

Nepal
National AIDS Spending Assessment (NASA)
2016 and 2017

Government of Nepal
Ministry of Health and population
National Centre for AIDS and STD Control

Prepared by
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November 2018

About the report: Nepal National AIDS Spending Assessment (NASA) report was prepared adhering to guideline and principles for conducting NASA by UNAIDS (2009), a standard framework for producing AIDS spending assessment.

This report provides the assessment of HIV and AIDS related expenditures occurred in Nepal estimated based on the expenditure boundaries, expenditure data, classification codes and estimation methodology. This document was produced with the technical and financial assistance of UNAIDS.

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National AIDS Spending Assessment Nepal (NASA Nepal) 2016 – 2017**Contents**

Contents.....	iii
Foreword	v
Executive summary	iv
Abbreviations and Acronyms.....	vii
1. Introduction and background	1
1.1 Nepal’s Socio-Economic Indicators	1
1.2 HIV situation and response in Nepal.....	2
1.3 Public Health Financing in Nepal.....	5
1.4 Public Financing for HIV in Nepal	6
1.5 Previous HIV resource tracking findings.....	7
2. The Rationale for an HIV Spending Assessment.....	8
3. Aim and objectives of NASA in Nepal	9
4. Methodology and scope	10
4.1 NASA Concept.....	10
4.2 Approach	10
4.3 NASA classifications	10
4.4 Data collection and processing	11
4.4.1 Data collection form	11
4.4.2 Sources of data.....	11
4.4.3 Estimations	11
4.4.4 Data processing	12
4.4.5 Data validation	12
4.5 Fund flow mapping	12
4.6 Scope and limitations	13
4.7 Assumptions and clarifications	13
4.8 Challenges	15
5. Findings	17
5.1 Overview of AIDS spending in Nepal 2007 – 2017.....	17
5.2 Total expenditure by source, agent and provider.....	17
5.2.1 AIDS spending by Financing Sources – who funds the HIV response in Nepal.....	17
5.2.2 Financing Agent by Financing Source – who manage the fund.....	20
5.2.3 Flow of fund to Providers of services (PS)	21
5.2.4 Production Factors (inputs).....	24
5.3 Spending on key programmatic areas (ASC analysis)	25
5.3.1 Trend in ASC spending 2013-2017.....	26
5.3.2 Spending on ASC by source 2016 - 2017.....	27
5.4 Expenditure on HIV prevention activities	28
5.5 NASA prevention expenditure and five prevention pillars.....	30
5.6 Expenditure on care and treatment related activities	31
5.7 Expenditure on programme management.....	32
5.8 Beneficiary populations	33
6. NASA Expenditure and the NHIP projection	35
7. Conclusion and recommendations.....	37

8.	Appendices:	38
8.1	Appendix A: NASA Data Collection Tools	38
8.2	Appendix B: NASA AIDS Spending Categories—Codes and Definitions	39
8.3	Appendix C: Technical Working Group Members	40
8.4	References	42





Tables

Table 1:	Investment Required for National HIV Investment Plans (2016-2021)...	3
Table 2:	Funding Landscape - National HIV Investment Plans (2016-2021)	4
Table 3:	AIDS spending (ASC) by Financing Sources (FS)	18
Table 4:	Flow of fund from Source to Agent	20
Table 5:	Spending by Agent (USD)	21
Table 6:	Flow of fund from source to providers	22
Table 7:	Spending by production factor (PF)	24
Table 8:	Materials supplies by source of fund	25
Table 9:	Programmatic spending 2013 -2017.....	26
Table 10:	Key intervention areas (ASC) by source (2016-2017) (in USD).....	27
Table 11:	Sources of fund for prevention activities (in USD).....	28
Table 12:	Prevention activities (in USD)	29
Table 13:	Care and treatment activities by year	32
Table 14:	Spending under Programme Management by ASC code (in USD)	32
Table 15:	Spending by beneficiaries population (in USD)	34
Table 16:	Beneficiaries' population by source (2016-2017)	34

Figures

Figure 1:	HIV Prevalence among adult population (15-49) 2017	2
Figure 2:	Share of domestic and external health spending (%).....	5
Figure 3:	GoN allocation for HIV Response	6
Figure 4:	NASA data source	11
Figure 5:	Fund flow mapping	12
Figure 6:	Total AIDS spending 2007 – 2017	17
Figure 7:	AIDS Spending by Financing Sources	17
Figure 8:	Percentage share by sources of fund (2016-2017)	18
Figure 9:	Spending by type of agent (USD)	21
Figure 10:	Spending by providers	23
Figure 11:	NGOs spending by ASC	23
Figure 12:	INGOs spending by ASC	24
Figure 13:	Spending by ASC (in USD)	25
Figure 14:	Spending in key programmatic areas (2013-2017)	26
Figure 15:	Spending in HIV prevention (ASC. 01) by source.....	28
Figure 16:	Spending on five prevention pillars by years (in USD)	30
Figure 17:	Five prevention pillars by source of fund	31
Figure 18:	Spending in treatment and care (ASC 02) by source (in USD)	31
Figure 19:	Source of fund for care and treatment (in USD)	32
Figure 20:	Spending on Programme Management by sources	33
Figure 21:	NHIP projection vs NASA spending	35
Figure 22:	NHIP vs commitment vs NASA.....	35

Foreword

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<p>Ref no.</p>		<p>Email: ncase@ncase.gov.np Website: www.ncase.gov.np Teku, Kathmandu Nepal</p>
<p>Date:</p>		
<p>Foreword</p>		
<p>National Centre for AIDS and STD Control takes pleasure to put forward the Nepal National AIDS Spending Assessment (NASA) 2018 as the fourth round of exercise of tracking resources used for the national HIV response in Nepal. The First and the Third rounds of NASA were conducted in 2007 and 2015 respectively premising upon the NASA methodology. The second resourcing tracking exercise was carried out in 2010 using a different methodology and classification system.</p>		
<p>NASA 2018 provides an accurate map of financial resources and the use of funds for the national response for the period of 2016 and 2017. Moreover, NASA 2018 combine with previous two rounds of NASA have put forward an overall trend of expenditures incurred for key areas of the national HIV response, notably: prevention; treatment and care, and program management. In addition to this, the current NASA 2018 also has comparatively linked the total HIV spending of the period of 2016-2017 to the resource requirements projected for the same period in National HIV Implementation Plan (2016/2017-2020/2021). Given all these, Nepal is well placed to: i) produce spending data for internationally adopted indicators and other national commitments, and; ii) bring about improvements on enhancing allocative efficiency and streamlining the resource spending for greater efficiency and cost effectiveness. I am also confident that NASA 2018 will be of much value to all stakeholders for a better understanding of financial flows and gaps in the national AIDS response.</p>		
<p>The accomplishment of fourth round of resource tracking exercises affirms Nepal's commitment towards advancing financial governance, transparency, accountability for attaining the goal of 90-90-90 with a greater efficiency and cost effectiveness of the national AIDS response. In this context, the National Centre for AIDS and STD Control thanks all civil society organizations, development partners, UN agencies and donors that provided data and contributed to the successful completion of this assessment.</p>		
<p>All the fellow members of The Technical Working Group - comprising of representatives from government ministries, key staff members of NCASC, and representatives from UNICEF, WHO, UNAIDS, FHI 360, AIDS Health Foundation Nepal; and Save the Children and entrusted with the responsibility of conducting this assessment - deserve a laudable acknowledgement for their sincere endeavors that they put in for the "Nepal National AIDS Spending Assessment (NASA) 2018".</p>		
		
<p>Dr. Tara Nath Pokhrel Director (Chair - Technical Working Group for NASA)</p>		
		

Executive summary

This is the third round of National AIDS Spending Assessment (NASA) and fourth in series in resource tracking exercise in the country. This exercise was conducted from March to December 2018.

The aim of the NASA 2018 was to undertake a comprehensive tracking of the resources from international, public and private sources including out of pocket expenses that comprises the national response to HIV in Nepal for the years 2016 and 2017. NASA followed the standardised classification method (UNAIDS 2009) that is compatible to the system of National Health Account and is internationally comparable. It describes the allocation of funds, from their origin to the end point beneficiary groups who benefit from specific interventions, goods and services.

Major findings

The total spending for HIV response was recorded at USD 18.8 million and USD 20 million in 2016 and 2017 respectively. The overall AIDS spending in Nepal appeared to have hovered between 17 and 20 million with some ups and down in between since 2007. Financing the HIV response in Nepal apparently is heavily dependent on international sources of financing. International sources took much of the share in AIDS spending (85%) followed by Domestic government share (8%). Private (out of pocket expenses) share was 7% during the assessment years. Among international sources, multilateral sources (including the Global Fund) took much of the share of AIDS financing. Government of Nepal (GON) and Household expenditure were two domestic sources for HIV financing in the country.

Some 14 different financing sources were recorded in this round of NASA, of which two were bilateral sources, six were multilateral sources, four international NGOs apart from two domestic sources (government of Nepal and public/private out of pocket). Fund from these fourteen sources were managed by some sixteen different financing agent (fund managers) and ultimately passed on to nine different categories of providers (i.e. NGOs, hospitals, laboratories, private agencies) who provided goods and services to intended beneficiaries.

On the programme intervention, out of eight NASA spending category, spending was recorded in seven categories. As with previous years, bulk of the resources, USD 17.8 million (46%) were spent on prevention related activities. Care and treatment received 29% (USD 11.4 million) of total AIDS spending in 2016-2017. Over the years from 2013, there appeared slight decline in prevention spending whereas steady rise in the care and treatment.

Similarly, spending for programme management and administration was recorded at 14% (USD 5.5 million) of total AIDS spending in the country. Spending on human resource 2 % (deploying additional human resources to point of care centres i.e. hospitals), social protection (1%), HIV related research (1.31%) and enabling environment (7%) were recorded. A declining trend was also observed in spending on enabling environment. HIV related research has always received low priority and in current years also same pattern was noticed with spending of 1.5% (USD 0.5 million) of total AIDS spending.

International NGOs were the largest fund manager (financing agent) managing 80% (USD 31.3 million) of total AIDS spending in 2016-2017, followed by government agencies who managed 7. % (USD 3 million). Household were the largest agent for their own spending on AIDS related goods and services managing 7.2% (2.8 million USD) of total spending.

NGOs appeared to be the most preferred providers by all financing sources with 49% of total spending by this category of the provider. NGOs received fund from almost all types of sources including government sources. Next largest providers were INGOs who provided goods and services worth 46% of total AIDS spending. INGOs procured ARV drugs and other pharmaceutical including CD4 count machine and viral load machine.

Nearly 28% (USD 10.8 million) of spending were made to procure ARV drugs, CD4 and VL machines in current assessment period. USD 11.4 million (29%) were used to pay wages and salaries of different types of health care providers including large number of field worker from NGOs. 42% of total spending were made on administrative and other services (i.e. consultancy services, rent and maintenance, transportation services).

Over the period, major spending was noted to have been targeted to PLHIV (all category) that accounted for highest spending among all beneficiaries 29.7% (USD 11 million). For other key population 5-8% was spent in each categories for IDUs, MSM/TG, migrants, children/mother (PMTCT). Next highest spending was noted on non-targeted interventions (such as, advocacy, research, programme management cost) which accounted for 29.1% (USD 11.3 million).

An analysis was made on NASA finding and NHIP resource projection to ascertain the appropriate investment (spending in NASA terms) was made to achieve the goal set by the NHIP. It was observed that overall NHIP projection for two years (2016/17 and 2017/18) was USD 55 million and actual NASA spending (2016-2017) was USD 37.9 million.

Detailed comparison and further analysis indicated that spending in Treatment and care was very close to NHIP projection for the year. Likewise, spending in programme management and enabling environment was noted to be much higher than NHIP plan. But spending in prevention, human resources were much lower than that of initial plan. It was also observed that NASA spending vs commitments received from different partners during NHIP preparation two years ago is fairly aligned despite some gaps in investment needs. NASA spending was nearly 70% of the total NHIP projection

Recommendations

- In order to ensure accountability and transparency and honouring the rights to information, a system needs to be set up to centrally obtain financial expenditure from all the fund managers (Agent) operating in the country in an agreed format once a year as envisioned in National HIV Strategic Information Guidelines. This will allow regular tracking of the resource flowing to HIV response in the country.
- Adequate dialogue and deliberation often do not happen around the allocative efficiency and spending efficiency during national process (i.e. reviews and planning meetings at various levels). Regular dialogues and reviews on AIDS spending is also

recommended for improving allocative and spending efficiency as well as to promote transparency and good financial governance. Regular deliberation and dialogue be initiated on spending and output of the programme in order to ensure the quality of services.

- NASA and National Health Account is conducted independently in different point of time and often not linked; effort should be made to link NASA and NHA. In other words, NASA can be institutionalised if linked with NHA.
- NASA classifications and boundaries needs to be reviewed in the light of changing nature of epidemic and global (and local) focus on AIDS responses. It is also recommended that a cross walk is prepared between NASA categories and other programme indicators i.e. PEPFAR indicators, new global AIDS monitoring indicators.
- Resource planning tends to be on higher side where as actual executed amount is low. It is recommended that while preparing NHIP or any such resource projection documents, NASA information to be a strong reference for making reasonable projection. It would be useful to revisit NHIP projection in the light of actual spending figures as well as revisit budgeting and programme implementation strategy so as to harmonise the NHIP and programme implementation.

Abbreviations and Acronyms*

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BCC	Behaviour change communication
BL	Bilateral Agencies
BP	Beneficiary Population
CCC	Community Care Centre
CHBC	Community Home Based Care
DACC	District AIDS Coordination Committee
DFID	UK Department for International Development
DIC	Drop-in Centre
eVT	Elimination of Vertical Transmission
FA	Financing Agent
FHI (360)	Family Health International (360)
FS	Financing Source
FSW	Female Sex Worker
GAM	Global AIDS Monitoring
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoN	Government of Nepal
GIZ	German Development Agency
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug User
INGO	International Non-Governmental Organization
KP	Key population
LDC	Least Developed Country
LGBTI	Lesbian, gay, bisexual, transgender and intersexual
MARP	Most at Risk Population
ML	Multilateral Agencies
MoHP	Ministry of Health and Population
MSM	Men Who Have Sex with Men
n.e.c	Not elsewhere classified
NAC	National AIDS Council
NACP	National AIDS Control Programme
NAP	National Action Plan
NASA	National AIDS spending assessment
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
NHIP	Nepal HIV and AIDS Investment Plan
OI	Opportunistic Infection
OST	Oral Substitution Therapy

* Note: NASA terminology still uses terms like MARPS, OVC etc. which is not much in use in recent days, instead terms like Key Population (KP) or CABA (Children Affected by AIDS) are used.

OVC	Orphans and Vulnerable Children
PF	Production Factor
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre Exposure Prophylaxis
PS	Provider of Services
RTS	Resource Tracking Software
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TI	Targeted Intervention
TWG	Technical Working Group
TOR	Term of Reference
TABUCS	Transaction Accounting and Budget Control System
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VL	Viral load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

1. Introduction and background

National AID Spending Assessment (NASA) measures the spending for the final consumption of goods and services in the national AIDS response. In other words, it tracks the flow of funds used to finance national responses to the HIV epidemic. The resource tracking process follows the financial transactions from their origin to the final destination (i.e. the beneficiaries receiving goods and services). NASA follows comprehensive methods that tracks health and non-health expenditures such as social mitigation, education, labour, and other sectors related to the multisectoral HIV response according to NASA guidelines (UNAIDS 2009).

First NASA was conducted in Nepal in 2007 and a similar resource tracking exercise was conducted in 2011 and the second round of NASA in 2015. In this line, this is the fourth effort in assessing the AIDS spending in the country. This assessment is expected to help in expanding the understanding on the trajectory of resources flow and its spending in producing goods and services. This will also serve as an important strategic information to monitor the progress and guide the stakeholders for better targeting the resource. NASA evidence also allows monitoring the progress on including the key indicators for Global AIDS Monitoring (GAM) adopted by the United Nations. It generate important strategic information for the management and the coordination of the national response to AIDS.

This report maps the flow of resources for the year 2016 and 2017 from its sources, its use and intended beneficiaries in a systematic table and graph. Effort is also made to draw the trends of such flow from previous exercises to the extent data are available. This allows stakeholders to estimate financing gaps for HIV/AIDS overall, and for specific interventions across the HIV/AIDS prevention, care, and treatment spectrum.

1.1 Nepal's Socio-Economic Indicators

Nepal is a least developed country (LDC) characterized by relatively moderate economic growth, socio- economic underdevelopment and a low level of human development. For the year 2017, Gross National Income (GNI) of Nepal was pegged at 23.27 billion USD. The country has recorded an annual GDP growth of 7.5% in 2017, a significant increase compared to 4.8% of 2010 (World Bank 2018). Similarly, per capita gross national income of 790 USD was observed for the year 2017 compared to 540 USD that of 2010 (World Bank 2018). The country has set the goal of graduating from LDC status by 2022. Of the three criteria for graduation - per capita gross national income (GNI), human assets and economic vulnerability - the country is likely to achieve two of them and lag behind in terms of GNI per capita (SDG Preliminary Report 2016-2030, National Planning Commission 2015). Absolute poverty decreased from 42 percent in 1995 to 25 percent in 2010 and decreased further to 23.8 percent in 2015 (SDG Preliminary Report 2016-2030, National Planning Commission 2015)

The total population of Nepal, as of 2017, was 29.3 million with an annual population growth rate of 1.1 percent (Population Monograph, CBS, 2014). A large volume of the youth population has been consistently moving abroad to different destinations of the world. The absent population reported in 2011 was 1,921,494, a big jump from the number of 762,181 of the census of 2001(Population Monograph, CBS, 2014).

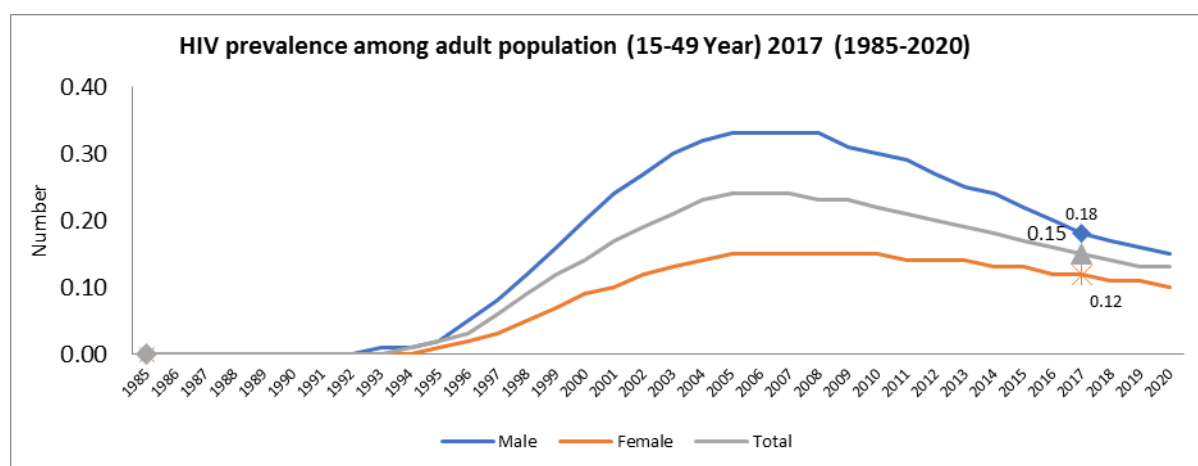
Life expectancy at birth for the year 2017 is estimated at 70 years improving further from 66.6 years in the census year 2011 (World Bank 2018). The life expectancy of females has overtaken males in the last 30 years. Life expectancy at birth for females has increased from 48.1 years in 1981 to 67.9 years in 2011 (Population Monograph, CBS, 2014). Substantial progress has been made in child health with the reduction on under-five mortality from 47 per 1,000 live births in 2010 to 34 per 1,000 live births in 2017 (World Bank 2018). Nepal has achieved impressive progress in reducing maternal mortality, from 850 per 100,000 live births in 1990 to 258 per 100,000 live births in 2015 (Factsheet, UNFPA 2017). The total fertility rate (TFR) of a woman throughout her lifetime is expected to be around 2.1 births in 2017- a significant reduction from 2.6 births in 2010 (World Bank 2018).

1.2 HIV situation and response in Nepal

Nepal's HIV epidemic remains concentrated among key populations. Recent Integrated Bio-Behavioural Surveillance (IBBS) Surveys conducted in various epidemic zones of the country noted HIV prevalence of 5% among men who sex with men (MSM) and 8.5% among Transgender (TG) people; 8.8% among males who inject drugs and 8.8% among women who inject.

Likewise, other key populations included in the national response to HIV of Nepal are male and female sex workers (FSWs), male labour migrants and their spouses; and prison inmates. Among these key populations, IBBS indicate that the HIV prevalence is 2.2% among female sex workers (FSW), and 0.4% among the male labour migrants in certain epidemic zones of the country (IBBS, 2017, 2016, NCASC). National HIV infection estimation 2017, estimated that around 835 new infections occurred during 2017 with HIV incidence at 0.039 per 1000 (Factsheet, 2018, NCASC). Furthermore, estimated annual number of AIDS-related deaths was around 1,306, out of which, 33 deaths of were among children aged (0-14 years) (Factsheet, 2018, NCASC).

Figure 1: HIV Prevalence among adult population (15-49) 2017



According to NCASC, out of the total of 32,747 (20,198 male and 12,361 female) ever reported cases of HIV, there were 21,148 (10,827 male and 10,215 female) alive cases (estimated) as of July 15, 2018. These figures denote HIV prevalence among adult population (15-49 years) in Nepal for the year 2017 is 0.15. Among these, a total of

16,428 (51.2% male, 48.3 % female and 0.5 TG) were receiving ART from 74 ART sites across the country in 2018.

Around 88% of people on ART were still on treatment after 12 months after initiation of the ART in 2018. Within the first seven months of 2018; a total of 6,038 were tested for viral load; of which 5,394 were found to have suppressed viral loads.

Out of 304 pregnant women diagnosed with HIV in 2017, around 192 (63%) of whom received ART and 118 babies also received prophylaxis for HIV.

National Response to HIV

National Policy on HIV and STI, 2011 provides the overarching policy and governance frameworks for the country's HIV and STI response in Nepal. National Drug Control Policy 2063 (2006 AD), National Drug Control Strategy, 2066 (2010 AD); National Blood Transfusion Policy; and National Policy on HIV/AIDS in the Workplace, 2064 BS (2007 AD) are also other key legal and policy frameworks that are reinforcing the national response to HIV in Nepal.

With the vision of "Ending the AIDS epidemic, as a public health threat in Nepal, by 2030" Nepal has put in operation its current National HIV Strategic Plan 2016-2021. Anchoring upon the paradigm of 90-90-90, this Strategic Plan has set the following targets to fast track the national response to HIV by 2021:

- Identify, recommend and test 90% of key populations;
- Treat 90% of those diagnosed as HIV positive;
- Retain 90% of those on ART;
- Eliminate vertical transmission of HIV and keep mothers alive and well;
- Eliminate congenital syphilis, and;
- Reduce 75% of new HIV infections.

Building upon NHSP 2016-2021, Nepal is implementing its National HIV Investment Plans (2016-2021) that specified necessary activities and their targets for five years to accomplish the targets of 90-90-90 by 2021. The Investment Plans have outlined activities and targets for the following two main components: a) basic program activities and b) critical enablers. The basic program activities are based on the strategy "Identify, Reach, Recommend, Test, Treat and Retain (IRRTTR)" that NHSP 2016-2021 adopted for ensuring retention with a prevention and treatment continuum, while critical enablers include programmatic as well as social enablers (Table 1).

Table 1: Investment Required for National HIV Investment Plans (2016-2021)

Investment Areas	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Reach and Recommend	16,066,785	17,641,507	20,684,329	22,787,738	25,274,841
Testing	1,037,985	1,272,760	1,431,787	1,578,871	1,695,603
Treatment and Retention in Treatment	5,134,179	6,028,741	8,588,846	9,522,381	10,014,658

Investment Areas	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Programme Enablers	3,752,865	2,208,882	1,642,133	1,032,150	1,141,921
Social Enablers	463,333	612,833	656,167	671,167	671,167
Strategic Information	773,583	990,407	723,413	777,658	1,295,800
Total	27,228,729	28,755,131	33,726,674	36,369,965	40,093,990

As shown in Table 1, the total resources required for the first year is 27.2 million, and for the second year 28.7 million. Global Fund for AIDS Tuberculosis and Malaria (GFATM), USAID and Government of Nepal are the major funding sources to the national response to HIV. National HIV Investment Plans (2016-2021) during its preparation in 2016 also mapped a funding landscape for the period of three financial years starting from 2016-2017 which is as follows (Table 2).

Table 2: Funding Landscape - National HIV Investment Plans (2016-2021)

Anticipated Funding Sources	2016/ 2017	2017/ 2018	Comments
Global Fund	16,220,211	9,895,778	
USAID	3,500,000	1,500,000	
GoN Core Fund	1,123,200	1,235,520	Assumed same level of funding as previous year with 10% increment every year
GoN Pool Fund	4,000,000	4,000,000	Indicative
AHF	500,000	500,000	Indicative
Mainline		1,500,000	
Other sources	1,000,000	1,000,000	Indicative
Total Committed Amount	26,343,411	19,631,298	

Currently the Global Fund and Government of Nepal are providing funding for the targeted interventions notably: 1) People who Inject drugs, 2) MSM/TG/MSW, 3) Migrants, and 4) Prison Inmates. Apart from these, GFATM and Government of Nepal are also involved in treatment, care and support of people living with HIV. The Government of Nepal has maintained a dual stream of resources to the national HIV response: (a) through its regular funding to NCASC and (b) through the Pool Fund. The Pool Fund, comprises of a basket of funds from both government as well as external resources. Majority of funding of Pool Fund for the HIV response, is being channelled through NGOs for the interventions targeted to key populations.

Over the past 25 years, USAID has been working in close partnership with the Government of Nepal, and has invested more than US\$ 95 million for comprehensive HIV prevention, care, support and treatment services in the country. USAID, at present, is solely providing technical and financial support for comprehensive HIV prevention, care support and treatment services for female sex workers (FSWs) and clients of FSWs in the country. In addition to this, USAID also provides comprehensive HIV prevention, care support and treatment services men having sex with men (MSM), male sex workers (MSWs) and transgender people in selected districts.

UN system - in particular, UNAIDS, WHO, UNICEF, UNFPA and UNODC- has been supporting the HIV response in Nepal in diverse areas notably; preparation of national strategy; size estimation of key affected populations; preparation of guidelines and directives; harm reduction; treatment and care; and expansion of services related to elimination of vertical transmission over the period of decades. Apart all these, UN system's role in providing technical assistance for resource mobilization is also noteworthy.

Apart these actors, AIDS Health Care Foundation has been involved in the response to HIV in Nepal. Its main areas of involvement are in supporting the government the delivery of service in two key programmatic areas: a) treatment care and support of people living HIV, and; b) HIV testing among general population groups. Many other partners like GiZ, Mainline Foundation, Sidaction and so on are supporting HIV response with different programmatic emphasis and focus.

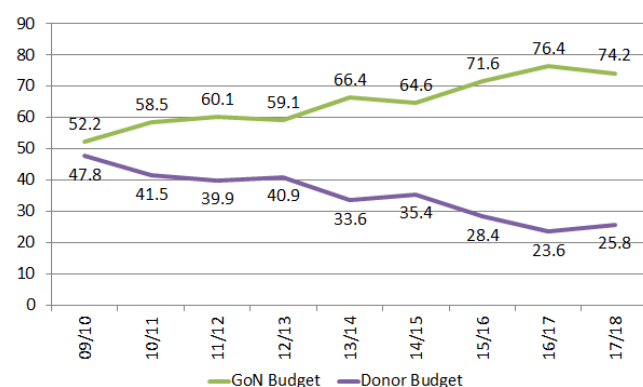
1.3 Public Health Financing in Nepal

Government health spending has increased steadily in terms of total volume over the last decade. As a percentage of GDP, it has remained around the 5-6% level over the last 5 years.

During this period, reliance on external funding has declined significantly, with GoN funding increasing from around 50% during the first health sector plan (NHSP-1) from 2005-2009, to some 75% at the start of NHSP-3 (2016) (Figure 2)¹.

This funding landscape is now in a period of transition, with external resources on a rapid downward trend since 2014—the reduced Global Fund envelope for 2018-2021 will result in a decrease of around 35% in 2018 —while the government has taken important steps towards securing the sustainability of the response by stepping up its contribution.

Figure 2: Share of domestic and external health spending (%).



National Health Account (2012/13-2015/16) estimated the total health care spending as % of GDP 5.78%, 6.8%, 6.56% and 6.72% from 2012/13 to 2015/16 respectively for last four years. The per capita current healthcare spending was pegged at 44.42 USD (NPR 5216) for the year 2015, a significant jump compared to that of 30USD in 2010. Domestic general government health expenditure (GGHE-D) per capita was found to be around 8 USD in 2015, while 31 USD per capita for Domestic private health expenditure

¹ Brief Overview of the Health Sector Funding. WHO

(PVT-D), and; around 5 USD per capita for External health expenditure (EXT). Moreover, the Domestic General Government Health Expenditure (GGHE-D) contributed to only 1.11 per cent of GDP in 2015.

Domestic General Government Health Expenditure (GGHE-D) contributed to 18.1 per cent of the current health care spending during 2015. In contrast, Domestic private health expenditure (PVT-D) accounted for 71.4 per cent of current health expenditure (CHE); whilst External health expenditure (EXT) made up 10.5 per cent of current health expenditure. A majority, 60 per cent of healthcare expenditure in the year 2015 came from the household out of pocket expenditure (OOPE) that was around 27 USD per capita.

National Health Account (2012/13 – 2015/16) estimated Current Health Expenditure (CHE) in the current price was NPR 141.46 billion (6.3% of Gross Domestic Product (GDP)) and the capital expenditure was NPR 9.70 billion (0.4% of GDP) in the year 2015/16. Households Out-of-Pocket (OOP) payment at 55.4% of all the current funds for health care services and goods, was the major source of funding the health system of the country in the year 2015/16. Next to the household, the government funded 18.6% of CHE from its domestic revenues, followed by Non-Profit Institutions Serving Households NPISH (12.0%) and direct foreign transfers were 8.6%. Among the multilateral and bilateral donors, the major funds were from the USAID (2.4%), GAVI (1.9%), DFID (1.5%), UNICEF (1.4%) and WHO (0.9%).

1.4 Public Financing for HIV in Nepal

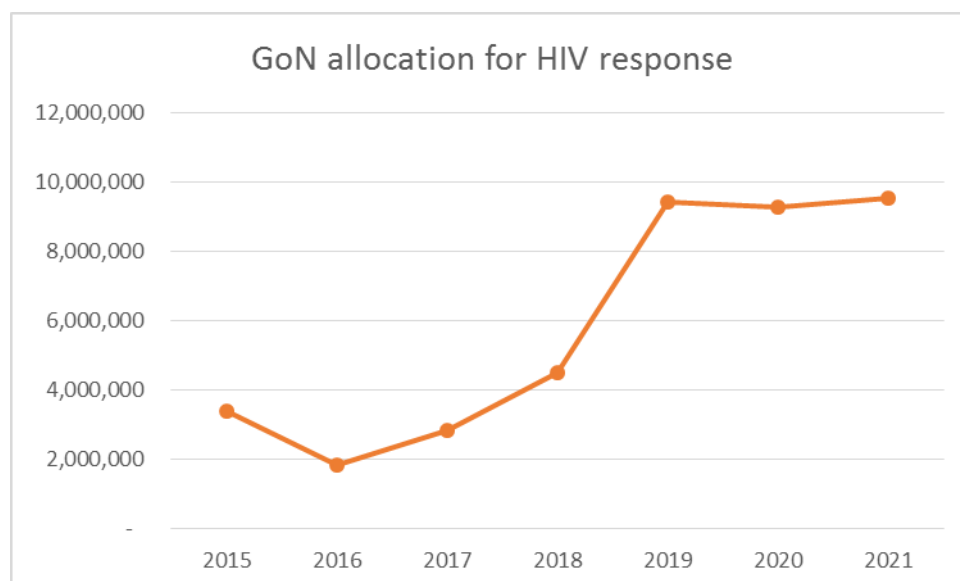
HIV programme in Nepal remains heavily dependent on external assistance. GoN financing for the programme comes both through direct sectoral budgets and through the Pooled Fund. The Pooled Fund accounted for around 10% of overall HIV spending in 2014,² and was used primarily to support comprehensive HIV prevention programme for key populations (including migrants).

The largest single contributor in the HIV response in Nepal is the Global Fund, which supported just under half of HIV expenditure in 2014, while bilateral funding—principally from USAID and GIZ—accounted for just over one-fourth of spending in 2014. Several other partners, including UN agencies and INGOs, also continue to support the response

Towards the national goal of ending AIDS by 2030, the GoN has indicated to a significant increase in resources for the HIV programme with an average 9.4 million for each of the three years (Figure 3). This includes covering 100% of the country's procurement of ARVs in 2019-20 and 2020 - 21, as well as the salaries of health staff hired specifically for the programme, such as HIV counsellors, who have to date been supported by the Global Fund. In addition, through this commitment, the GoN has assured regular budget allocations for core programme components, including treatment, eVT, TB-HIV, STI and strategic information that previously received significant Global Fund support (source: Global Fund funding application Nepal 2017).

Figure 3: GoN allocation for HIV Response

² NCASC: NASA 2015 (quoted in the Nepal Country Progress Report 2016).



1.5 Previous HIV resource tracking findings

Nepal has been able to conduct four rounds of resource tracking exercise and three of which is NASA. First round of NASA was conducted in 2007. Next resourcing tracking exercise was carried out in 2010 using a different methodology and classification system of tracking the resources. Third round (2015) and fourth (this one) was based on NASA methodology (UNAIDS 2009).

NASA 2007

About US\$ 33 million were committed by different partners for the two years period (2006-2008) or about 17 million for one year against US\$ 64 million budget plan of National Action Plan (NAP 2006-2008). It is observed that US\$ 17.5 million was actually spent indicating a fairly consistent pattern of commitments and actual spending, though this spending is only 50% of total requirement according to NAP 2006-2008. An overwhelming proportion (85%) of resources were spent through NGOs providing HIV services to different categories of beneficiaries.

Resource Tracking Survey (RTS 2010)

A total of USD 20.5 million was spent in the year 2009 and USD 19.1 million was obligated for the fiscal year 2010. Global Funds constituted one of major sources of funding, which provided 31.3% of funding for HIV response for the fiscal year 2009; this was followed by DFID (30.9%) and USAID (26.8%). Effort was made to analyse the spending data by district and regions (five regions).

NASA 2015

Overall US\$ 16,357,125 and US\$ 18,815,087 were spent for the year 2013 and 2014 respectively from 26 financing sources that fall within the five broader categories of financing sources (Government of Nepal, bilateral sources, multilateral sources, International organisations and private sources including out of pocket). Government of Nepal financed HIV programme utilising two mechanisms, national revenue sources and the pool fund mechanism of donors and government.

National Health Account 2012/13 - 2015/16

Total Health Expenditure (THE) was estimated at NPR 151.16 billion (USD 1.43 Billion) which was 6.7% of GDP and the per capita was NPR 5216 (USD 49) in the year 2015/16. Among the sources of health expenditure, household out of pocket comprised of 55.4% of all the current fund for health care services and goods.

Next, of the total Current Health Expenditure (NPR 28.93 billion) in the infectious and parasite disease category, HIV/AIDS and other STD accounts for 9.1%. NHA further estimated that CHE for DIS.1.1 HIV/AIDS and Other STDs and DIS.1.1.nec Unspecified HIV/AIDS and Other STDs (n.e.c.) USD 53.0 million (26.5+26.5) and USD 49.6 million (24.8+24.8) for 2014/15 and 2015/16 respectively³

There is a substantial differences in the total spending estimated by NASA and NHA for the same period of time. Primarily such differences are largely due to different methodological procedures adapted by NASA and NHA. NHA derives the ratio by estimating and apportioning the health expenditure by all health care providers, whereas NASA actually track the spending from its sources to the ultimate beneficiaries. For example, NHA apportions certain percentage of all health expenditures from all hospitals to HIV and AIDS irrespective of the HIV services used/available in that particular hospital. As such, in government hospital in Mugu or hospital in Dolpa may not have HIV services available or may not have users there, but as a methodological procedures certain percentage of expenditure of such hospital is also apportioned to HIV spending.

It was also noted that one of the major financing source for HIV, TB and Malaria response in the country since 2003, the Global Fund, did not strongly feature in the NHA.

2. The Rationale for an HIV Spending Assessment

The rationale and the benefit of the NASA are many fold, more so when the NASA results are used in combination with other key programmatic (costed strategy, budgetary allocation) and epidemiological data. The NASA results allows for;

1. Monitoring the implementation of national strategic plan (Investment case) as well as producing spending data for internationally adopted indicators (e.g. GAM) and national commitments to reports such data,
2. Understanding the trend in spending pattern and how the resources are used in response to HIV epidemic in the country,
3. Initiating dialogue for rational resource allocation (allocative efficiency) and streamlining the resource spending for greater efficiency and cost effectiveness.
4. Calculating the AIDS funding gap and assessing the overall absorptive capacity in order to learn lesson for improvement in absorptive capacity.

³ NHA used actual spending as well as Public Health Facility Survey (NHEA, 2014), MoHP plan and budget details, Financial Controller General's Office (FCGO) expenditure details of MoHP to derive the ratios for the distribution of the aggregated government expenditure to the disaggregated level compatible to SHA 2011 classification

5. Using NASA findings to initiate dialogue (and advocacy) for increasing the domestic investment for HIV response in the context of dwindling international resources.

3. Aim and objectives of NASA in Nepal

NASA aims to contribute to the strengthening of national response to HIV and AIDS in Nepal by generating valuable information on flow of national and international resources and its use in order for the country to take appropriate policy and strategic decision.

The objective of this NASA was to conduct a National AIDS Spending Assessment (health and non-health) by using six variables (financing sources, financing agents, functions or AIDS Spending categories (ASC), production factors, providers of services and intended beneficiaries) and to build the foundations for the development of a NASA system in Nepal in the coming years, including strategic investments in the strengthening of individual and institutional capacity.

The overall aim of the assessment was to undertake a comprehensive tracking of actual spending, based on internationally standardised system of NASA classification and guidelines, from international, public and private sources including out of pocket expenses that comprises the national response to HIV in Nepal for the years 2016 and 2017. The specific objectives were:

- Organise and facilitate the NASA orientation for enhancing local capacity for systematic monitoring of HIV financing flows using the NASA methodology and guidelines, with a view to institutionalized the NASA.
- Prepare data collection tools and support data collection to assess HIV financing flows and expenditures for 2016 and 2017 adapting the NASA methodology, classification and tools from public, private and international sources;
- Collect or estimate the household or individual out-of-pocket expenditures (OOPE) for HIV-related health services.
- Identify and measure the flows of resources for HIV by funding source, funding agent, service provider function/ intervention, cost components (factors of production) and beneficiary populations and by state wherever possible.
- Prepare a report of expenditure trends that will contribute to the evidence informed resource allocations through domestic sources as envisioned in National HIV Strategic Plan 2016-2021.

4. Methodology and scope

4.1 NASA Concept

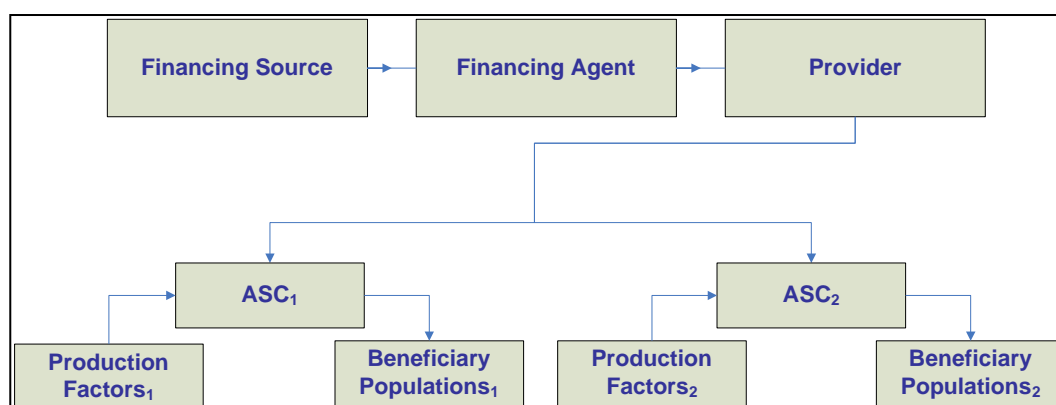
NASA approach is a comprehensive and systematic methodology developed by UNAIDS to determine the flow of resources from source to agent and to providers who provides goods and services to specific population group. It describes the allocation of funds, from their origin to the end point beneficiary groups who benefit from specific interventions, good and services (a schematic diagram is presented below). The most important aspects of NASA is that it is designed to track both health and non-health expenditure related to HIV/AIDS as well as track the expenditure by intended beneficiaries

4.2 Approach

The NASA assessment in Nepal followed the generic National AIDS Spending Assessment (NASA) methodology designed by UNAIDS.

NASA also produces a standardized reporting method and indicators to monitor progress towards the targets of the Declaration of Commitment adopted by the United Nations.

In Nepal, NASA study was approached with aim of capturing all the expenditure made during the year 2016 and 2017 from all sources, agents and providers. Therefore all the broad-based classifications for HIV and AIDS expenditure across three dimensions (source, financing, and use) were followed, which incorporate six vectors (sources, agents, providers, production factors, functions, and beneficiaries).



4.3 NASA classifications

NASA classification follows internationally agreed sectoring, financing, and production concepts and nomenclatures primarily following the System of National Health Account. Financial flows and expenditures related to the National Response to HIV are organized according to three dimensions: finance, provision, and consumption. The classification of the three dimensions and six categories comprise the framework of the NASA system (UNAIDS 2009). These dimensions incorporate six categories⁴:

⁴ For more detail please refer to UNAIDS (2009), National AIDS Spending Assessment (NASA) Classification and Definition.

4.4 Data collection and processing

- Under the leadership of NCASC, the preparatory work began with the preparation of concept note and detail road map of NASA exercise.
- NCASC formally sent information and request letter to relevant ministries, institutions, EDPs, NGOs and other stakeholders to support the NASA process and provide spending data to NASA team in a specified format.
- A NASA Technical Working Group (TWG) was constituted consisting of representatives of NCASC (overall coordination of the process); UNAIDS, Ministry of Health and Population and technical partners. Series of meetings of TWG took a number of decisions regarding mapping of institutions by source, agent and providers; time frame; division of tasks among the members and so forth.

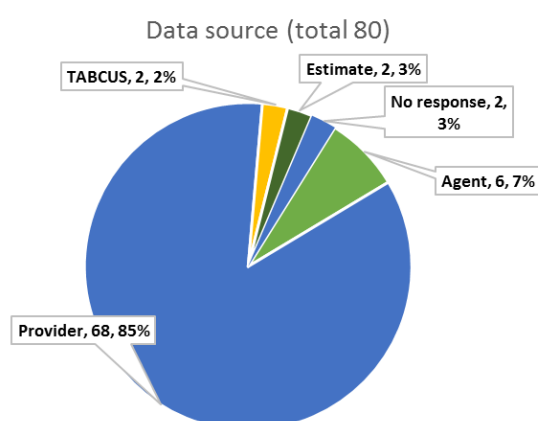
4.4.1 Data collection form

Generic data collection form developed by UNAIDS was adapted to suit country situation. Both electronic and hard copies were made available to all those organisations who were identified for the NASA data collection. The data collection form was pre designed in an Excel sheet aiming to collecting information regarding name of financing source/s, name of the project, activities and their descriptions, who are the intended beneficiaries of each of activity, whether or not any fund is transferred to other agency, total expenditure and production factor (inputs) for each of the activities. Instruction on how to fill form and a sample of completed form were part of data collection form.

4.4.2 Sources of data

A number of sources of data for NASA were identified in consultation with NCASC and other major implementing partners. The government agencies involved in HIV including the local government, the bilateral and multilateral agencies and major NGOs and INGOs were considered as sources (Figure 4).

Figure 4: NASA data source



For NCASC expenditure data available at Transaction Accounting and Budget Control System (TABUCS – a web based programme extensively used by the Ministry of Health and Population) was used.

4.4.3 Estimations

Two types of estimation were made for this round of NASA:

- a. Cost of human resources particularly from government hospitals and health facilities where ART and PMTCT services are provided was estimated. Time spend by the health personnel (medical doctor, nursing staff, laboratory staff) for HIV/ART and PMTCT clients were estimated and converted to monetary value using prevailing government salary and benefit package.
- b. Nepal Red Cross Society collects and distributes the blood through its blood transfusion centres throughout the country. Before distributing the blood, blood bank performs basic screening test for HIV, Hep B and C, syphilis and other. Blood

bank charges a fixed amount per unit of blood where cost of all such tests are included. Cost of each test for HIV, Hep B and C and total blood distributed in 2016 and 2017 was obtained from the blood transfusion centre. Total cost paid by individuals proportionately for screening tests of related infectious disease (like HIV, Hep B, C and other STI) is estimated against the total blood distributed. This is paid by individuals as 'out of pocket' expenses for HIV and STI prevention.

4.4.4 Data processing

Data collection and processing was a major task demanding much of the time of the NASA team. Data processing comprised a number of stages.

Stage 1: Once the data is received (hard or soft copy) first checked for consistency, clarity and depth of details. For any inconsistency and incomplete data, the organization is contacted again for clarifying the inconsistency.

Stage 2: Once the data is complete and consistent, NASA transaction was constructed in an excel sheet. This consisted of assigning a particular NASA classification for each of the expenditure items. This is also a process of cleaning the data and triangulating the three dimensions (source, provision and use) and six vectors (source, agent, providers, AIDS spending category, production factor, beneficiary population).

Stage 3: Once the transaction is constructed and all the data triangulated, in the stage 3, the data was entered into an excel spread sheet for further analysis.

Stage 4: Once the data entry was completed in excel, output was obtained in the form of recommended NASA matrix for analysis and interpretation.

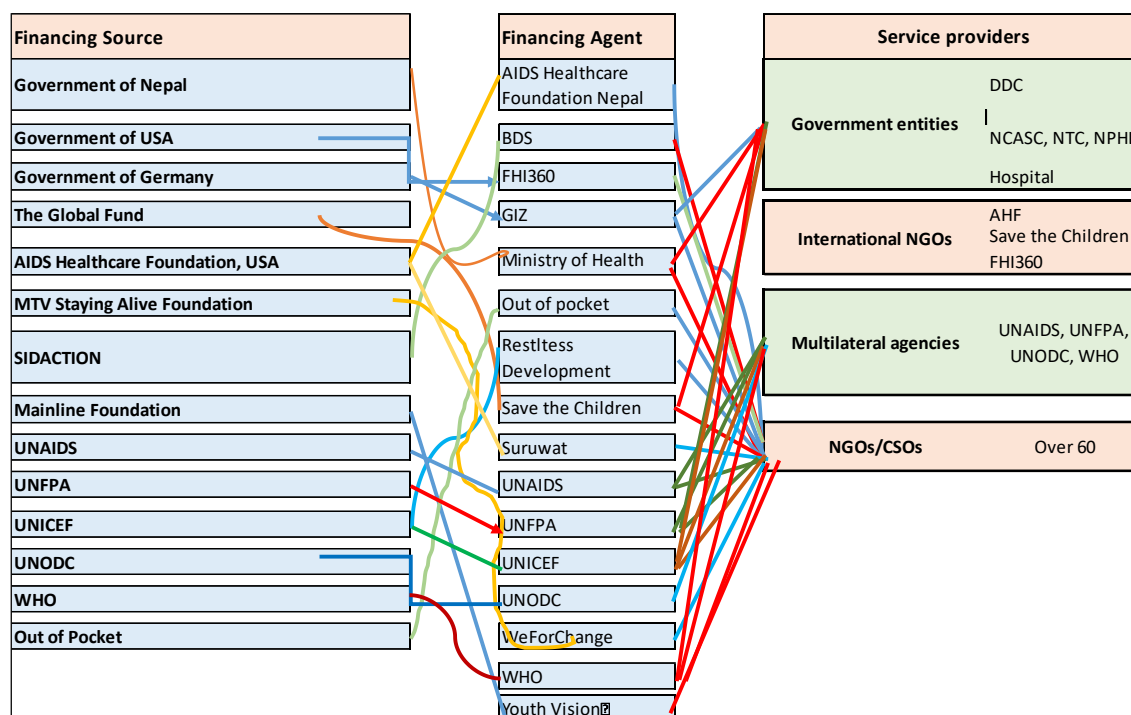
4.4.5 Data validation

Data validation was conducted with TWG meeting where along with TWG members, representatives from providers and agents who had submitted data were invited to review the final data. The comments, suggestions and views were incorporated in the final report to the extent it was related to NASA study framework.

4.5 Fund flow mapping

A mapping exercise with key stakeholders was carried out to get a broad picture of fund flow from potential financing sources (donors) to providers of services (Figure 5). Mapping would help establish how fund flows from particular source to agent and then to service providers. This exercise would also enable the NASA team to contact the source, agent and providers to obtain the spending data and other relevant information about the programme and intended beneficiaries.

Figure 5: Fund flow mapping



4.6 Scope and limitations

The scope of NASA was to capture spending occurring within the country in a given time frame and directly associated to HIV related expenses

Efforts were made to collect the 'bottom up' data from the providers directly from field. Providers (government health facilities, NGOs) were widely scattered in different parts of the country, communicating with them and accessing the data was found to be almost impossible in given time and resource, therefore it was decided to approach agencies (Financing Agent - purchaser of the services) to provide the spending data of their sub grantee NGOs.

Government of Nepal along with major external development partners have developed a pool fund mechanism where government and pool partners put money in one basket for MoHP to plan and disburse the fund. It was not possible to individually track and attribute spending made out of pool fund to individual pooling partners. Spending from pool fund therefore was considered government source and analysed accordingly.

Similarly, anecdotal information suggests that number of local government units had also allocation and spending some of their resources in HIV response. Collecting such information from local governments was out of the scope of current NASA.

4.7 Assumptions and clarifications

Average exchange rate used for 2016 was Rs 107.18 and for 2017 was 103.9 for one US\$ based on Nepal Rastra Bank (the central bank of Nepal) average rate for the year. All Nepali figures irrespective of spending month, were converted to US dollar using this exchange rate.

Considering the data received from major Sources and from almost all the Agents (who also provided data of almost all Providers under their purview) it is assumed that the

NASA 2016 and 2017 captures data from over 90% of AIDS spending organisations in the country for this round of NASA.

Where expenditures were not detailed according to production factor or beneficiary population, a proportionate distribution method was utilized. Most data received did have ASC and BP defined often fairly accurately, but a considerable level of confusion and differences existed in assigning the Production Factor.

Programmes and specific activities do greatly varied in their spending requirements and use of Production Factor. Most often, in the supplied data PF classification was not assigned nor the details of expenditure provided for NASA team to assign PF codes. In other words, production factory varies enormously by implementing partners for similar activities, therefore one single formula to assign a PF did not fit all. Specific factors or apportioning methods were agreed with implementing partners and applied to reflect true nature of production factor of that particular organization or functions. Following assumptions and apportioning were used when assigning PF category when detail were not available.

For NCASC spending data, information available/uploaded in TABUCS were provided to NASA team. As there was limited information available in TABUCS detail disaggregation and classification was not possible, only single digit ASC and PF were assigned. In other words, spending data for NCASC (including pool fund sources) were available from TABUCS where adequate detail was not available according to NASA classification. Therefore some assumptions were applied to reflect the true nature of the spending.

For out of pocket expenses, only estimation of expense related to safe blood could be made due to availability of data in a limited extent. Blood Bank exclusively tests all collected blood for HIV, syphilis, and Hepatitis B and C. The cost of such test is charged to blood recipient. Effort was made to capture these expenses under Household (out of pocket) expenses.

The NASA data provided by stakeholders contains "**Training**" as a major component for wide range of groups for which the actual details of expenditure (Production Factor) was not available. In order to assign PF category to the expenditure under training, the total amount of expenditures incurred was broken down as follows to assign right category of PF code:

- PF.01.02.02.05 Transportation and travel services 70%,
- PF.01.02.01.06 Food and nutrients 20%,
- PF.01.02.01.98 Material supplies not disaggregated by type 10%.

Likewise total of expenditures incurred for supporting the implementation of blood safety program was apportioned into three PF:

- a) PF.01.01.01 Wages accounting for 40%,
- b) PF.01.02.02.05 Transportation and travel services 30%, and
- c) PF.01.02.02.03 Publisher-, motion picture-, broadcasting and programming services 30%.

The total of expenditures incurred in Integrated Bio-Behavioral Surveillance (IBBS) was apportioned into four PF categories;

- a) PF.01.02.02.04 Consulting services, 50%
- b) PF.01.01.01 Wages 10%
- c) PF.01.02.02.05 Transportation and travel services, 30% and;
- d) PF.01.02.01.98 Material supplies not disaggregated by type, 10%

The total of expenditures incurred for conducting Quality Assurance activity through the National Quality Assurance System was allocated following PF categories

- a) PF.01.01.01 Wages, 30%
- b) PF.01.02.02.05 Transportation and travel 30%
- c) PF.98 Production factors not disaggregated by type 40%

Government spending on salary and wages of medical personnel (Doctors, Nurses, Laboratory technicians) on ART, VCT and PMTCT is calculated taking into consideration of time spent by the medical personnel for that particular function. These figures were derived in consultation with experts and persons actually involved in the service delivery.

For Pooled fund supported Targeted Interventions, following assumptions were made

1. PF.01.01.01 Wages, 50%
2. PF.01.02.02.05 Transportation and travel 30%
3. PF.98 Production factors not disaggregated by type 20%

For ART site establishment, following assumptions were made

- a) 10% Repair and maintenance
- b) 50% Material supplies not disaggregated
- c) 40% laboratory and other med equipment

CCM received some financial assistance from GiZ to improve its governance in 2017. Since CCM is responsible for all three diseases, the expenditure of CCM was distributed according to the disease split proportion provided by the GF for TB, Malaria and HIV.

Limitation

1. Out of pocket expenses other than blood safety was not possible to calculate – e.g. cost of HIV test prior to surgery in government and private hospitals, travel and associated cost of individual accessing HIV related services, and other financial cost incurred in relation to HIV services
2. Spending from local government at provincial and municipal level could not be tracked or estimated
3. Spending for individual or programme paid outside the country was also out of scope of current NASA. For example, training cost paid and organised outside the country which might have beneficial results to programme management in the country.

4.8 Challenges

Number of challenges were encountered during the exercise, some of the critical challenges were as follows.

Many organisations felt providing financial data with reasonable level of details to suit that NASA classification as an additional task and a burden, therefore there were significant delays in submitting the data from few organisations. Moreover, there was feedback from stakeholders to simplify the data collection template so that providers can easily submit their expenditure data.

Some Agents (particularly multilaterals and bilateral) often were reluctant to provide detail of expenditure as well as tend to distribute or mask benefit related expenses (wages, remuneration, international trainings/visits) under different ASC/PF heading/category.

Moreover, provider's interpretations and NASA coding varied enormously even for the similar nature of expenditure, therefore maintaining consistency in coding was a great challenge. Details of functions (ASC category) and PF category varied enormously even for the similar activities. For example, when a short term consultant was hired for specific task, some organisation assigned 'consulting service' as PF category where as other assigned 'wages' as PF for consultant. NASA Classification handbook was not clear enough to guide such classification.

There were significant variations in accounting systems (software used), fiscal years and the classification of spending among national institutions and donor supported projects, which created challenges for data synthesis and comparability. For example, the Government fiscal year is from June to July, whereas donors have different fiscal years. Also that the spending made for 'capacity building support' to NGO was termed as institutional building (ASC.07.03 AIDS-specific institutional development) by some organisation while other termed it as training (ASC.05.03 Training). NASA team left such classification as it is to reflect the institutional way of spending. Adjustments, however, were made where appropriate both in the fiscal years and classifications.

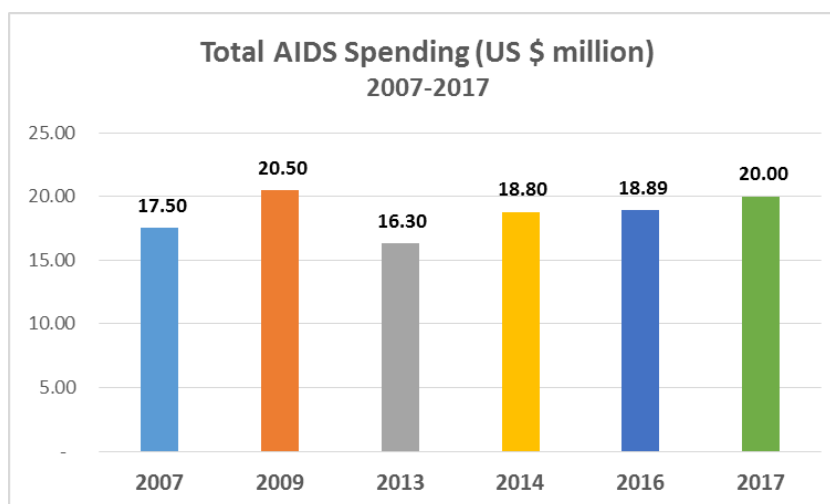
In some organisations there was lack of 'institutional memory' and adequate documentation of past expenditure and other budgetary and financial information, this resulted serious delays in identifying appropriate documentation as well as in obtaining adequate financial information and in classifying appropriate NASA category.

5. Findings

5.1 Overview of AIDS spending in Nepal 2007 – 2017

Nepal started resource tracking periodically from 2007 and continued till now. The overall AIDS spending for a year appeared to have hovered between 17 and 20 million with some ups and down in between (Figure 6).

Figure 6: Total AIDS spending 2007 – 2017



5.2 Total expenditure by source, agent and provider

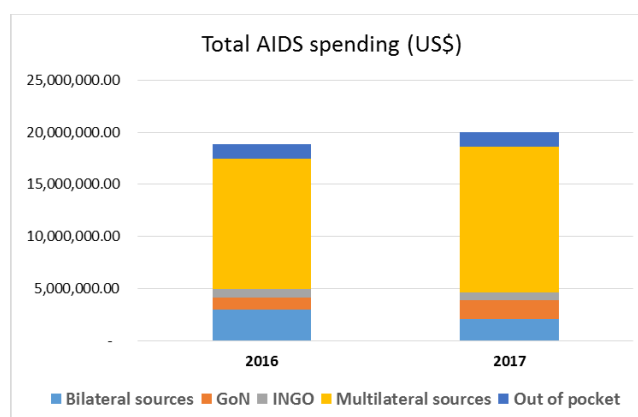
The total spending for HIV response was recorded at USD 18.8 million and USD 20 million in 2016 and 2017 respectively.

5.2.1 AIDS spending by Financing Sources – who funds the HIV response in Nepal

An analysis of financing sources is of a particular interest in countries where funding for the HIV response is heavily dependent on international sources.

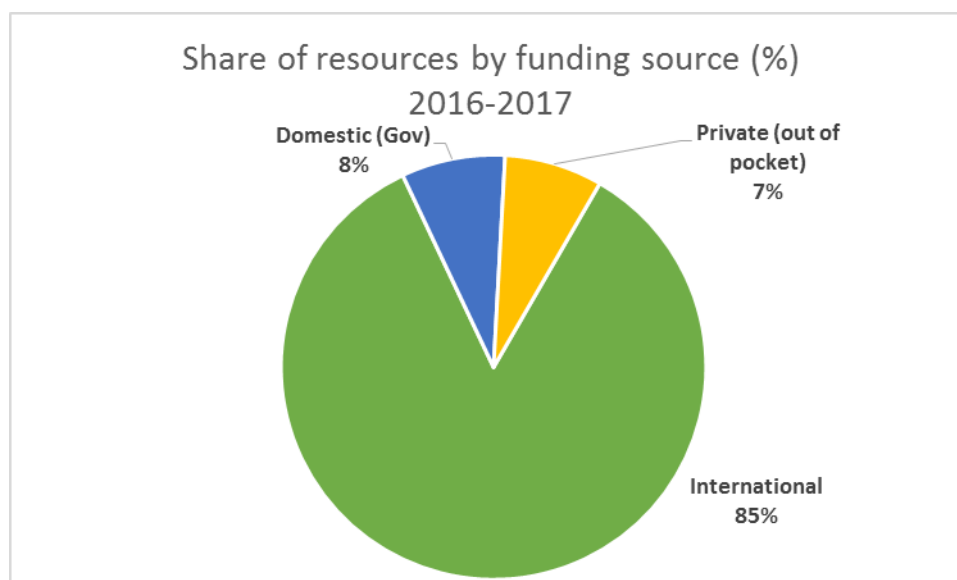
Among the financing sources (total 14 sources recorded including out of pocket), multilateral organisations (including the Global Fund) share the highest portion of AIDS spending both in 2016 and 2017 (Figure 7)

Figure 7: AIDS Spending by Financing Sources



It is observed that international sources took much of the share in AIDS spending (85%) followed by Domestic government share (8%). Private (out of pocket expenses) share was 7% during the assessment years (Figure 8)

Figure 8: Percentage share by sources of fund (2016-2017)



Likewise, Prevention activities consumed much of the resources from all sources. Out of pocket expenditure incurred by general public for safe blood is found to be notably significant amount for HIV prevention in Nepal (Table 3).

Table 3: AIDS spending (ASC) by Financing Sources (FS)

Financing Source	ASC 1 digit	2016	2017	Total (USD)
AIDS Healthcare Foundation, USA		638,729	514,422	1,153,152
	ASC 01 Prevention	12,305	75,000	87,305
	ASC 02 Care and treatment	237,815	4,196	242,010
	ASC.04 Programme management and administration	12,028	224,320	236,349
	ASC.05 Human resources	335,858	174,081	509,939
	ASC.07 Enabling environment	40,723	36,825	77,548
GFATM		11,723,290	13,653,553	25,376,843
	ASC 01 Prevention	3,919,428	5,756,220	9,675,649
	ASC 02 Care and treatment	4,784,847	5,363,256	10,148,103
	ASC.04 Programme management & administration	2,439,086	1,906,294	4,345,380
	ASC.06 Social protection and social service (excluding OVC)	140,619	147,459	288,078
	ASC.07 Enabling environment	258,647	338,316	596,963
	ASC.08 HIV related research (excluding operations research)	180,663	142,008	322,671

Financing Source	ASC 1 digit	2016	2017	Total (USD)
Government of Germany		30,521	14,878	45,399
	ASC 01 Prevention	30,521		30,521
	ASC.04 Programme management and administration		14,878	14,878
Government of Nepal		1,220,562	1,779,039	2,999,602
	ASC 01 Prevention	831,751	1,048,910	1,880,661
	ASC 02 Care and treatment	248,683	438,763	687,446
	ASC.04 Programme management and administration	89,308	131,049	220,357
	ASC.05 Human resources	49,673		49,673
	ASC.07 Enabling environment		1,684	1,684
	ASC.08 HIV related research (excluding operations research)	1,148	158,633	159,781
Mainline Foundation		144,487	157,564	302,051
	ASC 01 Prevention	144,487	157,564	302,051
MTV Staying Alive Foundation		12,217	12,603	24,820
	ASC 01 Prevention	12,217	12,603	24,820
Out of Pocket		1,416,230	1,416,230	2,832,460
	ASC 01 Prevention	1,416,230	1,416,230	2,832,460
Sidaction		12,683	28,949	41,632
	ASC 02 Care and treatment	12,683	27,986	40,669
	ASC.04 Programme management and administration		962	962
UNAIDS		93,539	90,008	183,547
	ASC 01 Prevention	12,129	2,000	14,129
	ASC.04 Programme management & administration	56,979	88,008	144,987
	ASC.07 Enabling environment	24,431		24,431
UNFPA		455,726		455,726
	ASC 01 Prevention	455,726		455,726
UNICEF		38,017	118,300	156,317
	ASC 01 Prevention	26,403	109,685	136,088
	ASC 02 Care and treatment		8,614	8,614
	ASC.04 Programme management & administration	1,698		1,698
	ASC.07 Enabling environment	9,916		9,916
UNODC		131,342	50,873	182,215
	ASC 01 Prevention	131,342	50,873	182,215
USAID		2,928,371	2,108,436	5,036,807
	ASC 01 Prevention	1,249,834	930,841	2,180,675
	ASC 02 Care and treatment	186,901	74,075	260,976
	ASC.04 Programme management & administration	353,169	259,729	612,897
	ASC.07 Enabling environment	1,126,234	843,791	1,970,025
	ASC.08 HIV related research (excluding operations research)	12,233		12,233

Financing Source	ASC 1 digit	2016	2017	Total (USD)
WHO		48,205	57,816	106,021
	ASC 02 Care and treatment		29,015	29,015
	ASC.04 Programme management & administration		6,497	6,497
	ASC.05 Human resources	32,087	18,291	50,378
	ASC.07 Enabling environment	2,379	4,013	6,392
	ASC.08 HIV related research (excluding operations research)	13,739		13,739
Grand Total		18,893,920	20,002,671	38,896,591

5.2.2 Financing Agent by Financing Source – who manage the fund

Financing Agent receives fund from Financing Sources which in turn procures goods and services through Providers of Services. Sixteen different financing agents received funds from different sources which procured goods and services from providers. Nine different types of providers (i.e. hospitals, NGOs, laboratories, research agencies) were recorded in the NASA data. Some national NGOs were also receiving fund directly from international sources (Table 4)⁵

Table 4: Flow of fund from Source to Agent

Financing source (FS)	Financing agent (FA)	2016	2017	Total (USD)
Bilateral sources		2,958,892	2,123,314	5,082,206
	FHI360	2,928,371	2,108,436	5,036,807
	GIZ	30,521	14,878	45,399
Government of Nepal		1,220,562	1,779,039	2,999,602
	Ministry of Health and Population	1,220,562	1,779,039	2,999,602
International NGOs		808,117	713,538	1,521,655
	AIDS Healthcare Foundation	403,476	502,849	906,325
	BDS	12,683	28,949	41,632
	Suruwat	235,253		235,253
	WeForChange	12,217	24,177	36,394
	Youth Vision	144,487	157,564	302,051
Multilateral sources		12,490,119	13,970,550	26,460,669
	Restless Development	16,675	48,769	65,444
	Save the Children	11,723,290	13,653,553	25,376,843
	UNAIDS	68,729	90,008	158,737
	UNFPA	480,536		480,536

⁵ For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions—*ASC.01 Prevention* and *ASC.02 Care and treatment*—and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well—*ASC.04 (Programme Management)*.

The incentives for human resources currently covers mainly nurses and doctors; in a broader public health approach, the concept should also apply to monetary incentives to counsellors, clinical officers, compliance supporters, and laboratory staff (NASA classification 2009).

Financing source (FS)	Financing agent (FA)	2016	2017	Total (USD)
	UNICEF	21,342	69,531	90,874
	UNODC	131,342	50,873	182,215
	WHO	48,205	57,816	106,021
Out of pocket		1,416,230	1,416,230	2,832,460
	Out of pocket	1,416,230	1,416,230	2,832,460
Grand total		18,893,920	20,002,670	38,896,590

Among the agent (fund manager) INGOs apparently were managing substantial proportion of fund received from different donors. Some of the notable INGOs that were managing fund includes Save the Children, FHI360, AIDS Health Care Foundation (Table 5, Figure 9). Spending by government agencies appears to have slightly declined in the recent years despite the government budget remaining fairly the same. Lower spending could be due to overall low burn rate and delay in outsourcing of the pool fund financed activities to NGOs.

Figure 9: Spending by type of agent (USD)

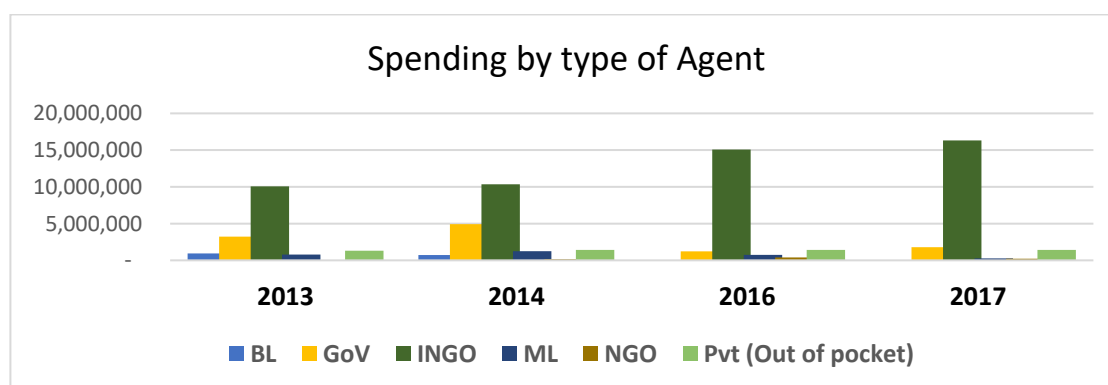


Table 5: Spending by Agent (USD)

FA type	2013	2014	2016	2017
Bilateral agencies	929,139	713,669	30,521	14,878
Government agencies	3,235,298	4,931,127	1,220,562	1,779,039
INGO	10,064,502	10,345,589	15,071,812	16,313,606
Multilateral agencies	786,662	1,251,334	750,154	268,228
NGO	38,522	157,138	404,641	210,689
Pvt (Out of pocket)	1,303,002	1,416,230	1,416,230	1,416,230
Grand Total (USD)	16,357,125	18,815,087	18,893,920	20,002,671

5.2.3 Flow of fund to Providers of services (PS)

Resources from different types of sources are ultimately passed down to providers through the fund manager (Financing Agent) in order to deliver goods and services to targeted beneficiaries. The table below explains the flow of fund to different types of providers. Providers of Services (PS) are responsible to provide services to different beneficiaries groups (KP), PLHIV, pregnant mothers, and also provides services like research and trainings. There were large numbers of providers (primarily NGOs and

organisations run by KP) recorded providing HIV related services in different parts of the country.

As noted, multilateral sources share the largest proportion of the fund to HIV response in the country (nearly 70% in 2016-2017), but they also act as provider of services (PS) in certain instances. They provide services worth of 2.2% directly by themselves. This include central level activities and their own operating costs.

Bilateral agencies on the other hand did not provide any services directly by themselves, it means all the resources for HIV was transferred to agent and providers.

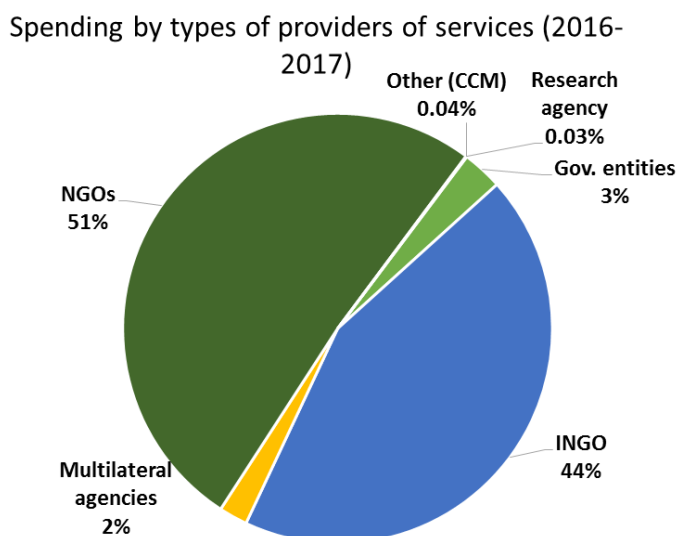
Table 6: Flow of fund from source to providers

FS type	PS type	2016	2017	Grand Total
BL		2,958,892	2,123,314	5,082,206
	INGO	1,072,783	802,034	1,874,817
	NGO	1,873,876	1,306,402	3,180,279
	Other		14,878	14,878
	Research	12,233		12,233
GoV		1,220,562	1,779,039	2,999,602
	Gov	345,279	682,148	1,027,427
	NGO	875,284	1,096,891	1,972,175
INGO		808,117	713,538	1,521,655
	INGO	399,667	465,889	865,557
	NGO	408,449	247,649	656,098
ML		12,490,119	13,970,550	26,460,669
	Gov	58,913	81,178	140,091
	INGO	6,893,584	7,364,461	14,258,045
	ML	682,774	165,876	848,650
	NGO	4,853,841	6,359,035	11,212,876
	Research	1,008		1,008
Out of pocket		1,416,230	1,416,230	2,832,460
	NGO	1,416,230	1,416,230	2,832,460
Grand Total		18,893,920	20,002,671	38,896,591

It is notable that NGOs appeared to be the most preferred providers by all financing sources with 51% of total spending by this category of the provider. NGOs received fund from almost all types of sources including government sources. Some multilateral agencies and INGOs act both as a source as well as providers, that they directly provide goods/services to intended beneficiaries (Figure 10).

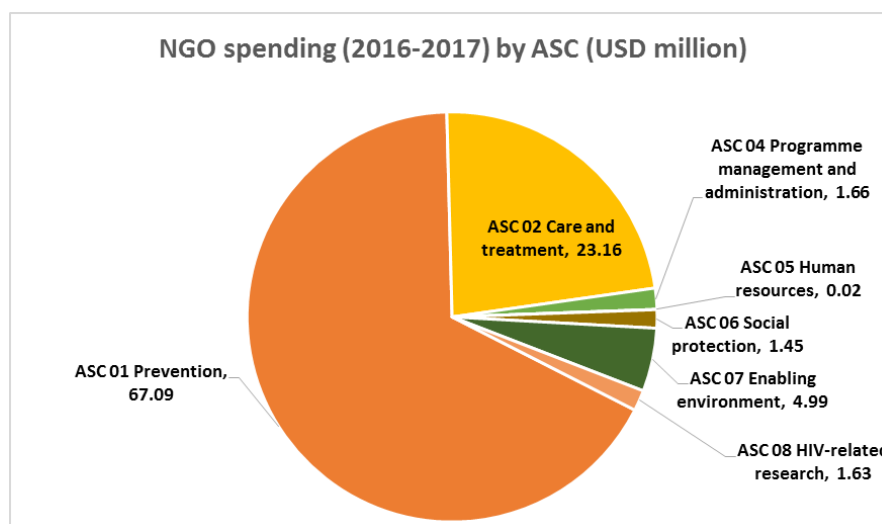
It was also noteworthy that the INGOs apparently offered goods and services worth 44% of total Aids spending during 2016 and 2017. This higher share of spending is largely due to procurement of ARV drugs, CD4 and viral load machine and other reagents and drugs directly of INGOs (particularly the Global Fund related procurement directly by the principal recipient (Save the Children).

Figure 10: Spending by providers

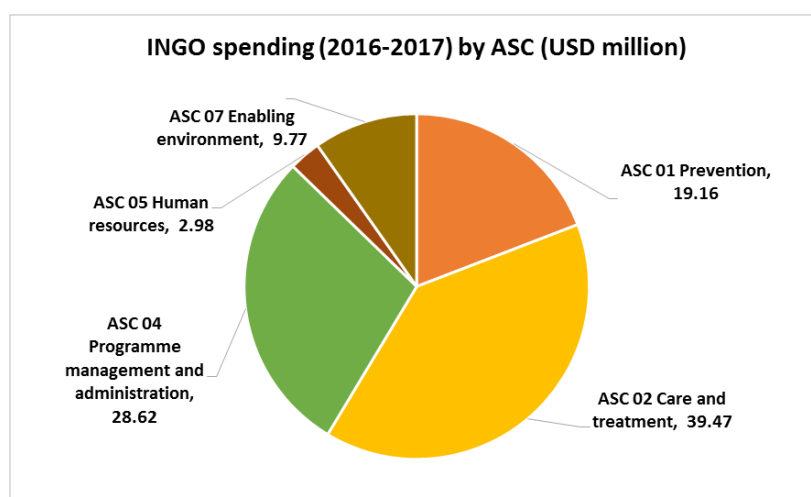


Of the total AIDS spending of 38.8 million USD, 51% of total AIDS spending (USD 19.8 million) was spent through NGOs as the providers of services. Out of this (19.8 million USD), NGOs provided nearly 67% worth of goods and services for prevention related activities and about 23% in care and treatment related activities. Spending on HIV related research like IBBS was also booked under NGO category therefore spending made through NGOs was recorded at 1.3%. Social protection related activities (which was mainly the CABA cash transfer related activities) were solely implemented by NGOs – there was no other providers taking this responsibility (Figure 11)

Figure 11: NGOs spending by ASC



Likewise INGOs as providers have provided goods and services worth USD 16.9 million (44% to total AIDS spending) in following categories. Spending in care and treatment is nearly 40% of INGOs spending – which largely consists of procurement of ARV drugs, CD4 and VL machines, reagents and other activities related to care and treatment.

Figure 12: INGOs spending by ASC

5.2.4 Production Factors (inputs)

Production Factors are critical inputs required to deliver intended services and goods to the beneficiaries. Inputs includes salaries and wages, drugs and pharmaceuticals, administrative and consulting services, capital goods like building and vehicles.

It is also worth noting that generating or disaggregating production factors from the expenditure as required by NASA classification was found to be most difficult by many partners. There was tendency to lump together different inputs (or production factor) into a single category to avoid repetitive and cumbersome calculation. Therefore level of detail and specificity in reported data varied enormously and was a challenge for NASA team to disaggregate the data, code it and analyse/interpret. For ease of reading spending on production factors were broadly grouped into five categories (Table 7),

Table 7: Spending by production factor (PF)

Production Factor	2016	2017	Total (USD)	%
PF 01.01 Wages	5,484,539	5,917,795	11,402,334	29.31
PF 01.02 Material supplies ((including ARVs, CD4 and VL machines)	5,414,216	5,462,178	10,876,393	27.96
PF 01.02 Services (Administrative and consulting)	7,909,741	8,488,396	16,398,136	42.16
PF 01.98 PF not broken down by type	82,842	128,425	211,267	0.54
PF 02 Capital expenditure	2,583	5,878	8,461	0.02
Grand Total (USD)	18,893,920	20,002,671	38,896,591	100.00

Providing HIV related goods and services to wide range of beneficiaries in different setting and circumstances required varied level of inputs at different times. Reaching beneficiaries with adequate goods and services require complex procedure and inputs. Therefore level of inputs (and cost) varies widely by service providers.

Large proportion (42.19%) of resources were used for administrative and consulting services to provide HIV responses. Spending on wages and salaries were accounted for

29% of total spending in this round of NASA. Moreover, there was tendency to mask HR related cost into programme interventions or at times such expenditure was never reported to NASA team for analysis. Therefore cautions is required while interpreting the inputs or production factors.

Material supplies (PF 01.02) is of particular relevance as this category includes ARV drugs and VL and CD4 machine and also source of financing this category indicates level of sustainability (Table 8). Antiretroviral drugs and other related pharmaceuticals as well as laboratory related equipment (i.e. CD4 machine) consumed 28% and 27% of total resources in 2016 and 2017 respectively, making it total 27.94% of total AIDS spending during 2016-2017. Of the total materials and supplies expenditure, the highest source of fund was multilateral agencies (particularly the Global Fund).

Table 8: Materials supplies by source of fund

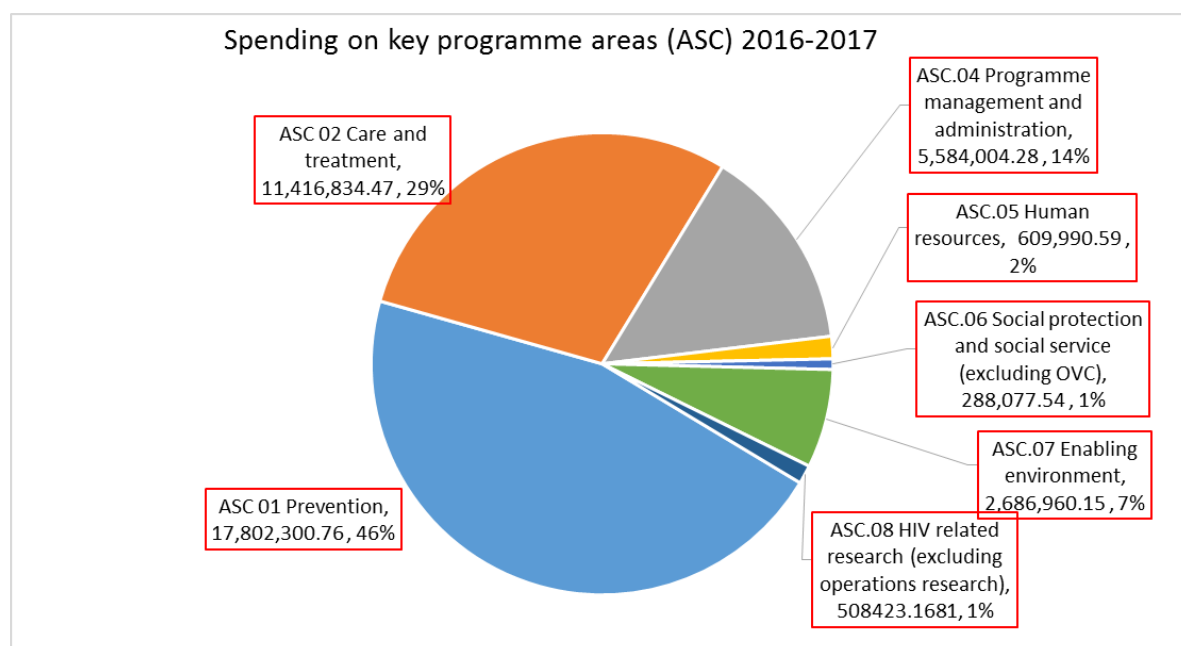
PF code	BL	GoV	INGO	ML	Grand Total
PF.01.02.01.01 Antiretroviral				6,703,490	6,703,490
PF.01.02.01.02 Other drugs and pharmaceuticals (excluding antiretroviral)			70,246	1,096	397,382
PF.01.02.01.05 Reagents and materials				2,011,377	2,011,377
PF.01.02.01.06 Food and nutrients	1,236	115,260	1,224	6,815	124,535
PF.01.02.01.98 Material supplies not disaggregated by type	455	11,622	35,288	1,071,483	1,118,848
PF.01.02.01.99 Other material supplies n.e.c.					449,420
Grand Total	1,691	197,128	37,607	10,639,967	10,876,393

5.3 Spending on key programmatic areas (ASC analysis)

Key programmatic areas (ASC) are the key categories where all AIDS spending is generally referred to. NASA recorded seven programmatic areas in this round. HIV Prevention related activities (Figure 13) shared a bulk (46%) of the total AIDS spending, whereas Care and treatment spending was 29%.

Similarly, spending for programme management and administration was recorded at fourteen percent of total AIDS spending in the country. Spending on human resource 2 % (deploying additional human resources to point of care centres i.e. hospitals), social protection (1%), HIV related research (1.31%) and enabling environment (7%) were also recorded.

Figure 13: Spending by ASC (in USD)



5.3.1 Trend in ASC spending 2013-2017

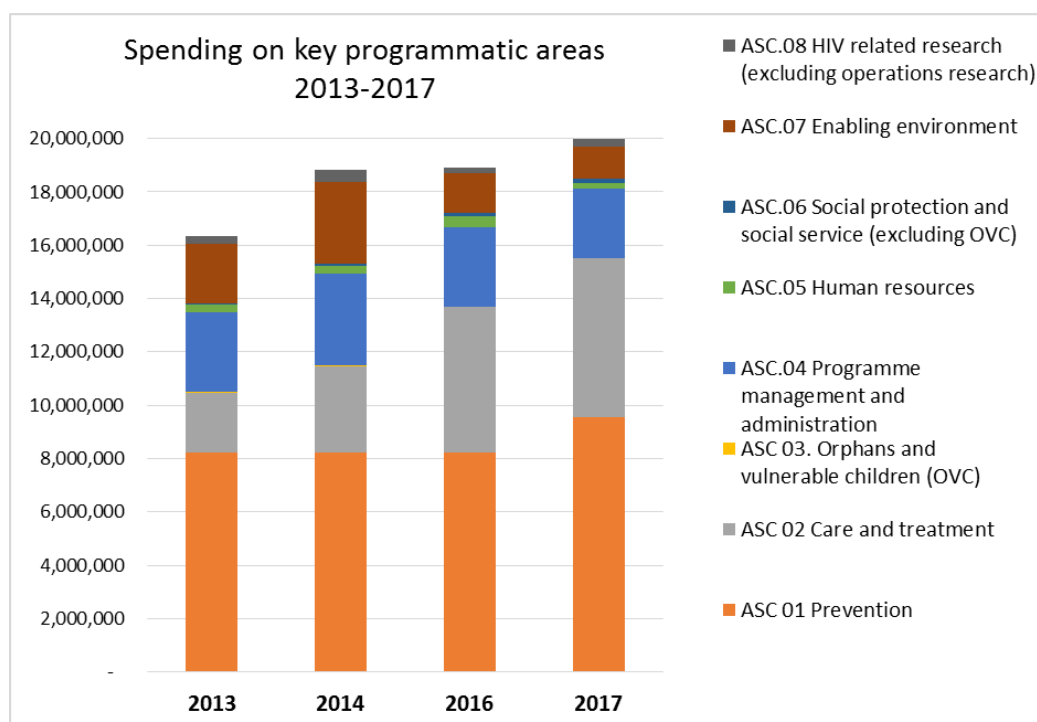
Compared to previous round of NASA 2013-2014, a major upward change in spending was noticed in Care and Treatment areas where there has been steady rise in the spending. Prevention spending was hovering between 50% and 43% where as sharp decline was noticed in spending on enabling environment. Likewise, spending on programme management and administration was also in declining trend. Spending in research has always been low, and much lower (less than 1%) was recorded in 2017 (Table 9, Figure 14).

Table 9: Programmatic spending 2013 -2017

(Percentage of the total spending of the year)

Programmatic areas	2013	2014	2016	2017	Trend
ASC 01 Prevention	50.39	43.62	43.62	47.79	
ASC 02 Care and treatment	13.67	17.26	28.96	29.73	
ASC 03. Orphans and vulnerable children (OVC)	0.11	0.21	0.00	0.00	
ASC.04 Programme management and	18.16	18.24	15.63	13.16	
ASC.05 Human resources	1.83	1.59	2.21	0.96	
ASC.06 Social protection and social service (excluding	0.37	0.41	0.74	0.74	
ASC.07 Enabling environment	13.55	16.21	7.74	6.12	
ASC.08 HIV-related research	1.93	2.46	1.10	1.50	
Grand Total	16,357,125	18,815,087	18,893,920	20,002,671	

Figure 14: Spending in key programmatic areas (2013-2017)



5.3.2 Spending on ASC by source 2016 - 2017

Prevention related activities was financed by all sources where multilateral sources was financing nearly 60% of total prevention activities. Likewise, multilateral source financed almost 90% of care and treatment followed by government source financing 6% care and treatment. Bilateral sources were funding nearly 60% on enabling environment followed by multilateral agencies financing 35.99%. While the overall spending on HIV related research was less than one percent, the bulk of spending came from government sources (86.2%) (Table 10).

While the spending on prevention appeared to be the key function financed by all sources with varied level of inputs, spending on other categories did not show any particular pattern. For example, while bilateral sources were spending almost 60% of all enabling environment spending, government sources spending in this category was negligible.

The available data did not allow further analysis and interpretation on such pattern of spending. It would be desirable for stakeholders to reflect on such pattern of spending in order to streamlining the spending.

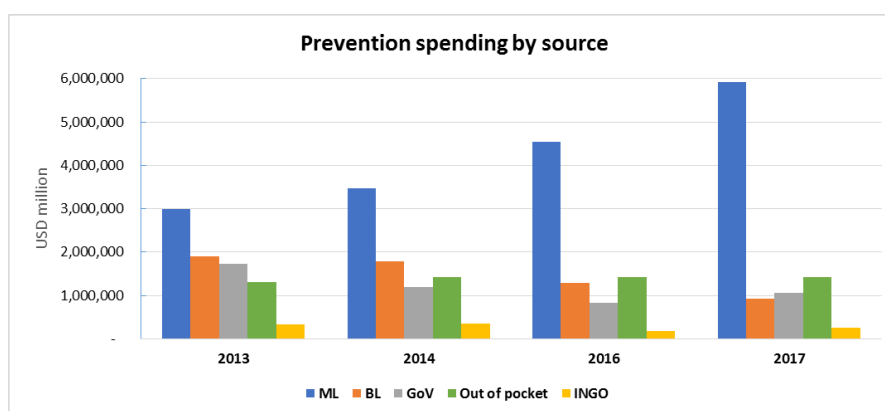
Table 10: Key intervention areas (ASC) by source (2016-2017) (in USD)

ASC 1 digit	BL	GoV	INGO	ML	Out of pocket	Grand Total
ASC 01 Prevention	2,211,196	1,880,661	414,176	10,463,808	2,832,460	17,802,301
ASC 02 Care and treatment	260,976	687,446	282,680	10,185,733		11,416,834
ASC.04 Programme management and administration	627,775	220,357	237,311	4,498,561		5,584,004
ASC.05 Human resources		49,673	509,939	50,378		609,991
ASC.06 Social protection and social service (excluding OVC)				288,078		288,078
ASC.07 Enabling environment	1,970,025	1,684	77,548	637,702		2,686,960
ASC.08 HIV related research (excluding operations research)	12,233	159,781		336,410		508,423
Grand Total (USD)	5,082,206	2,999,602	1,521,655	26,460,669	2,832,460	38,896,591

5.4 Expenditure on HIV prevention activities

Spending in HIV prevention related activities appeared to be mainstay of all sources. Spending from multilateral sources were steadily rising whereas spending from government and bilateral sources in the same areas is declining. The highest and steadily rising spending in HIV prevention related activities was largely due to the Global Fund (GFATM) financing (Figure 15)

Figure 15: Spending in HIV prevention (ASC. 01) by source



Total spending in the prevention appeared to be fairly levelled at around USD eight million every year except in 2017 where over nine million spending was recorded. Multilateral sources comprised almost 50% of total prevention spending in the later years with gradual rise from early years. Out of pocket comprised 16%, which is very close to spending from bilateral sources (17%). Government funding in prevention activities was 14% of total prevention activities during 2016-2017.

Table 11: Sources of fund for prevention activities (in USD)

FS type	2013	2014	2016	2017
BL	1,894,194	1,776,424	1,280,355	930,841
GoV	1,730,177	1,186,057	831,751	1,048,910
INGO	328,134	350,486	169,009	245,167
ML	2,987,027	3,478,248	4,545,029	5,918,779
Out of pocket	1,303,002	1,416,230	1,416,230	1,416,230
Grand Total (USD)	8,242,534	8,207,445	8,242,374	9,559,927

Further analysis of prevention activities, broadly re-categorised for ease of reference, revealed that overall trend in certain activities were declining (e.g. BCC, prevention-youth, NSP), while trend in PMTCT, OST were rising (Table 12). While the upward trend for PMTCT and OST is understandable, but the trend in BCC – not disaggregated, programme for youth and migrants needs further exploration as the current data and other information were inadequate to make further interpretations.

The increasing trend in PMTCT is largely due to programme expansion up to birthing centres, integrating it to Antenatal visits/care and expanding the training to different cadre of health workers who would directly contribute to PMTCT. As a result there was surge in HIV test of pregnant women in health care centres. The treatment part of HIV positive mothers is reflected in care and treatment spending as bulk of ARV drug is centrally procured and supplied to ART sites where pregnant women are enrolled for continued treatment and care services.

During the year 2016, a total of 181 pregnant women received antiretroviral therapy compared to 145 pregnant women in 2015. The eVT coverage was 62.8 percent in 2016 compared to 35 percent in 2015. Out of 181 pregnant women who were on ART in 2016, 141 (78%) initiated ART during the current pregnancy and remaining 40 (22%) were already on ART before the current pregnancy (GAM report 2016).

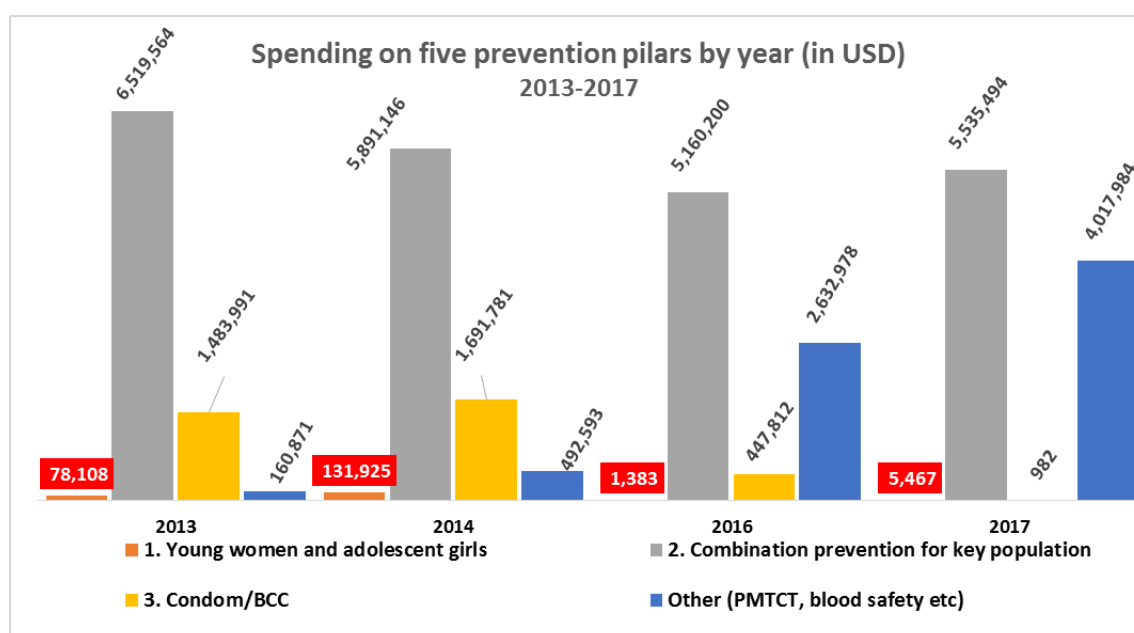
Table 12: Prevention activities (in USD)

Prevention activities (Broad categories)	2013	2014	2016	2017	Trend
PMTCT	148,600	223,769	1,204,619	2,566,328	
BCC - not disaggregated	994,070	1,170,190	1,009,463	798,991	
VCT - MARP	843,696	609,482	101,088	68,211	
Condom Promotion	5,671	99,092	426,531	680,806	
Programme - STI	16,509	142,677	-	-	
Programme - migrants	1,963,333	1,596,682	1,202,946	414,117	
Programme - youth	55,715	22,198	-	5,467	
VCT - SW	7,741	12,005	288,950	196,773	
Programme - SW	181,983	188,874	6,514	793	
VCT - MSM	-	-	7,448	27,273	
Programme - MSM	1,048,458	875,761	427,232	1,090,220	
Programme - IDU	1,411,567	1,574,356	1,375,579	1,466,246	
OST	262,189	250,789	775,775	828,471	
Blood safety	1,303,002	1,441,570	1,416,230	1,416,230	
Total	8,242,533.51	8,207,445.00	8,242,373.83	9,559,926.93	

5.5 NASA prevention expenditure and five prevention pillars

Prevention (ASC 01 category) related all spending was regroup into five prevention categories to better understand the spending on five prevention pillars⁶. A consistent pattern that was apparent over the period from 2013 – 2017 in spending on pillar 2 (key population) is a reflection of prevention focus which is in line with national strategy and epidemic characteristics of the country. Low spending on young women and adolescent (Pillar 1) could be due to number of factors such as, activities not specifically targeted to young women and adolescent girls, differences in expenses booking and reporting the non-disaggregated data and differences in NASA coding by different organisation for similar activities (Figure 16). Therefore some caution is required in interpreting the low spending on pillar 1 (young women and adolescent girls). There was no spending reported on pillar 4 (voluntary medical male circumcision) and pillar 5 (Pre exposure prophylaxis) in both rounds of NASA in Nepal.

Figure 16: Spending on five prevention pillars by years (in USD)



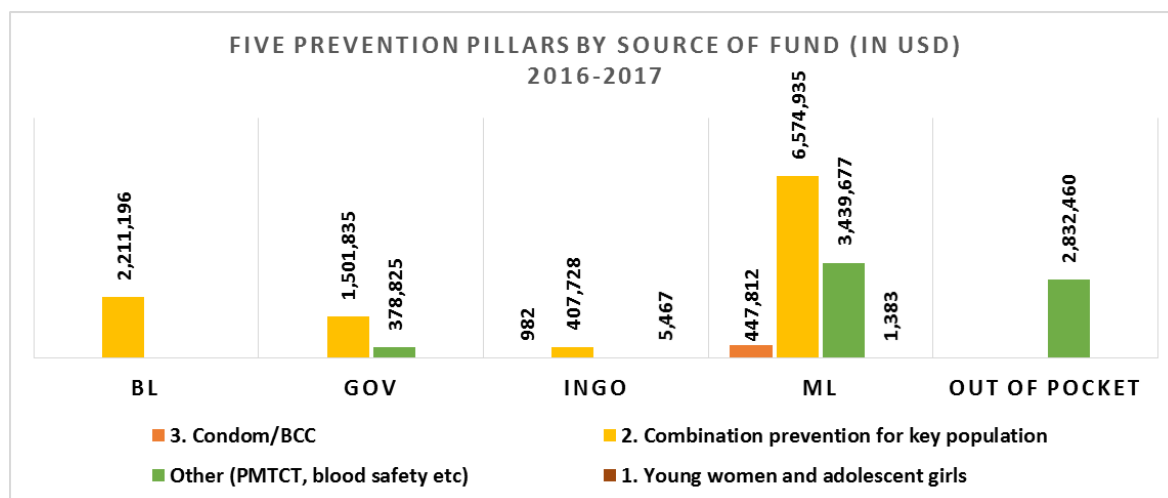
There are certain spending under ASC 07. Enabling environment which did not explicitly falls under the prevention (ASC 01) activities but contributes substantially to prevention activities such as advocacy (ASC 07.01 Advocacy) for better access to health services for key population, human rights related activities (ASC 07.02.01 human rights programme.....), and ASC.07.05-Program to reduce gender based violence has not been included in the five pillar analysis.

Likewise, for the year 2016-2017 five prevention pillars were disaggregated by source (Figure 17) where Multilateral sources (primarily the Global Fund) appeared to be the highest sources of funding for Pillar two and three. Spending from government (domestic) source was also noteworthy for pillar two as it was mostly financed using

⁶ A cross walk between NASA prevention categories beneficiaries population and five prevention pillar was prepared to analyse the NASA prevention by five pillars. Further reading on five prevention pillars is available at http://www.unaids.org/sites/default/files/media_asset/2016PreventionGapReportssummary_en.pdf

pool fund mechanism. For other prevention activities (PMTCT and blood safety) government of Nepal and out of pocket were the two main financing sources.

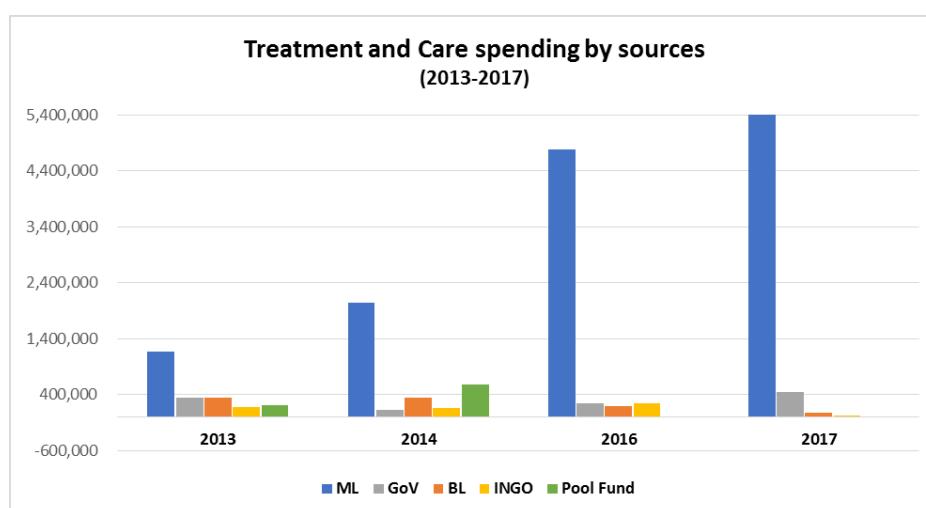
Figure 17: Five prevention pillars by source of fund



5.6 Expenditure on care and treatment related activities

Spending in care and treatment consists of almost 30% of total AIDS spending in 2016-2017. This is significant rise from the previous round of NASA. There have been a steady rise in spending from multilateral sources while spending from government remained fairly static with some decline in 2016. A declining trend was noticed on spending from other sources in treatment and care (Figure 18).

Figure 18: Spending in treatment and care (ASC 02) by source (in USD)



Over the period, an impressive spending upward trend was noticed in ARV related activities including drug procurement and other support. Similarly there has been a steady rise in HIV monitoring which particularly focused on CD4 count and viral load test with addition of new CD4 count and viral load machines in newer locations and hospitals. In summary, there have been impressive upward trend in spending in all category of care and treatment (Figure 18). Of the total spending on care and treatment,

almost 70% was spent on ARV procurement and related activities. Along the increasing number of PLHIV enrolment on ART treatment, spending on home base care including community care centre has also increased over the period.

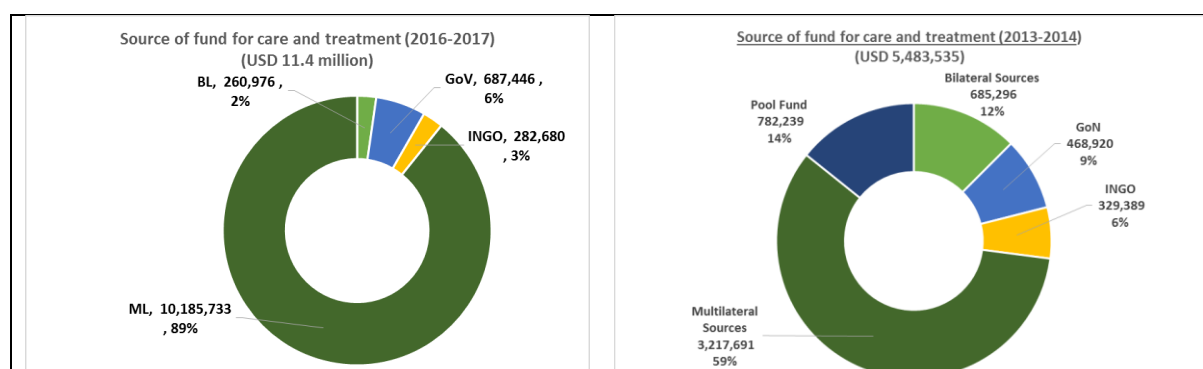
Table 13: Care and treatment activities by year

Care and treatment activities (Broad category)	2013	2014	2016	2017	Grand Total (USD)	%
ARV	769,257	893,415	4,788,470	5,373,375	11,824,518	69.97
HBC (including CCC)	408,262	375,767	184,418	64,984	1,033,432	6.11
Lab monitoring	12,811	236,647	216,094	428,438	893,990	5.29
OI	74,046	14,951	31,526	33,417	153,940	0.91
Not disaggregated	971,159	1,727,220	250,419	45,692	2,994,490	17.72
Grand total (USD)	2,235,535	3,248,000	5,470,929	5,945,906	16,900,369	100

Almost 90% of fund for care and treatment came from multilateral sources (primarily from Global Fund), government sources also accounted for 6%, in particular, for the years 2016 and 2017 (Figure 19).

Apparently, heavy reliant on external sources for treatment and care was visible in 2016-2017 data. Similar trend was notices in previous round of NASA (2013-2014)

Figure 19: Source of fund for care and treatment (in USD)



5.7 Expenditure on programme management

Of the total spending in 2016-2017, third highest spending (14%) was recorded under ASC 04. Programme management and administration after the prevention and treatment and care. Forty percentage of the spending under programme management was reported as 'not disaggregated', this means either lumping all the data together to avoid detail calculation or actual spending not properly targeted for. Ten percent of total spending was on monitoring and evaluation (Table 14).

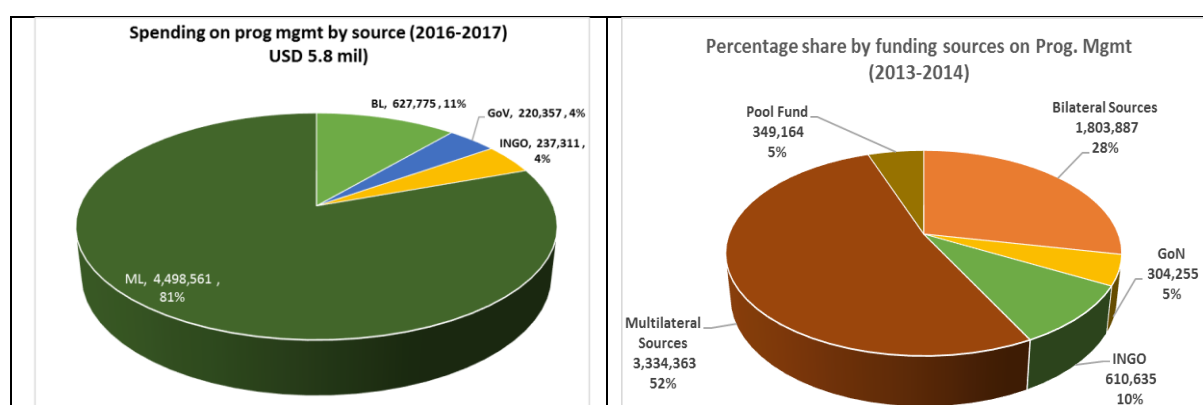
Table 14: Spending under Programme Management by ASC code (in USD)

ASC code	2013	2014	2016	2017
ASC.04.01 Planning, coordination and programme management	2,318,253	2,642,185	82,821	312,232

ASC code	2013	2014	2016	2017
ASC.04.03 Monitoring and evaluation	311,684	272,716	268,136	336,814
ASC.04.07 Drug supply systems		84,722	18,007	27,315
ASC.04.08 Information technology				6,015
ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	7,430	89,876		
ASC.04.10.98 Upgrading and construction of infrastructure not disaggregated by intervention		19,413		51,781
ASC.04.98 Programme management and administration not disaggregated by type	332,542	323,483	2,580,738	1,883,066
ASC.04.99 Programme management and administration n.e.c			2,566	14,514
Grand Total (USD)	2,969,909	3,432,395	2,952,267	2,631,737

In 2016-2017, over four-fifth (81%) of spending on programme management came from multilateral sources. Given the nature of implementation where large number of NGOs were engaged, the spending in programme management is likely to be high. However, it would be useful if further dialogue and self-reflection is initiated by all stakeholders in order to see the rational on heavy spending in the programme management. Similar pattern was noticed in 2013-2014 NASA as well (Figure 20).

Figure 20: Spending on Programme Management by sources



5.8 Beneficiary populations

The NASA also aims to track the flow of fund (goods and services) up to ultimate users or beneficiaries of the programme intervention.

Over the period, major spending was noted to have been targeted to PLHIV (all category) that accounted for highest spending among all beneficiaries. Second highest spending was noted on non-targeted interventions (this category includes spending on programme management, research and studies, cost of developing programme and strategies and like). However, it would be useful here again to reflect on such spending by all stakeholders so that programme can be better targeted (Table 15), data categorisation and reporting can be more systematic. IDUs and children (PMTCT programme) also received good share of spending. Some missing data (i.e. Truck driver

in 2013 and 2014, OVC in 2016 and 2017) may not be necessarily with no spending for that particular population group, but could be due to data reporting in different category.

Table 15: Spending by beneficiaries population (in USD)

Beneficiaries Population	2013	2014	2016	2017	Trend
BP 01. PLHIV (all category)	2,562,429	3,916,524	5,629,146	5,950,972	
BP 01. PLHIV (Women)			119,702	203,205	
BP 02 MSM/TG (all category)	1,006,500	970,236	1,148,745	1,846,492	
BP 02. FSWs (all category)	1,540,179	1,468,279	1,190,944	836,541	
BP 02. IDUs (all category)	1,742,679	1,484,819	1,486,041	1,987,550	
BP 02. MARP	161,029	195,055	177,282	101,669	
BP 03 Truck Drivers			12,217	12,603	
BP 03. Children (eVT)	18,948	43,967	1,076,895	2,279,078	
BP 03. Migrants	1,433,934	1,516,644	1,124,977	811,903	
BP 03. Other key population - not disag	124,413	138,720			
BP 03. OVC	18,458	27,045			
BP 03. Prisoners	266,776	62,046	53,322	43,407	
BP 04. Health care workers	974,684	754,999	429,635	257,756	
BP 04. Specific Accessible Population	105,784	41,203			
BP 05 Children (under 15)			601,943	149,114	
BP 05 General Population	13,255	39,964		20,677	
BP 06. Non targeted	6,388,057	8,155,586	5,843,071	5,501,702	
Grand Total	16,357,125	18,815,087	18,893,920	20,002,671	

Among key population groups, migrants, FSWs, MSM/TG and IDU received funding from almost all types of sources (i.e. multilateral, bilateral, government and INGOs). Almost all sources spend substantial amount of their resources in 'non-targeted' category.

Table 16: Beneficiaries' population by source (2016-2017)

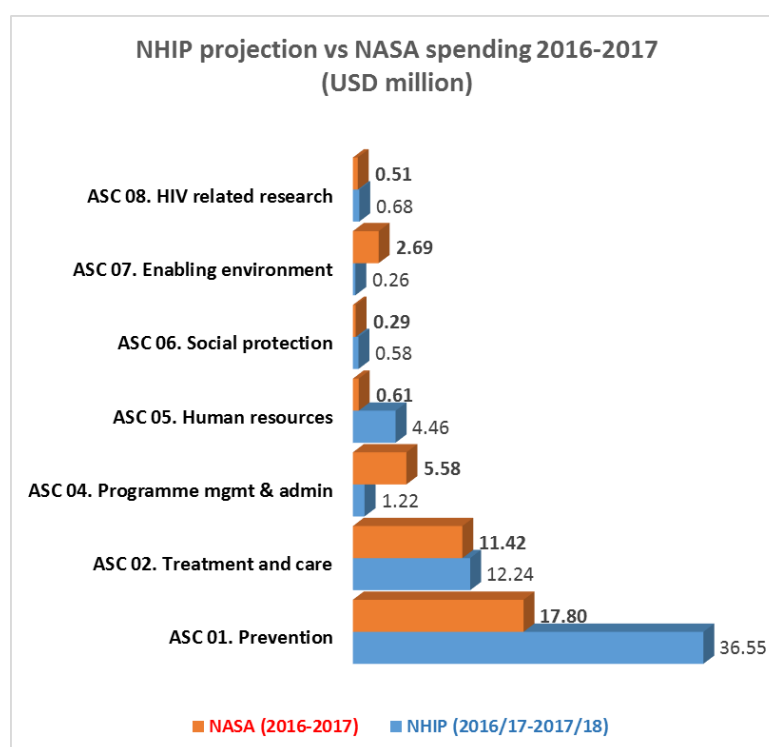
Beneficiaries population	BL	GoV	INGO	ML	Out of pocket	Total (USD)	%
BP 01. PLHIV (all category)	502,760	684,619	244,637	10,148,103	-	11,580,119	29.77
BP 01. PLHIV (Women)	-	321,884	-	1,023	-	322,907	0.83
BP 02 MSM/TG (all category)	196,752	681,221	41,632	2,075,632	-	2,995,237	7.70
BP 02. FSWs (all category)	2,011,625	5,831	1,197	8,832	-	2,027,485	5.21
BP 02. IDUs (all category)	30,521	363,664	302,051	2,777,355	-	3,473,591	8.93
BP 02. MARP	-	27,104	63,101	188,746	-	278,951	0.72
BP 03 Truck Drivers	-	-	24,820	-	-	24,820	0.06
BP 03. Children (eVT)	-	387	-	3,355,586	-	3,355,973	8.63
BP 03. Migrants	233,177	277,965	-	1,425,738	-	1,936,880	4.98
BP 03. Prisoners	-	96,729	-	-	-	96,729	0.25
BP 04. Health care workers	-	49,673	508,081	129,637	-	687,392	1.77
BP 05 Children (under 15)	-	-	1,655	749,402	-	751,057	1.93
BP 05 General Population	-	-	20,677	-	-	20,677	0.05
BP 06. Non targeted	2,107,371	490,524	313,803	5,600,615	2,832,460	11,344,773	29.17
Total (USD)	5,082,206	2,999,602	1,521,655	26,460,669	2,832,460	38,896,591	100.00

6. NASA Expenditure and the NHIP projection

NHIP (2016 – 2020) category was regrouped into NASA spending category for comparison of plan vs actual spending in each spending category. Overall NHIP projection for two years (2016/17 and 2017/18) was USD 55 million and actual NASA spending (2016-2017) was USD 38.8 million. Further, analysis indicated that spending in Treatment and care was almost equal to NHIP projection. Likewise, spending in programme management and enabling environment was noted to be much higher than initial NHIP plan. But spending in prevention, human resources were much lower than that of initial plan. In summary, NASA spending was nearly 70% of the total NHIP projection (Figure 21).

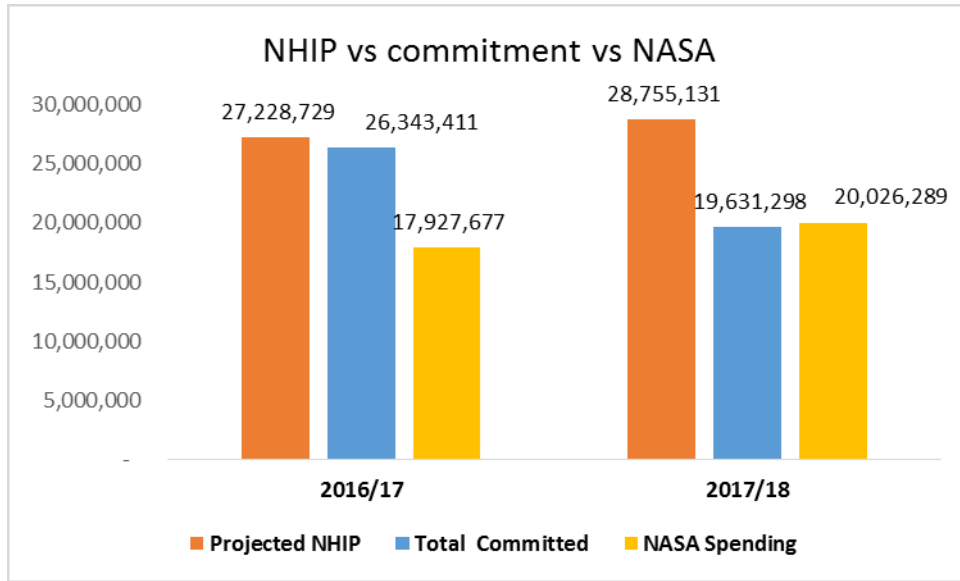
It would be useful to revisit NHIP projection in the light of actual spending figures as well as revisit budgeting and programme implementation strategy so as to harmonise the NHIP and programme implementation

Figure 21: NHIP projection vs NASA spending



It was also observed that NASA spending vs commitments received from different partners during NHIP preparation two years ago is fairly aligned while the gap in NHIP projection vs commitment remains (Figure 22).

Figure 22: NHIP vs commitment vs NASA



7. Conclusion and recommendations

Recommendations

A number of recommendations were made in previous round of NASA, most of which are still relevant in current round of NASA. Therefore NASA team would like to present previous recommendations along with some new recommendations.

1. Resource planning tends to be on higher side where as actual executed amount is low. Therefore it is recommended that while preparing NHIP or any such resource projection documents, NASA information to be a strong reference for making reasonable projection. It is also recommended to revisit budgeting and programme implementation strategy so as to harmonise the NHIP and programme implementation.
2. In order to ensure accountability and transparency and honouring the rights to information of responses to HIV and AIDS programme, a system needs to be set up to centrally obtain financial expenditure from all the fund managers (Agent) operating in the country in an agreed format once a year as envisioned in National HIV Strategic Information Guidelines. Such information should be made available in public domain (i.e. MOHP/NCASC web site).
3. Adequate dialogue and deliberation often do not happen around the allocative efficiency and spending efficiency during national process (i.e. reviews and planning meetings at various levels). Regular dialogues and reviews on AIDS spending is also recommended. This is best done if such dialogue is centred on National Investment Framework (or costed implementation plan) and NASA findings.
4. Spending efficiency and spending category (i.e. non-targeted intervention, programme management and administration) is best reviewed and reflected upon by each source and agent for cost efficiency, transparent and better alignment with national plan. Regular deliberation and dialogue be initiated on spending and output of the programme in order to ensure the quality of services.
5. NASA and National Health Account is conducted independently in different point of time and not linked, effort should be made to link NASA and NHA. In other words, NASA can be institutionalised if linked with NHA. For this, some elaboration is required to include NASA components while conducting NHA.
6. NASA has defined parameters and categories. To make NASA finding more useful, it is recommended to analyse NASA findings along with programmatic or other coverage data.
7. NASA classifications and boundaries needs to be reviewed in the light of changing nature of epidemic and global (and local) focus on AIDS responses. It is also recommended that a cross walk is prepared between NASA categories and other programme indicators i.e. PEPFAR indicators, new global AIDS monitoring indicators.

8. Appendices:

8.1 Appendix A: NASA Data Collection Tools

Excel sheet – separately submitted



National AIDS Spending Assessment (NASA)

Name of Organisation

Acronym of Organisation

Address of Organisation:

Status of Organisation
Crosscheck the appropriate cell

Organisation	Public	NGO	Bilateral	Multilateral
National	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Notes
Please report any activity and expenditure that is on HIV/AIDS areas
 1. Please submit the data by **17 September २०१८ (आश्विन १ गते)**
 2. Rename this sheet with **Name of your organisation**
 3. Please complete all four sheets along with information in this page
 4. For any technical queries contact Bir Rawal, Mahesh Sharma, Prabhu Paudel

Please do not change or reformat this sheet

Resources Used in 2016

In the template below, we ask you to report on: **sources** of your 2016 HIV/AIDS funding as well as the **title and description** of each project or activity your organization implemented; names of other organizations to which you transferred project funding, if applicable; the actual **amount spent** on each project or activity; and the **beneficiary population(s)** reached, including the **number reached**, if possible. For the Total Activity Amount, only include direct project costs that are spent in the country (e.g. clinic support, condom distribution, or in-country project office costs). Exclude indirect costs that support functions performed outside of the country (e.g. administrative costs of a home office abroad).

Financial resources used for specific activities

NOTE: Insert row to add activities as needed. Use one line per Beneficiary Population for the same activity.

#	Financing source (Origin of the funds)	Project or Activity	Description (1-2 sentences describing the project or activity)	Transferred Funds (to which organization?)	Total Activity Amount (Expenditures, not budgeted amounts)	Beneficiary Population <i>*See 'Beneficiary List' tab (Note: In case that the same activity has two different Beneficiary Populations, please fill two lines, one per BP)</i>
1						
2						
3						
4						

Please do not change or reformat this sheet

PRODUCTION FACTORS in 2017

Production factors are inputs used to produce an intervention/project activity

NOTE: Insert row to add production factor as needed

Production factors/inputs (list each item in one line) <i>*See 'Production Factors List' tab</i>	Description of the activity (as reported in worksheet '2009 Resources Used')										

8.2 Appendix B: NASA AIDS Spending Categories—Codes and Definitions

<http://www.unaids.org/en/site-search#?cludoquery=aids%20spending%20assessment&cludopage=1&cludorefpt=UNAIDS%20leads%20the%20world%E2%80%99s%20most%20extensive%20data%20collection%20on%20HIV%20epidemiology%2C%20programme%20coverage%20and%20finance%20%7C%20UNAIDS&cludorefurl=http%3A%2F%2Fwww.unaids.org%2Fen%2Ftopic%2Fdata&cludorefact=AIDS%20Spending%20&cludorefaci=1>

8.3 Appendix C: Technical Working Group Members

NASA 2018 -TWG members

1. Director, NCASC	Chair
2. SI Officer, NCASC	Member Secretary
Members	
3. Deputy Director,	National Centre for Aids and STD Control
4. Representative,	Finance Division, Ministry of Health and Population
5. Representative,	Planning Division. Ministry of Federal Affairs and General Administration
6. Representative,	Ministry of Home Affairs
7. Representative,	Ministry of Women Children and Senior Citizen
8. Representative,	Finance Department, Director General Office
9. Finance chief,	NCASC
10. Representative,	UNAIDS
11. Representative,	WHO
12. Representative,	Save the Children
13. Representative,	FHI360
14. Representative,	Aids Healthcare Foundation

Terms of Reference of NASA Technical Working Group (NTWG)

The overall objective of the full National AIDS Spending Assessment (NASA) is to review spending on HIV (health and non-health), using six variables (financing sources, financing agents, functions or AIDS Spending categories (ASC), production factors, providers of services and intended beneficiaries) and to build the foundations for the development of a NASA system in Nepal in the coming years, including strategic investments in the strengthening of individual and institutional capacity. The purpose of the NTWG is to oversee and be part of an inclusive and comprehensive NASA process from design to completion as well as the dissemination of the findings to wider audiences.

Collaboration and reporting:

The NASA is being conducted under the oversight and responsibility of National Centre of AIDS and STD Control. The NASA Technical Working Group (NTWG) will provide appropriate guidance and technical support in the development of the full NASA in Nepal and will work in close collaboration with the two consultants hired for this purpose and the Strategic and financial unit of NCASC who have received training/orientation on NASA methodology.

The NTWG and consultants will keep NCASC Director through focal point (member secretary of NTWG) informed on progress made and of obstacles or constraints which may arise in the course of the assignment and need to be addressed.

Major areas of tasks include:

1. Oversee the NASA development process:
 - Ensure timely accomplishment of all tasks
2. Coordination with Stakeholders:
 - Participate in committee meetings and consultations
 - Provide suggestion to ensure all relevant and key stakeholders contribute in the process
 - Define process, limitations and thresholds (eg. spending threshold to be included or not)
3. Facilitate data collection process:
 - Support the review of data collection forms for Nepal context
 - Facilitate data collection process by consultants from stakeholders and spending units
 - Help get permission/approvals from government and others as necessary to facilitate data collection
4. Data analysis and interpretations
 - Be aware of data gaps and conflicts and advice the team accordingly
 - Help obtain “big picture” by analysis and interpreting NASA information and linking it with other relevant information (epidemiological data, service utilisation, and data generalisations)
 - Help identify system and policy related information
5. Support development of documents, policy brief, presentation, facts sheets:
 - Review and provide contributions and inputs to the writing of the final NASA report and other relevant documents
6. Technical advice and support for the dissemination of NASA finding:
 - Dissemination of findings at National level, Regional level (this events can be combined with other national and regional level activities)

8.4 References

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