Nepal

National AIDS Spending Assessment Report

2007

HIV/AIDS and STI Control Board
GOVERNMENT OF NEPAL

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

With support from the
JOINT UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS)

NASA

Nepal
National AIDS Spending Assessment Report 2007

HIV/AIDS and STI CONTROL BOARD
GOVERNMENT OF NEPAL

With technical and financial support from the
JOINT UNITED NATIONS PROGRAMME ON HIV AND AIDS (UNAIDS)

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UNAIDS deserves special appreciation for providing both financial and technical support, supporting the training of two consultants on NASA who carried out the study. The Board therefore thanks UNAIDS Nepal for its untiring support, and the UNAIDS Headquarters in Geneva for sending a member of their team to Nepal to work with our national consultants and with HSCB and other partners for the assessment.

HSCB also gratefully acknowledges the collective as well as individual contribution of stakeholders, the NASA Task Force members, and consultants. This report that summarises the findings of the assessment was the product of diligence and hard work of all the cooperating partners. Working together has brought about broad-based cooperation between HSCB and stakeholders in response to the epidemic of HIV/AIDS in Nepal. We would like to put this on record for future NASA exercises as a clear manifestation of the coordination and cooperation that such an undertaking requires.

We hope that the data and information provided here will be used for future decision-making to make Nepal's national response more efficient effective, and more attuned to the country's needs in HIV/AIDS prevention, treatment care, and support.

THE HIV AIDS AND STI CONTROL BOARD
GOVERNMENT OF NEPAL
Kathmandu, April 2008

Abbreviations and acronyms

ADB	Asian Development Bank
ADRA	Adventist Development Relief Agency
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
ASC	AIDS spending category
AusAID	Australian Agency for International Development
BCC	behaviour change communication
BL	bilateral agencies
BP	beneficiary population
BDS	Blue Diamond Society
CHBC	community home-based care
CCM	country coordination mechanism
CSO	civil society organisation
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DFID	UK Department for International Development
DIC	drop-in centre
EU	European Union
FA	financing agent
FAO	Food and Agriculture Organization
FHI	Family Health International
FPAN	Family Planning Association of Nepal
FS	financing source
FSW	female sex worker
GFATM	Global Fund for AIDS, TB, and Malaria
GoN	Government of Nepal
GTZ	German Development Agency
HIV	Human immunodeficiency virus
HMIS	health management information system
HSCB	HIV AIDS and STI Control Board
IBSS	integrated behavioural surveillance surveys
IDU	injecting drug user
IEC	information, education, and communication
ILO	International Labour Organisation
INF	International Nepal Fellowship
INGO	international non-government organization
IOM	International Organization for Migration
JICA	Japanese International Cooperation Agency
KFW	Swiss Cooperation (Kreditanstalt für Wiederaufbau).
LGBTI	lesbian, gay, bisexual, transgender

MARP	most at-risk population
ML	multilateral agencies
MoHP	Ministry of Health and Population
MSM	males who have sex with males
n.d.t.	not differentiated by type
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-government organization
OI	opportunistic infection
ORT	oral substitution therapy
OVC	orphans and vulnerable children
PLHIV	persons living with HIV
PMTCT	prevention of mother to child transmission
PMU	Programme Management Unit (UNDP HIV/AIDS)
PS	provider of services
RTS	resource tracking software
SAE	semi-autonomous entity
SDC	Swiss Agency for Development and Cooperation
STD	sexually transmitted disease
STI	sexually transmitted infection
SW	sex worker
TOR	term of reference
UA	universal access targets
UMN	United Mission to Nepal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	UN Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Women 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

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Foreword

A concrete programme of response to HIV/AIDS, as a serious and expanding public health and socioeconomic problem in Nepal, is now firmly established in the country's development agenda and is accorded Priority One (P1) status in the country's National Three-Year Interim Plan.

The epidemic calls for commitment of corresponding proportion from all sectors. The commitment shown by the Nepal government, and by external development partners, to respond to the epidemic is better coordinated and harmonised now. This is evident in the regular flow of resources from our external development partners, and government's trust that our partners will strive to minimise the technical and resource gaps for programme. It is encouraging to see more and more national organisations joining the effort to respond to HIV/AIDS at various levels.

The Nepal National Aids Spending Assessment (NASA) exercise 2007 was an opportunity to gain insight into how we are applying these resources in the context of a visible resource gap in the National Action Plan 2006-2008. The NASA provides a systematic way to assess how much of the commitments made to HIV/AIDS translate into actual services at the grassroots level. It furthermore provides an opportunity to have a feel of where the resources are being utilised, and to see the nature and extent of the epidemic and how this links with a national strategy in Nepal to mitigate its impacts through a programme of measures, activities, and actions, and the commitments made by donor financing institutions to these efforts.

The findings of the NASA 2007 should inform our future decisions and actions on resource allocation and utilisation with regards to HIV/AIDs. It is our desire that focused interventions be made with the allocation of adequate resources to effectively curb this silent but growing epidemic in order to mount an effective response.

Giriraj mani

Giriraj mani Pokhrel
Honourable Minister of Health and Population
And
Chair of HIV/AIDS and STI Control Board

Preface

Nepal's National HIV/AIDS Strategy (2006-2011), and the supporting National Action Plans 2006-2008 and 2008-2011, aim unequivocally to achieve the universal access targets to HIV treatment, care, prevention and support as a contribution to attaining the larger Millennium Development Goals.

Nepal faces enormous challenges in providing HIV services, and high levels of coordination, consolidation, and focused interventions are needed to overcome the challenges. A clear understanding among the actors at all levels of what are available and being spent on HIV and AIDS is essential in order to determine if the expenditure is appropriately targeted to meet universal access targets. NASA is one proven method to provide a clear understanding of the programme's collective spending.

This report, the result of an extensive and rigorous spending assessment exercise coordinated by HSCB with partners and stakeholders, allows us to better understand how the present efforts are achieving results in reversing the HIV/AIDS epidemic. The assessment also encourages greater transparency and accountability among domestic oversight bodies such as the Country Coordination Mechanism, government agencies, HSCB, and the donor community accountable to the public and the donors.

In 2007, the Government of Nepal committed to undertake a comprehensive National AIDS Spending Assessment of HIV and AIDS expenditure in Nepal. This report is the realisation of that commitment. The analysis reveals several important findings particularly on patterns and categories of spending and groups benefiting from the effort.

The report makes several recommendations, among which include the following key needs.

1. Greater multi-sectoral engagement
2. Increased public sector spending on HIV/AIDS-related functions and better aligned spending with the National HIV/AIDS Strategy, for better results towards achieving the universal access targets
3. Donor alignment and harmonisation
4. Strengthened capacity of providers to deliver AIDS services

The importance of strengthening national capacity for resource mobilisation, and institutionalising NASA to collect, analyse, and disaggregate expenditure data regularly is also highlighted in the report. NAP 2006-2008 had estimated significant resource gaps based on resources committed by donors and the requirement of the country's HIV/AIDS Plan. At times, the country's spending or absorption capacity, the capacity to spend available resources from various sources for a programme on HIV/AIDS, was also put in question.

Finally, this report and its process can be considered a landmark in Nepal. The NASA is the first exercise of this kind in Nepal. The results, analysis, and lessons will hopefully guide us in our future endeavours towards curbing the HIV/AIDS epidemic.

Executive Summary

National AIDS Spending Assessment (NASA) was conducted for the first time in Nepal by the HIV/AIDS and STI Control Board (HSCB), Government of Nepal, with technical and financial assistance from UNAIDS.

Process and methodology

It began in 2008 with the formation of a 17-member Task Force to steer the process. A three-day training programme was also organised for programme and finance staffs of partner organizations to acquaint them with the objectives of the assessment, the process, NASA classification, and other details. Following a mapping of resource flow to the HIV/AIDS programme, NASA 2007 collected data from sources, agents, and provider organisations on overall spending during 2007 on HIV/AIDS. Information gathered was analysed using the NASA global methodology and software.

The exercise is assumed to have captured over 90% of spending on HIV/AIDS in Nepal. Most of the organizations involved submitted financial data, only a small number did not respond to the NASA data request. Overall, 53 data entries from sources and a number from agents and providers were entered into the NASA resource tracking software. Each entry consisted of data on specific categories of spending, beneficiary population, and production factors.

Purpose

NASA 2007 aimed to assess overall spending on the HIV/AIDS programme by examining programme financial flows – Sources of Funds, Agents, and Providers – beneficiary population, and specific functions and programmes where spending was being made. Attempt was made to see if sufficient resources were being invested in enhancing the capacity of the organizations' human resources to implement HIV/AIDS programme activities, as well as to enhancing overall national capacity for external and internal resource mobilisation.

Scope and limitations

The assessment was based on data supplied by selected agent/providers. Not all providers were approached directly. The assessment did not cover private spending, household and out-of-pocket spending, spending made by local governments and by the private sector.

Differences in fiscal reporting year among various organisations may, in some instances, reflect overlap or overflow in financial data.

Challenges

Among the major challenges of the exercise was obtaining data on time despite repeated requests and personal visits, and assigning appropriate NASA classification to expenditures items. Some of the financial data received from the organisations needed adequate explanation and took several repeated visits and consultations to verify and classify properly into the NASA classification.

Major findings

Where the resources came from, where they went

In 2007, Nepal received US$22,681,199 for HIV/AIDS-related initiatives and spent US$17,661,653 on activities supporting these initiatives. Overall absorption rate was almost 80%. Bilateral donors contributed 68% of the total fund followed by multilateral agencies, 25%. The Government of Nepal contributed 3% of total disbursements.

Of total spending for HIV-related activities in 2007, US$8,187,202 (46%) was spent on a prevention programme, and US$2,936,452 (17%) on care and treatment related activities. Over 28% (US$5 million) was spent on programme management and administration. More information and analysis are necessary to be able to detail expenditure on programme management in the context of strengthening national spending capacity for programme interventions.

Partners committed about US$33 million for the two-year period 2006-2008, or about US$17 million a year compared to the US$64 million budget plan of the National Action Plan (2006-2008). Some US$17.5 million was actually spent, indicating a fairly consistent pattern of commitments and actual spending although this spending is only 50% of total requirement according to the NAP 2006-2008.

Spending for six major strategic components of the programme was less than budgeted for. On the other hand, spending for advocacy and policy reform was much higher than what was planned. The reasons for over-expenditure could be unrealistic budgeting during the NAP preparation, additional efforts to respond to new challenges and opportunities in a period of changed political and social contexts in Nepal, spending made outside the NAP, changes in institutional plans but not reflected in the NAP accounting standard, and the NASA classification not accurately followed. Further discussion and investigation is needed to be able to draw some conclusions.

Who provided the goods and services?

Eight categories of providers – hospitals, the Ministry of Health, civil society organisations, multilateral agencies, among others – provided goods and services in HIV response worth US$ 17.6 million to 32 different targeted categories of the population. Almost 85% of the total fund was spent through civil society organisations such as international and local nongovernment organisations and community-based organisations; 9% was spent through government agencies for HIV-related activities. More than US$703,681 was spent on antiretroviral therapy and other drugs for the care and treatment of people living with HIV. Nearly 37% was spent on wages and 20% on current expenditures not disaggregated by type. There is a need to further clarify expenditures that are not disaggregated.

Who are the beneficiaries?

Most at-risk population or groups with higher risk of HIV exposure such as female sex workers, injecting drug users, and males who have sex with males, received the highest proportion of the spending (30%) followed by other key sectors – the youth, mobile population, prison inmates, others, and people living with HIV (12%). (ILO defines 'mobile populations' as those who move from one place to another, often for work, sometimes in a different country, and often without their families.)

More than 19% was spent on injecting drug users, followed by people living with HIV. Some 7.8% (US$1,387,30), 7.9% (US$1,295,018), and 3.3% were spent on mobile population, female sex workers and their clients, and males having sex with males, respectively. At least 27% (US$4.8 million) was expenditure not targeted to any specific sector of the population, for example mass media.

Spending alignment against disease burden and HIV prevalence

The government has been estimating disease burden and HIV prevalence for each of these population groups regularly. Disease burden is the burden that a particular disease process, in this case HIV/AIDS, has in a particular area as measured by cost, morbidity, and mortality (WHO). Correlating the NASA findings with disease burden and HIV prevalence brings out an irregular pattern or mismatch in some areas. Although it is not possible to draw a direct statistical correlation the logical pattern and realistic conclusion would have been that spending would be greater for groups with higher disease burden, risk of exposure, and prevalence. This has not always been the case, however.

For example, 7.8% of total spending went to the mobile population with 1.9% HIV prevalence and 39% total disease burden. At least 19% of overall spending went to injecting drug users, which had 34% HIV prevalence and 4% disease burden. The pattern of spending was also inconsistent for other groups. Clearly, there is a need to align resources and targets with HIV prevalence and disease burden. This aspect deserves further analysis and careful interpretation.

Key recommendations

The study advances the following key recommendations.

For the Government of Nepal

- Further alignment of HIV spending with the National Strategy Plan and the National Action Plan
- Engagement of other sectors including non-health sectors in programme efforts to respond to HIV/AIDS
- Institutionalisation of NASA as part of a national monitoring and evaluation programme by requiring regular and periodic reports from implementing partners
- Strengthening national capacity for conducting NASA on a regular basis

For UN agencies

- Alignment and harmonisation of financial reporting and requirements along with programme design
- Establishment of a continuing and sustainable capacity building programme on HIV/AIDS for service providers on NASA, to have a successful 'bottom-up' assessment

For providers

- Capacity building programme for HIV/AIDS service providers on NASA

General recommendation

- While the country has adequately engaged non-government sectors as providers of services in the programme of HIV and AIDS response, resource mobilisation remains heavily dependent on multilateral agencies which have mobilised over 51% of total resources from external sources. Government agencies have been able to mobilise only 10% of total resource. The government and its agencies need to be more proactive in strengthening capacity for resource mobilisation.

- Improved partner financial reporting system to accurately reflect classification and overall spending.
- Implementers should link expenditure records with activity outputs; the NASA classification offers a useful framework for this. Undertaken on a regular basis, NASA will make it easier to link reports from implementers with the NASA, thus providing a database of comparable data of the years.

1 Introduction

Towards a National Strategy (2006-2011) on AIDS

Nepal's National Strategic Plan (2006-2011) aims to contribute directly to the Millennium Development Goal, **Halt and begin to reverse the increasing trend of HIV by 2015**, through key strategies for HIV/AIDS prevention, treatment care, and support. In view of the current low coverage and access to services on HIV/AIDS interventions in Nepal, insufficient focus on treatment, care and support, as well as inadequate links between prevention and treatment, care and support, the National Strategic Plan (NSP) was designed to meet the universal access target of 80% coverage in prevention, treatment, care and support services to the most-at-risk population (MARP) and people living with HIV (PLH). The National Strategic Plan (NSP 2006-2011) was developed within the broader framework of the National HIV and AIDS Policy and the 11-point Guiding Principles.

The strategy has six components: two programmatic, and four crosscutting. For each component, a component goal, detailed strategies, strategic outcomes, and key activities have been developed. It is envisioned that development of a National Action Plan will subsequently detail the cost and other operational aspects of the strategy, including targets. The strategy has defined basic service packages and a specialised service package for various population groups based on vulnerability and needs.

Objectives of the National AIDS Spending Assessment

The objective of the National AIDS Spending Assessment (NASA) for Nepal was to assess HIV spending in the health and non-health sectors using six key variables: Financing sources, financing agents, functions or AIDS spending categories, production factors, providers of services, and intended beneficiaries. The other objective was to build the foundation for the development of a NASA system in Nepal including strategic investments in the areas of strengthening individual and institutional capacities for HIV/AIDS spending assessment.

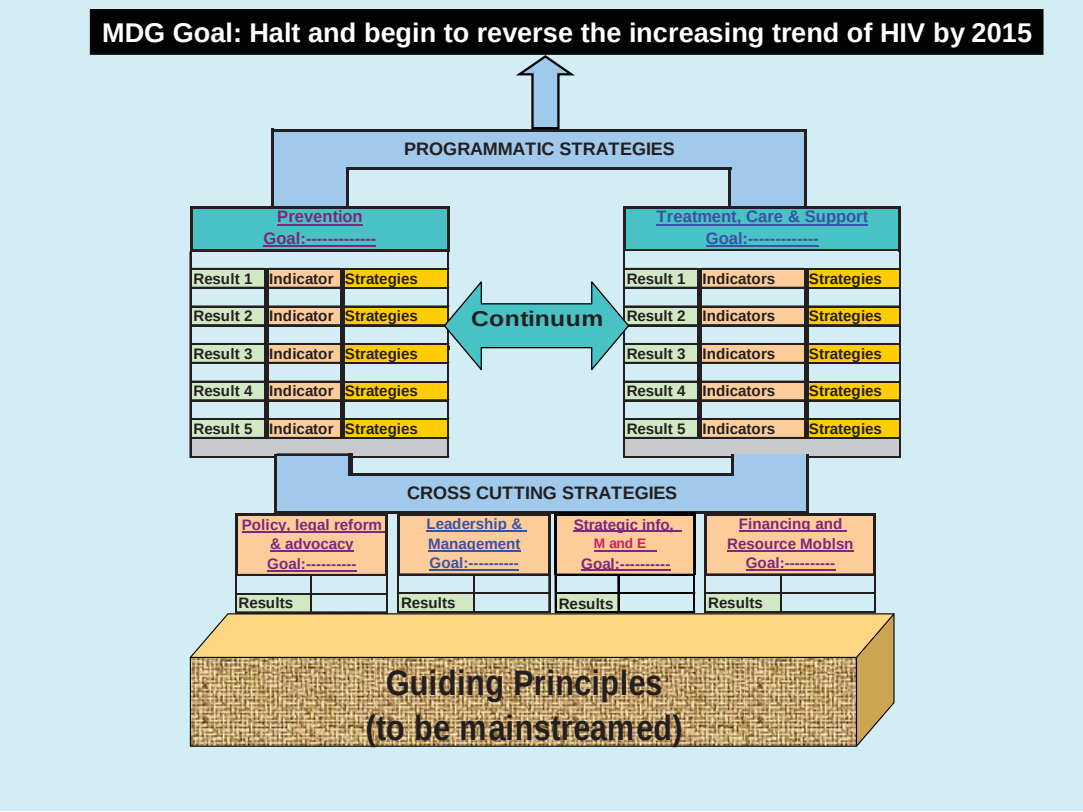
The specific objectives of the NASA are the following.

1. Gather data and information needed to be able to assess HIV and AIDS financing flows at national and international levels, and expenditures for eight AIDS spending categories.
2. Complete in a timely manner the national funding matrix and produce a set of NASA tables illustrating HIV and AIDS financing flows and expenditures.
3. Train national staff through workshops and on the job to build national capacity to put together a national resource tracking system that provides current information on AIDS financing and expenditures and other resource-related issues such as efficiency, effectiveness and equity in the allocation of financial resources.

The NASA study attempts to address the following key issues.

1. What are actually disbursed and spent in each of the components of HIV response? Are the expenditures going to priority HIV interventions?
2. How are HIV/AIDS funds allocated and spent in relation to the objectives and priorities of the National Strategic Plan and the National Operational Plan (2006-2008)?
3. Who are the major sources of the funds and where do the funds go? Who are the main service providers and who are the beneficiaries of these services?
4. Are sufficient resources being invested to enhance capacity for scaling up human resources?
5. Does international donor assistance contribute to enhancing national capacity particularly in external and internal resource mobilisation?

Figure 1: National Strategic Framework (2006-2011)



National Response to HIV and AIDS

According to the national estimate in 2008, adult HIV prevalence in Nepal is at 0.49% (Table 1). Nearly 70,000 adults and children are living with HIV in Nepal. As of December 2008, 2,387 HIV cases have been reported; almost 70% come from the young, productive and working age groups, 20-39 years old. Among HIV-positive persons, the male/female sex ratio is 2.1:1, that is, 2.1 infected males for every one infected female. A variety of modes of transmission have been reported, with sexual transmission and sharing of unclean needles as the most prevalent.

Table 1: National HIV Estimates		
Population age group	**Estimated number infected**	
Children (0-14)	1857	
Adults (15-49)	64585, of which 19061 are women	.49% of adult population
Adults (50+)	3348	
Total	**69790**	

Distribution of infection varied among population subgroups (Table 2). Almost 39% of disease burden is shared by labour migrants, and almost 27% borne by urban and rural women who have low-risk behaviours, with only 1.5% ever having had extramarital sexual relations. Three other most at-risk groups: injecting drug users, males who have sex with males, and female sex workers collectively bear almost 12% of total diseases burden.

Table 2: HIV Estimates Among Sub-population Groups		
Sub-population group (15-49 years old)	**Estimated number infected**	**Percentage of all groups (%)**
Labour migrants	25049	38.78
Clients of female sex workers (FSWs)	9282	14.37
Rural females	13611	21.07
Urban females	3514	5.44
Injecting drug users (IDUs)	4781	7.40
Men having sex with men (MSMs)	2321	3.59
Trafficked, returned to Nepal	798	1.24
Former IDUs	1776	2.75
Former migrant workers	1422	2.20
Former FSWs	689	1.07
Current FSWs	449	0.70
Former clients of FSWs	722	1.12
Former MSMs	171	0.26
Total	**64585**	**100.00**

Along with increased funding for HIV/AIDS activities, the number of HIV service outlets in both the public and private sectors increased over the period of the assessment. However, coverage of the interventions and access to services varied among population groups. For instance, while 39% of female sex workers in Kathmandu district were reached in 2006-2007, for the same period and in the same district only 31% of injecting drug users and 48% of clients of female sex workers, and

More than a quarter of disease burden is borne by urban and even rural women who have low-risk behaviours.

47% of males having sex with males were reached by prevention services. The *United Nations General Assembly Special Session (UNGASS) 2008 Report* also reported less than 2% coverage of prevention of mother-to-child transmission (PMTCT) services from the 11 service delivery sites in the whole of Nepal. The blood safety programme is effective, with consistency in programme coverage and total units of blood tested for HIV.

Despite encouraging improvements in many critical indicators, expansion of intervention and adequate provision of comprehensive management of sexually transmitted infection (STI) remains a challenge. It is estimated that some 165,000 people will be in need of services to treat sexually transmitted infection by year 2010.

Routine programme reporting shows a significant increase in coverage of the AIDS prevention programme for many population subgroups. For example, among female sex workers coverage grew from 31% to 81% for fiscal year 2006-2007; for males having sex with males from 18% to 31%, and harm reduction programme for injecting drug users increased from 23% to 31%. The migrants programme reported a dramatic increase in programme coverage from 32% to almost 103% for the same period.

The number of people on antiretroviral therapy was estimated in the UNGASS Report to be 1,240. With the implementation of the Global Fund-supported AIDS project, this number has increased to 1,992 in June 2008.

The country has been preparing a budgeted National Action Plan (NAP) every year to finance HIV/AIDS activities. A multi-year Action Plan 2006-2008 was prepared, which provided a framework for donors and funding partners to contribute to the national response and plan.

In the NAP (2006-2008), 66% was allotted to prevention-related activities, and 22% for treatment, care, and support (Table 3). The total budget for the two-year programme is US$ 64 million, distributed in the following six strategic components: prevention; treatment, care and support; advocacy, policy, legal reform; leasership and management; strategic information, M&E; and finance and resource mobilisation.

Table 3: NAP (2006-2008) Budgeting Priorities by Component

Programme Component	Budget (US$)	% of Budget
Prevention	42,588,596	66.4
Treatment, Care and Support	14,073,555	22.0
Leadership and management	3,251,600	5.1
Strategic information, M & E	2,429,536	3.8
Advocacy, Policy, Legal reform	932,000	1.5
Finance and resource mob	835,000	1.3
Total	**64,110,287**	**100**

Table 4: NAP (2006-2008) Budget Priorities

Programme Component	Budget (US$)	(%)
MARPs	28,717,895	44.8
Youth	28,717,895	16.9
Capacity building	5,033,000	7.9
Persons living with HIV (PLH)	4,392,000	6.9
Antiretroviral therapy (ARV)	3,883,880	6.1
Policy and management	2,658,136	4.1
General population	2,585,900	4.0
Voluntary counselling and training (VCT)	2,564,500	4.0
Universal precaution	1,258,700	2.0
Preventive Mother to Child Transmission (PMTCT)	1,146,276	1.8
Children	1,040,000	1.6
Total	**64,110,287**	**100**

Most at-risk populations (MARPs), population groups with the highest risk of exposure to HIV infection, received the biggest share of the total budget at 45%. The programme for the youth was allocated 17%, antiretroviral and other activities, specifically home-based care for persons living with HIV received 13% of total budget (Table 4). The National Action Plan focuses greater attention and allocation to MARPs.

Fifteen organizations committed resources for the HIV/AIDS programme during the time of the NAP preparation. It was not possible to record commitments made after completion of the NAP, but many more organisations made funds available for the programme after drafting of the NAP.

Table 5: NAP (2006-2008) Funding Commitments

Funding Partners	Estimated Pledges	% of Total
USAID	12,030,214	36.1
DFID	8,188,703	24.5
GFATM II	7,247,505	21.7
WHO	983,733	2.9
Nepal Red Cross	844,444	2.5
Action Aid	685,668	2.1
UNICEF	650,000	1.9
AusAid	600,000	1.8
Government of Nepal	272,233	0.8
Joint UN Programme	426,445	1.3
Family Planning Association Nepal	412,000	1.2
UNFPA	407,704	1.2
UNAIDS	258,000	0.8
World Vision	215,000	0.6
Lutheran World Federation	143,000	0.4
Total	**33,364,649**	**100.0**
Source: NAP (2006 - 2008) In US$		

Design, Methodology and Process

The assessment followed the global National AIDS Spending Assessment (NASA) methodology and guidelines, and made use of standard NASA tools. It considered all the broad-based classifications for HIV and AIDS expenditure across three dimensions (Source, Financing, and Use), which incorporate six vectors (Sources, Agents, Providers, Production Factors, Functions, and Beneficiaries). The summary of classification can be found in Annex 7. A mapping of organisations involved in the response to HIV and AIDS was prepared with an end in view of conducting a complete accounting of actual HIV and AIDS expenditures.

A detailed approach was instituted to collect, analyse, and report the flow of funds to HIV/AIDS expenditure. This spending assessment is therefore a reflection of country-wide HIV/AIDS spending categorised by function and beneficiary population.

NASA provides an opportunity to analyse and initiate informed discussion on HIV/AIDS spending and priorities in Nepal. The information provided here is valuable to be able to assess progress made towards the priorities set, and to point out spending gaps requiring attention. However, the NASA methodology is not an auditing tool and should not be used in determining or justifying the authenticity of expenditures.

Preparation

In the preparation stage for NASA, a taskforce was formed consisting of two consultants from UNAIDS (Annex 2: Task Force Members). The Task Force and the NASA consultants ensured that quality standards were kept every stage of the assessment process. The consultants interacted with various agencies with constant support from HSCB and UNAIDS. HSCB facilitated the interviews and, in many cases, data collection.

The Source/Agent, Agent, and Provider list was identified through a mapping exercise (Figure 2), and a data collection tool was distributed to these sources to report their HIV and AIDS expenditures for the fiscal year. After an initial briefing, the consultants made follow-up visits to offices followed by telephone and electronic communication. A three-day NASA orientation and training programme was also conducted among stakeholders, particularly the finance officers and one programme staffs from each of the stakeholder organisations. This is to acquaint various stakeholders with the NASA process, guidelines, and data collection requirements. This was followed up by intermittent and periodic orientation briefings of organisations by the consultants .

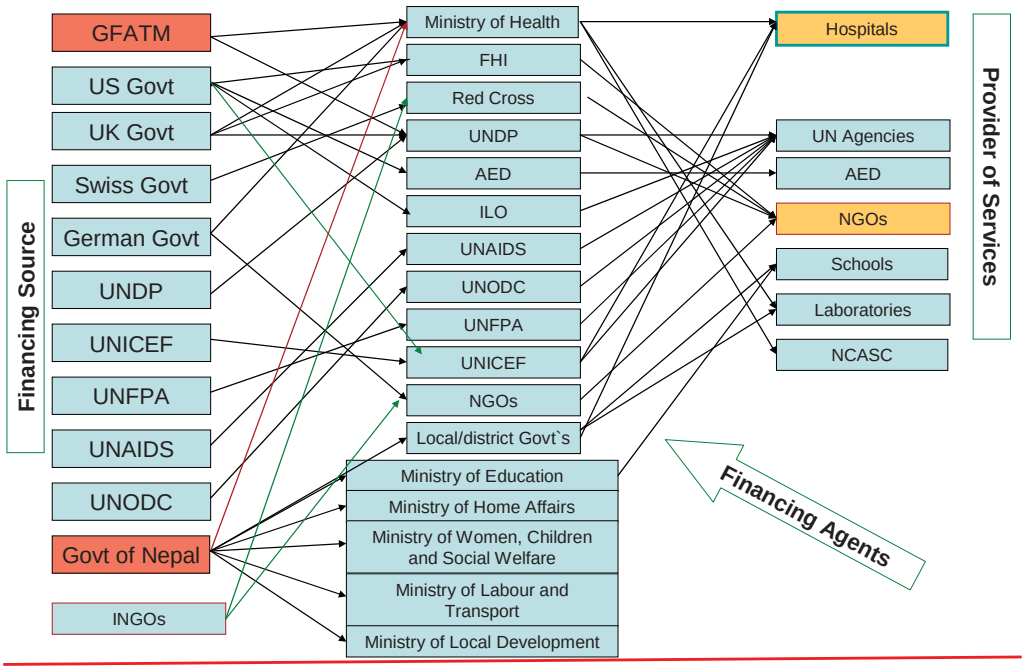
The Task Force reviewed the NASA tools developed by UNAIDS and adapted it to the Nepal country context to facilitate an easy and understandable method of data collection. This allowed for expansion of the NASA tools to include additional data or information where required, or on the other hand, to limit data collection to include only the required information in particular instances. Institutional forms were the major tools for data collection, which allowed the Task Force to categorise institutions as either Source, Agent, Source/Agent, or Provider of service based on function.

NASA Task Force presentating initial findings.

Data collection, processing, and analysis

The primary sources of data and information were agents and providers of services. In quite a few cases, both agent and provider was a single entity, including the Ministry of Health and Population, and UN agencies. For most NGOs who are, by and large, providers of goods and services, qualitative and quantitative expenditure data were obtained from their respective agents. For example, the UNDP Project Monitoring Unit, and Family Health International, as agents provided data of their NGO partner providers because the majority of NGOs were implementing programmes with two agents.

Figure 2: Mapping Funds Flow



Hard copies of data were printed, compiled, and systematically filed as they came in. These were used to counter-check data for completeness, accuracy, double count, and appropriate category classification. Whenever required during the process, such as when flaws were noted in the data, sources and agents were contacted for clarification. The consultants sat down with the concerned source and/or agent to sort out flaws and make the necessary adjustments and corrections. The data was then collated and structured into the standard NASA reporting matrices for analysis and entered manually by transaction in an Excel spreadsheet, where they were verified once more to ensure correctness before final entry into the NASA resource tracking software, which is the final database.

Data and process validation

Before preparing a first draft of the NASA report, the consultants, with support from HSCB and UNAIDS, requested a validation meeting with the data providers. This meeting, as well, provided the avenue for the data providers to air their views and to advance some recommendations on the findings. Validation of data was carried out, where pertinent and key suggestions and recommendation were made. These recommendations are included in the narrative and analysis sections of this Report.

Scope and limitations

This study aimed primarily to capture spending from January to December 2007. However, differences in reporting fiscal years of various organizations (some organizations begin fiscal year reporting in March or June) have made certain data overlaps or overflow unavoidable.

Both the financing agents (FAs) and providers of services (PS) reported actual spending. The study team did not approach all the providers of services directly, but rather relied on spending data received from the agents. It may be difficult to capture the generally unlikely scenario where funds remain with the provider but were reported to the agent as spent. Furthermore, the study team relied fully on the report of the agent/providers except in certain cases where the study team itself visited the organisations and collected information with the help of the organisation's finance and programme staffs.

Seventy-five district development committees (DDCs), 3,900 village development committees (VDCs), and 52 municipalities receive grants from the government and raised revenues on their own from local taxes and services charges. These revenues are reallocated to a variety of services and activities including HIV and AIDS related activities. As part of a decentralised governance programme, the DDCs comply with what is known as 'Minimum Condition Performance Measure' guidelines, where one of the key indicators is reduction in incidence of HIV/AIDS. Given the complexity of the process and the time required for data collection from DDCs and VDCs, the Task Force decided that detailed data collection is feasible only in the next round of the assessment. Therefore, this first round assessment excludes spending information from local governance bodies.

Careful consideration is necessary to involve the private sector in the assessment, given the sector's diversity and complexity. Some of the hotels and banks have workplace programmes; some manpower companies, training institutions, and allied groups may allot spending for HIV/AIDS-related activities (for example, awareness raising during pre-departure orientation for migrant workers); medical colleges and health training institutions such as nursing colleges, para-medic institutes, private medical colleges and hospitals, are likely to have some spending on HIV-related activities such as educational materials on the universal need for precaution. The Task Force decided not to include the private sector in this first round largely because the current level of spending by this sector on HIV-related activities is minimal and data collection from the sector also requires extra effort. Furthermore, many in the private sector are not yet fully sensitised about the problem of HIV/AIDS, and many may are not comfortable disclosing financial information.

Consumer and out-of-pocket expenses are often related to spending for opportunistic infection (diseases caused by various organisms some of which do not cause disease in persons with healthy immune systems) and on home-base care (HBC). However, since most opportunistic infection (OI) and HBC are funded through the programme, delineating out-of-pocket expenses could be difficult. Given the current coverage of services and access and utilisation as well as the tendency of clients to seek health services (for example, in the treatment of sexually transmitted infection through private providers), the possibility of out-of-pocket expenses cannot be ignored, particularly in the case of Nepal labour migrants to India. A proper and acceptable method for estimating such expenses is necessary.

Moreover, because treatment of sexually transmitted infection (STI), OI, and ART are free, out-of-pocket expenses related to HIV care and treatment could reflect as insignificant. The Task Force, therefore, agreed to consider this issue in the second round of the NASA exercise.

VDC members attend an awareness-raising meeting on HIV/AIDS.

Some organisations had difficulties and reluctance reporting human resource costs, mainly of international staff. This is partly because such expenditures were often borne by the Headquarters without much involvement of the country offices, and also partly because such costs to some organisation were much higher than actual programme delivery costs. Certain capacity building costs, such as cost for international training programmes, seminars, and visits, were also often not part of the regular programme and are usually borne directly by outside country sources or donors. These costs were out of the scope of this recent NASA exercise.

Assumptions and Clarifications

Based on data received from both major sources and agents, who in turn submitted the data of service providers, it is safe to assume that NASA 2007 captured 90% or more of HIV spending in Nepal in 2007.

Where expenditures were not detailed according to production factor or beneficiary population, these were represented in terms of percentage distribution. Most of the data collected seem to have defined AIDS spending categories and beneficiary population accurately. But there was some confusion in the interpretation of production factor; and where data providers were unclear on the definition, this data was sometimes not provided at all. In such cases, the consultants worked in consultation with the organisations concerned to help them understand and interpret production factor on the basis of proportionate allocation in each of the AIDS spending categories (ASC). For example, if certain ASC used up 25% of total expenditure, the same percentage was applied to calculate for wages under production factor.

Government spending on salaries and wages of medical personnel (doctors, nurses, laboratory technicians) on antiretroviral therapy, voluntary counselling and testing, and prevention of mother

or parent-to-child transmission was calculated taking into consideration time spent by the medical personnel to perform such tasks. The figures were derived in consultation with experts and persons involved in service delivery.

Unless otherwise explained, the term NGO is used throughout this study as an overall category for non-government organizations involved in HIV/AIDs programme activities and not to represent individual organizations, entities, or bodies.

According to the NASA Manual, Code classification categories .98 and .99 are assigned where there is inadequate information for assigning specific NASA classification for AIDS spending categories, beneficiary population, or production factor. These classification categories represent spending categories …"not disaggregated by type", or "not elsewhere classified".

The agents reported actual expenditures by service provider, and reported to their source donor agency amounts transferred to providers as expenses. Because of this transfer/conduit of funds channel, certain donor sources may note discrepancies between expenses as reflected in the NASA and the expense report received from agents. This has no effect on the NASA data, or its analysis and interpretation.

Additional expenses were discovered and reported by some partners at the time when the report was ready to go for printing. Since the additional expenses were insignificant compared to total spending, they are not included in the analysis. All expenses and figures have been converted to US dollar based on average exchange rate in 2007 of NRs 67-US$ (source: Nepal Rastra Bank).

2 Findings

Data Sources

Fifty-eight organizations including broad categories like the private sector were the target of NASA data collection efforts. They included major funding sources, funding agents and service providers, categorised as either domestic or international, and mostly operating or located in Kathmandu.

Organizations identified for the NASA assessment were primarily agencies likely to have mobilised substantial funding for the HIV/AIDS programme in Nepal (Table 6). More that 60% of these organizations are multilateral agencies or international or local NGOs. Only five government agencies participated in the NASA assessment based on their involvement as either source, agent, or provider of services. Of the 58 identified agencies, 10 were scheduled for the next round of NASA and are not included in this round. However, 30% of the organizations did not provide NASA information despite repeated requests. Profiles of the participating organizations and their status record is available in Annex 1, List of Organizations Targeted for the Nepal National AIDS Spending Assessment.

Table 6: NASA Respondents

Type of organisations	Number	(%)
Source, Agent, Provider		
Multilateral agencies	18	31
INGOs	18	31
Bilateral agencies	8	14
NGOs	8	14
Government agencies	5	9
Private sector	1	2
Total Number of Org'ns	**58**	**100**
Data received	**31**	**53**
Deferred to NASA 2010	**10**	**17**
No response	**17**	**29**

Comparing NASA 2007 Findings and NAP (2006-2008) Priorities

Efforts were made to compare the priorities of the National Action Plan (2006-2008) with the NASA findings. Although the data categories in NAP and NASA are different, commonalities make comparisons possible.

In total, the partners committed about US$ 33 million for the two-year period 2006-2008, as against US$64 million budgeted for in the Plan. On a yearly average, commitments amounted to about US$17 million a year (Table 7). Total disbursements in 2007 amounted to US$22.5 million, and US$17.5 million was actually spent, indicating a fairly consistent and realistic pattern of projection and actual spending. Over 67% of total spending was funds from bilateral sources.

Based on comparison of disbursements and spending, INGO sources appear to have a better overall absorption or spending rate of 95% compared to 77% absorption rate by bilateral and multilateral sources (Table 8).

Table 7: Funds Pledged (2006-2008) and Actual Spending in 2007

Agencies	2-Year Pledge (2006-08)	Disbursed	Spent
Bilateral donors	20,818,917	15,444,230	11,849,242
Govt of Nepal	272,233	617,687	617,687
INGOs	2,300,112	1,034,950	991,523
Multilateral sources	9,973,387	5,584,332	4,203,201
Total	**33,364,649**	**22,681,199**	**17,661,653**

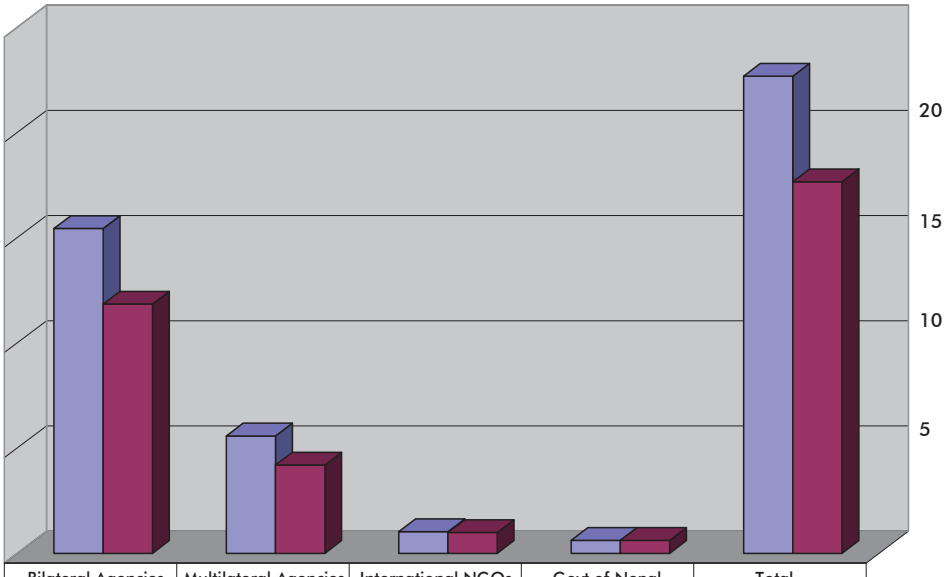
Source: National Action Plan (2006-2008) - Two-Year Pledge (In US$)

Table 8: Disbursements and Absorption Rate by Funding Source

Source	Disbursed	(%)	Total Spent	(%)	Absorption (%)
Multilateral Agencies	5,584,332	24.62	4,203,201	23.80	75.27%
Bilateral Agencies	15,444,230	68.09	11,849,242	67.09	76.72%
International NGOs	1,034,950	4.56	991,523	5.61	95.80%
Govt of Nepal	617,687	2.72	617,687	3.50	100.00%
Total (In US$)	**22,681,199**	**100**	**17,661,653**	**100**	**77.87%**

Government sources reflected a 100% absorption rate. However, this figure should be approached with some degree of caution; some government source data reported whatever was recorded as expenditure as also total disbursement, which is often not the case in the government financing system of Nepal (Figure 3).

Figure 3: Disbursements and Expenditure by Source

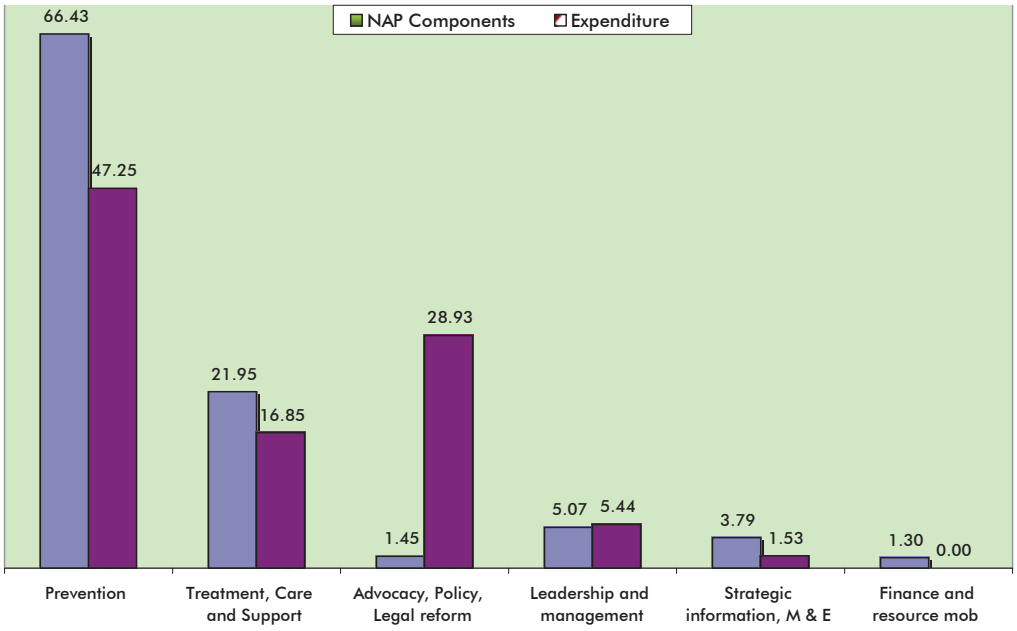


	Bilateral Agencies	Multilateral Agencies	International NGOs	Govt of Nepal	Total
Disbursed	15,444,230	5,584,332	1,034,950	617,687	22,681,199
Expendit	11,849,242	4,203,201	991,523	617,687	17,661,653

(In US$)

While there has been a fairly consistent pattern in resource commitment by different sources for NAP (2006-2008) and actual spending in 2007, spending in specific NAP components reflected wide variances. Of 66% total resources planned for the prevention component, actual spending was 47%. In actual terms, about US $42.5 million was budgeted for two years, or approximately US$21 million a year; actual spending at US$8.3 million is almost three times less than planned for. Similarly, in care and treatment, about 22% (US$14 million for 2006-2008) was allocated; actual spending was US $2.9 million (17%), also almost three times less than planned for (refer to Table 3 and Figure 4). The biggest expenditure next to prevention was in Advocacy, Policy, Legal Reform, and Leadership and Management components. Both components reflected overspending, with Advocacy spending way beyond the budget. Budget for the Advocacy component was US$932,000 for two years, actual spending was over US$5 million.

Figure 4: A Comparison of NAP (2006-2008) Components and NASA 2007 Expenditure
(In %)



Unrealistic budgeting during the NAP preparation, additional efforts and resources mobilised to respond to new challenges and opportunities under a changed Nepal political and social context, spending made outside of the NAP, changes in the institutional plan but not reflected in the NAP, and accounting practices and the NASA classification not accurately followed, are some of the reasons for gaps between planned and actual spending. But probing and discussion are required to be able draw specific conclusions.

Total Expenditure by Source, Agent, and Provider

Tables 9 and 10 explain the total amounts disbursed by source to different agents. Bilateral sources appear to be more versatile in disbursing funds to all kinds of agents (there are 16 different agent categories), whereas government sources appear to be more conservative in disbursing funds to non-government agents. For instance, bilateral donors have been able to engage 16 different categories of agents, whereas other sources appear to be less flexible in engaging a wide variety of agents.

Expenditure by financing source

Of the total spending of US$17,661,653 for HIV and AIDS in 2007, 67% was financed by bilateral donors, followed by multilateral sources including the Global Fund (24%). Government financing for the programme was 3%. International not-for-profit sources, mainly international non-government organizations, used up about 6% of total spending (Figure 3).

Different financing sources seem to have specific or certain functional focus, but all sources have consistently spent highest on prevention (ASC 01.01), and programme management and administration (ASC 04.01). Spending on programme management and administration needs careful and cautious interpretation; detailed breakdown of expenditures is necessary to be able to draw conclusions.

Table 9: Amount Disbursed by Source to Agent

	Agent					
Source	**BL**	**GoN**	**INGOs**	**ML**	**NGOs**	**Grand Total**
Bilateral donors	671,641	560,661	6,539,031	7,342,389	330,508	15,444,230
Multilateral sources	-	1,108,984	61,000	4,414,348	-	5,584,332
INGOs	-	-	681,922	13,585	339,443	1,034,950
Govt of Nepal	-	617,687	-	-	-	617,687
Grand Total	**671,641**	**2,287,332**	**7,281,953**	**11,770,322**	**669,951**	**22,681,199**
% mobilised by Agents	2.96	10.08	32.11	51.89	2.95	100
(In US$)						

Multilateral agents, specifically UN organisations, mobilised 51% of total resources from mainly bilateral sources for the HIV/AIDs programme. Of total disbursements from bilateral sources of US$15,444,230, nearly 48% was disbursed to multilateral agents. Some 24% or US$ 5,584,332 came from multilateral sources, out of which nearly 80% was channelled through multilateral agencies like UNDP. Government agencies, mainly the Ministry of Health and Population, mobilised 10% of total funds disbursed. Clearly, a more proactive campaign or advocacy is required to engage government agencies more actively in resource mobilisation for HIV/AIDs.

Table 10: Number of Agents Financed by Source

Source Agent	**BL**	**GoN**	**INGO**	**ML**	**INGO**	**Total**
Multilateral sources	0	1	1	15		17
INGO			9	1	7	17
Bilateral donors	2	1	6	6	1	16
Govt of Nepal		3				3
Total	**2**	**5**	**16**	**22**	**8**	**53**

Among financing sources, government sources paid for goods and services on four functions. Bilateral sources funded six functions including for orphans and vulnerable children (OVC). Multilateral sources also funded five functions. Overall pattern of spending indicates that OVCs and social protection have the lowest preference in spending (Fig. 5-9).

Figure 5: Funding by Function and Fund Source (In US$)

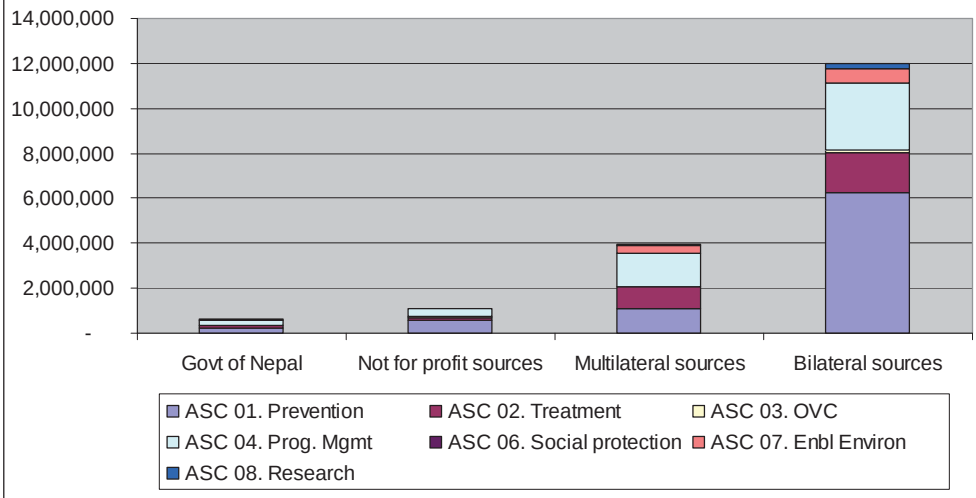


Figure 6: Government of Nepal Source Funding by Function

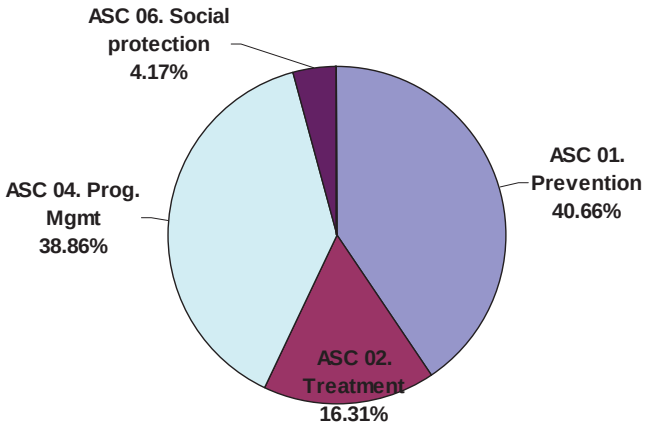


Figure 7: Bilateral Source Funding by Function

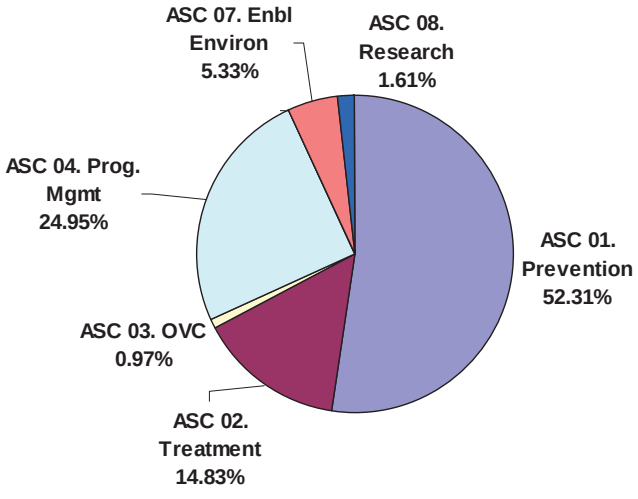


Figure 8: Multilateral Source Funding by Function

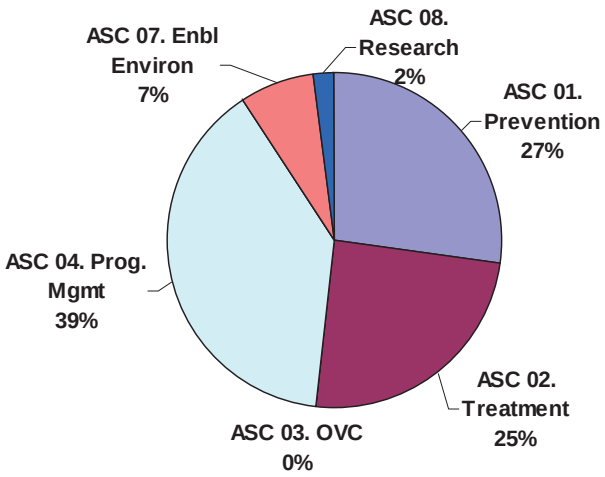
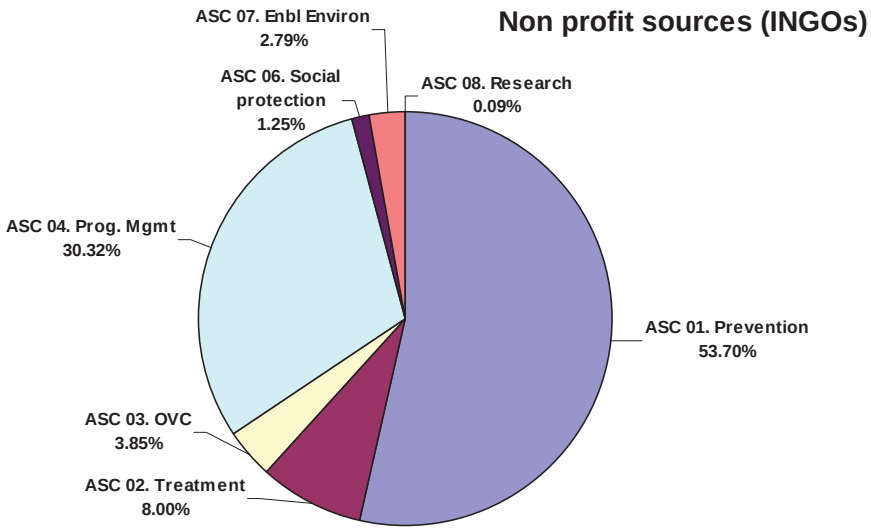


Figure 9: Not-for-Profit Source Funding by Function



Expenditure by agent

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

Agents who mobilise and receive financing from different sources in turn channel the funds to providers of goods and services such as government agencies, national and international NGOs. At times, an agent also acts as a provider of services. Expenditure by Agent is shown in Figure 10. Multilateral agencies (UN organisations) spent 45% of total spending in 2007. INGOs have a substantial share of the AIDS spending, with 38% total share of expenditure.

Total Spending by Agent

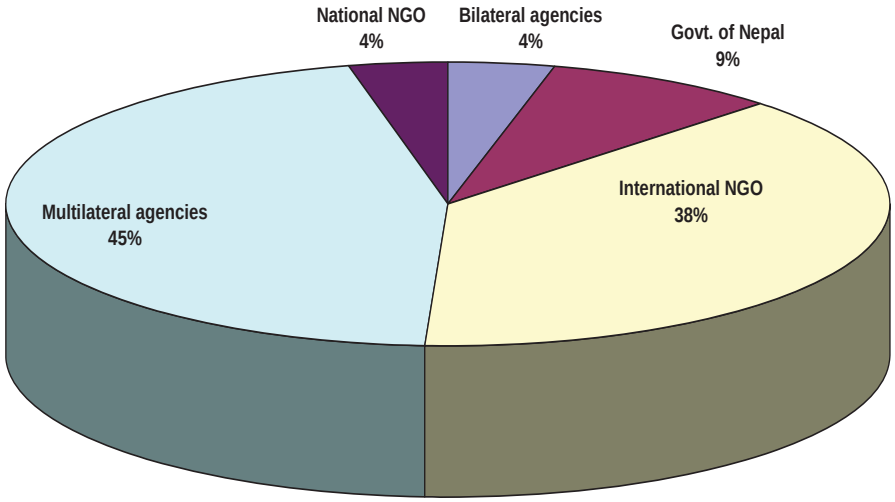
Three broad NASA categories of agents in Nepal have received or mobilised funds from different sources, spent through service providers, or they themselves acted as the providers of services (Table 11).

Table 11: Spending on Function and by Agent

ASC	FA.01 Public sector	FA.02 Private sector	FA.03 International organizations	Total
ASC.01 Prevention	444,509	126,149	7,616,544	8,187,202
ASC.02 Care and treatment	184,316	84,453	2,667,683	2,936,452
ASC.03 Orphans and vulnerable children (OVC)	-	115,868	42,871	158,739
ASC.04 Programme management and administration strengthening	900,496	58,164	4,151,141	5,109,801
ASC.05 Incentives for recruitment and retention of human resources	-	-	-	-
ASC.06 Social protection and social services (excluding OVC)	25,746	13,927	-	39,673
ASC.07 Enabling environment and community development	76,621	4,670	879,068	960,359
ASC.08 HIV and AIDS-related research (excluding operations research)	28,987	964	239,476	269,427
Grand total	**1,660,675**	**404,195**	**15,596,783**	**17,661,653**
(In US$)				

The public sector, notably government ministries and departments, as agent, has mobilised and spend over US$1.6 million from public or international sources for the programme on HIV/AIDs. Large numbers of UN and other international organisations were the major agents mobilising funds from different sources spent through number of providers.

Figure 10: Expenditure by Agent



Bilateral Spending

Of the total spending of US$11,849,242 from bilateral sources, almost half (48% or US$5,747,754) was from USAID, followed by 37% or US$4,339,702 from DFID (Table 12).

Table 12: Spending by Bilateral Source		
Bilateral source	**Expenditure (US$)**	**(%)**
USAID	5,747,754	48.51
DFID	4,339,702	36.62
Government of Germany	700,194	5.91
AusAid	580,116	4.90
SIDA	330,558	2.79
Royal Norwegian Embassy	128,570	1.09
Swedish National Committee	22,348	0.19
Grand Total	**11,849,242**	**100**

Multilateral Spending

A number of multilateral sources have financed the HIV/AIDS programme, of which 66% was financed from the Global Fund. Ten multilateral sources did not report for the NASA 2007. (Figure 11 and Table 13).

Of overall spending in 2007, multilateral sources financed 24%. Among the multilateral sources the Global Fund (Round 2, phase II) reflected the highest spending (62%) at US$2,628,542. Nine UN agencies spent 38%.

Figure 11: Disbursement by Multilateral Source

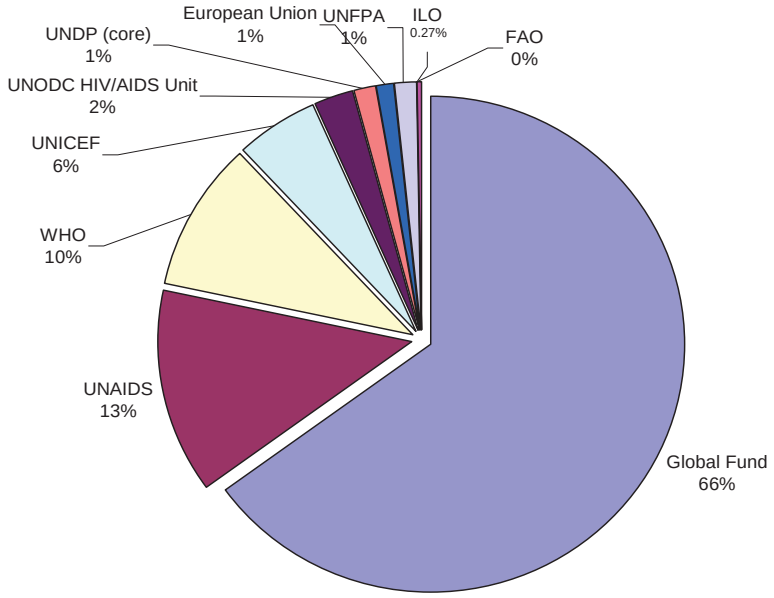


Table 13: Spending by Multilateral Source		
Multilateral sources	**Expenditure (US$)**	**(%)**
Global Fund (Rd 2, phase II)	2,628,542	62.54
WHO	538,635	12.81
UNAIDS	415,703	9.89
UNICEF	263,693	6.27
UNODC	165,089	3.93
UNDP	82,606	1.97
European Union	50,314	1.20
UNFPA	44,264	1.05
ILO	11,555	0.27
FAO	2,800	0.07
Grand Total	**4,203,201**	**100**

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. HIV and AIDS services are supplied in a wide range of settings in and out of the health industry. Service providers include government and other public entities, private for-profit and non-profit organisations, corporate and non-corporate enterprises, and self-employed persons whose activities fall within the NASA boundaries regardless of formal or informal legal status.

Leaving aside the private sector (which is not included in the current study), HIV service providers in Nepal can be broadly categorised into three: government, I/NGOs, and the UN system. Bilateral sources have disbursed funds to five providers while INGO sources have provided funds to eight providers (Table 14). Monies from government sources went only to government providers. Two government providers and three I/NGOs providers received financing from bilateral donors, while two government providers, one UN provider and two I/NGO providers, received funding from multilateral sources.

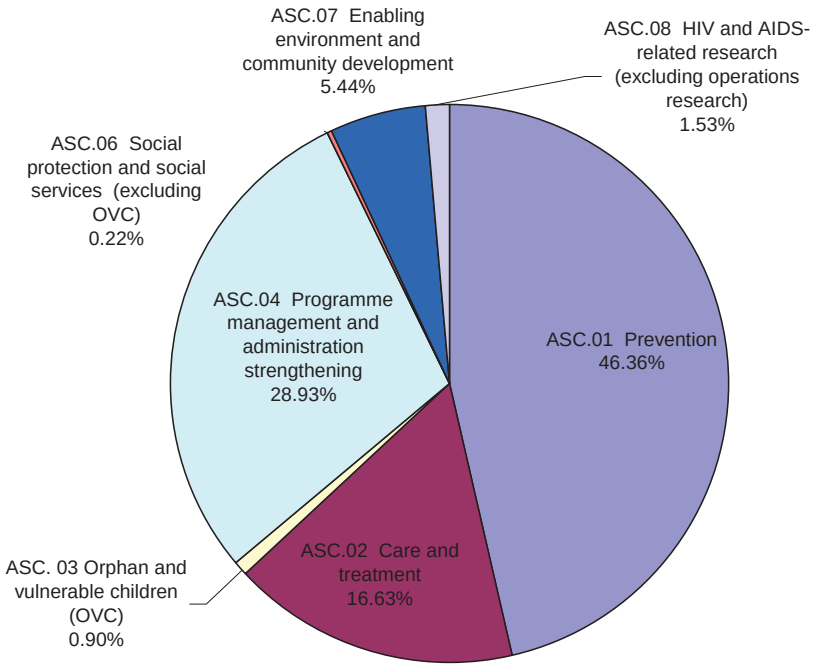
Table 14: Number of Providers by Financing Source				
Source	**Total**	**Govt**	**UN**	**I/NGO**
Bilateral donors	5	2		3
Govt. of Nepal	3	3		
INGOs	8		1	7
Multilateral sources	5	2	1	2
Grand Total	**14**	**7**	**2**	**12**

Expenditure on Core HIV/AIDS Functions

There are eight major spending areas or HIV/AIDS spending categories (ASC) as classified by the NASA methodology. In Nepal, except for one spending catagory (ASC 05: Incentive for recruitment and retention of human resources), all seven categories have recorded expenditure in 2007. Of total expenditure, nearly half (46% or US$8,187,202) was spent on prevention and 16% on treatment and care. Orphans and vulnerable children and social protection registered the lowest expenditure. Almost a quarter of the fund (24%) was spent on programme management and administration, comprising expenditures on monitoring and evaluation, operational research, drug supply system, upgrading infrastructure, and others (Table 15, Figure 12).

Table 15: Spending by HIV/AIDS Service Category		
Major AIDS Spending Categories	**Expenditure (US$)**	**(%)**
ASC.01 Prevention	8,187,202	46.36
ASC.02 Care and treatment	2,936,452	16.63
ASC. 03 Orphans and vulnerable children (OVC)	158,739	0.90
ASC.04 Programme management and administration strengthening	5,109,801	28.93
ASC.06 Social protection and social services (excluding OVCs)	39,673	0.22
ASC.07 Enabling environment and community development	960,359	5.44
ASC.08 HIV/AIDS-related research (excluding operations research)	269,427	1.53
Total	**17,661,653**	**100**

Figure 12: Spending by Major Programme Category



HIV/AIDS prevention interventions

Prevention programmes involve a comprehensive set of activities or interventions designed to reduce risk behaviours. The ultimate results of prevention programmes include a decrease in HIV infection among the population. The NASA Classification and Taxonomy has elaborated a comprehensive set of over 70 categories and subcategories of prevention interventions to capture all possible prevention activities.

Of total spending on HIV/AIDS, almost half (46% or US$8,187,202) went to prevention-related activities. The top 10 interventions (out of 31 sub-categories) consuming almost 80% of prevention resources are shown in Table 16.

Table 16: Top 10 Prevention Interventions		
	Total (US$)	**(%)**
ASC.01.04.99 Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c.)	1,756,383	21.45
ASC.01.02 Community mobilisation	719,920	8.79
ASC.01.04.03 Prevention and treatment of sexually transmitted infection (STI) as part of programmes for vulnerable and accessible populations	715,315	8.74
ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type	649,985	7.94
ASC.01.10.05 Sterile syringe and needle exchange as part of programmes for IDUs	645,736	7.89
ASC.01.03 Voluntary counselling and testing (VCT)	487,000	5.95
ASC.01.09.98 Programmatic interventions for MSM not disaggregated by type	440,595	5.38
ASC.01.01.01 Health social and behavioural change communication	403,362	4.93
ASC.01.10.98 Programmatic interventions for IDUs not disaggregated by type	377,020	4.60
ASC.01.08.01 VCT as part of programmes for sex workers and their clients	360,533	4.40
21 other interventions	1,631,353	19.93
Total for Prevention	**8,187,202**	**100.00**

The major areas of intervention include voluntary counselling and testing, STI for the accessible population, and programmes for injecting drug users and males having sex with males. Almost 21% of prevention spending went to the non-specific prevention programme (US$1.7 million).

The bottom 10 – interventions that consumed the least resources – include voluntary counselling and testing in the workplace, behavioural change and communication (BCC), and programmes for persons living with HIV (PLHIV) (Table 17). The bottom 10 interventions used about 1% of prevention resources.

Table 17: Bottom 10 Prevention Interventions		
ASC.01 Bottom 10 Prevention Interventions	**Total**	**(%)**
ASC.01.07.01 BCC as part of prevention of HIV transmission aimed at people living with HIV (PLHIV)	19,038	0.23
ASC.01.10.04 BCC as part of programmes for IDUs	14,092	0.17
ASC.01.07.99 Other prevention of HIV transmission aimed at PLHIV, n.e.c.	8,356	0.10
ASC.01.11.01 VCT as part of programmes in the workplace	8,058	0.10
ASC.01.17.01 Pregnant women counselling and testing in VCT programmes	8,282	0.10
ASC.01.08.99 Other programmatic interventions for sex workers and their clients, n.e.c.	3,613	0.04
ASC.01.11.98 Programmatic interventions in the workplace not disaggregated by type	2,985	0.04
ASC.01.11.03 Prevention and treatment of STI as part of programmes in the workplace	957	0.01
ASC.01.11.04 BCC as part of programmes in the workplace	939	0.01
ASC.01.99 Prevention activities n.e.c.	746	0.01
Other interventions	8,120,136	99.18
Total for Prevention	**8,187,202**	**100.00**

Care and treatment

Nearly US$3 million was spent on care and treatment; antiretroviral therapy, nutrition related expenses, and home-base care received the bulk of the resources. Nearly a million in spending was not classified in detail because of lack of adequate information and data from partners and was therefore grouped under ASC 2.98 and 2.99, not disaggregated data (Table 18).

Table 18: Expenditure in care and treatment by sub-category		
ASC.02 Care and treatment	**(US $)**	**(%)**
ASC.02.01.03.01.98 Adult antiretroviral therapy n.d.t	662,793	22.57
ASC.02.99 Care and treatment services n.e.c.	543,041	18.49
ASC.02.98 Care and treatment services not disaggregated by intervention	537,061	18.29
ASC.02.01.04 Nutritional support associated to ARV therapy	520,144	17.71
ASC.02.01.09.98 Home-based care not disaggregated by type	504,362	17.18
ASC.02.01.02.98 OI outpatient care prophylaxis and treatment n.d.t.	100,692	3.43
ASC.02.02.98 Inpatient care services not disaggregated by intervention	29,393	1.00
ASC.02.01.98 Outpatient care services not disaggregated by intervention	27,891	0.95
ASC.02.01.03.98 ART not disaggregated neither by age nor by line of treatment	4,373	0.15
ASC.02.01.02.02 OI outpatient treatment	2,787	0.09
ASC.02.01.99 Outpatient care services n.e.c.	1,587	0.05
ASC.02.01.09.01 Home-based medical care	1,486	0.05
ASC.02.01.05 Specific HIV-related laboratory monitoring	842	0.03
Total for Care and treatment	**2,936,452**	**100**

An important component of care and treatment is antiretroviral therapy (ART) services, in which ART drugs bear a large share of the cost. In the NASA report tracking system, total drug procurement cost as reported by UNDP/PMU is included, which does not necessarily mean the consumption or lost, or expiry of the drug. Additional effort was made to compare the difference between procurement and consumption (Table 19). The findings are that most of the drugs procured during 2007 were consumed in the same year, with a balance of US$ 57,000 worth of ART drugs.

Table 19: Procurement of Antiretroviral Therapy Drug vs. Consumption				
ASC: 2.1.3.1 Adult ARV				
		UNDP Procured (US$)	**NCASC consumed (US$)**	**Stock (2007)**
PF: 1.2.1.1	ARV drugs	270,017.26	212,537.73	57,479.53
PF: 1.2.1.2	Other Drugs	242,359.00		
PF: 1.2.1.5	Reagents	124,269.60		
	Total	**636,645.86**	**212,537.73**	**57,479.53**

Orphans and vulnerable children

Of the total HIV/AIDS spending, the share of orphans and vulnerable children (OVCs) was US $158,739, nearly 1% of the total (Table 20). Within OVCs, expenditure on education and family support consumed the bulk of the resources.

Table 20: OVC expenditure in 2007		
ASC. 03 Orphaned and vulnerable children (OVC)	**(US$)**	**(%)**
ASC.03.01 OVC education	60,154	37.89
ASC.03.03 OVC family/home support	51,066	32.17
ASC.03.04 OVC community support	17,919	11.29
ASC.03.99 OVC services n.e.c.	29,600	18.65
OVC Total	**158,739**	**100.00**

Programme management and administration

Programme management and administration consists of a wide variety of activities related to HIV/AIDS prevention and control. The NASA classification defines it as an essential component for effective and efficient delivery of goods and services.

Data received from various sources indicates an increasing tendency to lump expenditure under this category for ease of reporting to the NASA. While the study team exerted effort to separate expenses related to specific ASC and assign appropriate NASA classification, caution should be taken about interpreting the figures. They should not be interpreted merely as administrative or overhead expense of the agent or provider (Table 21).

Table 21: Expenditure on Programme Management

ASC.04 Programme management and administration strengthening	
ASC.04.01 Planning, coordination, and programme management	1,553,221
ASC.04.02 Prog/admin and transaction costs associated with managing	72,956
ASC.04.03 Monitoring and evaluation	253,338
ASC.04.04 Operations research	14,065
ASC.04.07 Drug supply systems	61,431
ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	32,199
ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.	97,701
ASC.04.12 Training	426,434
ASC.04.98 Prog management and admin strengthening not disaggregated by type	1,950,524
ASC.04.99 Programme management and administration strengthening n.e.c	647,932
Total	**5,109,801**

Social protection and social services

Expenditure under this component was negligible at 0.22% of overall spending, or US$39,000, mostly on income generation related activities.

Enabling environment and community development

This function includes a full set of services to generate increased and wider range support for the key principles and actions on HIV/AIDS including policy development. The component's share of total expenditure was 5.44% or US $960,359 (Table 22).

Table 22: Expenditure on Enabling Environment and Community Development

ASC.07 Enabling environment and community development	**(US $)**	**(%)**
Advocacy and policy development	703,919	73.30
AIDS-specific institutional development	194,205	20.22
Enabling environment not disaggregated by type	59,878	6.23
Provision of legal services	2,088	0.22
Capacity building in human rights	269	0.03
Total	**960,359**	**100.00**

HIV and AIDS related research

Research spending was 1.5% of total spending. The bulk of the resources were used in behavioural research such as for integrated behavioural surveillance surveys (Table 23).

Table 23: Expenditure on research

ASC.08 HIV/AIDS-related research (excluding operations research)	(US $)	(%)
ASC.08.04 Social science research	5,174	1.92
ASC.08.05 Behavioural research	193,577	71.85
ASC.08.99 HIV and AIDS-related research activities n.e.c.	70,676	26.23
HIV and AIDS-related research (excl operations research) Total	**269,427**	**00.00**

Providers and Production Factors

Providers are entities or organisations directly engaged in the provision of goods and services to one or more beneficiary population related to HIV/AIDS prevention and control. Eight categories of providers according to the NASA classification were recorded in Nepal. They include public sector providers like hospitals, government ministries, private or civil society organisations, and multilateral agencies. Some multilateral agencies function as both agent and provider in certain cases, and they get payments directly for certain services such as to pay consultants for voluntary counselling and testing, or for a computer purchased for a hospital, or similar expenses.

Of total spending in 2007 for HIV/AIDS, three categories of civil society organisations (CSOs) including faith-based organisations provided goods and services worth of US$14,895,801 (83%) to one or more beneficiaries (Table 24). The Ministry of Health and Population and its units was the second largest service provider. CSO spending was recorded for 28 different line items such as wages, condoms, transportations, current expenditures, other services. The hospital as a provider has spent only on one line item.

Table 24: Expenditure by Provider

Provider of Services (PS) Categories	Total (US$)	(%)	Budgetary items
PS.01.01.01 Hospitals	82,151	0.47	1
PS.01.01.14.02 Ministry of Health (including NAPs/NACPs)	2,247,182	12.72	21
PS.01.01.14.07 Ministry of Labour or equivalent	2,985	0.02	1
PS.01.01.14.99 Government entities n.e.c.	2,800	0.02	1
PS.02.01.01.15 Civil society organizations	9,195,292	52.06	28
PS.02.01.02.14 Civil society organizations (faith based)	5,522,965	31.27	13
PS.02.01.02.99 Other non-profit private sector providers n.e.c.	177,544	1.01	27
PS.03.02 Multilateral agencies	430,696	2.44	6
Grand Total	**17,661,615**	**100.00**	

Production factors by provider

Providers while dispensing goods and services use budgetary items. The pattern of budgetary items varies by nature and type of goods and services provided as well as by nature of the organisation. Among the top 10 budgetary items which consumed over 88% of total AIDS spending, 36% was spent on wages; 20% of spending was not disaggregated by type of spending. Spending on ARV drugs was 1.5% of total spending (Table 25). Details of production factors are in Annex 4: Production Factors by Provider.

Table 25: Top 10 Production Factors Spending		
Production Factors	**(US $)**	**(%)**
Wages	6,522,286	36.9
Current expenditures not disaggregated by type	3,594,184	20.4
Services not disaggregated by type	1,707,769	9.7
Consulting services	868,799	4.9
Other drugs and pharmaceuticals (excluding ARV)	763,039	4.3
Transportation and travel services	716,419	4.1
Administrative services	555,618	3.1
Material supplies not disaggregated by type	385,475	2.2
Housing services	275,943	1.6
Antiretroviral therapy	270,018	1.5
Total of top 10 budgetary items	15,659,550	88.7
The rest of the 25 items	2,002,065	11.3
Grand total	**17,661,615**	**100.0**

Major functions and expenditure items

The consumption of wages to deliver goods and services in eight major functional categories are as follows.

Table 26: Wages by Major Functional Categories			
ASC Categories	**Wages**	**(%)**	**Total**
Prevention	2,660,200	32.49	8,187,166
Care and treatment	779,798.00	26.56	2,936,453
OVC education	31,407	19.79	158,738
Programme management and administration	2,731,114	53.45	5,109,801
Incentives for retention of human resources	0	0	0
Social protection and social services	26,131	65.87	39,673
Enabling environment	231,389	24.09	960,357
HIV and AIDS-related research	62,247	23.10	269,427
Grand Total	**6,522,286.00**	**36.93**	**17,661,615**

Of the total in each ASC category, Programme management and administration spent about 53% on wages, whereas care and treatment consumed about 26% on the same item (Table 26). Overall spending on ASC 06 Social Protection was relatively low (US$39,673), and more than 63% was spent on wages. HIV/AIDS Prevention programme and programme management and administration consisted of a wide range of activities requiring different spending items. PF 01.98, current expenditure not disaggregated by type, was 20% of total spending. Agents and providers need to consider this carefully while making their spending; it is always desirable to have a specific spending item for better accountability and transparency.

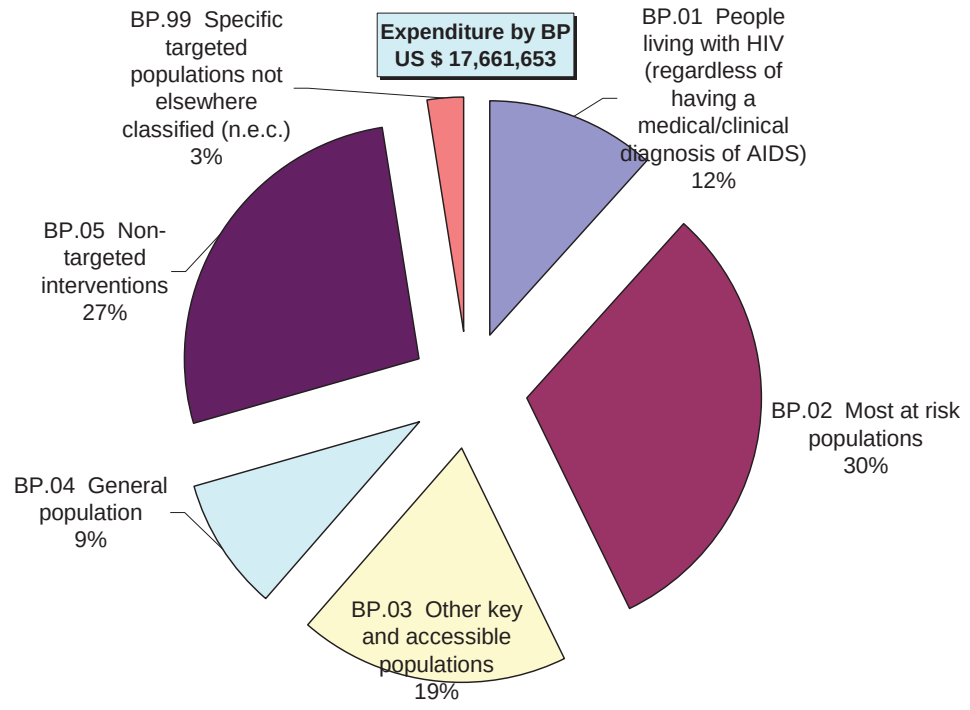
Beneficiary Population

HIV/AIDS functions and interventions are intended to reach 32 different population categories or groups in Nepal from the overall 56 NASA categories. The categories fall under six broad categories of beneficiary population as well as two categories each for non-targeted intervention and non-specific population. Within the six broad categories of beneficiary population the proportion of HIV spending in 2007 is reflected in Fig. 13.

Table 27: Top 10: Intervention Programme Functions

ASC Categories	PF.01.01.01 Wages	PF.01.02 .01.01 ARV	PF.01.02 .01.02 Other drugs and pharma-ceuticals	PF.01.02. 01.98 Material supplies not disaggre-gated	PF.01.02. 02.01 Admin services	PF.01.02. 02.07 Consult-ing services	PF.01.02. 02.08 Transport-ation, travel services	PF.01.02. 02.09 Housing services	PF.01.02. 02.98 Services not disag-gregated by type	PF.01.98 Current expen-ditures not disag-gregated by type	Total (ASC)	Total of top 10 PF	Rest of PF
Prevention	2,660,200	0	329,365	303,932	333,963	365,949	349,895	146,762	998,143	2,034,980	8,187,166	7,523,189	663,977
Care/ Treatment	779,798	270,017	433,674	6,871	64,462	12,725	111,001	89,867	76,790	481,308	2,936,453	2,326,513	609,940
OVC	31,407	0	0	15,181	7,477	26,344	10,431	14,325	746	0	158,738	105,911	52,827
Prog mgmt	2,731,114	1	0	9,700	37,197	93,074	191,420	24,549	606,279	777,996	5,109,801	4,471,330	638,471
Soc Protection	26,131	0	0	108	0	0	0	0	0	0	39,673	26,239	13,434
Enabling envir	231,389	0	0	50,628	91,314	312,964	51,919	440	25,811	173,712	960,357	938,177	22,180
Research	62,247	0	0	25	21,205	57,743	1,753	0	0	126,188	269,427	269,161	266
Grand Total	**6,522,286**	**270,018**	**763,039**	**386,445**	**555,618**	**868,799**	**716,419**	**275,943**	**1,707,769**	**3,594,184**	**17,661,615**	**15,660,520**	**2,001,095**

Figure 13: Expenditure by Beneficiary Population



The biggest portion of expenditure went to most at-risk population (MARP) followed by non-targeted intervention groups. Persons living with HIV cornered 12% of total spending.

Major beneficiary groups

Altogether, 32 beneficiary groups received goods and services from service providers. The top ten beneficiaries of spending for the programme are shown in Table 28.

Table 28: Expenditure by Top 10 Beneficiaries

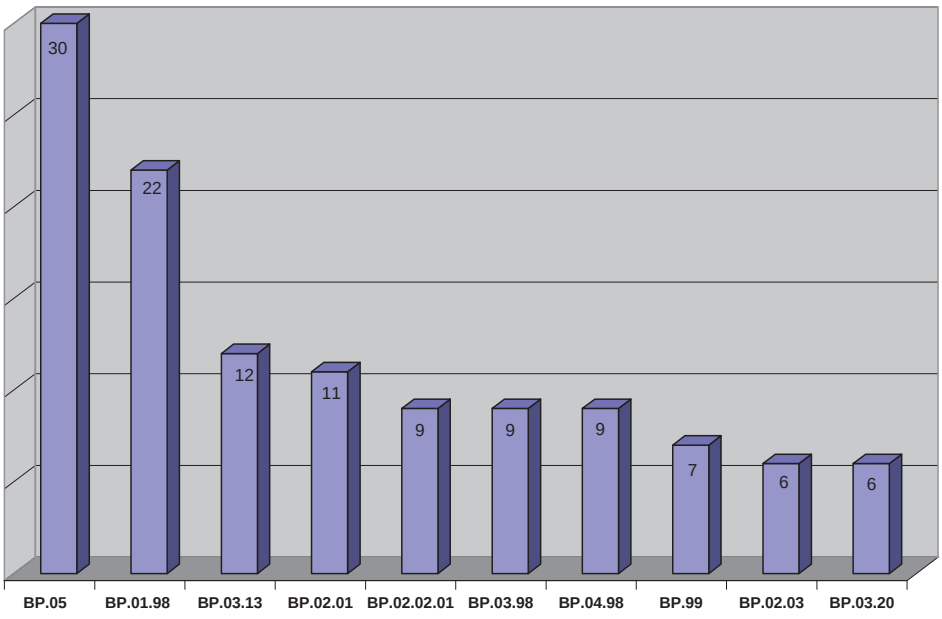
Top Ten Beneficiaries (out of 32 beneficiary categories)	**Amount** (US$)	(%)
Non-targeted interventions	4,859,020	27.51
Injecting drug users (IDUs) and their sexual partners	3,382,961	19.15
People living with HIV not disaggregated by age or gender	1,932,488	10.94
Migrants/mobile population	1,387,301	7.85
General population not disaggregated by age or gender.	1,084,701	6.14
Female sex workers and their clients	984,739	5.58
Males who have sex with males (MSM)	582,992	3.30
Partners of persons living with HIV	520,144	2.95
Specific targeted populations not elsewhere classified (n.e.c.)	451,721	2.56
Sex workers by gender and their clients	411,279	2.33
Total of top 10 beneficiaries	**15,597,346**	**88.31**
Other 21 beneficiaries	2,064,307	11.69
Total	**17,661,653**	**100.00**

The highest expenditure among beneficiary groups was on non-targeted interventions (not targeted to any particular group), followed by most at-risk groups to HIV exposure, injecting drug users (19%), persons living with HIV (11%), and migrants and mobile population (8%). Spending for female sex workers and their clients and the general population were both 6%, and for males who have sex with males (MSM), 3%. Cumulatively, these groups received 88% of total expenditure. Almost 12% was spent on the rest of the 21 categories of beneficiaries including the general adult population, children and young people, recipients of blood donations, partners of people living with HIVs and others.

Number of functions or programme interventions varied according to beneficiary group (Figure 14). People living with HIV received about 22 different kinds of interventions, the mobile population benefited from 13 interventions. Nine different interventions were implemented for female sex workers (BP 02.02.01), other key population groups (BP 03.98), and the general population (BP 04.98), with varying levels of expenditure within these groups. Despite relatively low expenditures on MSM, these groups have been the beneficiary of a wide range of programmes (BP 02.03). Factory workers received six different interventions (BP 03.02).

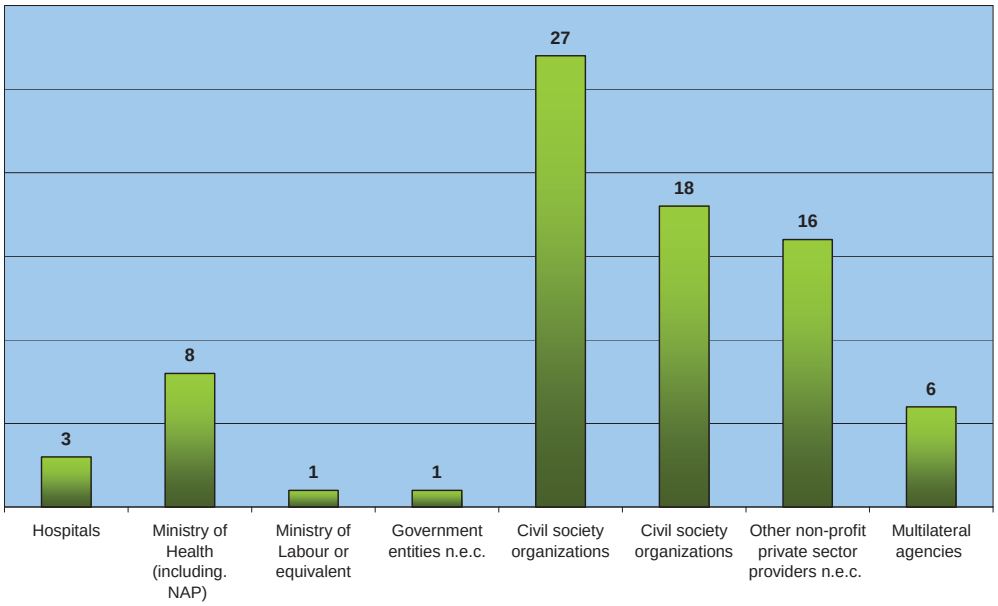
Eight different categories of providers provided goods and services to 32 categories of beneficiary population. The categories of the population reached by each of the eight providers is shown in Figure 15.

Figure 14: Top Ten Spending Categories by Beneficiary Group



Beneficiary Population Categories	
BP.05	Non-targeted interventions
BP.01.98	People living with HIV not disaggregated by age or gender
BP.03.13	Migrants/mobile populations
BP.02.01	Injecting drug users (IDUs) and their sexual partners
BP.02.02.01	Female sex workers and their clients
BP.03.98	Other key and accessible populations not disaggregated by type
BP.04.98	General population not disaggregated by age or gender.
BP.99	Specific targeted populations not elsewhere classified (n.e.c.)
BP.02.03	Males who have sex with males (MSM)
BP.03.20	Factory and other employees (for workplace interventions)

Figure 15: Beneficiaries Reached by Providers



Civil society organizations in general (there are three broad categories) have all been able to reach the broadest categories of beneficiaries including adults and young people 15 years old and over, people living with HIV, children under 15 years old, and injecting drug users and their sexual partners, among others. The Ministry of Health including the National AIDS Programme has been able to reach eight categories of beneficiaries including adults and young people over 15 years old, people living with HIV, and injecting drug users and their sexual partners as well as non-targeted interventions. Hospitals provided goods and services to three categories of beneficiaries: people living with HIV, the general population, and female sex workers, through care and treatment and prevention of mother-to-child transmission.

Spending Patterns

The Government of Nepal, in collaboration with stakeholders such as UNAIDS and Family Health International, regularly estimates HIV prevalence and has further disaggregated the data by differentiated population sub-groups.

The NASA has made an attempt to link spending in 2007 with disease burden as shown below in Figure 16. The country has regularly estimated disease burden and HIV prevalence for each population group. While it is not possible to draw a direct statistical correlation using such a method, a logical pattern and realistic expectation would be that greater spending would be with most at-risk population to address disease burden and/or higher prevalence. The Figure should be interpreted carefully, however. Some interventions are more expensive than others and, therefore, low spending with one group or one function may not necessarily mean an inadequate programme or inadequate programme coverage. It should also be noted that differences in terminology and classification used by the NASA and other documents (for example, the National HIV Estimate) may reflect different reporting systems. For example, the spending line "B.P 4.98 general population", can also be classified as "the rest of the population".

Figure 16: Comparison of HIV prevalence, disease burden, and spending

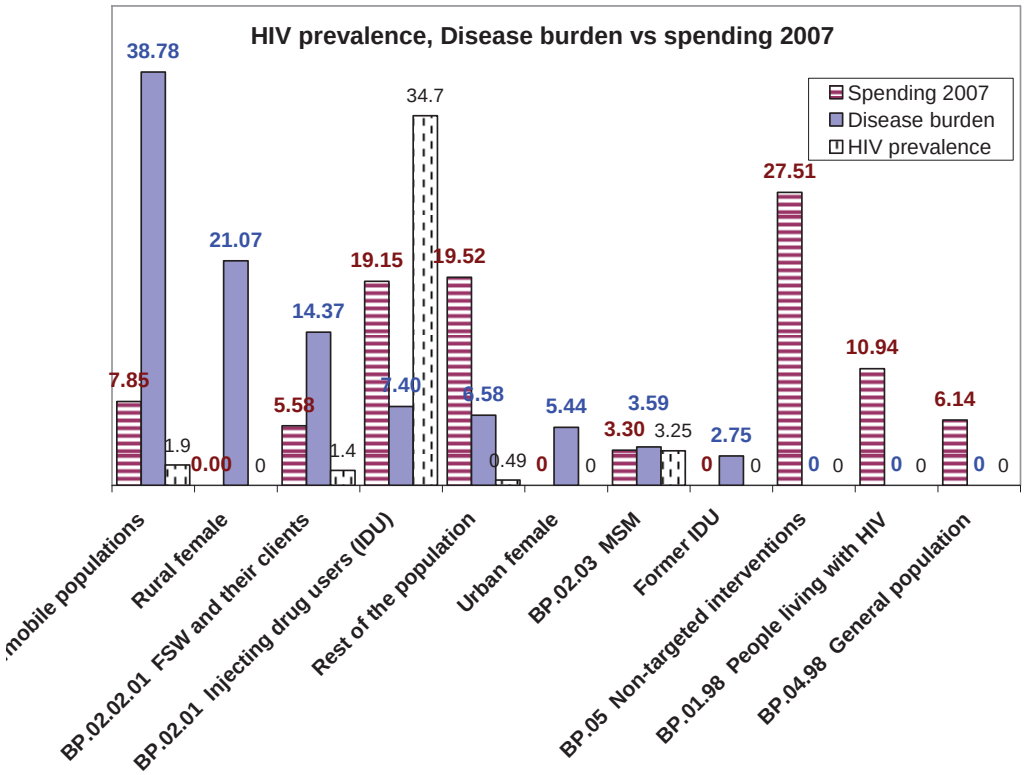


Figure 16 shows that migrant and mobile population share 39% of the burden and risk associated with HIV. Yet overall spending for this particular population group was only about 8%. Similarly, IDUs bear 7.4% of the disease burden whereas spending for this group was nearly 20%. Males having sex with males bear a 3.5% risk of exposure and had a 3.3% share of total spending in 2007. As a matter of principle, national response through spending on mitigation programmes should follow a defined trajectory of the epidemic (HIV prevalence, risk factors). HIV prevalence among different groups varies widely, with the highest prevalence occurring among IDUs, followed by MSM and migrants. Distribution of spending among these groups should realistically reflect more spending for higher risk groups. Clearly, there is a need to review and realign resources with HIV prevalence and higher risk groups.

3 Challenges

It took considerable time to obtain data from many organizations. Between the period a request for data was made and the data was delivered, and the time all the data were compiled according to the NASA forms and format involved substantial time. Some organizations were also reluctant to give financial data. In addition, it took awhile to reconcile differences in financial coding and reporting systems among organizations and to realign these different systems with the NASA coding system. Some of the data could not readily fit into the NASA format so that data had to be analyzed within the NASA context. Partners' interpretation of NASA coding also varied, even for similar nature expenditures and therefore, difficulties were encountered while analysing and entering data into the NASA tracking system.

The timing of the period of data collection also coincided with the preparation of yearend financial reports of many organizations, thus posing further delays in data collection beyond the time allotted for such activity.

VDC members present village intervention activities and AIDS spending

Administrative and salary-related costs appear to have been distributed proportionately to functions or spending categories (ASC). In quite a few cases, programme function did not reflect spending on, for example, wages.

NASA data received from the major organizations were sometimes not detailed enough to include spending categories, programme functions, and beneficiary population to be able to assign full NASA classification during data processing. Therefore, a special NASA classification code was assigned (.98 and .99) to classify data "…not disaggregated by type" or …"not classified elsewhere".

Often, different functions or spending categories were grouped together by agent/providers for convenience and data was reported accordingly. But different service providers can be performing the same functions. For example, spending category 1.03, voluntary counselling and testing, has been implemented by both government and NGO providers with different production factors (PF). While the resource tracking system allows for entry of different functions in same data entry sheet, there is only one place to enter data and therefore entry cannot accommodate more than one provider for the same production factors.

Therefore, discrepancies may have occurred and some data may have been omitted if there was no space to write them, even if data received from an agent was detailed enough or collected directly from several providers.

Many organizations reported "core operation cost" separately without assigning spending category or beneficiary and, without quoting the source of fund. The team assigned a NASA classification to such expenses to the best of their knowledge of the organisation and programme, making these assumptions apply in particular instances when direct consultation with the organisation in question was not possible.

Data from Family Health International (FHI) also required some reclassification, combining the same functions together and using spending classification percentage to derive production factors for each production factor category. Production factor figures initially provided by FHI was further divided into the same functions but with assigned different beneficiary population This resulted in reporting of negligible figures which make no sense if read independently, but the total figures remain the same.

Lesson Learned

This is the first attempt in Nepal to assess spending for the HIV programme in such a detailed and comprehensive manner. Out of this exercise the following lessons can be drawn.

1. Proper and realistic planning, appropriate composition of a NASA country team, advocacy and training for stakeholders, and adequate resources are crucial ingredients to successfully completing the NASA exercise.
2. Besides obtaining NASA data from partners and stakeholders, systematic, thorough and consistent classification is important to be able to make realistic analysis and interpretation of data.
3. The NASA software designed by the UNAIDS Headquarters was used for this exercise. Nevertheless, more time and training are needed to clarify certain functions such as search options and to iron out bugs in the system. The UNAIDS Headquarters needs to be in constant touch and in greater coordination with the NASA country team.

4. For many organisations, filling the NASA forms was an opportunity to reflect on their own spending for HIV and to realign resources accordingly to national priority.
5. Frequent consultation and discussions with major sources, agents, and providers of services are necessary to avoid last minute data corrections and data triangulation.

Recommendations

For the Government of Nepal

1. **Public sector funding and multisectoral coordination:** Compared to previous expenditures reported in the *UN General Assembly Special Session Country Report* and other programme reports, overall expenditure from public sources for HIV mitigation programmes is increasing in Nepal. The government has earmarked funding and indirect non-earmarked funding to mitigation programmes, measures, and activities to minimise the impact of HIIV/AIDS. It is essential to obtain data on government funding and analyse this properly. NASA 2007 did not reveal much information on multisectoral engagement of non-health public sectors and government agencies not dealing in health issues. More effort is required to engage multisectoral agencies in the programme and in the next round of the NASA exercise at all levels – central, ministerial, and local governance body levels.

2. **Alignment of the HIV/AIDS spending with the National Strategic Plan:** There is a clear need to align HIV/AIDS spending to the carefully planned and set National Strategic Plan (NSP). The Nepal NASA 2007 exercise tracked all the major HIV/AIDS expenditures and found some of the spending not in line with the strategic plan. There have been achievements in meeting the goals in some priority areas – best illustrated by expenditure on these items – but spending in other priority areas have not been met.

3. **Institutionalizing NASA:** The spending assessment exercise has provided a baseline study on major public sector and donor funding going to HIV/AIDS. It will be a relatively simpler process to maintain the NASA database if the expenditures are captured on a routine basis. This calls for the institutionalisation of NASA in the Monitoring and Evaluation (M&E) framework being coordinated by the HIV/AIDS STI Control Board. NASA information and reporting can be integrated into the existing mechanism for monitoring and evaluation within the M&E framework. These processes will require standardisation of expenditure information reporting from all the various organizations.

For UN agencies and development partners

Alignment and harmonisation: To push the third point further (institutionalising NASA) there is a need to align and harmonise financial years and reporting requirements among partner organisations and stakeholders. UNAIDS/HSCB should work collaboratively with UN agencies to develop and maintain a financial reporting systems that will disaggregate HIV/AIDS disbursement and expenditure in line with the NASA spending categories classifications. This would enhance the efficient and systematic planning and monitoring of the entire disbursement process and use of funds and will simplify NASA reporting processes.

For Providers of Service

Capacity building in conducting the spending assessment: To make the spending assessment process a successful and continuing bottom-up process, donor-partners and UN agencies should consider supporting the development of a sustainable capacity building programme over the long-term for implementing HIV/AIDS service providers and stakeholders, including the HSCB on the national AIDS spending assessment process. This will be enabling for the providers including the government and HSCB and will build capacity to be effective and efficient in documenting and maintaining a record system aligned with the NASA reporting requirements. To achieve this will need mobilising the support of all stakeholders – sources, agents, and providers of services – in a concerted effort. It goes without saying, building capacity in HSCB is also essential if NASA is to be institutionalised in the HIV/AIDS programme of Nepal.

General Recommendations

National capacity in resource mobilisation: While the country has adequately engaged non-government sectors in the HIV/AIDS response as providers of services, overall resource mobilisation for the programme remains heavily dependent on multilateral agencies, which have mobilised more than half (51%) of total funds for the programme from different sources during the period covered by the assessment. Government agencies mobilised only 10% of funds. A more proactive advocacy initiative is needed to strengthen the capacity of Nepal's public and private sectors and their instrumentalities to mobilise resources and to be able to claim ownership of the programme while contributing to reduce Nepal's poverty and vulnerability as part of contribution to achievement of the Millennium Development Goals.

Proper design and targeting of the interventions: Some non-specific spending areas such as non-targeted population, unclassified programme interventions, current expenditure not disaggregated by type, among others, need further clarification to come up with realistic analysis and interpretation. Also, there is a need for properly designed and targeted interventions.

Improved financial information systems: Financial information systems need to be improved in terms of the quality and accuracy of HIV/AIDS expenditure data. In some institutions, retrieval of the required information was difficult. Some institutions provided incomplete information or information not adequate enough to assign proper NASA classification and codes. Slow or late submission of information delayed the whole process, hence the importance of strengthening the financial information and reporting systems.

Improved Reporting and Alignment for Implementers: Different financial reporting systems and reporting fiscal years among different organizations has led to the inability of many agent providers and provider NGOs to report accurately and in a timely manner on their expenditures. In addition, classification of expenses based on donor reporting requirements, (e.g., the PEPFAR indicators) has made it difficult to match expenditure to NASA classifications. This was the biggest challenge while conducting the study. Therefore, this assessment recommends that implementers link their expenditure records with outputs of activities. The NASA classification might provide a useful framework for this purpose. Undertaken on a regular basis, this will make it easier to link the reports from the implementers within the NASA, thus providing a database of comparable data over the years.

Annexes

Annex 1

List of Organisations Targeted for the Nepal National Aids Spending Assessment

The following organisations were listed for the exercise. The list includes issues related to either data received from these organisations, or to overall status of the data submitted. Obtaining data was the biggest challenge of the NASA exercise. A similar colour-coded table in Excel sheet was used to track the NASA data collection process.

Most of the organisations listed were invited for a three-day training programme on NASA. Those who attended were able to provide more accurate data according to the NASA classification than those who did not have the benefit of NASA training.

Org Type	Organisation	Data received	Issues	Comments
	ADB	No	No HIV funding at country level	
	AusAid/Regional funding	No	No direct country level funding, but has regional funding to UNODC	Information to be obtained from UNODC Country Office
SOURCES	DANIDA	No	No previous HIV spending	
	DFID	Yes	Funds transferred to agent and provider (UNDP/PMUP	Contact the agent/provider (UNDP, NCASC)
	Elton John Foundation	Yes	Information received from BDS as its Agent/Provider	
	EU	No	No HIV funding in 2007	Informed team no funding in'07
	GFATM Rd 2	Yes	UNDP and NCASC as agent/provider of GF	
	GoN ministries	Yes	For the Ministry of Labour secondary data was used	
	GTZ	Yes	No detail received, NASA classification required	
	JICA	No	No country level funding	
	Local bodies	No	Letter was sent through UNDP (DLGSP), no response received Agreed to be considered for NASA 2010	
	SDC	Yes	Fund transferred to Provider (Nepal Red cross)	Contact Nepal Red Cross
	USAID	Yes	Information received from Family Health International, AED	
	World Bank	No	No HIV funding/spending in 2007	

Org Type	Organisation	Data received	Issues	Comments
AGENTS/SOURCES	Family Health International (FHI)	Yes	NASA reclassification and grouping required. Production factor ({F)not completed - ASC proportion to be applied to get PF	
	FAO	Yes	ASC, PF, BP not mentioned	
	ILO	Yes	Full data received, reclassification required	Full data received
	IOM	No		
	KFW	Yes	Figure on condom purchased for HIV, NASA classification required	PF can be worked out if ASC and BP are identified.
	UNAIDS	Yes	Raw data received. NASA classification required	
	UNDP (core)	Yes	Information received on what was spent in 2007	
	UNDP/PMU	Yes	Data needs minor reclassification and grouping	
	UNESCO	Yes	Data needs minor reclassification and grouping	
	UNFPA	Yes	Data needs reclassification and grouping	
	UNHCR	No		
	UNICEF	Yes	Fund transferred to Provider, but no PF&BP mentioned, ASC (ok),	Minor clarification required.
	UNIFEM	No		
	UNODC	Yes	Minor reclassification and re grouping required	
	WFP	No	No HIV spending from WFP	Not applicable
	WHO	Yes	NASA reclassification and grouping required.	Some overlap with 2006 spending reported
	NCASC	Yes	Raw data (ledger copy) received, complete classification required	
	Ministry of Labour	Yes	Government allocation/spending was entered in RTS	
	Ministry of Health	Yes	Spending on Human Resources at ART, VCT, PMTCT estimated	
	Nepal Red Cross	Yes	Minor classification required	
	Action Aid Nepal	No	Was invited for NASA orientation/training	
	World Vision Nepal	Yes	Data reclassification required	
	Save the Children in Nepal	Yes	SC Norway has submitted the NASA form	
	CARE Nepal	Yes	Some data reclassification required	
	CEDPA		For NASA 2010, was invited for NASA orientation/training	
	Plan International Nepal	No	Was invited for NASA orientation/training	
	UMN	Yes	Complete data received	

Org Type	Organisation	Data received	Issues	Comments
PROVIDERS	Lutheran World Federation	Yes	No detail information, NASA classification was missing; reclassified	Was invited for NASA orientation/training
	Britain Nepal Medical Trust		No HIV spending in 2007	
	Heifer International		For NASA 2010	
	CCS Italy		For NASA 2010	
	World Education Nepal		For NASA 2010	
	VSO Nepal	No	Was invited for NASA orientation/training	
	INF		For NASA 2010	
	ADRA		For NASA 2010	
	AED	Yes		
	Blue Diamond Society	Yes		
	Nava Kiran Plus	No	Was invited for NASA orientation/training	
	Maiti Nepal	No	Was invited for NASA orientation/training	
	FPAN	Yes	Ledger data received, thorough NASA classification required	
	GWP		For NASA 2010	
	Sahara Paramarsha Kendra		For NASA 2010	
	Youth Vision Nepal	No	Was invited for NASA orientation/training	
	Private sector		For NASA 2010, but detailed methodology needs to be worked out	

Note: 1) Official request from HSCB was sent to AIN 10 July '08, in turn forwarded request to its INGO members who had HIV spending in their programmes. Some NGOs get funding directly from source outside the country 2) A follow-up letter was sent from the Board 13 Nov '08 to a number of organisations to complete the NASA forms by 23 Nov '08

Annex 2

Task Force Members

A Task Force comprising the following members was constituted at the onset of the NASA exercise. Many critical issues were discussed and decisions were taken on a number of aspects which are also discussed in the methodology section.

Name	Designation	Organization	Email	Contact Number	
Dr. Padam Bahadur Chand	Director	National Centre for HIV/ AIDS and STI Control	drchand@ncasc.gov.np ncasc@mos.com.np	9851073242	4-261-653
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Ms. Susan Clapham	Health Advisor	DFID	s-clapham@dfid.gov.uk	9851075601	5-542980
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Mr. Stephen Nyanti	Consultant	UNAIDS	sjnyanti@yahoo.com		

Annex 3

Cost Calculation for Health and Medical Professionals

The cost of spending for health and medical professionals at the peripheral facilities such as district hospitals and health centres are directly borne by the regular health budget, which is often not reflected in HIV/AIDS spending. Given the increasing volume of work in ART, VCT, and PMTCT services and the time spent by these health professionals, the consensus was to conduct a thorough cost calculation to derive this part of the expenditure on AIDS. The calculation below is based on actual costs quoted by service provider in selected centres as well as expert view on the process.

Time/Cost Calculation of Health and Medical professionals in ART, VCT, and PMTCT services

Assumptions			**Average Salary of Govt personnel (in Nepalese Rs)**						
Total working days in a year	283		**Positions**	**Salary/month**	**Salary/yr**	**PF**	**Bonus**	**Benefits**	**Total/yr**
Total working hours in a day	283		Medical Officer	16,500	198,000	19,800	16,500	200	234,500
Exchange rate used for 2007	67		Nurse/Counsellor	10,500	126,000	12,600	10,500	200	149,300
			Laboratory Asst/Tech	9,500	114,000	11,400	9,500	200	135,100
ART clients make at least three visits	3		Store keeper/Drug Dispenser	9,500	114,000	11,400	9,500	200	135,100
			Others		-	-	-		-
VCT			**PMTCT**		**Pre-test Counselling**	**Testing**	**Post test counselling**		
Average time spent on one VCT client	**Time (minutes)**	**Cost/client**	**Time spent for PMTCT clients (minutes)**						
Medical Officer	5	9.9	Medical Officer		0	0	5		
Nurse/Counsellor	30	37.7	Nurse/Counsellor		15	0	15		
Laboratory Asst/Tech	25	28.4	Laboratory Asst/Tech (incl labour room)		0	25	0		
Store/Record/keeper/Drug Dispenser	0	0.0	Store keeper/Drug Dispenser		0	0	0		
Total time per client	60	76.0	**Total time per client**		**15**	25	20		
ART/visit									
Time spent for one ART Client per visit	**Time (min)**	**Cost/client**	**Time spent by each personnel (Minutes)**						
Medical Officer	10	19.7	**PMTCT clients**		**No. of clients**	**MO**	**Nurse**	**LabT/A**	**Total**
Nurse/Counsellor	30	37.7	Pretest counselling (in group of 20) 3527		1763	0	26445	0	26445
Laboratory Asst/Tech	25	28.4	HIV test		32553	0	0	813825	813825
Store keeper/Drug Dispenser	10	11.4	Post-test counselling		23047	115235	345705	0	460940
Total time per client/visit	75	97.2	Total Cost of each personnel (Rs)			115235	372150	813825	1301210
Average visit in a year	3	291.6	**Total Cost of each personnel (US$)**			**3393.26**	**6977**	**13806.3**	**24176.5**
Follow up visits 6									

Cost of health professional spent on services			
		Total cost (Rs)	**US$**
Total VCT attendance	28103	2,134,797	31,863
Total ART clients x 3	6000	1,749,495	26,112
PMTCT		1,619,825	24,176
Total spent on three services		5,504,117	82,151

Annex 4

Production Factors by Provider

S.N.	PF Categories	Hospitals	MOHP (NAPs/ NACPs)	MOLT	MOAgric	CSOs	CSOs (Faith based)	Non-Profit Orgs	Multi-lateral Agencies	Total	%
1	Wages	82,151	1,171,902			3,701,977	1,303,195	37,813	225,248	6,522,286	36.9
2	Social contributions					56,317		1,935		58,252	0.3
3	Non-wage labour income		69,456					2,147		71,603	0.4
4	Labour income not disaggregated by type							1,779		1,779	0.0
5	Antiretrovirals					270,018				270,018	1.5
6	Other drugs and pharmaceuticals		149,249			562,726			51,064	763,039	4.3
7	Medical and surgical supplies		47,791			86,794		439	61,842	196,866	1.1
8	Condoms		37,313			60,398				97,711	0.6
9	Reagents and materials		26,273			153,009		3,940		183,222	1.0
10	Food and nutrients					209,628		3,274		212,902	1.2
11	Material supplies not disaggregated by type		231,203			88,541	4,899	6,671	54,161	385,475	2.2
12	Other material supplies n.e.c.		31,897			77,473	5,072	5,700		120,142	0.7
13	Administrative services		15,788			165,550	366,357	7,923		555,618	3.1
14	Maintenance and repair services		23,074			26,511		865		50,450	0.3
15	Basic health care packages purchased on behalf of key population at higher risk		7,683					3,063		10,746	0.1
16	Family/home support							16,866		16,866	0.1
17	Publisher- motion picture- broadcasting and programming		39,327			1,295		8,782		49,404	0.3
18	Recurrent training in medical, paramedical, social care and related establishments		30,555			5,000		224		35,779	0.2
19	Consulting services		31,383			649,080	186,024	2,312		868,799	4.9
20	Transportation and travel services		34,228			546,833	128,850	5,542	966	716,419	4.1
21	Housing services					267,750	4,822	3,371		275,943	1.6
22	Transaction costs/financial intermediation services		510			2,967				3,477	0.0

S.N.	PF Categories	Hospitals	MOHP (NAPs/ NACPs)	MOLT	MOAgric	CSOs	CSOs (Faith based)	Non-Profit Orgs	Multi-lateral Agencies	Total	%
23	Services not disaggregated by type		20,883			801,287	872,180	13,419		1,707,769	9.7
24	Services n.e.c.					213,147		23,495		236,642	1.3
25	Current expenditures not disaggregated by type		139,609	2,985	2,800	994,255	2,414,127	2,993	37,415	3,594,184	20.4
26	Current expenditures n.e.c.					26,638	179,060	12,514		218,212	1.2
27	Laboratory and other infrastructure upgrading		74,627							74,627	0.4
28	Other buildings n.e.c.					8,223				8,223	0.0
29	Vehicles		8,268			9,942	16,748			34,958	0.2
30	Information technology (hardware and software)		56,163							56,163	0.3
31	Laboratory and other medical equipments					953		120		1,073	0.0
32	Other equipment n.e.c.					194,909	38,542	6,611		240,062	1.4
33	Capital expenditure not disaggregated by type					10,652		2,779		13,431	0.1
34	Capital expenditure n.e.c.							757		757	0.0
35	Production factors not disaggregated by type					3,419	3,089	2,210		8,718	0.0
	Grand Total	**82,151**	**2,247,182**	**2,985**	**2,800**	**9,195,292**	**5,522,965**	**177,544**	**430,696**	**17,661,615**	**100.0**
(In US$)											

Annex 5

Source, Agent, and Providers in the NASA Report Tracking System

RTS #	Source	Agent	Provider	Disbursed (US$)	Expense (US$)	Difference	Absorption rate (%)
1	Royal Norwegian Embassy	Save the Children Norway	NGO	128,570.00	128,570.00	-	100.00
2	Vass New Zealand	Save the Children Norway	NGO	44,286.00	44,286.00	-	100.00
3	Save the Children Fund UK	Save the Children Norway	NGO	98,572.00	98,572.00	-	100.00
4	Elton John Foundation	BDS	BDS	47,086.00	39,538.00	7,548.00	83.97
5	SIDACTION	BDS	BDS	22,413.00	22,413.00	-	100.00
6	USAID	Aed/N.MARC	NGO	1,768,409.00	1,365,043.00	403,366.00	77.19
7	USAID	ILO	NGO	125,387.00	100,473.00	24,914.00	80.13
8	ILO	ILO	NGO	12,000.00	11,555.00	445.00	96.29
9	World Vision Support Office	World Vision Support Office	World Vision Nepal	111,467.00	106,072.00	5,395.00	95.16
10	UNDP	UNDP	NGO	82,606.00	82,606.00	-	100.00
11	UNFPA -HQ (Regular)	UNFPA	NGO	25,000.00	6,074.00	18,926.00	24.30
12	UNFPA (UBW)	UNFPA	NGO	40,500.00	38,190.00	2,310.00	94.30
13	UNODC HIV/AIDS Unit	UNODC	NGO	134,800.00	165,089.00	(30,289.00)	122.47
14	AusAid	UNODC	NGO	541,363.00	580,116.00	(38,753.00)	107.16
15	SIDA	Nepal Red Cross Society	Nepal Red Cross Society	330,508.00	330,558.00	(50.00)	100.02
16	Norwegian Red Cross	Nepal Red Cross Society	Nepal Red Cross Society	133,790.00	133,790.00	-	100.00
17	Swiss Red Cross	Nepal Red Cross Society	Nepal Red Cross Society	56,219.00	56,219.00	-	100.00
18	German National Committee	UNICEF	NGO	28,802.00	28,553.00	249.00	99.14
19	Swedish National Committee	UNICEF	NGO	22,146.00	22,348.00	(202.00)	100.91
20	USAID	UNICEF	NGO	176,051.00	127,002.00	49,049.00	72.14
21	UNAIDS	UNICEF	NGO	152,695.00	98,303.00	54,392.00	64.38
22	Thematic Funds-Various donors in one basket	UNICEF	NGO	269,597.00	231,534.00	38,063.00	85.88
23	UNICEF Regular Resource	UNICEF	NGO	37,798.00	32,159.00	5,639.00	85.08
24	Japanese Trust Fund	FPAN	FPAN	73,809.00	65,452.00	8,357.00	88.68
25	Central Government (Nepal)	Department of Health Service	District Public Health Office	82,151.00	82,151.00	-	100.00

RTS #	Source	Agent	Provider	Disbursed (US$)	Expense (US$)	Difference	Absorption rate (%)
26	Church Of Scotland	UMN	UMN	31,997.00	32,463.00	(466.00)	101.46
27	PMU Interlife	UMN	UMN	21,022.00	21,419.00	(397.00)	101.89
28	ICCO	UMN	UMN	3,179.00	3,880.00	(701.00)	122.05
29	Central Government (Nepal)	Ministry of Labour & Transport Management	Ministry of Labour & Transport Management	2,985.00	2,985.00		100.00
30	Global Fund	NCASC	NCASC	1,108,984.00	837,212.00	271,772.00	75.49
31	DFID	Ministry of Health and Population	NCASC	560,661.00	84,252.00	476,409.00	15.03
32	DFID	UNDP	NGO	6,448,640.00	3,854,599.00	2,594,041.00	59.77
33	UNAIDS	UNAIDS	NGO	485,186.00	277,752.00	207,434.00	57.25
34	UNAIDS	UNAIDS	NGO	41,946.00	19,648.00	22,298.00	46.84
35	Ministry of Finance	NCASC	NCASC	532,551.00	532,551.00	-	100.00
36	European Union	CARE Nepal	CARE-Nepal	61,000.00	50,314.00	10,686.00	82.48
37	Care Germany	CARE Nepal	CARE-Nepal	21,000.00	16,328.00	4,672.00	77.75
38	USAID	CARE Nepal	CARE-Nepal	21,000.00	18,000.00	3,000.00	85.71
39	IPPF	IPPF	FPAN	275,361.00	257,104.00	18,257.00	93.37
40	Global Fund	UNDP	NGO	2,522,085.00	1,791,330.00	730,755.00	71.03
41	WHO Voluntary Contribution	WHO	WHO	417,111.00	417,111.00	-	100.00
42	AVON/IPPF	FPAN	FPAN	2,122.00	1,350.00	772.00	63.62
43	WHO Accessed Contribution	WHO	NCASC	121,524.00	121,524.00	-	100.00
44	Lutheran World Federation	Lutheran World Federation	NGO	75,038.00	75,038.00	-	100.00
45	Government of Germany	GTZ	NCASC	634,328.00	634,328.00	-	100.00
46	William and Flora Hewlett Foundation	FPAN	FPAN	4,004.00	4,014.00	(10.00)	100.25
47	USAID/ASHA Project	FHI	NGO	3,896,428.00	3,807,755.00	88,673.00	97.72
48	DFID	FHI	NGO	395,142.00	400,851.00	(5,709.00)	101.44
49	USAID/IMPACT	FHI	NGO	329,482.00	329,481.00	1.00	100.00
50	Government of Germany	KFW	MOHP/KFW	37,313.00	37,313.00	-	100.00
51	Japanese Trust Fund (JTF)	UNESCO	UNESCO	13,585.00	13,585.00	-	100.00
52	UNAIDS	FAO	NGO	61,500.00	20,000.00	41,500.00	32.52
53	FAO	FAO	Ministry of Agriculture	10,000.00	2,800.00	7,200.00	28.00
	Total			**22,681,199**	**17,661,653**	**5,019,546**	**77.87**

Annex 6

NASA Task Force TOR

Government of Nepal
HIV/AIDS and STI Control Board
in collaboration with NCASC and UNAIDS

Comprehensive National AIDS Spending Assessment (NASA) in Nepal

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The overall objective of the full Nepal National AIDS Spending Assessment (NASA) is to review spending on AIDS (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 NASA Task Force 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 the Semi-autonomous entity with close collaboration with the Director of the National Centre for AIDS and STD Control.

The NASA taskforce 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 two staff from the HSCB and National Centre for AIDS and STD Control (NCASC) who have received training on NASA methodology.

The taskforce and consultants will keep the HSCB and NCASC Director and UNAIDS UCC and Technical Adviser, M&E regularly 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 task include

1. Oversee the NASA development process
   - Ensure timely accomplishment of all tasks
   - Keep the momentum going all the time until the task is finished
2. Coordination with stakeholders
   - Participate in committee meetings and consultations
   - Link NASA to policy issues
   - Provide suggestion to ensure all relevant and key stakeholders contribute and are involved in the process.
   - Define process, limitations and thresholds (e.g., spending threshold to be included or not?)

3. **Facilitate data collection process**
    - Support the review of data collection forms for Nepal context
    - Troubleshoot and help facilitate data collection 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, cross country comparisons and data generalisations)
    - Help identify system and policy related information

5. **Support development of documents, policy brief, press release, presentation, facts sheets, etc (e.g. report is in consultant brief and TORs)**
    - Review and provide contributions and inputs to the writing of the final NASA report
    - Advise formulation of appropriate documents for different audiences

6. **Technical advice to the HSCB/NCASC and support for the dissemination of NASA results (as appropriate). This may include following**
    - Dissemination of findings at National level, Regional level (this events can be combined with other national and regional level activities i.e., UNGASS sharing, NAP sharing or consultation)
    - Press briefings

NASA taskforce membership profile

The task team will consist of representatives from Public, Private (including I/NGOs, profit and not for profit organisations) and Donor community. Ideally, the professionals on the Task Force should have broad understanding of Health Accounts or other Social Accounts; good contacts throughout the health system (both public and private); knowledge of key HIV/AIDS programme areas and issues, actors including partners from other sectors and spending potentials/units; analytical and facilitation skills; and able to devote adequate time to this national process.Annex 7

Annex 7

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. **FA: 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.

Annex 8

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Annex 9

List of Contributors

Many organisations and individuals contributed in many different ways and in different stages of progress of the NASA process. We would like to acknowledge them for their contributions.

Names	Organisation
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Mr. Kabindra Subba	DFID
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Dr. Padam Bahadur Chand	Ministry of Health and Population
Mr. Yogendra Gauchan	Ministry of Health and Population
Mr. Bishnu Lamsal	Ministry of Labour and Transport Management
Mr. Purna Chabdara Bhattrai	Ministry of Local Development
Ms. Upendra Adhikary	Ministry of Women, Children and Social Welfare
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Mr. Jan Marcus Hellstrom	UNAIDS
Mr. Jagdish Dhakal	UNAIDS
Ms. Anastasiya Nitsoy	UNAIDS HQ (one week onsite support)
Mr. Christian Aren	UNAIDS HQ (through email, direct meetings)
Mr. Dejan Loncar	UNAIDS HQ (through email, direct meetings)
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