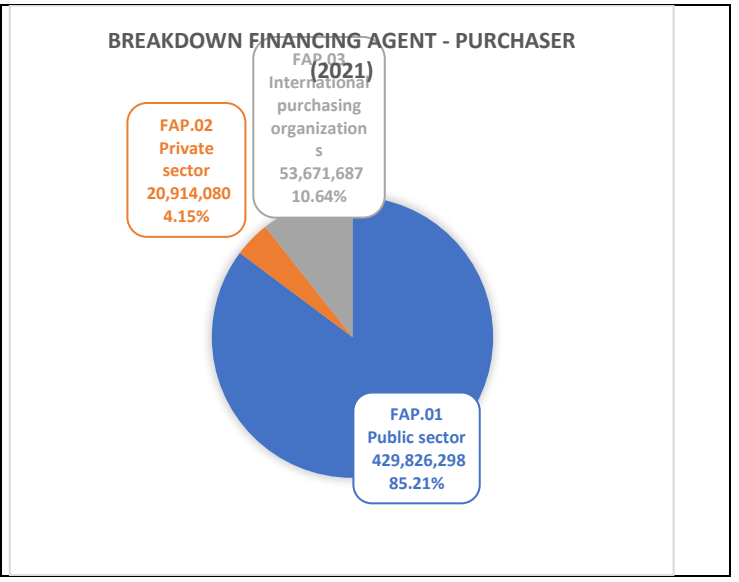


Figure 23.C: Year 2020

Figure 23.d: Year 2021





III.2.4. Provision of HIV & AIDS Services

III.2.4.1. Providers of services spending

Table 10 : Distribution of expenditure by type of service provider (2019-2021)

PROVIDERS OF SERVICES	2019	%	2020	%	2021	%	TOTAL	%
PS.01 Public sector providers	303 498 502	67.40%	334 003 083	67.56%	367 185 698	72.79%	1 004 687 283	69.33%
PS.01.01 Governmental organizations	303 460 617	67.39%	334 003 083	67.56%	367 088 523	72.78%	1 004 552 223	69.32%
PS.01.98 Public sector providers not disaggregated	37 885	0.01%		0.00%		0.00%	37 885	0.00%
PS.01.02 Parastatal organizations		0.00%		0.00%	97 175	0.02%	97 175	0.01%
PS.02 Private sector providers	69 277 211	15.38%	76 097 603	15.39%	65 618 753	13.01%	210 993 567	14.56%
PS.02.01 Non-profit providers	69 270 211	15.38%	76 090 603	15.39%	65 607 204	13.01%	210 968 018	14.56%
PS.02.02 Profit-making private sector providers	7 000	0.00%	7 000	0.00%	11 549	0.00%	25 549	0.00%
PS.03 Bilateral, multilateral entities, international NGOs and foundations – in country offices	77 521 740	17.22%	84 249 295	17.04%	71 607 614	14.20%	233 378 649	16.11%
PS.03.01 Bilateral agencies		0.00%		0.00%	176 954	0.04%	176 954	0.01%
PS.03.02 Multilateral agencies		0.00%	6 690 733	1.35%		0.00%	6 690 733	0.46%
PS.03.99 Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.	77 521 740	17.22%	77 558 562	15.69%	71 430 660	14.16%	226 510 962	15.63%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, the analysis of expenditure by type of entities who provided the goods and services show that mainly Public sector provided **69%** of shares followed by Bilateral, multilateral entities,

international NGOs and foundations with **16%** of shares and Private sector providers (Non-profit providers and Profit-making private sector providers) with **15%** of shares. (see figure 24.a)

As observed, very few resources were executed by civil society organizations compared to other actors. It is important to strengthen these organizations for a better contribution to the national HIV/AIDS response.

Analysis of trends by type of Service Provider

In 2020, the services provided by Public sector increased by **10%**. In 2021, spending on this type of providers increased by **10%** and between 2019 and 2021, expenditure increased by **21%**.

In 2020, the services provided by Bilateral, multilateral entities, international NGOs and foundations increased by **9%.** In 2021, spending on this type of providers decreased by **15%** and between 2019 and 2021, expenditure decreased by **8%**.

In 2020, the services provided by Private sector providers (Non-profit providers and Profit-making private sector providers) increased by **10%**. In 2021, spending on this type of providers decreased by **14%** and between 2019 and 2021, expenditure decreased by **5%**.

Analysis of shares in annual spending

In 2019, the shares show that services provided by Public sector took the largest share, at **67%** of shares followed by Bilateral, multilateral entities, international NGOs and foundations with **17%** of shares and Private sector providers (Non-profit providers and Profit-making private sector providers) with **15%** of shares. (see figure 24.b).

In 2020, the shares show that services provided by provided by Public sector took the largest share, at **68%** of shares followed by Bilateral, multilateral entities, international NGOs and foundations with **17%** of shares, Civil society organizations (private non-profit faith based) provided **15%** of shares. (see figure 24.c).

In 2021, the shares show that services provided by Public sector took the largest share, at **73%** of shares followed by Bilateral, multilateral entities, international NGOs and foundations with **14%** of shares, Private sector providers (Non-profit providers and Profit-making private sector providers) provided with **13%** of shares (see figure 24.d).

The figure below illustrates this analysis:

Figure 24: Shares in Providers of Services spending

Figure 24.a: Total spending (2019-2021)

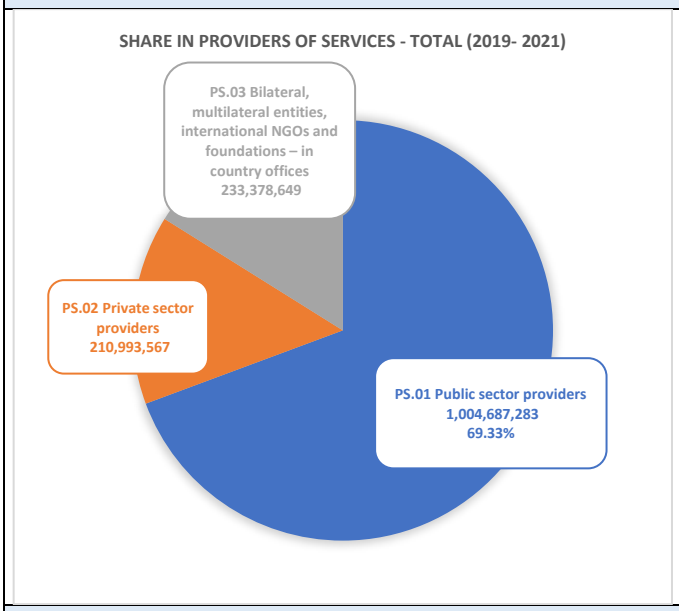


Figure 24.b: Year 2019

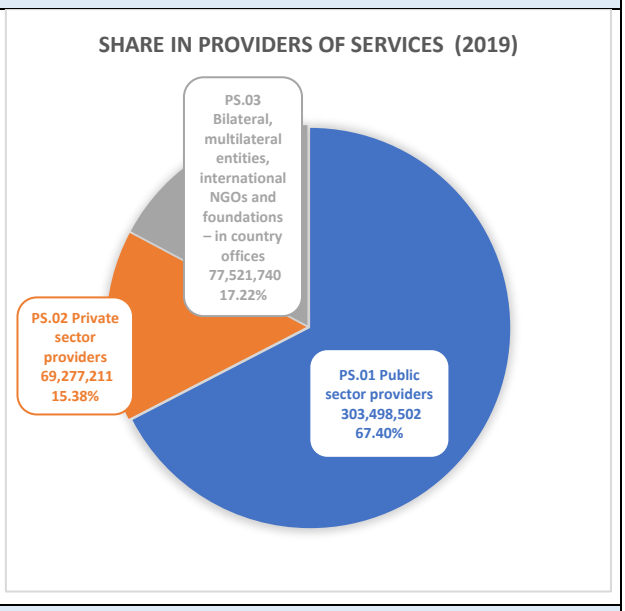


Figure 24.C: Year 2020

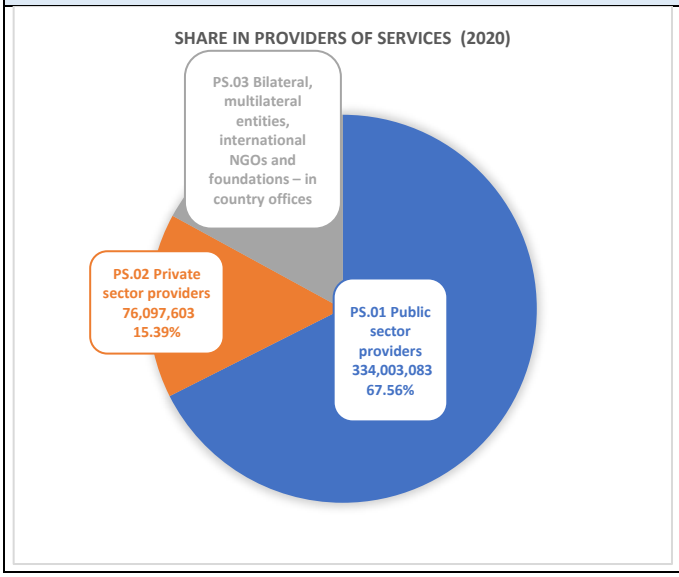
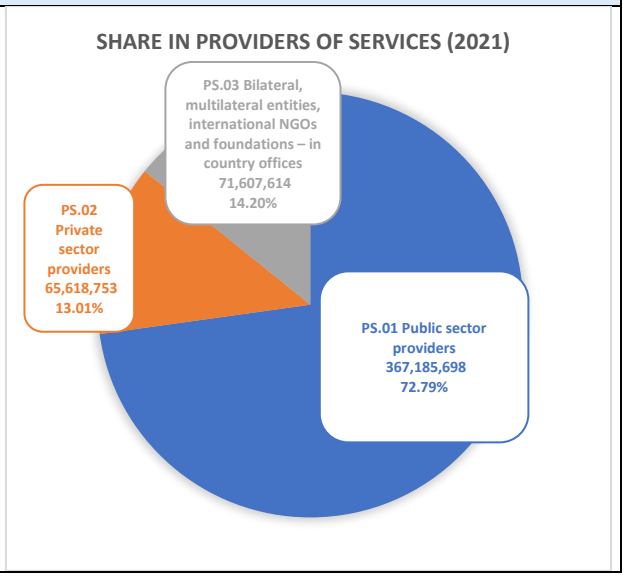


Figure 24.d: Year 2021



III.2.4.2. Service Delivery Modality Spending

Table 11: Breakdown of SDM spending (2019-2021)

Service Delivery Modalities (SDM)	2019	%	2020	%	2021	%	TOTAL	%
SDM.01 Facility-based service modalities	273 137 210	60.66%	289 049 217	58.47%	410 999 692	81.48%	973 186 119	67.16%
SDM.02 Home and community based service modalities	38 450 236	8.54%	38 034 172	7.69%	33 854 852	6.71%	110 339 260	7.61%

Service Delivery Modalities (SDM)	2019	%	2020	%	2021	%	TOTAL	%
SDM.03 Non applicable (ASC which does not have a specific SDM)	113 404 077	25.18%	148 585 594	30.06%	59 535 260	11.80%	321 524 930	22.19%
SDM.98 Modalities not disaggregated	25 303 603	5.62%	18 680 998	3.78%	22 262	0.00%	44 006 863	3.04%
SDM.99 Modalities n.e.c.	2 327	0.00%		0.00%		0.00%	2 327	0.00%
TOTAL	**450 297 453**	**100.00%**	**494 349 981**	**100.00%**	**504 412 065**	**100.00%**	**1 449 059 499**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, of total HIV and AIDS spending in Zambia, Facility-based service modalities took the largest share, at **67%** followed by Non applicable (ASC which does not have a specific SDM), at **22%.** The third largest expenditure was on Home and community based service modalities with **8%** of share. Modalities not disaggregated took the fourth place with for **3%** of share**.** (see figure 25.a).

Analysis of trends by type of Service Modalities Category

In 2020, expenditure on Facility-based service modalities increased by **6%**. In 2021, expenditure on this category increased by **42%** and between 2019 and 2021, expenditure increased by **50%**.

In 2020, expenditure on Non-targeted interventions category increased by **31%**. In 2021, expenditure decreased by **26%** and between 2019 and 2021, expenditure decreased by **3%**.

In 2020, expenditure on Non applicable (ASC which does not have a specific SDM) category increased by **31%**. In 2021, expenditure on this category decreased by **60%** and between 2019 and 2021, expenditure decreased by **48%**.

In 2020, expenditure on Home and community based service modalities decreased by **1%**. In 2021, expenditure decreased by **11%** and between 2019 and 2021, expenditure decreased by **12%**.

In 2020, expenditure Modalities not disaggregated decreased by **26%**. In 2021, expenditure decreased by **100%** and between 2019 and 2021, expenditure decreased by **100%**.

Analysis of shares in annual spending

In 2019, the shares show that Facility-based service modalities took the highest share, at **61%** followed by Non applicable (ASC which does not have a specific SDM), at **25%.** The third largest expenditure was on Home and community based service modalities with **9%** of share. Modalities not disaggregated took the fourth place with for **6%** of share (see figure 25.b),

In 2020, the shares show that Facility-based service modalities took the highest share, at **58%**. This was followed by Non applicable (ASC which does not have a specific SDM), at **30%.** The third largest expenditure was on Home and community based service modalities with **8%** of share. Modalities not disaggregated took the fourth place with for **4%** of share (see figure 25.c)

In 2021, the shares show that Facility-based service modalities took the highest share, at **81%**. This was followed by Non applicable (ASC which does not have a specific SDM), at **12%.** The third largest expenditure was on Home and community based service modalities with **7%** of share. (see figure 25.d)

Figure 25: Share of Service Delivery Modality spending (2019- 2021)

Figure 25.a: Total spending (2019-2021)

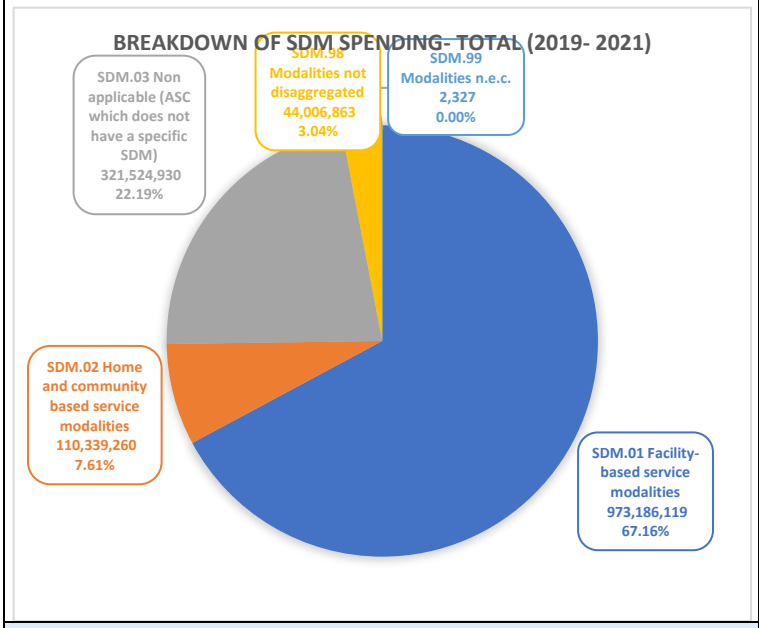


Figure 25.b: Year 2019

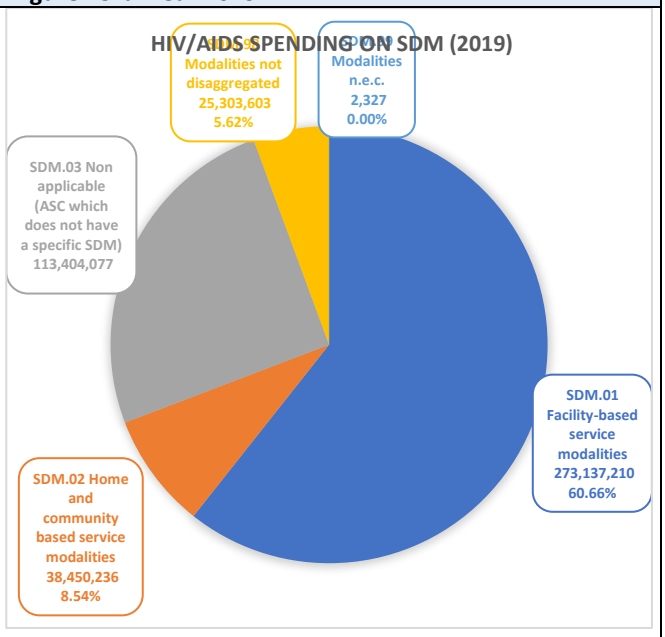


Figure 25.c: Year 2020

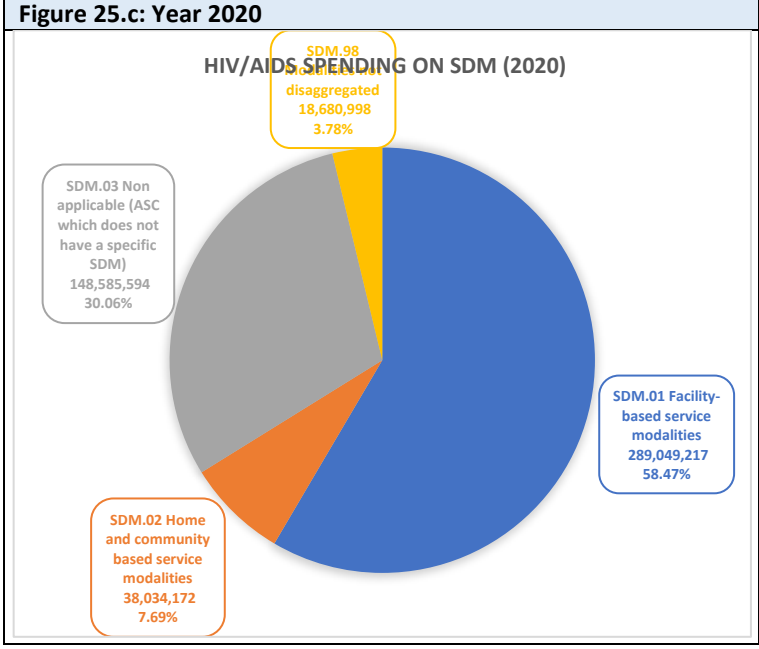
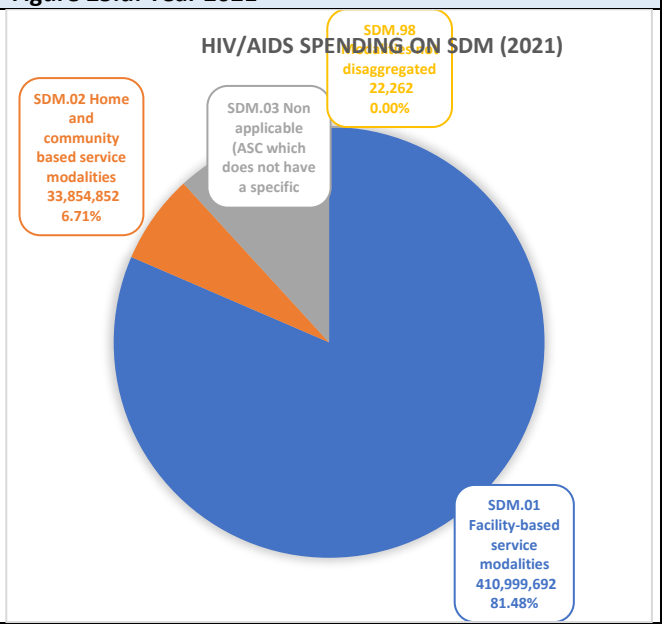


Figure 25.d: Year 2021



III.2.4.3. Production factors of HIV/AIDS spending

Production factors are critical inputs required to deliver planned services and goods to beneficiaries. Production factors comprise capital and recurrent expenditure. Capital expenditure is the value of the non-financial assets acquired. Recurrent expenditure is expenditure on goods and services consumed within the current year that needs to be made recurrently to sustain the production of services.

In NASA classification, recurrent expenditure includes, among other things, salaries and wages, medicines, and administrative and consulting services. Capital expenditure includes building, vehicles, IT equipment, and laboratory and other medical equipment.

The table below shows the breakdown of current expenses, capital expenses and expenses on Production factors not disaggregated.

Table 12: Breakdown of production factors spending (2019-2021)

PRODUCTION FACTORS - PF	2019	%	2020	%	2021	%	TOTAL	%
PF.01 Current direct and indirect expenditures	**431 875 506**	95.91%	**464 379 379**	93.94%	**466 957 396**	92.57%	**1 363 212 280**	94.08%
PF.01.01 Personnel costs	126 020 643	27.99%	147 108 106	29.76%	135 441 158	26.85%	408 569 906	28.20%
PF.01.02 Other operational and programme management current expenditures	25 335 888	5.63%	22 027 543	4.46%	23 089 842	4.58%	70 453 273	4.86%
PF.01.03 Medical products and supplies	175 288 244	38.93%	158 580 400	32.08%	196 361 890	38.93%	530 230 534	36.59%
PF.01.04 Contracted external services	30 842 157	6.85%	30 857 956	6.24%	38 916 965	7.72%	100 617 078	6.94%
PF.01.05 Transportation related to beneficiaries	502	0.00%		0.00%	879	0.00%	1 381	0.00%
PF.01.07 Financial support for beneficiaries	654 463	0.15%	424 151	0.09%	1 244 849	0.25%	2 323 463	0.16%
PF.01.08 Training- Training related per diems/transport/other costs	14 973 223	3.33%	13 509 189	2.73%	9 518 449	1.89%	38 000 861	2.62%
PF.01.09 Logistics of events, including catering services	17 156 364	3.81%	37 079 365	7.50%	792 806	0.16%	55 028 535	3.80%
PF.01.10 Indirect costs	19 374 088	4.30%	19 718 849	3.99%	19 205 729	3.81%	58 298 666	4.02%
PF.01.98 Current direct and indirect expenditures not disaggregated	16 480 742	3.66%	31 804 915	6.43%	40 009 526	7.93%	88 295 183	6.09%
PF.01.99 Current direct and indirect expenditures n.e.c.	5 749 192	1.28%	3 268 905	0.66%	2 375 303	0.47%	11 393 400	0.79%
PF.02 Capital expenditures	**15 573 273**	3.46%	**13 042 743**	2.64%	**9 417 287**	1.87%	**38 033 303**	2.62%
PF.02.01 Building	3 299 279	0.73%	2 110 808	0.43%	179 878	0.04%	5 589 965	0.39%
PF.02.02 Vehicles	817 671	0.18%	235 789	0.05%	341	0.00%	1 053 801	0.07%
PF.02.03 Other capital investment	11 456 323	2.54%	10 696 146	2.16%	9 237 068	1.83%	31 389 537	2.17%
PF.98 Production factors not disaggregated	**2 848 674**	0.63%	**16 927 859**	3.42%	**28 037 383**	5.56%	**47 813 916**	3.30%
TOTAL	450 297 453	100.00%	494 349 981	100.00%	504 412 065	100.00%	1 449 059 499	100.00%

Analysis of total spending (2019-2021)

From 2019 to 2021, the analysis of expenditure show that current expenditures accounted for the largest share of spending for the entire period **(94%)** followed by production factors not disaggregated **(3.30%)** and capital expenditures **(2.62%)**.

The above table shows that **37%** of expenses relate to purchases of Medical products and supplies. This is excellent in a context where Zambia would like to achieve viral suppression thereby accelerating the country's efforts in meeting the 95-95-95 Fast Track targets and ending AIDS as a public health threat. We also note that human resource expenditures are significant **(28%).**
It is also important to point out that very few resources **(3%)** from 2019 to 2021 were directed towards capital expenditures (information technology, laboratory and other medical equipment, non medical equipment).

Analysis of trends

In 2020, current expenditure increased by **8%**. In 2021, spending increased by **1%** and between 2019 and 2021, current expenditure increased by **8%**.

In 2020, capital expenditure decreased by **16%**. In 2021, spending decreased by **28%** and between 2019 and 2021, capital expenditure decreased by **40%**.

In 2020, production factors not disaggregated increased by **494%**. In 2021, spending increased by **66%** and between 2019 and 2021, expenditure increased by **884%**.

Analysis of shares in annual spending

In 2019, the shares show that current expenditures represent **96%** of the shares followed by capital expenditures with **3%** of shares and production factors not disaggregated with **1%** of shares.

In 2020, the shares show that current expenditure represents **94%** of the shares followed by production factors not disaggregated with **3%** of shares and capital expenditures with **3%** of shares.

In 2021, the shares show that Current direct and indirect expenditures represent **93%** of the shares followed by Production factors not disaggregated with **6%** of shares and Capital expenditures with **1%** of shares.
The figure below illustrates this analysis:

Figure 26: Share of Production factors spending (2019- 2021)

Figure 26.a: Total spending (2019-2021)

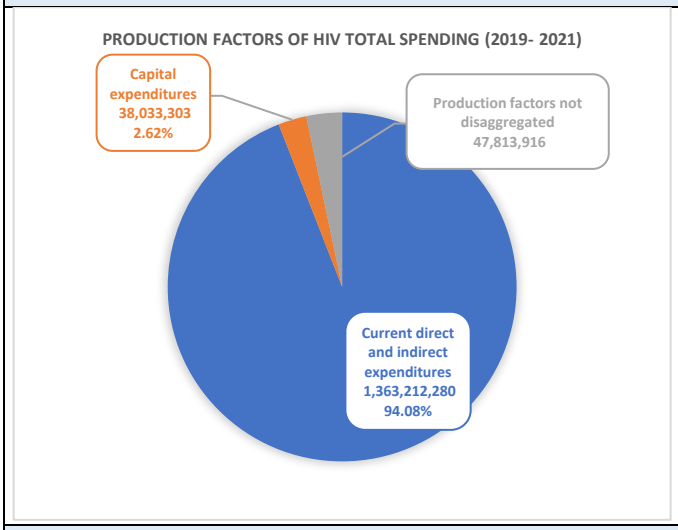


Figure 26.b: Year 2019

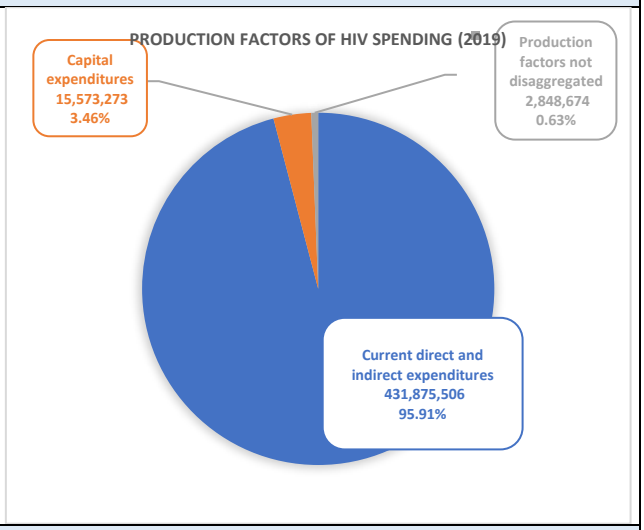
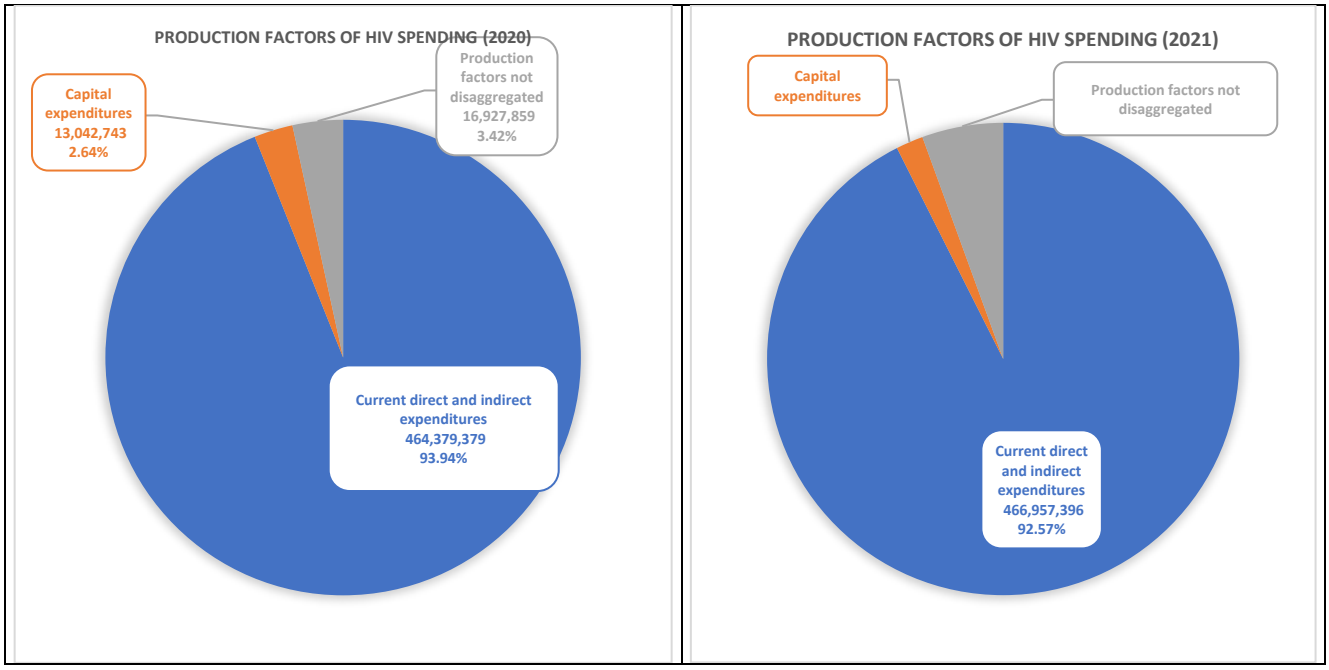


Figure 26.C: Year 2020

Figure 26.d: Year 2021



III.2.5. Utilization of HIV & AIDS Services

III.2.5.1. AIDS Spending Categories expenditures

NASA uses the term "AIDS spending categories" to define all HIV-related interventions and activities in the HIV and AIDS response. AIDS spending categories include prevention, care and treatment, and other health and non-health services related to HIV and AIDS.
This section presents the broader programme areas and a breakdown of each category. It is important to note that in the NASA 2019 classifications, the HIV testing and counselling programme has been separated into a new programme area. Previously, voluntary testing and counselling was considered part of prevention, and provider-initiated testing and counselling was part of treatment. In the new framework, all forms of HIV testing and counselling are combined.

Table 13: Breakdown of AIDS Spending categories expenditure (2019-2021)

AIDS SPENDING CATEGORIES (ASC)	2019	%	2020	%	2021	%	TOTAL	%
ASC.01 Prevention	48 928 466	10.87%	64 770 973	13.10%	61 348 668	12.16%	175 048 107	12.08%
ASC.02 HIV testing and counselling (HTC)	28 339 089	6.29%	21 473 042	4.34%	20 587 326	4.08%	70 399 457	4.86%
ASC.03 HIV Care and Treatment Care	246 755 326	54.80%	254 879 856	51.56%	305 421 029	60.55%	807 056 211	55.70%
ASC.04 Social protection and economic support (for PLHIV, their families. for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	12 870 495	2.86%	4 640 516	0.94%	7 457 177	1.48%	24 968 188	1.72%
ASC.05 Social Enablers (excluding the efforts for KPs above)	399 639	0.09%	-	0.00%	-	0.00%	399 639	0.03%
ASC.06 Programme enablers and systems strengthening	112 726 091	25.03%	113 357 074	22.93%	108 380 772	21.49%	334 463 936	23.08%
ASC.07 Development synergies	216 489	0.05%	34 847 965	7.05%	896 915	0.18%	35 961 369	2.48%
ASC.08 HIV-related research (paid by earmarked HIV funds)	61 858	0.01%	380 555	0.08%	320 179	0.06%	762 592	0.05%
TOTAL	**450 297 453**	**100%**	**494 349 981**	**100%**	**504 412 065**	**100%**	**1 449 059 499**	**100%**

Analysis of total spending (2019-2021)

From 2019 to 2021, of total HIV and AIDS spending in Zambia, care and treatment took the highest share, at **56%** followed by Programme enablers and systems strengthening, at **23%.** The third largest expenditure was on Prevention with **12%** of share. HIV with testing and counselling (HTC), accounted for **5%** of share. Development synergies accounted for **3%** of shares, Social protection and economic support accounted for **2%** of shares. The remaining subcategories (social enablers, research) combined accounted for **0.08%** of total HIV and AIDS spending. (see figure 27.a).

Analysis of trends by type of Aids Spending Category

In 2020, expenditure on care and treatment category increased by **3%**. In 2021, expenditure on this category increased by **20%** and between 2019 and 2021, expenditure increased by **24%**.

In 2020, expenditure on Programme enablers and systems strengthening category increased by **1%**. In 2021, expenditure decreased by **4%** and between 2019 and 2021, expenditure decreased by **4%**.

In 2020, expenditure on prevention category increased by **32%**. In 2021, expenditure on this category decreased by **5%** and between 2019 and 2021, expenditure increased by **25%**.

In 2020, expenditure on HIV testing and counselling (HTC) category decreased by **24%**. In 2021, expenditure decreased by **4%** and between 2019 and 2021, expenditure decreased by **27%**.

In 2020, expenditure on Development synergies category increased by **15997%**. In 2021, expenditure decreased by **97%** and between 2019 and 2021, expenditure increased by **314%**.

In 2020, expenditure on Social protection and economic support category decreased by **64%**. In 2021, expenditure decreased by **61%** and between 2019 and 2021, expenditure decreased by **42%**.

In 2020, expenditure on HIV-related research category increased by **515%**. In 2021, expenditure decreased by **16%** and between 2019 and 2021, expenditure increased by **418%**.

In 2020, expenditure on Social Enablers category increased by **100%**. In 2021, expenditure didn't increase or decrease and between 2019 and 2021, expenditure decreased by **100%**.

Analysis of shares in annual spending

In 2019, the shares show that care and treatment took the highest share, at **55%**. This was followed by Programme enablers and systems strengthening at **25%**. The third largest expenditure was on Prevention with **11%** of annual shares. HIV testing and counselling (HTC) takes the 4th place in shares with **6%** of shares and Social protection and economic support accounted for **3%.** Other subcategories (Social Enablers, Development synergies, HIV-related research) accounted for **0.15%** of shares (see figure 27.b).

In 2020, the shares show that care and treatment took the highest share, at **52%**. This was followed by Programme enablers and systems strengthening, at **23%. T**he third largest expenditure was on Prevention with **13%** of annual shares. Development synergies took the 4th place in shares with **7%** of share**,** HIV testing and counselling (HTC) took the 5th place in shares with **4%** and Social protection and economic support accounted for **1%.** HIV related research accounted for **0.08%** of shares (see figure 27.c)

In 2021, the shares show that care and treatment took the highest share, at **61%**. This was followed by Programme enablers and systems strengthening, at **21%. T**he third largest expenditure was on Prevention with **12%** of annual shares. HIV testing and counselling took the 4th place in shares with **4%** of share**,** Social protection and economic support took the 5th place in shares with **1.48%.** Development synergies took the

6th place in shares with **0.18%.** Other subcategories (Social Enablers, HIV-related research) accounted for **0.06%** of shares (see figure 27.d)

The figure below illustrates what is announced in the previous text.

Figure 27: Share of ASC expenditure by chapter of interventions (2019-2021)

Figure 27.a: Total spending (2019-2021)

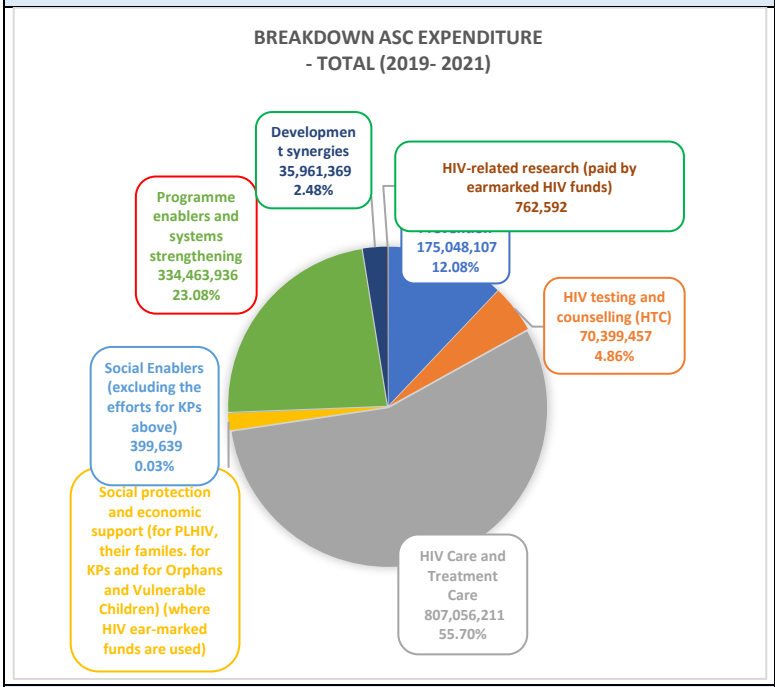


Figure 27.b: Year 2019

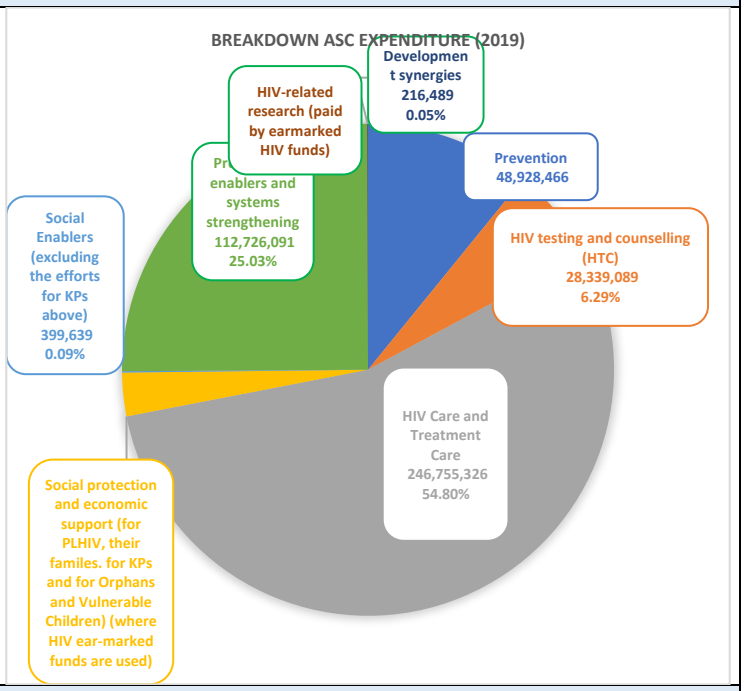


Figure 27.c: Year 2020

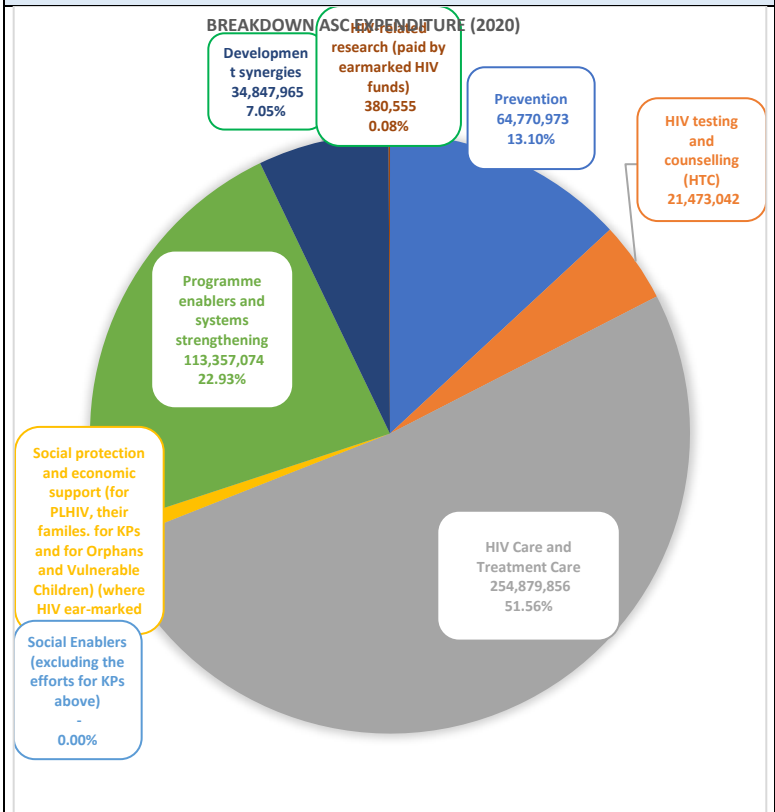


Figure 27.d: Year 2021

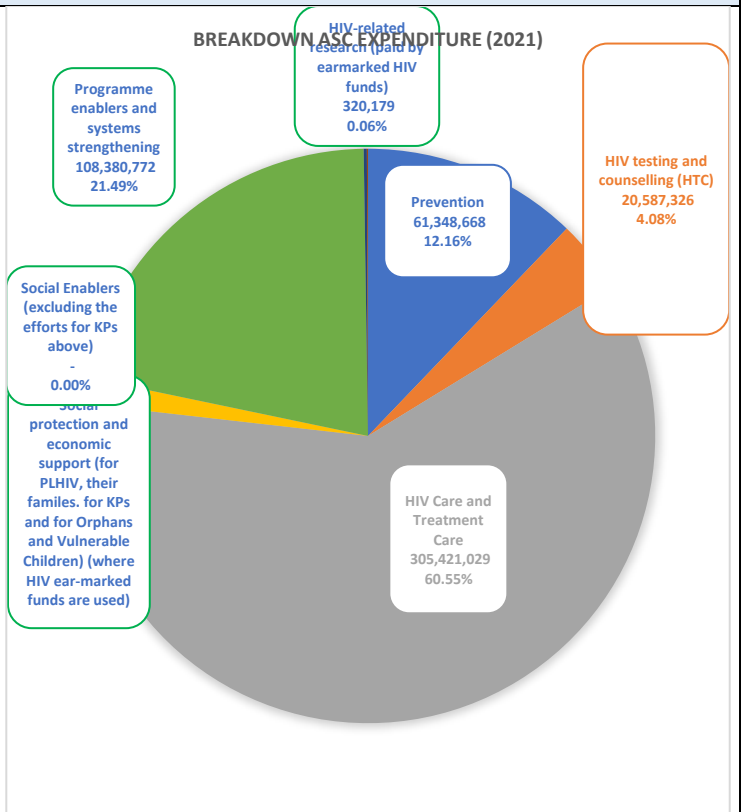


Table 14: Breakdown of prevention spending (2019-2021)

PREVENTION INTERVENTIONS	2019	%	2020	%	2021	%	TOTAL	%
ASC.01.01 Five Pillars of Prevention	**25 050 942**	**51.20%**	**31 452 334**	**48.56%**	**51 815 603**	**84.46%**	**108 318 879**	**61.88%**
ASC.01.01.01.01 Condom promotion and distribution as part of dedicated programmes for AGYW - only if earmarked HIV funds are spent	1 280	0.00%		0.00%	150 000	0.24%	151 280	0.09%
ASC.01.01.01.02 Youth-friendly SRH services for AGYW - only if earmarked HIV funds are spent		0.00%	620 605	0.96%	1 421 360	2.32%	2 041 965	1.17%
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	4 038 258	8.25%	2 966 509	4.58%	3 112 510	5.07%	10 117 277	5.78%
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	2 746 293	5.61%	2 245 792	3.47%	12 251 147	19.97%	17 243 232	9.85%
ASC.01.01.01.98 Programmatic activities for AGYW not disaggregated by type	144 873	0.30%	356 054	0.55%	47 153	0.08%	548 080	0.31%
ASC.01.01.01.99 Other activities for AGYW n.e.c.	91 288	0.19%	383 143	0.59%	1 013 813	1.65%	1 488 244	0.85%
ASC.01.01.02.01.01 Condom and lubricant programmes as part of programmes for sex workers		0.00%	23 068	0.04%		0.00%	23 068	0.01%
ASC.01.01.02.01.04 Community empowerment including prevention of violence against sex workers and legal support - only if earmarked HIV funds are spent	1 064 896	2.18%	922 604	1.42%		0.00%	1 987 500	1.14%
ASC.01.01.02.02.03 Behaviour change communication (BCC) as part of programmes for MSM	393 530	0.80%	625 704	0.97%		0.00%	1 019 234	0.58%
ASC.01.01.02.03.03 Behaviour change communication (BCC) as part of programmes for TG	28 024	0.06%	424 319	0.66%		0.00%	452 343	0.26%
ASC.01.01.02.04.03 Behaviour change communication (BCC) as part of programmes for PWID	82 841	0.17%		0.00%	114 247	0.19%	197 088	0.11%
ASC.01.01.02.05.03 Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners)	3 568	0.01%	8 837	0.01%		0.00%	12 405	0.01%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	636 644	1.30%	33 420	0.05%	5 096 577	8.31%	5 766 641	3.29%
ASC.01.01.03.01 Provision of free condoms for HIV prevention (excluding for KPs and AGYW)		0.00%	3 447 168	5.32%		0.00%	3 447 168	1.97%
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated		0.00%	616 814	0.95%	716 235	1.17%	1 333 049	0.76%
ASC.01.01.04.01 Voluntary medical male circumcision (VMMC) programmes	1 310 260	2.68%		0.00%	130 917	0.21%	1 441 177	0.82%
ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	13 027 414	26.63%	14 699 731	22.69%	16 028 413	26.13%	43 755 558	25.00%
ASC.01.01.05.01 PrEP as part of programmes for AGYW		0.00%		0.00%	1 263 453	2.06%	1 263 453	0.72%
ASC.01.01.05.98 PrEP not disaggregated by key population	974 264	1.99%	3 024 604	4.67%	10 469 778	17.07%	14 468 646	8.27%

PREVENTION INTERVENTIONS	2019	%	2020	%	2021	%	TOTAL	%
ASC.01.01.05.99 PrEP not else where classified n.e.c.	507 509	1.04%	1 053 962	1.63%		0.00%	1 561 471	0.89%
ASC.01.02 Other Prevention activities	**23 877 524**	48.80%	**33 318 639**	51.44%	**9 533 065**	15.54%	**66 729 228**	**38.12%**
ASC.01.02.01.01 Safe infant feeding practices (including substitution of breastmilk)	1 184	0.00%		0.00%	74 615	0.12%	75 799	0.04%
ASC.01.02.01.98 PMTCT not disaggregated by activity	987 983	2.02%		0.00%	664 473	1.08%	1 652 456	0.94%
ASC.01.02.02 Social and behavioural communication for change (SBCC) for populations other than key populations	10 038	0.02%	572 769	0.88%	289 861	0.47%	872 668	0.50%
ASC.01.02.03 Community mobilization for populations other than key populations	8 597 091	17.57%	6 121 036	9.45%	3 240 641	5.28%	17 958 768	10.26%
ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	3 147 866	6.43%	257 505	0.40%		0.00%	3 405 371	1.95%
ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type	61 271	0.13%		0.00%		0.00%	61 271	0.04%
ASC.01.02.04.99 Other programmatic activities for vulnerable and accessible populations n.e.c		0.00%	2 377	0.00%		0.00%	2 377	0.00%
ASC.01.02.05.01 Prevention activities implemented in school		0.00%	1 629 962	2.52%	51 601	0.08%	1 681 563	0.96%
ASC.01.02.05.98 Prevention activities for children and youth not disaggregated by type	1 024 705	2.09%	955 928	1.48%	875 846	1.43%	2 856 479	1.63%
ASC.01.02.05.99 Prevention activities for children and youth n.e.c		0.00%	101 796	0.16%		0.00%	101 796	0.06%
ASC.01.02.06.98 Programmatic activities for PLHIV and SDC not disaggregated by type		0.00%	21 863	0.03%		0.00%	21 863	0.01%
ASC.01.02.07 Prevention and wellness programmes in the workplace	53 878	0.11%	9 884	0.02%	22 262	0.04%	86 024	0.05%
ASC.01.02.98 Prevention activities not disaggregated	9 959 810	20.36%	23 645 519	36.51%	4 313 766	7.03%	37 919 095	21.66%
ASC.01.02.99 Other prevention activities n.e.c.	33 698	0.07%		0.00%		0.00%	33 698	0.02%
TOTAL	**48 928 466**	**100.00%**	**64 770 973**	**100.00%**	**61 348 668**	**100.00%**	**175 048 107**	**100.00%**

Analysis of total spending (2019-2021)

Expenditure on the 5 pillars of prevention

From 2019 to 2021, the 5 pillars of prevention accounted for **62%** of prevention expenditure followed by Other Prevention activities, at **38%** of share (see figure 28.a).

Within the category of the **five pillars of prevention,** Voluntary medical male circumcision (VMMC) took the highest share (**25%)** of all prevention spending. This was followed by Cash transfers, social grants and other economic empowerment as part of programmes for AGYW, at **10%** of shares. The third largest expenditure was on PrEP not disaggregated by key population which accounted for **8%.** The fourth largest expenditure was on Behaviour change communication (BCC) as part of programmes for AGYW and their male partners with **6%** of shares. The fifth largest expenditure was on Condom activities (for HIV prevention) not disaggregated with 3% of shares. The sixth largest expenditure was on Provision of free condoms for HIV prevention with **2%** of shares. The remaining sub categories combined accounted for **6%** of total HIV and AIDS spending. (see table 14).

Expenditure on Other prevention activities

Within the category of **Other Prevention activities,** Prevention activities not disaggregated took the highest share **(22%)** of prevention spending followed by spending on Community mobilization for populations other than key populations **(10%).** Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations accounted for **2%** of prevention shares. Prevention activities for children and youth not disaggregated by type accounted for **2%** of shares. The remaining sub categories combined accounted for **6%** of total HIV and AIDS spending. (see table 14)

Analysis of trends for principal prevention categories

Between 2019 and 2020, expenditure on the subcategory of **five pillars of prevention** increased by **26%.** Between 2020 and 2021, expenditure on this category increased by **65%.** Between 2019 and 2021, expenditure increased by **107%.**

Between 2019 and 2020, expenditure on subcategory of **Other Prevention activities** increased by **40%.** Between 2020 and 2021, expenditure on this subcategory decreased by **71%** and between 2019 and 2021, expenditure decreased by **60%.**

Analysis of shares in annual spending

In 2019, the shares show that **five pillars of prevention** took the highest share, at **51%.** This was followed by **Other Prevention activities** at **49%.** (see figure 28.b).

In 2020, the shares show that **Other Prevention activities** took the highest share, at **51%.** This was followed by **five pillars of prevention** at **49%.** (see figure 28.c),

In 2021, the shares show that **five pillars of prevention** took the highest share, at **84%.** This was followed by **Other Prevention activities** at **16%.** (see figure 28.d).

The figure below illustrates what is announced in the previous text:

Figure 28: Share of Prevention expenditure by chapter of intervention

Figure 28.a: Total spending (2019-2021)

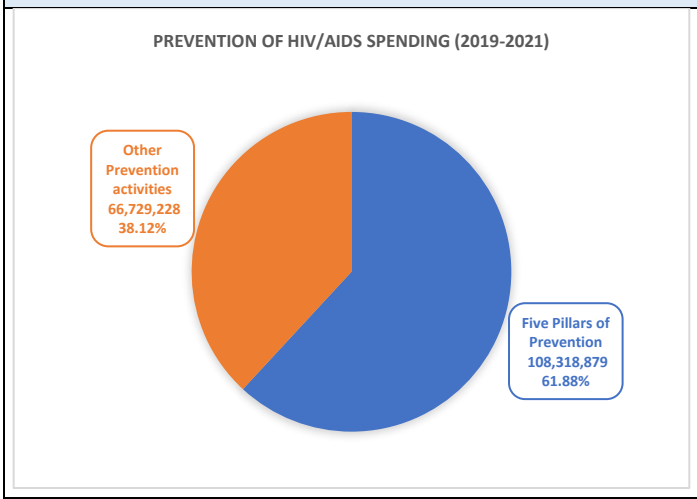


Figure 28.b: Year 2019

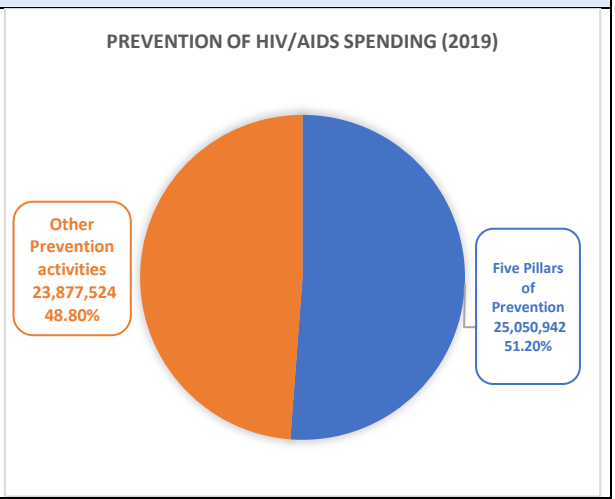
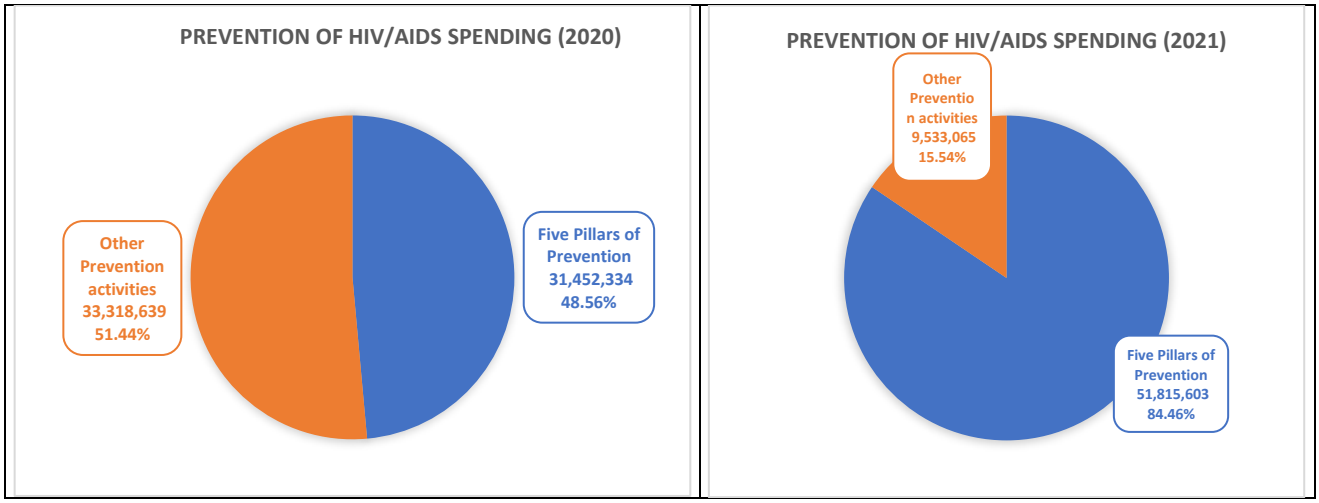


Figure 28.c: Year 2020

Figure 28.d: Year 2021



HIV Care and Treatment care expenditure

Table 15: Breakdown of HIV Care and Treatment Spending (2019-2021)

HIV Care and Treatment	2019	%	2020	%	2021	%	TOTAL	%
ASC.03.01 Anti-retroviral therapy	96 562 643	39.13%	78 444 114	30.78%	112 798 083	36.93%	287 804 840	35.66%
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	1 169 965	0.47%	27 892	0.01%	130 216	0.04%	1 328 073	0.16%
ASC.03.03 Specific ART-related laboratory monitoring	54 878 863	22.24%	35 373 926	13.88%	47 830 382	15.66%	138 083 171	17.11%
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	5 624 159	2.28%	16 651 668	6.53%	5 536 573	1.81%	27 812 400	3.45%
ASC.03.05 Psychological treatment and support service	353 550	0.14%	3 741 246	1.47%	7 534 601	2.47%	11 629 397	1.44%
ASC.03.98 Care and treatment services not disaggregated	88 166 146	35.73%	120 641 010	47.33%	131 591 174	43.09%	340 398 330	42.18%
TOTAL	**246 755 326**	**100%**	**254 879 856**	**100%**	**305 421 029**	**100%**	**807 056 211**	**100%**

Analysis of total spending (2019-2021)

From 2019 to 2021, Care and treatment services not disaggregated accounted for **42%** of total expenditure followed by Anti-retroviral therapy, at **36%** of share. The third largest expenditure was on Specific ART-related laboratory monitoring with **17%** of share. The fourth is Co-infections and opportunistic infections with **3%** of share. Psychological treatment and support service accounted for **1.44%** and Adherence and retention on ART – support accounted for **0.16%** of share (see figure 29.a).

Given that an estimated **1.3 million** people were living with HIV in Zambia in 2019 and the country has a high HIV prevalence rate of **11.2%,** care and treatment is a major cornerstone and strategy of the national response. Financing for care and treatment should be adequate and managed effectively to ensure more

than **1.2 million** people on antiretroviral therapy continue to receive treatment. Spending on care and treatment in 2019, 2020 and 2021 was below the cost estimate proposed by the NASF for the same years. This was estimated at **129 mio** in 2019, **128 mio** in 2020 and **130 mio** in 2021 while for the same period, expenditures are estimated at **450 mio, 494 mio** and **504 mio** dollars.

Trend analysis from 2019 to 2021

Between 2019 and 2020, spending on Care and treatment services not disaggregated increased by **37%**. Between 2020 and 2021, spending increased by **9%** and between 2019 and 2021, expenditure increased by **49%**

Between 2019 and 2020, spending on Anti-retroviral therapy decreased by **19%**. Between 2020 and 2021, spending increased by **44%** and between 2019 and 2021, expenditure increased by **17%**

Between 2019 and 2020, Specific ART-related laboratory monitoring decreased by **36%.** Between 2020 and 2021, spending increased by **35%** and between 2019 and 2021, expenditure decreased by **13%.**

Between 2019 and 2020, spending on Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs increased by **196%.** Between 2020 and 2021, spending decreased by **67%** and between 2019 and 2021, expenditure decreased by **2%.**

Between 2019 and 2020, spending on Psychological treatment and support service increased by **958%.** Between 2020 and 2021, spending decreased by **101%** and between 2019 and 2021, expenditure decreased by **2031%.**

Between 2019 and 2020, spending on Psychological treatment and support service increased by **958%.** Between 2020 and 2021, spending decreased by **101%** and between 2019 and 2021, expenditure decreased by **2031%.**

Between 2019 and 2020, spending on adherence and retention on ART - support (including nutrition and transport) and monitoring decreased by **98%.** Between 2020 and 2021, spending increased by **367%** and between 2019 and 2021, expenditure decreased by **89%.**

Analysis of shares in annual spending

In 2019, the shares show that Anti-retroviral therapy represent **39%** of the shares followed by care and treatment services not disaggregated with **36%** of shares. The third largest expenditure was on Specific ART-related laboratory monitoring with **22%** of shares. The fourth largest expenditure was on Co-infections and opportunistic infections with **2%** of shares. The fifth largest expenditure was on adherence and retention on ART - support (including nutrition and transport) and monitoring with **0.47%** of shares and the sixth expenditure was Psychological treatment and support service with **0.14%** of share (see figure 29.b).

In 2020, the shares show that care and treatment services not disaggregated represent **47%** of the shares followed by Anti-retroviral therapy with **31%** of shares. The third largest expenditure was on Specific ART-related laboratory monitoring with **14%** of shares. The fourth largest expenditure was on Co-infections and opportunistic infections with **7%** of shares. The fifth largest expenditure was on Psychological treatment and support service with **1%** of shares and the sixth expenditure was on Adherence and retention on ART - support (including nutrition and transport) and monitoring with **0.01%** of share (see figure 29.c).

In 2021, the shares show that care and treatment services not disaggregated represent **43%** of the shares followed by Anti-retroviral therapy with **37%** of shares. The third largest expenditure was on Specific ART-related laboratory monitoring with **16%** of shares. The fourth largest expenditure was Psychological treatment and support service **with 2.47%** of shares. The sixth largest expenditure was Co-infections and

opportunistic infections: prevention and treatment for PLHIV and KPs **with 1.81%** of shares. The seventh largest expenditure was adherence and retention on ART - support (including nutrition and transport) and monitoring with 0.04% of share (see figure 29.d).

The figure below illustrates this analysis:

Figure 29: Share of HIV Care and Treatment Spending

Figure 29.a: Total spending (2019-2021)

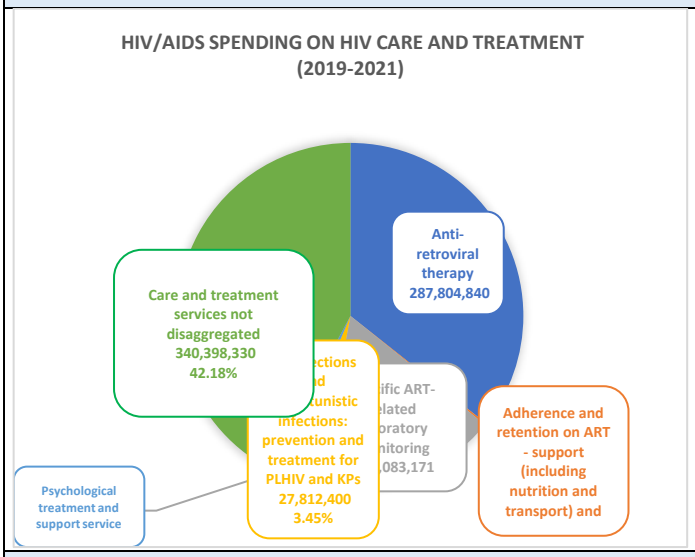


Figure 29.b: Year 2019

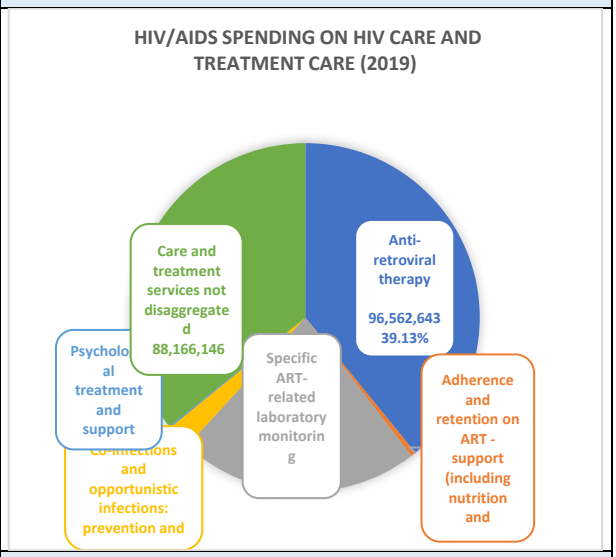


Figure 29.c: Year 2020

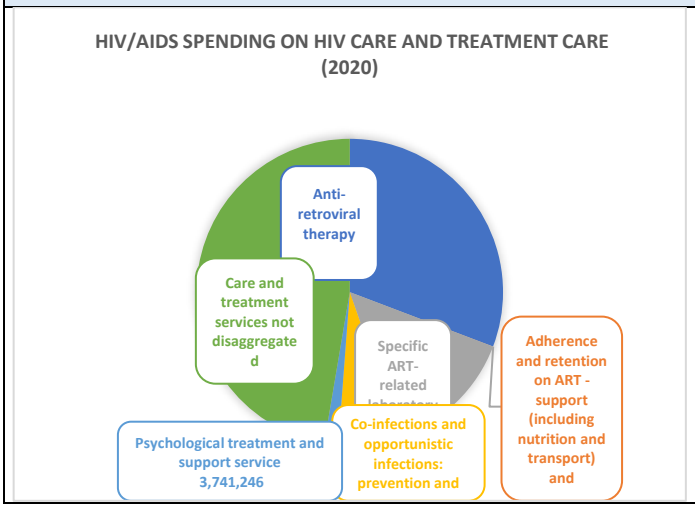
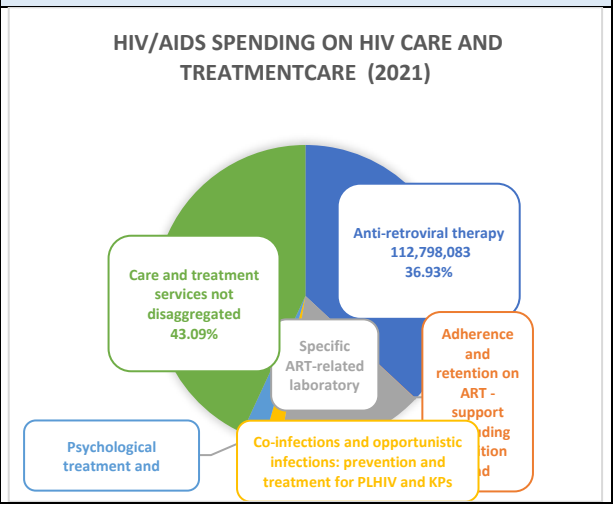


Figure 29.d: Year 2021



Testing and counselling expenditure

Table 16: Breakdown of HIV testing and counselling Spending (2019-2021)

HIV testing and counselling (HTC)	2019	%	2020	%	2021	%	TOTAL	%
ASC.02.01 HIV testing and counselling for sex workers	924 177	3.26%	339 531	1.58%		0.00%	1 263 708	1.80%
ASC.02.02 HIV testing and counselling for MSM	363 707	1.28%	339 531	1.58%		0.00%	703 238	1.00%
ASC.02.03 HIV testing and counselling for TG	28 024	0.10%	251 158	1.17%		0.00%	279 182	0.40%

HIV testing and counselling (HTC)	2019	%	2020	%	2021	%	TOTAL	%
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)		0.00%		0.00%	1 753 797	8.52%	1 753 797	2.49%
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	3 944 108	13.92%	751 969	3.50%		0.00%	4 696 077	6.67%
ASC.02.09 Voluntary HIV testing and counselling for general population	3 598 424	12.70%	17 985 980	83.76%	16 358 919	79.46%	37 943 323	53.90%
ASC.02.98 HIV testing and counselling activities not disaggregated	18 483 368	65.22%	556 090	2.59%	153 204	0.74%	19 192 662	27.26%
ASC.02.99 Other HIV counselling and testing activities n.e.c.	997 281	3.52%	1 248 783	5.82%	2 321 406	11.28%	4 567 470	6.49%
TOTAL	**28 339 089**	**100.00%**	**21 473 042**	**100.00%**	**20 587 326**	**100.00%**	**70 399 457**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, Voluntary HIV testing and counselling for general population accounted for **54%** of total expenditure followed by HIV testing and counselling activities not disaggregated, at **27%** of share. The third largest expenditure was on HIV testing and counselling for vulnerable and accessible populations with **7%** of share. The fourth is Other HIV counselling and testing activities n.e.c. with **6** % of share and the fifth is HIV testing and counselling for pregnant women (part of PMTCT programme) which accounted for **2%** of share. HIV testing and counselling for MSM accounted for 1% of share and HIV testing and counselling for TG accounted for **0.4%** of share (see figure 30.a).

Trend analysis from 2019 to 2021

Between 2019 and 2020, Voluntary HIV testing and counselling for general population total spending increased by **400%**. Between 2021 and 2020, spending decreased by **9%** and between 2019 and 2021, expenditure increased by **355%**.

Between 2019 and 2020, expenditure on HIV testing and counselling activities not disaggregated decreased by **97%.** Between 2020 and 2021, spending decreased by **72%** and between 2019 and 2021, expenditure decreased by **99%**.

Between 2019 and 2020, expenditure on HIV testing and counselling for vulnerable and accessible populations decreased by **81%.** Between 2020 and 2021, spending increased by **1000%** and between 2019 and 2021, expenditure decreased by **100%**.

Between 2019 and 2020, expenditure on Other HIV counselling and testing activities n.e.c. increased by **25%.** Between 2020 and 2021, spending increased by **86%** and between 2019 and 2021, expenditure increased by **133%**.

In 2019 and 2020, no expenditure registered on the HIV testing and counselling for pregnant women (part of PMTCT programme) no expenditure on this**.** In 2021, there was expenditure but no base of comparison.

Between 2019 and 2020, expenditure on HIV testing and counselling for MSM decreased by **7%.** Between 2020 and 2021, spending decreased by **100%** and between 2019 and 2021, expenditure decreased by **100%**.

Between 2019 and 2020, expenditure on HIV testing and counselling for TG increased by **796%.** Between 2020 and 2021, spending decreased by **100%** and between 2019 and 2021, expenditure decreased by **100%.**

Analysis of shares in annual spending

In 2019, the shares show that spending on HIV testing and counselling activities not disaggregated represent **65%** of shares followed by testing and counselling for vulnerable and accessible populations with **14%** of shares. The third largest expenditure was on Voluntary HIV testing and counselling for general population with **13%** of shares. The fourth largest expenditure was on Other HIV counselling and testing activities n.e.c. with **4%** of share. The fifth largest expenditure was on HIV testing and counselling for MSM with **1** % of share. The sixth largest expenditure was on HIV testing and counselling for TG with **0.10%** of share. (see figure 30.b).

In 2020, the shares show that spending on Voluntary HIV testing and counselling for general population represent **84%** of shares followed by Other HIV counselling and testing activities n.e.c. with **6%** of shares. The third largest expenditure was on HIV testing and counselling for vulnerable and accessible populations with **4%** of shares. The fourth largest expenditure was on HIV testing and counselling activities not disaggregated with **3%** of share. HIV testing and counselling for sex workers with HIV testing and counselling for MSM took the fifth largest with **2** % of share, each. The sixth largest expenditure was on HIV testing and counselling for TG with **1%** of share. (see figure 30.c).

In 2021, the shares show that spending on Voluntary HIV testing and counselling for general population represent **79%** of shares followed by Other HIV counselling and testing activities n.e.c. with **11%** of shares. The third largest expenditure was on HIV testing and counselling for pregnant women (part of PMTCT programme) with **9%** of shares. The fourth largest expenditure was on HIV testing and counselling activities not disaggregated with **1** % of share. Other subcategories (HIV testing and counselling for sex workers, HIV testing and counselling for MSM, HIV testing and counselling for TG, HIV testing and counselling for vulnerable and accessible populations) accounted for **0%** (see figure 30.d).

The figure below illustrates this analysis:

Figure 30: Share of HIV testing and counselling Spending

Figure 30.a: Total spending (2019-2021)

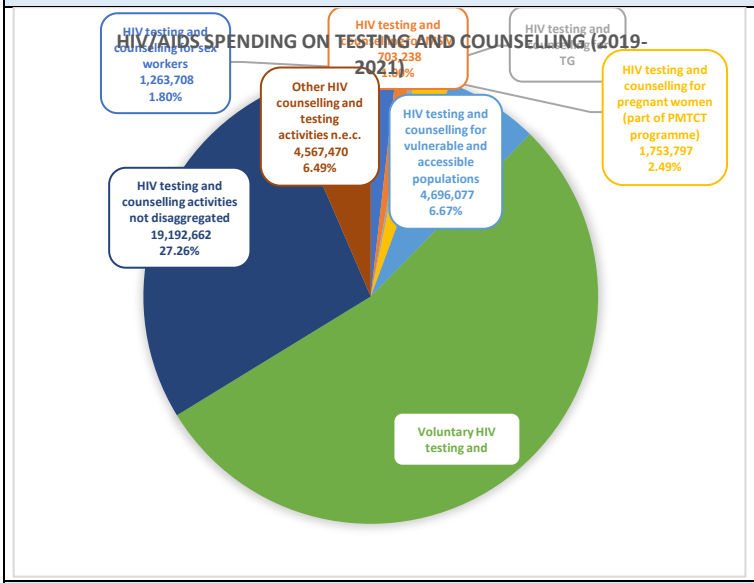


Figure 30.b: Year 2019

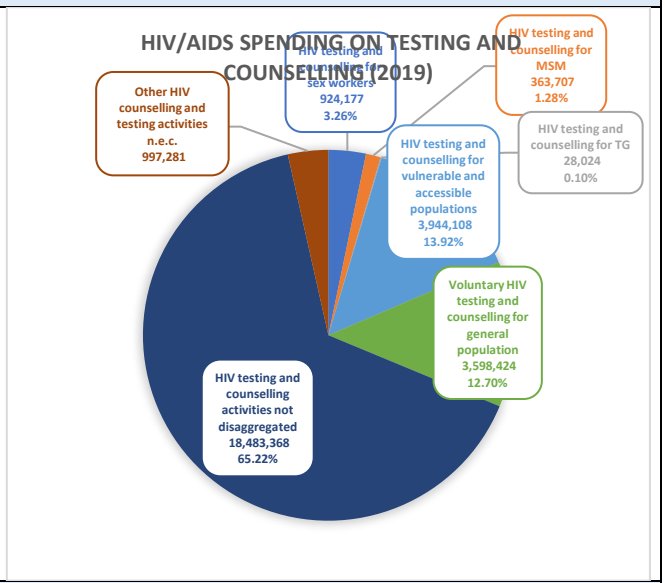
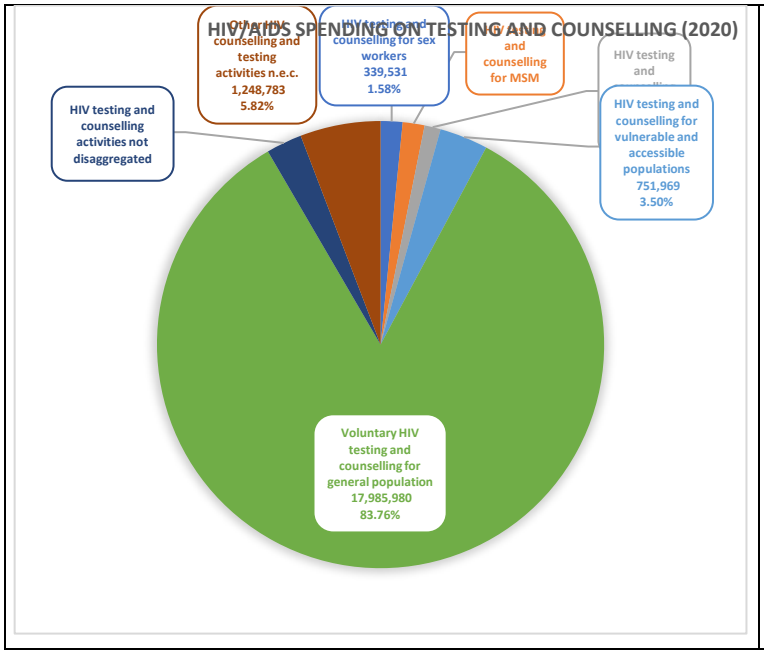
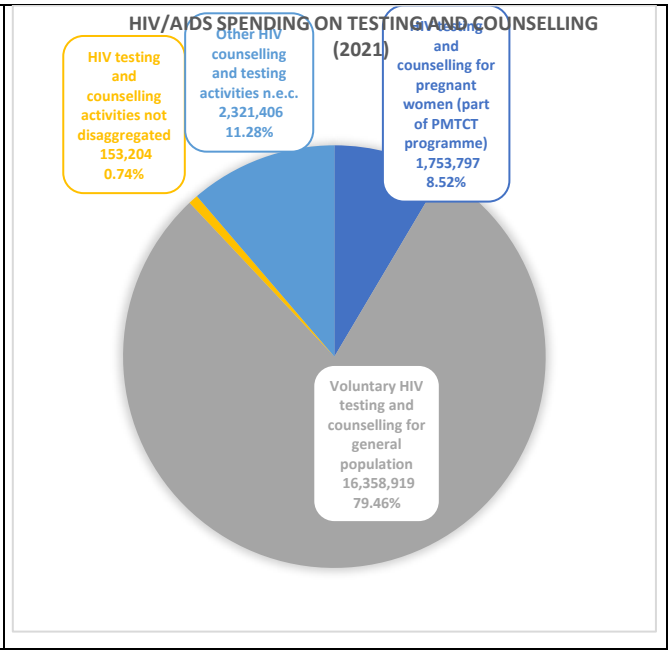


Figure 30.c: Year 2020

Figure 30.d: Year 2021





Programme enablers and systems strengthening expenditure (2019-2021)

Table 17: Breakdown of Programme enablers and systems strengthening Spending (2019-2021)

Programme enablers and systems strengthening	2019	%	2020	%	2021	%	TOTAL	%
ASC.06.01 Strategic planning, coordination and policy development	3 341 265	2.96%	1 963 731	1.73%	1 158 795	1.07%	6 463 791	1.93%
ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes	1 607 400	1.43%	2 791 410	2.46%		0.00%	4 398 810	1.32%
ASC.06.03 Programme administration and management costs (above service-delivery level)	57 887 937	51.35%	56 507 328	49.85%	52 162 675	48.13%	166 557 940	49.80%
ASC.06.04 Strategic information	7 425 387	6.59%	11 551 682	10.19%	15 176 022	14.00%	34 153 091	10.21%
ASC.06.05 Public Systems Strengthening	11 948 397	10.60%	17 835 331	15.73%	11 700 441	10.80%	41 484 169	12.40%
ASC.06.06 Community system strengthening	24 416	0.02%	362 328	0.32%	3 714 474	3.43%	4 101 218	1.23%
ASC.06.07 Human resources for health (above-site programmes)	28 514 523	25.30%	22 243 988	19.62%	24 346 984	22.46%	75 105 494	22.46%
ASC.06.98 Programme enablers and systems strengthening not disaggregated	1 976 766	1.75%	101 276	0.09%	1 893 811	1.75%	3 971 853	1.19%
TOTAL	**112 726 091**	**100.00%**	**113 357 074**	**100.00%**	**108 380 772**	**100.00%**	**334 463 936**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, Programme administration and management costs took the largest spending, at **50%** of total expenditure followed by Human resources for health, at **22%** of share. The third largest expenditure was on Public Systems Strengthening with **12%** of share. The fourth is Strategic information with **10** % of share and the fifth is HIV Strategic planning, coordination and policy development which accounted for **2%**

of share. Building meaningful engagement for representation in key governance, policy reform and development processes accounted for **1.32**% of share, Community system strengthening accounted for **1.23**% of share and Programme enablers and systems strengthening not disaggregated accounted for **1.19**% of share (see figure 31.a).

We note that Program coordination, administration and management expenditures represent 26% of total expenditures for the period from 2019 to 2021 and 50% of Programme enablers and systems strengthening expenditures. This cost doesn't include human resources costs. Better management of recurrent costs needs to be performed.

Trend analysis from 2019 to 2021

Between 2019 and 2020, Programme administration and management costs spending decreased by **2**%. Between 2021 and 2020, spending decreased by **8**% and between 2019 and 2021, expenditure increased by **10**%.

Between 2019 and 2020, expenditure on Human resources for health decreased by **22%.** Between 2020 and 2021, spending increased by **9**% and between 2019 and 2021, expenditure decreased by **15**%.

Between 2019 and 2020, expenditure on Public Systems Strengthening increased by **49%.** Between 2020 and 2021, spending decreased by **34**% and between 2019 and 2021, expenditure decreased by **2**%.

Between 2019 and 2020, expenditure on strategic planning, coordination and policy development decreased by **41%.** Between 2020 and 2021, spending decreased by **41**% and between 2019 and 2021, expenditure decreased by **65**%.

Between 2019 and 2020, expenditure on Building meaningful engagement for representation in key governance, policy reform and development processes increased by **74%.** Between 2020 and 2021, spending decreased by **100**% and between 2019 and 2021, expenditure decreased by **100**%.

Between 2019 and 2020, expenditure on Community system strengthening increased by **1384%.** Between 2020 and 2021, spending increased by **925**% and between 2019 and 2021, expenditure increased by **15133**%.

Between 2019 and 2020, expenditure on Programme enablers and systems strengthening not disaggregated decreased by **95%.** Between 2020 and 2021, spending increased by **1770**% and between 2019 and 2021, expenditure decreased by **4**%.

Analysis of shares in annual spending

In 2019, the shares show that spending on Programme administration and management costs took the largest spending, at **51**% of share followed by Human resources for health, at **25**% of share. The third largest expenditure was on Public Systems Strengthening with **11**% of share. The fourth is Strategic information with **7**% of share and the fifth is HIV Strategic planning, coordination and policy development which accounted for **3**% of share. Programme enablers and systems strengthening not disaggregated accounted for **1.75**% of share, Building meaningful engagement for representation in key governance, policy reform and development processes accounted for **1.43**% of share and Community system strengthening accounted for **0.02**% of share (see figure 31.b).

In 2020, the shares show that spending on Programme administration and management costs took the largest spending, at **50**% of share followed by Human resources for health, at **20**% of share. The third largest expenditure was on Public Systems Strengthening with **16**% of share. The fourth is Strategic information which accounted for **10**% of share. Spending on Building meaningful engagement for representation in key governance, policy reform and development processes represented **2.46**% of share and the fifth is Strategic

planning, coordination and policy development which accounted for **1.73**% of share. Community system strengthening accounted for **0.32**% of share, Programme enablers and systems strengthening not disaggregated accounted for **0.09**% of share. (see figure 31.c).

In 2021, the shares show that spending on Programme administration and management costs took the largest spending, at **48**% of share followed by Human resources for health, at **22**% of share. The third largest expenditure was on Strategic information with **14**% of share. The fourth is Public Systems Strengthening with **11**% of share and the fifth is Community system strengthening which accounted for **3**% of share. Programme enablers and systems strengthening not disaggregated accounted for **1.75**% of share, Strategic planning, coordination and policy development accounted for **1.07**% of share. Building meaningful engagement for representation in key governance, policy reform and development processes accounted for **0**% of share (see figure 31.d).

The figure below illustrates this analysis:

Figure 31: Share of Programme enablers and systems strengthening Spending

Figure 31.a: Total spending (2019-2021)

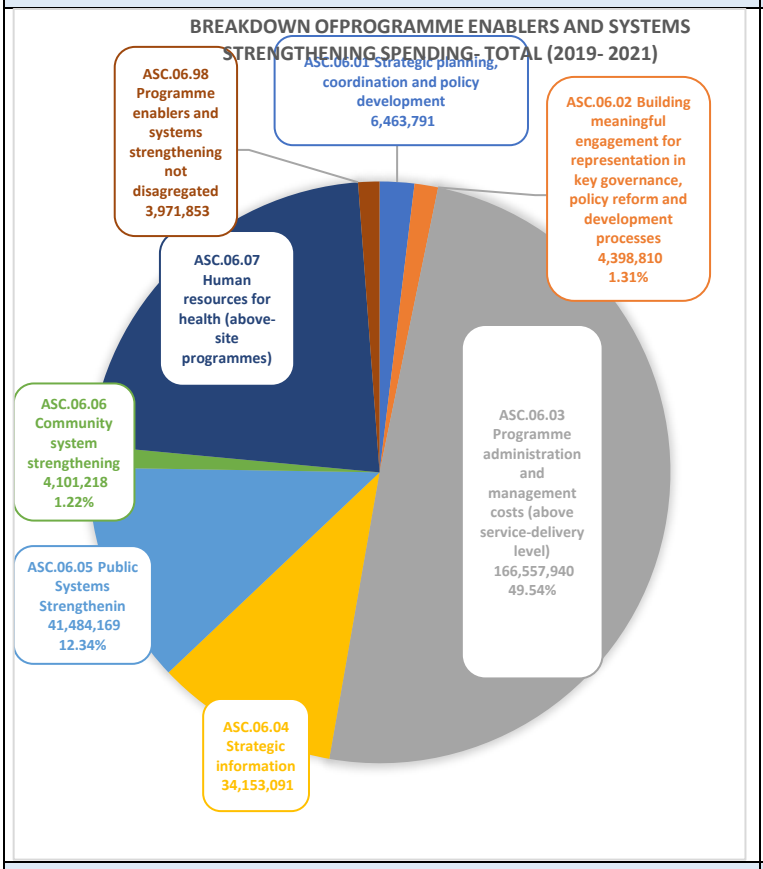


Figure 31.b: Year 2019

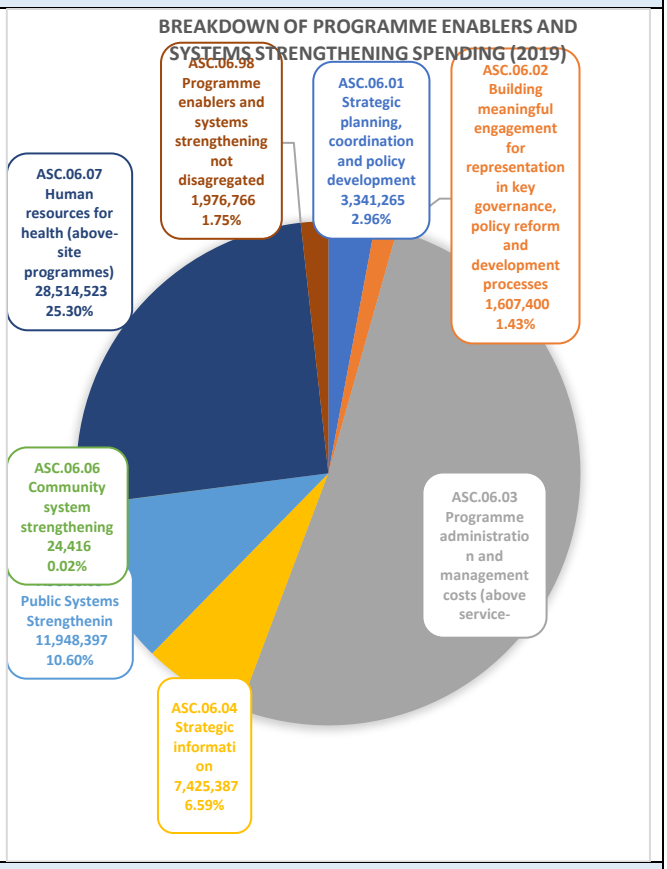
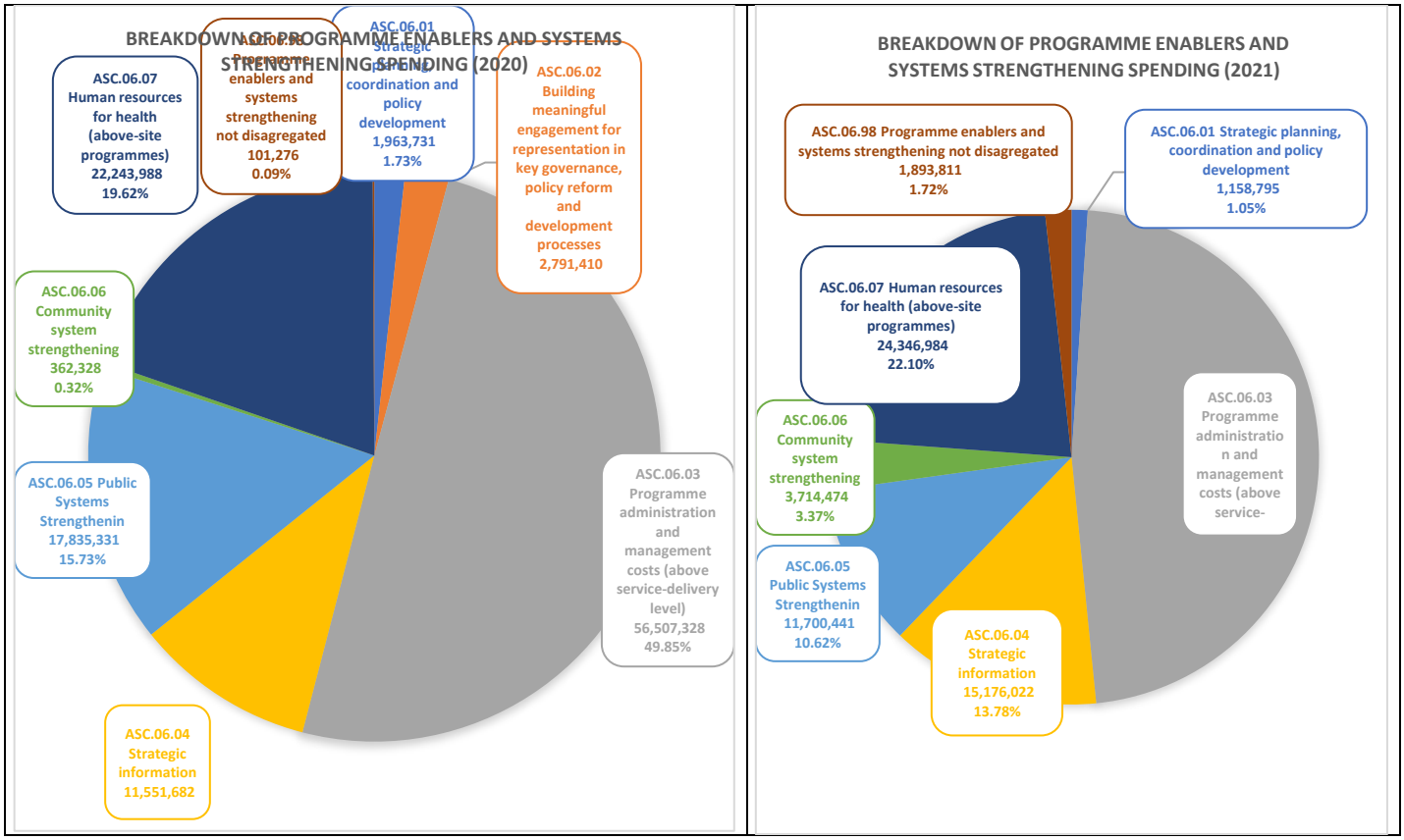


Figure 31.c: Year 2020

Figure 31.d: Year 2021



Development synergies

Table 18: Development synergies spending (2019-2021)

Development synergies	2019	%	2020	%	2021	%	TOTAL	%
ASC.07.02 Reducing gender based violence	216 489	100.00%	891 643	2.56%	896 915	100.00%	2 005 047	5.58%
ASC.07.98 Development synergies not disaggregated		0.00%	33 956 322	97.44%		0.00%	33 956 322	94.42%
TOTAL	**216 489**	**100.00%**	**34 847 965**	**100.00%**	**896 915**	**100.00%**	**35 961 369**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, Development synergies not disaggregated took the largest spending, at **94%** of share followed by Reducing gender based violence, at **6%** of share. (see figure 32.a).

Trend analysis from 2019 to 2021

Between 2019 and 2020, trend on Development synergies not disaggregated shows that, the denominator is **zero** in 2019 (there were no expenses) and therefore the calculation of the evolution is not possible. Between 2021 and 2020, spending decreased by **100%** and between 2019 and 2021, the denominator is **zero** in 2019 (there were no expenses) and therefore the calculation of the evolution is not possible.

Between 2019 and 2020, expenditure on Reducing gender based violence increased by **312%.** Between 2020 and 2021, spending increased by **1%** and between 2019 and 2021, expenditure increased by **314%.**

Analysis of shares in annual spending

In 2019, the shares show that spending on Reducing gender based violence took the largest share, at **100**%. Development synergies not disaggregated accounted for **0**% of share. (see figure 32.b).

In 2020, the shares show that spending on Development synergies not disaggregated took the largest share, at **97**% followed by Reducing gender based violence with **3**% of share (see figure 32.c).

In 2021, the shares show that spending on Reducing gender based violence took the largest share, at **100**%. Development synergies not disaggregated accounted for **0**% of share (see figure 32.d).

The figure below illustrates this analysis:

Figure 32: Share of Development synergies Spending

Figure 32.a: Total spending (2019-2021)

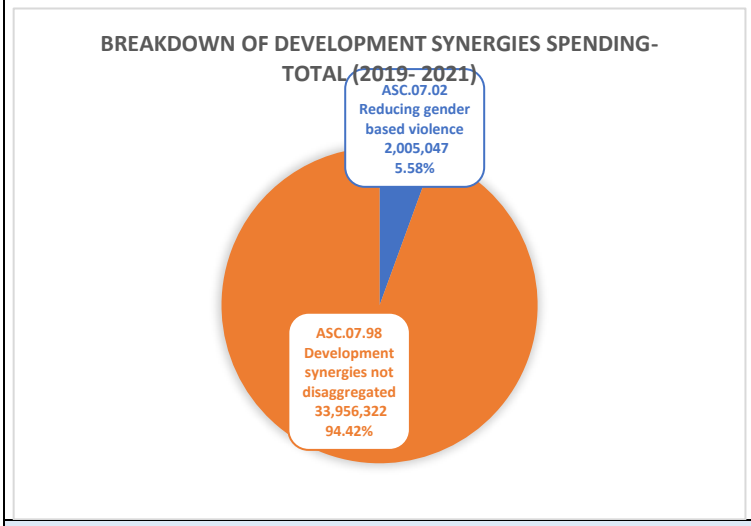


Figure 32.b: Year 2019

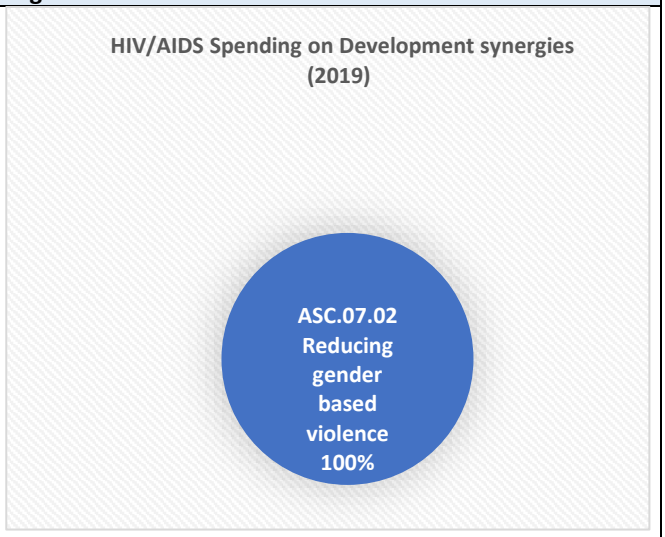


Figure 32.c: Year 2020

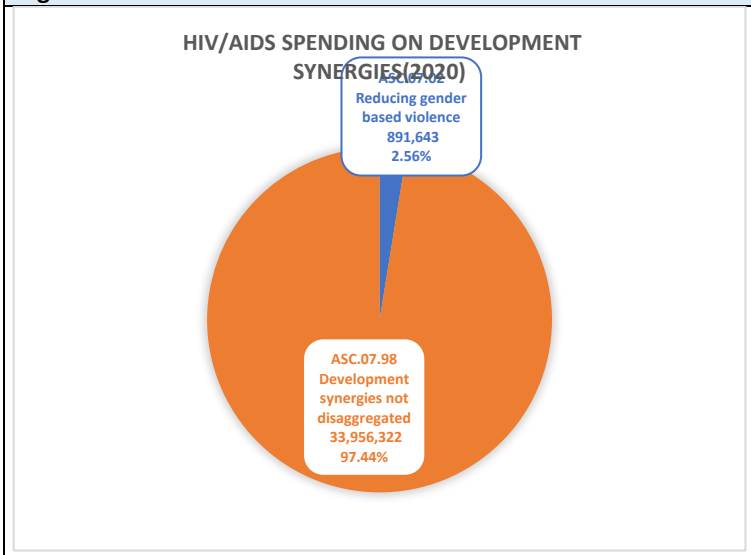
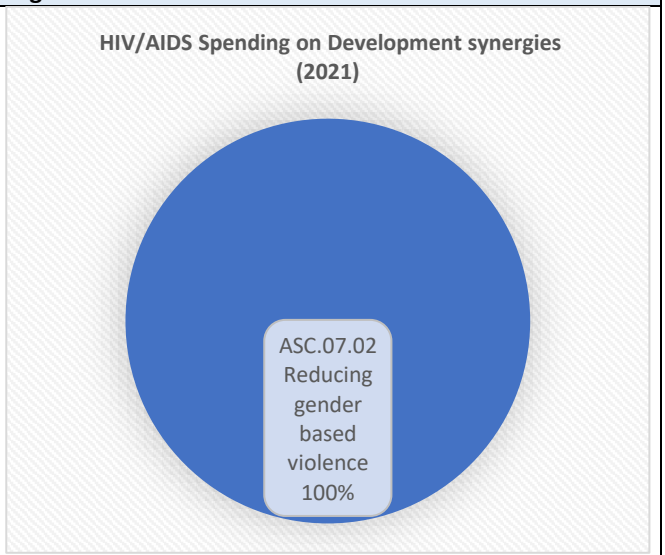


Figure 32.d: Year 2021



HIV related research

Table 19: Breakdown of HIV related research spending (2019-2021)

HIV-related research (paid by earmarked HIV funds)	2019	%	2020	%	2021	%	TOTAL	%
ASC.08.03 Epidemiological research	61 858	100.00%	60 484	15.89%	50 035	15.63%	172 377	22.60%
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type		0.00%	320 071	84.11%	270 144	84.37%	590 215	77.40%
TOTAL	**61 858**	**100.00%**	**380 555**	**100.00%**	**320 179**	**100.00%**	**762 592**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, HIV and AIDS-related research activities not disaggregated by type took the largest spending, at **77%** of share followed by Epidemiological research, at **23%** of share. (see figure 33.a).

Trend analysis from 2019 to 2021

Between 2019 and 2020, trend on HIV and AIDS-related research activities not disaggregated by type shows that, the denominator is **zero** in 2019 (there were no expenses) and therefore the calculation of the evolution is not possible. Between 2020 and 2021, spending decreased by **16%** and between 2019 and 2021, the denominator is **zero** in 2019 (there were no expenses) and therefore the calculation of the evolution is not possible.

Between 2019 and 2020, expenditure on Epidemiological research decreased by **2%.** Between 2020 and 2021, spending decreased by **17%** and between 2019 and 2021, expenditure decreased by **19%.**

Analysis of shares in annual spending

In 2019, the shares show that spending on Epidemiological research took the largest share, at **100%**. HIV and AIDS-related research activities not disaggregated by type accounted for **0%** of share. (see figure 33.b).

In 2020, HIV and AIDS-related research activities not disaggregated by type took the largest spending, at **84%** of share followed by Epidemiological research, at **16%** of share (see figure 33.c).

In 2021, HIV and AIDS-related research activities not disaggregated by type took the largest spending, at **84%** of share followed by Epidemiological research, at **16%** of share (see figure 33.d).

The figure below illustrates this analysis:

Figure 33: Share of HIV related research spending

Figure 33.a: Total spending (2019-2021)	Figure 33.b: Year 2019

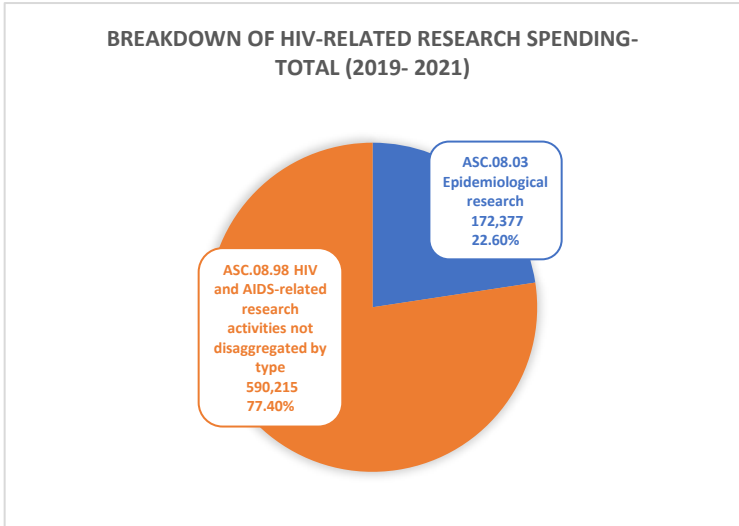


Figure 33.c: Year 2020

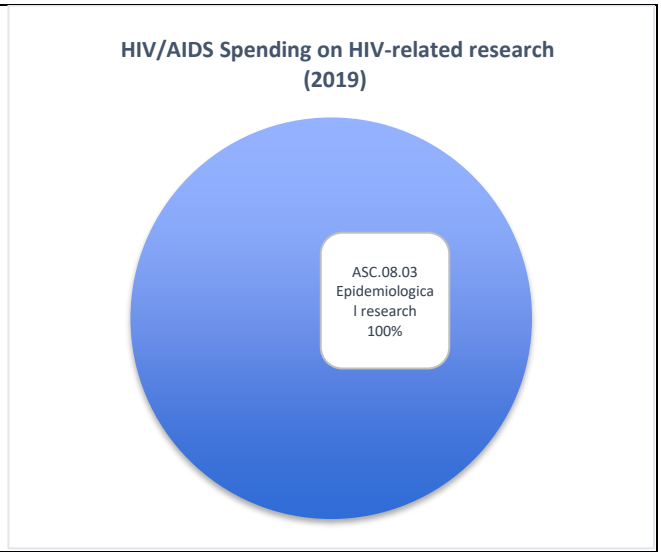
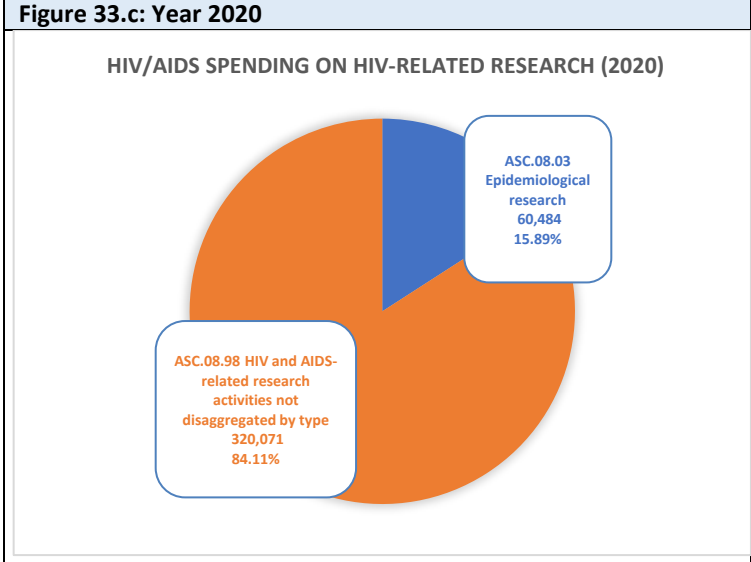
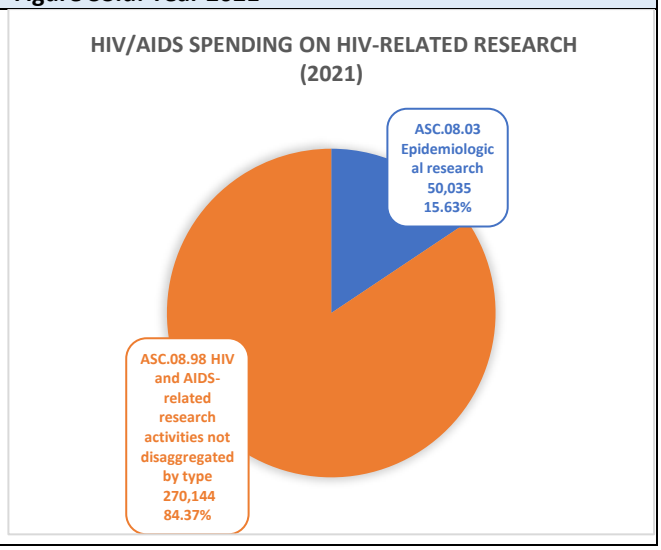


Figure 33.d: Year 2021





III.2.5.2. Beneficiary Population spending

Table 20: Breakdown of Beneficiary Population spending -Total (2019- 2021)

Beneficiary Populations	2019	%	2020	%	2021	%	TOTAL	%
BP.01 People living with HIV (regardless of having a medical/clinical diagnosis of AIDS)	246 842 890	54.82%	254 901 719	51.56%	306 625 657	60.79%	808 370 266	55.79%
BP.02 Key populations	4 769 869	1.06%	5 992 776	1.21%	17 418 603	3.45%	28 181 248	1.94%
BP.03 Vulnerable, accessible and other target populations	32 821 917	7.29%	15 113 099	3.06%	28 692 410	5.69%	76 627 426	5.29%
BP.04 General population	50 349 602	11.18%	69 756 793	14.11%	42 044 161	8.34%	162 150 556	11.19%
BP.05 Non-targeted interventions	113 404 077	25.18%	148 585 594	30.06%	109 597 866	21.73%	371 587 536	25.64%
BP.99 Specific targeted populations not elsewhere classified (n.e.c.)	2 109 098	0.47%		0.00%	33 369	0.01%	2 142 467	0.15%
TOTAL	**450 297 453**	**100.00%**	**494 349 981**	**100.00%**	**504 412 065**	**100.00%**	**1 449 059 499**	**100.00%**

Analysis of total spending (2019-2021)

From 2019 to 2021, people living with HIV (regardless of having a medical/clinical diagnosis of AIDS) accounted for **56%** of total expenditure followed by Non-targeted interventions, at **26%** of share. The third largest expenditure was on Vulnerable, accessible and other target populations with **5%** of share. The fourth is Key populations with **2%** of share and the fifth is Specific targeted populations not elsewhere classified which accounted for **0.15%** of share. (see figure 34.a).

As can be shown, the epidemic vectors (key populations) do not even benefit from **3%** of the total expenditure. Resource allocation should increasingly be evidence-based.

Trend analysis from 2019 to 2021

Between 2019 and 2020, People living with HIV spending increased by **3%**. Between 2021 and 2020, spending increased by **20%** and between 2019 and 2021, expenditure increased by **24%**.

Between 2019 and 2020, expenditure on Non-targeted interventions increased by **31%.** Between 2020 and 2021, spending decreased by **26%** and between 2019 and 2021, expenditure decreased by **3%**.

Between 2019 and 2020, expenditure on Vulnerable, accessible and other target populations decreased by **54%.** Between 2020 and 2021, spending increased by **90%** and between 2019 and 2021, expenditure decreased by **13%**.

Between 2019 and 2020, expenditure on Key populations increased by **26%.** Between 2020 and 2021, spending increased by **191%** and between 2019 and 2021, expenditure decreased by **265%**.

Between 2019 and 2020, expenditure on Specific targeted populations not elsewhere classified decreased by **100%.** Between 2020 and 2021, there was no spending in 2020 and between 2019 and 2021, expenditure decreased by **98%**.

Analysis of shares in annual spending

In 2019, the shares show that spending on People living with HIV represent **55%** of shares followed by Non-targeted interventions with **25%** of shares. The third largest expenditure was on General population with **11%** of shares. The fourth largest expenditure was on Vulnerable, accessible and other target populations with **7%** of share. The fifth largest expenditure was on Key populations with **1** % of share. The sixth largest expenditure was on Specific targeted populations not elsewhere classified with **0.47%** of share. (see figure 34.b).

In 2020, the shares show that spending on People living with HIV represent **52%** of shares followed by Non-targeted interventions with **30%** of shares. The third largest expenditure was on General population with **14%** of shares. The fourth largest expenditure was on Vulnerable, accessible and other target populations with **3%** of share. The fifth largest expenditure was on Key populations with **1** % of share. Specific targeted populations not elsewhere classified accounted for **0%** of share. (see figure 34.c).

In 2021, the shares show that spending on People living with HIV represent **61%** of shares followed by Non-targeted interventions with **22%** of shares. The third largest expenditure was on General population with **8%** of shares. The fourth largest expenditure was on Vulnerable, accessible and other target populations with **6%** of share. The fifth largest expenditure was on Key populations with **3** % of share. The sixth largest expenditure was on Specific targeted populations not elsewhere classified with **0.01%** of share (see figure 34.d).

The figure below illustrates this analysis:

Figure 34: Breakdown of Beneficiary Population spending -Total (2019- 2021)

Figure 34.a: Total spending (2019-2021)

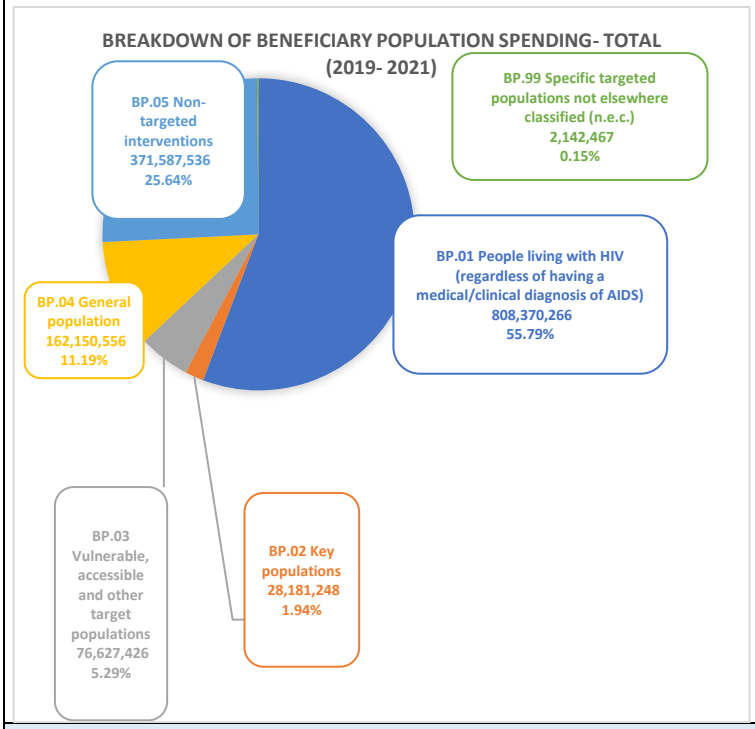


Figure 34.b: Year 2019

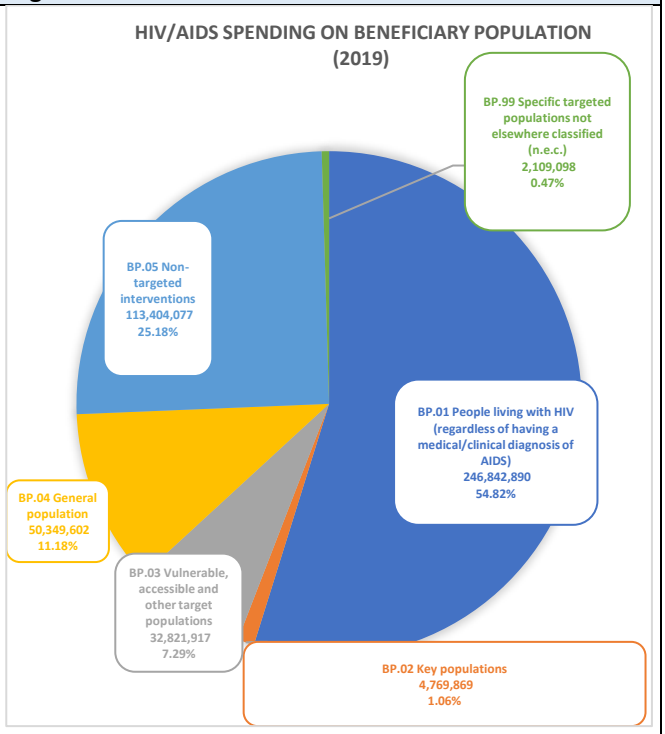


Figure 34.c: Year 2020

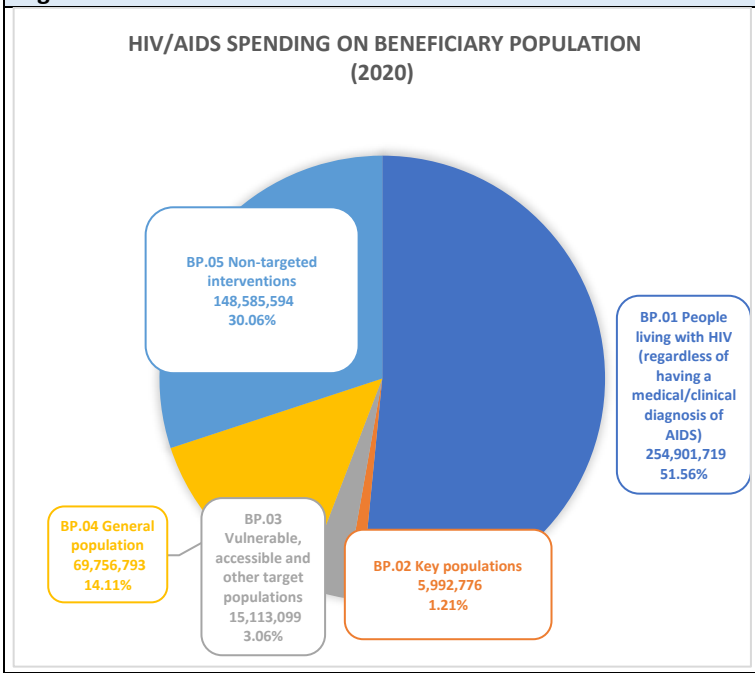
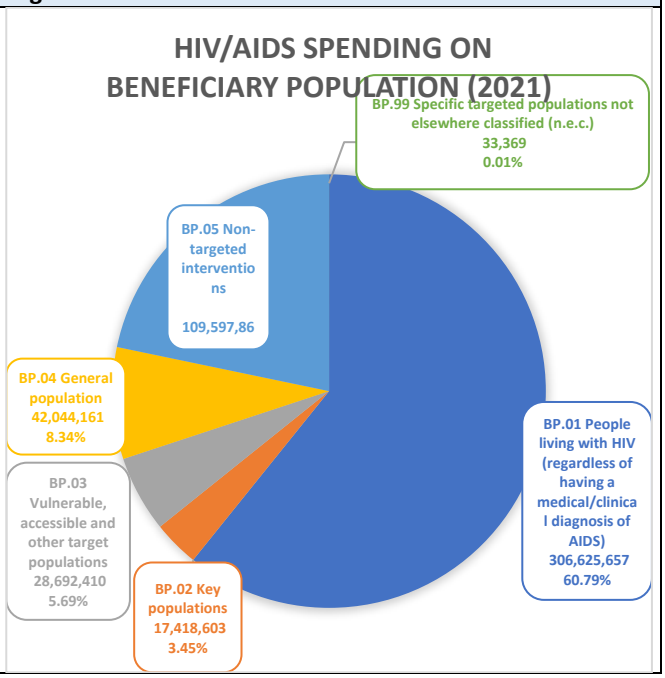


Figure 34.d: Year 2021



IV. DIFFICULTIES ENCOUNTERED AND CHALLENGES

Difficulties

The preparation of this report was not without difficulties. Among the difficulties encountered, we can mainly cite:

- the tendency to confuse NASA with an audit leading to the protection of financial data by certain implementation structures, making it difficult to access this data during collection;
- the delay in the transmission of data by certain data providers;
- the mobility of certain data providers who were not sufficiently available at the time of data collection;
- the new planning and reporting system for Government does not allow for expenditures to be disaggregated to a level sufficient to analyse expenditure categories, which led to the use of an estimate of expenditure for the years 2020 and 2021 based on the share of expenditure for the year 2019.

Challenges

For the future, several challenges remain:

- Capacity building of the finance officers/accountants of the various structures on the data filling canvas and on the NASA methodology and classification;
- Advocacy with the various structures for the timely supply of data;
- Wide distribution of this report at national and international level;
- Institutionalization of NASA in Zambia and the sustainability of the activity;
- Establishment of a team of national experts and the continuous strengthening of their capacities.

V. RECOMMENDATIONS

In order to help the National Programme in decision-making with a view to improving results for the coming years and in view of the results of this exercise to estimate resources and expenditure for the fight against HIV, AIDS and STIs and the difficulties inherent in the execution of the study, the following recommendations are made:

a) HEALTH ACCOUNTS

i) As noted under challenges, it was not possible to derive Government HIV expenditure data by intervention. This is due to the current Government planning and budgeting system. For HIV expenditure, it may be necessary to provide the framework for resource tracking at intervention level by developing a National Operational Plan for the NASF, which will provide the basis for tracking resources at intervention level. This will also enhance resource allocation once there is visibility regarding where resources are spent.

ii) Use NASA data to determine the comprehensiveness and robustness of the national HIV/AIDS strategic plan and framework. Use NASA data for priority setting in HIV/AIDS planning processes.

b) PUBLIC SPENDING

i) Though there is increased Government spending on Health and the HIV national response, clearly demonstrating commitment towards increased resource allocation and the achievement of the Abuja target, more still needs to be done in order to reduce dependence on donor funding. An exit strategy for reducing donor funds and achieving sustainability needs to be developed.

ii) Direct actors and development partners towards the financing of the priority areas of intervention of the NASF 2020-2023.
iii) Intensify advocacy with technical and financial partners, the Government and the private sector so that they invest more in financing the national response by favouring the population-location approach.

c) NASA PROCESSES

Recommendations for the NASA processes include the following:

i) Institutionalize the NASA process in Zambia for ease of data collection and reporting on HIV and AIDS spending.
ii) Sufficient time should be allocated to the planning of the data collection phase. It is necessary to first analyse and understand how expenditure data is organised. Stored and reported by different implementers and stakeholders before designing and developing the data collection plan. This will also reduce the proportion of expenditure which cannot be disaggregated for various reasons and reported in .98 and .99 codes.
iii) Regularly organize capacity building for data collection agents and managers of structures that support the NAC in the provision of HIV expenditure data, in particular all the structures involved in the fight against HIV and AIDS and especially the priority actors, namely coordinators, monitoring-evaluation managers and financial managers of structures at both national and district levels.
iv) Expand the number and build the capacity of the national team on the mastery of the NASA RTT3 software (national and district).
v) Raise awareness and develop advocacy with the structures holding the data to develop and transmit the data within the time limits set.
vi) Develop innovative ways of compelling the private sector to report HIV and AIDS spending, such as tying the issuance of annual licences to HIV and AIDS reporting as a matter of compliance.
vii) Take the necessary steps to popularize NASA results.

VI. CONCLUSION

The development of NASA 2019-2021 study was done in a participatory and inclusive process. It saw the involvement of the public sector, civil society, the private sector and financial partners. It highlights the point on the overall level of funding for the national response, gives a detailed description of the destination and use of resources. In summary, this report presents the financing situation for the HIV and AIDS response in Zambia between 2019 and 2021.

Despite the difficulties encountered in the process, the collection of financial data made it possible to successfully estimate the flow of resources and expenditure related to AIDS for the period 2019 to 2021.
We note a remarkable effort in the participation in the financing by the external partners (over **91%)** but efforts are still to be made by the external partners, the Government and the private sector because despite the efforts of each other, there is a gap between the funding needs of the National Strategic Framework (NSF 2020-2023) and the resources used in the fight against HIV/AIDS. There is also a good allocation of resources towards people living with HIV. However, the situation remains worrying with regard to key populations whose resource allocations remain very low. This has also been observed globally in spending on prevention which is below the UNAIDS standard.

The results from NASA are a response to the national authorities which will be a guide for better targeting of interventions and better allocation of resources at all levels. These results should absolutely help to make efficient use of the resources available in a context marked by the scarcity of resources and an increase in priorities at the international level.

According to this study, we can affirm that despite the few limitations of the study, NASA is an opportunity for the authorities in charge of the response, in the sense that it accurately provides important details concerning the financing of the national response. They (the authorities) have an information tool for monitoring and evaluating financial flows and advocacy. This tool will make it possible to carry out regular annual financial monitoring of the flow of resources and expenditure in the fight against AIDS, and to better operate its planning in this period of preparation for the NASF review and the development of a grant application to be submitted to the GFATM.

ANNEXES

Annex 1: NASA Classifications by vector

Table 1.a: Financing Entity (FE)

NASA Codes	Financing entity
FE.01.01.01	Central government
FE.01.01.02	State/provincial government
FE.01.01.03	Local/municipal government
FE.01.02	Social security institutions
FE.01.99	Other public n.e.c.
FE.02.01	Domestic corporations
FE.02.02	Households
FE.02.03	Domestic not-for-profit institutions (other than social insurance)
FE.02.99	Other Private financing n.e.c.
FE.03.01.01	Government of Australia
FE.03.01.02	Government of Austria
FE.03.01.03	Government of Belgium
FE.03.01.04	Government of Brazil
FE.03.01.05	Government of Canada
FE.03.01.06	Government of Denmark
FE.03.01.07	Government of Finland
FE.03.01.08	Government of France
FE.03.01.09	Government of Germany
FE.03.01.10	Government of Greece
FE.03.01.11	Government of India
FE.03.01.12	Government of Ireland
FE.03.01.13	Government of Italy
FE.03.01.14	Government of Japan
FE.03.01.15	Government of Korea
FE.03.01.16	Government of Luxembourg
FE.03.01.17	Government of Netherlands
FE.03.01.18	Government of New Zealand
FE.03.01.19	Government of Norway
FE.03.01.20	Government of People's Republic of China
FE.03.01.21	Government of Poland
FE.03.01.22	Government of Portugal
FE.03.01.23	Government of Russian Federation
FE.03.01.24	Government of South Africa
FE.03.01.25	Government of Spain
FE.03.01.26	Government of Sweden
FE.03.01.27	Government of Switzerland
FE.03.01.28	Government of United Arab Emirates
FE.03.01.29	Government of United Kingdom
FE.03.01.30	Government of United States
FE.03.01.99	Other government(s) /other bilateral agencies n.e.c.

NASA Codes	Financing entity
FE.03.02.01	Bureau of the Economic and Social Council (ECOSOC)
FE.03.02.02	European Commission
FE.03.02.03	Food and Agriculture Organization of the United Nations (FAO)
FE.03.02.04	International Labour Organization (ILO)
FE.03.02.05	International Organization for Migration (IOM)
FE.03.02.06	Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)
FE.03.02.07	The Global Fund to Fight AIDS, Tuberculosis and Malaria
FE.03.02.08	UNAIDS Secretariat
FE.03.02.09	United Nations Children's Fund (UNICEF)
FE.03.02.10	United Nations Development Fund for Women (UNIFEM)
FE.03.02.11	United Nations Development Programme (UNDP)
FE.03.02.12	United Nations Educational, Scientific and Cultural Organization (UNESCO)
FE.03.02.13	United Nations High Commissioner for Refugees (UNHCR)
FE.03.02.14	United Nations Human Settlements Programme (UN-HABITAT)
FE.03.02.15	United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FE.03.02.16	United Nations Office on Drugs and Crime (UNODC)
FE.03.02.17	United Nations Population Fund (UNFPA)
FE.03.02.18	World Bank Group (WB)
FE.03.02.19	World Food Programme (WFP)
FE.03.02.20	World Health Organization (WHO)
FE.03.02.99	Other Multilateral organizations n.e.c.
FE.03.03.01	International HIV/AIDS Alliance
FE.03.03.02	ActionAID
FE.03.03.03	Aga Khan Foundation
FE.03.03.04	Association François-Xavier Bagnoud
FE.03.03.05	Bernard van Leer Foundation
FE.03.03.06	Bill and Melinda Gates Foundation
FE.03.03.07	Bristol-Myers Squibb Foundation
FE.03.03.08	Care International
FE.03.03.09	Caritas Internationalis/Catholic Relief Services
FE.03.03.10	Deutsche Stiftung Weltbevölkerung
FE.03.03.11	Diana Princess of Wales Memorial Fund
FE.03.03.12	Elizabeth Glaser Pediatric AIDS Foundation
FE.03.03.13	European Foundation Centre
FE.03.03.14	Family Health International
FE.03.03.15	Foundation Mérieux
FE.03.03.16	Health Alliance International
FE.03.03.17	Helen K. and Arthur E. Johnson Foundation
FE.03.03.18	International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies
FE.03.03.19	King Baudouin Foundation
FE.03.03.20	Médecins sans Frontières
FE.03.03.21	Merck & Co., Inc

NASA Codes	Financing entity
FE.03.03.22	Plan International
FE.03.03.23	PSI (Population Services International)
FE.03.03.24	SIDACTION (mainly Francophone countries)
FE.03.03.25	The Clinton Foundation
FE.03.03.26	The Ford Foundation
FE.03.03.27	The Henry J. Kaiser Family Foundation
FE.03.03.28	The Nuffield Trust
FE.03.03.29	The Open Society Institute/Soros Foundation
FE.03.03.30	The Rockefeller Foundation
FE.03.03.31	United Nations Foundation
FE.03.03.32	Wellcome Trust
FE.03.03.33	World Vision
FE.03.03.34	International Planned Parenthood Federation
FE.03.03.35	Order of Malta
FE.03.03.36	PATH
FE.03.03.37	Chemonics International
FE.03.03.38	Pact
FE.03.03.39	Management Sciences for Health
FE.03.03.40	FHI 360
FE.03.03.99	Other International not-for-profit organizations and foundations n.e.c.
FE.03.04	International for profit organizations
FE.03.99	Other International n.e.c.
FE.99	Financial entity n.e.c.

Table 1.b: Revenue (REV)

NASA Codes	REVENUE (REV)
REV.01.01	Internal transfers and grants
REV.01.02	Transfers by government to social health insurance on behalf of specific groups
REV.01.03	Subsidies (Transfers from government domestic revenues to for-profit organization financing schemes)
REV.01.04	Transfers from government domestic revenues to non-profit organization financing schemes
REV.01.98	Transfers from government domestic revenue including reimbursable loans not disaggregated
REV.01.99	Transfers from government domestic revenue including reimbursable loans n.e.c.
REV.02	Transfers distributed by government from foreign origin
REV.03.01	Social insurance contributions from employees
REV.03.02	Social insurance contributions from employers
REV.03.03	Social insurance contributions from self-employed
REV.03.98	Social insurance contributions not disaggregated
REV.03.99	Social insurance contributions n.e.c.
REV.04.01	Compulsory prepayment from individuals/households
REV.04.02	Compulsory prepayment from employers
REV.04.98	Compulsory prepayment not disaggregated
REV.04.99	Compulsory prepayment n.e.c.

NASA Codes	REVENUE (REV)
REV.05.01	Voluntary prepayment from individuals/households
REV.05.02	Voluntary prepayment from employers
REV.05.98	Voluntary prepayment not disaggregated
REV.05.99	Voluntary prepayment n.e.c.
REV.06.01	Other revenues from households n.e.c.
REV.06.02	Other revenues from corporations n.e.c.
REV.06.03	Other revenues from non-profit institutions n.e.c.
REV.06.98	Other domestic revenues not disaggregated
REV.06.99	Other domestic revenues n.e.c.
REV.07.01.01	Direct bilateral financial transfers
REV.07.01.02	Direct multilateral financial transfers
REV.07.01.98	Direct foreign financial transfers not disaggregated
REV.07.01.99	Direct foreign financial transfers n.e.c.
REV.07.02.01.01	Direct bilateral aid in goods
REV.07.02.01.02	Direct multilateral aid in goods
REV.07.02.01.03	Other direct foreign aid in goods
REV.07.02.02	Direct foreign aid in kind: services (including TA)
REV.07.02.98	Other direct foreign aid in kind not disaggregated
REV.07.02.99	Other direct foreign aid in kind n.e.c.
REV.07.98	Other direct foreign transfers not disaggregated
REV.07.99	Other direct foreign transfers n.e.c.
REV.98	Revenues of health care financing schemes not disaggregated
REV.99	Other revenues of health care financing schemes n.e.c.

Table 1.c: Financing Schemes (SCH)

NASA Codes	FINANCING SCHEMES (SCH)
SCH.01.01.01	Central government schemes
SCH.01.01.02	State/regional/local government schemes
SCH.01.01.98	Government schemes not dissagregated
SCH.01.01.99	Government schemes n.e.c.
SCH.01.02.01.01	Private sector employee social health insurance schemes
SCH.01.02.01.02	Government employee social health insurance schemes
SCH.01.02.01.98	Social health insurance scheme not related to type of employment or not disaggregated
SCH.01.02.01.99	Social health insurance scheme n.e.c.
SCH.01.02.02	Compulsory private insurance schemes
SCH.01.02.98	Compulsory contributory health insurance schemes not dissagregated
SCH.01.02.99	Other compulsory contributory health insurance schemes n.e.c.
SCH.01.03	Compulsory Medical Saving Accounts (CMSA)
SCH.01.98	Government schemes not dissagregated
SCH.01.99	Other government schemes not elsewhere classified (n.e.c.)
SCH.02.01.01.01	Employer-based insurance (other than enterprises schemes)
SCH.02.01.01.02	Government-based voluntary insurance
SCH.02.01.01.98	Primary coverage schemes not disaggregated
SCH.02.01.01.99	Other primary coverage schemes n.e.c

NASA Codes	FINANCING SCHEMES (SCH)
SCH.02.01.02	Community-based insurance schemes and complementary/supplementary insurance schemes
SCH.02.01.03	Complementary/supplementary insurance (excluding Community-based insurance)
SCH.02.01.98	Voluntary insurance schemes not dissagregated
SCH.02.01.99	Other voluntary insurance schemes not elsewhere classified (n.e.c.)
SCH.02.02.01	Not-for-profit organisation schemes (excluding SCH.2.2.2)
SCH.02.02.02	Resident foreign agencies schemes
SCH.02.02.98	Not-for-profit organisation schemes not disaggregated
SCH.02.02.99	Not-for-profit organisation schemes n.e.c.
SCH.02.03.01	Enterprises (except health care providers) schemes
SCH.02.03.02	Health care providers schemes
SCH.02.03.98	For-profit enterprise schemes not dissagregated
SCH.02.03.99	For-profit enterprises not elsewhere classified (n.e.c.)
SCH.03.01	Out-of-pocket excluding cost-sharing
SCH.03.02.01	Cost sharing with government schemes and compulsory contributory health insurance schemes
SCH.03.02.02	Cost sharing with voluntary insurance schemes
SCH.03.98	Out-of-pocket not dissagregated
SCH.03.99	Out-of-pocket not elsewhere classified (n.e.c.)
SCH.04.01.01	Compulsory health insurance schemes (non-resident)
SCH.04.01.02	Other compulsory schemes (non-resident)
SCH.04.02.01	Voluntary health insurance schemes (non-resident)
SCH.04.02.02.01	Philanthropy/international NGOs schemes
SCH.04.02.02.02	Foreign development agencies schemes
SCH.04.02.02.03	Schemes of enclaves (e.g. international organisations or embassies)
SCH.04.98	Compulsory schemes (non-resident) not disaggregated
SCH.04.99	Compulsory schemes (non-resident) n.e.c.

Table 1.d: Financing Agent – Purchaser (FAP)

NASA Codes	Financing Agents - Purchaser
FAP.01.01.01.01	Ministry of Health (or equivalent sector entity)
FAP.01.01.01.02	Ministry of Education (or equivalent sector entity)
FAP.01.01.01.03	Ministry of Social Development (or equivalent sector entity)
FAP.01.01.01.04	Ministry of Defence (or equivalent sector entity)
FAP.01.01.01.05	Ministry of Finance (or equivalent sector entity)
FAP.01.01.01.06	Ministry of Labour (or equivalent sector entity)
FAP.01.01.01.07	Ministry of Justice (or equivalent sector entity)
FAP.01.01.01.08	Other ministries (or equivalent sector entities)
FAP.01.01.01.09	Prime Minister's or President's office
FAP.01.01.01.10	National AIDS Commission
FAP.01.01.01.99	Central or federal authorities' entities n.e.c.
FAP.01.01.02.01	Ministry of Health (or equivalent state sector entity)
FAP.01.01.02.02	Ministry of Education (or equivalent state sector entity)
FAP.01.01.02.03	Ministry of Social Development (or equivalent state sector entity)
FAP.01.01.02.04	Other ministries (or equivalent state sector entities)
FAP.01.01.02.05	Executive Office (or office of the head of the State/Province/Department)

NASA Codes	Financing Agents - Purchaser
FAP.01.01.02.06	State/Province/Department AIDS Commission
FAP.01.01.02.99	State/provincial/regional entities n.e.c.
FAP.01.01.03.01	Department of Health (or equivalent local sector entity)
FAP.01.01.03.02	Department of Education (or equivalent local sector entity)
FAP.01.01.03.03	Department of Social Development (or equivalent local sector entity)
FAP.01.01.03.04	Executive office (or office of the head of the local/municipal government)
FAP.01.01.03.05	Local/municipal government AIDS commission
FAP.01.01.03.99	Other local/municipal entities n.e.c.
FAP.01.02	Public social security
FAP.01.03	Government employee insurance programmes
FAP.01.04	Parastatal organizations
FAP.01.99	Other public financing agents n.e.c.
FAP.02.01	Private social security
FAP.02.02	Private employer insurance programmes
FAP.02.03	Private insurance enterprises (other than social insurance)
FAP.02.04	Private households' (out-of-pocket payments)
FAP.02.05	Not-for-profit institutions (other than social insurance)
FAP.02.06	Corporations other than providers of health services (nonparastatal)
FAP.02.99	Other private financing agents n.e.c.
FAP.03.01	Country offices of bilateral agencies managing external resources and fulfilling financing agent roles
FAP.03.02.01	Bureau of the Economic and Social Council (ECOSOC)
FAP.03.02.02	European Commission
FAP.03.02.03	Food and Agriculture Organization of the United Nations (FAO)
FAP.03.02.04	International Labour Organization (ILO)
FAP.03.02.05	International Organization for Migration (IOM)
FAP.03.02.06	Regional Development Banks (Africa, Asia, Latin America and the Caribbean, Islamic Development Bank, etc.)
FAP.03.02.07	UNAIDS Secretariat
FAP.03.02.08	United Nations Children's Fund (UNICEF)
FAP.03.02.09	UN Women
FAP.03.02.10	United Nations Development Programme (UNDP)
FAP.03.02.11	United Nations Educational, Scientific and Cultural Organization (UNESCO)
FAP.03.02.12	United Nations High Commissioner for Refugees (UNHCR)
FAP.03.02.13	United Nations Human Settlements Programme (UN-HABITAT)
FAP.03.02.14	United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and other Humanitarian Funding Mechanisms
FAP.03.02.15	United Nations Office on Drugs and Crime (UNODC)
FAP.03.02.16	United Nations Population Fund (UNFPA)
FAP.03.02.17	World Bank Group
FAP.03.02.18	World Food Programme (WFP)
FAP.03.02.19	World Health Organization (WHO)
FAP.03.02.99	Other Multilateral entities n.e.c.
FAP.03.03.01	International HIV/AIDS Alliance
FAP.03.03.02	ActionAID
FAP.03.03.03	Aga Khan Foundation
FAP.03.03.04	Association François-Xavier Bagnoud

NASA Codes	Financing Agents - Purchaser
FAP.03.03.05	Bernard van Leer Foundation
FAP.03.03.06	Bill and Melinda Gates Foundation
FAP.03.03.07	Bristol-Myers Squibb Foundation
FAP.03.03.08	Care International
FAP.03.03.09	Caritas Internationalis/Catholic Relief Services
FAP.03.03.10	Deutsche Stiftung Weltbevölkerung
FAP.03.03.11	Diana Princess of Wales Memorial Fund
FAP.03.03.12	Elizabeth Glaser Pediatric AIDS Foundation
FAP.03.03.13	European Foundation Centre
FAP.03.03.14	Family Health International
FAP.03.03.15	Foundation Mérieux
FAP.03.03.16	American International Health Alliance
FAP.03.03.17	Helen K. and Arthur E. Johnson Foundation
FAP.03.03.18	International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies
FAP.03.03.19	King Baudouin Foundation
FAP.03.03.20	Médecins sans Frontières
FAP.03.03.21	Merck & Co., Inc
FAP.03.03.22	Plan International
FAP.03.03.23	PSI (Population Services International)
FAP.03.03.24	SIDACTION (mainly Francophone countries)
FAP.03.03.25	The Clinton Foundation
FAP.03.03.26	The Ford Foundation
FAP.03.03.27	The Henry J. Kaiser Family Foundation
FAP.03.03.28	The Nuffield Trust
FAP.03.03.29	The Open Society Institute/Soros Foundation
FAP.03.03.30	The Rockefeller Foundation
FAP.03.03.31	United Nations Foundation
FAP.03.03.32	Wellcome Trust
FAP.03.03.33	World Vision
FAP.03.03.34	International Planned Parenthood Federation
FAP.03.03.35	Order of Malta
FAP.03.03.36	PATH
FAP.03.03.37	Chemonics International
FAP.03.03.38	Pact
FAP.03.03.39	Management Sciences for Health
FAP.03.03.40	FHI 360
FAP.03.03.99	Other International not-for-profit organizations n.e.c.
FAP.03.04	Projects within Universities
FAP.03.05	International for-profit organizations
FAP.03.99	Other international financing agents n.e.c.
FAP.99	FAP n.e.c.

Table 1.e: Providers of Services (PS)

NASA Codes	Providers of Services (PS)
PS.01.01.01	Hospitals (public)
PS.01.01.02	Ambulatory care (public)
PS.01.01.03	Mental health and substance abuse facilities (public)
PS.01.01.04	Laboratory and imaging facilities (public)
PS.01.01.05	Blood banks (public)
PS.01.01.06	Ambulance services (public)
PS.01.01.07	Pharmacies and providers of medical goods (public)
PS.01.01.08	Traditional or non-allopathic care providers (public)
PS.01.01.09.01	Primary education (public)
PS.01.01.09.02	Secondary education (public)
PS.01.01.09.03	Higher education (public)
PS.01.01.09.98	Public schools and training centres not disaggregated
PS.01.01.09.99	Public schools and training centres n.e.c.
PS.01.01.10	Foster homes/shelters (public)
PS.01.01.11	Orphanages (public)
PS.01.01.12	Research institutions (public)
PS.01.01.13.01	National AIDS Coordinating Authority (NACs)
PS.01.01.13.02	Departments inside the Ministry of Health or equivalent
PS.01.01.13.03	Departments inside the Ministry of Education or equivalent
PS.01.01.13.04	Departments inside the Ministry of Social Development or equivalent
PS.01.01.13.05	Departments inside the Ministry of Defence or equivalent
PS.01.01.13.06	Departments inside the Ministry of Finance or equivalent
PS.01.01.13.07	Departments inside the Ministry of Labour or equivalent
PS.01.01.13.08	Departments inside the Ministry of Justice or equivalent
PS.01.01.13.98	Government entities not disaggregated
PS.01.01.13.99	Government entities n.e.c.
PS.01.01.98	Governmental organizations not disaggregated
PS.01.01.99	Governmental organizations n.e.c.
PS.01.02.01	Hospitals (parastatal)
PS.01.02.02	Ambulatory care (parastatal)
PS.01.02.03	Mental health and substance abuse facilities (parastatal)
PS.01.02.04	Laboratory and imaging facilities (parastatal)
PS.01.02.05	Blood banks (parastatal)
PS.01.02.06	Ambulance services (parastatal)
PS.01.02.07	Pharmacies and providers of medical goods (parastatal)
PS.01.02.08	Traditional or non-allopathic care providers (parastatal)
PS.01.02.09.01	Primary education (parastatal)
PS.01.02.09.02	Secondary education (parastatal)
PS.01.02.09.03	Higher education (parastatal)
PS.01.02.09.98	Parastatal schools and training facilities not disaggregated
PS.01.02.09.99	Parastatal schools and training facilities n.e.c.
PS.01.02.10	Foster homes/shelters (parastatal)
PS.01.02.11	Parastatal orphanages
PS.01.02.12	Parastatal Research institutions
PS.01.02.98	Parastatal organizations not disaggregated

NASA Codes	Providers of Services (PS)
PS.01.02.99	Parastatal organizations n.e.c.
PS.01.98	Public sector providers not disaggregated
PS.01.99	Public sector providers n.e.c.
PS.02.01.01.01	Hospitals (private non-profit non-faith based)
PS.02.01.01.02	Ambulatory care (private non-profit non-faith based)
PS.02.01.01.03	Mental health and substance abuse facilities (private non-profit non-faith based)
PS.02.01.01.04	Laboratory and imaging facilities (private non-profit non-faith based)
PS.02.01.01.05	Blood banks (private non-profit non-faith based)
PS.02.01.01.06	Ambulance services (private non-profit non-faith based)
PS.02.01.01.07	Pharmacies and providers of medical goods (private non-profit non-faith based)
PS.02.01.01.08	Traditional or non-allopathic care providers (private non-profit non-faith based)
PS.02.01.01.09.01	Primary education (private non-profit non-faith based)
PS.02.01.01.09.02	Secondary education (private non-profit non-faith based)
PS.02.01.01.09.03	Higher education (private non-profit non-faith based)
PS.02.01.01.09.98	Private non-profit non-faith based non-profit schools and training centres not disaggregated
PS.02.01.01.09.99	Private non-profit non-faith based non-profit schools and training centres n.e.c.
PS.02.01.01.10	Foster homes/shelters (private non-profit non-faith based)
PS.02.01.01.11	Orphanages (private non-profit non-faith based)
PS.02.01.01.12	Research institutions (private non-profit non-faith based)
PS.02.01.01.13	Self-help and informal community-based organizations (private non-profit non-faith based)
PS.02.01.01.14	Civil society organizations (private non-profit non-faith based)
PS.02.01.01.98	Other private non-profit non-faith-based providers not disaggregated
PS.02.01.01.99	Other private non-profit non-faith-based providers n.e.c.
PS.02.01.02.01	Hospitals (private non-profit faith based)
PS.02.01.02.02	Ambulatory care (private non-profit faith based)
PS.02.01.02.03	Mental health and substance abuse facilities (private non-profit faith based)
PS.02.01.02.04	Laboratory and imaging facilities (private non-profit faith based)
PS.02.01.02.05	Blood banks (private non-profit faith based)
PS.02.01.02.06	Ambulance services (private non-profit faith based)
PS.02.01.02.07	Pharmacies and providers of medical goods (private non-profit faith based)
PS.02.01.02.08	Traditional or non-allopathic care providers (private non-profit faith based)
PS.02.01.02.09.01	Primary education (private non-profit faith based)
PS.02.01.02.09.02	Secondary education (private non-profit faith based)
PS.02.01.02.09.03	Higher education (private non-profit faith based)
PS.02.01.02.09.98	Private non-profit faith based schools and training centres not disaggregated
PS.02.01.02.09.99	Private non-profit faith based schools and training centres n.e.c.
PS.02.01.02.10	Foster homes/shelters (private non-profit faith based)
PS.02.01.02.11	Orphanages (private non-profit faith based)
PS.02.01.02.12	Self-help and informal community-based organizations (private non-profit faith based)
PS.02.01.02.13	Civil society organizations (private non-profit faith based)
PS.02.01.02.98	Other non-profit faith-based privatesector providers not disaggregated
PS.02.01.02.99	Other non-profit faith-based privatesector providers n.e.c.
PS.02.01.98	Other non-profit private sector providers not disaggregated
PS.02.01.99	Other non-profit private sector providers n.e.c.
PS.02.02.01	Hospitals (profit-making private)

NASA Codes	Providers of Services (PS)
PS.02.02.02	Ambulatory care (profit-making private)
PS.02.02.03	Mental health and substance abuse facilities (profit-making private)
PS.02.02.04	Laboratory and imaging facilities (profit-making private)
PS.02.02.05	Blood banks (profit-making private)
PS.02.02.06	Ambulance services (profit-making private)
PS.02.02.07	Pharmacies and providers of medical goods (profit-making private)
PS.02.02.08	Traditional or non-allopathic care providers (profit-making private)
PS.02.02.09.01	Primary education (profit-making private)
PS.02.02.09.02	Secondary education (profit-making private)
PS.02.02.09.03	Higher education (profit-making private)
PS.02.02.09.98	Profit-making private schools and training centres not disaggregated
PS.02.02.09.99	Profit-making private schools and training centres n.e.c.
PS.02.02.10	Foster homes/shelters (profit-making private)
PS.02.02.11	Orphanages (profit-making private)
PS.02.02.12	Research institutions (profit-making private)
PS.02.02.13	Consultancy firms (profit-making private)
PS.02.02.98	Profit-making private sector providers not disaggregated
PS.02.02.99	Profit-making private sector providers n.e.c.
PS.02.98	Private sector providers not disaggregated
PS.02.99	Private sector providers n.e.c.
PS.03.01	Bilateral agencies
PS.03.02	Multilateral agencies
PS.03.03	International NGOs and foundations
PS.03.98	Bilateral, multilateral entities, international NGOs and foundations – in country offices not dissagregated
PS.03.99	Bilateral, multilateral entities, international NGOs and foundations – in country offices n.e.c.
PS.04	Rest-of-the world providers (activities undertaken outside the country)
PS.98	Providers not disaggregated
PS.99	Providers n.e.c.

Table 1.f: Service Delivery Modalities (SDM)

NASA Codes	Types of Service Delivery Modalities
SDM.01.01	Facility-based: Outpatient
SDM.01.02	Facility-based: Inpatient
SDM.01.03	Directly observed treatment (DOT)
SDM.01.98	Facility-based not disaggregated
SDM.01.99	Other facility-based n.e.c.
SDM.02.01	Community-based: center
SDM.02.02	Community-based: pick up points (CPUP)
SDM.02.03	Community-based: automated distribution unit/dispensing machine
SDM.02.04	Community-based: mobile unit
SDM.02.05	Community-based: outreach
SDM.02.06	Community-based: home-based (including door-to-door)
SDM.02.07	HIV self-testing
SDM.02.98	Home and community based not disaggregated

NASA Codes	Types of Service Delivery Modalities
SDM.02.99	Home and community based n.e.c.
SDM.03	Non applicable (ASC which does not have a specific SDM)
SDM.98	Modalities not disaggregated
SDM.99	Modalities n.e.c.

Table 1.g: Production Factors (PF)

NASA Codes	Production Factors
PF.01.02.02	Office utilities costs (electricity, water, heating, etc.)
PF.01.02.03	Travel expenditure
PF.01.02.04	Administrative and programme management costs
PF.01.02.98	Other current costs not disaggregated
PF.01.02.99	Other current costs n.e.c.
PF.01.03.01.01	Antiretrovirals
PF.01.03.01.02	Anti-tuberculosis drugs
PF.01.03.01.03	OST drugs
PF.01.03.01.04	STI drugs
PF.01.03.01.05	Hepatitits vaccines
PF.01.03.01.06	Hepatitits treatment drugs
PF.01.03.01.07	OI other than TB drugs
PF.01.03.01.98	Pharmaceuticals not disaggregated
PF.01.03.01.99	Pharmaceuticals n.e.c.
PF.01.03.02.01	Syringes and needles
PF.01.03.02.02	Condoms
PF.01.03.02.03	Lubricants
PF.01.03.02.98	Medical supplies not disaggregated
PF.01.03.02.99	Medical supplies n.e.c.
PF.01.03.03.01	HIV tests screening/diagnostics
PF.01.03.03.02	VL tests
PF.01.03.03.03	CD4 tests
PF.01.03.03.04	Diagnostic tests for STI (including rapid testing)
PF.01.03.03.05	Diagnostic tests for TB (including rapid testing)
PF.01.03.03.06	Diagnostic tests for hepatitis (including rapid testing)
PF.01.03.03.98	Reagents and materials not disaggregated
PF.01.03.03.99	Reagents and materials n.e.c.
PF.01.03.04.01	Food and nutrients
PF.01.03.04.02	Promotion and information materials
PF.01.03.04.98	Non-medical supplies not disaggregated
PF.01.03.04.99	Non-medical supplies n.e.c.
PF.01.03.05	Office Supplies
PF.01.03.98	Medical products and supplies not disaggregated
PF.01.03.99	Medical products and supplies n.e.c.
PF.01.04	Contracted external services
PF.01.05	Transportation related to beneficiaries
PF.01.06	Housing/accommodation services for beneficiaries
PF.01.07	Financial support for beneficiaries

NASA Codes	Production Factors
PF.01.08	Training- Training related per diems/transport/other costs
PF.01.09	Logistics of events, including catering services
PF.01.10.01	Financial intermediary services
PF.01.10.02	Indirect cost rate
PF.01.10.98	Indirect costs not disaggregated
PF.01.10.99	Indirect costs n.e.c
PF.01.98	Current direct and indirect expenditures not disaggregated
PF.01.99	Current direct and indirect expenditures n.e.c.
PF.02.01.01	Laboratory and other infrastructure upgrading
PF.02.01.02	Construction and renovation
PF.02.01.98	Building not disaggregated
PF.02.01.99	Building n.e.c.
PF.02.02	Vehicles
PF.02.03.01	Information technology (hardware and software)
PF.02.03.02	Laboratory and other medical equipment
PF.02.03.03	Non medical equipment and furniture
PF.02.03.98	Other capital investment not disaggregated
PF.02.03.99	Other capital investment n.e.c.
PF.02.98	Capital expenditure not disaggregated
PF.02.99	Capital expenditure n.e.c.
PF.98	Production factors not disaggregated

Table 1.h: AIDS Spending Categories (ASC)

NASA Codes	Aids Spending Category (ASC)
ASC.01.01.01.01	Condom promotion and distribution as part of dedicated programmes for AGYW - only if earmarked HIV funds are spent
ASC.01.01.01.02	Youth-friendly SRH services for AGYW - only if earmarked HIV funds are spent
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
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
ASC.01.01.01.98	Programmatic activities for AGYW not disaggregated by type
ASC.01.01.01.99	Other activities for AGYW n.e.c.
ASC.01.01.02.01.01	Condom and lubricant programmes as part of programmes for sex workers
ASC.01.01.02.01.02	STI/SRH services for sex workers (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.01.03	Peer education for sex workers - only if earmarked HIV funds are spent
ASC.01.01.02.01.04	Community empowerment including prevention of violence against sex workers and legal support - only if earmarked HIV funds are spent
ASC.01.01.02.01.98	Programmatic activities for sex workers and their clients not disaggregated by type
ASC.01.01.02.01.99	Other programmatic activities for sex workers and their clients, n.e.c.
ASC.01.01.02.02.01	Condom and lubricant programmes for MSM
ASC.01.01.02.02.02	STI/SRH services for MSM (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.02.03	Behaviour change communication (BCC) as part of programmes for MSM
ASC.01.01.02.02.04	Empowerment including prevention of violence against MSM and legal support
ASC.01.01.02.02.98	Programmatic activities for MSM not disaggregated by type
ASC.01.01.02.02.99	Other programmatic activities for MSM n.e.c.
ASC.01.01.02.03.01	Condom and lubricant programmes for transgenders

NASA Codes	Aids Spending Category (ASC)
ASC.01.01.02.03.02	STI/SRH services for TG (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.03.03	Behaviour change communication (BCC) as part of programmes for TG
ASC.01.01.02.03.04	Community empowerment and prevention of stigma and discrimination among TG
ASC.01.01.02.03.98	Programmatic activities for TG not disaggregated by type
ASC.01.01.02.03.99	Other programmatic activities for TG n.e.c.
ASC.01.01.02.04.01	Condom and lubricant programme as part of programmes for PWID
ASC.01.01.02.04.02	STI/SRH services for PWID (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.04.03	Behaviour change communication (BCC) as part of programmes for PWID
ASC.01.01.02.04.04	Community empowerment and prevention of stigma and discrimination among PWID
ASC.01.01.02.04.05	Sterile syringe and needle exchange as part of programmes for PWID
ASC.01.01.02.04.06.01	Provision of drug substitution treatment for PWID
ASC.01.01.02.04.06.02	Social and psychological support for PWID on Opiod substitution therapy
ASC.01.01.02.04.06.98	Drug substitution treatment and social support not disaggregated
ASC.01.01.02.04.06.99	Drug substitution treatment and social support not elsewhere classified (n.e.c.)
ASC.01.01.02.04.07	Diagnosis and treatment of mental health disorders for PWID - only if earmarked HIV funds are spent
ASC.01.01.02.04.08	Overdose prevention for PWID (includes nolaxon) - only if earmarked HIV funds are spent
ASC.01.01.02.04.98	Other programmatic activities for PWID not disaggregated by type
ASC.01.01.02.04.99	Other programmatic activities for PWID, n.e.c.
ASC.01.01.02.05.01	Condom and lubricant programmes for inmates (prisoners)
ASC.01.01.02.05.02	STI/SRH services for inmates (excluding HTC/PrEP/ART) - only if earmarked HIV funds are spent
ASC.01.01.02.05.03	Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners)
ASC.01.01.02.05.04	Community empowerment and prevention of stigma and discrimination among inmates (prisoners)
ASC.01.01.02.05.98	Programmatic activities for inmates not disaggregated by type
ASC.01.01.02.05.99	Other programmatic activities for inmates n.e.c.
ASC.01.01.02.98	Services for key populations not dissagregated (exclusively for the five populations here described)
ASC.01.01.02.99	Services for key populations not elsewhere classified (n.e.c.) (exclusively for the five populations here described)
ASC.01.01.03.01	Provision of free condoms for HIV prevention (excluding for KPs and AGYW)
ASC.01.01.03.02	Social marketing of condoms for HIV prevention (excluding for KPs and AGYW)
ASC.01.01.03.03	Condom demand generation (excluding for KPs and AGYW)
ASC.01.01.03.04	Sale of condoms (purchased by individuals)
ASC.01.01.03.98	Condom activities (for HIV prevention) not disaggregated
ASC.01.01.03.99	Condom activities (for HIV prevention) n.e.c (excluding for KPs and AGYW)
ASC.01.01.04.01	Voluntary medical male circumcision (VMMC) programmes
ASC.01.01.04.02	Demand generation for VMMC programmes
ASC.01.01.04.98	VMMC activities (for HIV prevention) not disaggregated
ASC.01.01.04.99	Other programmatic activities on VMMC (for HIV prevention) n.e.c.
ASC.01.01.05.01	PrEP as part of programmes for AGYW
ASC.01.01.05.02	PrEP as part of programmes for sex workers and their clients
ASC.01.01.05.03	PrEP as part of programmes for gay men and other men who have sex with men (MSM)
ASC.01.01.05.04	PrEP as part of programmes for Transgenders (TG)
ASC.01.01.05.05	PrEP as part of programmes for PWIDs
ASC.01.01.05.06	PrEP as part of programmes for sero-discordant couples
ASC.01.01.05.07	PrEP as part of programmes for inmates of correctional facilities or pre-trial detention centres (prisoners)
ASC.01.01.05.98	PrEP not disaggregated by key population

NASA Codes	Aids Spending Category (ASC)
ASC.01.01.05.99	PrEP not elsewhere classified n.e.c.
ASC.01.02.01.01	Safe infant feeding practices (including substitution of breastmilk)
ASC.01.02.01.02	Delivery practices as part of PMTCT programmes
ASC.01.02.01.03	Reproductive health and family planning services as part of PMTCT programmes
ASC.01.02.01.98	PMTCT not disaggregated by activity
ASC.01.02.01.99	PMTCT activities n.e.c.
ASC.01.02.02	Social and behavioural communication for change (SBCC) for populations other than key populations
ASC.01.02.03	Community mobilization for populations other than key populations
ASC.01.02.04.01	Condom and lubricant promotion and provision as part of programmes for vulnerable and accessible populations
ASC.01.02.04.02	STI prevention and treatment as part of programmes for vulnerable and accessible populations
ASC.01.02.04.03	Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations
ASC.01.02.04.98	Programmatic activities for vulnerable and accessible population not disaggregated by type
ASC.01.02.04.99	Other programmatic activities for vulnerable and accessible populations n.e.c
ASC.01.02.05.01	Prevention activities implemented in school
ASC.01.02.05.02	Prevention activities implemented out-of-school
ASC.01.02.05.98	Prevention activities for children and youth not disaggregated by type
ASC.01.02.05.99	Prevention activities for children and youth n.e.c
ASC.01.02.06.01	BCC for PLHIV and SDC
ASC.01.02.06.02	Condoms and lubricants programmes for PLHIV and SDC
ASC.01.02.06.03	STI prevention and treatment as part of programmes for PLHIV and their partners
ASC.01.02.06.98	Programmatic activities for PLHIV and SDC not disaggregated by type
ASC.01.02.06.99	Other programmatic activities for PLHIV and SDC not elsewhere classified n.e.c.
ASC.01.02.07	Prevention and wellness programmes in the workplace
ASC.01.02.08	Microbicides
ASC.01.02.09	Post-exposure prophylaxis
ASC.01.02.10	STI prevention and treatment programmes for populations other than key populations - only if funded from earmarked HIV budgets
ASC.01.02.98	Prevention activities not disaggregated
ASC.01.02.99	Other prevention activities n.e.c.
ASC.02.01	HIV testing and counselling for sex workers
ASC.02.02	HIV testing and counselling for MSM
ASC.02.03	HIV testing and counselling for TG
ASC.02.04	HIV testing and counselling for PWID
ASC.02.05	HIV testing and counselling for inmates of correctional and pre-trial facilities
ASC.02.06	HIV testing and counselling for pregnant women (part of PMTCT programme)
ASC.02.07	Early infant (and paediatric??) diagnosis (EID) of HIV
ASC.02.08	HIV testing and counselling for vulnerable and accessible populations
ASC.02.09	Voluntary HIV testing and counselling for general population
ASC.02.10	Provider initiated testing and counselling (PITC)
ASC.02.11	HIV screening in blood banks
ASC.02.12	Mandatory HIV testing (not VCT) (including premarital, job applications, visas etc.)
ASC.02.98	HIV testing and counselling activities not disaggregated
ASC.02.99	Other HIV counselling and testing activities n.e.c.
ASC.03.01.01.01	First-line ART – adults

NASA Codes	Aids Spending Category (ASC)
ASC.03.01.01.02	Second-line ART – adults
ASC.03.01.01.03	Third-line or salvage ART - adults
ASC.03.01.01.98	Adult antiretroviral therapy not disaggregated by line of treatment
ASC.03.01.02.01	First-line ART – paediatric
ASC.03.01.02.02	Second-line ART – paediatric
ASC.03.01.02.03	Third-line or salvage ART - paediatric
ASC.03.01.02.98	Paediatric antiretroviral therapy not disaggregated by line of treatment
ASC.03.01.03	ART for PMTCT (for pregnant women not previously on treatment)
ASC.03.01.98	Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT
ASC.03.01.99	Antiretroviral therapy n.e.
ASC.03.02	Adherence and retention on ART - support (including nutrition and transport) and monitoring
ASC.03.03	Specific ART-related laboratory monitoring
ASC.03.04.01.01	TB prevention
ASC.03.04.01.02	TB screening, case detection and diagnosis
ASC.03.04.01.03.01	TB (drug-sensitive) treatment (including DOTS)
ASC.03.04.01.03.02	TB (drug-resistant) treatment
ASC.03.04.01.03.98	TB treatment not disaggregated by type of TB
ASC.03.04.01.03.99	TB treatment n.e.c
ASC.03.04.01.04	TB adherence and retention support
ASC.03.04.01.05	Nutritional support associated with TB treatment
ASC.03.04.01.06	TB psychosocial support
ASC.03.04.01.98	TB activities not disaggregated by type
ASC.03.04.01.99	Other TB activities n.e.c
ASC.03.04.02.01	Hepatitis prevention (including HBV vaccination)
ASC.03.04.02.02	Hepatitis screening and diagnosis
ASC.03.04.02.03	Hepatitis treatment
ASC.03.04.02.98	Hepatitis activities not disaggregated by type
ASC.03.04.02.99	Hepatitis activities n.e.c
ASC.03.04.03	Other OI prophylaxis (excluding TB and Hepatitis)
ASC.03.04.04	Other OI treatment (excluding TB and Hepatitis)
ASC.03.04.98	Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)
ASC.03.04.99	Other OI prophylaxis and treatment n.e.c (excluding TB and hepatitis)
ASC.03.05	Psychological treatment and support service
ASC.03.06	Palliative care
ASC.03.07	Traditional medicine and informal care and treatment services
ASC.03.98	Care and treatment services not disaggregated
ASC.03.99	Care and treatment services n.e.c.
ASC.04.01.01	OVC Basic needs (health, education, housing)
ASC.04.01.02	OVC Institutional and Community support
ASC.04.01.03	OVC Social Services (including financial benefits)
ASC.04.01.98	OVC Services not disaggregated by activity
ASC.04.01.99	OVC services n.e.c.
ASC.04.02.01	Social protection through monetary or in-kind benefits
ASC.04.02.02	Social protection through provision of social services
ASC.04.02.03	HIV-specific income generation projects

NASA Codes	Aids Spending Category (ASC)
ASC.04.02.98	Social protection services and social services not disaggregated by type
ASC.04.02.99	Social protection services and social services n.e.c.
ASC.04.98	Social protection activities not disaggregated
ASC.04.99	Social protection activities n.e.c
ASC.05.01	Advocacy
ASC.05.02.01	Stigma and discrimination reduction
ASC.05.02.02	HIV-related legal services
ASC.05.02.03	Monitoring and reforming laws, regulations and policies relating to HIV
ASC.05.02.04	Sensitization of law-makers and law enforcement agents
ASC.05.02.05	Reducing discrimination and violence against women in the context of HIV
ASC.05.02.06	Capacity building in human rights
ASC.05.02.98	Human rights programmes not disaggregated by type
ASC.05.02.99	Human rights programmes n.e.c.
ASC.05.98	Social enablers not disaggregated by type
ASC.05.99	Social enablers n.e.c.
ASC.06.01	Strategic planning, coordination and policy development
ASC.06.02.01	Representation of PLHIV in key processes
ASC.06.02.02	Representation of youth in key processes
ASC.06.02.03	Representation of women in key processes
ASC.06.02.04	Representation of key populations in key processes
ASC.06.02.98	Building meaningful engagement activities not disaggregated by target group
ASC.06.02.99	Building meaningful engagement activities n.e.c.
ASC.06.03	Programme administration and management costs (above service-delivery level)
ASC.06.04.01	Monitoring and evaluation
ASC.06.04.02	Operations and implementation science research
ASC.06.04.03	Serological-surveillance (serosurveillance)
ASC.06.04.04	Management information systems
ASC.06.04.05	HIV drug-resistance surveillance
ASC.06.04.06	Financial tracking and monitoring (National AIDS Spending Assessments -NASA)
ASC.06.04.98	Strategic information not disaggregated by type
ASC.06.04.99	Strategic information n.e.c.
ASC.06.05.01	Procurement and supply chain
ASC.06.05.02	Laboratory system strengthening
ASC.06.05.03	Institutional & organisational development (health, social, educational etc)
ASC.06.05.04	Financial and accounting systems strengthening
ASC.06.05.98	Public system strengthening not disaggregated
ASC.06.05.99	Public system strengthening n.e.c.
ASC.06.06.01	Civil society institutional and NGO development
ASC.06.06.02	Community worker education, training and support
ASC.06.06.03	Resource mobilisation for community-based organisations
ASC.06.06.04	Recruitment and retention of volunteers
ASC.06.06.98	Community system strengthening not disaggregated
ASC.06.06.99	Community system strengthening n.e.c.
ASC.06.07.01	Capacity building for health workers, excluding those at community level
ASC.06.07.02	Recruitment, retention and scale-up of health workers, excluding for community health workers (to be included under ASC.06.06)

NASA Codes	Aids Spending Category (ASC)
ASC.06.07.98	Health and community workforce intervention(s) not dissagregated
ASC.06.07.99	Other health and community workforce intervention(s) n.e.c.
ASC.06.98	Programme enablers and systems strengthening not disagregated
ASC.06.99	Programme enablers and systems strengthening not disagregated
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
ASC.07.02.01	Reducing violence against women and young girls
ASC.07.02.02	Reducing sexual diversity violence
ASC.07.02.98	Formative education to build-up an HIV workforce and other trainings not related to any specific activity not dissagregated
ASC.07.02.99	Formative education to build-up an HIV workforce and other trainings not related to any specific activity not elsewhere classified (n.e.c.)
ASC.07.03	Promote HIV-sensitive, cross-sectoral development
ASC.07.98	Development synergies not disaggregated
ASC.07.99	Development synergies n.e.c.
ASC.08.01	Biomedical research
ASC.08.02	Clinical research
ASC.08.03	Epidemiological research
ASC.08.04	Socio-behavioural research
ASC.08.05	Economic research
ASC.08.06	Vaccine-related research
ASC.08.98	HIV and AIDS-related research activities not disaggregated by type
ASC.08.99	HIV and AIDS-related research activities n.e.c.

Table 1.i: Beneficiary Population (BP)

NASA Codes	Beneficiary Population (BP)
BP.01.01.01	Adult and young men (aged 15 and over) living with HIV
BP.01.01.02	Adult and young women (aged 15 over) living with HIV
BP.01.01.03	Pregnant and breastfeeding women (and not on ART)
BP.01.01.98	Adult and young people (aged 15 over) living with HIV not broken down by gender
BP.01.02.01	Boys (aged under 15) living with HIV
BP.01.02.02	Girls (aged under 15) living with HIV
BP.01.02.98	Children (aged under 15) living with HIV not broken down by gender
BP.01.98	People living with HIV not broken down by age or gender
BP.02.01.01	Adults (>18years) who Inject drug users (PWID) and their sexual partners
BP.02.01.02	Children (<18years) who inject drugs
BP.02.02.01	Female sex workers and their clients
BP.02.02.02	Transgender sex workers
BP.02.02.03	Male sex workers (and their clients)
BP.02.02.98	Sex workers, not broken down by gender, and their clients
BP.02.03	Gay men and other men who have sex with men (MSM)
BP.02.04	Transgender
BP.02.05	Inmates of correctional facilities (prisoners) and other institutionalized persons
BP.02.98	"Key populations" not broken down by type
BP.03.01	Orphans and vulnerable children (OVC)

NASA Codes	Beneficiary Population (BP)
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
BP.03.03	Adolescent girls and young women in countries with high HIV prevalence
BP.03.04	Refugees (externally displaced)
BP.03.05	Internally displaced populations (because of an emergency)
BP.03.06	Migrants/mobile populations
BP.03.07	Indigenous groups
BP.03.08	Truck drivers/transport workers and commercial drivers
BP.03.09	Children and youth living in the street
BP.03.10	Children and youth gang members
BP.03.11	Children and youth out of school
BP.03.12	Institutionalized children and youth
BP.03.13	Partners of people living with HIV (including sero-discordant couples)
BP.03.14	Recipients of blood or blood products
BP.03.15	People attending STI clinics
BP.03.16	Elementary school students
BP.03.17	Junior high/high school students
BP.03.18	University students
BP.03.19	Health care workers
BP.03.20	Sailors
BP.03.21	Military
BP.03.22	Police and other uniformed services (other than the military)
BP.03.23	Ex-combatants and other armed non-uniformed groups
BP.03.24	Employees (e.g. for workplace interventions)
BP.03.98	Vulnerable, accessible and other target populations not broken down by type
BP.03.99	Other vulnerable, accessible and other target populations n.e.c.
BP.04.01.01	Male adult population
BP.04.01.02	Female adult population
BP.04.01.98	General adult population (aged older than 24) not broken down by gender
BP.04.02.01	Boys
BP.04.02.02	Girls
BP.04.02.98	Children (aged under 15) not broken down by gender
BP.04.03.01	Young men
BP.04.03.02	Young females (excluding the AGYW programmes in high HIV prevalence countries)
BP.04.03.98	Youth (aged 15 to 24) not broken down by gender
BP.04.98	General population not broken down by age or gender.
BP.05	Non-targeted interventions
BP.99	Specific targeted populations not elsewhere classified (n.e.c.)

ANNEX 2: NASF estimates of costs (2019-2021)

Annex 2.a: Estimated resources required for the NASF interventions (US$ million, 2016 prices)

NASF Intervention	2017	2018	2019	2020	2021	% over period
Maternal syphilis (diagnosis treatment t)	0.60	0.62	0.65	0.67	0.69	0.1%
Paediatric syphilis (diagnosis & treatment)	0.01	0.01	0.01	0.01	0.02	0.003%
Youth focused interventions	6.64	6.98	7.34	7.70	7.90	1.6%
Interventions for sex workers	0.48	0.50	0.51	0.53	0.55	0.1%
Cash transfers	3.33	4.39	5.92	6.52	7.78	1.2%
Interventions for MSM	0.02	0.03	0.03	0.03	0.03	0.01%
Community mobilisation	4.91	5.73	6.60	7.53	7.80	1.4%
Condom provision	32.06	35.51	39.47	43.38	47.63	0.0%
STI diagnosis & treatment	6.87	7.75	8.68	9.67	10.71	8.6%
HIV testing services (HTS)	19.29	20.94	22.69	24.54	26.47	1.9%
VMMC	24.03	25.10	26.22	27.39	28.90	4.9%
PrEP	1.62	1.72	1.83	1.95	2.07	0.4%
PMTCT	2.98	2.99	2.92	2.82	2.73	0.6%
Mass media	7.31	8.48	9.74	11.07	12.48	2.1%
Blood safety	0.13	0.13	0.14	0.14	0.15	0.03%
ARV therapy	230.79	258.50	262.96	270.25	272.97	56.3%
Enabling environment	2.71	3.02	3.15	3.29	3.41	0.7%
Programme management	8.81	9.80	10.22	10.70	11.08	2.2%
Research	2.37	2.64	2.75	2.88	2.98	0.6%
Monitoring and evaluation (8%)	27.11	30.16	31.46	32.93	34.09	6.8%
Strategic communication	7.79	8.67	9.04	9.47	9.80	1.9%
Logistics	4.07	4.52	4.72	4.94	5.11	1.0%
Laboratory (equip/strengthening)	6.78	7.54	7.86	8.23	8.52	1.7%
Total (US$ millions)	400.70	445.75	464.91	486.66	503.86	100.0%

Source: *National HIV/AIDS strategic framework 2017-2021*

Annex 2.b: Detailed RNASF resource need (US$ million, 2020-2023)

RNASF interventions (US$ millions)	2020	2021	2022	2023	% 2021-2023
HIV Testing					
Testing: Provider initiated	18.24	15.04	11.96	9.03	2%
Testing: Assisted partner notification	0.84	2.72	4.03	4.68	1%
Testing: Self-test	-	0.56	0.96	1.18	0%
Testing: Early infant diagnosis	0.92	1.09	1.25	1.41	0%
Treatment					
Adult ARVs: first line	86.10	83.49	85.07	86.53	14%
Adult ARVs: second line	14.30	14.80	15.30	15.80	2%
Adult ARVs: third line	13.10	13.55	14.01	14.47	2%
Adult ARVs: HR costs	10.20	10.56	10.37	10.16	2%
Adult ARVs: labs	10.81	11.18	11.56	11.94	2%
Pediatric ART	15.70	15.94	15.43	14.73	3%
VL testing	24.99	25.83	26.63	27.40	4%
ART support activities (adherence, DSDs, CLM etc)	42.14	43.61	45.09	46.55	7%
Additional ART service delivery costs	61.56	63.70	65.86	68.00	11%
PMTCT	2.27	2.54	2.51	2.47	0%
PEP	0.02	0.03	0.05	0.07	0%
Cervical Cancer	6.58	6.78	7.09	7.32	1%
TB preventive therapy	2.54	2.93	2.93	2.93	0%
General population 25+					
Condom promotion	7.27	8.58	10.15	11.83	2%
SBCC, comm-mobilization, demand creation	6.43	6.61	6.88	7.16	1%

PrEP (only AGYW, SW, MSM, PLW)	-	19.79	23.49	23.51	4%
STI treatment and prevention	4.54	4.71	4.89	5.09	1%
Key and vulnerable populations					
FSW services	11.07	11.52	13.64	15.80	2%
MSM services	1.02	2.71	3.15	3.78	1%
PWID services	-	1.15	1.32	1.49	0%
Vulnerable populations (package not defined)	5.16	5.16	5.16	5.16	1%
Programs for AGYW					
Family planning	0.11	0.27	0.38	0.49	0%
Parenting/care giver programs	1.15	2.55	3.37	4.25	1%
Educational subsidy	3.07	18.39	24.32	30.67	4%
Economic empowerment	1.64	12.42	18.04	24.05	3%
Comprehensive sexuality education	1.77	1.93	2.09	2.27	0%
Community norms change	0.77	1.10	1.45	1.82	0%
PrEP for adolescents	3.75	4.69	5.41	5.41	1%
Programs for ABYM					
VMMC	22.27	34.08	35.06	30.25	5%
Condoms for ABYM	0.82	0.85	0.88	0.91	0%
CSE for ABYM	2.82	3.04	3.28	3.53	1%
Mitigation and support					
OVC	22.15	22.15	22.15	22.15	4%
Critical enablers					
CE: CSS	4.00	4.04	4.24	4.45	1%
CE: Research, surveillance, M&E, HMIS	16.85	16.85	16.85	16.85	3%
CE: HSS PSM	16.85	16.85	16.85	16.85	3%
CE: HSS Lab strengthening	16.85	16.85	16.85	16.85	3%
CE: HSS HR capacity building	4.00	4.04	4.24	4.45	1%
CE: Policies, laws & human rights, stigma & discrimination reduction	2.00	2.02	2.12	2.23	0%
CE: Gender equality, empowerment, GBV interventions, access to SHRS	4.00	4.04	4.24	4.45	1%
CE: Planning, Coord, PM, QA, leadership & governance	38.93	43.81	46.59	48.29	8%
Total RNASF cost estimates (US$m)	**$ 509.61**	**$ 584.57**	**$ 617.21**	**$ 638.73**	**100%**

Source: *National HIV/AIDS strategic framework 2020-2023*

ANNEX 3: Data Collection Tool

National Aids Council of Zambia

National Aids Spending Assessment (NASA) 2029-2021					
Data Collection Tool					
Location/Region		**Year of the expenditure estimate**		**Currency**	
Financing entity (FE)					
Name of financing entity					
Financing Agent/Purchaser (FAP)					
Name of the Financing Agent/Purchaser					
Provider of Services (PS)					
Name of the Provider of Services (PS)					

	NASA Classification Code	**Comments**	**Amount spent (selected currency)**	**No of beneficiaries reached**
AIDS SPENDING CATEGORY (ASC) 1				Do not populate
Service Delivery Model (SDM)				Do not populate
Beneficiary population (BP)				
Production Factor (PF) 1				Do not populate
Production Factor (PF) 2				Do not populate
Production Factor (PF) 3				Do not populate
Production Factor (PF) 4				Do not populate
Production Factor (PF) 5				Do not populate
Production Factor (PF) 6				Do not populate
Production Factor (PF) 7				Do not populate
Production Factor (PF) 8				Do not populate
Production Factor (PF) 9				Do not populate

Production Factor (PF) 10				Do not populate
Production Factor (PF) 11				Do not populate
Production Factor (PF) 12				Do not populate
Total Spent PF				

AIDS SPENDING CATEGORY (ASC) 2				Do not populate
Service Delivery Model (SDM)				Do not populate
Beneficiary population (BP)				

Production Factor (PF) 1				Do not populate
Production Factor (PF) 2				Do not populate
Production Factor (PF) 3				Do not populate
Production Factor (PF) 4				Do not populate
Production Factor (PF) 5				Do not populate
Production Factor (PF) 6				Do not populate
Production Factor (PF) 7				Do not populate
Production Factor (PF) 8				Do not populate
Production Factor (PF) 9				Do not populate
Production Factor (PF) 10				Do not populate
Production Factor (PF) 11				Do not populate
Production Factor (PF) 12				Do not populate
Total Spent PF				
The total of "beneficiary population" must be equal to the total "Production Factor".				
Data provider focal point name		**Tel:**	**Email:**	
Data Collector name		**Tel:**	**Email:**	

- ✓ The information on the "Data collection tool" sheet must be provided for each service provider and for each intervention.
- ✓ There will be as many sheets as there are interventions per service provider. We therefore invite you to duplicate this "data collection tool" sheet as many times as needed.

APPENDIX 4: PEPFAR – NASA CROSSWALK

PEPFAR Program	PEPFAR Sub-program	PEPFAR Beneficiary	PEPFAR Sub-beneficiary	CONCAT	NASA ACS	NASA SDM	NASA BP
ASP	HMIS, surveillance, & research	Females	Adult women	ASP HMIS, surveillance, & research Females Adult women	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Females	Young women & adolescent females	ASP HMIS, surveillance, & research Females Young women & adolescent females	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Men having sex with men	ASP HMIS, surveillance, & research Key Pops Men having sex with men	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Not disaggregated	ASP HMIS, surveillance, & research Key Pops Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	People in prisons	ASP HMIS, surveillance, & research Key Pops People in prisons	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Sex workers	ASP HMIS, surveillance, & research Key Pops Sex workers	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Key Pops	Transgender	ASP HMIS, surveillance, & research Key Pops Transgender	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Males	Not disaggregated	ASP HMIS, surveillance, & research Males Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Non-Targeted Pop	Adults	ASP HMIS, surveillance, & research Non-Targeted Pop Adults	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Non-Targeted Pop	Not disaggregated	ASP HMIS, surveillance, & research Non-Targeted Pop Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Non-Targeted Pop	Young people & adolescents	ASP HMIS, surveillance, & research Non-Targeted Pop Young people & adolescents	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	OVC	Not disaggregated	ASP HMIS, surveillance, & research OVC Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	OVC	Orphans & vulnerable children	ASP HMIS, surveillance, & research OVC Orphans & vulnerable children	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Pregnant & Breastfeeding Women	Not disaggregated	ASP HMIS, surveillance, & research Pregnant & Breastfeeding Women Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

ASP	HMIS, surveillance, & research	Not Specified	Not Specified	ASP HMIS, surveillance, & research Not Specified Not Specified	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	OVC	Orphans & vulnerable children	ASP Human resources for health OVC Orphans & vulnerable children	ASC.06.07.98 Health and community workforce intervention(s) not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Non-Targeted Pop	Not disaggregated	ASP Human resources for health Non-Targeted Pop Not disaggregated	ASC.06.07.98 Health and community workforce intervention(s) not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Priority Pops	Military & other uniformed services	ASP Human resources for health Priority Pops Military & other uniformed services	ASC.06.07.98 Health and community workforce intervention(s) not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Institutional prevention	Non-Targeted Pop	Adults	ASP Institutional prevention Non-Targeted Pop Adults	ASC.01.02.99 Other prevention activities n.e.c.	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
ASP	Laboratory systems strengthening	Non-Targeted Pop	Children	ASP Laboratory systems strengthening Non-Targeted Pop Children	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Non-Targeted Pop	Not disaggregated	ASP Laboratory systems strengthening Non-Targeted Pop Not disaggregated	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Not Specified	Not Specified	ASP Laboratory systems strengthening Not Specified Not Specified	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Specified	Not Specified	Not Specified	ASP Not Specified Not Specified Not Specified	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laws, regulations & policy environment	Non-Targeted Pop	Not disaggregated	ASP Laws, regulations & policy environment Non-Targeted Pop Not disaggregated	ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Disaggregated	Non-Targeted Pop	Not disaggregated	ASP Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Disaggregated	Non-Targeted Pop	Young people & adolescents	ASP Not Disaggregated Non-Targeted Pop Young people & adolescents	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Non-Targeted Pop	Adults	ASP Human resources for health Non-Targeted Pop Adults	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Human resources for health	Females	Young women & adolescent females	ASP Human resources for health Females Young women & adolescent females	ASC.06.98 Programme enablers and systems strengthening not disaggregated	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Females	Young women & adolescent females	ASP Policy, planning, coordination & management Females Young women & adolescent females	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

ASP	Policy, planning, coordination & management	Key Pops	Not disaggregated	ASP Policy, planning, coordination & management Key Pops Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Males	Not disaggregated	ASP Policy, planning, coordination & management Males Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Non-Targeted Pop	Adults	ASP Policy, planning, coordination & management Non-Targeted Pop Adults	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Non-Targeted Pop	Children	ASP Policy, planning, coordination & management Non-Targeted Pop Children	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Non-Targeted Pop	Children	ASP Policy, planning, coordination & management of disease control programs Non-Targeted Pop Children	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management	Non-Targeted Pop	Not disaggregated	ASP Policy, planning, coordination & management Non-Targeted Pop Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Key Pops	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Key Pops Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Non-Targeted Pop	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Non-Targeted Pop Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Pregnant & Breastfeeding Women	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Pregnant & Breastfeeding Women Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	OVC	Orphans & vulnerable children	ASP Policy, planning, coordination & management of disease control programs OVC Orphans & vulnerable children	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Females	Adult women	ASP Policy, planning, coordination & management of disease control programs Females Adult women	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of	Non-Targeted Pop	Adults	ASP Policy, planning, coordination & management of disease control programs Non-Targeted Pop Adults	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

	disease control programs						
ASP	Policy, planning, coordination & management of disease control programs	Females	Young women & adolescent females	ASP Policy, planning, coordination & management of disease control programs Females Young women & adolescent females	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Policy, planning, coordination & management of disease control programs	Males	Not disaggregated	ASP Policy, planning, coordination & management of disease control programs Males Not disaggregated	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Procurement & supply chain management	Key Pops	Not disaggregated	ASP Procurement & supply chain management Key Pops Not disaggregated	ASC.06.05.01 Procurement and supply chain	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Procurement & supply chain management	Non-Targeted Pop	Not disaggregated	ASP Procurement & supply chain management Non-Targeted Pop Not disaggregated	ASC.06.05.01 Procurement and supply chain	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Public financial management strengthening	Non-Targeted Pop	Not disaggregated	ASP Public financial management strengthening Non-Targeted Pop Not disaggregated	ASC.06.05.04 Financial and accounting systems strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
C&T	HIV Clinical Services	Key Pops	Men having sex with men	C&T HIV Clinical Services Key Pops Men having sex with men	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Key Pops	Not disaggregated	C&T HIV Clinical Services Key Pops Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Non-Targeted Pop	Children	C&T HIV Clinical Services Non-Targeted Pop Children	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
C&T	HIV Clinical Services	Non-Targeted Pop	Not disaggregated	C&T HIV Clinical Services Non-Targeted Pop Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Pregnant & Breastfeeding Women	Not disaggregated	C&T HIV Clinical Services Pregnant & Breastfeeding Women Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Non-Targeted Pop	Young people & adolescents	C&T HIV Clinical Services Non-Targeted Pop Young people & adolescents	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender
C&T	HIV Clinical Services	Females	Adult women	C&T HIV Clinical Services Females Adult women	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV
C&T	HIV Clinical Services	Females	Not disaggregated	C&T HIV Clinical Services Females Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV

C&T	HIV Clinical Services	Non-Targeted Pop	Adults	C&T HIV Clinical Services Non-Targeted Pop Adults	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.98 Adult and young people (aged 15 over) living with HIV not broken down by gender
C&T	HIV Clinical Services	Females	Young women & adolescent females	C&T HIV Clinical Services Females Young women & adolescent females	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV
C&T	HIV Clinical Services	Males	Not disaggregated	C&T HIV Clinical Services Males Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.01 Adult and young men (aged 15 and over) living with HIV
C&T	HIV Clinical Services	Males	Adult men	C&T HIV Clinical Services Males Adult men	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.01 Adult and young men (aged 15 and over) living with HIV
C&T	HIV Clinical Services	Key Pops	Sex workers	C&T HIV Clinical Services Key Pops Sex workers	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Non-Targeted Pop	Children	C&T HIV Drugs Non-Targeted Pop Children	ASC.03.01.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
C&T	HIV Drugs	Not Specified	Not Specified	C&T HIV Drugs Not Specified Not Specified	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Non-Targeted Pop	Adults	C&T HIV Drugs Non-Targeted Pop Adults	ASC.03.01.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Non-Targeted Pop	Not disaggregated	C&T HIV Drugs Non-Targeted Pop Not disaggregated	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Key Pops	People who inject drugs	C&T HIV Laboratory Services Key Pops People who inject drugs	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Non-Targeted Pop	Children	C&T HIV Laboratory Services Non-Targeted Pop Children	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
C&T	HIV Laboratory Services	Non-Targeted Pop	Not disaggregated	C&T HIV Laboratory Services Non-Targeted Pop Not disaggregated	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	Men having sex with men	C&T Not Disaggregated Key Pops Men having sex with men	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender

C&T	Not Disaggregated	Key Pops	Not disaggregated	C&T Not Disaggregated Key Pops Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	People in prisons	C&T Not Disaggregated Key Pops People in prisons	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Key Pops	Sex workers	C&T Not Disaggregated Key Pops Sex workers	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Males	Not disaggregated	C&T Not Disaggregated Males Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Non-Targeted Pop	Adults	C&T Not Disaggregated Non-Targeted Pop Adults	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Non-Targeted Pop	Not disaggregated	C&T Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Pregnant & Breastfeeding Women	Not disaggregated	C&T Not Disaggregated Pregnant & Breastfeeding Women Not disaggregated	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	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
C&T	Not Specified	Non-Targeted Pop	Children	C&T Not Specified Non-Targeted Pop Children	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.02.98 Children (aged under 15) living with HIV not broken down by gender
C&T	Not Specified	Not Specified	Not Specified	C&T Not Specified Not Specified Not Specified	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
HTS	Not Specified	Not Specified	Not Specified	HTS Not Specified Not Specified Not Specified	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
HTS	Not Specified	Pregnant & Breastfeeding Women	Not Specified	HTS Not Specified Pregnant & Breastfeeding Women Not Specified	ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	SDM.01.01 Facility-based: Outpatient	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
HTS	Community-based testing	Females	Young women & adolescent females	HTS Community-based testing Females Young women & adolescent females	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
HTS	Community-based testing	Key Pops	People in prisons	HTS Community-based testing Key Pops People in prisons	ASC.02.05 HIV testing and counselling for inmates of	SDM.02.98 Home and community based not disaggregated	BP.02.05 Inmates of correctional facilities (prisoners) and other

					correctional and pre-trial facilities		institutionalized persons
HTS	Community-based testing	Key Pops	People who inject drugs	HTS Community-based testing Key Pops People who inject drugs	ASC.02.04 HIV testing and counselling for PWID	SDM.02.98 Home and community based not disaggregated	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
HTS	Community-based testing	Males	Adult men	HTS Community-based testing Males Adult men	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
HTS	Community-based testing	Males	Young men & adolescent males	HTS Community-based testing Males Young men & adolescent males	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.03.01 Young men
HTS	Community-based testing	Non-Targeted Pop	Children	HTS Community-based testing Non-Targeted Pop Children	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.02.98 Children (aged under 15) not broken down by gender
HTS	Community-based testing	Non-Targeted Pop	Not disaggregated	HTS Community-based testing Non-Targeted Pop Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Community-based testing	Non-Targeted Pop	Young people & adolescents	HTS Community-based testing Non-Targeted Pop Young people & adolescents	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Community-based testing	Priority Pops	Not disaggregated	HTS Community-based testing Priority Pops Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Facility-based testing	Key Pops	People in prisons	HTS Facility-based testing Key Pops People in prisons	ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities	SDM.01.01 Facility-based: Outpatient	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons
HTS	Facility-based testing	Non-Targeted Pop	Not disaggregated	HTS Facility-based testing Non-Targeted Pop Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.98 General population not broken down by age or gender.
HTS	Facility-based testing	Pregnant & Breastfeeding Women	Not disaggregated	HTS Facility-based testing Pregnant & Breastfeeding Women Not disaggregated	ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	SDM.01.01 Facility-based: Outpatient	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
HTS	Facility-based testing	Key Pops	Not disaggregated	HTS Facility-based testing Key Pops Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.02.98 "Key populations" not broken down by type

HTS	Not Disaggregated	Females	Not disaggregated	HTS Not Disaggregated Females Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.02 Female adult population
HTS	Not Disaggregated	Key Pops	Men having sex with men	HTS Not Disaggregated Key Pops Men having sex with men	ASC.02.02 HIV testing and counselling for MSM	SDM.98 Modalities not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)
HTS	Not Disaggregated	Key Pops	Not disaggregated	HTS Not Disaggregated Key Pops Not disaggregated	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
HTS	Not Disaggregated	Key Pops	People who inject drugs	HTS Not Disaggregated Key Pops People who inject drugs	ASC.02.04 HIV testing and counselling for PWID	SDM.98 Modalities not disaggregated	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
HTS	Not Disaggregated	Key Pops	Sex workers	HTS Not Disaggregated Key Pops Sex workers	ASC.02.01 HIV testing and counselling for sex workers	SDM.98 Modalities not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
HTS	Not Disaggregated	Males	Not disaggregated	HTS Not Disaggregated Males Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.01 Male adult population
HTS	Not Disaggregated	Non-Targeted Pop	Adults	HTS Not Disaggregated Non-Targeted Pop Adults	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
HTS	Not Disaggregated	Non-Targeted Pop	Not disaggregated	HTS Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
HTS	Not Disaggregated	Non-Targeted Pop	Young people & adolescents	HTS Not Disaggregated Non-Targeted Pop Young people & adolescents	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
HTS	Not Disaggregated	Pregnant & Breastfeeding Women	Not disaggregated	HTS Not Disaggregated Pregnant & Breastfeeding Women Not disaggregated	ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	SDM.01.01 Facility-based: Outpatient	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
PM	IM Closeout costs	Non-Targeted Pop	Not disaggregated	PM IM Closeout costs Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Program Management	Females	Young women & adolescent females	PM IM Program Management Females Young women & adolescent females	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions

PM	IM Program Management	Key Pops	Not disaggregated	PM IM Program Management Key Pops Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Program Management	Non-Targeted Pop	Not disaggregated	PM IM Program Management Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Program Management	OVC	Not disaggregated	PM IM Program Management OVC Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	IM Program Management	Priority Pops	Not disaggregated	PM IM Program Management Priority Pops Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	Program Management	Non-Targeted Pop	Not disaggregated	PM Program Management Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PM	USG Program Management	Non-Targeted Pop	Not disaggregated	PM USG Program Management Non-Targeted Pop Not disaggregated	ASC.06.03 Programme administration and management costs (above service-delivery level)	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
PREV	Comm. mobilization, behaviour & norms change	Females	Young women & adolescent females	PREV Comm. mobilization, behaviour & norms change Females Young women & adolescent females	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	SDM.02.99 Home and community based n.e.c.	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	Comm. mobilization, behaviour & norms change	Key Pops	Men having sex with men	PREV Comm. mobilization, behaviour & norms change Key Pops Men having sex with men	ASC.01.01.02.02.03 Behaviour change communication (BCC) as part of programmes for MSM	SDM.02.99 Home and community based n.e.c.	BP.02.03 Gay men and other men who have sex with men (MSM)
PREV	Comm. mobilization, behaviour & norms change	Key Pops	Not disaggregated	PREV Comm. mobilization, behaviour & norms change Key Pops Not disaggregated	ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	SDM.02.99 Home and community based n.e.c.	BP.02.98 "Key populations" not broken down by type
PREV	Comm. mobilization, behaviour & norms change	Key Pops	People in prisons	PREV Comm. mobilization, behaviour & norms change Key Pops People in prisons	ASC.01.01.02.05.03 Interpersonal communication on HIV prevention as part of programmes for inmates (prisoners)	SDM.02.99 Home and community based n.e.c.	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons
PREV	Comm. mobilization, behaviour & norms change	Key Pops	People who inject drugs	PREV Comm. mobilization, behaviour & norms change Key Pops People who inject drugs	ASC.01.01.02.04.03 Behaviour change communication (BCC) as part of programmes for PWID	SDM.02.99 Home and community based n.e.c.	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
PREV	Comm. mobilization, behaviour & norms change	Key Pops	Sex workers	PREV Comm. mobilization, behaviour & norms change Key Pops Sex workers	ASC.01.01.02.01.04 Community empowerment including prevention of violence against sex workers and legal support -	SDM.02.99 Home and community based n.e.c.	BP.02.02.98 Sex workers, not broken down by gender, and their clients

					only if earmarked HIV funds are spent		
PREV	Comm. mobilization, behaviour & norms change	Non-Targeted Pop	Not disaggregated	PREV Comm. mobilization, behaviour & norms change Non-Targeted Pop Not disaggregated	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.99 Home and community based n.e.c.	BP.04.98 General population not broken down by age or gender.
PREV	Comm. mobilization, behaviour & norms change	Non-Targeted Pop	Young people & adolescents	PREV Comm. mobilization, behaviour & norms change Non-Targeted Pop Young people & adolescents	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.99 Home and community based n.e.c.	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
PREV	Comm. mobilization, behaviour & norms change	OVC	Not disaggregated	PREV Comm. mobilization, behaviour & norms change OVC Not disaggregated	ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	SDM.02.99 Home and community based n.e.c.	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Comm. mobilization, behaviour & norms change	OVC	Orphans & vulnerable children	PREV Comm. mobilization, behaviour & norms change OVC Orphans & vulnerable children	ASC.01.02.04.03 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	SDM.02.99 Home and community based n.e.c.	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Comm. mobilization, behaviour & norms change	Non-Targeted Pop	Adults	PREV Comm. mobilization, behaviour & norms change Non-Targeted Pop Adults	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.99 Home and community based n.e.c.	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
PREV	Condom & Lubricant Programming	Pregnant & Breastfeeding Women	Not disaggregated	PREV Condom & Lubricant Programming Pregnant & Breastfeeding Women Not disaggregated	ASC.01.02.01.03 Reproductive health and family planning services as part of PMTCT programmes	SDM.01.01 Facility-based: Outpatient	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
PREV	Condom & Lubricant Programming	Non-Targeted Pop	Adults	PREV Condom & Lubricant Programming Non-Targeted Pop Adults	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
PREV	Condom & Lubricant Programming	Females	Not disaggregated	PREV Condom & Lubricant Programming Females Not disaggregated	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.02 Female adult population
PREV	Condom & Lubricant Programming	Males	Not disaggregated	PREV Condom & Lubricant Programming Males Not disaggregated	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.01 Male adult population
PREV	Condom & Lubricant Programming	Non-Targeted Pop	Not disaggregated	PREV Condom & Lubricant Programming Non-Targeted Pop Not disaggregated	ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.

PREV	Not Disaggregated	OVC	Orphans & vulnerable children	PREV Not Disaggregated OVC Orphans & vulnerable children	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.98 Modalities not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Not Specified	Not Specified	Not Specified	PREV Not Specified Not Specified Not Specified	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Medication assisted treatment	Key Pops	People who inject drugs	PREV Medication assisted treatment Key Pops People who inject drugs	ASC.01.01.02.04.06.01 Provision of drug substitution treatment for PWID	SDM.01.01 Facility-based: Outpatient	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
PREV	Not Disaggregated	Females	Young women & adolescent females	PREV Not Disaggregated Females Young women & adolescent females	ASC.01.01.01.98 Programmatic activities for AGYW not disaggregated by type	SDM.98 Modalities not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	Not Disaggregated	Key Pops	Men having sex with men	PREV Not Disaggregated Key Pops Men having sex with men	ASC.01.01.02.02.98 Programmatic activities for MSM not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)
PREV	Not Disaggregated	Key Pops	Not disaggregated	PREV Not Disaggregated Key Pops Not disaggregated	ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	Not Disaggregated	Key Pops	People in prisons	PREV Not Disaggregated Key Pops People in prisons	ASC.01.01.02.05.98 Programmatic activities for inmates not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons
PREV	Not Disaggregated	Key Pops	People who inject drugs	PREV Not Disaggregated Key Pops People who inject drugs	ASC.01.01.02.04.98 Other programmatic activities for PWID not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.01.01 Adults (>18years) who Inject drug users (PWID) and their sexual partners
PREV	Not Disaggregated	Key Pops	Sex workers	PREV Not Disaggregated Key Pops Sex workers	ASC.01.01.02.01.98 Programmatic activities for sex workers and their clients not disaggregated by type	SDM.98 Modalities not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
PREV	Not Disaggregated	Non-Targeted Pop	Adults	PREV Not Disaggregated Non-Targeted Pop Adults	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Not Disaggregated	Females	Adult women	PREV Not Disaggregated Females Adult women	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.01.02 Female adult population
PREV	Not Disaggregated	Non-Targeted Pop	Not disaggregated	PREV Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.
PREV	Not Disaggregated	Non-Targeted Pop	Young people & adolescents	PREV Not Disaggregated Non-Targeted Pop Young people & adolescents	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.98 General population not broken down by age or gender.

PREV	Not Disaggregated	OVC	Not disaggregated	PREV Not Disaggregated OVC Not disaggregated	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.98 Modalities not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Not Disaggregated	Priority Pops	Not disaggregated	PREV Not Disaggregated Priority Pops Not disaggregated	ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	PrEP	Females	Young women & adolescent females	PREV PrEP Females Young women & adolescent females	ASC.01.01.05.01 PrEP as part of programmes for AGYW	SDM.98 Modalities not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	PrEP	Key Pops	Not disaggregated	PREV PrEP Key Pops Not disaggregated	ASC.01.01.05.98 PrEP not disaggregated by key population	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	PrEP	Key Pops	Sex workers	PREV PrEP Key Pops Sex workers	ASC.01.01.05.02 PrEP as part of programmes for sex workers and their clients	SDM.98 Modalities not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
PREV	PrEP	Non-Targeted Pop	Not disaggregated	PREV PrEP Non-Targeted Pop Not disaggregated	ASC.01.01.05.98 PrEP not disaggregated by key population	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	PrEP	Priority Pops	Not disaggregated	PREV PrEP Priority Pops Not disaggregated	ASC.01.01.05.98 PrEP not disaggregated by key population	SDM.98 Modalities not disaggregated	BP.02.98 "Key populations" not broken down by type
PREV	Primary prevention of HIV and sexual violence	Females	Young women & adolescent females	PREV Primary prevention of HIV and sexual violence Females Young women & adolescent females	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Priority Pops	Not disaggregated	PREV Primary prevention of HIV and sexual violence Priority Pops Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	OVC	Not disaggregated	PREV Primary prevention of HIV and sexual violence OVC Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Males	Boys	PREV Primary prevention of HIV and sexual violence Males Boys	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Key Pops	Not disaggregated	PREV Primary prevention of HIV and sexual violence Key Pops Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	VMMC	Non-Targeted Pop	Not disaggregated	PREV VMMC Non-Targeted Pop Not disaggregated	ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV	SDM.98 Modalities not disaggregated	BP.04.01.01 Male adult population

PREV	VMMC	Key Pops	Not disaggregated	PREV VMMC Key Pops Not disaggregated	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Adult men	PREV VMMC Males Adult men	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Not disaggregated	PREV VMMC Males Not disaggregated	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Not Specified	PREV VMMC Males Not Specified	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Males	Young men & adolescent males	PREV VMMC Males Young men & adolescent males	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
PREV	VMMC	Priority Pops	Military & other uniformed services	PREV VMMC Priority Pops Military & other uniformed services	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.03.21 Military
SE	Case Management	OVC	Orphans & vulnerable children	SE Case Management OVC Orphans & vulnerable children	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Case Management	OVC	Not disaggregated	SE Case Management OVC Not disaggregated	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Economic strengthening	OVC	Orphans & vulnerable children	SE Economic strengthening OVC Orphans & vulnerable children	ASC.04.01.03 OVC Social Services (including financial benefits)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Economic strengthening	Females	Young women & adolescent females	SE Economic strengthening Females Young women & adolescent females	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	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Economic strengthening	Non-Targeted Pop	Young people & adolescents	SE Economic strengthening Non-Targeted Pop Young people & adolescents	ASC.04.02.03 HIV-specific income generation projects	SDM.02.98 Home and community based not disaggregated	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
SE	Economic strengthening	OVC	Not disaggregated	SE Economic strengthening OVC Not disaggregated	ASC.04.01.03 OVC Social Services (including financial benefits)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Economic strengthening	Females	Girls	SE Economic strengthening Females Girls	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	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Education assistance	Females	Girls	SE Education assistance Females Girls	ASC.01.01.01.04 Cash transfers, social grants and other economic empowerment as	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women

					part of programmes for AGYW - only if earmarked HIV funds are spent		in countries with high HIV prevalence
SE	Education assistance	Females	Young women & adolescent females	SE Education assistance Females Young women & adolescent females	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	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Education assistance	OVC	Orphans & vulnerable children	SE Education assistance OVC Orphans & vulnerable children	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Education assistance	OVC	Not disaggregated	SE Education assistance OVC Not disaggregated	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Legal, human rights & protection	Non-Targeted Pop	Not disaggregated	SE Legal, human rights & protection Non-Targeted Pop Not disaggregated	ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV	SDM.02.98 Home and community based not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
SE	Legal, human rights & protection	Females	Young women & adolescent females	SE Legal, human rights & protection Females Young women & adolescent females	ASC.01.01.01.99 Other activities for AGYW n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Legal, human rights & protection	OVC	Not disaggregated	SE Legal, human rights & protection OVC Not disaggregated	ASC.04.01.99 OVC services n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Legal, human rights & protection	OVC	Orphans & vulnerable children	SE Legal, human rights & protection OVC Orphans & vulnerable children	ASC.04.01.99 OVC services n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Legal, human rights & protection	OVC	Care givers	SE Legal, human rights & protection OVC Care givers	ASC.04.01.99 OVC services n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Not Disaggregated	Non-Targeted Pop	Not disaggregated	SE Not Disaggregated Non-Targeted Pop Not disaggregated	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.04.01.98 General adult population (aged older than 24) not broken down by gender
SE	Not Disaggregated	Females	Girls	SE Not Disaggregated Females Girls	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	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Not Disaggregated	OVC	Not disaggregated	SE Not Disaggregated OVC Not disaggregated	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)

SE	Not Disaggregated	OVC	Orphans & vulnerable children	SE Not Disaggregated OVC Orphans & vulnerable children	ASC.04.01.98 OVC Services not disaggregated by activity	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Psychosocial support	Non-Targeted Pop	Adults	SE Psychosocial support Non-Targeted Pop Adults	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
SE	Psychosocial support	Non-Targeted Pop	Not disaggregated	SE Psychosocial support Non-Targeted Pop Not disaggregated	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
SE	Psychosocial support	Non-Targeted Pop	Young people & adolescents	SE Psychosocial support Non-Targeted Pop Young people & adolescents	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.01.98 People living with HIV not broken down by age or gender
SE	Psychosocial support	OVC	Not disaggregated	SE Psychosocial support OVC Not disaggregated	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Psychosocial support	OVC	Orphans & vulnerable children	SE Psychosocial support OVC Orphans & vulnerable children	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
SE	Not Disaggregated	Females	Young women & adolescent females	SE Not Disaggregated Females Young women & adolescent females	ASC.01.01.01.99 Other activities for AGYW n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Not Specified	Not Specified	Not Specified	SE Not Specified Not Specified Not Specified	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Not Specified	OVC	Not Specified	SE Not Specified OVC Not Specified	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
Applied Pipeline	Applied Pipeline	Applied Pipeline	Applied Pipeline	Applied Pipeline Applied Pipeline Applied Pipeline Applied Pipeline	ASC.99	SDM.99	BP.99
ASP	HMIS, surveillance, & research	Females	Not disaggregated	ASP HMIS, surveillance, & research Females Not disaggregated	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	HMIS, surveillance, & research	Priority Pops	Military & other uniformed services	ASP HMIS, surveillance, & research Priority Pops Military & other uniformed services	ASC.06.04.98 Strategic information not disaggregated by type	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Key Pops	Not disaggregated	ASP Laboratory systems strengthening Key Pops Not disaggregated	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Laboratory systems strengthening	Priority Pops	Military & other uniformed services	ASP Laboratory systems strengthening Priority Pops Military & other uniformed services	ASC.06.05.02 Laboratory system strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Not Disaggregated	Priority Pops	Military & other uniformed services	ASP Not Disaggregated Priority Pops Military & other uniformed services	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.02.98 "Key populations" not broken down by type

ASP	Policy, planning, coordination & management of disease control programs	Priority Pops	Military & other uniformed services	ASP Policy, planning, coordination & management of disease control programs Priority Pops Military & other uniformed services	ASC.06.01 Strategic planning, coordination and policy development	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Procurement & supply chain management	Priority Pops	Military & other uniformed services	ASP Procurement & supply chain management Priority Pops Military & other uniformed services	ASC.06.05.01 Procurement and supply chain	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
ASP	Public financial management strengthening	Non-Targeted Pop	Adults	ASP Public financial management strengthening Non-Targeted Pop Adults	ASC.06.05.04 Financial and accounting systems strengthening	SDM.03 Non applicable (ASC which does not have a specific SDM)	BP.05 Non-targeted interventions
C&T	HIV Clinical Services	Females	Girls	C&T HIV Clinical Services Females Girls	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.02.02 Girls (aged under 15) living with HIV
C&T	HIV Clinical Services	Key Pops	People in prisons	C&T HIV Clinical Services Key Pops People in prisons	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Clinical Services	Priority Pops	Military & other uniformed services	C&T HIV Clinical Services Priority Pops Military & other uniformed services	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Drugs	Key Pops	Not disaggregated	C&T HIV Drugs Key Pops Not disaggregated	ASC.03.01.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment nor for PMTCT	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Females	Not disaggregated	C&T HIV Laboratory Services Females Not disaggregated	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	HIV Laboratory Services	Priority Pops	Military & other uniformed services	C&T HIV Laboratory Services Priority Pops Military & other uniformed services	ASC.03.03 Specific ART-related laboratory monitoring	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
C&T	Not Disaggregated	Females	Young women & adolescent females	C&T Not Disaggregated Females Young women & adolescent females	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.01.02 Adult and young women (aged 15 over) living with HIV
C&T	Not Disaggregated	Priority Pops	Military & other uniformed services	C&T Not Disaggregated Priority Pops Military & other uniformed services	ASC.03.98 Care and treatment services not disaggregated	SDM.01.01 Facility-based: Outpatient	BP.01.98 People living with HIV not broken down by age or gender
HTS	Community-based testing	Females	Adult women	HTS Community-based testing Females Adult women	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
HTS	Community-based testing	Key Pops	Transgender	HTS Community-based testing Key Pops Transgender	ASC.02.03 HIV testing and counselling for TG	SDM.02.98 Home and community based not disaggregated	BP.02.04 Transgender
HTS	Community-based testing	Key Pops	Not disaggregated	HTS Community-based testing Key Pops Not disaggregated	ASC.02.98 HIV testing and counselling activities not disaggregated	SDM.02.98 Home and community based not disaggregated	BP.02.98 "Key populations" not broken down by type
HTS	Community-based testing	Key Pops	Men having sex with men	HTS Community-based testing Key Pops Men having sex with men	ASC.02.02 HIV testing and counselling for MSM	SDM.02.98 Home and community based not disaggregated	BP.02.03 Gay men and other men who have sex with men (MSM)

HTS	Community-based testing	Key Pops	Sex workers	HTS Community-based testing Key Pops Sex workers	ASC.02.01 HIV testing and counselling for sex workers	SDM.02.98 Home and community based not disaggregated	BP.02.02.98 Sex workers, not broken down by gender, and their clients
HTS	Community-based testing	Males	Not disaggregated	HTS Community-based testing Males Not disaggregated	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
HTS	Community-based testing	OVC	Not disaggregated	HTS Community-based testing OVC Not disaggregated	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
HTS	Community-based testing	OVC	Orphans & vulnerable children	HTS Community-based testing OVC Orphans & vulnerable children	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
HTS	Community-based testing	Priority Pops	Mobile Pops	HTS Community-based testing Priority Pops Mobile Pops	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.02.98 Home and community based not disaggregated	BP.03.06 Migrants/mobile populations
HTS	Community-based testing	Priority Pops	Military & other uniformed services	HTS Community-based testing Priority Pops Military & other uniformed services	ASC.02.99 Other HIV counselling and testing activities n.e.c.	SDM.02.98 Home and community based not disaggregated	BP.03.21 Military
HTS	Facility-based testing	Females	Not disaggregated	HTS Facility-based testing Females Not disaggregated	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.02 Female adult population
HTS	Facility-based testing	Females	Adult women	HTS Facility-based testing Females Adult women	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.02 Female adult population
HTS	Facility-based testing	Females	Young women & adolescent females	HTS Facility-based testing Females Young women & adolescent females	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.01.01 Facility-based: Outpatient	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
HTS	Facility-based testing	Males	Young men & adolescent males	HTS Facility-based testing Males Young men & adolescent males	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
HTS	Facility-based testing	Males	Adult men	HTS Facility-based testing Males Adult men	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.01.01 Male adult population
HTS	Facility-based testing	Non-Targeted Pop	Children	HTS Facility-based testing Non-Targeted Pop Children	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.01.01 Facility-based: Outpatient	BP.04.02.98 Children (aged under 15) not broken down by gender
HTS	Facility-based testing	Non-Targeted Pop	Adults	HTS Facility-based testing Non-Targeted Pop Adults	ASC.02.09 Voluntary HIV testing and counselling for general population	SDM.01.01 Facility-based: Outpatient	BP.04.98 General population not broken down by age or gender.
HTS	Facility-based testing	OVC	Not disaggregated	HTS Facility-based testing OVC Not disaggregated	ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	SDM.01.01 Facility-based: Outpatient	BP.03.01 Orphans and vulnerable children (OVC)
HTS	Facility-based testing	Priority Pops	Military & other uniformed services	HTS Facility-based testing Priority Pops Military & other uniformed services	ASC.02.99 Other HIV counselling and testing activities n.e.c.	SDM.01.01 Facility-based: Outpatient	BP.03.21 Military

PREV	Comm. mobilization, behaviour & norms change	Females	Adult women	PREV Comm. mobilization, behaviour & norms change Females Adult women	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
PREV	Comm. mobilization, behaviour & norms change	Females	Not disaggregated	PREV Comm. mobilization, behaviour & norms change Females Not disaggregated	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
PREV	Comm. mobilization, behaviour & norms change	Key Pops	Transgender	PREV Comm. mobilization, behaviour & norms change Key Pops Transgender	ASC.01.01.02.03.03 Behaviour change communication (BCC) as part of programmes for TG	SDM.02.98 Home and community based not disaggregated	BP.02.04 Transgender
PREV	Comm. mobilization, behaviour & norms change	Males	Young men & adolescent males	PREV Comm. mobilization, behaviour & norms change Males Young men & adolescent males	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
PREV	Comm. mobilization, behaviour & norms change	Males	Adult men	PREV Comm. mobilization, behaviour & norms change Males Adult men	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.04.01.01 Male adult population
PREV	Comm. mobilization, behaviour & norms change	OVC	Care givers	PREV Comm. mobilization, behaviour & norms change OVC Care givers	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
PREV	Comm. mobilization, behaviour & norms change	OVC	Orphans & vulnerable children	PREV Comm. mobilization, behaviour & norms change OVC Orphans & vulnerable children	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.01 Orphans and vulnerable children (OVC)
PREV	Comm. mobilization, behaviour & norms change	Priority Pops	Military & other uniformed services	PREV Comm. mobilization, behaviour & norms change Priority Pops Military & other uniformed services	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.21 Military
PREV	Comm. mobilization, behaviour & norms change	Priority Pops	Mobile Pops	PREV Comm. mobilization, behaviour & norms change Priority Pops Mobile Pops	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.06 Migrants/mobile populations
PREV	Comm. mobilization, behaviour & norms change	Priority Pops	Not disaggregated	PREV Comm. mobilization, behaviour & norms change Priority Pops Not disaggregated	ASC.01.02.03 Community mobilization for populations other than key populations	SDM.02.98 Home and community based not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Condom & Lubricant Programming	Females	Young women & adolescent females	PREV Condom & Lubricant Programming Females Young women & adolescent females	ASC.01.01.01.01 Condom promotion and distribution as part of dedicated programmes for AGYW - only if earmarked HIV funds are spent	SDM.98 Modalities not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
PREV	Not disaggregated	Males	Not disaggregated	PREV Not disaggregated Males Not disaggregated	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
PREV	Not disaggregated	Non-Targeted Pop	Children	PREV Not disaggregated Non-Targeted Pop Children	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	BP.04.02.98 Children (aged under 15) not broken down by gender
PREV	Not disaggregated	Pregnant & Breastfeeding Women	Not disaggregated	PREV Not disaggregated Pregnant & Breastfeeding Women Not disaggregated	ASC.01.02.98 Prevention activities not disaggregated	SDM.98 Modalities not disaggregated	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
PREV	PrEP	Non-Targeted Pop	Young people & adolescents	PREV PrEP Non-Targeted Pop Young people & adolescents	ASC.01.01.05.99 PrEP not else where classified n.e.c.	SDM.98 Modalities not disaggregated	BP.04.03.98 Youth (aged 15 to 24) not broken down by gender
PREV	PrEP	Pregnant & Breastfeeding Women	Not disaggregated	PREV PrEP Pregnant & Breastfeeding Women Not disaggregated	ASC.01.01.05.99 PrEP not else where classified n.e.c.	SDM.98 Modalities not disaggregated	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
PREV	PrEP	Priority Pops	Military & other uniformed services	PREV PrEP Priority Pops Military & other uniformed services	ASC.01.01.05.99 PrEP not else where classified n.e.c.	SDM.98 Modalities not disaggregated	BP.03.21 Military
PREV	Primary prevention of HIV and sexual violence	Non-Targeted Pop	Not disaggregated	PREV Primary prevention of HIV and sexual violence Non-Targeted Pop Not disaggregated	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
PREV	Primary prevention of HIV and sexual violence	Priority Pops	Military & other uniformed services	PREV Primary prevention of HIV and sexual violence Priority Pops Military & other uniformed services	ASC.07.02.01 Reducing violence against women and young girls	SDM.98 Modalities not disaggregated	BP.03.21 Military
PREV	VMMC	Males	Boys	PREV VMMC Males Boys	ASC.01.01.04.98 VMMC activities (for HIV prevention) not disaggregated	SDM.98 Modalities not disaggregated	BP.04.02.01 Boys
SE	Case Management	Females	Young women & adolescent females	SE Case Management Females Young women & adolescent females	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	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Case Management	OVC	Care givers	SE Case Management OVC Care givers	ASC.04.01.01 OVC Basic needs (health, education, housing)	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Case Management	Priority Pops	Military & other uniformed services	SE Case Management Priority Pops Military & other uniformed services	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	SDM.02.98 Home and community based not disaggregated	BP.03.21 Military
SE	Economic strengthening	Females	Adult women	SE Economic strengthening Females Adult women	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	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population

SE	Economic strengthening	Males	Young men & adolescent males	SE Economic strengthening Males Young men & adolescent males	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Economic strengthening	Males	Adult men	SE Economic strengthening Males Adult men	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Legal, human rights & protection	Non-Targeted Pop	Adults	SE Legal, human rights & protection Non-Targeted Pop Adults	ASC.05.02.98 Human rights programmes not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
SE	Not disaggregated	Non-Targeted Pop	Adults	SE Not disaggregated Non-Targeted Pop Adults	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.04.98 General population not broken down by age or gender.
SE	Not disaggregated	OVC	Care givers	SE Not disaggregated OVC Care givers	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)
SE	Not disaggregated	Priority Pops	Not disaggregated	SE Not disaggregated Priority Pops Not disaggregated	ASC.04.02.98 Social protection services and social services not disaggregated by type	SDM.02.98 Home and community based not disaggregated	BP.03.98 Vulnerable, accessible and other target populations not broken down by type
SE	Psychosocial support	Females	Adult women	SE Psychosocial support Females Adult women	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.04.01.02 Female adult population
SE	Psychosocial support	Females	Young women & adolescent females	SE Psychosocial support Females Young women & adolescent females	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.03.03 Adolescent girls and young women in countries with high HIV prevalence
SE	Psychosocial support	OVC	Care givers	SE Psychosocial support OVC Care givers	ASC.03.05 Psychological treatment and support service	SDM.02.98 Home and community based not disaggregated	BP.99 Specific targeted populations not elsewhere classified (n.e.c.)