Nepal National AIDS Spending Assessment (NASA)
For the year 2013 and 2014

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

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National AIDS Spending Assessment Nepal (NASA Nepal) 2013 – 2014

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Executive summary

National AIDS Spending Assessment (NASA) was conducted for the year 2013 and 2014 with the aim of systematically capturing the flow of HIV-related financial resources from its origin (public, international and private (household) sources) to its ultimate beneficiary, flowing through the various agents and service providers to the specific interventions. It also aims to inform and support the development of national HIV and AIDS Strategy and costed implementation plan (2016-2020).

NASA followed the standardised classification method (UNAIDS 2009) that is compatible to the system of National Health Account and is internationally comparable.

At the onset, in order to build national capacity in resource tracking as well as to facilitate the NASA process, a two days training was organised in Kathmandu and a one day orientation in each of the four development regions (Morang, Kaski, Banke, Dhangadhi).

Number of challenges were faced while conducting the assessment, such as, delay in providing spending data, reluctance among the stakeholders in providing details adequate enough for NASA classification, and tendency to distribute/mask benefits related expenses under different category. Differences in accounting system (software), differences in fiscal year, institutional memory (retrieving past data/information) were also the practical challenges affecting the NASA process.

Given the diversity in programme interventions and diverse nature of organisations (public, NGOs, INGOs) engaged in service delivery, the level of detail in expenditure data varied enormously. Number of assumptions and estimation had to be made to calculate and apportion the expenditure data to reasonably fit to NASA classifications.

Major findings

A total of 16.3 million and 18.8 million AIDS spending was recorded in 2013 and 2014 respectively. International sources comprised of 78% of total AIDS spending followed by pool fund (11.5%), private spending (7.7%) and GoN (2.3%) during 2013 and 2014. Some 23 international sources channelled their resources to HIV and AIDS response in the country. Government of Nepal (MOH) and Household expenditure were two domestic sources for HIV financing in the country.

On the programmatic interventions, in two years period, prevention related activities shared highest percentage of total AIDS spending (47%), followed by programme management and administration (18%), enabling environment (14.9%) and care and treatment (15.5%). Interventions in the areas like HIV related research, social protection and vulnerable children received relatively low share (2%, 0.39% and 0.16% respectively) in the same period of time.

Of the total AIDS resources in the country, INGOs managed 58% and the government managed 23% of total AIDS spending. NGOs, bilateral and multilateral agencies managed the rest 20% of the resources.

The important institutions are the service providers who actually delivers goods and services to different beneficiaries group. NASA recorded nearly 200 service providers which included large numbers of NGOs, government institutions (i.e. hospitals), INGOs and bilateral and multilateral agencies.

NGOs appeared to be major service providers in the country. In two years period, NGOs provided goods and services worth of 58% of total AIDS spending in the country, followed by INGOs (19.1%), Government entity (17.6%) and others. Wages related expenditure were recorded at 30% of total spending followed by non-specific current expenditure 16%. Only 3.3% (USD 1.1 million) were recorded as spending on ART drugs in the same period.

Diverse range of beneficiaries were recorded during the assessment, of which 18.42% spending were intended to PLHIV followed by IDUs, FSWs and Migrants who all received around 8-9% of spending. Likewise, MSM and health care workers received 5.6% and 4.9% spending respectively in the same period of time. The highest spending was recorded at 41.3% as non-targeted intervention in 2013-2014. This high expenses could be largely due to insufficient expenditure detail to be able to disaggregate the data and classify accordingly.

Recommendations

1. In order to ensure accountability and transparency and honouring the rights to information, a system needs to be set up to centrally collect financial expenditure from all the fund managers (Agent) operating in the country in an agreed format and detail twice a year. Such information should be made available in public domain (i.e. MOH/NCASC web site).

2. Obtaining public spending data has been a challenge for various practical and structural reasons, therefore existing system like TABUCS should be updated regularly and should be made available for public use.

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). Wherever possible, the NASA findings can be used as a secondary source for costing and the estimation of unit costs for intervention packages.

4. 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.

5. The current narrow fiscal space in AIDS spending needs to be expanded by increasing allocative efficiency and spending efficiency (i.e. improving absorptive capacity within MOH/NCASC).

Forewords

(Director NCASC)
(to be added)

Message

(From Secretary of Health/ Chair of NASA Steering Committee)

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
CHBC	Community Home Based Care
DACC	District AIDS Coordination Committee
DFID	UK Department for International Development
DIC	Drop-in Centre
EDPs	External Development Partners
EU	European Union
FA	Financing Agent
FHI	Family Health International
FPAN	Family Planning Association of Nepal
FS	Financing Source
FSW	Female Sex Worker
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
IEC	Information, Education and Communication
INGO	International Non-Governmental Organization
LGBTI	Lesbian, gay, bisexual, transgender and intersexual
MARP	Most at Risk Population
ML	Multilateral Agencies
MoH	Ministry of Health
MoHP	Ministry of Health and Population (until 2014)
MSM	Men Who Have Sex with Men
n.e.c	Not elsewhere classified
NAC	National AIDS Council
NACC	National AIDS Coordination Committee
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
NIF	New Investment Framework
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.

OVC	Orphans and Vulnerable Children
PF	Production Factor
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
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
VDC	Village Development Committee
WB	World Bank
WHO	World Health Organization

1. Introduction

NASA seeks to ascertain the flows of funds used to finance national responses to the HIV epidemic. Therefore, the resource tracking process follows the financial transactions from their origin down to the final destination (i.e. the beneficiaries receiving goods and services). NASA is not limited to tracking health expenditures, it also tracks non-health expenditures such as social mitigation, education, labour, and other sectors related to the multisectoral HIV response.

First NASA was conducted in Nepal in 2007 and a similar resource tracking exercise was conducted in 2011. In this line, this is the third effort in assessing the AIDS spending in the country. NCASC and its partners have identified an urgent need for a spending assessment covering the period of 2013 and 2014 to elaborate a pattern of HIV expenditure in Nepal. This assessment is expected to help in expanding the understanding on resources flows and spending areas, which will guide and serve as important strategic information in preparation of HIV AIDS Strategy and Costed Implementation Plan (2016 – 2020).

NASA produces a standardized reporting method and indicators to monitor progress towards the targets of the Declaration of Commitment adopted by the United Nations General Assembly Special Sessions on HIV (UNGASS). It delivers strategic information for the management of the national response to AIDS by a single national AIDS coordinating authority that provides crucial input for the framework of action and is part of the construction of a single monitoring and evaluation framework.

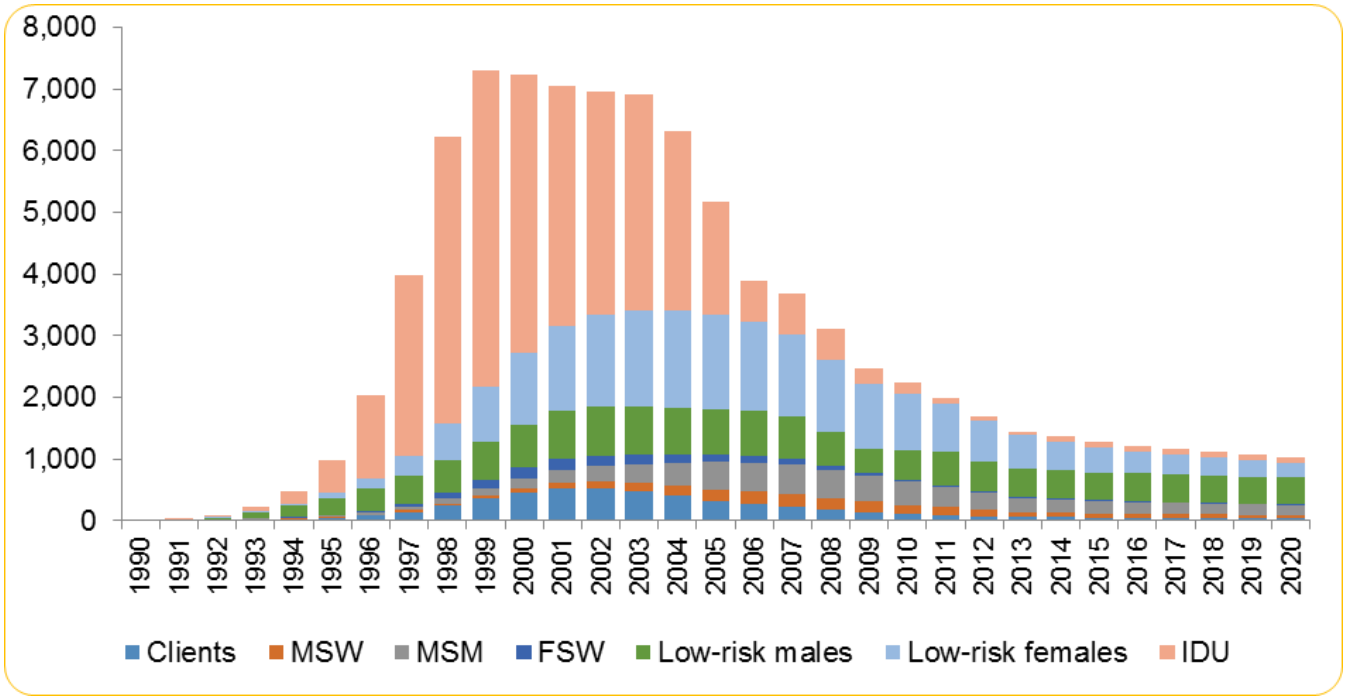
This reports presents a comprehensive analysis of flow of resources for the year 2013 and 2014 from its sources, its use and intended beneficiaries in a systematic table and graph within the broader framework of NASA guidelines (UNAIDS 2009). A set of recommendations are also presented for improving national monitoring of resource flow to HIV and AIDS response in the country.

2. Background

2.1 HIV and AIDS situation

Overall, the epidemic is largely driven by sexual transmission that accounts for more than 85% of the total new HIV infections. The HIV epidemic in Nepal remains concentrated among the key affected populations notably; people who inject drugs (PWID), men who have sex with men (MSM), transgendered people (TG), male sex workers (MSW), female sex workers (FSW) and male labour migrants (MLM), as well as their spouses. With an overall national HIV prevalence of 0.20 in the year 2015, currently there are an estimated total of 39,397 people living with HIV. Out of which only 22,267 have been tested diagnosed and reported. Following a declining trajectory, the number of new infections has dropped from its highest peak of over 7,500 in 2000 to 1,331 in 2015.

Figure 1: Estimated and projected new HIV infections, (1990-2020)



Source: National HIV infection Estimates, 2015

The prevalence among the establishment-based female sex workers stands at less than 1%; however, in a sharp contrast to this, prevalence among street-based female sex workers is at 4% (IBBS 2015). The latest IBBS Survey has showed the HIV prevalence among PWID has remained around 6.3% in Kathmandu Valley, while in the Eastern Terai the prevalence of 8.3% among PWID was recorded through the IBBS 2015. Among male sex workers (MSW) in Kathmandu Valley, HIV prevalence of 5.6% was observed in IBBS 2015. The prevalence of active syphilis among female sex workers in Kathmandu Valley has increased to 3.6% in 2015 from 0.7% in 2011.

A cumulative total of 11,089 (5,652 male and 5406 female) people living with HIV were on ART in Nepal as of July 2015. Out of this total, 92% are adult and remaining 8% are children. HIV prevalence among TB patients has been at 2.4%, and TB prevalence among people living with HIV at 11.2% (Status Report on TB-HIV in SEARO 2013). Despite the national HIV and TB guidelines, only 78.2% of people with HIV have been screened for TB and only 8.8% of TB patients have been tested for HIV in 2014. (GARPR 2014). An alarmingly high rate of HIV/Hepatitis C co-infections, ranging from 13.1% to 47.5%, has been diagnosed among injecting drug users in recent IBBS studies.

2.2 National response to HIV and AIDS

National Policy on HIV and STI, 2011 has made a structural arrangement involving key entities notably: National AIDS Council (NAC), HIV/AIDS and STI Control Board (HSCB), NCASC; and DACC for the effective implementation of the national response. Many of those structures are not convening leaving the NCASC (and to some extent) as the functional entity for steering national response.

In this context, National Centre for AIDS and STD Control is responsible for the implementation, monitoring and oversight of the National response to HIV through the public health service infrastructures at national, regional, district and village level. Its implementation takes place in coordination with other public entities and the private sector, including services that are provided by a wide range of civil societies/NGOs and other non-government networks and organizations.

This apart, NCASC, itself acting as a financing agent for the resources earmarked for HIV obtained through the pooled fund has procured HIV related services through a number of NGOs for key populations. At district level, there are District AIDS Coordination Committees (DACC) which works as a coordinating mechanism for generating local responses to HIV.

The policy and structural environment to ending HIV is guided by the frameworks in The National Policy on HIV and STI 2011, the National Strategy Plan 2011-2016 (NSP), the Nepal HIV Investment Plan 2014-2016 (NHIP), the Review of the National Response to HIV in Nepal 2013, and the Technical Report on the Epidemiological Analysis of HIV in Nepal and the Way Forward 2014.

Several other policies and guidelines notably the National Policy on HIV in the Workplace (2007), and the National Drug Control Policy (2006), National Guidelines on Opioid Substitution Therapy (OST-2014) and The National Consolidated Guidelines for Treating and Preventing HIV in Nepal" have reinforced the National HIV response, working in tandem with the National Strategy Plan 2011-2016.

1.1 National Health budget and spending

The MoHP[1] budget analysis (2010 – 2015) made following observations. Over the period there has been an increasing trend in health budget. MoHP's budget increased by about 50% over the NHSP-2 period compared to more than a 100% over the NHSP-1 period. In FY 2005/06 a beginning of NHSP-1 MoHP's budget was 6.29% of total national budget which has decreased to 5.42% in the last year of NHSP-2 period FY 2014/15. However, the volume of the budget has gone up from NPR 7.6 billion in FY 2005/06 to NPR 33.5 billion in FY 2014/15. At the same time, MoHP's budget decreased from 6.29% of the national budget in FY 2005/06 to 5.42% in FY 2014/15. This was mainly because the government increased the budget for other sectors, especially education and social security.

Except for FY 2012/13, MoHP's absorption rate in the NHSP-1 and 2 periods has been lower than that of the national budget. This data suggests that MoHP's budget absorption capacity needs to be improved.

[1] Ministry of Health and Population (MoHP) was restructured in 2015 by creating separate Ministry to look after the population activities. Most data and references used in this documents were from the period when population was part of Ministry of Health. Therefore MoHP and MoH is used interchangeably.

Table 1: GDP, National and MoHP budgets and expenditure (in NPR billion)

Categories	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
GDP	654	728	816	988	1,193	1,367	1,527	1,693	1,929	NA
National budget	127	144	169	236	286	338	385	405	517	618
MoHP budget	8	9	12	15	18	24	25	20	30	33.51
National expenditure	111	134	161	220	260	295	339	359	450	NA
MoHP expenditure	6	7	10	13	16	18	20	19	23	NA
National absorption rate	87.4	92.8	95.5	93.1	90.8	87.4	88.1	88.6	87	NA
MoHP absorption rate	76	80.6	81.4	84.9	89.2	76.3	81.2	94.1	75.1	NA

Source: MoH budget analysis (2013/14)

Budget analysis further analysed the programme by its absorptive capacity where NCASC was categories among the lowest performing programme over the period.

Table 2: Lowest performing programmes (2010/11 – 2013/14)

Lowest performing five programme (2010/11 – 2013/14)	%
Integrated Reproductive Health and Women's Health Program	59
National AIDS and STD Control Programme	56
National Tuberculosis Control Programme	55
National Health Education, Information and Communication Centre	55
Avian Flu Prevention and Control Programme	54

Source: MOHP budget analysis

1.2 Objectives of the assessment

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 specific objectives of the NASA were:

1. To gather data and information that are needed to assess HIV and AIDS financing flows (at least national and international) and expenditures for eight ASCs;
2. to complete in a timely manner the National Funding Matrix and produce a set of NASA tables within a short report illustrating HIV and AIDS financing flows and expenditures; and
3. to orient national staff through workshop(s) and on the job mentoring in order to build national capacity in this field which can effectively be employed in the future to build a national resource tracking system that provides recurrent information on Nepal's AIDS financing and expenditures and other resource related issues (e.g. efficiency, effectiveness and equity in the allocation of financial resources).

3. Study design and methodology

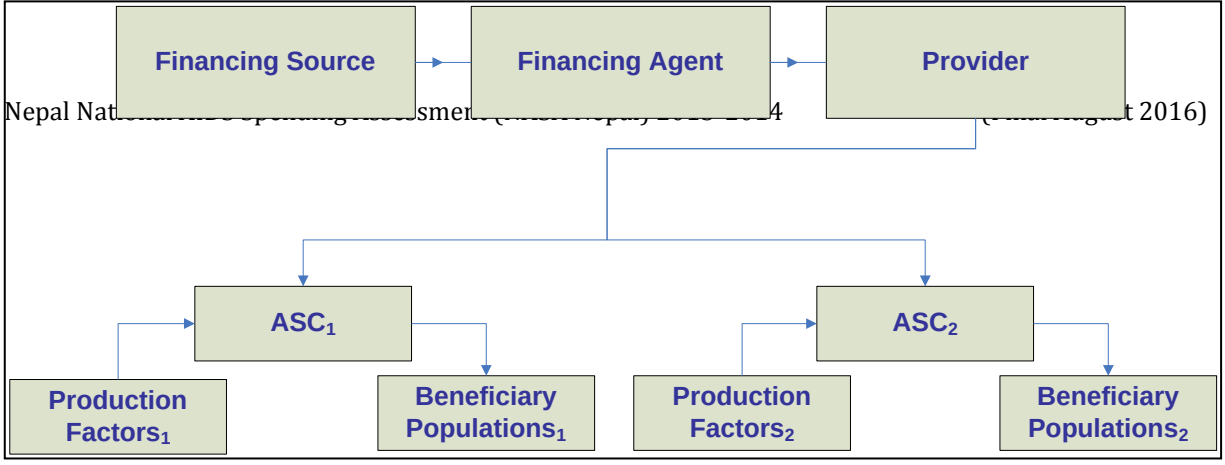
3.1 Approach

The NASA assessment in Nepal followed the generic National AIDS Spending Assessment (NASA) methodology designed by UNAIDS. According to UNAIDS (2009),

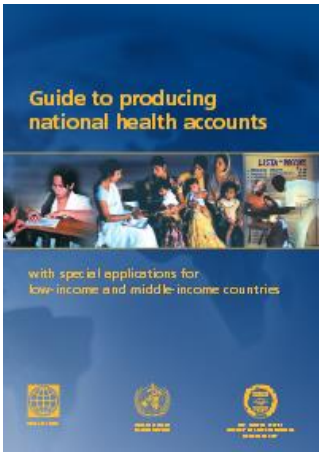
NASA approach is a comprehensive and systematic methodology to determine the flow of resources from source to agent and to providers who provides goods and services to specific population group. It describes the allocation of funds, from their origin to the end point beneficiary groups who benefit from 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.

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 General Assembly Special Sessions on HIV (UNGASS).

In Nepal, NASA study was approached with aim of capturing all the expenditure made during the year 2013 and 2014 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).



3.2 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 categories[2]:

Financing

1. Financing agents (FA) are entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent)
2. Financing sources (FS) are entities that provide money to financing agents

Provision of HIV services

3. Providers (PS) are entities that engage in the production, provision, and delivery of HIV services
4. Production factors/resource costs (PF) are inputs (labour, capital, natural resources, "know how", and entrepreneurial resources)

Use

5. AIDS spending categories (ASC) are HIV-related interventions and activities
6. Beneficiary segments of the population (BP), e.g., men who have sex with men, injecting drug users, etc.

(Detail of classification is in annex)

3.3 Data collection and processing

Preparation of the assessment and sensitization of key stakeholders

- Under the leadership of NCASC, the preparatory work began with the preparation of concept note and detail road map of NASA exercise.
- Two day NASA orientation was organised for government officials, External Development Partners, NGO members, implementing partners and related stakeholders. Two NASA consultants facilitated the orientation.

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

- NCASC formally sent information and request letter to relevant ministries, institutions, EDPs, NGOs and other stakeholders to support the NASA process and provide information to NASA team.
- A NASA task force was constituted consisting of representative of NCASC (overall coordination of the process); representatives from UNAIDS, Ministry of Health and technical partners. Series of meeting of task force took number of decisions regarding mapping of institutions by source, agent and providers; time frame; data collection form adapt into local language, role division among the members and so forth.

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 partners who were identified for the NASA data collection. The data collection form was pre designed in 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 the activity, whether or not fund is transferred to other agency, total expenditure and production factor (inputs) for each of the activities. Instruction on how to fill form and sample of completed form was part of data collection form.

Data collection consisted of serious of repetitive visits to organization, assisting in clarifying the issues and confusion related to classification and recording the expenditure in that particular category and rechecking back with the institution if any inconsistency found in the submitted data.

In order to better understand the types of intervention, implementation modality and beneficiaries, project documents, annual reports, progress reports, annual workplan and budgets or other such material that would help understanding and assigning NASA classification were collected to the extent possible.

EXAMPLE

Resources Used in 2008

Financial resources used for specific activities

					Currency	*US Dollar*	
	Financing source (Origin of the funds)	**Name of project**	**Name of Activity**	**Description of Activity** (1-2 sentences)	**Transferred Funds** (to which organization?)	**Total Activity Amount** (Expenditures, not budgeted amounts)	**Beneficiary Population** *See 'Beneficiary List' tab
1	Global Fund	YouthStart	Prevention program for youth at school	Prevention program for youth at school include free provision of condom and social marketing	HSPH	500	College students
2	Global Fund	YouthStart	Prevention program for youth at school	Media campaign and counseling	PAC An Giang	1,000	College students
3	Global Fund		VCT	VCT integrated to programs targeting sex workers		500	Sex workers
4	Global Fund		VCT	VCT integrated to programs targeting IDUs		500	IDUs
5	National AIDS programme		Treatment of STIs		-	500	Patients of STI
6	PEPFAR		Treatment of STIs		-	1000	Patients of STI
7	National AIDS programme		Prevention program			1000	Female sex workers
8	National AIDS programme		Treatment of STIs			1000	Female sex workers
9	PSI	SafeGuards	Condom distribution	Free condom distribution		1000	General population
	TOTAL					**7,000**	

3.3.1 Regional orientation

Three regional orientation was organized to the providers of HIV services (implementing partners) with the aim of orienting them on NASA concept, methodology, data collection process and use of NASA results. Through the orientation it was also expected that there would be consistency and enough detail when they submit NASA data in specified form.

More specifically, a two-day training program at Kathmandu and one-day regional orientation program each at Biratnagar, Pokhara, Nepalgunj and Dhangadhi were organized for facilitation of data collection process. These regional orientation programs were conducted with the following objectives[3]:

- Sensitize regional participants on NASA concept, process, classification and use of NASA data
- To familiarize participants on NASA data collection tool and reporting
- Develop work plan to submit data by the end of Magh (February 15, 2016)

The one-day regional orientation programs were participated by relevant staff members of a number of District Public Health Offices of the development regions. This apart, program officers and finance officers from a number of local NGOs working in the field of HIV, staff member s of the regional chapter of FHI 360 and Save the Children participated at the orientation program.

3.3.2 Sources of data

A number of sources of data 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.

For NCASC expenditure data available at Transaction Accounting and Budget Control System (TABUCS – a web based programme extensively used by the Ministry of Health) were used. Where detail expenditure figures were not available, budget for the particular year were used assigning same spending percentage as that of NCASC overall spending.

3.3.3 Estimations

In addition to the primary sources of data (data submitted by the Providers and the Agents) estimations were made on following expenditures

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, 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 2013 and 2014 was obtained from the blood transfusion centre. Total cost paid by individuals is estimated against the total blood distributed and included as 'out of pocket' expenses for HIV prevention.

[3] Cost sharing for field orientation from the Save the Children made it possible to organise four Regional workshops

c. Where expenditure totals submitted in the data-collection forms did not match the detailed disaggregated data per provider or per activity implemented, the data were rechecked with the organization from which they originated and only the data supported by detail expenditure was included for analysis to avoid double counting and avoiding unaccounted figures.

d. MoH has pool fund mechanism where number of donors and government pool resources and MoH allocate/spends money for programme and activities. Since it is virtually difficult to trace the individual pool partners' funding to point of care, pool fund is assumed to be a separate source (this is not in NASA classification).

   Besides, spending data for NCASC (including pool fund sources) were available from TABUCS where adequate detail was not available according to NASA classification. Similarly, spending from pool fund in 2013 were not updated in TABUCS particularly for targeted intervention (for Migrants, IDUs and MSM), it was agreed to use 80% of budgeted amount as spending in that year for targeted intervention.

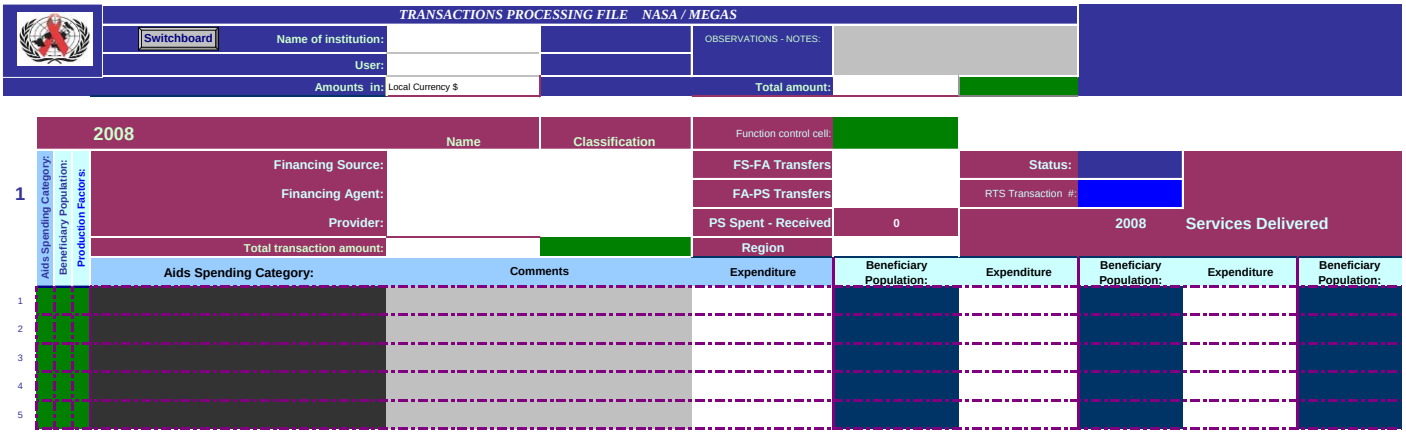
e. The processing of expenditure data by production factor was a time- and labour-intensive undertaking. In many instances, the data collected were insufficiently detailed to allow for a clear identification of production factors. In these cases, the NASA team used code PF.01.98 Current expenditures not broken down by type, or where it was not possible to identify whether expenditure was current or capital, the code PF.98 Production factors not broken down by type was used.

3.3.4 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 and tools.

Stage 1: Once the data is received (hard or soft copy) first checked for consistency, clarity and depth of details. For any inconsistency in data (e.g. total expenditure figure not matching with production factor figure), activity (Aids Spending Category) and production factor mismatched or figure not tallying) 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 a pre-designed excel sheet or in plain excel sheet depending on volume of data . 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 to be entered in Resource Tracking Software designed for NASA data analysis. Because of problem in software compatibility with Microsoft Office 2013, it was decided to use excel for final data entry 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.

3.3.5 Data validation

Data validation was conducted with expanded TWG meeting where along with TWG members, representatives from providers and agents who had submitted data were invited to review the final data, assigned NASA classifications and the output table. Validation meeting was organised to ensure that NASA data, classifications and output reflects the reality of the spending made in 2013 and 2014. The comments, suggestions and views were incorporated in the final report to the extent it was related to NASA study framework.

3.4 Scope and limitations

The scope of NASA is 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. Nonetheless, despite the difficulties number Providers submitted data directly to NASA team.

Government of Nepal along with major external development partners like World Bank, DFID, GIZ have developed a pool fund mechanism where government and pool partners put money in one basket for MoH 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 separate source and analysed accordingly.

3.5 Assumptions and clarifications

Average exchange rate used for 2013 was Rs 93 and for 2014 was 97 for one US$ based on Nepal Rastra Bank average rate for the year. All Nepali figures irrespective of spending month, is 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 2013 and 2014 captures over 90% of AIDS spending in the country during the study period.

Where expenditures were not detailed according to production factor or beneficiary population, a percentage distribution was utilized. Most data received did have ASC and BP defined often fairly accurately, considerable level of confusion existed in showing Production Factor and at time not provided at all.

In cases where there were no detail data available, budgetary information or reported financial expenditure was taken as actual expenditure.

Programme and specific activities do greatly varied in their spending requirements and use of Production Factor. Most often, in the supplied data PF was not assigned nor the details of expenditure provided for NASA team to assign PF. In other words, production factory varies enormously by implementing partners for similar activities, therefore one single formula 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, therefore NASA classification (assigning ASC/PF category) depended on the level of detail available in the TABUCS. As there was limited information available in TABUCS regarding targeted intervention (TI) financed through Pooled Fund mechanism detail disaggregation and classification (ASC and PF classification) was not possible, only single digit ASC and PF were assigned.

Number of occasions existed where individuals make expenses for accessing HIV related services. Only one such expenses was possible to include in NASA. 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 this expenses under Household (out of pocket) expenses. But other similar cost like PLHIV paying for transport and associated cost to access ART services, cost of HIV test conducted prior to major surgery (i.e. Caesarean section) in major hospitals could not be estimated.

The submission of data by stakeholders contains "Training" as a major component area 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 into is broken into three PF using a factor based on sample calculation of actual expenditure:

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

Similarly, since the Production Factor of expenditures of ARV/HIV program implemented through hospitals were not available, the total of expenditures incurred for ARV program of such hospital was apportioned two Production Factors:

a) PF.01.01.01 Wages 70%,
b) PF.01.02.02.05 Transportation and travel services 30%.

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 expenditure incurred for the condom promotion program is apportioned into three PF categories;

a) PF.01.02.02.05 Transportation and travel services, 50% and;
b) PF.01.01.01 Wages; 40%
c) PF.01.02.02.01 Administrative services 10%.

Crisis response package for MSM was apportioned into following PF categories;

a) PF.01.02.02.05 Transportation and travel services 50%
b) PF.01.01.01 Wages 40%
c) PF.01.02.02.01 Administrative services 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.

According to NASA manual, classification category (.98 and .99) is assigned where there are inadequate information for assigning specific NASA classification for ASC, BP or PF. This NASA code means ……..”not disaggregated by type…….” Or ……”not elsewhere classified”.

3.6 Challenges

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 was significant delays in submitting the data from large number of organisations.

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. For this matter, national NGOs (provider) were more transparent and detailed in providing their expenditures data.

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.

Since the data was obtained directly from Providers (i.e. NGOs) and from Agents/Source (or PR), the financial flows from different sources/agents particularly to Providers was often a challenge to reconstruct transactions correctly, and to avoid double-counting or data loss. Moreover, most data contained inaccuracy and inconsistency when submitted. Despite several email exchanges, telephone communication and face to face meeting, for quite a few organisation such inconsistency were not possible to resolve. Therefore only those data that was consistent were included in NASA analysis.

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 follows June – July whereas donors have different fiscal years. Also that the spending made for 'capacity building support' to NGO were 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.

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.

4. Findings

NASA finding are primarily analysed through following NASA recommended matrix. Additional matrix and tables are also generated for further analysis, clarification and discussions.

Recommended NASA tables
1. ASC x FS (Financing Sources by AIDS Spending Category)
2. FS x FA (Financing Sources by Financing Agents)
3. FA x ASC (Financing Agents by AIDS Spending Category)
4. PS x ASC (Providers by AIDS Spending Category)
5. FA x PS (Financing Agents by Providers)
6. PS x PF (Providers by Resources Costs)
7. ASC x BP (AIDS Spending Category by Beneficiary Populations)

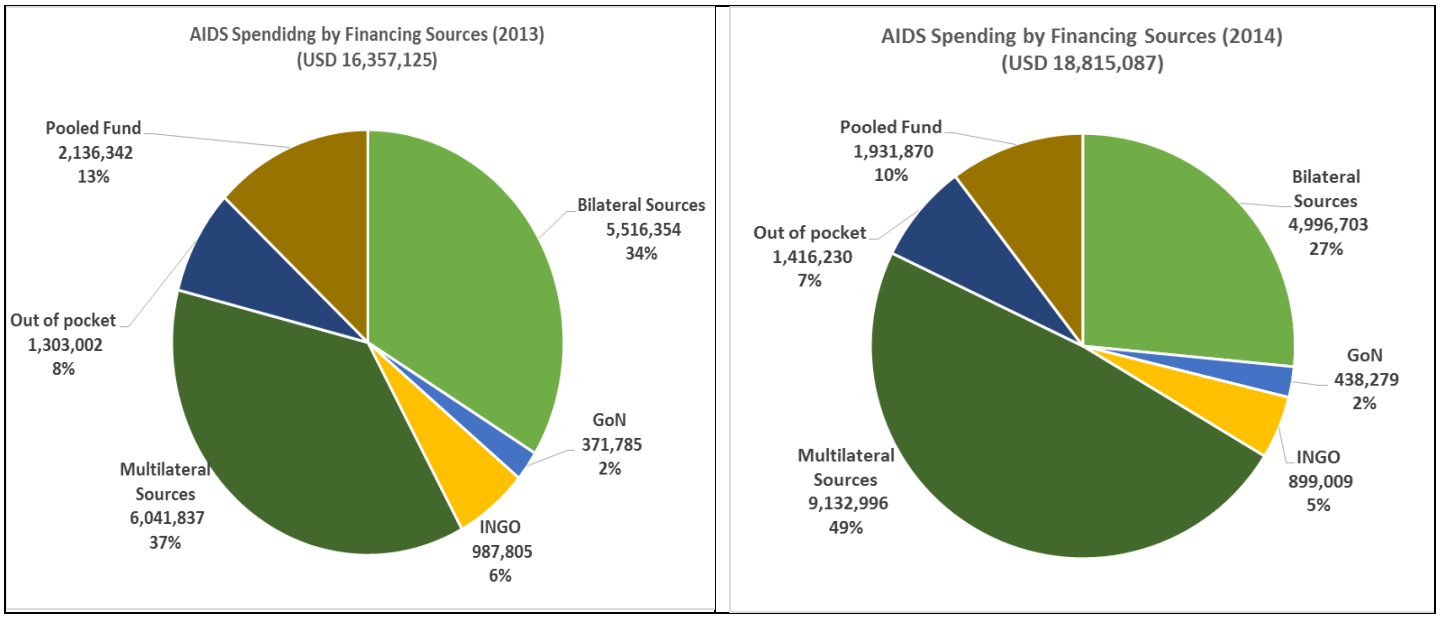
4.1 Total expenditure by source, agent and provider

4.1.1 AIDS spending by Financing Sources

Financing sources are entities or pools which purchasers, providers of financial intermediation services or paying agents, tap or use other forms of mobilization to fund HIV services. An analysis of financing sources is of particular interest in countries where funding for the HIV response is heavily dependent on international sources of financing or when there are few management entities.

A number of sources were identified financing AIDS programme in the country. The sources ranges from the Global Fund to International Non-Government Organisations, apart from the government of Nepal. This is the first attempt to estimate the sources from out of pocket by individual seeking HIV services.

Figure 2: AIDS Spending by Financing Sources



Overall US$ 16,357,125 and US$ 18,815,087 were spent for the year 2013 and 2014 respectively from 26 Financing Sources who falls within the five broader categories. Government of Nepal financed HIV programme utilising two mechanisms; national revenue sources and Pool fund mechanism. Pool fund comprises contribution from numbers of pool partners including the World Bank and DFID apart from government's own contribution.

Table 3: AIDS spending by Financing Sources (FS)

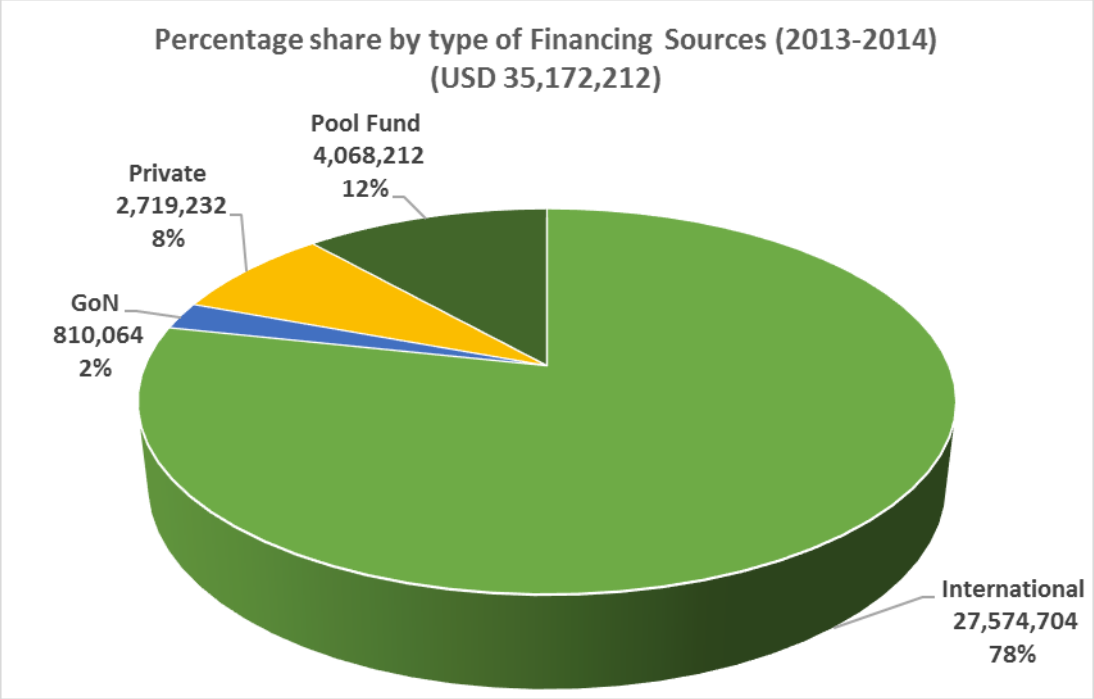
FS	ASC 1 digit	2013	2014	Grand Total	%
Bilateral Sources	ASC 01. Prevention	1,894,194	1,776,424	3,670,618	34.91
	ASC 02. Care and Treatment	345,886	339,410	685,296	6.52
	ASC 04. Prog management and admin	918,922	884,965	1,803,887	17.16
	ASC 05. Human Resources	58,294	6,520	64,814	0.62
	ASC 06. Social protection and social services	10,615	6,436	17,051	0.16
	ASC 07. Enabling Environment	1,980,327	1,783,174	3,763,501	35.80
	ASC 08. HIV-related research	308,116	199,774	507,890	4.83
	Total	**5,516,354**	**4,996,703**	**10,513,057**	**100**
GoN	ASC 01. Prevention	18,790	18,099	36,889	4.55
	ASC 02. Care and Treatment	338,985	129,935	468,920	57.89
	ASC 04. Prog management and admin	14,010	290,245	304,255	37.56
	Total	**371,785**	**438,279**	**810,064**	**100**
International NGO Source	ASC 01. Prevention	328,134	350,486	678,620	35.97
	ASC 02. Care and Treatment	178,106	151,283	329,389	17.46
	ASC 04. Prog management and admin	331,366	279,269	610,635	32.36
	ASC 05. Human Resources	58,402	19,469	77,871	4.13
	ASC 06. Social protection and social services	4,589	2,115	6,704	0.36
	ASC 07. Enabling Environment	87,208	96,387	183,595	9.73
	Total	**987,805**	**899,009**	**1,886,814**	**100**
Multi-Lateral Sources	ASC 01. Prevention	2,987,027	3,478,248	6,465,275	42.61
	ASC 02. Care and Treatment	1,168,762	2,048,929	3,217,691	21.20
	ASC 03. Orphans and vulnerable children	18,458	39,559	58,017	0.38
	ASC 04. Prog management and admin	1,484,452	1,849,911	3,334,363	21.97
	ASC 05. Human Resources	181,879	273,146	455,025	3.00
	ASC 06. Social protection and social services	44,754	68,120	112,874	0.74
	ASC 07. Enabling Environment	148,420	1,162,856	1,311,276	8.64
	ASC 08. HIV-related research	8,085	212,227	220,312	1.45
	Total	**6,041,837**	**9,132,996**	**15,174,833**	**100.00**
Out of pocket					
	ASC 01. Prevention	**1,303,002**	**1,416,230**	**2,719,232**	**100.00**

FS	ASC 1 digit	2013	2014	Grand Total	%
Pool Fund Source	ASC 01. Prevention	1,711,387	1,167,958	2,879,345	70.78
	ASC 02. Care and Treatment	203,796	578,443	782,239	19.23
	ASC 04. Prog management and admin	221,159	128,005	349,164	8.58
	ASC 07. Enabling Environment		7,001	7,001	0.17
	ASC 08. HIV-related research		50,463	50,463	1.24
	Total	**2,136,342**	**1,931,870**	**4,068,212**	**100.00**
Grand Total		**16,357,125**	**18,815,087**	**35,172,212**	

In summary, the largest sources for HIV financing in Nepal were from Multilateral (which includes the Global Fund) and Bilateral sources and the second largest sources of HIV money is from Pooled Fund and Out of pocket expenses. The Government of Nepal financing stands close to 3% for the year 2013 and 2014. The financing from INGOs sources comprises 5-6% over the period of two years.

Over the two years period (2013-2014), public financing comprised of slightly over 2% direct financing in addition to the percentage contributed through pool fund; international sources occupied 78% in addition to the percentage contributed through pool fund; and private household source (out of pocket) comprised of 8% to total spending in country during two years period (Figure 3).

Figure 3: Percentage share by sources of fund (2013-2014)



4.1.2 Financing Agent by Financing Source

Financing agents are entities which mobilize financial resources collected from different Financing sources (pools) and transfer them to pay for or to purchase health care or other services or goods. These entities directly purchase from providers or steer in full, or as co-guarantors of payment, resources earmarked for the provision of

commodities (services and/or goods) to satisfy a need. Financing Agent receives fund from Financing Sources and procure good and services through Providers of Services.

Some 26 agents (fund managers) were recorded in 2013 and 2014 who received fund from different sources for HIV programme in Nepal.

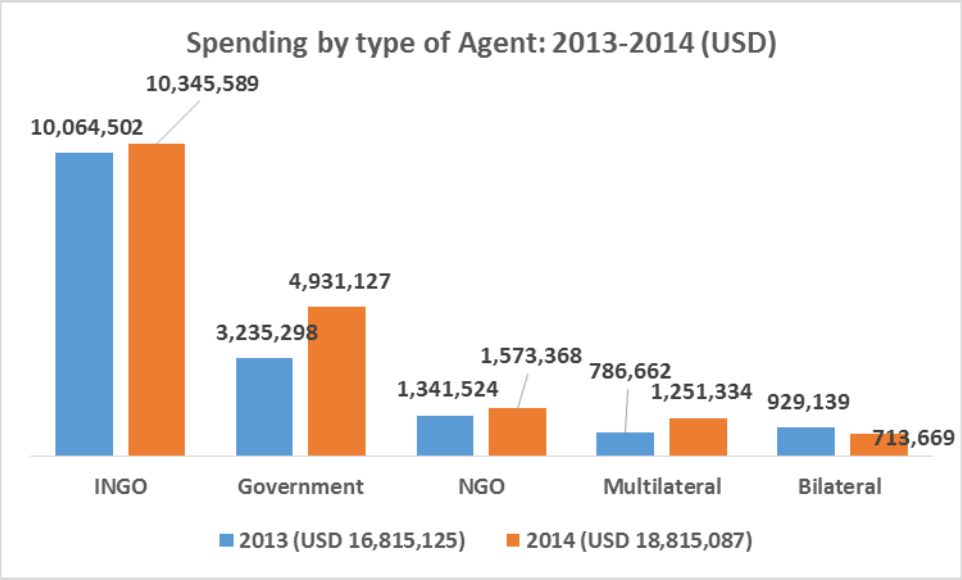
International NGOs like Save the Children and FHI 360 who received fund from different financing sources were among the highest spending agent in 2013 and 2014. Ministry of Health as an Agent who received fund from central revenue and from sources like the Global Fund and pooled fund stands at third highest position in terms of managing fund to procure goods and services for HIV programme.

Table 4: Flow of fund from Source to Agent

Financing Source	Financing Agent	2013	2014	Grand Total	%
Bilateral sources	Care International	360,009	166,318	526,327	5.01
	FHI 360	4,130,265	3,949,929	8,080,194	76.86
	GIZ	929,139	713,669	1,642,808	15.63
	UNICEF	96,941	166,787	263,728	2.51
Bilateral Total		**5,516,354**	**4,996,703**	**10,513,057**	**100.00**
GoN	MOH	371,785	438,279	810,064	100
GoN Total		**371,785**	**438,279**	**810,064**	100
International Non-governmental Sources (INGOs)	Asal Chhimeki	11,714	5,431	17,145	0.91
	AIDS Health Care Foundation	203,009	251,060	454,069	24.07
	Care International	255,913	119,780	375,693	19.91
	FPAN	38,522	157,138	195,660	10.37
	IFRC	191,110	99,630	290,740	15.41
	Mainline Foundation	204,880	193,221	398,101	21.10
	Robert Carr Foundation	23,156	36,083	59,239	3.14
	Sidaction	41,363	36,666	78,029	4.14
	The Danish Aids Foundation (Aids Fundet)	18,138		18,138	0.96
INGOs Total		**987,805**	**899,009**	**1,886,814**	**100**
Multilateral Sources (ML)	APN+	10,338	43,541	53,879	0.36
	CCM	90,001	101,929	191,930	1.26
	FHI 360	78,293	257,163	335,456	2.21
	FPAN	1,094,318		1,094,318	7.21
	MOH	637,170	2,459,049	3,096,219	20.40
	PSI	41,479		41,479	0.27
	Save the Children	3,400,517	5,186,767	8,587,284	56.59
	UNAIDS	133,016	108,199	241,215	1.59
	UNDP, APRC, Bangkok		221,112	221,112	1.46
	UNFPA	73,937	55,160	129,097	0.85

Financing Source	Financing Agent	2013	2014	Grand Total	%
	UNICEF	173,625	228,880	402,505	2.65
	UNODC	233,497	209,965	443,462	2.92
	WHO	75,646	261,231	336,877	2.22
ML Total		**6,041,837**	**9,132,996**	**15,174,833**	**100**
Out of pocket	Red Cross	1,303,002	1,416,230	2,719,232	100
Out of pocket Total		**1,303,002**	**1,416,230**	**2,719,232**	**100**
Pool Fund	MOH	2,136,342	1,931,870	4,068,212	100
Pool Fund Total		**2,136,342**	**1,931,870**	**4,068,212**	**100**
Grand Total		**16,357,125**	**18,815,087**	**35,172,212**	

Figure 4: Spending by type of agent



4.1.3 Flow of fund to Providers of services (PS)

Financing Agent (FA) is responsible to manage fund received from the sources (FS), they procure goods and services through various services providers including NGOs and private agencies. In other words, Providers of Services (PS) directly provide services to different groups (KAP), PLHIV, pregnant mothers, and also provides services like research and trainings. There were over 165 providers (primarily NGOs and organisations run by KAP) recorded providing HIV related services in different parts of the country.

Resources from different types of sources are ultimately passed down to providers through the fund manager (Agent). The table below explains the flow of fund to different types of providers.

Table 5: Flow of fund from source to providers

Financing Source	Providers of services (PS type)	2013	2014	Total	%
BL					
	BL	464,569	381,836	846,405	8.05
	Govt Entity	96,941	166,787	263,728	2.51
	INGO	146,392		146,392	1.39
	NGOs	4,779,077	4,447,406	9,226,483	87.76
	Pvt. Agency	29,375	674	30,049	0.29
BL Total		**5,516,354**	**4,996,703**	**10,513,057**	100
GoV					
	Govt Entity	371,785	438,279	810,064	100
GoV Total		**371,785**	**438,279**	**810,064**	**100**
INGO					
	INGO	361,550	322,037	683,587	36.23
	NGOs	626,255	576,972	1,203,227	63.77
INGO Total		**987,805**	**899,009**	**1,886,814**	**100**
ML					
	Govt Entity	906,539	2,910,855	3,817,394	25
	INGO	1,086,736	5,362,975	6,449,711	43
	ML	261,516	343,727	605,243	4
	NGOs	3,697,045	332,555	4,029,600	27
	Other	90,001	101,929	191,930	1
	Pvt. Agency		80,955	80,955	1
ML Total		**6,041,837**	**9,132,996**	**15,174,833**	**100**
Out of pocket					
	NGOs	1,303,002	1,416,230	2,719,232	**100**
Out of pocket Total		**1,303,002**	**1,416,230**	**2,719,232**	**100**
Pool Fund					
	Govt Entity	424,955	783,643	1,208,598	29.71
	NGOs	1,711,387	1,148,227	2,859,614	70.29
Pool Fund Total		**2,136,342**	**1,931,870**	**4,068,212**	**100**
Grand Total		**16,357,125**	**18,815,087**	**35,172,212**	

It is notable that NGOs appeared to be the most desired providers by all sources. NGOs receive fund from almost all types of sources.

Table 6: Flow of fund from Agent to Providers of services

Financing Agent	Providers of Service (PS code)	2013	2014	Total
BL				
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	464,570	331,833	796,403
	PS.03.01 Bilateral agencies	464,569	381,836	846,405
BL Total		**929,139**	**713,669**	**1,642,808**
GoV				
	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	1,433,910	3,672,889	5,106,799
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	1,711,387	1,148,227	2,859,614
	PS.03.02 Multilateral agencies		8,082	8,082
	PS.99 Providers n.e.c.	90,001	101,929	191,930
GoV Total		**3,235,298**	**4,931,127**	**8,166,425**
INGO				
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	10,035,127	10,263,960	20,299,087
	PS.02.02.13 Research institutions (For profit)	29,375	81,629	111,004
INGO Total		**10,064,502**	**10,345,589**	**20,410,091**
ML				
	PS.01.01.14.02 Departments inside the Ministry of Health or equivalent (including. NAPs/NACPs)	290,664	357,362	648,026
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	158,836	289,014	447,850
	PS.03.02 Multilateral agencies	337,162	604,958	942,120
ML Total		**786,662**	**1,251,334**	**2,037,996**
NGO				
	PS.02.01.01.15 Civil society organizations (Non-profit non faith-based)	1,341,524	1,573,368	2,914,892
NGO Total		**1,341,524**	**1,573,368**	**2,914,892**
Grand Total		**16,357,125**	**18,815,087**	**35,172,212**

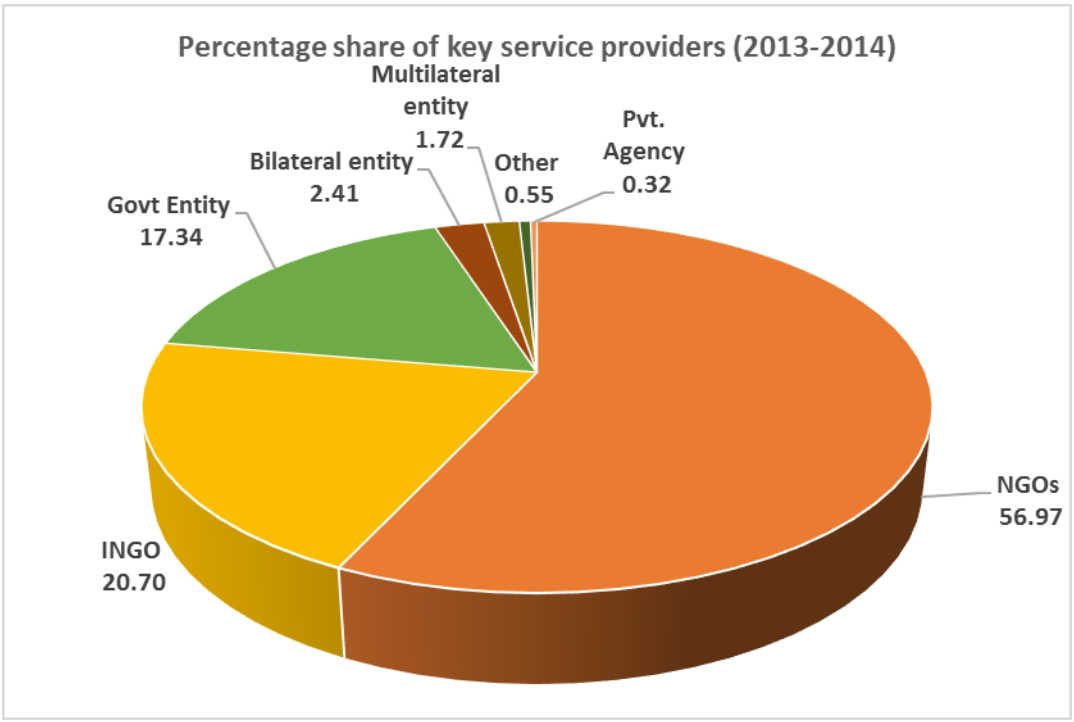
Civil society organisations apparently were the most preferred Providers. Bilateral Agents were using only the civil society organisations for procuring goods and services to different beneficiaries population, whereas INGOs and Multilateral agencies did choose government and private service providers as well.

Table 7: Spending by Providers category

Provider category (PS type)	2013	2014	Grand Total	%
NGOs	12,116,766	7,921,390	20,038,156	56.97
INGO	1,594,678	5,685,012	7,279,690	20.70
Govt Entity	1,800,220	4,299,564	6,099,784	17.34
Bilateral entity	464,569	381,836	846,405	2.41
Multilateral entity	261,516	343,727	605,243	1.72
Other	90,001	101,929	191,930	0.55
Pvt. Agency	29,375	81,629	111,004	0.32
Grand Total	**16,357,125**	**18,815,087**	**35,172,212**	**100**

As a provider of services, NGOs spent 57% (2013-2014), where as in single year (2013) NGOs were reported to have spent almost 75% of total resources in the country. Government agencies (NCASC, DHOs, and Hospitals) also provided services with significant amount of spending with 11% and 22% in 2013 and 2014 respectively. Increase in spending from government providers are related to expansion of ART, PMTCT service sites as well as expansion in other activities.

Figure 5: Spending share by key service providers



4.1.4 Provider by Production Factors

Service provider produces outputs with the inputs of human resources (labour) and materials. In NASA the classification of production factors categorizes expenditures in 38 different production factors (budgetary items – PF classifications) under five broader categories, such as wages/labours, material supplies (including antiretroviral

drugs and other drugs), services (consulting services, trainings), capital expenditures and production factors not specified or broken down by type.

Labour and capital are two factors that contribute to the creation of output. Since the provider and production factors classifications are focused on HIV outputs, it is also desirable to analyse the inputs or production factors that create these outputs.

It is also worth noting that generating or disaggregating production factors from the expenditure as required by NASA was found to be most difficult by many partners. Therefore level of detail and specificity in reported data varied enormously for NASA team to disentangle, post the data and analyse/interpret.

Table 8: Spending by production factor (PF) by Providers (PS)

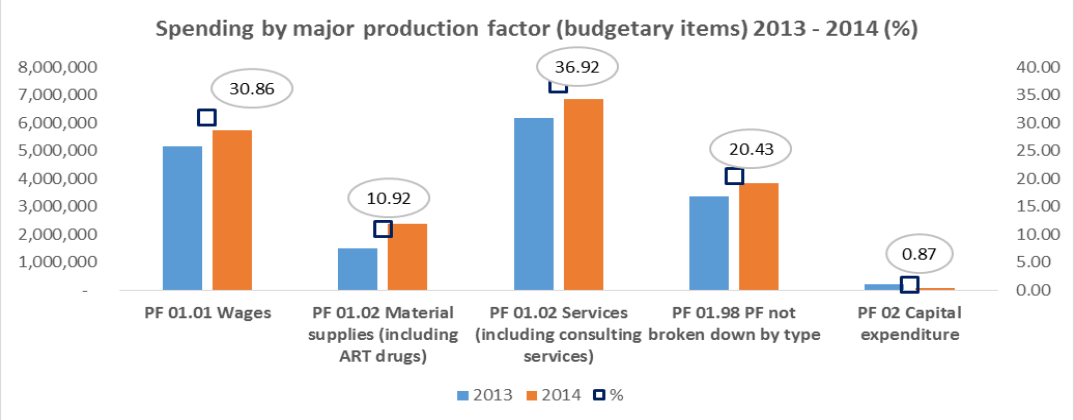
Providers type	Production Factory (PF type)	2013	2014	Grand Total
BL				
	PF 01.02 Material supplies		50,000	50,000
	PF 01.02 Services	464,569	331,836	796,405
BL Total		**464,569**	**381,836**	**846,405**
Govt Entity				
	PF 01.01 Wages	198,203	472,852	671,055
	PF 01.02 Material supplies	720,406	1,390,167	2,110,573
	PF 01.02 Services	390,092	1,442,908	1,833,000
	PF 01.98 PF not broken down by type	491,519	993,637	1,485,156
Govt Entity Total		**1,800,220**	**4,299,564**	**6,099,784**
INGO				
	PF 01.01 Wages	572,066	2,660,670	3,232,736
	PF 01.02 Material supplies	218,481	723,188	941,669
	PF 01.02 Services	604,941	894,862	1,499,803
	PF 01.98 PF not broken down by type	185,281	1,406,125	1,591,406
	PF 02 Capital expenditure	13,909	167	14,076
INGO Total		**1,594,678**	**5,685,012**	**7,279,690**
ML				
	PF 01.01 Wages	104,676	120,021	224,697
	PF 01.02 Material supplies	26,187	52,982	79,169
	PF 01.02 Services	118,240	131,520	249,760
	PF 01.98 PF not broken down by type	12,413	39,204	51,617
ML Total		**261,516**	**343,727**	**605,243**
NGOs				
	PF 01.01 Wages	4,219,890	2,410,456	6,630,346

Providers type	Production Factory (PF type)	2013	2014	Grand Total
	PF 01.02 Material supplies	505,894	129,513	635,407
	PF 01.02 Services	4,528,368	3,924,115	8,452,483
	PF 01.98 PF not broken down by type	2,656,601	1,372,937	4,029,538
	PF 02 Capital expenditure	206,013	84,369	290,382
NGOs Total		**12,116,766**	**7,921,390**	**20,038,156**
Other				
	PF 01.01 Wages	44,055	49,894	93,949
	PF 01.02 Material supplies	11,879	13,454	25,333
	PF 01.02 Services	20,813	23,571	44,384
	PF 01.98 PF not broken down by type	13,254	15,010	28,264
Other Total		**90,001**	**101,929**	**191,930**
Pvt. Agency				
	PF 01.02 Services	29,375	81,629	111,004
Pvt. Agency Total		**29,375**	**81,629**	**111,004**
Grand Total		**16,357,125**	**18,815,087**	**35,172,212**

Goods and services were produced by the providers using some 24 different categories of production factors (inputs). Among the production factors, wages comprises 32% of total AIDS spending. There were number of spending areas that were not adequately detailed to assign specific production factors.

Spending by key production factors (budgetary line) shows that highest spending (36.9%) was on Services (which includes trainings, transportation, consultants), followed by wages (30.8%) related expenses. Material supplies which includes ART drugs, reagents etc. recorded 11% of total AIDS spending. Lowest spending was recorded on capital expenditure (which includes upgrading physical infrastructures, laboratory upgrading etc.)

Figure 6: Spending by major production factor (2023 – 2014)



Top ten production factors consumes almost 94% of total AIDS financing in the country for the year 2013-2014. Highest expenditure was recorded for wages related expenses followed by expenditure not disaggregated by type.

Table 9: Top 10 Production Factors

Production Factor (PF code)	2013	2014	Total	%
PF.01.01.01 Wages	5,134,301	5,711,778	10,846,079	30.84
PF.01.98 Current expenditures not disaggregated	2,736,758	2,914,248	5,651,006	16.07
PF.01.02.02.05 Transportation and travel services	1,704,434	2,503,608	4,208,042	11.96
PF.01.02.02.98 Services not disaggregated	1,481,663	1,556,774	3,038,437	8.64
PF.01.02.02.07 Logistics of events	1,162,499	916,919	2,079,418	5.91
PF.01.02.02.04 Consulting services	962,168	1,056,090	2,018,258	5.74
PF.98 PF not disaggregated by type	609,897	802,202	1,412,099	4.01
PF.01.02.02.01 Administrative services	689,200	716,349	1,405,549	4.00
PF.01.02.01.01 Antiretroviral	453,843	675,565	1,129,408	3.21
PF.01.02.01.98 Material supplies not disaggregated	391,414	673,843	1,065,257	3.03
Total of top 10 production factors	**15,326,177**	**17,527,376**	**32,853,553**	**93.41**
Total of remaining 16 production factors	**1,030,948**	**1,287,711**	**2,318,659**	**6.59**
Grand Total	**16,357,125**	**18,815,087**	**35,172,212**	

As discussed in challenges section elsewhere, there was a tendency to mask wages or benefit related expenses under different budgetary items (or production factor) or not sharing such expenses at all, therefore the data on production needs to be cautiously interpreted and used.

4.2 Spending on key programmatic areas (ASC analysis)

The NASA 2013 and 2014 recorded spending on eight key AIDS Spending Categories (or Functions). The spending pattern in both year was very similar. This is largely due to multiyear programming by the main financing sources like Global Fund, USAID and others.

HIV Prevention related activities (Figure 7) shared a bulk (47%) of the total AIDS spending, whereas Care and treatment and enabling environment spending was 16%. Support to orphans and vulnerable children (OVC) or children affected by AIDS (CABA) received negligible share in total spending (0.15%).

Similarly, spending for programme management and administration was recorded at eighteen percent of total AIDS spending in the country. The lowest spending were recorded for orphan and vulnerable children (0.15%), human resource (deploying additional human resources in point of care centres i.e. hospitals), social protection (0.36%) and HIV related research (2.08%).

Figure 7: Spending by ASC

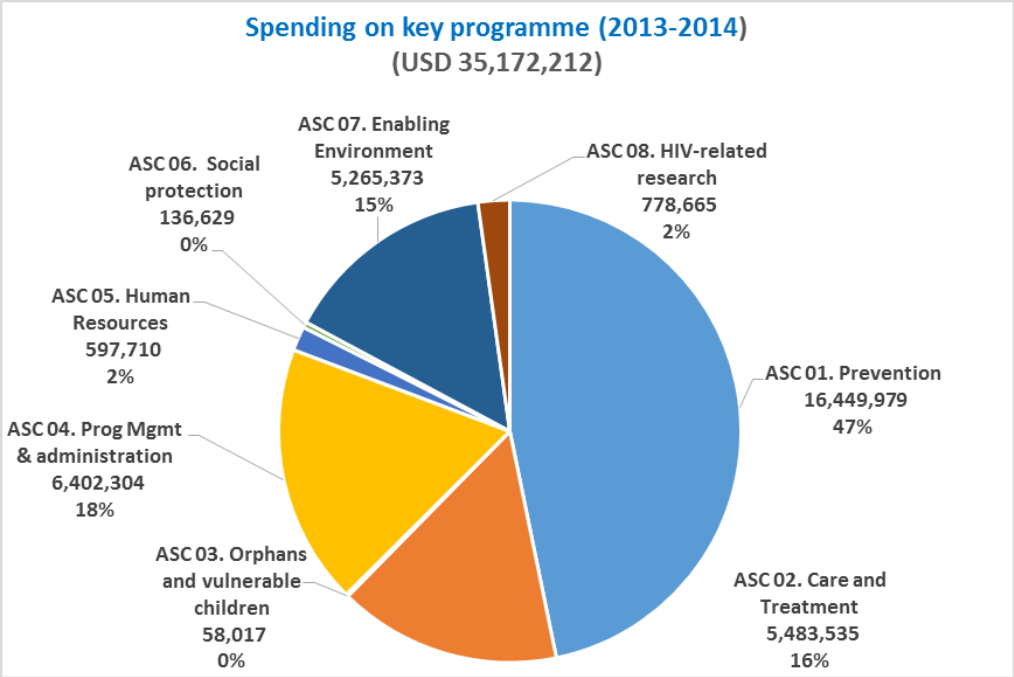


Table 10: Spending in major programmatic areas by years

ASC 1 digit	2013	%	2014	%	Total	%
ASC 01. Prevention	8,242,534	50	8,207,445	44	16,449,979	46.77
ASC 02. Care and Treatment	2,235,535	14	3,248,000	17	5,483,535	15.59
ASC 03. Orphans and vulnerable children	18,458	0.1	39,559	0.2	58,017	0.16
ASC 04. Prog Mgmt & administration	2,969,909	18	3,432,395	18	6,402,304	18.20
ASC 05. Human Resources	298,575	2	299,135	2	597,710	1.70
ASC 06. Social protection	59,958	0.4	76,671	0.4	136,629	0.39
ASC 07. Enabling Environment	2,215,955	14	3,049,418	16	5,265,373	14.97
ASC 08. HIV-related research	316,201	2	462,464	2	778,665	2.21
Grand Total	**6,357,125**	100	**18,815,087**	100	**35,172,212**	

Table 11: Key intervention areas by source (2013-2014)

	International	GoN	Private	Pool Fund	Total	%
ASC 01. Prevention	10,814,513	36,889	2,719,232	2,879,345	16,449,979	46.77
ASC 02. Care and Treatment	4,232,376	468,920		782,239	5,483,535	15.59
ASC 03. Orphans and vulnerable children (OVC)	58,017				58,017	0.16
ASC 04. Prog mgmt and admin	5,748,885	304,255		349,164	6,402,304	18.20
ASC 05. Human Resources	597,710				597,710	1.70
ASC 06. Social protection	136,629				136,629	0.39
ASC 07. Enabling Environment	5,258,372			7,001	5,265,373	14.97
ASC 08. HIV-related research	728,202			50,463	778,665	2.21
Total	**27,574,704**	**810,064**	**2,719,232**	**4,068,212**	**35,172,212**	**100.00**
Percentage	**78.40**	**2.30**	**7.73**	**11.57**	**100**	

4.2.1 Expenditure on HIV prevention activities

Prevention is defined as a comprehensive set of activities or programmes designed to reduce risk behaviour. Results include a decrease in HIV infections among the population and improvements in quality and safety in health facilities with regard to therapies administered exclusively or in large part to HIV patients. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals (NASA 2009)

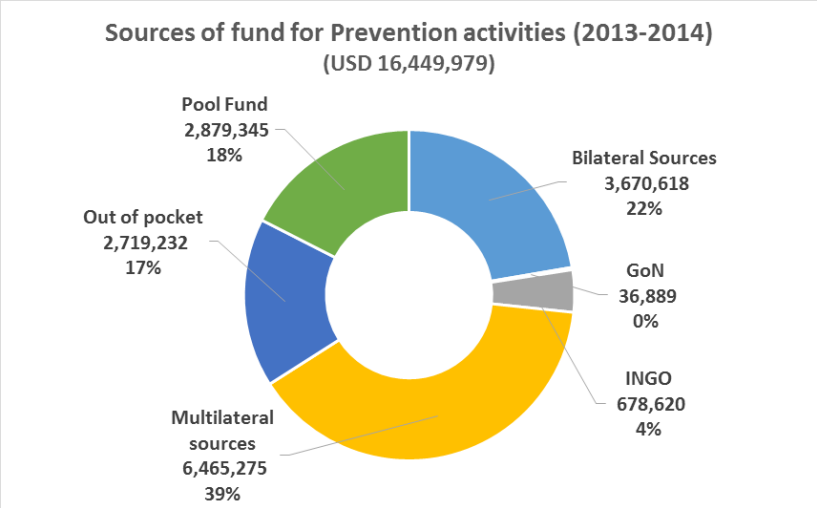
Wide range of prevention related activities (25 different activities) were recorded in 2013 and 2014 comprising 47% of total AIDS spending in the country.

Table 12: Prevention activities by specific ASC code

Specific prevention activities (ASC code)	2013	2014	Total	%
ASC.01.01.01 Health-related communication for social and behavioural change	27,943	22,139	50,082	0.30
ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	956,883	1,130,140	2,087,023	12.69
ASC.01.02 Community mobilization	9,244	3,726	12,970	0.08
ASC.01.03 Voluntary counselling and testing (VCT)	345,981	415,323	761,304	4.63
ASC.01.04.01 VCT as part of programmes for vulnerable and accessible populations	497,715	194,159	691,874	4.21
ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	5,671	99,092	104,763	0.64
ASC.01.04.03 STI prevention and treatment as part of programmes for vulnerable and accessible populations	16,509	6,121	22,630	0.14
ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	1,603,930	1,160,881	2,764,811	16.81
ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type	15,317	435,801	451,118	2.74
ASC.01.04.99 Other programmatic interventions for vulnerable and accessible populations not elsewhere classified	344,086		344,086	2.09
ASC.01.05 Prevention – youth in school	55,715	22,198	77,913	0.47
ASC.01.08.01 VCT as part of programmes for sex workers and their clients	7,741	12,005	19,746	0.12
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients	80,324	124,560	204,884	1.25
ASC.01.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type	101,659	64,314	165,973	1.01
ASC.01.09.04 Behaviour change communication (BCC) as part of programmes for MSM	492,685	263,536	756,221	4.60
ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type	555,773	612,225	1,167,998	7.10
ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs	252,049	390,706	642,755	3.91
ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for IDUs	10,957	16,189	27,146	0.17
ASC.01.10.06 Drug substitution treatment as part of programmes for IDUs	262,189	250,789	512,978	3.12

Specific prevention activities (ASC code)	2013	2014	Total	%
ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type	1,148,561	1,167,461	2,316,022	14.08
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)		136,556	136,556	0.83
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	158	20,394	20,552	0.12
ASC.01.17.98 PMTCT not disaggregated by intervention	148,442	203,375	351,817	2.14
ASC.01.19 Blood safety	1,303,002	1,441,570	2,744,572	16.68
ASC.01.98 Prevention activities not disaggregated by intervention		14,185	14,185	0.09
Grand Total	**8,242,534**	**8,207,445**	**16,449,979**	**100**

Figure 8: Sources of fund for prevention activities (2013-2014)



Thirty nine percent of total cost for prevention related activities was funded by Multilateral Sources (incl. Global Fund). Spending from government sources in prevention activities comprised of 0.22%. Out of pocket spending for prevention related activities was 17% during 2013-2014.

4.2.2 Expenditure on care and treatment related activities

Care and treatment received about 15.48% of total AIDS spending in 2013 and 2014. Following specific spending category (key activities) were recorded under care and treatment.

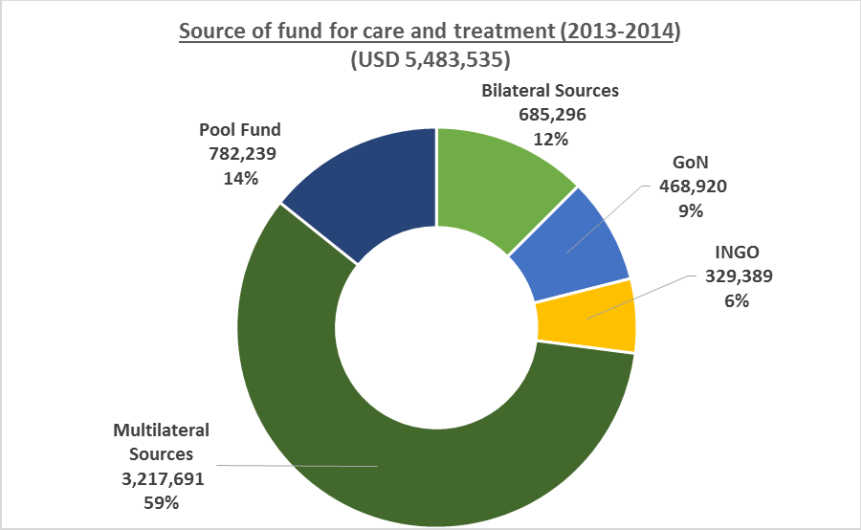
Table 13: Care and treatment activities by specific ASC code

ASC code	2013	2014	Total	%
ASC.02.98 Care and treatment services not disaggregated by intervention	962,826	1,716,880	2,679,706	48.87
ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	615,103	865,991	1,481,094	27.01
ASC.02.01.09.98 Home-based care not disaggregated by type	261,067	284,280	545,347	9.95
ASC.02.01.09.02 Home-based non medical/non-health care	147,195	91,487	238,682	4.35
ASC.02.01.05 Specific HIV-related laboratory monitoring	12,811	210,670	223,481	4.08
ASC.02.01.04 Nutritional support associated to ARV therapy	135,177	20,445	155,622	2.84
ASC.02.02.01 Inpatient treatment of opportunistic	73,700	13,644	87,344	1.59

ASC code	2013	2014	Total	%
infections (OI)				
ASC.02.01.01 Provider-initiated testing and counselling (PITC)		25,977	25,977	0.47
ASC.02.01.98 Outpatient care services not disaggregated by intervention	8,333	8,815	17,148	0.31
ASC.02.03 Patient transport and emergency rescue	10,734		10,734	0.20
ASC.02.01.03.02.01 First-line ART – paediatric	8,243		8,243	0.15
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment		6,979	6,979	0.13
ASC.02.01.02.98 OI outpatient prophylaxis and treatment not disaggregated by type	346	1,307	1,653	0.03
ASC.02.99 Care and treatment services n.e.c.		1,525	1,525	0.03
Grand Total	**2,235,535**	**3,248,000**	**5,483,535**	**100.00**

While 59% of total fund for care and treatment came from multilateral sources, government sources also accounted for 9% in addition to the government share through pool fund.

Figure 9: Source of fund for care and treatment



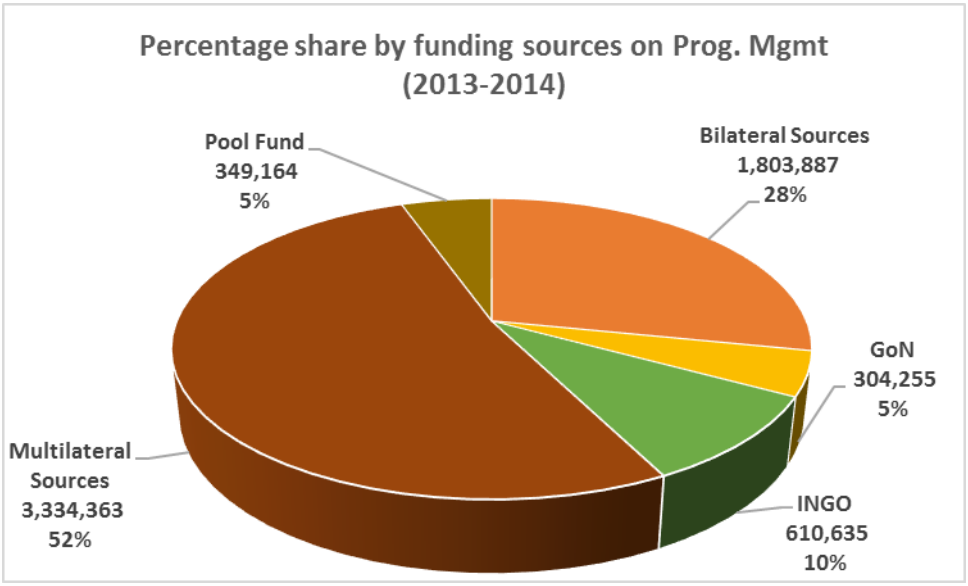
4.2.3 Expenditure on programme management

Spending on Programme management and Administration was about 19% in both years.

Table 14: Spending by different categories under Programme Management

Programme Management (ASC code)	2013	2014	Grand Total	%
ASC.04.01 Planning, coordination and programme management	2,318,253	2,642,185	4,960,438	77.48
ASC.04.03 Monitoring and evaluation	311,684	272,716	584,400	9.128
ASC.04.07 Drug supply systems		84,722	84,722	1.323
ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	7,430	89,876	97,306	1.52
ASC.04.10.98 Upgrading and construction of infrastructure not disaggregated by intervention		19,413	19,413	0.303
ASC.04.98 Programme management and administration not disaggregated by type	332,542	323,483	656,025	10.25
Grand Total	**2,969,909**	**3,432,395**	**6,402,304**	**100**

Figure 10: Spending on Planning Coordination and Programme Management by sources



4.2.4 Beneficiary populations

The NASA also allows for the classification of AIDS expenditure by beneficiary population. Table below itemizes annual AIDS expenditure by the six NASA BP categories: people living with HIV; most-at-risk populations; other key populations; specific "accessible" populations; the general population; and non-targeted interventions.

BP 06 comprises expenditures not belonging explicitly to selected or targeted populations. Interventions not targeted to a specific population, or interventions benefiting a population in an indirect way, such as interventions coded under ASC.04 Programme management and administration, and ASC.08 HIV-related research are booked under this category. Also when there was no explicit intention of directing the benefits to a specific population, the expenditures was labelled BP.06 Non-targeted interventions.

Table 15: Spending by beneficiaries population

BP short	2013	2014	Grand Total	%
BP 01. PLHIV (all category)	2,562,429	3,916,524	6,478,953	18.42
BP 02. FSWs (all category)	1,540,179	1,468,279	3,008,458	8.55
BP 02. IDUs (all category)	1,742,679	1,484,819	3,227,498	9.18
BP 02. MARP	161,029	195,055	356,084	1.01
BP 02. MSM	1,006,500	970,236	1,976,736	5.62
BP 03. Children (eVT)	18,948	43,967	62,915	0.18
BP 03. Migrants	1,433,934	1,516,644	2,950,578	8.39
BP 03. Other key population - not disaggregated	124,413	138,720	263,133	0.75
BP 03. OVC	18,458	27,045	45,503	0.13
BP 03. Prisoners	266,776	62,046	328,822	0.93
BP 04. Health care workers	974,684	754,999	1,729,683	4.92
BP 04. Specific Accessible Population	105,784	41,203	146,987	0.42
BP 05. General Popln	13,255	39,964	53,219	0.15
BP 06. Non targeted	6,388,057	8,155,586	14,543,643	41.35
Grand Total	**16,357,125**	**18,815,087**	**35,172,212**	**100.00**

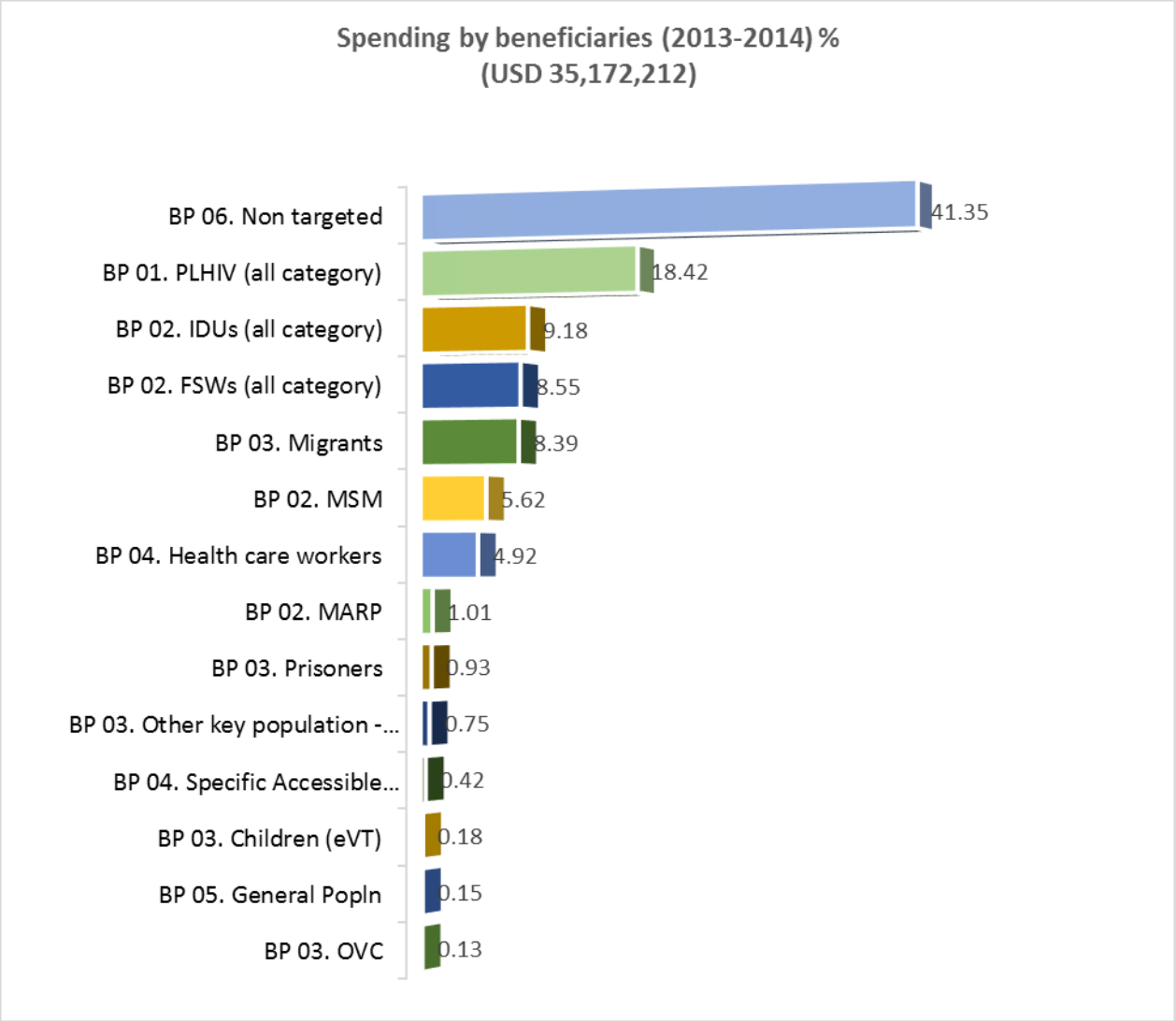
Of the specific targeted populations, PLHIV received highest share (18.42%) of expenditure in 2013 and 2014. IDUs, FSWs and Migrants received around 8 – 9% of total AIDS spending where as another key population group MSM received nearly 6% of expenditure in the same period of time. Other KP (not disaggregated by type) received less than a million in each year.

Table 16: Spending by source for beneficiaries' population

BP (1st digit)	BL	GoV	INGO	ML	Out of pocket	Pool Fund	Grand Total
BP 01. PLHIV (all category)	1,348,398	537,776	275,198	3,118,703		1,198,878	6,478,953
BP 02. FSWs (all category)	2,594,042			414,416			3,008,458
BP 02. IDUs (all category)	385,998		398,101	1,905,764		537,635	3,227,498
BP 02. MARP			184,149	143,353		28,582	356,084
BP 02. MSM	49,726		96,167	918,723		912,120	1,976,736
BP 03. Children (eVT)		36,806	821	5,557		19,731	62,915
BP 03. Migrants	591,450		1,308	1,679,765		678,055	2,950,578
BP 03. Other key population - not disaggregated	175,698		49,581	37,854			263,133
BP 03. OVC				45,503			45,503
BP 03. Prisoners				136,209		192,613	328,822
BP 04. Health care workers	300,562	4,730	296,394	1,043,471		84,526	1,729,683
BP 04. Specific Accessible Population	25,358		108,671	12,958			146,987

BP (1st digit)	BL	GoV	INGO	ML	Out of pocket	Pool Fund	Grand Total
BP 05. General Popln		83	10,125	18,526		24,485	53,219
BP 06. Non targeted	5,041,825	230,669	466,299	5,694,031	2,719,232	391,587	14,543,643
Grand Total	**10,513,057**	**810,064**	**1,886,814**	**15,174,833**	**2,719,232**	**4,068,212**	**35,172,212**

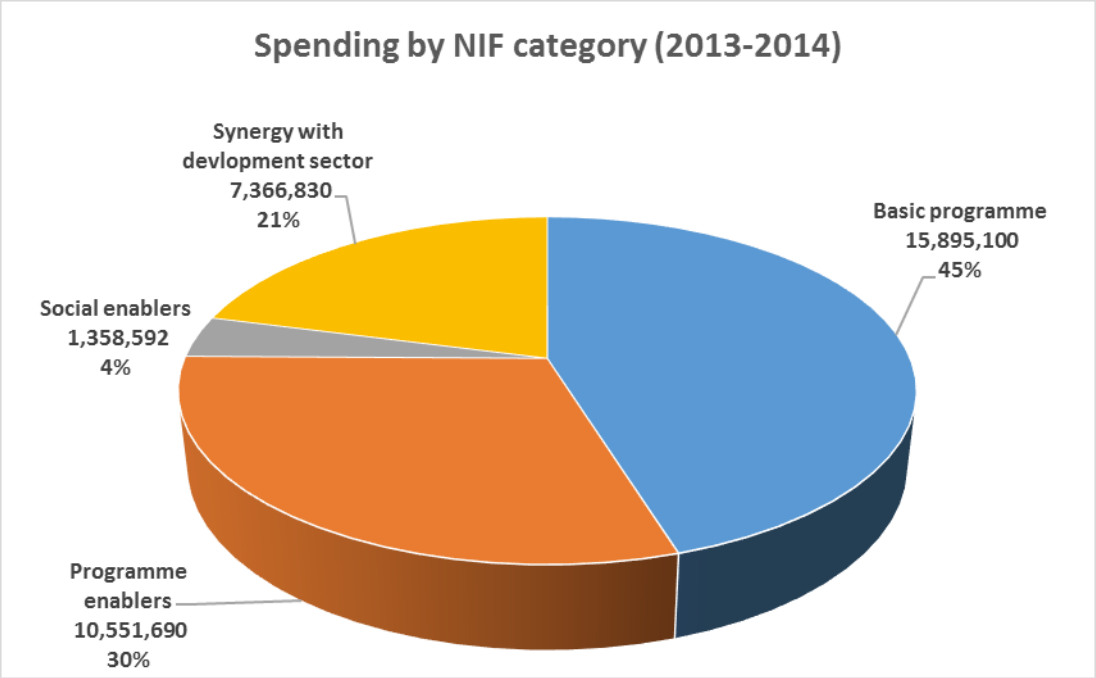
Figure 11: Percentage share by Beneficiaries population



4.3 Additional analysis by investment category

There are increasing focus on allocating resources and analysis the spending around New Investment Framework (NIF) category. Attempt is made to analyse the AIDS spending for 2013 and 2014 by NIF.

Figure 12: Spending by NIF category (2013-2014)



5. Lessons learned

Initially it was designed to collect the data in such a way that spending by districts would be available either from Providers or from the Agent. In support of this, four regional workshops were also organised and was anticipated that district HIV focal point would be able to collect and provide local spending from various sources (local government, DDC and Municipalities). But practically this was not possible. District HIV focal points were not in position in collecting the data from different providers in the district. Absence of DACC coordinator was felt who otherwise would have been able to collect district specific spending information. Consequently, no spending from local government sources (DDC, Municipalities) could be included in NASA analysis.

6. Conclusion and recommendations

Recommendations

1. 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 and detail twice a year; one in June (according to Nepali fiscal year) and one in December (by calendar year). Such information should be made available in public domain (i.e. MOH/NCASC web site).

2. Obtaining public spending data has been a challenge for various practical and structural reasons, therefore existing system like TABUCS should be updated regularly and should be made available for public use.

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 around National Investment Framework (or costed implementation plan).

4. 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.

5. The current narrow fiscal space in AIDS spending needs to be expanded by increasing allocative efficiency and spending efficiency (i.e. improving absorptive capacity within MOH/NCASC)

6. Wherever possible, the NASA findings can be used as a good secondary source for costing and the estimation of unit costs in current intervention packages.

7. Annexes

7.1 NASA Classification

NASA Classification:
As defined in National AIDS Spending Assessment (NASA) Classification taxonomy and Definitions; UNAIDS, 2009

In NASA, as with most classification schemes, transactions are allocated to exactly one category without duplication or omission, that is, categories of the NASA classification are mutually exclusive and exhaustive. Mutually exclusive means that no transaction can be allocated to more than one category (there is no duplication). When categories are not mutually exclusive they overestimate spending by double counting some transactions. Exhaustiveness means that each and every transaction can go into one category (there is no omission)

1. **ASC: AIDS spending categories:** Following categories under which spending are incurred. There are 8 main categories and many sub categories under each main category.

ASC.01 Prevention: Prevention is defined as a comprehensive set of activities or programmes designed to reduce risky behaviour. Prevention services involve the development, dissemination, and evaluation of linguistically, culturally, and age-appropriate materials supporting programme goals.

ASC.02 Treatment and Care: refers to all expenditures, purchases, transfers and investment incurred to provide access to clinic- and home- or community-based activities for the treatment and care of HIV-infected adults and children.

ASC.03 Orphans and Vulnerable Children (OVC): An orphan is defined as a child under the age of 18 years who has lost one or both parents regardless of financial support (AIDS programme related or not). Vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them.

ASC.04 Strengthening of Programme Management and Administration:
Programme expenditures are defined as expenses that are incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and facility upgrading through purchases of laboratory equipment and of telecommunications.

ASC.05 Incentives for the Recruitment and Retention of Human Resources–Human Capital: This category refers to services of the workforce through approaches for recruitment, retention, deployment and rewarding of quality performance of health care workers and managers for work in the HIV and AIDS field.

ASC.06 Social Protection and Social Services (excluding OVC): Social protection conventionally refers to functions of government relating to the provision of cash benefits and benefits in-kind to categories of individuals defined by needs such as sickness, old age, disability, unemployment, social exclusion and so on.

ASC.07 Enabling Environment and Community Development:
It includes a full set of services that generate an increased and wider range of support key principles and essential actions as well as policy development.

ASC.08 HIV and AIDS-Related Research (excluding operations research): It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS.

2. **BP: Beneficiaries Population Targeted or intended:** The populations presented here are explicitly targeted or intended to benefit from specific activities. In principle, the identification of the BPs is dictated by the intended use of the funds.

3. **PS: Providers of Services**. Providers are entities or persons that engage directly in the production, provision and delivery of services against a payment for their contribution. Providers include government and other public entities, private for-profit and non-profit organizations, corporate and non-corporate enterprises and self-employed persons.

4. **PF: Production Factors:** Since the provider and production factors classifications are focused on the HIV and AIDS outputs, it is also desirable to analyse the inputs or production factors that create these outputs. In NASA the classification of production factors categorizes expenditures in terms of resources used for the production, i.e. wages, salaries, new buildings, renovations, etc. (budgetary items)

5. **FA: Financing Agent:** Entities which mobilize financial resources collected from different financing sources (pools) and transfer them to pay for or to purchase health care or other services or goods. These entities directly purchase from providers or steer in full, or as co guarantors of payment, resources earmarked for the provision of commodities (services and/or goods) to satisfy a need.

6. **FS: Financing Sources:** Financing sources are entities or pools which *purchasers*, providers of financial intermediation services or paying agents, tap or use other forms of mobilization to fund the HIV and AIDS services.

7.2 References

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