National AIDS Authority

National AIDS Spending Assessment 2009-2010

National AIDS Spending Assessment

NASA III (2009-2010)

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ACRONYMS AND ABBREVIATIONS

ABC	Abstain, Be faithful and Condomise
ADB	Asia Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
ASC	AIDS Spending Categories
BP	Beneficiary Population
BCC	Behavior Change Communication
BSS	Behavioral Sentinel Surveillance
CBCA	Cambodian Business Coalition on AIDS
CCW	Cambodian Community of Women Living with HIV
CDHS	Cambodia Demographic and Health Survey
CMDG	Cambodia's Millennium Development Goals
CPN+	Cambodian Network of People Living with HIV/AIDS
CSO	Civil Society Organization
DFID	Department for International Development
DUs	Drug Users
CoC	Continuum of Care
ELISA	Enzyme-linked immunosorbent assay
EW	Entertainment Worker
FA	Financing Agent
FHI	Family Health International
FS	Financing Source
GFTAM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HACC	HIV/AIDS Coordinating Committee
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IDUs	Injecting Drug user
INGO	International Non-Governmental Organization
NAA	National AIDS Authority
NASA	National AIDS Spending Assessment
NSDP	National Strategic Development Plan
NSP	National Strategic Plan for Comprehensive and Multisectoral Response to HIV and AIDS in Cambodia
MoH	Ministry of Health
M & E	Monitoring and Evaluation
MARPs	Most-At-Risk Populations
MoLVT	Ministry of Labour and Vocational Training
MSM	Men who have Sex with Men
NCHADS	National Centre for HIV/AIDS Dermatology and STDs
NGOs	Non-Governmental Organizations
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PF	Production Factors

PLHIV	People Living with HIV
PMER	Department for Planning, Monitoring and Evaluation and Research
PMTCT	Prevention of Mother-to-Child Transmission
PR	Principal Recipient of the GFATM
PS	Service Provider
PSI	Population Services International
RHAC	Reproductive Health Association of Cambodia
SW	Sex Worker
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
WFP	World Food Programme
VCT	Voluntary Confidential Testing

BASIC FACT SHEET ON CAMBODIA HIV AND AIDS EXPENDITURE FOR THE PERIOD 2009-2010[1]

HIV and AIDS Expenditure

2009: $53,735,198
2010: $58,059,469

Table 1: HIV and AIDS Expenditure by Financing Source

Financing Source	2009		2010	
	US$	%	US$	%
GFTAM	19,023,377	35	22,711,245	39
Bilaterals	15,565,137	29	15,662,527	27
International NGOs	9,119,295	17	7,516,331	13
UN	7,547,437	14	8,382,652	14
Public	1,703,403	4	2,436,832	4
Multilaterals	612,307	1	1,043,168	2
Other	164,241	0	306,714	1
Total	**53,735,197**	**100**	**58,059,469**	**100**

Table 2: HIV and AIDS Expenditure by Financing Agent

Financing agent	2009		2010	
	US$	%	US$	%
Public	22,366,790	42	25,740,278	44
International NGOs	15,642,467	29	16,501,376	28
UN	7,277,948	14	7,288,577	13
National NGOs	6,499,858	12	7,407,339	13
Bilaterals	1,948,145	4	1,121,900	2
Total	**53,735,208**	**100**	**58,059,470**	**100**

Table 3: HIV and AIDS Expenditure by Service Provider

Service provider	2009		2010	
	US$	%	US$	%
Private sector (Incl. NGOs)	32,833,057	61	33,857,780	58
Public Sector	18,129,514	34	21,076,127	36
Bi-Multilaterals	2,618,739	5	3,016,173	5
Other	153,888	0	109,390	0
Total	**53,735,198**	**100**	**58,059,470**	**100**

Table 4: HIV and AIDS Expenditure by Beneficiary Population

Beneficiary Population	2009		2010	
	US$	%	US$	%
Non-targeted intervention	19,649,805	37	23,956,024	41
PLHIV	19,362,361	36	18,579,570	32
MARPs	5,018,419	9	5,945,850	10
OVC	4,073,178	8	4,425,541	8
General population	3,450,029	6	2,552,841	4
Other key & accessible populations	2,157,215	4	2,568,724	4
Other beneficiary populations	24,191	0	30,019	0
Total	**53,735,198**	**100**	**58,058,569**	**100**

Table 5: HIV and AIDS Expenditure by MARPs

MARPs	2009		2010	
	US$	%	US$	%
MARPs not disaggregated[2]	2,437,510	49	2,320,826	39
Sex Workers and clients	1,076,937	21	1,665,801	28
IDUs	816,509	16	1,027,244	17
MSM	687,463	14	931,979	16
Total	**5,018,419**	**100**	**5,945,850**	**100**

Table 6: HIV and AIDS Expenditure by AIDS Spending Categories

Beneficiary Population	2009		2010	
	US$	%	US$	%
Prevention	10,806,903	20	11,048,070	19
Care & Treatment	15,128,794	28	13,653,403	24
OVC	4,185,535	8	4,418,420	8
Programme Management & Administration	15,841,868	29	19,211,252	33
Human Resources	955,575	2	999,166	2
Social Protection & Social Services	3,434,866	6	4,212,826	7
Enabling Environment	2,708,324	5	3,410,437	6
Research	673,333	1	1,105,895	2
Total	**53,735,198**	**100**	**58,059,469**	**100**

[1] All expenditures are expressed in US dollars

AIDS Spending Categories: Sub-categories

Prevention

- Out of the total spending on prevention in the two years, the largest shares were spent on condom social marketing and distribution (14%), communication for social and behavior change (12%) and prevention for sex workers and their clients (12%).

Care and Treatment

- On average for both years, a total of 74% of expenditure for care and treatment was spent on outpatient care. The next closest sub-categories were other care and treatment services (16%), and inpatient care (10%).

Orphans and Vulnerable Children

- Out of the total spent on OVC programmes, 61% was spent on family and home support. The specific purpose of 31% of total spending on OVC could not be identified because not enough information was submitted by respondents. Only small shares were spent on education and basic health care for OVC (4%).

Programme Management and Administration

- When expenditure on programme management and administration is disaggregated by more specific, universally recognised spending categories, it becomes apparent that 80% was spent on planning, coordination and programme management.

Social Protection and Social Services

- The primary sub-category groups which befitted from social protections and socialservices spending was in-kind benefits (60%), provision of social services (26%), and monetary benefits (10%).

Enabling Environment

- An average of 36% of spending on enabling environment was spent on advocacy over the two years. 31% was spent on AIDS-specific institutional development involving, among others, the capacity development of NGOs.

Research

- There was no further breakdown of spending on research sub categories provided in the NASA.

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[2] "MARPs not disaggregated" is identified expenditure on MARPs that could not be further broken down to a separate MARPs sub population.

EXECUTIVE SUMMARY

The National AIDS Authority (NAA), as part of its mandate to monitor and evaluate the national response to HIV and AIDS in Cambodia, conducted the third National AIDS Spending Assessment (NASA III) in early 2011. The assessment covered 2009 and 2010, and together with data obtained in the two previous NASA rounds, has allowed for analysis of trends in resource flows from 2006 to 2010. The three assessments have produced valuable data which are used to monitor Cambodia's National Strategic Plan for Comprehensive and Multisectoral Response to HIV and AIDS (NSP) and to report on expenditures nationally and globally.

NASA have allowed the NAA to analyze HIV and AIDS related spending in the health and non-health sectors, including expenditure on HIV prevention, care and treatment, orphans and vulnerable children, programme management and administration, human resources, social protection and social services, enabling environment, and research. The NASA methodology has evolved over the years, and in this round the assessment provided more detailed information about specific interventions and beneficiary groups, as well as minimized the risks of double counting. Overall, NASA III reflects a more comprehensive and detailed reflection of the state of AIDS spending in Cambodia.

Over the course of 2009 and 2010, NASA III documented a total expenditure of US$111,794,667 (US$53,735,198 in 2009, and US$58,059,469 in 2010). Spending per person living with HIV in Cambodia remained more or less the same at US$334 in 2009 and US$331 in 2010. Like previous NASA, this report demonstrates an increase in total expenditure from all previous years. This is in large part due to methodological improvements that have allowed this NASA to capture a more accurate reflection of total AIDS expenditure in Cambodia. These methodological improvements include greater specificity in the categorization of spending, as well as an increase in the number of respondents taking part in the reporting process.

AIDS Spending Categories

Programme management and administration, care and treatment and prevention activities received the highest amount of spending. These three main AIDS spending categories accounted for US$85,690,290 out of the total US$111,794,667 spent over the two years.

Programme Management and Administration: represented the largest portion of spending. Bilateral entities and Global Fund for HIV/AIDS, Malaria and TB (GFATM) were the primary financing sources for spending in this category. These expenditures were largely managed by public institutions followed by international NGOs. Activities were mainly implemented by private actors such as non-government organizations (NGOs) and government entities. By definition spending on programme management and administration was all not targeted at specific beneficiary populations. Expenditures on this spending category constituted 31% of the total spending in the two years.

Care and Treatment alone: represented one quarter of all spending on HIV and AIDS. Care and treatment services benefited PLHIV and their families and represented 26% of the whole spending in 2009 and 2010. It was primarily financed with funds received from GFATM and international NGOs whilst public entities were the main financing agents and service providers for these activities.

Prevention interventions were the third largest AIDS spending category constituting 20% of total expenditures in the biennium. The primary financing agent were bilateral donors and the GFATM,

however the funds were largely managed by international NGOs and public entities, then implemented by international and national NGOs. AIDS spending to avert new infections primarily benefited MARPs. Today, the HIV and AIDS epidemic is considered the highest within this group. The estimated HIV prevalence in these groups are 24.4% among injecting drug users, 5.1% men who have sex with men, and 13.9% among entertainment workers. Prevention activities also benefitted the general population, however to a significantly lesser extent as the estimated HIV prevalence rate for both years in 2009 and 2010 within the general population was only 0.8%.

The other five categories represented just under a quarter of total spending (24%). Spending on ***OVC programmes*** was significantly less than prevention and care and treatment, representing only 8% of total expenditure over the two-year period. This amount was mainly derived from UN and GFATM. UN and international NGOs managed the majority of financial assistance to support OVC and their families however the programmes were implemented by national and international NGOs.

The UN was the primary source and main financing agent of the funds utilized to deliver ***Social Protection and Social Services interventions***. This support, which benefited PLHIV and their families, was implemented by national and international NGOs. Spending on Social Protection and Social Services constituted 7% of all spending on HIV and AIDS.

Expenditures on initiatives aimed at creating an ***Enabling Environment*** represented 5% of the total AIDS spending. Spending for enabling environment activities was mainly derived from GFATM grants and public sources. Financial support to implement enabling environment activities were managed largely by public entities and spent by national and international NGOs followed by public sector institutions. These activities were mostly considered non-targeted interventions, but with some spending intended to benefit PLHIV.

The two AIDS spending categories with the lowest amount of expenditure were ***Human Resources (Training)*** and HIV-Related Research. Collectively, they represented 4% of total spending over the two years. The majority of Human Resources (Training) related spending originated from GFATM and bilateral entities. Public entities were the main financing agents of spending related to training of human resources. These non-targeted interventions were provided by international and national NGOs as well as public entities.

Whilst, bilateral entities were the main financing source for ***HIV-related Research*** these funds were managed by international NGOs and bilateral entities, then implemented by research institutes and national and international NGOs. All spending on HIV-related Research were non-targeted interventions and constituted a share of less than 2% of all AIDS Spending.

Spending by financing source, agent and service provider

The most prominent financing source in 2009-2010 was the GFATM followed by bilateral entities (mainly the US Government) and international NGOs. Public entities were the largest financing agent for AIDS spending in 2009-2010, followed by international NGOs. The private sector was the primary service provider for the spending. These non-governmental entities such as national and international NGOs implemented 60% of all interventions.

The GFATM was the largest financing source of spending on HIV and AIDS in 2009-2010; 37% of all spending originated from GFATM grants. Out of the total US$111,794,667 that was spent in the biennium, US$41,734,623 came from GFATM. The primary financing agents of spending of GFATM

monetary support were public entities and the activities implemented by public entities and national and international NGOs. The majority of GFATM grants were spent on care and treatment, followed by programme management and administration and prevention, and benefitted mainly PLHIV when the activities were considered targeted interventions.

Bi- and multilateral organizations managed 16% of total funds and implemented 5% of all AIDS spending in 2009-2010. With 28%, ***bilateral entities*** were the second biggest financing source of the total spending in 2009-2010. The third largest financing sources were multilateral organizations such as UN agencies, World Bank, European Commission and Asia Development Bank which constituted 16% of the total response. The majority of spending originating from bilateral and ***multilateral organizations*** were spent on programme management and administration followed by prevention interventions. This financial support was largely managed by international NGOs and UN agencies and implemented primarily by private sector providers, including non-governmental organizations.

The US Government was the largest bilateral entity identified as the financing source; 22% of all AIDS spending in Cambodia in 2009-2010 (or 82% of the bilateral support) originated from this source. The World Food Programme was the largest multilateral financing source with 7.1% of the total spending in 2009-2010 derived from this UN agency. The majority of spending using financing support from bi- and multilateral organizations was for non-targeted interventions. Out of the spending with an intended target population, PLHIV constituted the largest group followed by MARPs and OVC.

International NGOs were the financing source for 15% of total AIDS spending in 2009-2010. The majority of spending originating from these organizations was spent on care and treatment, prevention and social protection and social services, benefitting mostly PLHIV. International NGOs were the financing agent for most of its financial support, but around half of the assistance was spent by public sector entities and half by private sector service providers (including NGOs). International NGOs were the second largest financing agent of the total spending in 2009-2010, regardless of financing source. Together with national NGOs and other private service providers, international NGOs implemented 60% of total expenditure on HIV and AIDS.

3% in 2009 and 4% in 2010 of all AIDS spending originated from ***the Government of Cambodia***. In 2006, 2007 and 2008 this share was 13%, 11% and 10%. However, in these years, the majority of public funds were spent on blood safety which included testing for other diseases as well as the management cost of the blood safety programme. In 2009-2010, the blood safety spending only included the HIV component. When excluding the blood safety spending, 5% in 2006, 4% in 2007 and 4% in 2008 of all AIDS spending were derived from public revenues. This represented approximately US$2 million per year.

The majority of all funds spent on HIV in 2009-2010, regardless of financing source, were managed by national entities, such as government institutions and national NGOs. Most of the spending was for non-targeted interventions. Out of the funds with an intended beneficiary population, the spending went to recipients of blood and blood products, school students and general population. Public sector entities such as ministries, government departments and public hospitals, and were identified as the service providers for 35% of all AIDS spending. National NGOs provided a considerable share of the services as part of the classification private sector service providers.

Beneficiary Populations

This assessment provided data that allows for a more in-depth analysis of how spending benefited different target populations. The largest portion of spending, 39% of the total AIDS spending in 2009

and 2010 did not intend to target any specific population. NASA classifies spending that cannot be disaggregated by one single specific beneficiary population in to this category. These interventions were primarily for programme management and administration, human resources, enabling environment and HIV-related research. Expenditures on this category grew from US$19,649,805 (34%) in 2009 to US$23,956,924 (42%) in 2010. This is partly due to an increase in spending on categories that cut across the national response (e.g., programme management).

After non-targeted interventions ***PLHIV*** were the main beneficiary population benefitting from 34% (US$37,941,931) of total AIDS spending over the two years. The spending was related to care and treatment and social protection and social services. The primary funding sources were GFATM and international NGOs, whereas the main financing agents were public institutions. The services were provided by public entities and national and international NGOs.

MARPs and OVC benefitted from 18% of total expenditure and had an accumulative total of US$9,091,597 over the biennium. 10% of all AIDS spending intended to prevent new infections among ***most-at-risk populations.*** These prevention interventions were to a large extent funded by bilateral entities and GFATM. International NGOs were identified as the main financing agents and national and international NGOs provided the services. 46% of the spending targeting MARPs in 2009 and 39% in 2010 could not be disaggregated by the specific type of target group. Of the remaining populations, spending targeting entertainment workers and their clients, injecting drug users and men who have sex with men, all experienced an increase from 2009 to 2010. Trend analysis shows that spending on MARPs prevention already started to grow prior to these two years. This is a positive indicator suggesting that interventions have become more strategic, targeting groups that are at high risk of HIV infection.

Orphans and Vulnerable Children were the intended beneficiaries of 8% of the AIDS Spending in the two years of assessment and were only identified as beneficiary population for OVC programmes. These activities were primarily financed by UN agencies and GFATM; the financial assistance was managed largely by UN and international NGOs and implemented by national and international non-government organisations.

Prevention interventions and enabling environment activities targeting the general population constituted 5% of all AIDS Spending in 2009-2010. Expenditures on interventions benefitting ***the general population*** were primarily aimed at preventing HIV. Spending on this category of beneficiaries has decreased from US$3,357,521 in 2009 to US$2,426,048 in 2010. Whilst spending on ***other key and accessible populations*** has increased from 2009 2010 it still represents a small share in both years (less than 4% of total spending). The largest share of this spending, whose targets could be identified in the data provided by respondents, benefitted children born or to be born from HIV-infected mothers (24%) and school students (17%).

1. INTRODUCTION

Cambodia is located in South East Asia and shares borders with Lao People's Democratic Republic, Thailand and Viet Nam. It is the home of a population of close to 14 million.[3] The majority of the population is young with slightly more than 50% under the age of 24, with a median age of 20.96.[4] Cambodia is considered a least developed country, with 30.1% living below the national poverty line.[5] Cambodia was rated 0.494 on the human development index in 2010.[6] Cambodia real GDP growth slowed in 2009 to 0.1% but recovered in 2010 at 5.9%.[7]

The first HIV case in Cambodia was detected in the early 1990s. The epidemic reached its peak in 1998, with an estimated HIV prevalence of 2.0% in the general population aged 15 to 49 years, and then dropped to 0.8% in 2010.[8] Currently, the epidemic is still highest among key affected populations with a prevalence of 24.4% among injecting drug users[9], 8.7% among men who have sex with men (in Phnom Penh)[10] and 13.9% among female entertainment worker who have more than 14 clients per week.[11]

The multi-sectoral response to HIV and AIDS has been successful in preventing HIV infections in these groups as well as in providing care and treatment to all those in need. As a result, Cambodia is one of the few countries in the world which can claim universal access to treatment.

The Royal Government of Cambodia is committed to realizing the Three Ones principle. It has established the National AIDS Authority (NAA) to coordinate the national response, introduced National Strategic Plans for a Comprehensive and Multi-sectoral Response to HIV and AIDS (NSP) and established one single national HIV and AIDS related monitoring and evaluation (M&E) system to generate strategic information that is needed to track the epidemic and progress made through the national response.

As part of its role to monitor and evaluate the national response, the NAA has been conducting National AIDS Spending Assessments (NASA) since 2007. The NASA reports are conducted every two years in order to assess trends in AIDS financing and spending in Cambodia. Three assessment rounds have successfully been accomplished and spending data are now available for the years from 2006 to 2010.

NASA do not only produce data that are needed to monitor the current NSP, but also to report progress on the first indicator of the Declaration of Commitment to the UN General Assembly Special Session on HIV/AIDS (UNGASS). The capacity to conduct NASA has considerably increased over the years as has the interest of stakeholders in producing and using reliable spending data.

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[3] National institute of statistics (2009). Cambodia Social Economic Survey 2009.

[4] National institute of statistics (2009). General Population Census of Cambodia 2008.

[5] World Bank 2007. Accessed on line June 22, 2011. http://data.worldbank.org/country/cambodia

[6] UNDP 2010. http://www.mef.gov.kh/ Acchttp://hdrstats.undp.org/en/countries/profiles/KHM.htmlessed on line June 22, 2011.

[7] Ministry of Economics And Finance 2011. Accessed on line June 22, 2011. Speech by deputy prime minister Keat Chhun, Minister of Economic and Finance at the Mekong Forum 2011.

[8] NCHADS (2011a): Estimate of the HIV prevalence among general population in Cambodia. Power point presentation.

[9] NCHADS (2007) HIV Prevalence Study Among Drug Users.

[10] NCHADS (2005) Cambodia STI Prevalence Survey (SSS).

[11] NCHADS (2011): Estimate of the HIV prevalence among general population in Cambodia. Power point presentation.

NASA III used a comprehensive and systematic approach to assess the flow of financial resources. It applied an improved methodology which is globally recognized to assess actual expenditure in the health and in the non-health sector. Similar to the NASA I and II, this assessment endeavoured to answer questions related to how the HIV and AIDS response is financed, who pays for what and how much, who provided goods and services, and to whom. Spending was categorized into eight major AIDS-spending categories; HIV prevention; care and treatment; orphans and vulnerable children; programme management and administration; human resources; social protection and social services; enabling environment; and research.

This report first provides details of how the NASA data was collected, with an explanation of the spending categories and the data limitations. Secondly an overview of the multi-sectoral response is given for the biennium providing a picture of the response to situation the final sections of the report where the findings are presented and discussed.

2. METHODOLOGY OF THE SPENDING ASSESSMENT

The third National AIDS Spending Assessment (NASA III) was conducted 2011. The data was collected for the calendar years 2009 and 2010. A team, constituted of three staff of NAA's Department for Planning, Monitoring and Evaluation and Research (PMER) and two consultants, carried out the data collection, processing and analysis. In addition, two staff of the NAA assisted with logistical tasks including the organization of the launch and validation meetings. The assessment was overseen and supported by senior staff of the NAA and UNAIDS Cambodia.

For assessing financial resource flows in previous NASAs, NAA used the assessment methodology developed globally by UNAIDS as reference document. In 2009, the UNAIDS guidance National AIDS Spending Assessment (NASA): Classification and Definitions[12] (hereafter NASA Guidance document) was published and provided a more detailed approach to collecting and processing data. This revised approach was used in NASA III including a set of improved data collection and processing tools.

NASA III has systematically captured flows of resources from the financial sources to the service providers, through identifying the various elements of a transaction. As per the global methodology, the NAA decided to apply both a top-down and bottom-up approach to obtain and validate information. With the top-down approach, spending data was tracked from the sources of funds (e.g. donor reports) to recipient organisations and down to the service provision or implementing level. The bottom-up approach identified the expenditures at the level of service provision to the funding source based on the reports and the data collection forms of the organisations which implement actual activities and provide services.

2.1 NASA definitions and classifications

All of the three NASA that were conducted in Cambodia used internationally agreed definitions and classifications based on standard concepts and terms in order to assess how interventions are financed, how much is spent and on what, who benefits from the spending?

Financial resource flows and expenditures are structured around three main dimensions:

Financing Dimension

Financing Sources (FS) are entities that allocate funding to HIV in general and provide money to financing agents.
Financing Agents (FA) are entities that pool financial resources to finance service provision (purchaser-agent) and make programmatic decisions on the type of provided activities and the exact service provider involved in service delivery.

Provision of HIV Services Dimension

Providers (PS) are entities that engage in the production, provision, and delivery of HIV services.
Production Factors (PF) are inputs (i.e., labour, capital, natural resources, "know how", and entrepreneurial resources).

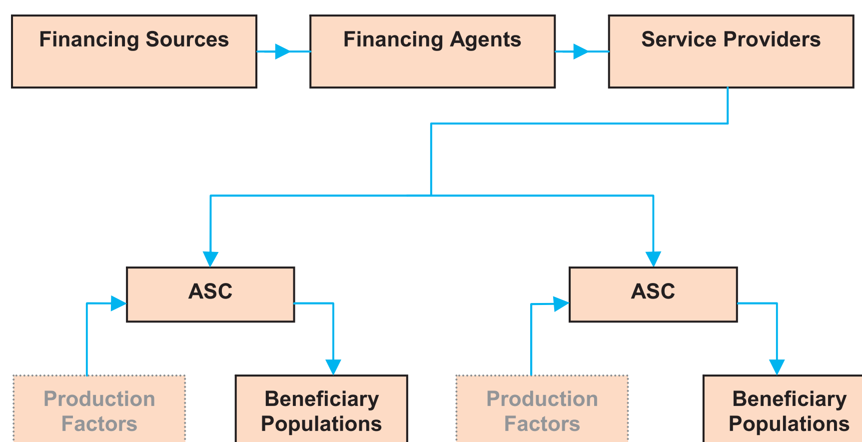
[12] UNAIDS (2009): National AIDS Spending Assessment (NASA): Classification and Definitions

During the preparatory stage of NASA III, it was decided that the current assessment could not focus on production factors due to a lack of time and resources. This dimension will be tackled in the next round of NASA in 2013. At that time it is hoped stakeholders will have become familiar with the improved NASA methodology and tools which help to gather more reliable results.

Use/Consumption Dimension

AIDS Spending Categories (ASCs) are HIV-related interventions and activities.
Beneficiary Populations (BP) (e.g., PLHIV, MSM, IDU, general population).

Figure 1: Financial flow scheme



2.2 Assessment process and instrumentation

2.2.1 Preparation of the assessment

The preparation for NASA III started in November 2010 when the NAA organized a workshop to revise the NASA methodology and tools and to train the NASA Assessment Team. The workshop was attended by staff of the NAA and of UNAIDS Cambodia and facilitated with the help of a national consultant and international consultant. Since NASA III aimed to gather data from a wide range of entities including government institutions, non-governmental organizations and bi- and multilateral agencies a mapping was undertaken prior to collecting the data and later revised based on the finding of assessment.[13]

After refining the NASA method and tools, a few government and non-government organizations were asked to assist in the NASA preparations by taking part in a pre-test through filling the revised data collection form. Based on the data they submitted and on their questions and recommendations, the data collection form and instructions were revised.

The NASA launch meeting was held in early February 2011 to present the revised NASA methodology and tools to all the main stakeholder organizations. The meeting was attended by 80 participants from 42 organizations who were invited to submit their spending data.

[13] Annex 1: Mapping of organizations participating in NASA III.

2.2.2 Improvement of data collection tools

The data collection form used for NASA III was adapted from the standard form which has been developed by UNAIDS for use in different countries. Both the form and instructions on how to fill it in were translated into Khmer. In the form, respondents were asked to provide information regarding their: financing sources, name of projects, project activities with a brief description, intended beneficiaries, and amounts spent by themselves and/or transferred to other organizations. Additional comments could be provided as well. Lastly, the data collection form had a section where the respondents could identify in-kind contributions such as condoms and drugs.

The data collection started in the first week of February 2011 and continued until mid-March 2011. Throughout this period extensive follow-up with respondents via phone and email was necessary in order to ensure a timely submission of the data. Furthermore, a series of meetings and face-to-face interviews were conducted with representatives of some of the main organizations to better understand their spending and in particular to ask questions about the nature of their interventions, the implementation modalities, beneficiaries, and to seek other types of clarifications.

The meetings proved very helpful to ensure a correct processing of data and to identify and eliminate double counting. Some organizations also submitted financial and programme progress reports and other documents that are a very useful source of information. In fact, a number of organizations opted for submitting their financial reports, instead of completing the data collection form.

Where the NASA team identified inconsistencies in the data submitted, it sought clarifications from the concerned organizations. Moreover, data and information for the narrative NASA report were gathered through a review of reports as well as communication with various partners.

The results of NASA III are based on the actual spending data from key players in the national response to HIV in Cambodia; as well as, through meetings, and review of background information, understand informants' mandates, interests and interventions. For NASA III it was also important to establish a team at the NAA to facilitate access to information as well as manage processing and analysis of data.

2.2.3 Participation in the assessment

A request to complete the data collection form in Khmer or in English was sent by the NAA to 35 governmental institutions (i.e., NAA, ministries and entities within ministries such as NCHADS) and by the UNAIDS Country Office to 32 bilateral, United Nations (UN) and other multilateral organizations. In addition, the request was sent by HACC to 120 civil society organizations (CSOs). In particular, 68 CSOs were prioritized based on the degree of their involvement in the national response to HIV in Cambodia.

In total 91 organizations replied to the data collection request. Out of these, nine reported to have had no HIV expenditures in 2009 and 2010. Out of the remaining 82 organizations data was obtained from 11 government organizations, 15 UN agencies, 49 civil society organizations CSOs, and 7 donor agencies. Data was also processed from reports of sub-recipients of the GFATM for HIV/AIDS, Tuberculosis and Malaria (GFATM). The organizations who participated in NASA III are illustrated in the mapping chart in Annex 1.

Table 7: Overview of participants in the assessment

Type of organization	# of organizations requested to submit data	# of organizations who responded	# of organizations who reported they had no HIV spending	# of organizations who submitted data of HIV spending	% of organizations who received data request and who submitted the data
Government ministries and other entities (e.g. NCHADS)	35	24	0	11	31
UN organizations	18	1	2	15	83
NGOs	68	17	2	49	72
Bi- and multilateral organizations (US Government, CDC, EC)	14	1	5	7	50
Total	**135**	**43**	**9**	**82**	**61**

2.2.4 Processing of the data

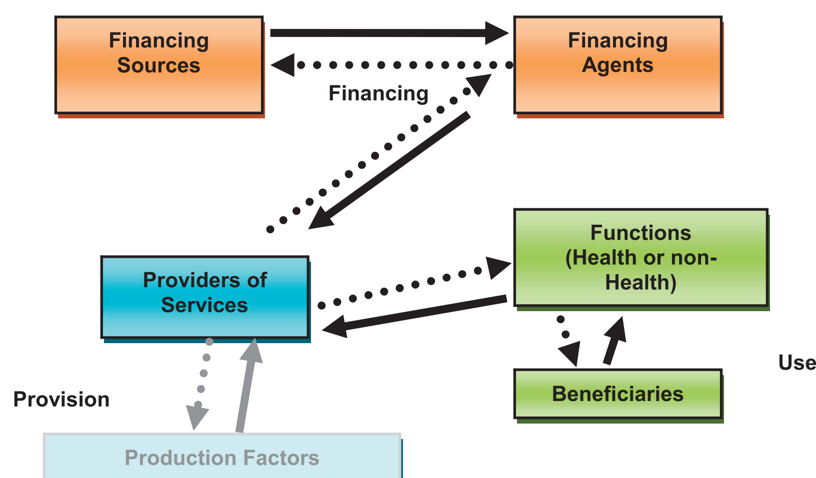
Once the data was received by the NASA Team, it was processed through the following steps.

Step 1 included an immediate check of the data submitted. For example, the NASA Team identified if data was missing or if the spending was not adequately broken down by different spending categories.

During step 2, each expenditure item was assigned a NASA classification code to identify the source, the financing agent, the provider of services, the AIDS spending category, and the beneficiary population.

In step 3 the final provider of services was identified and the transactions were reconstructed in pivot tables . Similar resource flows were highlighted and noted to be excluded from the data set to avoid double counting. The data was then transferred into individual Data Processing Files and then transferred into one dataset in Microsoft Excel.

Figure 2: Reconstruction of Financial Transactions



Lastly, step 4 consisted of the creation of pivot tables and charts by using the complete dataset in Excel. The data was then further validated as well as analysed and interpreted by the NASA Team and senior staff at NAA and UNAIDS, for inclusion in this report.

2.2.5 Validation of the data

The validation of data was undertaken in dialogue with individual organisations who submitted financial data at a validation meeting in early April 2011 and involved 74 participants from 51 organisations. During the meeting the assumptions made in the data processing and analysis were presented, and discussed. These were used by the NASA Team to refine the assumptions for the data processing and analysis and to adjust the coding of expenditures where necessary.

2.3 Comparing NASA III with NASA I and II

NASA has been conducted in Cambodia since 2007 as part of data collection efforts to report on progress made with regard to the declaration of commitment it made at the UN General Assembly Special Session (UNGASS) on HIV and AIDS. The first assessment (NASA I) focused on 2006 and the second assessment (NASA II) covered 2007 and 2008.

The methods and tools used in NASA III differ from NASA I and NASA II. In the first two assessments data was collected by using the NASA Spending/Funding Matrix which was adapted from the matrix used to report for UNGASS on Indicator 1. The matrix included two sections. In the first section, respondents were required to break down their funding and their spending based on specific ASCs. In the second section, they were expected to specify the total amount they had available, the total amount they spent, and the amounts they transferred to other organizations and for what purpose.

The matrix was sent with a data request and instructions on how to fill the matrix to a large number of governmental and non-governmental and bi- and multilateral organizations as well as a few private firms. Data was submitted by mail or email, either in Khmer or English. In NASA II a total of 58 organizations submitted data. This is a much smaller number than that of respondents who submitted data in NASA III (82) probably meaning that a significantly larger share of total spending on HIV and AIDS has been captured. It is important to acknowledge that the increase in total spending registered in 2009 and in 2010 could be attributed to this.

While NASA I and NASA II produced valuable information, NASA III represents a more in depth and accurate measure of national expenditure based on global NASA methodology. A clearer distinction between funding and actual spending was used in NASA III. Transactions were all tracked through the financial flow in a more systematic manner than before by using an improved data collection tool and more effective data processing formats. NASA I and NASA II did not allow for the reconstruction of transactions or fully allow double counting to be ruled out. They also did not capture the intended beneficiary populations of all of the spending.

In NASA III each transaction was processed and verified individually and was the subject of multiple coding. Another difference with previous rounds is that NASA III used improved NASA classifications and definitions that were determined by the NASA Team based on information provided by the respondents. It is important to bear in mind that some activities, such as the development of guidelines or coordination of meetings, may in previous rounds have been classified by respondents under a specific intervention area (i.e., Prevention; Care and Treatment), whereas in NASA III they systematically have been assigned to Programme Management and Administration (ASC.04). This has resulted in the substantial increases that were registered in the last two years in this spending category.

NASA III provides more information on actual expenditures, the providers of the services, as well as the beneficiary populations that the services intended to reach. It also allows for a more in-depth analysis because AIDS spending categories in NASA III were more detailed compared to those used in previous rounds. In previous NASA, it was a challenge to get all respondents to report for the calendar year because different accounting timeframes are used by different organizations. This problem has been overcome in NASA III with the exception of two organizations.

The definition of the Financing Agent (FA) applied in NASA III differs slightly from the one that was used in NASA I and II. FAs are those entities which receive financial resources and then channel the funds to the service providers. They manage the funds and decide on their use. NASA I and NASA II distinguished between three types of FAs: central government, national NGOs; and international organizations. NASA III used instead these different categories: central government, national NGOs, international NGOs, UN agencies and bilateral organizations.

The sub-categories for spending under ASC 01 Prevention used in NASA III are somewhat different from those employed in the past.[18] Some categories were dropped for example, Abstain, Be faithful and Condomise (ABC). Others were further disaggregated like that for Voluntary Counseling and Testing (VCT) which was broken down by target population (e.g., entertainment workers and their clients, men who have sex with men, injecting drug users, and general population). In NASA III expenditures related to interventions targeting out-of-school youth, including street children, were captured either under ASC.01.04 Risk-Reduction Programmes for Vulnerable and Accessible Populations or under ASC.01.06 Prevention – Youth out of School.

In NASA III spending on blood safety concerns testing only for HIV and not for “HIV and other diseases” as in previous rounds which also included overall expenses for managing the blood safety programme (e.g., salaries, building etc). This explains why the share of total spending sourced through public funds has dropped from 11% in 2007 and 10% in 2008 to 3% in 2009 and 4% in 2010. It is estimated that the contribution to the national response by the Government of Cambodia has roughly remained the same over the years.

Due to a change in the definition of ASC.06 Social Protection and Social Services NASA III includes expenditures which previously were included under Home-Based Care (HBC) or OVC related spending categories. In particular, this is the case of expenditures reported by the World Food Program of USD 3,987,020 USD in 2009 and 3,949,337 USD in 2010[14].

NASA III tried to systematically capture expenditures made by offices abroad for services that were provided in Cambodia. Bank charges and audit costs were also more frequently captured in NASA III than in the past. These were charged to ASC.04.02 Administration and Transaction Costs Associated with Managing and Disbursing Funds and represented a total of USD 1,194,456 in 2009 and 2010. Expenditures to upgrade buildings and infrastructures were also captured in NASA III for a total of USD 1,266,876 in the biennium. Finally, as was mentioned before, NASA III includes HIV related expenses made under health system strengthening initiatives for a total amount of USD 719,551 in 2009/10. This kind of expenditure were not captured in NASA I and NASA II.

2.4 Limitations of NASA III

Although the process and results of NASA III reflect a great improvement in the methodological approach used in the assessment, a number of limitations remain which need to be mentioned.

Firstly, not all of the organizations involved in the national response to HIV in Cambodia submitted data. Therefore not all of the HIV related expenditures could be captured.

Expenses to cover shared costs of health facilities for example or the salaries of health care providers are not included in NASA III. This data could not be obtained from the Ministry of Health in previous NASA either. Where expenditures on staff salaries and on incentives were reported these were included. If an organization paid incentives, then this expense was captured under the relevant AIDS spending category and not under Human Resources (ASC.05). Salaries of staff working in Cambodia which are paid fully or in part abroad were only partially reported.

Because production factors were not included in the assessment and NASA III cannot answer questions on how much was spent on salaries, consultancy fees, goods, equipment, etc.

Two organizations submitted data for periods which did not matching the calendar year. Their expenditures of an amount of USD 256,730 were all captured under 2010.

NASA III was expected to provide information on the absorption capacity of organizations by asking respondents to indicate the total amount of funds they had and what out of this they sent. However, not all of the organizations provided this data making a meaningful analysis very difficult.

The intention was to use costing techniques to calculate expenditure on drugs. However, this was not possible because data needed for these calculations were submitted by NCHADS very late in the process. The costs of ARV and OI were therefore assessed on the basis of actual expenditure to procure drugs that were delivered to hospitals in 2009 (as reported by MoH GFATM PR) and only the costs related

14 In NASA II WFP's spending included the overhead costs at their headquarter offices (USD 167,664 in 2007; USD 301,872 in 2008) since these could not be separated from the overall WFP expenditures at that time. The total spending also included expenses for transportation of goods to Cambodia (USD 239,520 in 2007 and USD 431,246 in 2007). Similarly NASA III includes spending for cargo and sea freight (USD 424,659 in 2009; USD 428,711 in 2010) but not expenses for headquarter overheads.

to the procurement of drugs in 2010 (as reported by NCHADS). Expenditures on-ARV and OI drugs were processed as part of the data collection forms or the sub-recipients reports and not through costing.

NASA III did not capture data from the private sector except when reported as for-profit source of funds by the receiving organizations, CBCA data and MoLVT data. In NASA II, the response from the private sector was very weak with expenditures below USD 1,000 per year.

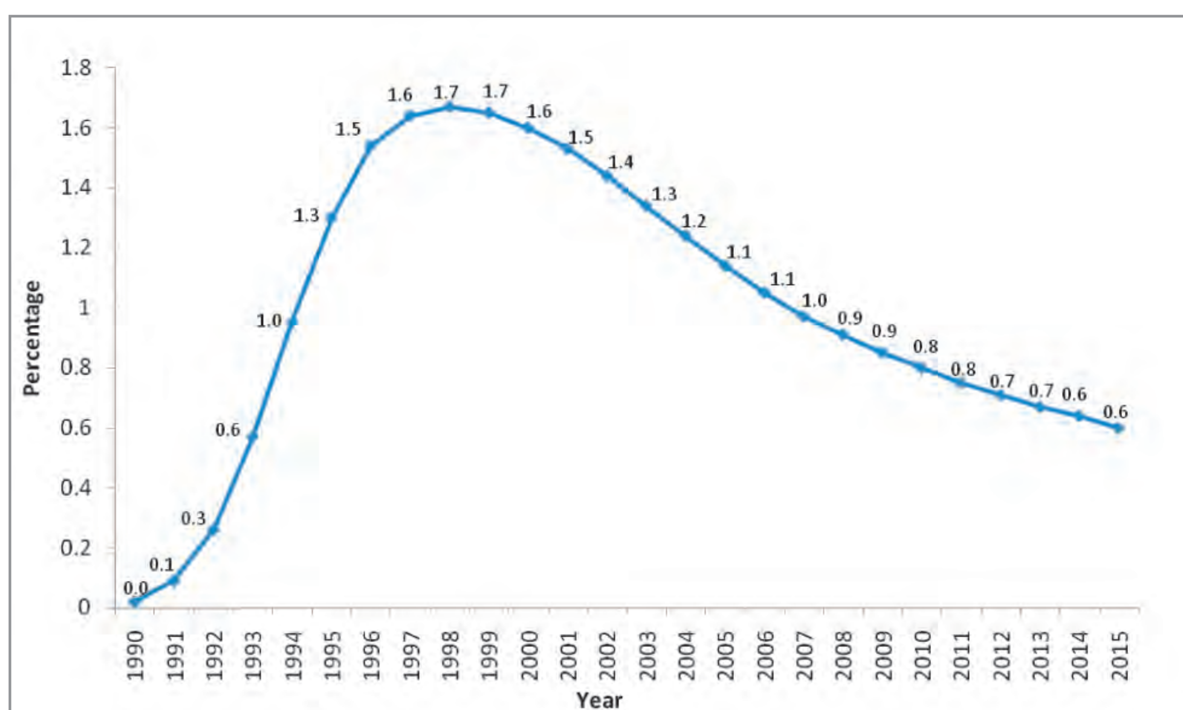
Data which arrived late was processed in a more aggregated manner based on service delivery area and objectives and not on the detailed activities (mainly GFATM R7 sub-recipient reports).

Private spending such as cost of the condoms paid by individuals at the distribution points (out-of-pocket expenditure) is not captured.

NASA III does not provide gender disaggregation data since the respondents did not identify males or females as their specific target populations. Data for entertainment workers and men who have sex with men is included. The assessment does not identify expenditures disaggregated by provinces or rural and urban data since the data collection form had not introduced this variable. Data submitted by province would also result in a higher reporting burden on the respondents and data processing load on the NASA team which would not have been feasible within the time constraints.

3. OVERVIEW OF THE NATIONAL RESPONSE TO HIV AND AIDS

Figure 3: Trend of HIV prevalence among general population aged 15-49 years1990-2012[15]



The first HIV case in Cambodia was detected in 1991 and the epidemic has reached a peak in 1998 with an estimated prevalence of 2.0% in the general population[16]. Figure 3 shows prevalence rate among adults aged 15 to 49 years from 1990 to 2015. For the years 2009 and 2010, prevalence in this group of the population was estimated at 0.8%. New estimates and projections will be released in the second part of 2011.

Cambodia is implementing the Three Ones Principle, accordingly the National AIDS Authority (NAA) is the government entity mandated to coordinate the multi-sectoral response to HIV and AIDS in the country. National Strategic Plans for a Comprehensive and Multi-sectoral Response to HIV and AIDS in Cambodia (NSP) to guide the national response are developed in a participatory manner by a wide range of stakeholders under the leadership of the NAA. The NSP contributes to achieving aims established under the overarching National Strategic Development Plan (NSDP) and Cambodia's Millennium Development Goals (CMDGs).

In the biennium 2009-2010 the NSP II was guiding the response to HIV. The overall goals of NSP II were to reduce the number of new HIV infections by taking to scale targeted prevention interventions; to increase coverage and quality of care, treatment and support for people living with and affected by AIDS; and to alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society. In order to achieve these three main goals, seven strategies with objectives and activities were identified. The strategies are listed in Figure 4. A well elaborated and defined multi-sectoral M&E system was developed under the NSP II in order to monitor and evaluate progress and to assess the results of different

15 NCHADS (2007): Report of a Consensus Workshop HIV Estimates and Projections for Cambodia 2006 - 2012

16 NCHADS (2007): Report of a Consensus Workshop HIV Estimates and Projections for Cambodia 2006 - 2012

interventions. Regularly repeated national spending assessments are an integral part of this system. They ensure adequate information is available to guide efforts to achieve the aims established under the Strategy 7.

Figure 4: The seven strategies of the revised Second National Strategic Plan for a Comprehensive and Multisectoral Response to HIV and AIDS in Cambodia, 2008-2010 (NSP II)

Strategy 1: Increased coverage of effective prevention interventions
Strategy 2: Increased coverage of effective interventions for comprehensive care and support
Strategy 3: Increased coverage of effective interventions for impact mitigation
Strategy 4: Effective leadership by government and non-government sectors for implementation of the national response to HIV and AIDS, at central and local levels.
Strategy 5: A supportive legal and public policy environment for the national response to HIV and AIDS.
Strategy 6: Increased availability and use of information by policy makers and programme planners through monitoring, evaluation and research.
Strategy 7: Increased, sustainable and efficiently allocated resources for the national response to HIV and AIDS.

The Royal Government of Cambodia, together with civil society and other partners, has set ambitious targets to achieve universal access to prevention, treatment and care of all those in need. Universal access had almost been achieved with more than 97% of people eligible for treatment on ART at the end of 2010.

The seven strategies of the NSP II which were revised in 2008 and lasted until 2010 can be summarized as follows:

3.1 Prevention

During 2009-2010 Cambodia's prevention interventions focused on communication for behavioral change, voluntary counseling and testing, treatment of sexually transmitted diseases, prevention of mother-to- child transmission of HIV, and blood safety. Activities targeted most-at-risk populations such as entertainment workers, men who have sex with men and injecting drug users and to a lesser extent the general population, especially youth in and out of schools.

The last couple of years have seen a focused profiling of urban clients of female entertainment workers by conducting behavioral studies and interventions in places such as beer gardens and restaurants. PSI has concentrated its interpersonal communication intervention on high risk urban men, 34% of whom have concurrent sexual relationships[17].

FHI, PSI, and NCHADS have contributed to understanding clients of entertainment workers better. FHI through its BROS Khmer integrated behavioral and biological survey among urban men, PSI through its TraC surveys with high risk urban men, and NCHADS through the Behavioral Sentinel Surveillance (BSS) Survey which uses moto taxi drivers as proxies for clients of sex workers.

[17] PSI (2010) TRac Survey among high risk urban men with sweethearts in Phnom Penh, Battambang, Siem Reap, and Preah Sihanouk province, Cambodia. Power point presentation, February 2010.

During 2010 extensive targeted condoms distribution efforts were necessary to ensure that condoms were available in and within 50 meters of high risk venues. This was an important activity as nearly 30% of Karaoke establishments reported in 2010 that they were not selling condoms on site due to police/ government reactions. This is quite a change from 2008 when only 3% reported this concern.[18]

In 2010 PSI, the main supplier of condoms in Cambodia, sold and distributed more than 23 million condoms with an estimated 19% sold to outlets in high-risk areas and the remaining in other shops across the country[19]. PSI estimates that 7.5 million condoms were sold to MSM, 4.5 million to entertainment workers and 11.5 million to the general population.[20]

Highly targeted interventions with MSM, such as FHI's MStyle program have contributed to improving the knowledge and health seeking behavior of MSM. Outreach workers have been facilitating the uptake of testing and treatment services, selling and providing condoms for free.

The NAA finalized National MSM Guidelines during 2010 which is intended to be the national guiding document on all interventions with MSM. A plan for developing a training curriculum on the guidelines has also been developed.

A crucial component of prevention, the needle syringe program, was reduced in coverage during 2010 as one of the two NGOs licensed for this activity did not have their license renewed at the end of 2009. In mid 2010 KHANA opened a drug user drop in center in Phnom Penh where needles can be exchange and referrals made to health services.

Cambodia's first Methadone Maintenance Treatment (MMT) clinic, which opened in Phnom Penh in July 2010. An agreement was also signed this year between the UNODC and Banteay Meanchey Provincial Health Department (PHD) for the implementation of community based drug treatment approach.

Most at Risk Community Partnerships has conducted 10 training workshops on strengthening the capacity of Law Enforcement Officials on Drugs and HIV/AIDS during 2010. These workshops covered topics such as law enforcement, HIV, and global and regional experiences in implementing harm reduction.

59 specialized sexual health clinics are continuing to provide essential care and treatment for MARPS. By the end of 2010 more than 55,000 direct female sex workers, entertainment workers, and MSM[21] had visited used one of these clinics. All 33 of the Government Family Health Clinics now have the laboratory technology to perform Rapid Plasma Reagin (RPR) tests and microscopy which enables them to use refined algorithms for the management of STIs in high-risk populations.

By the end of 2010, voluntary counseling and testing (VCT) was available in 246 health facilities across Cambodia and more than half a million clients were tested. According to the most recent data, 81.5%

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18 PSI (2010) Annual Progress Report October 1, 2009 –September 30, 2010. PSI Cambodia.

19 Ibid

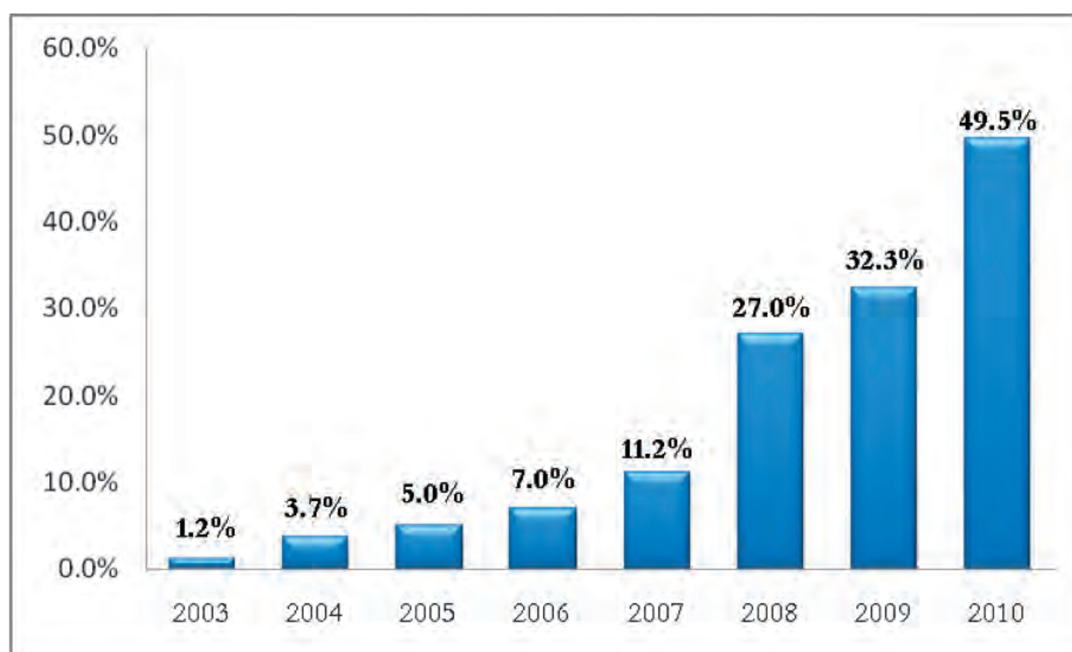
20 Ibid

21 NCHADS (2011b). Annual report 2010. Phnom Penh.

of entertainment workers (more than two clients per day)[22]; 57% of short hair MSM[23]; and 53% of IDUs[24] have had an HIV test in the past 12 months. Nearly all people tested received their results together with counseling.

Since 2008, 100% of donated blood is tested for HIV in Cambodia, with 0.81% of the units testing positive for HIV in 2007. 77% of all blood transfusions in 2008 were with whole blood rather than blood components. The number of voluntary blood donations has increased over the years from 25% in 2007 to 31% in 2009 and 2010[25].

Figure 5: Percentage of HIV infected pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child-transmission, 2003-2010



The programme to eliminate the transmission of HIV from mother-to-child has been taken to scale in recent years, mainly through the Linked Response initiative which was launched in 2008 with the aim to promote a better integration of HIV, maternal and newborn, and reproductive health services. In 2010, 57% of pregnant women nationwide received HIV counseling and testing, up from 42% in 2009 and 16% in 2007[26]. 49.5% of HIV-infected pregnant women received antiretroviral treatment to reduce the risk of mother-to-child transmission in 2010, compared to 32.3% in 2009 and 11% in 2007. (Figure 5)[27]

HIV education in primary schools continued during 2009-2010 but the percentage of secondary schools teaching HIV has declined 2006-2007 levels because of the closure of an externally funded project. During 2010 the MoEYS also drafted a National Youth Policy and Strategy which incorporates activities on HIV and sexual reproductive health for young people.

22 NCHADS 2010 BSS.

23 NCHADS (2007a) BSS. Phnom Penh

24 NCHADS 2007 HIV Prevalence Study among drug users. Phnom Penh

25 NBCT routine data

26 WHO (2011). Monitoring and reporting on the health sector response. Joint reporting tool. Phnom Penh

27 Ibid

3.2 Care and Support

In April 2010 NCAHDS issued new guidance on antiretroviral (ARV) treatment; changing the threshold for starting ARV from a CD4 count of 250 to a CD4 count of 350. The MoH also approved changes to TB treatment during 2010 so antiretroviral therapy is to begin in TB-HIV patients 14 days after anti-TB treatment regardless of CD4 count.

As such, the number of PLHIV on antiretroviral treatment (ART) has grown from 12,335 in 2005 (11,284 adults and 1,071 children) to 46,901 in 2010 (42,799 adults and 4,102 children)[28]. Overall this constituted 96.7% of all of the people in need of ART. About 3% of the adults and 11% of children are receiving second line treatment.

In 2010 a total of 51 health facilities offered OI and ART services in 44 operational districts (ODs) (>50%) in 21 out of 24 provinces. 48 OI/ART sites were run by the Government and 3 sites by NGOs. 32 sites also provided paediatric care in 29 operational districts.

The complete package of CoC services is now available to PLHIV in 44 ODs. Home-based care (HBC) teams and PLHIV support groups are an important component of the CoC and delivered with the help of NGOs. These structures have grown in number in recent years, at the end of 2010 there were 356 HBC teams supporting a total of 31,127 PLHIV.[29]

To improve case finding among PLHIV the Standard Operating Procedure (SOP) for Implementing the Three Is in CoC and HBC settings and was released in 2010. A core feature of this strategy is the administration of isoniazid preventive therapy (IPT) for latent TB.

3.3 Impact Mitigation

In Cambodia 14% of children aged 0 to 17 years were either orphans or considered vulnerable due to a chronically ill parent.[30] Impact mitigation interventions target households with orphans and vulnerable children (OVC) living with food insecure grandparent(s); living with food insecure sibling(s); living with food insecure extended family(ies); and living with food insecure foster parent(s). Support provided to HIV-affected OVC households includes: food, medical, shelter, education, psychological and rights protection. It is estimated that 44,000 households and 58,000 households with OVC received such assistance in 2009, and 2010 respectively[31]. The world Food Program reached more than 16,000 OVC and PLHIV households in both 2009, and 2010 with food assistance.[32]

A Socio-Economic Study on the Impact of HIV at the Household Level was conducted in 2010 and confirmed that children in HIV affected households experience greater hardship from many points of view.[33]

During 2010 MoSVY led the National OVC Taskforce to develop National Standards for the Care, Support and Protection of Orphans and Vulnerable children. These standards will replace the Minimum Package of Supports, and are accompanied by a national reporting system.

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[28] NCHADS (2011b). Annual Report 2010. Phnom Penh

[29] Ibid

[30] UNICEF. No date. accessed on line http://www.unicef.org/eapro/Summary_of_OVC_Situation_Assessment_in_Cambodia.pdf

[31] NAA 2011. A Review of Progress Towards Cambodia Universal Access. Draft Report.

[32] WFP (2010). As reported to the NASA team

[33] UN 2010. Socio Economic Impact Of HIV at the Household Level in Cambodia. Draft Report

3.4 Leadership by government and non-government sectors

An important activity led by the NAA in 2010 was the development of the new Situation and Response Analysis and of the Third National Strategic Plan 2011-2015 (NSPIII). The NAA also supported the work of eleven technical working groups and led several national consultation meetings (for example on Universal Access). In addition, the NAA carried out a functional task analysis to review the coordination of the national response and the systems and structures involved with it at the national and sub-national level.

Civil society also plays an important role in the national response to HIV as a service and care provider. There are two PLHIV networks, the Cambodian Network of People Living with HIV (CPN+) and the Cambodian Community of Women living with HIV and AIDS (CCW) providing support through home-based care and self-help groups. Several NGOs provide services for MARPs and there is one MSM network (Bandanh Chaktomuk) and several entertainment worker networks. The HIV/AIDS Coordinating Committee (HACC) is the umbrella organization for more than one hundred national and international NGOs. During 2010 CPN+ and Bandanh Chaktomuk were supported to strengthen their strategic vision and internal organization.

The UNDP's Legislative Assistance Project (LEAP) continued to provide important space for dialogue and learning with parliamentarians on a range of HIV issues. A Parliamentary Handbook on HIV/AIDS was produced through LEAP, and launched by the ***First Lady Lok Chumtiev Bun Rany Hun Sen***, early in 2010.

3.5 An enabling legal and public policy environment

During 2009 and 2010, the NAA conducted training and public forums to raise awareness on the AIDS Law. Also a topic of debate during the biennium was The Law on Drug Control which is currently under review by the National Agency for Drug Control (NACD).

The Ministry of Labour and Vocational Training (MoLVT) in cooperation with the ILO finalized the "Guidelines on HIV/AIDS in the Workplace" which are a user friendly tool on how to establish and implement a program and policy on HIV/AIDS in the workplace.

Stigma and discrimination toward PLHIV and MARPs continue being a major source of concern and represent a huge barrier in achieving universal access to essential services for all those in need. The Stigma Index study was conducted to better understand the experiences of PLHIV.

3.6 Strategic Information for Policy Planners and Programmers

The strengthening of monitoring and evaluation (M&E) systems is increasing the ability to track progress and assess results achieved through the national response. Routine programme monitoring was improved and several surveillance surveys and other studies were conducted including new Behavior Sentinel Surveillance and HIV Sentinel Surveillance surveys, a study on high risk males (Bros Khmer), and a study on the socio-economic impact of HIV at the household level.

M&E and research capacity was further developed in government and non-governmental organizations through formal and on-the-job training.

National data collection and reporting continued to improve during 2009 and 2010. NCHADS continues to provide, detailed information on the health sector response. The Country Response Information System (CRIS), housed at the NAA, has been updated to CRIS version 3 and staff trained in its maintenance and use.

At the international level, Cambodia's UNGASS, and Universal Access reports were developed with extensive input from key ministries, civil society, and donor organizations, with the results discussed and validated through a national workshop.

3.7 Sustainable and efficiently allocated resources

Financial resources for the national response to HIV were mainly mobilized through the GFATM, and Cambodia also composed and submitted proposals for further funding in 2009 and 2010. To look at the different options for the future financing of the response the Aids2031 was commissioned by the NAA. The study emphasis the need for resources to be targeted better for better informed long term planning as global allocations for HIV and AIDS declines. The NSPII was costed, predicting that the total resources required for the years 2011-2015 to be US$ 516.3 million.

A cost effectiveness study of the Linked Response in two sites was completed in 2010, finding that large improvements in ANC uptake, testing, and treatment of exposed infants, with efficiencies possible through better targeting of higher risk and higher prevalence populations.[34]

PSI has repositioned in brands to allow for cost recovery, and recreate more room for the commercial sector, and reduce reliance of door funding. The condom brand Number One is now at 160% full commodity plus packaging cost recovery and the brand Ok is 10% below commodity and packaging cost recovery.

[34] The economist intelligence unit (2010) A "Linked response" to the PMTCT in Cambodia: Analysiing the effectiveness and costs of operational linkages for HIV/AIDS and sexual and sexual and reproductive health. final draft May 2010.

4. FINDINGS OF THE SPENDING ASSESSMENT

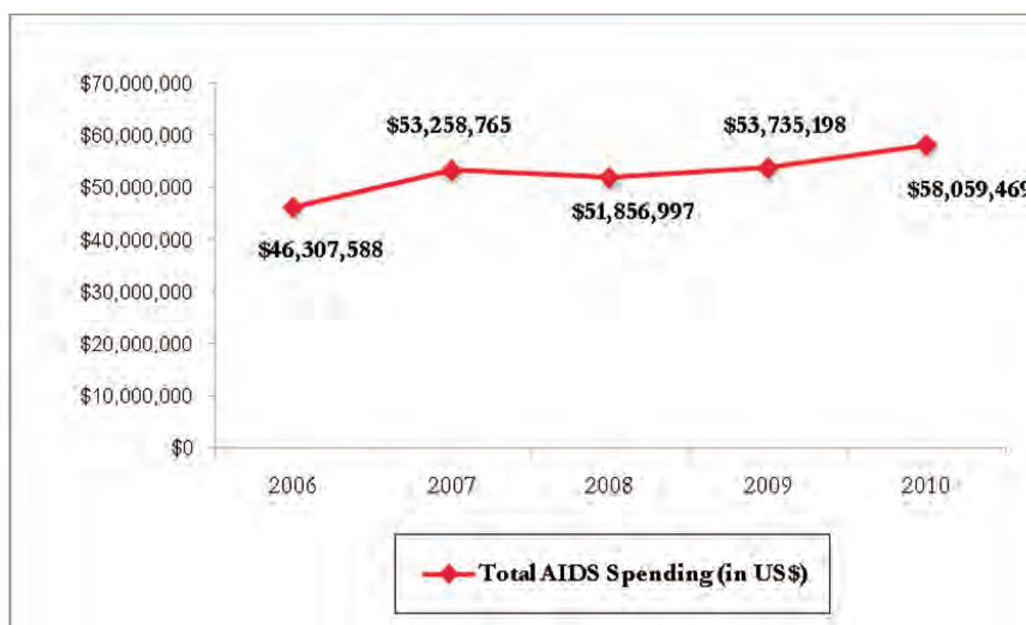
The following section presents the findings of the assessment and includes an analysis of spending on HIV and AIDS in the two years under investigation and of trends in spending in the past 5 years. Firstly, a general overview of findings is provided to address the main questions NASA III sought to answer. Thereafter, different dimensions and aspects of financial flows are presented in more detail. Attention is first focused on spending by financing sources, then on financing agents, service providers, beneficiary populations and finally on spending categories. The most important data is displayed in tables and figures in the text, whilst additional tables can be found in the annex.[35]

4.1 Trend in spending on HIV and AIDS

A total of US$53,735,198 was spent in 2009 and US$58,059,469 in 2010 on HIV and AIDS (Figure 6). Spending per capita was US$3.95 in 2009 and US$4.20 in 2010. Spending per person living with HIV in Cambodia remained more or less the same at US$334 in 2009 and US$331 in 2010.

Whilst NASA II identified a drop in spending of 2.6% from 2007 to 2008, NASA III registered an increase in AIDS spending of 8% from 2009 to 2010.

Figure 6: Total spending on HIV and AIDS, 2006-2011



The increase in AIDS spending over the years may be due to the larger number of organizations who submitted financial data in NASA III which allowed the report to capture a larger share of overall expenditure on HIV and AIDS compared to previous NASA.

4.1.1 How is the HIV/AIDS sector financed?

The great majority of funds spent on HIV related interventions in the biennium originated from external sources such as the GFATM, bilateral donors, UN agencies and international NGOs (Figure 7).

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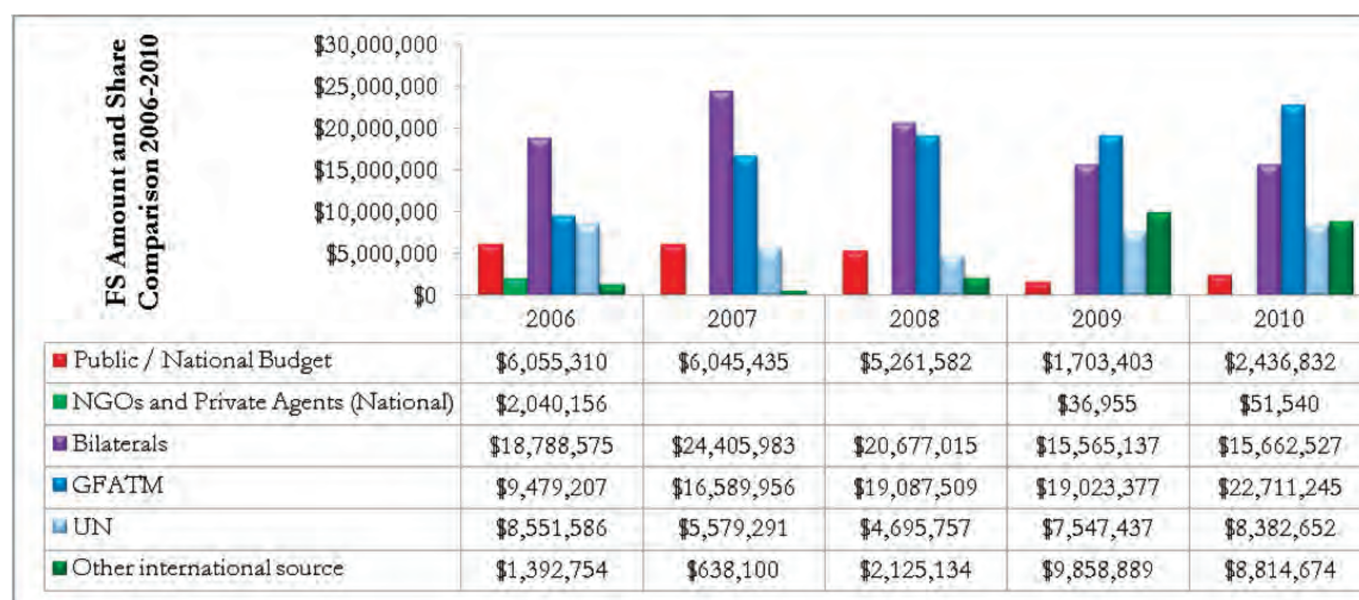
35 See annex 2 : main data table

Spending of money from GFATM increased steadily over the years and more than doubled in the five year period from US$9,479,207 in 2006 to US$22,711,245 in 2010.

Spending from bilateral sources decreased over this period but with some significant fluctuations. It peaked in 2007 at US$24,405,983 and thereafter declined to US$15,662,527 in 2010. This represents a decline of 36%. There were considerable fluctuations also in spending of funds from UN agencies: a drop of 45% was registered from 2006 to 2008 and an increase of 79% from 2008 to 2010.

Figure 7: Total spending by financing source, 2006-2010



	2006	2007	2008	2009	2010
Public / National Budget	$6,055,310	$6,045,435	$5,261,582	$1,703,403	$2,436,832
NGOs and Private Agents (National)	$2,040,156			$36,955	$51,540
Bilaterals	$18,788,575	$24,405,983	$20,677,015	$15,565,137	$15,662,527
GFATM	$9,479,207	$16,589,956	$19,087,509	$19,023,377	$22,711,245
UN	$8,551,586	$5,579,291	$4,695,757	$7,547,437	$8,382,652
Other international source	$1,392,754	$638,100	$2,125,134	$9,858,889	$8,814,674

Spending of funds obtained from national NGOs, private agents and from other international sources cannot be compared because of definitional changes over the years. Similarly, a comparison of expenditure of funds sourced from the national budget is complicated because from 2006 to 2008 this money was mostly spent on blood safety which could not be disaggregated by HIV and other diseases. NASA III blood safety spending in 2009 and 2010 only counted HIV spending, and so the spending results are considerably lower than in the past and explains why the share of spending derived from public sources dropped considerably after 2008[36]. However, a closer look at this issue is necessary.

Table 8 displays expenditures of public funds overall including blood safety and other spending. These latter expenses remained relatively constant over the five year period at 5% in 2006, 4% in 2007, 4% in 2008, 3% in 2009 and 4% in 2010. These expenditures were mainly on media and communication activities, and to develop and administer programmes.

[36] From a2006 to 2009 there was a decrease in expenditures sourced from the National Budget because NASA I and NASA II included expenditures on blood safety not only to prevent HIV but also to avert other infections as well as expenses for the management of the whole national blood safety programme. Since NASA III only includes HIV related expenditures on blood safety the amount spent originating from public funds is much lower. This is why the data shows a considerable drop in spending of public funds in both absolute and relative terms as most of these were used for blood safety in 2007 and in 2008.

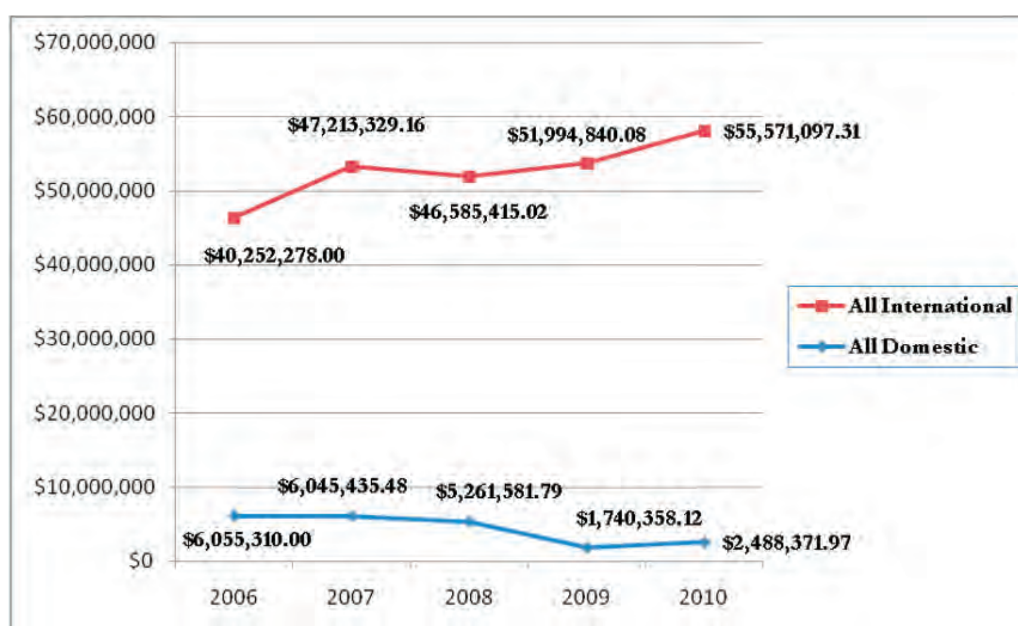
Table 8: Spending from national budget on blood safety, 2006-2010

	2006	2007	2008	2009	2010
All public spending excl. blood safety	$1,925,801	$2,119,864	$1,999,151	$1,556,603	$2,244,832
Public spending on blood safety	$4,129,509	$3,925,571	$3,262,431	$146,800	$192,000
Total	$6,055,310	$6,045,435	$5,261,582	$1,703,403	$2,436,832

After HIV related expenses for blood safety has been captured in this round of NASA, an increase in spending from public sources can be detected. Total spending from public sources increased by US$733,429 from US$1,703,402 in 2009 to US$2,436,832 in 2010 (Table 8). This is a positive development suggesting there is a growing national ownership of the response.

Comparatively speaking, the contribution of domestic resources to the national response to HIV appears very small. Out of total spending only US$1,740,358 (3%) in 2009 and US$2,488,372 (4%) in 2010 were financed from national sources. Figure 8 shows trends in spending of money on HIV and AIDS drawn from domestic and international financing sources.[37]

Figure 8: Total spending by type of financing source (2006-2010)



It is important to acknowledge that not all expenses could be captured by the NASA. The running costs of public health services and of government institutions could only be captured in part because financial data on salaries and on infrastructure and equipment related expenditure were not provided and included in the spending calculations.

Lastly, only very small amounts, US$36,955 in 2009 and US$51,540 in 2010, were also sourced from national for-profit entities and national non-profit organizations through donations for example from Cambodian firms or citizens.

[37] This is about the same proportion than in the past if the non-HIV related blood safety expenditures are deducted from the roughly 10% AIDS spending that NASA I and NASA II found had been drawn from national sources in the years 2006-2008.

4.1.2 Who pays for what, and how much?

All three NASA have collected data on how the money was spent by using the same eight AIDS Spending Categories. Table 9 shows total spending by each spending category over the five years. It clearly illustrates that spending on prevention has decreased each year and is it at present, half of what it was in 2006. Prevention spending dropped from $20,775,489 (45% of total spending) in 2006 to $11,048,070 (19%) in 2010. In 2009 and 2010 bilateral entities (46% in 2009 and 42% in 2010) and GFATM (over 30% each year) were the main financing sources. Public spending on prevention more than doubled from 2009 to 2010 both in absolute figures and as percentage, although it still covers only 5% of prevention expenditures.

Meanwhile spending on care and treatment has increased overall from US$9,856,777 in 2006, to US$13,653,403 in 2010. Over the last two years it has started to exceed spending on prevention also because a lot of what was previously captured in Prevention is now captured in Program Management and Administration. Expenditures on care and treatment have fluctuated over the five year period, reaching a peak in 2009 at 28% of total AIDS spending.[38] At this time it exceeded spending on prevention by about 50% - largely due to the vast scale up of ART.

Table 9: Total spending by main AIDS Spending Categories (ASC), 2006-2010

ASC	2006		2007		2008		2009		2010	
	US $	%	US $	%	US $	%	US $	%	US $	%
1. Prevention	$20,775,489	45%	$23,273,407	44%	$19,928,804	38%	$10,806,903	20%	$11,048,070	19%
2. Care and treatment	$9,856,777	21%	$13,481,788	25%	$14,809,076	29%	$15,128,794	28%	$13,653,403	24%
3. OVC	$2,177,112	5%	$2,787,594	5%	$2,224,681	4%	$4,185,535	8%	$4,418,420	8%
4. Programme management & Administration	$9,133,465	20%	$9,494,033	18%	$10,279,877	20%	$15,841,868	30%	$19,211,252	33%
5. Human resources	$1,082,450	2%	$2,046,001	4%	$2,317,106	4%	$955,575	2%	$999,166	2%
6. Social protection and social services	$146,619	0%	$39,810	0%	$19,248	0%	$3,434,866	6%	$4,212,826	7%
7. Enabling environment	$2,344,496	5%	$647,502	1%	$257,497	0%	$2,708,324	5%	$3,410,437	6%
8. Research	$791,180	2%	$1,488,630	3%	$2,010,709	4%	$673,333	1%	$1,105,895	2%
Total	**$46,307,590**	**100%**	**$53,258,765**	**100%**	**$51,846,997**	**100%**	**$53,735,198**	**100%**	**$58,059,468**	**100%**

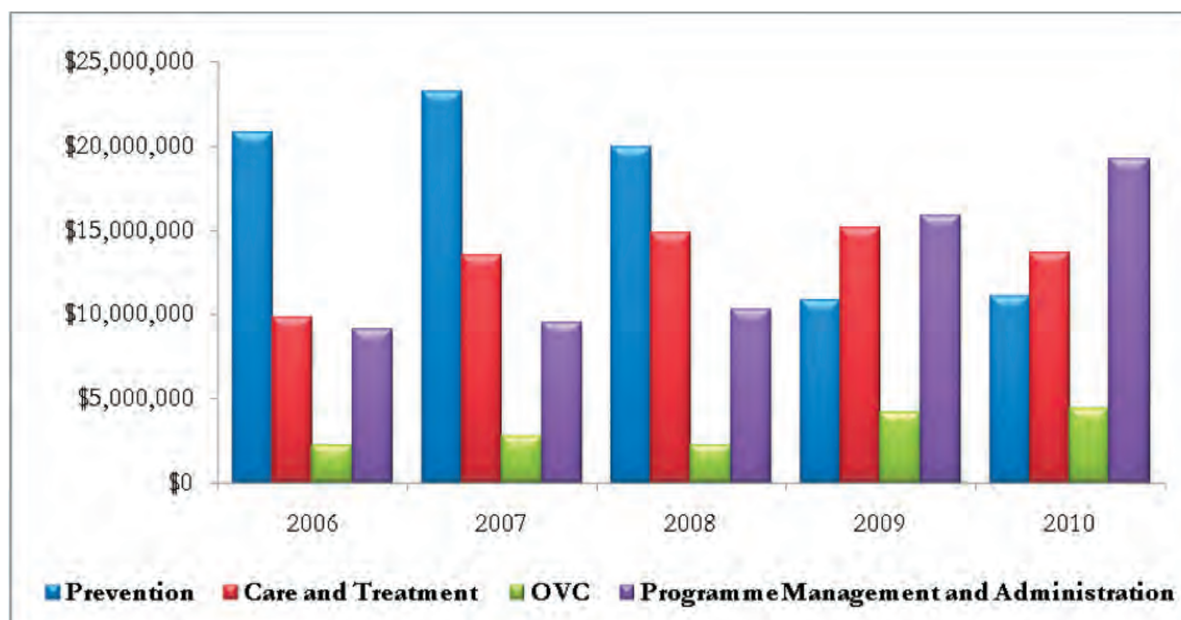
Expenses on OVC more than doubled - from US$2,177,112 in 2006 to US$4,418,420 in 2010. The same is the case of expenditure on programme management and administration which rose significantly in the past two years. This increase which is illustrated in Figure 9 is largely due to a change in definitions of NASA spending categories and thus in the coding of expenditures. Spending related to such things like programming, planning and consultation meetings has more often been accounted for under Programme Management and Administration rather than under thematic categories like Prevention. This means that the prevention spending would have been smaller in the past if the current definition had been used.

Within the last two years, the majority of this spending (around 90%) was coverd by international donors. Among them, bilaterals started bo pay less for program management while spending from GFATM increased from 5.4 million to 8.3 million frin 2009 to 2010. Approximately 11% of the program management and administration strengthening was paid for by UN agencies.

[38] Both in relative and absolute terms spending on this category dropped in 2010 which is surprising considering the increasing number of PLHIV who were enrolled in antiretroviral treatment. This could only be explained by a failure to capture all expenditure based on the accrual method. This means that spending is accounted for when the service is actually delivered and not at the time of procurement which may have happened earlier.

Spending related to such things like programming, planning, and consultation meeting has often been accounted for under program management and administration rather than under thematic categories like prevention. This means that prevention spending would have been smaller in the past if the current definition had been used.

Figure 9: Total spending by spending category, 2006-2010



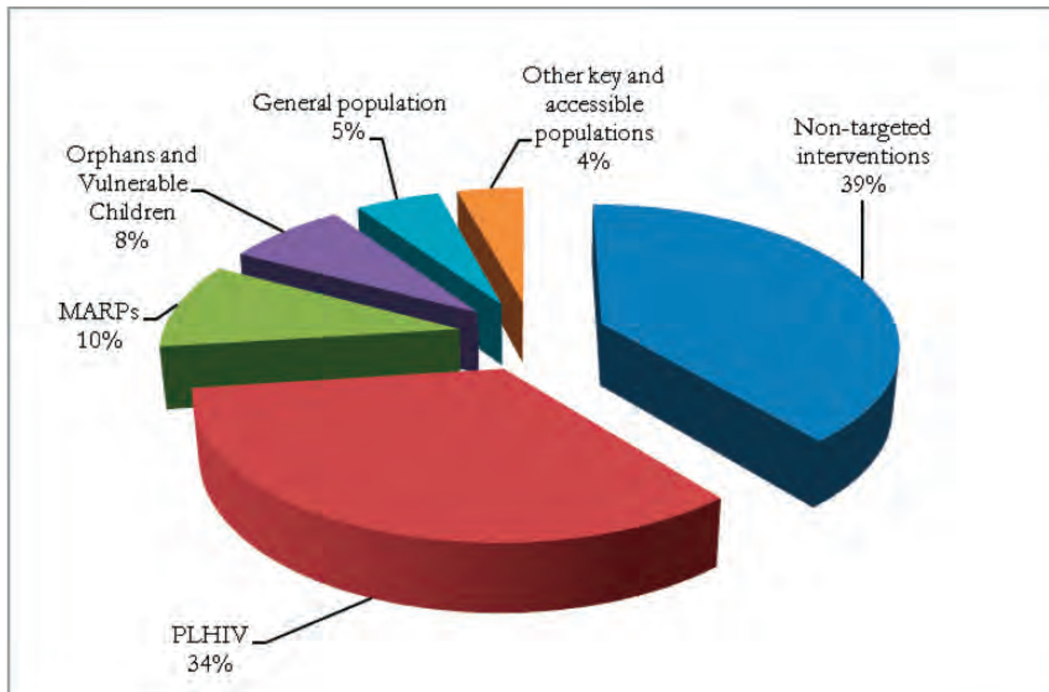
A change in definitions has also resulted in higher spending in this assessment than in previous ones on categories such as Social protection and social services and Enabling Environment. Previously advocacy activities related to prevention were coded under the category of Prevention but in this assessment they were coded under the category of Enabling Environment. Furthermore, the increase in spending on social protection and social services is due to in-kind contributions made by WFP (i.e., food support for PLHIV) being accounted for in this expenditure category whereas previously they fell under the Home-Based Care sub-category of Care and Treatment.

4.1.3 Who drew benefit from the spending?

For the first time, NASA III provides a more systematic analysis of who the spending benefited.[39] Figure 10 shows that the largest share of money (an average of 39% in the two years) was spent on non-targeted interventions or activities that did not specifically target one single population. The increase in spending in this category in 2009 and 2010 may be due to an increase in spending on activities that cut across several categories such as those carried out to design, plan, manage, coordinate and monitor programmes or to difficulties of classification, or of both.

[39] There are however two important issues that need to be acknowledged. Firstly, an important share of spending benefited more than one population and therefore is classified under the label of 'Non-targeted Intervention'. This category includes mainly activities falling under the AIDS Spending categories of Programme Management and Administration, Enabling Environment; and Research. Secondly, not always has all expenditure been adequately disaggregated by beneficiary population by the respondents. Spending which could not adequately be classified by beneficiary populations was accounted for under the Non-targeted Interventions category.

Figure 10: Total spending by beneficiary population (Average 2009/2010)



More than one third of total spending targeted PLHIV which is not surprising with a decrease from 36% of total spending in 2009 to 32% in 2010. MARPs benefited from only 10% of total expenditure which is concerning given that Prevention is the third largest category of spending and should largely be targeted at people most at risk of HIV infection based on epidemiological evidence.

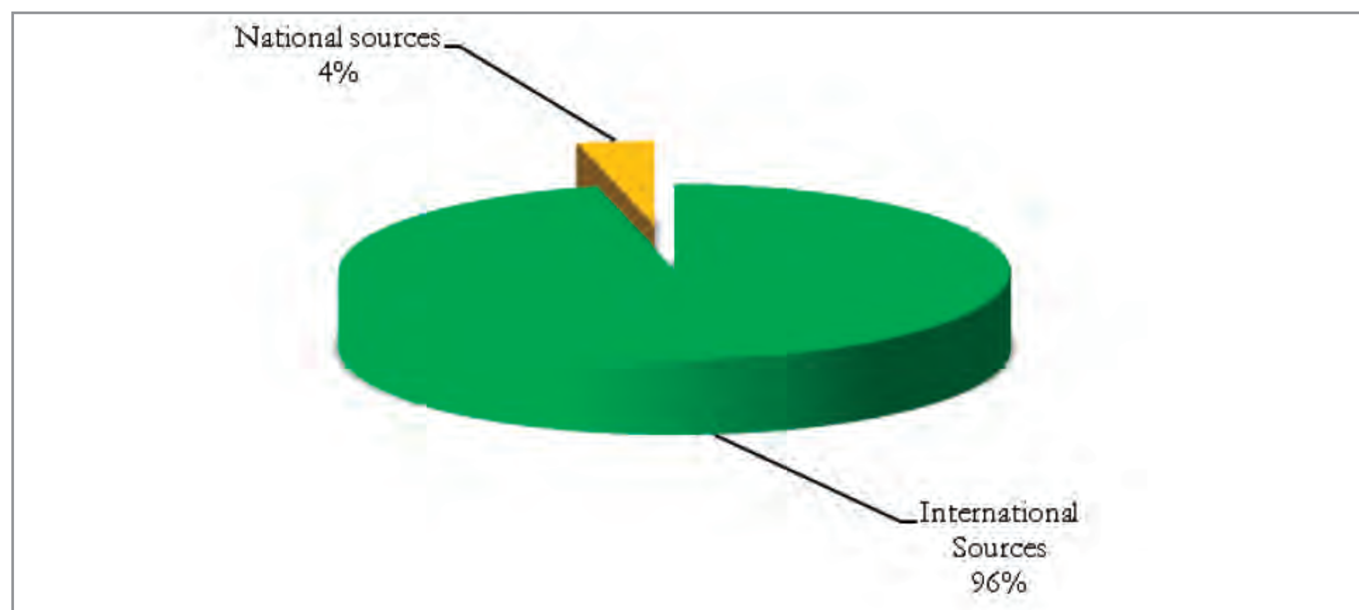
There was little difference in spending between the two years by the general population and other targeted and accessible populations (9% in total) including the military, police and school students for example. The same is the case of OVC who on average benefited 8% of total expenditure.

In the next sections spending levels and patterns will be examined in more depth by focusing on financing sources, financing agents, service providers, beneficiary populations and AIDS spending categories.

4.2 Spending by financing source

As seen earlier, only a very small portion of the money spent on HIV and AIDS was obtained from national sources. 96% of all spending came from international sources (Figure 11).

Figure 11: Total spending by type of financing sources (Average 2009/2010)



In 2009 and 2010 the largest source of funding was GFATM who financed 37% of total spending on HIV and AIDS (Table 10).[40] Out of the total US$111,794,667 that was spent in the biennium, US$41,734,623 came from GFATM. Spending from this source increased by US$3,687,868 from 2009 to 2010.

Table 10: Spending by financing source, 2009 and 2010[41]

Financing Source	2009		2010		Total	
	US $	%	US $	%	US $	%
GFATM	$19,023,377	37%	$22,711,245	39%	$41,734,623	37%
Bilaterals	$15,565,137	28%	$15,662,527	27%	$31,227,664	28%
International NGOs	$9,119,295	15%	$7,516,331	13%	$16,635,626	15%
UN	$7,547,437	14%	$8,382,652	14%	$15,930,089	14%
Public	$1,703,403	4%	$2,436,832	4%	$4,140,235	4%
Other Multilateral	$612,307	1%	$1,043,168	2%	$1,655,475	1%
International for-profit	$127,286	0%	$255,175	0%	$382,461	0%
NGOs and Private Agents (National)	$36,955	0%	$51,540	0%	$88,495	0%
Total	**$53,735,198**	**100%**	**$58,059,469**	**100%**	**$111,794,668**	**100%**

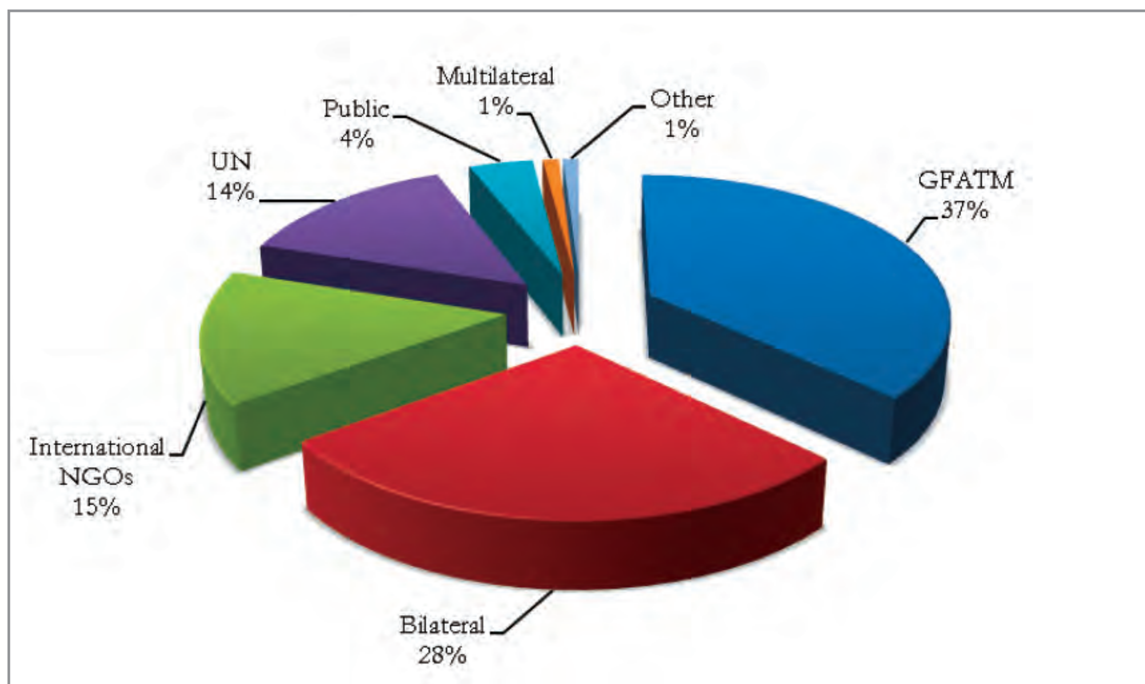
The second largest source of spending in the HIV sector were bilateral organizations (28%). Multilateral organizations, including UN agencies, were the source of 15% of spending. Other multilateral sources like the European Commission and ADB contributed only 1% of total spending. A share of 15% of total expenditure was instead financed by international NGOs. Among the latter, the most important sources of financing were the Clinton Foundation and World Vision.[42]

40 The definition and classifications of Financing Agents was repeatedly changed and too different in NASA I, II and III to allow for meaningful comparisons over the years.

41 Due to rounding of decimal values, the percentage in some places of this report do not add up to 100% and in some cases categories show 0% value although they have recorded spending.

42 See Annex 2: Main data tables

Figure 12: Total spending by financing source (Average 2009/2010)[43]



4.2.1 Spending by source and beneficiary population

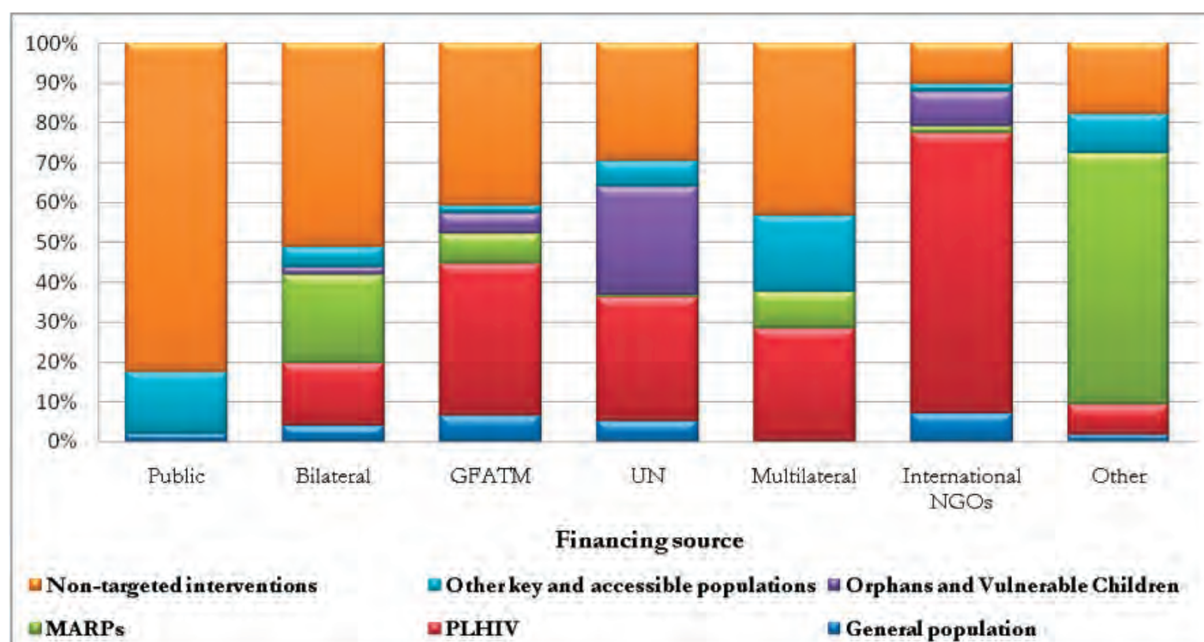
Figure 13 (below) shows that more than one third (38%) of total spending sourced from GFATM (US$41,734,623) in the two years benefited PLHIV.[44] This is because GFATM has become the primary source of spending on antiretroviral treatment (ART). Only 8% of GFATM financed spending targeted MARPs and 5% targeted OVC.

MARPs drew the largest benefit from money obtained from bilateral sources. They benefited from 22% of total spending financed from these sources. This is not surprising given that the US Government was by far the largest bilateral financer in the HIV sector and that it channels funds through international and national NGOs (e.g., FHI, KHANA) whose interventions strongly target populations at high risk of HIV infection. However, PLHIV also drew significant benefit from bilateral contributions (16% of spending from this source).

[43] Other international sources are ADB, IOM, EC and private international sources

[44] See Annex 2: Main data tables

Figure 13: Spending by financing source and beneficiary population (Average 2009/2010)



Financial resources from the UN mainly benefited PLHIV (27% of spending from the UN) as well as OVC (31%) because a large share of the UN's contributions consisted of WFP's food support.

Overall, the general population and other key and accessible populations benefited from spending to much lesser extent in 2009 and in 2010. A very large portion of spending from all sources was used to pay for interventions that did not target any beneficiary population in particular. Of the total of public funds used to address HIV, the majority (82%) was spent on 'Non-targeted interventions' and the remaining mostly on other key and accessible populations (i.e., school students).[45]

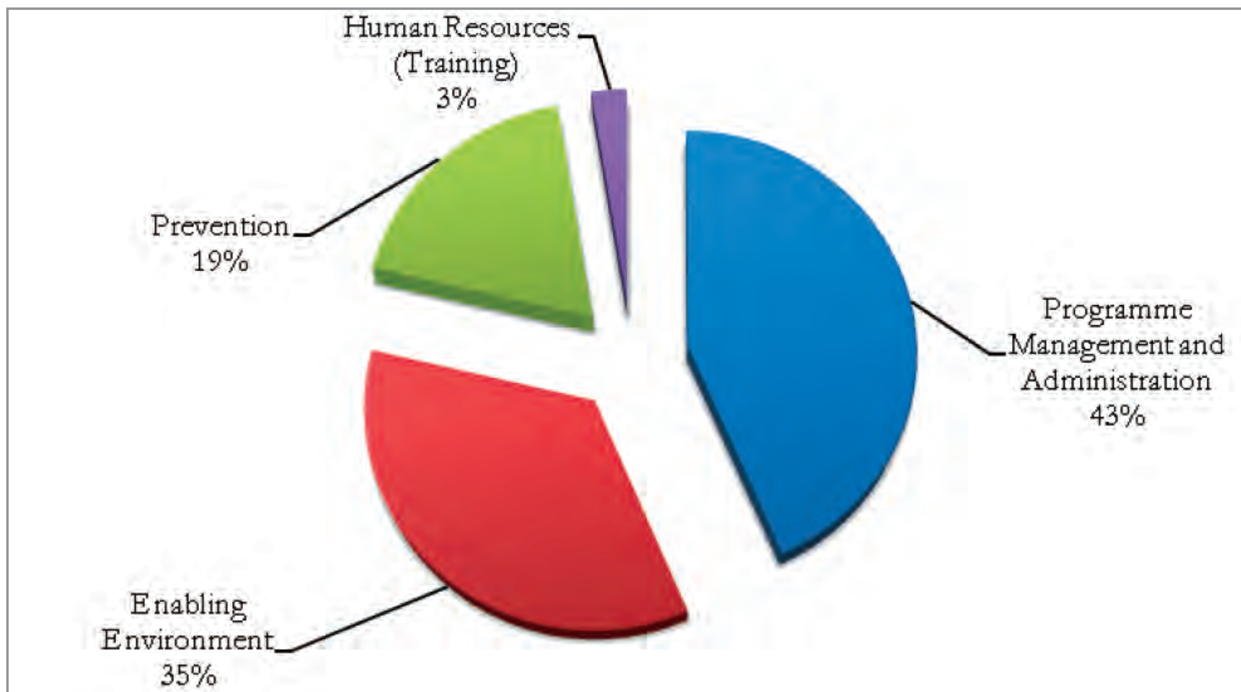
Expenditure on this category from other sources was 51% from bilaterals, 43% from multilaterals, 41% from GFATM and 30% from the UN. It is important to analyze in more depth expenditure by sources in the two years.

4.2.2 Spending of funds from public sources

Spending of funds from public sources was US$1,703,402 in 2009. 42% of these funds were spent on advocacy to create an enabling environment for the national response, 40% on programme management, 12% on prevention, and 6% on human resources. Out of the US$2,436,832 of public funds spent in 2010 a larger share was for programme management (46%), and a smaller share on initiatives to create an enabling environment (30%). Public fund expenditure doubled for prevention and reached 24% in 2010 (Figure 14) Spending of public funds within the category of prevention was mostly on blood safety, HIV prevention for in- and out-of-school youth, and on the provision of condoms.

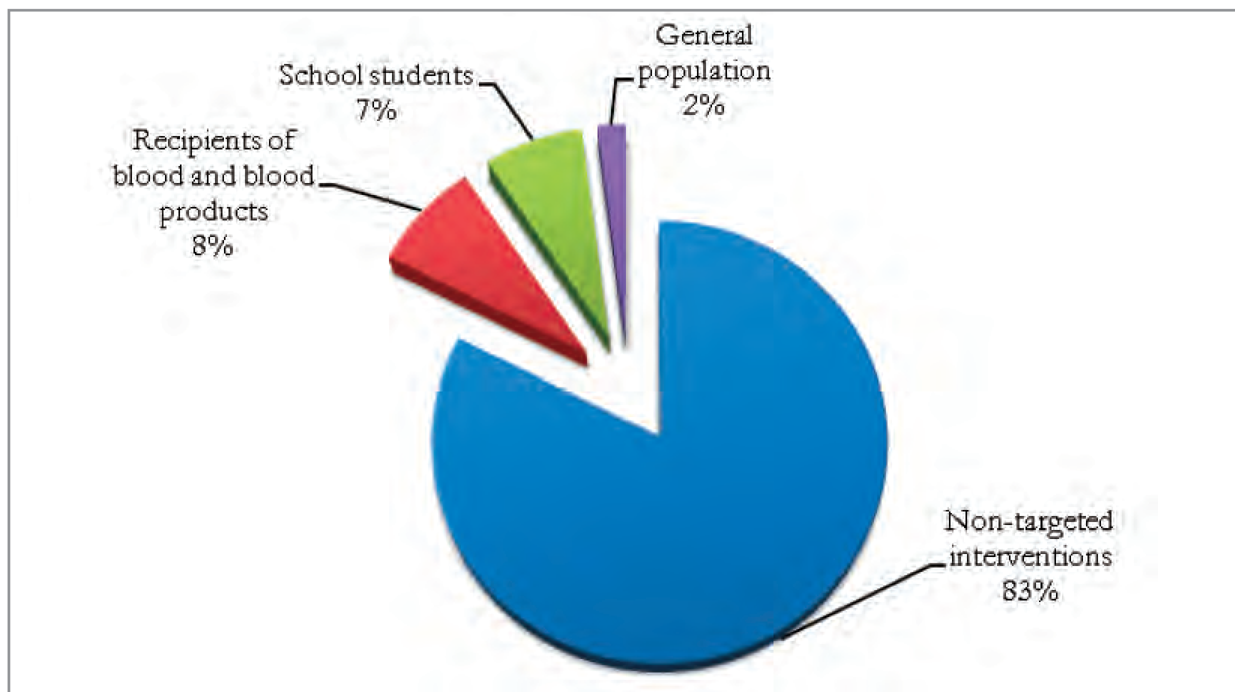
[45] 'Non-targeted Interventions' include spending on activities that benefit more than one single population which often belong to the categories of Programme Management and Administration, Enabling Environment; and Research. They also include spending for which the beneficiary population could not be identified.

Figure 14: Public spending by spending categories (Average 2009/2010)



Government funds were exclusively managed and spent by government entities, with the majority of funds spent on non-targeted interventions and programme management and administration[46]. On average for the two years, 8% of public funds were intended to benefit recipients of blood products, 7% school students and 2% the general population (Figure 15).

Figure 15: Public spending by beneficiary population (Average 2009/2010)



[46] Non-targeted interventions are activities that are not designed to benefit any population in particular or activities whose beneficiary population could not be determined in the assessment.

4.2.3 Spending of funds from GFATM

Spending of GFATM funds increased by US$3,687,868 over the two years from US$19,023,377 in 2009 to US$ 22,711,245 in 2010 (Table 11).The most notable difference in spending was in the area of programme management and administration with an increase of US$2,852,461.

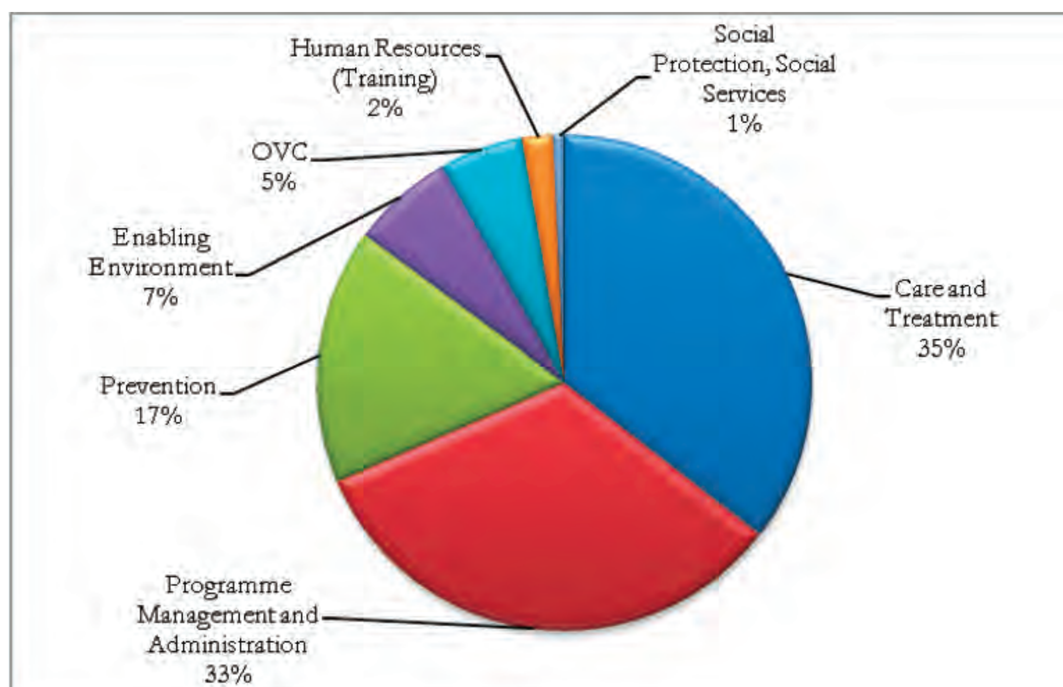
Table 11: Spending sourced from GFATM by spending category, 2009 and 2010

AIDS Spending Categories	2009		2010		Total	
	US $	%	US $	%	US $	%
1.Prevention	3,493,397	18	3,414,280	15	6,907,678	17
2.Care and Treatment	7,400,318	39	7,356,958	32	14,757,276	35
3.OVC	1,056,774	6	1,207,378	5	2,264,152	5
4.Programme Management and Administration	5,439,678	29	8,292,139	37	13,731,817	33
5.Human Resources (Training)	391,979	2	474,989	2	866,968	2
6.Social Protection, Social Services	184,282	1	91,459	0	275,741	1
7.Enabling Environment	961,664	5	1,827,603	8	2,789,267	7
8.Research	95,284	1	46,439	0	141,723	0
Total	**19,023,377**	**100**	**22,711,245**	**100**	**41,734,622**	**100**

In 2009-2010, an average of 35% of spending originating from GFATM was spent on treatment and care services, 33% on the management and administration of programmes, and 17% on prevention (Figure 16). Other spending categories were only small proportions of total spending of funds sourced from GFATM.

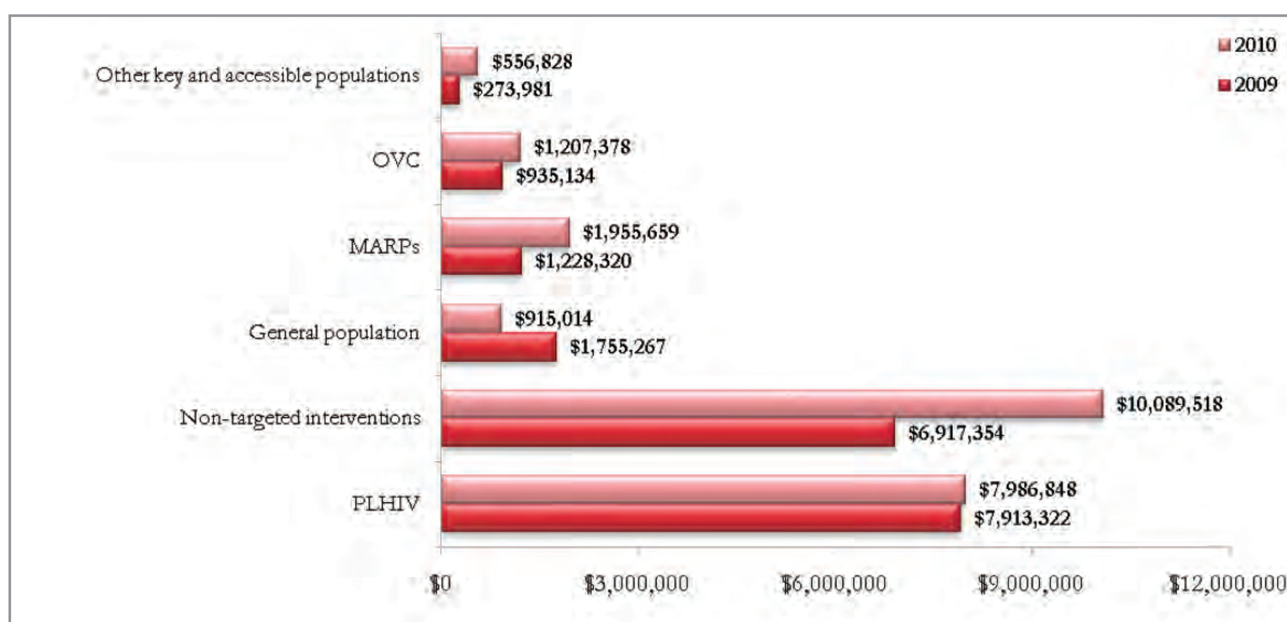
In 2009-2010, 81% of the expenditures of funds drawn from the GFATM were managed by public entities acting as Principal Recipients (i.e., Ministry of Health and NCHADS). International and national NGOs managed the remaining 19%. Nearly half of the service providers who used GFATM money were public entities (government institutions) and the other half were private entities (NGOs).

Figure 16: Spending sourced from GFATM by spending category (Average 2009/2010)



In the biennium, the primary beneficiaries of financial resources from the GFATM were PLHIV, 42% in 2009 and 35% in 2010 (Figure 17 below).The drop in spending for this target group is due to an increase in the share of non-targeted interventions (36% in 2009; 44% in 2010). This increase is a result of either a growth in spending on programme management and administration or to a difficulty in capturing sufficiently detailed data allowing the beneficiaries of the spending to be identified. The other intended beneficiaries of GFATM resources were the general population (2009: 9%; 2010 4%), MARPs (2009: 7%; 2010 9%), OVC (5% in both years) and other key and accessible populations (2009: 1%; 2010: 3%).[47]

Figure 17: Spending sourced from GFATM by beneficiary population, 2009 and 2010



4.2.4 Spending of funds from bi- and multilateral organizations

Spending of financial aid granted by bilateral entities such as the United States of America (US), Australia and France remained almost the same over the two years (US$15,565,137 in 2009 and $15,662,527 in 2010). This represents an average of 28% of the total spending on HIV and AIDS in the two years.
UN agencies, and other multilateral organizations, such as the Asia Development Bank (ADB) and the European Commission were recorded as the financing sources for 16% of the total spending (combined totals of US$8,159,745 in 2009 and US$9,425,820 in 2010) (Table 12).

Table 12: Spending by type of bi-and multilateral funding source, 2009 and 2010

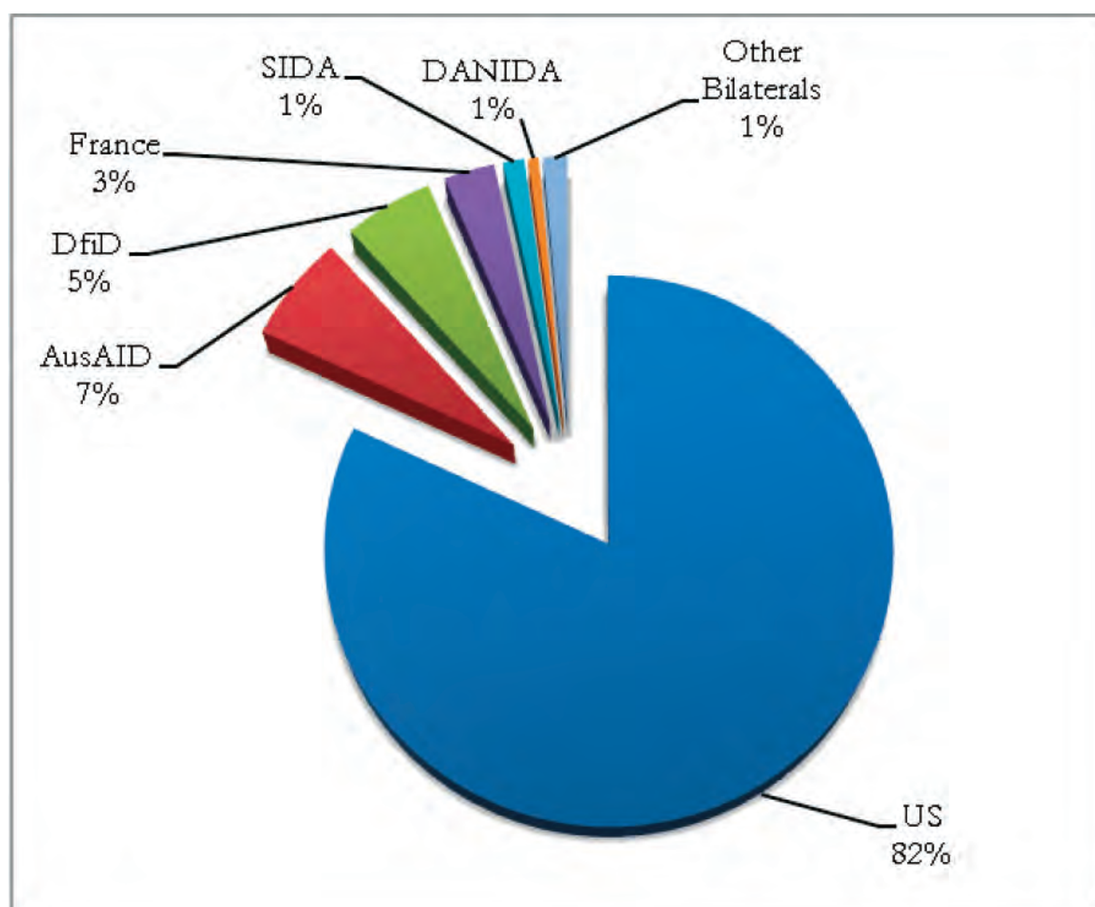
Financing Source	2009		2010		Total	
	US $	%	US %	%	US $	%
Bilaterals	15,565,137	66	15,662,527	62	31,227,664	64
UN	7,547,437	32	8,382,652	33	15,930,089	33
Other Multilateral	612,307	3	1,043,168	4	1,655,475	3
Total	**23,724,881**	**100**	**25,088,347**	**100**	**48,813,228**	**100**

47 Other key and accessible population include military, police and school students for example.

The combined spending of funds originating from bi-lateral, UN and other multilateral sources rose by 6% from US$23,724,881 in 2009 to US$25,088,347. Hence, in the two years, 44% of total spending was derived from bi-and multilateral organizations.

By far the largest share of spending drawn from a bilateral source came from the US through USAID (Figure 18 below). On average over the two years the contribution of the US represented 23% of the total spending on HIV and AIDS, and 82% of all of the bilateral support for the sector. Other bilateral sources contributed significantly less in comparison. As the second most important bilateral source, Australia financed 6% of spending from bilateral sources through AusAID. The United Kingdom (UK) through DFID contributed 5% of expenditures financed from bilateral sources and France 3%.

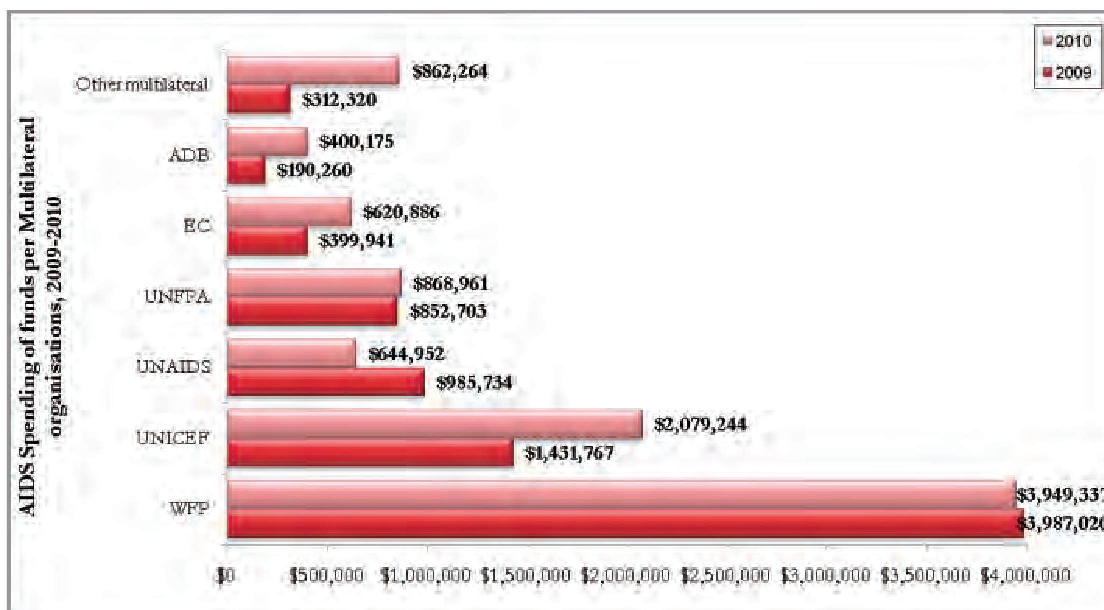
Figure 18: Spending by individual bilateral donors (Average 2009/2010)



WFP was the most important multilateral source of AIDS spending. Its food support represented 49% in 2009 and 42% in 2010 of the total financing of AIDS spending by multilateral agencies (Figure 19).

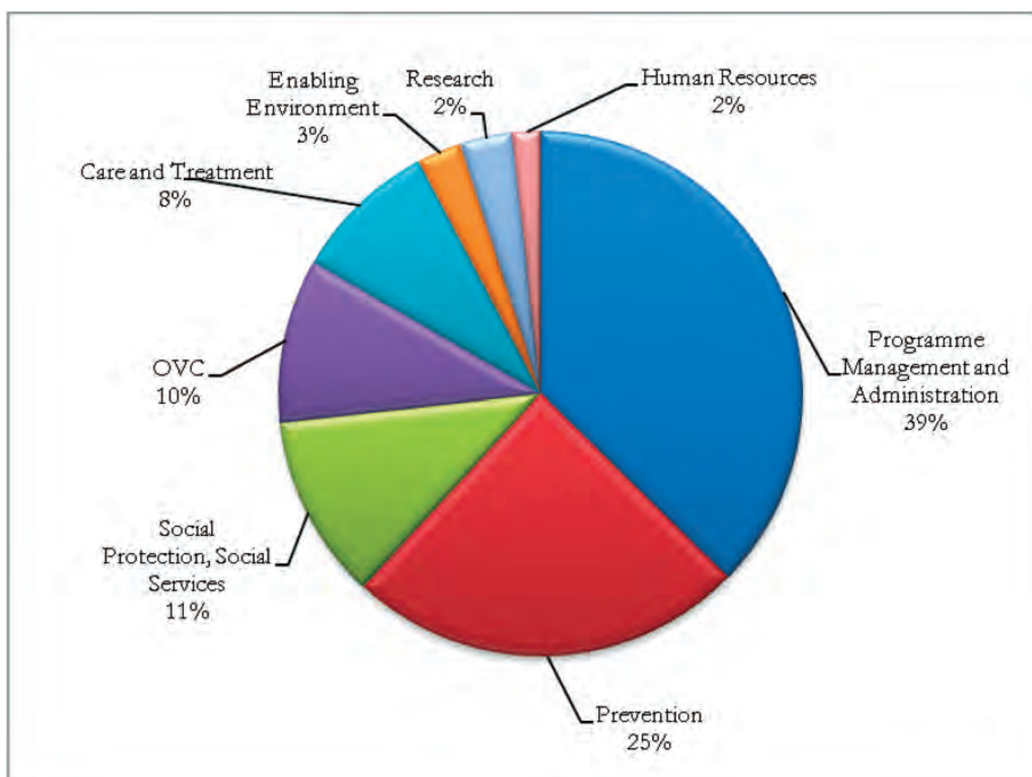
These correspond to 7% of total AIDS spending in each of the two years. UNICEF was the second largest UN source of financing with a share of 18% in 2009 and 22% in 2010 of all multilateral monetary contributions. Spending financed by UNAIDS decreased from 12% in 2009 to 8% in 2010 of the AIDS UN agencies and other multilateral organizations.

Figure 19: Spending by multilateral organisations, 2009 and 2010



Most spending sourced from bi- and multilateral organizations (excluding GFATM) was for programme management and administration (39%) and for prevention interventions (25%)(Figure 20). Smaller shares of money obtained from these sources was spent on social protection and social services (11%), OVC (10%) and on treatment and care.

Figure 20: Spending sourced from bi- and multilateral organisations by spending categories (Average 2009/2010)



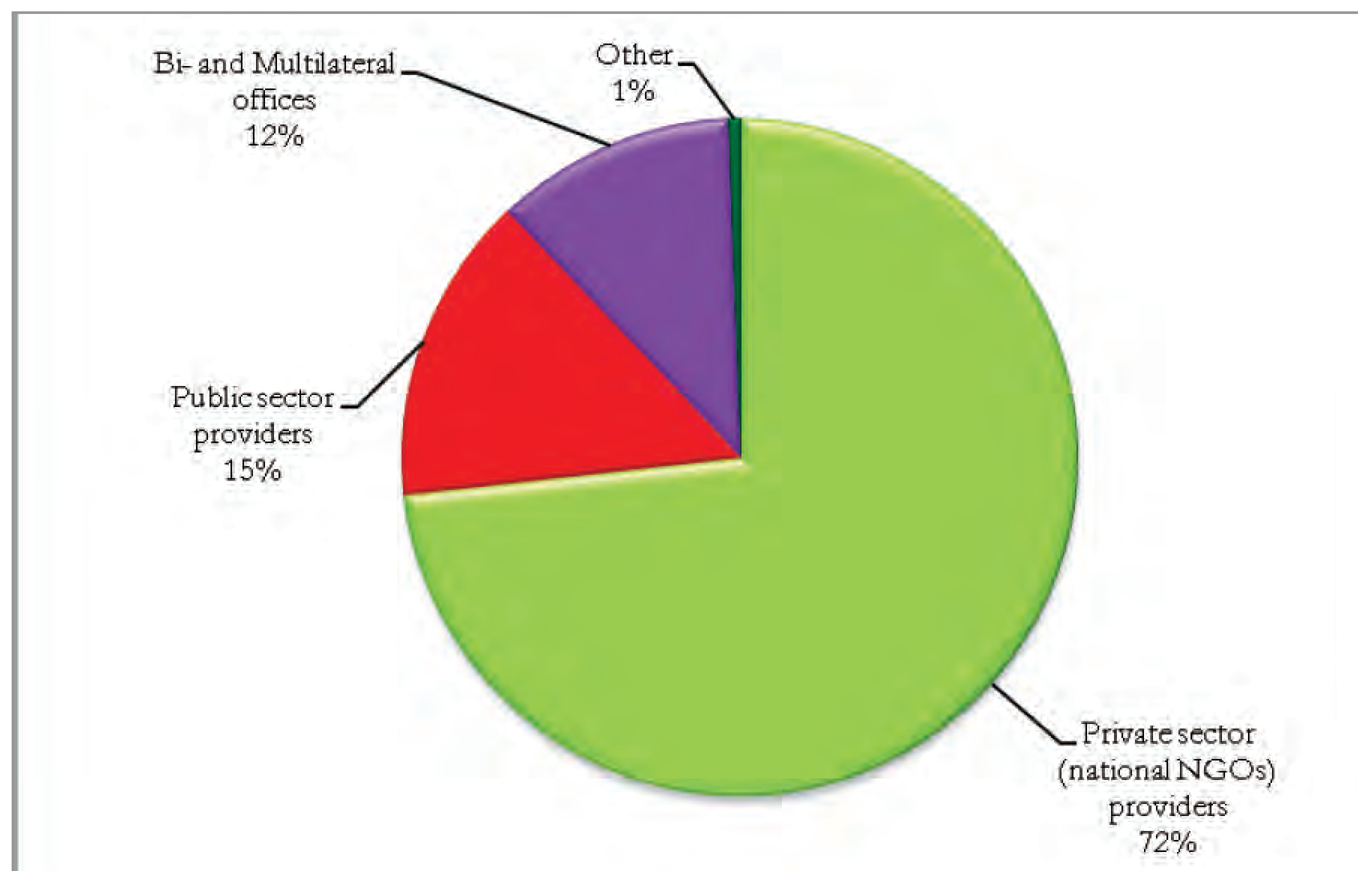
Out of the combined 2009 and 2010 expenditures originating from bi- and multilateral organizations, 35% was managed by international NGOs, 30% by UN agencies, 17% by national NGOs, 11% by government entities and 6% by bilateral organizations (Table 13).

Table 13: Spending sourced from bi-and multilateral organizations by financing agents, 2009 and 2010

Financing Agent	2009		2010		Total	
	US $	%	US $	%	US $	%
International NGOs	8,173,410	34	9,134,050	36	17,307,460	35
UN	7,277,948	31	7,288,577	29	14,566,525	30
National NGOs	3,889,087	16	4,425,582	18	8,314,669	17
Public	2,436,291	10	3,118,237	12	5,554,528	11
Bilaterals	1,948,145	8	1,121,900	4	3,070,045	6
Total	**23,724,881**	**100**	**25,088,347**	**100**	**48,813,228**	**100**

The main service providers who used funds coming from bi- and multilateral sources were national NGOs and other private sector entities. US$17,492,064 were spent in 2009 by this kind of service provider and US$18,261,208 in 2010, reflecting an increase of 4%. Public sector service providers were identified as the implementing entities for US$3,460,190 in 2009 and US$3,701,576 in 2010 of spending financed by bi- and multilateral organizations. The latter spent themselves US$2,618,739 in 2009 and US$3,016,173 in 2010[48].

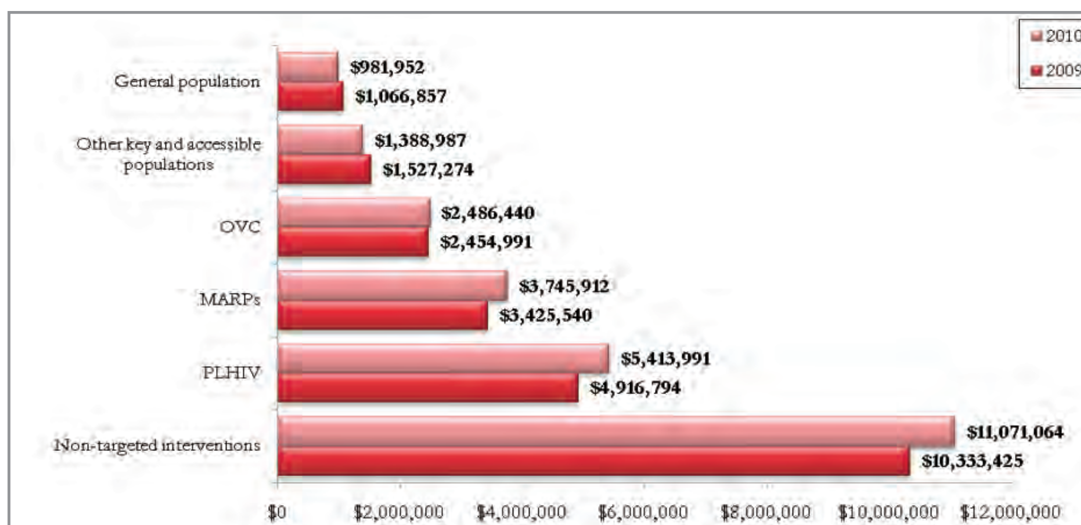
Figure 21: Spending sourced from bi-and multilateral organizations by service providers (Average 2009/2010)



[48] The HIV/AIDS Technical Support Facility for South-East Asia and the Pacific in Kuala Lumpur was categorized as part of the Rest of the world provider category with less than US$200,000 spent per year.

In 2009-2010, 44% of the funds originating from bi-and multilateral organizations were spent on activities which did not have a specific target group or that were not categorized according to this criterion. 21% of the expenditures targeted PLHIV, 15% MARPs, 10% OVC, 6% other key and accessible populations such as the police and school students, and 4% the general population. The amounts spent on interventions targeting different beneficiary populations are displayed in Figure 22.

Figure 22: Spending sourced from bi-and multilateral organizations by beneficiary populations, 2009/2010



4.2.5 Spending of funds from international NGOs and foundations

In 2009 a total of US$9,199,295 was spent on HIV using financial resources from international NGOs and from foundations. Spending decreased by US$1,602,964 (18%) in 2010 to a total of US$7,516,331. In the biennium the most prominent financing sources among international NGOs were the Clinton Foundation, Médecins Sans Frontières, World Vision and Maryknoll.

During 2009 and 2010 58% of spending originating from international NGOs and foundations was for care and treatment services (Table 14). US$5,765,525 was spent on this category in 2009 and US$3,891,715 in 2010 - a decrease of one third. The other major areas of spending were prevention and social protection and social services. Spending on the latter increased by 79% from $637,341 in 2009 to US$1,143,027 in 2010. Programme management and administration remained virtually the same. Spending on the creation of an enabling environment also remained constant. The other spending categories did not see any meaningful investment by international NGOs and foundations.

Table 14: Spending sourced from international NGO by spending categories (Average 2009/2010)

ASC	2009		2010		Total	
	US $	%	US $	%	US $	%
Treatment and care	5,765,525	63	3,891,715	52	9,657,240	58
Prevention	1,051,554	12	778,282	10	1,829,836	11
OVC	683,053	7	731,724	10	1,414,778	9
Social protection, social services	637,341	7	1,143,027	15	1,780,367	11
Program management & admin.	634,949	7	606,745	8	1,241,695	7
Enabling environment	270,068	3	274,526	4	544,595	3
Training	47,126	1	68,439	1	115,565	1
Research	29,679	0	21,873	0	51,552	0
Total	**9,119,295**	100	**7,516,331**	100	**16,635,626**	100

The majority of funds originating from international NGOs and foundations were managed by themselves in the role of financing agents (63% in 2009 and 72% in 2010)(Table 15).The role of the Government as the financing agent of this kind of funds decreased from 31% in 2009 to 21% in 2010. It is interesting to note that national NGOs played only a nominal role as financing agent of spending sourced from international NGO and foundations. This means national NGOs only rarely managed these kind of funds or made decisions on how the funds needed to be used.

Table 15: Spending sourced from international NGOs by financing agents, 2009 and 2010

Financing Agent	2009		2010		Total	
	US $	%	US $	%	US $	%
International NGOs	5,783,006	63	5,414,141	72	11,197,147	67
Public	2,856,371	31	1,602,623	21	4,458,993	27
Private (national NGOs)	479,919	5	499,567	7	979,486	6
Total	**9,119,295**	**100**	**7,516,331**	**100**	**16,635,626**	**100**

The share of funds obtained from international NGOs and from foundations that were spent by public sector service providers was 56% in 2009 and 39% in 2010 (Table 16 below). Private sector providers including national and international NGOs represent 44% in 2009 and 61% in 2010.

Table 16: Spending sourced from international NGOs by service providers, 2009 and 2010

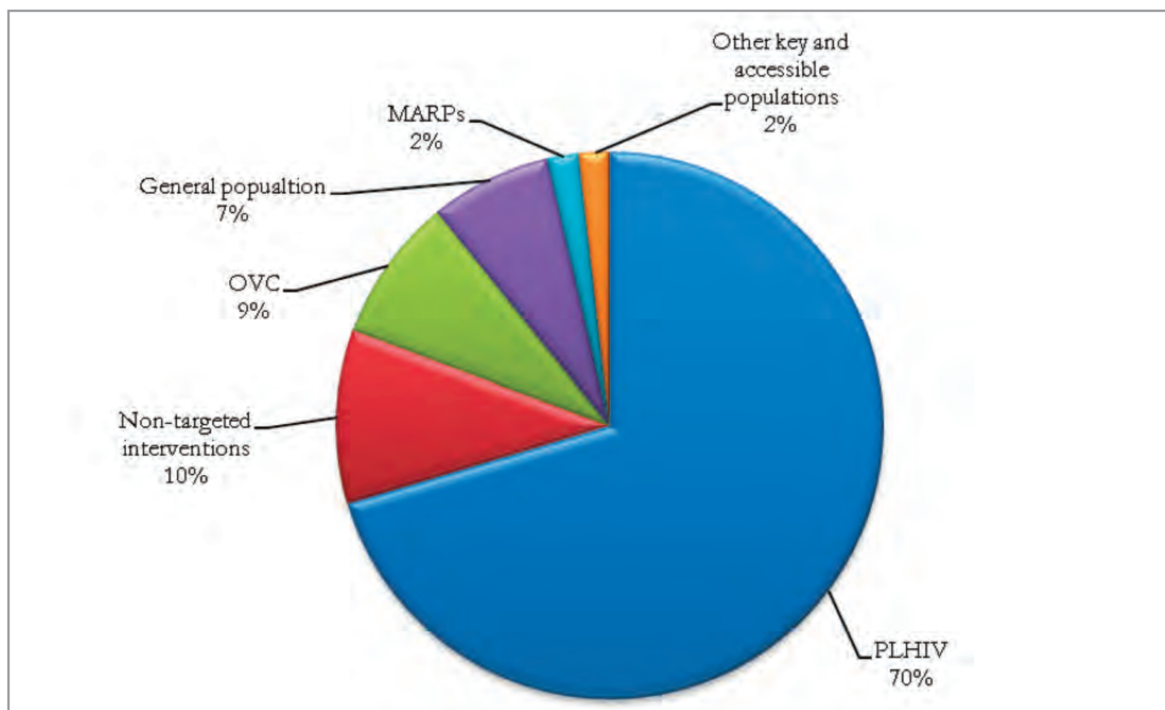
Service Provider	2009		2010		Total	
	US $	%	US $	%	US $	%
Public sector	5,077,176	56	2,963,253	39	8,040,429	48
Private sector	4,042,119	44	4,553,078	61	8,595,197	52
Total	**9,119,295**	**100**	**7,516,331**	**100**	**16,635,626**	**100**

The majority of funds from international NGOs and foundations in 2009 (70%) were recorded as benefitting PLHIV (Figure 23).This is logical because large shares of these were used for the provision of treatment and care and social protection and services to support PLHIV. However, a considerable decrease in spending on this category of spending by beneficiary was registered from 2009 to 2010.[49]

Spending on interventions benefiting OVC and their families increased was 9% in the two years. Meanwhile spending on activities targeting the general population, MARPs and other key and accessible populations (e.g., police, military and school children) was 4%. Expenditure from this particular source of financing for MARPs related interventions decreased by 70% from 2009 to 2010. Non-targeted interventions involving activities that were not intended to benefit any specific population remained about the same in the two years or could not be classified represented 10% of spending.

[46] See Annex 4: Spending by thematic area

Figure 23: Spending sourced from international NGOs by beneficiary populations (Average 2009/2010)



4.3 Spending by financing agent

The share of spending that was managed by the Cambodian Government decreased over the years (Figure 24). This is mainly due to a change in the definition of financing agents. In NASA III financing agents were understood as the organizations who managed the funds, made decisions on their spending and who did this closest to the service provider level. As a result the role as financing agent, more often than in the past, was attributed to international NGOs (GFATM sub-recipients) than the government (GFATM principle recipients). There are also differences between NASA I and NASA II in the definition that was used for financing agents. The definition used in NASA III is similar to that used in NASA I. This change occurred because of alterations in universal classifications, definitions and improvements that were applied to the most recent NASA.

Figure 24: Spending by type of financing agent, 2006-2010

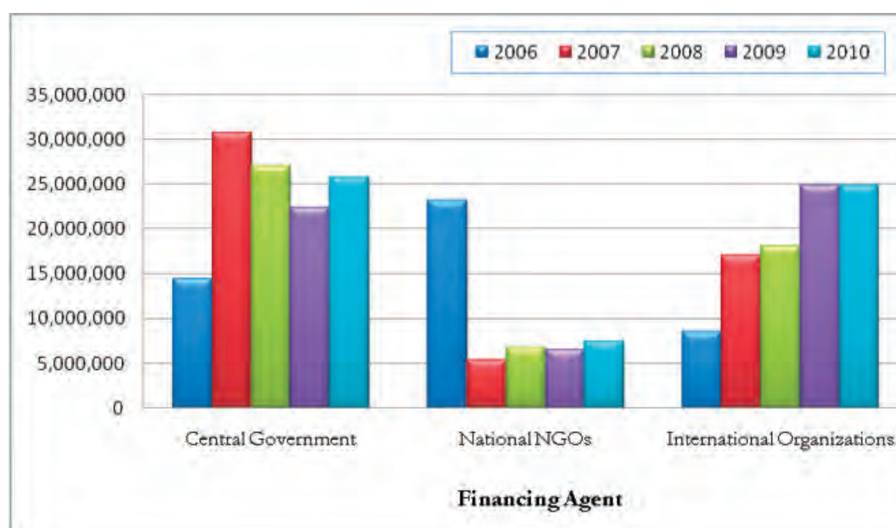


Figure 25 includes spending on HIV and AIDS in 2009 and 2010 by financing agents. It shows that in this biennium 43% of the expenditures were made on interventions managed by public sector entities. 29% were managed by international NGOs, 13% by UN agencies and 12% by national NGOs.

Figure 25: Spending by financing agents (Average 2009/2010)

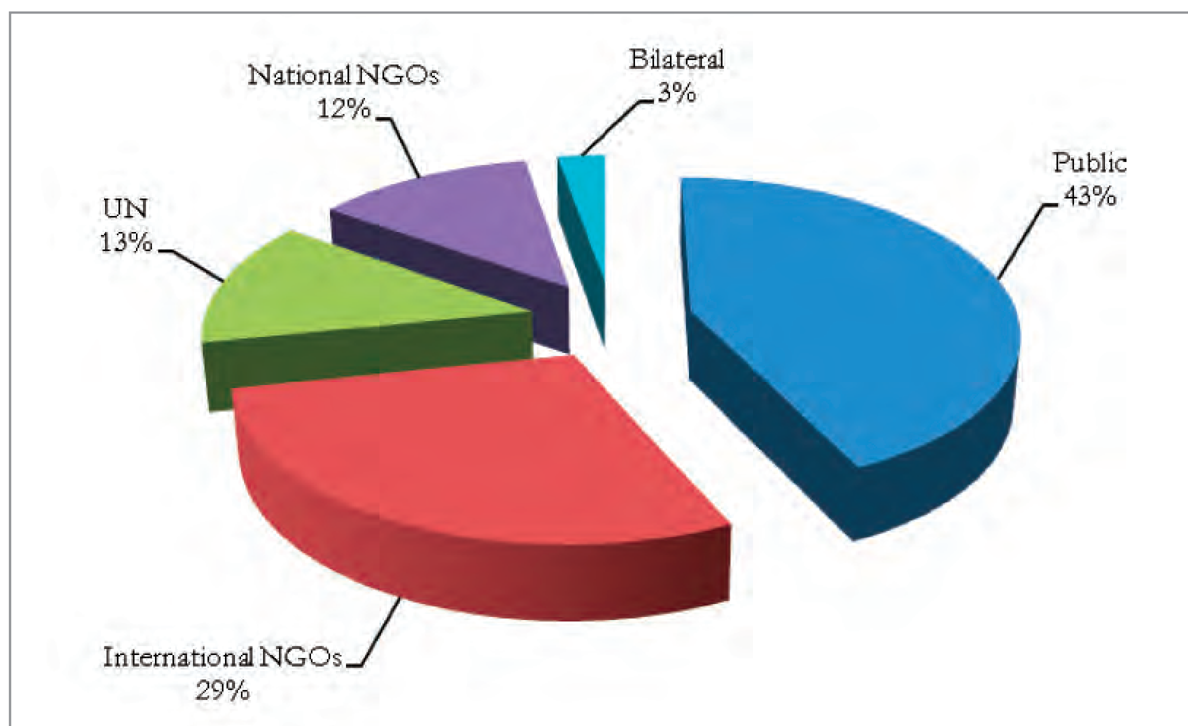


Table 17 shows that there was little variation in the share of expenditure that was spent on HIV and AIDS by different financing agents in the two years covered by the assessment. The public sector remained the main financing agent in both years and spent an average of US$24,053,534 per year. The three main organizations acting as funding agents were the MoH, NCHADS and FHI. The spending of all three of these organizations increased significantly from 2009 to 2010 with expenditure almost doubling in this time period. In comparison, WFP and KHANA both managed 7% over the two years.

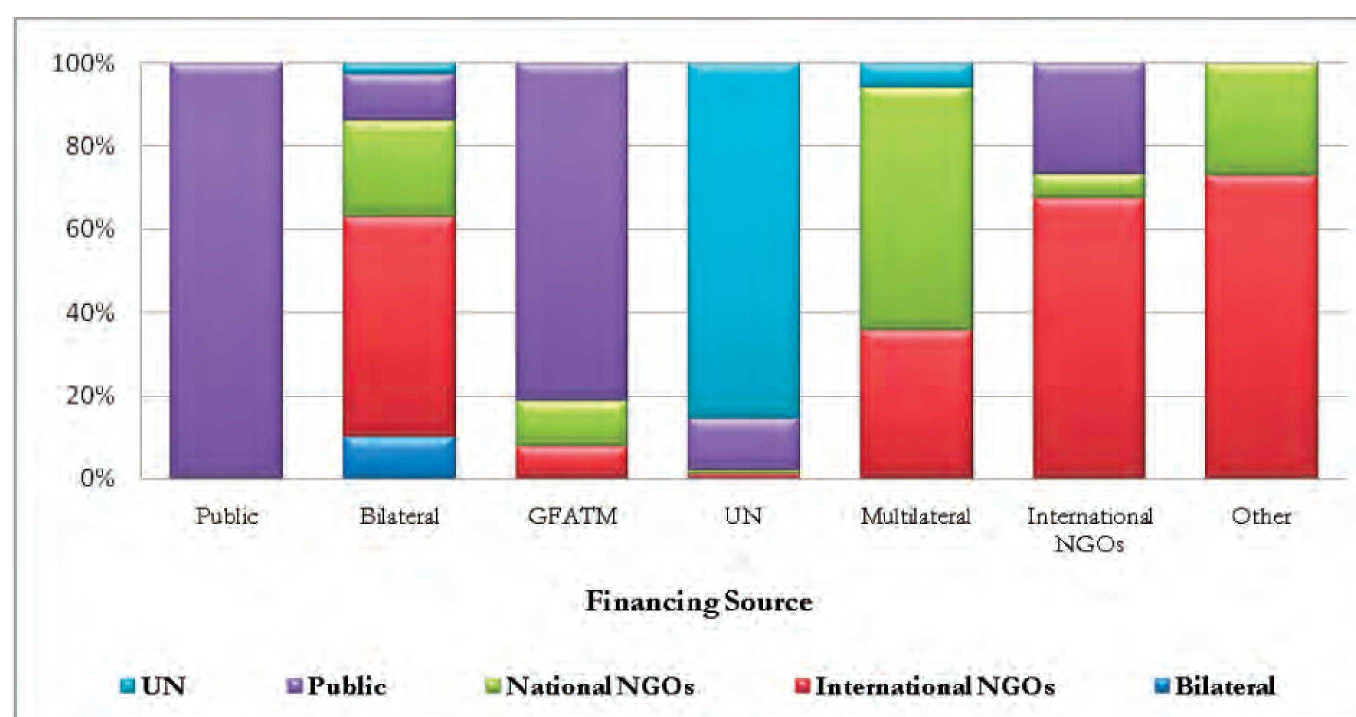
Table 17: Spending by financing agents, 2009-2010

Financing Agent	2009		2010		Total	
	US $	%	US $	%	US $	%
Public	22,366,790	42	25,740,278	44	48,107,068	43
International NGOs	15,642,457	29	16,501,376	28	32,143,833	29
UN	7,277,948	14	7,288,577	13	14,566,525	13
National NGOs	6,499,858	12	7,407,339	13	13,907,196	12
Bilaterals	1,948,145	4	1,121,900	2	3,070,045	3
Total	**53,735,198**	**100**	**58,059,469**	**100**	**111,794,667**	**100**

Out of the total of US$111,794,667 spent on HIV and AIDS over the two years, the largest portion (19%) was managed by NCHADS.[47] This is not surprising given the major role NCHADS plays in the sector and as principal recipient (PR) of GFATM. FHI was another very prominent financing agent managing 12% of total spending, whilst WFP and KHANA both managed 7%.

In both 2009 and 2010 public funds were managed exclusively by public entities (Figure 26). The government was the primary financing agent for grants obtained from GFATM (i.e., NCHADS and MoH). An analysis of the flow of funds shows that bilateral organizations mainly channeled their funds through international and national NGOs who managed them and who made decisions on how to spend them. To a large extent UN agencies and international NGOs managed their own funds. Other multilateral organisations and international for-profit entities channeled their funds mostly to NGOs to deliver services.

Figure 26: Spending by financing agents and financing sources (Average 2009/2010)



4.4 Spending by service provider

Private sector providers including national and international NGOs were the main implementers of services to address HIV and AIDS in the two years covered by the assessment (Table 18). To deliver services these non-governmental entities spent a total of $66,690,837 over the biennium. Their share in spending on service delivery increased from 2009 to 2010 and was 60% of the total over the two years. FHI, KHANA, PSI, RHAC and World Vision were the most important service providers in the private sector. These organisations alone were responsible for around one quarter of the total expenditure (26%)[50].

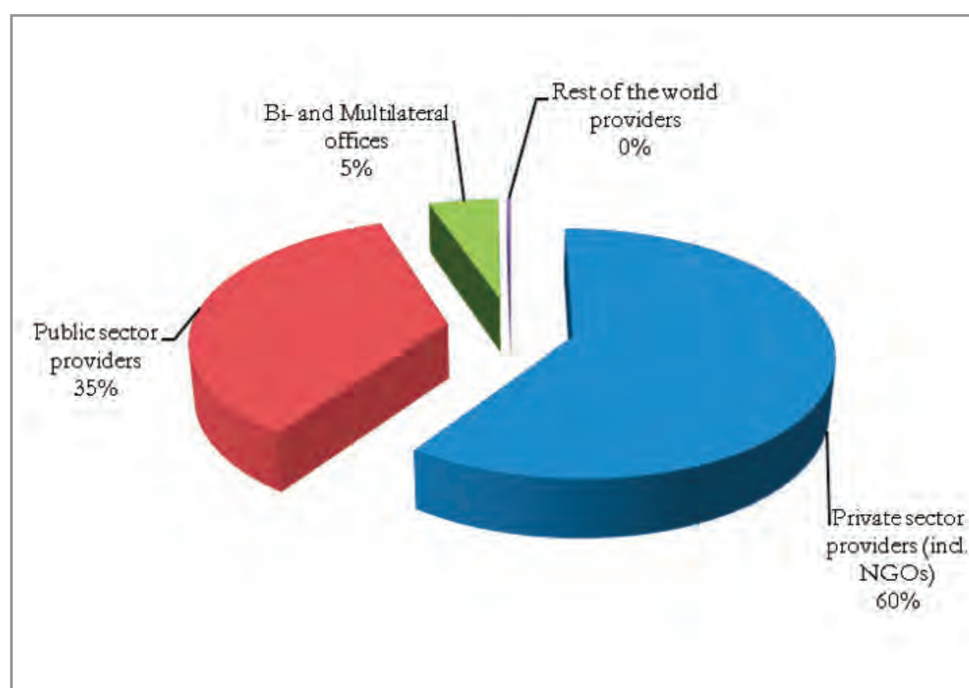
[49] See Annex 2: Main data tables

Table 18: Spending by type of service providers, 2009 and 2010

Service Providers	2009		2010		Total	
	US $	%	US $	%	US $	%
Private sector (incl. NGOs)	32,833,057	61	33,857,780	58	66,690,837	60
Public sector	18,129,514	34	21,076,127	36	39,205,641	35
Bi- and Multilateral offices	2,618,739	5	3,016,173	5	5,634,911	5
Other	153,888	0	109,390	0	263,278	0
Total	**53,735,198**	**100**	**58,059,469**	**100**	**111,794,667**	**100**

Public sector entities such as ministries and government departments, hospitals and health centers delivered services for 39% of total spending in 2009 and 35% in 2010.[50] Private sector entities instead implemented services for 60% of total spending. Bi- and multilateral organizations including UN agencies delivered services for only 5% of total expenditure. The average spending by service provider for the two years is shown in (Figure 27).

Figure 27: Spending by service provider type (Average 2009/2010)



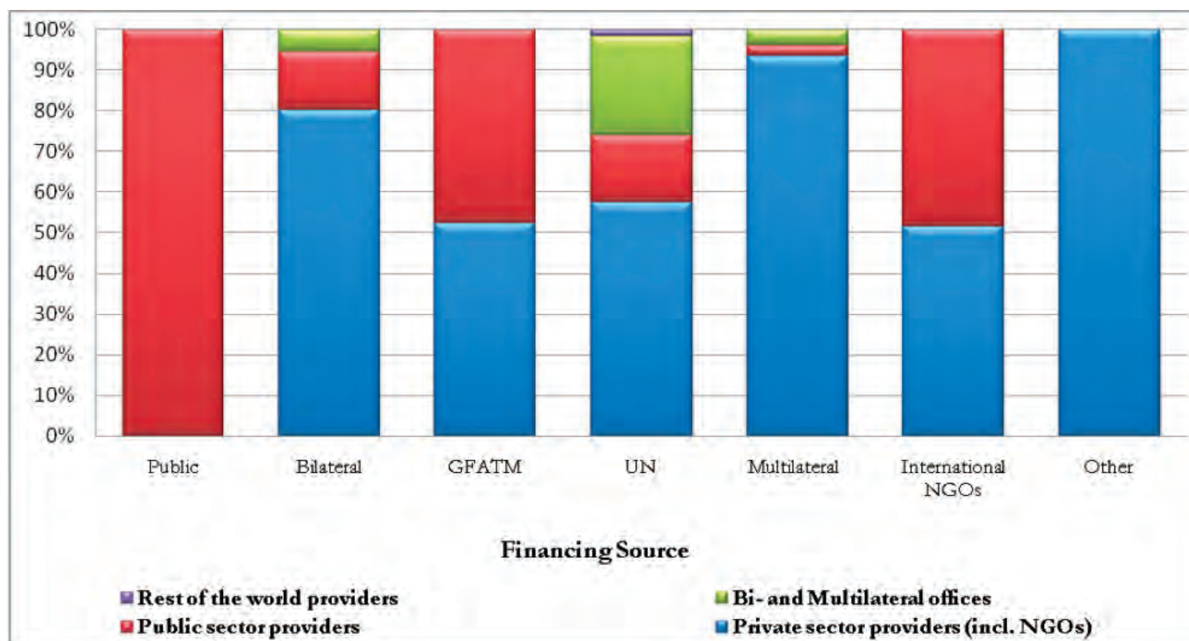
Further analysis of the data illustrated in (Figure 28) reveals that public sector institutions were mainly providing services with funding originating from public sources, GFATM and international NGOs.[51] To a lesser extent, public sector entities implemented interventions with funding from the UN and bilateral agencies.

Private sector organizations were the primary service providers under spending provided from all sources other than Government and GFATM. In particular, they operated with funding coming from bilateral agencies (especially the US Government), UN and other multilateral organizations and from their own organizations.

50 Hospitals were found to be the main public service provider responsible for more than 40% of spending from public sources and 16% of total AIDS expenditure but this may be an underestimation because spending data from hospitals was not obtained.

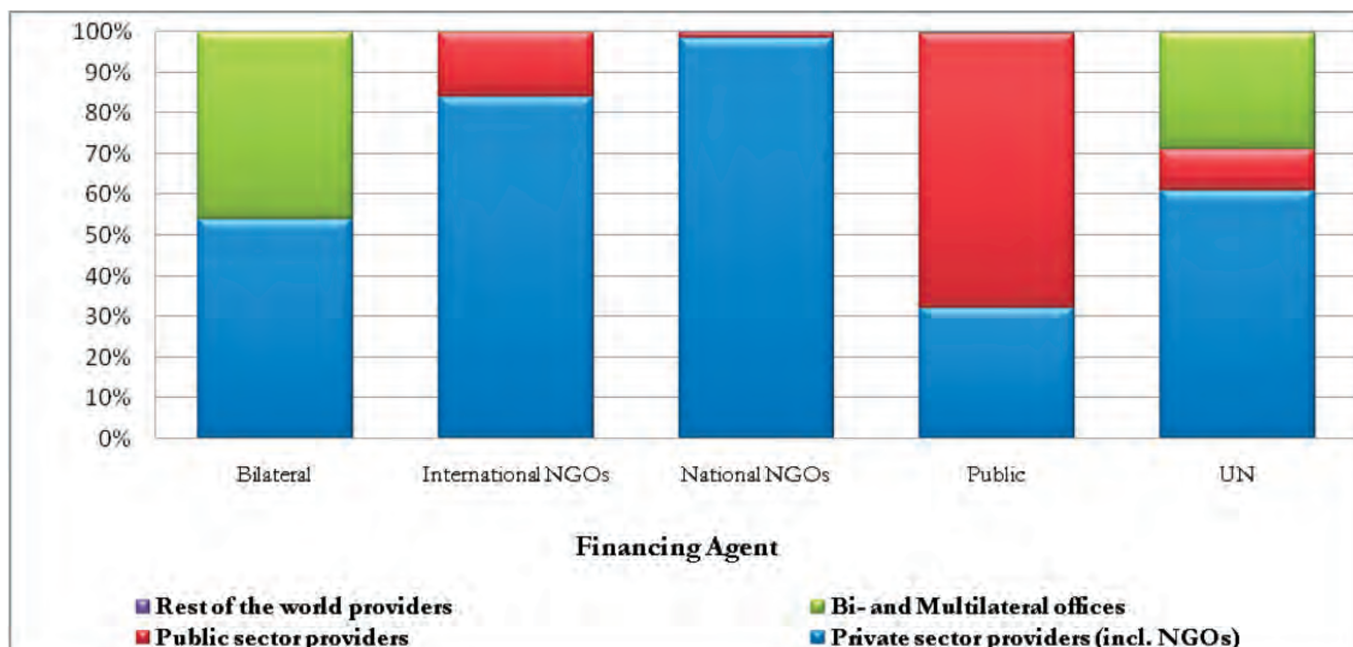
51 Government made expenditures on treatment and care with financial resources form international NGOs such as AHF and Clinton Foundation for example.

Figure 28: Spending by service providers and financing sources (Average 2009/2010)



In 2009/2010 the primary service provider for spending managed by bilateral, international and national NGOs and by the UN were civil society organizations (Figure 29). Public sector entities were the main service providers for funds managed by public financing agents. The implementing entities for funds managed by UN agencies were national and international NGOs (private sector providers) and bi- and multilateral offices.

Figure 29: Spending by service providers and financing agents (Average 2009/2010)



4.5 Spending by beneficiary population

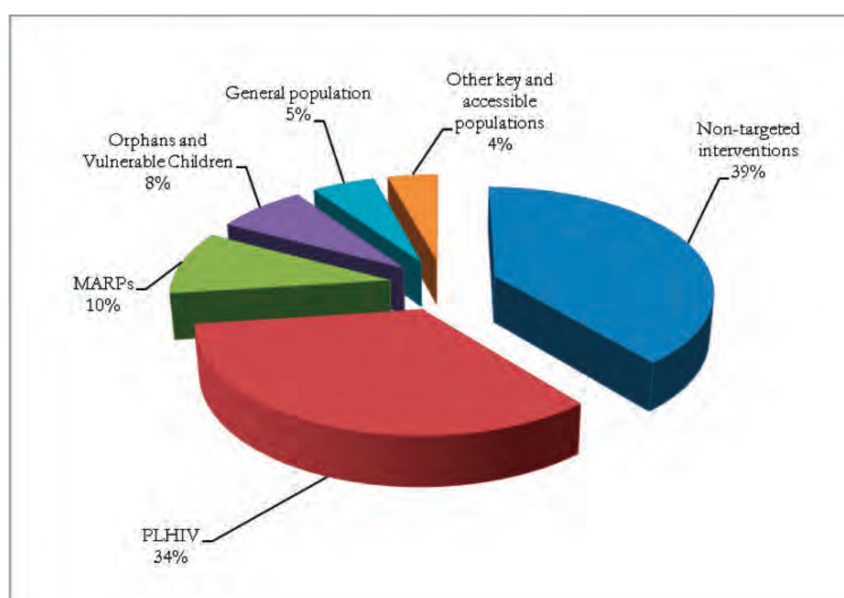
This assessment provided data that allows in-depth analysis of how spending benefited different target populations, this data is shown below in Table 19. As was indicated earlier, NASA classifies spending that cannot be disaggregated by one single specific beneficiary population in the Non-targeted Interventions category. Expenditures in this category grew from US$19,649,805 in 2009 to US$23,956,924 in 2010. This may be due to an increase in spending on categories that cut across the national response (e.g., programme management) or to a difficulty in classifications or to both.

Table 19: Spending by beneficiary populations, 2009 and 2010[53]

Spending by Beneficiary Population	2009		2010		Total	
	US $	%	US $	%	US $	%
PLHIV	19,362,361	36	18,579,570	32	37,941,931	34
MARPs	5,018,419	9	5,945,850	10	10,964,269	10
OVC	4,073,178	8	4,425,541	8	8,498,720	8
General Population	3,450,029	6	2,552,841	4	6,002,870	5
Other Key and Accessible Populations	2,157,215	4	2,568,724	4	4,725,939	4
Other Beneficiary Populations	24,191	0	30,019	0	54,210	0
Non-targeted Interventions	19,649,805	37	23,956,924	41	43,606,730	39
Total	**53,735,198**	**100**	**58,059,469**	**100**	**111,794,667**	**100**

As shown in (Figure 30) when spending on non-targeted interventions is excluded on average in the two years 34% was spent on interventions specifically targeting PLHIV, 10% was spent on MARPs, 5% on programmes for the general population, 4% on other key and accessible groups such as the military and the police and school students, and 8% benefited OVC.

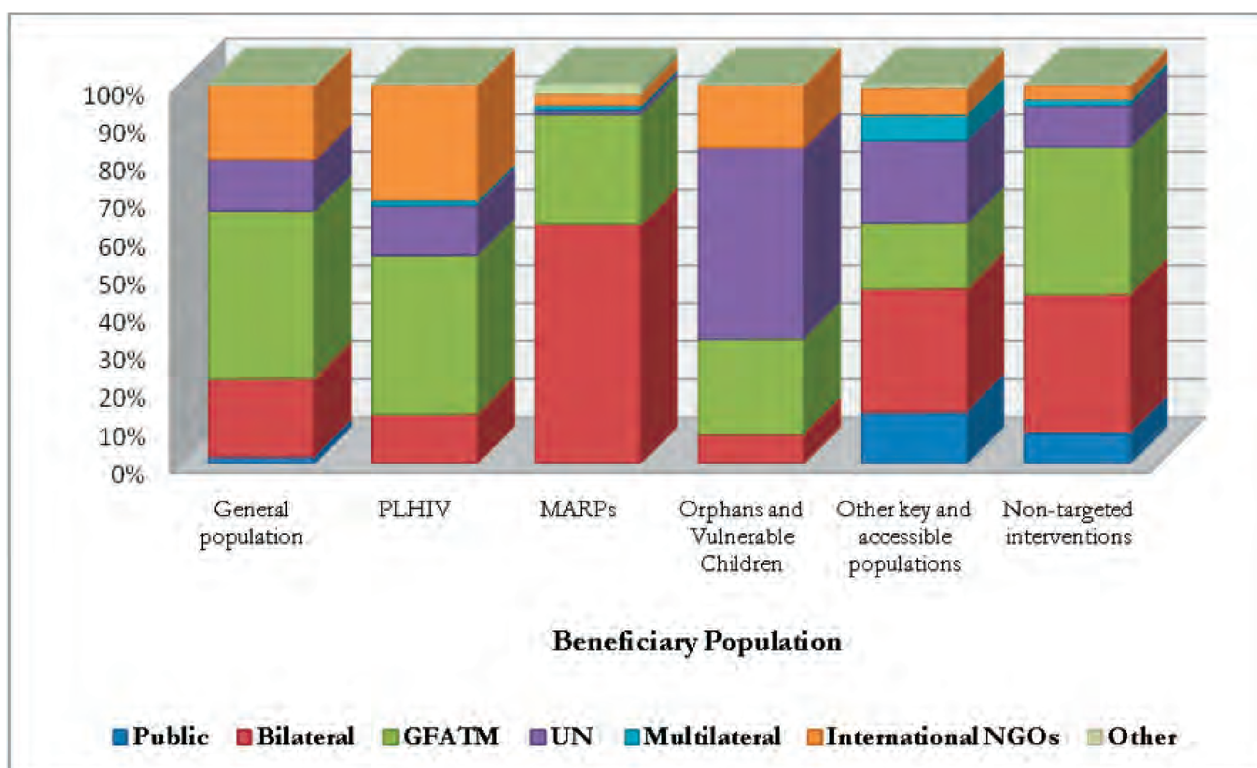
Figure 30: Spending by beneficiary population excluding non-targeted interventions (Average 2009/2010)



[53] Because of rounding some categories display 0% though they have seen a small amount of spending.

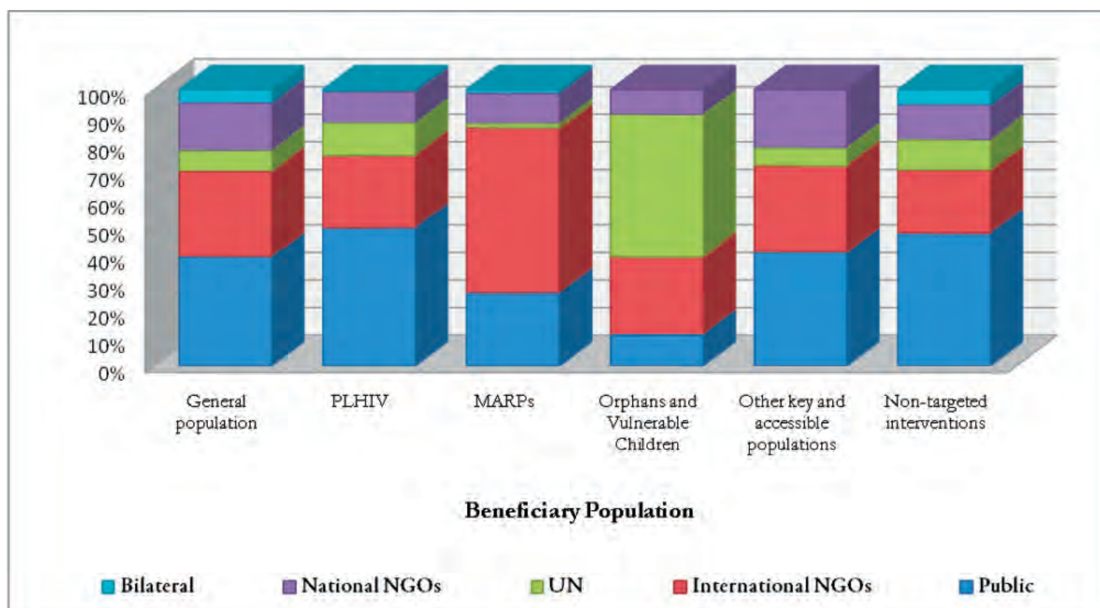
Figure 31, below, on beneficiary population by financing source, shows that spending on interventions for PLHIV in the two years was mostly financed by GFATM and by international NGOs (total value of US$37,941,931). Programmes targeting MARPs, which totaled US$10,964,269, were primarily funded by bilateral agencies, especially the US Government, and by the GFATM. Expenditures on OVC and on the general population were respectively US$8,498,720 and US$6,002,870. The former were financed mostly by the UN, and the latter predominantly by the GFATM. Interventions for other key and accessible populations attracted funding for a total of US$4,780,149 mainly from bilateral sources and the GFATM. Out of the total spent on non-targeted interventions (US$43,606,730) more than one third was funded by bilaterals and by GFATM.

Figure 31: Beneficiary population by financing source (Average 2009/2010)



Funds spent in the biennium on interventions targeting MARPs and OVC were managed in large part by international NGOs (Figure 32). PLHIV and non-targeted interventions were identified as beneficiary populations for funds mainly managed by government institutions and international NGOs. The general population and other key and accessible populations benefitted to the largest extent from funds managed by public entities and international NGOs.

Figure 32: Beneficiary population by financing agent (Average 2009/2010)



Nearly all of the implementation of interventions targeting MARPs and OVC were by private sector service providers, in particular by national and international NGOs (Figure 33). Interventions devised to benefit the general population were primarily implemented by NGOs. Public sector service providers were identified as implementers for roughly half of the activities involving PLHIV, other key and accessible populations and non-targeted interventions. To a much lesser extent these latter interventions were also implemented by bi- and multilateral organizations.

Figure 33: Beneficiary population by service provider (Average 2009/2010)

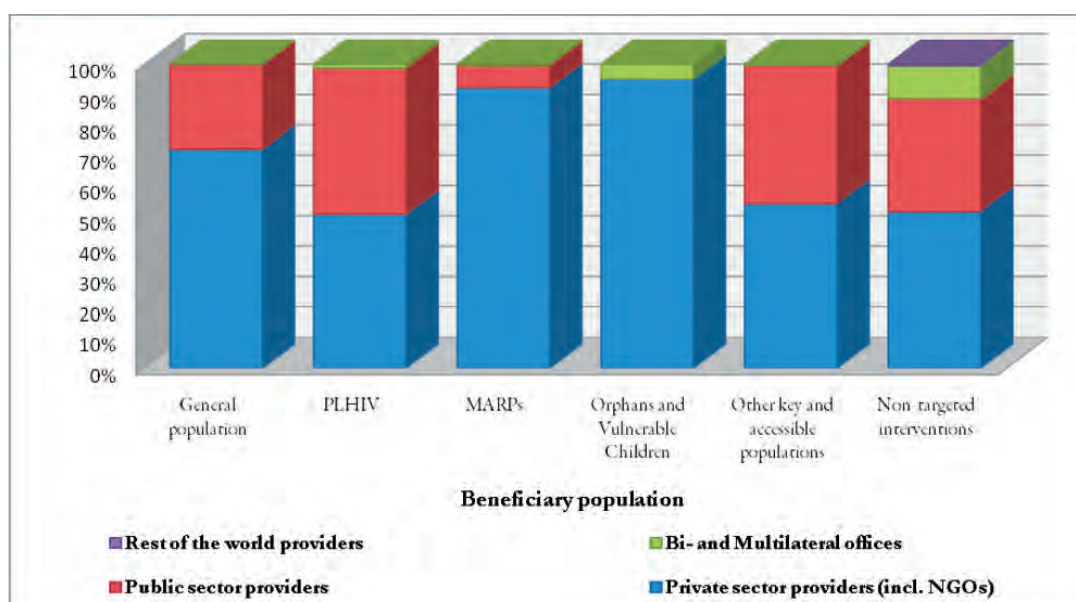
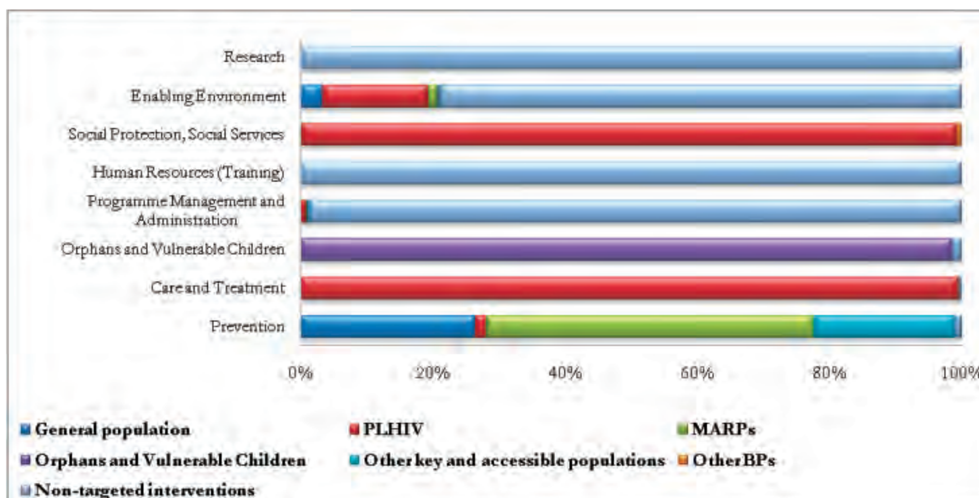


Figure 34 below shows beneficiary population by AIDS spending categories for the biennium. Half of the total spending on prevention for an amount of US$10,861,337 was targeted at MARPs, whilst 26% benefited the general population and 21% other key and accessible populations. PLHIV were the intended target group for care and treatment programmes and for social protection and services for a combined total of US$36,429,889. Spending on non-targeted interventions concerned mainly activities carried out in the field of programme management and administration and represented a total of US$35,053,120.

Figure 34: Beneficiary population by spending categories, 2009-10



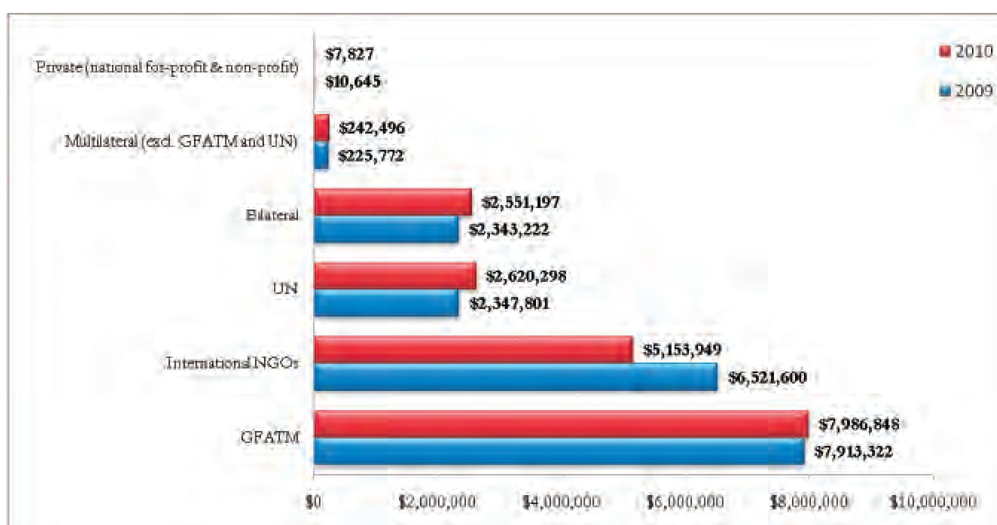
The spending on specific beneficiary populations is discussed more in detail in the next sections.[54]

4.5.1 People living with HIV

Expenditure for interventions targeting people living with HIV (PLHIV) represents 34% of total spending, 26% of this expenditure was on care and treatment. Expenditure on PLHIV was particularly high because of the large number of PLHIV on antiretroviral therapy in the biennium. In fact, it needs to be kept in mind that the number of eligible PLHIV on ART grew from 12,335 in 2005 to 44,280 in 2010.[54]

Figure 35 below shows AIDS spending targeting PLHIV by financing source for 2009 and 2010.The primary funder of care and treatment was GFATM who in the two years contributed a total of US$15,900,170 to this important cause. The MoH including NCHADS was the most important financing agent managing funds from GFATM and other sources for a total of US$18,976,856. Care and treatment services were mainly delivered by private and public sector providers. They spent US$19,171,267 and US$18,976,856 respectively over the two years.

Figure 35: Spending targeting PLHIV by financing source, 2009 and 2010

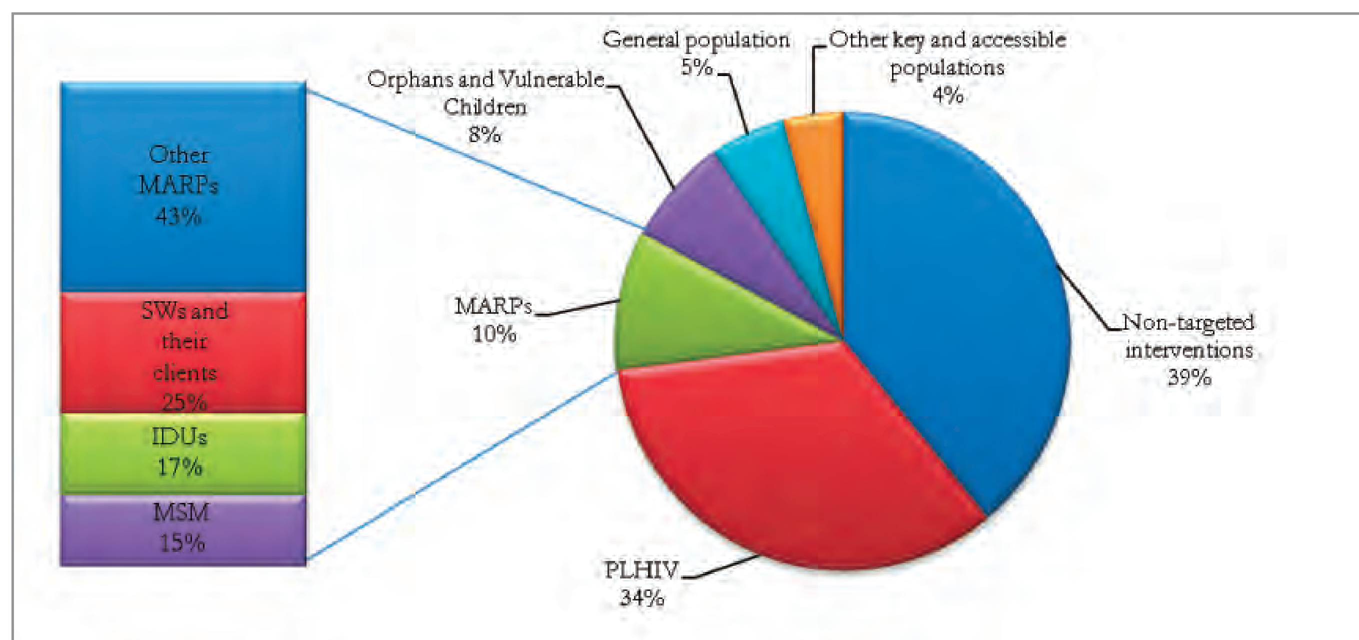


54 NCHADS (2011b): Annual report 2010. Phnom Penh

4.5.2 Most-at-risk populations

In the two years, most-at-risk populations (MARPs) including entertainment workers and their clients, men who have sex with men (MSM) and injecting drug users (IDU) benefitted from US$10,964,269 (10%) of total spending (excluding non-targeted interventions) (Figure 36).

Figure 36: Spending targeting MARPs as beneficiary population (Average 2009/2010)



49% of the spending targeting MARPs in 2009 and 39% in 2010 could not be disaggregated by the specific type of target group. The spending on MARPs targeted at sex workers and their clients increased by more than one third over the two years from US$1,076,937 in 2009 to US$1,665,801 in 2010. Similarly, spending on the other two MARPs, IDU and MSM, increased from 2009 to 2010. Spending on all MARPs has increased over the years rising to the double between 2007 and 2010. This is a positive indicator suggesting that interventions have become more strategic, targeting groups that are at high risk of HIV infection. The average of total spending in 2009 and 2010 on MARPs interventions is illustrated in Figure 30.

Table 20: Spending targeting MARPs as beneficiary population, 2009 and 2010

Beneficiary Population	2009	%	2010	%	Total	%
	US $	%	US $	%	US $	%
MARPs in general	2,437,510	49	2,320,826	39	4,758,336	43
SW and clients	1,076,937	21	1,665,801	28	2,742,738	25
IDUs	816,509	16	1,027,244	17	1,843,753	17
MSM	687,463	14	931,979	16	1,619,442	15
Total	**5,018,419**	**100**	**5,945,850**	**100**	**10,964,269**	**100**

Table 21 shows that in the two years the majority of spending on MARPs was funded by bilateral entities. The share funded by this source decreased from 2009 to 2010 by 6%.. The main bilateral entities financing MARPs prevention were the US Government and AusAid.

Table 21: Spending targeting MARPs by financing sources, 2009 and 2010

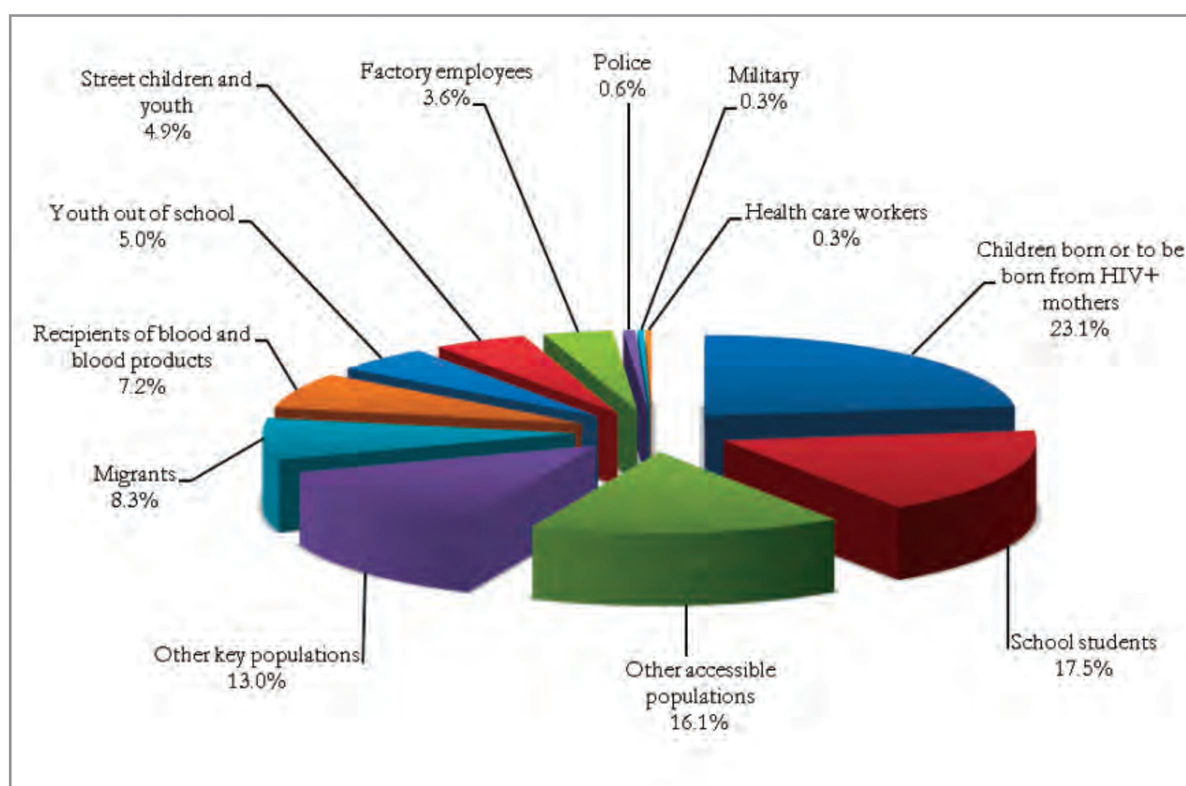
Financing Source	2009		2010		Total	
	US $	%	US $	%	US $	%
Bilateral	3,331,680	66	3,588,815	60	6,920,494	63
GFATM	1,228,320	24	1,955,659	33	3,183,979	29
International NGOs	239,773	5	71,971	1	311,744	3
International for-profit	124,786	2	172,308	3	297,094	3
Multilateral	66,926	1	86,532	1	153,458	1
UN	26,934	1	70,566	1	97,500	1
Total	**5,018,419**	**100**	**5,945,850**	**100**	**10,964,269**	**100**

GFATM was the second largest source of spending targeting MARPs. GFATM funded 24% of the total spending on MARPs in 2009 and 33% in 2010. More than half of the spending on MARPs was managed by international NGOs in the two years. Almost all of it was implemented by private sector service providers and was invested on prevention[55].

4.5.3 Other key and accessible populations

Spending on other key and accessible populations represented a small share in both years (less than 5% of total spending). Figure 37 below shows that the largest share of this spending benefitted children born or to be born from HIV-infected mothers and school students. Factory employees and migrants benefitted from very little spending, and the police and military received the least attention.

Figure 37: Spending by type of key and accessible populations, 2009-10



[55] See Annex 4: Spending by thematic area

The main financing sources for spending targeting other key and accessible populations were bilateral entities. The majority of interventions were implemented by private sector entities.

4.5.4 General population

Expenditures on interventions benefitting the general population were primarily aimed at preventing HIV (Table 22). Spending on this category of beneficiaries has decreased from US$3,357,521 in 2009 to US$2,426,048 in 2010.

Table 22: Spending targeting the general population[56]

AIDS Spending Categories	2009		2010		Total
	US $	%	US $	%	US $
Prevention	3,357,521	97	2,426,048	95	5,783,569
Enabling environment	92,507	3	111,807	4	204,315
Program management and administration	0	0	3,434	0	3,434
Social protection, social services	0	0	11,552	0	11,552
Total	**3,450,029**	**100**	**2,552,841**	**100**	**6,002,870**

Funds employed for spending on interventions for the general population originated primarily from GFATM and to a lesser extent from bilaterals and international NGOs. The money was managed primarily by public institutions, whilst the interventions were implemented mainly by private sector service providers.

4.6 SPENDING ON AIDS SPENDING CATEGORIES

Spending assessments are an important source of data to determine how effectively money is spent. In the two years covered by NASA III, one quarter of total spending on HIV and AIDS was invested in care and treatment, whilst one fifth of it on prevention interventions (Table 23). Close to one third of all expenditures were on the management and administration of programmes.

Table 23: Spending by AIDS spending categories 2009-2010

AIDS Spending Categories	2009		2010		Total	
	US $	%	US $	%	US $	%
Prevention	10,806,903	20	11,048,070	19	21,854,973	20
Care & Treatment	15,128,794	28	13,653,403	24	28,782,197	26
OVC	4,185,535	8	4,418,420	8	8,603,956	8
Programme Management & Administration	15,841,868	29	19,211,252	33	35,053,120	31
Human Resources	955,575	2	999,166	2	1,954,741	2
Social Protection & Social Services	3,434,866	6	4,212,826	7	7,647,692	7
Enabling Environment	2,708,324	5	3,410,437	6	6,118,761	5
Research	673,333	1	1,105,895	2	1,779,228	2
Total	**53,735,198**	**100**	**58,059,469**	**100**	**111,794,667**	**100**

[56] Because of rounding some categories display 0% though they have seen a small amount of spending.

Spending on other programmatic areas including OVC related interventions, social protection, social services and activities aimed at the creation of an enabling environment was much less between 2009 and 2010 (Figure 38).

Figure 38: Total spending by main AIDS spending categories (Average 2009/2010)

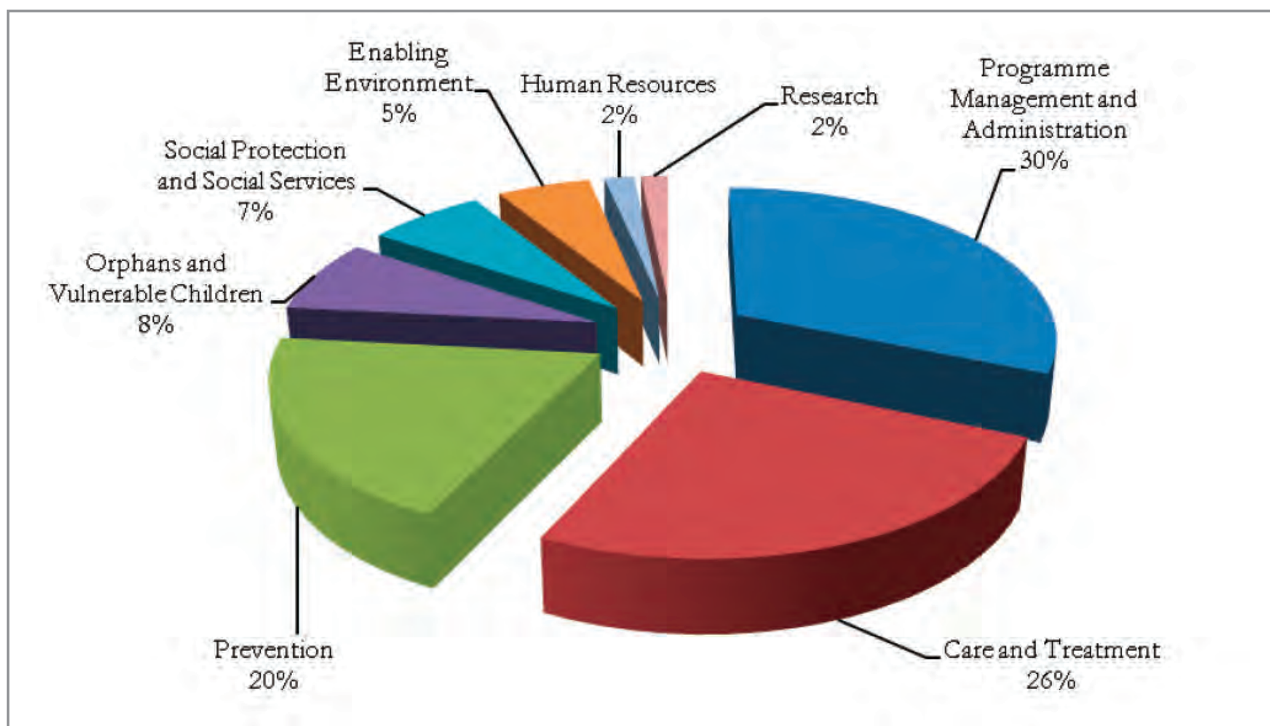
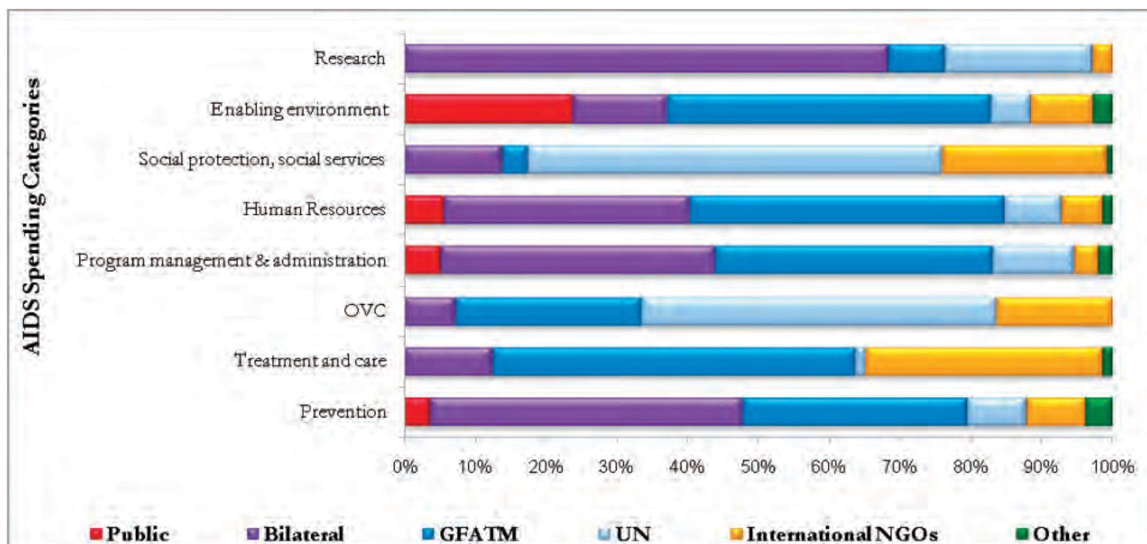


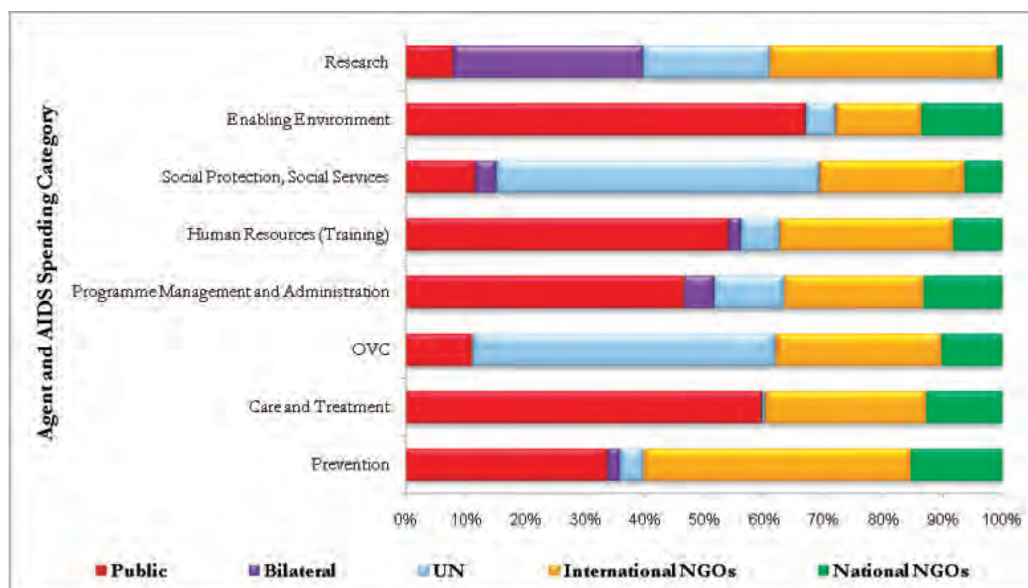
Figure 39 shows that spending on treatment and care and of OVC support was largely financed by GFATM and international NGOs. Whilst expenditures on prevention, programme management and administration, and human resources were principally funded by bilateral organizations and by GFATM. UN agencies were the main financers of social protection and social services because of the prominent role played in this sector by WFP's food support. Activities to establish an enabling environment were mostly funded by GFATM and through the national budget. Meanwhile, research was primarily funded by bilateral organizations and by UN agencies.

Figure 39: Spending by financing source and by spending category (Average 2009/2010)



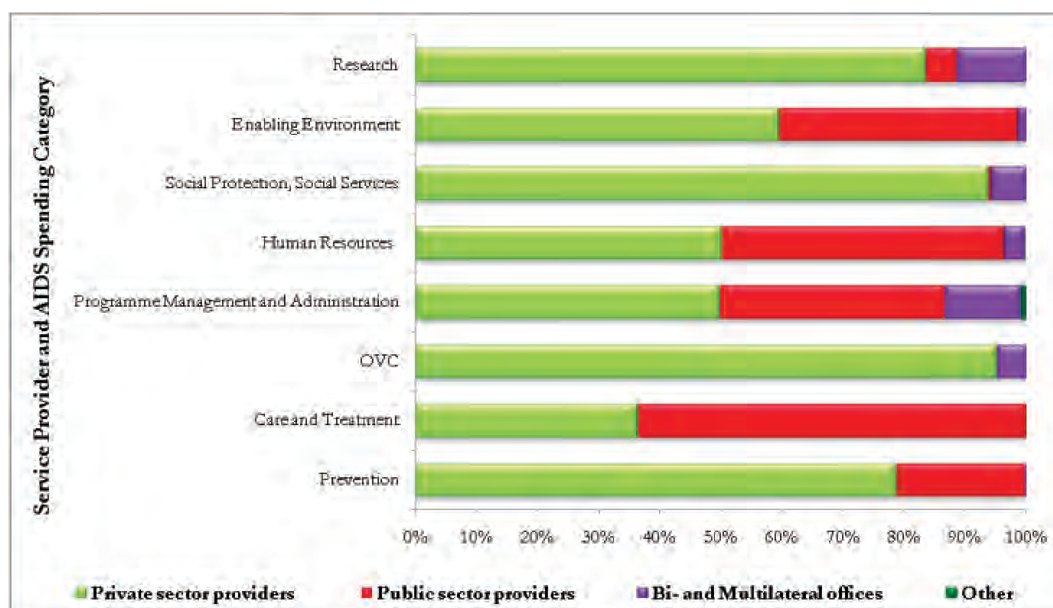
The money that was spent on prevention interventions over the two years, was in large part managed by international NGOs and by public entities (Figure 40). Public entities also managed more than half of the financial resources used to provide care and treatment services, to create an enabling environment and develop human resources through training. Bilateral entities were relatively prominent in the management of funds employed for HIV-related Research together with international NGOs and UN agencies.

Figure 40: Spending by financing agent and by spending category (Average 2009/2010)



Public sector entities were the most prominent service providers in the area of care and treatment whilst also playing an important role in delivering interventions to create an enabling environment and develop human resources (Figure 41). Private sector entities (including NGOs) were more prominent in delivering prevention interventions. They acted as almost exclusive service providers in the areas of OVC support and of social protection and social services. Bi- and multilateral agencies in general did not play a major role in the provision of services across all areas.

Figure 41: Spending by service provider and by spending category (Average 2009/2010)



4.6.1 Spending on HIV Prevention-

Since 2006 there has been a significant drop in spending on HIV prevention both in absolute and proportional terms. Spending on prevention and on other categories of intervention have fluctuated considerably in the past five years (Figure 42). The fluctuations can in large part be attributed to changes in definitions and classifications. Expenditures that in NASA I and II would have been coded under the spending category of Prevention, in NASA III were more often coded under the Programme Management and Administration and the Enabling Environment categories.

Figure 42: Spending on main AIDS spending categories, 2006-2010

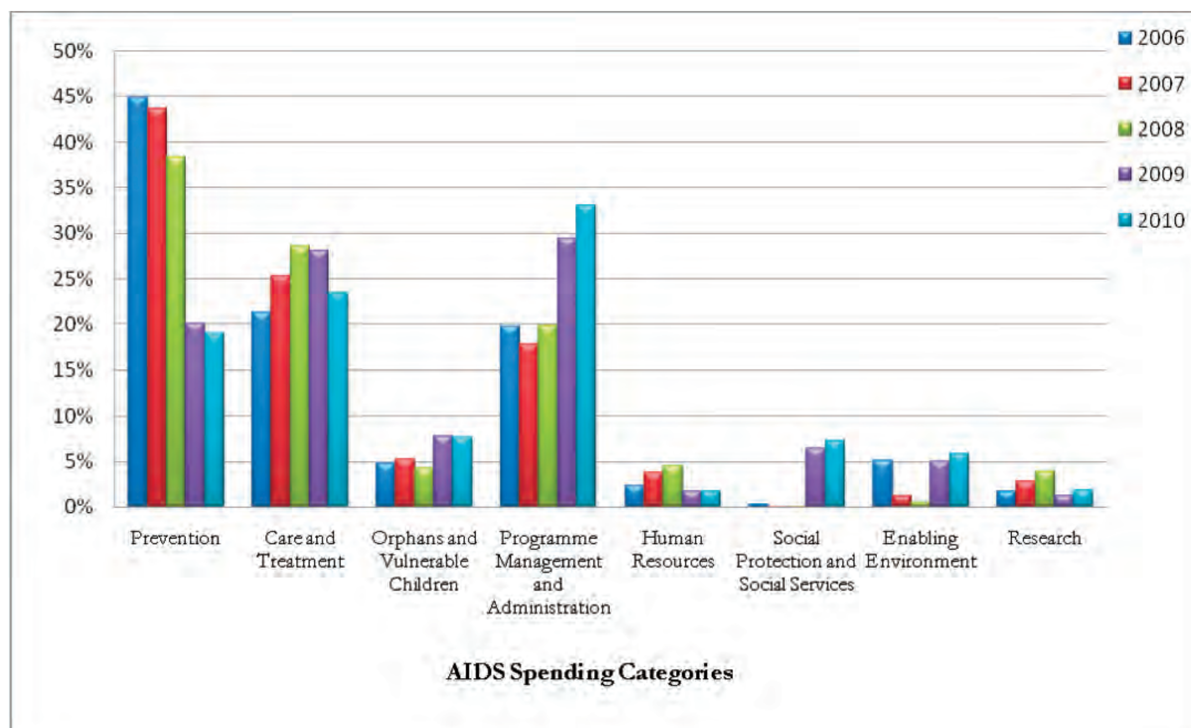


Table 24 shows that in 2006 almost half of all expenditures on HIV and AIDS was on HIV prevention. Spending on this spending category peaked in 2007 at US$23,273,407. Between 2008 and 2009 it dropped roughly by half and then increased slightly again to reach US$11,048,070 in 2010.

Table 24: Spending on prevention, 2006-2010

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
20,775,489	45	23,273,407	44	19,928,804	38	10,806,903	20	11,048,070	19

Spending on prevention remained nearly constant in the two years (US$10,806,903 in 2009 and US$11,048,070 in 2010). On average it represented one fifth of all HIV expenditures. Table 25 shows that the funds that covered these expenditures originated mainly from bilateral organizations and from the GFATM. International NGOs and the UN contributed much less for this particular purpose.

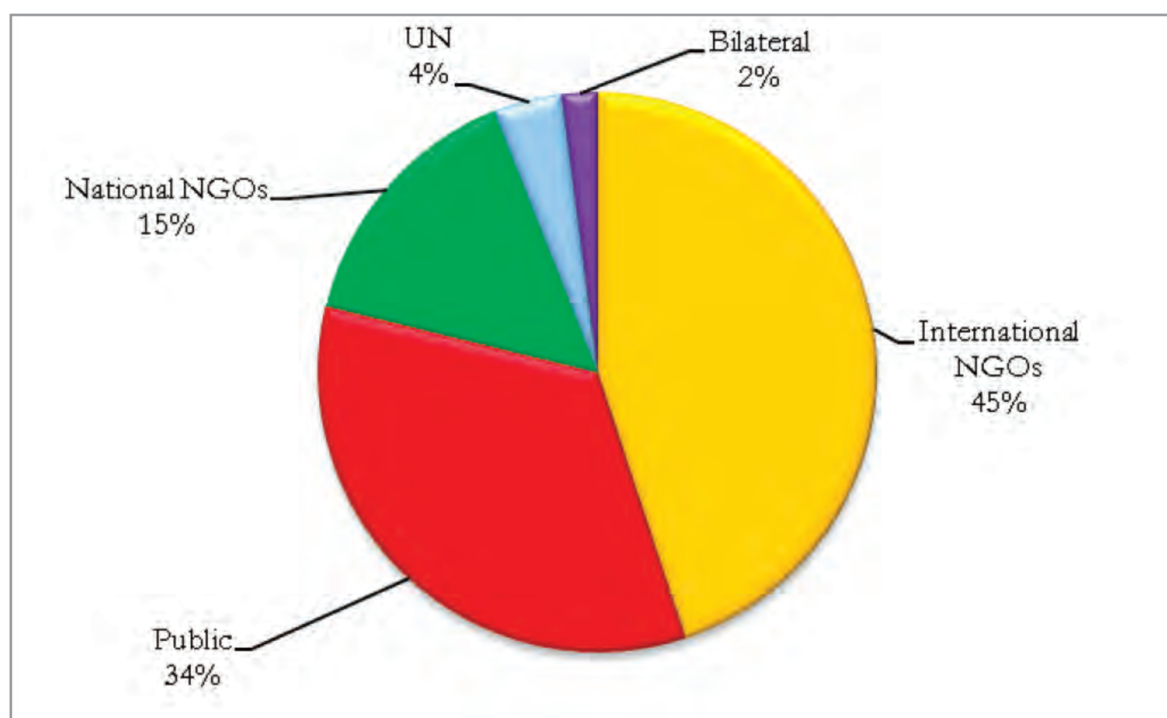
Table 25: Spending on prevention by financing sources, 2009 and 2010

Financing Source	2009		2010		Total	
	US $	%	US $	%	US $	%
Bilateral	4,998,270	46	4,670,319	42	9,668,589	44
GFATM	3,493,397	32	3,414,280	31	6,907,677	32
International NGOs	1,051,554	10	778,282.00	7	1,829,836	8
UN	795,175.00	7	1,058,076	10	1,853,251	8
Public	201,675.00	2	575,121.00	5	776,796	4
International for-profit	124,786.00	1	172,308.00	2	297,094	1
Multilateral	117,106.00	1	350,657.00	3	467,763	2
Private	24,939.00	0	29,026.00	0	53,965	0
Total	**10,806,903**	**100**	**11,048,070**	**100**	**21,854,973**	**100**

The most relevant change in the two years was that spending on prevention from public and multilateral sources other than GFATM and the UN increased, whilst expenditure from international NGOs decreased from 2009 to 2010.

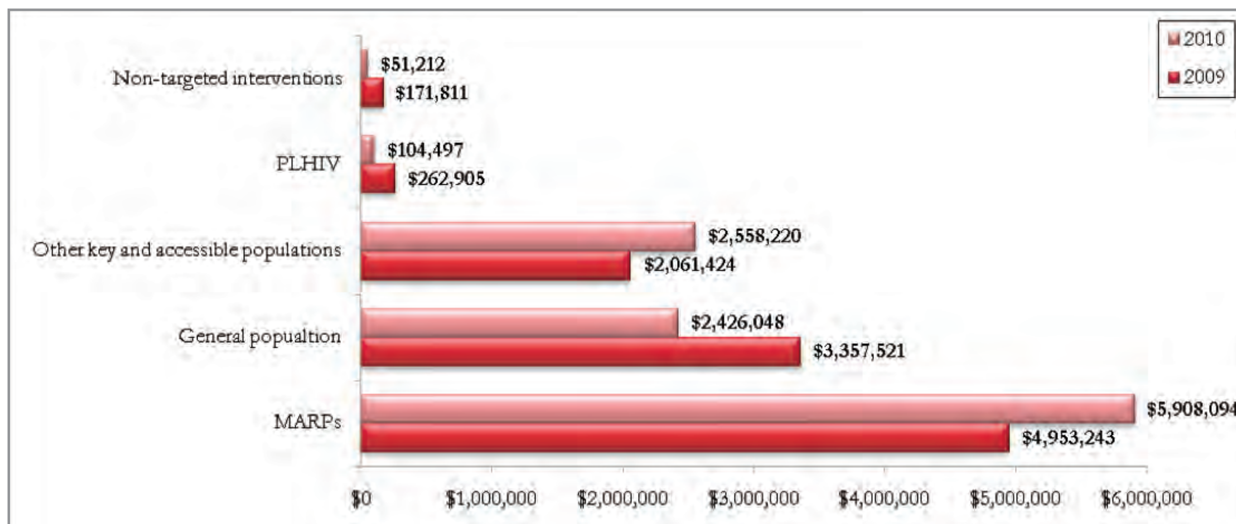
International NGOs were the primary manager of funds spent on prevention interventions in the biennium (Figure 43). A total of US$4,645,542 in 2009 and US$5,168,537 in 2010 were managed by them to in order to deliver prevention interventions. There were no significant changes in the amount channeled through public entities and national NGOs over the years. In general, the UN and bilateral organizations managed only a small portion of the spending on prevention.

Figure 43: Spending on prevention by financing agents (Average 2009/2010)



Prevention interventions were primarily implemented by international and national NGOs (79%) and to a much lesser extent by public sector entities (21%). Bi- and multilateral agencies did not play any major role in the delivery of these interventions.

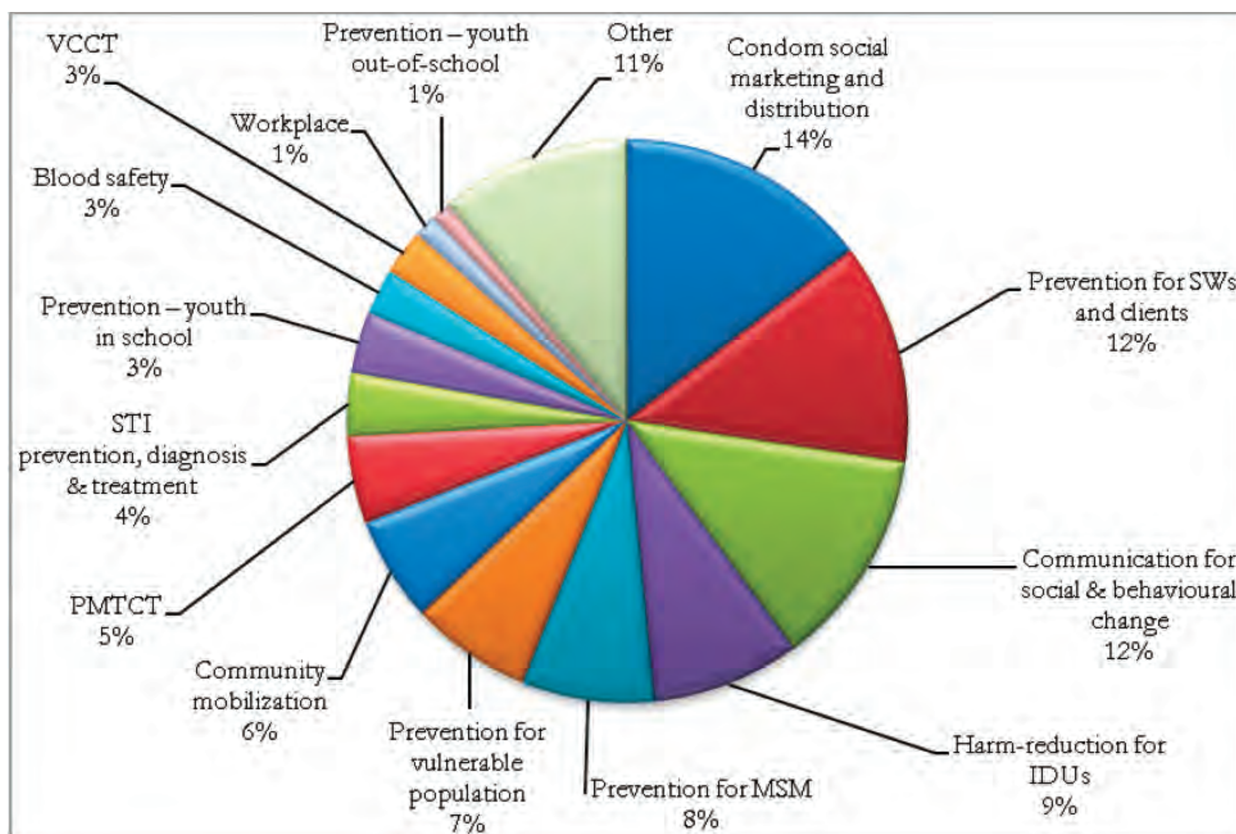
Figure 44: Spending on prevention by beneficiary populations, 2009 and 2010



Most of the spending on prevention was aimed to avert new infections among MARPs including sex workers (SW), men who have sex with men (MSM) and drug users (DUs). Spending on MARPs prevention rose from 46% in 2009 to 54% in 2010 while spending on prevention for the general population decreased from 31% in 2009 to 22% in 2010.

This positive trend can also be detected in the past as spending on MARPs prevention doubled from 2007 to 2010. This is encouraging considering the need in Cambodia to focus on averting infections among people who are at a particularly high risk of infection. The expenditure figures are displayed in Figure 45.

Figure 45: Spending on prevention spending sub-categories (Average 2009/2010)



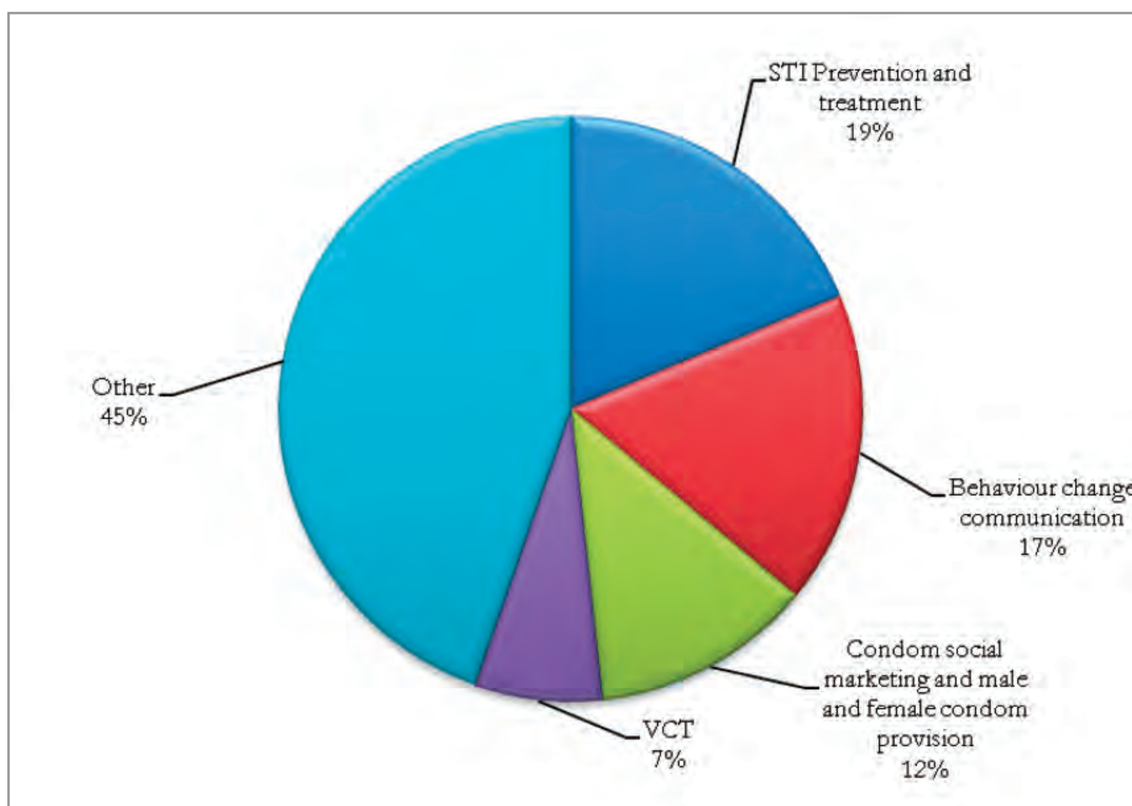
A more in-depth analysis of spending is also useful given the great wealth of data that was obtained in NASA III. Out of the total spending on prevention in the two years, the largest shares were spent on condom social marketing and distribution (15%), communication for social and behavioral change (13%) and prevention for sex workers and their clients (13%).[57] Expenditures on MARPs increased by 53% from $1,090,036 in 2009 to $1,665,126 in 2010 becoming the largest prevention spending sub-category. The second largest spending sub-category in 2010 was that of condom social marketing and distribution (US$ $1,562,442). Significantly, spending on communication for social and behavioral change decreased by 27%. Figure 38 above illustrates spending by prevention sub-categories.

Spending on prevention interventions targeting MARPs increased by 19% from US$4,953,243 in 2009 to US$5,908,094 in 2010, representing half of the total prevention expenditures. Almost half of these prevention interventions could not be disaggregated by type and hence included activities targeting all three main populations (i.e., SW, MSM and IDUs).

From spending which could be disaggregated by one of the MARPs sub groups, an increase from 2009 to 2010 was documented for each; sex workers and their clients (US$1,076,937 in 2009 and US$1,665,126 in 2010); IDUs (US$829,657 in 2009 and US$1,021,792 in 2010); and MSM (US$641,859 in 2009 and US$911,700 in 2010).[58]

Figure 46 shows that spending on prevention programmes focusing on SW and their clients mostly concerned interventions that provided STI prevention and treatment, behaviour change communication, condoms and social marketing and voluntary counseling and testing (VCT). Nearly half of the expenditure could not be disaggregated because data was incomplete.

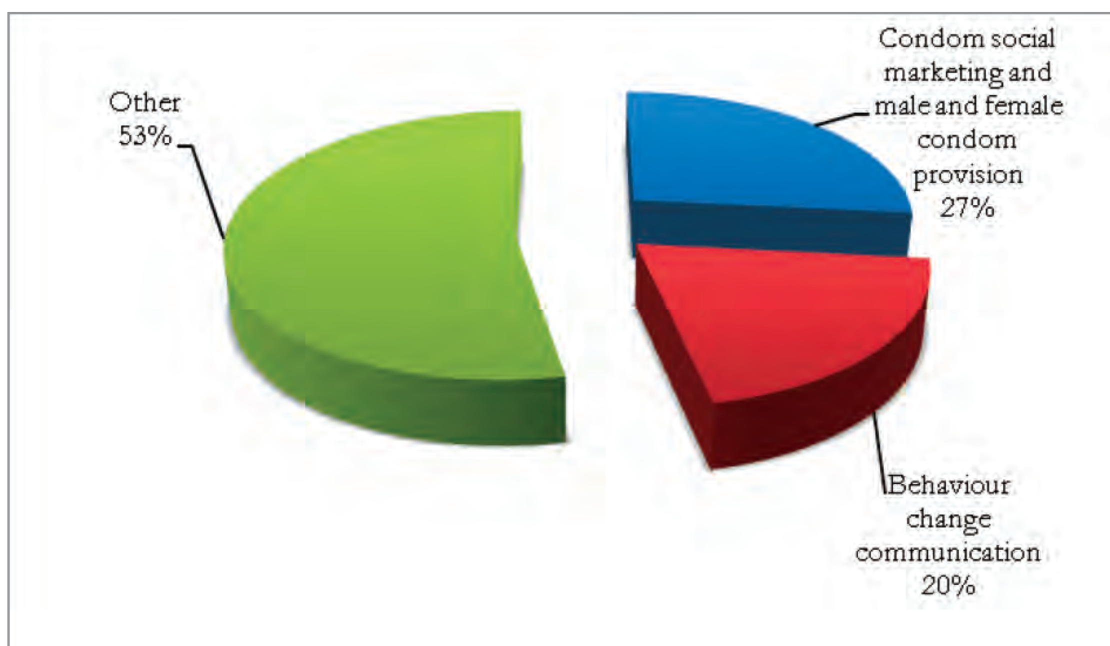
Figure 46: Spending on prevention for sex workers and their clients (Average 2009/2010)



57 See Annex 3: AIDS spending matrixes
58 See Annex 4: Spending by thematic area

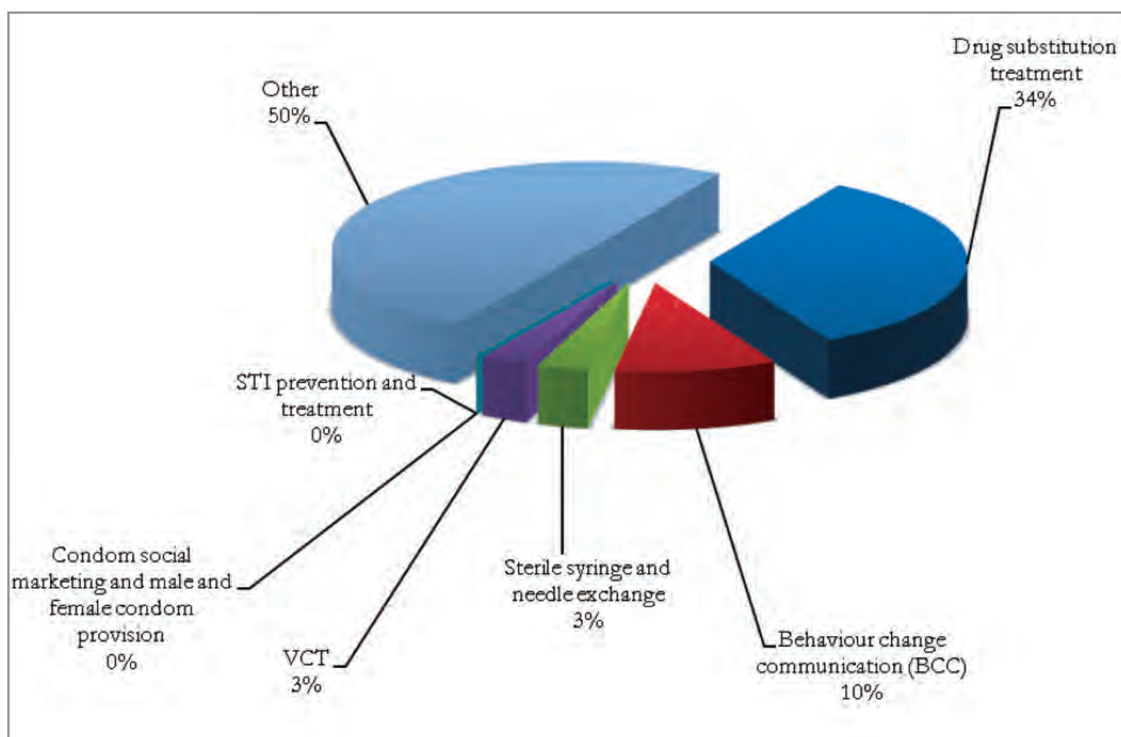
Over the two years, spending on prevention programmes for MSM was primarily focused on condom social marketing and condom provision, and communication for behaviour change. As demonstrated in Figure 47, a large share of expenditures could not be disaggregated by more specific activities.

Figure 47: Spending on prevention programmes for MSM (Average 2009/2010)



Spending on programmes for IDUs increased by 22% from US$836,656 in 2009 to US$1,021,793 in 2010. In particular, there was a significant growth in spending on sterile syringe and needle (NSP) exchange programmes and on drug substitution therapy. Figure 48 illustrates the distribution of expenditure on harm reduction programmes for IDUs.

Figure 48: Spending on harm reduction programmes for IDUs (Average 2009/2010)



A total of US$1,631,989 in 2009 and US$1,562,442 in 2010 were spent on condom social marketing and male condom provision for both MARPs and the general population.[59] This represented 15% and 14% of all of the spending on prevention, and nearly 3% of the total expenditure on HIV and AIDS over the two years.[60]

In the biennium, 7% of total prevention expenditure was spent on prevention for vulnerable and accessible populations such as migrants, truck drivers, indigenous groups, recruits and prisoners. Roughly 4% was instead targeted at youth in school. Spending on prevention for out-of-school youth increased over the two years but represented only 1% of all spending on prevention. This share is however complemented by spending recorded under the category of risk-reduction for vulnerable and accessible populations which included street children.

In 2009, 5% and in 2010, 6% of all the expenditures that were made on prevention were on the prevention of mother-to-child transmission (PMTCT). This corresponded to 1% of total spending on the national response to HIV in both years. There was an increase of 24% (US$117,259) from 2009 to 2010. 97% of the money spent on PMTCT could not be classified more in detail because of a lack of information.

4.6.2 Spending on care and treatment

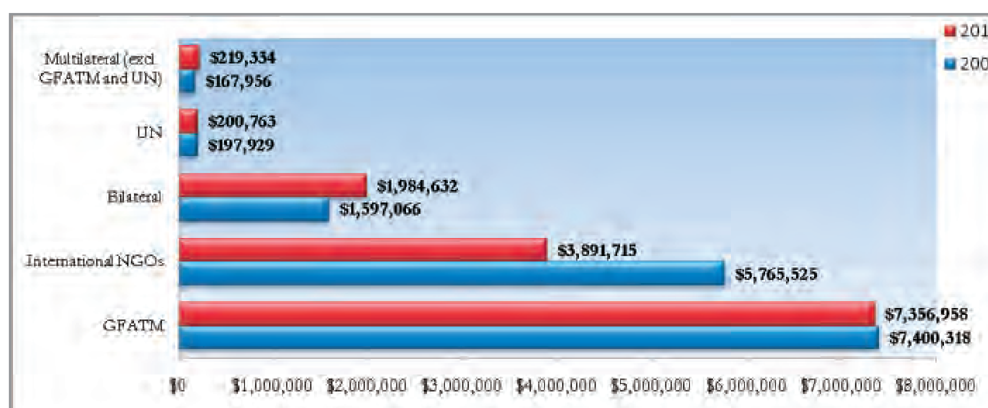
Spending on care and treatment services increased by 53% from US$9,856,777 in 2006 to US$15,128,794 in 2009, and then dropped by 10% (US$1,475,392) to US$13,653,403 in 2010 (Table 26: Spending on care and treatment, 2006-2010). Spending on this category fluctuated considerably over the five years.

Table 26: Spending on care and treatment, 2006-2010

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
9,856,777	21	13,481,788	25	14,809,076	29	15,128,794	28	13,653,403	24

Figure 49 shows that about half of the money spent on care and treatment originated from GFATM (49% in 2009 and 54% in 2010).[61] International NGOs provided about one third of the funds and bilateral organizations over one tenth.

Figure 49: Spending on care and treatment by financing source (Average 2009/2010)



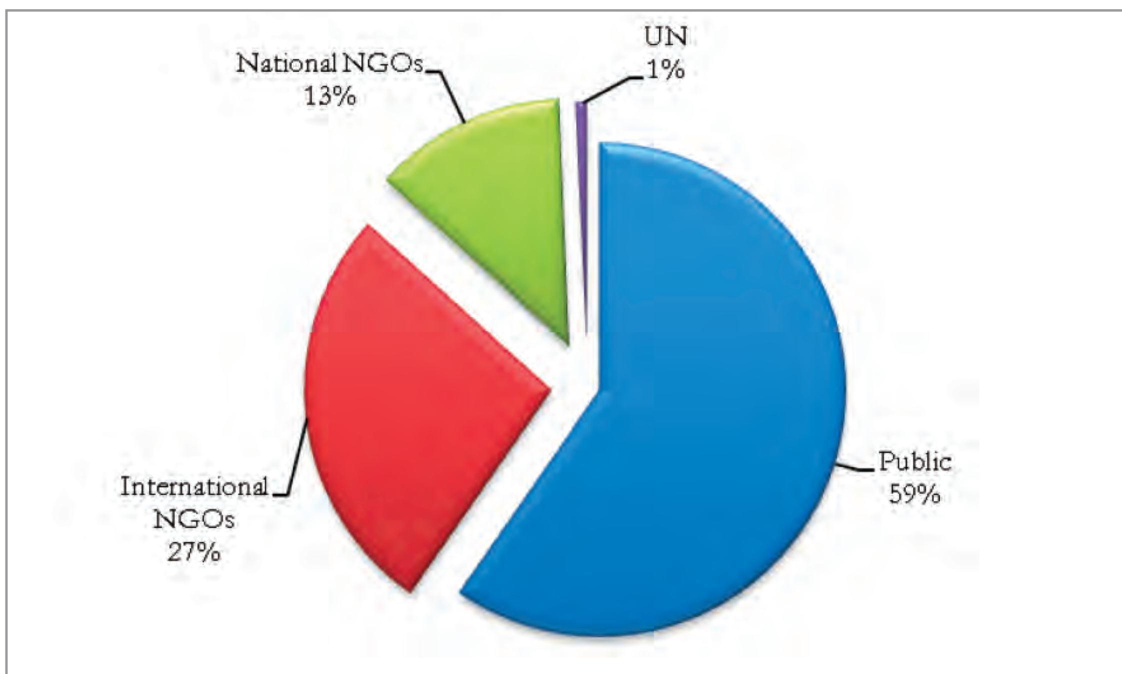
59 See Annex 3: AIDS spending matrixes

60 It need to be remembered that these figures do not include all expenses on condom social marketing and condom provision because some of these are captured under other prevention sub-categories including Prevention programmes for sex workers and their clients, Prevention Programmes for MSM and Harm-reduction programmes for injecting drug users. Expenditures

61 See Annex 4: Spending by thematic area

Most of the money spent on care and treatment was managed by government entities (58% in 2009 and 61% in 2010) (Figure 50). This represented an amount of US$8,811,275 in 2009 and US$8,365,456 in 2010.

Figure 50: Spending on care and treatment by financing agents (Average 2009/2010)



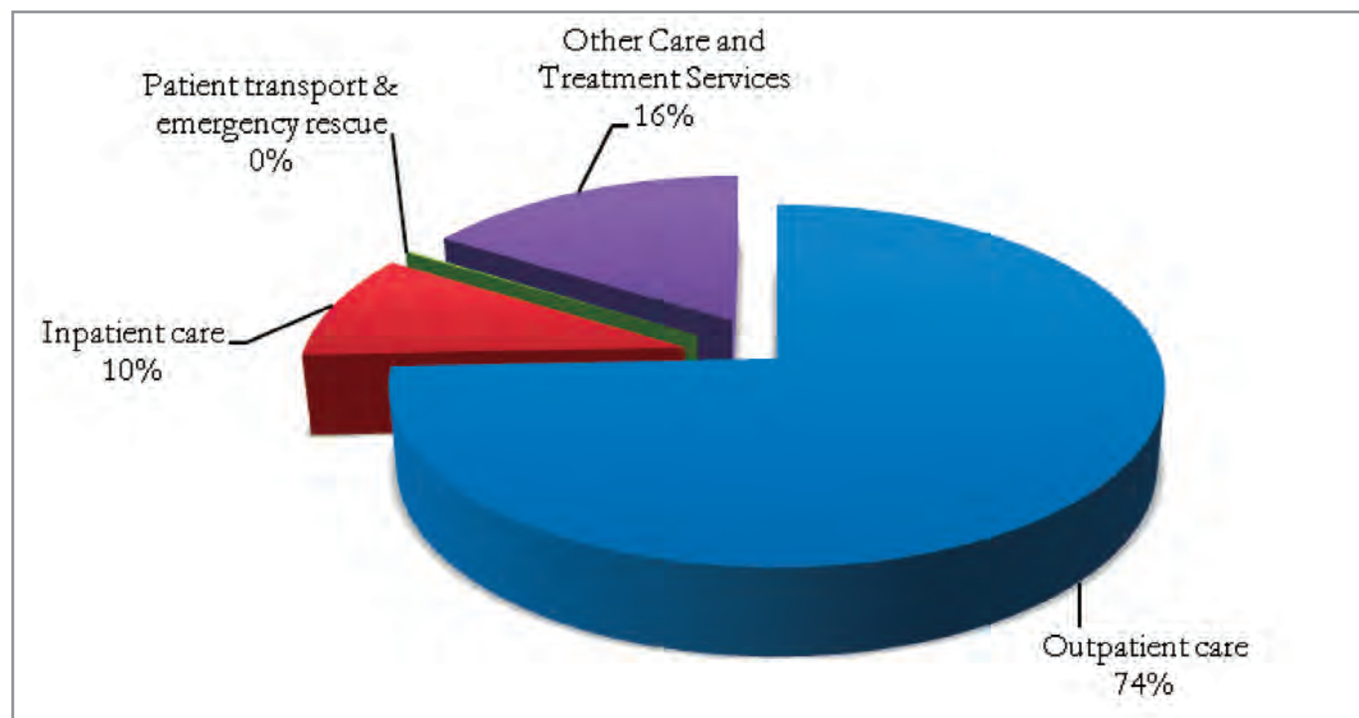
International NGOs were the second largest financing agent for care and treatment with US$4,487,408 in 2009 and US$3,290,753 in 2010 (30% in 2009; 24% in 2010). National NGOs followed, with (US$1,707,862 in 2009; US$1,931,140 in 2010).[62]

All care and treatment services benefitted PLHIV and the services were provided by public and private sector organizations (NGOs), with the share more or less constant in the two year; 64% implemented by public sector institutions and 37% by national NGOs.

Figure 51 illustrates spending in the two years on care and treatment by sub-categories. The largest share was on outpatient care (74%). Only 10% was spent on inpatient care and the remaining was spent on other care and treatment services.

[62] See Annex 4: Spending by thematic area

Figure 51: Spending on care and treatment by spending sub-categories (Average 2009/2010)



A total of US$11,302,146 in 2009 and US$10,085,742 in 2010 were spent on outpatient care and treatment services.[63] The largest share of this spending was on adult and pediatric antiretroviral therapy (ART). Spending on ART was 64% of all spending on out-patient care in the biennium (Figure 52).[64] Expenditure on ART constituted 50% in 2009 and 44% in 2010 of spending on care and treatment.

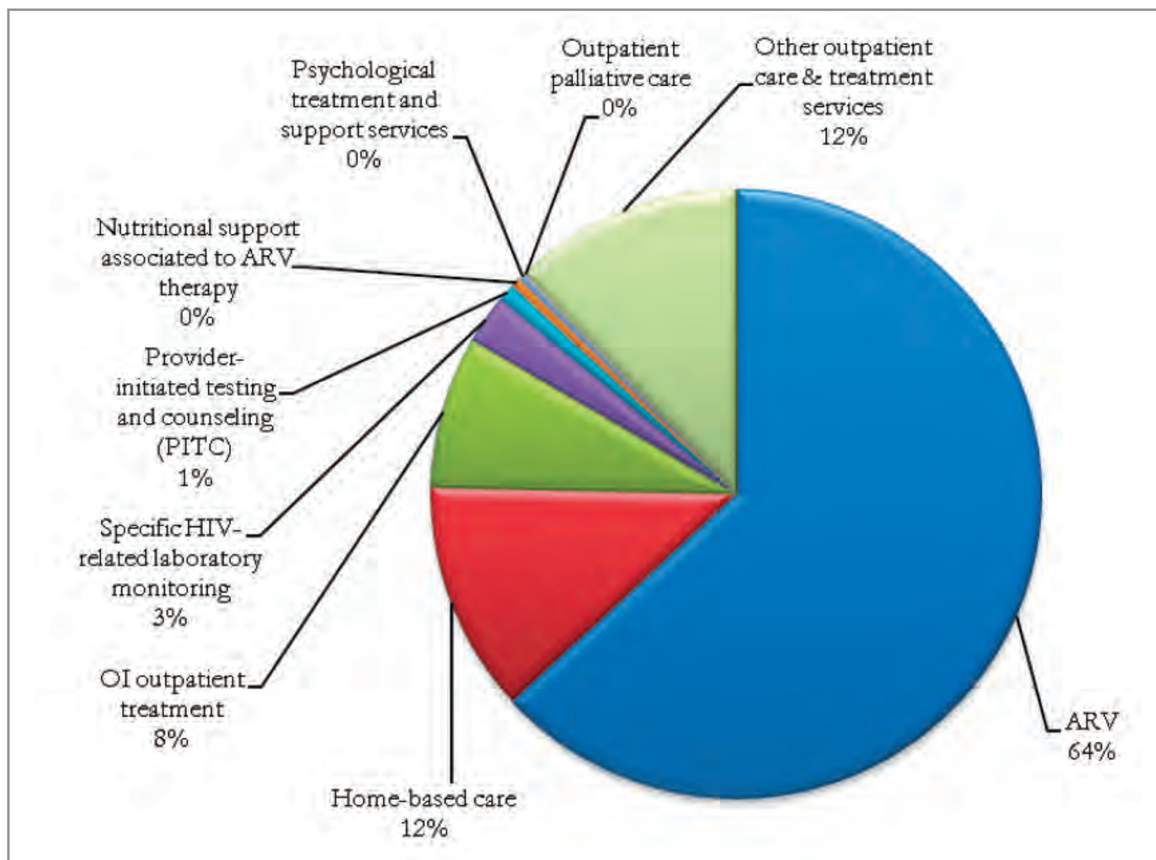
Home-based care (HBC) and opportunistic infections (OI) outpatient prophylaxis and treatment represented 12% and 8% of all the expenditures made on outpatient care and treatment. 3% was spent on specific HIV-related laboratory monitoring and 1% on provider initiated testing and counseling (PITC). Spending on outpatient palliative care, nutritional support associated to ART and psychological treatment and support services was less than 1%.[65] 12% of all expenditure on outpatient care and treatment could not be disaggregated and were classified under the label 'Other'.

[63] See Annex 3: AIDS spending matrixes

[64] Costs related to ART, regardless of the setting in which it was provided (ambulatory clinic, hospital) were classified as part of the ASC.02.01.03 Antiretroviral Therapy, as stipulated by the global NASA methodology. Spending on ARV drugs as well as all costs related to the supply and service delivery is included as ARV spending.

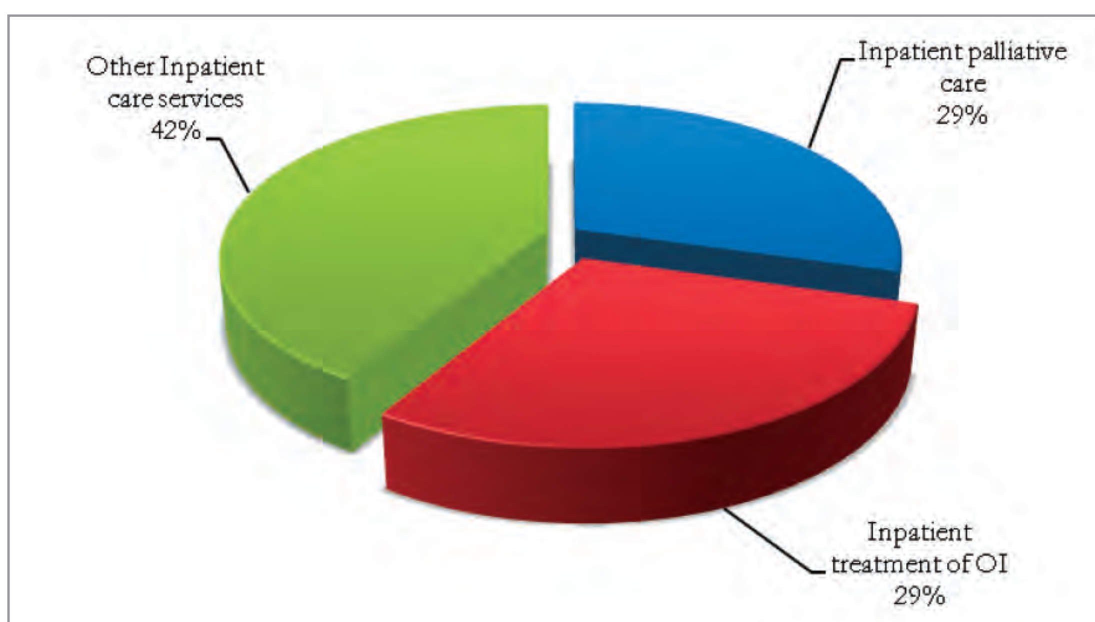
[65] Because of rounding amounts less than 1% show as 0% in graphs.

Figure 52: Spending on outpatient care and treatment, (Average 2009/2010)



Spending on inpatient care and treatment services was US$1,662,922 in 2009 and US$1,073,890 in 2010.[66] From one year to the other there was a drop by 35% in spending on inpatient care activities. Figure 53 shows spending over the two years.

Figure 53: Spending on inpatient care and treatment services (Average 2009/2010)



[66] This spending category does not include spending on ART because this was recorded under outpatient care (i.e., ART).

An equal share of 29% was spent in the two years on inpatient OI and palliative care services. The remaining expenditure (42%) could not be disaggregated because insufficient data was available.

4.6.3 Spending on orphans and vulnerable children

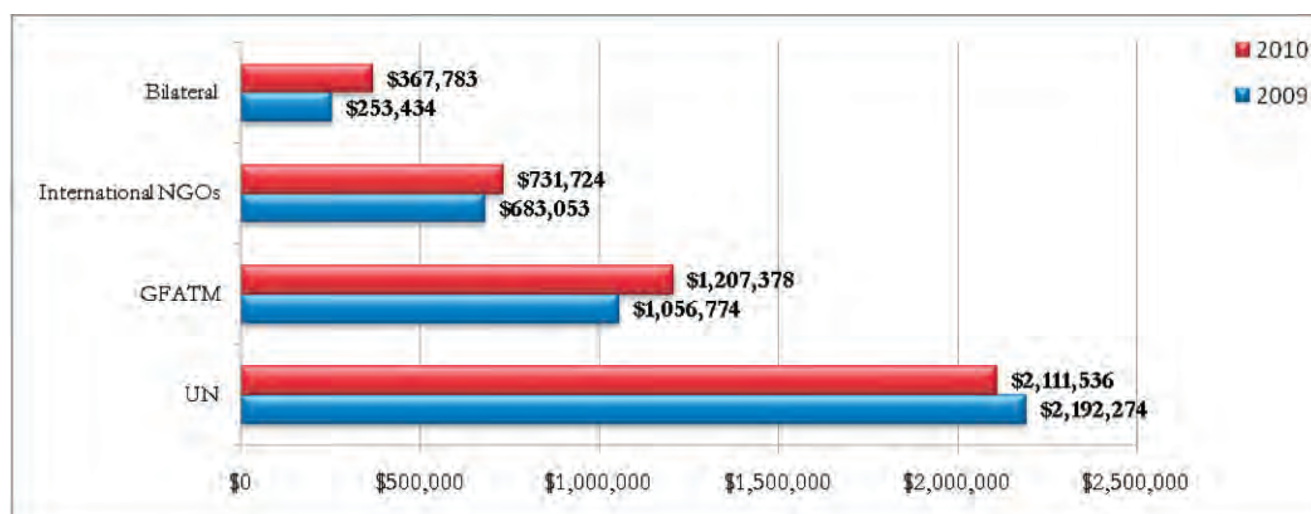
Spending on orphans and vulnerable children (OVC) more than doubled from 2006 to 2010 (Table 27). This represented 8% in out of total spending on HIV and AIDS in 2009 and 2010. The sharp increase in spending on this category from 2008 to 2009 is due to the scale up of OVC programmes with funding from GFATM Round 5 and 7.

Table 27: Spending on orphans and vulnerable children, 2006-2010

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
2,177,112	5	2,787,594	5	2,224,681	4	4,185,535	8	4,418,420	8

More than half of the money spent on OVC programmes in 2009 and 2010 originated from UN agencies, in particular from the WFP and UNICEF (Figure 54).[67] 26% of it came from GFATM, 16% from international NGOs and 7% from bilateral agencies.

Figure 54: Spending on OVC by financing sources (Average 2009/2010)



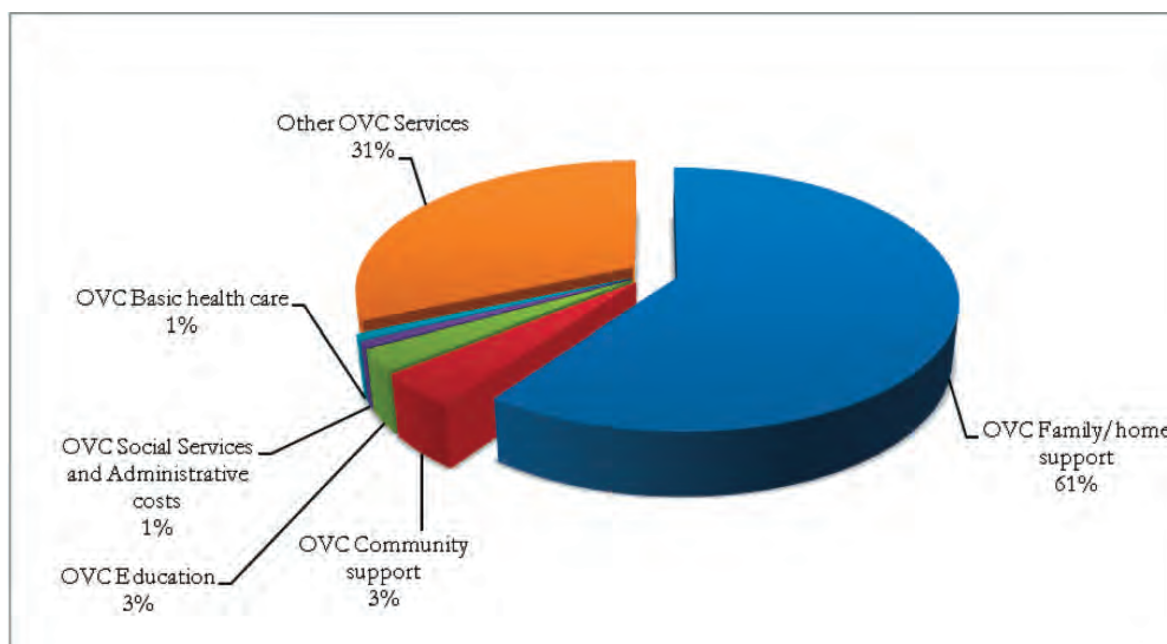
UN agencies were also the main manager of funds invested in OVC programmes. 50% of spending on OVC programmes was managed by these entities. The role of international NGOs as financing agent increased from 24% of the spending channeled through these organizations in 2009 to 32% in 2010. Public entities and national NGOs were identified as the financing agents for around one-tenth of all OVC spending per year.

All OVC programmes were implemented by national and international NGOs with only a small amount, the costs for cargo and other logistically related expenditures, attributed to UN as the service provider. All other spending was intended for OVC and their households.

[67] See Annex 4: Spending by thematic area

Figure 55 shows that, out of the total spent on OVC programmes, 61% was spent on family and home support. Only small shares were spent on education and basic health care for OVC. The specific purpose of 31% of total spending on OVC could not be identified because not enough information was submitted by respondents.

Figure 55: Spending on OVC by spending sub-category (Average 2009/2010)



4.6.4 Programme management and administration

As already mentioned, a very large share of total spending on HIV and AIDS was on activities falling under the category of programme management and administration. Table 28 shows the trend in spending on this specific spending category over the past five years. Spending on this category remained nearly the same in the years from 2006 to 2008 representing roughly 20% of the total spending. Thereafter it increased by more than one third in 2009 and by another quarter in 2010. In 2009 it constituted 30% of total spending on HIV and AIDS and in 2010 33%.

Table 28: Spending on programme management and administration, 2006-2010

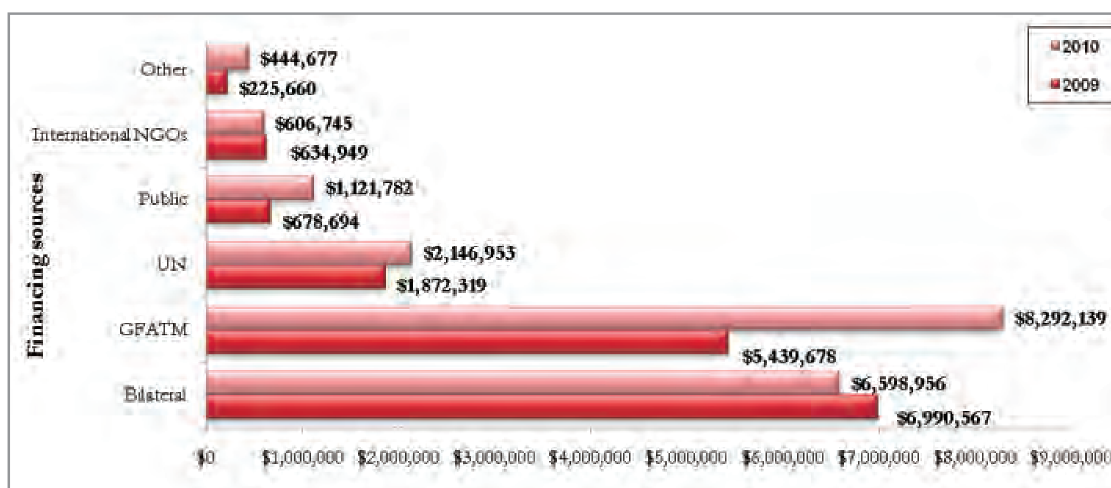
2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
9,133,465	20	9,494,033	18	10,279,877	20	15,841,868	30	19,211,252	33

No quick conclusions can be drawn however, because this trend may largely be due to changes in classifications that occurred over the years. For example, the development of strategic plans and coordination meetings were previously often accounted for under each specific thematic area (e.g., prevention, care and treatment) rather than in this category.[68]

[68] Expenditures related to the planning and management of projects and the running of offices were also accounted for under this spending category. This may be another reason why there has been such a significant increase in this kind of spending given that in the past expenditures related to the running of offices was captured to a much lesser degree.

Programme management and administration was the largest of all the main spending categories in the biennium. This category included spending on planning, coordination and programme management, monitoring and evaluation, information technology, and the upgrading and construction of infrastructure.

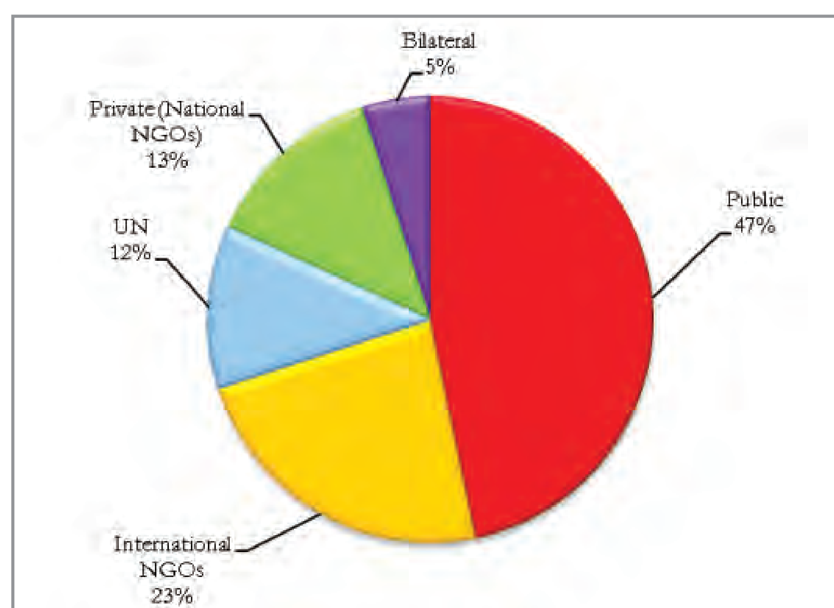
Figure 56: Spending on programme management and administration by financing sources (2009/2010)



As Figure 56 shows the money which was spent on the management of programmes and on administration was primarily sourced from bilateral organisations (45%) and from the GFATM (34%). 12% of spending on this category came from UN agencies in 2009 and only 4% respectively from international NGOs and public sources.

Public institutions were the main managers of expenditures related to programme management and administration (Figure 57). They became more prominent from 2009 to 2010 in managing this kind of spending.

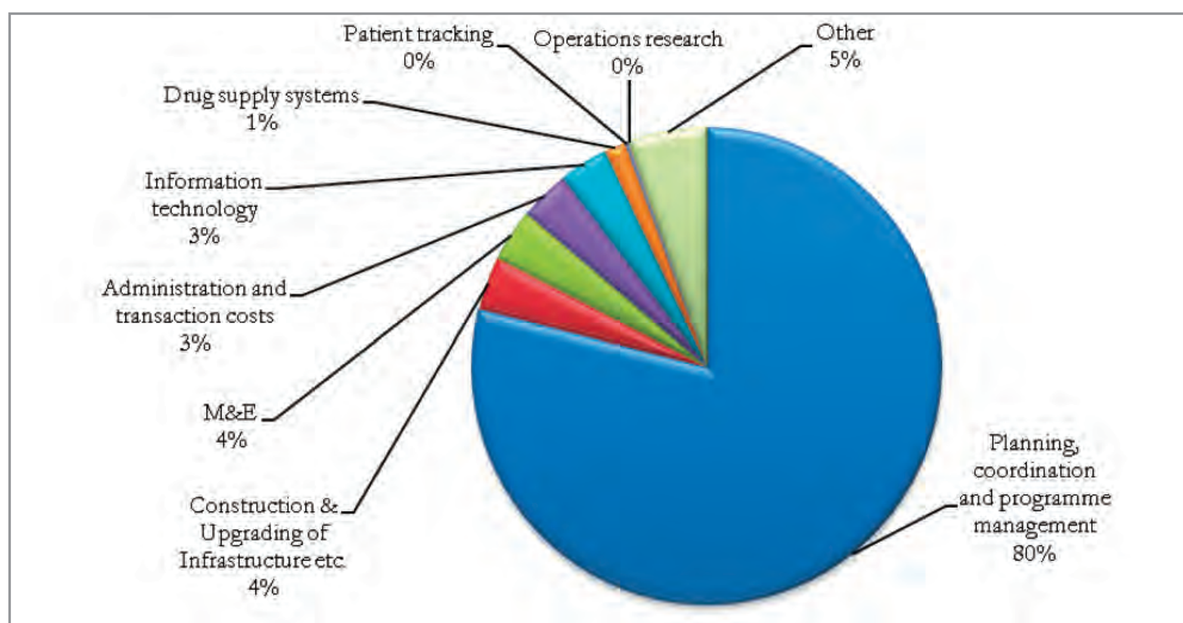
Figure 57: Spending on programme management and administration by financing sources (Average 2009/2010)



69 See Annex 3: AIDS spending matrixes

Most of the spending on programme management and administration was on activities belonging to the category of non-targeted interventions. These expenditures were made to an almost equal extent by private sector providers including international and national NGOs and by public sector entities.

Figure 58: Spending on programme management and administration by spending sub-category (Average 2009/2010)



When expenditure on programme management and administration is disaggregated by more specific, universally recognised spending categories, it becomes apparent that 80% was spent on planning, coordination and programme management (Figure 58). This type of expenses constituted around one quarter of the total that was spent on HIV and AIDS in the two years (23% in 2009 and 26% in 2010).

A total of US$12,558,297 in 2009 and of US$15,087,935 were spent on planning, coordination and programme management in support of the Three Ones (i.e., coordination of one single HIV/AIDS action framework, coordinating authority and M&E system). This included the review and development or national strategic plans, guidelines and standard operating procedures as well as coordination meetings, data analysis and vetting workshops, and meetings to disseminate strategic information.

Expenditure on the spending category of planning, coordination and programme management increased by 20% from 2009 to 2010.Spending on this sub-category also included expenses related to the development of GFATM proposals and to the strengthening of capacity to implement GFATM grants. The shares spent on other categories such as M&E, information technology, drug supply systems, construction and upgrading of health centers and of laboratory infrastructure were much smaller. It should be acknowledged however that expenses on M&E for example were recorded mostly under the thematic spending categories rather than under this general category.

4.6.5 Human resources (training)

The amounts spent on human resources and especially on training increased from US$1,082,450 in 2006 to US$2,317,106 in 2008 (Table 29). These expenditures included those made on activities related to the development of the workforce such as recruitment, retention, deployment and rewarding to ensure good staff performance.

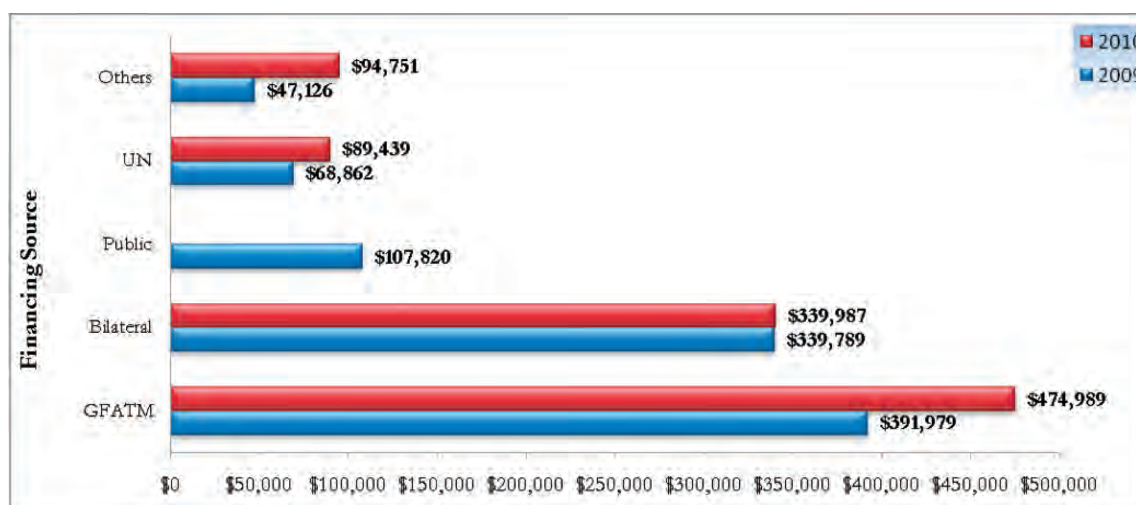
Only 2% of total HIV related expenditure was on this spending category with the exception of 2007 and 2008 when it was double that.[70] Spending on human resources decreased by 50% between 2008 and 2009. This was largely due to changes that occurred in definitions and classifications.

Table 29: Spending on human resources, 2006-2010

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
1,082,450	2	2,046,001	4	2,317,106	4	955,575	2	999,166	2

The main financing source for expenditures made in the area of human resources was the GFATM (Figure 59). 41% was drawn from this external source in 2009 and 48% in 2010 for this purpose. Bilateral organizations were the second most important funding source (36% in 2009; 34% in 2010). Whilst in 2009 11% of the spending on training originated from public sources, no spending sourced from the national budget could be identified in 2010. Other financing sources such as UN agencies and International NGOs only contributed small amounts to Human Resources (Training).

Figure 59: Spending on human resources by financing sources (2009 - 2010)



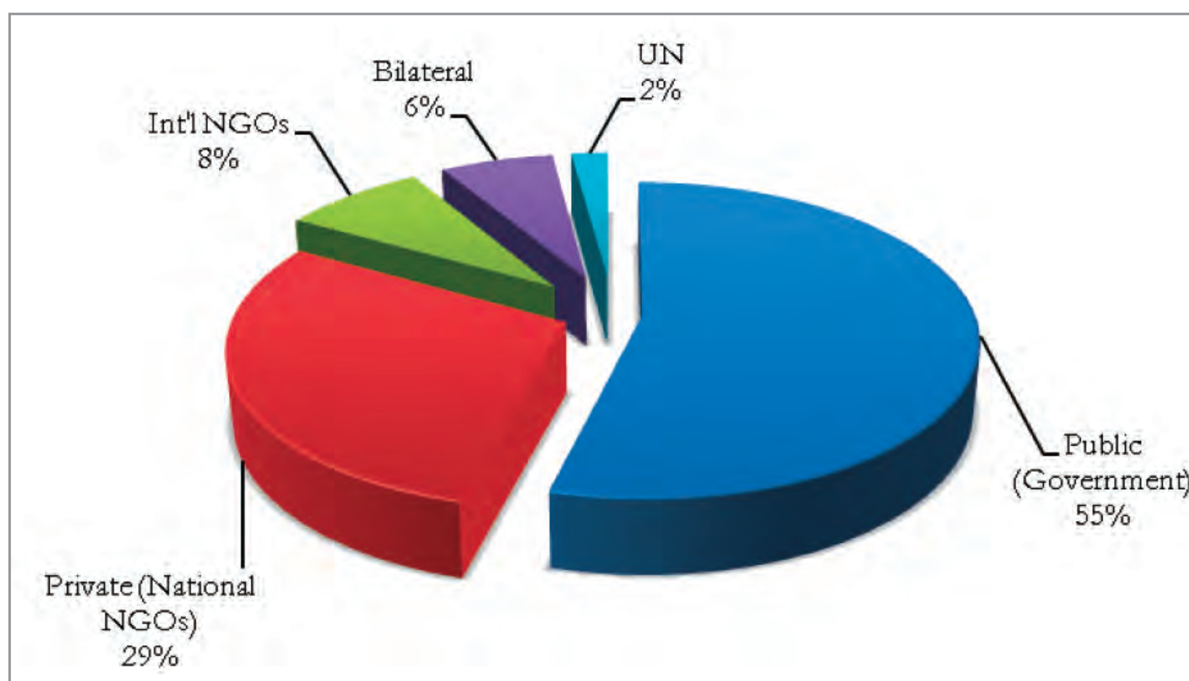
Public institutions were the most significant financing agent that employed spending for the development of human resources, especially on training. Public sector institutions managed 52% in 2009 and 54% in 2010 of funds invested in this kind of activities.[71] The share of spending on human resources that was managed by international NGOs diminished from 28% in 2009 to 7% in 2010. Currently, the share managed by private entities increased from 9% to 30%.

The distribution by service providers for spending on human resources varied over the two years. Private sector providers dropped from 54% in 2009 to 5% in 2010. The share of spending on human resources by bi- and multilateral organizations instead increased from 1% to 47%. Meanwhile, the share of public sector providers remained constant around 46%.

[70] In NASA I and II the amount spent on Human Resources also included monetary incentives. In NASA III such spending were captured under the specific service delivery area (for example incentives for doctors under Treatment and Care) since no salaries for doctors, nurses or other personnel was reported by MoH. Recommendation has been made to capture incentives under the relevant ASC instead of under ASC.05 Human Resources for future NASA. The reason is that the incentives are part of delivering the actual service to the people.

[71] See Annex 3: AIDS spending matrixes

Figure 60: Spending on human resources by financing agents (Average 2009/2010)



4.6.6 Social protection and social services

Spending on social protection and social services was very little from 2006 to 2008 (Table 30). However, it increased significantly in the last biennium. Spending on this category rose from US$3,434,866 in 2009 to US$4,212,826 in 2010 representing 6% and 7% of the total expenditure in each respective year.

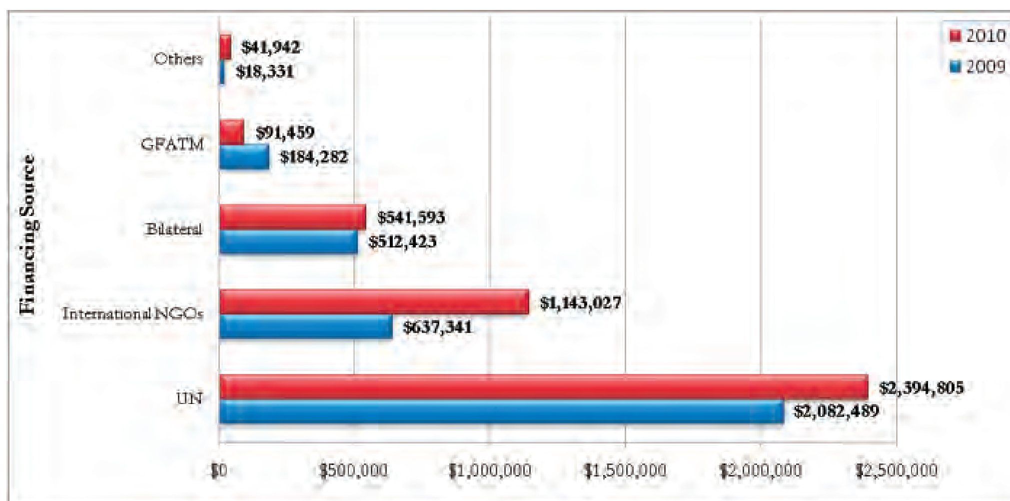
Table 30: Spending on social protection and social services, 2006-2010

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
146,619	0	39,810	0	19,248	0	3,434,866	6	4,212,826	7

The main reason why there was such a considerable increase is that, contrary to previous assessments, in NASA III spending by WFP on food support benefiting PLHIV was classified under this spending category instead of under care and treatment (i.e., home-based care). Expenditures related to support that was provided to PLHIV and their families who were relocated from Borei Keila to Toul Sambo were also included in this category.

Spending on social protection and social services was mostly financed by the UN (59%) in the two years (Figure 61). International NGOs were the second largest financer (23%), followed by bilateral entities (14%). Only 4% of expenditures on this main spending category was sourced from GFATM and no public funds were reported to have been employed for this purpose.

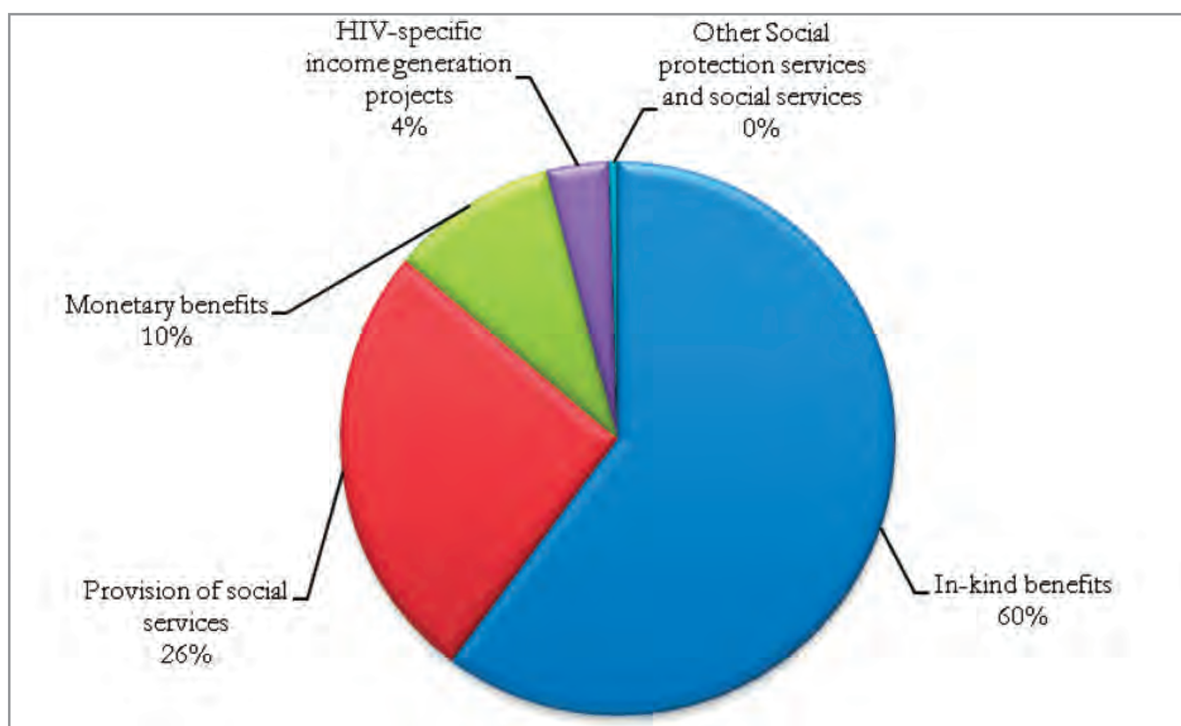
Figure 61: Spending on social protection and social services by financing source (2009 - 2010)



More than half of spending on social protection and social services was managed by UN agencies (59%).[73] 23% was managed by international NGOs and 14% by public entities.

Almost all of the social protection activities and social services were provided by private sector entities including international and national NGOs. PLHIV were the primary beneficiaries of the spending which covered in-kind benefits (60%), provision of social services (26%), monetary benefits (10%) and income generation activities (4%)(Figure 62).[74]

Figure 62: Spending on social protection and social services by sub-categories (Average 2009/2010)



[73] See Annex 3: AIDS spending matrixes

[74] Expenditure below 1% will appear as 0% in graphs because of rounding.

4.6.7 Enabling environment

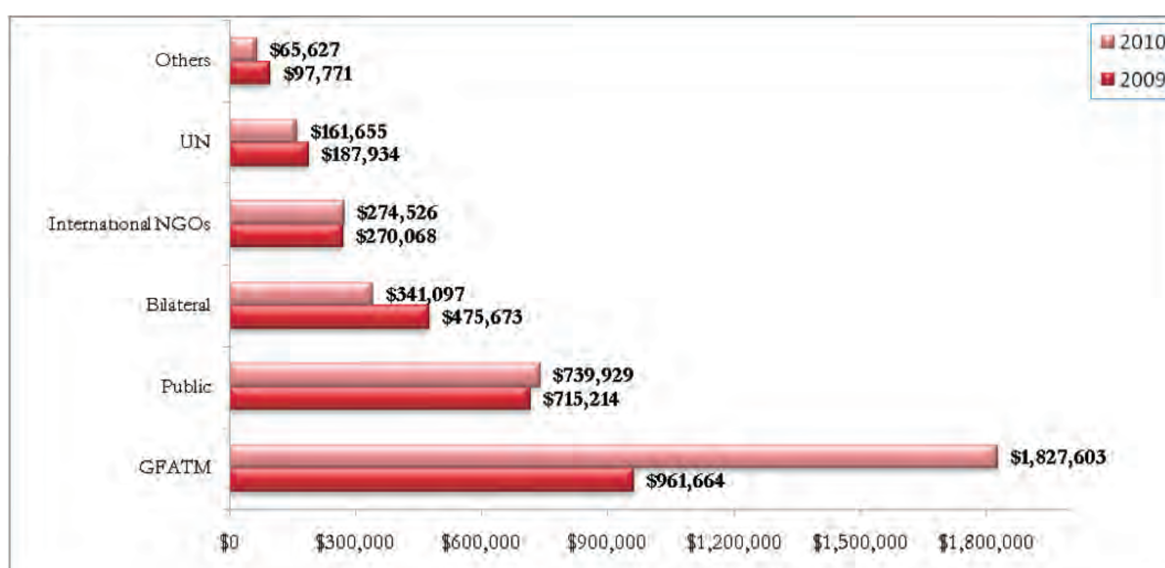
Spending on the creation of an enabling environment has fluctuated over the years. Table 31 shows that compared to the other years spending on this category was very low in 2007 and in 2008. While in 2009 a total of US$2,708,324 was spent on Enabling Environment interventions. The largest amounts were spent in the past two years (US$2,708,324 in 2009 and US$3,410,437 in 2010). Out of the total spending on HIV and AIDS this represented 5% in each respective year.

Table 31: Spending on enabling environment, 2006-2010[75]

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
2,344,496	5	647,502	1	257,497	0	2,708,324	5	3,410,437	6

GFATM financed more than one third of these expenditures in 2009 and more than half of them in 2010.[76] Money drawn from public sources and spent in this area decreased slightly from 2009 to 2010 and so did that obtained from bilateral sources. Figure 63 shows the average distribution for the two years.[77]

Figure 63: Spending on the enabling environment, 2009 and 2010



The Government was the main manager of money spent on activities aimed at creating an enabling environment (61% in 2009 and 71% in 2010).[78] The role of private entities (national NGOs) as financing agents diminished. They managed 18% of this kind of spending in 2009 and only 10% in 2010. The role of UN agencies as financing agents slightly weakened whereas that of international NGOs remained the same in the biennium.

The majority of activities that were aimed at developing an enabling environment were implemented by national and international NGOs (i.e., private sector providers)(Figure 64).

75 Expenditure below 1% will appear as 0% in graphs because of rounding.
76 See Annex 4: Spending by thematic area
77 Ibid
78 Ibid

Figure 64: Spending on the enabling environment by service providers (Average 2009/2010)

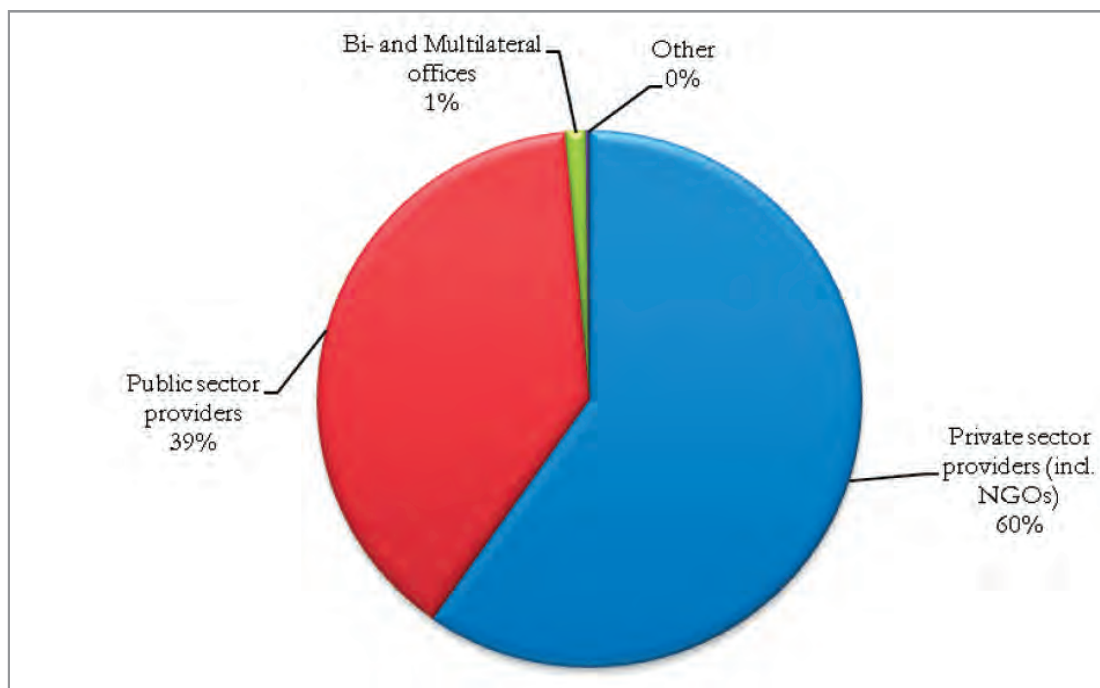
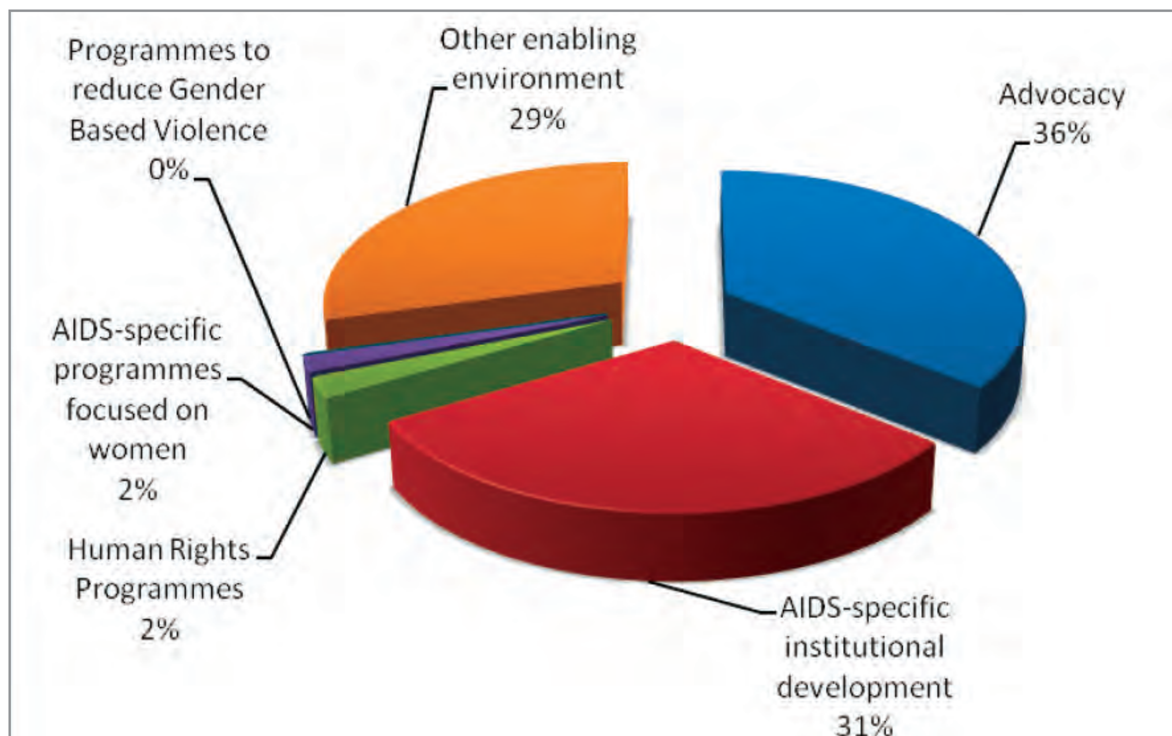


Figure 65 shows that 36% of spending on this category was spent on advocacy in the two years. 31% was spent on AIDS-specific institutional development involving among other the development of capacity of NGOs. The remaining was spent on other activities to create an enabling environment for HIV programmes including on human rights based initiatives. It is should be noticed that there was hardly any HIV-related spending on programmes aimed at reducing gender based violence.[79]

Figure 65: Spending on the enabling environment by spending sub-categories (Average 2009/2010)



[79] Expenditure below 1% will appear as 0% in graphs because of rounding.

4.6.8 HIV-related research

Since 2006 spending on HIV-related research constitutes only a very small part of total spending. Table 32 shows that in the last five years spending on this category never exceed 4%. Under this category spending was recorded on biomedical, clinical and social sciences research. Spending on operational research was not included under this category.

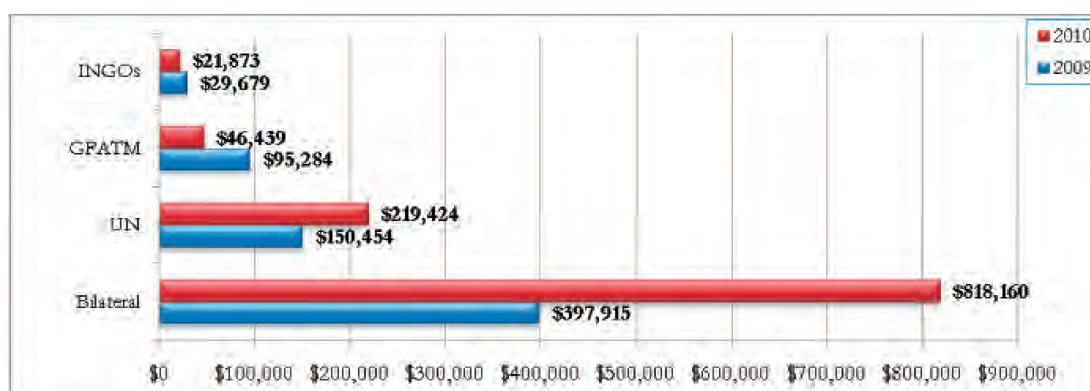
In 2009, US$673,333 was spent on HIV-related research. This amount increased by 63% to US$1,105,895 in 2010 and represented in that year 2% of the total expenditure on HIV and AIDS. The increase is in part due to the costs related to a few major studies including the Study on the Socio-economic Impact of HIV and AIDS at the Household Level, the Stigma Index and the Study on Most-at-Risk Adolescents and Young People.

Table 32: Spending on HIV-related research, 2006-2010

2006		2007		2008		2009		2010	
US $	%	US $	%	US $	%	US $	%	US $	%
791,180	2	1,488,630	3	2,010,709	4	673,333	1	1,105,895	2

The main source of money spent on HIV related research were bilateral organizations with 59% of the research spending originating from these sources in 2009.[80] In 2010, this share increased to 74%. UN provided 23% of the resources which were spent in 2009, and 20% in 2010. GFATM's and international NGOs' shares decreased from 14% to 4% and from 4% to 2%, respectively in the two years (Figure 66).

Figure 66: Spending on HIV related research by financing sources, 2009 and 2010



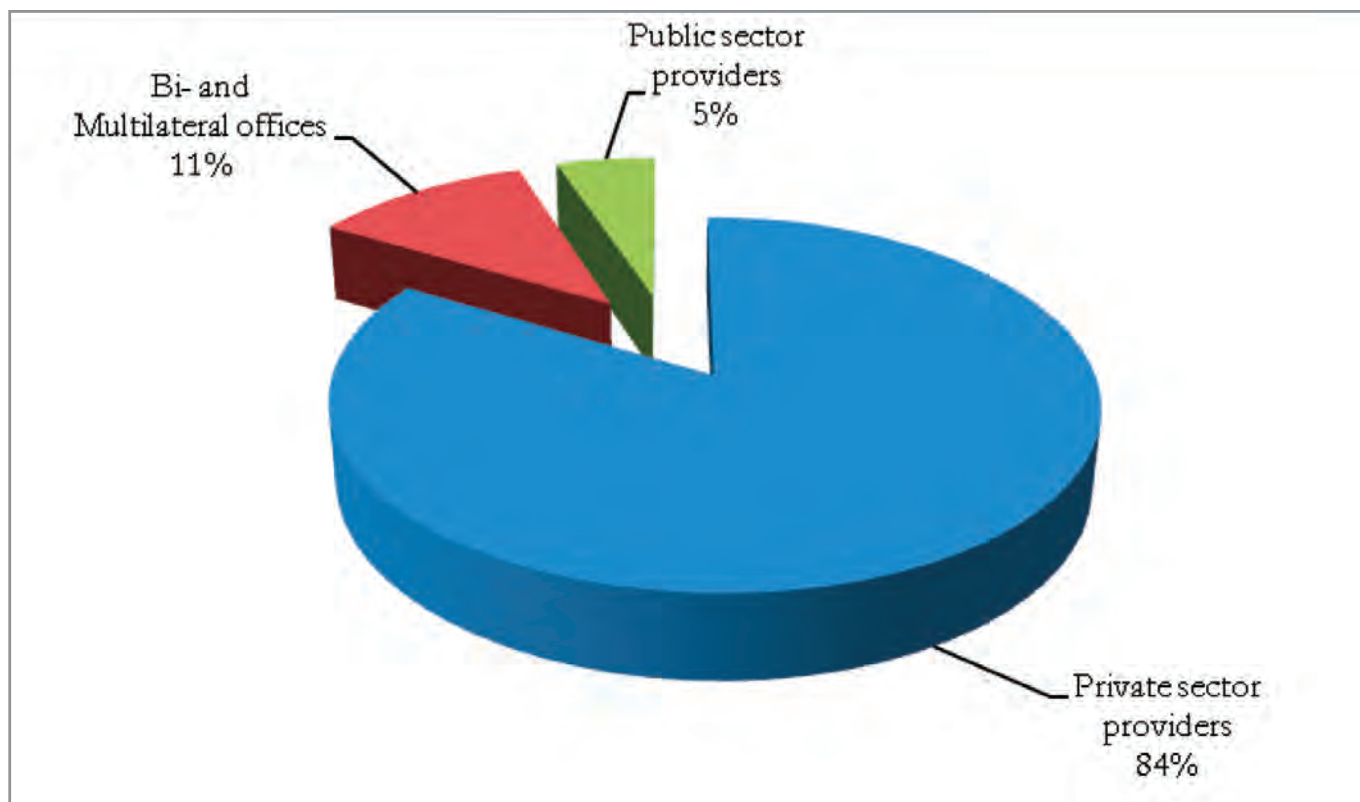
The shares of money spent by different type of entities who managed the expenditures as financing agents varied a lot in the two years. This is probably is due to the fact that specific research assignment rarely last longer than one year and are carried out by different organizations.

Figure 67 shows that over the two year period HIV related research was primarily implemented by the private sector (national and international NGOs)(84%). However, the share of HIV related research carried out by private sector entities declined from 93% in 2009 and 78% in 2010. In the meantime, the role of bi- and multilateral agencies in the implementation of HIV related research expanded whilst that of public institutions remained approximately the same.

80 See Annex 4: Spending by thematic area

81 Ibid

Figure 67: Spending on HIV related research by service providers, (Average 2009/2010)



5. CONCLUSIONS AND RECOMMENDATIONS

After implementing three national AIDS spending assessments Cambodia today has a rich dataset. The data is useful to analyze patterns and trends in spending on HIV and AIDS. Over the years the assessment methods as well as the definitions and classifications have improved considerably, as has national capacity to conduct the survey and appreciate its results.

NASA III has allowed the NAA to gather data of unprecedented quality and as such the data used in this report to examine and document financial transactions is much more detailed than that utilized in the past.

Not all of the results of NASA III can be easily compared with those of NASA I and II. In several cases definitions and classifications have changed and therefore make a trend analysis impossible. Still, the data is of great value to answer the following key questions: How are HIV and AIDS related interventions financed? Who pays for what, and how much? How is this being distributed among different service providers? Who benefits?

A number of findings from NASA III are worthwhile summarizing here briefly at end of this report. In 2009 and 2010, like in the preceding three years covered by NASA, Cambodia relied to a very large extent on external resources to finance its national response to HIV and AIDS. Spending in these two years was mainly sourced from GFATM and from the US Government. Cambodia's response remained highly dependent on foreign support.

NASA III confirmed that spending of funds drawn from traditional bilateral sources is decreasing and that expenditures against GFATM grants steadily increased. Indicators show clearly that there has been a concentration of spending on HIV and AIDS from one single source – the GFATM.

This third spending assessment had greater participation from HIV and AIDS organizations than past NASA which maybe one of the reasons why total spending increased between NASA II and NASA III. Still, there has been a significant growth over the past five years in spending from international sources which suggests that in reality spending has increased.

It should be clear that spending levels in this report do not necessarily indicate whether there was an increase or a decrease in actual financial contributions from different sources. There are situations where entities have more money available than what they manage to spend. And vice-versa, there can be situations where more money is spent than what is actually available, though this is somewhat more unlikely. This discussion leads on to questions around gaps in financing and the absorption capacity of different entities which should be answered by future NASA.

The role of the government of Cambodia will have to be seen in the light of the fact that a lot of the spending where public entities were involved, either as financing agents or service providers is for ARV. Although the role of public entities is not so prominent outside the scope of care and treatment, the role of the health system as a whole in supporting the functions of a HIV and AIDS response is not adequately captured by NASA. For example, the costs of human resources at various levels within ministries who contribute to the HIV and AIDS response, and the costs of maintaining public facilities have not been captured by the assessment. In the future it is hoped that NASA will be able to obtain data allowing to assess more comprehensively spending from public sources and to better determine the contributions made by national sources of funds.

Cambodia's epidemic is concentrated among sex workers and their clients, men who have sex with men and injecting drug users, however, only 10% of all spending on HIV and AIDS in 2009 and 2010 was on activities targeting these MARPs. An increase in prevention activities for these populations, however, is noted suggesting that a more targeted and strategic approach to investment in the response to the HIV and AIDS epidemic is increasingly followed in Cambodia. There has indeed been a doubling in dollar spending on MARPs prevention between the years 2007 and 2010. The extent that this is enough to meet the needs of this population needs debate.

There is also very little spending of prevention targeting PLHIV which has been discussed as an area where scale-up is needed in order to provide these people with the knowledge and means to protect themselves, their partners and future children.

With an increasing number of people living with HIV and AIDS, the financing for care and treatment services needs to be further explored. The fact that almost all expenditures on care and treatment nowadays are covered by GFATM raises serious concerns. A sharp decrease of funds from international NGOs for these services was noticed in 2010 highlighting the need to secure stable and diversified funding to maintain the extremely good record of universal access and support to PLHIV in the future.

Comparing expenditures over the different NASA rounds should be done with an understanding of the improvements that have been made in the assessment methodology over the years and that this affects assessment results. In a similar vein, comparing costings of strategies in national strategic plans with NASA results requires an adequate understanding of the concepts and methodological approaches used in these different areas of work.

Cambodia has successfully institutionalized NASA over the last five years. The assessments have much improved over time and many useful lessons have been learned. Most importantly, it has become clear that NASA should continue to be regularly conducted every two years in order to obtain data needed to track expenditure trends. Future NASA should as much as possible use the same globally accepted methodology. This will allow stakeholders not only to consistently monitor resource flows in the national context over time but also to report spending data that can be utilized for regional and global analyses and for comparisons in spending across countries.

Annex 1: Mapping of organization participating in NASA III, 2009-2010

Financing Sources	Financing Agents	Service Providers
Public Sources	**Government**	**Govt entities**
Government of Cambodia	MoEYS	Blood Bank
Bilateral	MoH/PR	CENAT
Australia (AusAid)	MoWA	Hospitals
Denmark (DANIDA)	NAA	MoEYS
France	NCHADS/PR	MoSVY
Germany	NIPH	MoWA
Sweden (SIDA)	NMCHC	NAA
UK (DFID)	*Other public entities*	NBTC
US (USAID, CDC)	**Bi- and Multilateral**	NCHADS
Other bilaterals	USAID	NIPH
Multilateral	UNICEF	NMCHC
Global Fund	WFP	NPH
ADB	UNAIDS	OPC
European Commission	UNFPA	PR MoH
UNAIDS	UNODC	Schools
UNDP	WHO	Other
UNESCO	*Other bi- and multilaterals*	**NGOs**
UNFPA	**International NGOs**	FHI
UNICEF	FHI	KHANA
UNODC	PSI	RHAC
WFP	World Vision	PSI
WHO	MSF	World Vision
World Bank	Maryknoll	NGO

Other multilaterals

International NGOs (& Foundations)

ActionAid

AHF

Clinton Foundation

MSF

Maryknoll

CAFOD

Caritas

CRS

CHEC

DCA

ESTHER

PSF

World Vision

Other Internatonal NGOs

Private Sector

Deutsche Bank

Johnson & Johnson

Private individuals

Other private

DCA

ESTHER

Friends Int

Caritas

PSF

AHF

SCA

CRS

URC

Australian Red Cross

DSF

Other International NGOs

National NGOs

KHANA

RHAC

RACHA

Korsang

Medicam

CHEC

Other National NGOs

SCA

SHCH

Maryknoll

SEAD

CRC

Mith Samlanh

PSF

CARE

CPN+

BBC WST

RACHA

Caritas

Korsang

BLI

MSIC

CWPD

WOMEN

CHEC

Friends International

PC

AHEAD

MHSS

MHC

HACC

AHF

Other NGOs

Other service Providers

Guesthouse

Massage parlours

Pagodas

Pasteur Institute

Radio

Bi- and multilateral organizations

Annex 2: Main Data Tables

Total AIDS Expenditure by Type of Financing Source, 2006-2010

Total AIDS Expenditure by Type of Finacing Source	2006		2007		2008		2009		2010	
	US$	%	US$	%	US$	%	US$	%	US$	%
National source	8,095,466	17	6,045,435	11	5,261,582	10	1,740,358	3	2,488,372	4
International Source	38,212,122	83	47,213,329	89	46,585,415	90	51,994,840	97	55,571,097	96
Total	**46,307,588**	**100**	**53,258,765**	**100**	**51,846,997**	**100**	**53,735,198**	**100**	**58,059,469**	**100**

Total AIDS Expenditure by Financing Source, 2006-2010

Financing Source	2006		2007		2008		2009		2010	
	US$	%	US$	%	US$	%	US$	%	US$	%
Public / National Budget	6,055,310	13	6,045,435	11	5,261,582	10	1,703,403	3	2,436,832	4
NGOs and Private Agents (National)	2,040,156	4	0	-	0	-	36,955	0	51,540	0
Bilaterals	18,788,575	41	24,405,983	46	20,677,015	40	15,565,137	29	15,662,527	27
UN	8,551,586	18	5,579,291	10	4,695,757	9	7,547,437	14	8,382,652	14
Global Fund	9,479,207	20	16,589,956	31	19,087,509	37	19,023,377	35	22,711,245	39
International NGOs	-	-	-	-	-	-	9,119,295	17	7,516,331	13
International for-profit	-	-	-	-	-	-	127,286	0	255,175	0
Multilateral (excl. GFATM & UN)	-	-	-	-	-	-	612,307	1	1,043,168	2
Other international source	1,392,754	3	638,100	1	2,125,134	4	-	-	-	-
Total	**46,307,588**	**100**	**53,258,765**	**100**	**51,846,997**	**100**	**53,735,198**	**100**	**58,059,469**	**100**

Total AIDS Expenditure by Financing Agent 2006-2010

Financing Agent	2006		2007		2008		2009		2010	
	US$	%	US$	%	US$	%	US$	%	US$	%
Government	14,476,217	31	30,811,515	58	27,076,130	52	22,366,790	42	25,740,278	44
National NGOs	23,222,057	50	5,356,411	10	6,712,485	13	6,499,858	12	7,407,339	13
International Organisations	8,609,314	19	17,090,839	32	18,058,381	35	-	-	-	-
International NGOs	-	-	-	-	-	-	15,642,457	29	16,501,376	28
UN Agencies	-	-	-	-	-	-	7,277,948	14	7,288,577	13
Bilaterals	-	-	-	-	-	-	1,948,145	4	1,121,900	2
Total	**46,307,588**	**100**	**53,258,765**	**100**	**51,846,997**	**100**	**53,735,198**	**100**	**58,059,469**	**100**

Total AIDS Expenditure by Service Provider 2006-2010

Service Provider	2006-08	2009		2010	
		US$	%	US$	%
Private sector (incl. NGOs)	-	32,833,057	61	33,857,780	58
Public sector	-	18,129,514	34	21,076,127	36
Bi- and Multilaterals	-	2,618,739	5	3,016,173	5
Other	-	153,888	0	109,390	0
Total	**-**	**53,735,198**	**100**	**58,059,469**	**100**

Total AIDS Expenditure by Beneficiary Population 2006-2010

Beneficiary Population	2006-2008	2009		2010	
	US$	US$	%	US$	%
PLHIV	-	19,362,361	36	18,579,570	32
MARPs	-	5,018,419	9	5,945,850	10
OVC	-	4,073,178	8	4,425,541	8
General population	-	3,450,029	6	2,552,841	4
Other key & accessible populations	-	2,157,215	4	2,568,724	4
Other BPs	-	24,191	0	30,019	0
Non-targeted interventions	-	19,649,805	37	23,956,924	41
Total	**-**	**53,735,198**	**100**	**58,059,469**	**100**

Total AIDS Expenditure by AIDS Spending Categories 2006-2010

AIDS Spending Categories	2006		2007		2008		2009		2010	
	US$	%	US$	%	US$	%	US$	%	US$	%
Prevention	20,775,489	45	23,273,407	44	19,928,804	38	10,806,903	20	11,048,070	19
Care & Treatment	9,856,777	21	13,481,788	25	14,809,076	29	15,128,794	28	13,653,403	24
OVC	2,177,112	5	2,787,594	5	2,224,681	4	4,185,535	8	4,418,420	8
Programme Management & Administration	9,133,465	20	9,494,033	18	10,279,877	20	15,841,868	29	19,211,252	33
Human Resources	1,082,450	2	2,046,001	4	2,317,106	4	955,575	2	999,166	2
Social Protection & Social Services	146,619	0	39,810	0	19,248	0	3,434,866	6	4,212,826	7
Enabling Environment	2,344,496	5	647,502	1	257,497	0	2,708,324	5	3,410,437	6
Research	791,180	2	1,488,630	3	2,010,709	4	673,333	1	1,105,895	2
Total	**46,307,588**	**100**	**53,258,765**	**100**	**51,846,997**	**100**	**53,735,198**	**100**	**58,059,468**	**100**

List of Financing Sources

Type of Finance Sources	2009 in US$	2009 % of total	2010 in US$	2010 % of total
Public Funding Source (MoEF)				
Public Total	***1,703,403***	***3.2***	***2,436,832***	***4.2***
Private (national for-profit & non-profit)				
Private (national for-profit & non-profit) Total	***36,955***	***0.1***	***51,540***	***0.1***
Bilateral Funding Source				
AusAID	642,084	1.2	1,367,857	2.4
CIDA	8,755	0.0	39,964	0.1
DANIDA	108,186	0.2	82,296	0.1
DfiD	785,749	1.5	869,079	1.5
French Govt	629,541	1.2	306,747	0.5
Germany	74,391	0.1	51,398	0.1
Irish Govt	29,275	0.1	9,074	0.0
Japan	86,700	0.2	55,100	0.1
Norway	76,897	0.1		0.0
SIDA	296,972	0.6	92,010	0.2
Spanish Govt	7,558	0.0	7,558	0.0
US	12,819,029	23.9	12,781,444	22.0
Bilateral Total	***15,565,137***	***29.0***	***15,662,527***	***27.0***
UN Funding Source				
OHCHR		0.0	15,021	0.0
UNAIDS	985,734	1.8	644,952	1.1
UNDP	69,947	0.1	330,704	0.6
UNESCO	80,915	0.2	73,035	0.1
UNFPA	852,703	1.6	868,961	1.5
UNICEF	1,431,767	2.7	2,079,244	3.6
UNIFEM	5,000	0.0		0.0
UNODC		0.0	186,440	0.3
UNRC	5,583	0.0	3,330	0.0
WB	74,077	0.1	135,797	0.2
WFP	3,987,020	7.4	3,949,337	6.8
WHO	54,692	0.1	95,831	0.2
UN Total	***7,547,437***	***14.0***	***8,382,652***	***14.4***
GFATM Funding Source				
GFATM Total	***19,023,377***	***35.4***	***22,711,245***	***39.1***
Multilateral (excl. GFATM and UN) Funding Source				
ADB	190,260	0.4	400,175	0.7
EC	399,941	0.7	620,886	1.1
IOM	22,107	0.0	22,107	0.0
Multilateral (excl. GFATM and UN) Total	***612,307***	***1.1***	***1,043,168***	***1.8***
International NGOs Funding Source				
ActionAid	150,505	0.3	143,115	0.2
AHF	222,198	0.4	474,240	0.8
CAFOD	63,905	0.1	56,637	0.1
Caritas	338,038	0.6	437,183	0.8

Catholic Relief Service (CRS)	91,643	0.2	188,900	0.3
CHEC	57,338	0.1	51,062	0.1
Clinton Foundation	2,769,312	5.2	1,525,386	2.6
DCA	225,798	0.4	262,253	0.5
DCA/CA	112,534	0.2	97,464	0.2
Elton John Foundation	217,373	0.4	122,161	0.2
GIP ESTHER	395,908	0.7	345,199	0.6
Mainline Foundation	78,899	0.1	138,862	0.2
Maryknoll	862,678	1.6	862,678	1.5
MSF	1,796,235	3.3	839,865	1.4
PSF	243,382	0.5		0.0
Tearfund/Samaritan's Purse	73,341	0.1	78,716	0.1
World Vision	1,041,829	1.9	1,419,809	2.4
Other International NGOs	378,379	0.7	472,803	0.8
International NGOs Total	***9,119,295***	***17***	***7,516,331***	***12.9***
International for-profit Funding Source				
Deutsche Bank		0.0	83,367	0.1
Johnson & Johnson	127,286	0.2	171,808	0.3
International for-profit Total	***127,286***	***0.2***	***255,175***	***0.4***
Grand Total	**53,735,198**	**100**	**58,059,469**	**100**

List of Financing Agent - Annex for report

Type of Finance Agents	2009	2009 % of total	2010	2010 % of total
Bilateral				
France (ANRC)	618,632	1.2	251,174	0.4
AusAID	154,749	0.3	198,546	0.3
USAID	1,174,764	2.2	672,180	1.2
Bilateral Total	***1,948,145***	***3.6***	***1,121,900***	***1.9***
International NGOs				
FHI	5,991,979	11.2	6,796,402	11.7
PSI	2,276,587	4.2	2,327,583	4.0
World Vision	1,168,085	2.2	1,631,132	2.8
MSF	1,796,235	3.3	839,865	1.4
Maryknoll	1,139,282	2.1	1,139,282	2.0
DCA	489,391	0.9	449,876	0.8
ESTHER	395,908	0.7	345,199	0.6
Friends Int	240,058	0.4	404,456	0.7
Caritas	121,549	0.2	466,953	0.8
PSF	409,706	0.8	165,828	0.3
AHF	149,934	0.3	397,003	0.7
SCA	239,178	0.4	262,869	0.5
CRS	210,754	0.4	249,686	0.4
URC	109,802	0.2	340,031	0.6
Australian Red Cross	156,402	0.3	202,530	0.3
DSF	212,179	0.4	145,411	0.3
Other International NGOs	535,430	1.0	337,272	0.6
International NGOs Total	***15,642,457***	***29.1***	***16,501,376***	***28.4***
National NGOs				
KHANA	3,480,050	6.5	4,106,951	7.1
RHAC	1,941,329	3.6	2,032,303	3.5
RACHA	377,995	0.7	272,429	0.5
Korsang	95,124	0.2	272,925	0.5
Medicam	107,598	0.2	143,017	0.2
CHEC	117,349	0.2	113,158	0.2
Other National NGOs	380,413	0.7	466,556	0.8
National NGOs Total	***6,499,858***	***12.1***	***7,407,339***	***12.8***
Public				
DoH	491,503	0.9	559,534	1.0
MoEYS	345,378	0.6	980,908	1.7
MoH	3,479,638	6.5	3,470,336	6.0
NAA	1,154,316	2.1	1,149,861	2.0
NCHADS	4,293,209	8.0	6,938,452	12.0
NIPH	299,000	0.6	200,000	0.3
NMCHC	209,133	0.4	242,504	0.4
PR MoH	9,132,980	17.0	4,929,533	8.5
PR NCHADS	2,893,437	5.4	7,229,124	12.5
Other Public entities	68,196	0.1	40,025	0.1
Public Total	***22,366,790***	***41.6***	***25,740,278***	***44.3***
UN				

UNAIDS	620,639	1.2	519,395	0.9
UNDP	105,870	0.2	277,326	0.5
UNESCO	117,796	0.2	61,929	0.1
UNFPA	622,300	1.2	462,695	0.8
UNICEF	1,312,820	2.4	1,359,918	2.3
UNODC	56,700	0.1	252,040	0.4
WFP	3,987,020	7.4	3,949,337	6.8
WHO	369,162	0.7	305,866	0.5
Other UN agencies	85,641	0.2	100,071	0.2
UN Total	***7,277,948***	***13.5***	***7,288,577***	***12.6***
Grand Total	**53,735,198**	**100**	**58,059,469**	**100**

List of Service Provider

Type of Service Provider	2009 in US$	2009 % of total	2010 in US$	2010 % of total
Private sector providers (incl. NGOs)				
AHEAD	163,833	0.3	179,579	0.31
AHF	130,075	0.2	260,071	0.45
BBC WST	433,894	0.8	90,824	0.16
BFD	138,898	0.3	139,194	0.2
BFH,RHAC,and BFH	0	0.0	361,349	0.6
BLI	251,557	0.5	280,917	0.5
CARE	579,133	1.1	277,934	0.5
Caritas	308,758	0.6	673,514	1.2
CHEC	177,278	0.3	212,126	0.4
CPN+	524,470	1.0	569,406	1.0
CRC	715,844	1.3	793,359	1.4
CWPD	183,498	0.3	273,913	0.5
DCA	86,146	0.2	131,763	0.2
FHI	3,824,982	7.1	4,338,401	7.5
Friends Int	177,252	0.3	246,034	0.4
HACC	130,085	0.2	82,895	0.1
Hotel. Guesthouse, Massage	693,000	1.3	693,000	1.2
KHANA	3,506,777	6.5	3,689,542	6.4
Korsang	297,661	0.6	313,347	0.5
KYA	252,306	0.5	226,305	0.4
Maryknoll	1,139,282	2.1	1,150,834	2.0
Medicam	107,598	0.2	143,017	0.2
MHC	133,247	0.2	171,290	0.3
MHSS	136,694	0.3	159,594	0.3
Mith Samlanh	587,681	1.1	471,647	0.8
MSIC	184,263	0.3	280,298	0.5
New Hope	57,302	0.1	250,031	0.4

NGO	1,803,804	3.4	2,381,360	4.1
OP clinic (NGO)	86,096	0.2	124,770	0.2
Orange Brand Elements	239,334	0.4		0.0
Pasteur Institute	623,317	1.2	251,174	0.4
PC	174,932	0.3	202,399	0.3
PSF	581,624	1.1	663,653	1.1
PSI	1,966,833	3.7	2,122,599	3.7
RACHA	377,995	0.7	272,429	0.5
RHAC	2,437,097	4.5	2,609,238	4.5
SCA	1,606,574	3.0	1,287,858	2.2
SCC	111,731	0.2	114,937	0.2
SEAD	836,556	1.6	836,253	1.4
SHCH	1,215,299	2.3	951,226	1.6
WOMEN	179,611	0.3	192,798	0.3
WORLD RELIEF CORPORATION	472,000	0.9		0.0
World Vision	1,832,101	3.4	2,230,527	3.8
Other	3,366,641	6.3	3,156,375	5.4
Private sector providers (incl. NGOs) Total	***32,833,057***	***61.1***	***33,857,780***	***58.3***
Public sector providers				
Ambulatory care	444,722	0.8	546,699	0.9
Blood Bank	146,800	0.3	192,000	0.3
CENAT	284,370	0.5	289,607	0.5
Hospitals	9,687,468	18.0	9,419,458	16.2
MoEYS	243,202	0.5	463,499	0.8
MoSVY	130,384	0.2	234,337	0.4
MoWA	99,462	0.2	80,303	0.1
NAA	1,204,167	2.2	1,527,648	2.6
NBTC	138,616	0.3	101,260	0.2
NCHADS	3,611,076	6.7	5,958,670	10.3
NIPH	429,447	0.8	200,000	0.3
NMCHC	383,555	0.7	420,870	0.7
NPH	161,017	0.3	252,126	0.4

OPC	151,404	0.3	208,304	0.4
PR MoH	487,329	0.9	538,933	0.9
Schools	204,143	0.4	515,055	0.9
Other	322,352	0.6	127,358	0.2
Public sector providers Total	***18,129,514***	***33.7***	***21,076,127***	***36.3***
Bi- and Multilateral offices				
UNAIDS	486,447	0.9	423,594	0.7
UNDP	19,560	0.0	200,241	0.3
UNFPA	202,162	0.4	202,162	0.3
UNICEF	516,079	1.0	667,335	1.1
UNODC		0.0	252,040	0.4
USAID	702,764	1.3	672,180	1.2
WFP	428,712	0.8	424,660	0.7
WHO	162,888	0.3	46,764	0.1
Other	100,127	0.2	127,197	0.2
Bi- and Multilateral offices Total	***2,618,739***	***4.9***	***3,016,173***	***5.2***
Rest of the world providers				
TSF	153,888	0.3	109,390	0.2
Rest of the world providers Total	***153,888***	***0.3***	***109,390***	***0.2***
Grand Total	**53,735,198**	**100**	**58,059,469**	**100**

Funding Source vs ASC - Who is financing what?

AIDS Spending Category	Public funding source				Private funding source				International Funding Source																							
									Bilateral				Multilateral												International NGOs and Foundations				International for profit organisations			
													GFATM				UN agencies				Other multilateral											
	2009		2010		2009		2010		2009		2010		2009		2010		2009		2010		2009		2010		2009		2010		2009		2010	
	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%
Prevention	201,675	12	575,121	24	24,939	67	29,026	56	4,998,270	32	4,670,319	30	3,493,397	18	3,414,280	15	795,175	11	1,058,076	13	117,106	19	350,657	34	1,051,554	12	778,282	10	124,786	98	172,308	68
Care and Treatment	-	-	-	-	-	-	-	-	1,597,066	10	1,984,632	13	7,400,318	39	7,356,958	32	197,929	3	200,763	2	167,956	27	219,334	21	5,765,525	63	3,891,715	52	-	-	-	-
OVC	-	-	-	-	-	-	-	-	253,434	2	367,783	2	1,056,774	6	1,207,378	5	2,192,274	29	2,111,536	25	-	-	-	-	683,053	7	731,724	10	-	-	-	-
Programme Management & Administration	678,694	40	1,121,782	46	865	2	392	1	6,990,567	45	6,598,956	42	5,439,678	29	8,292,139	37	1,872,319	25	2,146,953	26	222,295	36	379,079	36	634,949	7	606,745	8	2,500	2	65,205	26
Human Resources	107,820	6	-	-	-	-	10,445	20	339,789	2	339,987	2	391,979	2	474,989	2	68,862	1	89,439	1	-	-	15,160	1	47,126	1	68,439	1	-	-	707	0
Social Protection, Social Services	-	-	-	-	9,685	26	7,827	15	512,423	3	541,593	3	184,282	1	91,459	0	2,082,489	28	2,394,805	29	8,646	1	17,160	2	637,341	7	1,143,027	15	-	-	16,955	7
Enabling Environment	715,214	42	739,929	30	1,466	4	3,850	7	475,673	3	341,097	2	961,664	5	1,827,603	8	187,934	2	161,655	2	96,305	16	61,777	6	270,068	3	274,526	4	-	-	-	-
Research	-	-	-	-	-	-	-	-	397,915	3	818,160	5	95,284	1	46,439	0	150,454	2	219,424	3	-	-	-	-	29,679	0	21,873	0	-	-	-	-
Total	*1,703,403*	*100*	*2,436,832*	*100*	*36,955*	*100*	*51,540*	*100*	*15,565,137*	*100*	*15,662,527*	*100*	*19,023,377*	*100*	*22,711,245*	*100*	*7,547,437*	*100*	*8,382,652*	*100*	*612,307*	*100*	*1,043,168*	*100*	*9,119,295*	*100*	*7,516,331*	*100*	*127,286*	*100*	*255,175*	*100*

Service Providers vs ASC - Who is implementing what?

AIDS Spending Category	Public sector providers				Private sector providers				Bi- and Multilateral offices				Rest of the world providers			
	2009		2010		2009		2010		2009		2010		2009		2010	
	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%	US$	%
Prevention	2,143,177	13	2,437,998	12	8,654,604	36	8,544,312	34	9,122	0	65,759	2	-	-	-	-
Care and Treatment	9,643,824	60	8,624,180	41	5,484,272	23	5,029,222	20	698	0	-	-	-	-	-	-
Orphans and Vulnerable Children	-	-	-	-	3,971,179	16	4,218,830	17	214,356	8	199,590	7	-	-	-	-
Programme Management and Administration	4,858,371	30	8,094,405	38	8,699,489	36	8,787,660	35	2,138,900	82	2,226,188	75	145,108	-	102,999	-
Human Resources (Training)	429,298	-	472,106	-	514,206	2	469,065	2	12,072	-	53,633	-	-	-	4,362	-
Social Protection, Social Services	33,437	0	1,080	0	3,187,073	13	3,986,676	16	214,356	-	225,070	8	-	-	-	-
Enabling Environment	977,168	6	1,399,918	7	1,693,140	7	1,963,636	8	29,235	1	44,853	-	8,780	-	2,030	-
Research	44,239	0	46,439	0	629,094	3	858,377	3	-	-	201,079	7	-	-		-
Grand Total	***15,986,337***	***100***	***21,076,127***	***100***	***24,178,453***	***100***	***25,313,468***	***100***	***2,618,739***	***100***	***2,950,413***	***100***	***153,888***	***100***	***109,390***	***100***

Financing Flow from source to agent – 2009

FA Code	FA Name	Public	Private (national for and non-profit)	Bilateral	GFATM	United Nations	Multilateral (excl.GF &UN)	INGOs	International for-profit	Grand Total (USD)	Grand Total (%)
Financing Agents		Financing Sources									
				International							
					Multilateral						
Government entities											
FA.01.01.01.01 Ministry of Health (or equivalent sector entity)	CENAT			29,036						29,036	0.05
	MoH	552,479		385,502	2,480,784	60,872				3,479,638	6.48
	NCHADS			736,194	714,089	1,350		2,841,577		4,293,209	7.99
	NIPH			299,000						299,000	0.56
	NMCHC			59,697	149,436					209,133	0.39
	PR MoH				9,132,980					13,803,770	25.69
	PR NCHADS				2,893,437					2,893,437	5.38
FA.01.01.01.02 Ministry of Education (or equivalent sector entity)	MoEYS	118,000		1,487		225,891				345,378	0.64
FA.01.01.01.08 Other ministries (or equivalent sector entities)	MoWA	18,840								18,840	0.04
FA.01.01.01.10 National AIDS Commission	NAA	993,764				145,758		14,794		1,154,316	2.15
FA.01.01.02.01 Ministry of Health (or equivalent state sector entity)	DoH			173,181		318,322				491,503	0.91
FA.01.01.02.02 Ministry of Education (or equivalent state sector entity)	DoEYS	20,320								20,320	0.04
Total Government entities		*1,703,403*	*0*	*1,684,097*	*15,370,725*	*752,193*	*0*	*2,856,371*	*0*	*27,037,580*	*50.32*
National NGOs											
FA.02.05 Not-for-profit institutions (other than social insurance)	AOC							46,067		46,067	0.09
	CACHA					7,494		5,963		13,457	0.03
	CBCA		16,906							16,906	0.03
	CHEC							117,349		117,349	0.22
	CPN+					2,230				2,230	0.00
	DYMB							87,032		87,032	0.16
	HACC							28,995		28,995	0.05
	KHANA			1,616,043	1,530,704	2,998	330,305			3,480,050	6.48
	Korsang			95,124						95,124	0.18
	Medicam				107,598					107,598	0.20

	MS							65,494		65,494	0.12
	NYEMO		4,485					22,425		26,910	0.05
	PC					12,605		6,028		18,633	0.03
	RACHA			377,995						377,995	0.70
	RHAC			1,392,765	471,160		50,180	27,225		1,941,329	3.61
	SCC					1,350				1,350	0.00
	TASK							73,341		73,341	0.14
Total National NGOs		*0*	***21,391***	***3,481,926***	***2,109,461***	***26,676***	***380,485***	***479,919***	*0*	***6,499,858***	***12.10***
Bilateral											
FA.03.01.01 Government of Australia	AusAID			154,749						154,749	0.00
FA.03.01.07 Government of France	ANRS			618,632						618,632	0.01
FA.03.01.22 Government of United States	USAID			1,174,764						1,174,764	0.02
Total Bilateral		*0*	*0*	***1,948,145***	*0*	*0*	*0*	*0*	*0*	***1,948,145***	***3.63***
United Nations											
FA.03.02.04 International Labour Organization (ILO)	ILO			7,558		31,520				39,078	0.07
FA.03.02.05 International Organization for Migration (IOM)	IOM						22,107			22,107	0.04
FA.03.02.07 UNAIDS Secretariat	UNAIDS					620,639				620,639	1.15
FA.03.02.08 United Nations Children's Fund (UNICEF)	UNICEF			109,179		1,203,641				1,312,820	2.44
FA.03.02.09 United Nations Development Fund for Women (UNIFEM)	UNIFEM					5,000	19,456			24,456	0.05
FA.03.02.10 United Nations Development Programme (UNDP)	UNDP			29,275		76,596				105,870	0.20
FA.03.02.11 United Nations Educational, Scientific and Cultural Organization (UNESCO)	UNESCO					117,796				117,796	0.22
FA.03.02.15 United Nations Office on Drugs and Crime (UNODC)	UNODC			56,700						56,700	0.11
FA.03.02.16 United Nations Population Fund (UNFPA)	UNFPA					622,300				622,300	1.16
FA.03.02.18 World Food Programme (WFP)	WFP					3,987,020				3,987,020	7.42
FA.03.02.19 World Health Organization (WHO)	WHO			289,103		80,059				369,162	0.69
Total United Nations		*0*	*0*	***491,815***	*0*	***6,744,571***	***41,563***	*0*	*0*	***7,277,948***	***13.54***
International NGOs											
FA.03.03.02 ActionAID	ActionAid							150,505		150,505	0.28

FA.03.03.08 Care International	Care International				6,150			2,605		8,755	0.02
FA.03.03.09 Caritas Internationalis/Catholic Relief Services	Caritas							121,549		121,549	0.23
	CRS				178,791			31,963		210,754	0.39
FA.03.03.14 Family Health International	FHI			5,294,709	526,437		170,833			5,991,979	11.15
FA.03.03.18 International Federation of Red Cross and Red Crescent Societies, International Committee of Red Cross and National Red Cross Societies	Australian Red Cross			156,402						156,402	0.29
	FRC				135,994					135,994	0.25
FA.03.03.20 Médecins sans Frontières	MSF							1,796,235		1,796,235	3.34
FA.03.03.23 PSI (Population Services International)	PSI			2,117,664	31,636				127,286	2,276,587	4.24
FA.03.03.33 World Vision	World Vision				126,256			1,041,829		1,168,085	2.17
FA.03.03.99 Other International not-for-profit organizations and foundations n.e.c.	The Asia Foundation							3,816		3,816	0.01
	AHF							149,934		149,934	0.28
	AJWS							8,051		8,051	0.01
	DCA			108,186				381,205		489,391	0.91
	DSF				212,179					212,179	0.39
	ESTHER							395,908		395,908	0.74
	Fondation Marc-French							2,847		2,847	0.01
FA.03.03.99 Other International not-for-profit organizations n.e.c.	Friends Int			4,112	137,619		19,427	78,899		240,058	0.45
	HI			10,909				14,879		25,788	0.05
	Holt International							1,000		1,000	0.00
	IRD			6,450						6,450	0.01
	Maryknoll							1,139,282		1,139,282	2.12
	PACT		15,564	150,920		23,996				190,480	0.35
	PSF				166,324			243,382		409,706	0.76
	SCA				21,805			217,373		239,178	0.45
	Solidarit Sida Association							1,743		1,743	0.00
	URC			109,802						109,802	0.20
Total International NGOs		*0*	*15,564*	*7,959,154*	*1,543,191*	*23,996*	*190,260*	*5,783,006*	*127,286*	*15,642,457*	*29.11*
Grand Total		**1,703,403**	**36,955**	**15,565,137**	**19,023,377**	**7,547,437**	**612,307**	**9,119,295**	**127,286**	**53,735,198**	**100**

Financing Flow from source to agent – 2010

Financing Agents		Financing Sources									
				International							
					Multilateral						
FA Code	FA Name	Public	Private (national for and non-profit)	Bilateral	GFATM	United Nations	Multilateral (excl.GF& UN)	INGOs	International for-profit	Grand Total (USD)	Grand Total (%)
Government entities											
FA.01.01.01.01 Ministry of Health (or equivalent sector entity)	CENAT			21,305						21,305	0.04
	MoH	849,860		784,552	1,683,542	152,383				3,470,336	5.98
	NCHADS			793,426	4,542,403			1,602,623		6,938,452	11.95
	NIPH			200,000						200,000	0.34
	NMCHC			44,521	197,984					242,504	0.42
	PR MoH				4,929,533					4,929,533	8.49
	PR NCHADS				7,229,124					5,974,059	10.29
FA.01.01.01.02 Ministry of Education (or equivalent sector entity)	MoEYS	510,712				470,196				980,908	1.69
FA.01.01.01.08 Other ministries (or equivalent sector entities)	MoWA	18,720								18,720	0.03
FA.01.01.01.10 National AIDS Commission	NAA	1,057,541				92,321				1,149,861	1.98
FA.01.01.02.01 Ministry of Health (or equivalent state sector entity)	DoH			133		559,401				559,534	0.96
Total Government entities		*2,436,832*	*0*	*1,843,936*	*18,582,586*	*1,274,301*	*0*	*1,602,623*	*0*	*24,485,213*	*42.17*
National NGOs											
FA.02.05 Not-for-profit institutions (other than social insurance)	AOC							58,718		58,718	0.10
	AUA							8,057		8,057	0.01
	CBCA		16,415			5,000				21,415	0.04
	CCW					2,030				2,030	0.00
	CHEC							113,158		113,158	0.19
	CPN+					12,564		2,447		15,011	0.03
	CRC							17,270		17,270	0.03
	DYMB							97,445		97,445	0.17
	HACC							39,832		39,832	0.07
	KHANA			1,810,705	1,781,445		514,801			4,106,951	7.07
	Korsang			195,677		77,248				272,925	0.47
	Medicam				143,017					143,017	0.25
	MS								83,367	83,367	0.14
	NYEMO		6,129					30,644		36,772	0.06
	PC					7,924				7,924	0.01

	RACHA			272,429						272,429	0.47
	RHAC			1,455,121	451,817		72,083	53,281		2,032,303	3.50
	TASK							78,716		78,716	0.14
Total National NGOs		*0*	*22,544*	*3,733,932*	*2,376,279*	*104,766*	*586,884*	*499,567*	*83,367*	*7,407,339*	*12.76*
Bilateral											
FA.03.01.01 Government of Australia	AusAID			198,546						198,546	0.34
FA.03.01.07 Government of France	ANRS			251,174						251,174	0.43
FA.03.01.22 Government of United States	USAID			672,180						672,180	1.16
Total Bilateral		*0*	*0*	*1,121,900*	*0*	*0*	*0*	*0*	*0*	*1,121,900*	
United Nations											
FA.03.02.04 International Labour Organization (ILO)	ILO			7,558		32,535				40,093	0.07
FA.03.02.05 International Organization for Migration (IOM)	IOM						22,107			22,107	0.04
FA.03.02.07 UNAIDS Secretariat	UNAIDS					519,395				519,395	0.89
FA.03.02.08 United Nations Children's Fund (UNICEF)	UNICEF			52,467		1,307,451				1,359,918	2.34
FA.03.02.09 United Nations Development Fund for Women (UNIFEM)	UNIFEM						34,002			34,002	0.06
FA.03.02.10 United Nations Development Programme (UNDP)	UNDP			9,074		268,252				277,326	0.48
FA.03.02.11 United Nations Educational, Scientific and Cultural Organization (UNESCO)	UNESCO					61,929				61,929	0.11
FA.03.02.15 United Nations Office on Drugs and Crime (UNODC)	UNODC			55,100		196,940				252,040	0.43
FA.03.02.16 United Nations Population Fund (UNFPA)	UNFPA					462,695				462,695	0.80
FA.03.02.18 World Food Programme (WFP)	WFP					3,949,337				3,949,337	6.80
FA.03.02.19 World Health Organization (WHO)	WHO			249,884		55,981				305,866	0.53
FA.03.02.99 Other Multilateral entities n.e.c.	UNRC					3,870				3,870	0.01
Total United Nations		*0*	*0*	*374,083*	*0*	*6,858,385*	*56,109*	*0*	*0*	*7,288,577*	*12.55*
International NGOs											
FA.03.03.02 ActionAID	ActionAid							143,115		143,115	0.25
FA.03.03.06 Bill and Melinda Gates Foundation	BILL & MELINDA GATES			8,060						8,060	0.01
FA.03.03.08 Care International	Care International				4,000					4,000	0.01
FA.03.03.09 Caritas Internationalis/Catholic	Caritas					145,200		321,753		466,953	0.80
Relief Services	CRS				190,563			59,123		249,686	0.43
FA.03.03.14 Family Health International	FHI			5,702,652	693,575		400,175			6,796,402	11.71

FA.03.03.18 International Federation of Red Cross and Red Crescent Societies,	Australian Red Cross			202,530						202,530	0.35
International Committee of Red Cross and National Red Cross Societies	FRC			30,858				30,858		61,717	0.11
FA.03.03.20 Médecins sans Frontières	MSF							839,865		839,865	1.45
FA.03.03.23 PSI (Population Services International)	PSI			2,110,975	44,800				171,808	2,327,583	4.01
FA.03.03.33 World Vision	World Vision				211,323			1,419,809		1,631,132	2.81
	AHF							397,003		397,003	0.68
	DCA			82,296				367,580		449,876	0.77
	DSF				145,411					145,411	0.25
	ESTHER							345,199		345,199	0.59
	Fondation Marc-French							3,864		3,864	0.01
	Friends Int			76,092	189,502			138,862		404,456	0.70
	HI			24,715				40,685		65,400	0.11
FA.03.03.99 Other International not-for-profit organizations n.e.c.	Holt International							5,840		5,840	0.01
	IRD			6,451						6,451	0.01
	Maryknoll							1,139,282		1,139,282	1.96
	PACT		28,996	4,016						33,012	0.06
	PSF				165,828					165,828	0.29
	SCA				107,380			155,488		262,869	0.45
	Solidarit Sida Association							5,814		5,814	0.01
	URC			340,031						340,031	0.59
Total International NGOs		*0*	*28,996*	*8,588,675*	*1,752,381*	*145,200*	*400,175*	*5,414,141*	*171,808*	*16,501,376*	*28.42*
Grand Total		**2,436,832**	**51,540**	**15,662,527**	**22,711,245**	**8,382,652**	**1,043,168**	**7,516,331**	**255,174**	**58,059,469**	**100**

Annex 3: AIDS SPENDING MATRIX FOR 2009-2010

AIDS Funding Matrix 2009	Grand Total (USD)	%	National Sources		International					
			Public sources (Central Government revenue)	Private (national for-profit & non-profit)	Bilaterals	Multilaterals			International NGOs and foundations	International for-profit organizations
						GFATM	UN agencies	Other multilaterals		
ASC.01 Prevention	**10,806,903**	**20.1**	**201,675**	**24,939**	**4,998,270**	**3,493,397**	**795,175**	**117,106**	**1,051,554**	**124,786**
ASC.01.01.01 Health-related communication for social and behavioural change	222,203	0.4	-	-	-	204,328	16,807	-	1,068	-
ASC.01.01.02 Non-health-related communication for social and behavioural change	62,267	0.1	-	-	24,623	-	18,523	-	19,121	-
ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	1,293,204	2.4	-	-	289,850	868,376	36,180	-	98,799	-
ASC.01.02 Community mobilization	947,338	1.8	-	8,033	318,625	378,168	81,347	-	161,166	-
ASC.01.03. Voluntary confidential counselling & testing (VCCT)	291,935	0.5	-	-	178,113	1,051	112,771	-	-	-
ASC.01.04.01 VCCT as part of programmes for vulnerable and accessible populations	2,764	0.0	-	-	2,764	-	-	-	-	-
ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	10,328	0.0	-	-	-	9,983	-	-	345	-
ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible populations	76,324	0.1	-	-	9,605	63,872	-	-	2,847	-
ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	448,917	0.8	-	-	448,917	-	-	-	-	-
ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type	86,763	0.2	-	-	77,300	9,463	-	-	-	-
ASC.01.05 Prevention – youth in school	343,644	0.6	30,000	-	1,487	-	312,157	-	-	-
ASC.01.06 Prevention – youth out-of-school	70,543	0.1	-	-	-	-	11,088	-	59,456	-
ASC.01.07.01 BCC as part of prevention of HIV transmission aimed at PLHIV	3,550	0.0	-	-	-	1,150	2,400	-	-	-
ASC.01.07.98 Prevention of HIV transmission aimed at PLHIV not disaggregated by type	32,002	0.1	-	-	-	-	-	-	32,002	-
ASC.01.08.01 VCCT as part of programmes for sex workers and their clients	23,896	0.0	-	-	12,917	10,978	-	-	-	-
ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients	167,078	0.3	-	-	138,600	28,478	-	-	-	-
ASC.01.08.03 STI prevention and treatment as part of programmes for sex workers and their clients	123,395	0.2	-	-	25,722	97,673	-	-	-	-
ASC.01.08.04 BCC as part of programmes for sex workers and their clients	211,916	0.4	-	-	66,930	144,986	-	-	-	-

ASC.01.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type	563,752	1.0	-	-	438,966	-	-	-	-	124,786
ASC.01.09.02 Condom social marketing and male and female condom provision as part of programmes for MSM	221,760	0.4	-	-	221,760	-	-	-	-	-
ASC.01.09.04 BCC as part of programmes for MSM	87,728	0.2	-	-	87,728	-	-	-	-	-
ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type	444,813	0.8	-	-	230,116	214,697	-	-	-	-
ASC.01.10.01 VCCT as part of programmes for IDUs	300	0.0	-	-	300	-	-	-	-	-
ASC.01.10.02 Condom social marketing and male and female condom provision as part of programmes for IDUs	494	0.0	-	-	-	494	-	-	-	-
ASC.01.10.03 STI prevention and treatment as part of programmes for IDUs	364	0.0	-	-	-	364	-	-	-	-
ASC.01.10.04 BCC as part of programmes for IDUs	88,385	0.2	-	-	30,732	54,892	2,761	-	-	-
ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for IDUs	2,912	0.0	-	-	2,912	-	-	-	-	-
ASC.01.10.06 Drug substitution treatment as part of programmes for IDUs	200,617	0.4	-	-	200,617	-	-	-	-	-
ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type	543,584	1.0	-	-	296,346	45,978	10,561	-	190,699	-
ASC.01.11.04 BCC as part of programmes in the workplace	73,410	0.1	-	-	6,378	-	13,547	50,180	3,305	-
ASC.01.11.98 Programmatic interventions in the workplace not disaggregated by type	43,792	0.1	-	16,906	20,736	6,150	-	-	-	-
ASC.01.12 Condom social marketing	737,168	1.4	-	-	737,168	-	-	-	-	-
ASC.01.13 Public and commercial sector male condom provision	894,820	1.7	24,875	-	779,296	84,177	-	-	6,472	-
ASC.01.16 Prevention, diagnosis and treatment of STIs	486,802	0.9	-	-	-	486,802	-	-	-	-
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	1,359	0.0	-	-	-	1,359	-	-	-	-
ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	2,637	0.0	-	-	-	2,637	-	-	-	-
ASC.01.17.03 Safe infant feeding practices (including substitution of breastmilk)	3,855	0.0	-	-	-	-	-	-	3,855	-
ASC.01.17.04 Delivery practices as part of PMTCT programmes	259	0.0	-	-	-	259	-	-	-	-
ASC.01.17.98 PMTCT not disaggregated by intervention	483,247	0.9	-	-	94,126	158,911	128,893	-	101,317	-
ASC.01.19 Blood safety	285,416	0.5	146,800	-	-	138,616	-	-	-	-

ASC.01.20 Safe medical injections	12,479	0.0	-	-	-	-	12,479	-	-	-
ASC.01.21 Universal precautions	2,396	0.0	-	-	-	-	2,396	-	-	-
ASC.01.98 Prevention activities not disaggregated by intervention	1,206,488	2.2	-	-	255,636	479,557	33,267	66,926	371,102	-
ASC.02 Care and Treatment	**15,128,794**	**28.2**	**-**	**-**	**1,597,066**	**7,400,318**	**197,929**	**167,956**	**5,765,525**	**-**
ASC.02.01.01 Provider- initiated testing and counselling (PITC)	129,673	0.2	-	-	-	30,792	98,881	-	-	-
ASC.02.01.02.02 OI outpatient treatment	335,569	0.6	-	-	-	11,769	-	-	323,800	-
ASC.02.01.02.98 OI outpatient prophylaxis and treatment not disaggregated by type	832,812	1.5	-	-	2,573	280,726	-	-	549,513	-
ASC.02.01.03.01.02 Second-line ART – adults	1,649,232	3.1	-	-	-	-	-	-	1,649,232	-
ASC.02.01.03.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	1,846	0.0	-	-	-	1,846	-	-	-	-
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	981,409	1.8	-	-	-	975	99,049	-	881,386	-
ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	4,820,145	9.0	-	-	753	4,391,838	-	-	427,554	-
ASC.02.01.04 Nutritional support associated to ARV therapy	40,207	0.1	-	-	-	40,207	-	-	-	-
ASC.02.01.05 Specific HIV-related laboratory monitoring	372,135	0.7	-	-	-	248,404	-	-	123,731	-
ASC.02.01.07 Psychological treatment and support services	41,580	0.1	-	-	2,886	36,770	-	-	1,924	-
ASC.02.01.08 Outpatient palliative care	11,391	0.0	-	-	-	11,391	-	-	-	-
ASC.02.01.09.01 Home-based medical care	34,922	0.1	-	-	-	34,922	-	-	-	-
ASC.02.01.09.98 Home-based care not disaggregated by type	1,486,556	2.8	-	-	93,351	760,811	-	18,823	613,571	-
ASC.02.01.98 Outpatient care services not disaggregated by intervention	564,670	1.1	-	-	335,007	77,805	-	-	151,858	-
ASC.02.02.01 Inpatient treatment of opportunistic infections (OI)	504,354	0.9	-	-	2,382	304,017	-	-	197,954	-
ASC.02.02.02 Inpatient palliative care	441,381	0.8	-	-	-	345,813	-	-	95,568	-
ASC.02.02.98 Inpatient care services not disaggregated by intervention	717,187	1.3	-	-	68,161	21,464	-	-	627,561	-
ASC.02.03 Patient transport and emergency rescue	19,311	0.0	-	-	-	12,830	-	-	6,482	-

ASC.02.98 Care and treatment services not disaggregated by intervention	2,134,576	4.0	-	-	1,091,953	786,150	-	149,133	107,341	-
ASC.02.99 Care and treatment services n.e.c.	9,839	0.0	-	-	-	1,788	-	-	8,051	-
ASC.03 Orphans and Vulnerable Children (OVC)	**4,185,535**	**7.8**	**-**	**-**	**253,434**	**1,056,774**	**2,192,274**	**-**	**683,053**	**-**
ASC.03.01 OVC Education	131,416	0.2	-	-	-	73,082	-	-	58,334	-
ASC.03.02 OVC Basic health care	46,028	0.1	-	-	6,450	39,578	-	-	-	-
ASC.03.03 OVC Family/home support	2,559,988	4.8	-	-	110,257	181,218	2,192,274	-	76,239	-
ASC.03.04 OVC Community support	127,091	0.2	-	-	-	75,173	-	-	51,918	-
ASC.03.05 OVC Social Services and Administrative costs	26,181	0.0	-	-	-	26,181	-	-	-	-
ASC.03.98 OVC Services not disaggregated by intervention	1,294,832	2.4	-	-	136,727	661,542		-	496,563	-
ASC.04 Programme Management and Administration	**15,841,868**	**29.5**	**678,694**	**865**	**6,990,567**	**5,439,678**	**1,872,319**	**222,295**	**634,949**	**2,500**
ASC.04.01 Planning, coordination and programme management	12,558,297	23.4	678,694	615	5,789,345	3,667,358	1,623,177	212,410	586,697	
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	534,332	1.0	-	-	18,389	406,967	63,978	3,016	41,982	
ASC.04.03 Monitoring and evaluation	583,039	1.1	-	250	96,928	396,026	74,196	6,869	6,270	2,500
ASC.04.04 Operations research	1,300	0.0	-	-	1,300	-	-	-	-	
ASC.04.07 Drug supply systems	238,562	0.4	-	-	-	238,562	-	-	-	
ASC.04.08 Information technology	260,526	0.5	-	-	30,000	230,526	-	-	-	
ASC.04.09 Patient tracking	32,039	0.1	-	-	4,140	27,899	-	-	-	
ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	394,957	0.7	-	-	337,215	57,086	656	-	-	
ASC.04.10.02 Construction of new health centres	318,504	0.6	-	-	47,590	172,524	98,390	-	-	
ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.	8,278	0.0	-	-	-	-	8,278	-	-	
ASC.04.98 Programme management and administration not disaggregated by type	910,410	1.7	-	-	665,661	242,729	2,020	-	-	
ASC.04.99 Programme management and administration n.e.c	1,624	0.0	-	-	-	-	1,624	-	-	
ASC.05 Human Resources	**955,575**	**1.8**	**107,820**	**-**	**339,789**	**391,979**	**68,862**	**-**	**47,126**	**0**

ASC.05.03 Training	955,575	1.8	107,820	-	339,789	391,979	68,862	-	47,126	
ASC.06 Social Protection and Social Services	**3,434,866**	**6.4**	**-**	**9,685**	**512,423**	**184,282**	**2,082,489**	**8,646**	**637,341**	**0**
ASC.06.01 Social protection through monetary benefits	261,312	0.5	-	-	185,498	25,062	50,752	-	-	
ASC.06.02 Social protection through in-kind benefits	2,199,003	4.1	-	-	-	17,831	1,998,578	-	182,594	
ASC.06.03 Social protection through provision of social services	815,891	1.5	-	5,200	320,648	141,161	8,160	8,128	332,595	
ASC.06.04 HIV-specific income generation projects	143,410	0.3	-	-	6,277	228	25,000	518	111,388	
ASC.06.98 Social protection services and social services not disaggregated by type	15,249	0.0	-	4,485	-	-	-	-	10,764	
ASC.07 Enabling Environment	**2,708,324**	**5.0**	**715,214**	**1,466**	**475,673**	**961,664**	**187,934**	**96,305**	**270,068**	**0**
ASC.07.01 Advocacy	1,186,992	2.2	715,214	960	202,875	112,189	90,886	40,175	24,693	
ASC.07.02.01 Human rights programmes empowering individuals to claim their rights	29,571	0.1	-	-	17,403	-	-	-	12,168	
ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment	22,297	0.0	-	-	12,912	2,884	4,483	-	2,019	
ASC.07.02.98 Human rights programmes not disaggregated by type	28,419	0.1	-	-	3,116	17,706	4,649	-	2,949	
ASC.07.03 AIDS-specific institutional development	744,605	1.4	-	506	41,577	473,521	26,426	16,396	186,179	
ASC.07.04 AIDS-specific programmes focused on women	85,329	0.2	-	-	-	-	60,566	-	24,763	
ASC.07.05 Programmes to reduce Gender Based Violence	126	0.0	-	-	57	-	-	-	69	
ASC.07.98 Enabling environment not disaggregated by type	610,984	1.1	-	-	197,733	355,364	926	39,733	17,228	
ASC.08 HIV-related Research	**673,333**	**1.3**	**-**	**-**	**397,915**	**95,284**	**150,454**	**-**	**29,679**	**0**
ASC.08.01 Biomedical research	44,239	0.1	-	-	-	44,239	-	-	-	
ASC.08.02 Clinical research	347,079	0.6	-	-	347,079	-	-	-	-	
ASC.08.04.01 Behavioural research	14,556	0.0	-	-	14,556	-	-	-	-	
ASC.08.04.98 Social science research not disaggregated by type	180,269	0.3	-	-	36,280	-	142,960	-	1,028	
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	87,190	0.2		-	-	51,045	7,494	-	28,651	
Total Expenditure on HIV and AIDS in 2009	**53,735,198**	**100**	**1,703,403**	**36,955**	**15,565,137**	**19,023,377**	**7,547,437**	**612,307**	**9,119,295**	**127,286**

AIDS Funding Matrix 2010	Grand Total (USD)	%	National Sources		International					
						Multilaterals				
			Public Sources (Central Government Revenue)	Private (National for-profit & non-profit)	Bilaterals	GFATM	UN agencies	Other multilaterals	International NGOs and foundations	International for-profit organizations
ASC.01 Prevention	**11,048,070**	**0**	**575,121**	**29,026**	**4,670,319**	**3,414,280**	**1,058,076**	**350,657**	**778,282**	**172,308**
ASC.01.01.01 Health-related communication for social and behavioural change	198,025	0.3	-	-	11,447	186,578	-	-	-	-
ASC.01.01.02 Non-health-related communication for social and behavioural change	46,220	0.1	-	-	-	-	37,240	-	8,979	-
ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	911,589	1.6	-	-	298,059	496,217	68,083	-	49,231	-
ASC.01.02 Community mobilization	369,359	0.6	-	12,611	14,876	75,457	124,083	-	142,332	-
ASC.01.03 Voluntary counselling and testing (VCCT)	272,661	0.5	-	-	75,536	743	196,382	-	-	-
ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	10,386	0.0	-	-	-	10,386	-	-	-	-
ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible populations	70,364	0.1	-	-	-	70,364	-	-	-	-
ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	597,232	1.0	-	-	353,444	243,088	-	-	700	-
ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type	220,124	0.4	-	-	19,276	8,806	-	192,042	-	-
ASC.01.05 Prevention – youth in school	426,457	0.7	273,340	-	-	-	153,117	-	-	-
ASC.01.06 Prevention – youth out-of-school	168,659	0.3	85,500	-	-	-	78,814	-	4,346	-
ASC.01.07.02 Condom social marketing and male and female condom provision as part of prevention of HIV transmission aimed at PLHIV	409	0.0	-	-	-	409	-	-	-	-
ASC.01.07.98 Prevention of HIV transmission aimed at PLHIV not disaggregated by type	38,929	0.1	-	-	3,696	-	-	-	35,233	-
ASC.01.08.01 VCCT as part of programmes for sex workers and their clients	170,239	0.3	-	-	17,277	152,962	-	-	-	-
ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients	171,287	0.3	-	-	138,600	32,687	-	-	-	-
ASC.01.08.03 STI Prevention and treatment as part of programmes for sex workers and their clients	391,292	0.7	-	-	35,988	355,305	-	-	-	-
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients	265,163	0.5	-	-	101,234	163,929	-	-	-	-

ASC.01.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type	667,144	1.1	-	-	495,335	-	-	-	-	171,808
ASC.01.09.02 Condom social marketing and male and female condom provision as part of programmes for MSM	221,760	0.4	-	-	221,760	-	-	-	-	-
ASC.01.09.04 Behaviour change communication (BCC) as part of programmes for MSM	248,648	0.4	-	-	164,344	76,441	-	-	7,863	-
ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type	441,293	0.8	-	-	276,462	148,475	-	-	16,356	-
ASC.01.10.01 VCCT as part of programmes for IDUs	55,100	0.1	-	-	55,100	-	-	-	-	-
ASC.01.10.02 Condom social marketing and male and female condom provision as part of programmes for IDUs	449	0.0	-	-	-	449	-	-	-	-
ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs	100,029	0.2	-	-	20,923	72,723	6,383	-	-	-
ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for IDUs	56,100	0.1	-	-	-	40,000	16,100	-	-	-
ASC.01.10.06 Drug substitution treatment as part of programmes for IDUs	432,394	0.7	-	-	432,394	-	-	-	-	-
ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type	377,720	0.7	-	-	313,788	37,433	24,400	-	2,099	-
ASC.01.11.04 Behaviour change communication (BCC) as part of programmes in the workplace	90,175	0.2	-	-	8,147	-	9,945	72,083	-	-
ASC.01.11.98 Programmatic interventions in the workplace not disaggregated by type	82,853	0.1	-	16,415	-	4,000	62,438	-	-	-
ASC.01.12 Condom social marketing	677,679	1.2	-	-	677,679	-	-	-	-	-
ASC.01.13 Public and commercial sector male condom provision	884,763	1.5	24,281	-	813,938	37,009	-	-	9,035	500
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	288,612	0.5	-	-	-	256,612	32,000	-	-	-
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	17,010	0.0	-	-	-	17,010	-	-	-	-
ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	801	0.0	-	-	-	801	-	-	-	-
ASC.01.17.03 Safe infant feeding practices (including substitution of breastmilk)	4,133	0.0	-	-	-	-	-	-	4,133	-
ASC.01.17.98 PMTCT not disaggregated by intervention	586,671	1.0	-	-	17,320	202,323	247,923	-	119,104	-
ASC.01.19 Blood safety	293,260	0.5	192,000	-	-	101,260	-	-	-	-
ASC.01.98 Prevention activities not disaggregated by intervention	1,193,081	2.1	-	-	103,698	622,813	1,169	86,532	378,869	-

ASC.02 Care and Treatment	**13,653,403**	**23.5**	**-**	**-**	**1,984,632**	**7,356,958**	**200,763**	**219,334**	**3,891,715**	**-**
ASC.02.01.01 Provider- initiated testing and counselling (PITC)	66,748	0.1	-	-	-	30,748	36,000	-	-	-
ASC.02.01.02.02 OI outpatient treatment	337,436	0.6	-	-	-	236,915	-	-	100,521	-
ASC.02.01.02.98 OI outpatient prophylaxis and treatment not disaggregated by type	217,859	0.4	-	-	-	3,423	-	-	214,436	-
ASC.02.01.03.01.02 Second-line ART – adults	907,788	1.6	-	-	-	-	-	-	907,788	-
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	595,726	1.0	-	-	-	4,638	164,763	-	426,325	-
ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	4,537,477	7.8	-	-	-	4,122,343	-	-	415,135	-
ASC.02.01.04 Nutritional support associated to ARV therapy	60,464	0.1	-	-	-	60,464	-	-	-	-
ASC.02.01.05 Specific HIV-related laboratory monitoring	191,844	0.3	-	-	-	89,545	-	-	102,299	-
ASC.02.01.07 Psychological treatment and support services	36,566	0.1	-	-	4,080	28,406	-	-	4,080	-
ASC.02.01.08 Outpatient palliative care	5,816	0.0	-	-	-	5,816	-	-	-	-
ASC.02.01.09.98 Home-based care not disaggregated by type	1,096,659	1.9	-	-	66,832	335,927	-	30,049	663,851	-
ASC.02.01.98 Outpatient care services not disaggregated by intervention	2,031,359	3.5	-	-	369,038	1,255,065	-	-	407,255	-
ASC.02.02.01 Inpatient treatment of opportunistic infections (OI)	300,547	0.5	-	-	-	127,947	-	-	172,600	-
ASC.02.02.02 Inpatient palliative care	364,261	0.6	-	-	-	268,693	-	-	95,568	-
ASC.02.02.98 Inpatient care services not disaggregated by intervention	409,083	0.7	-	-	172,910	115,265	-	-	120,908	-
ASC.02.03 Patient transport and emergency rescue	22,815	0.0	-	-	6,690	7,227	-	-	8,898	-
ASC.02.98 Care and treatment services not disaggregated by intervention	2,462,898	4.2	-	-	1,365,082	664,536	-	189,286	243,994	-
ASC.02.99 Care and treatment services n.e.c.	8,057	0.0	-	-	-	-	-	-	8,057	-
ASC.03 Orphans and Vulnerable Children (OVC)	**4,418,420**	**7.6**	**-**	**-**	**367,783**	**1,207,378**	**2,111,536**	**-**	**731,724**	**-**
ASC.03.01 OVC Education	98,348	0.2	-	-	2,000	35,466	-	-	60,881	-
ASC.03.02 OVC Basic health care	21,096	0.0	-	-	6,451	14,645	-	-	-	-

ASC.03.03 OVC Family/home support	2,594,412	4.5	-	-	270,480	139,733	2,111,536	-	72,663	-
ASC.03.04 OVC Community support	241,553	0.4	-	-	3,771	186,344	-	-	51,438	-
ASC.03.05 OVC Social Services and Administrative costs	45,017	0.1	-	-	2,023	42,559	-	-	435	-
ASC.03.98 OVC Services not disaggregated by intervention	1,417,995	2.4	-	-	83,058	788,630	-	-	546,307	-
ASC.04 Programme Management and Administration	**19,211,252**	**33.1**	**1,121,782**	**392**	**6,598,956**	**8,292,139**	**2,146,953**	**379,079**	**606,745**	**65,205**
ASC.04.01 Planning, coordination and programme management	15,087,935	26.0	828,488	-	5,400,536	6,148,655	1,764,137	369,667	511,246	65,205
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	660,125	1.1	269,094	-	23,676	279,272	18,341	-	69,741	-
ASC.04.03 Monitoring and evaluation	676,493	1.2	24,200	-	115,557	334,848	182,238	9,413	10,238	-
ASC.04.04 Operations research	20,116	0.0	-	392	800	5,070	13,854	-	-	-
ASC.04.07 Drug supply systems	267,612	0.5	-	-	-	266,224	1,387	-	-	-
ASC.04.08 Information technology	929,669	1.6	-	-	60,000	869,669	-	-	-	-
ASC.04.09 Patient tracking	41,701	0.1	-	-	6,742	34,959	-	-	-	-
ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	325,563	0.6	-	-	200,000	93,191	32,372	-	-	-
ASC.04.10.02 Construction of new health centres	219,573	0.4	-	-	15,872	93,957	94,224	-	15,520	-
ASC.04.98 Programme management and administration not disaggregated by type	982,466	1.7	-	-	775,773	166,292	40,400	-	-	-
ASC.05 Human Resources	**999,166**	**1.7**	**-**	**10,445**	**339,987**	**474,989**	**89,439**	**15,160**	**68,439**	**707**
ASC.05.03 Training	999,166	1.7	-	10,445	339,987	474,989	89,439	15,160	68,439	707
ASC.06 Social Protection and Social Services	**4,212,826**	**7.3**	**-**	**7,827**	**541,593**	**91,459**	**2,394,805**	**17,160**	**1,143,027**	**16,955**
ASC.06.01 Social protection through monetary benefits	483,301	0.8	-	-	352,158	-	131,143	-	-	-
ASC.06.02 Social protection through in-kind benefits	2,405,102	4.1	-	-	40,763	-	2,099,370	-	264,969	-
ASC.06.03 Social protection through provision of social services	1,168,192	2.0	-	1,698	145,724	90,334	137,113	16,361	760,006	16,955
ASC.06.04 HIV-specific income generation projects	134,268	0.2	-	-	2,948	-	27,179	799	103,342	-
ASC.06.98 Social protection services and social services not disaggregated by type	21,963	0.0	-	6,129	-	1,125	-	-	14,709	-

ASC.07 Enabling Environment	**3,410,437**	**5.9**	**739,929**	**3,850**	**341,097**	**1,827,603**	**161,655**	**61,777**	**274,526**	**-**
ASC.07.01 Advocacy	1,002,715	1.7	739,929	3,850	29,460	37,799	121,938	3,228	66,512	-
ASC.07.02.01 Human rights programmes empowering individuals to claim their rights	13,999	0.0	-	-	3,739	-	-	-	10,260	-
ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment	20,279	0.0	-	-	12,912	2,884	4,483	-	-	-
ASC.07.02.98 Human rights programmes not disaggregated by type	27,705	0.0	-	-	8,353	12,007	-	-	7,345	-
ASC.07.03 AIDS-specific institutional development	1,138,270	2.0	-	-	42,817	901,232	35,235	6,002	152,983	-
ASC.07.04 AIDS-specific programmes focused on women	23,299	0.0	-	-	-	-	-	-	23,299	-
ASC.07.05 Programmes to reduce Gender Based Violence	2,222	0.0	-	-	1,000	-	-	-	1,222	-
ASC.07.98 Enabling environment not disaggregated by type	1,181,949	2.0	-	-	242,815	873,682	-	52,547	12,905	-
ASC.08 HIV-related Research	**1,105,895**	**1.9**	**-**	**-**	**818,160**	**46,439**	**219,424**	**-**	**21,873**	**-**
ASC.08.01 Biomedical research	70,110	0.1	-	-	25,871	44,239	-	-	-	-
ASC.08.02 Clinical research	172,947	0.3	-	-	172,947	-	-	-	-	-
ASC.08.04.01 Behavioural research	215,119	0.4	-	-	215,119	-	-	-	-	-
ASC.08.04.02 Research in economics	200,241	0.3	-	-	-	-	200,241	-	-	-
ASC.08.04.98 Social science research not disaggregated by type	432,090	0.7	-	-	404,223	-	19,183	-	8,684	-
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	15,389	0.0	-	-	-	2,200	-	-	13,189	-
Total Expenditure on HIV and AIDS in 2010	**58,059,469**	**100**	**2,436,832**	**51,540**	**15,662,527**	**22,711,245**	**8,382,652**	**1,043,168**	**7,516,331**	**255,175**

Annex 4: AIDS APENDING BY THEMATIC AREA

Prevention

Who is financing Prevention?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	4,998,270	4,670,319	9,668,590	-327,951	46.3	42.3	44.2
GFATM	3,493,397	3,414,280	6,907,678	-79,117	32.3	30.9	31.6
INGOs	1,051,554	778,282	1,829,836	-273,272	9.7	7.0	8.4
UN	795,175	1,058,076	1,853,252	262,901	7.4	9.6	8.5
Public	201,675	575,121	776,796	373,446	1.9	5.2	3.6
International for-profit	124,786	172,308	297,094	47,521	1.2	1.6	1.4
Multilateral (excl. GFATM and UN)	117,106	350,657	467,763	233,551	1.1	3.2	2.1
Private (national for- and non-profit)	24,939	29,026	53,965	4,087	0.2	0.3	0.2
Total	**10,806,903**	**11,048,070**	**21,854,973**	241,167	100	100	100

Who is the FA for prevention?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
International NGOs	4,645,542	5,168,537	9,814,079	522,995	43.0	46.8	44.9
Public	3,569,591	3,837,608	7,407,199	268,018	33.0	34.7	33.9
National NGOs	1,761,813	1,555,149	3,316,961	-206,664	16.3	14.1	15.2
UN	477,384	393,869	871,253	-83,515	4.4	3.6	4.0
Bilateral	352,574	92,907	445,481	-259,667	3.3	0.8	2.0
Total	**10,806,903**	**11,048,070**	**21,854,973**	241,167	100	100	100

Who is implementing prevention?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector (NGOs)	8,654,604	8,544,312	17,198,917	-110,292	80.1	77.3	78.7
Public sector	2,143,177	2,437,998	4,581,175	294,822	19.8	22.1	21.0
Bi- and Multilateral	9,122	65,759	74,881	56,637	0.1	0.6	0.3
Total	**10,806,903**	**11,048,070**	**21,854,973**	241,167	100	100	100

Who is benefiting from prevention?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
MARPs	4,953,243	5,908,094	10,861,337	954,851	45.8	53.5	49.7
General popualtion	3,357,521	2,426,048	5,783,569	-931,474	31.1	22.0	26.5
Other key and accessible populations	2,061,424	2,558,220	4,619,644	496,796	19.1	23.2	21.1
PLHIV	262,905	104,497	367,402	-158,408	2.4	0.9	1.7
Non-targeted interventions	171,811	51,212	223,023	-120,599	1.6	0.5	1.0
Total	**10,806,903**	**11,048,070**	**21,854,973**	241,167	100	100	100

Care and Treatment

Who is financing Treatment?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
GFATM	7,400,318	7,356,958	14,757,276	-43,360	48.9	53.9	51.3
International NGOs	5,765,525	3,891,715	9,657,240	-1,873,810	38.1	28.5	33.6
Bilateral	1,597,066	1,984,632	3,581,699	387,566	10.6	14.5	12.4
UN	197,929	200,763	398,692	2,833	1.3	1.5	1.4
Multilateral (excl. GFATM and UN)	167,956	219,334	387,290	51,379	1.1	1.6	1.3
Total	**15,128,794**	**13,653,403**	**28,782,197**	-1,475,392	100	100	100

Who is implementing treatment?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public sector providers	9,643,824	8,624,180	18,268,005	-1,019,644	63.7	63.2	63.5
Private sector providers (incl. NGOs)	5,484,272	5,029,222	10,513,494	-455,050	36.3	36.8	36.5
Bi- and Multilateral offices	698		698	-698	0.0	0.0	0.0
Grand Total	**15,128,794**	**13,653,403**	**28,782,197**	-1,475,392	100	100	100

Who is the financing agent (manager) of Treatment?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	8,811,275	8,365,456	17,176,732	-445,819	58.2	61.3	59.7
International NGOs	4,487,408	3,290,753	7,778,162	-1,196,655	29.7	24.1	27.0
National NGOs	1,707,862	1,931,140	3,639,001	223,278	11.3	14.1	12.6
UN	122,249	66,053	188,302	-56,195	0.8	0.5	0.7
Total	**15,128,794**	**13,653,403**	**28,782,197**	-1,475,392	100	100	100

Who is the intended beneficiary population for treatment services?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
PLHIV	15,029,282	13,650,194	28,679,476	-1,379,088	99.3	100	99.6
Non-targeted interventions	94,848	2,711	97,559	-92,137	0.6	0.0	0.3
Other BPs	3,981		3,981	-3,981	0.0	0.0	0.0
Other key and accessible populations	684	310	994	-374	0.0	0.0	0.0
MARPs		188	188	188	0.0	0.0	0.0
Grand Total	**15,128,794**	**13,653,403**	**28,782,197**	-1,475,392	100	100	100

Orphans and Vulnerable Children as Beneficiary Population

Who is funding activities targeting OVC?

Financing Source	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
UN	2,195,557	2,116,657	4,312,214	-78,900	53.9	47.8	50.7
GFATM	935,134	1,207,378	2,142,512	272,243	23.0	27.3	25.2
International NGOs	683,053	731,724	1,414,778	48,671	16.8	16.5	16.6
Bilateral	259,434	369,783	629,216	110,349	6.4	8.4	7.4
Total	**4,073,178**	**4,425,541**	**8,498,720**	352,363	100	100	100

Who is the financing agent for activities targeting OVC?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
UN	2,248,512	2,137,106	4,385,618	-111,406	55.2	48.3	51.6
International NGOs	987,632	1,414,911	2,402,543	427,280	24.2	32.0	28.3
Public	481,313	470,273	951,586	-11,040	11.8	10.6	11.2
National NGOs	355,722	403,251	758,973	47,529	8.7	9.1	8.9
Total	**4,073,178**	**4,425,541**	**8,498,720**	352,363	100	100	100

Who is implementing activities targeting OVC?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers (incl. NGOs)	3,858,822	4,225,951	8,084,774	367,129	94.7	95.5	95.1
Bi- and Multilateral offices	214,356	199,590	413,946	-14,766	5.3	4.5	4.9
Total	**4,073,178**	**4,425,541**	**8,498,720**	352,363	5.3	4.5	4.9

OVC and ASC

ASC 1 digit	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Orphans and Vulnerable Children	4,063,895	4,418,420	8,482,316	354,525	99.8	99.8	99.8
Enabling Environment	6,000	2,000	8,000	-4,000	0.1	0.0	0.1
Programme Management and Administration	3,283	5,121	8,404	1,838	0.1	0.1	0.1
Total	**4,073,178**	**4,425,541**	**8,498,720**	352,363	100	100	100

Programme Management and Administration

Who is the funding source for Programme Management and Administration?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	6,990,567	6,598,956	13,589,523	-391,611	44.1	34.3	38.8
GFATM	5,439,678	8,292,139	13,731,817	2,852,461	34.3	43.2	39.2
UN	1,872,319	2,146,953	4,019,272	274,634	11.8	11.2	11.5
Public	678,694	1,121,782	1,800,476	443,088	4.3	5.8	5.1
INGOs	634,949	606,745	1,241,695	-28,204	4.0	3.2	3.5
Multilateral (excl. GFATM and UN)	222,295	379,079	601,374	156,784	1.4	2.0	1.7
International for-profit	2,500	65,205	67,705	62,705	0.0	0.3	0.2
Private (national for- and non-profit)	865	392	1,257	-473	0.0	0.0	0.0
Total	**15,841,868**	**19,211,252**	**35,053,120**	3,369,384	100	100	100

Who is the Financing Agent for Programme Management and Administration?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	6,835,089	9,540,746	16,375,836	2,705,657	43.1	49.7	46.7
Int'l NGOs	4,207,404	3,947,984	8,155,388	-259,420	26.6	20.6	23.3
UN	2,008,016	2,150,682	4,158,698	142,666	12.7	11.2	11.9
Private (National NGOs)	1,835,819	2,782,733	4,618,553	946,914	11.6	14.5	13.2
Bilateral	955,540	789,106	1,744,646	-166,433	6.0	4.1	5.0
Total	**15,841,868**	**19,211,252**	**35,053,120**	3,369,384	100	100	100

Who is implementing Programme Management and Administration?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	8,699,489	8,787,660	17,487,150	88,171	54.9	45.7	49.9
Public sector providers	4,858,371	8,094,405	12,952,776	3,236,034	30.7	42.1	37.0
Bi- and Multilateral offices	2,138,900	2,226,188	4,365,088	87,288	13.5	11.6	12.5
Rest of the world providers	145,108	102,999	248,107	-42,109	0.9	0.5	0.7
Total	**15,841,868**	**19,211,252**	**35,053,120**	3,369,384	100	100	100

Human Resource (Training)

Who is the financing source for Human Resources (Training)?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
GFATM	391,979	474,989	866,968	83,010	41.0	47.5	44.4
Bilateral	339,789	339,987	679,775	198	35.6	34.0	34.8
Public	107,820		107,820	-107,820	11.3	0.0	5.5
UN	68,862	89,439	158,300	20,577	7.2	9.0	8.1
International NGOs	47,126	68,439	115,565	21,313	4.9	6.8	5.9
International for-profit		707	707	707	0.0	0.1	0.0
Multilateral (excl. GFATM and UN)		15,160	15,160	15,160	0.0	1.5	0.8
Private (national for-profit & non-profit)		10,445	10,445	10,445	0.0	1.0	0.5
Total	**955,575**	**999,166**	**1,954,741**	43,591	100	100	100

Who is the financing agent for Human Resources (Training)?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	536,345	520,140	1,056,485	-16,205	56.1	52.1	54.0
iNGOs	269,340	70,144	159,796	-199,196	28.2	7.0	8.2
Private	89,652	301,301	570,641	211,649	9.4	30.2	29.2
UN	60,238	41,069	41,069	-19,169	6.3	4.1	2.1
Bilateral		66,512	126,750	66,512	0.0	6.7	6.5
Total	**955,575**	**999,166**	**1,954,741**	43,591	100	100	100

Who is implementing Human Resources (Training)?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	514,206	469,065	65,705	-45,140	53.8	46.9	3.4
Public sector providers	429,298	472,106	983,271	42,808	44.9	47.2	50.3
Bi- and Multilateral offices	12,072	53,633	901,403	41,562	1.3	5.4	46.1
Rest of the world providers		4,362	4,362	4,362	0.0	0.4	0.2
Total	**955,575**	**999,166**	**1,954,741**	43,591	100	100	100

Who is the beneficiary population for Human Resources (Training)?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Non-targeted interventions	955,575	997,868	1,953,442	42,293	100	99.9	99.9
PLHIV		1,298	1,298	1,298	0.0	0.1	0.1
Total	**955,575**	**999,166**	**1,954,741**	43,591	100	100	100

Social Protection, Social Services

Who is the financing source for Social protection, Social Services?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
UN	2,082,489	2,394,805	4,477,294	312,315	60.6	56.8	58.5
International NGOs	637,341	1,143,027	1,780,367	505,686	18.6	27.1	23.3
Bilateral	512,423	541,593	1,054,016	29,170	14.9	12.9	13.8
GFATM	184,282	91,459	275,741	-92,823	5.4	2.2	3.6
Private (national for-profit & non-profit)	9,685	7,827	17,512	-1,858	0.3	0.2	0.2
Multilateral (excl. GFATM and UN)	8,646	17,160	25,806	8,514	0.3	0.4	0.3
International for-profit		16,955	16,955	16,955	0.0	0.4	0.2
Total	**3,434,866**	**4,212,826**	**7,647,692**	777,960	100	100	100.

Who is the financing agent for Social protection, Social Services?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
UN	2,026,885	2,118,149	4,145,034	91,264	59.0	50.3	54.2
International NGOs	629,684	1,236,028	1,865,713	606,344	18.3	29.3	24.4
Public	369,265	525,104	894,369	155,839	10.8	12.5	11.7
Bilateral	272,000		272,000	-272,000	7.9	0.0	3.6
National NGOs	137,032	333,545	470,576	196,513	4.0	7.9	6.2
Total	**3,434,866**	**4,212,826**	**7,647,692**	777,960	100	100	100

Who is implementing Social protection, Social Services?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers (incl. NGOs)	3,187,073	3,986,676	7,173,749	799,603	92.8	94.6	93.8
Bi- and Multilateral offices	214,356	225,070	439,426	10,714	6.2	5.3	5.7
Public sector providers	33,437	1,080	34,517	-32,357	1.0	0.0	0.5
Total	**3,434,866**	**4,212,826**	**7,647,692**	777,960	100	100	100

Who is the beneficiary population for Social protection, Social Services?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
PLHIV	3,416,326	4,170,130	7,586,456	753,804	99.5	99.0	99.2
Other BPs	18,540	30,019	48,559	11,479	0.5	0.7	0.6
MARPs		1,125	1,125	1,125	0.0	0.0	0.0
General population		11,552	11,552	11,552	0.0	0.3	0.2
Total	**3,434,866**	**4,212,826**	**7,647,692**	777,960	100	100	100

Enabling Environment

Who is the financing source for Enabling Environment?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
GFATM	961,664	1,827,603	2,789,267	865,939	35.5	53.6	45.6
Public	715,214	739,929	1,455,143	24,715	26.4	21.7	23.8
Bilateral	475,673	341,097	816,769	-134,576	17.6	10.0	13.3
INGOs	270,068	274,526	544,595	4,458	10.0	8.0	8.9
UN	187,934	161,655	349,590	-26,279	6.9	4.7	5.7
Multilateral (excl. GFATM and UN)	96,305	61,777	158,082	-34,528	3.6	1.8	2.6
Private (national for- and non-profit)	1,466	3,850	5,316	2,384	0.1	0.1	0.1
Total	**2,708,324**	**3,410,437**	**6,118,761**	702,114	100	100	100

Who is the financing agent for Enabling Environment?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	1,661,077	2,434,511	4,095,588	773,433	61.3	71.4	66.9
Private	490,413	333,377	823,790	-157,036	18.1	9.8	13.5
iNGOs	376,333	500,647	876,980	124,314	13.9	14.7	14.3
UN	180,501	141,902	322,403	-38,598	6.7	4.2	5.3
Total	**2,708,324**	**3,410,437**	**6,118,761**	702,114	100	100	100

Who is implementing Enabling Environment?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	1,693,140	1,963,636	3,656,777	270,496	62.5	57.6	59.8
Public sector providers	977,168	1,399,918	2,377,086	422,750	36.1	41.0	38.8
Bi- and Multilateral offices	29,235	44,853	74,088	15,618	1.1	1.3	1.2
Rest of the world providers	8,780	2,030	10,810	-6,750	0.3	0.1	0.2
Total	**2,708,324**	**3,410,437**	**6,118,761**	702,114	100	100	100

Who is the beneficiary population for Enabling Environment?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Non-targeted interventions	2,057,936	2,764,458	4,822,394	706,522	76.0	81.1	78.8
PLHIV	493,331	491,708	985,039	-1,623	18.2	14.4	16.1
General popualtion	92,507	111,807	204,315	19,300	3.4	3.3	3.3
MARPs	47,567	36,444	84,011	-11,124	1.8	1.1	1.4
Other key and accessible populations	10,982	4,020	15,002	-6,962	0.4	0.1	0.2
OVC	6,000	2,000	8,000	-4,000	0.2	0.1	0.1
Total	**2,708,324**	**3,410,437**	**6,118,761**	702,114	100	100	100

HIV Related Research

Who is the financing source for HIV Related Research?

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	397,915	818,160	1,216,075	420,244	59.1	74.0	68.3%
UN	150,454	219,424	369,878	68,970	22.3	19.8	20.8
GFATM	95,284	46,439	141,723	-48,845	14.2	4.2	8.0
INGOs	29,679	21,873	51,552	-7,806	4.4	2.0	2.9
Total	**673,333**	**1,105,895**	**1,779,228**	432,563	100	100	100

Who is the financing agent for HIV Related Research?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	368,032	198,818	566,850	-169,214	54.7	18.0	31.9
UN	157,447	219,424	376,871	61,977	23.4	19.8	21.2
Public	95,284	46,439	141,723	-48,845	14.2	4.2	8.0
Int'l NGOs	39,113	641,214	680,328	602,101	5.8	58.0	38.2
National NGOs	13,457		13,457	-13,457	2.0	0.0	0.8
Total	**673,333**	**1,105,895**	**1,779,228**	432,563	100	100.0	100

Who is implementing HIV Related Research?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	629,094	858,377	1,487,471	229,284	93.4	77.6	83.6
Public sector providers	44,239	46,439	90,678	2,200	6.6	4.2	5.1
Bi- and Multilateral offices		201,079	201,079	201,079	0.0	18.2	11.3
Total	**673,333**	**1,105,895**	**1,779,228**	432,563	100	100	100

Who is the intended target group for HIV Related Research?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Non-targeted interventions	673,333	1,105,895	1,779,228	432,563	100	100	100
Total	**673,333**	**1,105,895**	**1,779,228**	432,563	100	100	100

Public Funds

What does the Government of Cambodia fund?

ASC Code	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Enabling Environment	715,214	739,929	1,455,143	24,715	42.0	30.4	35.1
Programme Management and Administration	678,694	1,121,782	1,800,476	443,088	39.8	46.0	43.5
Prevention	201,675	575,121	776,796	373,446	11.8	23.6	18.8
Human Resources (Training)	107,820		107,820	-107,820	6.3	0.0	2.6
Grand Total	**1,703,403**	**2,436,832**	**4,140,235**	733,429	100	100	100

Who manages public funds?

FA Name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
NAA	993,764	1,057,541	2,051,305	63,776	58.3	43.4	49.5
MoH	552,479	849,860	1,402,339	297,381	32.4	34.9	33.9
MoEYS	118,000	510,712	628,712	392,712	6.9	21.0	15.2
DoEYS	$20,320		20,320	-20,320	1.2	0.0	0.5
MoWA	18,840	18,720	37,560	-120	1.1	0.8	0.9
Public Total	**1,703,403**	**2,436,832**	**4,140,235**	733,429	100	100	100

Service Providers of Public Funds

PS Name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
NAA	993,764	1,057,541	2,051,305	63,776	58.3	43.4	49.5
NCHADS	405,679	657,860	1,063,539	252,181	23.8	27.0	25.7
Blood Bank	146,800	192,000	338,800	45,200	8.6	7.9	8.2
MoEYS	88,000	151,872	239,872	63,872	5.2	6.2	5.8
Schools	30,000	358,840	388,840	328,840	1.8	14.7	9.4
DoEYS	20,320		20,320	-20,320	1.2	0.0	0.5
MoWA	18,840	18,720	37,560	-120	1.1	0.8	0.9
Public Total	**1,703,403**	**2,436,832**	**4,140,235**	$733,429	100	100	100

Beneficiary Population of Public Funds

BP detailed	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Non-targeted interventions	1,526,603	1,885,992	3,412,595	359,389	89.6	77.4	82.4
Recipients of blood and blood products	146,800	192,000	338,800	45,200	8.6	7.9	8.2
School students	30,000	273,340	303,340	243,340	1.8	11.2	7.3
General population		85,500	85,500	85,500	0.0	3.5	2.1
Public Total	**1,703,403**	**2,436,832**	**4,140,235**	733,429	100	100	100

Global Fund Grants

What did GFATM fund?

ASC	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Care and Treatment	7,400,318	7,356,958	14,757,276	-43,360	38.9	32.4	35.4
Programme Management and Administration	5,439,678	8,292,139	13,731,817	2,852,461	28.6	36.5	32.9
Prevention	3,493,397	3,414,280	6,907,678	-79,117	18.4	15.0	16.6
Orphans and Vulnerable Children	1,056,774	1,207,378	2,264,152	150,604	5.6	5.3	5.4
Enabling Environment	961,664	1,827,603	2,789,267	865,939	5.1	8.0	6.7
Human Resources (Training)	391,979	474,989	866,968	83,010	2.1	2.1	2.1
Social Protection, Social Services	184,282	91,459	275,741	-92,823	1.0	0.4	0.7
Research	95,284	46,439	141,723	-48,845	0.5	0.2	0.3
Grand Total	**19,023,377**	**22,711,245**	**41,734,622**	3,687,868	100	100	100

Who managed the funds from GFATM?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	15,370,725	18,582,586	33,953,311	3,211,860	80.8	81.8	81.4
National NGOs	2,109,461	2,376,279	4,485,740	266,818	11.1	10.5	10.7
International NGOs	1,543,191	1,752,381	3,295,572	209,190	8.1	7.7	7.9
GFATM Total	**19,023,377**	**22,711,245**	**41,734,622**	3,687,868	100	100	100

Who implemented the funds from GFATM?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers (incl. NGOs)	11,134,633	10,736,779	21,871,412	-397,854	58.5	47.3	52.4
Public sector providers	7,888,744	11,974,466	19,863,210	4,085,721	41.5	52.7	47.6
GFATM Total	**19,023,377**	**22,711,245**	**41,734,622**	3,687,868	100	100	100

Who was the intended beneficiary population of funds from GFATM?

BP name	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
PLHIV	7,913,322	7,986,848	15,900,170	73,527	41.6	35.2	38.1
Non-targeted interventions	6,917,354	10,089,518	17,006,872	3,172,164	36.4	44.4	40.8
General population	1,755,267	915,014	2,670,281	-840,252	9.2	4.0	6.4
MARPs	1,228,320	1,955,659	3,183,979	727,339	6.5	8.6	7.6
Orphans and Vulnerable Children	935,134	1,207,378	2,142,512	272,243	4.9	5.3	5.1
Other key and accessible populations	273,981	556,828	830,809	282,847	1.4	2.5	2.0
Grand Total	**19,023,377**	**22,711,245**	**41,734,622**	3,687,868	100	100	100

What did GFATM fund?

AIDS Spending Category	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Care & Treatment	7,400,318	7,356,958	14,757,276	-43,360	38.9	32.4	35.4
Programme Management & Administration	5,439,678	8,292,139	13,731,817	2,852,461	28.6	36.5	32.9
Prevention	3,493,397	3,414,280	6,907,678	-79,117	18.4	15.0	16.6
OVC	1,056,774	1,207,378	2,264,152	150,604	5.6	5.3	5.4
Enabling Environment	961,664	1,827,603	2,789,267	865,939	5.1	8.0	6.7
Human Resources (Training)	391,979	474,989	866,968	83,010	2.1	2.1	2.1
Social Protection, Social Services	184,282	91,459	275,741	-92,823	1.0	0.4	0.7
Research	95,284	46,439	141,723	-48,845	0.5	0.2	0.3
Total	**19,023,377**	**22,711,245**	**41,734,622**	3,687,868	100	100	100

Bilateral, Multilateral (excl. GFTAM and UN) and UN funds

Total Spending of Bilateral, Multilateral (excl. GFATM and UN) and UN funds

FS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	15,565,137	15,662,527	31,227,664	97,390	29.0	27.0	27.9
UN	7,547,437	8,382,652	15,930,089	835,215	14.0	14.4	14.2
Multilateral	612,307	1,043,168	1,655,475	430,861	1.1	1.8	1.5
Grand Total	**23,724,881**	**25,088,347**	**48,813,228**	1,363,465	44.2	43.2	43.7
Response Total	*53,735,198*	*58,059,469*	*111,794,667*				
				UN and other multilateral	8,159,745	9,425,820	17,585,565

What wre the funds spents on?

ASC	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Programme Management and Administration	9,085,181	9,124,988	18,210,170	39,807	33.3	36.4	37.3
Prevention	5,910,552	6,079,053	11,989,605	168,501	24.9	24,2	24.6
Social Protection, Social Services	2,603,558	2,953,558	5,557,116	349,999	11.0	11.8	11.4
Orphans and Vulnerable Children	2,445,708	2,479,319	4,925,026	33,611	10.3	9.9	10.1
Care and Treatment	1,962,951	2,404,730	4,367,681	441,778	8.3	9.6	8.9
Enabling Environment	759,912	564,529	1,324,441	-195,382	3.2	2.3	2.7
Research	548,369	1,037,584	1,585,953	489,214	2.3	4.1	3.2
Human Resources (Training)	408,650	444,586	853,236	35,936	1.7	1.8	1.7
Total bi- and multilateral	**23,724,881**	**25,088,347**	**48,813,228**	1,363,464	100	100	100

Who managed the funds from bilateral, UN and other multilaterals?

Type of Financing Agent	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
International NGOs	8,173,410	9,134,050	17,307,460	960,641	34.5	36.4	35.5
UN	7,277,948	7,288,577	14,566,525	10,628	30.7	29.1	29.8
National NGOs	3,889,087	4,425,582	8,314,669	536,495	16.4	17.6	17.0
Public	2,436,291	3,118,237	5,554,528	681,946	10.3	12.4	11.4
Bilateral	1,948,145	1,121,900	3,070,045	-826,246	8.2	4.5	6.3
Total	**23,724,881**	**25,088,347**	**48,813,228**	1,363,465	100	100	100

Who implemented the funds from bilateral, multilaterals and the UN?

Type of Servcie Provider	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector (national NGOs) providers	17,492,064	18,261,208	35,753,272	769,144	73.7	72.8	73.2
Public sector providers	3,460,190	3,701,576	7,161,766	241,385	14.6	14.8	14.7
Bi- and Multilateral offices	2,618,739	3,016,173	5,634,911	397,434	11.0	12.0	11.5
Rest of the world providers	153,888	109,390	263,278	-44,498	0.6	0.4	0.5
Total	**23,724,881**	**25,088,347**	**48,813,228**	1,363,465	100	100	100

Who was the intended beneficiary population of funds from bilateral, UN and other multilaterals?

Type of beneficiary population	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Non-targeted interventions	10,333,425	11,071,064	21,404,489	737,639	43.6	44.1	43.8
PLHIV	4,916,794	5,413,991	10,330,785	497,197	20.7	21.6	21.2
MARPs	3,425,540	3,745,912	7,171,452	320,373	14.4	14.9	14.7
OVC	2,454,991	2,486,440	4,941,430	31,449	10.3	9.9	10.1
Other key and accessible populations	1,527,274	1,388,987	2,916,261	-138,288	6.4	5.5	6.0
General population	1,066,857	981,952	2,048,810	-84,905	4.5	3.9	4.2
Total	**23,724,881**	**25,088,347**	**48,813,228**	1,363,465	100	100	100

International NGOs funds

What did International NGOs fund?

ASC	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Treatment and care	5,765,525	3,891,715	9,657,240	-1,873,810	63.2	51.8	58.1
Prevention	1,051,554	778,282	1,829,836	-273,272	11.5	10.4	11.0
OVC	683,053	731,724	1,414,778	48,671	7.5	9.7	8.5
Social protection, social services	637,341	1,143,027	1,780,367	505,686	7.0	15.2	10.7
Program management & administration	634,949	606,745	1,241,695	-28,204	7.0	8.1	7.5
Enabling environment	270,068	274,526	544,595	4,458	3.0	3.7	3.3
Training	47,126	68,439	115,565	21,313	0.5	0.9	0.7
Research	29,679	21,873	51,552	-7,806	0.3	0.3	0.3
Total	**9,119,295**	**7,516,331**	**16,635,626**	-1,602,964	100	100	100

Who managed the funds from International NGOs?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
International NGOs	5,783,006	5,414,141	11,197,147	-368,865	63.4	72	67.3
Public	2,856,371	1,602,623	4,458,993	-1,253,748	31.3	21.3	26.8
National NGOs	479,919	499,567	979,486	19,648	5.3	6.6	5.9
Total	**9,119,295**	**7,516,331**	**16,635,626**	-1,602,964	100	100	100

Who implemented the funds from International NGOs?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	4,042,119	4,553,078	8,595,197	510,959	44.3	60.6	51.7
Public sector providers	5,077,176	2,963,253	8,040,429	-2,113,923	55.7	39.4	48.3
Total	**9,119,295**	**7,516,331**	**16,635,626**	-1,602,964	100	100	100

Who was the intended beneficiary population of funds from International NGOs?

Type of Service Provider	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
PLHIV	6,521,600	5,153,949	11,675,549	-1,367,651	71.5	68.6	70.2
Non-targeted interventions	868,552	829,751	1,698,302	-38,801	9.5	11.0	10.2
OVC	683,053	731,724	1,414,778	48,671	7.5	9.7	8.5
General popualtion	619,871	570,374	1,190,246	-49,497	6.8	7.6	7.2
MARPs	239,773	71,971	311,744	-167,803	2.6	1.0	1.9
Other key and accessible populations	162,254	128,543	290,797	-33,710	1.8	1.7	1.7
Other BPs	24,191	30,019	54,210	5,828	0.3	0.4	0.3
Total	**9,119,295**	**7,516,331**	**16,635,626**	-1,602,964	100	100	100

PLHIV as Beneficiary Population

Who is funding activities targeting PLHIV?

Financing Source	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
GFATM	7,913,322	7,986,848	15,900,170	$73,527	40.9	43.0	41.9
International NGOs	6,521,600	5,153,949	11,675,549	-1,367,651	33.7	27.7	30.8
UN	2,347,801	2,620,298	4,968,099	272,497	12.1	14.1	13.1
Bilateral	2,343,222	2,551,197	4,894,419	207,975	12.1	13.7	12.9
Multilateral (excl. GFATM and UN)	225,772	242,496	468,268	16,725	1.2	1.3	1.2
Private (national for-profit & non-profit)	10,645	7,827	18,472	-2,818	0.1	0.0	0.0
International for-profit		16,955	16,955	16,955	0.0	0.1	0.0
Total	**19,362,361**	**18,579,570**	**37,941,931**	-782,791	100	100	100

Who is the financing agent for activities targeting PLHIV?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	9,567,042	9,409,814	18,976,856	-157,227	49.4	50.6	50.0
International NGOs	5,272,673	4,632,783	9,905,456	-639,890	27.2	24.9	26.1
UN	2,226,094	2,212,644	4,438,739	-13,450	11.5	11.9	11.7
National NGOs	2,024,552	2,324,328	4,348,880	299,777	10.5	12.5	11.5
Bilateral	272,000		272,000	-272,000	1.4	0.0	0.7
Total	**19,362,361**	**18,579,570**	**37,941,931**	-782,791	100	100	100

Who is implementing activities targeting PLHIV?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public sector providers	9,678,610	8,646,930	18,325,540	-1,031,680	50.0	46.5	48.3
Private sector providers (incl. NGOs)	9,463,697	9,707,570	19,171,267	243,873	48.9	52.2	50.5
Bi- and Multilateral offices	220,054	225,070	445,124	5,016	1.1	1.2	1.2
Total	**19,362,361**	**18,579,570**	**37,941,931**	-782,791	100	100	100

ASC 1 digit	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Care and Treatment	15,029,282	13,650,194	28,679,476	-1,379,088	77.6	73.5	75.6
Social Protection, Social Services	3,416,326	4,170,130	7,586,456	753,804	17.6	22.4	20.0
Enabling Environment	493,331	491,708	985,039	-1,623	2.5	2.6	2.6
Prevention	262,905	104,497	367,402	-158,408	1.4	0.6	1.0
Programme Management and Administration	152,967	161,743	314,711	8,776	0.8	0.9	0.8
Orphans and Vulnerable Children	7,550		7,550	-7,550	0.0	0.0	0.0
Human Resources (Training)		1,298	1,298	1,298	0.0	0.0	0.0
Total	**19,362,361**	**18,579,570**	**37,941,931**	-782,791	100	100	100

MARPS (SW, MSM, IDU, MARPs not broken down by type) as Beneficiary Population

Who is funding activities targeting MARPs?

Financing Source	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	3,331,680	3,588,815	6,920,494	257,135	66.4	60.4	63.37
GFATM	1,228,320	1,955,659	3,183,979	727,339	24.5	32.9	28.68
Int'l NGOs	239,773	71,971	311,744	-167,803	4.8	1.2	2.99
Int'l for-profit	124,786	172,308	297,094	47,521	2.5	2.9	2.69
Multilateral (excl. GFATM & UN)	66,926	86,532	153,458	19,606	1.3	1.5	1.39
UN	26,934	70,566	97,500	43,632	0.5	1.2	0.86
MARPs Total	**5,018,419**	**5,945,850**	**10,964,269**	927,430	100	100	100

Who is the financing agent for activities targeting MARPs?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
iNGOs	3,107,590	3,446,002	6,553,592	338,411	61.9	58	59.8
Public	1,069,275	1,822,587	2,891,862	753,312	21.3	30.7	26.4
Private	599,518	584,479	1,183,996	-15,039	11.9	9.8	10.8
Bilateral	152,363		152,363	-152,363	3.0	0.0	1.4
UN	89,674	92,783	182,456	3,109	1.8	1.6	1.7
Total	**5,018,419**	**5,945,850**	**10,964,269**	927,430	100	100	100

Who is implementing activities targeting MARPs?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	4,719,437	5,416,569	10,136,006	697,133	94.0	91.1	92.4
Public sector providers	298,983	474,180	773,163	175,197	6.0	8.0	7.1
Bi- and Multilateral offices		55,100	55,100	55,100	0.0	0.9	0.5
Total	**5,018,419**	**5,945,850**	**10,964,269**	927,430	100	100	100

ASC 1 digit	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Prevention	4,953,243	5,908,094	10,861,337	954,851	98.7	99.4	99.1
Enabling environment	47,567	36,444	84,011	-11,124	0.9	0.6	0.8
Program management and administration strengthening	17,609		17,609	-17,609	0.4	0.0	0.2
Care and treatment		188	188	188	0.0	0.0	0.0
Social protection, social services		1,125	1,125	1,125	0.0	0.0	0.0
Total	**5,018,419**	**5,945,850**	**10,964,269**	927,430	100	100	100

Other BPs and Key and Accessible Populations as Beneficiary Population

Who is funding activities targeting other BPs and key and accessible populations?

Financing Source	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	939,206	616,141	1,555,347	-323,066	43.1	23.7	32.5
UN	537,888	505,493	1,043,381	-32,395	24.7	19.5	21.8
GFATM	273,981	556,828	830,809	282,847	12.6	21.4	17.4
INGOs	186,445	158,562	345,007	-27,882	8.5	6.1	7.2
Public	176,800	465,340	642,140	288,540	8.1	17.9	13.4
Multilateral	50,180	267,353	317,532	217,173	2.3	10.3	6.6
Private (national for- and non-profit)	16,906	29,026	45,932	12,120	0.8	1.1	1.0
Total	**2,181,406**	**2,598,743**	**4,780,149**	417,337	100	100	100

Who is the financing agent for activities targeting other BPs and key and accessible populations?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	850,453	1,157,925	2,032,569	307,472	39.0	44.6	42.5
Int'l NGOs	589,590	892,679	1,482,269	303,089	27.0	34.4	31.0
National NGOs	537,957	443,825	957,591	-94,133	24.7	17.1	20.0
UN	203,405	104,314	307,719	-99,091	9.3	4.0	6.4
Total	**2,181,406**	**2,598,743**	**4,780,149**	417,337	100	100	100

Who is implementing activities targeting other BPs and key and accessible populations?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bi- and Multilateral offices	9,122	10,159	19,281	1,037	0.4	0.4	0.4
Private sector providers	1,173,948	1,408,509	2,582,457	234,562	53.8	54.2	54.0
Public sector providers	998,336	1,180,074	2,178,410	181,738	45.8	45.4	45.6
Total	**2,181,406**	**2,598,743**	**4,780,149**	417,337	100	100	100

Other BPs and key and accessible populations by ASC

ASC 1 digit	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Prevention	2,061,424	2,558,220	4,619,644	496,796	94.5	98.4	97.8
Program management and administration	85,795	6,173	90,299	-79,622	3.9	0.2	1.9
Enabling environment	29,522	34,039	15,002	4,517	1.4	1.3	0.3
Care and Treatment	4,665	310	994	-4,355	0.2	0.0	0.0
Total	**2,181,406**	**2,598,743**	**4,725,939**	417,337	100	100	100

General Population as Beneficiary Population

Who is funding activities targeting general populations?							
Financing Source	**USD in 2009**	**USD in 2010**	**Grand Total**	**USD in change 2009-10**	**% in 2009**	**% in 2010**	**% Total**
GFATM	1,755,267	915,014	2,670,281	-840,252	50.9	35.8	44.5
Bilateral	732,691	507,731	1,240,422	-224,961	21.2	19.9	20.7
Int'l NGOs	619,871	570,374	1,190,246	-49,497	18.0	22.3	19.8
UN	334,166	474,222	808,388	140,056	9.7	18.6	13.5
Private (national for- and non-profit)	8,033		8,033	-8,033	0.2	0.0	0.1
Public		85,500	85,500	85,500	0.0	3.3	1.4
Total	**3,450,029**	**2,552,841**	**6,002,870**	-897,188	100	100	100

Who is the financing agent for activities targeting general population?							
FA type	**USD in 2009**	**USD in 2010**	**Grand Total**	**USD in change 2009-10**	**% in 2009**	**% in 2010**	**% Total**
Public	1,516,364	863,737	2,380,101	-652,628	44.0	33.8	39.6
iNGOs	939,588	901,548	1,841,137	-38,040	27.2	35.3	30.7
Private	521,364	502,362	1,023,726	-19,001	15.1	19.7	17.1
UN	272,502	192,287	464,789	-80,215	7.9	7.5	7.7
Bilateral	200,211	92,907	293,118	-107,304	5.8	3.6	4.9
Total	**3,450,029**	**2,552,841**	**6,002,870**	-897,188	100	100	100

Who is implementing activities targeting general population?							
PS type	**USD in 2009**	**USD in 2010**	**Grand Total**	**USD in change 2009-10**	**% in 2009**	**% in 2010**	**% Total**
Private sector providers	2,540,738	1,781,243	4,321,981	-759,495	73.6	69.8	72.0
Public sector providers	909,290	770,254	1,679,544	-139,036	26.4	30.2	28.0
Bi- and Multilateral offices		1,344	1,344	1,344	0.0	0.1	0.0
Total	**3,450,029**	**2,552,841**	**6,002,870**	-897,188	100	100	100.0

ASC 1 digit	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Prevention	3,357,521	2,426,048	5,783,569	-931,474	97.3	95.0	96.3
Enabling environment	92,507	111,807	204,315	19,300	2.7	4.4	3.4
Program management and administration		3,434	3,434	3,434	0.0	0.1	0.1
Social protection, social services		11,552	11,552	11,552	0.0	0.5	0.2
Total	**3,450,029**	**2,552,841**	**6,002,870**	-897,188	100	100	100

Non-targeted Interventions

Who is funding non-targeted interventions?

Financing Source	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Bilateral	7,958,903	8,028,862	15,987,765	69,958	40.5	33.5	36.7
GFATM	6,917,354	10,089,518	17,006,872	3,172,164	35.2	42.1	39.0
UN	2,105,092	2,595,416	4,700,508	490,324	10.7	10.8	10.8
Public	1,526,603	1,885,992	3,412,595	359,389	7.8	7.9	7.8
INGOs	868,552	829,751	1,698,302	-38,801	4.4	3.5	3.9
Multilateral (excl. GFATM and UN)	269,430	446,787	716,217	177,357	1.4	1.9	1.6
International for-profit	2,500	65,912	68,412	63,412	0.0	0.3	0.2
Private (national for- and non-profit)	1,371	14,687	16,058	13,316	0.0	0.1	0.0
Total	**19,649,805**	**23,956,924**	**43,606,730**	4,307,119	100	100	100

Who is the financing agent for non-targeted interventions?

FA type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Public	8,882,343	12,045,961	20,928,304	3,163,618	45.2	50.3	48.0
iNGOs	4,745,383	5,213,453	9,958,836	468,070	24.1	21.8	22.8
Private	2,460,746	3,119,074	5,579,821	658,328	12.5	13.0	12.8
UN	2,237,761	2,549,443	4,787,204	311,682	11.4	10.6	11.0
Bilateral	1,323,572	1,028,993	2,352,565	-294,578	6.7	4.3	5.4
Total	**19,649,805**	**23,956,924**	**43,606,730**	4,307,119	100	100	100

Who is implementing non-targeted interventions?

PS type	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Private sector providers	11,076,416	11,317,937	22,394,353	241,521	56.4	47.2	51.4
Public sector providers	6,244,295	10,004,688	16,248,983	3,760,393	31.8	41.8	37.3
Bi- and Multilateral offices	2,175,207	2,524,909	4,700,116	349,703	11.1	10.5	10.8
Rest of the world providers	153,888	109,390	263,278	-44,498	0.8	0.5	0.6
Total	**19,649,805**	**23,956,924**	**43,606,730**	4,307,119	100	100	100

ASC 1 digit	USD in 2009	USD in 2010	Grand Total	USD in change 2009-10	% in 2009	% in 2010	% Total
Programme Management and Administration	15,582,213	19,034,780	34,616,994	3,452,567	79.3	79.5	79.4
Enabling Environment	2,057,936	2,764,458	4,822,394	706,522	10.5	11.5	11.1
Human Resources (Training)	955,575	997,868	1,953,442	42,293	4.9	4.2	4.5
Research	673,333	1,105,895	1,779,228	432,563	3.4	4.6	4.1
Prevention	171,811	51,212	223,023	-120,599	0.9	0.2	0.5
Orphans and Vulnerable Children	114,090		114,090	-114,090	0.6	0.0	0.3
Care and Treatment	94,848	2,711	97,559	-92,137	0.5	0.0	0.2
Total	**19,649,805**	**23,956,924**	**43,606,730**	4,307,119	100	100	100