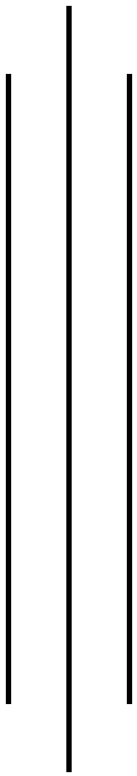
Resource inflow for the HIV & AIDS Programmes in Nepal - 2010

HIV AIDS & STI Control Board

Study to track resource inflow for the HIV & AIDS programme in Nepal-2010



HIV/AIDS and STI Control Board

with technical support from UNAIDS and World Bank

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FOREWORD

HIV and AIDS has emerged as a major public health and socio-economic problem affecting most of the South Asian country including Nepal. After first HIV case detected in 1988, Nepal's response to the HIV epidemic has expanded over the years with an increasing number of partners and stakeholders involved in HIV and AIDS prevention, treatment, care and support. This brought substantial resources for the HIV responses that support Nepal's commitment to reduce new HIV infections and reverse the epidemic by 2015, as stated by the countries at the United Nations General Assembly Special Session on HIV and AIDS and in the Millennium Development Goals.

Most resources available to support HIV and AIDS programming in Nepal come from a variety of External Development Partners. Very few of the interventions are being implemented by Government especially HSCB and NCASC. Most interventions for prevention for the most-at risk populations (FSW, IDU, and MSM) are implemented by non government actors.

There is a need of strong mechanism of tracking the resources in order to clearly reflect the coverage of donor supported programmes and the duration of their support which will allow the government to harmonize resource flow and ensure sustainability of interventions and services. Thus, this study is conducted to track fund flow in HIV and AIDS programming in Nepal, which tracks the flow and distribution of resources from donor agencies to implementing agencies for the response of HIV at national and sub national levels.

I am pleased to share this study to track the inflow of resources for the HIV/AIDS programmes in Nepal which was developed in consultation with government and non-government stakeholders. We have now a tool that will allow donor coordination at national level and regular updating will facilitate harmonization of resources.

I take this opportunity to thank UNAIDS and World Bank for financial and technical support as well as MITRA Samaj for conducting study and preparing report. I also like to express my sincere thanks to Mr. Alankar Malviya, UNAIDS for conceptualizing the study and for his technical inputs. Additionally, I am also thankful to Mr. Sanjay Rijal and Mr. Komal Badal from HSCB for their continuous support and inputs to complete this study.

This exercise is a major step to strengthen the implementation of the "Three Ones" principle by providing a common roadmap indicating resources available, identify gaps and help the country undertake the development/ revision of the national strategic plan, along with information derived from the geographic prioritization study.

Dr. Shyam Sunder Mishra
Vice Chair and Chief Executive
HIV AIDS and STI Control Board (HSCB)

ACKNOWLEDGEMENTS

HSCB would like to thank World Bank, DFID for their financial support to conduct this study without which this study was not possible. Technical inputs from UNAIDS and World Bank resulting in this quality report are highly appreciated.

We are grateful to NCASC for their timely support in conducting the study. HSCB would like to thanks MITRA Samaj for their sincere and high quality work within the said timeline to all individual stakeholders who are part of this study we appreciate each one's cotribution.

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

HIV AIDS and STI Control Board (HSCB)

Abbreviations and acronyms

ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BL	Bilateral Agencies
BDS	Blue Diamond Society
CHBC	Community Home-based Care
DFID	UK Department for International Development
FPAN	Family Planning Association of Nepal
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, TB, and Malaria
GTZ	German Development Agency
HIV	Human Immunodeficiency Virus
HSCB	HIV AIDS and STI Control Board
IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
INGO	International Non-government Organization
MARP	Most At-Risk Population
MoHP	Ministry of Health and Population
MSM	Males Who Have Sex with Males
NAP	National Action Plan
n.e.c	not elsewhere classified
NCASC	National Centre for AIDS and STD Control
NGO	Non-government Organization
OI	Opportunistic Infection
OST	Oral Substitution Therapy
OVC	Orphans and Vulnerable Children
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother to Child Transmission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organization

Executive Summary

National Centre for AIDS and STD Control (NCASC) estimates that approximately 70,000 adults and children are infected with HIV with an estimated prevalence of 0.49 in adults (15-49 years). (NCASC 2007) The groups who are at risk of HIV in Nepal are IDUs, MSMs, and FSWs including the labour migrants moving into high risk regions (particularly in India).

Resources available to support HIV and AIDS programming in Nepal come primarily from a variety of External Partners. Most interventions for prevention for the most-at risk populations (FSWs, IDUs, MSM) are not implemented by the government (NCASC or HSCB) but rather through some strong I/NGOs. There is a multiplicity of donors each financing their own vertically structured prevention programme among MARPs, implemented through NGOs, INGOs and CBOs. There is no strong and effective system to coordinate and harmonize the inflow of resources aimed at prevention amongst MARPs. Gradual reduction of donor support for HIV programming, exacerbated by the recent economic recession, and Nepal's failure to receive Global Fund Round 9 financing highlights even further the importance of reducing duplication and improving the optimum use of available funds. In order to clearly reflect the coverage of donor supported programmes and the duration of their support there is need of a strong mechanism of tracking of resources to ensure the continuity of ongoing preventive programmes.

This study, while fulfilling the need mentioned earlier, is conducted to track fund flow in HIV/AIDS programming in Nepal from donor agencies to implementing agencies. This report is based on the information received from the government, multilaterals, bi-laterals and non-governmental agencies. The external and domestic financial resource flows for the response of HIV presented in this report are based on the adopted categories of NASA, and the categories comprised are attached in the Annex I.

This study will enable the Government of Nepal, MoHP, national programme management entity namely HSCB and NCASC to track the influx of and distribution of resources from various donor agencies to HIV Programmes and assess the gap to meet the involved population coverage. This study complements the National AIDS Spending Assessment (NASA) which is more focused on the spending aspect of HIV response/programmes in Nepal.

As suggested by HSCB and stakeholders participating in the consultation meeting, 11 broad key categories of National AIDS Spending Assessment (NASA) were adopted for this study.

The key steps followed by the study team were: i) listing of all sources of financing for HIV and AIDS in Nepal; ii) identifying, for each source of financing, the implementing entities, the amount and the duration of the financing period; iii) disaggregating data to provide better understanding of programming outlay; iv) disaggregating data sets by geographic coverage; v) validating the data sets through multiple sources and designing a database in close consultation.

Key findings:

- The major financing sources for HIV response in Nepal are public, bilateral, multilateral and private/ INGOs. Eight key sources provide the majority of funds for the HIV response in Nepal. A total of USD 20.5 million were spent in 2009 and USD 19.1 million obligated for fiscal 2010.
- Global funds constitute the major source of funding, which provided 31.3% of funds for HIV response for the fiscal year 2009; this is followed by DFID (30.9%) and USAID (26.8%).
- A total of USD 20.5 million was provided for HIV response in the year 2009. This amount has been reduced to USD 19.1 million in 2010. Both years major portion of funds was provided for prevention activities (46%), followed by programmme management and administration; enabling environment (23%); VCT (7%) and care and treatment (7%).
- Only USAID and private /INGOs have allocated budget for the FY 2011. Other agencies are in process of allocating budget.
- During the year 2010 four districts have five or more to support the HIV programme. Fifteen districts have 4 donors and nine districts have three donors. Five districts have no presence of any funding agency for HIV response (excluding GON).
- Ten districts received funds from two donors to implement VCT programme in 2010.
- In 2009 the central region continued to be the largest recipient of funds with 50% of the total funds allocated for the districts in Nepal, which is 44% in 2010 followed by Far Western Region 16% and 20 % in 2009 and 2010 respectively.
- The epidemiological region-wise analysis shows that large amounts of funds were allocated for the highway district (45% in 2009 and 53% in 2010) and this is followed by Kathmandu Valley (35% in 2009 and 25% in 2010). Far-western hills were receiving 10% of funds out of total funds allocated for the districts.
- Organizations working on HIV response have different reporting formats and different timelines for reporting (financial and programme).
- There is no donor coordination mechanism in place.

Key conclusions:

- All the donors are reducing the amount for the HIV response over the years, i.e., funding is decreasing over the years. There is a big gap in the funds received for HIV response work and need indicated in the NAP 2008-2011.
- There is overlapping of donors and programme (especially prevention)
- There is no effective donor coordination and harmonization
- Majority of districts have not assured funding after December 2010.
- There are different reporting schedules and formats which make resource tracking and compilation of information difficult.

Recommendations:

General

1. Institutionalizing resource tracking system is a very important aspect of monitoring. This will help to period ically review and coordinate for better programming among the stakeholders.
2. Strategy of institutionalization of Resource Tracking strongly depends on the existing reporting system of key actors of HIV response. One of the first steps for institutionalising the Resource Tracking exercise would be to map information on the various organizations working in each district of Nepal.
3. In order to make the resource tracking feasible and effective, explore the possibility of developing programme categories that are accepted by all stakeholders and use them for programming and reporting.
4. NAP 2008-2011 is in place in Nepal and it is of utmost urgency to ensure that need-based resource allocation be done by the donor and the government.
5. Effective donor coordination mechanism needs to be instituted to reduce overlapping of funds and working area and create synergistic impact of the programme.

Relevant to Government of Nepal

1. Facilitate to use consistent programme categories and recording of budget and expenses on the same as far as possible
2. Coordinate with and facilitate key donors and implementing partners to use the fund tracking system and database on a timely basis

Donors and multilaterals

1. Facilitate adoption of similar programme categories to contribute for institutionalizing the resource tracking .

Implementing agencies / service providers

1. Provide information based on the resource tracking software to the HSCB.
2. Facilitate implementing partners in orientation of software and programme categories so that report on expenditure is disaggregated by programme and MARPs.

1. Background

National Centre for AIDS and STD Control (NCASC) estimates that approximately 70,000 adults and children are infected with HIV with an estimated prevalence of 0.49 in adults (15 - 49 years) (NCASC 2007). The groups who are at risk of HIV in Nepal are injecting drug users (IDUs), men who have sex with men (MSMs), and female sex workers (FSWs) including the labour migrants moving into high risk regions (particularly in India).

Most resources available to support HIV and AIDS programming in Nepal come from a variety of External Partners. And, most interventions for prevention for the Most At risk Population (FSWs, IDUs, MSM) are not implemented by government (NCASC or HSCB) but rather through some strong I/NGOs like FHI, Save the Children, CARE Nepal.

As the Commission on AIDS in Asia has rightly pointed out, although funding for HIV and AIDS in most Asian countries has increased, funds are not allocated to the most effective interventions. Evidence has long shown that focusing resources on interventions involving the Most At Risk Population (MARPs) in a concentrated epidemic like Nepal is the most cost effective utilisation of available resources.

There is no strong and effective system to coordinate and harmonize the inflow of resources aimed at prevention amongst MARPs. Gradual reduction of donor support for HIV programming, exacerbated by the recent economic recession, and Nepal's failure to receive Global Fund Round 9 financing highlights even further the importance of reducing duplication and improving the targeting of available funds. In order to clearly reflect the coverage of donor supported programmes and the duration of their support there is need for a strong mechanism of tracking of resources to ensure the continuity of ongoing preventive programmes.

This study is conducted to track fund flow in HIV and AIDS programming in Nepal, from donor agencies to implementing agencies for the response of HIV. This report is based on the information received from the Government, multilaterals, bi-laterals and non-governmental agencies. The external and domestic financial resource flows for the response of HIV presented in this report are based on the adopted categories of National AIDS Spending Assessment (NASA); the categories comprised are attached in Annex I.

This study will enable Government of Nepal, Ministry of Health and Population's (MoHP), national programme management entity namely HSCB and NCASC to track the influx of and distribution from various resources to the HIV Programmes and assess the gap to meet the priority population coverage. This study complements NASA which is more focused on the spending aspect of HIV prevention programme in Nepal.

2. Objective of the study

The purpose of this study was to obtain a "mapping" of available resources to complement the geographic prioritisation study (geographic mapping/size estimation of Most at Risk populations being conducted in 41 Districts) being conducted concurrently, to allow an assessment of the need/demand for services and their supply. This exercise is expected to help strengthen the implementation of the 'Three ONES' principles by providing a common roadmap indicating resources available, identifing gaps and helping the country undertake the development/ revision of the national strategic plan, along with information derived from the geographic prioritization study.

3. Categories agreed for tracking the resource

HIV AIDS and STI Control Board (HSCB) and key stakeholders participating in the consultation meeting suggested adopting the following broad key categories of National AIDS Spending Assessment (NASA) for this study. :-

1. Prevention
2. Prevention, diagnosis, and treatment of sexually transmitted infections (STI)
3. Voluntary Counseling and Testing
4. Prevention of Mother to Child Transmission (PMTCT)
5. Care and treatment
6. Orphans and vulnerable children
7. Programme management and administration
8. Human Resources
9. Enablement of environment
10. HIV related research (excluding operational research)
11. Other budgeted programme category (PC) not classified elsewhere

The definition of these categories is attached as Annex II.

4. Methodology

The following methodologies were adopted for this study:

- Listing of all sources of financing for HIV and AIDS in Nepal including multilaterals, bi-laterals, INGOs, NGOs and government resources with an ultimate objective to build a resource mapping database.
- Identifying, for each source of financing, the implementing entities, the amount and the duration of the financing period.
- Disaggregating data to provide better understanding of programming outlay. The broad suggested categories are (1) Prevention: General Population and MARPs (IDUs, MSM, FSWs, (2) Care support and Treatment, (3) Institutional strengthening, (4) Monitoring Evaluation and Research.
- Disaggregating data sets by geographic coverage (district - wise), and taking into account the duration of the financing.
- Validating the data sets through multiple sources in consultation with key stakeholders during the process.
- Designing a database in close consultation with HSCB, World Bank (WB) and Joint United Nations Program on HIV/AIDS (UNAIDS) to enter the financial data and easen periodic tracking of funding sources and funds available for the programme.

5. Study team

The study team comprised of three persons led by Deepak C. Bajracharya as Team Leader; Chandra B. Thapa, Nilesh Man Joshi and Prajuna KC as team member for the study. UNAIDS provided technical support to finalize tools and database. World Bank and HSCB provided the coordination and guidance for the study.

6. Work schedule

a) Preparatory phase

Prior to the launch of this study, HSCB in collaboration with WB and UNAIDS organized consultative meetings with key programmers and financial authorities to formally introduce the objective of the study and emphasize the need for accurate information on budget allocation for HIV programme and services by districts for three consecutive years 2009, 2010 and 2011.

b) Data Collection and Processing

At first all donors, service providers and government bodies involved in HIV response were listed. The agencies for the study were sorted based on the agreed criteria for selection, e.g., volume of expenditure, programme coverage in Nepal etc. The sorted agencies were visited by the study team to brief them about the study tool and software. The expenditure of 2009/10 and budget allocated for 2010/11 were collected, checked and balanced later in Excel sheets. All the information obtained/collected was verified to ensure the validity of data. From the raw data produced then summary analysis tables were generated.

c) Data Validation

Validation of the data is a crucial step in this exercise. This required a meeting of technical people who can check the correctness of results and validate the assumptions made by the tracking team. Key organizations (who operate the largest share of the response to HIV): Global Fund for AIDS, TB, and Malaria (GFATM) project implementers, United Nations Development Program (UNDP), key NGOs (FHI, CARE, Plan, etc.) who manage funds of donors like USAID, UK Department for International Development (DFID, UN), etc. were visited for a data validation

During validation the resource tracking team explained the methodology and made an excel file presentation. The feedback during the validation came up with some suggested recommendations which were duly incorporated into the report.

In order to avoid double accounting of resources, funds provided by Australian Agency for International Aid (AusAID) and DFID were not included in the database, These, get accounted in the budget information provided by UNDP and the United Nations Office on Drugs and Crime (UNODC) respectively. The funds for Blue Diamond Society (BDS) from DFID were also not included since they were provided through UNDP and had already been counted for.

d) Analysis and reporting

Once the data was validated for the accuracy, analysis was done in respect to key areas of interests funding sources and programme categories; district-wise budget and plan; MARP wise expenses and allocation of funds; agency-wise programme budget and activities; and duration of the programme.

7. Source of Data

With technical assistance from WB and UNAIDS, and inputs from the consultation meeting, MITRA Samaj study team identified and mapped all key players in HIV response. The questionnaire for the resource tracking was developed but later it was realized that the respondent would be more comfortable providing data in a soft version than in a hard copy. Therefore, it was decided to capture the information in software designed by the study team in close consultation with UNAIDS, WB and HSCB.

Suggested list include:

1. National TB Centre
2. National Centre for AIDS and STD Control (NCASC)
3. Australian Agency for International Development (AusAID)
4. UK Department for International Development (DFID)
5. German Development Agency (GTZ)
6. United States Agency for International Development (USAID)
7. JICA
8. UNDP-Programme Management Unit
9. United Nations Population Fund (UNFPA)
10. United Nations Children's Fund (UNICEF)
11. The United Nations Office on Drugs and Crime (UNODC)
12. World Health Organization (WHO)
13. World Bank (WB)
14. International Labor Organization (ILO)
15. CARE Nepal
16. Save the Children
17. Family Planning Association of Nepal (FPAN)
18. NAPN+
19. Blue Diamond Society (BDS)

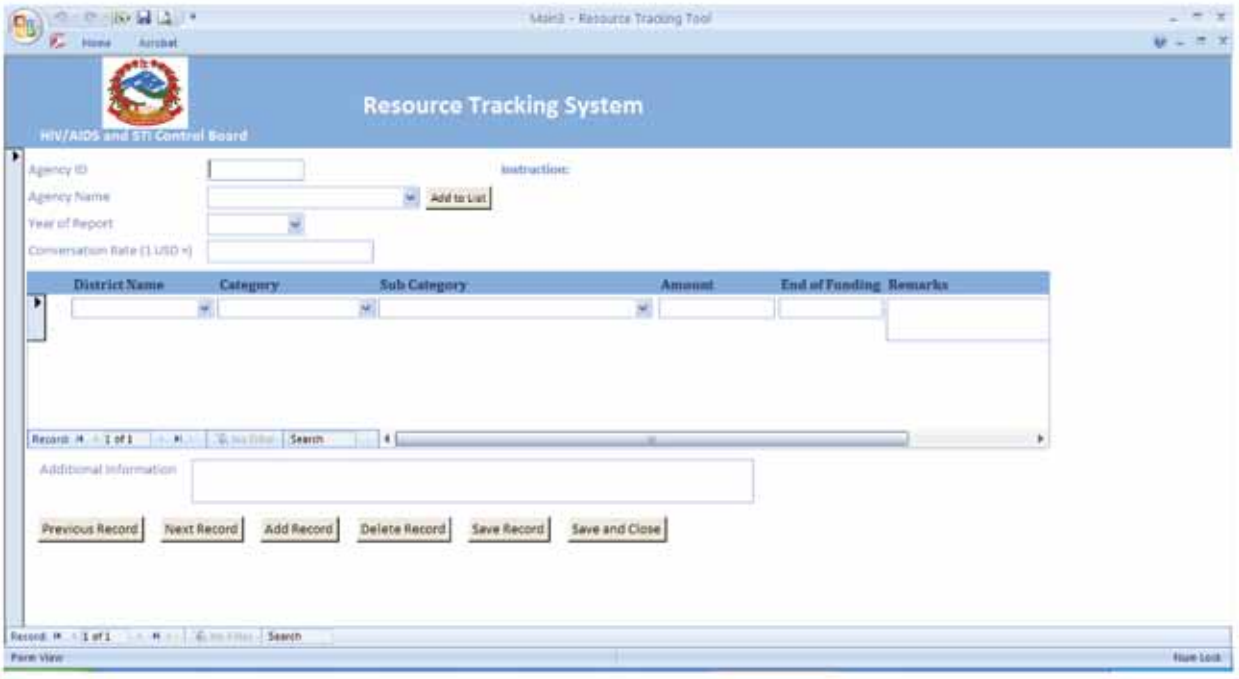
8. Assumptions and limitations

Tracking the resources allocated and spent for HIV is a challenge and following are a number of limitations to the study. The major ones include the following:

i. It is assumed that the data provided for 2010 by the respondents is based on their actual budget allocation, but not actual expenditures. All the analysis is done based on this assumption.
ii. It is assumed that selected agencies for this study provided a more or less a complete picture fund flow within the HIV sector of Nepal.
iii. The major limitation of this study is the agencies could not provide the estimated budget for the year 2011 (with the exception of USAID and private/INGOs); they are in the process of forecasting for the year 2011. This was a limiting factor for analysing the resource gap and need for the year 2011.
iv. There was no system to track the routine financial reporting; however, NASA was conducted only in 2007.
v. Data from some agencies have not been received by the deadline, so the analysis is based on the information received from key agencies.
vi. Quality of data: The nature of data given and the difficulty in determining the proportion of allocated funds to specific programme category; no desegregation and comprehensive analysis for all MARPs could be provided. For e.g., Family Planning Association of Nepal (FPAN) has Voluntary Counselling and Testing (VCT), Sexually Transmitted Infection (STI) and Care and Support merged together for a single comprehensive package; International Labour Organization (ILO) has the budget allocation for multiple districts, UNICEF has not made district wise break down yet for 2010.
vii. Data on beneficiaries were not disaggregated and detailed enough. The bulk of it was assumed to be involving the broad category of MARPs as a comprehensive package, e.g., Mass Media and Behaviour Change Communication (BCC). It is 34% in 2009 and 48% in 2010 of the total amount allocated for prevention.
viii. Few agencies had different financial reporting periods from that used by the Government of Nepal (July - July), e.g., USAID (October - September), UNICEF (January - December). By agencies the efforts was made to capture the actual expenditure within each fiscal year, according to the government's fiscal year.
ix. The year 2009 represents the fiscal year (FY) covering July 2008 to June 2009 (Nepali FY 2065/66); 2010 covering July 2009 to June 2010 (Nepali FY 2066/67); and similarly 2011 covers the period from July 2010 to June 2011 (Nepali FY 2067/68). These three years provide the funding information as 2009 spending amount; 2010 spending and budgeted; and 2011 amount obligated for the HIV programme.
x. The exchange rate is US$ 1 equals NRS 72.00 . The Euro exchange rate of 1 EURO equals NRS 109.90 was used for the study.
xi. Even though the study team used the " Resource Tracking System Software " as access based relational database to process all spending data, the overall analysis can be performed in Excel, e.g., using pivot tables.
xii. This study was focused to collect funding information from the headquarter offices located in Kathmandu only.
xiii. Fund flow information has been collected from the organizations whose level of funds accounts for more than 1% of overall fund for HIV response.

9. Database

A database was developed that can be used by the Government of Nepal in future to manage and harmonise available resources in the country and plan for its optimum utilisation. This database is an easy-to-use interface to access the information and it can be easily updated. The interface of the database is presented below:



10. Findings

a) Financing Sources for HIV and AIDS activities

The major financing sources for HIV response in Nepal are public, bilateral, multilateral and private/INGOs. Eight key sources provide the majority of funds for the HIV response in Nepal (Table 1). Information received during the study shows that a total of US$ 20.5 million were invested in 2009 and US$ 19 million for fiscal year 2010. Global funds constitute the major source of funding, which provided 31.71% of funds for HIV response for fiscal year 2009; this is followed by DFID and USAID. These three major funding institutions have reduced funding level in 2010 as compared to year 2009.

Table 1: Key funding sources for HIV and AIDS response

Year/Funding Agency	2009		2010		2011	
	US$	Percent	US$	Percent	US$	Percent
Global Fund	6,402,853	31.30	6,227,524	32.62	NA	NA
DFID	6,326,322	30.93	4,568,313	23.93	NA	NA
USAID	5,477,411	26.78	4,320,346	22.63	3,596,515	86.50
AusAID	752,242	3.68	419,967	2.20	NA	NA
UN Agency	652,766	3.19	2,270,406	11.89	NA	NA
Private/INGOs	476,246	2.33	654,554	3.43	561,151	13.50
GON	265,417	1.30	384,875	2.02	NA	NA
GTZ	101,544	0.50	244,248	1.28	NA	NA
Grand Total	20,454,801	100.00	19,090,232	100.00%	4,157,666	100.00%

Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal
Note: Amount accounting <1% of overall funds for HIV response has not been taken into consideration in the study.

Table 2 shows that out of the total funds in HIV and AIDS sector in Nepal from 2009 to 2011 the largest chunk of assistance comes from bi-lateral agencies (US$ 24.6 million) and this is followed by multilaterals (US$ 16.7 million). Overall funding size is reducing as compared to the year 2009 by 6.7% (1.4 million US$). Similarly bilateral funding for HIV response has been reduced in 2010 where as multilateral and private/INGO funds has been increased by 14% (US$ 1 million) and 37% (US$ 178 thousands) respectively.

The Private/INGOs mainly consist of non-governmental organizations and other private organizations. In Nepal the general trend of provision of HIV services are relied heavily on private non-profit providers (NGOs). The study reflected that INGOs provided US$ 1.7 million in between 2009 - 2011 (Table 2).

Table 2: Sources of funds for HIV and AIDS response

Sources of Fund	Year			Total
	2009	2010	2011	
Government				
NCASC	265,417	384,875	-	650,292
Sub-total	265,417	384,875	-	650,292
Bi-laterals				
DFID/BDS	688,349	-	-	688,349
DFID/UNDP-PMU/BDS	-	402,897	-	402,897
DFID/UNDP-PMU/ILO	254,626	-	-	254,626
DFID/UNDP-PMU	5,383,347	4,165,416	-	9,548,763
USAID/FHI	5,069,467	4,320,346	3,475,133	12,864,946
USAID/Social Marketing/N-MARC	407,944	-	-	407,944
USAID/Social Marketing/Nepal CRS	-	-	121,382	121,382
GTZ	101,544	244,248	-	345,792
Sub-total	11,905,277	9,132,907	3,596,515	24,634,699
Multilaterals				
Global Fund/BDS	133,022	274,992	-	408,014
Global Fund/FPAN	762,181	1,596,162	-	2,358,343
Global Fund/Save The Children	1,257,763	1,642,552	-	2,900,315
Global Fund/UNDP-PMU	3,772,665	2,445,132	-	6,217,797
Global Fund/UNDP-PMU/NCASC	284399	232521	-	516,920
Global Fund R II/UNDP-PMU	192,824	36,165	-	228,989

Sources of Fund	Year			Total
	2009	2010	2011	
ILO/UNAIDS/PAF	43,261	-	-	43,261
ILO-HEADQUARTERS	35,385	-	-	35,385
UNDP-PMU	-	1,453,219	-	1,453,219
UNFPA	126,058	193,294	-	319,351
UNICEF	448,062	586,393	-	1,034,455
UNODC	752,242	419,967	-	1,172,209
WHO/NCASC	-	37,500	-	37,500
Sub-total	7,807,862	8,917,896	-	16,725,758
Private/INGO				
CARE Nepal/EMPHASIS	-	237,354	274,448	511,802
CARE Nepal/Safe Passage	313,538	261,933	286,703	862,174
IPPF/FPAN	162,708	155,267	-	317,975
Sub-total	476,246	654,554	561,151	1,691,951
Grand Total	20,454,801	19,090,232	4,157,666	43,702,700

Source: Study to track the inflow of resources for the HIV and AIDS programme in Nepal.

b) Financing Sources for key programme categories

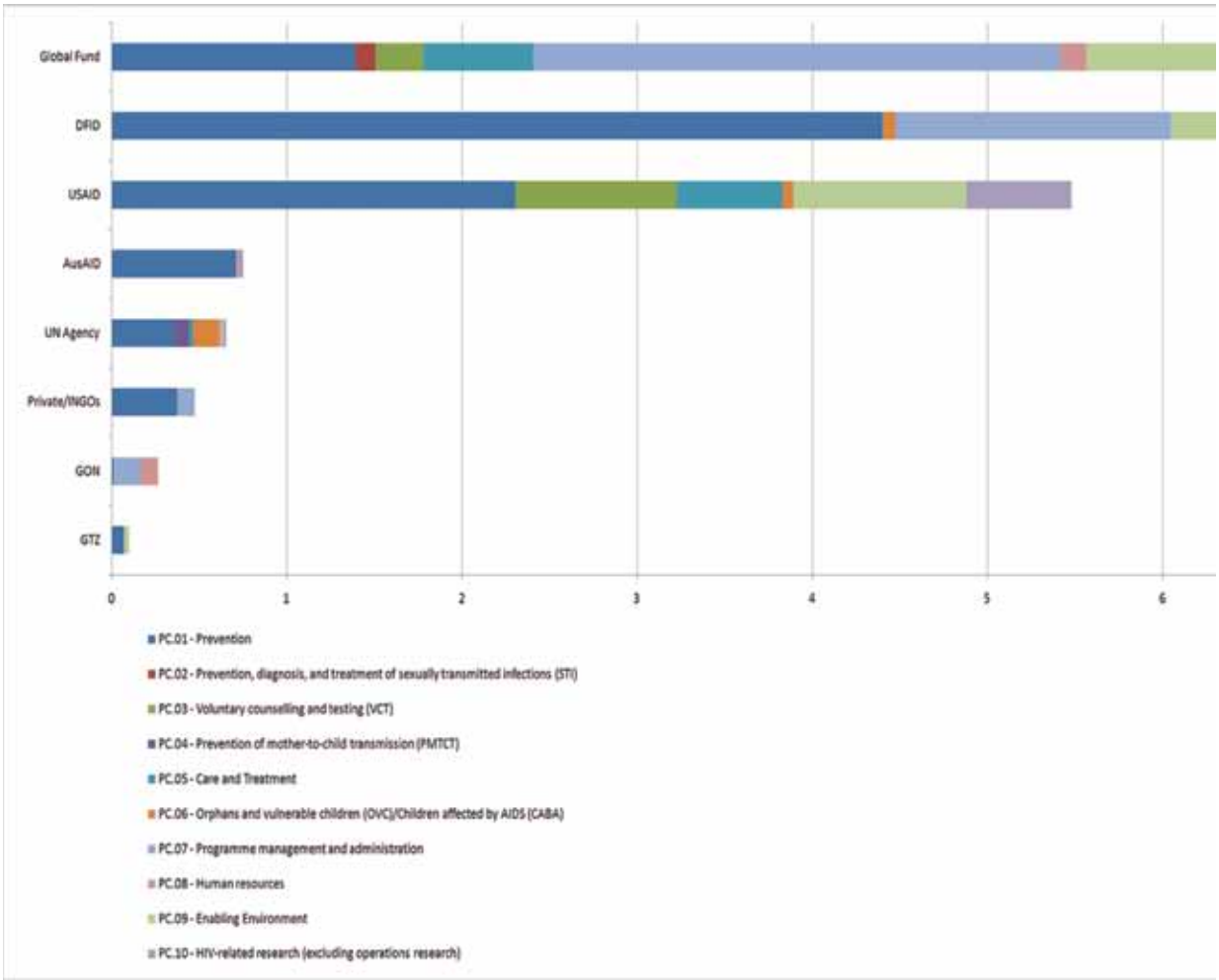
The total spending in HIV sector in Nepal during 2009 was US$ 20.5 million. Major funding under HIV response is prioritised for prevention. This is followed by programme management and administration, enabling environment, care and treatment and VCT respectively.

Out of total funding for prevention DFID contributes 46% of funding, which is followed by USAID (24%) and global fund (14%).

Table 3: Key funding agencies with their programme categories for FY 2009 (in `000 US $)

Funding Agency	PC.01 - Prevention	PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	PC.03 - Voluntary counselling and testing (VCT)	PC.04 - Prevention of mother-to-child transmission (PMTCT)	PC.05 - Care and Treatment	PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	Total Amount
Global Fund	1,393	113	276		623		3,008	149	840		6,403
DFID	4,400	-				75	1,569		282		6,326
USAID	2,306	-	917		609	60			988	598	5,477
AusAID	712	-						12		28	752
UN Agency	362	-		79	25	142		19	13	13	653
Private/INGOs	373	-					103				476
GON	11	-					155	100			265
GTZ	72	-							30		102
Total Amount	9,630	113	1,193	79	1,257	277	4,835	279	2,153	638	20,455

Source: Study to track the inflow of resources for the HIV and AIDS programme in Nepal

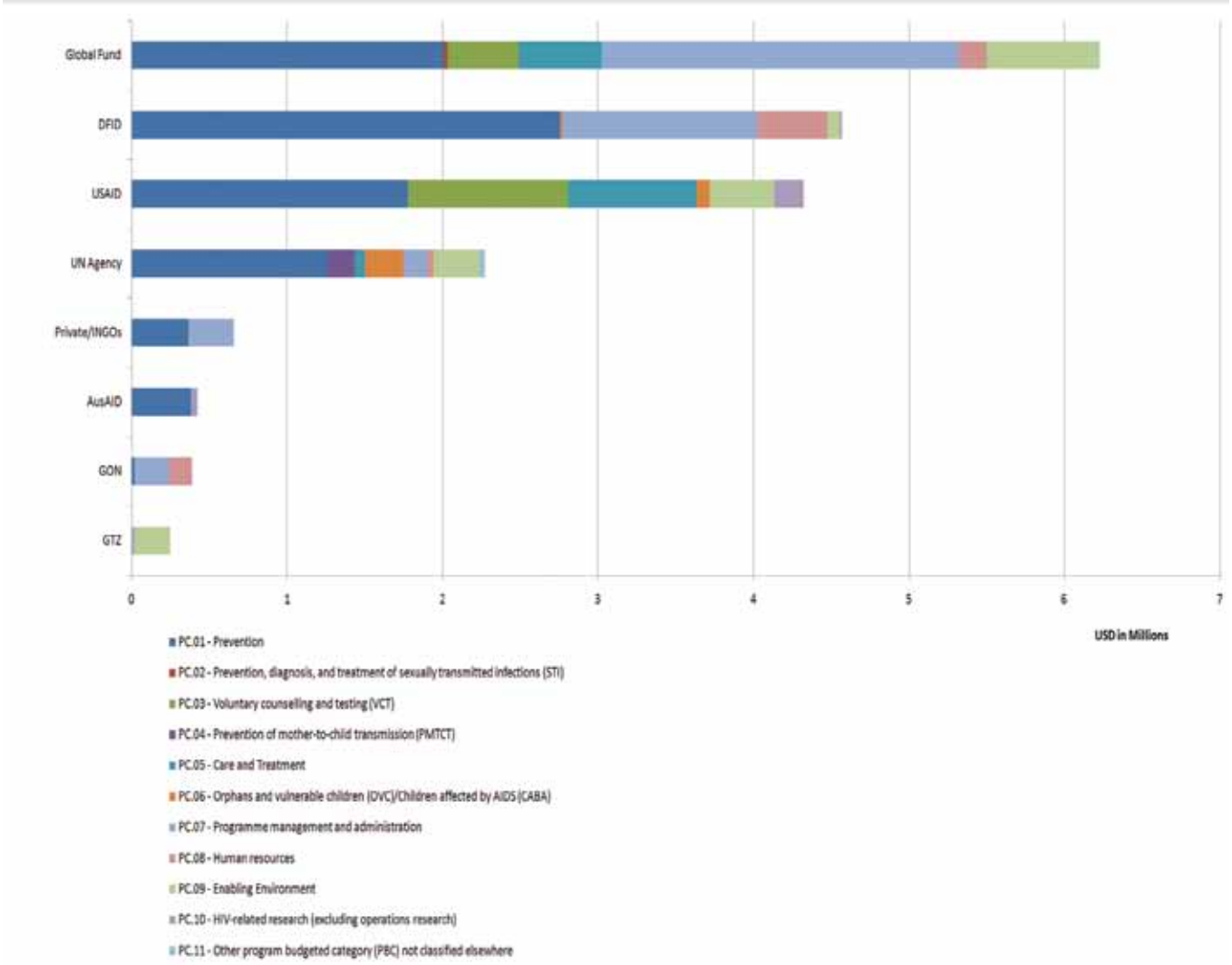


The total spending in HIV sector in Nepal during 2010 is US$ 19.1 million which is slightly less than the funds provided for the FY 2009 (US$ 20.5 million). Major funding under HIV response for this fiscal year is also Prioritised for the prevention. This is followed by programme management and administration, enabling environment, VCT and care and treatment respectively (Table 4).

Table 4: Key funding agencies with their programme categories for FY 2010 (in `000 US$)

Funding Agency	PC.01 - Prevention	PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	PC.03 - Voluntary counselling and testing (VCT)	PC.04 - Prevention of mother-to-child transmission (PMTCT)	PC.05 - Care and Treatment	PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	PC.11 - Other program budgeted category (PBC) not classified elsewhere	Total Amount
Global Fund	2,007	25	457		533		2,298	182	725			6,228
DFID	2,757					13	1,256	450	83	10		4,568
USAID	1,776		1,031		827	82			419	186		4,320
UN Agency	1,259			176	66	245	157	38	296		33	2,270
Private/INGOs	363						291					655
AusAID	380									40		420
GON	15						225	144				385
GTZ							14	2	229			244
Total Amount	8,557	25	1,488	176	1,426	340	4,241	816	1,752	236	33	19,090

Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal



Only USAID and private/INGOs have allocated budget for the FY 2011. Other agencies are in the process of allocating budget. USAID fund for 2010 has been reduced as compared to year 2009 and 2010.

Table 5: Key funding agencies with their programme categories for FY 2011

Funding Agency	PC.01 – Prevention	PC.03 – Voluntary counseling and testing (VCT)	PC.05 – Care and treatment	PC.06 – OVC/CABA	PC.07 – Programme management and administration	PC.09 – Enabling environment	Total
Private/INGOs	298,808	-	-	-	262,344	-	561,151
USAID	1,550,736	942,374	743,570	61,830	-	298,005	3,596,515
Grand Total	1,849,544	942,374	743,570	61,830	262,344	298,005	4,157,666

Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal

c) Funds available in the districts

A total of US$ 17.5 million was provided to the districts for the HIV response in the year 2009, 2010 and 2011. This amount has been reducing in the subsequent years. A total of US$ 8.8 million was provided in year 2009 and it was US$ 6.7 million in year 2010. Both years a major portion of funds were provided for prevention activities, followed by programmme management and administration; enabling environment; VCT and care and treatment (Table 6).

Table 6: Fund allocated for the districts (in `000 US$)

Fiscal Year	PC.01 – Prevention	PC.03 - VCT	PC.04 - PMTCT	PC.05 - Care and Treatment	PC.06 - OVC/CABA	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	Total fund allocated for the districts
2009	6,938	640	24	680	218	103	19	176	13	8,811
2010	4,749	652	14	789	55	291		157	3	6,711
2011	918	408		323	20	262		53		1,984
Total	12,604	1,700	38	1,792	293	657	19	386	15	17,505

Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal

Table 7 below shows that the overall allocation of the funds for the district is 40% with respect to the total funds allocated for the country for HIV response over three years. The trend of funds allocation to the district is reducing in the year 2010 as compared to 2009. It is increased on 2011 to 48%, however, this increment cannot represent the situation since majority of the donors have not allocated funds for the year yet.

Table 7: Fund allocated for the districts in respect to total funds received for HIV response (in `000 US$)

Fiscal Year	Total fund allocated for the districts	Total fund received for HIV response	% age of fund provided to the districts
2009	8,811	20,455	43
2010	6,711	19,090	35
2011	1,984	4,158	48
Total	17,506	43,703	40

Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal

An analysis was done with respect to funding level for the different districts. The level of funding is divided into five categories viz :- i) < 20, ii) 20 - 50, iii) 50 - 100, iv) 100 - 200, v) > 200 thousands US$.

Map 1 presents the availability of funds in the districts with the level of funding. The analysis shows that 22 districts have less than US$ 20 thousands; 4 districts have 20 - 50 thousands; 18 districts have 50 - 100 thousands; 9 districts have US$ 100-200 thousands; and 17 districts have more than US$ 200 thousands in 2009. Similarly 26 districts have less than US$ 20,000; 2 districts have 20-50 thousands; 19 districts have US$ 50 - 100 thousands; 11 districts have US$ 100-200 thousands; and 12 districts have more than US$ 200 thousands in 2010. Detail programme-wise and district-wise fund flow is provided in the Annex 8.

Figure 1: Map of Nepal showing five categories (USD <20; 20-50; 50-100, 100-200 and >200 thousand) for year 2009

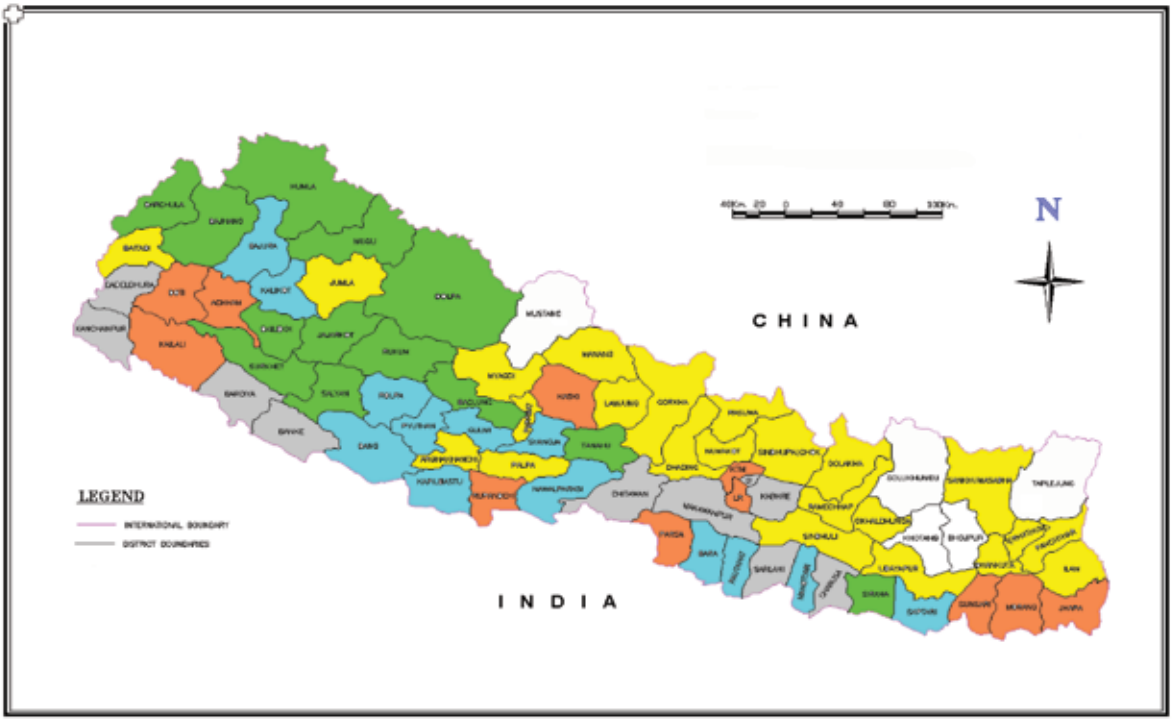
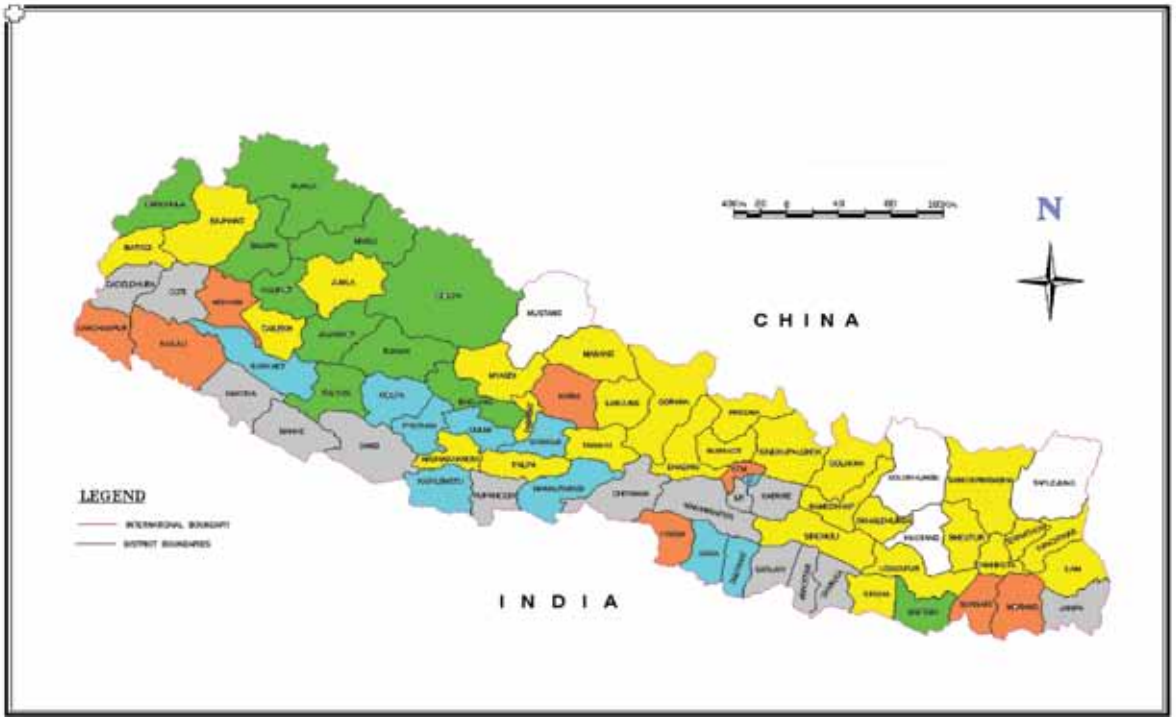


Figure 2: Map of Nepal showing five categories (USD <20; 20-50; 50-100, 100-200 and >200 thousand) for year 2010



d) Expenditures for HIV and AIDS activities by geographic region

Table 8. Expenditure by administrative regions

Region	Total Spent in 2009		Planned for 2010		Planned for 2011	
	USD(%)	USD	(%)	USD	(%)	
Central	4,406	50	2,939	44	625	31
Eastern	854	10	706	11	174	9
Far-western	1,451	16	1,371	20	806	41
Mid-western	972	11	829	12	146	7
Western	1,129	13	865	13	233	12
Grand Total	8,811	100	6,711	100	1,984	100

In 2009 Central region continues to be the largest recipient of funds which is receiving 50% of the total funds allocated for the districts in Nepal, which is 44% in 2010 followed by Far Western Region 16% and 20 % in 2009 and 2010 respectively. The 2011 data are limited to the funding of USAID/FHI; USAID/Social Marketing/Nepal CRS Company; and CARE Nepal only. The level of funding from other sources is not available during the study period so no realistic trend analysis is possible.

e) Expenditures for HIV and AIDS activities by epidemiological region

An analysis was made in reference to epidemiological regions of Nepal developed in 2003 dividing the country into four epidemic zones: 1) Kathmandu Valley; 2) Highway districts: Mahendra, Prithvi and Pokhara –Butwal highways; 3) Far – western hills: 7 hill districts of the Far – western development region 4) Remaining Hill Districts. (UNGASS Country Report 2010).

The epidemiological region-wise analysis shows that large amounts of funds were allocated for the highway district (45% in 2009 and 53% in 2010) and is followed by Kathmandu Valley (35% in 2009 and 25% in 2010). Far-western hills were receiving 10% of funds out of total funds allocated for the districts.

Table 9. Expenditure by epidemiological regions

Epidemic Zone	Total Spent in 2009		Planned for 2010		Planned for 2011	
	US$	(%)	US$	(%)	US$	(%)
Far-western Hills	860	10%	743	11%	402	20%
Highway Districts	3,989	45%	3,563	53%	1,215	61%
Kathmandu Valley	3,084	35%	1,701	25%	338	17%
Remaining Hill	878	10%	704	10%	29	1%
Grand Total	8,811	100%	6,711	100%	1,984	100%

f) Budget for key HIV and AIDS programme

The Resource tracking exercise shows that overall. Nepal spent a total of US$ 40 million on HIV and AIDS between 2009 and 2010.

A disaggregated data categoy - wise show that the key spending priorities between 2009 and 2010 have been on prevention (46%); programme management and administrative strengthening (23%); and Enabling Environment (10%). The other categories were care and treatment (7%); VCT (7%); Human Resource (3%); HIV related research (2%); OVC/CABA (2%); PMTCT, Prevention, diagnosis, and treatment of sexually transmitted infections and other s not elsewhere classified (n.e.c.) (1%).

Total expenditure on prevention prgrammes declined from 47% to 45% in 2010; similarly expenditures on programme management and administration, prevention, diagnosis, and treatment of sexually transmitted infections, and enabling environment had also declined. Meanwhile, expenditure on Human Resource increased from 1% in 2009 to 3% in 2010. Another important key intervention area where spending has been stagnant is VCT, Orphans and Vulnerable Children (OVCs) / CABA, Care and Treatment and Prevention of Mother to Child Transmission (PMTCT). The total spending on all these areas is 1% of total spending respectively between 2009 and 2010.

Table 10. Expenditures for HIV and AIDS activities by category of activity (in `000 US$)

Programme Category	Expenditure 2009		Budget 2010		Total in 2009-2010		2011	
	US$	(%)	US$	(%)	US$	(%)	US$	(%)
PC.01 - Prevention	9,630	47.08	8,557	44.82	18,187	45.99	1,850	44.49
PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	113	0.55	25	0.13	138	0.35	-	-
PC.03 - Voluntary counselling and testing (VCT)	1,193	5.83	1,488	7.79	2,681	6.78	942	22.67
PC.04 - Prevention of mother-to-child transmission (PMTCT)	79	0.39	176	0.92	255	0.64	-	-
PC.05 - Care and Treatment	1,257	6.15	1,426	7.47	2,683	6.78	744	17.88
PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	1.35	340	1.78	617	1.56	62	1.49	
PC.07 - Programme management and administration	4,835	23.64	4,241	22.22	9,076	22.95	262	6.31
PC.08 - Human resources	279	1.37	816	4.27	1,095	2.77		
PC.09 - Enabling Environment	2,153	10.52	1,752	9.18	3,905	9.88	298	7.17
PC.10 - HIV-related research (excluding operations research)	638	3.12	236	1.23	874	2.21	-	-
PC.11 - Other programme budgeted category (PBC) not classified elsewhere	-	-	33	0.17	33	0.08	-	-
Grand Total	20,455	100	19,090	100	39,544	100	4,158	100

Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal

Table 11 shows that the major focus on MARP in respect to cumulative funding for 2009 and 2010 is found to be on IDUs (17.33%); migrants and their wives (16.85%) and FSWs and their clients (15.83%). 17.5% of budget allocated for the prevention activities in 2009 could not be segregated by MARPs specific category; this proportion has increased to 29.5% in 2010.

Table 11 : Expenditures for HIV and AIDS prevention activities

Prevention Program	Expenditure 2009		Budget 2010		Total in 2009-2010		2011	
	US$	(%)	US$	(%)	US$	(%)	US$	(%)
MARPS								
FSWs and their clients	2,020	20.98	859	10.04	2,879	15.83	1,321	71.44
MSM	821	8.53	1,393	16.28	2,214	12.17	-	-
IDUs	1,665	17.29	1,486	17.37	3,151	17.33	124	6.71
Migrants and Their Wives	1,859	19.30	1,205	14.08	3,064	16.85	216	11.68
Youth	372	3.86	208	2.43	581	3.19	-	-
PLHIV	1,211	12.58	878	10.26	2,088	11.48	135	7.30
Prevention activities not segregated	1,682	17.47	2,528	29.54	4,210	23.15	53	2.87
Total for prevention	9,630	100.00	8,557	100.00	18,187	100.00	1,850	100.00

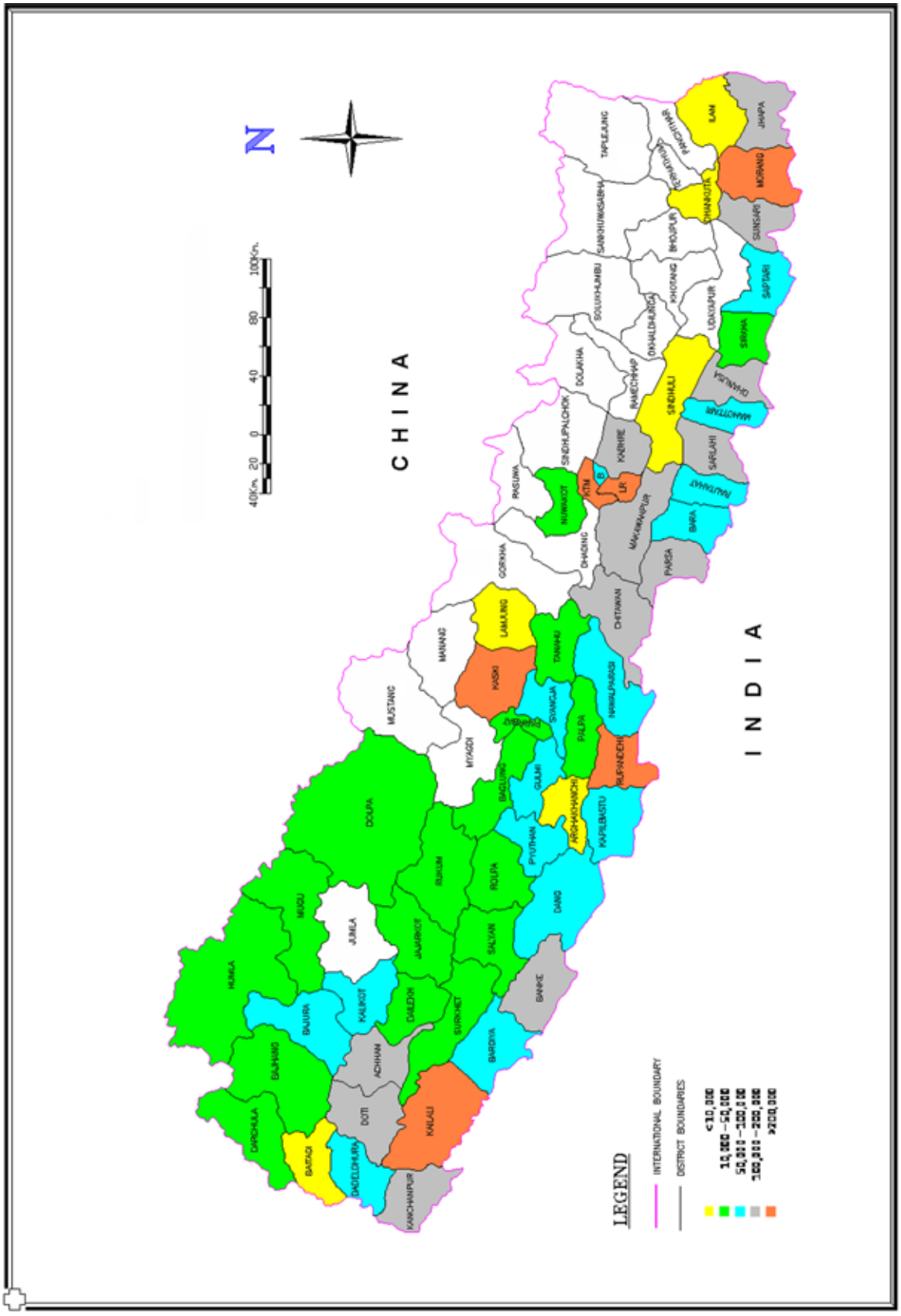
Source: Study to track the inflow of resources for the HIV/AIDS programme in Nepal

Note: Prevention activities not segregated included funds for BCC and community mobilization, condom social marketing, prevention activities not broken down by category, and prevention activities not classified into category.

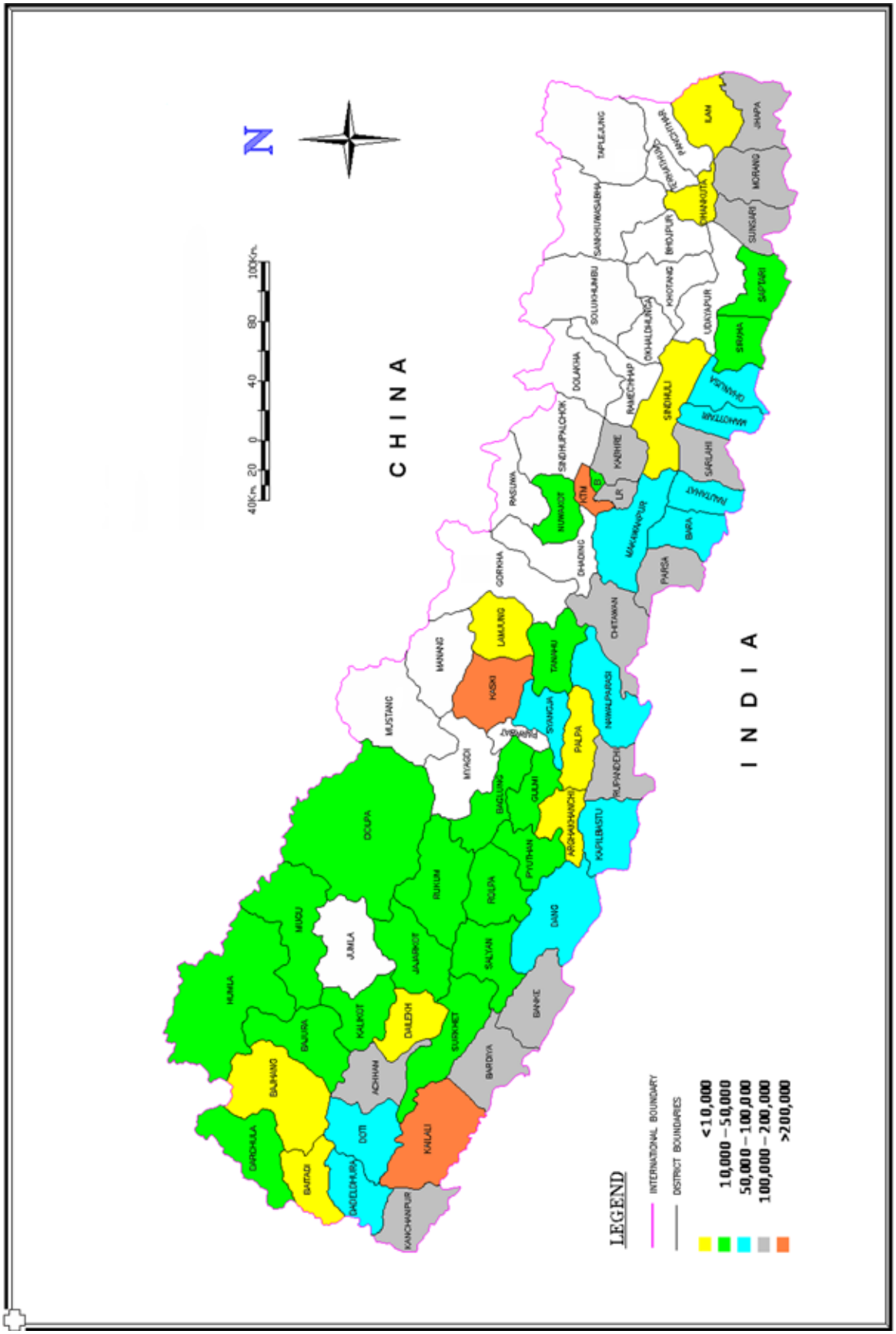
g) Funds allocation for districts prioritising HIV and AIDS Prevention for key MARPs

Funds for HIV prevention programme involving MARPs has been presented in the subsequent maps. These maps show level of funding in different categories (US$ <20; 20-50; 50-100, 100-200 and >200 thousand). Six districts in 2009 and three districts have more than US$ 200 thousand for the prevention program involving MARPs. Nineteen districts in 2009 and twenty districts in 2010 are yet to receive funds for HIV prevention involving MARPs. Funds allocated for other MARPs for the fiscal year 2009 and 2010 are presented in the subsequent maps.

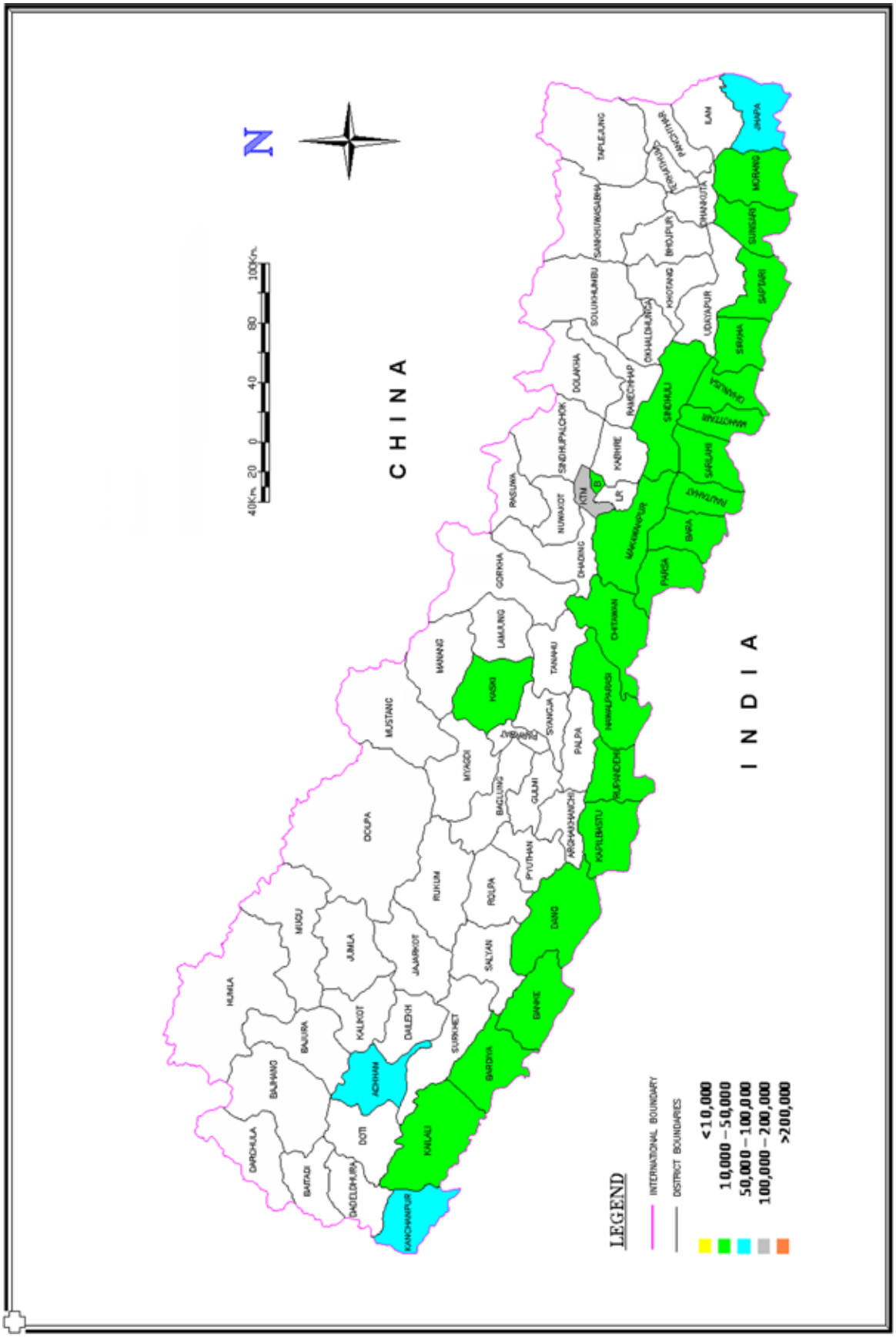
Prevention Programme – Overall prevention programme involving for MARPs in the different districts in year 2009



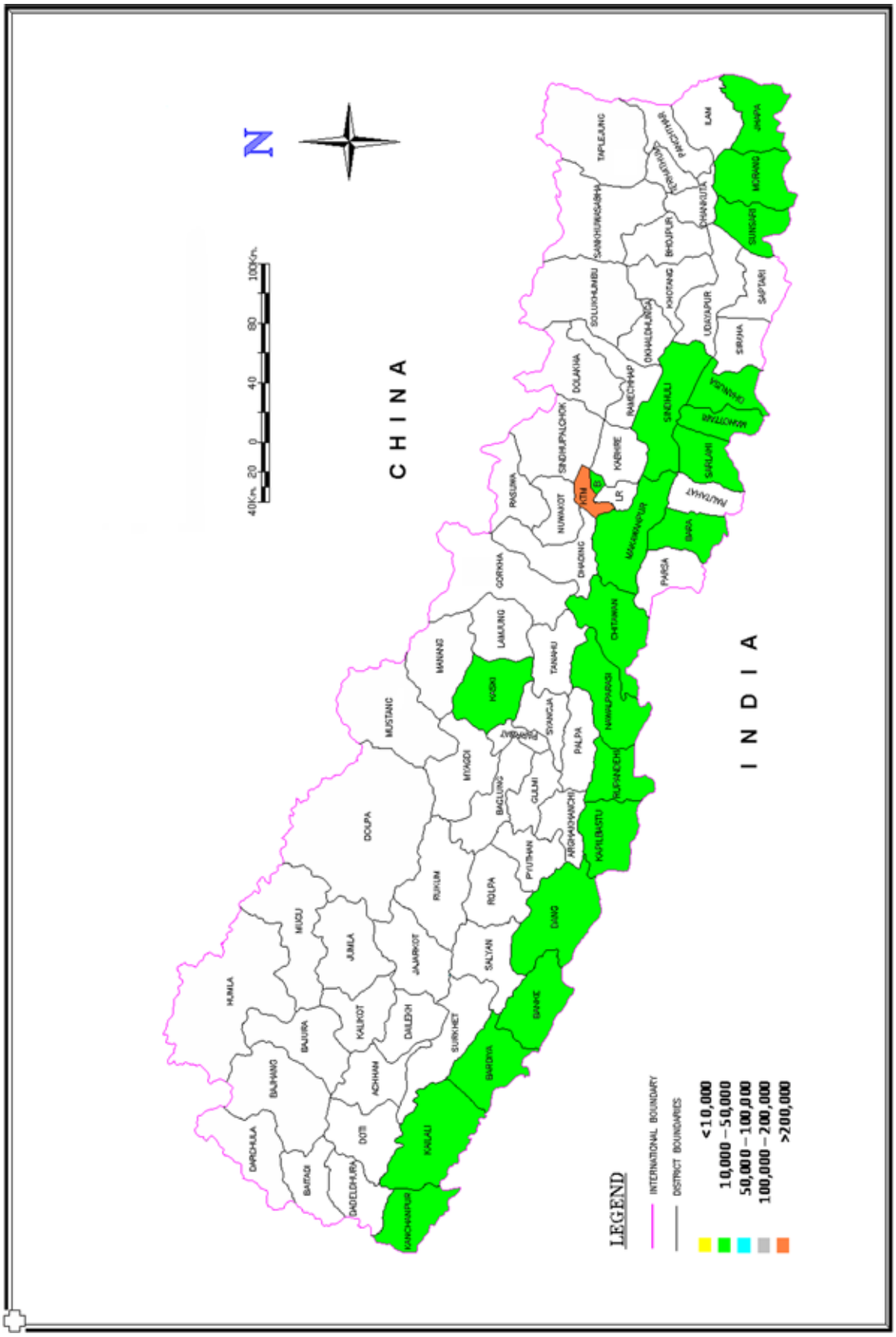
Prevention Programme – Overall prevention programme targeted for MARPs in the different districts in 2010



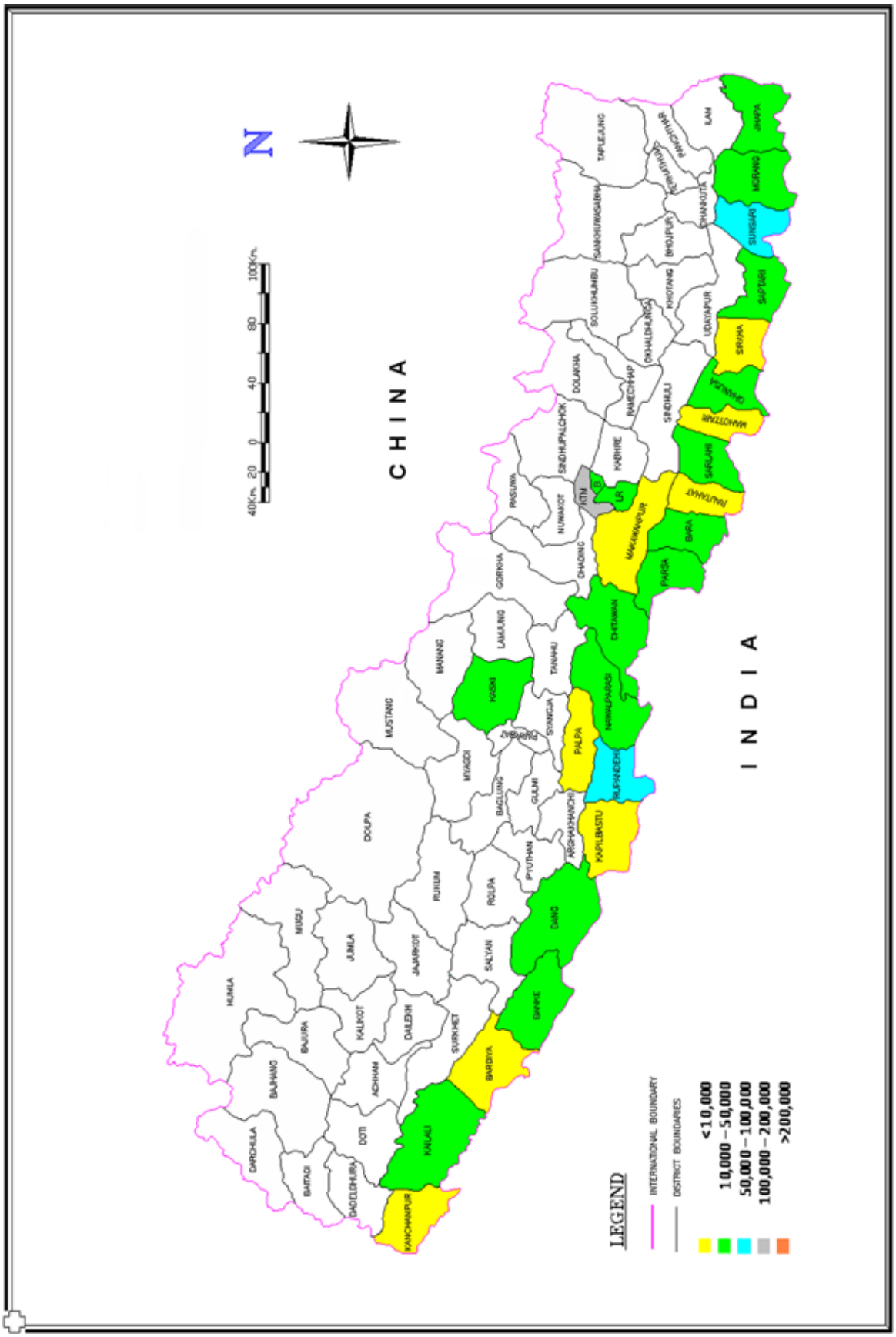
Prevenion programme : Targeted for FSWs and level of funding in 2009



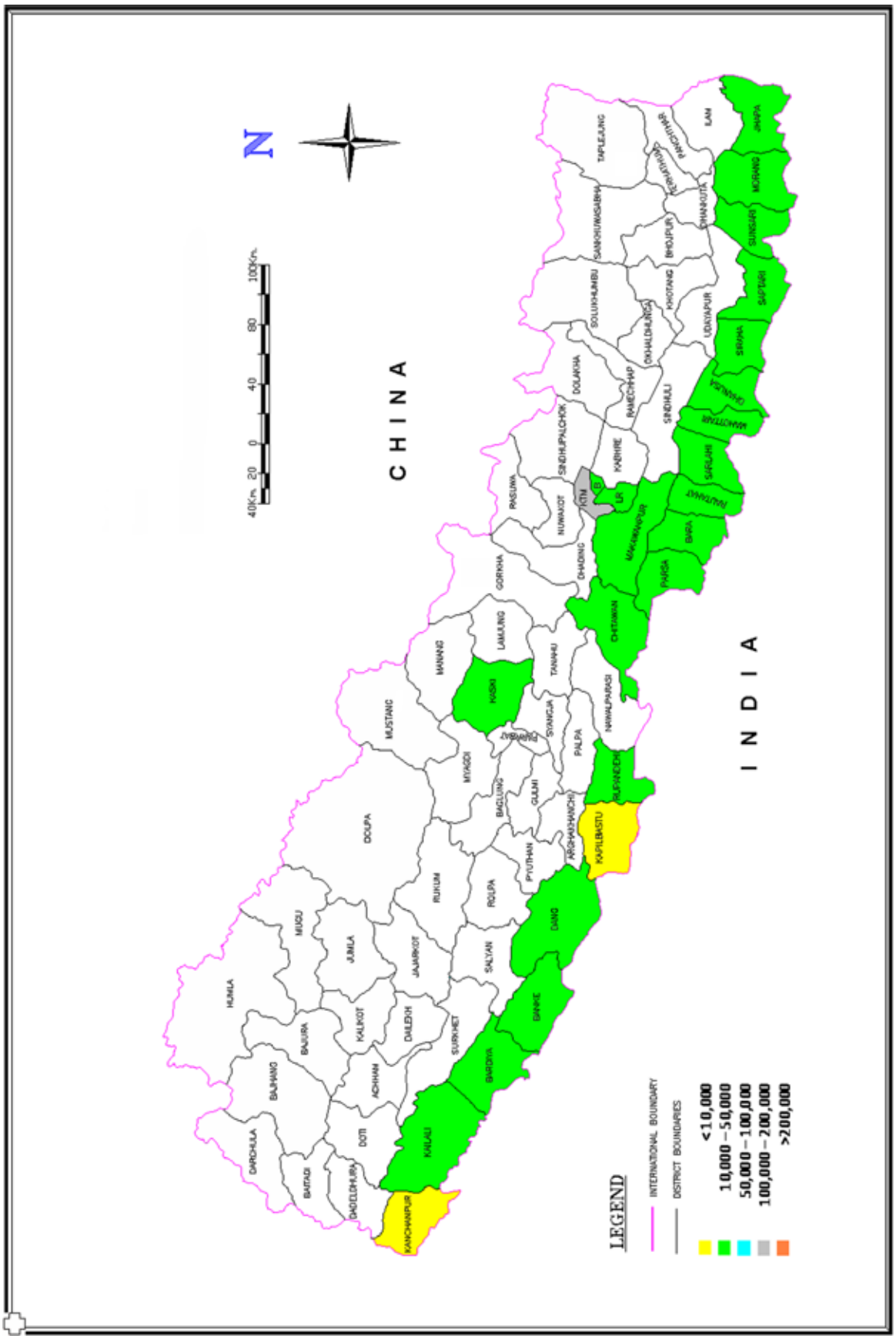
Prevenion programme : Targeted for FSWs and level of funding in 2010



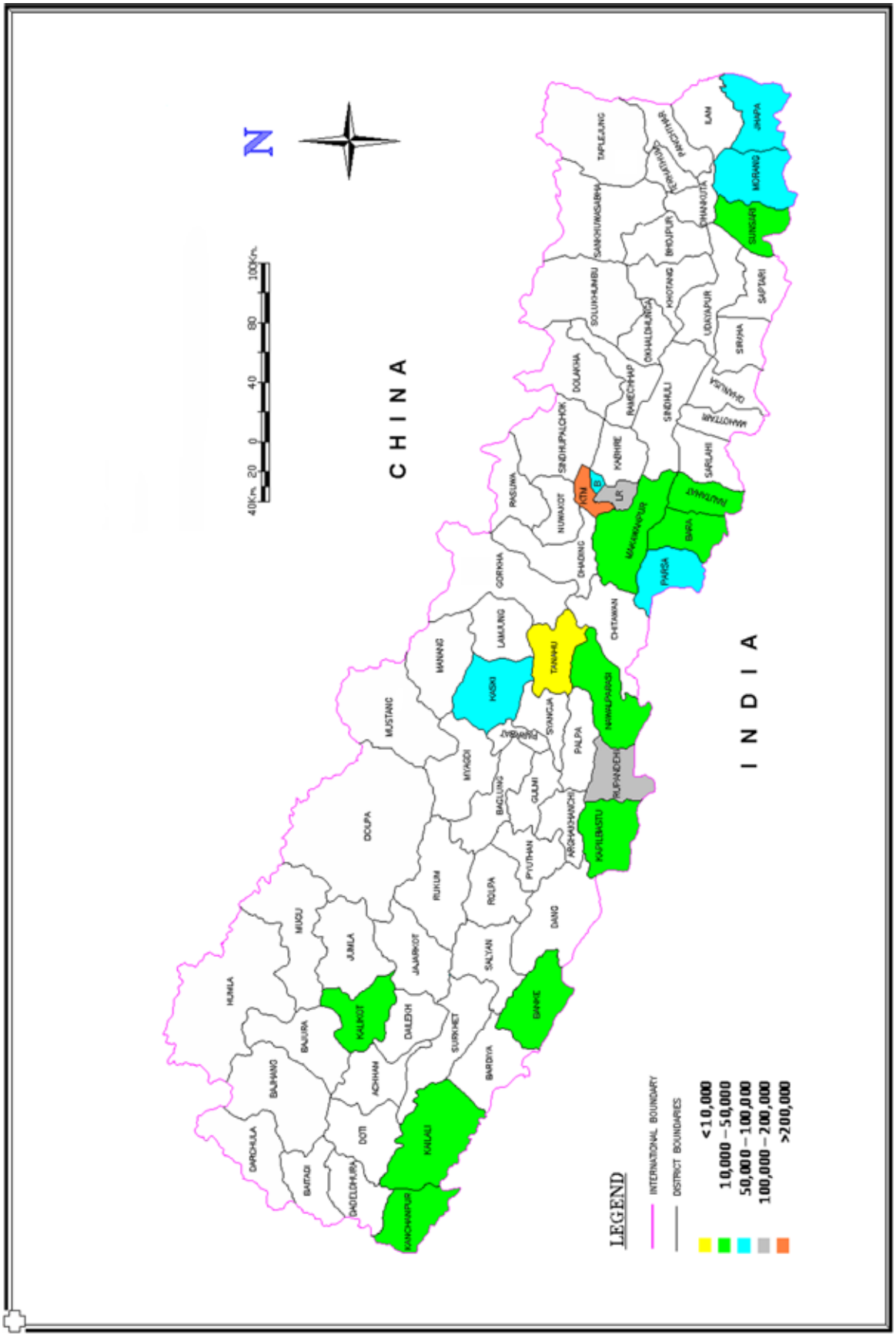
Prevention programme : Targeted for MSM and level of funding in 2009



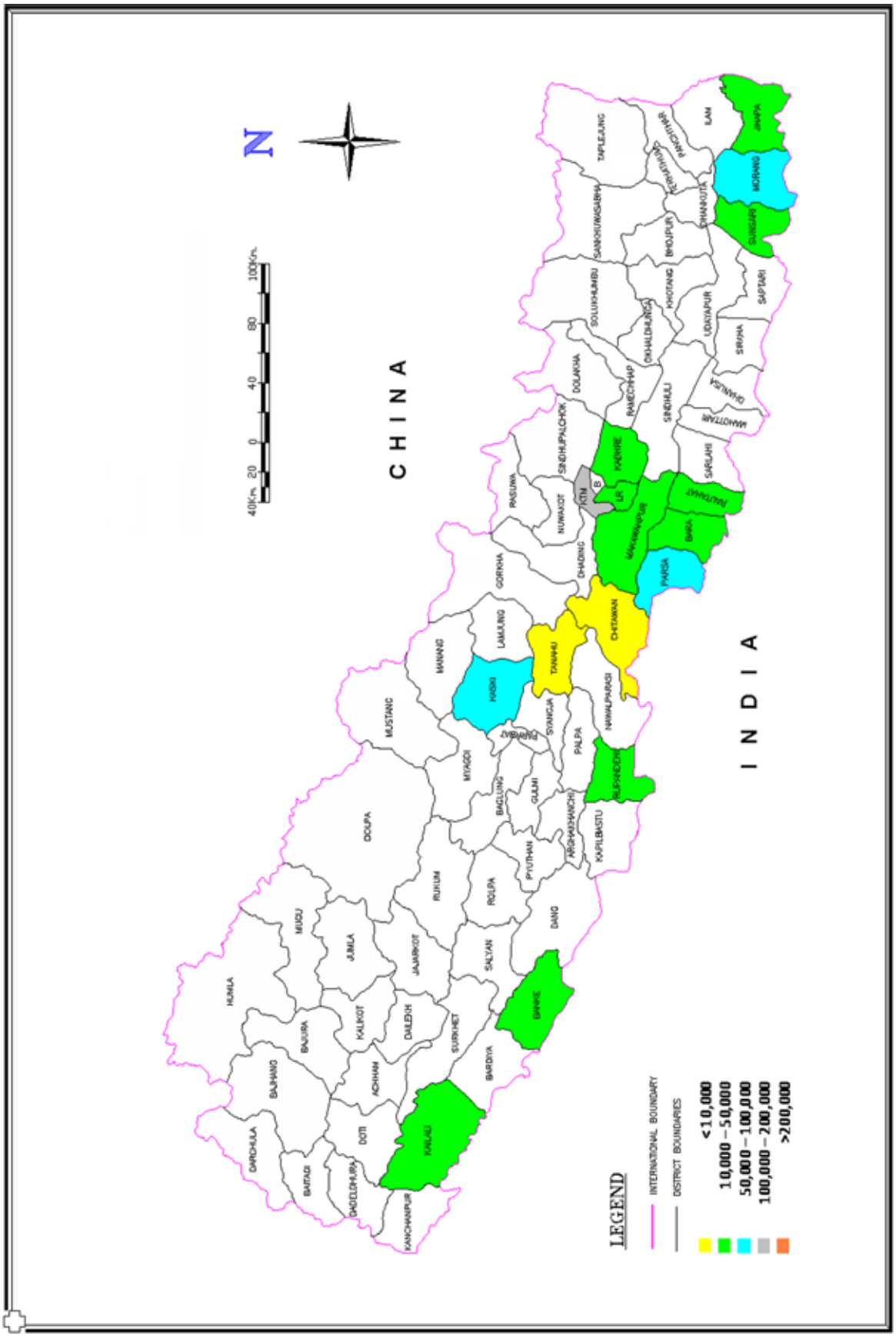
Prevention programme : Targeted for MSM and level of funding in 2010



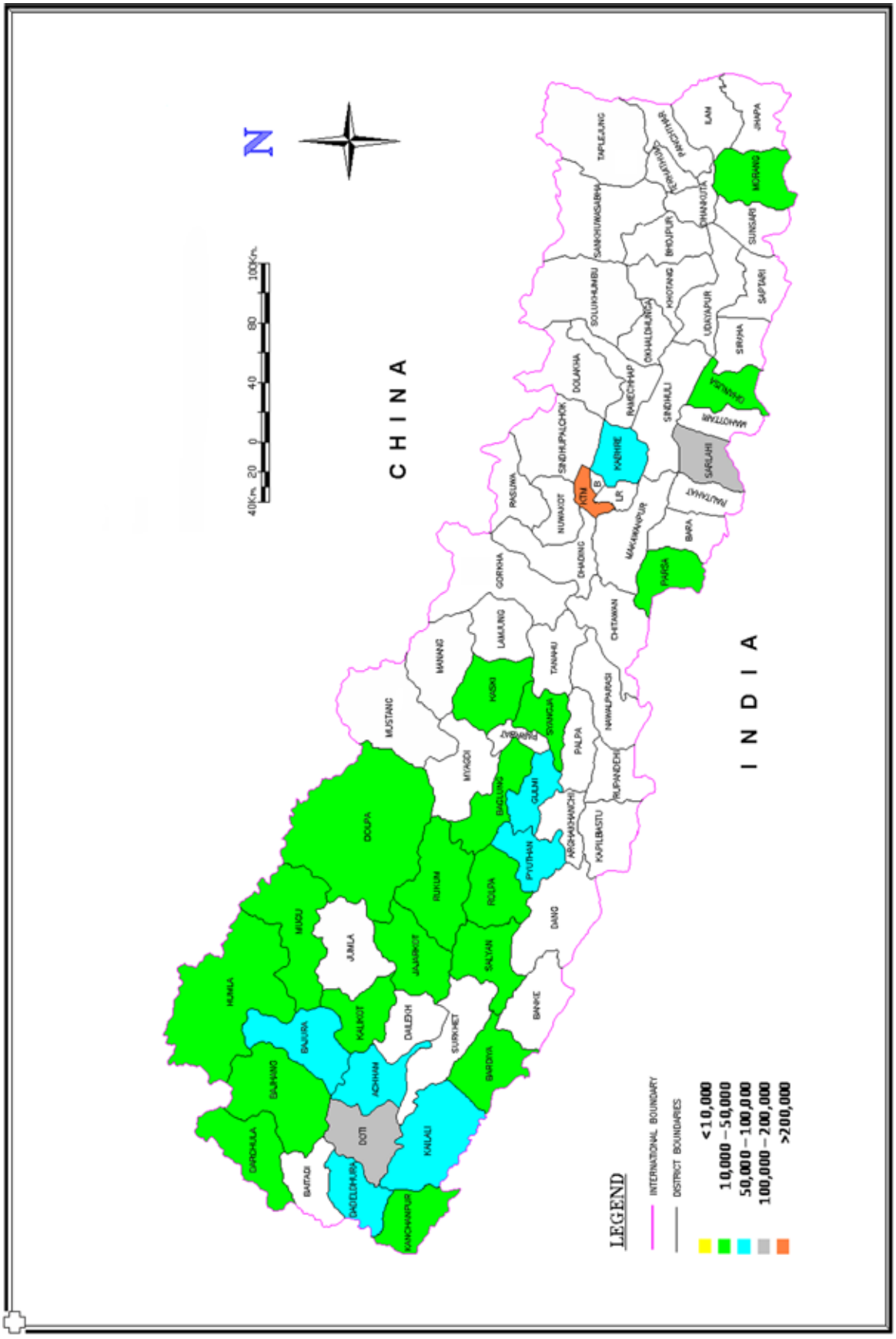
Prevention programme : Targeted for IDU and level of funding in 2009



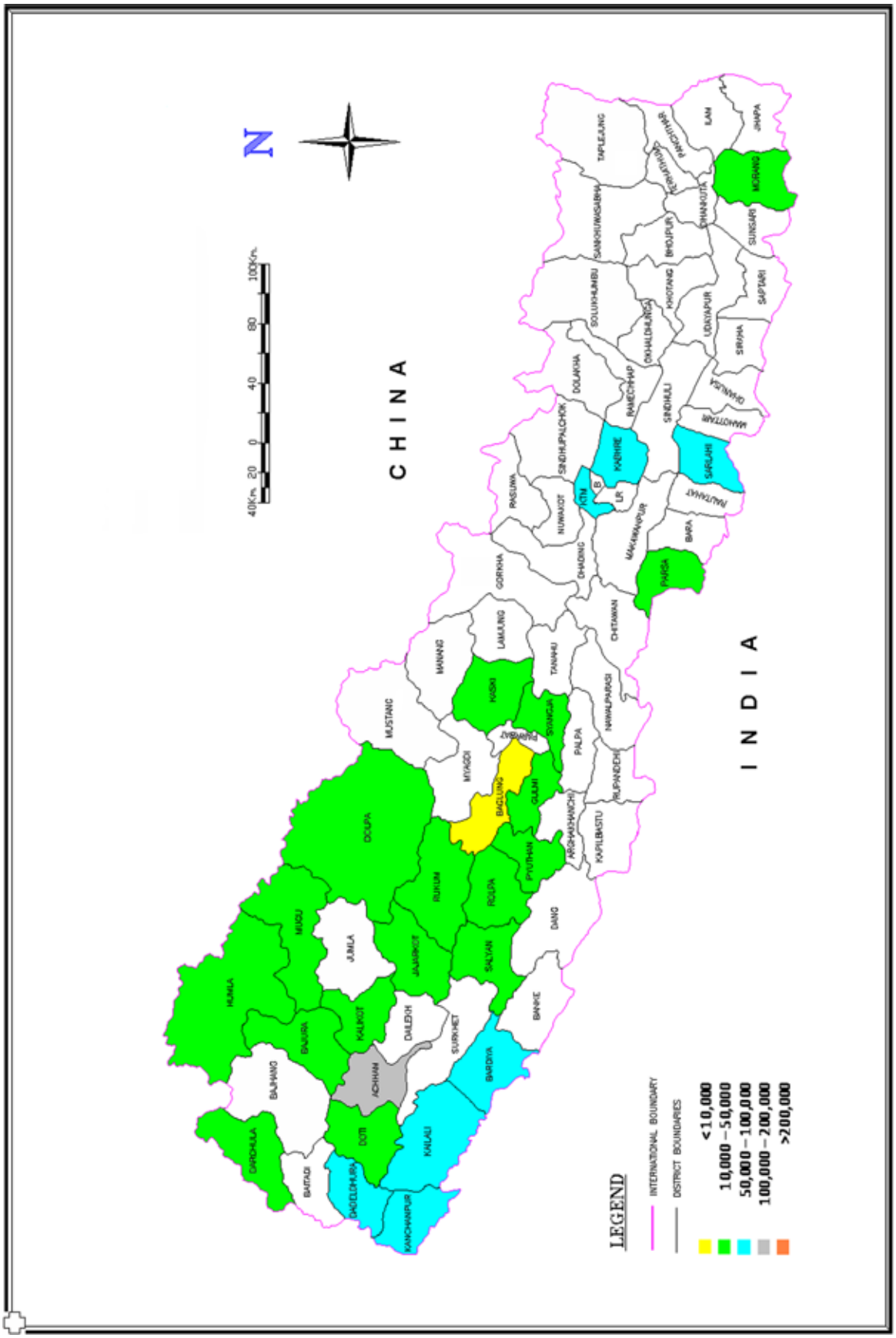
Prevention programme : Targeted for IDU and level of funding in 2010



Prevention programme : Targeted for Migrants and level of funding in 2009



Prevention programme : Targeted for Migrants and level of funding in 2010



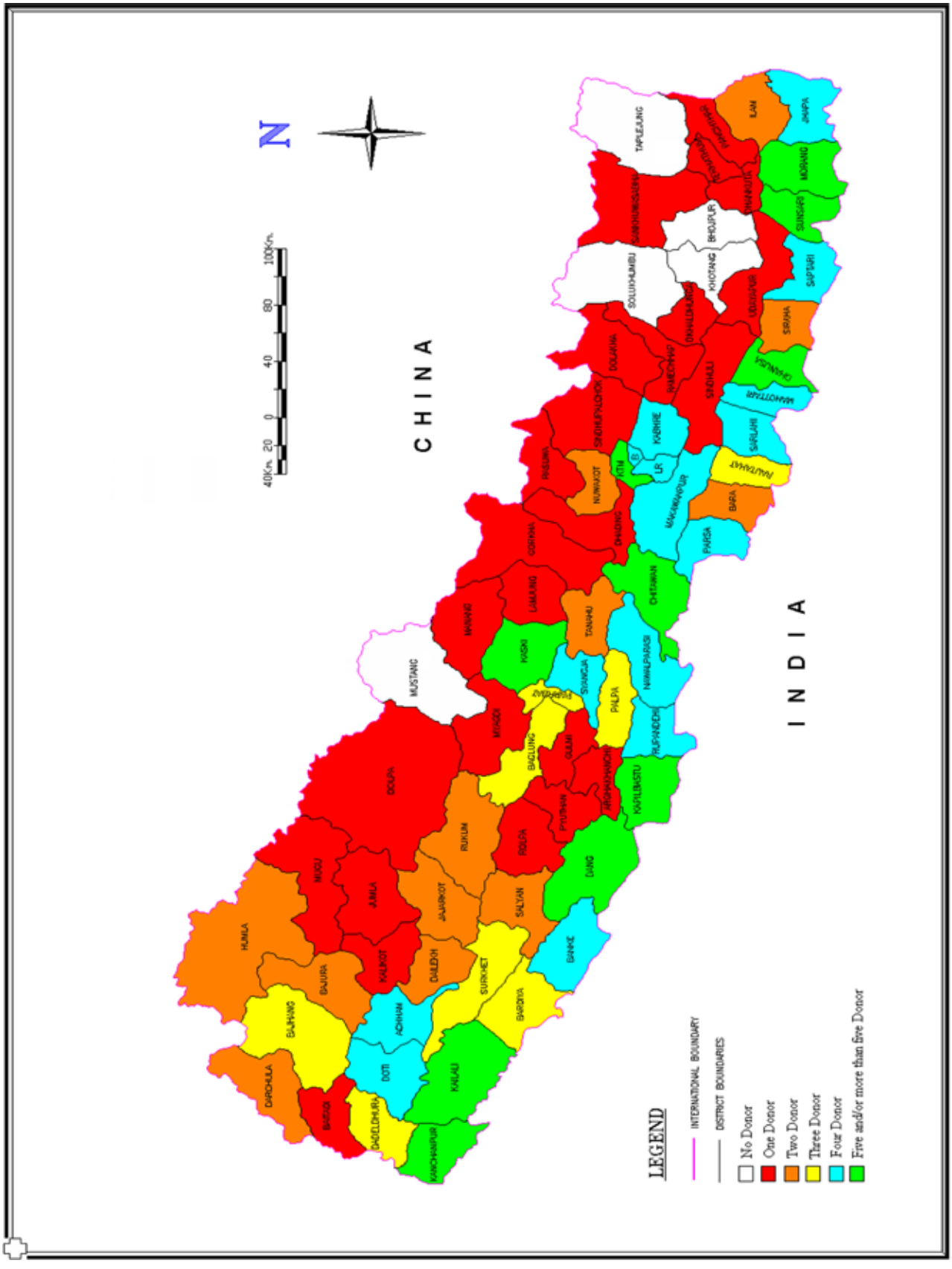
h) Presence of donors in the district for HIV response

Analysis of donor presence shows that there are five districts with no donors for HIV response; where as 28 districts have more than 3 donors in 2010.

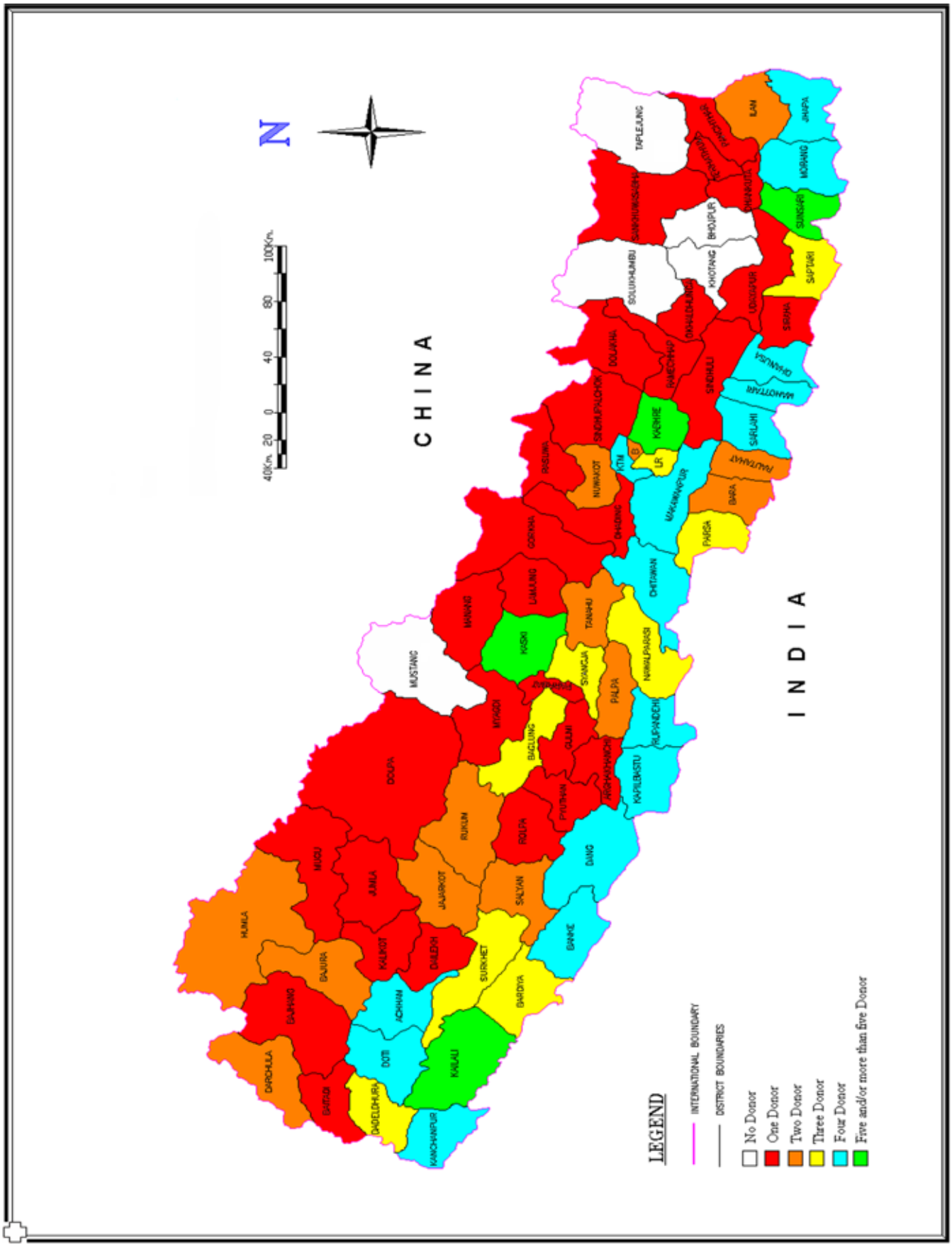
No. of Donor(s)	Overall HIV Response		Prevention		VCT		Care and Treatment	
	2009	2010	2009	2010	2009	2010	2009	2010
No Donor	5	5	19	20	14	14	24	39
One Donor	25	29	18	22	50	51	21	21
Two Donor	12	13	9	9	11	10	30	15
Three Donor	8	9	9	7				
Four Donor	15	15	12	14				
Five or more Donor	10	4	8	3				

Following maps provide the information on the number of donors in the districts involved in HIV programmes. Number of donors is represented by i) white – no donors; ii) red – one donor; iii) orange – two donors; iv) yellow - three donors; v) sky blue - four donors; and vi) green – five or more donors in the district. First two maps present the donors for HIV response where as subsequent maps provide information on donors for specific programmes.

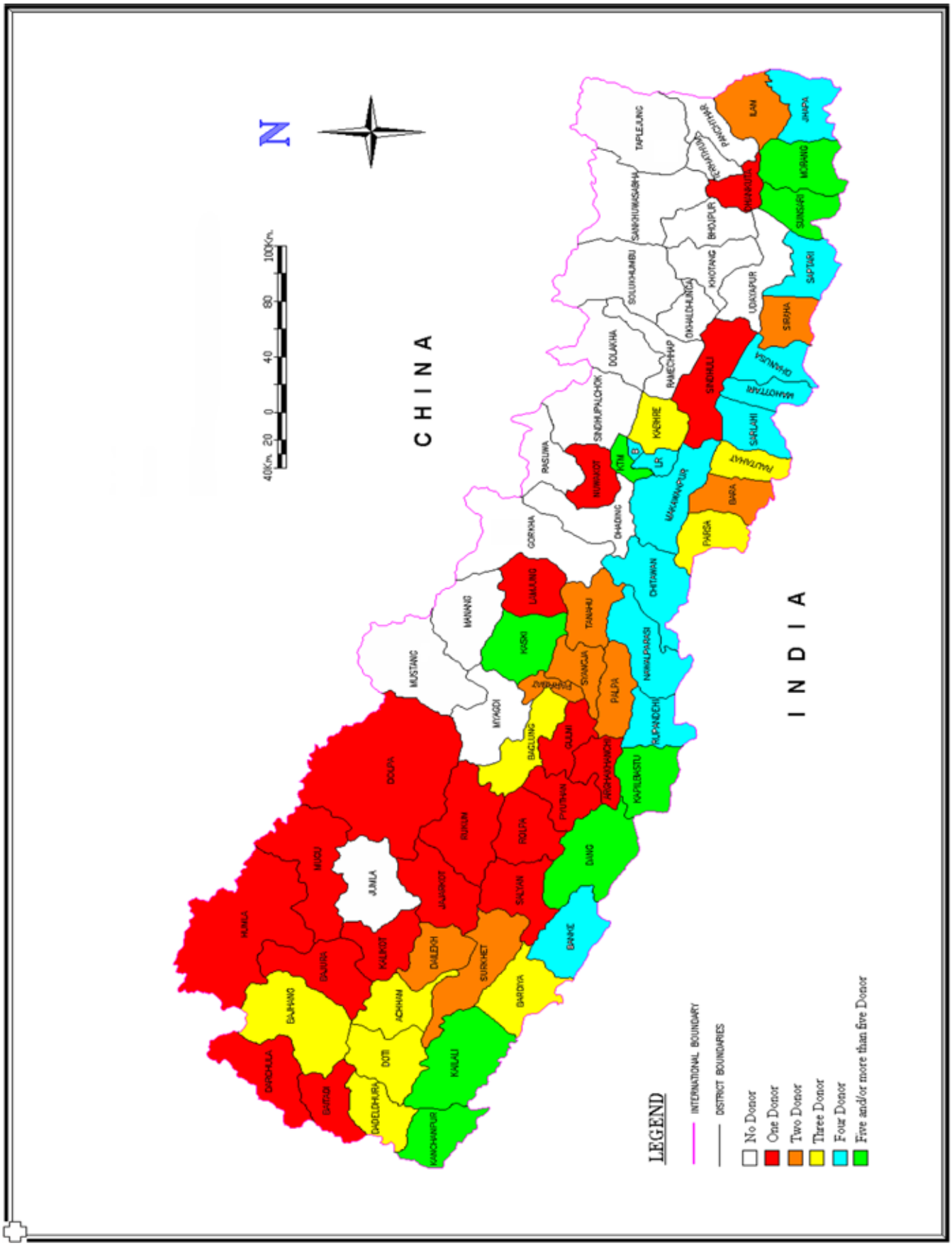
Number of donors in the districts for HIV response in 2009



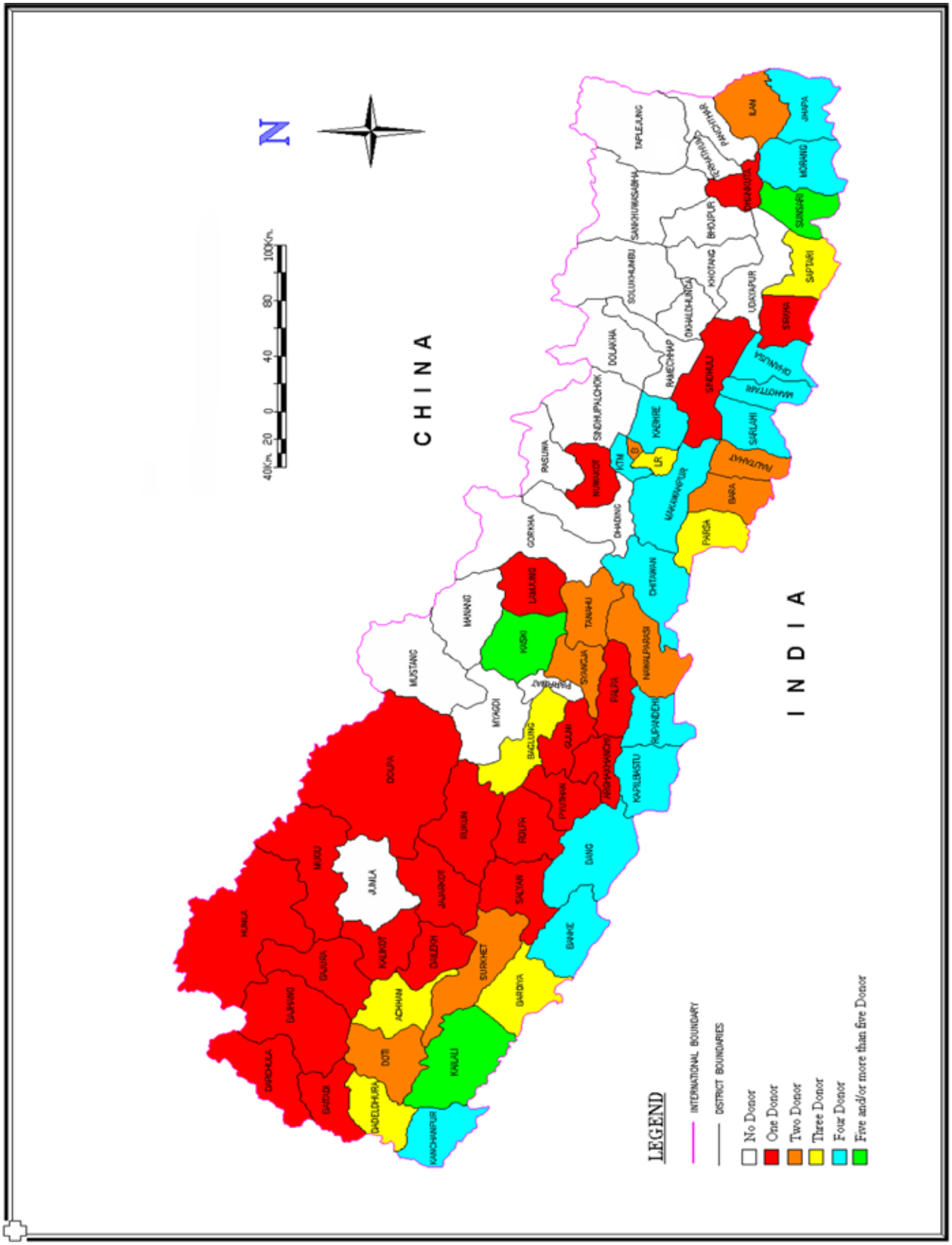
Number of donors in the districts for HIV response in 2010



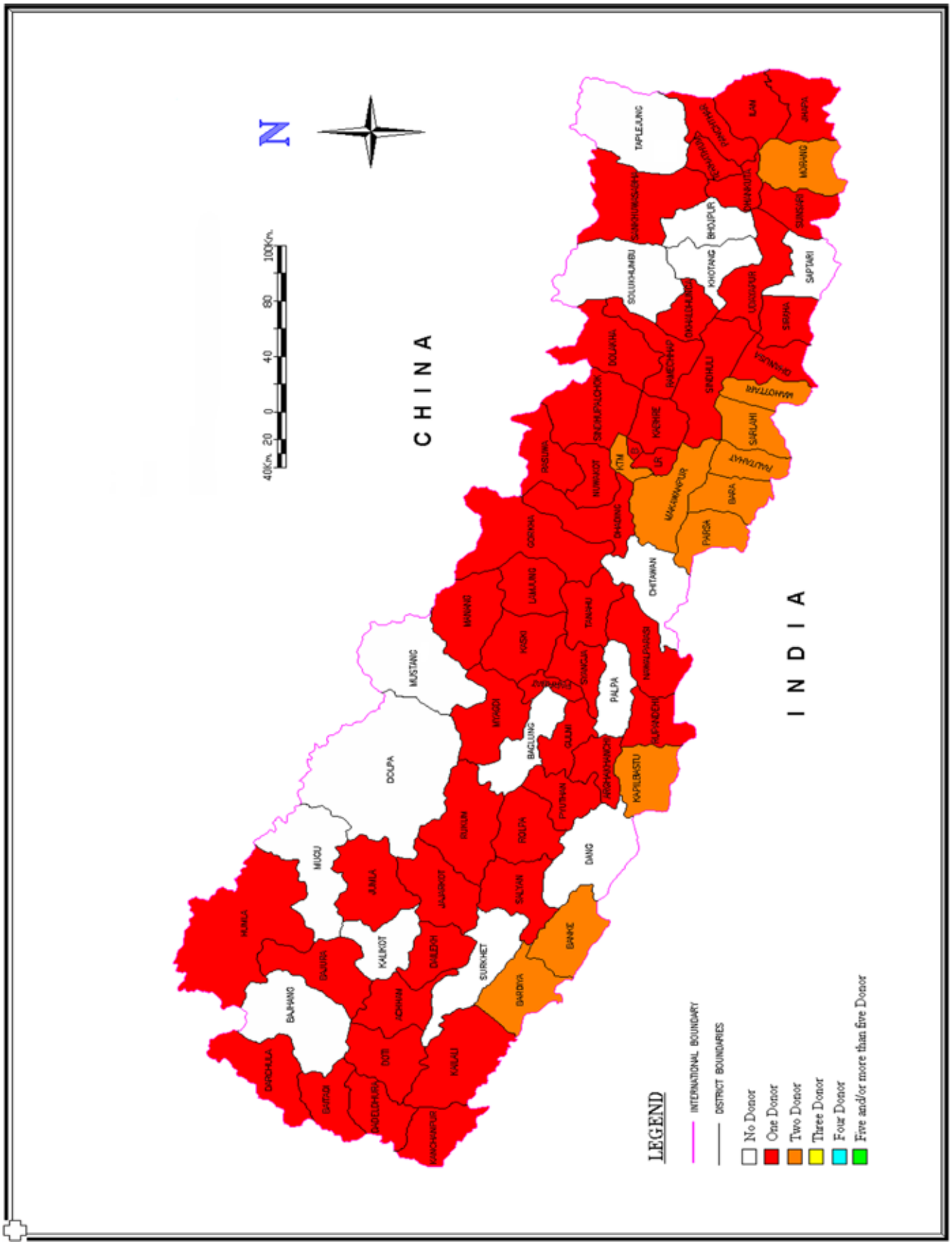
Number of donors present in the districts for HIV prevention programme in 2009



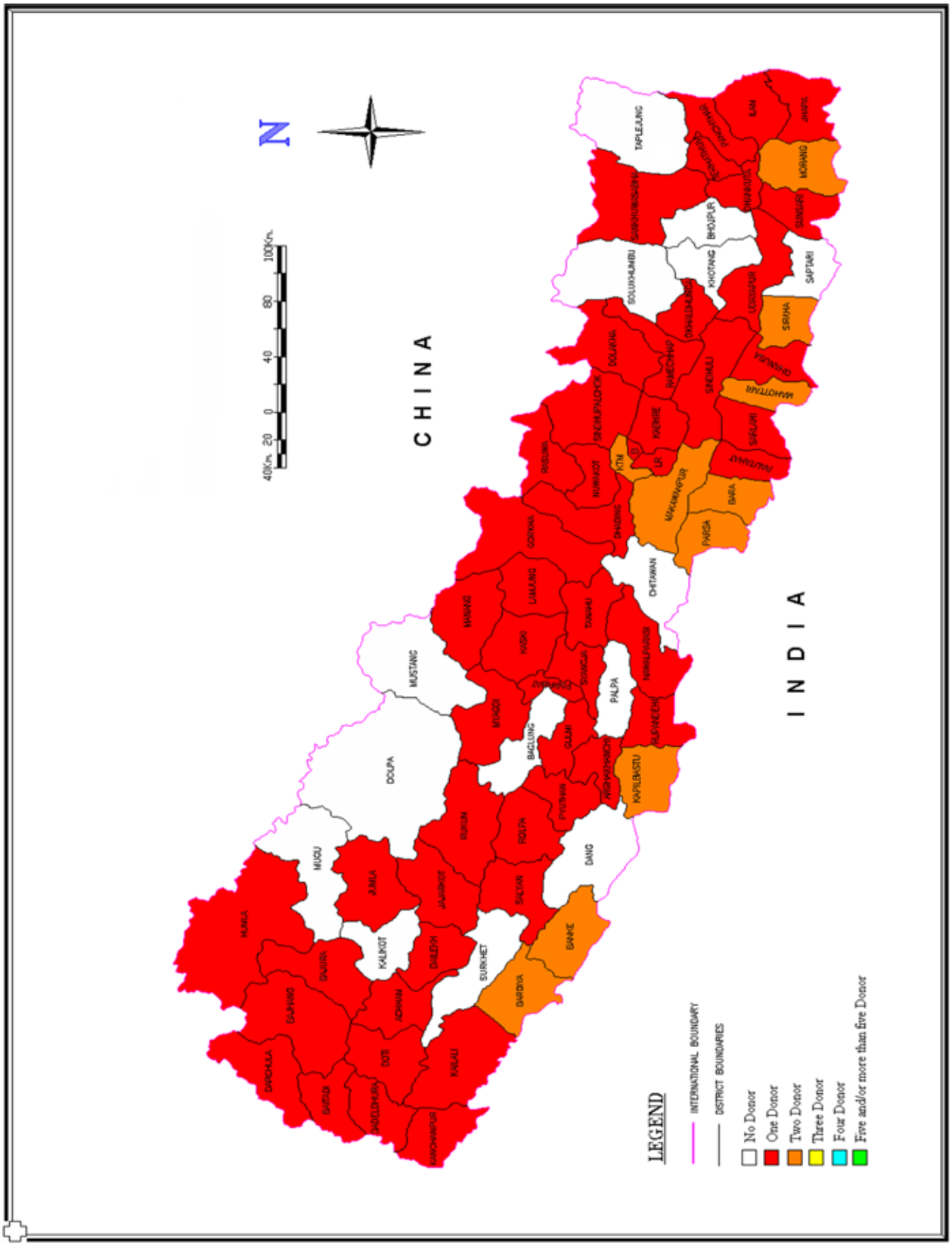
Number of donors present in the districts for HIV prevention programme in 2010



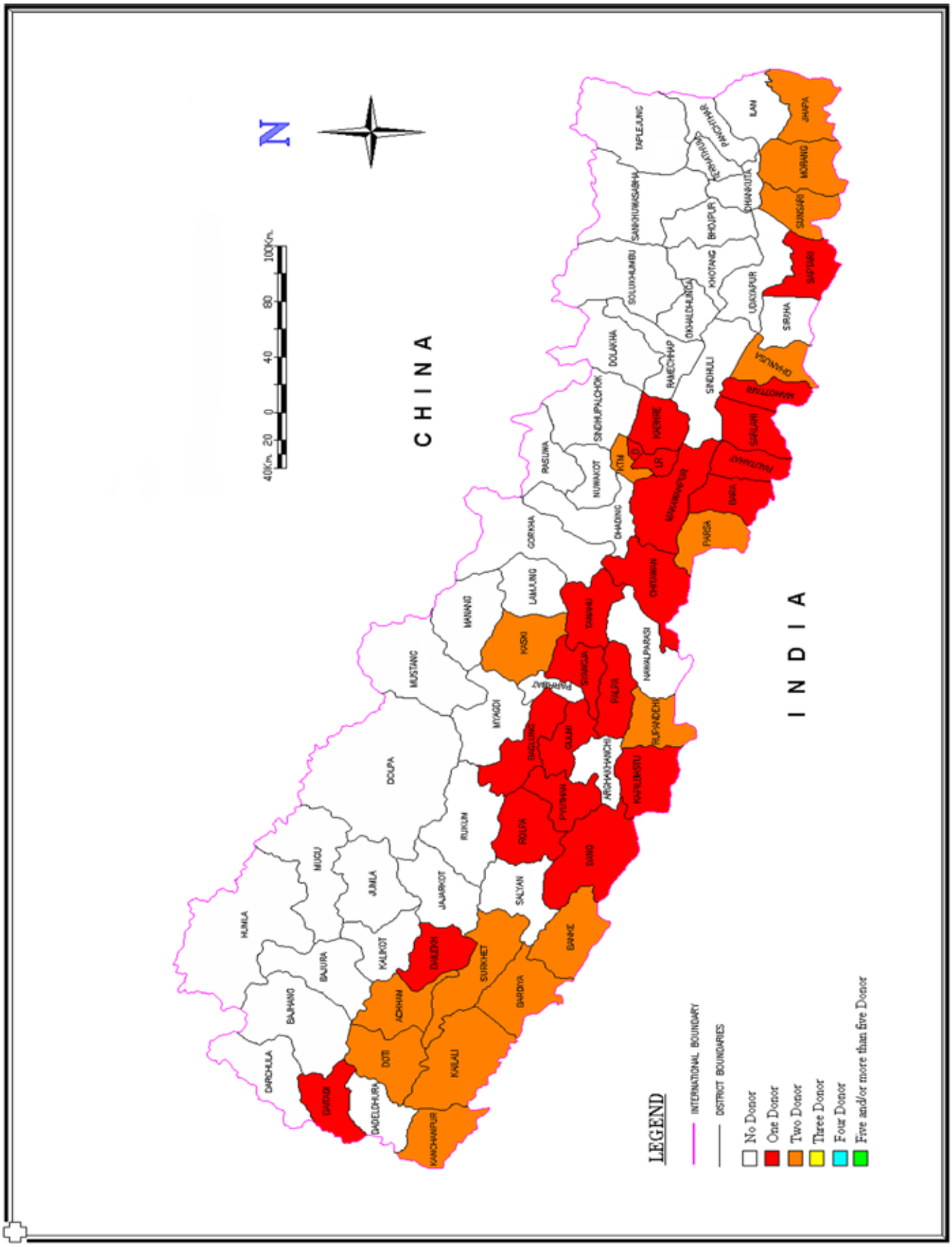
Number of donors present in the districts for VCT in 2009



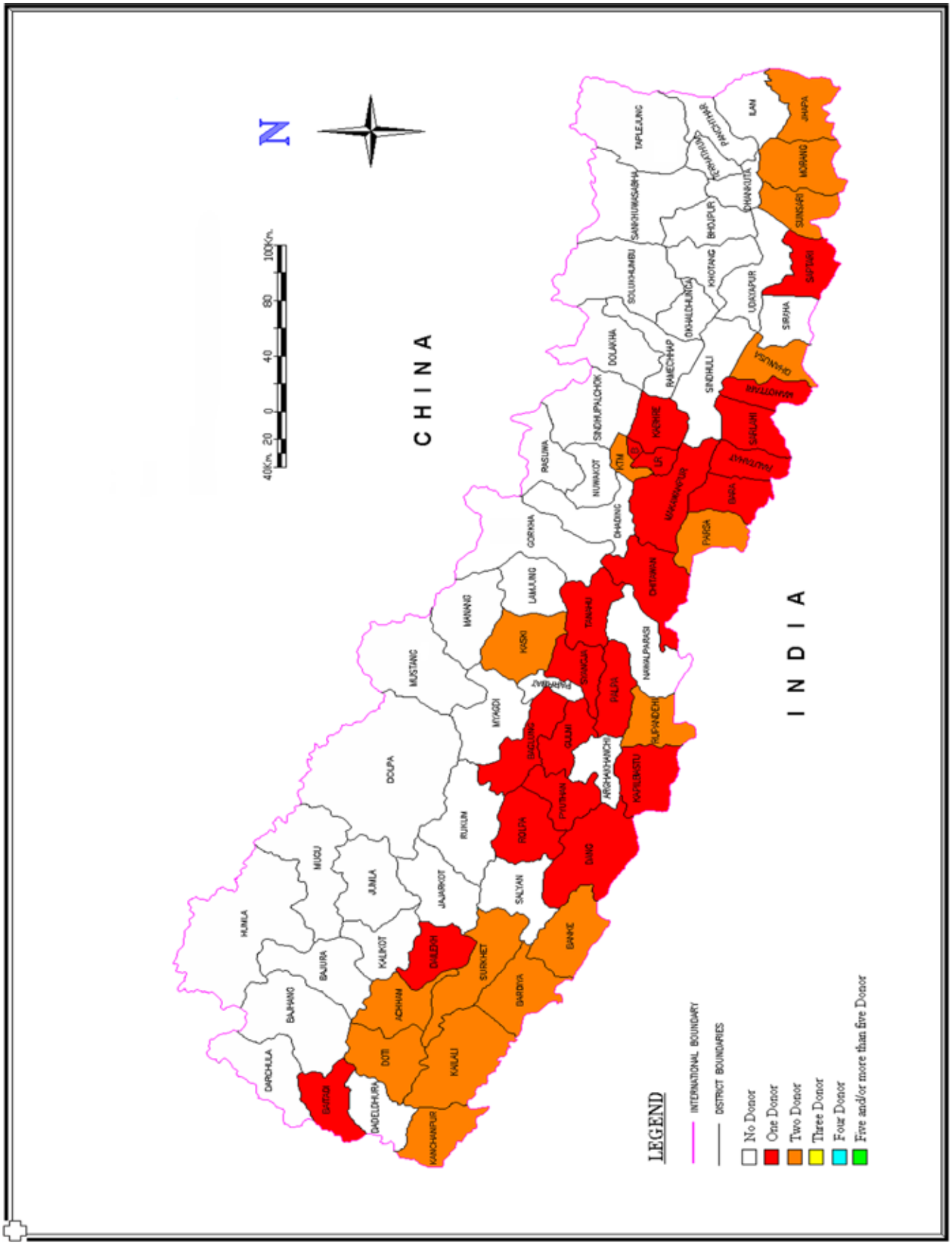
Number of donors present in the districts for VCT in 2010



Number of donors present in the districts for Care and Treatment in 2009



Number of donors present in the districts for Care and Treatment in 2010



11. Conclusion

- The major financing sources for HIV response in Nepal are public, bilateral, multilateral and private/INGOs. Seven key sources provide the majority of funds for the HIV response in Nepal. A total of US$ 20.5 million were invested in 2009 and US$ - 19.1 million for fiscal 2010.
- For the two years major portion of funds were provided for prevention activities. Major part of funds are provided or the prevention programme followed by programmme management and administration; enabling environment; VCT and care and treatment.
- Over the years, majority of the donors are reducing their funds for the HIV response. There is big gap in the funds received for HIV response and need indicated in the NAP 2008 - 2011.
- Global funds constituted the major source of funding, having provided 31.3% of funds for HIV response for the fiscal year 2009, This was followed by DFID (30.9%) and USAID (26.8%). For the year 2010, Global funds constitute 32.6% of funds for HIV response; this is followed by DFID (23.9%) and USAID (22.6%).
- A total of 70 districts have been covered by the HIV programme in terms of funding availability (excluding GON resources). Study shows there was no fund flow for HIV prevention in Taplejung, Bhojpur, Solukhumbu, Khotang and Mustang districts in 2009 and 2010
- Only USAID and private /INGOs has allocated budget for the FY 2011. Other agencies are in the process of allocating budget.
- There is overlapping of donors and programme (especially for Prevention)
- There is no effective donor coordination and harmonization
- Majority of districts have not assured funding after December 2010.
- There are different reporting schedules and formats. This makes it difficult for resource tracking and compilation of information.

12. Recommendations

General recommendation

1. Institutionalizing resource tracking system is very important for monitoring. This will help for periodic reviewing and coordination for better programming among the stakeholders.
2. Strategy of institutionalization of Resource Tracking strongly depends on the existing reporting system of key actors of HIV response. One of the first steps for institutionalising the Resource Tracking exercise would be to map existing information on who is doing what in each districts of Nepal .
3. In order to make the resource tracking feasible and effective ; explore developing programme categories for those accepted by all stakeholders and use them for programming and reporting.
4. The National Action Plan 2008 - 2011 is in place in the country and; it is of utmost urgency to ensure that need-based resource allocation be done by the donor and the government.
5. Effective donor coordination mechanism needs to be instituted to reduce overlapping of funds, working area and create synergistic impact of the programme .

Relevant to Government of Nepal

1. Facilitate using of consistent programme categories and recording of budget and expenses of the same as far as possible
2. Coordinate with and facilitate key donors and implementing partners to use the fund tracking system and database on a timely basis

Donors and multilaterals

1. Facilitate adoption of similar programme categories to contribute for institutionalising the resource tracking

Implementing agencies / service providers

1. Provide information based on the resource tracking software to the HSCB.
2. Facilitate implementing partners in orientation of software and programme categories so that report on expenditure is disaggregated by programme and MARPs.

Annexes

Annex 1: Programme Category

CODE	CATEGORY
PC.01	*Prevention*
PC.01.01	Communication for social and behaviour change and Community mobilization
PC.01.02	Condom social marketing
PC.01.03	Prevention – Youth
PC.01.04	Prevention of HIV transmission aimed at people living with HIV (PLHIV)
PC.01.05	*Prevention programmes for sex workers and their clients*
PC.01.05.01	Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients
PC.01.05.02	STI prevention and treatment as part of programmes for sex workers and their clients
PC.01.05.03	Behaviour change communication (BCC) as part of programmes for sex workers and their clients
PC.01.05.98	Programmatic interventions for sex workers and their clients not broken down by type
PC.01.05.99	Other programmatic interventions for sex workers and their clients, n.e.c.
PC.01.06	*Programmes for men who have sex with men (MSM)*
PC.01.06.01	Condom social marketing and male and female condom provision as part of programmes for MSM
PC.01.06.02	STI prevention and treatment as part of programmes for MSM
PC.01.06.03	Behaviour change communication (BCC) as part of programmes for MSM
PC.01.06.98	Programmatic interventions for MSM not broken down by type
PC.01.06.99	Other programmatic interventions for MSM n.e.c.
PC.01.07	*Harm-reduction programmes for injecting drug users (IDUs)*
PC.01.07.01	Condom social marketing and male and female condom provision as part of programmes for IDUs
PC.01.07.02	STI prevention and treatment as part of programmes for IDUs
PC.01.07.03	Behaviour change communication (BCC) as part of programmes for IDUs
PC.01.07.04	Sterile syringe and needle exchange as part of programmes for IDUs
PC.01.07.05	Drug substitution treatment as part of programmes for IDUs
PC.01.07.98	Programmatic interventions for IDUs not broken down by type
PC.01.07.99	Other programmatic interventions for IDUs, n.e.c.
PC.01.08	*Programmes for migrants and their wives*
PC.01.08.01	Condom social marketing and male and female condom provision as part of programmes for migrants and their wives
PC.01.08.02	STI prevention and treatment as part of programmes for migrants and their wives
PC.01.08.03	Behaviour change communication (BCC) as part of programmes for migrants and their wives
PC.01.08.98	Programmatic interventions for migrants and their wives not broken down by type
PC.01.08.99	Other programmatic interventions for migrants and their wives n.e.c.
PC.01.98	Prevention activities not broken down by intervention
PC.01.99	Prevention activities n.e.c.
PC.02	*Prevention, diagnosis, and treatment of sexually transmitted infections (STI)*
PC.02.98	Prevention, diagnosis, and treatment of sexually transmitted infections (STI) activities not broken down by type
PC.03	*Voluntary counselling and testing (VCT)*
PC.03.98	Voluntary counselling and testing (VCT) activities not broken down by type
PC.04	*Prevention of mother-to-child transmission (PMTCT)*
PC.04.98	Prevention of mother-to-child transmission (PMTCT) activities not broken down by type
PC.05	*Care and treatment*
PC.05.01	Provider-initiated testing and counselling (PITC)
PC.05.02	Opportunistic infection (OI) outpatient prophylaxis and treatment

CODE	CATEGORY
PC.05.03	*Antiretroviral therapy*
PC.05.03.01	*First-line antiretroviral therapy – adults*
PC.05.03.02	*Second-line antiretroviral therapy – adults*
PC.05.04	*Paediatric antiretroviral therapy*
PC.05.04.01	*First-line antiretroviral therapy – paediatric*
PC.05.04.02	*Second-line antiretroviral therapy – paediatric*
PC.05.05	*Home-based care*
PC.05.05.01	*Home-based medical care*
PC.05.05.02	*Home-based non-medical/non-health care*
PC.05.05.98	*Home-based care not broken down by type*
PC.05.98	*Care and treatment services not broken down by intervention*
PC.05.99	*Care and treatment services n.e.c.*
PC.06	*Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)*
PC.06.01	*OVC/CABA Education, family/home support and community support*
PC.06.02	*OVC/CABA Basic health care*
PC.06.98	*OVC/CABA Services not broken down by intervention*
PC.06.99	*OVC/CABA services n.e.c.*
PC.07	*Programme management and administration*
PC.07.01	*Planning, coordination, and programme management*
PC.07.02	*Administration and transaction costs associated with managing and disbursing funds*
PC.07.03	*Monitoring and evaluation and operations research*
PC.07.98	*Programme management and administration not broken down by type*
PC.07.99	*Programme management and administration n.e.c*
PC.08	*Human resources*
PC.08.01	*Monetary incentives for human resources*
PC.08.02	*Training and capacity building*
PC.08.98	*Human resources not broken down by type*
PC.08.99	*Human resources n.e.c.*
PC.09	*Enabling environment*
PC.09.01	*Advocacy*
PC.09.02	*Human rights programmes (Provision of legal and social services to promote access to prevention, care and treatment)*
PC.09.03	*Institutional development*
PC.09.98	*Enabling environment not broken down by type*
PC.09.99	*Enabling environment n.e.c.*
PC.10	*HIV-related research (excluding operations research)*
PC.10.01	*HIV-related research activities*
PC.10.02	*Serological-surveillance (serosurveillance)*
PC.10.98	*HIV-related research activities not broken down by type*
PC.10.99	*HIV-related research activities n.e.c.*
PC.11	*Others not classified elsewhere (n.e.c.)*
PC.11.98	*Others not broken down by type*

Note:
PC = Programme Category
n.e.c. = not elsewhere categorized

Annex 2: Program categories (PC): definitions and descriptions

The program category is a functional classification that includes the categories of prevention, care and treatment, and other health and non-health services related to HIV. After reviewing the past response strategies to HIV and discussion with key stakeholders during the consultation meeting, the programmes and budget categories have been structured into eleven categories:

1. Prevention
2. Prevention, diagnosis, and treatment of sexually transmitted infections (STI)
3. Voluntary counselling and testing (VCT)
4. Prevention of mother-to-child transmission (PMTCT)
5. Care and treatment
6. Orphans and vulnerable children/Children affected by AIDS
7. Programme management and administration
8. Human resources
9. Enabling environment
10. Research
11. Others not classified elsewhere

PC.01 PREVENTION

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

PC.01.01 Communication for social and behaviour change and Community mobilization: Programmes that focus on social change and social determinants of individual change. A campaign for social and behavior change provides general information addressing regions, states or countries. This entry includes, but is not limited to, brochures, pamphlets, handbooks, posters, newspaper or magazine articles, comic books, TV or radio shows or spots, songs, dramas or interactive theatre. This category excludes condom social marketing as a result of an activity coded under *PC.01.02 Condom social marketing* and any other information services which are part of any of the spending categories described as prevention programmes (mother-to-child transmission prevention programme, to reduce stigmatization or to promote access to voluntary counselling and testing), and any other communication for social and behaviour change recorded in prevention programmes: *PC.01.03 Prevention – youth, PC.01.04 Prevention of HIV transmission aimed at people living with HIV (PLHIV), PC.01.05 Prevention programmes for sex workers and their clients, PC.01.06 Programmes for men who have sex with men (MSM), PC.01.07 Harm-reduction programmes for injecting drug users (IDUs), PC.01.08 Programmes for migrants and their wives, PC.01.02 Condom social marketing, and PC.02 Prevention, diagnosis, and treatment of sexually transmitted infections (STI). PC.09.01 Advocacy* constitutes the locus for reporting non-health communication for social behaviour change programmes.:

- Health-related communication for social and behaviour change: Programmes targeting the health risks of HIV prevention campaigns (e.g. ABC addressing general population4); campaigns with an explicit prevention purpose.
- Non-health-related communication for social and behavior change: Programmes targeting the non-health risks; addressed in HIV prevention campaigns and any other mass media-related activities whose contents are not within the boundaries of health (as described in NHA), and whose content is not recorded under PC.09.
- Community mobilization: Activities that create community commitment and involvement in achieving programme goals. This includes, but is not limited to: involvement of community groups (e.g. neighbours of PLHIV or OVC) in programme planning and mobilization of community resources, peer education, including training of peer educators on prevention, support groups, and self-representation. These activities are aimed at behaviour change and risk reduction but are focused mainly on small communities ` members rather than on the broader population. These activities are usually performed by the community members to target their own community.

- *Communication for social and behaviour change not broken down by type:* Campaigns for which it is not possible to break down its contents as health or non-health.

PC.01.02 Condom social marketing refers to programmes that make condoms more accessible and acceptable. They include public campaigns to promote the purchase and use of condoms and exclude commercials made by corporations and procurement programmes as a public service. Programmatic interventions to promote the use of condoms as part of programmes for vulnerable, accessible, and most-at-risk populations should be coded in their corresponding PC (i.e.: *PC.01.04 Prevention of HIV transmission aimed at people living with HIV (PLHIV), PC.01.05 Prevention programmes for sex workers and their clients, PC.01.06 Programmes for men who have sex with men (MSM), PC.01.07 Harm-reduction programmes for injecting drug users (IDUs), PC.01.08 Programmes for migrants and their wives and PC.04 Prevention of mother-to-child transmission (PMTCT)).*

PC.01.03 Prevention – youth:

- *Youth in school:* Programmes that focus on young people enrolled in primary and secondary schools. Prevention programmes in schools include a full complement of tools to prevent HIV transmission. These comprise a comprehensive, appropriate, evidence based and skills-based sex education; youth-friendly health services offering core interventions for the prevention of transmission through unsafe drug injecting practices; and consistent access to male and female condoms. A critical element is the integration into school-based settings of life-skills-education programmes. Skills-based health education and interactive teaching methods have been shown to promote healthy lifestyles and to reduce risky behaviour. The life-skills based HIV education in schools is a didactic and specific learning process that teaches young people to understand and assess the individual, social, and environmental factors that raise and lower the risk of HIV transmission. (Teacher training—when measurement is required—should be measured in accordance with the latest UNICEF guidelines.) To track benefits, the accountant may wish to report expenditure on life-skills activities in both primary and secondary schools as a part of the education system spending (either independent or jointly with the health system). This programme should be coded and cross-classified with the specific beneficiary populations receiving the services, principally young people enrolled in primary and secondary schools (aged 6 – 11 and 12 – 15).
- *Youth out of school:* Programmes that focus on young people aged between 6 and 15 out of school. The tools of these programmes are comprehensive, appropriate, evidence-based and skills-based sexual education; youth-friendly health services (through drop-in centres or outreach work) offering core interventions for the prevention of the transmission; and consistent access to male and female condoms. The cost of training peer educators for peer outreach working with youth out of school should be included under this category.

PC.01.04 Prevention of HIV transmission aimed at people living with HIV (PLHIV): Programmes to reduce risky behaviours by infected people are aimed to decrease the rate of infection in the population. The goal is to empower people living with HIV to avoid acquiring new STIs and prevent the transmission of HIV to others. The programmatic interventions should be coded according to their characteristics as follows:

- *Behaviour change communication (BCC) as part of prevention of HIV transmission aimed at PLHIV:* interventions aimed to promote risk reduction measures, including peer outreach.
- *Condom social marketing and male and female condom provision as part of prevention of HIV transmission aimed at PLHIV*
- STI prevention and treatment as part of prevention of HIV transmission aimed at PLHIV

PC.01.05 Prevention programmes for sex workers and their clients: Programmes to promote risk-reduction measures including outreach (including by peers), voluntary and confidential HIV counselling and testing, prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs) and consistent access to male and female condoms. Interpersonal communication (face-to-face) to reach sex workers at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behaviour change and sustained engagement to prevent HIV infection. The programmatic interventions should be coded according to their characteristics as follows:

PC.01.05.01 Condom social marketing and male and female condom provision as part of programmes for sex workers and their clients includes all the programme costs related to condom promotion and provision for sex workers and their clients, not only the cost of the fungibles.

PC.01.05.02 STI prevention and treatment as part of programmes for sex workers and their clients

PC.01.05.03 Behaviour change communication (BCC) as part of programmes for sex workers and their clients: interventions aimed to promote risk reduction measures, including peer outreach.

PC.01.05.98 Programmatic interventions for sex workers and their clients not broken down by type

PC.01.05.99 Other programmatic interventions for sex workers and their clients not elsewhere classified (n.e.c.)

PC.01.06 Programmes for men who have sex with men (MSM). Programmes that focus on men who regularly or occasionally have sex with other men. These programmes include risk-reduction activities, outreach (including by peers), voluntary and confidential HIV counselling and testing, and prevention of sexual transmission of HIV (including condoms, prevention and treatment of STIs). Interpersonal communication (face-to-face) to reach MSM at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behavior change and sustained engagement to prevent HIV infection. The programmatic interventions should be coded according to their characteristics as follows:

PC.01.06.01 Condom social marketing and male and female condom provision as part of programmes for men who have sex with men (MSM)

PC.01.06.02 STI prevention and treatment as part of programmes for men who have sex with men (MSM)

PC.01.06.03 Behaviour change communication (BCC) as part of programmes for men who have sex with men (MSM): interventions aimed to promote risk reduction measures, including peer outreach.

PC.01.06.98 Programmatic interventions for men who have sex with men (MSM) not broken down by type

PC.01.06.99 Other programmatic interventions for men who have sex with men (MSM) not elsewhere classified (n.e.c.)

PC.01.07 Harm-reduction programmes for injecting drug users (IDUs): Programmes that focus on reducing harm because of drug use and reducing risk of spread. They include a set of treatment options such as substitution treatment and the implementation of harm-reduction measures (peer outreach, and sterile needle and syringe programmes), voluntary and confidential HIV counselling and testing and prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs). The programmatic interventions should be coded according to their characteristics as follows:

PC.01.07.01 Condom social marketing and male and female condom provision as part of programmes for injecting drug users (IDUs)

PC.01.07.02 STI prevention and treatment as part of programmes for injecting drug users (IDUs)

PC.01.07.03 Behaviour change communication (BCC) as part of programmes for injecting drug users (IDUs): interventions aimed to promote risk reduction measures, including peer outreach.

PC.01.07.04 Sterile syringe and needle exchange as part of programmes for injecting drug users (IDUs)

PC.01.07.05 Drug substitution treatment as part of programmes for injecting drug users (IDUs)

PC.01.07.98 Programmatic interventions for injecting drug users (IDUs) not broken down by type

PC.01.07.99 Other programmatic interventions for injecting drug users (IDUs) not elsewhere classified (n.e.c.)

PC.01.08 Programmes for migrants and their wives: Programmes that focus on reducing risk factors including outreach (including by peers), voluntary and confidential HIV counselling and testing, prevention of sexual transmission of HIV (including condoms and prevention and treatment of STIs) and consistent access to male and female condoms. Interpersonal communication (face-to-face) to reach migrants at risk; programmes on developing and acquiring skills to negotiate safer behaviour, behavior change and sustained engagement to prevent HIV infection. The programmatic interventions should be coded according to their characteristics as follows:

PC.01.08.01 Condom social marketing and male and female condom provision as part of programmes for migrants and their wives

PC.01.08.02 STI prevention and treatment as part of programmes for migrants and their wives

PC.01.08.03 Behaviour change communication (BCC) as part of programmes for migrants and their wives: interventions aimed to promote risk reduction measures, including peer outreach.

PC.01.08.98 Programmatic interventions for migrants and their wives not broken down by type

PC.01.08.99 Other programmatic interventions for migrants and their wives not elsewhere classified (n.e.c.)

PC.01.98 Prevention activities not broken down by intervention includes all preventive programmes, interventions, and activities for which the resource tracking team does not have available information to classify them into a specific PC.

PC.01.99 Prevention activities not elsewhere classified (n.e.c.) includes all other preventive programmes, interventions, and activities which the country considers relevant and are not listed above.

- *Public and commercial sector male condom provision* refers to procurement of male condoms regardless of mode of distribution (cost-free, subsidized or commercially priced; accessibility to the general population or to specific groups). This includes the fungibles (condoms) and any other cost incurred in the distribution and provision. Nonetheless, not all the condoms distributed have a HIV prevention component (some people use condoms exclusively for birth control purposes). There are different approaches to estimate the expenditures on HIV-related condom use. One recommended approach is to use nationally available demographic surveys or sexual behaviour surveys to ascertain the fraction of condoms attributable exclusively to birth control. This fraction or percentage should then be subtracted from the total numbers of condoms estimated for public and commercial sector male condom provision. Male condoms as part of specific programmes for key populations and populations at higher risk should not be coded in PC.01.99, but on their corresponding PC (i.e.: PC.01.04 Prevention of HIV transmission aimed at people living with HIV (PLHIV), PC.01.05 Prevention programmes for sex workers and their clients, PC.01.06 Programmes for men who have sex with men (MSM), PC.01.07 Harm-reduction programmes for injecting drug users (IDUs), PC.01.08 Programmes for migrant and their wives and PC.04 Prevention of mother-to-child transmission (PMTCT)).
- *Public and commercial sector female condom provision* refers to procurement of female condoms regardless of the mode of distribution (cost-free, subsidized or commercially priced; accessibility to women). The fraction of female condoms attributable exclusively to birth control should be subtracted from the total numbers of condoms estimated for Public and commercial sector female condom provision (as described in Public and commercial sector male condom provision). Female condom distribution as part of programmes for vulnerable, accessible, and most-at-risk populations should be coded in their corresponding PC (i.e.: PC.01.04 Prevention of HIV transmission aimed at people living with HIV (PLHIV), PC.01.05 Prevention programmes for sex workers and their clients, PC.01.06 Programmes for men who have sex with men (MSM), PC.01.07 Harm-reduction programmes for injecting drug users (IDUs), PC.01.08 Programmes for migrant and their wives and PC.04 Prevention of mother-to-child transmission (PMTCT)).

- *Microbicides* refers to procurement of compounds applied inside the vagina or rectum to confer protection against STI. Once these become available, the resource tracking team should identify investment in programmes, making microbicides available proven to be safe and an effective complement to prevent, or at least, reduce new HIV infections.
- *Blood safety:* Blood safety (including blood products and donated organs) expenditures and investment in activities supporting a nationally coordinated blood programme to prevent HIV transmission. This category included policies, infrastructure, equipment, and supplies for testing activities and management to ensure a safe supply of blood and blood products.
- *Safe medical injections:* Medical transmission/injection safety targets the development of policies, in-service training, advocacy, and other activities to promote (medical) injection safety. They include distribution/supply chain, cost, and appropriate disposal of injection equipment and other related equipment and supplies. Only expenditure targeting the prevention of HIV transmission should be included.
- *Universal precautions* (when the main or exclusive purpose to implement them is to limit HIV transmission) refer to the use of gloves, masks, and gowns by health care personnel to avoid HIV infection through contaminated blood. These are standard infection control practices to be used universally in health care settings to minimize the risk of exposure to pathogens, e.g. the use of gloves, barrier clothing, masks, and goggles to prevent exposure to tissue, blood and body fluids, waste-management systems (except disposal of injection equipment, tracked under Safe medical injections). This activity aims to target health care workers. Universal precautions are shared across the health system and are not AIDS-specific. Expenditures within universal precautions are limited to those specifically aimed to prevent the transmission of HIV in health care facilities. Expenditure on safety procedures in blood banks may not be separable from the other costs incurred by that activity and are reported under Blood safety.
- *Post-exposure prophylaxis (PEP).* This includes interventions and antiretroviral drugs after exposure to risk, which may be developed adding one digit as:
  - *PEP in health care setting*
  - *PEP after high-risk exposure (violence or rape)*
  - *PEP after unprotected sex*

PC.02 PREVENTION, DIAGNOSIS, AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI):

PC.02.98 Prevention, diagnosis, and treatment of sexually transmitted infections (STI) activities not broken down by type
Prevention and care services, including diagnosis and treatment, related to STIs. From a HIV perspective, the treatment of STIs is coded as preventive (from a health system's perspective, this treatment is curative). The expenses for improved clinical management of STIs include medical consultations, tests, and treatment for syphilis, gonorrhoea, herpes, candidiasis, and trichomoniasis.

The services comprised under this heading are programmes targeting the general population; services targeting specific population segments should be coded under:*PC.01.04 Prevention of HIV transmission aimed at people living with HIV (PLHIV), PC.01.05 Prevention programmes for sex workers and their clients, PC.01.06 Programmes for men who have sex with men (MSM), PC.01.07 Harm-reduction programmes for injecting drug users (IDUs) or under PC.01.08 Prevention programmes for migrants and their wives.*

PC.01.03 VOLUNTARY COUNSELLING AND TESTING (VCT)

PC.03.98 Voluntary counselling and testing (VCT) activities not broken down by type
This is the process by which an individual undergoes counselling, enabling them to make an informed choice about being tested for HIV. Client-initiated confidential voluntary counseling and testing includes activities in which both HIV counselling and testing are accessed by people who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). All HIV testing must be carried out under the conditions of the three Cs: counselling, confidentiality, and informed consent. The cost of VCT includes the whole process of provision including the physician, counsellor, laboratory, and the post-test counselling.

Testing to identify people requiring treatment is included in the Treatment and Care section and should be coded as provider-initiated testing.

Counselling and testing in the context of preventing mother-to-child transmission is coded under prevention of mother-to-child transmission (PMTCT).

PC.04 PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)

PC.04.98 Prevention of mother-to-child transmission (PMTCT) activities not broken down by type

Prevention of mother-to-child transmission (PMTCT) refers to services aimed at avoiding mother-to-child HIV transmission. These include counselling and testing for pregnant women, antiretroviral prophylaxis for HIV-positive pregnant women and neonates, counselling and support for safe infant feeding practices. PMTCT-plus ARV-treatments should be coded under antiretroviral therapy (treatment after delivery) PC.05.03. When a HIV-positive woman receives antiretroviral therapy before she knows she is pregnant and no change in the antiretroviral prescription occurs, the antiretroviral treatment should be included under PC.05.03 ARV therapy. When adequate information is accessible, the position may be split, using another digit, between:

- *Pregnant women counselling and testing in PMTCT programmes.* This category includes activities in which both HIV counselling and testing are accessed by pregnant women who seek to know their HIV status (as in traditional VCT) and, as indicated in other contexts (e.g. sexually transmitted infection (STI) clinics). The cost of this activity includes the entire process of provision including the physician, counsellor, laboratory, and the post-test counselling.
- *Antiretroviral prophylaxis for HIV-positive pregnant women and neonates*
- *Safe infant feeding practices (including substitution of breast milk)*
- *Delivery practices as part of PMTCT programmes.* This includes delivery (both vaginal delivery and elective Caesarean section) and postpartum care as a part of PMTCT programmes.
- *Condom social marketing and male and female condom provision as part of PMTCT programmes* performed on PMTCT sites and/or antenatal clinics aimed to prevent mother-to-child HIV or STI transmission during pregnancy or breastfeeding. This includes condoms and any other cost incurred in the distribution and provision.
- PMTCT activities not elsewhere classified (n.e.c.).

PC.05 CARE and TREATMENT

Care and treatment refers to all expenditures, purchases, transfers, and investment incurred to provide access to clinic-based, home-based or community-based activities for the treatment and care of HIV-positive adults and children. The treatment and care component includes the following interventions and activities.

PC.05.01 Provider-initiated testing and counselling (PITC) refers to the expenditures related to the delivery of HIV testing for diagnostic purposes. Under certain circumstances, when an individual is seeking medical care, HIV testing may be offered. This may be part of the diagnosis—the patient presents symptoms that may be attributable to HIV or has an illness associated with HIV, such as tuberculosis—or this may be a routine offer to an asymptomatic person. For example, HIV testing may be offered as part of the clinical evaluation of patients with STIs.

The cost of testing includes an initial test, followed by a confirmatory test if reactive. The cost of PITC includes the entire provision process: physician, laboratory, and post-test counselling. PITC excludes the testing under PMTCT coded as *Pregnant women counseling and testing.* Voluntary counselling and testing is a preventive intervention, and must be coded under *PC.03 Voluntary counselling and testing (VCT).*

PC.05.02 Opportunistic infections (OI) outpatient prophylaxis and treatment.

- *Opportunistic infections (OI) outpatient prophylaxis:* includes but is not limited to the cost of isoniazid to prevent TB and cotrimoxazole to protect against pathogens responsible for pneumonia, diarrhoea, and their complications. Children born to women living with HIV receive 18 months of treatment with cotrimoxazole on a prophylactic basis.

- *Opportunistic infections (OI) outpatient treatment:* refers to a package of medications, diagnoses, and care used for treatment of HIV-related diseases provided on an outpatient basis. OI are illnesses caused by various organisms, some of which do not cause usually disease in people with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic illnesses common in people diagnosed with AIDS include Pneumocystis carinii pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral, and fungal infections. The total cost of outpatient treatment of opportunistic infections is to be reported, not the AIDS treatment cost.
- *Inpatient treatment of opportunistic infections (OI):* The treatment of opportunistic infections (OI) refers to a package of medications, diagnoses, and care used for treatment of HIV-related diseases. OI are illnesses caused by various organisms, some of which do not usually cause disease in people with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes, and other organs. Opportunistic illnesses common in people diagnosed with AIDS include Pneumocystis carinii pneumonia, cryptosporidiosis, histoplasmosis, and other parasitic, viral, and fungal infections.

PC.05.03 Antiretroviral therapy. The specific therapy includes a comprehensive group of recommended antiretroviral drugs, including the cost of supply logistics and the entire ART service delivery (including the cost of human resources involved) for either adults or children. The number of people being treated is based on country-specific evidence of current coverage. ART includes all modalities of ARV therapy. When an aggressive therapeutic course is received, which is intended to suppress viral replication and to slow the progress of HIV, the therapy is labelled highly active antiretroviral therapy (HAART); the usual combination of three or more different drugs such as two nucleoside reverse transcriptase inhibitors (NRTIs) and a protease inhibitor, two NRTIs and a non-nucleoside reverse transcriptase inhibitor or other combinations characterize this subclass, which has been shown to reduce the presence of the virus to a point where it becomes undetectable in a patient's blood. Where detailed information is collated, it may be broken down into:

PC.05.03.01 First-line ART – adults

PC.05.03.02 Second-line ART - adults

PC.05.04 Paediatric antiretroviral therapy

PC.05.04.01 First-line ART – paediatric

PC.05.04.02 Second-line ART – paediatric

PC.05.05 Home-based care is external support for individuals chronically ill with AIDS. This may include but is not limited to the home visits of medical or non-medical staff to assess living conditions, address psychological needs, accompany ill people with HIV to the hospital. These visits might include provision of in-family home-based psychological support to the family members, teaching family members basic information on HIV, first aid, nutrition etc.

PC.05.05.01 Home-based medical care: minor medical care, supplies for medical care mainly including human resources (nurse, social worker or relevant). This category excludes ARV (PC.05.03), nutritional support for ART (PC.05.99), psychological support and treatment (PC.05.99), and Palliative care (PC.05.99).

PC.05.05 02 Home-based non medical non-health care.

PC.05.05.98 Home-based care not broken down by type.

PC.05.98 Care and treatment services not broken down by intervention includes all care and treatment programmes, interventions, and services for which the resource tracking team does not have available information to classify it into a specific two-digit PC.

PC.05.99 Care and treatment services not elsewhere classified (n.e.c.). Includes all other care and treatment programmes, interventions, and activities not recorded above and considered by the country as a relevant expense. The resource tracking team will create subheadings to provide a comprehensive picture of all expenditures allocated to the care and treatment of people living with HIV and patients with advanced HIV-related disease and not listed above (e.g. some types of cancers). These services are aimed at people living with HIV and patients with advanced HIV-related disease and should be coded under PC.05.99.

- *Nutritional support associated with ARV therapy.* Nutrition plays an important role in maintaining the health of people living with HIV. Adequate nutrition is essential to maintain a person's immune system, to sustain healthy levels of physical activity, and for quality of life. Adequate nutrition is also necessary for optimal benefits from antiretroviral therapy. Nutrition should become an integral part of countries' response to HIV. The consumption of nutrients and all the logistics involved in the delivery process of nutritional support should be accounted under this category.
- *Specific HIV-related laboratory monitoring* includes laboratory expenditures for the delivery of CD4 cell count, viral load determination, and testing for drug resistance aimed to monitor the biological response to antiretroviral therapy and to determine the disease progression for a person with HIV-related disease. The CD4 cell count is a measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV. A CD4 cell count is used by health care providers to determine when to begin, interrupt, or halt anti-HIV therapy; when to administer preventive treatment for opportunistic infections; and to measure response to treatment. A normal CD4 cell count is between 500 cells/mm3 and 1400 cells/mm3 of blood, but an individual's CD4 count can vary. In HIV-positive individuals, a CD4 count at or below 200 cells/mm3 is considered an AIDS-defining condition. The viral load (VL) determines the amount of HIV RNA copies in a blood sample, reported as the number of HIV RNA copies per ml of blood plasma. The VL provides information about the number of cells infected with HIV and is an important indicator of HIV progression and the efficacy of a treatment. The VL can be measured by different techniques, including branched-chain DNA (bDNA) and reverse transcriptase-polymerase chain reaction (RT-PCR) assays. VL tests are usually performed when an individual is diagnosed as HIV-positive and repeated at regular intervals after diagnosis. Resistance testing consists of a laboratory test to determine whether an individual's HIV strain is resistant to any anti-HIV drugs and to guide their clinical treatment. Other tests to monitor patients, e.g. biochemical and haematological tests should also be included as Specific HIV-related laboratory monitoring.

  HIV drug resistance surveillance is aimed at the epidemiological monitoring of the prevalence and circulation of resistant viral strains among HIV-positive specific populations. The authorities are therefore provided with the number or proportion of HIV-positive people in a given population whose HIV is resistant to particular anti-HIV drugs. The former activity for epidemiological purposes should therefore be coded under PC.10.02Serological-surveillance (HIV drug-resistance surveillance).
- *Dental programmes for people living with HIV* refers to odontological and related services performed on people living with HIV.
- *Psychological treatment and support service* refers to psychological ambulatory services for people living with HIV including the consultation and antidepressant drugs prescribed in the treatment; e.g. if the National AIDS Programme hires the psychologist to be available for provision of psychological support and treatment to any person with HIV it should be recorded under this AIDS program category. This category excludes all other psychological support services recorded under VCT activities (i.e.: in PC.03 Voluntary counselling and testing (VCT) and PC.05.03 Antiretroviral therapy).
- *Outpatient palliative care* refers to treatment that addresses pain and discomfort associated with HIV. This includes all basic health care and support activities, whether clinic-based, home-based or community-based activities for HIV-positive adults and children and their families aimed at optimizing quality of life for HIV-positive people and their families throughout the continuum of care by means of symptom diagnosis and relief, and culturally-appropriate end-of-life care. Clinic-based, home-based or community-based care and support activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV should be coded under Orphans and Vulnerable Children and the antiretroviral treatment coded under antiretroviral therapy.
- *Inpatient palliative care* refers to treatment that addresses pain and discomfort associated with HIV. This includes all inpatient basic health care and support activities aimed at optimizing quality of life for HIV-positive people throughout the continuum of care by means of symptom diagnosis and relief, and culturally-appropriate end-of-life care. Clinic-based inpatient activities for HIV-positive children within programmes for orphans and other vulnerable children affected by HIV should be coded under Orphans and Vulnerable Children and the antiretroviral treatment coded under antiretroviral therapy.

- *Traditional medicine and informal care and treatment services.* Traditional medicine refers to health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose, and prevent HIV or maintain well-being, e.g. traditional Chinese medicine, homeopathy, naturopathy, herbal medicine, and chiropractic methods. Complementary therapies are additional forms of treatment used as an adjunct to standard therapy, while alternative therapies are used instead of standard therapy. These services are usually delivered by alternative and informal providers and specifically include AIDS-related activities.
- *Patient transport and emergency rescue:* includes transport by ambulance and all other means of transport used for HIV patients undergoing treatment, and costs incurred by relatives travelling for the purpose of providing company and assistance to these patients.

PC.06 ORPHANS and VULNERABLE CHILDREN (OVC)/CHILDREN AFFECTED by AIDS (CABA)

An orphan is defined as a child aged under 18 who has lost one or both parents regardless of financial support (whether national AIDS programme-related or not). In the Resource Tracking Study context, all expenditures to substitute for the parents taking care of their children because they have died from HIV; expenditures incurred in providing social mitigation to all double orphans and half or single orphans need to be included. In this context, vulnerable children refer to those who are close to being orphans and who are not receiving support as orphans because at least one of their parents is alive, and at the same time their parents are too ill to take care of them.

All services aimed at improving the lives of orphans and other vulnerable children and families affected by HIV should be accounted. The "preventive health services for orphans and vulnerable children", duly identified under *PC.01 Prevention,* should not be counted twice. Palliative care, including basic health care and support and TB/HIV prevention, management, and treatment, in addition to the related laboratory services and pharmaceuticals, when delivered within programmes for orphans and other vulnerable children affected by HIV, should be coded in this class. Other health care associated with the continuum of HIV illness, including HIV/TB services, when delivered outside a programme for orphans and other vulnerable children affected by HIV, should be coded under the specific care programme. ART for children should be coded under *PC.05.04 Paediatric antiretroviral therapy.* The OVC component includes the following interventions and activities.

PC.06.01 OVC/CABA Education; Family/home support; and Community support.

- *Education* refers Primary school and secondary school (school fees, uniforms, books and supplies, special fees/assessments).
- *Family/home support* refers to in-kind support such as bednets, clothes and shoes, blankets and bedding, food (not an ART-related nutritional support), and other support. PC
- *Community support* refers to identification of OVC in the community, outreach for OVC, training and supporting full-time community workers, child care.
- *Social services and administrative costs* e.g. birth certificates and other administrative and institutional arrangements necessary for implementing OVC care. Child welfare, a term used to refer to a broad range of social programmes that contribute to the wellbeing of children should be coded under this category.
- *Institutional care* refers to integrated care provided in an institutional setting, including food (not an ART-related nutritional support), health care, education, clothes, shoes, bedding, psychosocial support and economic self-sufficiency, and all other services addressing the needs of orphaned children. These can be categorized as support services, supplementary programmes, or substitute care. Communal foster care is an integrated service provided by children's homes, orphanages, mission and boarding schools, workhouses, borstals, monasteries, and convents.

PC.06.02 OVC/CABA Basic health-care refers to basic child care services such as immunizations, routine health care, nutritional supplements (e.g. vitamins, proteins etc), sexual and reproductive health services for older children). The expenditures to be included under this code refer to those for any children who in principle should be provided for by the parents; in their absence, social protection programmes pay for their access to basic services. The health services here are not HIV-specific. ART for children should be coded under PC.05.03.

PC.06.98 OVC/CABA Services not broken down by intervention Services addressing the needs of and specifically targeting orphans and vulnerable children, for which the resource tracking team does not have available information to classify it into a specific two-digit PC.

PC.06.99 OVC/CABA Services not elsewhere classified (n.e.c). All other services addressing the needs of and specifically targeting orphans and vulnerable children, not listed above.

PC.07 PROGRAMME MANAGEMENT and ADMINISTRATION

Programme expenditures are defined as expenses incurred at administrative levels outside the point of health care delivery. Programme expenditures cover services such as management of AIDS programmes, monitoring and evaluation (M&E), advocacy, pre-service training, and facility upgrading through purchases of laboratory equipment and telecommunications. It also includes longer-term investment, such as health facility construction, which benefits the health system as a whole. It is important to note that when linking programme expenditure to people's access to treatment and prevention, only the share of investment that contributes to a HIV response and required to finance the services provided as part of the response to the HIV scourge be included. The programme management component includes the following interventions and activities:

PC.07.01 Planning, coordination, and programme management refers to expenditure incurred or budgeted amount at the administrative level outside the point of health care delivery, including the dissemination of strategic information, on best practice—programme efficiency and effectiveness, planning/evaluation of prevention, care, and treatment efforts; analysis and quality assurance of demographic and health data related to HIV, and the testing of implementation models even though these may be conducted in a delivery institution. Also included are coordination activities, for instance in support of the "Three Ones" principles: Coordination of a single approved AIDS action framework and support to build/strengthen one National AIDS Coordinating Authority. Also included are expenditures or budgeted amount related to the conduct of national AIDS strategic planning and of human resource planning (e.g. district level). The resource tracking for human resources under programme costs is different to the disbursements of human resources as reported for personnel providing prevention and treatment —PC.01, PC.02, PC.03, PC.04 and PC.05 - because they are offered as part of health care delivery services (e.g. salary of a doctor dedicated to PMTCT, which would be a component of PMTCT).

PC.07.02 Administration and transaction costs associated with managing and disbursing funds. Costs incurred or planned budget in managing programmes within the national response to HIV, providing routine and ad-hoc administrative supervision and technical assistance to the programme staff. Expenditures aimed at searching for and contracting a financing agent authorized to assume the purchasing function for a given AIDS program category, are also included under PC.07.02. This may be a multiple layer process, identified and monitored or external to the financing process proper. This item attempts to trace the costs of this procedure. This category records a sometimes multi-layered process by which the designer or primary designer of a HIV programme decides to entrust the running of a programme to an agent. Overheads related to the management of funds should be recorded here.

PC.07.03 Monitoring and evaluation and Operations research: The purpose of M&E is to provide the data required to: 1) guide the planning, coordination, and implementation of the HIV response; 2) assesses the effectiveness of the HIV response; and 3) identify areas for programme improvement. In addition, M&E data are required to ensure accountability to those affected by HIV, in addition to those providing financial resources for the HIV response. M&E therefore includes expenses or planned budget related to ascertaining the direction and ultimate achievement of measurement of programme progress, the provision of feedback for accountability and quality, and implementation of targeted programmatic evaluation, the implementation and upgrading of information management systems (e.g. other monitoring and health management information systems), the evaluation of prevention, care, and treatment efforts. Amount on M&E should include the salaries of the staff who implement M&E programmes. Budget/expenditures to conduct Resource Tracking Study should be included under this code.

Operations research refers to investments and expenses incurred in performing applied operations research aimed at improving the management, delivery, and quality of health services. An operations researcher faced with a new problem is expected to determine which techniques are most appropriate given the nature of the system, the goals for improvement, and constraints on time and computing power.

PC.07.98 Programme management and administration not broken down by type includes all programme expenditures for which the resource tracking team does not have available information to classify it into a specific PC.

PC.07.99 Programme management and administration not elsewhere classified (n.e.c) includes all other programme expenditures not listed above.

- *Drug supply systems* include the procurement processes, logistics, transportation, and supply of antiretroviral and other essential drugs for the care of people living with HIV. These expenditures aim to increase the capacity of logistics and drug supply systems, including staffing, development of administrative systems, and upgrading of transportation infrastructure. These activities involve support systems for pharmaceuticals, diagnostics, medical equipment, medical commodities, and supplies to provide care and treatment of people living with HIV and related infections. This includes the design, development, and implementation of improved systems for forecasting, procurement, storage, distribution, and performance monitoring of HIV pharmaceuticals, and of relevant commodities and supplies. This includes actual spending to improve ordering, procurement, shipment, and delivery of the full range of HIV-related pharmaceuticals, diagnostics, and other medical commodities. Antiretroviral drugs purchased and delivered, must be coded under PC.05.03 Antiretroviral therapy.
- *Information technology.* Implementation and upgrades of information systems, software, and hardware integrated in information networks to manage HIV-related information.
- *Patient tracking.* The activities and resources to provide adherence support or treatment preparedness require to be accounted explicitly. Including resources and personnel working in the field on supervision activities or direct tracking of patients ensuring compliance with and preparation of treatment. These activities need to be accounted explicitly for HIV patients and special populations (e.g. IDUs). Salaries for the personnel required to provide treatment and care services are covered to some extent in PC.05 Care and Treatment (e.g. community health workers) and the human resource component in PC.08.01 Monetary incentives.
- *Upgrading and construction of infrastructure* deals with investments, purchases, and expenses on the construction, renovation, leasing, procurement (equipment, supplies, furniture, and vehicles), overheads and/or installation for the implementation of HIV programmes. They include capital investments for building infrastructure that provide HIV services. The programme investments include high fixed start-up costs (e.g. buying computers and e-mail connectivity), specifically activities for clinical monitoring and for the purchase of new equipment. Also included are development and strengthening of laboratory facilities to support HIV-related activities including purchase of equipment and commodities, provision of quality assurance, staff training, and other technical assistance.
    - *Upgrading laboratory infrastructure and new laboratory equipment*
    - *Construction of new health centres* includes investment in new facilities to handle the prevention, treatment, and care of people living with HIV.
- *Mandatory HIV testing (not VCT).* In some countries HIV testing is being performed on a mandatory basis as a part of the employment policy or visa requirements. Although UNAIDS does not recommend mandatory testing as part of prevention or care and treatment strategies, some countries spent significant funds on this intervention.

PC.08 HUMAN RESOURCES

This category refers to services of the workforce through approaches for training, recruitment, retention, deployment, and rewarding of quality performance of health care workers and managers for work in the HIV field. The HIV workforce is not limited to the health system. Included in this category is the direct payment of wage benefits for health care workers. These expenditures are aimed at ensuring the availability of human resources from what is currently available in the health sector. They only aim therefore at including the additional incentives for this purpose. The direct cost associated with human resources is included in the costs of each of the other spending categories.

For example, the human resources are accounted for within the unitary costs of prevention and treatment interventions — *PC.01 Prevention* and *PC.05 Care and treatment* — and, where it concerns human resources required outside the point of care delivery, they are included in the programme costs as well — PC.07 (Programme Management).

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

PC.08.01 Monetary incentives for human resources.

- *Monetary incentives for physicians.* Wage benefits for doctors incorporated into the total remuneration package as a way of attracting and retaining human resources for health (prevention; care and treatment; and programme management and administration).
- *Monetary incentives for nurses.* Wage benefits for nurses incorporated into the total remuneration package as a way of attracting and retaining human resources for health (prevention; care and treatment; and programme management and administration).
- *Monetary incentives for other staff.* Wage benefits for laboratory personnel, and other staff associated with delivering HIV-related services (prevention; care and treatment; and programme management and administration). Strengthening the cadres of community health workers is also covered. This should include the costs for health workers, social workers, especially nurse practitioners, clinical officers, and laboratory technicians.
- *Monetary incentives for human resources not broken down by staff* includes all incentive programmes for human resources expenditures for which the resource tracking team does not have available information to classify it into a specific PC.

PC.08.02 Training and capacity building. Pre-service training sessions for all the appropriate professionals and para-professionals, both health and non-health. This includes continuing education delivered through various means, organized specifically for this purpose, such as workshops. Support for building specific skill areas should also be included here, for example, strengthening interpersonal communication, improving laboratory skills, and nutritional education for people living with HIV and their families. This category excludes in-service "learning-by-doing" training and mentoring, which is considered a part of the related service e.g. in-service (when a social worker or a nurse shows family members which particular actions should be performed in terms of care inside the family) training for relatives to carry out home-based care for their family members should be counted. *PC*This category also excludes training for teachers to build their capacity to provide HIV-related information as a part of school programme (tracked under *PC.01.02 Prevention - Youth),* and training for peer educators on HIV prevention (tracked under *PC.01.01 Communication for social and behaviour change and Community mobilization)* - to be consistent with the Resource Needs Model.

- *Formative education to build up an AIDS workforce* includes the provision of education for additional nurses and physicians who will be required in the future. Activities to strengthen or expand pre-service education, such as curriculum development or faculty training, are also coded under this category.

PC.08.98 Human resources not broken down by type includes all human resources expenditures for which the resource tracking team does not have available information to classify it into a specific PC.

PC.08.99 Human resources not elsewhere classified (n.e.c) includes all other human resources expenditures not listed above.

PC.09 ENABLING ENVIRONMENT

PC.09.01. Advocacy - Advocacy in the field of HIV includes a full set of services that generate an increased and wider range of support of the key principles and essential actions to promote HIV prevention and reduce stigma and discrimination. It also includes the promotion of the scaling-up of national, regional HIV programmes by national governments with key partners, such as bilateral and multilateral donors, civil society, and the private sector.
Also included are promotion and support of the development of a strong HIV constituency at the regional and country level, among civil society, including: community groups, policymakers, opinion leaders, leaders of faith-based organizations, women's groups, youth leaders, and people living with HIV to strengthen their capacity to advocate for effective HIV prevention, care, and social support. Spending on all advocacy efforts to enhance the national response to HIV. Expenditures related to strategic communication (e.g. distribution of strategic information) and policy development should be recorded under *PC.07.01. Planning, management and programme coordination.*

PC.09.02. Human rights programmes cover all the activities and resources invested for the protection of human rights, legislative aspects of a broad number of areas of social life, such as employment and discrimination, education, liberty, association, movement, expression, privacy, legal counselling and services, efforts to overcome discrimination and improve accessibility to social and health services. Advocacy for human rights should be coded as *PC.09.01 Advocacy.*

- *Human rights programmes empowering individuals to claim their rights* by providing knowledge and understanding of their rights and responsibilities under human rights and/or domestic legal systems, including dissemination of information and materials relating to human rights. This includes general human rights programmes aimed at the general population in generalized and concentrated epidemics. This category includes specific stand-alone programmes that aim to empower and enable members of vulnerable groups to participate meaningfully in decision-making processes. When human rights consultation is a part of Behaviour Change Communication (BCC) for specific most-at-risk or other key and vulnerable populations these expenditures should be included in the respective categories in Prevention.
- *Provision of legal services and advice to promote access to prevention, care, and treatment:* includes cost of legal consultancy, legal representation of the individuals in court and related expenditures.
- *Capacity building in human rights* includes but is not limited to the specific activities targeting national human rights institutions, ombudsmen or other independent bodies aimed at strengthening the protection against human rights violations that are HIV-related or increase vulnerability to HIV.
- *AIDS-specific programmes focused on women.* Programmes targeting women and girls, in addition to those explicitly included in the spending categories described above, for instance improved reproductive health activities, assistance, and counselling addressing abused women and programmes to protect the property and inheritance rights of women and girls.
- *Programmes to reduce gender-based violence.* Programmes to reduce violence against women. Also known as violence against women (VAW), this is a major public health and human rights problem throughout the world. VAW has implications for HIV transmission and is often ignored. Expenditures for the response to sexual violence include the design of social and health policies, all the services that provide comprehensive, sensitive, and quality care to victims of sexual violence. The expenditures cover several areas: assistance and counseling addressing abused women, promotion, and policy measures that will support the provision of comprehensive and ethical services to people who have experienced sexual violence; activities of police departments, health services, prosecutors, social welfare agencies, and nongovernmental service providers, such as rape crisis centres.

PC.09.03 Institutional development. This refers to investment in capacity building of non-governmental organizations (including faith-based organizations). It includes strengthening the ability of key local institutions to implement HIV programmes efficiently with diminishing reliance, over time, on external technical assistance. This includes services that improve the financial management, human resource management, quality assurance, strategic planning, and leadership and coordination of partner organizations. Expenditures on the institutional development of nation-wide organizations, e.g. National AIDS Coordinating Authority, are recorded under PC.07.01. Planning, coordination and programme management.

PC.09.98 Enabling environment activities not broken down by type includes environmental and community enablement programmes for which the resource tracking team does not have available information to classify it into a specific two-digit PC.

PC.09.99 Enabling environment activities not elsewhere classified (n.e.c.) includes all other environmental and community enablement programmes not included in the above classes.

PC.10 HIV-RELATED RESEARCH (excluding operations research)

HIV-related research is defined as the 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. It covers researchers and professionals engaged in the conception or creation of new knowledge, products, processes, methods, and systems for HIV and in the management of the programmes concerned with HIV and AIDS. Managers and administrators should be included when they spend at least 10 of their time supporting research activities. Researchers include postgraduate students but do not include technicians. Technicians and equivalent staff are people whose main tasks require technical knowledge and experience. They participate in R&D by performing scientific and technical tasks involving the application of concepts and operational methods, normally under the supervision of researchers. This category excludes operations research on health systems aimed to improve health outcomes, including project or programme evaluation, which should be coded under PC.07.03.

Research — with the exception of operations research—is not directly linked to the provision of services, and therefore, might be considered to be a satellite component of the expanded response to HIV. Care should be taken to correctly classify research activities properly and not to include other activities frequently confused with research, such as population studies for epidemiological surveillance, or monitoring and evaluation of the programmes. The following activities are included when directly related to HIV

PC.10.01 HIV-related research activities

- *Biomedical research,* which comprises the study of detection, cause, treatment, and rehabilitation of persons with specific diseases or conditions, the design of methods, drugs, and devices to address these health problems, and scientific investigations in areas such as the cellular and molecular bases of disease, genetics, and immunology.
- *Clinical research,* which is based on the observation and treatment of patients or volunteers.
- *Epidemiological research,* which is concerned with the study and control of diseases and exposures and other situations suspected of being harmful to health: care should be taken to exclude epidemiological surveillance.
- *Social science research,* which investigates the broad social aspects of HIV.
    - *Behavioural research,* which is associated with risk factors for ill health and disease with a view to promoting health and preventing disease. Care should be taken to exclude epidemiological surveillance as well as evaluation of preventive interventions.
    - *Research in economics,* which investigates a wide range of economic aspects of HIV and the AIDS epidemic.
- *Vaccine-related research.* Specific activities aimed to support basic, laboratory, clinical, and field-related research for developing and testing a HIV vaccine.

PC.10.02 Serological-surveillance (serosurveillance),

This category includes expenditure on registry, processing of information to be used to document the incidence, and specific prevalence of the epidemic in the general population as well as in specific populations. Also included are sentinel studies, mandatory reporting of cases, and epidemiological analysis. Surveillance implies ongoing and systematic collection, analysis, and interpretation of data on a disease or health condition. Collecting blood samples for the purpose of surveillance is called serosurveillance. Built upon a country's existing data collection system, second-generation HIV surveillance systems are designed to be adapted and modified to meet the specific needs of differing epidemics. For example, HIV surveillance in a country with a predominantly heterosexual epidemic will differ radically from surveillance in a country where HIV infection is mostly found among MSM or IDUs. Surveillance for drug resistance is to be recorded under *PC.04.06 HIV drug-resistance surveillance.* The surveillance programmes aim to improve the quality and diversity of information sources by developing and implementing standard and rigorous study protocols, using appropriate methods and tools.

- *HIV drug-resistance surveillance* includes the setting up of sentinel sites, laboratory operations, materials and goods, and the integration and support for the activities of a National HIV-Drug Resistance Committee. HIV drug resistance surveillance is aimed at the epidemiological monitoring of the prevalence and to determine the circulation of resistant viral strains among specific HIV-positive populations. This provides the number or proportion of HIV positive people in a given population whose HIV is resistant to particular anti-HIV drugs. The genotypic antiretroviral resistance test (GART) determines whether a particular strain of HIV has specific genetic mutations associated with drug resistance. The test analyses a sample of the virus from an individual's blood to identify any genetic mutations associated with resistance to specific drugs. The phenotypic assay is different from a genotypic assay; it uses an indirect method, and determines by a direct experiment whether a particular strain of HIV is resistant to anti-HIV drugs.

PC.10.98 HIV-related research activities not broken down by intervention includes HIV-related research programmes for which the resource tracking team does not have available information to classify it into a specific two-digit PC.

PC.10.99 HIV-related research activities not elsewhere classified (n.e.c.) includes all other HIV-related research programmes not included in the above classes.

PC.11 OTHER NOT CLASSIFIED ELSEWHERE (N.E.C.)

Includes all other HIV-related programmes not included in the above program categorises.

- *Social Protection and Social Services:* Social protection usually refers to functions of government or nongovernmental organizations relating to the provision of cash benefits and benefits-in-kind to categories of individuals defined by requirements such as sickness, old age, disability, unemployment, social exclusion, etc. Social protection comprises personal social services and social security. It includes expenditures on services and transfers provided not only to individual people but also to households, in addition to expenditures on services provided on a collective basis.
  - *Social protection through monetary benefits* refers to conditional or unconditional financial support, such as grants and cash transfers (including child social assistance grants, foster care grants, disability grants, "medical pensions", early retirement and disability benefits for people living with HIV, or family members). Cash transfers and grants aim to reduce poverty by making welfare programs conditional or unconditional upon the receivers' actions. Cash transfers and grants provide money directly to poor families via a "social contract" with the beneficiaries — for example, sending children to school regularly or bringing them to health centres. For extremely poor families, cash provides emergency assistance, while the conditionalities promote longer-term investments in human capital.
  - *Social protection through in-kind benefits* refers to food security, food parcels (not associated with ART nutritional support), clothing, school fee rebates, books, transport and food vouchers, and other in-kind support for HIV-positive people.
  - *Social protection through provision of social services* refers to the development of activities aimed at social mitigation for people living with HIV and their families including funeral expenses, burial society fees, day care services, and transportation for patients.
  - *HIV-specific income generation* relates to projects and efforts to develop public work programmes, skills development, sheltered employment, livelihood, micro-credit, and financing. Small grants for business activities for people living with HIV are also included.
  - *Social protection services and social services not elsewhere classified (n.e.c.)* includes all other direct financial support and social assistance to families affected by HIV that comprises a social protection aspect not included above.

Annex 3: List of key agencies/organizations

S.No	Organization	Address
1.	NCASC	Teku, Kathmandu
2.	UNDP (Program Management Unit)	UN House, Pulchowk, Lalitpur
3.	WHO	UN House, Pulchowk, Lalitpur
4.	UNICEF	UN House, Pulchowk, Lalitpur
5.	FPAN/IPPF	Pulchowk, Lalitpur
6.	FPAN/Global Funds	Pulchowk, Lalitpur
7.	Save the Children	Bagdarbar, Sundhara, Kathmandu
8.	UNODC	Pulchowk, Lalitpur
9.	NAP+N	Bansbari, Kathmandu
10.	DFID	Ekantakuna, Lalitpur
11.	USAID/FHI	Baluwatar, Kathmandu
12.	USAID/AED	Baluwatar, Kathmandu
13.	USAID/CRS	Tokha, Kathmandu
14.	USAID/NFHP	Teku, Kathmandu
15.	ILO	Dhobighat, Lalitpur
16.	UNFPA	Sanepa, Lalitpur
17.	JICA	Pulchowk, Lalitpur
18.	GTZ	Teku, Kathmandu
19.	BDS	Lazimpat, Kathmandu
20.	World Bank	Durbar Marg, Kathmandu
21.	CARE Nepal	Pulchowk, Lalitpur
22.	AusAID	Bansbari, Kathmandu

Annex 4: Minutes of consultation meeting

Venue : HSCB Conference Hall
Date : May 21, 2010
Time : 10:00 am - 12:00 pm

1. Key donors to be focused first
   - Considering the available time for the study and wise use of resources, first focus on key donors providing major chunk of fund in HIV/ADIS sectors. If time permit consider collecting information from other sources also. Major sources include USAID, DFID, GFATM, CARE, GON, UNDP, HIV/AIDS TB Centre and BDS.
   - Social Welfare Council will be a potential source for the information
2. Program categories to be standardized
   - In order to have the standard program category, the study team could take the reference of i) NASA categories ii) International accounting system iii) GFATM category.
   - Develop standard coding or operational definition of program categories so that all the stakeholders have similar understanding
   - Consider how to include the funds supported for education for Children Affected by AIDS (CABA)
   - Make the tool somewhat flexible so that the major program categories adopted by key donors are captured
   - Concerned organization will be responsible for charging the percentage of resources if the time of a person is shared to different program categories. For example a person working for IEC, institutional strengthening, research and management, the concerned organization will be the best to segregate the proportion of budget. However, this should be consistent in all cycle of reporting.
3. Allocated fund and expenditure
   - Get information on expenditures for last one years (2009)
   - Collect information on proposed funding for three years 2010-2012
4. Tools to be modified
   - Instead of fund allotted, write fund proposed
   - Instead of Year I, II, III; specify year 2009, 2010, 2011, 2012
   - Collect data from HQ/central but segregated on a district wise

Next steps
- Incorporate the comments received on tool and finalize
- Circulate to all key donors for the reference.
- Individual donors to inform respective departments to provide information
- Study team to visit to individual organization from next week to collect information

Annex 5: Data collection Tools

Annex 6: List of Contributors

Name	*Organization*
Mr. Peter Oyloe	AED
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Mr. Yamnath Yogi	CARE Nepal
Mr. Darinji Sherpa	CARE Nepal
Mr. Kabindra Subba	DFID
Mr. Satish Raj Pandey	FHI/USAID
Mr. Prabesh Aryal	FHI/USAID
Mr. K.B. Bista	FPAN
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Ms. Sandra Rosenhouse	World Bank
Dr. Min Thwe	WHO
Dr. Atul Dahal	WHO

Annex 7: Terms of Reference (TOR)

Terms of References

Study to track the inflow/coverage/sustainability of resources for the HIV/AIDS programme in Nepal

Background and Rationale

As of 2007, National Centre for AIDS and STD Control (NCASC) estimates that approximately 70,000 adults and children are infected with HIV with an estimated prevalence of 0.49 in adults (15-49 years). The groups who are at risk of HIV in Nepal are IDUs, MSMs, and FSWs including the labour migrants migrating to high risk regions (particularly in India).

Most resources available to support HIV/AIDS programming in Nepal come from a variety of External Partners. And, most interventions for prevention forthe most-at risk populations (FSW, IDU, MSM) are not implemented by government (NCASC or HSCB) but rather through some strong I/NGOs like FHI, Save Children. .

As the commission on AIDS in Asia has rightly pointed out, although funding for HIV/AIDS in most Asian countries has increased, funds are not allocated to the most effective interventions. Evidence has long shown that focusing resources on interventions targeting MARPs in a concentrated epidemic like Nepal's is the most cost effective utilisation of available resources.

As mentioned in the preceding paragraph, there is a multiplicity of donors each financing their own vertically structured prevention programme among MARPs, implemented through NGOs, INGOs and CBOs . There is no system to coordinate and harmonize the inflow of resources aimed at prevention amongst MARPs. Recent economic recession and failure of Nepal's proposal to successfully make it to Global Fund RD 9 application coupled with a gradual reduction in donor support to HIV programming in Nepal has further complicated the situation. Because of a lack of a database to clearly reflect the coverage of donor supported programmes and their end date of their support there is no mechanism to ensure the continuity of ongoing preventive programmes.

The proposed study plans to enable government of Nepal MoHP, national Programme management entity namely HSCB and NCASC to track the influx of resources from various resources to HIV Programme and assess the gap to meet the target coverage and their sustainability. The study will also help in decision making about prioritisation of World Bank resources in the country.

Objective

The purpose of the proposed study is to obtain a "mapping" of available resources to complement the geographic prioritisation (geographic mapping/size estimation of most at risk populations being conducted in approximately 40 Districts), allowing an assessment of the need/demand for services and their supply. This exercise will also help in strengthening the 'Three ONES' principles by providing a common roadmap indicating resources available, identify gaps and help country undertake development/revision of national strategic plan, along with information derived from the geographic prioritization study.

Methodology

- List all sources of financing for HIV-AIDS in Nepal including multilaterals, bilaterals, INGOs, NGOs and government resources with an ultimate objective to build a resource mapping data base.
- Identify, for each source of financing, the implementing entities, the amount and the duration of the financing period.
- Instead of just focusing on total allocations by different agents, the data should be disaggregated to provide better understanding of programming outlay as well. The broad suggested categories can be (1) Prevention: General Population and MARPs (IDU, MSM, FSW) specifically, 2) Care support and Treatment 3) institutional strengthening 4) Monitoring Evaluation and Research. This data set should be disaggregated by geographic coverage (district- wise), and take into account the duration of the financing.
- Throughout the process validate the data sets through multiple sources in consultation with key stakeholders.

Deliverables

A consultant/agency is required to deliver the follows:

- A study that maps inflow of resources from various sources: multilateral, bilateral, INGOs, Government, private sectors and others-into HIV/AIDS programme in Nepal. The study should also indicate the implementing entity (e.g. UNDP implements but DfID finances). To ensure no double financing, even the direct implementer... e.g. the NGO contracted by UNDP...should be identified.
- A database that can be used by government of Nepal in future to manage and harmonise available resources in the country and plan for its optimum utilisation will be developed.
- The consultants should develop an easy-to-use interface to access the information and so it can be easily updated.
- The dissemination, consultation/workshop with government of Nepal and various stakeholders to share the info, about the study and how it can be utilised by various players in the country.

Annex 8: Expenditure by program and districts

Year: 2009

District Name	PC.01 - Prevention	PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	PC.03 - Voluntary counselling and testing (VCT)	PC.04 - Prevention of mother-to-child transmission (PMTCT)	PC.05 - Care and Treatment	PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	Total Amount
National/Head Quarter			125								11,378,442
Aacham	137,735		19,644	20,893	33,313						349,783
Arghakhanchi			756								4,666
Baglung	178,959		19,644		9,898	16,323					36,131
Baitadi			125								5,061
Bajhang			742								37,352
Bajura	4,208		742								51,670
Banke	48,000		125								192,991
Bara	2,681,181	112,986	552,990	54,748	577,203	58,656	4,577,129	160,916	1,977,154	625,479	84,353
Bardiya	14,603		742								107,700
Bhaktapur	174,442		51,520	1,081	19,285				4,897		111,154
Chitawan	45,799		9,804		12,191						164,976
Dadeldhura	59,864		12,340		4,800						125,094
Dailekh	273,386		96,806		29,297						47,777
Dang	11,196				2,027						95,729
Darchula	42,298		125								28,446
Dhading	45,403		742		1,632						756
Dhankuta	28,321		125								4,652
Dhanusha	67,298		12,913		2,517				5,646		159,469
Dolakha	194,597		17,161		67,631	70,395					125
Dolpa	282,639		28,707		51,056		34,363				39,806
Doti	4,208		458								262,771
Gorkha	83,054		18,553		6,093						742
Gulmi	246,628		27,701		19,167				1,542		77,275
Humla	2,105,154		72,763		247,463	44,222		18,865	110,600	12,830	47,820
Ilam	39,806										9,270
Jajarkot	62,119										42,423
Jhapa	75,301				2,041				1,776		224,824
Jumla	86,872		16,188		8,094						742
Kailali	64,258		742		120	30,577					396,764
Kalikot	62,312		19,852		7,857				1,578		62,119
Kanchanpur	251,855		16,414		6,139	9,630					193,576
Kapilbastu			125								95,910

District Name	PC.01 - Prevention	PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	PC.03 - Voluntary counselling and testing (VCT)	PC.04 - Prevention of mother-to-child transmission (PMTCT)	PC.05 - Care and Treatment	PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	Total Amount
Kaski	18,860		458		1,141						399,48
Kathmandu			742								2,611,89
Kavrepalanchowk			125								126,52
Lalitpur	34,327				13,568						360,50
Lamjung	128,874		19,644	1,081	9,870						4,95
Mahotari	14,295		756								91,59
Makwanpur			125								138,22
Manang	4,208		458								12
Morang	27,717		125								295,03
Mugu	63,657		16,872		4,104	9,630			1,647		47,20
Myagdi	118,567			1,081	2,041	37,447			5,840		74
Nawalparasi			742								80,37
Nuwakot			742								15,05
Okhaldhunga	34,110				2,022						12
Palpa	182,550		11,965		33,894		34,363				13,22
Panchthar	4,194		742		125						12
Parbat	54,229		11,599		11,447						15,34
Parsa	152,068		32,525		7,857				3,189		251,22
Pyuthan			125								77,00
Ramechhap	36,893		458								12
Rasuwa	51,212		458								12
Rautahat	74,071		458						5,840		88,37
Rolpa	106,467		22,185		4,438				5,131		67,79
Rukum	315,245		19,868		5,676				19,714		48,12
Rupandehi			756								284,03
Salyan	169,951		10,802		12,824						46,69
Sankhuwasabha	57,092		20,612		2,345				4,303		45
Saptari	47,202										79,11
Sarlahi	46,574		125								195,63
Sindhuli	4,194		458								4,66
Sindhupalchowk	92,062				2,022				1,646		75
Siraha	8,812		458								27,84
Sunsari			458								211,58
Surkhet	125,664		756		104						47,89
Syangja			125								95,69
Tanahu	47,695		125								20,45
Terhathum	88,412		742				34,363		1,578		74
Udaypur	138,390		18,009		35,962				631		12
Total Amount	**9,619,081**	**112,986**	**1,193,277**	**78,884**	**1,257,258**	**276,880**	**4,680,217**	**179,781**	**2,152,711**	**638,309**	**20,189,38**

Year: 2010

District	PC.01 - Prevention	PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	PC.03 - Voluntary counselling and testing (VCT)	PC.04 - Prevention of mother-to-child transmission (PMTCT)	PC.05 - Care and Treatment	PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	PC.11 - Other program budgeted category (PBC) not classified elsewhere	Total Amount
National/Head Quarter	3,793,011	24,939	835,979	162,153	636,866	284,466	3,724,604	633,859	1,595,389	233,036	33,000	11,957,302
Aacham	151,143		30,134		94,643		69,178			2,603		347,701
Arghakhanchi	2,998		542									3,540
Baglung	32,412				2,031							34,443
Baitadi	3,012		519		1,208							4,740
Bajhang	3,012		542									3,554
Bajura	36,352		542									36,894
Banke	105,178		17,345		47,065				178			169,766
Bara	74,729		14,533		3,637				3,590			96,488
Bardiya	106,933		17,835		6,333							131,101
Bhaktapur	37,188		18,030		4,507							59,725
Chitawan	120,971				2,040				6,718			129,729
Dadeldhura	71,480		533	7,143			50,969					130,124
Dailekh	3,012		519		1,479							5,010
Dang	95,417			7,143	2,031							104,591
Darchula	28,432		542									28,974
Dhading			519									519
Dhankuta	2,540		542									3,082
Dhanusha	82,238		19,809		9,992							112,039
Dolakha			542									542
Dolpa	29,223											29,223
Doti	75,648		13,001		51,282		50,969					190,899
Gorkha			533									533
Gulmi	47,491		13,929		18,213							79,633
Humla	29,428		542									29,970
Ilam	8,087		542									8,628
Jajarkot	29,616		542									30,158
Jhapa	139,244		19,809		9,964	20,457						189,474
Jumla			533									533
Kailali	228,456		38,695		66,688		50,969					384,808
Kalikot	32,028											32,028
Kanchanpur	129,096		21,487		23,532		69,178					243,293
Kapilbastu	62,076		16,981		4,110	11,018						94,184
Kaski	234,500		86,583		25,407							346,490
Kathmandu	1,053,766		42,847		236,084	12,987			100,590			1,446,274
Kavrepalanchowk	119,280		519		618							120,418
Lalitpur	133,109		24,543		7,012				30,599			195,263
Lamjung	2,998		533									3,531

District	PC.01 - Prevention	PC.02 - Prevention, diagnosis, and treatment of sexually transmitted infections (STI)	PC.03 - Voluntary counselling and testing (VCT)	PC.04 - Prevention of mother-to-child transmission (PMTCT)	PC.05 - Care and Treatment	PC.06 - Orphans and vulnerable children (OVC)/Children affected by AIDS (CABA)	PC.07 - Programme management and administration	PC.08 - Human resources	PC.09 - Enabling Environment	PC.10 - HIV-related research (excluding operations research)	PC.11 - Other program budgeted category (PBC) not classified elsewhere	Total Amount
Mahotari	73,326		20,601		7,924							101,851
Makwanpur	83,077		22,085		6,173				3,788			115,123
Manang			542									542
Morang	183,269		29,234		27,210				833			240,546
Mugu	36,092											36,092
Myagdi			519									519
Nawalparasi	50,824		542						6,718			58,084
Nuwakot	16,293		519									16,812
Okhaldhunga			542									542
Palpa	6,385				2,054							8,439
Panchthar			542									542
Parbat			533									533
Parsa	188,919		79,398		29,200				3,617			301,134
Pyuthan	49,914		16,073		5,220							71,207
Ramechhap			542									542
Rasuwa			542									542
Rautahat	59,666		274		2,754				292			62,986
Rolpa	45,198		12,984		18,392							76,574
Rukum	27,143		542									27,684
Rupandehi	122,626		16,439		6,141	11,018						156,224
Salyan	28,979		542									29,520
Sankhuwasabha			542									542
Saptari	42,586				2,040							44,626
Sarlahi	146,886		20,351		7,924							175,161
Sindhuli	2,998		542									3,540
Sindhupalchowk			519									519
Siraha	14,651		542									15,192
Sunsari	151,946		19,809		30,409							202,164
Surkhet	31,894				23,424							55,318
Syangja	58,417		533		616							59,567
Tanahu	16,414		542		1,970							18,926
Terhathum			519									519
Udaypur			542									542
Total Amount	**8,541,610**	**24,939**	**1,488,052**	**176,439**	**1,426,196**	**339,946**	**4,015,865**	**633,859**	**1,752,312**	**235,639**	**33,000**	**18,667,857**

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