



FEDERAL GOVERNMENT OF NIGERIA

**NATIONAL AIDS SPENDING ASSESSMENT
(NASA)
FOR THE PERIOD: 2009-2010**

**LEVEL AND FLOW OF RESOURCES AND EXPENDITURES
OF THE NATIONAL HIV AND AIDS RESPONSE**



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Foreword

The National AIDS Spending Assessment (NASA) is a comprehensive and systematic resource tracking method that describes the financial flow, actual disbursements and expenditures for HIV/AIDS by identifying financing sources (who finances the AIDS response), agents (who manages the funds), service providers and beneficiary populations.

The first National AIDS Spending Assessment (NASA) was conducted in 2009 covering the period of 2007 and 2008, to address the challenges of inadequate information on HIV/AIDS expenditure. The gains of the first NASA led the National Agency for the Control of AIDS (NACA) in collaboration with UNAIDS, ENR Programme, PEPFAR and other development partners to conduct NASA 2009 and 2010.

This document describes the HIV/AIDS financial flow and expenditure for both health and non-health in Nigeria for the period of 2009 and 2010 according to three dimensions and six vectors. The NASA dimensions are: Financing, Provision and Use. Financing has funding sources (FS) and financing agents (FA) as vectors, Provision has providers of HIV/AIDS services (PS) and production factor (PF) while Use has AIDS spending categories (ASC) and intended beneficiary population (BP).

The conduct of NASA 2009 and 2010 has given estimates on the expenditures of the public and private sectors and the international donors on the national HIV/AIDS response as well as the amounts spent on prevention activities, care and treatment, orphans and vulnerable children (OVC), human resources and HIV/AIDS research.

Findings from the study will be used to monitor the implementation of the National Strategic Plan, and provide useful information towards the completion of international and national reporting obligations. This report is a significant tool for in-country policy and evidence-based decision making.

I, therefore, recommend this as a reference document to all the stakeholders in the national HIV and AIDS response.

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I wish to acknowledge the NASA national steering committee for their untiring support, the HIV/AIDS division of the Federal ministry of Health, members of the M&E technical working group, Ministries, Departments and Agencies that availed the NASA process with data.

I wish to appreciate the PEPFAR coordinator, for going the extra mile to ensure PEPFAR implementing partners turn in data for the study.

Finally, I wish to thank the NASA core team for the technical support that made this study possible, the strategic knowledge management and resource mobilization departments for their immense contributions and support.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASC	AIDS spending category
BCC	Behavioral Change
BP	Beneficiary population
CBO	Community-based Organization
CD4	Cluster of Differentiation 4
CDC	Centers for Disease Control
CHEW	Community Health Extension Worker
CSO	Civil Society Organization
CSS	Care and Support Services
DFID	Department for International Development (United Kingdom)
FA	Financing agent
FBO	Faith-based Organization
FGN	Federal Government of Nigeria
FS	Financing source
FTE	Full-time Equivalent
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB, Malaria
HAPSAT	HIV/AIDS Program Sustainability Analysis Tool
HIV	Human Immunodeficiency Virus
HR	Human resources
IEC	Information, Education, Communication
JICA	Japan International Co-operation Agency
JSI	John Snow International
ILO	International Labor Organization
MAP	Multi-country HIV/AIDS Programme (World Bank)
MoH	Ministry of Health
NACA	National Agency for the Control of AIDS
NASA	National AIDS Spending Assessment
NASCP	National AIDS and STI Control Programme
NGO	Nongovernmental Organization
NHA	National Health Accounts

OI	Opportunistic Infections
OPP	Out of Pocket expenditure
OVC	Orphans and Vulnerable Children
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
PHDP	Positive Health Diagnostic and Prevention
PMTCT	Prevention of Mother-to-Child Transmission
PS	Provider of HIV/AIDS service
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on HIV/AIDS
USD	US Dollar
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Definition of terms

AIDS Spending Category (ASC) – it is the broad categories to which the assessment assigns expenditure on HIV and AIDS. Any expenditure captured has to be for a function / an ASC (used interchangeably). The basic 8 ASCs or functions are defined below.

Beneficiary Population: The populations presented here are explicitly targeted or intended to benefit from specific activities, e.g. the intended recipients of the various services. The identification of the beneficiary population (BP) is aimed at quantifying the resources specifically allocated to a population as part of the service delivery process of a programmatic intervention. The BP will be selected according to the intention or target of the expenditure in such programmatic intervention. This represents an outcome linked to the resources spent, regardless of its effectiveness or effective coverage.

Capital expenditure: The main categories of the classification features are buildings, capital equipment and capital transfers. These categories may include major renovation, reconstruction or enlargement of existing fixed assets, as these interventions can improve and extend the previously expected service life of the asset.

Capital transfers to providers: Are considered as a governmental provision of assets without receiving in return any form of good, asset or service.

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

Civil Society Organization (CSO): The formal and informal networks and organizations that is active in the public sphere between the state and family. They include a wider range of associate forms such as trade Unions, churches, cooperatives, professional associations and informal community-based groups

Current Expenditures: Refers to the total value of the resources in cash or in kind, payable to a health provider by a financing agent on behalf of the final consumer of health services in return for services performed (including the delivery of goods) during the year of the assessment.

Direct bilateral contributions: Allocations as grant or non-reimbursable financial cooperation that higher per capita income countries provide to recipient countries directly, either as earmarked contributions or nonearmarked contributions, e.g. budget support directly to the treasury of recipient countries.

Financing Agent: Institutions that take programmatic decisions on the use of the funds.

The programmatic decisions are the goods and services that the fund will be used for, the provider of the goods and services and the beneficiary population of the goods and services.

Financing Sources: Entities that provide money to financing agents to be pooled and distributed for HIV goods and services.

Foreign for-profit entities: For-profit entities whose home base or headquarters are located outside of the country where the services, or goods, are being provided, including among others, multinational pharmaceutical and biotechnology companies.

HIV and AIDS- related research– generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect, and improve the population's development and the people's well-being.

Human Capital– the expenditure on health care workers and managers who work in the HIV and AIDS field through their recruitment, retention, deployment and rewarding of quality performance.

International Funds: Resources originating from outside the country and executed in the current year. Bilateral and multilateral international grants as well as funds contributed by institutions and individuals outside the country are included to the extent that they are used in the current period. The terminology used by the specialists of NHA is “Rest of the world”.

Multilateral Agencies: International Public or public/private organizations, institutions or Agencies which receive contributions from donor countries and from other sources, thus multilateral funding is a mechanism whereby assistance investments are pooled by different donors and granted in not necessarily one-to-one relationships between donor and recipient countries. This usually occurs via international agencies within the UN system, development banks. The GFATM is a private/public multilateral organization

Non-Governmental Organization (NGO): Organizations separate from the state that usually value-based, nonprofit and established to benefit others.

Out of Pocket Expenses– it is expenditure carried out by households and individuals to get services related to HIV and AIDS. For example, household income spent on treatment and care services and pooled funds of support groups to provide support.

Prevention– set of activities or programmes designed to reduce risky behavior. Results include a decrease in HIV infections among the population and improvements in the quality and safety in health facilities in regard of therapies administered to HIV and AIDS patients.

Programme Management and Administration Strengthening– expenses that are incurred at administrative levels outside the point of health care delivery e.g. M&E, management of AIDS programmes, facility upgrading through purchases of laboratory equipment and of telecommunications, etc.

Provider: The provider of services is contracted by the financing agent for the provision of specific services. The provider will decide on the best way to produce this services (even subcontracting) but will remain as the responsible for the production and delivery

Public Funds: All bodies of territorial governments, i.e. departments and establishments—central, state or local—that engage in a wide range of activities such as administration, defense, health, education and other social services, promotion of economic growth and welfare, and technological development.

Social contributions: Includes social contributions received by health personnel. Exceptions include employers’ social contributions, in-kind payments of supplies and services required for work, and payments made to non-active workers.

Social Protection and Social Services– 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.

Supplies and services: Consists of all goods and subcontracted services used as inputs in production of health services. This category includes goods that are entirely used up when they are fed into the production process, during which they deteriorate or are lost, accidentally damaged or pilfered. Such goods include inexpensive durable goods, for example hand tools, and goods that are cheaper than machinery and equipment. The category also includes tools used exclusively or mainly at work, for example clothing or footwear worn exclusively or mainly at work (such as protective clothes and uniforms). One of the most important types of supplies is pharmaceuticals..

Wages: Includes all kinds of wages, salaries, and other forms of compensation, including extra payments of any nature, such as payments for overtime or night work, bonuses, various allowances and annual holidays. In-kind payments include meals, drinks, travel, special clothing, transportation to and from work, car parking, day-care for children, and the value of interest forgone when loans are provided at nil—or reduced—interest rate. Also included are payments to recruit or retain workers (health or else) in providing HIV or AIDS services

Basic Fact sheet on Nigeria HIV and AIDS Expenditure for the period 2009-2010

	2009		2010	
	Amount(USD)	%	Amount(USD)	%
HIV and AIDS Expenditure by Funding Sources				
Total Spending	415,287,430.00		496,917,471.00	
Public	97,790,519.00	23.55	125,139,587.00	25.18
Private Funds*:	278,303.00	0.07	850,547.00	0.17
International	317,218,608.00	76.39	370,927,337.00	74.65
HIV and AIDS Expenditure by Financing Agent				
Public	98,073,517.00	23.62	125,294,375.00	25.21
Private	4,256,866.00	1.03	26,774,251.00	5.39
International	312,957,047.00	75.36	344,848,845.00	69.40
HIV and AIDS Expenditure by Service Provider				
Public Providers	140,782,985.00	33.90	177,719,983.00	35.76
Private Non-Profit	269,069,366.00	64.79	302,395,926.00	60.85
Bilateral and Multilaterals	5,435,079.00	1.31	16,801,562.00	3.38
Rest of the world providers	0.00	0.0	0.00	0.0
HIV and AIDS Expenditure by Programmatic Area				
Prevention	36,184,378.00	8.71	61,877,789.00	12.45
Care and treatment	204,304,508.00	49.20	186,032,729.00	37.44
OVC activities	9,099,704.00	2.19	7,118,795.00	1.43
Program management activities	77,212,683.00	18.59	121,831,097.00	24.52
Human resources	84,989,602.00	20.47	95,919,210.00	19.30
Social protection and social services	83,718.00	0.02	183,189.00	0.04
Enabling environment	2,679,626.00	0.65	21,870,065.00	4.40
Research activities	733,211.00	0.18	2,084,597.00	0.42
HIV and Expenditure by Beneficiary				
People Living with HIV	207,110,810.00	49.87	187,424,838.00	37.72
Most at risk populations	378,255.00	0.09	557,700.00	0.11
Other key populations	20,332,659.00	4.90	22,744,908.00	4.58
Specific" accessible" populations	1,130,254.00	0.27	3,118,459.00	0.63
General Population	23,452,982.00	5.65	62,125,892.00	12.50
Non-targeted interventions	162,882,470.00	38.41	220,787,650.00	44.43
Specific targeted populations not elsewhere classified	0	0.0	158,024.00	0.03
Out of Pocket Expenditure				
	170,634,393		202,290,739	

Executive Summary

The national HIV prevalence reduced to 4.1% in 2010 from the 2008 figure of 4.6%. The key drivers of the HIV epidemic in Nigeria are the low risk heterosexuals in a marriage setting or co-habiting, casual heterosexual and their partners. The National Strategic plan (NSP) 2010-2015 priority is to reposition HIV prevention as the centerpiece of the national HIV/AIDS response. In the spirit of the “three ones” principles of one agreed framework, one coordinating body and one monitoring and evaluation system, National Agency for the Control of AIDS (NACA) has one of its mandates to mobilize resources (local and foreign) and coordinate equitable application for HIV/AIDS activities. NACA in an attempt to strengthen national assessments of AIDS-related spending in Nigeria conducted the 2009 and 2010 National AIDS Spending assessment (NASA). This is a second survey after the first one in 2009 which covered 2007 and 2008. The objective is to track the allocation of HIV and AIDS funds, from their origin down to the end point of service delivery, among the different financing sources (public, private or external) and among the different providers and beneficiaries (target groups). The key issue addressed by this NASA study was what was actually disbursed and spent in each component of the multi-sectorial HIV and AIDS response and the allocation of AIDS spending in relation to the objectives and targets of the National HIV/AIDS Strategic framework and Plan. NASA describes the flow of resources from their origin down to the beneficiary populations. The financial flows for the national HIV response are grouped in three dimensions: finance, provision and consumption. Expenditures are reconciled from these three dimensions using data triangulation. A mapping of all institutions involved in the HIV/AIDS response was carried out followed by a desk review of key National policy documents, programme documentation and available budgetary and expenditure reports for the period 2009-2010. Cascaded training was held at national and state levels and a standard NASA questionnaires adjusted to suit the country context was sent to all identified institutions. All the information obtained/collected was verified as far as possible, to ensure the validity of data from the records of the source, the agents and the providers and also to avoid double counting. The data processing was done using the resource tracking module of NASA Excel files and NASA Resource Tracking Software (RTS) followed by data analysis and triangulation to establish the level and proportion of funding from different sources. The data validation was done in four stages for accuracy and consistency by the core team, UNAIDS international Technical consultant, individual institutions and the national HIV/AIDS Stakeholders. The limitations of the assessment were limited data from private sector and state level expenditure in only 10 States.

Main Findings

There had been an increased funding for HIV and AIDS national response in Nigeria from \$299,246,295.00 in 2007 to \$496,917,471.00 in 2010. The HIV spending by Government in 2010 increased by 73% from the 2007 figure (\$73,203,526.00). However, the funding for the implementation of the vast majority of HIV/AIDS goods and services was heavily dependent on international funds (76.3% and 75.0% in 2009 and 2010 respectively) with the direct bilateral contribution accounting for majority of the funds. The programmatic decisions (type of goods and services to purchase, service providers and beneficiary population) for the HIV/AIDS response in Nigeria in 2009 and 2010 was taken by the International/purchasing Organizations (75.4% and 69.4% in 2009 and 2010 respectively).

The provision of HIV goods and services to the national response was mainly through the private sector which accounted for 65.0% of the services provided in 2009 and 61.0% in 2010. The bilateral and multilateral entities provided minimal services in both years. The AIDS spending categories (HIV goods and services) in 2009 and 2010 was mainly on care and treatment. Only 8.7% and 12.5% in 2009 and 2010 respectively of the total expenditure was

on prevention. The major beneficiaries of the HIV/AIDS response in Nigeria in 2009 and 2010 were the people living with HIV/AIDS (50.0% in 2009 and 38.0% in 2010).

Conclusions and Recommendations

The public sector funding increased substantially in 2010 by 73% from the 2007 figure. However, the proportion of this fund to the overall funding was still minimal. International funding is still the main source of funds for the national response. The coordination mechanism of NACA with the private sector requires strengthening. The funding for HIV and AIDS Care and treatment outpaced that for other interventions.

One major limitation of the study was the inability to undertake a comprehensive assessment of private sector and all States of the Federation funding. Waivers on HIV goods by the government were not tracked.

The key recommendations from this study are centered on the need to institutionalize NASA instead of adhoc surveys, improved public sector funding for sustainability and improved stakeholders coordination platform by NACA for coordination, planning, advocacy, resource mobilization, evaluation and accountability.

1 Introduction

1.1 HIV and AIDS Epidemic

1.1.1 Global/Regional Epidemic

In 2009, there were an estimated 2.6 million [2.3 million–2.8 million] people who became newly infected with HIV. This is nearly one fifth (19%) fewer than the 3.1 million [2.9 million–3.4 million] people newly infected in 1999, and more than one fifth (21%) fewer than the estimated 3.2 million [3.0 million–3.5 million] in 1997, the year in which annual new infections peaked.

In 2009 alone, 1.2 million people received HIV antiretroviral therapy for the first time—an increase in the number of people receiving treatment of 30% in a single year. Overall, the number of people receiving therapy has grown 13-fold, more than five million people in low- and middle-income countries since 2004. Expanding access to treatment has contributed to a 19% decline in deaths among people living with HIV between 2004 and 2009. Efforts are now underway for Treatment 2.0, a new approach to simplify the way HIV treatment is currently provided and to scale up access to life-saving medicines. Using a combination of efforts, this new approach could bring down treatment costs, make treatment regimens simpler and smarter, reduce the burden on health systems, and improve the quality of life for people living with HIV and their families. Modeling suggests that, compared with current treatment approaches, Treatment 2.0 could avert an additional 10 million deaths by 2025.

In 33 countries, the HIV incidence has fallen by more than 25% between 2001 and 2009 (Figure. 2.2); 22 of these countries are in sub-Saharan Africa. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million [1.6 million–2.0 million] people became infected in 2009; considerably lower than the estimated 2.2 million [1.9 million–2.4 million] people in sub-Saharan Africa newly infected with HIV in 2001. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics. The biggest epidemics in sub-Saharan Africa—Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe—have either stabilized or are showing signs of decline.¹

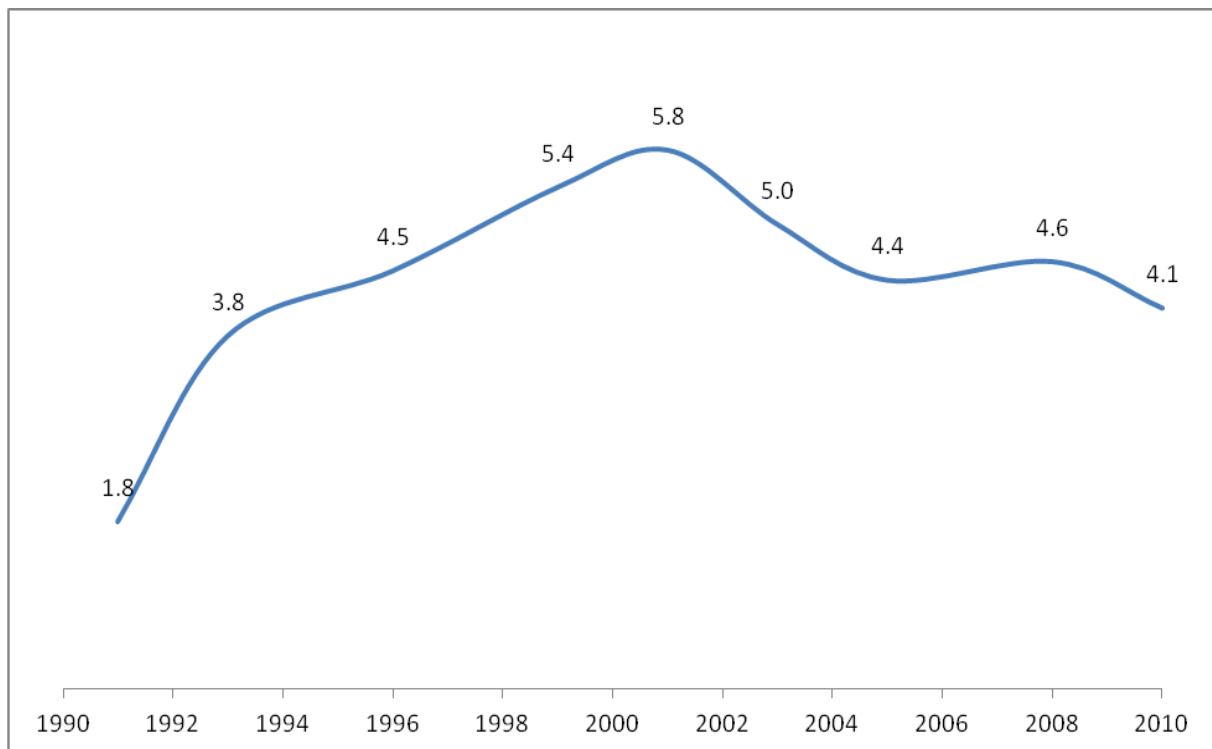
1.1.2 National Status of the Epidemic

There was a declining trend of HIV prevalence in Nigeria as reported from 5.8% in 2001 through 5% in 2003 to 4.4% in 2005. However, the national prevalence seemed to stabilize between 2005 and 2010 as shown below by the reported prevalence - 4.4% (2005), 4.6% (2008) and 4.1% (2010). While six States showed a consistent downward trend between 2005 and 2010, eight States showed a consistent rise. Other States showed no consistency in trend. Trend analysis of HIV prevalence among youths 15-24 years showed a consistent decline from 2001 to 2010 (i.e. from 6.0% (2001), through 5.3% (2003), 4.3% (2005), 4.2% (2008) to 4.1% (2010).²

¹UNAIDS(2010):Report on global AIDS epidemic

²FMOH(2010):National HIV sero-prevalence sentinel survey

Figure 1: National HIV Prevalence between 1991-2010



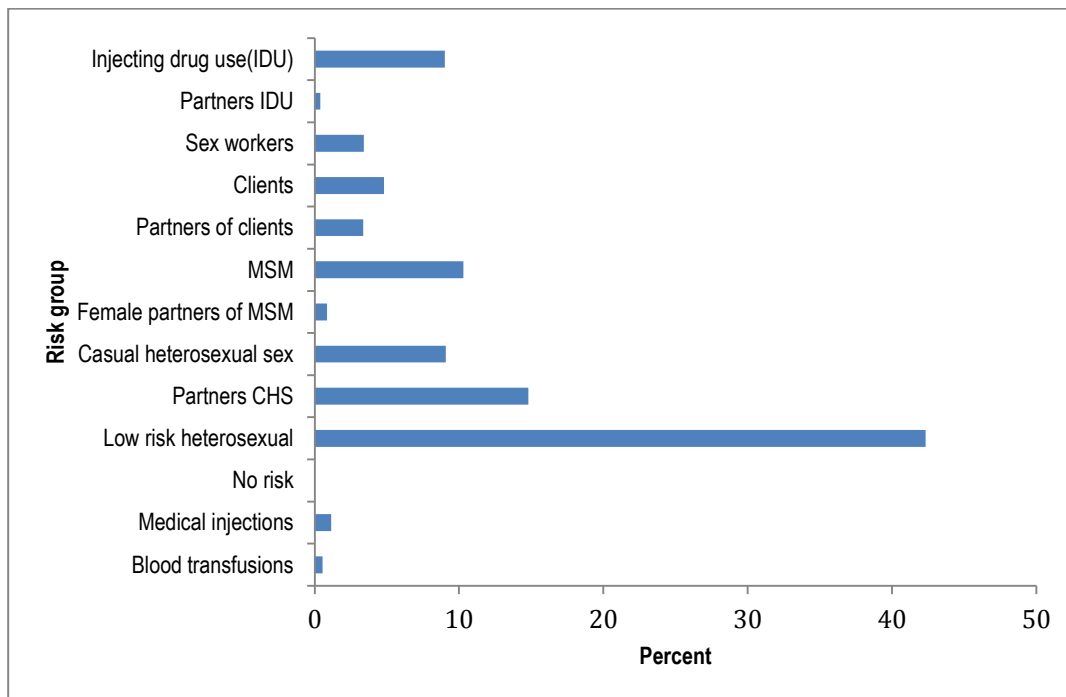
Source: 2010 ANC report

The 2010 ANC report revealed a national HIV prevalence of 4.1%. The prevalence ranged from 1.0% in Kebbi State to 12.7% in Benue State. A total of 16 States and FCT had prevalence above 5%. Five of the six States in the South South Zone, three of the five in the South East Zone, five of the seven in North Central Zone, two of the six in North East Zone, and one of the six in South West Zone had prevalence of 5% and above. The three States with the highest rates were Benue, Akwa Ibom and Bayelsa. The prevalence was generally higher in urban than rural areas except in eight States, namely Benue, Adamawa, Kaduna, Akwa Ibom, Yobe, Jigawa, Kebbi and Ondo where the reverse was the case. The highest site prevalence of 21.3% in the country was reported in Wannune (Benue State) while the lowest prevalence of 0.0% was reported in four sites, namely Kwami (Gombe State), Rano (Kano State), Owhelogbo (Delta State) and Ganawuri (Plateau State).

The prevalence rose with increasing age-group and peaked at age 30-34 years (5.7%) after which it declined. A higher HIV prevalence among singles than married was observed. Based on the overall national prevalence of 4.1% obtained in this survey, it is estimated that 3.1 million people in Nigeria are living with HIV/AIDS in 2010. Of these people, about 1.5 million require ARV drugs.

Key drivers of the HIV epidemic in Nigeria include: low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of healthcare services. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection

Figure 2: Distribution of new infections by mode of exposures



Source: Modes of HIV transmission in Nigeria, 2009

The NACA commissioned HIV sexual transmission study analysis of 2008 showed that 62% of new infections occurred among persons perceived as practicing “low risk sex” in the general population including married sexual partners. The rest (38%) of the new infections is attributable to persons practicing high risk sex” including injecting drug users (IDUs), female sex workers (FSWs), and men who have sex with men (MSM) and their partners who constitute about 3.5% of the adult population.³

The leading route of HIV transmission in Nigeria is heterosexual intercourse, accounting for over 80 percent of the infections. Mother-to-child transmission and transfusion of infected blood and blood products are generally estimated as ranking next as common routes of infection; arguably, each of these two are believed to account for almost ten percent of infections. However, other modes of transmission such as intravenous drug use and same-sex intercourse are slowly growing in importance.

1.1.3 Nigeria National Strategic plan 2010-2015

The NSP 2010-15 is the third in a series of national HIV/AIDS strategic plans which started with the HIV/AIDS Emergency Action Plan (HEAP) 2001-04. Gains from the Emergency Plan informed the development of the second HIV/AIDS Strategic Plan, the National Strategic Framework (NSF) 2005-09, which ushered in a period of significant scale-up of HIV/AIDS services especially access to HIV treatment. This NSP 2010-2015 is six years long and is coterminous with two important international commitments that Nigeria has signed on especially the Millennium Development Goals and the Universal Access (UA) to HIV/AIDS prevention and care and treatment services. The overarching priority of the NSP 2010-15 is to reposition HIV prevention as the centerpiece of the national HIV/AIDS response.⁴ Thus greater focus will be placed on scaling-up HIV prevention services that enable individuals to maintain their HIV negative status as well as improve access to quality treatment and care services for PLHIV including positive health, dignity and prevention (PHDP) interventions that reduce their transmitting HIV to others.

The key HIV/AIDS thematic areas of the NSP 2010-15 correspond to the thematic areas identified by the

³UNAIDS(2008):Mode of HIV transmission in Nigeria

⁴NACA(2010):Nigeria National strategic plan 2010-2015

National HIV/AIDS Policy 2010-15. Gender issues related to the various thematic areas are addressed under the specific thematic activities as well as in the indicators. The thematic areas are:

1. Promotion of Behavior Change and Prevention of New HIV Infections
2. Treatment of HIV/AIDS and Related Health Conditions
3. Care and Support of PLHIV, PABA, and OVC
4. Policy, Advocacy, Human Rights, and Legal Issues
5. Institutional Architecture, Systems, Coordination, and Resourcing
6. Monitoring and Evaluation Systems comprising M&E, Research, and Knowledge Management

The NSP targets are ambitious. This conforms to the advice given by the Universal Access (UA) commitment encouraging countries to set ambitious country specific targets that can be used to plan and monitor progress towards UAs. It is also based on Nigeria's experience of increasing access to ART from near zero to 35% between 2005 and 2009 with limited resources. The targets are premised upon the commitments to secure significantly increased resources (human, material, financial, and technical) for the national HIV/AIDS response from both domestic and external sources.

A number of broad interventions have been identified as critical for the success of the NSP. They are therefore important components that must be addressed in all six HIV/AIDS thematic areas. These interventions include gender mainstreaming, advocacy at all levels, and capacity building including training and skills development, increased access to material goods, technical assistance, and sustainable funding.

1.2 The National Response to the AIDS Epidemic

1.2.1 Policy Context

The Nigeria National response is anchored in the “**three ones**” principles of one agreed framework, one coordinating body and one monitoring and evaluation system. The national response in Nigeria, in line with the country's federal constitution is coordinated through a three-tier system of administration led by the National Action Committee on AIDS (NACA), State Action Committee on AIDS (SACA), and the Local Government Action Committee on AIDS (LACA).

The National Policy on HIV/AIDS remains the corner stone and the main thrust for the renewed vision and efforts to combat the HIV/AIDS challenge. The strategies as enunciated in the National HIV/AIDS Strategic Framework and Plan are derived and designed to achieve the goals set forth by the National Policy on HIV/AIDS. The first National HIV/AIDS Strategic Plan (HEAP- HIV/AIDS Emergency Action Plan 2001-3) was developed in 2000/2001 and mainly addressed the issues of creating public awareness, at a time when the epidemic was beginning to spread in the country and when awareness, knowledge and behavior change were critical to nip the epidemic in the bud. The HEAP was reviewed in 2004/2005 at its expiration and a new National Strategic Framework for action tagged NSF 2005-9 developed, with the expectation that all stakeholders within the response will draw and derive their implementation plans from it. In December 2007, the implementation of the NSF 2005-9 was reviewed through a joint mid-term review process in collaboration with partners and stakeholders in the response with the outcome influencing the implementation in the remaining period of its life span.

The expiration of the NSF 2005-9 has provided yet another opportunity to review the National response with a view to deploy new strategies to ensure the attainment of national development goals and objectives such as the vision 20/20/20, MDGs, 7 point agenda, etc. The overall goal of the current review is to provide a framework and plan for advancing the multi-sectorial response to the epidemic in Nigeria so as to achieve effective control of the disease by reducing the number of new infections, providing equitable care and support, and mitigating the impact of the infection. Consequently the thrust of the National HIV/AIDS

Strategic Plan 2010-15 include Behavior Change and prevention of new infections while sustaining the momentum in HIV/AIDS treatment, care and support for adults and children infected and affected by the epidemic. In addition the plan aims to address gender inequality, knowledge management and research in a bid to ensure that interventions are evidence driven.⁵

The NSF 2010-15 was developed to provide guidance and ensure uniformity and consistency in the development of the strategic plans by all stakeholders including all the 36 states of the Federation and the Federal Capital Territory (FCT); Government Ministries, Departments, and Agencies (MDAs); and the Constituency Coordinating Entities of the Civil Society Organizations (CSOs) Networks. The guidance is based on and informed by the findings and recommendations of the NSF 2005-09 Response Analysis and incorporates the comments from individuals and groups.

The overarching priority of the NSF is to reposition Prevention of New HIV infections as the major focus of the national HIV/AIDS response for the National HIV/AIDS Strategic Plan (NSP) 2010-15. This will be achieved through the implementation of evidence-based behavior change communication and HIV prevention interventions; creating an enabling environment for people living with HIV (PLHIV) to reduce the transmission of HIV to others through increasing access to positive health, dignity, and prevention (PHDP) interventions; and increasing access to anti-retroviral treatment (ART) for PLHIV who are eligible for treatment.

1.2.2 Resource Mobilization for the fight against HIV and AIDS

The National Agency for the Control of AIDS (NACA)

The National Agency for the Control of AIDS (NACA) started as a committee in 2000 and transformed into an agency in February 2007 by an enabling act of the Federal republic of Nigeria. The agency is the apex institution in Nigeria's multi-sectorial HIV and AIDS response architecture, mandated to provide overall coordination of the national response and interfacing with all the stakeholders involved in the fight against HIV and AIDS in Nigeria in line with three one's principle. The agency has staff strength of 132 with seven departments and three units all reporting to the Director General.

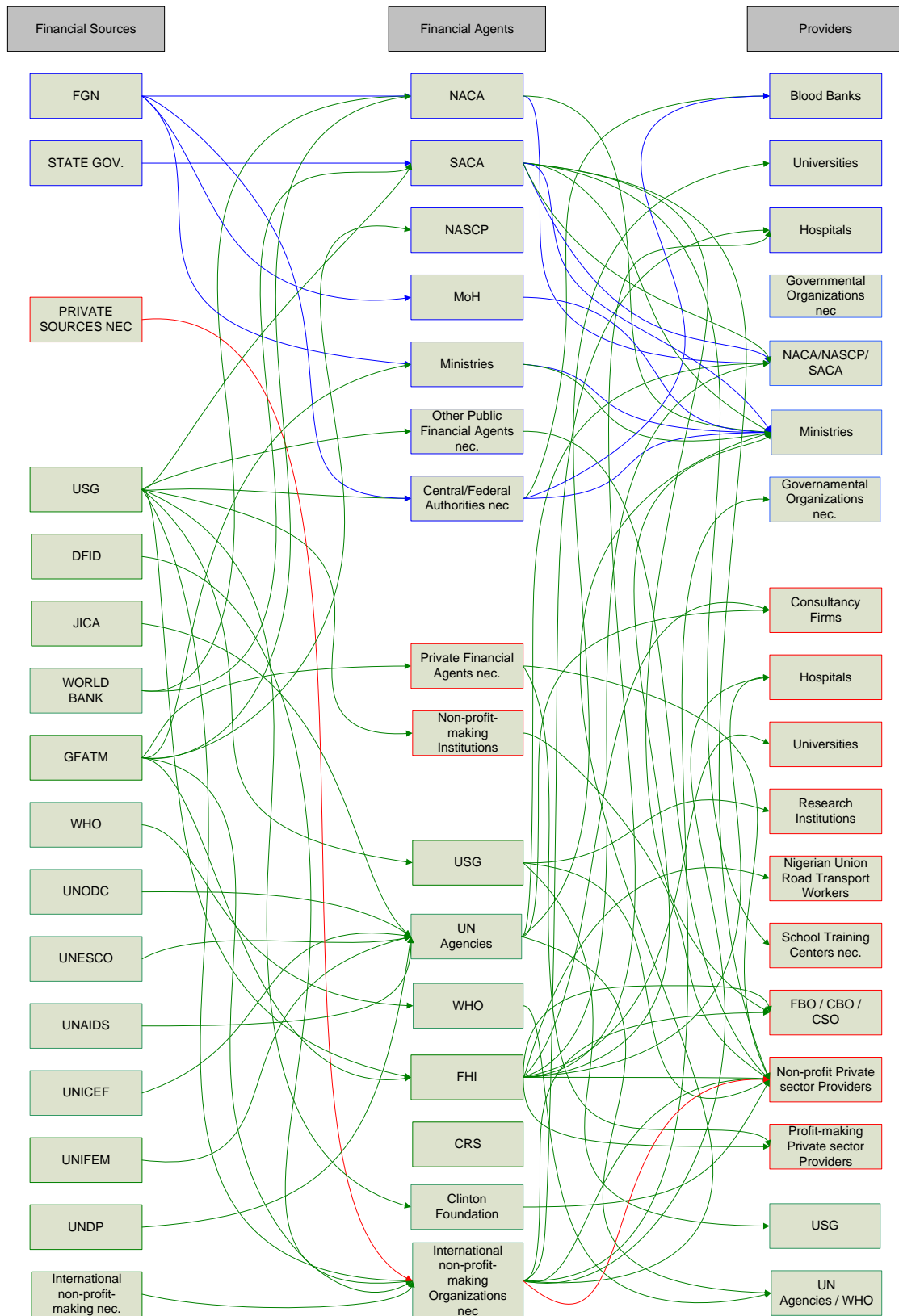
The agency has as its vision to be a cutting edge organization in the coordination, policy, research, monitoring and facilitating of HIV/AIDS intervention in Africa with a mission to continuously undertake and facilitate the coordination of programmes to contain the HIV/AIDS pandemic in Nigeria, planning and evaluation, advocacy and resource mobilization. The agency has as one of its mandates to mobilize resources (local and foreign) and coordinate equitable application for HIV/AIDS activities; this it has been able to achieve through collaboration with the public and private sector and the international donor agencies.

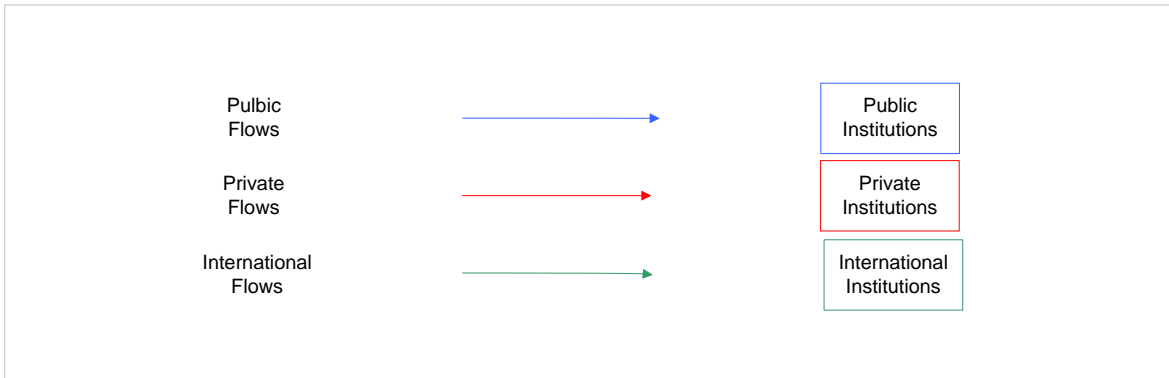
In the course of its existence since creation, NACA has made giant strides in establishing interactive platforms for effective engagement of stakeholders and coordination of the various activities of the multi-sectorial response. It has facilitated the formation, funding and capacity building of CSOs and CSO networks into constituent coordinating entities that provide viable platforms for CSO engagement in the national response. The financial, management and human resources systems have been reengineered to enhance performance, not only is NACA an agency but it has ensured the transformation of twenty-nine states and FCT action committees into agencies and mainstreaming HIV/AIDS into the activities of government Ministries, Departments and Agencies (MDAs) resulting in 28 of them currently planning and implementing HIV/AIDS response activities. The Agency worked towards the passage of the NACA Bill on stigma and discrimination and the review of the country's HIV/AIDS policy (2003) in 2010. Engagement and capacity strengthening of the organize private sector typified by the establishment of a Nigeria Business Coalition against AIDS (NiBUCAA) to coordinate and facilitate the private sector response to HIV and AIDS. To further boost research, the

⁵NACA(2010): National HIV/AIDS strategic framework 2010-2015

Agency recently inaugurated the national HIV and AIDS research reference group and the New Prevention Technology Technical working group.

Figure 3: National Response – NASA Mapping of actors and funding flow





Note: International flow also goes to public institutions in some cases

2.0 Study Design and Methodology

2.1 Context for the Assessment

Nigeria conducted the first ever NASA in 2009 to track the flow of financial resources from funding source to the beneficiary population covering the period 2007 and 2008. This exercise served as baseline for the current one covering the periods 2009 and 2010. It was also in response to the 2009 sustainability analysis of HIV/AIDS services in Nigeria (HAPSAT) which revealed that it was not possible to get a comprehensive picture of how and where resources are being expended, how much was spent in specific service delivery points or geographical areas, or on specific activities as the nation responded to the epidemic.⁶ The 2009 and 2010 will be used to measure the national commitment and action towards the 2001 UNGASS Declaration and the national strategic framework and action plan.

Nigeria, Africa's most populous country with a population of 156.2 million has a national HIV prevalence of 4.1%. The prevalence ranged from 1.0% in Kebbi State to 12.7% in Benue State. A total of 16 States and FCT had prevalence above 5%. Five of the six States in the South South Zone, three of the five in the South East Zone, five of the seven in North Central Zone, two of the six in North East Zone, and one of the six in South West Zone had prevalence of 5% and above. The three States with the highest rates were Benue, Akwa Ibom and Bayelsa.⁷

2.2 Objectives

The overall objective of this NASA activity is to strengthen national assessments of AIDS-related spending in Nigeria in support of the coordination, harmonization and alignment of HIV and AIDS resource use. The specific objectives of the study include:

- ⌘ To track the allocation of HIV and AIDS funds, from their origin down to the end point of service delivery, among the different financing sources (public, private or external) and among the different providers and beneficiaries (target groups).
- ⌘ To catalyze and facilitate actions which strengthen capacities to effectively track expenditures on HIV and AIDS and synthesize this data into strategic information for decision-making.
- ⌘ To leverage both technical and financial support to develop a mechanism for institutionalizing HIV Spending Assessments.

Key issues that should be addressed by this NASA study are as follows:

- ⌘ What is actually disbursed and spent in each component of the multi-sectorial HIV and AIDS response? Are increased allocations of expenditure going to priority HIV and AIDS interventions based on the strategic action plan?
- ⌘ What is the allocation of AIDS spending in relation to the objectives and targets of the National HIV/AIDS Strategic framework and Plan?
- ⌘ Where do HIV and AIDS funds go – Who are the main service providers and beneficiaries of these services?

⁶ sustainability analysis of HIV/AIDS services in Nigeria, 2009

⁷ National HIV Sero-Prevalence Sentinel Survey Among the Antenatal Clinic Attendees, 2010

2.3 Scope of the Assessment

The assessment focused on tracking national level HIV expenditure available at central level and 10 States for the year 2009 and 2010. Data collection covered domestic and external spending in HIV and AIDS, including funds channeled through the government. The assessment did not include household out-of-pocket expenditure on HIV and AIDS; however NACA commissioned a consultant to carry out a study on it which was included in this report. Duty waivers on HIV goods by government were not tracked.

2.4 NASA Methodology

The National HIV and AIDS Spending Assessment (NASA) approach to resource tracking is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV and AIDS. The tool tracks actual expenditure (public, private and international) both in health and non-health sectors (social mitigation, education, labour, and justice) that comprises the National Response to HIV and AIDS⁸.

The need to track HIV expenditure stems from the fact that decisions regarding allocations for HIV and AIDS related activities must be based on the true effect of previous expenditure patterns on face of the epidemic in the various States in the country. NASA is expected to provide information that will contribute to a better understanding of a country's financial absorptive capacity, equity and the efficiency and effectiveness of the resource allocation process.

In addition to establishing a finance tracking system of HIV and AIDS activities, NASA facilitates a standardized approach to reporting of indicators that monitor the progress towards the achievement of the targets of the *Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)⁹.

NASA follows a system of expenditure tracking that involves the systematic capturing of the flow of resources by different financial sources to service providers, through diverse mechanisms of transaction. A transaction comprises of all the elements of the financial flow, the transfer of resources from a financial source to a service provider, which spends the money in different budgetary items to produce functions (or interventions) as a response to the HIV and AIDS epidemic for the benefit of specific target groups or to address unspecified nonspecific populations (or the general population). NASA uses both top-down and bottom-up techniques for obtaining and consolidating information. The top-down approach tracks sources of funds from donor reports, commitment reports, government budgets whilst the bottom-up tracks expenditures from service providers' expenditure records, facility level records and governmental department expenditure accounts.

In cases where there are missing data, costing techniques are used to estimate actual expenditure based on internationally accepted costing methods and standards to retrogressively measure past actual expenditure. Ingredient and step-down costing is used for direct and shared expenditure for HIV and AIDS, whilst shared costs are allocated to the most appropriate utilization factor.

As part of its methodology, NASA employs double entry tables or matrices to represent the origin and destination of resources, avoiding double-counting the expenditures by reconstructing the resource flows for every transaction from funding source to service provider and beneficiary population, rather than just adding up the expenditures of every agent that commits resources to HIV and AIDS activities.

⁸UNAIDS, 2006: National AIDS Spending Assessment: a notebook on methods, definitions and procured for the measurement of HIV/AIDS financing flows and expenditures at country level.

⁹*Declaration of Commitment* adopted by the United National General Assembly Special Session on HIV and AIDS (UNGASS)

The feasibility of NASA relies on background information, identification of key players and potential information sources, understanding users' and informants' interests, as well as the development of an inter-institutional group responsible for facilitating access to information, participating in the data analysis, and contributing to the data dissemination.

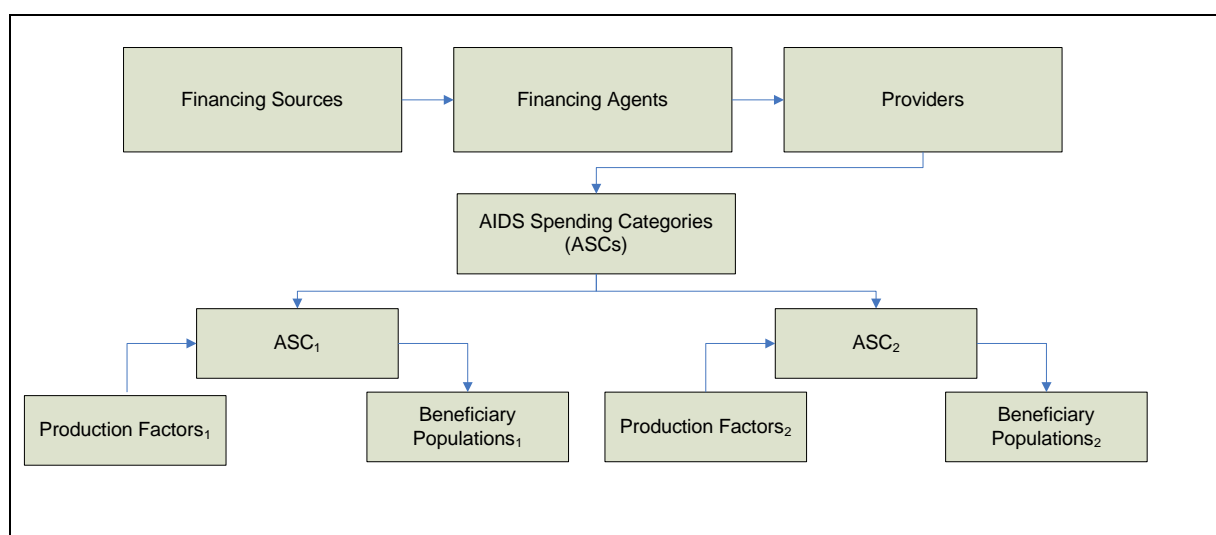
NASA was recommended as a methodology for reporting to UNGASS the No 1 Indicator on in-country spending for the whole set of activities within the national response to HIV and AIDS from different sources. Out of 145 countries that submitted their reports for review at the 2010 High-level Meeting, 107 included information on HIV spending.

NASA describes the flow of resources from their origin down to the beneficiary populations. The financial flows for the national HIV response are grouped in three dimensions: finance, provision and consumption. Expenditures are reconciled from these three dimensions using data triangulation.

The financial flows refer to the dimension in which financing agents obtain resources from the financing sources to “purchase” the transformation of those resources into goods and services by providers.

A transaction is a transfer of resources between different economic agents. The unit of observation to reconstruct the flows from the origin to its end is the transaction. Central to the resource tracking work is the comprehensive reconstruction of all transactions to follow the money flows from the financing sources, through buyers and providers and finally to the beneficiaries. NASA methodology uses this concept to reflect the transfer of resources from a financing source to financing agent and finally to a provider of goods or services, who invests in different production factors to generate ASC intended to benefit specific beneficiary populations (Figure 5). The illustration shows the financing flow linking the financing source with the financing agent and the provider. The provider can produce several ASC (two in this example: ASC1 and ASC2). Each ASC is produced by a specific combination of resources consumed: production factors1 and production factors2. Also, each of the ASC is produced to reach one or more specific intended beneficiary populations: beneficiary population1 and beneficiary population2.

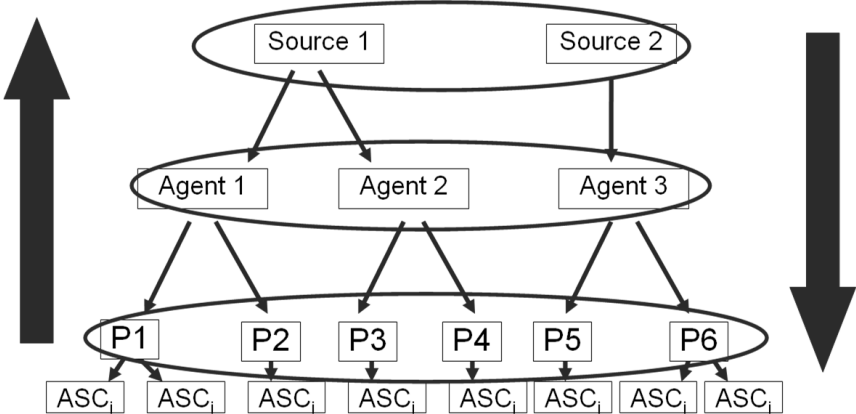
Figure 4 Transactions



The identification of transactions starts during the planning step with the mapping of the different actors involved in the HIV and AIDS response. The source-agent-provider relation is established here, transfer mechanisms and all kind of activities that are financed this way are identified. During data collection the transaction is complemented with the amount of the resources implicit on it.

Finally, during data analysis all transactions are completed and crosschecked doing a “bottom up” and “top down” reconciliation to avoid double counting and to ensure that the amounts inputted to the transaction reflect actual spending (Figure 6).

Figure 5 “Bottom up” and “Top down” approach.



Therefore, each financial transaction must be recreated to eventually add up to the total national (or any sub-national) unit and each dimension can be cross-tabulated against any other dimensions. Working with transactions from the beginning of data collection means that all data collected must be accounted for regarding its specific source, agent, provider, ASC(s), production factor(s) and beneficiary population(s). By doing so all data collected is matched in all of its dimensions (financing, production and use) before they are accounted in the matrixes, consequently the closure of the matrixes is guaranteed in advance. If all transactions are complete and closed, the matrix and estimations will close as well.

Another important fact to be considered during any resource tracking assessment is to avoid double counting. Especially on HIV responses, where there are several layers of intermediary institutions before the resources reach the service providers. Care must be taken to avoid double counting expenditures because disbursements of one entity may be the income of another one, and these intra-sectorial flows must be handled so as to capture the resources only when expenses are finally incurred.

In NASA, financial flows and expenditures related to the National Response to HIV are organized according to three dimensions: finance, provision, and consumption. The classification of the three dimensions and six categories comprise the framework of the NASA system. These dimensions incorporate six categories as shown in table 1:

Table 1: NASA dimensions and categories.

Financing	
1. Financing agents (FA)	Entities that pool financial resources to finance service provision programmes and also make programmatic decisions (purchaser-agent).
2. Financing sources (FS)	Entities that provide money to financing agents.
Provision of HIV services	
3. Providers (PS)	Entities that engage in the production, provision, and delivery of HIV services.
4. Production factors (PF)	Resources used for the production of ASC.
Use	
5. AIDS spending categories (ASC)	HIV-related interventions and activities.
6. Beneficiary segments of the population (BP)	Populations intended to benefit from specific activities.

2.5 NASA Preparatory Activities

The second NASA in Nigeria was conducted by the national core team made up of a lead national consultant, two junior consultants and four national data managers under the direct supervision of NACA Director of strategic knowledge management, ENR Programme Director and UNAIDS Nigeria M & E Advisor. A five day workshop facilitated by the lead national consultant was held for the core team.

A steering committee made up of officers from different governmental institutions (NACA, Ministry of Health, Ministry of Finance, the Ministry of National Planning and/or other Governmental offices),UNAIDS and ENR was set up to provide supervision on the overall process and to facilitate data collection. The timeline of the NASA implementation is presented in Appendix 2. Several advocacy and sensitization meetings were held with partners to facilitate the process. Data collection forms were refined and distributed to key HIV/AIDS national response actors. The NASA teams obtained all necessary permissions from the national authorities to access relevant data and conduct the assessment. The letter of support for the mission is presented in Appendix 11.

2.6 Data Collection and Processing

2.6.1 Sources of Data

In collaboration with national stakeholders, NASA team identified and mapped HIV financial sources, financial agents, service providers, and AIDS spending categories.

Although a lot of sources of data (detailed expenditure records) were obtained from the primary sources for 2009 and 2010, secondary sources were widely used where primary sources were not available (e.g. expenditure of NGOs who received direct funding from donors which were not captured, donor report or more detailed data on expenditure). In some cases costing techniques were used to estimate some of the expenditures of HIV and AIDS related activities using the best available data and most suitable assumptions.

For the list of institutions visited to collect HIV and AIDS expenditure data (Appendix 1) and the status of data collected refer to Appendix 13.

2.6.2 Qualitative Data Collection

The initial data collection process involved cascaded training at the National and state level. The members of the Core team (2 Junior Consultants and 4 Data Managers) and 10 State Consultants (drawn from Akwa Ibom, Benue, Cross River, Anambra, Sokoto, Kaduna, Lagos, Nassarawa, Ondo and Ogun States) were trained at the National level for a week. The second level of trainings was at the National and State levels for the focal persons (Finance and Programme Officers) from each of the donor institutions and implementing partners. The objective of the second level training was to acquaint them with the NASA process, enable them to reconstruct all the transactions related to HIV and AIDS activities showing the actual spending, consumption and delivery to the beneficiary population and enable them to completely fill the NASA data forms. The training session was also an opportunity to sensitize and solicit their support for the release of financial data.

A mapping of all institutions involved in the HIV/AIDS response was carried out followed by a desk review of key National policy documents, programme documentation and available budgetary and expenditure reports for the period 2009-2010. This review was followed by ten weeks of data collection from institutions.

NACA sent out letters of request for financial data to government ministries, NGOs, bilateral and multilateral organizations. NASA objectives, expected outputs and key methodological principles were presented to stakeholders at various fora during the preparatory mission and the first week of the main mission.

The standard NASA questionnaires were adjusted to suit the country context and sent to all identified institutions. NASA consultants were also on hand to support organizations to complete the questionnaires.

2.6.3 Data Processing

During the **data processing** the resource tracking module of NASA Excel files and RTS software were used. The expenditure data collected was first captured in Excel® Data processing Files, and checked and balanced. All the information obtained/collected was verified as far as possible, to ensure the validity of data from the records of the source, the agents and the providers and also to avoid double counting. The data was then transferred to the NASA Resource Tracking Software (RTS), which has been developed to facilitate the NASA data processing. It provides a step-by-step guidance along the estimation process and makes it easier to monitor the crosschecking among the different classification axes.

Further analyses comprised of **data analysis and triangulation**. It allowed to establish the: (i) level and proportion of funding from different sources; (ii) which providers were receiving funds and from what sources; (iii) amount of funding allocated to services and functions related to HIV/AIDS. The RTS results databases were then exported to Excel to produce summary tables and graphics for analysis.

2.6.4 Data validation

The data validation was done in four stages for accuracy and consistency.

- The initial stage was by the NASA core team who went through each transaction using the generated RTS beneficiary population and production factor outputs. This was to ensure that the classification of the financing source, financing agent, service providers, AIDS spending categories and the beneficiary populations were consistent with the NASA classification and definitions manual and to ensure the accuracy of the financial data with the submitted one by the various institutions.
- The second stage was carried by the international consultant with technical support from UNAIDS in Geneva. After this stage, all observations and comments were incorporated into the RTS and a new set of outputs were generated.
- The third stage of the validation was by the individual institutions that submitted data. The financial data was sent to the Programme and finance focal persons in the institutions for confirmation. A final set of RTS outputs was generated after including their comments to produce tables and graphs for the final report.
- The final stage of this process was by the national HIV/AIDS Stakeholders. The draft report was shared to all stakeholders for their input. All their comments were captured in the report and a one day validation meeting was held afterwards with all of them in attendance

2.7 Limitations of the Assessment

Tracking the HIV and AIDS expenditure proved to be a challenging task and there are a number of limitations to the study. The major ones include the following:

⚠ **Dearth of Private sector HIV expenditure data:**

Data from the private sector was limited despite several appeals to NIBUCCA, the umbrella body for all the private organizations involved in the HIV/AIDS response

⚠ **State Government expenditure:**

The assessment was limited to State level expenditure in ten out of 36 states and Federal Capital territory. The next round should be designed to cover all States.

⚠ **Duty waivers by Government:** This was not tracked.

3.0 Findings of 2009 and 2010 NASA

Figure 6: Total Expenditure Trend 2007-2010(USD) in Nigeria

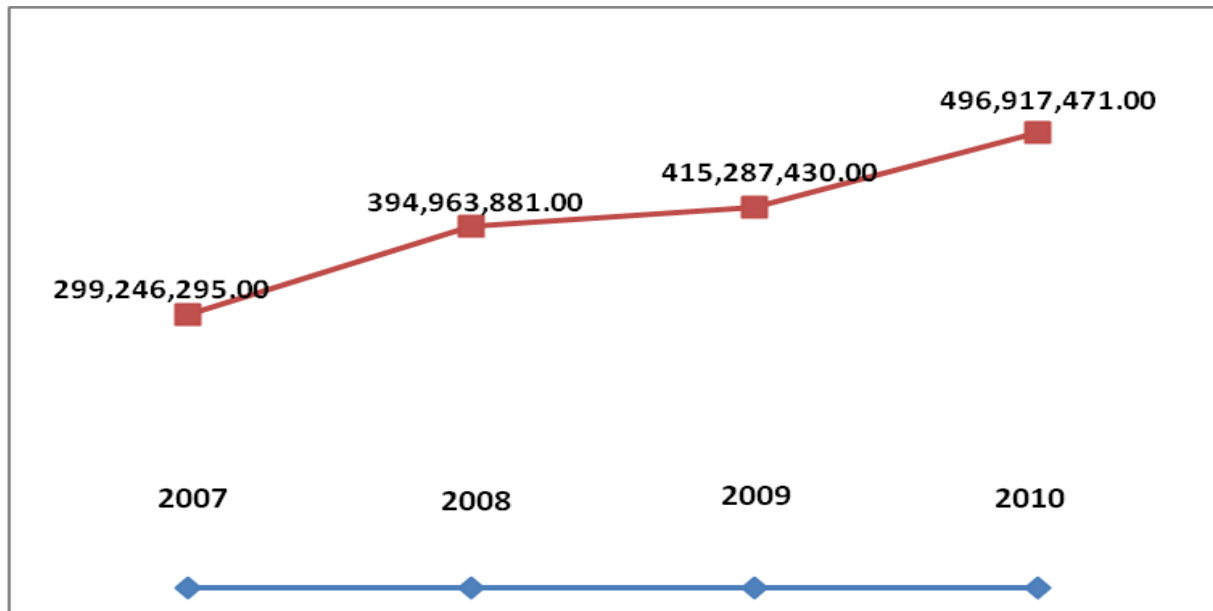
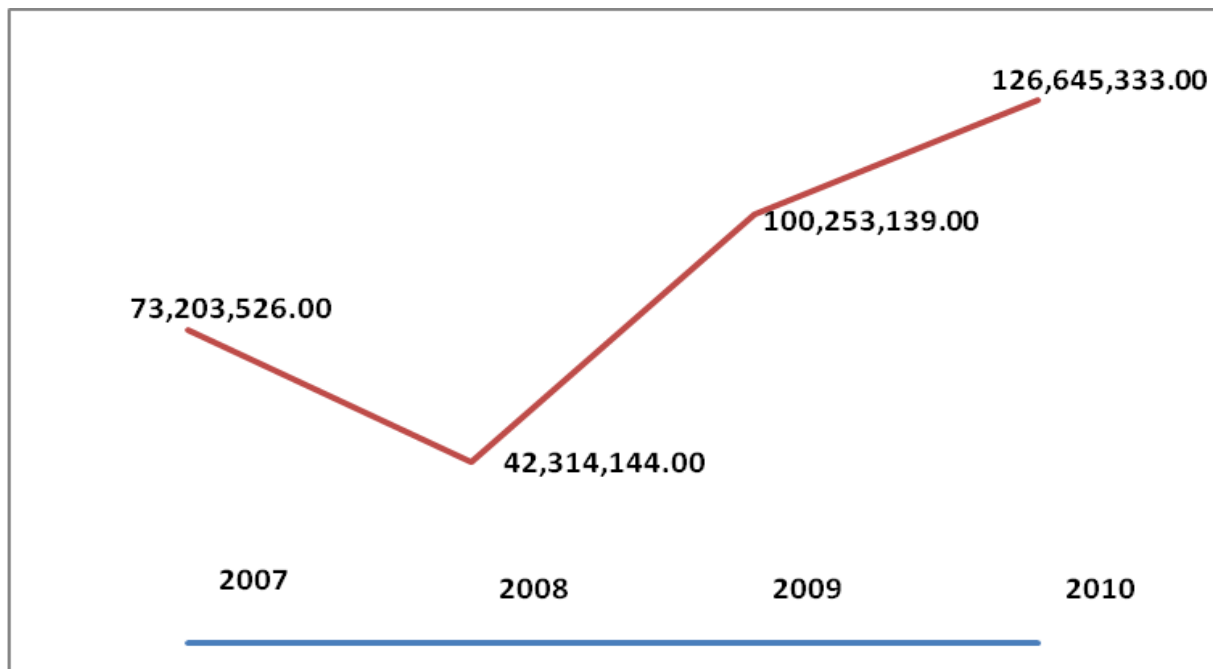


Figure 7: Public Sector Expenditure Trend 2007-2010(USD) in Nigeria



* The Public sector expenditure includes the World Bank credits

3.1 Total expenditure on HIV and AIDS with sources of Funding

The expenditure on HIV and AIDS was \$415 million and \$496million in 2009 and 2010 respectively. Direct bilateral contributions were the main source of funding followed by public source which accounted for about a quarter of all funds in both years under review. (See Tables 2 and 3 for details). The level of details of spending data allows the analysis of the areas of spending by Financing Sources (See Appendix 6). The comparison of the spending profile of five main financing sources (three – external, one – public and one private) are graphically depicted in Figures 10 and 11. As clearly seen in the graph, care and treatment remain the key spending priorities for the public and direct bilateral funds while programme management and administration was the most financed area within multilateral agencies and international non-profit making organizations and foundations

Table 2: Financing Sources in 2009 and 2010 – Table (1st and 2nd digits analysis):

Financing Sources	USD 2009	%	USD 2010	%
FS.01 Public Sources	97,790,519.00	23.55	125,139,587.00	25.18
FS.02 Private Funds	278,303.00	0.07	850,547.00	0.17
FS.03 International Funds	317,218,608.00	76.39	370,927,337.00	74.65
FS.03.01 Direct bilateral contributions	272,915,916.00	65.72	284,908,865.00	57.34
FS.03.02 Multilateral Agencies	44,174,013.00	10.64	85,861,856.00	17.28
FS.03.03 International not-for-profit organization	107,596.00	0.03	100,588.00	0.02
FS.03.04 International for profit Organizations	21,083.00	0.01	56,028.00	0.01
Total	415,287,430	100	496,917,471	100

Figure 8: Financing Source in 2009 and 2010

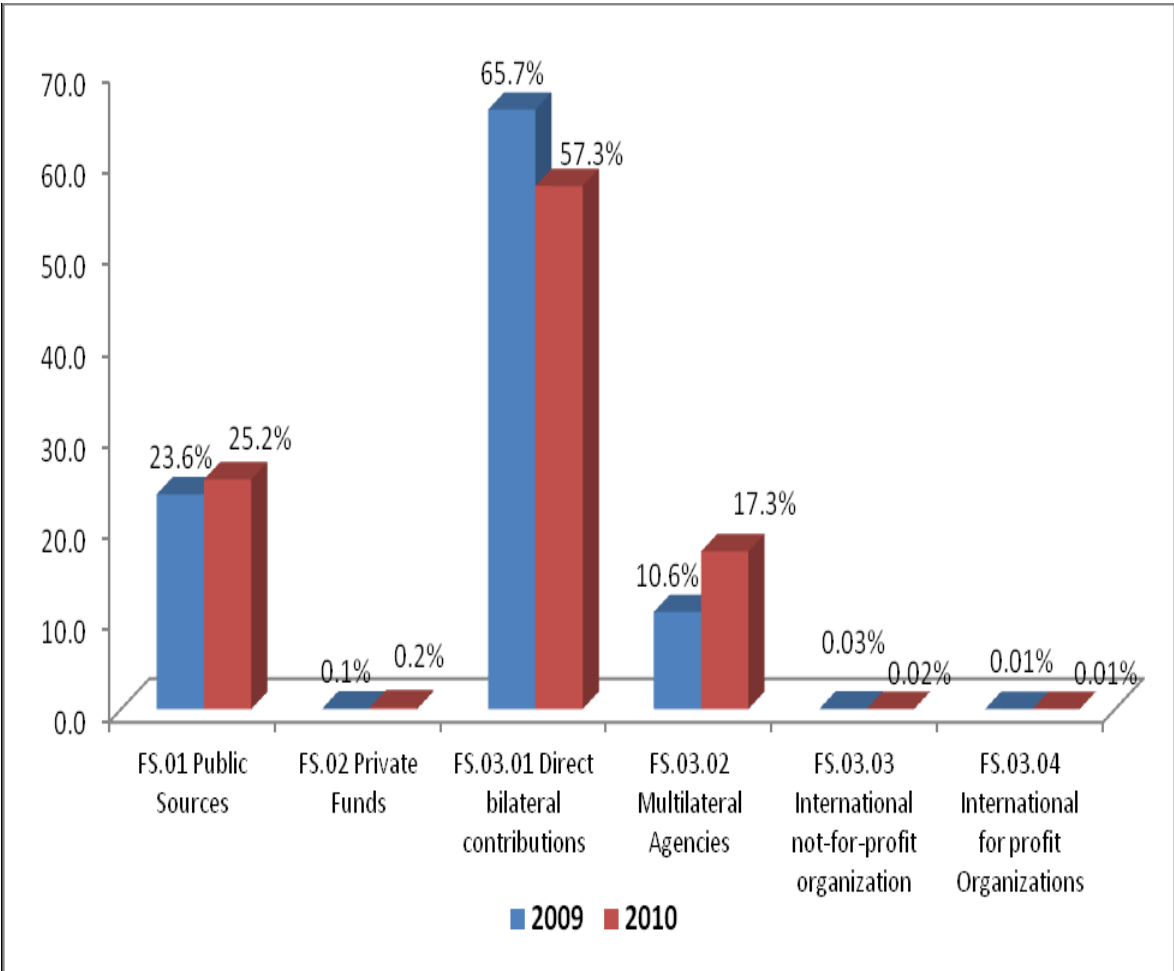


Figure 9: Spending by Financing Sources 2009

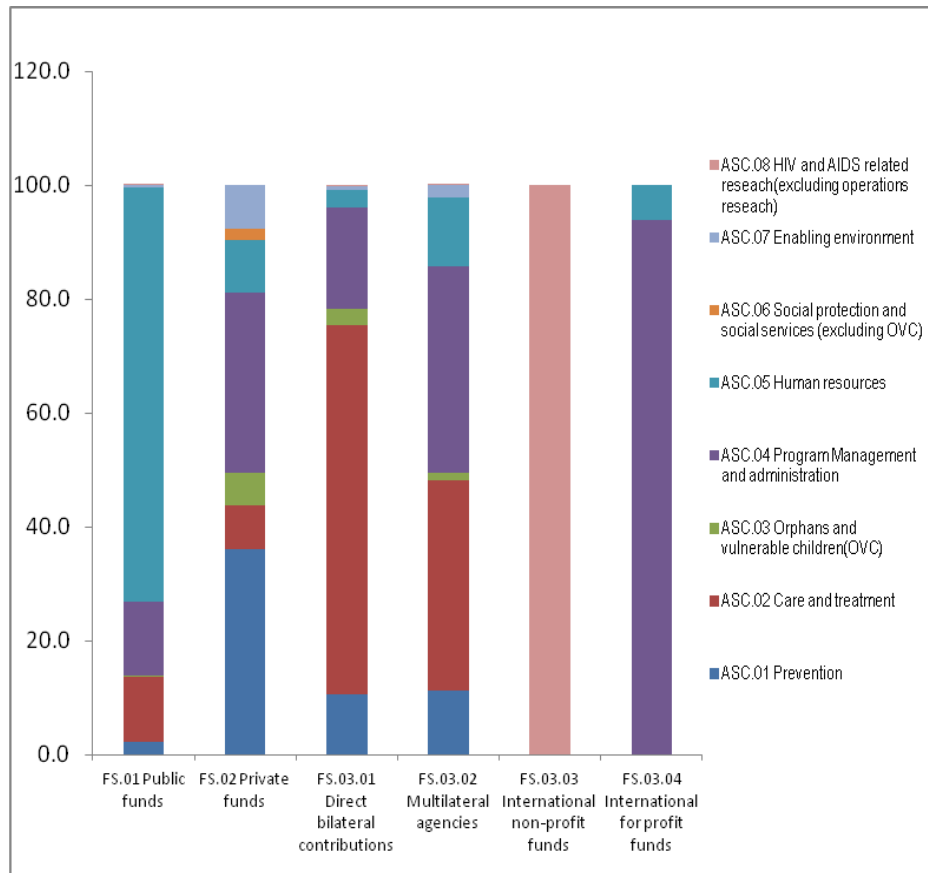
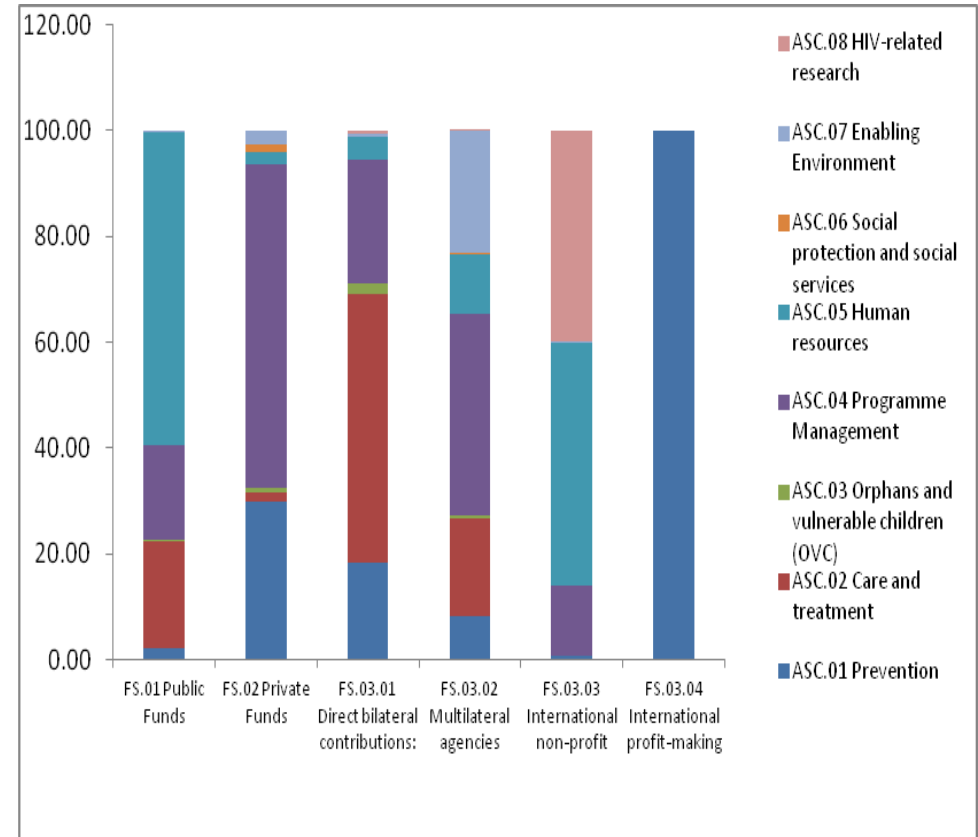


Figure 10: Spending by Financing Sources 2010



3.2 Expenditure by Programmatic Decision Makers

In 2009, the programmatic decisions on goods/services to be purchased, provider of goods/services and the beneficiary of the goods/services were mainly the international purchasing Organizations (75.4%) in 2009 closely followed by the public sector (23.6%). The pattern was similar in 2010. (Table 5 highlights the details).

Table 3: Financing Agents in 2009 and 2010 (1st and 2nd digits analysis)

Financing Agents	2009		2010	
	Amount (USD)	%	Amount (USD)	%
FA.01 Public Sector	98,073,517.00	23.6	125,294,375.00	25.2
FA.02 Private Sector	4,256,866.00	1.0	26,774,251.00	5.4
FA.03 International Purchasing Organizations	312,957,047.00	75.4	344,848,845.00	69.4
FA.03.01 Country offices of bilateral agencies	273,164,456.00	65.8	284,157,870.00	57.2
FA.03.02 Multilateral Agencies	9,919,624.00	2.4	53,336,072.00	10.7
FA.03.03 International not for profit making organizations and foundations	29,872,967.00	7.2	7,354,903.00	1.5
Total	415,287,430.00	100.0	496,917,471.00	100.0

Figure 11: Financing Agents in 2009 and 2010

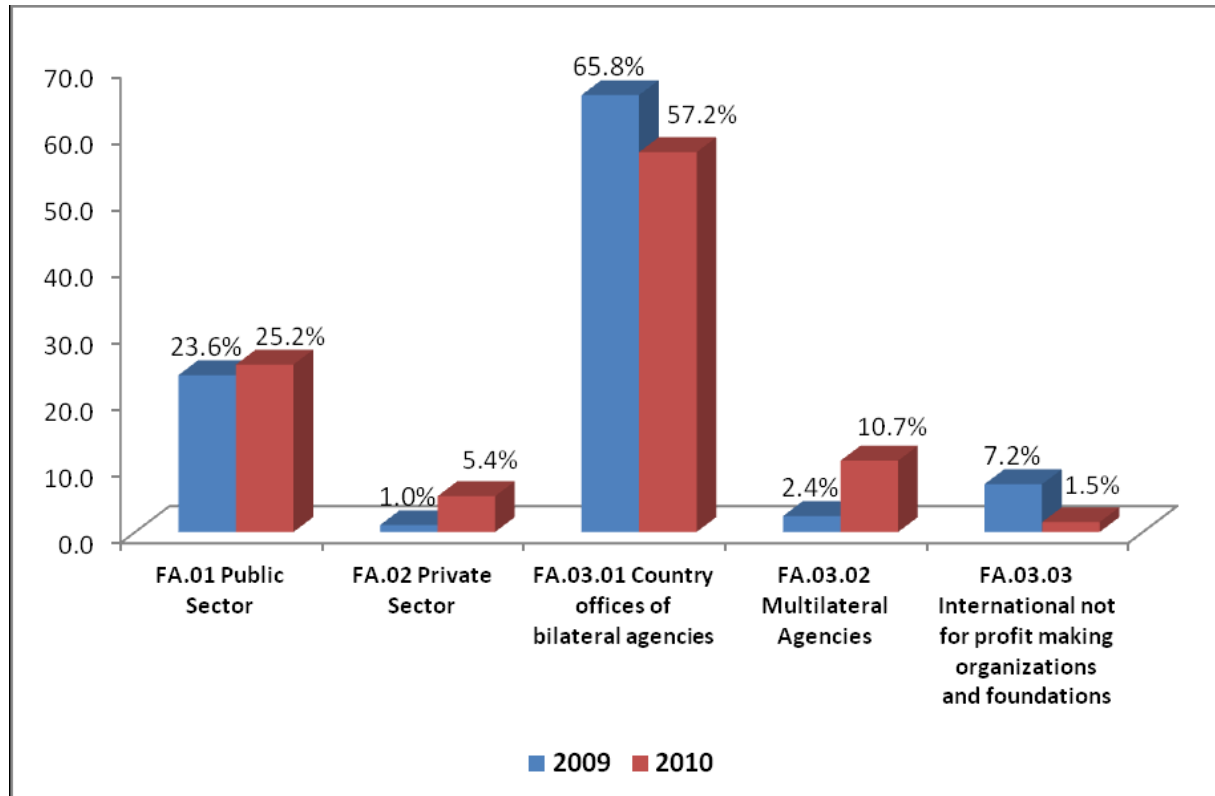


Table 4: Financing Sources to financing agents- 2009

Financing Sources to Financing Agent		Financing Sources						Total
		Central Government Revenue	Private Funds	Direct Bilateral Contributions	Multilateral Agencies	International not-for-profit organizations and foundation	International organizations for profit	
Financing Agent	Public Sector	97,007,689.00	47,438.00	35,714.00	982,676.00	-	-	98,073,517.00
	Private Sector	-	230,865.00	-	4,004,918.00	-	21,083.00	4,256,866.00
	Bilateral Agencies	770,250.00	-	272,394,206.00	-	-	-	273,164,456.00
	Multilateral Agencies	12,580.00	-	182,746.00	9,724,298.00	-	-	9,919,624.00
	International Non-profit	-	-	263,252.00	5,200,355.00	107,596.00	-	5,571,203.00
	International for-profit	-	-	39,998.00	24,261,766.00	-	-	24,301,764.00
	Total	97,790,519.00	278,303.00	272,915,916.00	44,174,013.00	107,596.00	21,083.00	415,287,430.00

Table 5: Financing Sources to financing agents-2010

Financing Sources to Financing Agent		Financing Sources						Total
		Central Government Revenue	Private Funds	Direct Bilateral Contributions	Multilateral Agencies	International not-for-profit organizations and foundation	International organizations for profit	
Financing Agent	Public Sector	124,768,949.00	-	-	469,398.00	-	56,028.00	125,294,375.00
	Private Sector	-	850,547.00	-	25,923,704.00	-	-	26,774,251.00
	Bilateral Agencies	-	-	284,157,870.00	-	-	-	284,157,870.00
	Multilateral Agencies	370,638.00	-	402,809.00	52,562,625.00	-	-	53,336,072.00
	International Non-profit	-	-	348,186.00	5,418,943.00	100,588.00	-	5,867,717.00
	International for-profit	-	-	-	1,487,186.00	-	-	1,487,186.00
	Total	125,139,587.00	850,547.00	284,908,865.00	85,861,856.00	100,588.00	56,028.00	496,917,471.00

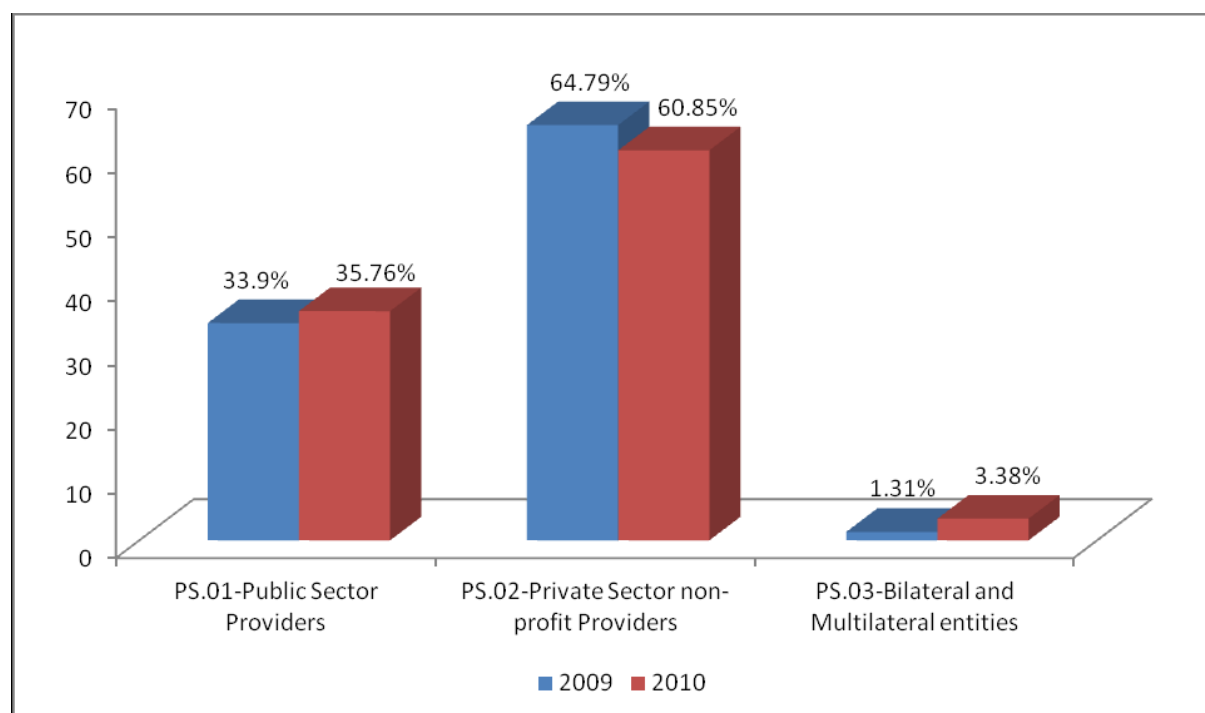
3.3 HIV Expenditure through Provider of Service

A third of the HIV goods and services were provided by the public sector in both years in the country while the private sector non-profit institutions accounted for about two third in the provision of HIV goods and services. (See table 8 below for details)

Table 6: HIV Service providers in 2009 and 2010(1st digit analysis)

HIV/AIDS Service Providers	2009		2010	
	Amount (USD)	%	Amount (USD)	%
PS.01-Public Sector Providers	140,782,985.00	33.90	177,719,983.00	35.76
PS.02-Private Sector non-profit Providers	269,069,366.00	64.79	302,395,926.00	60.85
PS.03-Bilateral and Multilateral entities	5,435,079.00	1.31	16,801,562.00	3.38
Total	415,287,430.00	100	496,917,471.00	100

Figure 12: HIV/AIDS Service Providers in 2009 and 2010



3.4 Expenditure on HIV goods and services

The key spending priorities in 2009 and 2010 as highlighted in tables 9 was on Care and treatment (49.2% - \$204million in 2009 and 37.4%-\$186million in 2010). Figures 13 and 14 are graphic representations of the broad AIDS spending categories

Table 7: AIDS spending categories in 2009 and 2010(1st digit analysis)

AIDS Spending Categories	2009		2010	
	Amount(USD)	%	Amount(USD)	%
Prevention	36,184,378.00	8.71	61,877,789.00	12.45
Care & Treatment	204,304,508.00	49.20	186,032,729.00	37.44
OVC	9,099,704.00	2.19	7,118,795.00	1.43
Program management	77,212,683.00	18.59	121,831,097.00	24.52
Human Resources	84,989,602.00	20.47	95,919,210.00	19.30
Social Protection	83,718.00	0.02	183,189.00	0.04
Enabling Environment	2,679,626.00	0.65	21,870,065.00	4.40
Research	733,211.00	0.18	2,084,597.00	0.42
Total	415,287,430.00	100.0	496,917,471.00	100.0

Figure 13: Broad AIDS Spending Categories in 2009

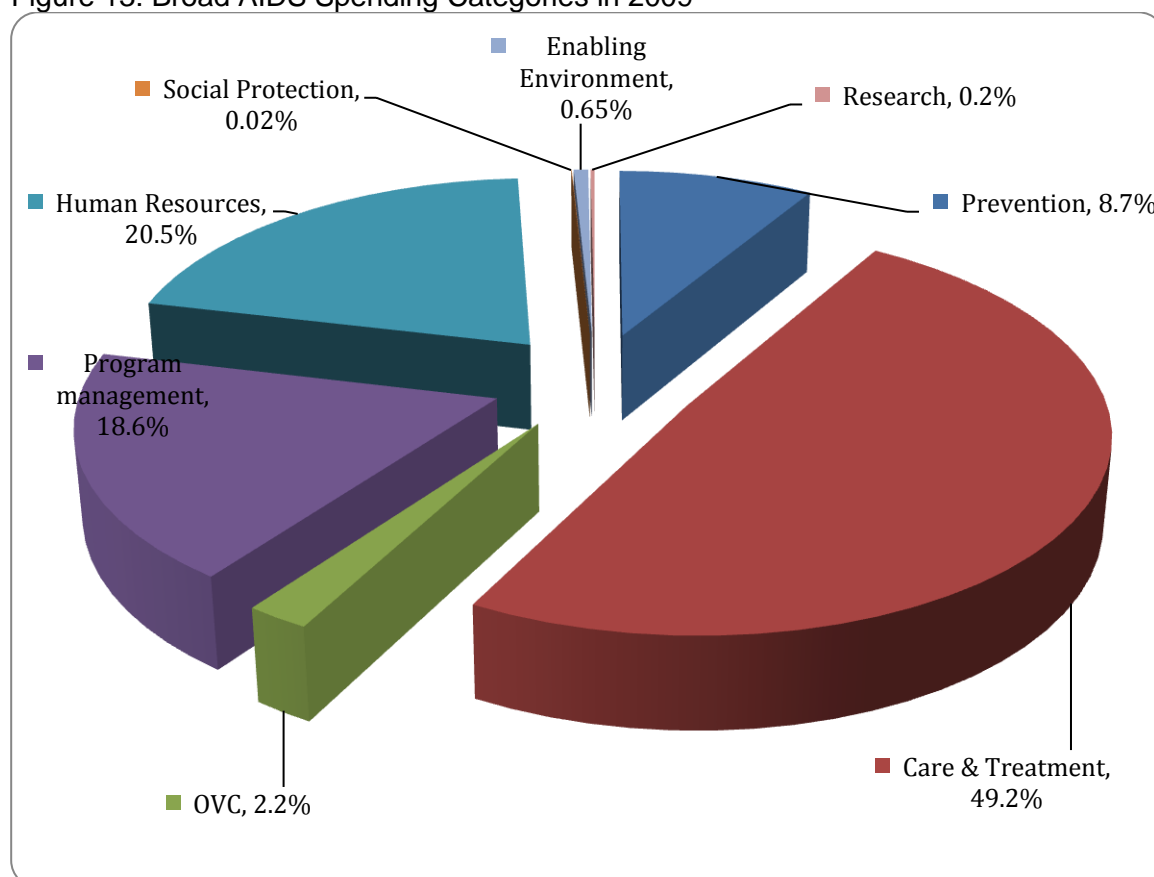
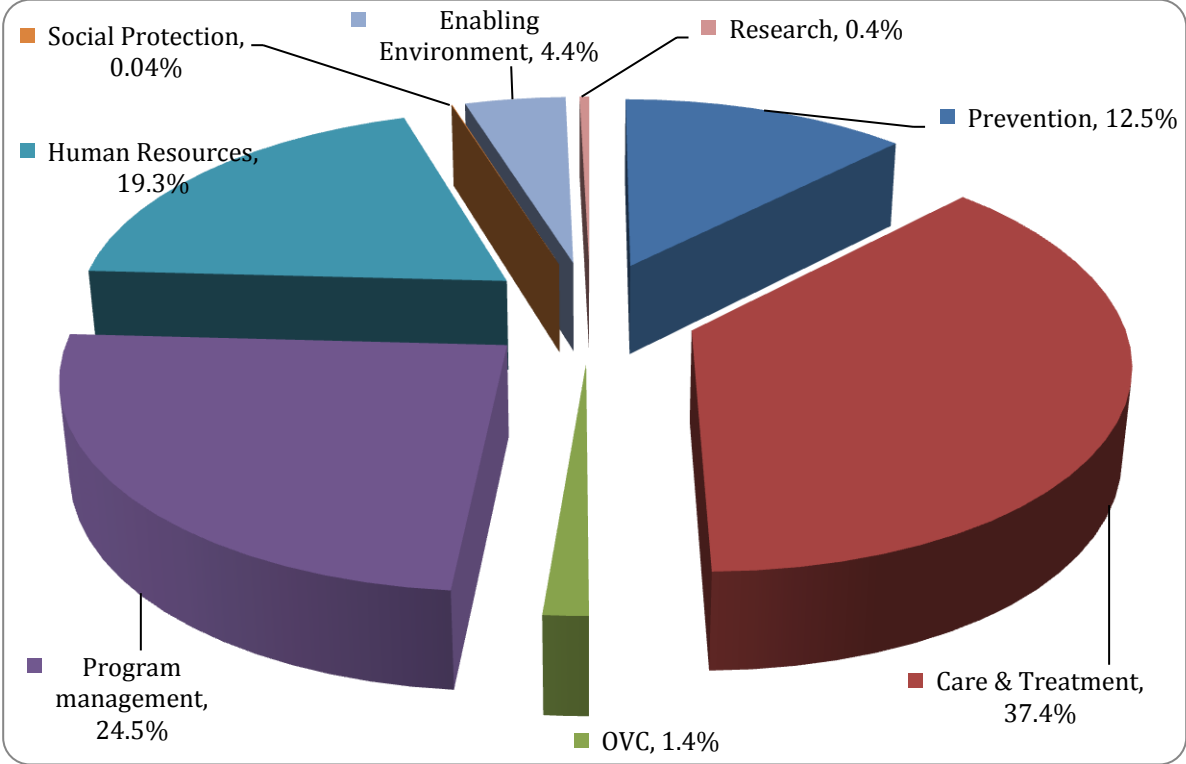


Figure 14: Broad AIDS Spending categories in 2010



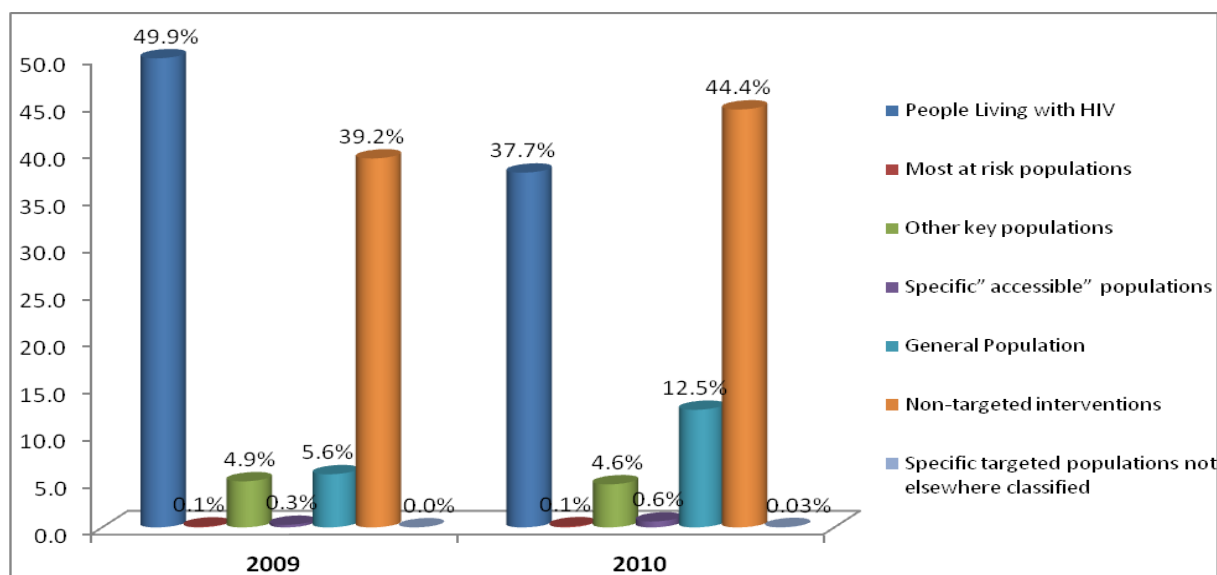
3.5 Expenditure on beneficiary populations

People living with HIV/AIDS (50.0% in 2009 and 38.0% in 2010) were the major beneficiaries of the HIV/AIDS response in Nigeria during the period under review closely followed by non-targeted intervention of 39.0% and 44.4% in 2009 and 2010 respectively. Table 10 highlights the beneficiary populations in the years under review.

Table 8: Beneficiary Populations of the HIV and AIDS response in 2009 and 2010(1st digit analysis)

Beneficiary population	2009		2010	
	Amount (USD)	%	Amount (USD)	%
BP.01-People living with HIV	207,110,810.00	49.87	187,424,838.00	37.72
BP.02-Most-at-risk populations	378,255.00	0.09	557,700.00	0.11
BP.03-Other key populations	20,332,659.00	4.90	22,744,908.00	4.58
BP.04-Specific accessible population	1,130,254.00	0.27	3,118,459.00	0.63
BP.05-General population	23,452,982.00	5.65	62,125,892.00	12.50
BP.06-Non-targetted interventions	162,882,470.00	39.22	220,787,650.00	44.43
BP.99-Specific targeted populations not elsewhere classified	0	0	158,024.00	0.03
Total	415,287,430.00	100	496.917.471.00	100

Figure 15: Beneficiary population in 2009 and 2010



In 2009 and 2010, most of the public fund expenditure was for non-targeted interventions while people living with HIV were the major beneficiary population of the direct bilateral contributions which was spent on care and treatment. The private sources of fund were spent on the general population as shown in figures 16 and 17 below. Appendix 10 highlights the beneficiary population by financing source in a tabular manner.

Figure 16: Beneficiary populations by Financing Source-2009

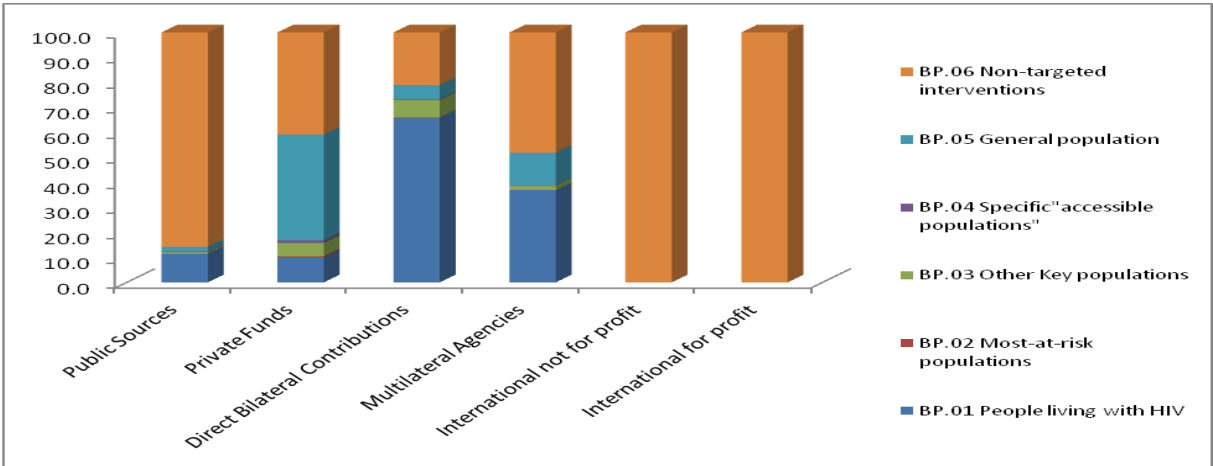
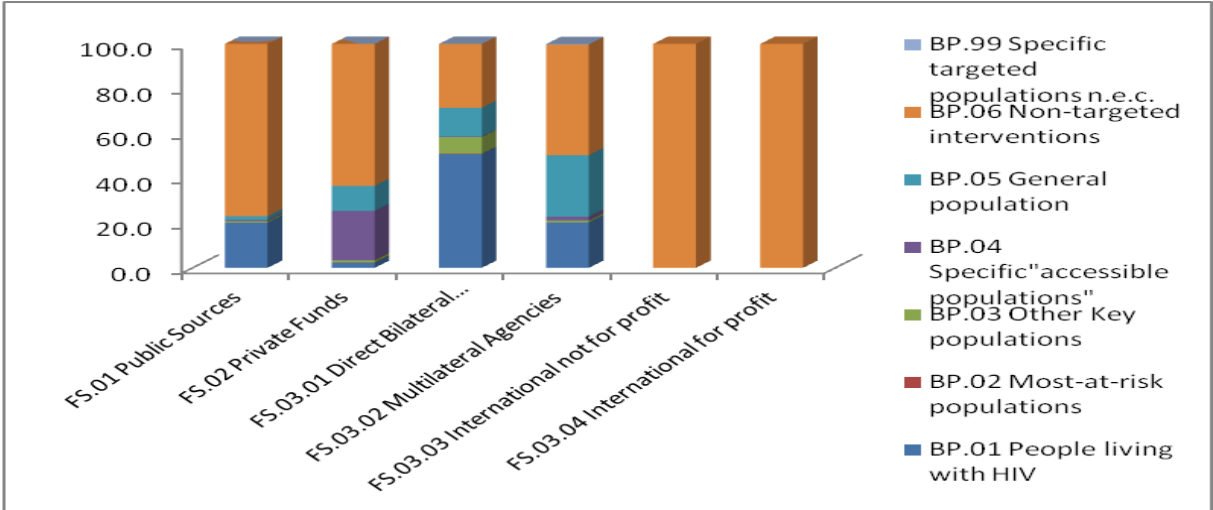


Figure 17: Beneficiary populations by Financing Source-2010



4.0 Discussion of results

4.1 Financing Sources

The public sector funding (including the World Bank grant) had increased from \$100 million in 2009 to \$127 million in 2010. This was a remarkable improvement over the 2007(\$73 million) and 2008(\$42 million) figures in line with the strategic framework. The overall goal of the strategic framework to advance the multi-sectorial response to the epidemic in Nigeria so as to achieve effective control of the disease by reducing the number of new infections, providing equitable care and support, and mitigating the impact of the infection can only be achieved by increasing the public sector funding.

However, the funding for the implementation of the vast majority of HIV/AIDS goods and services is still heavily dependent on international funds (76.0% and 75.0% in 2009 and 2010 respectively) with the direct bilateral contribution accounting for majority of the funds. The Government of United States was responsible for majority of the direct bilateral contributions through PEPFAR. A mechanism for tracking the private sector fund by NACA needs to be developed and maintained through effective coordination platform.

4.2 Financing Agents

The public sector accounted for about a quarter of all programmatic decisions on the national response however, majority of the programmatic decisions (type of goods and services to purchase, service providers and beneficiary population) for the HIV/AIDS response in Nigeria in 2009 and 2010 was taken by the International/purchasing Organizations (75.4% and 69.4% in 2009 and 2010 respectively). The international financing agents were made up of country offices of bilateral agencies, International not-for-profit making organizations and foundations and multilateral agencies. This is so because of the high contributions of the donors to the national response.

4.3 HIV/AIDS Service Providers

The provision of HIV goods and services to the national response was mainly through the private sector. This comprises private (nongovernmental) non-profit and for profit actors not directly part of the structure of Government. They accounted for two third of HIV goods and services provided in 2009 and 2010. There had been a progress in the provision of HIV goods and services by the public sector expenditure over the years. The bilateral and multilateral entities provided minimal services in both years.

4.4 AIDS Spending Categories

The trend of the expenditure on HIV goods and services in 2009 and 2010 was not different from what obtained in 2007 and 2008 which were mainly on care and treatment. This was not in sync with the strategic framework which proposed 50.0% expenditure on prevention. Only 8.7% and 12.5% in 2009 and 2010 respectively of the total expenditure was on prevention despite the 2010-2015 UN declaration of getting to zero new HIV infections and the acceptance of prevention as a core HIV/AIDS intervention area. Prevention is a comprehensive set of activities or programmes to reduce risky behavior. This intervention leads to decrease in HIV infections among the population and improvements in quality and safety in health facilities.¹⁰Funding generally increased for most of the activities from 2009 to 2010 with the exception of care and treatment and that for orphans and vulnerable children.

4.5 Beneficiary Population

¹⁰*National AIDS Spending Assessment classifications and definition,2009*

The major beneficiaries of the HIV/AIDS response in Nigeria in 2009 and 2010 were the people living with HIV/AIDS. This was due to the fact that the bulk of the expenditure was on care and treatment. The HIV mode of transmission study revealed that 62% of new infections will be among persons perceived as practicing “low risk sex” in the general population including married sexual partners but only 6.0 % of the total HIV expenditure was spent in 2009 on the general population. There was a doubling of the expenditure on the general population in 2010 but still below the set target of 50.0% in the strategic framework for the general population in the area of prevention of new infection. This poses a challenge to all stakeholders in Nigeria HIV response programmes in attaining the “getting to zero” target of 2015. The expenditure on the most at risk populations was dismally low in both years.

4.6 NASA findings against the background of the HIV epidemic in Nigeria

Globally, 33.3 million persons were estimated to be infected with HIV, of these 22.5 million (68%) are in sub-Saharan Africa and 3.1 million in Nigeria. Nigeria has the second highest number of PLWHA in the world (UNAIDS 2010). With continuous advancements in medical technologies and care, more people with HIV/AIDS are living longer, therefore the number of PLWHA in Nigeria remain high (given that the population is huge).

The review of NASA (2007 – 2010), shows that the expenditure on HIV has increased by 66% from \$299 million in 2007 to \$497 million in 2010. Consequently, overall the expenditure in most categories has also increased (except bilateral service provision). During this period, there are some notable variations in the pattern of spending. Public funds accounts for 25.2% of total funds and international funding is about 74.7% (\$371 million in 2010). This significant finding implies that our national response to HIV is heavily reliant on international funding. The evidence suggests that other African countries are similarly reliant on international funding (Ghana 75%) and Kenya (75%)¹¹ for their national HIV response. Reliance on external funding is not a sustainable approach for addressing a chronic major public health issue. It is encouraging that overall the public funding for HIV response in Nigeria has increased and this is in line with the expected national contribution of 35% by 2015¹².

4.6.1. Expenditure by service provider and programmatic area

In terms of expenditure by service provider, the expenditure by private-non-profit has increased from \$143 million (48%) in 2007 to \$302 million (61%) in 2010. During this period, service provision by public providers and bilateral/multilaterals has decreased. The reduction in expenditure by public service providers is worrisome, given that a higher capacity development and ownership of the national programme is expected in this arena/category. The reason for the decreased proportionate expenditure for public service providers should be explored.

The report on sustainability analysis of HIV services in Nigeria highlighted that cost estimates for scaling up services to achieve universal access in 2010 is \$647 million⁸. This assumes that 80% of all detected eligible cases are placed on ART. Overall, the actual expenditure on HIV in 2009 and 2010 is far less than the estimated funding

¹¹ Kenya National AIDS Spending Assessment : Report for the financial years 2006/07 and 2007/08-

¹²NACA 2009. National HIV/AIDS Strategic Framework 2010 – 2015. Institutional architecture, systems and resourcing, p42.

that is required. It is important to scale up the response and effectively manage the high numbers of PLWHA.

A review of HIV/AIDS expenditure by programmatic area in the past 4 years range from 12.6% (in 2007) to 12.45% (in 2010), with \$36million (8.7%) and \$62million (12.5%) actually spent in 2009 and 2010 respectively for prevention. Over this period (2007 – 2010), the actual expenditure for prevention has increased by 68%.

The 2010 IBBS reported that the prevalence of HIV among female sex workers is about 7 times higher than that of the general population (27.4% V 4.1%)¹³. The average number of clients per week for FSW is about 26 and their consistent condom use with casual partner in the last 12 months was only 70%. Another high priority group in terms of prevalence is the men-who have sex with men (MSM). HIV prevalence among MSM was 17.2% and condom use at last anal sex with paid partner was only 48%. Overall, the percentage of respondents who had a comprehensive and correct knowledge of HIV prevention methods is very low: BBFSW 31.8%, MSM 33.1%, transport workers 28.3% and police (36%).

Given the significant increase in expenditure for prevention, the targets for prevention were not achieved. These findings indicate that a lot of prevention work should be carried among these high priority groups. The funding allocated to MARP beneficiary group remains unacceptably low 0.1% (\$558,000 in 2010). The MARPs groups (FSW, MSM) are disproportionately affected by HIV, since they constitute only about 3.5% of the population. In fact, it is of great concern that HIV prevalence has increased among MSM from 13.5% in 2007 to 17.2% (2010). Consequently, it is important to target resources efficiently at these groups and increase the level of knowledge about HIV and its prevention. Prevention programmes should be evaluated for their cost-effectiveness and non-effective interventions should be de-commissioned.

In 2010, there were 281,130 new HIV infections. The Mode of Transmission (MOT) study reported that 62% of new infections occur among persons perceived as practicing 'low risk sex' in the general population including married sexual partners and the leading route of transmission is heterosexual intercourse accounting for over 80% of HIV infections. Therefore evidence-based preventive interventions should be funded to ensure that higher numbers of Nigerians remain HIV negative.

In addition, of those newly diagnosed with HIV infection, it is vital that the CD4 count is determined, and treatment commenced in line with new WHO guidelines. A useful national indicator for late diagnosis should be proposed and used to monitor HIV prevention programmes. There is clear evidence that a person with HIV may have the infection for up to 8 years before symptoms begin to manifest. During this period (of being unaware of the underlying HIV infection), an undiagnosed person will unknowingly transmit the infection to their sexual partners during unprotected sexual intercourse. There is evidence that early diagnosis and treatment reduces early mortality by up to 35%.

Given, that 95% of Nigerians are HIV negative and that prevention is a major cornerstone and strategy for the national response, resources should be efficiently and effectively used to address the HIV epidemic. Therefore, HIV prevention

¹³Federal Ministry of Health 2010. HIV Integrated Biological and Behavioural Surveillance Survey (IBBS) 2010

intervention programmes should seek to address the key drivers of the HIV epidemic in Nigeria including: low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient sexual health services, inadequate access to and poor quality of healthcare services, gender inequalities, HIV stigma and discrimination (HIV NSP2010- 2015).

In 2010, a high proportion of HIV fund (\$221million, 44%) was spent on non-targeted interventions as against the general population expenditure of \$62 million, 12.5% (funding by beneficiary population). It may be useful to review the spending pattern and evaluate these interventions for their cost-effectiveness and inform future HIV resource allocation decisions given the limited funding. Resources should be allocated to give priority to states with high burden of the HIV epidemic.

The expenditure on treatment and care in 2009 and 2010 were \$204 million (49%) and \$186 million (37%) respectively. These figures are well below the cost estimates of \$ 241 million (2009) and \$245 million (2010) proposed by the sustainability analysis report. Monetary allocations for treatment and care should be adequate and effectively managed to ensure that 1.5 million PLWHA eligible for ART received their therapy. As at 2010, only 23% of eligible PLWHA were on ART, even though the treatment target for 2011 was 60%.

4.6.2. Research

Research is identified as one of the strategic priorities for 2010 -2011¹⁴, but only \$2.1 million (0.42%) was spent on research in 2010. This is grossly below the 5% budgetary allocation stipulated in the National HIV /AIDS Research Policy 2010¹⁵. Although expenditure allocations for research has increased from \$68,376 (in 2007) to \$2.1 million (in 2010), biomedical and operations research in Nigeria is required to inform HIV policy, planning and effective programme implementation. Efforts to promote the research agenda are being made: with the recent publications of National HIV/AIDS Research Policy and the National research agenda on HIV/AIDS in Nigeria 2010-2015 and the setting up of an operations research technical committee group.

However, anecdotal evidence suggests that infrastructures for operational research are in their formative stages and research agenda are often subsumed / overshadowed by the Monitoring & Evaluation activities. Though both M & E and research are linked, their separate agenda should not be confused. It is vital to give prominence to research, as a tool to add to the scientific knowledge on HIV work and programme in Nigeria. Therefore a clear budget line for research should be safeguarded, with annualized prioritized work plan and indicators of successes clearly defined.

Furthermore, the findings of the Joint Annual Review on HIV highlighted that research at state and local government levels are virtually non-existent; and this should be addressed. The findings of research should be clearly and promptly disseminated for implementation; therefore a research communication strategy/plan should be developed and implemented. It is important that the research policy and agenda are implemented, with support and enabling environment created within states, health and community settings to promote research.

¹⁴NACA January 2010. National HIV/AIDS strategic priorities 2010 -2011

¹⁵NACA. National HIV/AIDS Research Policy 2010, p29

4.6.3. Monitoring and Evaluation (M & E)

In line with the national indicators for Monitoring and Evaluation, the national HIV M & E systems have been developed and are applauded by stakeholders (e.g. HIV NNRIMS operational plan 2007 -10¹⁶). There are 53 indicators in the HIV NNRIMS document and 68 indicators in the national strategic plan (NSP). However, some of the indicators in the NSP do not have a baseline. Therefore it is difficult to monitor degree of progress without a clearly defined starting point. Furthermore, milestones and trajectories need to be adjusted regularly (e.g. annually) in line with progress made so far. For example, if a milestone is not achieved by mid-term review, then the trajectory for that indicator to the endpoint (2015) will be steeper and the intense effort is required to still meet the target (within a shorter period of time).

The National Policy on HIV/AIDS 2009 recommended that a minimum of 8% of HIV/AIDS programme budget of all institutions engaged in the implementation of HIV activities should be committed to M & E¹⁷ several challenges are noted in the delivery of the M & E agenda: some SACAs do not render account of their activity without consequences. Some data collections are dependent on outreach adhoc survey by NACA team (e.g. collation of the NASA), without involvement of state actors as data collectors. Non-involvement of state actors can raise some resentment and can be a missed opportunity for capacity building of state personnel.

Given, the limited resource, future M & E planning should consider developing web-based reporting mechanism, institutionalizing the NASA data collection and other periodic surveys as part of the routine data collection process. A streamlined synchronized data collection programme, would mean that key members of the healthcare system will be reporting their data returns at the same time (HR, Finance and M&E officer rendering their data returns via the web-based system or other technologically appropriate methods). Consequently, the national M & E team can focus on data validation exercises and capacity building at the state level. Similarly, State M & E officers' will cascade training and support to LGA personnel. Given, the limited resources for HIV response, our local system needs to be more efficient. Other challenges noted at the JAR include: dataflow structure defined in NOP-1 are not complied with, HIV data and reports are not widely disseminated, some national studies have small sample sizes, which limit analysis at the state level and poor supervision and capacity building at the state and LGA levels.

4.6.4. Coordination of the national HIV response

Some of the infrastructures and global mechanism for an effective national HIV response are in place in Nigeria. Nigeria has complied with the 'three ones' principles. The latest NSP 2010-15, re-positioned HIV prevention as a core strategy for halting the HIV epidemic and major progress achieved in reducing the national HIV prevalence to 4.1%.

The States perceive HIV response as a national issue, hence their poor commitment to funding and limited activity at their local level. The States are not held accountable for achieving any targets on HIV, without penalties or incentives for achievement. NACA in its advocacy role should seek for a few key HIV indicators/targets to be

¹⁶NACA October 2011. Joint Annual Review of the National Response to HIV/AIDS 2011

¹⁷NACA. National Policy on HIV/AIDS. October 2009.

included in the national health sector reform agenda and States are held accountable for their delivery, with penalties or incentives for achieving HIV targets on the national health scoreboard. Furthermore, NACAs advocacy role to increase public and private sector funding within Nigeria should be a priority agenda in future year.

A general failure of the national response is lack of cost-effectiveness studies and evaluation studies of HIV programmes in Nigeria (against their objectives). The expenditure for social protection and social services are regrettably very low, given the high level social issues associated with HIV/AIDS.

4.6.5. The out of pocket expenditure (OOP)

Though most HIV and AIDS services are rendered free, the out of pocket expenditure study revealed that individuals spent a total of \$170million and \$202million in 2009 and 2010 respectively. About 14.5% of their household incomes were spent in accessing HIV services, which is above the 10% catastrophic threshold. It may be comparatively cheaper and beneficial for PLWHA to channel some of these funds into an insurance scheme.

Finally, the findings of this NASA report and the joint annual review in 2011, should inform annual plans for 2011/12 and trajectories for key indicators should be revised and monitored with feedback to each state for clear action to deliver.

4.6.6. Budgets against actual expenditure in the National Response

The national response budget for HIV AIDS was \$809,690,334.00 in 2010¹⁸; the national AIDS spending assessment for 2010 recorded an expenditure of \$498,917,471.00, which is 61% of total budgeted figures. This may look good and encouraging for the national response. However the fact remains that the funds for implementation of vast majority of HIV AIDS goods and services is largely dependent on international funds (76% and 75% for 2009 and 2010 respectively)

Budget against expenditure for 2010.

S/N	Item	Amounts Budgeted in 2010	Expenditures in 2010	% of 2010 budget expended.
1	Total Budget	\$809,690,334.00	\$496,917,471.00	61
2	Prevention	\$283,381,82.00	\$61,877,789.00	21
3	Care and treatment	\$395,723,910.00	\$186,032,729.00	47
4	M&E and research	\$66,959,079.00	\$10,678,721.00	15

In the period under review, prevention recorded an increase in expenditure (8.7% and 12.45% for 2009, 2010 respectively). This is only 21% of the total planned for prevention in 2010. The amounts have played down the need for greater prevention work among MARPS and the general population.

The expenditure for HIV care and treatment in 2010 was \$186million (47%) of the planned figure of \$395million. To be able to place the 1.5million PLWA eligible for ART on treatment, there is need to increase funding for care and treatment.

The national strategic plan 2010-2015, grouped Monitoring and Evaluation and research together, while they are separate and key components of the national response. The expenditure for research and monitoring and evaluation amounted to \$10,678,721.00 (15%) against the \$66,959,079.00 planned. These figures are grossly inadequate if effective monitoring and evaluation and research into the activities of the national HIV response must be conducted. Considerable attention must be given to these areas in terms of funding.

¹⁸ NACA (2010): Nigeria. National strategic plan 2010-2015

5.0 Conclusion and Recommendations

5.1 Conclusion

#	Key Message	Details
1.	HIV spending:	HIV spending in the country increased from \$415,287,430 in 2009 to \$496,917,471 in 2010
2.	Increased spending by Government:	HIV spending by Government in 2010 increased by 58% compared to 2007. (\$ 73 million in 2007 to \$126 million in 2010)*
3.	Funding of the HIV response:	The HIV response in Nigeria was highly dependent on international funds with bilateral agencies as the main source of international funds.
4.	Financial decision making for the HIV response:	The programmatic decisions on what HIV goods and services that were purchased, provider of the goods and services and the beneficiary population were determined by the international organizations.
5.	Profile of Spending:	Most of the HIV spending in 2009 and 2010 was on Care and treatment.
6.	People living with HIV/AIDS was the main beneficiary population:	People living with HIV/AIDS benefited from half of the HIV expenditure in 2009 and 38.0% of the expenditure in 2010.
7.	Relatively low spending on the general population.	The expenditure on the general population increased to 12.5% of the total expenditure in 2010 compared to 5.6% in 2009. This is still considered low.

* The World Bank funds was added to the Public sources of fund

5.2 Recommendations

#	Key Message	Details
1.	Institutionalize NASA	Institutionalize the NASA process in Nigeria for ease of data collection and also reporting on HIV and AIDS spending. The key issues that need to be addressed are: a) greater advocacy to all stake holders especially the private sector b) streamlining of financial disbursement and reporting mechanisms c) the NACA coordinating mandate has to be enforced - that is a suitable mechanism has to be introduced that will track HIV and AIDS from source to provider in Nigeria and d) institutions should be more open in their disclosure of financial records on HIV to allow a more robust categorization of the expenditure
2.	Use NASA for National planning	Use NASA data to determine the comprehensiveness and robustness of the national HIV/AIDS strategic plan and framework. Use NASA data for priority setting in HIV/AIDS planning processes.
3.	Increase level of spending on General population, including positive pregnant women and their children.	Prevention programmes targeting general population should be strengthened and expanded. The mode of HIV transmission study conducted in Nigeria revealed that about 60% of new infections will occur among the general population including positive pregnant women (Low risk and casual heterosexual). Therefore PMTCT should receive a great priority in terms of funding to increase coverage and achieve the target of eMTCT in Nigeria.
4.	Improve Government Spending	Government spending on the HIV national response be increased in line with the strategic framework and action plan to reduce dependence on international funds, for scale up of all interventions, exit strategy for reducing donor funds and most importantly for sustainability
5.	Dissemination of report	The dissemination of an abridged form of the report in the 6 geographical regions of the country will ensure that the document is used for planning and allocation of resources.
6.	Priority states	Future resource allocation should give priority to states with a high burden of the HIV epidemic
7.	Out of pocket	The out of pocket studies should include household surveys and proportionate sampling to reflect the prevalence of HIV.
8.	Research	Identify a clear budget line for research, which should be safeguarded, with annualized prioritized work plan, milestones and indicators of successes clearly defined

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Appendices

Appendix 1 – Contacted Institutions and data collectors

S/N	Institution	Contact person
1	Access Bank	Omobolanle Babatunde
2	Adeoyo Maternity Hospital	NIL
3	Ahmadu Bello University Teaching Hospital	Abimaje Isiaka
4	Aids Prevention Initiative in Nigeria	Tinuade Oyebode
5	Clinical and Laboratory Standards Institute	Frances Ingersoll
6	Akwa Ibom State Action Committee on AIDS	Mrs. Glory Etuknwa
7	Akwa Ibom State Ministry of Education	Esang Akpan
8	Anambra State Action Committee on AIDS	NIL
9	Archdiocesan Catholic Action Committee on HIV/AIDS	Rev sr. Teresa Dung
10	Association for Reproductive and Family Health	Mrs. Joke Ojo
11	Association of Orphans & Vulnerable Children Nassarawa	Emmanuel Lorkumbur
12	Benue State Ministry Of Health and Human Resources	Dr. G.M.G. Dura
13	Catholic Relief Service	Augustina Useire
14	Center for Peace	Audu Sanni
15	Centre for Health Works Development and Research	Mr. Felix N. Ukam
16	Centre for Women Youth and Community Action	Mr. Nawani Aboki
17	Civil Society Against AIDS	Thomas
18	Civil Society Organizations	NIL
19	Country Women Association (COWAN)	Bitrus John
20	Cross Rivers State Ministry of Health	Etaba David Agbor
21	Daughters Of Charity	NIL
22	Deloitte Consulting	Dr. Victoria Agbara
23	Dreamboat Theatre for Development Foundation	Edisua Oko-Offoboche
24	Education as a Vaccine	Fadakemi Akinfaderin
25	Enhancing Nigeria's Response to HIV and AIDS Programme	Joy Ikede
26	Excellence Community Education Welfare Scheme	Jim Godwin
27	Family Health Care Foundation	Mary N. Ashenanye
28	Family Health Care Nassarawa	Mrs. Mary N. Ashenanye

29	Family Health International	Nkata Chuku
30	Federal Ministry of Education	Offiah Bidy
31	Federal Ministry of Health	Dr. Francis Ukwuije
32	Federal Ministry of Women Affairs and Social Dev.	Odo T.I
33	Federal Road Safety Corp	Mr. Ken Nwaegbe
34	Federation of Muslim Women Association of Nigeria	Hajiya Iyabo Sanni
35	First Step Action For Children Initiative	Rosemary Hua
36	For profit private Hospital	NIL
37	Government Hospital	NIL
38	Greenwatch initiative	Emmanuel Tembe
39	Hygeia Foundation	Dr. Etsetowaghan
40	I Care Women and Youth Initiative	Abdullahi Bala
41	Institute of Human Virology, Nigeria	Debo Olateju
42	International Labour Office	Pius Udo
43	International Centre for AIDS care & treatment programme	Bola Oyeledun
44	Family Health International	Nkata Chuku
45	Joint United Nations Programme On HIV/AIDS	Are Shodeinde
46	JSI/ AIDSTAR-One Injection Safety	Dr. Abimbola Sowande
47	Lagos State Ministry of Education	Mrs. M.K Hazoume
48	Management Sciences For Health	Donna Coulibay
49	Measure Evaluation	NIL
50	Millennium Development Goal Office	Dr. Ibrahim Kana
51	Nassarawa State AIDS Control Agency	NIL
52	National Agency for the Control of AIDS	Dr. Kayode Ogungbemi
53	National Population Council	NIL
54	National Youth Aid Program	Mr. Kelvin Ezechiedo
55	National Youth Service Corps	NIL
56	Network of People living with HIV/AIDS in Nigeria	NIL
57	Nigerian Institute of Medical Research, Lagos	NIL
58	Ogun State Action Committee on AIDs	Adekunle Adebayo
59	Old Netim Health and Development Organisation	NIL
60	Partners For Development	Ediri Iruaga
61	Pathfinder International	Olamide Oyelade
62	Sagamu Community Centre	Dr. O. A. Jeminusi

63	Society For Family Health	Kenneth Oboh
64	Sokoto State Action Agency for the Control of AIDS	Usman Abdullahi
65	State Hospital Ota	Babayode Tunde
66	State Hospital Isara	Akapo R .O
67	Taimako Women Health Foundation	NIL
68	The Holy Order of Cherubim and Seraphim	Oluleye .A. Odebumi
69	United Nations Development Programme Akwa Ibom	Idongesit Ekpo
70	United Nations Development Programme Sokoto	Alh. Imam Dogondaji
71	United Nations Children's Fund	NIL
72	United Nations Development Programme	David Owolabi
73	United Nations Population Fund	Uzoma Okoye
74	Women, Youth and Children Upliftment	Lilian Ekanem
75	World Health Organization	Dr. Okello David
76	Youth Empowerment Foundation	NIL

Appendix 2-Time line for NASA implementation

TASK	JUNE				JULY				AUGUST				SEPTEMBER				OCTOBER				NOVEMBER			
	WK1	WK2	WK3	WK4	WK1	WK2	WK3	WK4	WK1	WK2	WK3	WK4	WK1	WK2	WK3	WK4	WK1	WK2	WK3	WK4	WK1	WK2	WK3	WK4
Hiring of Consultants																								
Setting up of Secretariat																								
Development of implementation plan																								
Stakeholders Meeting																								
Training of NASA Core team																								
Training of Focal persons from Institutions																								
Training of Data Collectors/SACA																								
Data Collection																								
Data processing and analysis																								
Data validation by Institutions																								
Data validation (Triangulation) by Core team																								
Report writing																								
Presentation of preliminary findings																								
Final report																								

Appendix 3- Reported Official Development assistance for HIV to Nigeria, 2001-2010 (US\$ millions)

The reported official development assistance for HIV to Nigeria is presented below. However, only funds from the governments of United Kingdom, United States and Japan, UNICEF, UNAIDS, UNFPA, EC, GFTAM and UNDP were captured by NASA. There was no financial data from the other donors. It is hoped that data from all donors in Nigeria will be incorporated in future NASA.

Donor	2001	2002	2003	2004	2005	2006	2009	2010
Canada	-	6.365	-	2.031	4.434	2.577	1.758	0.882
Finland	-	-	-	-	-	0.027		
France	0.102	0.060	0.071	0.049	-	-		
Germany	-	-	0.017	-	0.266	0.001	0.046	0.018
Greece							0.015	
Ireland	-	-	-	-	0.068	0.124	0.145	0.081
Italy							0.056	
Japan							0.157	
Norway	-	-	-	-	0.006	-	0.035	0.030
Sweden	-	-	-	-	-	0.009	0.010	0.007
United Kingdom	2.388	1.244	1.510	2.890	3.601	25.281	30.076	32.609
United States	-	4.781	33.738	54.962	51.538	95.693	170.503	286.028
IDA	-	1.100	2.000	6.700	55.530	-		4.224
UNICEF	0.980	0.163	0.563	0.175	0.065	1.647	2.291	3.352
UNAIDS	1.103	0.275	0.884	-	1.125	-	1.151	0.988
UNFPA	-	-	0.030	-	-	-	0.279	0.315
GFATM	-	-	2.523	0.303	15.273	19.678	6.675	40.182
EC								0.507
UNDP							1.548	1.138
Total	4.57	13.99	41.34	67.11	131.91	145.04	214.74	370.36

Source: OECD database

Appendix 4– Assumptions and Estimations

Assumption on Exchange rate

The Naira to US dollars exchange fluctuated tremendously in 2009 and 2010. An average exchange rate of N150 to 1 USD was assumed for all the public funds, GFTAM and World Bank transactions. The other institutions reported all their expenditure in US dollars.

Estimation of ART drug consumption and costs

The Federal Medical Store did not provide information on the followings:

- STI drugs distributed
- Antiretroviral distributed for treatment and prevention
- The first and second line ARVs distributed in 2009 and 2010
- Disaggregation of the first and second line ARVs distributed by adult and pediatrics

Assumptions for ART laboratory monitoring and OI diagnostics estimations

	2009	2010
Number of patients on ART	302,973	359,181
Male patients on ART	N/A	120,497
Female patients on ART	N/A	238,684

Source: Federal Ministry of Health

Type of test	Number of tests per patient per year	Cost per test	Cost of tests in 2009	Cost of tests in 2010
HIV Serology	1	\$3.33	\$1,008,900.09	\$1,196,072.73
CD4	2	\$10.00	\$6,059,460.00	\$7,183,620.00
Hib	3	\$1.33	\$1,208,862.27	\$1,433,132.19
Liver function test	2	\$5.00	\$3,029,730.00	\$3,591,810.00
Renal function test	2	\$10.00	\$6,059,460.00	\$7,183,620.00
HB2Aq	1	\$2.67	\$808,937.91	\$959,013.27
UDRL and TPHA (STI tests)	1	\$20.00	\$6,059,460.00	\$7,183,620.00
Chest testing	1	\$4.00	\$1,211,892.00	\$1,436,724.00
sputum test	1	\$6.00	\$1,817,838.00	\$2,155,086.00

Source: Federal Ministry of Health

STI treatment estimations

STIs

In Nigeria, there are about 3 million reported annual cases of STI's mainly caused by Chlamydia, N. Gonorrhoeae and trichomonasvaginalis. There are also increasing reports of genital ulcer disease (GUD) due to chancroid, herpes, and primary syphilis.¹⁹

¹⁹ FMOH, National Guidelines on Syndromic Management of Sexually Transmitted Infections (STIs) and other Reproductive Tract Infections (RTIs)

OI prophylaxis and treatment estimations

O.I TREATMENT COSTS

OIs		Drug to be used (OIs)	Treatment Regimen	Number of tabs/ regimen	Number of episodes /patient	Unit Cost (\$)	Year 1 (2009)		Year 2 (2010)	
Candidiasis							Patient Population			
							Number of tabs/pop	Total Cost	Number of tabs/pop	Total Cost
	Oral	Nystatin- 500,000 IU	4x/day for 5 days	20	1	0.0461	6059460	279341.11	7183620	331164.88
	Oesophagitis	Fluconazole- 200 mg	1/day for 105 days	105	1	0.0416	31812165	1323386.1	37714005	1568902.6
	Vulvo-vaginal	Clotrimazole- 500 mg	1/day	1	6	0.183	1817838	332664.35	2155086	394380.74
Herpes								0	0	0
	Oral and genital	Acyclovir 200 mg	5/day for 10 days	50	1	0.045	15148650	681689.25	17959050	808157.25
	Herpes zoster	Acyclovir 200 mg	20/day for 10 days	200	1	0.045	60594600	2726757	71836200	3232629
Diarrhea								0	0	0
	Bacterial	Metronidazole 400 mg	2x/day for 10 days	20	2	0.0039	12118920	47263.788	14367240	56032.236
		Cotrimoxazole 960 mg	2x/day for 10 days	20	2	0.0228	12118920	276311.38	14367240	327573.07
		Ciprofloxacin 500 mg	1x/day for 10 days	10	2	0.0253	6059460	153304.34	7183620	181745.59
Pneumonia								0	0	0
	Bacterial	Amoxicillin 500 mg	4x/day for 10 days	40	1	0.0352	12118920	426585.98	14367240	505726.85
	PCP prophylaxis	Cotrimoxazole 960 mg	1x/day for 360 days	360	1	0.0228	109070280	2486802.4	129305160	2948157.6
	PCP	Cotrimoxazole 960 mg	8x/day for 21 days	168	1	0.0228	50899464	1160507.8	60342408	1375806.9

Cryptococcal Meningitis								0	0	0
		Amphotericin B 50 mg (INJ)	1 (0.7 mg/kg) x/day for 14 days	14	1	7.1837	4241622	30470540	5028534	36123480
		Flucytosine 100 mg	1x/day for 14 days	14	1	N/A	4241622	0	5028534	0
		Fluconazole- 200 mg	2x/day for 56 days	56	1	0.0416	16966488	705805.9	20114136	836748.06
Toxoplasmosis								0	0	0
	<60 kg	Pyrimethamine-25 mg	2x/day for 42 days	42	1	0.0055	12724866	69986.763	15085602	82970.811
	>60 kg	Pyrimethamine-25 mg	3x/day for 42 days	42	1	0.0055	12724866	69986.763	15085602	82970.811
		Clotrimoxazole 960 mg	2x/day for 42 days	84	1	0.0228	25449732	580253.89	30171204	687903.45
Fungal Skin Infections		Miconazole, 2% in 30 mg	2 tube/patient	2	2	0.333	1211892	403560.04	1436724	478429.09
Scabies		Benzyl Benzoate, 25 %, 100ml	1bottle/patient	1	1	0.0025	302973	757.4325	359181	897.9525
Bacterial Skin Infections		Amoxicillin 500 mg	4x/day for 5 days	20	1	0.0352	6059460	213292.99	7183620	252863.42
TOTAL								42,408,797.16		50,276,540.07

Source: NACA

Calculation of opportunistic infection drugs

Number of tab or tube/Population= No of tabs/regimen X No of episodes X No on ART

Annual cost on OI drugs(USD) = Number of tablets or tube/population X Unit cost

The out of pocket expenditure (OOP) for 2009 and 2010

An out of pocket study was undertaken in five states of Lagos, Akwa-Ibom, Cross Rivers, Benue and Abia using a sample size of 485 PLWHAs by NACA to obtain how much PLWHA spent in 2009 and 2010 in accessing HIV services.

Annual out-of pocket payment spending for Laboratory services, ART and non-ART drugs by PLWHA

HIV service	2009	2010
Laboratory	N115,129,740 (\$719,561)	N136,488,780 (\$909,925)
ART	N23,231,970 (\$145,200)	N27,541,999 (\$183613)
Non-ART	N78,3003,421 (\$4,893,771)	N928,267,376 (\$6188449)

1. Laboratory services: Include test s like HIV serology, CD4, Hb, Liver function test, Renal function test ,HBsAg, UDRL and TPHA (STI test), chest testing and sputum test.

2. ART: Payments made for ARVS.

3. Non-ART: Payments made for drugs other than ARVs.

4. HIV Services : Any care that is paid for and received on account of accessing ART by a PLWHA

Summary of findings

Annual household income	N586,584 (\$3,910)
Average annual out-of-pocket expenditure for HIV services	N84,480 (\$563)
Total annual out-of pocket expenditure for HIV services in 2009	N25,595,159,040 (\$170,634,393)
Total annual out-of pocket expenditure for HIV services in 2010	N30,343,610,880 (\$202,290,739)
The proportion of household income spent on HIV services	14.5%
Average annual OOP spend on condoms	N7728 (\$52)
Total annual OOP spend on condoms in 2009	N1,381,320,263 (\$9,208,801)
Total annual OOP spend on condoms in 2010	N1,637,694,576 (\$10,917,963)

Appendix 5 – PEPFAR-NASA categories Crosswalk for Nigeria

	PEPFAR Program Codes		NASA AIDS Spending Categories		NASA Beneficiary Populations	
Prevention	01 - MTCT	Prevention: PMTCT	ASC.01.17	PMTCT	BP.03	Other Key Populations
	02 - HVAB	Sexual Prevention: AB	ASC.01.01	Communication for social and behavior change	BP.05	General Population
	03- HVOP	Sexual Prevention: Other Sexual Prevention	ASC.01	Prevention	BP.02	Most-as-risk Populations
	04 - HMBL	Biomed. Prevention: Blood Safety	ASC.01.19	Blood Safety	BP.03.14	Recipients of blood or blood products
	05 - HMIN	Biomed. Prevention: Injection Safety	ASC.01.20	Safe Medical Injections	BP.05	General Population
	06 - IDUP	Biomed. Prevention: Injecting and Non-Injecting Drug Use	ASC.01	Prevention	BP.02	Most-as-risk Populations
	07 - CIRC	Biomed. Prevention: Male Circumcision	ASC.01.18	Male Circumcision	BP.05	General Population
	14 - HVCT	Care: Care and Counseling	ASC.01	Prevention	BP.05	General Population
Care	08 - HBHC	Care: Adult Care and Support	ASC.02	Care and treatment	BP.01	People Living with HIV/AIDS
	10 - PDCS	Care: Pediatric Care and Support	ASC.02	Care and treatment	BP.01	People Living with HIV/AIDS
	12 - HVTB	Care: TB/HIV	ASC.02	Care and treatment	BP.01	People Living with HIV/AIDS
	13 - HKID	Care: OVC	ASC.03	Orphans and vulnerable children	BP.03	Other Key Populations
Treatment	09 - HTXS	Treatment: Adult Treatment	ASC.02.03	Care and treatment	BP.01	People Living with HIV/AIDS
	11 - PDTX	Treatment: Pediatric Treatment	ASC.02	Care and treatment	BP.01	People Living with HIV/AIDS
	15 - HTXD	ARV Drugs	ASC.02	Antiretroviral therapy	BP.01	People Living with HIV/AIDS
	16 - HLAB	Laboratory Infrastructure	ASC.04.10 ASC 02.01.05	Upgrading laboratory infrastructure and new laboratory equipment HIV-related laboratory monitoring	BP.06	Non-Targeted Interventions
Other	17 - HVSI	Strategic Information	ASC.04	Programme management and administration	BP.06	Non-Targeted Interventions
	18 - OHSS	Health Systems Strengthening	ASC.04 ASC.05 ASC.07	Programme management and administration Human Resources Enabling environment	BP.06	Non-Targeted Interventions
	19 - HVMS	Management and Operations	ASC.05	Human resources	BP.06	Non-Targeted Interventions

Appendix 6-Financing Sources 2009 and 2010 – (3rd digit analysis)

Financing Source	USD 2009		USD 2010	
	Amount(USD)	%	Amount(USD)	%
FS.01 Public Sources	97,790,519.00	23.55	125,139,587.00	25.18
FS.01.01.01 Central government revenue	96,936,124.00	23.34	123,920,712.00	24.94
FS.01.01.02 State/provincial government revenue	852,312.00	0.21	1,162,795.00	0.23
FS.01.99 Other public funds n.e.c.	2,083.00	0.001	56,080.00	0.01
FS.02 Private Funds	278,303.00	0.07	850,547.00	0.17
FS.02.01 Profit-making institutions and corporations	142,479.00	0.03	699,712.00	0.14
FS.02.03 Non-profit-making institutions (other than social insurance)	134,925.00	0.03	150,835.00	0.03
FS.02.99 Private financing sources n.e.c.	899	0.0002	0	0.00
FS.03 International Funds	317,218,608.00	76.39	370,927,337.00	74.65
FS.03.01 Direct bilateral contributions	272,915,916.00	65.72	284,908,865.00	57.34
FS.03.01.12 Government of Japan	35,714.00	0.01	71,773.00	0.01
FS.03.01.21 Government of the United Kingdom	9,440,310.00	2.27	97,997,081.00	19.72
FS.03.01.22 Government of the United States of America	263,257,146.00	63.39	186,427,869.00	37.52
FS.03.01.23 Government of the People's Republic of China	0.00	0.00	9,333.00	0.002
FS.03.01.99 Other government(s)/other bilateral agencies n.e.c.	182,746.00	0.04	402,809.00	0.08
FS.03.02 Multilateral Agencies	44,174,013.00	10.64	85,861,856.00	17.28
FS.03.02.02 European Commission	42,308.00	0.01	45,762.00	0.01
FS.03.02.04 International Labour Organization (ILO)	12,000.00	0.003	53,848.00	0.01
FS.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	35,087,474.00	8.45	65,899,650.00	13.26
FS.03.02.08 UNAIDS Secretariat	725,440.00	0.17	4,500,924.00	0.91
FS.03.02.09 United Nations Children's Fund (UNICEF)	3,151,115.00	0.76	4,742,838.00	0.95
FS.03.02.10 United Nations Development Fund for Women (UNIFEM) now UNWomen	0.00	0.00	5,282,649.00	1.06
FS.03.02.11 United Nations Development Programme (UNDP)	1,368,444.00	0.33	1,661,434.00	0.33
FS.03.02.17 United Nations Population Fund (UNFPA)	212,105.00	0.05	378,479.00	0.08
FS.03.02.18 World Bank (WB)	2,462,620.00	0.59	1,505,746.00	0.30

FS.03.02.20 World Health Organization (WHO)	1,112,507.00	0.27	1,790,526.00	0.36
FS.03.03 International non-profit-making organizations and foundations	107,596.00	0.03	100,588.00	0.02
FS.03.03.02 ActionAID	0	0.00	60,589.00	0.01
FS.03.03.26 The Ford Foundation	107,596.00	0.03	39,999.00	0.01
FS.03.04 International for Profit Making	21,083.00	0.01	56,028.00	0.01
Total	415,287,430.00	100	496,917,471.00	100

Spending pattern by financing source-2009

Aids Spending Categories	FS.01 Public funds	%	FS.02 Private funds	%	FS.03.01 Direct bilateral contributions	%	FS.03.02 Multilateral agencies	%	FS.03.03 International non-profit funds	%	FS.03.04 International for profit funds	%	Total
ASC.01 Prevention	2,131,656	2.2	100,577	36.1	28,966,760	10.6	4,985,385	11.3	0	0	0	0	36,184,378
ASC.02 Care and treatment	11,181,773	11.4	21,207	7.6	176,829,220	64.8	16,272,308	36.8	0	0	0	0	204,304,508
ASC.03 Orphans and vulnerable children(OVC)	313,297	0.3	15,799	5.7	8,142,584	3.0	628,024	1.4	0	0	0	0	9,099,704
ASC.04 Program Management and administration	12,668,195	13.0	88,346	31.7	48,458,966	17.8	15,977,375	36.2	0	0	19,801	93.9	77,212,683
ASC.05 Human resources	71,193,742	72.8	25,407	9.1	8,448,029	3.1	5,321,142	12.0	0	0	1,282	6.1	84,989,602
ASC.06 Social protection and social services (excluding OVC)	14,737	0.02	5,621	2.0	44,149	0.02	19,211	0.04	0	0	0	0	83,718
ASC.07 Enabling environment	284,555	0.3	21,346	7.7	1,407,587	0.5	966,138	2.2	0	0	0	0	2,679,626
ASC.08 HIV and AIDS related research(excluding operations research)	2,564	0.003	-	0.0	618,621	0.2	4,430	0.01	107,596	100	0	0	733,211
Total	97,790,519	100	278,303	100	272,915,916	100	44,174,013	100.0	107,596	100	21,083	100	415,287,430

Spending categories by financing source-2010

AIDS Spending Categories	FS.01 Public Funds	%	FS.02 Private Funds	%	FS.03.01 Direct bilateral contributions:	%	FS.03.02 Multilateral agencies	%	FS.03.03 International non-profit	%	FS.03.04 International profit-making	%	Total
ASC.01 Prevention	2,600,309	2.08	254,909	29.97	52,018,264	18.26	6,947,659	8.09	620	0.62	56,028	100	61,877,789
ASC.02 Care and treatment	25,245,294	20.17	13,938	1.64	144,797,193	50.82	15,976,304	18.61	0	0.00	0	0	186,032,729
ASC.03 Orphans and vulnerable children (OVC)	439,648	0.35	6,853	0.81	6,117,313	2.15	554,981	0.65	0	0.00	0	0	7,118,795
ASC.04 Programme Management	22,387,811	17.89	521,862	61.36	66,280,930	23.26	32,626,922	38.00	13,572	13.49	0	0	121,831,097
ASC.05 Human resources	73,933,602	59.08	17,467	2.05	12,159,804	4.27	9,762,285	11.37	46,052	45.78	0	0	95,919,210
ASC.06 Social protection and social services	10,224	0.01	14,232	1.67	43,864	0.02	114,869	0.13	0	0.00	0	0	183,189
ASC.07 Enabling Environment	522,699	0.42	21,286	2.50	1,463,494	0.51	19,862,241	23.13	345	0.34	0	0	21,870,065
ASC.08 HIV-related research	0	0.00	0	0.00	2,028,003	0.71	16,595	0.02	39,999	39.77	0	0	2,084,597
Total	125,139,587	100	850,547	100	284,908,865	100	85,861,856	100	100,588	100.00	56,028	100	496,917,471

Appendix 7: Financing Agents in 2009 and 2010 (3rd digit analysis)

Financing Agents	2009		2010	
	Amount (USD)	%	Amount (USD)	%
FA.01 Public Sector	98,073,517	23.62	125,294,375	25.21
FA.01.01.01.01 Ministry of Health (or equivalent sector entity)	7,368,463	1.77	13,034,138	2.62
FA.01.01.01.02 Ministry of Education (or equivalent sector entity)			32,914	0.01
FA.01.01.01.05 Ministry of Finance (or equivalent sector entity)	69,851,380	16.82	70,208,391	14.13
FA.01.01.01.06 Ministry of Labour (or equivalent sector entity)			17,522	0
FA.01.01.01.08 Other ministries (or equivalent sector entities)			2,447	0
FA.01.01.01.10 National AIDS Commission	11,121,912	2.68	19,127,908	3.85
FA.01.01.01.99 Central or federal authorities' entities n.e.c.	7,952,578	1.91	21,721,854	4.37
FA.01.01.02.01 Ministry of Health (or equivalent state sector entity)			27	0
FA.01.01.02.02 Ministry of Education (or equivalent state sector entity)	107,897	0.03	59,446	0.01
FA.01.01.02.03 Ministry of Social Development (or equivalent state sector entity)	351	0	131	0
FA.01.01.02.04 Other ministries (or equivalent state sector entities)	3,921	0	67,101	0.01
FA.01.01.02.05 Executive Office (or office of the head of the State/Province/Department)	27,586	0.01	27,586	0.1
FA.01.01.02.06 State/Province/Department AIDS Commission	1,607,783	0.39	962,016	0.1
FA.01.99 Other public financing agents n.e.c.	31,646	0.01	32,894	0.01
FA.02 Private Sector	4,256,866	1.03	26,774,251	5.39
FA.02.05 Not-for-profit institutions (other than social insurance)	4,161,308	1	26,074,208	5.25
FA.02.06 Private non-parastatal organizations and corporations (other than health insurance)	702	0	702	0
FA.02.99 Other private financing agents n.e.c.	94,856	0.02	699,341	0.14
FA.03 International Purchasing Organizations	312,957,047	75.36	344,848,845	69.4
FA.03.01 Country offices of bilateral agencies	273,164,456	65.78	284,157,870	57.18
FA.03.01.12 Government of Japan			71,773	0.01
FA.03.01.21 Government of United Kingdom	9,322,386	2.24	30,464,725	6.13
FA.03.01.22 Government of United States	263,842,070	63.53	253,612,039	51.04
FA.03.01.23 Government of People's Republic of China			9,333	0
FA.03.02 Multilateral Agencies	9,919,624	2.39	53,336,072	10.73
FA.03.02.02 European Commission	956	0	956	0
FA.03.02.04 International Labour Organization (ILO)	12,000	0	53,848	0.01
FA.03.02.07 UNAIDS Secretariat	725,440	0.17	4,500,924	0.91
FA.03.02.08 United Nations Children's Fund (UNICEF)	3,151,115	0.76	4,742,838	0.95
FA.03.02.09 United Nations Development Fund for Women (UNIFEM)			5,282,649	1.06
FA.03.02.10 United Nations Development Programme (UNDP)	1,551,190	0.37	2,064,243	0.42
FA.03.02.16 United Nations Population Fund (UNFPA)	224,685	0.05	454,886	0.09
FA.03.02.17 World Bank (WB)	1,479,944	0.36	1,330,579	0.27
FA.03.02.19 World Health Organization (WHO)	1,112,507	0.27	1,790,526	0.36

FA.03.02.99 Other Multilateral entities n.e.c.	1,661,787	0.4	33,114,623	6.66
FA.03.03 International not for profit making organizations and foundations	29,872,967	7.19	7,354,903	1.48
FA.03.03.02 ActionAID	56,322	0.01	105,395	0.02
FA.03.03.26 The Ford Foundation	107,596	0.03	39,999	0.01
FA.03.03.99 Other International not-for-profit organizations n.e.c.	5,407,285	1.3	5,722,323	1.15
FA.03.99 Other international financing agents n.e.c.	24,301,764	5.85	1,487,186	0.3
Total	415,287,430		496,917,471	100

Appendix 8- HIV/AIDS Service providers in 2009 and 2010(2nd and 3rd digit analysis)

HIV/AIDS Service Providers	2009		2010	
	Amount (USD)	%	Amount (USD)	%
PS.01-Public Sector Providers	140,782,985.00	33.90	177,719,983.00	35.76
PS.01.01.01 Hospitals (Governmental)	86,773,075.00	20.89	83,797,350.00	16.86
PS.01.01.10.03 Higher education	0	0.00	125,370.00	0.03
PS.01.01.13 Research institutions	1,048,453.00	0.25	1,261,372.00	0.25
PS.01.01.14.01 National AIDS Commission	33,204,248.00	8.00	49,820,648.00	10.03
PS.01.01.14.02 Departments inside the Ministry of Health	14,279,034.00	3.44	34,927,111.00	7.03
PS.01.01.14.03 Departments inside the Ministry of Education	186,589.00	0.04	1,586,211.00	0.32
PS.01.01.14.04 Departments inside the Ministry of Social Development	675,402.00	0.16	3,836,595.00	0.77
PS.01.01.14.99 Government entities not elsewhere classified	4,039,679.00	0.97	2,177,970.00	0.44
PS.01.01.99 Governmental organizations not elsewhere classified	31,646.00	0.01	154,243.00	0.03
PS.01.02.99 Parastatal organizations not elsewhere classified	447,873.00	0.11	0	0.00
PS.01.99 Public sector providers not elsewhere classified	96,986.00	0.02	33,113.00	0.01
PS.02-Private Sector non-profit Providers	269,069,366.00	64.79	302,395,926.00	60.85
PS.02.01.01.01 Hospitals (non governmental)	306,415.00	0.07	155,274.00	0.03
PS.02.01.01.05 Laboratory and imaging facilities	185,326.00	0.04	144,460.00	0.03
PS.02.01.01.13 Research institutions	0	0.00	40,450,934.00	8.14
PS.02.01.01.15 Civil society organizations	244,315.00	0.06	19,649,059.00	3.95
PS.02.01.01.99 Non-profit non-faith-based providers (N.E.C)	263,896,689.00	63.55	207,812,202.00	41.82
PS.02.01.02.01 Hospitals (non-profit non faith-based)	500,458.00	0.12	905,281.00	0.18
PS.02.01.02.14 Civil society organizations	830,332.00	0.20	256,954.00	0.05
PS.02.01.02.99 Other non-profit faith-based private sector provider N.E.C	1,583,861.00	0.38	694,528.00	0.14
PS.02.01.99 Other non-profit private sector providers n.e.c.	635,620.00	0.15	28,688,735.00	5.77

PS.02.02.01 Hospitals (for profit)	792,011.00	0.19	343,810.00	0.07
PS.02.02.13 Research institutions	0	0.00	29,872.00	0.01
PS.02.02.99 Profit-making private sector providers (n.e.c.)	94,339.00	0.02	1,788,350.00	0.36
PS.02.99 Private sector providers (n.e.c.)	0	0.00	1,476,467.00	0.30
PS.03-Bilateral and Multilateral entities	5,435,079.00	1.31	16,801,562.00	3.38
PS.03.02 Multilateral agencies	5,435,079.00	1.31	16,801,562.00	3.38
Total	415,287,430.00	100	496,917,471.00	100

Appendix9-AIDS Spending Categories in 2009 and 2010(2nd and 3rd digit analysis)

AIDS Spending Categories	2009 (USD)	%	2010 (USD)	%
ASC 01-Prevention	36,184,378.00	8.71	61,877,789.00	12.45
ASC.01.01.01 Health-related communication for social and behaviour change	10,222,321.00	2.46	29,448,810.00	5.93
ASC.01.01.02 Non-health-related communication for social and behaviour change	1,923.00	0.0005	3,699.00	0.001
ASC.01.01.98 Communication for social and behaviour change not broken down by type	471,923.00	0.11	199,281.00	0.04
ASC.01.02 Community mobilization	156,378.00	0.04	1,069,561.00	0.22
ASC.01.03 Voluntary counselling and testing (VCT)	4,602,852.00	1.11	1,644,481.00	0.33
ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	88,930.00	0.02	1,690.00	0.00
ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	9,643.00	0.00	25,372.00	0.01
ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not broken down by type	701,601.00	0.17	450,055.00	0.09
ASC.01.04.99 Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c.)	0.00	0.00	930,019.00	0.19
ASC.01.05 Prevention – youth in school	386,506.00	0.09	2,377,043.00	0.48
ASC.01.06 Prevention – youth out-of-school	647,450.00	0.16	734,435.00	0.15
ASC.01.07.01 Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV	61,764.00	0.01	49,017.00	0.01
ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients	15,243.00	0.00		0.00
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients	21,753.00	0.01	8,087.00	0.00
ASC.01.08.98 Programmatic interventions for sex workers and their clients not broken down by type	323,765.00	0.08	51,855.00	0.01
ASC.01.08.99 Other programmatic interventions for sex workers and their clients, n.e.c.	15,243.00	0.00	419,750.00	0.08
ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs	2,251.00	0.00	1,731.00	0.00
ASC.01.11.01 VCT as part of programmes in the workplace	22,152.00	0.01	23,026.00	0.005
ASC.01.11.02 Condom social marketing and male and female condom provision as part of programmes in the workplace	3,200.00	0.00	0.00	0.00
ASC.01.11.04 Behaviour change communication (BCC) as part of programmes in the workplace	9,678.00	0.00	3,311.00	0.00

ASC.01.11.98 Programmatic interventions in the workplace not broken down by type	18,439.00	0.00	194,767.00	0.04
ASC.01.12 Condom social marketing	208,280.00	0.05	107,034.00	0.02
ASC.01.13 Public and commercial sector male condom provision	341,477.00	0.08	1,016,896.00	0.20
ASC.01.14 Public and commercial sector female condom provision	0.00	0.00	92.00	0.00002
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	38,476.00	0.01	154.00	0.00
ASC.01.17.02	0.00	0.00	3,267,456.00	0.66
ASC.01.17.03 Safe infant feeding practices (including substitution of breast milk)	34,869.00	0.01	9,936.00	0.00
ASC.01.17.98 PMTCT not broken down by intervention	9,824,135.00	2.37	10,678,037.00	2.15
ASC.01.17.99 PMTCT activities n.e.c.	27,157.00	0.01		0.00
ASC.01.19 Blood safety	276,557.00	0.07	56,795.00	0.01
ASC.01.20 Safe medical injections	262,408.00	0.06	367,983.00	0.07
ASC.01.21 Universal precautions	10,748.00	0.00	0.00	0.00
ASC.01.22.98 Post-exposure prophylaxis not broken down by intervention	0.00	0.00	3,210.00	0.001
ASC.01.98 Prevention activities not broken down by intervention	7,377,256.00	1.78	8,734,206.00	1.76
ASC.02-Care and Treatment	204,304,508.00	49.20	186,032,729.00	37.44
ASC.02.01.01 Provider-initiated testing and counselling (PITC)	436,205.00	0.11	455,689.00	0.09
ASC.02.01.02.01 outpatient prophylaxis	596,615.00	0.14	1,669,417.00	0.34
ASC.02.01.02.02 OI outpatient treatment	71,605.00	0.02	78,123.00	0.02
ASC.02.01.02.98 OI outpatient prophylaxis and treatment not broken down by type	4,777,418.00	1.15	4,418,944.00	0.89
ASC.02.01.03.01.01 First-line ART – adults	87,008,579.00	20.95	32,710,206.00	6.58
ASC.02.01.03.01.02 Second-line ART – adults	9,585,847.00	2.31	12,797,896.00	2.58
ASC.02.01.03.01.98 Adult antiretroviral therapy not broken down by line of treatment	6,435,667.00	1.55	7,633,036.00	1.54
ASC.02.01.03.02.01 First-line ART – paediatric	1,124,259.00	0.27	1,474,812.00	0.30
ASC.02.01.03.02.02 Second-line ART – paediatric	1,124,259.00	0.27	1,474,812.00	0.30
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not broken down by line of treatment	1,578,742.00	0.38	2,193,427.00	0.44
ASC.02.01.03.98 Antiretroviral therapy not broken down either by age or line of treatment	20,490,977.00	4.93	36,271,772.00	7.30
ASC.02.01.04 Nutritional support associated with antiretroviral therapy	758,519.00	0.18	1,033,557.00	0.21
ASC.02.01.05 Specific HIV-related laboratory monitoring	3,644,278.00	0.88	4,541,560.00	0.91
ASC.02.01.08 Outpatient palliative care	2,736,343.00	0.66	1,892,623.00	0.38
ASC.02.01.09.01 Home-based medical care	9,000.00	0.002	16,220.00	0.003
ASC.02.01.09.02 Home-based non medical/non-health care	14,516.00	0.003	64.00	0.00001

ASC.02.01.09.98 Home-based care not broken down by type	19,934.00	0.005	7,240.00	0.00
ASC.02.01.98 Outpatient care services not broken down by intervention	384,583.00	0.09		0.00
ASC.02.01.99 Outpatient care services n.e.c.	0.00	0.00	3,942.00	0.001
ASC.02.98 Care and treatment services not broken down by intervention	63,506,719.00	15.29	77,359,389.00	15.57
ASC.02.99 Care and treatment services n.e.c.	443.00	0.00	0.00	0.00
ASC.03-Orphans and Vulnerable Children	9,099,704.00	2.19	7,118,795.00	1.43
ASC.03.01 OVC Education	391,694.00	0.09	340,684.00	0.07
ASC.03.02 OVC Basic health care	1,165,844.00	0.28	1,304,673.00	0.26
ASC.03.03 OVC Family/home support	1,790,277.00	0.43	1,125,465.00	0.23
ASC.03.04 OVC Community support	1,678.00	0.0004	1,920.00	0.0004
ASC.03.05 OVC Social services and administrative costs	267,287.00	0.06	32,818.00	0.01
ASC.03.06 OVC Institutional care	4,945.00	0.00		0.00
ASC.03.98 OVC Services not broken down by intervention	5,473,924.00	1.32	4,309,325.00	0.87
ASC.03.99 OVC services n.e.c.	686.00	0.0002	3,910.00	0.001
ASC 04-Programme Management and administration	77,212,683.00	18.59	121,831,097.00	24.52
ASC.04.01 Planning, coordination, and programme management	53,817,927.00	12.96	82,840,718.00	16.67
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	290,266.00	0.07	916,350.00	0.18
ASC.04.03 Monitoring and evaluation	9,715,153.00	2.34	8,594,124.00	1.73
ASC.04.04 Operations research	28,074.00	0.01	17,467.00	0.00
ASC.04.05 Serological-surveillance (serosurveillance)	400,000.00	0.10	100,000.00	0.02
ASC.04.07 Drug supply systems	1,420,350.00	0.34	1,209,506.00	0.24
ASC.04.08 Information technology	4,719.00	0.001	114,417.00	0.02
ASC.04.09 Patient tracking	6,667.00	0.002	6,955.00	0.001
ASC.04.10.01 Upgrading laboratory infrastructure and new laboratory equipment	6,269,497.00	1.51	6,523,085.00	1.31
ASC.04.10.02 Construction of new health centres	2,345.00	0.001	4,621.00	0.001
ASC.04.10.98 Upgrading and construction of infrastructure not broken down by intervention	3,931,354.00	0.95	5,291,437.00	1.06
ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.	105,255.00	0.03	55,860.00	0.01
ASC.04.98 Programme management and administration not broken down by type	1,034,295.00	0.25	14,512,528.00	2.92
ASC.04.99 Programme management and administration n.e.c	186,781.00	0.04	1,644,029.00	0.33
ASC 05- Human Resources	84,989,602.00	20.47	95,919,210.00	19.30
ASC.05.01.01.01 Monetary incentives for physicians for prevention	5,743.00	0.00	5,757.00	0.00
ASC.05.01.02.02 Monetary incentives for nurses for care and treatment	2,289.00	0.00	2,535.00	0.00
ASC.05.01.02.98 Monetary incentives for nurses not broken down by intervention	0.00	0.00	800.00	0.00

ASC.05.01.03.01 Monetary incentives for other staff for prevention	5,105.00	0.00	21,816.00	0.00
ASC.05.01.03.02 Monetary incentives for other staff for care and treatment	91,030.00	0.02	92,261.00	0.02
ASC.05.01.03.03 Monetary incentives for other staff for programme management and administration	2,466.00	0.001	2,466.00	0.0005
ASC.05.01.03.98 Monetary incentives for other staff not broken down by type	20,800.00	0.01	25,023.00	0.01
ASC.05.03 Training	13,154,392.00	3.17	21,317,346.00	4.29
ASC.05.98 Human resources not broken down by type	71,707,777.00	17.27	74,451,206.00	14.98
ASC 06-Social Protection and Social services	83,718.00	0.02	183,189.00	0.04
ASC.06.01 Social protection through monetary benefits	3,621.00	0.001	7,007.00	0.001
ASC.06.02 Social protection through in-kind benefits	74,266.00	0.02	135,004.00	0.03
ASC.06.03 Social protection through provision of social services	0.00	0.00	410.00	0.00
ASC.06.04 HIV-specific income generation projects	5,831.00	0.001	36,420.00	0.01
ASC.06.99 Social protection services and social services n.e.c.	0.00	0.00	4,348.00	0.001
ASC 07-Enabling Environment	2,679,626.00	0.65	21,870,065.00	4.40
ASC.07.01 Advocacy	382,450.00	0.09	289,368.00	0.06
ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment	197.00	0.00005	0.00	0.00
ASC.07.02.98 Human rights programmes not broken down by type	0.00	0.00	281.00	0.00
ASC.07.03 AIDS-specific institutional development	1,255,411.00	0.30	20,710,025.00	4.17
ASC.07.04 AIDS-specific programmes focused on women	775,428.00	0.19	547,843.00	0.11
ASC.07.98 Enabling environment not broken down by type	266,140.00	0.06	322,548.00	0.06
ASC 08-HIV- Related Research	733,211.00	0.18	2,084,597.00	0.42
ASC.08.01 Biomedical research	63,432.00	0.02	12,640.00	0.003
ASC.08.04.01 Behavioural research	112,533.00	0.03	622,604.00	0.13
ASC.08.04.02 Research in economics	0.00	0.00	4,667.00	0.001
ASC.08.04.98 Social science research not broken down by type	16,729.00	0.004	17,014.00	0.003
ASC.08.04.99 Social science research n.e.c.	33,084.00	0.01	0.00	0.00
ASC.08.98 HIV-related research activities not broken down by type	490,344.00	0.12	1,412,672.00	0.28
ASC.08.99 HIV-related research activities n.e.c.	17,089.00	0.004	15,000.00	0.00
TOTAL	415,287,430.00	100.00	496,917,471.00	100.00

Appendix 10-Beneficiary Populations in 2009 and 2010(2nd and 3rd digit analysis)

Beneficiary population	2009		2010	
	AMOUNT(USD)	%	AMOUNT(USD)	%
BP.01-People living with HIV	207,110,810.00	49.87	187,424,838.00	37.72
BP.01.01.01-Adult and young men (aged 15 and over) living with HIV	0	0.00	1,754.00	0.0004
BP.01.01.02-Adult and young women (aged 15 and over) living with HIV	338,718.00	0.08	2,577.00	0.001
BP.01.01.98-Adult and young people (aged 15 and over) living with HIV not broken down by gender	107,414,321.00	25.87	57,681,481.00	11.61
BP.01.02.02-Girls (under 15 years) living with HIV	0	0.00	9.00	0.000002
BP.01.02.98-Children (under 15 years) living with HIV not broken down by gender	4,744,410.00	1.14	6,764,949.00	1.36
BP.01.98-People living with HIV not broken down by age or gender	94,613,361.00	22.78	122,974,068.00	24.75
BP.02-Most-at-risk populations	378,255.00	0.09	557,700.00	0.11
BP.02.01-Injecting drug users (IDU) and their sexual partners	2,251.00	0.001	1,731.00	0.0003
BP.02.02.01-Female sex workers and their clients	373,114.00	0.09	478,658.00	0.10
BP.02.02.02-Male transvestite sex workers (and their clients)	2,890.00	0.001	1,034.00	0.0002
BP.02.98-Most at-risk populations not broken down by type	0	0.00	76,277.00	0.02
BP.03-Other key populations	20,332,659.00	4.90	22,744,908.00	4.58
BP.03.01-Orphans and vulnerable children (OVC)	9,112,493.00	2.19	7,118,795.00	1.43
BP.03.02-Children born or to be born of women living with HIV	9,909,322.00	2.39	13,958,961.00	2.81
BP.03.07-Prisoners and other institutionalized persons	2,251.00	0.001	11,215.00	0.002
BP.03.08-Truck drivers/transport workers and commercial drivers	380,800.00	0.09	857,453.00	0.17
BP.03.11-Children and youth out of the school	647,450.00	0.16	734,435.00	0.15
BP.03.14-Recipients of blood or blood products	276,557.00	0.07	56,795.00	0.01
BP.03.98-Other key populations" not broken down by type	863.00	0.0002	1,034.00	0.0002
BP.03.99-Other key populations	2,923.00	0.001	6,220.00	0.001
BP.04-Specific accessible population	1,130,254.00	0.27	3,118,459.00	0.63
BP.04.03-Junior high/high school students	386,506.00	0.09	2,363,759.00	0.48
BP.04.04-University students	0	0.00	10,475.00	0.002
BP.04.05-Health care workers	273,156.00	0.07	60,877.00	0.01
BP.04.08-Police and other uniformed services (other than the military)	350,345.00	0.08	501,304.00	0.10

BP.04.10-Factory employees (i.e. for workplace interventions)	28,006.00	0.01	178,733.00	0.04
BP.04.98-Specific "accessible" populations not broken down by type	88,930.00	0.02	0	0.00
BP.04.99-Accessible populations not elsewhere classified (n.e.c.)	3,311.00	0.00	3,311.00	0.00
BP.05-General population	23,452,982.00	5.65	62,125,892.00	12.50
BP.05.01.01- Male adult population	341,477.00	0.08	0.00	0.00
BP.05.01.02-Female adult population	5,502.00	0.00	421,475.00	0.08
BP.05.02.02-Girls	71,509.00	0.02	50192.00	0.01
BP.05.02.98-Children (under 15 years) not broken down by gender	0	0.00	142,996.00	0.03
BP.05.03.02-Young females	374,766.00	0.09	0	0.00
BP.05.03.98-Youth (aged 15 to 24) not broken down by gender	121,523.00	0.03	255,941.00	0.05
BP.05.98-General population not broken down by age or gender	22,538,205.00	5.43	61,255,288.00	12.33
BP.06-Non-targetted interventions	162,882,470.00	39.22	220,787,650.00	44.43
BP.99-Specific targeted population n.e.c.	0	0.00	158,024.00	0.03
Total	415,287,430.00	100	496,917,471.00	100

Financing sources expenditure by beneficiary populations-2009

2009 USD													
Beneficiary Population	FS.01 Public Sources	%	FS.02 Private Funds	%	FS.03.01 Direct Bilateral Contributions	%	FS.03.02 Multilateral Agencies	%	FS.03.03 International not for profit	%	FS.03.04 International for profit	%	Total
BP.01 People living with HIV	11,196,510	11.4	27,670	9.9	179,595,111	65.8	16,291,519	36.9	0	0	0	0	207,110,810
BP.02 Most-at-risk populations	-	0.0	1,369	0.5	376,886	0.1	-	0.0	0	0	0	0	378,255
BP.03 Other Key populations	581,151	0.6	14,702	5.3	18,951,249	6.9	785,557	1.8	0	0	0	0	20,332,659
BP.04 Specific "accessible populations"	224,823	0.2	3,200	1.1	839,939	0.3	62,292	0.1	0	0	0	0	1,130,254
BP.05 General population	1,923,534	2.0	117,609	42.3	15,627,115	5.7	5,784,724	13.1	0	0	0	0	23,452,982
BP.06 Non-targetted interventions	83,864,501	85.8	113,753	40.9	57,525,616	21.1	21,249,921	48.1	107,596	100	21,083	100	162,882,470
Total	97,790,519	100	278,303	100	272,915,916	100	44,174,013	100.0	107,596	100	21,083	100	415,287,430

Financing sources expenditure by beneficiary populations-2010

2010 USD													
Beneficiary Population	FS.01 Public Sources	%	FS.02 Private Funds	%	FS.03.01 Direct Bilateral Contributions	%	FS.03.02 Multilateral Agencies	%	FS.03.03 International not for profit	%	FS.03.04 International for profit	%	Total
BP.01 People living with HIV	25,255,518	20.2	18,885	2.2	144,722,930	50.8	17,427,505	20.3	0	0	0	0	187,424,838
BP.02 Most-at-risk populations	-	0.0	1,087	0.1	483,113	0.2	73,500	0.0	0	0	0	0	557,700
BP.03 Other Key populations	830,111	0.7	8,711	1.0	21,189,298	7.4	716,788	0.8	0	0	0	0	22,744,908
BP.04 Specific "accessible populations"	664,510	0.5	187,964	22.1	757,073	0.3	1,508,912	1.8	0	0	0	0	3,118,459
BP.05 General population	2,068,035	1.7	94,571	11.1	36,334,968	12.8	23,571,325	27.5	965	0	56028	0	62,125,892
BP.06 Non-targeted interventions	96,321,413	77.0	539,329	63.4	81,421,483	28.6	42,405,802	49.4	99,623	100		100	220,787,650
BP.99 Specific targeted populations n.e.c.	-	0.0	-		-	0.0	158,024	0.2	-	0	-	0	158,024
Total	125,139,587	100.0	850,547	100.0	284,908,865	100.0	85,861,856	100	100,588	100	56,028	100	496,917,471

Appendix 11 – Letter used for data collection

Letter to Donors and Government Ministries

The _____ 16th June 2011.

Sir/Ma,

REQUEST FOR REPRESENTATIVES FROM YOUR ORGANIZATION AT THE FORTHCOMING NATIONAL AIDS SPENDING ASSESSMENT (NASA) TRAINING WORKSHOP

In its effort to monitor and evaluate the response to the AIDS pandemic and achieve the financing goals set out in the 2001 UNGASS Declaration, NACA in collaboration with UNAIDS and ENR is carrying out a National AIDS Spending Assessment(NASA), to track the flow of financial resources from funding source to expenditure.

NASA describes the financial flows, actual disbursements and expenditures for HIV/AIDS by identifying financing sources, Agents, Beneficiary Populations and Providers.

NASA is a comprehensive and systematic methodology used to determine the flow of resources intended to combat HIV/AIDS and it describes the allocation of funds, from their origin down to the end point of service delivery, among the different institutions dedicated in the fight against the disease using the bottom-up and top-down approach. Financial resources are tracked by financing source whether it is public, private or international and among the different providers and beneficiaries (target groups).

To this end, your organization has been selected to be a part of this training. We hereby request that two representatives (preferably finance officers and programme officers) from your organization be sent to participate in the two day training on the NASA methodology and tracking tools. Your organizations' representatives at this meeting will also be the focal persons for the NASA consultants to liaise with when the actual data collection activity will commence in your organization.

The Objectives of this training are:

1. To sensitize key stakeholders on the NASA project
2. To provide technical training on the NASA methodology, tracking tools and analysis

The detail for this meeting is as follows:

Venue: Lagos House opp. NACA HQ, Abuja.

Date: Thursday 30th June and Friday 1st July 2011.

TIME: 9am

Thank you.

Prof. John Idoko
Director General.

Appendix 12 – NASA data collection form

FORM [1] – Year: _____ (2009 or 2010)

HIV RESPONSE INSTITUTIONS

This information is confidential

Year under study: _____ Date: _____ / _____ / 2011

1. - Identification of the Institution

Name of the Institution:	
Contact (Name and Position):	
Address:	E-mail:
Telephone:	Fax:

Select with an x the legal status of the institution (may be more than one option)

Legal Status	National	International
Public		
Private		
For profit		
Not for profit		
Bilateral agency		
Multilateral agency		

The institution receives funds coming from other institutions to finance or produce HIV related activities?	Yes (please fill section 2)
The institution used its own funds to finance or to produce HIV related activities?	Yes (please fill line 10, in Section 2)
The institution transfers funds to other institutions for HIV related activities?	Yes (please fill section 3)
The institution produces HIV related activities (goods or services)?	Yes (please fill the 3 first columns in section 2)

Select with an x if values are in local currency:

Select with an x if values are in USD (**Recommended**):

Other (Euro, etc), please specify:

	Exchange rate Range(Average)
Nigerian naira	
USD	

2. Origin of funds (OF)

Indicate:

- Name of the institution from which the funds were received.
- Amount of money expended in the year of the estimation disaggregated per financing source.
For In kind donations Fill tables 5 & 6

<u>Name of the Institution</u>	<u>Amount received in 2009</u>	<u>Amount received in 2010</u>	<i>Amount spent in 2009</i>	<i>Amount spent in 2010</i>	<i>Amount transferred to other Institutions in 2009</i>	<i>Amount transferred to other Institutions in 2010</i>	<i>Who took decision on the funds for goods and services to purchase, provider of goods and services and beneficiary population</i>
OF [1]							
OF [2]							
OF [3]							
OF [4]							
OF [5]							
OF [6]							
OF [7]							
OF [8]							
OF [9] Personal Donation							
OF [10] Own funds							
TOTAL							

-If the institution utilized funds, proceed to fill in section 4 for each of the amount utilized.

-Personal Donations: cash gifts from individuals (Note: Corporations or other institutions should be captured on OF [1] to OF [8]).

-Own funds: funds generated by the institution (e.g.: income generation activities such as: lottery, raffle draws, etc)

3. Use of Funds:

Indicate in the next 10 tables how the funds from each origin of funds were spent:

Describe the categories conducted

If one activity is targeting more than one beneficiary population, please fill in the next row

OF [1] Funds				
Activity (Description)	NASA Code for the Activity (please refer to NASA Catalogues code and name)	Beneficiary population (Description)	2009	2010

4. Funds transferred:

For each institution identified in table 2. (OF [1] to OF [10]) please indicate in the following tables:

- Name of institutions for which funds were transferred in the year of the estimation and
- Amount reported as expenditure in the year by each institution

<u>Name of the institution which received the fund coming from source OF [1]</u>	<u>Amount transferred in 2009</u>	<u>Amount transferred in 2010</u>	<i>Amount reported as spent in 2009</i>	<i>Amount reported as spent in 2010</i>
DF [1]				
DF [2]				
DF [3]				
DF [4]				
DF [5]				
DF [6]				
DF [7]				
DF [8]				
DF [9]				
DF [10]				
TOTAL				

a) If sections 2 and 3 were filled, the sum of the transferred amount calculated in section 3, it must equal to the sum of amount transferred to other institutions calculated in section 2. If not please indicate difference causes.

Details of Goods and services the transferred funds was used for by the institutions

Indicate in the next 10 tables how the funds from each origin of funds was spent:

Describe the categories conducted

If one activity is targeting more than one beneficiary populations, please fill in the next row

OF [1] Funds				
Activity (Description)	NASA Code for the Activity (please refer to NASA Catalogues code and name)	Beneficiary population (Description)	2009	2010

5. Condom distribution:

In the following table, please fill information regarding the use of condoms donated from other institutions (e.g.: condoms from NACA). Condoms purchased with donors funds and / or the logistic costs associated with the condom distribution should be accounted in the correspondent tables of section 3. "Use of the funds".

Name of the Institution from which the condoms were received	Description of the condom distribution	Beneficiary population receiving the condoms. (e.g.: general population). Please use NASA catalogue to identify the Beneficiary	Quantity received in 2009 (units)	Quantity received in 2010 (units)	Quantity distributed in 2009 (units)	Quantity distributed in 2010 (units)

6. In-kind donations:

In the following table, please fill information regarding the use of in kind donations.

Name of the Institution from which the donation was received	Description of items received (type and quantity)	Description of the use of the items received	Quantity received in 2009 (units)	Quantity received in 2010 (units)	Quantity distributed in 2009 (units)	Quantity distributed in 2010 (units)

Appendix 13 – Status on data collected

Institution	2009		2010	
	Transac tion	Type of Data	Transac tion	Type of Data
Adeoyo Maternity Hospital	↓	RE	↓	RE
Ahmadu Bello University Teaching Hospital	↓	RE	↓	RE
Aids Prevention Initiative in Nigeria	↑	RE,B	↑	RE,B
Clinical and Laboratory Standards Institute	↑	RE,B	↑	RE,B
Akwa Ibom State Action Committee on AIDS	↑	RE,B	↑	RE,B
Akwa Ibom State Ministry of Education	↑	RE,B	↑	RE,B
Anambra State Action Committee on AIDS	↓	RE	↓	RE
Archdiocesan Catholic Action Committee on HIV/AIDS	↑	RE	↑	RE
Association for Reproductive and Family Health	↑	RE,B	↑	RE,B
Association of Orphans & Vulnerable Children Nassarawa	↑	RE,B	↑	RE,B
Benue State Ministry Of Health and Human Resources	↑	RE,B	↑	RE,B
Catholic Relief Service	↑	RE,B	↑	RE,B
Center for Peace	↑	RE,B	↑	RE,B
Centre for Health Works Development and Research	↑	RE,B	↑	RE,B
Centre for Women Youth and Community Action	↑	RE,B	↑	RE,B
Civil Society Against AIDS	↑	RE,B	↑	RE,B
Country Women Association (COWAN)	↑	RE,B	↑	RE,B
Cross Rivers State Ministry of Health	↑	RE,B	↑	RE,B
Daughters Of Charity	↑	RE,B	↑	RE,B
Deloitte Consulting	↑	RE,B	↑	RE,B
Dreamboat Theatre for Development Foundation	↑	RE,B	↑	RE,B
Education as a Vaccine	↑	RE	↑	RE
Enhancing Nigeria Response to HIV and AIDS Programme	↑	RE,B	↑	RE,B
Excellence Community Education Welfare Scheme	↑	RE,B	↑	RE,B
Family Health Care Foundation	↑	RE	↑	RE
Family Health Care Nassarawa	↑	RE	↑	RE

Family Health International	↕	RE,B	↕	RE,B
Federal Ministry of Education	↓	RE,B	↓	RE,B
Federal Ministry of Health	↓	RE,B	↓	RE,B
Federal Ministry of Women Affairs and Social Dev.	↓	RE,B	↓	RE,B
Federal Road Safety Corp	↓	RE,B	↓	RE,B
Federation of Muslim Women Association of Nigeria	↓	RE,B	↓	RE,B
First Step Action For Children Initiative	↓	RE	↓	RE
Greenwatch initiative	↓	RE	↓	RE
Hygeia Foundation	↕	RE,B	↓	RE,B
I Care Women and Youth Initiative	↓	RE,B	↓	RE,B
Institute of Human Virology, Nigeria	↕	RE,B	↕	RE,B
International Labour Office	↕	RE,B	↕	RE,B
International Centre for Aids care & treatment programme	↕	RE,B	↕	RE,B
JSI/ AIDSTAR-One Injection Safety	↕	RE,B	↕	RE,B
Lagos State Ministry of Education	↓	RE,B	↓	RE,B
Management Sciences For Health	↕	RE,B	↕	RE,B
Measure Evaluation	↕	RE,B	↕	RE,B
Millennium Development Goal Office	↕	RE	↕	RE
Nassarawa State AIDS Control Agency	↕	RE,B	↕	RE,B
National Agency for the Control of AIDS	↕	RE,B	↕	RE,B
National Population Council	↕	RE,B	↕	RE,B
National Youth Aid Program	↕	RE,B	↕	RE,B
National Youth Service Corps	↓	RE,B	↓	RE,B
Network of People living with HIV/AIDS in Nigeria	↓	RE,B	↓	RE,B
Nigerian Institute of Medical Research, Lagos	↓		↓	
Ogun State Action Committee on AIDs	↕	RE,B	↕	RE,B
Old Netim Health and Development Organisation	↕	RE		RE
Partners For Development	↕	RE,B	↕	RE,B
Pathfinder International	↕	RE,B	↕	RE,B
Sagamu Community Centre	↕	RE,B	↕	RE,B
Society For Family Health	↕	RE,B	↕	RE,B

Sokoto State Action Agency for the Control of AIDS	↓↑	RE	↓↑	RE
State Hospital Ota	↓↑	RE	↓↑	RE
State Hospital Isara	↓↑	RE	↓↑	RE
Taimako Women Health Foundation	↓↑	RE	↓↑	RE
The Holy Order of Cherubim and Seraphim	↓↑	RE	↓↑	RE
United Nations Development Programme Akwa Ibom	↓↑	RE	↓↑	RE
United Nations Development Programme Sokoto	↓↑	RE	↓↑	RE
United Nations Children's Fund	↓↑	RE	↓↑	RE
United Nations Development Programme	↓↑	RE,B	↓↑	RE,B
United Nations Population Fund	↓↑	RE,B	↓↑	RE,B
Women, Youth and Children Upliftment	↓↑	RE	↓↑	RE
World Health Organization	↓↑	RE,B	↓↑	RE,B
Youth Empowerment Foundation	↓↑	RE	↓↑	RE
<i>"Transaction":</i>				
↓Top down		↑Bottom up		
↓↑Top down and Bottom up				
<i>"Type of Data":</i>				
RE Reported Expenditures				
E Estimated based on the production of good and services using P*Q approach				
B Budget figures				

Appendix 14 – UNGASS Matrixes

2009– Financing Sources to AIDS Spending Categories – USD

ASC Level 1	ASC Level 2	FS.01 Public funds	FS.02 Private funds	FS.03.01 Direct bilateral contributions	FS.03.02 Multilateral Agencies	FS.03.03 International non-profit making Organizations	FS.03.04 International for profit organizations	Grand Total
ASC.01 Prevention	ASC.01.01.01 Health-related communication for social and behavioural change	1,327,905	60,939	6,334,436	2,499,041			10,222,321
	ASC.01.01.02 Non-health-related communication for social and behavioural change	1,923	-	-	-			1,923
	ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	-	-	471,923	-			471,923
	ASC.01.02 Community mobilization	-	-	68,241	88,137			156,378
	ASC.01.03 Voluntary counselling and testing (VCT)	209,761	-	3,741,938	651,153			4,602,852
	ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	88,930	-	-	-			88,930
	ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	-	-	9,643	-			9,643

ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type	-	-	701,601	-			701,601
ASC.01.05 Prevention – youth in school	110,430	-	230,899	45,177			386,506
ASC.01.06 Prevention – youth out-of-school	-	587	646,863	-			647,450
ASC.01.07.01 Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV	-	-	61,764	-			61,764
ASC.01.08.02 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients	-	-	15,243	-			15,243
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients	-	1,369	20,384	-			21,753
ASC.01.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type	-	-	323,765	-			323,765
ASC.01.08.99 Other programmatic interventions for sex workers and their clients, n.e.c.	-	-	15,243	-			15,243
ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs	-	-	2,251	-			2,251
ASC.01.11.01 VCT as part of programmes in the workplace	22,152	-	-	-			22,152

ASC.01.11.02 Condom social marketing and male and female condom provision as part of programmes in the workplace	-	3,200	-	-			3,200
ASC.01.11.04 Behaviour change communication (BCC) as part of programmes in the workplace	3,311	-	-	6,367			9,678
ASC.01.11.98 Programmatic interventions in the workplace not disaggregated by type	-	-	18,439	-			18,439
ASC.01.12 Condom social marketing	1,887	4,577	170,000	31,816			208,280
ASC.01.13 Public and commercial sector male condom provision	-	-	341,477	-			341,477
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	-	-	14	38,462			38,476
ASC.01.17.03 Safe infant feeding practices (including substitution of breastmilk)	-	-	-	34,869			34,869
ASC.01.17.98 PMTCT not disaggregated by intervention	241,364	-	9,535,640	47,131			9,824,135
ASC.01.17.99 PMTCT activities n.e.c.	26,490	-	667	-			27,157
ASC.01.19 Blood safety	-	-	239,486	37,071			276,557
ASC.01.20 Safe medical injections	-	-	262,408	-			262,408
ASC.01.21 Universal precautions	-	-	-	10,748			10,748
ASC.01.98 Prevention activities not disaggregated by intervention	97,503	29,905	5,754,435	1,495,413			7,377,256
ASC.01 Prevention Total	803,751	39,638	22,632,324	2,486,344	-	-	25,962,057

ASC.02 Care and treatment	ASC.02.01.01 Provider- initiated testing and counselling (PITC)	-	-	436,205	-		436,205
	ASC.02.01.02.01 OI outpatient prophylaxis	-	-	596,615	-		596,615
	ASC.02.01.02.02 OI outpatient treatment	-	-	-	71,605		71,605
	ASC.02.01.02.98 OI outpatient prophylaxis and treatment not disaggregated by type	542,585	-	4,234,833	-		4,777,418
	ASC.02.01.03.01.01 First-line ART – adults	-	-	87,008,579	-		87,008,579
	ASC.02.01.03.01.02 Second-line ART – adults	-	-	9,585,847	-		9,585,847
	ASC.02.01.03.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	-	-	6,435,667	-		6,435,667
	ASC.02.01.03.02.01 First-line ART – paediatric	-	-	1,124,259	-		1,124,259
	ASC.02.01.03.02.02 Second-line ART – paediatric	-	-	1,124,259	-		1,124,259
	ASC.02.01.03.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	2,899	-	1,575,843	-		1,578,742
	ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	6,815,510	21,207	13,654,260	-		20,490,977
	ASC.02.01.04 Nutritional support associated to ARV therapy	-	-	758,519	-		758,519
	ASC.02.01.05 Specific HIV-related laboratory monitoring	-	-	3,628,930	15,348		3,644,278
	ASC.02.01.08 Outpatient palliative care	107,249	-	2,629,094	-		2,736,343
ASC.02.01.09.01 Home-based medical care	-	-	9,000	-		9,000	

	ASC.02.01.09.02 Home-based non medical/non-health care	-	-	-	14,516			14,516
	ASC.02.01.09.98 Home-based care not disaggregated by type	-	-	10,424	9,510			19,934
	ASC.02.01.98 Outpatient care services not disaggregated by intervention	384,583	-	-	-			384,583
	ASC.02.98 Care and treatment services not disaggregated by intervention	3,328,947	-	44,016,443	16,161,329			63,506,719
	ASC.02.99 Care and treatment services n.e.c.	-	-	443	-			443
ASC.02 Care and treatment Total		11,181,773	21,207	176,829,220	16,272,308	-	-	204,304,508
ASC.03 Orphans and Vulnerable children	ASC.03.01 OVC Education	195,042	5,615	7,822	183,215			391,694
	ASC.03.02 OVC Basic health care	563	151	996,883	168,247			1,165,844
	ASC.03.03 OVC Family/home support	129	1,786	1,788,362	-			1,790,277
	ASC.03.04 OVC Community support	-	-	1,678	-			1,678
	ASC.03.05 OVC Social Services and Administrative costs	-	4,457	40,915	225,284			270,656
	ASC.03.06 OVC Institutional care	-	-	4,945	-			4,945
	ASC.03.98 OVC Services not disaggregated by intervention	117,563	3,621	5,301,462	51,278			5,473,924
	ASC.03.99 OVC services n.e.c.	-	169	517	-			686
ASC.03 Orphans and Vulnerable children Total		313,297	15,799	8,142,584	628,024	-	-	9,099,704
ASC.04 Programme Management and administration	ASC.04.01 Planning, coordination and programme management	12,052,129	62,468	30,181,674	11,521,656			53,817,927
	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	8,943	-	983	280,340			290,266
	ASC.04.03 Monitoring and evaluation	274,682	-	6,935,632	2,485,038		19,801	9,715,153

	ASC.04.04 Operations research	-	-	-	28,074			28,074
	ASC.04.05 Serological-surveillance (serosurveillance)	-	-	-	400,000			400,000
	ASC.04.07 Drug supply systems	-	-	1,408,020	12,330			1,420,350
	ASC.04.08 Information technology	3,423	200	-	1,096			4,719
	ASC.04.09 Patient tracking	-	-	6,667	-			6,667
	ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	312,078	-	5,957,419	-			6,269,497
	ASC.04.10.02 Construction of new health centres	-	2,345	-	-			2,345
	ASC.04.10.98 Upgrading and construction of infrastructure not disaggregated by intervention	-	-	2,721,499	1,209,855			3,931,354
	ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.	16,940	-	49,329	38,986			105,255
	ASC.04.98 Programme management and administration not disaggregated by type	-	23,333	1,010,962	-			1,034,295
	ASC.04.99 Programme management and administration n.e.c	-	-	186,781	-			186,781
	ASC.04 Programme Management and administration Total	12,668,195	88,346	48,458,966	15,977,375	-	19,801	77,212,683
ASC.05 Human resources	ASC.05.01.01.01 Monetary incentives for physicians for prevention	-	-	5,743	-			5,743
	ASC.05.01.02.02 Monetary incentives for nurses for care and treatment	-	-	2,289	-			2,289
	ASC.05.01.03.01 Monetary incentives for other staff for prevention	-	-	5,105	-			5,105
	ASC.05.01.03.02 Monetary incentives for other staff for care and treatment	-	-	15,012	76,018			91,030
	ASC.05.01.03.03 Monetary incentives for other staff for programme management and administration	-	-	-	2,466			2,466

	ASC.05.01.03.98 Monetary incentives for other staff not disaggregated by type	-	20,800	-	-			20,800
	ASC.05.03 Training	1,342,362	4,607	8,419,880	3,386,261		1,282	13,154,392
	ASC.05.98 Human resources not disaggregated by type	69,851,380	-	-	1,856,397			71,707,777
ASC.05 Human resources Total		71,193,742	25,407	8,448,029	5,321,142	-	1,282	84,989,602
ASC.06 Social Protections and social services	ASC.06.01 Social protection through monetary benefits	-	3,621	-	-			3,621
	ASC.06.02 Social protection through in-kind benefits	14,737	596	39,722	19,211			74,266
	ASC.06.04 HIV-specific income generation projects	-	1,404	4,427	-			5,831
ASC.06 Social Protections and social services Total		14,737	5,621	44,149	19,211	-	-	83,718
ASC.07 Enabling environment	ASC.07.01 Advocacy	281,755	19,486	19,588	61,621			382,450
	ASC.07.02.02 Provision of legal and social services to promote access to prevention, care and treatment	-	-	197	-			197
	ASC.07.03 AIDS-specific institutional development	-	-	350,894	904,517			1,255,411
	ASC.07.04 AIDS-specific programmes focused on women	2,800	1,860	770,768	-			775,428
	ASC.07.98 Enabling environment not disaggregated by type	-	-	266,140	-			266,140
ASC.07 Enabling environment Total		284,555	21,346	1,407,587	966,138	-	-	2,679,626
ASC.08 Research	ASC.08.01 Biomedical research	-	-	63,432	-			63,432
	ASC.08.04.01 Behavioural research	2,564	-	109,969	-			112,533
	ASC.08.04.98 Social science research not disaggregated by type	-	-	14,479	2,250			16,729

ASC.08.04.99 Social science research n.e.c.	-	-	32,105	979			33,084
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	-	-	381,547	1,201	107,596		490,344
ASC.08.99 HIV and AIDS-related research activities n.e.c.	-	-	17,089	-			17,089
ASC.08 Research Total	2,564	-	618,621	4,430	107,596	-	733,211
Grand Total	97,790,519	278,303	272,915,916	44,174,013	107,596	21,083	415,287,430

2010-Financing sources to AIDS Spending categories

ASC. Level 1	ASC Level 2	FS.01 Public Funds	FS.02 Private Funds	FS.03.01 Direct bilateral contributions	FS.03.02 Multilateral Agencies	FS.03.03 International non-profit Organizations	FS.03.04 International for profit organizations	Grand Total
ASC.01 Prevention	ASC.01.01.01 Health-related communication for social and behavioural change	1,452,668	22,226	24,809,468	3,164,138	310		29,448,810
	ASC.01.01.02 Non-health-related communication for social and behavioural change	-	-	-	3,699	-		3,699
	ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	-	-	199,281	-	-		199,281
	ASC.01.02 Community mobilization	-	-	816,907	196,316	310	56,028	1,069,561
	ASC.01.03 Voluntary counselling and testing (VCT)	12,509	-	1,221,404	410,568	-		1,644,481
	ASC.01.04.02 Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	-	-	1,690	-	-		1,690
	ASC.01.04.04 Behaviour change communication (BCC) as part of programmes for vulnerable and accessible populations	-	-	6,226	19,146	-		25,372

ASC.01.04.98 Programmatic interventions for vulnerable and accessible population not disaggregated by type	376,555	-	-	73,500	-	450,055
ASC.01.04.99 Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c.)	-	-	930,019	-	-	930,019
ASC.01.05 Prevention – youth in school	666,532	-	217,918	1,492,593	-	2,377,043
ASC.01.06 Prevention – youth out-of-school	-	-	725,605	8,830	-	734,435
ASC.01.07.01 Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV	-	-	49,017	-	-	49,017
ASC.01.08.04 Behaviour change communication (BCC) as part of programmes for sex workers and their clients	-	-	8,087	-	-	8,087
ASC.01.08.98 Programmatic interventions for sex workers and their clients not disaggregated by type	-	-	51,855	-	-	51,855
ASC.01.08.99 Other programmatic interventions for sex workers and their clients, n.e.c.	-	-	419,750	-	-	419,750

ASC.01.10.04 Behaviour change communication (BCC) as part of programmes for IDUs	-	-	1,731	-	-	1,731
ASC.01.11.01 VCT as part of programmes in the workplace	23,026	-	-	-	-	23,026
ASC.01.11.04 Behaviour change communication (BCC) as part of programmes in the workplace	3,311	-	-	-	-	3,311
ASC.01.11.98 Programmatic interventions in the workplace not disaggregated by type	-	178,733	16,034	-	-	194,767
ASC.01.12 Condom social marketing	11,753	4,668	34,652	55,961	-	107,034
ASC.01.13 Public and commercial sector male condom provision	-	-	1,016,896	-	-	1,016,896
ASC.01.14 Public and commercial sector female condom provision	-	92	-	-	-	92
ASC.01.17.01 Pregnant women counselling and testing in PMTCT programmes	-	-	9	145	-	154
ASC.01.17.02 Antiretroviral prophylaxis for HIV-infected pregnant women and newborns	-	-	3,267,456	-	-	3,267,456

	ASC.01.17.03 Safe infant feeding practices (including substitution of breastmilk)	-	-	-	9,936	-	9,936
	ASC.01.17.98 PMTCT not disaggregated by intervention	13,908	-	10,540,379	123,750	-	10,678,037
	ASC.01.19 Blood safety	-	-	56,795	-	-	56,795
	ASC.01.20 Safe medical injections	-	-	367,983	-	-	367,983
	ASC.01.22.98 Post-exposure prophylaxis not disaggregated by intervention	-	-	-	3,210	-	3,210
	ASC.01.98 Prevention activities not disaggregated by intervention	40,047	49,190	7,259,102	1,385,867	-	8,734,206
	ASC.01 Prevention Total	2,600,309	254,909	52,018,264	6,947,659	620	56,028
ASC.02 Care and treatment	ASC.02.01.01 Provider- initiated testing and counselling (PITC)	-	-	455,689	-	-	455,689
	ASC.02.01.02.01 OI outpatient prophylaxis	-	-	1,669,417	-	-	1,669,417
	ASC.02.01.02.02 OI outpatient treatment	-	-	-	78,123	-	78,123
	ASC.02.01.02.98 OI outpatient prophylaxis and treatment not disaggregated by type	-	-	4,418,944	-	-	4,418,944
	ASC.02.01.03.01.01 First-line ART – adults	-	-	32,710,206	-	-	32,710,206
	ASC.02.01.03.01.02 Second-line ART – adults	-	-	12,797,896	-	-	12,797,896

ASC.02.01.03.01.98 Adult antiretroviral therapy not disaggregated by line of treatment	-	-	7,633,036	-	-	7,633,036
ASC.02.01.03.02.01 First-line ART – paediatric	-	-	1,474,812	-	-	1,474,812
ASC.02.01.03.02.02 Second-line ART – paediatric	-	-	1,474,812	-	-	1,474,812
ASC.02.01.03.02.98 Paediatric antiretroviral therapy not disaggregated by line of treatment	-	-	2,193,427	-	-	2,193,427
ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	22,816,125	13,938	13,441,709	-	-	36,271,772
ASC.02.01.04 Nutritional support associated to ARV therapy	-	-	1,027,317	6,240	-	1,033,557
ASC.02.01.05 Specific HIV-related laboratory monitoring	-	-	4,515,506	26,054	-	4,541,560
ASC.02.01.08 Outpatient palliative care	-	-	1,892,623	-	-	1,892,623
ASC.02.01.09.01 Home-based medical care	-	-	16,220	-	-	16,220
ASC.02.01.09.02 Home-based non medical/non-health care	-	-	64	-	-	64
ASC.02.01.09.98 Home-based care not disaggregated by type	-	-	5,911	1,329	-	7,240
ASC.02.01.99 Outpatient care services n.e.c.	-	-	-	3,942	-	3,942

	ASC.02.98 Care and treatment services not disaggregated by intervention	2,429,169	-	59,069,604	15,860,616	-		77,359,389
	ASC.02 Care and treatment Total	25,245,294	13,938	144,797,193	15,976,304	-	-	186,032,729
ASC.03 Orphans and vulnerable children	ASC.03.01 OVC Education	63,093	6,014	129	271,448	-		340,684
	ASC.03.02 OVC Basic health care	-	-	1,050,977	253,696	-		1,304,673
	ASC.03.03 OVC Family/home support	-	137	1,105,076	20,252	-		1,125,465
	ASC.03.04 OVC Community support	-	-	1,920	-	-		1,920
	ASC.03.05 OVC Social Services and Administrative costs	-	702	30,351	1,765	-		32,818
	ASC.03.98 OVC Services not disaggregated by intervention	376,555	-	3,928,860	3,910	-		4,309,325
	ASC.03.99 OVC services n.e.c.	-	-	-	3,910	-		3,910
	ASC.03 Orphans and vulnerable children Total	439,648	6,853	6,117,313	554,981	-	-	7,118,795
ASC.04 Programme management and administration	ASC.04.01 Planning, coordination and programme management	21,531,984	162,079	35,119,564	26,014,760	12,331		82,840,718
	ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	160,005	241	158,213	597,891	-		916,350
	ASC.04.03 Monitoring and evaluation	690,212	-	4,333,147	3,569,524	1,241		8,594,124
	ASC.04.04 Operations research	-	-	-	17,467	-		17,467

	ASC.04.05 Serological-surveillance (serosurveillance)	-	-	-	100,000	-	100,000
	ASC.04.07 Drug supply systems	-	-	1,198,404	11,102	-	1,209,506
	ASC.04.08 Information technology	4,339	67	5,954	104,057	-	114,417
	ASC.04.09 Patient tracking	-	-	6,955	-	-	6,955
	ASC.04.10.01 Upgrading laboratory infrastructure and new equipment	-	-	6,460,942	62,143	-	6,523,085
	ASC.04.10.02 Construction of new health centres	-	4,621	-	-	-	4,621
	ASC.04.10.98 Upgrading and construction of infrastructure not disaggregated by intervention	1,234	-	3,192,481	2,097,722	-	5,291,437
	ASC.04.10.99 Upgrading and construction of infrastructure n.e.c.	37	-	3,606	52,217	-	55,860
	ASC.04.98 Programme management and administration not disaggregated by type	-	9,333	14,503,195	-	-	14,512,528
	ASC.04.99 Programme management and administration n.e.c	-	345,521	1,298,469	39	-	1,644,029
	ASC.04 Programme management and administration Total	22,387,811	521,862	66,280,930	32,626,922	13,572	-
ASC.05 Human Resources	ASC.05.01.01.01 Monetary incentives for physicians for prevention	-	-	5,757	-	-	5,757

	ASC.05.01.02.02 Monetary incentives for nurses for care and treatment	-	-	2,535	-	-	2,535
	ASC.05.01.02.98 Monetary incentives for nurses not disaggregated by intervention	-	800	-	-	-	800
	ASC.05.01.03.01 Monetary incentives for other staff for prevention	-	-	19,176	2,640	-	21,816
	ASC.05.01.03.02 Monetary incentives for other staff for care and treatment	-	-	37,980	54,281	-	92,261
	ASC.05.01.03.03 Monetary incentives for other staff for programme management and administration	-	-	-	2,466	-	2,466
	ASC.05.01.03.98 Monetary incentives for other staff not disaggregated by type	-	16,667	-	8,356	-	25,023
	ASC.05.03 Training	3,725,211	-	12,094,356	5,451,727	46,052	21,317,346
	ASC.05.98 Human resources not disaggregated by type	70,208,391	-	-	4,242,815	-	74,451,206
	ASC.05 Human Resources Total	73,933,602	17,467	12,159,804	9,762,285	46,052	-
ASC.06 Social protections and social services	ASC.06.01 Social protection through monetary benefits	-	7,007	-	-	-	7,007
	ASC.06.02 Social protection through in-kind benefits	9,957	702	29,476	94,869	-	135,004
	ASC.06.03 Social protection through provision of social services	-	-	410	-	-	410

	ASC.06.04 HIV-specific income generation projects	267	2,175	13,978	20,000	-		36,420
	ASC.06.99 Social protection services and social services n.e.c.	-	4,348	-	-	-		4,348
	ASC.06 Social protections and social services Total	10,224	14,232	43,864	114,869	-	-	183,189
ASC.07 Enabling environment	ASC.07.01 Advocacy	119,816	11,274	19,808	138,125	345		289,368
	ASC.07.02.98 Human rights programmes not disaggregated by type	-	-	281	-	-		281
	ASC.07.03 AIDS-specific institutional development	-	-	1,026,776	19,683,249	-		20,710,025
	ASC.07.04 AIDS-specific programmes focused on women	402,883	10,012	94,081	40,867	-		547,843
	ASC.07.98 Enabling environment not disaggregated by type	-	-	322,548	-	-		322,548
	ASC.07 Enabling environment Total	522,699	21,286	1,463,494	19,862,241	345	-	21,870,065
ASC.08 Research	ASC.08.01 Biomedical research	-	-	12,640	-	-		12,640
	ASC.08.04.01 Behavioural research	-	-	622,604	-	-		622,604
	ASC.08.04.02 Research in economics	-	-	4,667	-	-		4,667
	ASC.08.04.98 Social science research not disaggregated by type	-	-	17,014	-	-		17,014
	ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	-	-	1,371,078	1,595	39,999		1,412,672
	ASC.08.99 HIV and AIDS-related research activities n.e.c.	-	-	-	15,000	-		15,000
	ASC.08 Research Total	-	-	2,028,003	16,595	39,999	-	2,084,597
	Grand Total	125,139,587	850,547	284,908,865	85,861,856	100,588	56,028	496,917,471

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Joint United Nations Programme on HIV/AIDS



Enhancing Nigeria's Response to HIV & AIDS Programme

¹⁸NACA (2010): Nigeria. National strategic plan 2010-2015